



**REPORT OF THE
UN ASIA - PACIFIC REGIONAL TASK FORCE ON
PREVENTION OF
MOTHER-TO-CHILD
TRANSMISSION OF HIV**

MARCH 2005, MUMBAI, INDIA

**CONVENED BY:
UNICEF REGIONAL OFFICE FOR SOUTH ASIA (ROSA) &
UNICEF EAST ASIA AND PACIFIC REGIONAL OFFICE (EAPRO)**



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Mother and a child in Maldives

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A baby from rural area in India

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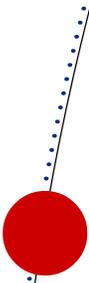
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List of Abbreviations

ANC	Ante-Natal Care
ART	Anti-retroviral Treatment
ARV	Anti-retroviral
AZT	Zidovudine
BCC	Behaviour Change Communication
CDC	Centers for Disease Control
CST	Care, Support and Treatment
CSW	Commercial Sex Worker
EAPRO	East Asia and Pacific Regional Office (UNICEF)
EFV	Efavirenz
FBO	Faith Based Organization
FHI	Family Health International
FP	Family Planning
FSW	Female Sex Worker
GFATM	Global Fund to fight AIDS, TB and Malaria
IATT	Inter-Agency Task Team
IDU	Injecting Drug User/Use
IEC	Information, Education and Communication
IYCF	Infant and Young Child Feeding
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MOH	Ministry of Health
MSM	Men who have sex with men
NACO	National AIDS Control Organization
NAP	National AIDS Programme
NCASC	National Centre for AIDS and STD Control
NGO	Non Governmental Organisation
NNRTIs	Non Nucleoside Reverse Transcriptase Inhibitors
NRTIs	Nucleoside Reverse Transcriptase Inhibitors
NVP	Nevirapine
OI	Opportunistic Infections
OPD	Out Patient Department
OVC	Orphans and Vulnerable Children
PCP	Pneumocystis Carinii Pneumonia



PEP	Post Exposure Prophylaxis
PHC	Primary Health Care
PHIMS	Perinatal HIV Intervention Monitoring System
PLWHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother-to-Child Transmission
PNC	Post-Natal Care
PPTCT	Prevention of Parent-to-Child Transmission
RH	Reproductive Health
RHC	Rural Health Center
RCH	Reproductive and Child Health
ROSA	Regional Office for South Asia (UNICEF)
SACS	State AIDS Control Society (India)
SRHC	Sub-Rural Health Center
STI	Sexually Transmitted Infection
TB	Tuberculosis
TFV	Tenofovir
TRIPS	Trade Related aspects of Intellectual Property rights
UNGASS	United Nation General Assembly Special Session on AIDS
UNICEF	United Nations Children Fund
UNFPA	United Nations Population Fund
UNAIDS	Joint United Nations Programme on AIDS
VCT	Voluntary and Confidential Counseling and Testing (also used as VCCT)
WFP	World Food Programme
WHO	World Health Organization



Executive Summary and Recommendations

The fifth meeting of the UN Asia-Pacific Regional Task Force on Prevention of Mother-to-Child Transmission of HIV met from 8th to 11th March 2005 in Mumbai, India.

Delegations from 15 countries, made up of government, non-government and UN agency staff, along with regional and headquarters technical staff from UNICEF, UNFPA, WHO and WFP participated in the meeting. The 15 countries represented were: Afghanistan, Bangladesh, Cambodia, China, Fiji, India, Indonesia, Lao PDR, Maldives, Myanmar, Nepal, Pakistan, Papua New Guinea, Thailand and Vietnam.

Convened by the UNICEF Regional Offices for South Asia (ROSA) and for East Asia & the Pacific (EAPRO) under the UNAIDS umbrella, the meeting aimed to strengthen understanding and accelerate action on the four-pronged comprehensive approach to PMTCT through:

- Reviewing experiences, opportunities and best practices in countries of implementing the four prongs of PMTCT
- Updating participants on the latest science on PMTCT
- Recommending strategies and concrete activities for accelerating scale up
- Discussing the possibilities to adapt country strategies in line with the meeting recommendations

During the meeting presentations by invited experts/resource persons were made linked to each of the four prongs as well as the important issue of monitoring and evaluation. These, mixed with country presentations, group work and field visits to local PPTCT programmes guided the participants through technical updates and programmatic discussions on the four pronged approach to PMTCT of HIV. In addition, an emphasis was placed on the supply chain management as well as procurement of HIV/AIDS commodities linked to PMTCT.

The major conclusions and recommendations of the meeting were:

1. Vertical transmission has been the primary focus on PMTCT

Despite some progress since the last meeting, the major emphasis on PMTCT in nearly all countries represented was on the vertical transmission (prong 3) and increasingly on prong 4 (care & support).

2. Increased action on primary prevention is required (prongs 1 & 2)

Most countries indicated a need to strategically revisit their programme goals, targets and strategies based on a comprehensive four prong approach and analysis of the status and driving factors of the epidemic(s) in their



country (at national and sub-national levels). A set of key interventions for primary prevention linked to PMTCT were identified during the meeting including:

- Information and communication through multiple channels (interpersonal, media, etc) on HIV/AIDS prevention.
- Couple counselling and testing (pre-test, post-test, preventive counselling)
- STI prevention and treatment
- Condom promotion
- Referrals to and from PMTCT services
- Couple counselling on family planning
- Promotion of dual protection

3. **Scaling up PMTCT – different emphasis in different country settings**

Based on the four prong approach (comprehensive PMTCT approach), the meeting recommended in general for scaling up PMTCT that settings with HIV prevalence <1% should focus on primary prevention (prong 1) and prevention of unintended pregnancies among HIV-positive women (prong 2) for scale-up; prevalence >1% on prongs 1-4. It was noted that there was a need for targeted comprehensive PMTCT in all countries, linked to geographical locations and high risk behaviours.

4. **PMTCT as an entry point for targeting HIV prevention to women of reproductive age**

The large majority of women of reproductive age in Asia and the Pacific (over 99%) are HIV-negative and their primary need is to be helped to remain negative. PMTCT offers a unique opportunity to provide women with HIV prevention information and services as for some of these women pregnancy

might be the only point of contact with the health system.

5. **Reaching the UNGASS PMTCT target**

In the Asia and Pacific regions only Thailand and Malaysia are expected to reach the UNGASS 2005 PMTCT target and hence other countries should accelerate action for a phased scaling up/ rolling out of PMTCT.

6. **Challenges**

The major challenges to implementing comprehensive PMTCT at scale in many countries in the region have not changed since the previous meeting. One overarching challenge remains the very limited integration into the MCH/RCH systems and structures. Other key challenges continue to include:

- pervasive stigma and discrimination at all levels, from community to health workers
- limited community mobilisation
- lack of involvement of male partners in all elements of PMTCT
- inadequate attention to HIV and infant feeding
- low utilization of MCH/ANC service
- inadequate resources (financial and human)
- inadequate planning of scaled up PMTCT interventions

7. **Using PMTCT to strengthen MCH/ANC service quality**

The challenge of very low utilisation rates of ANC services presents an opportunity for using commitment and resources for PMTCT for improving ANC service quality. At the same time it is acknowledged that taking a comprehensive four-prong approach to PMTCT requires moving beyond ANC settings to the communities in order to reach those who do not have access to MCH services.



8. Routine VCT

Routine VCT (sometimes referred to as “routine testing”) at ANC is a recommended VCT testing method since it puts less strain on human resources and has a higher service uptake by clients. Routine VCT means that after group counselling at ANC, pregnant women have the option to opt out of the routinely offered HIV test. Post test counselling is provided. Routine testing is not mandatory testing.

9. Resources

Human, financial and organizational resources presently focussing on prong 3 and 4 should be reassessed and increasingly made available for prong 1 and 2. The meeting agreed that UNICEF, and other UN agencies will work together with the national PMTCT Task Forces or coordinating committees to advocate for, and where required, provide technical support to the inclusion of PMTCT (all 4 prongs) into GFATM round five project proposal developments and other funding opportunities.

10. Supply chain management

Supply chain management is a critical challenge in all countries in particular now PMTCT uses more complex drug regimens and since ARV are more commonly used for the treatment of advanced HIV/AIDS. There is need for a coordinated effort to build country level capacity for readiness assessments, forecasting, supply chain system development and management – not just for PMTCT but for all HIV diagnostics, and preventive and treatment elements except condoms which generally have a strong supply chain system and management.

11. Global guidelines

Global guidelines and tools are very useful but need strengthening particularly in relation to prongs 1, 2 and 4. Development of operational goals/targets and indicators for each of the four prongs is needed. Further, these should all be linked into a comprehensive four prong PMTCT results matrix.

In relation to prong 3 the new WHO guidelines include guidance on the use of ARVs for PMTCT in different scenarios. Several of the recommended PMTCT ARV regimens now constitute different types of drugs that are more potent than the previously recommended single drug regimens. Countries are recommended to update their PMTCT ARV guidelines based on these new recommendations and to ensure that adequate amounts of the recommended ARVs are available at the PMTCT facilities and that health practitioners have received the updated protocols.

12. Monitoring and evaluation

Global core and additional monitoring indicators are at present primarily focussed on prong 3. The meeting identified a need for globally agreed core indicators for PMTCT prongs 1, 2 and 4 which can be added to at country levels. Countries need to define a road map for integration of monitoring and evaluating progress towards national PMTCT goals. This should include monitoring impact of all four prongs. UNICEF/WHO/UNFPA regional and global levels need to provide more support to ensure that prong 1 and 2 are incorporated in measuring progress towards UNGASS targets.



13. Adapting national guidelines and regimens

Rapidly adapting national guidelines and standards in the very dynamic PMTCT technical and scientific environment has proven difficult. It is suggested that a 'scientific Task Force' of the National PMTCT Committee or national Care, Support & Treatment Committee convenes preferably twice yearly to review the latest science and global technical updates and recommend to appropriate authorities for rapid changes in guidelines and standards. Practitioners working on PMTCT should be updated accordingly on changes in national guidelines and PMTCT protocols.

14. Linking PMTCT to Care, Support and Treatment

With the growing emphasis on increasing access to treatment in many countries, there is potential for both using PMTCT as a major entry point for early care, support and treatment of mothers, fathers/partners, and children identified through the programme, and for accelerating PMTCT by integrating treatment and PMTCT initiatives. The meeting noted that the treatment targets of the 3 by 5 Initiative do not have specific targets for children; but that in general, 15% of the disease burden is in children.

15. Involvement of men in PMTCT

Throughout the meeting the importance of greater involvement of adolescent males and men in PMTCT (all prongs)

was highlighted. With much of the PMTCT strategy focussed on ANC/MCH settings, the question of 'male-friendly' health settings was raised. Linked to this, new evidence from Uganda shows that pregnant women have an increased risk of HIV infection due to biological and social factors. Therefore prevention of HIV infection during pregnancy requires increased attention. Interventions should focus on safe sexual practices and will require active involvement of male partners. It was noted that there was little research into male attitudes to PMTCT.

16. The strategic intent of PMTCT—child and child survival

The strategic intent of PMTCT needs to be improved maternal and child survival and the importance of placing it within a Child (and maternal) Survival and Development approach was highlighted

17. Cotrimoxazole prophylaxis

Only one of the countries represented at the meeting had a policy for providing cotrimoxazole prophylaxis to all children born to HIV-positive mothers as per the WHO/UNICEF recommendations. The importance of this intervention will be taken up by WHO and UNICEF at regional and country levels with the appropriate government authorities

18. Next meeting

The group recommended that the next meeting will be tentatively scheduled for February 2006.



Background, Conceptual Framework and Objectives

Background

Every day 8,500 children and young people around the world are infected with HIV. As of the end of 2004, some 2.2 million children under 15 years were living with HIV. Many children were born to mothers with HIV acquiring the virus around the time of birth or from breastfeeding. As increasing numbers of infected and affected children are unavoidable, it is necessary to ensure that healthcare providers, families and communities are prepared to support the prevention of mother-to-child transmission (PMTCT) to reduce the spread of HIV among women, children and young people.

National HIV infection levels in Asia are low compared with some other continents, notably Africa. However the populations of many Asian nations are so large that even low national HIV prevalence means large numbers of people are living with HIV. Latest estimates show some 8.2 million people were living with HIV/AIDS at the end of 2004 in Asia, including 1.2 million people who became newly infected in the past year. Among these people 2.3 million were adult women living with HIV infection.

Overall, Asian countries can be divided into several categories, according to the epidemics they are experiencing. While some countries were hit early (i.e. Thailand, Cambodia, Myanmar), others are only now

starting to experience rapidly expanding epidemics and need to mount swift and effective responses. They include Indonesia, Nepal, Vietnam, and several provinces of China. In Myanmar and in parts of China and India, HIV has become well-entrenched in some sections of society, despite modest efforts to halt the virus's spread.

In some parts of India, HIV prevalence has crossed the 1% mark among pregnant women. HIV prevalence measured at ante-natal clinics in the Manipur cities has risen from 1% to over 5%, with many of the women testing positive appearing to be the sex partners of male drug injectors. In parts of India, Myanmar and South-Western China, HIV has acquired a strong foothold among people who have been exposed to a high risk of infection for several years. Inadequate prevention efforts have allowed the virus to filter from people with high risk behaviours to their regular sex partners, which accounts for rising HIV infection levels among women who report having only one sexual partner.

In the absence of any interventions, about a third of children born to HIV infected mothers will be born with HIV or infected through breastfeeding. This can be cut by half if women are given appropriate



antiretroviral (ARV) or safe alternatives to normal breastfeeding practices. It can be cut by almost three quarters if women receive both ARV **and** infant feeding counselling and support.

Children born with HIV have very high mortality. They are over four times more likely to die by the age of two than children born without HIV. HIV has contributed to a rise or stagnation in under-5 mortality in several countries in Africa, but is not the only factor behind these trends. HIV infected children in countries with generalized epidemics often die of the same things that kill most other children; they just die faster. Effective interventions to reduce transmission to children exist. They pose many challenges, but significant progress is being made to meeting those challenges.

The rapid spread of HIV infection among women is alarming. Roughly 47 percent of the new infections in the world each day are in women of child bearing age. Women are biologically more vulnerable to HIV infection and other Sexually Transmitted Infections (STIs). This is exacerbated by socio-cultural and economic circumstances that make it difficult for women to have control over their own sexuality, particularly in the Asian context. The pandemic is therefore taking a toll on women and children in the region. The reasons for focus on primary prevention especially among pregnant women are manifold – pregnancy is usually the only time many women in Asia access health services, targeting pregnant women simultaneously benefits the women, their partners and children; HIV prevention messages provided during pregnancy can carry over postpartum when HIV risk is high and throughout lifetime. Scaling up the response is imperative for Asia to meet the UN General Assembly Special Session (UNGASS) target of

ensuring that 80 percent of pregnant women accessing antenatal care have information, counseling and other HIV prevention services available to them by 2005.

The same social, economic and cultural factors which make women vulnerable to infection with HIV also limit their access to HIV treatment, care and support and worsen the impact of sexual and reproductive ill-health. The factors also make women more vulnerable to stigma and discrimination. Furthermore, the physical, emotional and social effects of HIV, all impact on sexual health and well-being of women. There is need for programming to adapt sexual and reproductive health services to address the treatment, care, prevention and support needs of women with HIV and integrating these activities in the health system.

Preventing mother-to-child transmission (PMTCT) has been put to discussion, previously, as an issue of prevention for children, however it is an equally important potential entry point in providing treatment and care for pregnant women and mothers who are HIV-positive. Anti-retroviral drugs should be used within a framework of prevention, treatment and care both to prevent transmission to the child and to maintain the health of the mother and all other HIV-positive family members. At the same time, primary prevention activities and reproductive health/family planning interventions need to be linked with PMTCT services in order to have a maximum impact of limited resources in HIV/AIDS prevention and care. Very recent analysis demonstrated the importance of integrating expanded care activities with prevention activities, if there are to be long term reductions in the number of new HIV infections and significant declines in AIDS mortality.



Conceptual Framework for Comprehensive PMTCT

Four Prongs of the Comprehensive PMTCT Approach

- Prong 1: Targeted Primary Prevention among Women of Child Bearing Age
- Prong 2: Prevention of Unintended Pregnancies in HIV-Positive Women
- Prong 3: Prevention of Infection from HIV-Positive Mothers to Infants
- Prong 4: Care and Support for Women, their Children and Family

The comprehensive PMTCT approach consists of a combination of interventions that offer to prevent HIV infection at different stages of the life cycle: among pre-marital, young married couples, women of reproductive age and their partners, and pregnant women. It also ensures that there is adequate and appropriate follow-up care, treatment and support for women and children after delivery, along with their partners. The approach extends primary prevention initiatives across the spectrum of health systems and services; linking with safe motherhood (maternal health) interventions of ante-natal care (ANC), family planning services for couples, safe delivery and post-natal care (PNC) where efforts should be exerted for pregnant women and their partners to remain negative.

Recognising the huge diversity in HIV prevalence rates across the world, a conceptual framework to guide comprehensive PMTCT interventions has been developed, based on the four prongs and HIV prevalence levels (table 1 below).

All countries in Asia-Pacific have relatively low national HIV prevalence, with many being very low. In these countries, the overwhelming majority of women will fall within the first 2 quadrants of the conceptual framework – being HIV-negative and either pregnant or non-pregnant (see table 1 below). The conceptual framework indicates that in such situations, Prong 1 (primary prevention) should be the major programming emphasis.

To help women with HIV to prevent unintended pregnancies and couples with risk behaviour, quadrant 3, is another important component in low prevalence/ concentrated epidemic areas for prevention of mother to child HIV transmission (prong 2 and 3). In general, there is often a weak linkage between on-going PMTCT interventions and this important component of the comprehensive approach.

The fourth quadrant includes interventions to reduce HIV transmission from infected women to their children however it needs to be complemented by interventions that address the provision of treatment, care and support – a care continuum for HIV-infected women, their children and families. The last implies elements of prongs 2, 3 and 4.



Table 1: Conceptual Framework for Comprehensive PMTCT

	Not Pregnant	Pregnant
HIV (-)	<p>QUADRANT ONE</p> <p>PROGRAMMING EMPHASIS - PRONG 1</p> <p><i>Target Groups</i> Young Married Couples</p> <p><i>Core Interventions</i> STI/HIV/RH Knowledge Counseling and referral VCCT through MCH, RH if possible</p>	<p>QUADRANT TWO</p> <p>PROGRAMMING EMPHASIS - PRONG 1</p> <p><i>Target Groups</i> Married Couples, Women of Reproductive Age</p> <p><i>Core Interventions</i> STI/RH counseling/treatment VCCT at regular ANC Safe Delivery and PNC</p>
	<p>QUADRANT THREE</p> <p>PROGRAMMING EMPHASIS - PRONGS 2 & 4</p> <p><i>Target Groups</i> Women of Reproductive Age Couples with Risk Behaviour</p> <p><i>Core Interventions</i> VCCT RH needs of HIV+ women Treatment (OI/ARV)</p>	<p>QUADRANT FOUR</p> <p>PROGRAMMING EMPHASIS - PRONGS 2, 3 and 4</p> <p><i>Target Groups</i> Pregnant Women in ANC and their partners</p> <p><i>Core Interventions</i> PMTCT, Safe delivery Infant Feeding, RH/FP PMTCT Plus, treatment, OVCs</p>
HIV (+)		

Task Force Meeting Objectives

Based on the recommendations made during the previous Task Force meeting in Bangkok in May 2004, the Task Force meeting was designed to ensure a balance of presentations and discussions in technical, programmatic as well as advocacy aspects, based around the four prongs of PMTCT approach, plus other key programme elements including supply chain management, and programme monitoring.

Summaries of the presentations follow in the next section of this report. A field trip was included and group work was carried out.

Discussions were guided through the four pronged comprehensive approach with wide and in-depth participation of national teams

along with technical experts from UN agencies (WHO, UNFPA, WFP, UNICEF) and key NGOs and institutions.

PRONG 1: Targeted Primary Prevention among Women of Child Bearing Age

Session Objectives:

- To enhance understanding and dialogue on key aspects related to prong one on targeted primary prevention
- To share ideas and program experiences in operationalising prong one for lessons learned and possible replication and scaling up.
- To provide a platform for discussions on regional priority actions and way forward in the Asian context.



Background: The previous Task Force meeting held in Bangkok in May 2005 stressed that countries in the region with low HIV prevalence should focus their human and financial resources on targeted primary prevention rather than provision of a comprehensive approach in all ANC health facilities. It was noted that the setting up of such full PMTCT services should be focused on ensuring access to these services by high-risk behaviour groups, and/or in geographical areas with higher HIV prevalence, or the setting up of PMTCT reference services. The emphasis on primary prevention would then be widespread and focused on all women of reproductive age, married women and women with partners of high-risk behaviours. This targeted approach aims to prevent HIV infection even before the conception started. In this approach, targeted primary prevention would not be only limited to ANC services but integrated into other reproductive health, family planning and maternal and child health services. A key strategy would be to ensure the role of men and their involvement in primary prevention.

PRONG 2: Prevention of Unintended Pregnancies in HIV-Positive Women

Session Objectives:

- To provide an update and enhance understanding on the reproductive health needs of HIV-positive women
- To develop an action plan with concrete actions/interventions for strengthening linkages between RH services and PMTCT programs
- To review and provide recommendations for revision of RH policies and practices that could affect the reproductive rights of HIV-positive women

Background: The conclusions from the previous Task Force meeting showed that support for the reproductive health needs of HIV-positive women is still not adequately addressed in most of the PMTCT programmes. Reproductive health/family planning counseling, and birth spacing services have to be well integrated into on-going PMTCT interventions. There are several controversial issues in this area where countries may have different policies and programmatic experiences such as termination of unwanted pregnancy requested by a HIV-positive woman, and forced sterilization of HIV-positive women without any consent. Since this is a relatively new component, sufficient time in the 2005 Task Force meeting was allocated to allow the country teams to discuss policy and advocacy agendas in their own settings.

PRONG 3: Prevention of Infection from HIV-Positive Mothers to Infants

Session Objectives:

- To update technical knowledge on latest ART guidelines, testing issues and studies
- To review programmatic as well as logistic implications of comprehensive PMTCT including quality counseling services, infant feeding options and management of supplies
- To learn and share different country experiences in program implementation including capacity building on PMTCT, improving quality of training and adaptation of global training guidelines
- To have a better understanding of opportunities and challenges of different country settings in implementing PMTCT interventions



Background: Much of the emphasis in PMTCT programming in recent years has been placed on access to and coverage of counseling and testing services for pregnant women and the provision of ARV prophylaxis for vertical transmission prevention. However, many experiences are indicating that targets linked only to access and coverage is not sufficient, and that the quality of counseling services makes a major contribution to programme success. Quality counseling of pregnant women who tested HIV-negative is also an essential primary prevention intervention. In order to have effective counselling, adequate and appropriate training, counseling aids, adequate and efficient human as well as financial resource allocations, and supportive supervision is needed for implementers and health care providers.

In the period since the last Task Force meeting new or updated technical elements of PMTCT have emerged including the programmatic and logistical aspects of HIV testing in different settings, new antiretroviral treatments (ART) and their efficacy, along with continued discussion and evidence around infant feeding options.

PRONG 4: Care and Support for Women, their Children and Family

Session Objectives:

- To have a better understanding of comprehensive care and support i.e. comprehensive care package and to come up with strategy recommendations
- To update technical knowledge on latest developments in ARV, pediatric AIDS treatment guidelines, pediatric ARV formulations and recent developments
- To come up with recommendations on linking up with the “3 by 5 Initiative” for a comprehensive PMTCT program

Background: This area encompasses a comprehensive package of care continuum for all women and children infected or affected by HIV/AIDS. Under the four prong approach, care and support services need to be linked with programme initiatives for orphans and vulnerable children (OVC) and strengthening capacities and skills within organisations of people living with HIV/AIDS. It is also important to look into the issues related to nutritional and food support, and family and community care for people infected and affected. The strategy aiming to reach the most vulnerable through community home-based care should also be reviewed for future expansion of such innovative approaches.

Along with the “3 by 5 Initiative”, some countries have commenced or are starting to roll out broader care, treatment and support programmes including the provision of ARV for people living with HIV/AIDS. This provides an opportunity for linkage to on-going PMTCT activities, in addition to pursuing equitable access of women and children to care, support and treatment including ARVs. Within the accelerated work on care support and treatment – including Prong 4 of PMTCT – the country teams in the meeting were asked to reflect upon how they intend to define comprehensive care packages for those who do not need ART, those who are on ART and at the same time for those who require but are not on ART.

Other Programmatic Issues: M&E; Scaling-up PMTCT

Session Objectives:

- To discuss different approaches, strategies and actions to strengthen PMTCT programme monitoring and evaluation
- To review and recommend approaches for accelerating PMTCT scale up to achieve UNGASS goals



Background: In general the primary emphasis given to existing PMTCT programmes has been on prong three. Even the global indicators and targets have emphasised prong three, rather than a comprehensive approach.

The UNGASS Declaration of June 2001 commits States and the international community to reduce mother-to-child HIV transmission by 20% and 50% by 2005 and 2010 respectively. However, studies showed that only 8% of all pregnant women globally were receiving PMTCT services, and about

2% of women tested HIV-positive received ARVs for their own health in 2003.

The follow up of women and children in PMTCT initiatives remains a major challenge in most programmes. With the scaling up of PMTCT programmes beyond pilot sites, monitoring and follow up become real challenges. As a result, a significant number of children do not receive the infant dose of ARV prophylaxis. In addition, many children born to HIV-infected women do not receive adequate care within the context of PMTCT programmes.



Presentation Summaries

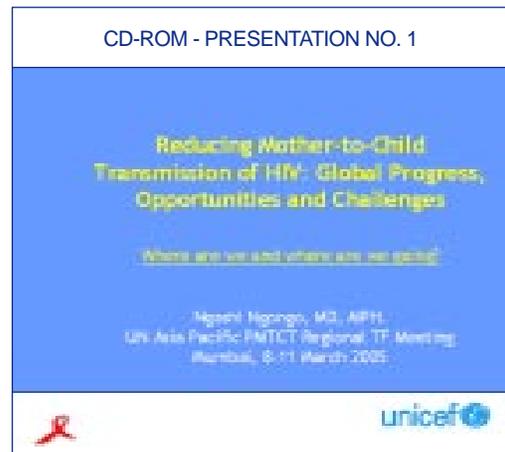
Reducing Mother-to-Child Transmission of HIV: Global progress, Opportunities and Challenges

Presented by Dr. Ngashi Ngongo, UNICEF New York

Dr. Ngongo opened the meeting by stating that in a world where 2.3 million children are born to women with HIV there is a great need to focus on PMTCT. Studies show that HIV/AIDS has become a major cause of maternal mortality in high prevalence settings. He therefore emphasized the global importance of working towards the UNGASS 2001 targets, which state that: *“by 2005, reduce the proportion of infants infected with HIV by 20%, and by 50% by 2010, by ensuring that 80% of pregnant women accessing antenatal care have information, counseling and other HIV prevention services available to them...”*. Despite global progress in the acceptance of PMTCT services such as counseling, testing and ARV prophylaxis and the fact that more than 100 countries at present have PMTCT programmes in place - still only 1 in 12 pregnant women is offered PMTCT services globally!

Dr. Ngongo outlined several challenges that need to be addressed in order to reach the UNGASS targets:

- Coverage remains low
- Programme effectiveness is limited
- The focus is too narrow – a comprehensive package is needed including primary prevention and family planning



- Weak health systems e.g. M&E, supervision
- Limited capacity: human and infrastructure
- Communities and male partners not adequately involved

To overcome these challenges, he stated that focus needs to be directed towards prong 1, 2 and 4 and not solely on prong 3 as is seen in many countries. The increased funding to HIV/AIDS coupled with an increased access to treatment at present reveals opportunities for scaling up on all the 4 prongs. It was highlighted that the primary prevention and family planning are keys to achieving UNGASS goals. The



UNICEF approach to scale up was briefly presented (see slide 16 in presentation), recommending which prongs to focus on in various prevalence settings – again emphasizing the need for scaling up on prong 1 and 2 in all settings.

The scale up, it was stated, implies following the recommendations of the IATT to focus on:

1. Strengthening MCH services – in order to reach the women in question
2. Accelerating the geographical expansion – scale up to achieve national coverage
3. Improving service uptake and effectiveness by addressing bottlenecks to acceptance of services, and
4. Linking PMTCT with CST (care, support

and treatment) programmes to ensure that the care needs of HIV-positive women and children are addressed.

The presentation in many ways set the scene for the following days, presentations and discussions on the four prongs and the challenges implied in the implementation of them. Participants agreed the need for scaling up and the need to emphasizing prong 1, 2 and 4. However, the presentation also raised a need for clarification on how to define 'focus' in the UNICEF scale up approach and questions on routine testing versus mandatory testing. One participant noted the value of being able to share lessons learned with countries in similar prevalence settings and at similar PMTCT programme level.

PRONG ONE: Targeted Primary Prevention among Women of Child Bearing Age

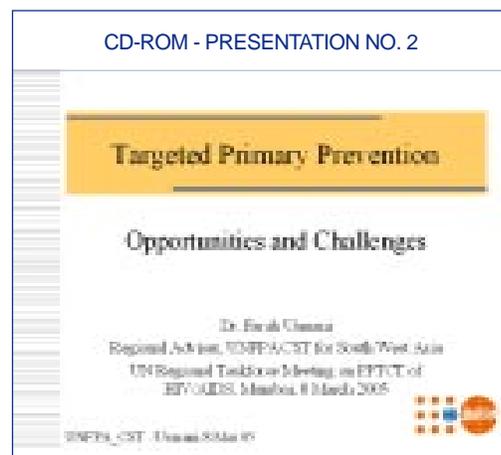
Targeted Primary Prevention - Opportunities and Challenges

Presented by Dr. Farah Usmani, UNFPA

Prong 1 aims to prevent MTCT of HIV infection even before conception occurs. That means taking steps to protect young women of reproductive age, pregnant women and couples from becoming infected in the first place and thereby prevent transmission to children.

Dr. Farah Usmani, in her presentation, put forward the rationale for a targeted primary prevention approach by pinpointing the facts that:

- There is a rapid spread of HIV infection among young women in the reproductive age group globally
- Biological, social, cultural, economic and gender factors contribute to women's vulnerability to HIV/AIDS worldwide



- Women's vulnerability to HIV increases during pregnancy, and
- Concentrating efforts on the majority of HIV-negative pregnant women ensures that they stay negative



It was strongly emphasized that different target groups (e.g. pregnant women, women in reproductive age, adolescent girls or men as partners in PMTCT) requires different strategic approaches and can only be reached at different entry points. For example, ANC settings are perceived to be good points of entry for women – although a limitation is that many pregnant women in developing countries do not access antenatal care and hence there is a need for community outreach.

Dr. Usmani shared the UNFPA basic package for country level prevention of HIV infection in young women in reproductive age. The package for settings with low prevalence, low utilization and low resources included:

- Information, Education and Communication on HIV/AIDS
- Group education strategies
- Prevention counseling including dual protection
- Counseling on infant feeding
- Condom programming (male and female)
- Referral linkages VCT, STI services, TB screening, PMTCT services and treatment, care and support services
- Linking PMTCT with targeted primary prevention for young women/ women in RH age group in order to strengthen community linkages

In settings with higher prevalence or higher level of resources further interventions should be added such as expanded midwifery and community health worker programmes and targeted outreach to vulnerable sub-populations of women. It was made clear that the combination of strategies for preventing MTCT will depend on a variety of factors unique to each setting and hence programmes need to be fitted to the local context. This implies considering the stage of the epidemic, the political will and commitment to MTCT and the status of the existing health system. Dr. Usmani particularly stressed the

importance of linking up with referrals and providing male friendly services.

In the regional context she stressed the need for action on the following points:

- Policy/Advocacy level: Ensure that women's vulnerability and needs are kept high on the HIV prevention agenda through inclusion of prong one in national PMTCT programmes.
- Programme level: 1) Support the operationalisation of primary prevention as part of PMTCT programmes in different country contexts, 2) Support action research models for integrating/linkages between targeted primary prevention/ RH and HIV/PMTCT programming, and 3) Find innovative strategies for involving men.
- Capacity building level: Develop or adapt national and regional tools and guidelines on prong 1 and document lessons learnt and good practices for enhancing availability of strategic information.

To conclude Dr. Usmani stated that it is grabbing with basic maternal health which in turn becomes the programming challenge.

Whilst praising the need for targeted primary prevention some Task Force members questioned the issue of referrals fearing that some women might get lost in the system. They pointed out that some women even find it difficult to go for ANC. A participant suggested that in countries with very low ANC service uptake women could be approached through the already operating immunization programmes instead. Another issue that was picked up on was the involvement of men. There was general agreement that targeting men is very important but also some hesitation as to how it can actually be carried out. How to get the men to the service centers? Some examples can be drawn from the following two case study presentations.



Integrating HIV/AIDS Prevention into Reproductive Health Settings - Sharing experiences from a FPAI Clinic in Lucknow, India

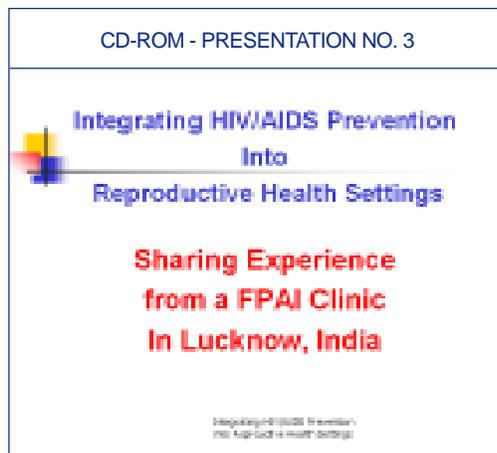
Presented by Dr. Brinda Frey, FPAI

Based on the experiences gained in a FPAI clinic in Lucknow, Dr. Brinda Frey gave the participants an understanding of what it takes to integrate HIV/AIDS prevention into a reproductive health setting.

Dr. Frey pointed out that initially a number of awareness raising activities had been vital. Not only to inform the public about HIV, its modes of transmission and the availability of VCT services but also to overcome fears and attitudinal problems within the service providers. In many cases fear of exposure to HIV, of an increased work load or of a deteriorating image of the clinic made service providers judgmental and lacking empathy. Hence, focus was initially placed on ensuring client's right to confidentiality through improving the service provider's knowledge about HIV, their counseling skills and the provision of a protocol for VCT sessions.

Since Lucknow has a big population of migrating men and since, in India, 90% of HIV-positive women get the infection from their husbands male involvement was crucial. As a result extension counters for male clients as well as awareness activities with partners were carried out.

Dr. Frey found the integration of services beneficial because it normalizes the access for clients to the services and facilitates a discussion on HIV/AIDS also among vulnerable monogamous women who before were hard to access. Further, it enhances the perception of risk amongst people in general and last but not least it is cost effective.



Her recommendations for other integration programmes were that:

- De-stigmatizing is a crucial first step to reduce anxiety, create hope and confidence
- Alliance building with likeminded networks is essential
- VCT outreach - particularly for male involvement is important
- Training of existing personnel has to take place as it is good to have people with expertise not only in HIV/AIDS
- Low cost testing should be used
- Media involvement is required in order to get the themes and issues up-front

Dr. Frey as a conclusion made people aware of the importance of VCT settings by pointing out the ostrich complex – infection does not happen to us, only to others. Awareness campaigns make people aware of HIV and the routes of transmission but through VCT there is a greater chance of internalizing the risk of being infected with HIV by for example your husband.



Targeted Primary Prevention activities by UNFPA in Myanmar

Presented by Ms. Khin Ma Ma Aye, UNFPA Myanmar

Ms. Khin Ma Ma Aye shared the Myanmar experience of targeted PMTCT primary prevention within UNFPA supported townships.

The programme had constituted a new area for UNFPA and hence it had required development of policy guidelines and procedures as well as advocacy and training of service providers.

The programme had put efforts and resources into strengthening the health services MCH/RHC/SRHC through capacity building of health care providers, provision of material support to health services and of VCT/PMTCT services to MCH and community based health centers in UNFPA assisted townships.

As important lessons learned Ms. Ma Ma Aye emphasized the following points:

- The need for strong community participation in the training of young people and adolescents
- The need for understanding from policy and decision makers
- The need for regular reviews of service provisions



- The need for further collaboration with the NAP (National AIDS Programme) and MCH sections for effective interventions

The future plans for the programme included a strengthening of the community based activities, stronger involvement of youth as peer educators and an expansion of institutional based PMTCT activities. The community mobilization approach amongst others emphasized more male involvement in the training of youth, in outreach activities and in the utilization of health services.



PRONG TWO: Prevention of Unintended Pregnancies in HIV-Positive Women

Prevention of unintended pregnancies among HIV-infected women

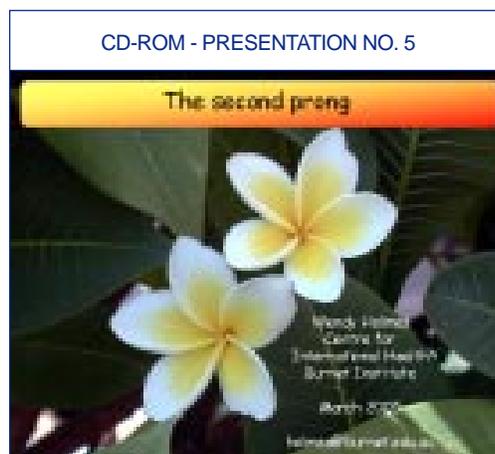
Presented by Dr. Wendy Holmes, Centre for International Health Burnet Institute

Dr. Holmes in her presentation discussed why this prong has been neglected, and looked closely at the wording.

She drew attention to the word 'unintended'. Many health workers, including doctors, believe that HIV-infected women should not become pregnant because they wrongly believe that all babies born to HIV-positive mothers will be infected or they are concerned about the child being orphaned. It is important, from both a public health and a rights perspective, to provide women with accurate information about the risks and help them to make their own decision, if possible, with their husband and family. The desire of many women, men and their families to have a child should not be underestimated.

Because many HIV-positive women do not know that they are infected, and because uninfected women are at higher risk of becoming infected with HIV during pregnancy and post-partum, strengthening family planning services for *all* women is important to reduce the numbers of babies with HIV. The unmet need for contraception remains high in many Asian countries, and Dr. Holmes discussed some of the barriers.

Dr. Holmes noted that while the prong refers only to 'women' there is also a need for engaging men and address the reproductive concerns of HIV-positive men too. During the presentation the need to look at the couple or the family as a whole when concerned about sexual behaviour and PMTCT was often stressed. Men often have multiple partners, and Dr. Holmes



noted that the first sexual encounter of a young woman often takes place within the family. VCT services, family planning and general health care should therefore be seen as an integrated part of preventing HIV infection in children.

Other important points made by Dr. Holmes were:

- Marginalized women tend to be more vulnerable to HIV
- Where termination of pregnancy is legal provide HIV-positive pregnant women with an assessment of their specific risk of MTCT so that they do not feel obliged to terminate a wanted pregnancy.
- Women who have HIV related disease have higher viral load and greater risk of transmission of HIV to the baby. So it is important to train health workers to advise women with any chronic illness (they don't need to know whether it is HIV related) to avoid pregnancy until they have been well for six months.
- Do not expect integration of services to work without strengthening and investing in the systems needed for



effective delivery of any health service. However, integration is important to reduce stigma and increase awareness of healthy sexual behaviour.

- With the aim being children's survival there is a need to consider that HIV is not the only cause of preventable deaths of infants and children in Asia and Pacific.

During the discussion Dr. Holmes was asked about the problem that it can be difficult for unmarried women to access contraception. She shared her experience from the Australian Aboriginal community, that when young women were allowed to see the doctor with a friend or two they were more willing to talk to the doctor about their reproductive health needs.

PRONG THREE: Prevention of Infection from HIV-Positive Mothers to Infants

Current WHO Recommendations for Use of Antiretroviral Drugs for PMTCT - Issues related to ART use in pregnancy and NVP resistance

Presented by Dr. Chewe Luo, UNICEF New York

In a technical presentation, Dr. Chewe Luo, reviewed the current WHO recommendations on antiretroviral regimens for treating HIV infected women during pregnancy and preventing mother to child transmission of HIV. A range of treatment scenarios were presented and analyzed for efficacy, toxicity as well as subsequent resistance to ARV therapies.

Among the key findings raised by Dr. Chewe Luo were:

- Up to 50% of women with HIV/AIDS can pass on infection to their babies.
- New WHO recommendations are more focused on women's HAART needs and what is optimal for PMTCT.
- There are better interventions than simple single treatments like AZT alone or NVP alone.

Further Dr. Luo pinpointed that when talking to policy planners one needs to ensure they understand that it is not clinically responsible or appropriate to give HAART to every pregnant woman. Even if there is a background treatment with other drugs, the risk of resistance is still high and there are

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Current WHO Recommendations for Use of Antiretroviral Drugs for PMTCT – Issues related ART use in pregnancy and NVP resistance

Dr. Chewe Luo (MScPhD, MPhil, PhD)
Health Services
Programs Division

For more information, visit
www.unicef.org/health



side effects as well as limited knowledge of what the drugs do to the fetus. Only women who qualify for HAART, therefore, should receive it.

- Nevirapine (NVP): Serious side effects, like rash and hepatic toxicity, with chronic therapy. Hepatic toxicity is found to be higher in women than in men and maybe more common in pregnancy. Hence chronic administration of NVP should not be given with caution. Chronic NVP administration should be limited to women with CD4 below 250.
- Efavirenz (EFV): Should be avoided in



women of childbearing age unless effective contraception can be assured. If it has to be administered it should not be used in first trimester due to risk of teratogenicity.

- Tenofovir (TFV): Might be a replacement drug to Nevirapine. However there concerns of bone toxicities from animal studies and there are ongoing studies on the implications for humans.
- Indinavir, Atazanavir: Possibly hyperbilirubinemia – not enough information on implications.

According to Dr. Luo the way forward is to offer women, as best possible within the various settings, what is best for them and

their babies vis a vis efficacy, toxicity issues and resistance. Keeping in mind that at population level, single dose NVP is still applicable in settings where there are no other options.

Participants raised concerns that whatever regimen is used resistance is an issue. Dr. Luo emphasized that keeping the resistance issue in mind, the decision on which drugs to use still depends on what is available, applicable and feasible in the respective settings. Asked for experiences on how to monitor systems of resistance at country level Dr. Luo responded that monitoring is not easy but that central laboratories should be used to try and keep track and monitor the spread of resistance.

Ensuring Secure and Reliable Supply and Distribution Systems in Developing Countries, in the Context of HIV/AIDS and PMTCT

Presented by Helen Moller, UNICEF Supply Division

In an eye-opening session Ms. Helen Moller focused on the challenges and steps implied in ensuring secure and reliable supply of drugs in developing countries.

Ms. Moller started by stating that procurement of ARV or PMTCT is not only about drugs.

For a comprehensive PMTCT care package there is a need to take into account elements of clinical care and psychological, socio-economic and legal support. This implies considering the need for a wide variety of products like reproductive health supplies, laboratory items, essential medicines, medical equipment, nutritional support, test kits (HIV and STI), condoms etc. Further, it is needed to consider whether the aim is home based care, community based care or public care.

A five step approach to help countries develop a HIV/PMTCT supply strategy



hence implies the need to ensure that supply management is appropriately coordinated. That equipment and consumable commodities of appropriate quality are selected and procured through reliable, cost-effective mechanisms. That appropriate storage and reliable, cost-effective distribution of essential commodities are ensured, and finally that commodities are appropriately used.



Ms. Moller pointed out that going through the PMTCT procurement approach a number of challenges might occur. These challenges include:

- Registration of drugs and the need for import licenses.
- Coordination between different departments and stakeholders can be lengthy and difficult making it difficult to synchronize availability of supplies with programme launch.
- Integration into existing (often non-functioning) public health systems. UNICEF needs to avoid the risk of setting up parallel systems through for example INGOs.
- Not all products are specifically developed for PMTCT and combined with rapid development in technology this result in frequent updates or changes in the supply strategy.
- PMTCT equipments are often add-ons to existing equipment which then needs to be bought as well.

Estimating the supply need is one of the largest challenges in a new PMTCT programme. Ms. Moller revealed to participants a 4 step approach to gain an estimate for their programme:

1. Postulate a patient profile at site(s) of service delivery
2. Estimate the growth in numbers of patients on treatment
3. Estimate the number of packs needed to start, to prevent stock outs
4. Monitor stock situation and reorder/redistribute until data on stock movement are available

Ms. Moller also mentioned the challenges caused by TRIPS and generic competition and stated that WHO is ensuring the quality of the drugs supplied by UNICEF. Further, she presented the newest information on various types of tests and test kits. As a closure she stated: *"A lot is expected from users of ARV, but products and suppliers have to perform equally."*

Following the presentation, participants acknowledged the need to include supply officers and recommended that these would be invited for the next meeting.

During her presentation. Ms Moller presented background on UNICEF's role in ARV and other HIV/AIDS supplies procurement, noting that in 2004 alone, UNICEF supply division supplied ARVs to 33 countries in 5 regions.

PPTCT Programme Experience by NACO India

Presented by Dr. Alka Gogate, Project Director, Mumbai Districts AIDS Control Society

Dr. Gogate shared the experiences of the PPTCT programme carried out by NACO India.

The overall HIV prevalence among pregnant women in India is 0.3% but in high prevalence states the figure is more than 1%. Out of 27 million delivering every year 35,000 infants become HIV infected. HIV is particularly found in high risk groups (CSWs and IDUs) and spreads from there via bridge populations (clients or partners)

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**PPTCT Program
Experience by NACO India**

DR. ALKA GOGATE
Project Director
Mumbai Districts AIDS Control Society



to the general population. The alarming news is that a rise is seen in HIV prevalence among pregnant women and that the epidemic is found to be shifting towards young people.

Dr. Gogate described the essentials of a PPTCT centre as follows:

- Counseling facility
- VCCT (Counseling and HIV testing)
- Integrate PPTCT services in to RCH
- Promote institutional delivery by trained person
- Post natal follow-up essential, feeding, immunization, growth monitoring, HIV testing of the baby at 6 and 18 months.

Dr. Gogate presented the strategy for scaling up which is currently being implemented. She pointed out a number of challenges and dilemmas that NACO has dealt with:

- How to maintain Quality Assurance while going to scale?
- PPTCT only for institutional deliveries? – the need for outreach strategies
- How to complete the PPTCT package with primary prevention and continuum of care? – the need to link up with NGOs
- Infant feeding dilemma and how to perform follow up testing of babies?
- Integration into the national

reproductive and child health programme – how?

- Stigma, discrimination, attitude of health care providers – the need for communication strategy and male involvement
- NVP resistance?
- Need for public-private partnership to be able to reach all
- Should testing be mandatory?

At the end Dr. Gogate shared the specific experience of the PPTCT programme implemented in the B.Y.L. Nair Hospital. At the hospital peer counseling, PLWHA support groups, linkages with NGOs, micro-credit and vocational schemes and nutritional support all form part of the PMTCT programme. And soon the hospital will also be providing antiretroviral therapy (ART) to HIV-positive mothers.

The presentation raised a heated debate on the issue of testing. The Indian experience shows that only 20% of the women come back to get the result after having consented to testing during their ANC visit. Participants asked why rapid testing was not used instead. The human rights and confidentiality issue of whether to mark the journal of HIV-positive women was also discussed. The discussion highlighted that stigma and discrimination are still issues that needs to be taken very seriously.



Initiating Preventing Mother-to-Child Transmission of HIV (PMTCT) Interventions in Pilot Sites - Nepal's Experience

Presented by Dr. Sushila Shrestha, Senior Consultant Gynecologist, Maternity Hospital

Dr. Shrestha began her presentation on the Nepal PMTCT experience by outlining the characteristics of the epidemic in the country. 26% of HIV cases in Nepal are estimated to be in women and it is estimated that 1,800 children are born to HIV-infected mothers annually. The epidemic is mainly concentrated in high risk groups and in their clients and partners.

An outline of the recently finalized PMTCT process in Nepal was presented, highlighting the following steps:

- Govt. commitment to PMTCT in selected facilities
- Situation Assessment – showed that women are at particular risk to HIV often through their husbands. The assessment showed the need for an active approach.
- National PMTCT Working Group
- PMTCT national guidelines/protocols, training modules, IEC materials developed
- Monitoring guidelines developed
- Site preparedness assessment
- Training on PMTCT for 34 health workers from 3 initial sites and five secondary sites

This process has led to a comprehensive package of PMTCT being initiated at 3 initial sites and partial packages being carried out at 4 secondary sites from early 2005. The comprehensive national guidelines imply action on all 4 prongs with a great emphasis on VCT.



Dr. Shrestha explained that the working group and the PMTCT programmes had had to deal with a number of challenges due to the political climate in Nepal, the inadequate manpower and the ever-changing staff in MOH. Further, only a few women do actually deliver in hospitals, the HIV epidemic is concentrated in high risk groups and the capacity for counseling and community linkages is lacking at some sites. However, experience had also shown that team work, shared responsibility, commitment by partners and not the least timely and adequate availability of resources (human and financial) can yield real and fruitful results.

With regards to training the generic UNFPA modules had been adjusted to Nepal's context and had provided a good basis for the participants. However, intensive follow up and further revision of the training material is needed – particularly training for special groups like lab technicians and counselors.



Revision of NACO-UNICEF Training Module for PPTCT Teams - the India Experience

Presented by Dr. Bir Singh, PPTCT Project Officer, ICO UNICEF

Training in PPTCT in India is taking place as a cascade effect starting from centers of excellence and trickling down to medical colleges, district hospitals and maternity homes. UNICEF is a key partner in India's PPTCT Programme – taking part in research, monitoring and evaluation and quality assurance of services.

The initial NACO-UNICEF PPTCT training manual was developed in 2002 by NACO in collaboration with ARCON and UNICEF. The manual outlines 5 days training programme

Dr. Bir Singh explained that during observations of implementation of this training program it was found that the training was not interactive and participatory with doctors dominating the training. Neither the training content, the training process nor the reference materials were standardized, resulting in conflicting messages at times. A high proportion of counselors, nurses and lab technicians were therefore not completely satisfied with the training. Further, the manual was found to lack scope for participatory learning, be unsuitable for refreshers' training as it was not modular and the monitoring and evaluation component of the PPTCT services was not strong.

These findings were discussed with NACO, CEs, SACS and within UNICEF and it was decided to revise the PPTCT training. The revised training manual is based on the WHO-CDC generic PMTCT training manual and has been field tested in India. The



manual is at present ready for printing and dissemination including a sensitization training draft. It has been recommended as being the only document for training of PPTCT teams at all levels in India.

The manual now includes:

- Trainer's manual
- Participant's manual
- Wall charts
- Clinical Pocket Guide
- Sensitization Training Module

All manuals are presented in a structured, modular and comprehensive manner which encourages participatory learning. It is technically correct and updated covering all relevant issues including strengthened section on monitoring and evaluation.

A similar revision of the counselors' training module has taken place. Hence, India can today offer two quality documents to ensure quality in training, quality in counseling and quality in PPTCT services including an improved monitoring and evaluation format.



Capacity Building on PMTCT: Issues Related to Training and Adaptation of Global Guidelines at Country Level

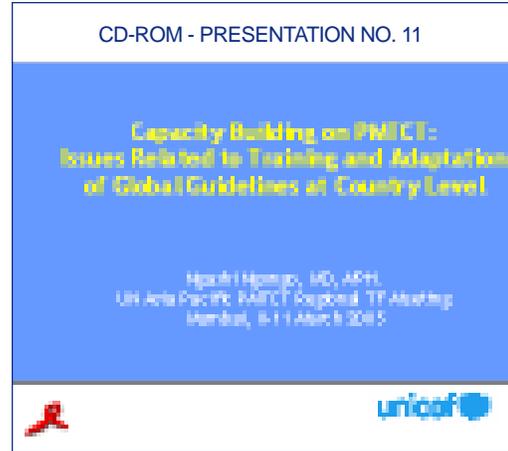
Presented by Dr. Ngashi Ngongo, UNICEF New York

As part of the effort to scale-up PMTCT programmes UNICEF wanted to create a generic training package guiding the user from adaptation to implementation and evaluation.

WHO and the partners aim to include all the core programme components of PMTCT in the generic training package and allow for country adaptation. Hence, the content is made in such a way that it allows for flexibility with nine interactive modules to be held over five days. The purpose of the course is to improve the knowledge and skills of all service providers these being doctors, nurses, counselors, midwives lay counselors and outreach workers.

Further, following the discussions on prong 1 and 2 during the first days of the meeting Dr. Ngongo recommended that additional training in testing and counseling as well as infant feeding should be provided within the training.

Dr. Ngongo emphasized that the adaptation process to country level is important and listed out the various steps that needs to be followed for successful adaptation. He gave the examples of Mozambique (no training curriculum, limited policy), Guyana (no curriculum, existing policy) and Cameroon (existing curriculum). He stated the importance of adapting the generic training package to include national policies, guidelines and programme descriptions. And to make sure that the generic text is amended to reflect the national policy and context including the availability of resources. If required additional modules should be developed by the country.



Reminding the participants of the UNICEF approach to scale-up including all four prongs, Dr. Ngongo had a look back at the previous day's presentation and discussions and concluded that the following key interventions for primary prevention and prevention of unintended pregnancies need to take place in MCH settings:

- Information, Education and Communication
- Couple counseling and testing (pre-, post and preventive counseling)
- Couple counseling on family planning
- STI prevention and treatment
- Promotion of dual protection
- Condom promotion
- Referrals

WHO will in 2005 be developing a number of supportive tools that will help countries in the implementation of the interventions.

Participants suggested to include infant feeding practices even in populations where the prevalence is not high and to include premarital counseling. They further raised the concern that when talking about primary prevention the tendency is to



include everything, making it difficult to draw the line between what is done within PMTCT programmes and what is done within HIV/AIDS control programmes in general. As a response to this a participant

highlighted that it is important in advocacy to acknowledge that the benefits of PMTCT interventions do not only benefit HIV related people but broadly benefits the entire population.

HIV and Infant Feeding

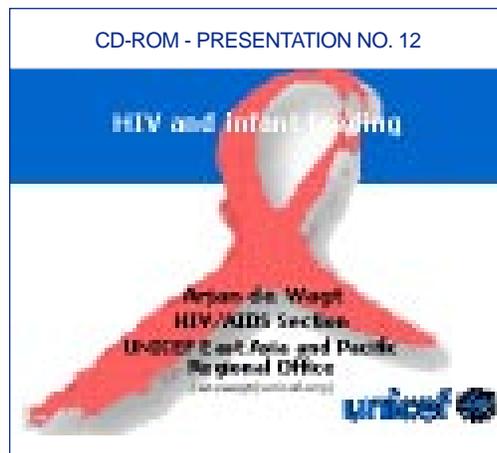
Presented by Arjan de Wagt, HIV/AIDS Section, UNICEF EAPRO

Mr. Arjan de Wagt started by stating that the issue of breastfeeding is widely ignored in the region although infections through breastfeeding have been increasing. Up to 50% of women with HIV/AIDS can pass on infection to their babies. The total risk of transmission of HIV through breastfeeding (generally mixed feeding) between 0 and 24 months is about 14%.

The MASHI study on infant feeding from Botswana was presented briefly. It concluded that treating infants ARV together with breastfeeding does not significantly decrease the risk of HIV infection in comparison to those infants who are formula fed. If child formula is given the baby is less protected against other diseases (pneumonia or diarrhea) than those children that are breastfed. Hence, after 18 months the risk of HIV infection is leveled out between the two ways of feeding. However, most of the mothers in the study were mix-feeding and hence it is not known exactly what happened regarding exclusively breastfeeding. Exclusively breastfeeding is known from other studies to be protecting the child against HIV also.

Mr. de Wagt pointed out the following measures to be taken in order to prevent MTCT:

- Safe replacement feeding
- Shorter duration of breastfeeding – maximum 6 months
- Exclusive breast feeding during the initial 6 months



- Safe sex practices of mothers during lactation in order to prevent re-infection or infection
- Good lactation management (attachment, positioning, frequency) to avoid mastitis
- Prevent and avoid feeding from cracked nipples
- ARVs? (still awaiting results)

For the majority of the women in the Asian and Pacific regions breastfeeding is the ONLY option. Therefore there is a need to develop a comprehensive national Infant and Young Child Feeding (IYCF) policy which protects, promotes and supports appropriate IYCF with particular focus on HIV-infected women, their babies and their chosen infant feeding method. It is also necessary to implement a Code of Marketing for formula feeding and to promote further research into the field. These priority areas are all outlined in the publication: "HIV & Infant feeding: Framework for Priority Action (2003)".



Participants recognized how difficult it is in this region to get women to exclusively breastfeed. Mr. de Wagt responded that yes it is difficult people often also do not know that it is important. The mother will need a lot of guidance. It is important to be careful about the messages that are given about exclusive breastfeeding – in the initial 6 months exclusive breastfeeding is good. The advice for HIV-positive women is

different to the advice given in general to pregnant women. Hence, it was pointed out that there is a great need for counseling and awareness raising within this area. Dr. Chewe Luo pointed out that the MASHI study had a lot of methodological problems. And that it should be realized that it is the baby that receives ARVs not the mother. Whether this is a conducive way is still not known.

HIV and Infant Feeding – the experience of Viet Nam

Presented by Dr. Vu Thi Thanh, Deputy Director of Maternal Health Project, Vice director of PMTCT Project, RHD, MOH

Dr. Vu Thi Thanh, presenting the Viet Nam experience on HIV and infant feeding, began by sharing that before 2003, the generally agreed guideline was that women living with HIV should not breastfeed.

In 2003, in light of new information, the Ministry of Health, with UNICEF's support, started discussing and preparing a study to guide the implementation of the global guidelines on HIV and infant feeding. The study carried out to guide the implementation of the global guidelines on HIV and infant feeding revealed that:

- Mix-feeding is very common in Viet Nam.
- Exclusive breast feeding is highly acceptable but it is a new and rare concept. There is a perception among health staff and community people that breast milk is insufficient.
- The supportive environment for exclusive breastfeeding is lacking.
- Expressing milk is a familiar practice but not in quantities to be fed to an infant. Great skepticism is found regarding safety of saving milk and feeding it later.
- Feasibility of heat treatment is uncertain.

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HIV and Infant Feeding

The experience of Viet Nam

- It is considered feasible to stop breastfeeding after about 6 months and stopping rapidly (within a week) is also considered feasible.
- The acceptability, feasibility, affordability and safety of replacement feeding in general were found to be low.

The findings have led to a PMTCT action plan currently being developed – including specific advice on HIV and infant feeding. Dr. Thanh concluded by explaining that the next steps that now needs to be considered will be to strengthen policies and guidelines on HIV and infant feeding in Viet Nam, to further research on infant



feeding practices, influencing factors among HIV-infected mothers and finally to document lessons learned from pilot PMTCT project in infant feeding. Further, it was added that Viet Nam is currently working on a national code on the marketing of formula feeding which is an important component of a breastfeeding policy or guidelines.

During the following discussion participants raised the concern of the health of the breast feeding mothers. Old studies

showed that HIV-positive women who breastfed had got a higher risk of dying but newer studies conclude that there is no risk for HIV-positive women to breastfeed. One participant requested assistance to the countries on issues related to infant and young children's feeding and was requested to contact either UNICEF ROSA or EAPRO or the WHO office for such guidance. It was highlighted that it is important to not wait with action until studies have been done. It should be possible in most countries to get going now with drafting general guidelines.

PRONG FOUR: Care and Support for Women, their Children and Family

Prevention of Mother-to-Child Transmission in the Continuum of Care and Treatment

Presented by Dr. Ying-Ru Lo, WHO, Regional Office for South-East Asia

Dr. Ying-Ru Lo started out by explaining that '3 by 5' is a shared global target to provide antiretroviral therapy to 3 million people with HIV/AIDS by the end of 2005, with the goal of achieving universal access.

The '3 by 5' framework for scaling-up of Antiretroviral Therapy (ART) at country level builds on the 3 guiding principles that ART should be an integral part of HIV prevention and care, that the capacity of the health systems needs to be strengthened and that the intervention has to build on existing health facilities. Further the framework includes 5 strategic elements:

- Mobilizing political commitment
- Building capacity of health services
- Uninterrupted supply of drugs and diagnostics
- Ensuring treatment adherence
- Monitoring and evaluation

The essence is that early access, meaning referrals from ANC/MCH services to HIV/AIDS care and treatment for children and adults is needed.



Dr. Ying-Ru Lo outlined the treatment regimes recommended in the WHO treatment guidelines from 2003. 2 NRTIs are the backbone of any recommended effective combination. The most used combination NNRTIs in Asia are NVP or EVZ. The guidelines give the option not to rely on laboratory testing but to allow for clinical staging as the basis for starting treatment. Treatment should start at stage IV disease if CD4 tests are available. Countries in which CD4 testing is not



available were encouraged to strengthen their laboratory capacity or instead use lymph counts and start treatment at WHO stage III and IV disease.

It was pointed out that very high adherence rates (>95%) are required to prevent the development of resistance to ART medicines. Missing more than one dose in a three-week period can create resistance and hence it is very important to establish systems for ensuring treatment adherence as part of comprehensive care and support. The example of Comprehensive Continuum Care Centers in hospitals in Thailand was shared. These centers provide extensive information, support and counseling alongside the provision of ART. It was emphasized that if there is a treatment failure, whether in child or adult, all drugs should be replaced. And since the replacement drugs are hardly if at all available in Asian it is very important to ensure adherence to the first line regimen.

Further, the need for treatment of opportunistic infections was raised. A joint WHO/UNAIDS/UNICEF statement in November 2004 stated that:

- Prophylactic dosing with cotrimoxazole for HIV-infected children with any signs or symptoms suggestive of HIV is a key intervention that should be offered as part of a basic package of care to reduce morbidity and mortality.
- Cotrimoxazole prophylaxis is also a crucial potentially life saving intervention that should be given to all HIV exposed children born to HIV-infected mothers, in settings when HIV infection status cannot be reliably confirmed in the first 18 months of life.

Dr. Ying-Ru Lo ended by indicating the progress in the region with regards to provision of ART. Art is a part of national programme in most countries, demand is increasing and implementation accelerating. The '3 by 5' targets have been achieved in Thailand, but other countries are on the way.

The ultimate challenges for "3 by 5" were conclusively set out as:

- Prevention still remains the most important intervention. 3 by 5 should not be at the expense of basic prevention interventions
- Transform HIV/AIDS from a death sentence to a chronic disease might mean management problems like with diabetes
- Build capacity of all partners in particular NGO/Private sector and civil society – particularly PLWHA
- Establishing referral linkages from PMTCT to care and treatment.

Following the presentation participants raised the point that also malnutrition should be considered in relation to treatment. Malnutrition has an affect on the treatment and many of the women and children who are HIV-positive in this region are suffering from malnutrition. Hence, along ARV and treatment for opportunistic infections nutritional support should also be considered. Another participant raised the question on which social and economic considerations to consider before starting treatment. Dr. Ying-Ru lo answered that the countries have decided to go for clinical criteria for treatment, not socio-economic but it is needed that people are ready to adhere to the treatment and the consecutive counseling – issues that might well be affected by socio-economic problems.



Defining the Role of Food and Nutritional Support in PMTCT and Related Programmes

Presented by Dr. Judit Katona-Apte, WFP, Regional Bureau, Bangkok

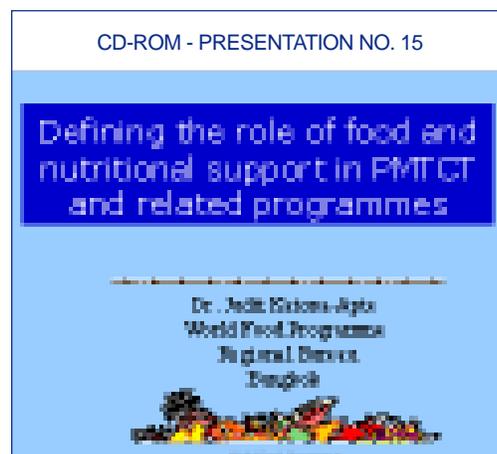
Dr. Judit Katona-Apte outlined the opportunities and challenges that exist for providing food and nutritional support to HIV affected families through PMTCT and related programmes. She stressed that the triad of (HIV) infection, nutritional status and immune function are intimately related, each factor having effects on the other.

HIV/AIDS impacts on both the individual level and the household level. When infected the individual has increased nutrient requirements and erosion of immune system is observed. At the household levels the individual deterioration leads to diminished capacity to produce food, raise income, or to take care of young children and those who are sick. Further, by ensuring food security, people are less likely to become for example female sex workers or undertake other risky behaviour.

One of the main challenges in planning food and nutritional support for PLWHA is how to reach them. PMTCT is a possibility that enables early intervention before onset of symptoms. The programmes provide an opportunity to reach HIV-positive and pregnant/lactating women in early stages of illness as well as their family members (HIV-infected), spouses and children.

Dr Katona-Apte highlighted the following points on nutritional support and its relation to PMTCT:

- Nutritional interventions for PLWHA are likely to have greatest impact the earlier they are implemented
- Nutritional support may extend life before ARVs are needed
- PMTCT programmes reach HIV-positive pregnant and lactating women. Low birth weight is a common problem



among this group, food support might help to prevent it

- For symptomatic people, some evidence is found that micronutrient supplementation can slow progression
- Non-breastfed children (6-12 months) have very specific nutritional needs – growth faltering is common (and mortality may result from malnutrition). PMTCT programmes have an obligation to address this problem which is inherent to the intervention.

It was further mentioned that the duration of food assistance is a big challenge. MTCT+ sites generally requested food for 12 months post-delivery whereas most PMTCT projects that deliver food do so in the last trimester and 6 months after delivery.

The logistics around setting up provision of food are time-consuming. Issues of storage, duration of support and obligation to receive food are not easily dealt with. Also indicators for measuring impact is a challenge since nutritional indicators or other biological forms of assessment may not be appropriate to measure impact of food aid for these programmes. Hence, new measures of the overall well-being and status of family as a whole are needed.



As a conclusion Dr. Katona-Apte stated that nutritional support can make a dramatic difference in two different cohorts that are underserved to date – PLWHA receiving ARV through MTCT-Plus projects and PLWHA identified through PMTCT programmes not receiving support.

During the following discussion the importance of the vicious circle – infection, malnutrition and poverty – was emphasized

particularly in Asian region. A concerned participant shared the story of people who were sad to be tested negative because they were then not able to get the food supplies from WFP as the ones that are tested HIV-positive. Dr. Katona-Apte responded that WFP do not want to use food supplies as an incentive for getting tested. The policy not to allocate food only on the basis of HIV status. The provision should be done on geographical terms.

PMTCT and Children Orphaned and made Vulnerable by HIV/AIDS

Presented by Ian MacLeod, Regional Adviser, UNICEF ROSA

Mr. Ian MacLeod started out by asking whether the PMTCT programme visited during the fieldtrips were creating more orphans. The answer, he stated, is yes. By reducing the number of children who are infected the number of children living with HIV-positive women is increased – and these mothers will die within the next 0 -10 years.

However, that is not a rationale for not doing PMTCT. It should rather broaden the thinking on using the many opportunities presented by PMTCT. Mr. MacLeod emphasized that it simply is not ethically and morally correct to prevent vertical transmission from mother to baby through PMTCT programmes without ensuring lifelong care, support and treatment for the mother, the child and partner. It was stressed that a child who is orphaned runs a higher risk of infection, abuse, malnutrition, loss of schooling, health care and higher workload.

It is likely that there will be a significant increase in the number of HIV related orphans in the future. Presenting epidemic curves it was seen that orphans represent

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PMTCT and Children Orphaned and made Vulnerable by HIV/AIDS

Asia Pacific Region of India Post-Test
Prevention of Mother to Child Transmission
of HIV
Monday, 11th March 2008



the third wave of the epidemic after the HIV curve and the AIDS curve. In Afghanistan and Lao PDR, more than 10% of all children were orphans in 2003.

Mr. MacLeod then presented the “Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World of HIV and AIDS”. The aim of the framework is to support countries to develop approaches which ensure that children affected by HIV/AIDS live within family environments, have equal access to health, education, care and protection. The framework includes five key strategies:



- Strengthen the capacity of families
- Mobilise and strengthen community-based responses
- Ensure access to essential services
- Ensure that governments protect the most vulnerable children
- Raise awareness to create a supportive environment

The presentation spelled out each of the 5 key strategies, provided valuable programming guidance and ended up defining the key areas of action as equal access to basic services, psychological and emotional support for families, the aim to ensure inheritance and protection legislation and to prolong the lives of parents.

Mr. MacLeod concluded that just as PMTCT is now seen as a primary entry point for expanded access to care, treatment and support (incl. ART) it is also a primary access point for ensuring that rights and needs of affected – and infected – children are met. The Framework is

currently being introduced across countries in Asia and the Pacific.

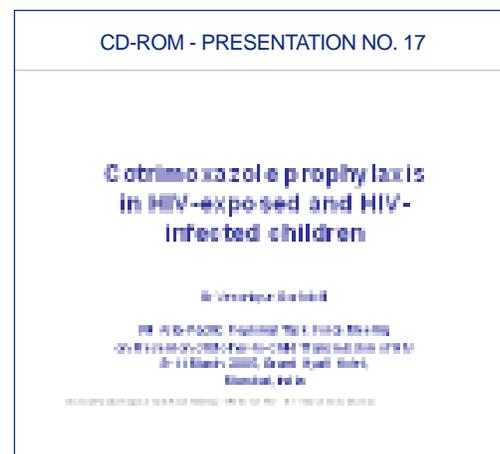
Participants agreed on the importance of the focus on children affected by HIV/AIDS and their families. The fact that in many countries in the region, a large percentage of these children would be living in families and communities that are already marginalized, including children of sex workers, migratory labourers, and drug users. Mr. MacLeod agreed that it is essential to understand more about the additional violations of rights of children in these very marginalized and stigmatized families. The usefulness of micro-planning and participatory village-level assessment and planning exercises in relation to defining vulnerability of children and families and developing action was highlighted. In addition, the importance of creating linkages from PMTCT to programmes for children that are older than two years old was highlighted and to ensure that there are no gaps in ensuring access to support and care.

Cotrimoxazole Prophylaxis in HIV-exposed and HIV-infected Children

Presented by Dr. Veronique Bortolotti, WHO

Dr. Bortolotti initiated her presentation by stating that cotrimoxazole as prophylaxis against opportunistic infections in HIV-infected patients is very effective and highly recommended by WHO, UNICEF and UNAIDS. She shared the example of a recent trial in Zambian children aged 1-14 years with clinical features of HIV infection where the mortality was 28% in the children in the cotrimoxazole group against 42% in the children in the placebo group.

Pneumocystis carinii Pneumonia (PCP) is very common amongst HIV-infected children, particularly in their first year of life.



It causes high mortality and poor prognosis in the absence of ART. Cotrimoxazole is



very effective in preventing PCP and possibly also other opportunistic infections such as bacterial pneumonia, non typhoid salmonellosis, isosporiasis. Moreover, cotrimoxazole prophylaxis has shown to reduce mortality in HIV-infected adults with tuberculosis.

In developing countries the use of cotrimoxazole prophylaxis in HIV-exposed and HIV-infected children is not yet widely recommended and implemented at national level. Reasons may include:

- the low awareness at national and field level – making advocacy important
- the risk of toxicity – which is in fact negligible
- the antimicrobial resistance – already existing or the risk of resistance development
- the high proportion of children exposed to HIV who will receive cotrimoxazole whereas they are not infected with HIV
- the logistics and costs
- Cotrimoxazole prophylaxis may hamper the effectiveness of other health care strategies

Cotrimoxazole is widely available and used as treatment. Mass cotrimoxazole prophylaxis may bring an additional risk of induced resistance to pathogens. The risks include that children become colonized with resistant bacteria; that resistant pathogens spread in the families and communities and that cross-resistance may take place with sulfadoxine-pyrimethamine which is used for malaria.

In developing countries the HIV-status of the child is often only known when the child is 18 months old due to breastfeeding or lack of testing possibilities. A significant proportion (60-98%) of the infants born to

HIV-infected mothers will not be infected but might receive cotrimoxazole prophylaxis for more than a year, thus increasing the risk of bacterial resistance to cotrimoxazole and having impact on the programme cost. Dr. Bortolotti therefore stressed the importance of improving early diagnosis of HIV infection in infants born to HIV-infected mothers; the need to prospectively monitor the microbiological effects of “mass” cotrimoxazole prophylaxis and of course the importance of reducing the number of children exposed to HIV and the number of children with HIV infection.

Dr. Bortolotti spelled out the WHO/UNICEF/UNAIDS recommendations for the use of cotrimoxazole as prophylaxis in HIV-exposed and HIV-infected children stating that it is a key intervention that should be offered as part of a basic package of care in:

- *All HIV exposed children* (children born to HIV-infected mothers) from 4-6 weeks of age (whether or not part of a PMTCT programme). Treatment should be maintained until HIV infection has been definitively ruled out and the mother is no longer breastfeeding
- *Any child identified as HIV-infected* with any clinical signs or symptoms suggestive of HIV, regardless of age or CD4 count. Treatment should be maintained indefinitely where ARV treatment is not yet available. For children on ART, cotrimoxazole can be stopped only when evidence of immune restoration has occurred.

The conclusion was very clear:

“cotrimoxazole prophylaxis should be part of a routine care of HIV-infected children and HIV-exposed children until HIV infection has been definitively ruled out. DO IT – and do not forget the mother!”.



Prevention of Mother-to-Child Transmission of HIV/AIDS in China

Presented by Ms. Wang Linhong, National Center of MCH, China CDC

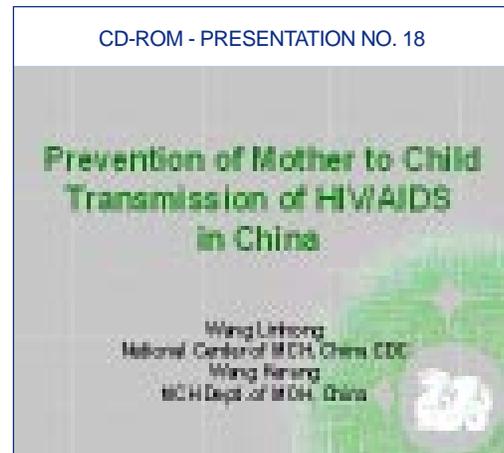
The PMTCT project in China was initially started with a UNICEF supported pilot project in Shanghai. Based on the experiences of this programme the MCH Department of the Ministry of Health in 2003 initiated a national PMTCT pilot project as part of the National HIV/AIDS Control Programme. The programme has since been further scaled-up and will in 2005 have scaled-up to 241 counties all over China.

The objectives of the programme are to provide comprehensive PMTCT services to pregnant women, support HIV-infected women in making informed reproductive health choices, to provide treatment and care for HIV-positive mothers, their children and families and ultimately reduce the occurrence of HIV infections caused by MTCT.

The activities undertaken in order to reach the objectives are public awareness raising, capacity building of MCH and family planning workers, provision of VCT services, the undertaking of applied research and various intervention services for pregnant women and infants.

The PMTCT programme has revised the PMTCT management protocol, produced a new PMTCT technical handbook, new training materials and a variety of IEC materials for pregnant women, their families and young people.

With particular focus on the HIV/AIDS situation among children in China a guideline on treatment and care for HIV-infected children has been developed and also a child HIV/AIDS treatment programme was launched throughout the



country in 2004. Further, two training workshops on child HIV/AIDS treatment has been held in 2004 and 2005 respectively. The constraints found in relation to the implementation of the guidelines are many. Ms. Linhong pointed out the following:

- Low awareness among local government and target population
- Lack of financial support and harmonious cooperation between different sections
- Lack of knowledge and skills related to PMTCT and children's treatment and care in MCH settings and hospitals
- Lack of high quality counseling
- Weak information system
- Difficult to conduct child HIV/AIDS epidemiology survey for the entire country
- ARV drugs tailored for children are not available in China

It was explained that the National Plan of PMTCT is trying to deal with these constraints through community mobilization, health education activities, capacity building as well as through improvement of the relations to other sections and programmes and strengthening of information management systems.



- *Build strategic alliances and partnerships to support programme implementation*
 - Promotion of the 3 ones is important – one strategy, one coordinating mechanism and one monitoring and evaluation system. When thinking scale there is a need to build on existing opportunities and leverage the existing in-country resources.

Networking and pooling of data bases is necessary.

Dr. Luo emphasized the need for concerted action to put children on the treatment agenda. Participants agreed to this and asked when the ARV guidelines for children would come. The answer to that however lies with WHO that is developing the guidelines.

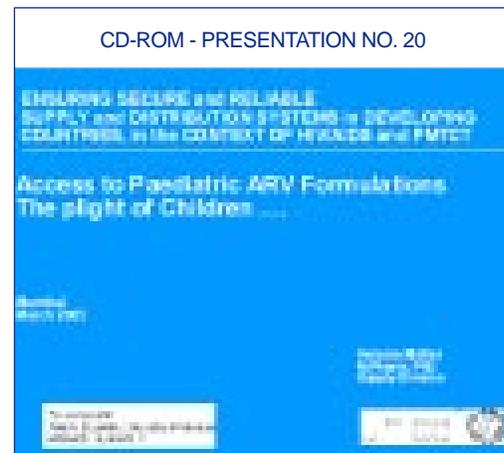
Access to Paediatric ARV Formulations - the Plight of Children...

Presented by Helene Moller, UNICEF Supply Division, Copenhagen

Ms. Helen Moller initially explained that access to paediatric ARV formulations depends on effective supply chain management. She emphasized that a chain is only as strong as one link of the chain and hence all links has to be considered when in need of paediatric ARV formulations. The challenge is to neither be out of stock or to be held accountable for expired drugs.

Regarding demand the question is when to start and what to start with. Participants were reminded that WHO guidelines exist for both PMTCT and for treatment and care in first and second line (see <http://www.who.int/hiv/pub/mtct/guidelines/en/>).

The UNICEF Supply Division product portfolio includes 42 formulations of ARV in 75 different presentations. Of these formulations 30-40% can be used for children. Also different test kits and PCR equipment can be supplied. Ms. Moller however stated, that it can be problematic to select the right products since the products might not be available in the right doses. For example Zidovudine oral liquid is commercially available as 100ml, 200ml and 240ml bottles but for PMTCT treatment approximately 35ml per week is needed.



Another big question is how to estimate the needed amount. It is necessary to look closely at the guidelines and determine which kinds of treatment are required within the programme. Ms. Moller showed the recommended doses for treatment and care in first and second line and then outlined five steps that need to be investigated in order to estimate the number of treatments needed:

- Step 1. Estimated number of births, existing death-rates, HIV prevalence in ANC settings
- Step 2. Estimated PMTCT coverage and transmission rates = estimated HIV-positive infants born



- Step 3. What is the chance of survival? Morbidity? Mortality? Coverage with cotrimoxazole prophylaxis?
- Step 4. Estimated number of children at different ages eligible for treatment (assumptions around disease progression)
- Step 5. Reality check – who will enroll them into treatment, etc.

Further, the money flow needs monitoring. Cost of treatment drops when switching to adult formulations (peak around 14 kg of bodyweight) and using tablets for a child (20kg) reduces the cost per treatment per yearly 8 times. However, managing the switch increases complexities in resource poor settings. Other challenges are that some products need cold storage, are available in breakable glass bottles only, are not available in fixed dose combinations or they simply taste bad making it difficult to feed them to children.

The supply chain management is further challenged by the absence of comprehensive procurement policies, rules, regulations and structures, insufficient funding, conflicting procurement regulations and the lack of trained procurement staff.

Ms. Moller concluded that the access to drugs has improved but that a large gap still remains. She stated that with the currently available formulations, children can and should be treated. Greater advocacy is needed for access to appropriate formulations for both PMTCT and HIV care and treatment. The supply cycle is almost completed but need the support of partners.

Ms. Moller's presentation raised a number of questions and comments among participants. One participant regretted that training on supply chain management was not included in the PMTCT guidelines. Another raised the concern of having enough human resources available for implementing the programme. Ms. Moller added that reality checks are necessary. The presence of adequate human resources has an immense affect on the supply, particularly if skilled people leave the programme. Drugs cannot just be saved for later as the shelf life of many of the drugs is very short. Participants were advised to resist the temptation to drop drugs in a facility and think that it will act as a magnet and make the project work. Often money needs to be spent and then procurement of drugs becomes a last minute decision – not an approvable way of managing supplies.



Monitoring and Evaluation of PMTCT Programmes: Major Challenges in Implementation and Monitoring of UNGASS Goals

Presented by Dr. Ngashi Ngongo, UNICEF New York

Monitoring and evaluation (M&E) of PMTCT is important, Dr. Ngongo stated, as it helps programmers monitor progress towards attaining local, national and international targets (e.g. the UNGASS PMTCT goals). The findings can be used to identify problems that need to be addressed, to refine and adapt implementation strategies and to assess the effectiveness and impact of PMTCT interventions.

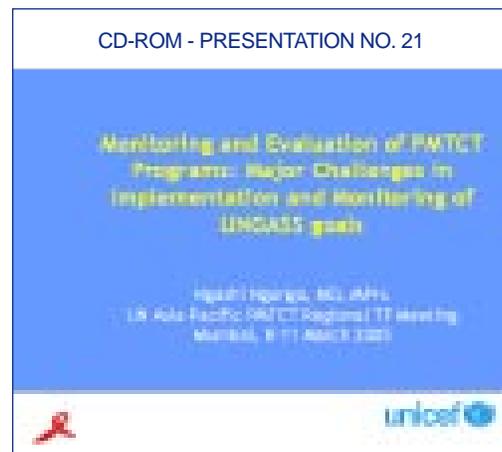
When monitoring PMTCT programmes, focus should be put on government commitment, programme coverage, uptake of services and programme effectiveness. The latter brings about the special challenge of evaluating infant infection status and programme effectiveness.

Core national level indicators have been developed by UNAIDS working group and includes:

- Existence of guidelines
- Number and % of trained health workers
- % of prevention and care service points
- % of women counseled and tested
- % of women receiving ARV prophylaxis
- % of HIV-positive infants born to HIV-positive women

As additional national level indicators the following has been suggested:

- Number of HIV-positive women referred for family planning services
- % of PMTCT venues that refer to care and support facilities
- % of HIV-positive women receiving infant feeding counseling at first follow-up visit



- Number of condom distributed in ANC settings and average number of days of stock out

Dr. Ngongo pointed out that these indicators to some extent cover all four prongs in the PMTCT strategy. But he concluded that the current indicators need further refinement to adequately address prong 1 and 2.

A PMTCT M&E system needs the following components:

- Monitoring committee
- Targets and implementation plan
- Data collection tools – standardized registers and monthly summary forms
- PMTCT database
- Feedback mechanism
- Support materials: training material and job aids

Dr. Ngongo pinpointed the importance of considering which type of data, which type of system and which data collection tools to be used as well as the capacity to utilize



these data at all levels. And how the various data and processes are being quality assured.

Dr. Ngongo concluded that reporting on PMTCT indicators is important for programme monitoring and strengthening. Countries need to assess their M&E to identify weaknesses that need to be addressed building on successful stories.

During the discussion Dr. Ngongo pointed out the importance of countries filling in the PMTCT monitoring sheet in order to establish a baseline for the region and assess where the individual countries are in

terms of PMTCT. The wish is to update it every year. The monitoring sheet includes both quantitative and qualitative questions that looks at the status of the monitoring system, explores the partnerships etc. A participant raised the question of how to coordinate information through both public sector, private sector and NGOs. Dr. Ngongo recognized this as an important challenge. The solution needs to be determined in the PMTCT coordination mechanisms at national level. Once this mechanism is on board, when consensus on indicators and goals has been reached then then it should be possible to keep coordination in place later on also.

Experience in M&E of PMTCT: Thailand

Presented by Pornsinee Amornwichee, Ministry of Public Health, Thailand

Ms. Pornsinee Amornwichee shared the example of the Perinatal HIV Intervention Monitoring System (PHIMS) in Thailand.

The objectives of the system were:

- To monitor the implementation of the national PMTCT programme at the hospital level.
- To create a model system for simple and systematic collection and reporting of essential PMTCT programme activities
- To provide administrative data for resource allocation planning
- To provide surveillance data on the prevalence of HIV infection among women in antenatal care.

The system was established through:

- Reviewing experiences from the monitoring system used during pilot PMTCT intervention
- Designing a reporting form for collecting key monitoring indicators of the programme including data items, frequency of data collection, and units of measurement (i.e. hospital months)

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Experience in M & E of PMTCT: Thailand

Pornsinee Amornwichee
Department of Health
Ministry of Public Health
Thailand

- Designing a series of 9 standard reports for each organizational level (province, region, nation)
- Designing a writing computer programmes for data management
- Developing manual of operations - distributed programme to sites via CD Rom
- Training staff in completion of monthly report form and sending data
- Conducting training sessions for regional staff, regional staff responsible for instructing provincial staff for PHIMS



computer programme use, data flow and data dissemination.

Data are collected monthly at ANC settings, delivery rooms and pediatric OPDs. These monthly reports are then forwarded to the Ministry of Public Health where the data are merged into a national database allowing for national reports to be generated.

The national monitoring system was successfully implemented and is being used to improve the PMTCT programme by identifying problems and creating solutions. The reasons for success, according to Ms. Amornwichee, relates to the fact that the system is:

- Specifically designed for PMTCT programme evaluation
- Feasible to integrate into maternal-child health system
- A reliable, simple and user-friendly database management system, and that

- It gives quick feedback of information which allows for identification of gaps and helps in the surveillance and administration of the implementation.

The system captures data from approximately 90% of country's total deliveries and includes more than 90% of maternity service government hospitals. A limitation found is that the system does not capture deliveries outside the government system i.e. private hospitals.

The following discussion focused on the tools and time needed when implementing M&E. One participant was concerned that the M&E would just be an extra burden on already overburdened service providers. This point grew into a discussion on the need for developing and sharing efficient and good tools for monitoring. Tools that do not just further strain service providers. The example of Thailand was found very illustrative and useful.



Group Work Recommendations

Participants were split into four different groups throughout the meeting. The groups were formed based on the HIV prevalence in their countries and the level of PMTCT programming present. Further, due to the high number of participants from India and the size of the country, a pure Indian group was formed.

The four groups were set as follows:

Group 1	Group 2	Group 3	Group 4
Low prevalence with small or no PMTCT programme	Low prevalence with Initial phase of PMTCT programming	High prevalence with established PMTCT programme	India country team
Afghanistan, Bangladesh, Maldives, Pakistan	Pacific Islands, Indonesia, Nepal, Lao PDR, Papua New Guinea	Cambodia, Vietnam, Myanmar, Thailand, China	India (7 states represented)

Sessions for group discussions were carried out following the presentations on each of the four prongs. Participants were asked to, in their groups, for each of the four prongs to:

1. Describe the situation and identify challenges and opportunities
2. Suggest recommendations on how to address gaps and issues and how to use existing opportunities
3. Identify three priority actions for

country/region - who is responsible for follow up and which resource are needed (technical, human and financial)

The groups reported back to plenum during two sessions. First session's presentations focused on prong 1 and 2 and the second session focused on prong 3 and 4. The groups' recommendations for PMTCT programming has been gathered in the matrix below.



Group Recommendations - PMTCT of HIV/AIDS Recommendations for Prong 1 & 2

	Group 1 Low prevalence Small or no PMTCT programme	Group 2 Low prevalence Initial phase of PMTCT programme	Group 3 Group 3 High Prevalence Established PMTCT programmes	Group 4 India Country Team
	Afghanistan, Bangladesh, Maldives and Pakistan	Fiji, Indonesia, Nepal, Lao PDR and Papua New Guinea	Cambodia, Vietnam, Myanmar, Thailand and China	India
Policies and guidelines	Develop country specific policy and strategy. Strengthen the legal and strategic framework		Establishment of policy and guidelines - and put to practice.	Strengthen policy, resource coordination and management at state level, e.g. RCH, HIV and TB programme performance could be reviewed jointly by the line departments.
Advocacy	Proper advocacy required at all levels and followed up by the implementation of policies	Intensified communication strategy and communication activities - linked to advocacy for policy makers and partners. A coordination mechanism needs to be established/strengthened.		Advocacy to synergize PMTCT/ ART/TB/VCCT service at hospital/institutional level and to integrate PMTCT/RCH/ICDS; condoms, FP services, ANM/ ANW workers orientation.
BCC and awareness raising	Increase awareness among target populations and general population	Importance of documentation of best practices and success stories.	BCC interventions - involve media personnel who can disseminate to the general population	Develop appropriate messages for communication.
	Address socio-cultural issues - e.g. low female status, stigma and discrimination, early marriages, violence, inter/spousal communication, girls education	Address "work place" issues		Audio-visual and health information materials available at all clinics.





	Group 1 Low prevalence Small or no PMTCT programme	Group 2 Low prevalence Initial phase of PMTCT programme	Group 3 Group 3 High Prevalence Established PMTCT programmes	Group 4 India Country Team
	Afghanistan, Bangladesh, Maldives and Pakistan	Fiji, Indonesia, Nepal, Lao PDR and Papua New Guinea	Cambodia, Vietnam, Myanmar, Thailand and China	India
Capacity building	Build Capacity to scale up/ expand coverage through: 1) policy, 2) Programme, 3) Technical, 4) implementation 5) M&E	Build capacity in the area of counseling (adequate and good quality) for all health care providers, managers etc. - at all levels.		Sensitization/ training of all the health care functionaries
Integration of services	Integrate PMTCT into MCH, FP, PHC, RH, STI and curative services. Mainstream HIV/AIDS prevention into education, labour, information and communication, health, religious affairs and women's development	Integration of prong 1 into existing services as e.g. MCH, STI	Include VCT services within the MCH service (ANC and FP)	All RCH services to provide HIV services
VCT	Increase access to VCCT services	Innovative approach to VCT need to be found (e.g. group counseling, lay counselors)	Multi-sectoral response Make use of couple counseling, waiting rooms for men and pre-marital counseling consultations	
		Acknowledge counselors as professionals (i.e. nurses, midwife, lay counselors are getting new roles)		

	Group 1 Low prevalence Small or no PMTCT programme	Group 2 Low prevalence Initial phase of PMTCT programme	Group 3 Group 3 High Prevalence Established PMTCT programmes	Group 4 India Country Team
	Afghanistan, Bangladesh, Maldives and Pakistan	Fiji, Indonesia, Nepal, Lao PDR and Papua New Guinea	Cambodia, Vietnam, Myanmar, Thailand and China	India
Community/ male mobilization	Improve availability and quality of services to address unmet needs including e.g. male involvement, religious/community leaders and youth	Specific/ targeted approach to vulnerable and hard to reach groups needed (i.e. build on existing service such as immunization/vitamin A, CHWs, counselors)	Community mobilization - role of TBA (traditional birth attendant) to support the PMTCT programme	More adolescent friendly services
	Strengthening men's involvement			
Partnerships		Involvement of PLWAs (GIPA) as well as negative mothers and young people	Harmonization, collaboration, cooperation, coordination among partners and programmes including mass media	Involvement of private sector for delivery of PMTCT services: Need a strategy to be developed.
M & E	Establish data collection and analysis system for evidence based decision making	Strengthen/ establish good M&E of Prong 1 and 2 (regular programme review). Need to think about sustainable strategies and mechanisms	Monitoring, supervision, evaluation mechanisms	Comprehensive PMTCT reviews at the state level to develop 4 pronged strategy (including ART, GFATM).
Resource mobilization		Utilize new opportunities (GFATM funds) to strengthen HR gap in counseling	Resource mobilization - manpower, materials, money	





Group Recommendations - PMTCT of HIV/AIDS Recommendations for Prong 3 & 4

	Group 1 Low prevalence Small or no PMTCT programme	Group 2 Low prevalence Initial phase of PMTCT programme	Group 3 High Prevalence Established PMTCT programmes	Group 4 India Country Team
	Afghanistan, Bangladesh, Maldives and Pakistan	Fiji, Indonesia, Nepal, Lao PDR and Papua New Guinea	Cambodia, Vietnam, Myanmar, Thailand and China	India
Advocacy	Advocacy	Advocate for better coordination among all the players	Develop appropriate IEC materials - for target groups. The key stakeholder has to be selected... e.g. links with Women's union, youth groups etc.	Advocacy at all levels for integration
BCC and awareness raising		Provision of information		Implement the National communication strategy - standardization of messages
		Using different sites to spread messages e.g. TB settings		
Coordination, collaboration and partnerships	National coordination mechanism - clearly defined roles and responsibilities with Government as lead.	Link up with existing systems e.g. DOTS can maybe be used as an entry point to ARV etc.	Collaboration between different health sectors, ANC, NNC etc. Link between different ministries and different service providers.	Strengthening links with NGOs - drop in centres
	CB of NGOs, positive networks - advocacy with government and police	Get Government commitment for PMTCT	Partnership - coordination and collaboration seems to be weak. Need to work together in order to find out how to best support the government.	

Group 1 Low prevalence Small or no PMTCT programme	Group 2 Low prevalence Initial phase of PMTCT programme	Group 3 High Prevalence Established PMTCT programmes	Group 4 India Country Team
Afghanistan, Bangladesh, Maldives and Pakistan	Fiji, Indonesia, Nepal, Lao PDR and Papua New Guinea	Cambodia, Vietnam, Myanmar, Thailand and China	India
	Strengthening the collaboration with NGOs and FBOs, civil societies and partners	Need to identify one coordination body within the government who will be coordinating	
Integration of services	Strengthening of the existing ANC/MCH/FP/PHC	Set up and improve health service for all people - if available then improve quality	
	Improve and expand delivery of quality service	VCT and PMTCT should be integrated into existing services - counseling for pre-married couples, pregnant women and for couples. The important thing is to provide post-test counseling for both positive and negative.	
Community support and involvement	Male involvement (multi-sectoral approach) - as well as involvement of religious leaders, community, labour, male youth groups and the Ministry of Education	Community practices - improve awareness and HIV prevention	
	Marriage counseling for newly wed couples	Assessment of what is available in the country for care and support	





	Group 1 Low prevalence Small or no PMTCT programme	Group 2 Low prevalence/initial phase of PMTCT programme	Group 3 High Prevalence Established PMTCT programmes	Group 4 India Country Team
	Afghanistan, Bangladesh, Maldives and Pakistan	Fiji, Indonesia, Nepal, Lao PDR and Papua New Guinea	Cambodia, Vietnam, Myanmar, Thailand and China	India
Resource mobilisation and supply	Resource mobilization and donor coordination	Develop and strengthen proposals to include/reinforce PMTCT component for Global fund		Harmonize funding/budgeting
		Continued supply of ARVs and OI treatment/prophylaxis as well as nutritional support		Inclusion of HIV test kits in RCH kits.
Regional support and knowledge base	Regional/ HQ support in national strategy formulation/plan of action	Pool of resource people to help other countries start up services	Need to be very well prepared before implementation is started - goal, strategy, scaling up process, selection of areas.	
	Country specific approaches	Learning hubs in the region (was promised last year), including E-web space		
M & E	M&E evaluation			State level reviews to define scaling up processes - capacity building, M&E

Presentation of scale-up framework

The presentations on programmatic issues in relation to PMTCT revealed a need for thorough programming. Therefore, participants were introduced to a very simple framework in the last group working session. The framework intended to focus the participant's minds on the importance of setting goals, targets and indicators as well as developing strategies and partnerships and assessing the need for technical, human and financial resources.

The framework was discussed and filled in by each group. It turned out to be a very useful tool for participants to apply their knowledge and hence, following the presentations it was decided that work on the framework was to be followed up after the meeting with support from the regional offices. Examples of group 1 and 2's frameworks are presented below.

During the presentation of the frameworks Dr. Chewe Luo, Dr Grace Kariwiga and Dr Faizullah Kakar were asked to draw their conclusions and give their comments. They highlighted that:

- PMTCT is not only about saving children – it is part of a bigger picture
- PMTCT is challenging and beyond the boundaries of health infrastructure of doctors and nurses. People without medical backgrounds need to be involved – behaviour specialists, sociologists etc.
- “What happens in Thailand might not work in India” – to some extent there is a need to learn by doing whilst at the same time base initiatives on knowledge gained from previous experience and studies
- Production of IEC materials should start from listening to what is best for the recipients. Do not assume that programmers know what works best
- When scaling up of PMTCT – think about who will be driving the agenda. It will require repositioning at many levels
- Whilst planning take into account geographical, cultural and economic access to services
- Confidentiality needs to be ensured to convince people to utilize facilities



Example of the PMTCT scale-up framework Group 1 - Low prevalence/ small or no PMTCT programmes

Brief description of the situation in terms of disease burden and drivers of the epidemic	Low prevalence, unsafe medical practices and low availability of services. Drivers of the epidemic are poverty, gender disparity, internal and external migration.
PMTCT programme goal	To maintain low HIV prevalence among men and women of reproductive age
Define 2 to 3 key programme targets	<ol style="list-style-type: none"> 1. Establish integrated HIV prevention in at least 30% of appropriate health care settings 2. By 2006 basic PMTCT package in at least 2 to 5 sites 3. By 2007 at least 20% of affected families have access and receive care and support
Key Monitoring Indicators(2-3)	<ol style="list-style-type: none"> 1. Policy guidelines in place 2. Number of families reached 3. Number of health care workers trained
Package of interventions within the 4 prongs	<p>Prong 1: IEC/BCC interventions and counselling</p> <p>Prong 2: Scale-up VCCT and strengthen FO referrals</p> <p>Prong 3: Safe delivery and access to prophylaxis</p> <p>Prong 4: Comprehensive care and support to support groups living with HIV. Referral system and network.</p>
Strategies for accelerating action on each of the prongs to achieve the defined programme goal and targets including level of coverage (maximum 5)(For coverage define whether the intervention will be targeted towards specific populations or facilities)	<ol style="list-style-type: none"> 1. Comprehensive BCC and advocacy to strengthen the MCH. 2. Capacity building of health care providers. 3. Establishment or strengthening of existing support groups of people living with HIV.
Partnerships and coordinating mechanisms	Support groups of people living with HIV, NGOs, private sector and key ministries.
Definition of required support	Technical support on policy and treatment guidelines and financial support.



Example of a PMTCT scale-up framework

Group 2 - Low prevalence/ Initial phase of PMTCT programme

Brief description of the situation in terms of disease burden and drivers of the epidemic	Disease burden varies from 0.01 prevalence to 1,5% but is rapidly increasing in some countries. Drivers of the epidemic are IDUs, sex workers and clients, migrants, MSM, seafarers and tourists.
PMTCT programme goal	Reduce MTCT by 20%
Define 2 to 3 key programme targets	<ol style="list-style-type: none"> 1. Set up centres of excellence with comprehensive PMTCT package integrated into MCH/RH in all the countries 2. Delivery of PMTCT services to all pregnant women at selected sites 3. Reach all of community with information/ messages on PMTCT
Key Monitoring Indicators(2-3)	<ol style="list-style-type: none"> 1. Number of pregnant women receiving PMTCT 2. Number of centres of excellence established 3. Number of centres distributing condoms
Package of interventions within the 4 prongs	<p>Prong 1: Prevention, communication, IEC materials, integration and linkages with different partners. Delivering sexual and reproductive health education to schools. PEP availability for abuse cases.</p> <p>Prong 2: Integration of family planning and counselling into the education system and into reproductive health/ MCH services.</p> <p>Prong 3: Improve clinical linkages especially to OBGYN and also to community level. Commodities supply and availability.</p> <p>Prong 4: Minimum care and support package</p>
Strategies for accelerating action on each of the prongs to achieve the defined programme goal and targets including level of coverage (maximum 5)(For coverage define whether the intervention will be targeted towards specific populations or facilities)	<ol style="list-style-type: none"> 1. Communication package at all levels 2. IEC materials 3. In-service and pre-service training 4. Supplies 5. Monitoring Interventions should initially be targeted at mothers coming to health facilities and then to the rest of the populations.
Partnerships and coordinating mechanisms	Private, public partnerships, NGOs, FBOs, civil societies and community groups.
Definition of required support	Technical and financial support especially with access to the Global Fund.



Annex 1: Agenda

Day One: 8 March 2005 (Tuesday)

08:00 – 09:00	Registration	
09:00 – 09:20	Welcome Remarks: Ian Macleod, ROSA Arjan de Wagt, EAPRO	Advocacy for PMTCT
09:20 – 09:30	Logistics Myo Zin Nyunt, ROSA	
Morning Session of Day One (Chairperson : Arjan de Wagt)		
09:30 – 10:15	PMTCT Global Overview: Opportunities and Challenges (30 minutes) Ngashi Ngongo, HIV/AIDS Officer UNICEF NYHQ Discussions (15 minutes)	- Update the global perception and trends of PMTCT
10:15 – 10:30	Morning Break	
10:30 – 11:30	PRONG ONE Targeted Primary Prevention (20 minutes) Dr. Farah Usmani, Regional Adviser HIV and RH, UNFPA CST for South and West Asia Integrating HIV information and counseling services into RH settings (10 minutes) Dr. Brinda Frey, FPAI, Lucknow, India HIV prevention in MCH/FP settings: Myanmar Experiences (10 minutes) Ms. Khin Ma Ma Aye, ARR, UNFPA Myanmar Discussions (20 minutes)	- To provide an overview of targeted primary prevention as an important strategy in the regional context especially for low-prevalence countries- To share the experience of a pilot UNFPA supported multi-country project
11:30 – 12:30	Group Work: 4 working groups (60 minutes)	- Review strategies and concrete activities being carried out- Identify priorities and key actions to scale-up targeted primary prevention in PMTCT programme
12:30 - 13:30	Lunch Break	



Afternoon Session of Day One (Chairperson : Ivonne Camaroni)

13:30 - 14:30	<p>PRONG TWO Overview presentation/Preventing unintended pregnancy in HIV-positive women Dr. Wendy Holmes, Deputy Director Technical Programmes, Centre for International Health Macfarlane Burnet Institute (40 minutes presentation) Discussion (20 minutes)</p>	<ul style="list-style-type: none"> - To share biomedical update as well as programming issues related to RH needs of HIV-positive women including policy matters in Asian context.
14:30 - 15:30	Group work: (60 minutes)	<ul style="list-style-type: none"> - Review and plan concrete activities and interventions
15:30 - 15:45	Afternoon Break	
15:45 - 16:15	Continue Group Work	
16:15 - 17:15	Group Presentations and discussions	<ul style="list-style-type: none"> - Technical support/joint advocacy
17:15 - 17:30	<p>Briefing of field visit on Day 2 Dr. Sanjana Bhardwaj, UNICEF Mumbai</p>	
End of Day One		
18:30 - 20:30	Reception - hosted by UNICEF ROSA and EAPRO	

Day Two: 9 March 2005 (Wednesday)

Morning Session of Day Two (Chairperson : Agatha Pratt)

08:00 - 09:00	<p>PRONG THREE Technical session on updating ARVs, issues related to Nevirapine and recommendations Chewe Luo, Senior Health Adviser UNICEF NYHQ (30 minutes presentation/30 minutes discussion)</p>	<ul style="list-style-type: none"> - Technical updates and clarification on use of Nevirapine - Update with latest recommendations
09:00 - 10:00	<p>Procurement, distribution and supply management of ARVs and HIV test kits Helene Moller, Field Support Officer, HIV/AIDS, UNICEF SD/CPH (30 minutes presentation/30 minutes discussion)</p>	<ul style="list-style-type: none"> - Supply management of ARVs and test kits - UNICEF role in procurement of ARVs/kits at national/regional level
10:00 - 10:15	Morning Break	



10:15 - 10:30	Comprehensive PMTCT Programme: India Country Experience Dr. Alka Gogate, Project Director Mumbai Districts AIDS Control Society	- Understanding how Indian going ahead with opportunities/ challenges
10:30 - 10:45	Country Presentation Initiating PMTCT Interventions in pilot sites Dr. Sushila Shrestha, Sr. Consultant Gynaecologist, Ministry of Health	- Understanding of issues, problems and possible solutions - initial phase
10:45 - 11:00	Country experiences on training and adaptation of global guidelines Dr. Bir Singh, UNICEF India	- Understanding of issues, problems and possible solutions with training and adaptation of guidelines
11:00 - 11:30	Discussions and wrap up	
11:30 - 12:00	Lunch Break	
Afternoon Session of Day Two		
FIELD VISIT TO FOUR PMTCT CENTERS IN MUMBAI (4 GROUPS)		

Day Three: 10 March 2005 (Thursday)

Morning Session of Day Three (Chairperson : Vidhya Ganesh)		
08:00 - 08:30	Finalize report by field visit teams	
08:30 - 09:00	Reflection of Field Visit Experience (5 minutes per group/10 minutes wrap up)	- Exchange views and share lessons learned
09:00 - 09:40	Capacity Building on PMTCT: Issues related to PMTCT training and adapting global guidelines at country level (20 minutes) Ngashi Ngongo, HIV/AIDS Officer UNICEF NYHQ Discussion (20 minutes)	- Improve the capacity and quality of training - Support to training plans for regional/ national/sub-national level training
09:40 - 10:00	HIV and Infant Feeding (20 minutes) Arjan de Wagt, UNICEF EAPRO	- HIV and Infant feeding as integral part of PMTCT
10:00 - 10:15	Morning Break	
10:15 - 10:45	Integrating HIV and Infant Feeding into PMTCT: challenges and opportunities Vietnam experience (15 minutes) Overall Discussion on HIV and Infant Feeding (15 minutes)	- Understanding of issues, problems and possible solutions



10:45 - 12:15	Group Work (Hanne Fink Moller) Four groups - nationwide/scaling up/initial phase on recommendations to overcome issues and problems	- Understanding of issues, problems and possible solutions
12:15 - 13:15	Lunch Break	
Afternoon Session I of Day Three (Chairperson: Dr Asma Bokhari)		
13:15 - 14:00	PRONG FOUR Care Continuum and linkage with “3 by 5 Initiative”: Treatment regimens and follow up for mothers, children and their partners Dr. Ying-Ru Lo, WHO (30 minutes Presentation) Discussion (15 minutes)	- Understand comprehensive care and support - Recommendations for linkage with “3 by 5”
14:00 - 14:30	Integration of food supplementation and nutritional support for people affected/infected Dr. Judit Katona-Apte Senior Programme Advisor, WFP Bangkok (20 minutes Presentation) Discussion (10 minutes)	- Understand comprehensive care and support - Networking with other agencies in the domain of care and support
14:30 - 15:00	Orphans and Vulnerable Children (OVC): Initiatives, Partnership and Framework Ian Macleod UNICEF ROSA (20 minutes) Discussion (10 minutes)	- Understand comprehensive care and support
15:00 - 15:15	Afternoon Break	
Afternoon Session II of Day Three (Chairperson: Myo Zin Nyunt)		
15:15 - 15:45	Experiences in use of co-trimoxazole in pediatric care of HIV exposed infants Veronique Bortolotti WHO (20 minutes) Discussion (10 minutes)	- Update knowledge on care and treatment of HIV exposed infants
15:45 - 16:00	Promoting Pediatric ARVs China Country Experience – China (15 minutes presentation)	- Understanding of issues, problems and possible solutions in scaling up
16:00 - 16:45	Pediatric AIDS: Care, treatment and implications for PMTCT programming Chewe Luo UNICEF NYHQ (30 minutes) Discussions (15 minutes)	- Update on pediatric AIDS treatment and ARVs - Strategic recommendations for working in Pediatric AIDS
16:45 - 17:30	Access to pediatric formulations and recent developments Helene Moller UNICEF SD/CPH (30 minutes presentation/15 minutes discussion)	- Update on pediatric formulations in Pediatric AIDS
End of Day Three		



Day Four: 11 March 2005 (Friday)**Morning Session of Day Four (Chairperson : Ian MacLeod)**

08:00 - 08:10	Feedback from Day 3 Hanne Fink Moller, Assistant Programme Officer, ROSA	
08:10 - 09:00	PROGRAMMATIC ISSUES Monitoring and Evaluation of PMTCT Intervention: Major Challenges in project implementation and achieving UNGASS goals Ngashi Ngongo, UNICEF HQ (20 minutes presentation) Experience in M & E of PMTCT: Thailand (10 minutes presentation) Discussion (20 minutes)	<ul style="list-style-type: none"> - Discussion (20 minutes) - Strengthen national M & E and improve quality data - Monitor the impact of PMTCT - How to achieve UNGASS goals
09:00 - 09:05	Introduction to group work	
09:05 - 10:00	Group Work Four groups working on prong IV (and prong III if not finished) and draft scaled-up (comprehensive) PMTCT.	Work plans or key next steps at national or sub-national level
10:15 - 10:30	Morning Break	
10:30 - 11:30	Group Work continued	
11:30 - 12:30	Group Presentations (10 minutes each) Comments on the presentations by panel	Understanding of issues, problems and possible solutions
12:30 - 13:00	Wrap Up Session Myo Zin Nyunt, Hanne Fink Moller, Arjan de Wagt Synthesis of key recommendations, proposed work plan, issues to be discussed further, next Task Force meeting	Key Recommendations of the Task Force
13:00 - 14:00	Lunch Break	
End of the Task Force Meeting		



Annex 2: List of Participants

Country Team	Participant	Organisation/Designation	Signature
Afghanistan	Dr Faizullah Kakar	Deputy Minister of Health (Policy, Planning and Preventive Medicine), Ministry of Public Health	Ministry of Public Health Government of Afghanistan Kabul, Afghanistan Tel: +92 70064572 E-mail: moph_ppdeputy@yahoo.com
	Dr Shafiqullah Shahim	HIV/AIDS Surveillance Officer Ministry of Public Health	Ministry of Public Health of Afghanistan Kabul, Afghanistan Tel: +92 79319682 E-mail: nacpmoh@yahoo.com
	Dr Kunihiko Chris Hirabayashi	Chief of Health and Nutrition, UNICEF Afghanistan	UNICEF Afghanistan Tel: +92 790607600 E-mail: khirabayashi@unicef.org
Bangladesh	Dr Fatima Parveen Chowdhury	Line Director, National AIDS/STD Programme	National AIDS/STD Programme House No. 376/A Road 28, New DOHS Mohakhali, Dhaka Tel: 880 2 8853378 Fax: 880 2 8829720
	Prof A Q M Serajul Islam	Head of Department of Dermatology and STD, Dinajpur Medical College	Dinajpur Medical College & Hospital Dinajpur, Bangladesh Tel: 88 031 657620/ 88 0171 749449 Fax: 88 031 635152 E-mail: aqmseraj@gononet.com
	Dr Md. Moshtaq Pervez	Physician, Jagori, VCT Unit	Jagori, VCT Unit HIV/AIDS Programme ICDDR, B, Mohakhali Dhaka-1212, Bangladesh Tel: 880 2 8811751 60 Fax: 880 2 8823116 E-mail: drmp6817@yahoo.com
	Ivonne Camaroni	HIV Project Officer, UNICEF Bangladesh	UNICEF Bangladesh 1 Minto Road Dhaka, Bangladesh Tel: +880 2 9336731 Fax: +880 2 933564 E-mail: icamaroni@unicef.org



Country Team	Participant	Organisation/Designation	Signature
Cambodia	Dr Seng Sutwantha	Vice Director, National Center for HIV/ AIDS, Dermatology and STD (NCHADS/MOH)	National Center for HIV/AIDS, Dermatology and STD Tel: +855 12 21 22 77 E-mail: swantha@online.com.kh
	Dr Kazuhiro Kakimoto	Chief Advisor & Medical Doctor, JICA Maternal and Child Health Project	JICA Maternal and Child Health Project P.O.Box 613 Pnom Penh Cambodia Tel: +855 12 983 091 Fax: +855 23 722 805 E-mail: kakimoto@sannet.ne.jp
	Chin Sedtha	HIV/AIDS Assistant Project Officer, UNICEF Cambodia	UNICEF Cambodia P.O.Box 176 No. 11, 75th Street Srachark Quartier Phnom Penh, Cambodia Tel: +855 12 819 915 E-mail: schin@unicef.org
China	Dr Wang Kerang	Programme Officer, Ministry of Health	Ministry of Health No. 1 Xi Zhimen Wai Nanlu Beijing, China Tel: 8610 68792309 Fax: 8610 68792321 E-mail: wangbin@moh.gov.cn
	Dr Wang Linhong	Professor, National Center for Women and Child Health	National Center for Women and Child Health China CDC Tel: 8610 64298136 Fax: 8610 64298136 E-mail: linhong@chinawch.org.cn
Fiji	Judith Leveillee	Project Officer (Adolescent Development), UNICEF Fiji	UNICEF Fiji 360 Victoria Parade Suva, Fiji Tel: +679 330-0439 Fax: +679 330-1667 E-mail: jleveillee@unicef.org
	Dr Rosalina Sa'aga- Banuve	Assistant Project Officer, Health and Nutrition, UNICEF Fiji	UNICEF Fiji 360 Victoria Parade Suva, Fiji Tel: +679 330-0439 Fax: +679 330-1667 E-mail: rsaagabanuve@unicef.org



Country Team	Participant	Organisation/Designation	Signature
India	Dr P. Somasekhar Reddy	Additional Project Director, A.P.State AIDS Control Society	A.P. State AIDS Control Society D.M. & H.S. Campus Sultan Bazar, Koti Hyderabad - 500 095 Andhra Pradesh, India Tel: +91 40 24743897 Fax: +91 40 24650776 E-mail: addlpd@yahoo.co.in
	Dr N. Seethalakshmi	Additional Project Director, Karnataka State AIDS Control Society	Karnataka State AIDS Prevention Society No. 4/13-1, Crescent Road High Grounds Bangalore - 560 001, India Tel: 080 22201465/ 22201436 Fax: 080 22201435 E-mail: ksaps@vsnl.com or ksaps_apd@hotmail.com
	Dr M.V. Karnataki	Joint Director (Training), Maharashtra State AIDS Control Society	Maharashtra State AIDS Control Society R.A. Kidwai Marg, Wadala (W) Mumbai 400 031, India Tel: 022 2411 3097 Fax: 022 24113123 E-mail: msacs@bom8.vsnl.net
	Dr Alka Gogate	Project Director, Mumbai Districts AIDS Control Society	Mumbai District AIDS Control Society Acworth Complex R. A. Kidwai Marg Wadala (West) . Mumbai-400031, India Tel: 022-2410 0249 or 09821045048 Fax: 022-2410 0250 E mail: mdacs@vsnl.com
	Dr Vizolie Suokhrie	Additional Project Director, Nagaland State AIDS Control Society	Nagaland State AIDS Control Society, Kohima. Tel: 0370 -22 41046/ 2222508
	Dr Yogesh Chandra	Joint Director, UP State AIDS Control Society	UP State AIDS Control Society 4th Floor, 'A' PICUP Bhavan Gomti Nagar Lucknow 226010, India Tel: 0522 2721871 or 093352 12602 E-mail: sacs_up@nacoindia.org
	Dr Pallav Bhattacharya	Programme Officer, PPTCT & AIDS West Bengal State AIDS Prevention & Control Society	West Bengal State AIDS Prevention and Control Society 1st Floor, Wing-B, Swasthya Bhawan GN-29, Sector-V, salt Lake City Kolkata-700091 Tel: 033-23574400 Fax: 033-23570122 E-mail: pallav001@hotmail.com



Country Team	Participant	Organisation/Designation	Signature
India (contd.)	Dr Vidhya R. Ganesh	Chief, HIV/AIDS, UNICEF India	UNICEF India 73, Lodhi Estate New Delhi 110003, India Tel: 24606107/ 24690401 Fax: 24627521/ 24691414 E-mail: vganesh@unicef.org
	Dr Bir Singh	Project Officer, PPTCT & HIV/AIDS, UNICEF India	UNICEF India 73, Lodhi Estate New Delhi 110003, India Tel: 24606107/ 24690401 Fax: 24627521/ 24691414 E-mail: bsingh@unicef.org
	Deepika Srivastava	CDN, UNICEF India	UNICEF India 73, Lodhi Estate New Delhi 110003, India Tel: 24606107/ 24690401 Fax: 24627521/ 24691414 E-mail: dsrivastava@unicef.org
	Dr Marzio Babilie	Chief, Health, UNICEF India	UNICEF India 73, Lodhi Estate New Delhi 110003, India Tel: 24606205 Fax: 24627521 E-mail: mbabilie@unicef.org
	Dr Khanindra Bhuyan	Project Officer, HIV/AIDS, UNICEF Kolkata	UNICEF Field Office Kolkata 219/2, AJC Bose Road Kolkata - 700017, West Bengal, India Tel: 91 33 2289 2477 Fax: 033 2289 2510 E-mail: kbhuyan@unicef.org
	Dr Shalini Shah	Assistant Project Officer, Health, UNICEF Hyderabad	UNICEF Field Office Hyderabad H.No. 3-6-15/2 M. No. 865, Street No 19, Himayatnagar Hyderabad 500029, AP, India Tel: +91 040 23227226/ 23227236 Fax: +91 040 23227207 E-mail: shali777@hotmail.com
	Dr Sanjana Bhardwaj	Assistant Project Officer, Young People and HIV / AIDS, UNICEF Mumbai	UNICEF Field Office Mumbai 19 Parsi Panchayat Road Andheri East Mumbai 400 069, India Tel: +91 22 28269727/ 28253663 Fax: 91 22 28269539 E-mail: sbhardwaj@unicef.org



Country Team	Participant	Organisation/Designation	Signature
India (contd.)	Dr Devashish Dutta	Project Officer HIV/AIDS, UNICEF Chennai	UNICEF Field Office Chennai 2, Chittaranjan road, Teynampet Chennai 18, India Tel 044 24350332 Fax: 044 24343342 E-mail: ddudda@unicef.org
Indonesia	Ms Gita Maya Koemara Sakti	Head of section on Maternal and Perinatal, Directorate for Family Health, Ministry of Health	Departemen Kesehatan RI Direktorat "Kesehatan Keluarga" Jalan Rasuna Said Blok X5 Kapling No. 4-9 Building C, 8th floor, Jakarta - 12950, Indonesia Tel: 62-21-527 0969 Fax: 62-21-520 3884 E-mail: gmsakti@cbn.net.id
	Mr Toha Muhaimin	Chairperson, Pelita Ilmu Foundation	Pelita Ilmu Foundation Jln. Tebet timur Dalam VIII Q/6 Jakarta Selatan - 12820, Indonesia Tel: 62-21-8511577 Fax: 62-21-8311577 E-mail: tohamuhaimin@yahoo.com
	Ms Gelora Manurung	National Project Officer, HIV/AIDS Unit, UNICEF Jakarta	UNICEF Jkarta Wisma Metropolitan II, 10th and 11th Floor Jalan Jendral Sudirman Kav. 31 Jakarta 12920, Indonesia Tel: 62-021-570 5816 Fax: 62-21-5711326 E-mail: gmanurung@unicef.org
Lao PDR	Dr Mrs Sivixay Thammalangsy	PMTCT Focal Point, Ministry of Health	Ministry of Health Mother and Child Helath Hospital Center Vientiane, Lao PDR Tel: +856 21 252621 Fax: +856 21 212128 E-mail: hqcross@laotel.com or thammalngsysivixay@yahoo.com
Maldives	Dr Jumailath Beygum	Senior Registrar in Obstetrics & Gynacology, Indragandi Memorial Hospital	Indragandi Memorial Hospital Male Maldives Tel: +960 316641 Fax: +960 316639 E-mail: ceo@igmh.gov.mv
Myanmar	Khin Ma Ma Aye	Assistant Representative, UNFPA	UNFPA No. 6 Natmauk Road Yangon, Myanmar Tel: 095 1 542911 Fax: 095 1 546029 E-mail: ayek@unfpa.org



Country Team	Participant	Organisation/Designation	Signature
Myanmar (contd.)	Ni Ni Khaing	Project Officer, UNFPA	UNFPA No. 6 Natmauk Road Yangon, Myanmar Tel: 095 1 542911 Fax: 095 1 546029 E-mail: khaing@unfpa.org
	Dr Hlaing Min Swe	APO (HIV/AIDS), UNICEF Myanmar	UNICEF Myanmar 5th Floor, Yangon International Hotel 330, Ahlone Road Dagon Township, Yangon, Myanmar Tel: +951 212086 Fax: +951 212063 E-mail: hmswe@unicef.org
	Dr Thanda Khin	APO (HIV/AIDS), UNICEF Myanmar	UNICEF Myanmar 5th Floor, Yangon International Hotel 330, Ahlone Road Dagon Township, Yangon, Myanmar Tel: +951 212086 Fax: +951 212063 E-mail: tkhin@unicef.org
	Khin Mon Nyein	APO (HIV/AIDS), UNICEF Myanmar	UNICEF Myanmar 5th Floor, Yangon International Hotel 330, Ahlone Road Dagon Township, Yangon, Myanmar Tel: +951 212086 Fax: +951 212063 E-mail: knyein@unicef.org
Nepal	Dr Shyam Sundar Mishra	Director, National Centre for AIDS & STD Control	Ministry of Health Teku Kathmandu, Nepal Tel: +977 1 4261653/ 4258219 Fax: +977 1 261406 E-mail: ncasc@ntc.net.np
	Dr Sushila Shrestha	Sr Consultant Gynaecologist, Ministry of Health/Maternity Hospital	MOH/ Maternity Hospital Thapathali Kathmandu, Nepal Tel: +977 1 4253276 E-mail: sshrestha8@hotmail.com
	Dr Nibedita Basnet	Assistant Professor, Obys/ Gyn Department & PMTCT Coordinator, B.P. Koirala Institute of Health and Sciences	B.P. Koirala Institute of Health & Sciences Dharan, Nepal Tel: +977 25 525555 ext. 2365 E-mail: nibeditabasnet@yahoo.com



Country Team	Participant	Organisation/Designation	Signature
Nepal (contd.)	Dr Debendra Karki	National Operations Officer, WHO	WHO UN House, Pulchowk Kathmandu, Nepal Tel: +977 1 4262185 Fax: +977 1 5527756 E-mail: karkid@who.org.np
	Agatha Pratt	Chief, Health Section, UNICEF Nepal	UNICEF Nepal UN House Pulchowk P.O.Box 1187 Kathmandu, Nepal Tel: +977 1 5523200 Fax: +977 1 5527280 E-mail: apratt@unicef.org
	Ms Midori Sato	Project Officer, HIV/AIDS, UNICEF Nepal	UNICEF Nepal UN House Pulchowk P.O.Box 1187 Kathmandu, Nepal Tel: +977 1 5523200 Fax: +977 1 5527280 E-mail: msato@unicef.org
Pakistan	Dr Asma Bokhari	National Manager, National AIDS Control Programme, MOH	National AIDS Control Programme NIH Chak Shahzad Islamabad, Pakistan Tel: 092 51 9255096 Fax: 092 51 224266 E-mail: bokhari_asma@yahoo.com
	Dr Nabila Zaka	Project Officer (Women's Health), Maternal and Child Health Care Section, UNICEF	UNICEF Pakistan 6th Floor, Saudi Pak Tower Jinnah Avenue, Blue Area Islamabad, Pakistan Tel: 092 51 2800118 Fax: 092 51 2800132 E-mail: nzaka@unicef.org
Papua New Guinea	Dr Grace Kariwiga	PMTCT consultant/ Obstetrician & Gynaecologist, UNICEF PNG	HIV Team UNICEF, Port Moresby P.O.Box 472, Port Moresby Papua New Guinea Tel: +675 3213000 Fax: +675 3211372 E-mail: amoaba@daltron.com.pg
Thailand	Ms Pornsinee Amornwichee	Bureau of Health Promotion, Ministry of Public Health	Bureau of Health Promotion, Department of Health Ministry of Public Health, Tiwanond Road Nonthaburi 11000, Thailand Tel: (66 2) 590 4435 Fax: (66 2) 590 4427 E-mail: porsinee@health.moph.go.th or pornsinee@amornwichee.com



Country Team	Participant	Organisation/Designation	Signature
Viet Nam	Dr. Vu Thi Thanh	Deputy director of Maternal Health Project, Vice director of PMTCT Project, RHD, MOH	MOH 138A Giang Vo Hanoi, Vietnam Tel: 84 4 7261360/ 84 4 8231042 Fax: 84 4 8231042 Email: daskbm@hotmail.com
	Ms Luisa Brumana	Project Officer, Maternal and Child Health and PMTCT, UNICEF Vietnam	UNICEF Vietnam 72 Ly Thuong Kiet Hanoi, Vietnam Tel: +84 4 9425706 Fax: +84 4 9425705 E-mail: lbrumana@unicef.org
	Ha Pham Bich	Project Officer, PMTCT, UNICEF Vietnam	UNICEF Vietnam 72 Ly Thuong Kiet Hanoi, Vietnam Tel: +84 4 9425706 Fax: +84 4 9425705 E-mail: hapb@unicef.org
RESOURCE TEAM			
Centre for International Health, Burnet Institute	Dr Wendy Holmes	Deputy Director Technical Programmes, Centre for International Health, Burnet Institute	Centre for International Health Macfarlane Burnet Institute for Medical Research and Public Health Commercial Road, Melbourne 3004 GPO Box 2284, Melbourne, Australia 3001 Tel: +61 3 9282 2145 Fax: +61 3 9282 2144 E-mail: holmes@burnet.edu.au
FPIA	Dr Brinda Frey	Medical Officer FPAI Clinic, Lucknow FPIA India	FPIA India B 104/17 Nirala Nagar Luknow, India Tel: 2789223 E-mail: brinda_frey@hotmail.com
WHO	Dr Ying - Ru Lo	Medical Officer (AIDS), WHO Regional Office for South-East Asia (SEARO)	WHO South-East Asia Regional Office New Delhi, India Tel: 011 23309130 Fax: 011 23378412 E-mail: loy@WHOSEA.ORG
	Dr Veronique Bortolotti	STC-HIV Treatment and Prevention Scale-up, WHO	WHO South-East Asia Regional Office New Delhi, India Tel: 011 23309130 Fax: 011 23378412 E-mail: vbortolotti@hotmail.com



Country Team	Participant	Organisation/Designation	Signature
UNFPA	Dr Farah Usmani	Adviser, Reproductive health and HIV/AIDS, UNFPA	UNFPA Country Technical Services Team for South and West Asia P.O. Box. 5940 Kathmandu, Nepal Tel: +977 1 5523880 Fax: +977 1 5527257 E-mail: fusmani@unfpa.org.np
WFP	Dr Judit Katona-Apte	Senior Programme Adviser, WFP	World Food Programme Bangkok, Thailand Tel: +66 1 701 9206 Fax: +66 2 655 4415 E-mail: judit.katona-apte@wfp.org
UNICEF HQ	Ngashi Ngongo	Project Officer, HIV/AIDS, UNICEF HQ	UNICEF Three UN Plaza New York, NY 10017 Tel: 212 824 6312 Fax: 212 824 6464 E-mail: nngongo@unicef.org
	Chewe Luo	Senior Health Adviser, UNICEF HQ	UNICEF Three UN Plaza New York, NY 10017 Tel: 212 824 6312 Fax: 212 824 6464 E-mail: cluo@unicef.org
UNICEF Supply Division	Helene Moller	Field Support Officer, HIV/AIDS UNICEF Supply Division	UNICEF Supply Division UNICEF Plads, Freeport Copenhagen Oe, Denmark Tel: +45 3727 3080 Fax: +45 3526 9421 E-mail: hmoller@unicef.org
EAPRO	Mr Arjan de Wagt	Regional Project Officer PMTCT, UNICEF EAPRO	UNICEF East Asia and Pacific Regional Office 19 Phra Atit Road Bangkok 10200, Thailand Tel: +66-2 356-9468 Fax: +66-2 280 3563 E-mail: adewagt@unicef.org
	Ms Wassana Kulpisitthicharoen	Project Assistant, UNICEF EAPRO	UNICEF East Asia and Pacific Regional Office 19 Phra Atit Road Bangkok 10200, Thailand Tel: +66-2 356-9467 Fax: +66-2 280 3563 E-mail: wkulpisitthicharoen@unicef.org



Country Team	Participant	Organisation/Designation	Signature
ROSA	Mr Ian MacLeod	Regional HIV/AIDS Adviser, UNICEF ROSA	UNICEF Regional Office for South Asia PO Box 5815, Lekhnath Marg Kathmandu, Nepal Tel: +977-1-4417 082 Fax: +977-1-4418466/ 4419479 E-mail: imacleod@unicef.org
	Dr Myo Zin Nyunt	Regional Project Officer, UNICEF ROSA	UNICEF Regional Office for South Asia PO Box 5815, Lekhnath Marg Kathmandu, Nepal Tel: +977-1-4417 082 Fax: +977-1-4418466/ 4419479 E-mail: mnyunt@unicef.org
	Ms Hanne Fink Moller	Assistant Programme Officer, UNICEF ROSA	UNICEF Regional Office for South Asia PO Box 5815, Lekhnath Marg Kathmandu, Nepal Tel: +977-1-4417 082 Fax: +977-1-4418466/ 4419479 E-mail: hfmoller@unicef.org
	Ms Geeta Wali Rai	Programme Assistant, UNICEF ROSA	UNICEF Regional Office for South Asia PO Box 5815, Lekhnath Marg Kathmandu, Nepal Tel: +977-1-4417 082 Fax: +977-1-4418466/ 4419479 E-mail: gwrai@unicef.org



Annex 3: Evaluation Summary

Analyzing the evaluation forms filled in every day showed that participants in general found the presentations relevant and balanced between technical and programmatic issues. Time allocated for each of the four prongs was found to be reasonable and the field visit was found to be very relevant to a majority of the participants.

On the administrative side the facilities, food and administrative services were rated high. A general request for being provided with a printed version of the presentations prior to its presentation was made and has been noted for next meeting.

The strengths of the meeting were found to be:

- The involvement of UN agencies, UNICEF regional offices and Government offices.
- The possibility for sharing ideas and experiences
- The update of knowledge through good technical updates
- The coverage of all four prongs

The weaknesses of the overall programme were pointed out as:

- The need for more time for questions and discussion
- The wish for more practical examples and best practices within the four prongs
- A need for more specific tasks for the group work

- The poor involvement of PLWHA
- The lack of a concrete country level work plan as the outcome of the meeting

Several ideas and suggestions on the form and content of the next Task Force meeting were also shared in the evaluations - key points were split between programmatic issues and themes or topics to include:

Programmatic issues:

- Have a theme
- Involve more diverse group of participants – e.g. gynecologists, pediatricians, supply staff
- Include field visit

Themes or topics:

- Presentation of follow-up action taken in different countries following this years meeting
- Good practices on how communication strategies can be used in relation to PMTCT
- Focus on integration of services – e.g. health and family planning
- Breastfeeding and mothers health
- ARV therapy and HIV testing guidelines in poor settings – advantages and disadvantages
- Quality counseling – how is it obtained?
- Reduction of stigmatization and discrimination – examples
- Sharing of experiences for community mobilization approaches



Contact information:

United Nations Children's Fund
Regional Office for South Asia
P. O. Box 5815
Lekhnath Marg
Kathmandu, Nepal
Telephone: 977-1-4417082
Fax: 977-1-4418466 / 4419479

United Nations Children's Fund
East Asia and Pacific Regional Office
19 Phra Atit Road
Bangkok 10200
Thailand
Tel: 66-2-3569468
Fax: 66-2-2803563