



REPORT
The 7th Asia-Pacific United Nations
Prevention of Mother-to-Child Transmission
Task Force Meeting

**Making the most of PMTCT in low and
concentrated epidemic settings**

22 - 24 September 2009
Chennai, India

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¹ Please note that Annex 6 and Annex 7 is not printed but is available on the attached CD.

Acronyms

AIDS	Acquired immunodeficiency syndrome
ANC	Antenatal care
APN+	Asia Pacific Network of People Living with HIV/AIDS
APSSC	Asia Pacific Shared Services Centre of UNICEF
ART	Antiretroviral therapy
ARV	Antiretrovirals
AZT	Azidothymidine
BF	Breastfeeding
BFHI	Baby-friendly Hospital Initiative
CMIS	Computerized management information system
CST	Care, support and treatment
DBS	Dried blood spot
DG	Deputy General
DNA	Deoxyribo nucleic acid
EAPRO	East Asia and the Pacific Regional Office of UNICEF
EBF	Exclusive breastfeeding
EID	Early infant diagnosis
EPI	Expanded Programme on Immunization
FP	Family planning
HAART	Highly active antiretroviral therapy
HIV	Human immunodeficiency virus
IBFAN	International Baby Food Action Network
HQ	Headquarters
INR	Indian Rupee
IYCF	Infant and young child feeding
LBW	Low Birth Weight
M&E	Monitoring and evaluation

MCH	Maternal and child health
MDGs	Millennium Development Goals
MNCH	Maternal, neonatal and child health
MoH	Ministry of Health
NACO	National AIDS Control Organization
NGO	Non-governmental organization
PCR	Polymerase chain reaction
PEPFAR	US President's Emergency Plan for AIDS Relief
PICT	Provider-initiated counselling and testing
PPTCT	Prevention of mother to child transmission (of HIV)
PNG	Papua New Guinea
PPTCT	Prevention of parent to child transmission (of HIV)
ROSA	Regional Office for South Asia of UNICEF
SEARO	South East Asia Regional Office of WHO
SIAAP	South India AIDS Action Programme
SRH	Sexual and reproductive health
STI/D	Sexually transmitted infection/disease
TB	Tuberculosis
ToR	Terms of reference
UN	United Nations
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNITAID	A partnership to scale up access to treatment for AIDS, TB and malaria
VCT	Voluntary counselling and testing
WHO	World Health Organization
WPRO	Western Pacific Regional Office of WHO

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Finally we wish to thank UNAIDS for its financial contribution through Unified Budget and Workplan (UBW), which made it possible to convene a meeting of this magnitude at this critical time of commitment to the virtual elimination of vertical transmission of HIV from mother-to-child.

Executive Summary

The seventh meeting of the Asia-Pacific United Nations Prevention of Mother-to-Child (PMTCT) of HIV Task Force meeting was held in Chennai, India, 22 – 24 September 2009. The meeting was conducted with joint technical support from UNICEF ROSA/APSSC/EAPRO and HQ; WHO/SEARO/WPRO and HQ; UNFPA Asia Pacific Regional Office and UNAIDS Regional Support Team (RST). It followed the sixth UN PMTCT Task Force Meeting held in Kuala Lumpur, Malaysia, in November 2006. That meeting was combined with the “Asia-Pacific Consultation on Integrating Prevention and Management of STI/HIV into Reproductive, Maternal and Newborn Health Services”. The Kuala Lumpur meeting had two overlapping agendas: to promote the value of linkages between maternal and newborn health, sexual and reproductive health (SRH), and HIV prevention and care; and to promote the importance of primary prevention, especially for young women and pregnant or breastfeeding women, and of increased access to family planning advice and services.

The meeting participants included senior health officials from MCH departments and national HIV programmes from 16 countries in South Asia, South East Asia and the Pacific; UNAIDS Country Coordinators from India, Indonesia and Nepal; UNICEF, WHO and UNFPA regional and national HIV specialists; representatives of international organizations; and several specialists, including people living with HIV, attending as resource persons.

A review of progress was undertaken prior to the meeting which helped to inform the objectives for the meeting.

Meeting objectives

1. To develop policy recommendations and options, appropriate to specific contexts, to maximize HIV-free child survival, based on available evidence and experiences in the region
2. To discuss and make recommendations in relation to the cross-cutting challenges identified in the review of progress in the past two years. These were:
 - Coordination to establish or strengthen linkages
 - Communication
 - Reaching vulnerable and at-risk populations
 - Greater engagement of men
3. To discuss and identify processes to ensure that updated technical recommendations are rapidly incorporated in relation to common challenges in implementing antenatal PPTCT programmes

To achieve these objectives, there were presentations on country experiences, poster presentations from a variety of countries in the regions, technical presentations from resource people, and rich discussions both in small groups and in plenary.

Objective 1

Presentations from countries with low HIV prevalence, concentrated epidemics and relatively high child mortality provided examples of different strategic approaches to increasing the proportion of HIV-positive pregnant women identified and able to access interventions to lower the risk of MTCT. In Pakistan, risk assessment aimed at pregnant women was not found to be effective, with the conclusion that it is more rational to prioritize the offer of ANC testing in districts with higher concentrations of returned migrants and at-risk populations, strengthen referrals from NGOs working with people living with HIV and/or people at greater risk while focusing on primary prevention through MNCH services for the general population. In India and Nepal the scale up strategy for HIV testing is based on prioritizing districts with higher prevalence or greater vulnerability, such as high numbers of returned migrant workers. In Myanmar, because it was found that offering routine ANC HIV testing in rural areas was resource-intensive with logistical difficulties and problems in referring positive women for appropriate services, there has been a strategic shift to basing PPTCT services at the township (district) hospital level, based on HIV prevalence data, and to target higher risk women and couples in urban settings.

A presentation on the promotion of exclusive breastfeeding for all mothers and babies provided an example of the significance of population-wide strategies to contribute to prevention of HIV infection in children and to maternal and child health in general.

Participants had discussions in small groups, sharing experiences about key strategic approaches, and made suggestions to inform the development of context-specific policy guidance.

Objective 2

The rationale and evidence for operational linkages between programmes and services for HIV, sexually transmitted infections, SRH and MCH, were presented and the synergies in preventing congenital syphilis and the transmission of HIV from a positive pregnant woman to her infant highlighted. A case study from Cambodia showed that the linked response approach can be successful.

Presentations about women drug users, partners of drug users, and women in sex work showed the importance of reaching these groups with information and services relevant to SRH and PPTCT. Involving a variety of sectors, peer-to-peer approaches, outreach services and addressing discrimination are crucial factors. In discussion, the need to reach men who have sex with men and migrant workers with PPTCT advice and services was also raised.

Findings from participatory action research by the Asia Pacific Positive People's Network emphasized high levels of stigma and discrimination, especially in health care settings, and that stigma may be associated both with HIV status and with risk factors such as drug use and sex work. Ms Linda John Hay and Mr Maniyam Somesh described their experiences of learning their positive HIV status and showed the value of resourcing positive people to support others and address discrimination.

There is increasing recognition and evidence that encouraging men to be involved in SRH and MCH care has broad benefits including prevention of HIV infection in children. Experiences presented from Thailand and Lao PDR showed that progress can be made in changing men's behaviour and attitudes to MCH care.

Participants shared their experiences of these cross-cutting challenges in small group discussions and their suggestions were captured and synthesized. In a panel discussion representatives of UNAIDS, WHO, UNICEF and UNFPA agreed on the importance of greater coordination between and within UN agencies to ensure a more integrated approach to advice and support for PPTCT.

Objective 3

There were valuable discussions in small groups about particular technical challenges in implementing antenatal PMTCT programmes. The complex and rapidly changing nature of the technical aspects of HIV testing, assessment for treatment, antiretroviral prophylaxis regimens, safer infant feeding counselling, and early infant diagnosis was acknowledged. It was considered essential to improve the training of health care providers and incorporate mechanisms to ensure that updated technical recommendations are rapidly incorporated into national programmes.

Major conclusions from the meeting

- ❖ The meeting reaffirmed the importance of identifying synergies and linking HIV prevention and care for parents and children with improved services for MCH, SRH, and nutrition. This will strengthen efforts for primary prevention of HIV and for the prevention of unintended pregnancies, and contribute to maternal and child survival.
- ❖ There was consensus on the need to reshape programmes to ensure that PPTCT information and services reach the most vulnerable and at risk populations, informed by epidemiological evidence.
- ❖ The meeting agreed that these strategic shifts be guided by principles of planning based on rights, with attention to addressing stigma and discrimination; involving affected communities, including people living with HIV; and gender analysis, including greater involvement of men.
- ❖ Operational research, monitoring and evaluation are crucial to ensure the response is guided by evidence and by updated IATT technical recommendations from the Global Expanded Inter-Agency Task Team on Prevention of HIV Infection in Pregnant Women, Mothers and their Children.
- ❖ Aware of the overall low coverage of PPTCT in the region, the meeting was unanimous in calling for sustained high level advocacy, political leadership and stronger coordination at all levels.

Key recommendations of the meeting

1. Advocate for greater policy commitment, including resources, for comprehensive approaches to HIV prevention and care for mothers and children. Gather evidence and develop costed plans for more effective advocacy and result-based planning.
2. Strengthen effective governance, financial and delivery arrangements within health systems, and ensure effective implementation strategies. For primary health care, the debate focused on selective (or vertical) versus comprehensive (horizontal) delivery, but it is now shifting towards combining the strengths of both approaches in health systems.
3. Achievement of high and equitable coverage of integrated primary health-care services requires consistent political and financial commitment, incremental implementation based on local epidemiology, use of data to direct priorities and assess progress, especially at district level, and effective linkages with communities and non-health sectors.

4. Ensure greater coordination and effective linkages between all MOH health programmes, at national and sub-national level, and with non-health sectors, such as social welfare and education.
5. Formulate clear guidance on which approach to HIV testing should be followed in different contexts based on criteria of HIV prevalence and patterns of spread, vulnerability to HIV, cost-effectiveness, and capacity of health care systems. Research on scaling-up should be embedded in large-scale delivery programmes with a strong emphasis on assessment.
6. Bearing in mind the need to improve MNCH in general, invest in population-wide strategies to reduce HIV infection in children. For example, allocate resources for PPTCT to promote optimal breastfeeding for all mothers and newborns, as this will both prevent paediatric HIV from HIV-positive mothers unaware of their status and improve child survival in general; and strengthen access to family planning for all women, including young, marginalized and vulnerable women. Integrate packages for maternal, newborn and child health care within a gradually strengthened primary health care system, in order to improve continuity of care, including access to basic referral care before and during pregnancy, birth, the postpartum period, and throughout childhood.
7. Explore innovative strategies to reach populations most at-risk. Consider strengthening outreach services; working through trusted community organizations; and creating spaces for delivery of information, counselling and services that are male- and youth-friendly.
8. Normalize the involvement of men in reproductive, maternal and child health services. Provide information and services to men when planning marriage/pregnancy. Empower men as fathers.
9. Improve training, support and supervision for health care providers in counselling and communication skills.
10. Ensure mechanisms to incorporate new technical guidance into pre- and in-service training (make use of the internet) and support health care providers.
11. Include people living with HIV and representatives of most at-risk populations in planning and implementing both prevention and care, support, and treatment responses
12. Strengthen and evaluate follow-up of HIV-positive women and their families. Consider use of outreach services, with trained village health volunteers for those in rural and remote areas; potential of mobile phones; and operational research for system of incentives to motivate both clients and providers.
13. Strengthen capacity for M&E to generate strategic information to inform planning and implementation at both national and sub-national level. Incorporate M&E indicators for primary prevention and prevention of unintended pregnancies.
14. Continue to work towards a more coordinated approach and management excellence at central and decentralized level.

Immediate follow-up action points are to revise the terms of reference of the PMTCT Task Force developed in 2004 to reflect new and emerging developments on PPTCT in the region, and identify a spokesperson to spearhead high level advocacy on PPTCT to accelerate efforts towards elimination of paediatric HIV infection and quality health for mothers and children.

Background

The seventh meeting of the Asia-Pacific United Nations Prevention of Mother-to-Child (PMTCT²) of HIV Task Force meeting was held at the Taj Connemara Hotel in Chennai, India from 22 – 24 September, 2009. It followed the sixth UN PMTCT Task Force Meeting held in Kuala Lumpur, Malaysia, in November 2006.

Representatives of National Governments, comprising Programme Managers of National AIDS Control Programmes, Maternal Child Health, HIV, Nutrition, PMTCT/ Paediatric HIV care and treatment (CST) experts from 19 countries in Asia and the Pacific region including technical experts from USAID, Clinton Foundation, IBFAN, Asia Pacific Network of People Living with HIV/AIDS, Burnet Institute, Specialists and Advisors from UNICEF, WHO, UNFPA and UNAIDS from the region were present. The meeting was conducted with joint technical support from UNICEF ROSA/APSSC/EAPRO and HQ; WHO/SEARO/WPRO and HQ; UNFPA Asia Pacific Regional Office and UNAIDS Regional Support Team.

The objectives of the seventh PMTCT Task Force meeting were threefold.

- ❖ Develop policy recommendations and options, appropriate to specific contexts, to maximize HIV-free child survival, based on available evidence and experiences in the region.
- ❖ Identify recommendations to address cross-cutting challenges based on discussion of country experiences.
- ❖ Discuss and identify processes to ensure updated technical recommendations are rapidly incorporated in relation to common challenges in implementing antenatal PPTCT programmes.

The focus of the three-day meeting was to review progress since the last Task Force 2006 meeting held in Kuala Lumpur, Malaysia. The Kuala Lumpur meeting had a focus on strengthening linkages between sexual and reproductive health, maternal and child health, and HIV prevention and care, in particular to contribute to the first two strategic elements (also known as ‘prongs’) of the comprehensive approach to PPTCT. The four strategic elements of PPTCT are:

1. Primary prevention of HIV infection;
2. Prevention of unintended pregnancies among HIV-positive women;
3. Prevention of HIV transmission from HIV-positive women to their children; and
4. Provision of care, support and treatment for HIV-infected mothers and their infants.

In this regard, the meeting allowed the opportunity to discuss new developments in PPTCT and their implications for the region, namely to contextualize the regional response against global guidance documents and to review achievements, challenges and lessons learned, which enabled the region to identify policy recommendations and options appropriate for the countries of the region.

2 A note re terminology: Increasingly countries in the region are using the term ‘Prevention of parent to child transmission’ (PPTCT). In this report of the meeting we use this term when referring to policies and programmes unless referring to a document or meeting that uses ‘prevention of mother to child transmission’ (PMTCT). We also use ‘PMTCT’ when referring to interventions that reduce the risk of transmission to the infant when an HIV-positive woman knows her status.

7th Asia-Pacific United Nations Prevention of Mother-to-Child Transmission Task Force Meeting

"Making the most of PMTCT in low and concentrated epidemic settings"

22-24 September 2009

Hotel Taj Connemara
Chennai, India



Above (from left to right): Ms Rachel Odede, Regional HIV and AIDS Advisor, UNICEF ROSA; Ms Frances Turner, Deputy Regional Director, UNICEF ROSA; Mr V.K. Subburaj, Principal Secretary of Health, Government of Tamil Nadu; Dr Charles Gilks, Country Coordinator, UNAIDS India and Dr Satish Kumar, Chief of Field Office.

Meeting Proceedings

Welcome remarks

Ms Frances Turner, Officer-in-Charge and Deputy Regional Director, UNICEF ROSA

Ms Turner welcomed participants to the meeting. She spoke of the importance of basing policy decisions on evidence and experience. The recent International Congress on AIDS in Asia and the Pacific identified PPTCT as needing immediate attention in the regions. Ms Turner pointed out that change will only be possible if attention is paid to the underlying factors driving the epidemic – sex work, injecting drug use and male-male sex. She acknowledged the challenge of stigma and discrimination, and the many technical challenges in implementation. She urged UN agencies to act together with an integrated approach to ensure greater progress towards the linked MDGs 4, 5 and 6. Integrating prevention, detection and treatment of sexually transmitted infections (STIs) in maternal and child health services will assist in progress towards the elimination of congenital syphilis as well as preventing HIV infection in mothers and children. She invited participants to identify recommendations for policy development based on epidemiological evidence to ensure context-specific policy guidance for the region.

Mr V.K. Subburaj, Principal Secretary of Health, Government of Tamil Nadu

Mr Subburaj welcomed delegates to the meeting and described the HIV epidemic and the strong responses in Tamil Nadu. Prevalence of HIV has declined from more than 1% to less than 0.25%. Mr Subburaj pointed out the need, in India, to pay attention also to maternal and infant deaths from other causes and mentioned the significant role of the National Rural Health Mission in improving pregnancy and delivery facilities. The estimated institutional delivery rate in India is only 50%, whereas in Tamil Nadu it is 99%, which has greatly facilitated the introduction of antenatal PPTCT programmes in both the public and private sectors. Mr Subburaj pointed out that the amount spent on infectious and chronic diseases is small compared to the amount spent on HIV, but there is a strong desire to stop the spread of HIV because of the associated stigma and discrimination. He described successful efforts in Tamil Nadu to raise awareness among health professionals, young people and rural women to reduce stigma and the importance of learning lessons from other countries.

Dr Charles Gilks, Country Coordinator, UNAIDS India

Dr Gilks reminded the participants that at the Abuja global PMTCT meeting in 2005 there was a commitment to the goal of elimination of paediatric HIV infection. He urged that this meeting also adopt this vision. He also emphasized that elimination cannot be achieved without a greater focus on strengthening health systems and in particular increasing the coverage and quality of antenatal care services and of attended deliveries. This in turn will contribute to better maternal health. Dr Gilks also stressed the need to view PPTCT in a comprehensive and broad way, and that all four strategic elements are important if HIV infection in infants is to be eliminated. Preventing HIV infection in the first place among women and men of reproductive age is the most important way to prevent HIV infection in children. There is a need to do more to ensure that HIV-positive women can access family planning service, and to strengthen follow up of women identified to be HIV-positive to ensure that they receive prophylaxis and treatment when needed.

Overview of meeting objectives and expected outcomes

Ms Rachel Odede, Regional HIV and AIDS Advisor, UNICEF ROSA

Ms Odede welcomed the participants and pointed out that the commitment by UNAIDS to eliminate mother to child transmission of HIV is also reflected in the report of the AIDS in Asia Commission, which identified PPTCT as a priority, and in the new UNAIDS Framework 2009-2011. At this meeting we will revisit commitments from the Kuala Lumpur meeting which focused on the need for greater emphasis on prongs 1 and 2 in our regions and on the need to strengthen linkages between sexual and reproductive health services, maternal and child health services and HIV/STI prevention and care. Ms Odede noted that the good progress in Tamil Nadu demonstrates the importance of strong leadership from which other countries can learn. Even with strong PPTCT services in place, fear of stigma may prevent mothers from accessing them. Ms Odede outlined the objectives for the meeting, as follows.

Objective 1: To develop context-specific recommendations and options to inform the development of regional policy guidance based on available evidence and experiences in the region.

Objective 2: To discuss and make recommendations in relation to addressing the cross-cutting challenges identified in the review of progress in the past two years. These were:

- Coordination to establish or strengthen linkages;
- Communication – including addressing stigma and discrimination;
- Reaching vulnerable and at risk populations; and
- Greater engagement of men.

Objective 3: To discuss and identify processes to ensure updated technical recommendations are rapidly incorporated in relation to common challenges in implementing antenatal PPTCT programmes.

Ms Odede also set out the **key outcomes** expected from the meeting:

1. Key principles to inform context-specific policy recommendations to guide responses to HIV prevention and care for mothers and children in the Asia-Pacific region
2. Greater understanding of progress, challenges with regard to coverage, scale-up plans and policies relevant for PPTCT in low and concentrated epidemic settings
3. Increased awareness of updated international technical recommendations
4. A collection of ‘good practice’ and ‘lessons learned’ for a regional PPTCT ‘good practice’ document
5. Updated terms of reference for the Asia-Pacific Regional Task Force for PMTCT that reflect the current needs of countries in the room

Ms Odede identified some useful funding opportunities, including the Global Fund for AIDS, TB and Malaria which plans to support PPTCT and paediatric HIV treatment for children with HIV, PEPFAR and Clinton Foundation through UNITAID. Ms Odede concluded that the world is committed to strengthening health systems and there is an opportunity to use PPTCT funds to contribute towards achieving this goal. She pointed out that a major challenge is to strengthen links between MCH and other health services. She called for political leadership to halt and reverse the epidemic in Asia and the Pacific region.

PPTCT – global and regional trends and regional progress since the 6th Annual PMTCT Task Force Meeting

Dr Padmini Srikantiah, PMTCT Medical Officer, WHO SEARO

Scaling up PMTCT Programmes: Global Progress, Regional Challenges

Dr Srikantiah presented data showing that globally the percentage of pregnant women in low- and middle-income countries who know their HIV status remains low but is increasing. In 2008, about 21% of pregnant women in low- and middle-income countries received an HIV test, up from 15% in 2007.³ In East, South and South-East Asia the prevalence of HIV is low or very low, and the pattern of spread is concentrated among certain populations or settings. Coverage of antenatal care (ANC) is low, and home deliveries are high, so approaches to offering women testing need to differ. In 2008, access to HIV services for women and children improved globally, with about 45% of HIV-positive pregnant women receiving antiretroviral (ARV) prophylaxis, up from 35% in 2007. Proportions are lower in East and South-East Asia, and women often do not receive the more efficacious regimens recommended by WHO. Accurate data collection is necessary so that effective evaluation can lead to good programme outcomes. There has been a ten-fold increase in access to ART for people living with HIV globally. Dr Srikantiah suggested that active follow-up may be an option in some settings to increase uptake of ARV prophylaxis and that CD4 testing at the time of the HIV test in ANC settings could increase identification of women who should be started on ART for their own health. She pointed out that WHO is currently revising global guidelines for safe and effective ARV prophylactic regimens, including during breast-feeding. Next steps need to include identifying strategies to test and link women to PPTCT and ART services in low prevalence and concentrated epidemic settings.

Dr Paula Bulancea, Regional HIV and AIDS Specialist (PMTCT/Paediatric HIV), UNICEF APSSC

Regional progress in PPTCT since the 6th annual PMTCT Task Force meeting

While reflecting on the themes of the last Asia Pacific PMTCT Task Force meeting held in Kuala Lumpur, Malaysia, in November 2006, Dr. Bulancea, Regional PMTCT and Paediatric HIV Specialist, presented an overview of progress made in implementation of PMTCT in the region since then.

In November 2006, WHO, UNICEF, UNFPA and UNAIDS co-convened a Joint Forum in Kuala Lumpur, Malaysia: i) the Consultation on Integrating Prevention and Management of STI/HIV into Reproductive, Maternal and Newborn Health Services and ii) the 6th UN Asia-Pacific Prevention of Mother-to-Child Transmission of HIV Task Force Meeting. *Key themes* included that the integration agenda has great potential to contribute to the achievement of Prongs 1 and 2 and that strengthened linkages and efforts towards prong 1 and 2 can contribute to general SRH and MCH – assisting progress towards MDGs 4 and 5. *Key recommendations* from that meeting were:

- Integrate PPTCT components into existing service delivery points
- Ensure reproductive rights of girls/women, particularly those HIV-positive
- Greater involvement of males in SRH and MNCH
- PPTCT programming should be targeted, evidence-based and result-oriented
- Have a broad approach to comprehensive PPTCT
- Ensure a continuum of care
- Follow-up and diagnose the HIV-exposed child

³ Towards Universal Access: Scaling Up Priority HIV/AIDS Interventions in the Health Sector, 6 October 2009

- Build capacity at country level within rollout plans to manage paediatric ART
- Identify TRIPS flexibilities
- Universal Access covers prevention, treatment, care and support of which ARVs are only one part; consider a “package” of supplies
- Consider additional process indicators for prongs 1, 2 and 4 for National HIV Monitoring and Evaluation Frameworks
- Incorporate PPTCT monitoring into National Health Management Information System

The review of implementation progress of PMTCT in Asia-Pacific since 2006 was based on a literature review; consultations with UN country/regional teams, governments, and NGOs, country review reports, relevant technical documents and resource materials.

Key findings from the review included:

- **PPTCT trends**

Most countries have continued to concentrate on scaling up capacity for ANC HIV counselling and testing and prongs 3 and 4. Primary prevention and prevention of unintended pregnancies among women living with HIV or at higher risk have continued to be relatively neglected. The report shows slow progress in ensuring that women (and their partners) attending ANC are able to access condoms, lubricants, sexual health information, detection and treatment for STIs and FP services. Post-test counselling often does not occur when the result is negative, and partners are often asked to attend only after a pregnant woman has had a positive test result. Thus, specific guidance is needed to prevent new maternal infections, along with an emphasis on primary prevention among young people. ‘PMTCT’ tends to be understood as ‘ANC testing and prophylaxis’ – but if primary prevention, population level strategies, and reaching out to those most at risk are undertaken, this also constitutes ‘PMTCT’, even though all pregnant women may not be routinely offered an HIV test.

- **Working with high-risk populations**

Asia-Pacific is a region where HIV is currently spreading predominantly among vulnerable and at-risk groups. We can see progress in coverage and uptake of ANC PMTCT services, but women at greatest risk of infection with HIV are often neglected. General HIV responses targeted to vulnerable and at-risk populations often fail to include information and services relevant to primary prevention, preventing unintended pregnancy, and preventing MTCT. These populations include drug users and their partners; women in sex work and their clients; men who have sex with men and their female partners; migrant workers; and prisoners and their partners.

- **Involving men**

There is increased recognition of the need to include men both through MCH services and in the community and workplaces. Generally little progress so far in achieving this, although Lao PDR and Thailand have good examples.

- **Population-level interventions**

There is a need to recognize and include population level interventions within PPTCT programmes. Investment in management and control of STIs, promoting exclusive breastfeeding (EBF) for all babies, strengthening family planning services for all women, are examples that will avert HIV infection in children and improve overall maternal and child health and survival.

- **Integrating and linking HIV, MNCH, SRH and FP services**

A few countries in the Asia and Pacific regions have made progress with the agenda of integrating or linking HIV prevention and care, MNCH, SRH and FP services, for example, Myanmar, Lao PDR, and Cambodia. But coordination is a major challenge at international, regional and national level.

- **Stigma**
Stigma and the fear of stigma and discrimination present a major challenge to effective HIV prevention and care efforts for mothers and children.
- **Communication**
There are some useful examples of good communication strategies in the region, but this is a relatively neglected component of PPTCT.
- **Challenges in implementing antenatal screening PMTCT**
The review found several challenges related to antenatal screening PMTCT interventions that are common to many countries. These include: inconsistent or ineffective HIV testing algorithms; high rates of testing during labour; weak counselling skills; shortage of trained staff; loss to follow-up; limited support for disclosure; continued use of single dose Nevirapine rather than higher efficacy regimens; poor supplies management; weak infant feeding counselling; poor management of discordant couples; delivery care not based on evidence; and weak data collection, analysis and use.
- **Treatment**
Coverage of HAART for people living with HIV remains low in the region, but great strides have been made in increasing access, and there is growing experience of effective paediatric HIV treatment, especially in Thailand. However, in many settings pregnant women who test HIV-positive are not assessed for treatment eligibility, and referral links to HIV treatment services may be weak or absent.

Key recommendations from the review for policy development:

- A regional policy for HIV prevention and care for parents and children should be developed, based on evidence and equity considerations, taking into account the varied patterns of the HIV epidemic within and between the countries of the Asia and Pacific regions, with a child survival goal.
- National/provincial health departments require support to undertake systematic coordination and planning, recognizing the interdependence of health system governance, financing, health workforce management, information systems, and the connection with the community through consultation and communication.
- The commonly identified weaknesses in implementation of Prong 3 and 4 need to be addressed before scaling up in low prevalence settings
- Health care providers need good training in confidential and non-judgmental communication and counselling skills
- New terms of reference should be developed for the UN Asia-Pacific PMTCT of HIV Task Force.

Meeting Objectives

Objective 1: Towards regional context-specific policy guidance to maximize HIV-free child survival

Introduction

The great burden of HIV infection in children (over 90%) is borne by countries in sub-Saharan Africa. The context of the epidemic, in terms of prevalence and patterns of spread, is very different in the Asia-Pacific region, with great diversity between and within countries. There is a need for context-specific policy guidance and a different mix of strategies to those appropriate for sub-Saharan Africa.

The review of progress from the last Task Force meeting in 2006 suggested five key strategic approaches both to prevent HIV infection in mothers and children and to contribute to reducing the greater burden of child illness and death from other causes and to improved maternal health.

- Strategies for primary HIV prevention for young, pregnant and breastfeeding women within and beyond the antenatal clinic
- Strategies for prevention of unintended pregnancies among women (and couples) living with HIV
- Strategies to increase the likelihood that pregnant women and expectant fathers with HIV will be diagnosed and receive PMTCT interventions and follow up care, support and treatment
- Strategies to ensure that pregnant women and mothers living with HIV are assessed for eligibility for treatment with HAART and can access early diagnosis for their infants
- Population-level strategies to prevent HIV infection in children and improve child survival by increasing access to family planning services; promoting optimal infant feeding practices, and improving detection and management of STIs (during pregnancy)

During the session focused on Objective 1, there were four presentations from India, Pakistan, Myanmar and Nepal, respectively, providing examples of different strategic approaches to increasing the proportion of HIV-positive pregnant women identified and able to access interventions to lower the risk of MTCT. All these countries have predominantly low and declining HIV prevalence with the concentration of HIV mainly among higher-risk populations, and relatively high child and maternal mortality from other causes. There was also a presentation about the promotion of EBF by Dr JP Dadhich of the International Baby Food Action Network (IBFAN) as an example of an important population level PPTCT strategy.

Participants broke into five small groups. Each group shared experiences, knowledge and opinions about one of the five key strategic approaches listed above and made suggestions to inform the development of context-specific policy guidance.

Experiences and examples

Country experiences of strategies to increase the likelihood that HIV-positive pregnant women will be diagnosed and receive PMTCT interventions and follow-up care, support and treatment

Evaluation of risk assessment approach

In Pakistan⁴, HIV prevalence in the general population is estimated to be 0.1%. The epidemic is concentrated among people who inject drugs (>20%), *hijra* sex workers (>6%), male sex workers and returned migrant workers. With very low HIV prevalence among pregnant women and high child mortality rates, the strategy has been to use a risk assessment approach to HIV diagnosis rather than offering the test routinely to all pregnant women. At the six comprehensive PPTCT sites, almost all HIV-positive cases came through referral with a confirmed diagnosis already made. Thus because the risk assessment questions were not identifying any positive pregnant women, a study was undertaken to correlate the risk assessment questionnaire with diagnosis of HIV. The sample size was 5,572. The risk assessment questions asked about a history of working abroad, blood transfusion, injections, injecting drug use, treatment for STI, and extramarital relationship. 38% of the women reported one of these risk factors. Of these, 94.5% reported having ever received an injection and 19% had had a blood transfusion. Only 2.2% reported a history of STI and 0.5% reported injecting drugs. All the women reported sex only with their spouse. None of the women had a confirmed positive HIV test. During the study period only nine HIV-positive pregnant women were seen, all referred for ANC from HIV treatment centres/NGOs. Conclusions: These risk assessment questions were not helpful in identifying women more likely to test positive for HIV in very low prevalence settings; studies are needed to evaluate risk criteria for risk assessment. It is more rational to prioritize offer of ANC testing in

4 Presentation: Dr Naveeda Shabbir. Approaches to risk assessment and tool

districts with higher concentrations of returned migrants and at-risk populations. Primary prevention through MNCH services for general population should be strengthened. The risk assessment approach requires more evaluation. Referrals from NGOs working with people living with HIV and/or people at greater risk, and from treatment, care and support centres are critical and must be strengthened.

Scale up strategy based on prioritizing districts with higher prevalence or greater vulnerability

In **India**⁵, 0.38% of pregnant women are estimated to be HIV-positive, but this masks very low prevalence in most areas, and concentrated prevalence among some populations and settings. HIV is declining in the general population in some states, but surveillance data indicate rising levels among those with high risk behaviours and in some districts of northern states. Since 2000 there has been a great increase in the number of testing centres and in the numbers of pregnant women tested for HIV. The National AIDS Control Organization (NACO) estimates that currently about 35% of positive pregnant women receive an HIV test and of these about 52% receive ARV prophylaxis. To take into account the varied pattern of the epidemic and allow rational prioritization, NACO shifted from a state-based to district-based strategy in its 2007-2012 national plan. NACO plans to scale up the routine offer of ANC HIV testing in those districts with prevalence greater than 1% and/or prevalence greater than 5% among high risk populations. In these districts, efforts will also be made to reach women who do not attend ANC through community-based screening by frontline workers such as Auxiliary Nurse Midwives. Integrated Counselling and Testing Centres now provide entry points for men and women for different services. Pregnant women are provided with PPTCT services, those with STI symptoms are referred to STD clinics and those with TB symptoms to the National Tuberculosis Control Programme. To improve testing and rates of uptake of interventions for positive women, close links have been created between NACO and the National Rural Health Mission (responsible for MCH services), the Ministry of Women and Child Development, the network of positive people who provide outreach, the private sector, and the UN agencies.

Nepal⁶ also has a concentrated epidemic with very low prevalence among pregnant women (0.19% of 78,552 pregnant women tested). The national response has included antenatal PPTCT services, and there are plans to prioritize districts known to have higher prevalence or vulnerability – for example the western region has more migrant workers who have higher prevalence. To improve uptake of the interventions by positive women, there are plans to improve the capacity of health workers and to integrate PPTCT into the MNCH structure. But only 18% of deliveries are in institutions in Nepal, the terrain makes transport difficult, and infant mortality from other causes remains high. Targeting those women at higher risk with good quality tertiary level facilities will be prioritized as a strategic approach. Enhancing public/private partnerships is another strategy planned to strengthen follow-up and uptake of interventions.

Strategic shift from rural to more urban settings

In **Myanmar**⁷, prevalence of HIV infection has been declining since 2000. Low risk women are estimated to make up about one third of HIV infections. Prevalence among antenatal women was about 1.4% in 2007. But prevalence is much higher among those with risk factors such as injecting drug users, sex workers and their clients, and men who have sex with men. Initially the strategy in Myanmar was to offer HIV testing and provide PPTCT services at rural health centres because 70% of pregnant women live in rural areas and 80% give birth at home. This approach, however, required great resources with logistical difficulties and difficulties in referring positive women for appropriate services. From 2004, services were also provided in urban hospitals because HIV prevalence is higher and there are learning opportunities for students and new doctors and nurses. Since 2005 there has been a strategic shift towards basing PPTCT services at the township (district) hospital level, based on HIV prevalence data and to target higher risk women and couples in urban settings. Prevention for negative women and follow-up care, support and treatment for positive women are emphasized. People living with HIV are increasingly being involved to encourage follow-up for care and support.

⁵ Presentation: Dr Suresh Mohamed. PPTCT programme in India; challenges and recommendations

⁶ Presentation: Dr Usha Bhatta. PMTCT in Nepal: progress, challenges and recommendations

⁷ Presentation: Dr Ohnmar Aung. National strategy for scale up to priority districts in Myanmar

Plenary discussion

- There is a need to standardize the meaning of ‘PMTCT coverage’ – in some places it means ‘coverage of counselling and testing’, while in Cambodia, for example, it refers to when the mother receives prophylaxis. ‘PMTCT’ also encompasses primary prevention, so ‘PMTCT coverage’ could include ANC facilities that include information about HIV for pregnant women and expectant fathers, condoms and lubricants, STI detection and treatment, family planning and counselling for optimal breastfeeding, even if counselling and testing for HIV is not available.
- In India, condoms are given to positive pregnant women and partners are offered HIV testing.
- There was some discussion about the challenge of increasing rates of follow-up for HIV-positive women in Myanmar, including addressing the problem of stigma and fear of stigma. One suggestion was that mobile phones could be used for follow-up.
- There was discussion about the reason for high loss to follow-up between pre- and post-test counselling in Myanmar, which is also a problem in many countries in the region. Poor quality of counselling was identified as a major cause. Loss to follow-up is a serious problem because those few women identified as HIV-positive do not return to receive their ARV prophylaxis or treatment, so the purpose of the intervention is lost.
- Questions were raised about some positive women choosing abortion when they learn their status. Good quality counselling with accurate assessment of risk of MTCT is needed to prevent terminations of wanted pregnancies and unsafe abortions.

Presentation: Dr JP Dadhich, IBFAN – Potential of promotion and support for optimal breastfeeding to all mothers and babies to prevent HIV infection in children

Dr Dadhich presented the argument that promotion and support for optimal breastfeeding for all mothers and babies has great potential to contribute both to prevention of paediatric HIV and to prevention of child morbidity and mortality from other causes.

- Exclusive breast feeding (EBF) is a vital component for child survival, but EBF rates to 6 months are low.
- EBF has a lower risk of HIV transmission from mother to child compared to mixed feeding.
- Prevalence of HIV is very low in most Asian countries.
- Coverage of HIV testing in pregnant women remains very low in many settings, and many women deliver at home.
- There is strong evidence for the cost-effectiveness of interventions to increase rates of EBF (meta-analysis of six studies found that group counselling achieved a fivefold increase in EBF at six months).
- Yet there is little investment in promoting optimal breastfeeding for all in MCH and PPTCT programmes.

There is a lack of skilled health workers, lack of maternity benefits (such as maternity leave, baby-friendly workplaces), and inadequate implementation of the International Code of Marketing of Breastmilk Substitutes. Dr Dadhich described the successful Infant and Young Child Feeding Counselling training programme in India which has resulted in large numbers of trained health care providers through a cascade training of trainers system. He emphasized that it is feasible to achieve high EBF rates and called for national, well-coordinated and resourced plans of action focused on the 10 action points set out in the Global Strategy for Infant and Young Child Feeding.

- A question was asked about the timing of counselling to support EBF, and Dr Dadhich clarified that mothers were counselled every month to maintain exclusive BF at 6 months.

- Cultural contexts differ, but it can be helpful to think about two major reasons why many babies in all settings are not EBF. First, in the first week of life, babies are often given sugar water, herbal mixtures or other substances before the breastmilk ‘comes in’. Second, in the first weeks of life many mothers worry that they do not have sufficient milk but rarely receive the important advice that the more the baby sucks the more milk will be produced.

There was also some discussion about safer infant feeding counselling for HIV-positive mothers which is presented in the section on Objective 3 ‘challenges in prong 3’ under ‘HIV and infant feeding counselling’.

Conclusion

Resources for PPTCT should also be allocated to promotion and support for optimal breastfeeding for all mothers and infants in order to reduce MTCT of HIV from HIV-positive mothers who are newly infected or unaware of their positive status. This will also contribute significantly to child survival.

Key suggestions for objective 1

This section highlights the main suggestions that resulted from the group discussions about the five strategic approaches listed in the introduction and from the presentations. Some recommendations were relevant to more than one of the different strategic approaches, so we present here a synthesis of the recommendations to reduce repetition. The following suggestions were made by participants for consideration in developing context-specific policy guidance.

Integration and linkages

- ❖ Ensure effective linkages between all MoH health programmes, at national and sub-national level and with non-health sectors, including social welfare and education
- ❖ Integrate HIV prevention and care into all health service provider training curricula, especially counselling and communication skills
- ❖ Strengthen primary prevention of HIV and STIs through MNCH services for general population
- ❖ Referrals from NGOs working with people living with HIV and/or people at greater risk, and from treatment, care and support centres, are critical for HIV-positive pregnant women and pregnant spouses of HIV-positive men to access PPTCT services. Effort to strengthen these services was also emphasized.

Strategic planning and leadership

- ❖ Advocate for greater policy commitment, including resources, for comprehensive approaches to HIV prevention and care for women and children. Such advocacy efforts should include religious and opinion leaders.
- ❖ Develop action plans for scaling up comprehensive PPTCT, prioritizing according to the epidemiological situation in the country (greater analysis needed based on local epidemiology).
- ❖ Normalize the involvement of men in maternal and child health services, and empower men as fathers. Provide HIV and sexual and reproductive health information and services to men when planning marriage/pregnancy. Encourage expectant fathers to attend antenatal and postnatal care including parental education, and encourage employers to allow leave for this purpose. Include discussion of safety of sex during pregnancy and need to avoid unprotected sex with a different partner. Train male workers to talk to young men and expectant fathers
- ❖ Involve people living with HIV, and representatives of most at-risk populations, in planning and implementing prevention, care, support and treatment responses.
- ❖ Develop creative communication strategies tailored for each population group, especially those most at-risk. Messages should emphasize the impact on children and families, and encourage primary prevention, health care seeking and knowledge of HIV status.

- ❖ Strengthen capacity for M and E to generate strategic information for planning and implementation at all levels, in particular at the sub-national level.

Increasing proportion of people with knowledge about their HIV status

- ❖ Widely increase availability of non-stigmatizing HIV testing, both within and beyond MCH services, including good quality counselling for both HIV negative and positive.
- ❖ Where HIV prevalence is very low, conduct risk assessment (after evaluation) in antenatal care facilities with referral for HIV testing and follow-up interventions.
- ❖ Increase counselling and HIV testing services for most at-risk populations through community organizations and strengthen outreach services.
- ❖ Strengthen capacity of laboratories to support quality HIV testing and subsequently improve mothers' health.

Ensuring HIV-positive mothers receive ARV prophylaxis or HAART, and family-centred, integrated treatment, care and support for their children

- ❖ Strengthen follow up of HIV-positive women and their families.
- ❖ Undertake operational research to evaluate benefits and potential harms of system of incentives for follow up to motivate both clients and providers.
- ❖ Advocate for HIV infection to be included in health insurance schemes.
- ❖ Equip health facilities to deliver quality services.
- ❖ Address stigma and discrimination in health care facilities.

Population level strategies to reduce HIV infection in children, bearing in mind the need to improve MCH in general

- ❖ Improve prevention, detection and management of STIs for men and women, especially in the antenatal clinic.
- ❖ Ensure better health of pregnant women – invest in quality ANC services and prioritize efforts to increase attendance at ANC, with mobile services, including possibility of mobile technology, and with trained village health volunteers for those in remote/rural areas.
- ❖ Allocate resources for PPTCT to promote optimal breastfeeding for all mothers and newborns. This will both prevent paediatric HIV from HIV-positive mothers unaware of their status and improve child survival in general. Coordinate well between HIV and MCH/Nutrition departments.
- ❖ Improve access to FP information and services for all; regulatory barriers should be addressed and a wider range of centres should offer FP services.
- ❖ Invest in improving youth-friendly reproductive health services, involving youth in all decisions regarding their reproductive health and investigate use of new technologies for communication.

Objective 2: Addressing the cross-cutting challenges to develop and strengthen comprehensive PPTCT programmes

Introduction

The country consultations and review reports revealed that there are certain cross-cutting issues that are relevant to all four strategic elements of comprehensive PPTCT programmes that tend to need greater and urgent attention in low and concentrated epidemic settings. These were:

1. Coordination to establish or strengthen linkages:

- Coordination within and between UN agencies, and between donors
- Management structures at national and sub-national level including coordination within and between government departments (MNCH, FP, HIV, SRH, STI, HE, youth); between UN agencies and government departments; between governments and civil society/NGOs and private sector

2. Communication:

- Strengthening communication and counselling skills of health care providers
- Communication strategies for preventing HIV infection in mothers and children, and reducing stigma and discrimination

3. Strategies to ensure that vulnerable and at-risk populations have access to comprehensive SRH, STI and PPTCT information and services

4. Greater engagement of men in SRH and MNCH services

Operational research and monitoring and evaluation (M&E) are also key elements of objective 2 as they are cross-cutting processes which are critical to successful implementation of PMTCT programmes. They have been included as part of this objective, although they were mentioned in the context of the other objectives as well. This section highlights the experiences, discussion points and suggestions related to these cross-cutting challenges from the presentations, plenary and small group discussions.

Experiences and examples

Coordination to establish and/or strengthen linkages⁸

- Sexual, reproductive, maternal and newborn health problems, including STIs and HIV, have common underlying causes and shared solutions, so it makes sense to address them together.
- Investing in stronger linkages will strengthen health systems and contribute to the achievement of the MDGs.
- Strengthening linkages will also facilitate inclusion of men, young people, and those at greater risk of infection with HIV.
- Linking SRH and HIV services was found to be beneficial and feasible, especially in family planning clinics, HIV testing sites, and HIV clinics. There is strong potential to improve access to services, efficiency of outreach, reduction of stigma, community involvement, and reproductive health outcomes, including institutional deliveries.
- Congenital syphilis can be prevented by providing ANC to pregnant women with screening for syphilis and by treating women who test positive, as well as their partners and infants.
- There are clear synergies in preventing congenital syphilis and the transmission of HIV from a positive pregnant woman to her infant.
- A regional framework for integration and guide to how to link services in practice was developed in 2006 and refined following the joint forum in Kuala Lumpur and a follow-up consultation in Guilin, China. This includes policy linkages between different departments, vertical links through stronger referral systems, and horizontal links between different services. There are useful examples showing the effectiveness of this approach. A recent systematic review of 58 studies⁹ showed improvements in access to and uptake of services; in health and behavioural outcomes; in HIV and STI knowledge; and in quality of service.
- Cambodia, China, PNG, and Viet Nam have pilot projects to determine how to better reach men, young people and people most at risk of being infected by HIV with HIV and SRH services.
- A response linking HIV and SRH services in Cambodia was determined by several factors such as:
 - All health services not available at the same facility
 - Missed opportunities to provide information and refer patients to relevant health services for appropriate testing or treatment
 - Limited access to health services due to geographical constraints
 - Poor referral and follow-up between health services and the community
 - Low coverage of HIV testing among pregnant women and uptake of PMTCT services

⁸ Presentation: Dr Naoko Ishikawa, WHO WPRO. Experiences of operational linkages between SRH, MNCH and HIV/STI services with elimination of congenital syphilis

⁹ WHO, IPPF, UNAIDS, UNFPA Linkages: evidence review and recommendations UCSF. 2009

Cambodia's example of linked response¹⁰

- A linked response technical working group was set up at national level in Cambodia, and a standard operating procedure was developed for implementing at operational district level. Tools were developed for training and monitoring.
- In 2008, a demonstration linked response project was established in five districts of two provinces in Cambodia, showing a clear increase in uptake of HIV testing among pregnant women at these sites and high follow-up rates among those that were HIV-positive.
- At the health system level, the linked response approach revitalized management mechanisms at operational district level and ownership and leadership at local level by:
 - Decentralizing coordination and improving the use of data for programme implementation
 - Strengthening the culture of partnership between vertical programmes and partners by developing a joint statement, standardizing the operating procedure, and monitoring tools, joining training activities, and enabling a joint proposal for scaling up the linked response countrywide that was submitted to the Global Fund
- At the level of the beneficiaries, ANC coverage increased through strong referral and follow-up.
- HIV-positive mothers and exposed infants received comprehensive PPTCT services.
- Health providers changed from clinical management to a client-centred public health approach and worked together in teams.
- The approach had demonstrated benefits for both preventing HIV infection in children and improving maternal and child health.
- There are plans to expand to a further seven provinces, introduce syphilis and TB screening in the ANC, and pay attention to a continuum of care for those at greater risk of HIV.
- Difficulties experienced included limited political will, concerns about increased workload for health providers, limited capacity of management and leadership at the district level, inadequate staffing levels, concerns about confidentiality for HIV testing during outreach ANC, and doubts about the financial sustainability of the linked-response approach.

Communication – including addressing stigma and discrimination

- Dr Susan Paxton presented data from a participatory action research study by the Asia-Pacific Positive People's Network (APN+) about Asian women's access to HIV treatment and services. A non-random snowball sample (1,306 respondents) of rural and urban women in China, India, Thailand, Cambodia, Indonesia, and Viet Nam was surveyed.
- Challenges for HIV-positive women in receiving HIV treatment and services:
 - Diagnosis often happens late.
 - Financial barriers to treatment are common.
 - A lack of knowledge among both the women and health care providers; for example, about 14% of women stopped ARVs because they thought they didn't need them.
 - The greatest obstacle to adherence is limited counselling.
 - Many of the women reported discrimination in health services, and there were concerns about coercive sterilization. Older women and women in villages faced more discrimination, while women in cities tend to be more anonymous. Women partners of male drug users and women drug users are often stigmatized and thus don't access health services.
- Ms Linda John Hay and Mr Maniyam Somesh gave moving and compelling accounts of their own experience of learning their positive HIV status (see boxes). It is clear that this can be a devastating time with great need for emotional support to minimize harmful outcomes for the individual and their family. They both went on to describe the different ways in which they have become involved in supporting others to learn their status and then to cope with the results. This has included supporting others in disclosing their status to partners and family. Their stories provided a strong argument for the importance of building the capacity of positive people to play roles in both HIV prevention and care, and especially in preventing HIV transmission to children. HIV-positive people are trusted by those newly diagnosed in a way that health professionals who have not had this life experience cannot be. It is clear that it is important to provide both resources and support to enable positive people to play these valuable roles in the response.

¹⁰ Presentation: Dr Samreth Sovannarith. Linked response in Cambodia

Reaching vulnerable and at risk populations¹¹

- Rates of injecting drug use are increasing in the region, and there is a trend towards greater use of injecting pharmaceutical drugs.
- There is a clear increase in the numbers of women injecting, although they tend to remain hidden because they are marginalized and face stigma.¹³
- Most drug users are in the reproductive age group and sexually active, often at a young age, and often have multiple partners.
- Women partners of male drug users and women drug users often do not perceive themselves as at-risk for HIV and have low rates of testing but high rates of infection with HIV, STIs, TB and hepatitis C. They lack access to health care services. The children of these women and their partners are vulnerable to emotional and physical neglect and abuse.
- Women are vulnerable to transmission of HIV and other STIs through unsafe injecting practices and through unsafe sex.
- Studies in the region reveal low rates of condom use, high levels of selling sex, and anal sex. Women partners of male drug users and women drug users have little power in sexual negotiation and sexual violence is commonly reported. These women also lack knowledge about how to protect themselves from HIV and other STIs and have many false beliefs.
- In India, South India AIDS Action Programme (SIAAP) focused initially on legal advocacy for women in sex work who are detained for being HIV-positive. SIAAP works through a community participatory model establishing trusted relationships, helping sex workers to exercise their civil rights, ensuring school and hostel admission for children of sex workers, and promoting advocacy against violence. They address discrimination in public health care facilities enhancing access to STI- and HIV-related services and promote risk perception and safer sexual practices. Peers support and educate each other. Women in sex work are supported to access services, including reproductive health and PPTCT services, through a Community Counselling Centre.
- Several participants mentioned the significance of reaching migrant workers and their partners with information and services because they are also vulnerable to infection with HIV. This is particularly relevant for South Asian countries.

Greater engagement of men¹⁴

- Sexual, reproductive, maternal and newborn health problems relate to areas of life that have great cultural and social significance of intimate concern to women and yet are often governed by men. Men's behaviour affects the health of their partner and children, and men have a right to information about their own reproductive health and that of their partners. Engaging men can lead to several useful outcomes for the health and well-being of men, women and children:
 - Less risk of STIs and HIV for men, women and children
 - Higher uptake of contraception use with fewer induced abortions
 - Better maternal nutrition with lower risk of anaemia and LBW
 - Less delay in reaching emergency obstetric care when there are delivery complications
 - Higher rates of EBF with lower rates of infant infections and deaths
 - Improved couple communication and greater support for women with better mental and emotional health and well-being
 - Increased communication and counselling skills of health workers and greater job satisfaction
- Some children with HIV in a population will have become infected from a mother that became newly infected with HIV late in pregnancy or during breastfeeding. Men are often more likely to have sex with someone outside the marriage when they are not having sex with their wife during or after the pregnancy. If they become infected with HIV, they have a high viral load just at the time they are likely to resume sex with their wife and so are very infectious.

¹¹ Presentation: Dr Pratima Murthy, National Institute of Mental Health and Neurosciences. Reaching men and women who inject drugs and their partners with comprehensive SRH and PMTCT services.

Presentation: Dr Indumathi, South India AIDS Action Programme, Tamil Nadu. Reaching women in sex work with SRH and PPTCT services.

¹² Kumar S. Rapid Situation and Response Assessment on drugs and HIV in Bangladesh, Bhutan, India, Nepal and Sri Lanka. UNODC RAS/H13 June 25 2008, New Delhi.

¹³ UNODC. Substance use amongst women and HIV/AIDS risk (SWAHA) study. 2008.

¹⁴ Presentation: Dr WR Holmes, Burnet Institute, Australia. Letting men in: involving men in SRH and MNCH

- Pregnancy increases women’s susceptibility to HIV for biological reasons. If the woman becomes infected when pregnant or breastfeeding, there is a very high risk of transmission to the baby because they have a very high viral load for several weeks. To eliminate HIV infection in children, it is necessary to prevent new maternal infections. The proportion of paediatric HIV from new maternal infections will depend on the incidence of HIV compared to the prevalence.
- Expectant fathers and pregnant women need to know that sex is safe throughout pregnancy if there are no complications and can resume post-partum after the woman’s bleeding stops (however, the woman’s wishes should be followed).
- There are opportunities to provide information to young men in and out of school, to men when planning marriage/pregnancy, to expectant fathers at the ANC, in the workplace or community, at the time when the husband fetches his wife and newborn from the clinic or hospital, and at a post-natal visit.
- Barriers to engaging men in SRH and MNCH issues include:
 - Cultural beliefs that family planning, pregnancy, childbirth, infant feeding and care of infants are women’s business
 - The vertical nature of planning and delivery of many programmes
 - Busy clinics that are not welcoming for men
 - Difficulty for men in attending clinics during usual hours because of work and men away from home working
- **Risk assessment for expectant fathers:** Dr Holmes¹⁵ presented an idea for a risk assessment quiz for expectant fathers as a strategy to identify men and pregnant women with HIV and to give men the information that they need. Women at risk because of their partner’s behaviour are often unaware, and risk assessment is a difficult task for busy ANC staff to conduct in a confidential, sensitive and non-stigmatizing way. We could encourage men to assess their own risk by completing a private, entertaining magazine-style quiz. This lets them know which risk category they are in, encourages them to seek testing if appropriate, and motivates them by telling them that there are medicines that can reduce the risk of HIV to the baby. This quiz now needs to be evaluated.
- In **Lao PDR**¹⁶, only 28.5% of women access ANC services (2005), and few men accompanied wives to ANC visits. The government aimed to strengthen male involvement in PPTCT in order to encourage fathers to care for children and protect their families from HIV through adoption of safer sex practices. Fathers are encouraged to support their wives to access ANC and get tested for HIV by 1) making it easier for men to help prevent HIV infection in mothers and children; 2) communicating to expectant fathers their important role in protecting and caring for their families; and 3) equipping health care professionals to be sensitive to men. The “Caring Dad” communication campaign was launched in 2006 and appeals to fathers to prevent HIV transmission and promote their role in MCH.
- In **Thailand**¹⁷, in 2005, 38% of new HIV infections were in women infected by their husbands (6,600 cases per year). HIV prevalence was 0.67% in pregnant women, 0.85% in male partners, and 48% of female partners were HIV negative. It was therefore a priority to prevent HIV negative pregnant women from becoming infected. A service model capable of actively involving men in ANC to jointly prevent HIV in couples was developed to increase male engagement. A training manual and module for couple and disclosure counselling were developed. Men were invited to participate at a range of service delivery points. Information and behaviour change materials were developed for risk assessment and the promotion of condoms. The model has been well accepted by both health care providers and couples with gradually increasing participation. The project name has been changed from “stay negative” to “men as partners for

¹⁵ Presentation: Dr Wendy Holmes. Letting men in: Engaging men in sexual, reproductive, maternal and child health in Asia and the Pacific

¹⁶ Presentation: Dr Kaisone Chounramany. Involving men in antenatal care in the Lao People’s Democratic Republic

¹⁷ Presentation: Dr Taweessap Siraprasiri. Male Involvement to Prevent HIV and Protect Maternal and Child Health

preventing HIV and protecting maternal health”. Couples’ counselling has increased from 39% in 2005/6 to 62.5% in 2008. Now free couples’ counselling and testing is covered under the Universal Health Care Scheme.

Plenary discussion on cross-cutting issues

Below is a summary of key points raised during plenary discussion on the cross-cutting issues.

Coordination to establish or strengthen linkages

- The Global Fund encourages proposals for Round 8 that include strengthening integration or linkages under the ‘health systems strengthening’ window.
- How to reach youth in relation to sexual and reproductive health remains a challenge for many. Much work is being done on this, for example in Cambodia. Dr Indumathi from SIAAP in Tamil Nadu described how SIAAP has trained STI counsellors in villages who talk to youth, one-on-one or in a group, and have established youth centres.
- Low cost point-of-care tests for STIs (in addition to syphilis) are being developed, which will add to the potential of links between SRH and MCH.
- The chair of the technical session on coordination, Dr Song Li, concluded that it is essential to have a clear definition of linkages adapted to the epidemiological situation, and objectives should be measurable and practical.
- There was some discussion about how to ensure that mothers who choose to breastfeed do so exclusively and whether there has been a problem with spill over. Dr Samreth agreed that this is a challenge. In Cambodia, EBF rather than replacement feeding is promoted. The home-based care group provides counselling, there is information at the health centre, and a community team visits mothers to support her to exclusively breastfeed.
- The link approach is based on international funding. Each programme has its own financial, and technical support so it can be difficult to make sure that objectives are aligned.

Communication – including addressing stigma and discrimination

- The validity and representativeness of the findings of the APN+ study were questioned because this was not a random sample. It was noted that, although not random, it was a large sample, and the findings may be expected to be better for this sample because these were women who use services.
- On the issue of coerced sterilization, points were made that the providers may have had a medical reason for doing the sterilization, and that in Thailand providers listen to people living with HIV when planning interventions for Prong 2.
- It was suggested that the reason why some Thai women did not know their children’s HIV status may be because they are very mobile. On the other hand, the women did give information about how long they had lived in one place, so that did not seem to be the explanation. Participants from Thailand also pointed out that many mothers’ reasons for not returning for the 18 month test are beliefs that the child looks healthy or that children will get better with age. Counsellors need to tell mothers about the benefit of co-trimoxazole prophylaxis. Now, because of PCR test at two and four months, women come back for testing more and earlier.
- It was suggested to involve people living with HIV to change attitudes of health care providers. Health workers often wrongly fear they will get HIV through occupational exposure – we need to give these workers the evidence about how small the risk of occupational exposure is, provide equipment for infection control, and have post-exposure prophylaxis available at health facilities to reassure workers and help to reduce stigma.
- Most positive people’s networks do not include children – in India, children are ‘beneficiary members’. There is a group of Asian women with HIV who are open to young people but probably not appealing to young people.

Reaching vulnerable and at-risk populations

- Patterns of selling sex and taking drugs vary greatly. In Thailand the sex industry is organized and mostly brothel-based. In Lao PDR, for example, young women from rural areas may sometimes travel to the city for the weekend and sell sex to make money. Part-time sex work is also common in Karnataka. Not all women who sell sex identify as 'sex workers'. In Mumbai, more than 50% of sex workers are from Bangladesh. Some drug users are middle-class, for example, in Indonesia and Bangladesh.
- There are high rates of emotional problems among women drug users. A participant from China highlighted that many abused girls show a tendency to early sex debut, early drug use and suicide. The point was made that girls under 18 years who sell sex should not be referred to as sex workers but rather as sexually exploited children. Counselling services strategies would need to be different for these people who have a long history of emotional trauma.
- Women who use drugs or sell sex often have or want children and have a right to do so. Having children may motivate them to change risk behaviours. Women who inject drugs and are pregnant require support in relation to PMTCT and in other ways, for example, their infants may need early treatment to prevent symptoms of drug withdrawal. Male partners of those who inject drugs or sell sex also need to be included in PPTCT efforts.
- Women in sex work may be rejected within positive support groups. For example, in Cambodia some positive housewives said they blamed sex workers when they were diagnosed, but once they got to know them they changed their views completely. SIAAP has formed a partnership with the positive network, so there is understanding and little discrimination against sex workers. Peer-to-peer approaches may be useful, although language may be a barrier when many sex workers are migrants. There is a coalition of organizations that work with sex workers across India.
- Women in sex work may use condoms with clients but may not use them in their private relationships.
- We need to do more to sensitize health care workers, including doctors, to provide non-judgmental services. Sometimes women in sex work attend private doctors because they believe the service will be more confidential.
- There was also some discussion about the wives and female partners of men who have sex with men. In Pakistan PPTCT services are being offered to MSM organizations.
- It was suggested that it is important to seek new partners in order to provide PPTCT information and services to those women most likely to be infected with HIV, such as Response beyond Borders. It is also important to have links with child protection services because they may be needed by children of parents who inject drugs or sell sex – although it was noted that it will often be best not to remove children from their families.

Greater engagement of men

- It is important to think about what changes are needed to be made to the clinic space and times to attract men. In Lao PDR, there is no special space for men, but they are thinking of having a special counselling room for men to motivate them to come. In Thailand it is considered a critical component of the programme. Now health providers are looking at the couple rather than just the woman and also doing group couple counselling. The clinic should look like a place that would make men want to be there – for example, posters of cars or sport can be outside the clinic itself. Men don't like to wait, but if you keep it interesting, with information or games then they will wait. In Lao PDR, counselling is done with groups of men waiting for wives at ANC. No country has yet tried to provide ANC after normal working hours, but this could be possible once a month.
- It is best if a male worker can be trained to talk to the men (it does not need to be a health care professional).

- There is often concern about increased workload for health workers – how can we motivate them to include men? In Thailand, the results motivate health workers, and the idea that in the long term the burden on health services will be less. Before, the burden was on the woman to get her husband to get tested. But now, with the healthy family model, they are encouraging men to come with the woman to get tested.
- It would be best to reach men before the first pregnancy. People rarely plan for pregnancy, but pregnancy and marriage are often associated in time so pre-marriage counselling may be feasible.
- Engaging men in SRH and MNCH is a PPTCT intervention that can be implemented both where there is routine ANC offer of testing and where testing is not available.

Testimonials by Ms Linda John Hay from Papua New Guinea and Mr Maniyam Somesh from Tamil Nadu

Mr Maniyam Somesh is President of the Coimbatore Network for Positive People (CNP+) in India.
Panel on coordination within and between UN agencies

Maniyam's story

“I was diagnosed with HIV infection 12 years ago. I only worried about marriage when I got diagnosed. I experienced a lot of stigma and discrimination, especially within the family. I was worried at first about how people will react when I disclosed my status. The community still does not support people living with HIV, but there is less discrimination than previously – it is getting better.

I joined the HIV+ people's network where I could share information with others, and from there I got motivation and confidence that I could live. When I found out my status, I thought I was the only one with HIV. After seeing others with HIV I was relieved and learned what others are doing to improve their quality of life. At the time of my marriage, I didn't know that HIV+ people could be married. I married a woman from the HIV+ person network.

Then I started providing services to PLHA communities and started a district-level PLHA network. My main intention when starting the network was to provide services. I didn't want other people who are positive to face stigma and discrimination. A PPTCT programme was also started in this network with support from TANSAC. When the project began my wife was also pregnant, and with the interventions our baby was negative. Most babies born within this programme have been negative. Such good results are because of community and family support, ANC cooperation, nevirapine administration, and accurate lab results on time. Many people can't afford replacement feeding, and people enrolled in this programme also ask for financial support. We have links with the district health system, and CBOs and NGOs.

I am glad that I can help others who are HIV-positive.”

Ms Linda John Hay is a Field Support Officer with the Sirius Naraq Foundation in Papua New Guinea.

Linda's story

"I was diagnosed in 2004 through the antenatal clinic. I have been living with the virus for five years, and I'm not on antiretroviral drugs. My child is now five years old and is HIV negative.

In 2004 I was in school and getting sick, so I had to leave to concentrate on my health and went for checkups to the clinics. The doctors did not tell me what was wrong with me. I also had problems with my family. I got married to get away from the problems, but the problems continued. I became pregnant and after four months went to the antenatal clinic. I had counselling in a group, which I wasn't satisfied with, I did not feel well prepared to have the test. But I didn't know my HIV status, so I had the test. My heart was beating, and I knew that I had a problem.

I came back to the clinic two weeks later for the result. I was standing on the scale when the counsellor came and said, "When you've finished, you must come and see me." She was monitoring me so that I wouldn't escape – and I had to follow her into a counselling room. I burst out crying when she asked if I was a sex worker. I cried and cried – I couldn't accept that I have HIV. I cried until the afternoon and had all sorts of negative thoughts and considered suicide. My sister was keeping an eye on me, although she didn't know my HIV status. She said, "You're not the only one having a child without being married – you should continue to go to the clinic."

After the delivery I was admitted to the ward. I saw men visiting their wives. I lost focus on my child. To make it worse my bed was right by the corner next to the window, and I was thinking of committing suicide. Luckily my mum came and told one of the nurses to come and check my baby. The baby was crying which touched my attention, and I realized I had to look after my child. Counsellors came and other mothers would stare at me, and I felt they would know my HIV status. So I asked the doctors if I could take care of my child at home. I suffered discrimination at home because I had a child with a man that my father didn't approve of. I went to the social work department and a local NGO with my problems. My baby was given co-trimoxazole. Only later, when my baby tested negative, I began to look after my own care.

Then I started to help other women. I think it is important that I came out to share my experience with other positive mothers – so that their babies would not get HIV.

I had to learn to help myself. In 2007 I began helping the Friends Foundation (a support organization founded by social worker, Tessie Soi, with support from UNICEF, dedicated to helping prevent mother-to-child transmission of HIV and also to supporting mothers and children who are already living with the virus). I worked as a volunteer in their community home-based care programme. Then the Friends Foundation employed me as a Team Leader.

I came across a guy who was very sick that the health workers had lost contact with. I listened to his story and asked if I could refer him to the clinic, but he said no. I thought perhaps it was HIV, so I shared my experience with him, and he disclosed his status to me. I asked him "Does your wife know about your status?" Their first child had died, and they had another child. I had to explain to him the importance of disclosing his HIV diagnosis to his partner and helped him to disclose his status to his wife. Then I helped his wife to go to the clinic for a test. Sadly, while waiting for the second test, the child developed oral thrush and died in the paediatric ward. I have also helped new mothers with HIV in the postnatal ward to accept their situation. I suggest to them that we walk along together and find a good space to tell stories, and then under a tree I share my experiences and it helps them to look after their own babies."

Panel on coordination within and between UN agencies

A panel discussion was held to specifically address the problem of poor coordination within and between UN agencies, and between UN agencies and governments and other partners. Below are the key recommendations from this panel.

Panellists included the following UN representatives:

Ms Nancy Fee, UNAIDS Indonesia

Dr Padmini Srikantiah, WHO SEARO

Ms Wing Sie Cheng, UNICEF EAPRO

Dr Taweesap Siraprapasiri, UNFPA Thailand

Ms Rachel Odede, UNICEF ROSA

Recommendations:

- Focus on advocacy, leadership and accountability.
- Determine how to spend money most effectively.
- Determine how individual agencies or programmes can sustain national efforts and make each other accountable.
- Place PPTCT further up on the political agenda.
- Balance technical support with leadership and advocacy.
- Ensure coordination and clear delineation between UN agencies so countries are aware of which agency is the best resource for a specific issue, to lessen confusion and to minimize duplication of efforts.
- Encourage governments to call on UN agencies for support.
- UN agencies should support strong policy research so long term benefits of linkages at MCH/HIV and other sectors can be seen and to help convince leadership of the importance of PPTCT programmes.
- Convince governments that PPTCT linkages will be beneficial in terms of outcomes at all levels.
- Putting people as the first priority is the most important consideration for UN agencies.
- Move towards a collective effort in building capacity among the agencies, since not just one agency can move coordination forward. The member states expect UN agencies to support their national priorities – not individual agencies to do their own mission.
- Remember that all efforts in this field are ultimately being done to save a child's life.

Key suggestions for objective 2

The key suggestions emerging from this section are primarily from the group discussion about the cross-cutting challenges. Key recommendations emerging from the presentations are also included here to minimize repetition.

Leadership, advocacy and policy

- ❖ Create advocacy messages that are linked to the country's priority health issues. For example, we should show how investing in SRH and MCH services will both reduce the problem of children with HIV and other causes of morbidity and mortality that are more common.
- ❖ Promote leadership at all levels. It is important to gain consensus for consistent messages among all partners.
- ❖ Provide real facts and figures based on country situations and costed plans that are more likely to gain support.
- ❖ Advocate effectively for the importance of quality data for improved programming and ensure that governments understand the role of each UN agency in collating data and preparing reports.
- ❖ Argue for the benefits of PPTCT for health system strengthening.
- ❖ Develop messages in communication campaigns that emphasize the saving of the life of the unborn child and the appeal of the 'family concern'.

- ❖ Develop messages that are applicable to the audience.
- ❖ Ensure that messages do not promote services that are not available.
- ❖ Involve media but ensure confidentiality.
- ❖ Be careful with language. Avoid using terms like ‘AIDS’, ‘disease’ and ‘patient’ when talking about people living with HIV.

Improved coordination and communication as well as implementation strategies, including linkages between HIV prevention and care, MNCH and SRH services

- ❖ Improve coordination within and between UN agencies, within and between government departments (e.g. HIV, MCH, and child protection) and with NGOs and community organizations.
- ❖ Address stigma as a barrier to coordination between departments – for example the TB department or MCH department may not want to engage with HIV because of the associated stigma, and attitudes towards working with marginalized groups, such as women in sex work, may differ greatly.
- ❖ Explore opportunities to coordinate with other relevant non-health ministries for PPTCT – for example, the Ministry of Women and Child Development.
- ❖ Develop linked responses that are specific to different country health systems because of differences in decentralization and organization of responsibilities between different departments.
- ❖ Consider further links including youth-friendly services, TB, EPI, and malaria.
- ❖ Explore ways to encourage the private sector to adopt and follow national guidelines
- ❖ Integrate information, education and communication.
- ❖ Assess and address staffing capacities (ensure health workers in an RH setting are trained to address HIV).
- ❖ Integrate PPTCT of HIV into in- and pre-service training and integrate training manuals.
- ❖ Involve communities, people living with HIV, and those at greater risk of HIV; i.e. engage women living with HIV to train health workers on HIV and train women with HIV as counsellors.
- ❖ Integrate outreach cadres for HIV related programmes: for example, PPTCT outreach workers could also give information about palliative care.
- ❖ Organize physical spaces (create spaces that are male- and youth-friendly, and converge youth-related services around HIV testing and counselling, and PPTCT).
- ❖ Use opportunities where men already gather (work place, sports clubs etc) to reach men.
- ❖ Provide subsidies/incentives for referral to PPTCT services.
- ❖ Explore strategies for reaching those most at-risk for HIV in non-stigmatizing ways: for example, offer regular health checks rather than ‘STI’ checks.

Presentations:

- ❖ Cross-network across agencies to address the needs of women drug users and partners of drug users for information, family planning advice and services, male and female condoms, STI prevention, detection and treatment, and comprehensive PPTCT services.
- ❖ Develop capacity in terms of facilities and human resources to provide or link with peer-led interventions, harm reduction services including substitution and needle exchange, overdose management, and comprehensive health services including mental health services.
- ❖ Provide resources for ARV treatment literacy.
- ❖ Support HIV-positive women’s income generation schemes, and provide micro-credit schemes, since HIV impoverishes women. This will also help long-term HIV care for woman and keep mothers alive.
- ❖ Ensure HIV-friendly reproductive health services are integrated with HIV services, and promote regular pap smears. No woman should be coerced into sterilization.
- ❖ Assist women in understanding their rights.
- ❖ Give pregnant women a personally addressed invitation to their husband to attend the next ANC visit.

- ❖ Approach male leaders in communities to mobilize community members to become more involved.
- ❖ Provide information about HIV, AIDS, STI and reproductive health and related services directly to men outside the ANC or MCH clinic.
- ❖ Conduct a study on men's attitudes and behaviours regarding MCH.
- ❖ Train all levels of staff involved in care of women with HIV in knowledge, attitudes, and values, so that they understand how very small the risk of transmission is, even after a needle-stick incident.
- ❖ Make post-exposure prophylaxis available for staff.
- ❖ Use legal systems to combat stigma and discrimination.

Operational research and M&E

- ❖ Support collection of baseline information/data to guide programme design, implementation and subsequent evaluation.
- ❖ Improve quality of M&E data.
- ❖ Analyze and use routinely collected data effectively at implementation as well as central level.
- ❖ Develop M&E indicators for Prongs 1 and 2.
- ❖ Disaggregate indicators by risk factor, gender and age.
- ❖ Develop one integrated system of data collection and reporting to avoid the problems of vertical programmes. Include PPTCT indicators in health management information systems, so that data is useful to sub-national level, Ministries of Health and to donor agencies
- ❖ Conduct operational research studies, and make sure that the findings are used to inform programme planning. Use and share existing relevant study data
- ❖ Address the need to conduct operational research to determine priorities for linkages in low prevalence settings, cost-effectiveness, influence on stigma of routine testing for HIV and syphilis, and whether there are benefits or harmful effects on maternal and child health outcomes.
- ❖ Collect, collate and report for evaluation data on men's involvement in SRH, and MNCH services should be regularly collected, collated and reported for evaluation.

Objective 3: Addressing common challenges in implementing antenatal PPTCT programmes

Introduction

Country review reports identify a number of weaknesses in implementation common to many antenatal PPTCT programmes. These included issues in relation to HIV testing and counselling; loss to follow-up; assessment of HIV-positive pregnant women for HAART; the transition from single dose nevirapine to more efficacious and safer regimens; HIV and infant feeding counselling; and early infant diagnosis with links to paediatric care. As new research findings become available, international guidance is refined. It is important to ensure that updated technical recommendations are rapidly incorporated into national programmes.

The discussion points from small group discussions of key topics and the plenary discussion that followed are presented below. The conclusions and recommendations are then presented together.

Discussion points about the common challenges

HIV testing and counselling

- Some key barriers to implementing widespread ANC HIV counselling and testing are availability of quality counselling and to ARV drugs for prophylaxis and treatment, lack of staff, perceptions that risk for housewives is low, and stigma and discrimination among health staff.

- Experience in the region suggests that low prevalence countries with concentrated epidemics should target PPTCT information and services to those at higher risk of infection.
- To reduce the perception that housewives are at low-risk for HIV, PNG has pointed out high levels of STIs in that population.
- Study of cost-effectiveness from Andhra Pradesh found that it is cost-effective to test in urban centres – but costs per woman become very high in lower density, low prevalence rural settings, so it is better in such settings to invest resources to prevent women becoming infected in the first place.
- This is the first time that, through HIV programming, there is an opportunity to introduce a mental health component to public health services – to introduce counselling as a widespread skill.
- In many settings where ARV prophylaxis is available, a relatively large proportion of women arrive in labour, without having received ANC or knowing their HIV status. Testing during labour can cause problems, and it may be too late for a dose of nevirapine to be effective. On the other hand, timely testing and administration of nevirapine can reduce the risk of transmission to the baby. This dilemma was discussed for different types of settings. The main reasons why health professionals want to test during labour include (i) fear of occupational exposure to HIV and (ii) providing accurate treatment and care to HIV-positive women and HIV-exposed babies.
- Many births take place at home – so people don't come into contact with health workers. We need to consider how to reach these women and couples.
- There are difficulties for positive women who are the first in the family to test HIV-positive, since they may be blamed for bringing HIV into the family.
- It is still a challenge to reach men in the workplace, in rural areas, and in the ANC. We need to emphasize to men the value of family and use opportunities where men already gather.
- Positive women talking to newly diagnosed women can support disclosure when couples have not been counselled together

Minimizing loss to follow-up

- The definition of 'loss to follow-up' varies between countries. Some countries do not have a definition. It is most often defined as those who tested positive and did not return to the centre.
- The following were identified as reasons for loss to follow-up:
 - Failure of counselling services to establish trusting relationships with mother affecting the likelihood she will return to services – problem with quality of counselling was emphasized
 - Distance away from ANC service (time taken away from job and family)
 - Cultural practices (e.g. returning home to village to give birth)
 - Health care providers asking questions about how the woman became HIV-positive
 - Financial implications (travel costs and time off work)
 - Perceptions of counsellors and health care workers (stigma)
 - Limited ANC services (especially in rural settings)
- In all countries there is a follow-up programme for all who test HIV-positive, but there is little attempt to follow-up with those who are not infected. In low epidemic settings most testing occurs in 'high risk groups', so post-test counselling should be essential for all women. In Malaysia women from high risk groups are encouraged to return for repeat testing. The use of rapid test kits encourages post-test counselling, but post-test counselling is still limited.
- The following were identified as strategies used to minimize loss to follow-up:
 - In the Philippines, which has very low prevalence and where people travel long distances, 'half-way homes' are offered for women post-delivery, and emergency and travel funds are available.
 - Outreach workers (positive network of women) are responsible for 5-10 HIV-positive mothers to follow them through antenatal and postnatal care in Tamil Nadu, India.
 - Follow-up with local NGOs and local ART centre in Pakistan
 - In Malaysia, with 'Collective Confidentiality', attending doctors, nurses, obstetricians and paediatricians care for mother and child alongside a government-employed and trained counsellor for home visits.

- In China, a comprehensive ANC programme is provided free, and public health workers follow-up.
- Advocacy and awareness is needed to mainstream service provision, so health care workers are responsible for tracking all pregnant women, including those who are HIV-positive to reduce discrimination.
- Ability of mother to choose the clinic where she would like to receive her antenatal, delivery and post-natal care
- Improvement in counselling practices
- Increase in trained human resources is key to improving follow-up.

Assessment of HIV-positive pregnant women for HAART

- Loss to follow-up occurs between ANC and referral for CD4 count. Reasons include CD4 testing and treatment services delivered as a vertical programme make linkages difficult. Psychologically, pregnant positive women may not want to be overwhelmed by meeting too many medical people, and the distance to travel to obtain CD4 assessment and ART may be too great.
- Lack of availability/upkeep and maintenance of CD4 machines means that often provision of ART is based on clinical signs.
- Results of CD4 assessment take too long to report, and communication links are poor.
- Health workers are often not familiar with recommended PMTCT ARV prophylactic and treatment regimens during pregnancy.
- There are weaknesses and gaps in recording and reporting.
- Very long waiting lists of patients await the provision of ART.

Transition to more effective multi-drug prophylaxis regimens

- Women do not present early enough in pregnancy (often post 28 weeks) to receive longer regimens.
- Low rates of supervised delivery prevent doses during labour and the post-delivery 'tail'.
- Health workers lack knowledge about the expanded regimens.

HIV and infant feeding counselling

Participants identified a number of challenges to supporting HIV-positive women to EBF.

- EBF rates very low
- Influence of formula companies
- Short maternity leave (only three months or less)
- Difficult to reach the many women who deliver at home to follow-up with proper BF counselling.
- No budgeted and coordinated programme on IYCF in many countries
- Skills of service providers to support pregnant and lactating women depend on commitment, capacity and competence; different trainings offered by different organizations
- Not all service providers (some NGOs) follow the national guidelines
- BFHI incorporates provisions for how to support HIV-positive mothers but has not been harmonized with international HIV and infant feeding guidelines
- Mothers that do not breastfeed may be stigmatized.

A discussion about infant feeding advice for HIV-positive mothers following the group presentation on promotion of optimal breastfeeding for all mothers and babies is presented here.

- A question was asked from PNG whether there is guidance about how to convince a mother to continue to breastfeed when the HIV DNA PCR result at six weeks is negative.¹⁸ Dr Srikantiah (WHO, SEARO) explained that the PCR test at six weeks reflects transmission during pregnancy or delivery, and when the result is negative, we still need to promote EBF. There was agreement from several participants that it is

¹⁸ WHO advice on infant feeding after HIV DNA PCR test at six weeks:

"If the child is breast-fed and the result is negative the child is probably uninfected but another test should be performed 6 weeks after the baby ceases breastfeeding. Continue co-trimoxazole prophylaxis. Counsel the mother to continue to breastfeed unless it is affordable, feasible, acceptable, safe, and sustainable to stop." (WHO. Early detection of HIV infection in infants and children. 2007 http://www.who.int/hiv/paediatric/EarlydiagnostictestingforHIVVer_Final_May07.pdf)

difficult to encourage a mother to continue to breastfeed after explaining to her that we cannot be sure the baby is uninfected despite the negative result because the baby may have become infected in the previous six weeks through breastfeeding. Dr Dutta (UNICEF, Tamil Nadu) warned that a 'one-size fits all' approach might have problems and that a rights-based approach is needed. He raised the question that if we are going to promote EBF for positive mothers, then should we be introducing PCR testing at six weeks at all? One participant said that in Pakistan, PCR is not promoted in the midst of breastfeeding. Many countries are moving to early infant diagnosis – this is very important for those children who are infected because they can start treatment early with better outcomes.

- Dr Paxton (APN+) emphasized the importance of having HIV-positive counsellors, saying that she would not have breastfed her son if she had had a negative PCR test at six weeks, unless she had had a positive counsellor who understood the difficulty of the decision.
- There will be new WHO guidelines on infant feeding and HIV, based on review of recent major clinical trials and programme experience, likely to be available at the end of October 2009. It is important to look out for these.
- If positive woman is on HAART and her CD4 is still 500, risk of transmission through breastfeeding is very low.
- There is a need to increase number of counsellors and need better follow-up of women in order to make sure babies are EBF (rather than mixed fed).
- In 2005, UNICEF India did a project in Delhi state in 10 hospitals. All PPTCT counsellors trained in infant feeding and HIV, mothers were followed-up, and it was found that the majority of mothers EBF.
- In Cambodia, the health provider counsels the mother. Biased counselling can make the mother change her mind. Counsellors need good training and training materials need to be revised.
- Bridget Job Johnson (UNICEF, Bangladesh) pointed out that consistency is a problem because guidance changes from one training to the next.
- We need to be aware that in many settings the husband, mother or mother-in-law have a great influence on how the baby is fed, and they need to be included in counselling and provided with information too. In PNG, we need to look at investing in NGOs to avoid mixed messages being given.
- It is important that recommendations are guided by principles like evidence-based, rights-based, gender-based, and non-discrimination.

Early infant diagnosis and links to paediatric care

- Thailand has been implementing early infant diagnosis (EID) for a number of years. In India they are going to roll out EID from next month.
- Dried blood spot (DBS) specimens for HIV DNA PCR: problems mentioned with logistics, quality assurance, price, life-span, shelf-life, confirmation (specificity), time-lag (specimen collection to report) – although, as Dr Srikantiah pointed out, DBS method has great logistic advantages over whole blood samples.
- MoH and HIV programme may have parallel systems for transport of specimens increasing costs, and parallel reporting systems for early infant diagnosis.
- Follow-up past the initial six week visit is difficult – community-based care not linked to health services/facilities.
- Paediatric HIV treatment training has been separate to training for adult treatment, which is especially a problem when trying to decentralize treatment.
- Outreach workers are not coordinated (also with PLHIV groups), capacities are low, and confidentiality is difficult to maintain.
- Private sector was reported to often lack interest in following reporting or prescribing guidelines and tend to attend training only if paid.

Key suggestions for objective 3

HIV Testing and counselling

Targeting strategies

- ❖ There is a need for modelling to see which testing strategy would have the most impact on reducing HIV infection in children in low prevalence settings.
- ❖ Encourage institutions that can look at a cost-benefit analysis to guide policy in relation to routine testing vs. targeted testing. Where routine testing does make cost-benefit sense, more momentum can be gained by ensuring accompaniment by counselling about condoms and STI prevention so that primary prevention of HIV is an additional benefit.
- ❖ Consider feasibility of routine testing in low prevalence settings, taking into account the strength of the health system and level of preventable child and maternal morbidity and mortality.
- ❖ Encourage men to learn their status, given that it is often difficult for women who test positive first, as they will be blamed for bringing HIV into the family. Reach men through mass media campaigns, ANC, and use opportunities where men already gather (work place, sports clubs etc).
- ❖ Encourage couple counselling – there are multiple benefits to involving men in ANC.
- ❖ Use positive women to talk to newly diagnosed women so they can support disclosure when a couple is not counselled together.

HIV testing during labour

- ❖ Recommend testing during labour in a high prevalence epidemic only if the following are in place:
 - Strong health systems with sufficient staff and resources
 - Rapid tests available and appropriate testing algorithms
 - Antiretroviral prophylaxis and treatment, and infant feeding counselling available
 - Gathering more evidence about potential benefits of HIV testing during labour for low prevalence settings.

Minimizing loss to follow-up

- ❖ Propose a definition of loss to follow-up as ‘any mother tested but not receiving the result (whether negative or positive) and not receiving interventions / treatment.’
- ❖ Consider providing financial support for follow up where distance is a major barrier.
- ❖ Employ positive women to contact and support newly diagnosed HIV-positive pregnant women.
- ❖ Improve counselling practices.
- ❖ Strengthen national policy to reduce stigma and discrimination.

Assessment of HIV-positive pregnant women for HAART

- ❖ Ensure strong communication between ANC/CD4 assessment and linkages to ART treatment centres.
- ❖ Create a ‘one stop shop’ for clients, i.e. bring the treatment specialists to the ANC (pool all HIV-positive pregnant woman for one day at ANC and arrange ART specialist to meet them in the ANC clinic).
- ❖ Create linkages to NGO/CBO partners to provide transport assistance and psycho-social support.
- ❖ Follow-up at an individual level in areas of very low prevalence, tracing all the way back to the woman’s residence.
- ❖ Use a client-held pregnancy book/card with coding for HIV.
- ❖ Place referral workers in labour wards and in ANC clinics to assist women.
- ❖ Use a different name for the ART clinic to lessen discrimination.
- ❖ Provide funding to assist with travel costs.
- ❖ Collect whole blood at ANC on a periodic basis, and send to CD4 labs.
- ❖ Ensure priority treatment for positive pregnant women to reduce waiting times.
- ❖ Use mobile CD4 units to offer testing to groups.
- ❖ Improve capacity and equipment for CD4 testing in the coming years.

The transition to a more effective multi-drug prophylaxis regimens

- ❖ Investigate feasibility of longer multi-drug, more effective regimens by introducing in stages, starting in referral centres and settings with higher prevalence. Start by introducing a post-natal ‘tail’ for the mother (to reduce possibility of nevirapine resistance) and four weeks of AZT for the infant.
- ❖ Ensure global guidelines reflect operational realities of low ANC usage that make the regimen difficult to implement.

HIV and infant feeding counselling

- ❖ National policy on IYCF should be in place with a budgeted and coordinated programme.
- ❖ Promote maternity/paternity benefits (in Tamil Nadu poor pregnant women qualify for INR 1,000 per month for six months) or maternity leave, facilities at work places and crèches, especially for rural mothers – aim should be universal EBF. Housewives should also receive support, not just working mothers.
- ❖ Have appropriate, frequent and refresher trainings of service providers and health workers to support pregnant and lactating women.
- ❖ Individual, evidence-based, infant feeding counselling, with skilled support and family involvement, should provide information on EBF and should be the responsibility of the state.
- ❖ Increase awareness that HIV-positive mothers who choose to replacement feed can become pregnant again quickly and need good advice re contraception.
- ❖ Devise national, well-coordinated and resourced plans of action focused on the 10 action points set out in the Global Strategy for Infant and Young Child Feeding to achieve high EBF rates.

Early infant diagnosis and links to paediatric care

- ❖ Establish National Policy Frameworks for linkages/integration of HIV, MNCH, SRH and FP.
- ❖ For some countries with small numbers of exposed infants, international links (e.g. to India or Thailand) for referring DBS for early diagnosis may be most useful, and UN agencies could play a role in facilitating this.
- ❖ Add indicators for EID and paediatric treatment to computerized data systems.
- ❖ Encourage results-based management for projects implemented by CBOs/NGOs.
- ❖ Build public/private sector capacity in comprehensive care including infection control, stigma and discrimination. The “Connect” project with FHI may be a good example for engaging with the private sector.
- ❖ Utilize existing health systems for dispensing cotrimoxazole, and reinforce cotrimoxazole adherence with parents, as a precursor to ART adherence.
- ❖ Engage the private medical sector on PPTCT/EID and in M&E National Guidelines.
- ❖ Coordinate outreach worker cadres, including PLHIV.
- ❖ Have an integrated training package on MNCH and HIV for outreach cadres.
- ❖ Strengthen linkages between community and health systems at community/district/tertiary levels.
- ❖ Form a sub-committee within the Task Force to work on a checklist that should be in place for the introduction of EID.
- ❖ Consider the useful experience of treating children in Thailand since 2002. They created a team from each hospital including about five nurses, doctors and pharmacists. Observe children for one day, and then take a few children to their own families and train staff in the community hospital. We have to remember that children are not like adults and also remember the impact on mothers and the emotional stress they experience in coping with their own adherence and their child.
- ❖ Think about HIV management for adolescents. We can be better prepared by thinking about this now. This could be another issue for task force meetings in coming years. For example, in Thailand, in one province there are nearly 500 positive children on ARVs and about 40% are going into the teenage years. Thailand is facing difficult decisions about when to tell them, and many challenges with drug use, early pregnancies etc, are already looming.

Closing Remarks

Dr Lubna Hassan from Pakistan gave a vote of thanks.

Dr Srikantiah thanked the Government of India for holding the meeting in Chennai and thanked UNICEF for organizing the meeting, especially the Chennai office. She thanked Dr Paula Bulancea, Ms Geeta Wali Rai and Ms Wassana Kulpisitthicharoen for their organization of the meeting, as well as the participants for their contributions. Dr Srikantiah also reminded the audience that much progress has been made in improving PPTCT in recent years. In low and concentrated settings and in large countries with pockets of epidemic, it is hard to scale-up PPTCT services effectively. Different methods are needed for each setting. Linkages between agencies, government departments and M&E linkages are key in taking forward PPTCT activities. There is a need to recognize how much progress has been made – yet much has been done. There are many challenges, but each challenge is also a tremendous opportunity.

Major Conclusions and Key Recommendations of the Meeting

Major conclusions

- The meeting reaffirmed the importance of identifying synergies and linking HIV prevention and care for parents and children with improved services for maternal and child health, sexual and reproductive health, and nutrition. This will strengthen efforts for primary prevention of HIV and for the prevention of unintended pregnancies and contribute to maternal and child survival.
- There was consensus on the need to reshape programmes to ensure that PPTCT information and services reach populations that are most vulnerable and at-risk, as informed by epidemiological evidence
- The meeting agreed that these strategic shifts be guided by principles of planning based on rights, with attention given to addressing stigma and discrimination; involving affected communities, including people living with HIV; and gender analysis, including greater involvement of men.
- Operational research, monitoring and evaluation are crucial to ensure the response is guided by evidence and by updated IATT technical recommendations from the Global Expanded Inter-Agency Task Team on Prevention of HIV Infection in Pregnant Women, Mothers and their Children.
- Aware of the overall low coverage of PPTCT in the region, the meeting was unanimous in calling for sustained high level advocacy, political leadership and stronger coordination at all levels.

Key recommendations of the meeting

1. Advocate for greater policy commitment, including resources, for comprehensive approaches to HIV prevention and care for mothers and children. Gather evidence and develop costed plans for more effective advocacy and result-based planning.
2. Strengthen effective governance, financial and delivery arrangements within health systems, and ensure effective implementation strategies. For primary health care, the debate focused on selective (or vertical) versus comprehensive (horizontal) delivery but is now shifting towards combining the strengths of both approaches in health systems.
3. Achievement of high and equitable coverage of integrated primary health-care services requires consistent political and financial commitments, incremental implementation based on local epidemiology, the use of data to direct priorities and assess progress (especially at the district level) and effective linkages with communities and non-health sectors.

4. Ensure greater coordination and effective linkages between all MOH health programmes, at national and sub-national level, and with non-health sectors, such as social welfare and education.
5. Formulate clear guidance on which approach to HIV testing should be followed in different contexts based on criteria of HIV prevalence and patterns of spread, vulnerability to HIV, cost-effectiveness, and capacity of health care systems. Research on scaling-up should be embedded in large-scale delivery programmes with a strong emphasis on assessment.
6. Bearing in mind the need to improve MNCH in general, invest in population-wide strategies to reduce HIV infection in children. For example, allocate resources for PPTCT to promote optimal breastfeeding for all mothers and newborns, as this will both prevent paediatric HIV from HIV-positive mothers unaware of their status and improve child survival in general; and strengthen access to family planning for all women, including young, marginalized and vulnerable women. Integrate packages for maternal, newborn and child health care within a gradually strengthened primary health-care system, in order to improve continuity of care, including access to basic referral care before and during pregnancy, birth, the postpartum period, and throughout childhood.
7. Explore innovative strategies to reach populations most at risk. Consider strengthening outreach services, working through trusted community organizations, and creating spaces for delivery of information, counselling and services that are male- and youth-friendly.
8. Normalize the involvement of men in reproductive, maternal and child health services. Provide information and services to men when planning marriage/ pregnancy. Empower men as fathers.
9. Improve training, support and supervision for health care providers in counselling and communication skills.
10. Ensure mechanisms to incorporate new technical guidance into pre- and in-service training (make use of the internet), and support health care providers.
11. Include people living with HIV and representatives of most at-risk populations in planning and implementing prevention and care, support, and treatment responses.
12. Strengthen and evaluate follow-up of HIV-positive women and their families. Consider use of outreach services, with trained village health volunteers for those in rural and remote areas; the potential of mobile phones; and operational research for system of incentives to motivate both clients and providers.
13. Strengthen capacity for M&E to generate strategic information to inform planning and implementation at both national and sub-national level. Incorporate M&E indicators for primary prevention and prevention of unintended pregnancies.
14. Continue to work towards a more coordinated approach and management excellence at central and decentralized level.

Immediate action points

Immediate follow-up action points are to revise the terms of reference of the PMTCT Task Force developed in 1999 and amended in 2004 to reflect new and emerging developments on PPTCT in the region and identify a spokesperson to spearhead high level advocacy on PPTCT to accelerate efforts towards elimination of paediatric HIV infection and quality health for mothers and children.

Annexes

Annex 1. Meeting agenda

DAY ONE	
Towards appropriate regional-specific policy guidance on HIV prevention and care for mothers and children.	
08:00 – 08:30	Chair: Rachel Odede, UNICEF Registration
08:30 – 08:45	Welcome remarks and objectives of the meeting (Ms. Frances Turner, OIC UNICEF ROSA & Deputy Regional Director) Opening of the meeting (Mr. Subbu Raj, Principal) Statement by UNAIDS RST (Dr. Charles Gilks, UNAIDS Country Coordinator, India)
08:45 – 09:00	Review meeting agenda and logistics (Dr. Devashish Dutta, UNICEF, Chennai)
09:00 – 09:10	Self-introduction by participants
09.10 – 09.20	Group photograph
09:20 – 09:30 Morning break	
09:30 – 09:40	Chair: Dr. Suresh Mohammad, Government of India Co-chair: Wing-Sie Cheng, UNICEF Introduction to the objective and structure of the day (Dr. Wendy Holmes)
09:40 – 09:55	Presentation: Global perspective and regional challenges (Dr. Padmini Srikantiah, WHO SEARO)
09:55 – 10:10	Presentation: Findings from review of progress since the 2006 6th Asia-Pacific UN PMTCT Task Force Meeting (Dr. Paula Bulancea, UNICEF APSSC)
10.10 – 10.30	Discussion
10.30 – 10.45	Country presentation: India – PMTCT programme (challenges, recommendations) (Dr. Suresh Mohamed)
10.45 – 11.00	Country presentation: Myanmar – National strategy for scale up to priority districts (Dr. Ohnmar Aung)
11.00 – 11.20	Discussion
11.20 – 11.35	Country presentation: Pakistan – Approaches to risk assessment and tool ()
11.35 – 11.50	Country presentation: Nepal – progress, challenges & Recommendation (Dr. Usha Bhatta)
11.50 – 12.15	Discussion
12.15 – 13.15 Lunch	
13.15 – 13.25	Chair: Rachel Odede, UNICEF Co-chair: , Government of Sri Lanka Presentation on objective 1 (Rachel Odede, UNICEF)
13.25 – 14.35	Group discussion 1: Structured discussion in small groups – countries grouped by similar characteristics: prevalence of HIV; U5 MR, capacity of health care system – see attachment. Groups will be provided with a discussion guide and relevant materials to assist them to identify key principles to inform regional policy recommendations relevant to Objective 1.
14.35 – 15:30	Feedback from groups and plenary discussion (facilitator: Rachel Odede, UNICEF)
15:30 – 15:45 Afternoon break	
15.45 – 16.00	Chair: Government of Indonesia; Co-Chair: Ivonne Camaroni, UNICEF Presentation: Potential of promotion and support for optimal breastfeeding to all mothers and babies to prevent HIV infection in children (Dr. JP Dadhich, IBFAN Asia)
16:00 – 17.00	Plenary discussion on infant feeding

DAY TWO	
Addressing the cross-cutting challenges to develop and strengthen comprehensive PMTCT programmes	
08.30 – 08.40	Chair: Dr. Song Li, Government of China; Co-Chair: , UNFPA Introduction to the objective and structure of the day (Dr. Song Li, chairperson)
Coordination to establish or strengthen linkages	
08.40 – 09.00	Presentation: Experiences of operational linkages between SRH, MNCH and HIV/STI services with elimination of congenital syphilis (Dr. Naoko Ishikawa, WHO WPRO)
09:00 – 09:15	Country presentation: Cambodia – linked response (Dr.)
09.15 – 11.00	Group discussion 2: Share experiences, evidence and ideas, and develop recommendations in relation to: a) leadership, advocacy and policy; b) improved coordination and communication as well as implementation strategies, including linkages between HIV and MNCH, SRH etc; c) operational research and monitoring and evaluation (Groups will be provided with a discussion guide and relevant materials to assist them to identify key principles to inform regional policy recommendations) Morning break (served during group discussion, in the breakout rooms)
11.00 – 12.00	Chair: Song Li, Government of China; Co-Chair: , UNFPA Feedback from groups and plenary discussion
12.00 – 13.00 Lunch	
13.00 – 13.15	Chair: Dr. Sh’ari Bin Ngadiman, Government of Malaysia; Co-Chair: Bettina Schunter, UNICEF Reaching vulnerable groups Presentation: Reaching men and women who inject drugs and their partners with comprehensive SRH and PMTCT services. (Dr. Pratima Murthy, National Institute of Mental Health and Neuro Sciences)
13.15 – 13.30	Case study: Tamil Nadu/India – Reaching women in sex work with SRH and PPTCT services (Indu Methi, South India AIDS Action Programme)
13.30 – 14.30	Plenary discussion: Share experiences, evidence and ideas, and develop recommendations in relation to reaching and working with vulnerable and at risk populations
14:30 – 14:45 Afternoon break	
14.45 – 15.00	Chair: Nancy Fee, UNAIDS Co-Chair: Government of Nepal Presentation: Women’s experiences from the APN+ 6 country study of women living with HIV (Thailand, Vietnam, China, Indonesia, Cambodia, India) (Dr Susan Paxton)
15.00 – 16.00	Presentation from mother/father living with HIV Followed by plenary discussion of ideas for strategies to reduce stigma and discrimination and decrease loss to follow up
16.30	Departure for dinner

DAY THREE**Addressing common challenges in implementing antenatal PMTCT programmes**

08.30 – 08.40	<p>Chair: Government of Afghanistan Co-Chair: Jennifer Georgeson, Clinton Foundation Greater engagement of men Introduction of the objective and structure of the day (chairperson)</p>
08.40 – 08.55	Regional Perspective: Male involvement (Dr. Wendy Holmes, Burnet Institute)
08:55 – 09:05	Country presentation: Lao PDR – Involving men in antenatal care
09.05 – 09:15	Country presentation: Thailand – Male involvement in Maternal Health (Dr. Taweesap Siraprapasiri, UNFPA)
09.15 – 09:45	Plenary discussion: Share experiences, evidence and ideas, and develop recommendations in relation to greater engagement of men
10:00 – 10.15	<p>Chair: Padmini Srikantiah, WHO Co-Chair: Dr. Sonam Ugen, Government of Bhutan Brief introduction on groups discussion (Dr. Padmini Srikantiah)</p>
10.15 – 12.00	<p>Morning break (served during group discussion, in the breakout rooms) Group discussion 5 – participants will divide into 5 small groups which will each discuss one of the issues. We will provide the group with the most recent relevant international recommendations and any necessary background information about the existing evidence, and some questions to structure the discussion. Each group will have a knowledgeable facilitator. Key points will be written up on a poster for display and appear in the meeting report. The groups will have a mix of different countries and agencies in order to allow sharing of experiences and ideas.</p> <ol style="list-style-type: none"> <i>HIV testing and counseling, including discordant couples and stigma with OB/GYN.</i> Addressing: testing/counseling strategies for pregnant women, HIV testing protocols; use of rapid test kits; minimising false positives; couple counselling; testing during labour; weak counselling skills; shortage of trained staff; confidentiality of results; disclosure issues Facilitator: Susan Paxton, Positive Response <i>Minimising loss to follow up.</i> Links with community support groups; outreach workers; minimising stigma and discrimination within health care/social services, general population Facilitator: Jennifer Georgeson, Clinton Foundation <i>Assessment of HIV positive pregnant women for HAART; managing the transition from single dose nevirapine to more efficacious and safer regimens; determination of the best way forward regarding provision of ART.</i> Facilitator: Dr Padmini Srikantiah, WHO <i>HIV and infant feeding counseling</i> good nutrition practices/supporting breastfeeding, establishing processes to deal with changes in recommendations with new evidence; need for caution with early weaning for HIV exposed infants. Facilitator: JP Dadhich, IBFAN <i>Early infant diagnosis and links to paediatric care:</i> EID and DBS, linkage to co-trimoxazole prophylaxis, paediatric HAART, and family-centered care/support. Facilitator: Paula Bulancea, UNICEF
12.00 – 13.00	Feedback from group discussions and plenary discussion (Facilitator: Wendy Holmes)
13.00 – 14.00	Lunch
14.00 – 15.00	<p>Chair: Wing-Sie, UNICEF Co-Chair: Government of Mongolia Synthesis of meeting, key agreements, recommendations, conclusions, next steps for countries</p>

15.00 – 15.20 Afternoon break	
15.20 – 16.30	<p>Chair: Rachel Odede, UNICEF Co-Chair: Padmini Srikantiah, WHO</p> <p>Plenary discussion about the role of the Asia-Pacific regional PMTCT Task Force Panel discussion: Towards better coordination between UN agencies at national and regional level – what is needed to overcome the barriers? (5 minutes presentation identifying key barriers to coordination from WHO, UNICEF, UNFPA, UNAIDS followed by questions and discussion)</p>
16.30 – 16:45	Closure of meeting, next meeting

Annex 2. Concept note

Introduction

The seventh meeting of the Asia-Pacific United Nations Prevention of Mother-to-Child (PMTCT) of HIV Task Force meeting will be held in Chennai, India, 22 – 24 September, 2009. It follows the sixth UN PMTCT Task Force Meeting held in Kuala Lumpur, Malaysia in November 2006. That meeting was combined with the “Asia-Pacific Consultation on Integrating Prevention and Management of STI/HIV into Reproductive, Maternal and Newborn Health Services”. The Kuala Lumpur meeting had two overlapping agendas: to promote the value of integration and linkages between maternal and newborn health, SRH, and HIV/STI prevention and care; and to promote the importance of primary prevention, especially for young women and pregnant or breastfeeding women, and of increased access to family planning advice and services (Prongs 1 and 2). A key theme of the meeting was that the integration agenda has great potential to contribute to the achievement of Prongs 1 and 2.

This meeting of the regional Task Force is being organized by the UNICEF Regional Office for South Asia, in conjunction with the East Asia and the Pacific Regional Office. The meeting will allow an opportunity to review progress since the 2006 meeting, to discuss recent research findings and the global guidance document for scaling up PMTCT, achievements and lessons learned, to make policy recommendations appropriate to this diverse region.

Key recommendations for Member States from the Kuala Lumpur meeting were¹:

- Implement the operational framework for linking HIV/STI services with reproductive, adolescent, maternal, newborn and child health services, and develop national guidelines.²
- Further strengthen political commitment and formulate clear policy on prevention of STIs and HIV for pregnant women and their babies, ensuring that services are provided using an integrated approach.
- Engage the media more actively and reach communities effectively
- Promote partnership and intersectoral and interagency collaboration
- Strengthen human resources in all related disciplines - clinical, laboratory, counseling, equipment and drugs
- Strengthen coordination among donors
- Reach out to vulnerable and at risk populations including women in sex work, people who inject drugs and men who have male-male sex.
- Strengthen data management and map facilities.

Themes

The title: **“Making the most of PMTCT”** relates to a number of themes:

“Making the most of antenatal and postnatal care services to prevent HIV infection in mothers, fathers and children”

This emphasizes the importance of fulfilling the potential of antenatal care PMTCT programs to contribute to primary prevention, especially during pregnancy and breastfeeding and to prevention of unintended pregnancies.

“Making the most of resources for PMTCT to improve women’s and children’s survival”

This emphasizes the importance of ensuring that resources invested in PMTCT of HIV also strengthen sexual and reproductive health (SRH) and maternal and child health (MCH) more generally, contributing to MDGs 4 and 5.

¹ WHO WPRO Report of consultation on integrating prevention and management of STI/HIV/AIDS into reproductive, maternal and newborn health services. Kuala Lumpur, Malaysia. 6- 8 November 2006.

² UNICEF, WHO, UNFPA. UNAIDS. Asia-Pacific operational framework for linking HIV/STI services with reproductive, adolescent, maternal, newborn and child health services. 2008.

“Making the most of PMTCT by scaling up with equitable access”

This emphasizes the need to increase coverage of context-appropriate interventions for the prevention and treatment of HIV infection for mothers and children while prioritizing equitable access.

“Making the most of what we have learned about PMTCT policy and practice to date”

This emphasizes the importance of building on and learning from what has gone before, including reviewing national PMTCT reports and the recommendations from previous Asia-Pacific regional UN Task Force meetings.

“Making the most of PMTCT by ensuring that HIV positive mothers and their family members receive effective treatment, nutrition, care and support”

This emphasizes the value of following up HIV positive women to ensure that they are assessed early for antiretroviral treatment, that their children receive early diagnosis and, if positive, prophylaxis for opportunistic infections, and effective HIV treatment, and that these mothers and their families receive psychosocial care and support.

Background

In Asia an estimated nine million people have been infected with HIV.³ They and their families have often suffered illness, pain, loss of income, the consequences of stigma and discrimination, and deaths. The scale and pattern of the HIV epidemic differs greatly between and within countries in this region, and is very different to that in sub-Saharan Africa, which suffers the greatest burden of HIV infection. Most areas of the region have very low prevalence of HIV infection except among vulnerable and high risk populations such as those who inject drugs, buy and sell sex, and have male-male sex. UNAIDS estimates that 4.9 million people were living with HIV in Asia in 2007, and that there were 440,000 new infections. An estimated 300,000 people died from AIDS-related illnesses in 2007. Although the rate of HIV infection is reportedly declining in some countries in the region, the epidemic is constantly changing, and therefore analyses of new infections must be undertaken at regular intervals. At the same time, an analysis of challenges in reproductive, maternal-newborn health continuum of care and the implications of these for PMTCT should be conducted. For instance Asian women, categorized as low-risk group, now represent less than 25 percent of all HIV infections but the proportion could have shoot up to 30 percent by 2015, mostly infected through their husbands and sex partners. In Thailand, already the largest group of people newly infected are housewives who get infected by their husbands.

Furthermore, a study in Bangladesh shows that more than 57 per cent of the IDUs are married⁴. A survey in Pakistan showed that 15 per cent of the wives of married IDU were infected⁵. In Nepal, HIV prevalence among seasonal migrant labourers is 1.9 per cent⁶. More than 40 per cent of all PLHIV are seasonal migrant labourers and an additional 21 per cent are their wives. These women are therefore likely to pass the virus to their children when they subsequently give birth and/or breastfeed. Attention has to remain focused on the most high-risk communities such as sex workers, injecting drug users and men who have sex with men. This can be achieved through a re-commitment to prongs 1 and 2 to avert not only new infections in persons of reproductive age but also ensure protection of HIV+ women who choose to get pregnant.

In most countries, the largest infected population group is men who buy sex. Their wives and children are then exposed to the risk of HIV infection. It is projected that an increasingly large proportion of those infected with HIV will be married women without other risk factors.

³ Commission on AIDS in Asia. Redefining AIDS in Asia: Crafting an effective response. 2008.

⁴ UNODC, ROSA, Rapid situation and response assessment of drugs and HIV in Bangladesh, Bhutan, India, Nepal and Sri Lanka: A regional report 2007.

⁵ The Hidden Truth – A study on HIV vulnerability, risk factors and HIV prevalence among injecting drug users and their wives. March 2008, Supported by the Punjab AIDS Control Programme, ministry of Health, Pakistan and the Global Coalition on Women and AIDS, UNAIDS.

⁶ ERA/SACTS/USAID/FHI (2006) Integrated Bio-Behavioural survey among male labor migrants in 11 districts in western and mid far western regions of Nepal.

Efforts to prevent these women becoming infected, especially during pregnancy and breastfeeding, are the priority in preventing paediatric HIV infection in this region. However, it is also important to recognise that women in sex work, men, women and the partners of men who inject drugs, and men who have sex with men (who often also have sex with women) have children too and are concerned about reproduction. If they are HIV positive they want to know whether and how they can have healthy children, or how to prevent conception. They need access to information and to PMTCT services, including family planning and detection and management of STIs.

Progress and areas of need

Review of progress in the region shows the emphasis has continued to be on Prongs 3 and 4. Efforts to prevent young women, expectant fathers, and pregnant and breastfeeding women from becoming infected with HIV have continued to be relatively neglected both within and outside MCH services (Prong 1). There are also few settings with evidence that women living with HIV are now more likely to receive appropriate and non-judgmental family planning information and services (Prong 2).

While there are some good examples of strengthening linkages between MNCH, FP, STI, and HIV prevention and care services, there has continued to be relatively little attention at national level to coordination of linked or integrated delivery of services. South Asia has enormous maternal health challenges, with coverage of ANC and skilled delivery falling well short of targets and painfully slows progress towards MDG 5. While majority of Asia countries are on track to reach MDG 4, there has been little progress in improving services for newborns (home- and facility-based) and, among all child deaths, more than 30% (up to nearly 50% in some countries) occur in the first month of life. Care-seeking behavior for maternal health is low *even in the middle and higher quintiles in many countries*. The goal of linked or integrated delivery of services will contribute to both Prong 1 and Prong 2, and have additional benefits for SRH and MCH more generally, including progress towards the elimination of congenital syphilis.

There has also been little recognition of the potential impact on paediatric HIV of population level interventions that do not depend on HIV testing, such as improving access to family planning for all, including those at higher risk of HIV infection; promoting and supporting optimal breastfeeding for all mothers and babies; detecting and managing STIs; and greater participation of men in MCH and SRH services. These interventions also contribute to maternal and child survival.

In many settings HIV responses targeted at vulnerable and at risk populations continue to lack components addressing SRH and PMTCT of HIV.

Most countries in the region have made progress in scaling up the offer of HIV testing and counseling to pregnant women, with provision of antiretroviral prophylaxis, safer delivery care and safer infant feeding counseling and support for those who test HIV positive (Prong 3). In some settings of some countries, such as Thailand, Cambodia, and Tamil Nadu in India, there has also been progress in improving access to clinical or laboratory assessment and antiretroviral treatment for eligible HIV positive mothers, and less often, for children (Prong 4). Some countries, such as Mongolia and Fiji, have aimed to introduce testing into antenatal care country wide. Most countries, such as Myanmar, Vietnam and Cambodia, have chosen to scale up prioritising those districts with higher HIV prevalence or judged to be at greater risk of spread of HIV. Some have instead established centres with well trained, experienced staff to which people living with HIV can be referred for PMTCT and other services.

The Inter-Agency Task Team on PMTCT and Paediatric HIV Care and Treatment (IATT) in their “Guidance on global scale-up of the prevention of mother-to-child transmission of HIV: Towards universal access for women, infants and young children and eliminating HIV and AIDS among children. 2007.” recommends that in concentrated and low-level HIV epidemics, “the decision to make provider-initiated testing and counseling part of antenatal, childbirth and postpartum services needs to be based on the local epidemiological and social

context and resources.” However, there is limited guidance for appropriate evidence-based policy and strategies for PMTCT in concentrated and low-level epidemic settings.

There is an opportunity to learn from experiences in the region to inform urgently needed policy advice on different approaches to counseling and testing during pregnancy. In those settings where it is not appropriate or cost-effective to aim to offer counseling and HIV testing in the antenatal clinic to every pregnant woman, approaches need to be evaluated to enable risk assessment for expectant fathers, pregnant women or both, with encouragement to consider an HIV test for those who may have been exposed to HIV. Those positive could then be referred to centres with well trained staff who can provide effective anti-retroviral prophylaxis, safer delivery care, safer infant feeding counseling and support, and follow up integrated care, support and treatment. Strategies to reach pregnant women and expectant fathers in vulnerable and at risk populations with counseling and testing should also be a priority.

Country consultations and review reports reveal that there are certain cross-cutting issues that are relevant to all four ‘prongs’ of comprehensive PMTCT programs that tend to need greater attention:

1. Coordination to establish or strengthen linkages:
 - coordination within and between UN agencies, and between donors
 - management structures at national and sub-national level including coordination within and between government departments (MNCH, FP, HIV, SRH, STI, HE, youth); between UN agencies and government departments; between governments and civil society / NGOs and private sector.
2. Communication:
 - strengthening communication and counseling skills of health care providers
 - communication strategies for preventing HIV infection in mothers and children, and reducing stigma and discrimination
3. Strategies to ensure that vulnerable and at risk populations have access to comprehensive SRH, STI and PMTCT information and services
4. Greater engagement of men in SRH and MNCH services

Country review reports identify a number of weaknesses in implementation common to many antenatal PMTCT programmes that could be strengthened on the basis of updated international recommendations.

Objectives for the meeting, addressing the areas of need identified above

1. Based on available evidence and experiences in the region, develop regional policy recommendations and options, appropriate to specific contexts, to maximize HIV-free child survival including:
 - Strategies for primary prevention for young, pregnant and breastfeeding women within and beyond the antenatal clinic;
 - Strategies for prevention of unintended pregnancies among women (and couples) living with HIV;
 - Strategies to increase the likelihood that pregnant women and expectant fathers with HIV will be diagnosed and receive PMTCT interventions and follow up care, support and treatment;
 - Strategies to ensure that pregnant women and mothers living with HIV are assessed for eligibility for treatment with HAART and can access early diagnosis for their infants;
 - Population level strategies to prevent HIV infection in children and improve child survival by increasing access to family planning services; promoting optimal infant feeding practices, and improving detection and management of STIs (during pregnancy).
2. Based on discussion of country experiences, identify research questions and policy recommendations to address the following cross-cutting challenges:
 - Coordination to establish or strengthen linkages
 - Communication
 - Reaching vulnerable and at risk populations
 - Greater engagement of men

3. To discuss and identify processes to ensure updated technical recommendations are rapidly incorporated in relation to common challenges in implementing antenatal PMTCT programmes, including:
- Challenges in HIV testing and counselling – HIV testing protocols; testing during labour; weak counseling skills; shortage of trained staff;
 - Challenges in detection and management of STIs (including syphilis);
 - Challenges in providing care and treatment – loss to follow up; assessment of eligibility for ARV treatment; support for disclosure; use of appropriate perinatal ARV prophylaxis; management of discordant couples; weak management of supply of commodities;
 - Challenges in paediatric HIV – early diagnosis in exposed infants; weak infant feeding counseling; delivery care not based on evidence; lack of integrated services for treatment, care and support for paediatric HIV including prophylaxis and ARVs; nutritional and psychosocial support for HIV positive mothers, infants and children,
 - Challenges in data collection, analysis and use.

Country presentations

Countries will be invited to prepare a poster about their work in prevention and care for HIV infection in mothers and children – focusing on national progress in terms of policies, coverage and scale up plans in the settings of generally low prevalence and concentrated epidemics. These will be displayed around the venue. Some countries will be invited to present particular aspects of their programs that have been successful or where lessons have been learned to contribute to the discussion sessions.

Participants

Participants at the meeting will include relevant national government officials for Maternal and Child Health, HIV infection, and Nutrition; representatives from implementing partners; and representatives from the regional and country offices of WHO, UNFPA, UNODC, UNAIDS and UNICEF.

Expected outcomes

- Key principles to inform a policy document setting out “Guidance on scale-up for HIV prevention and care for mothers and children in the Asia-Pacific region” to assist WHO, UNFPA, UNICEF and partner agencies to collaborate with governments
- Greater understanding of progress, challenges with regard to coverage, scale up plans and policies relevant for PMTCT in low and concentrated epidemic settings
- Increased awareness of updated international technical recommendations
- Consensus on key issues for the development of the promised UN document in early 2010
- Collection of examples of ‘good practice’ and ‘lessons learned’ for a regional PMTCT ‘good practice’ document
- Updated terms of reference for the Asia-Pacific Regional Task Force for PMTCT

Annex 3. Terms of Reference for the UN Task Force on Prevention of Parent-to-Child Transmission of HIV

Annex 4. List of participants

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Annex 5. Evaluation

Meeting Feedback

Of the 96 participants at the meeting, 53 completed the meeting evaluation form handed out at the end of the meeting. The results of the evaluation follow below.

Expected outcomes of the meeting

- 1) Key principles to inform a policy document setting out guidance on scale-up for HIV prevention and care for mothers and children in Asia-Pacific region to assist the UN - WHO, UNFPA, UNICEF, UNAIDS - and partners agencies to collaborate with Government

1 (very much)	2	3	4	5 (not at all)
9.4%	39.6%	37.7%	13.2%	0.0%

- 2) Greater understanding of progress, challenges with regards to coverage for PMTCT in low and concentrated epidemic setting; Consensus on key issues for the development of the promised UN document in early 2010

1 (very much)	2	3	4	5 (not at all)
18.9%	43.4%	28.3%	9.4%	0.0%

- 3) Increased awareness of updated international technical recommendations;
Collection of 'good practices' and 'lessons learned' for a regional PMTCT 'good practice' document

1 (very much)	2	3	4	5 (not at all)
13.2%	34.0%	30.2%	20.8%	1.9%

- 4) Updated terms of reference for the Asia-Pacific Regional task force for PMTCT

1 (very much)	2	3	4	5 (not at all)
9.4%	35.8%	20.8%	17.0%	1.9%

NOTE: Some rows will not add up to 100% because blank responses are not reported here.

Strengths and weaknesses of the meeting

	Strongly Agree	Agree	Disagree	Strongly Disagree
1. Objectives and expected outcomes were clearly presented	35.8%	60.4%	1.9%	0.0%
2. The structure of the task Force Meeting provided me with the relevant information for my work	35.8%	50.9%	9.4%	1.9%
3. The plenary discussion allowed rich discussion on the PMTCT & paediatric HIV and implications for programming in low prevalence settings in Asia-Pacific	35.8%	58.5%	3.8%	0.0%
4. The session on country presentations provided varied contexts within and among countries	41.5%	58.5%	0.0%	0.0%
5. Group work was useful and added value to my knowledge of PMTCT/paediatric HIV CST	41.5%	45.3%	11.3%	0.0%
6. It was greatly beneficial to have participants from other regions working together throughout the meeting	66.0%	32.1%	1.9%	0.0%

NOTE: Some rows will not add up to 100% because blank responses are not reported here.

Next meeting

The following locations were selected as the top four preferred locations for the 8th Asia Pacific PMTCT Task Force meeting, in order of popularity: Thailand, Maldives, Bhutan, and Pacific Islands (including Fiji). 2011 was the most popular choice for the timing of the next meeting, and it was suggested by a few participants that the meeting should not coincide with any major festivals/holidays.

Most useful aspects

One of the most useful aspects of the meeting that was cited was the opportunity to learn from other countries and to hear about challenges they are facing with PMTCT and to share relevant experiences.

Learning about and discussing some of the specific technical aspects of PMTCT such as infant feeding policies, male involvement PMTCT and ANC, reaching most-at-risk populations and linkages between HIV and MNCH programs and involving HIV positive people in PMTCT programming, for example, were also cited as useful aspects of the meeting. Learning about UN technical documents that are or will be available was also listed.

Least useful aspects

The group work sessions were among the least useful aspects of the meeting, some participants suggested that there was not enough time for substantial discussion and to come up with good key points for the presentation of the group work. Some discussions went beyond the target objectives of the meeting. Also, the session on male involvement was not considered useful by some people and some of the presentations were considered to be too technical and not programmatic enough.

Key issues not addressed

Some participants felt that the issue of paediatric HIV (including EID, paediatric ART management and new WHO Paediatric HIV Guidelines) was not adequately addressed. Also, more could have been discussed

regarding strategies to reach youth and partners. Prevention of unplanned pregnancies, including family planning methods, and how to program for PMTCT in countries that have low ANC coverage, as well as ART management for pregnant women could all have been better addressed. Participants also felt that operational issues, including how to roll out guidelines at the country level and how to monitor and evaluate PMTCT programs, were not properly discussed. More about the latest international evidence and trends in PMTCT could have been covered.

Topics to be included in future task force meeting

Participants thought that more science/evidence-based sessions could be included in the future. Also, pediatric issues from prophylaxis to EID to infant feeding practices and treatment management as well as issues related to adolescence should be included. ARVs for PMTCT for adults and children, TB and HIV, more on linkages of PMTCT to government MNCH/SRH services, contraceptive options, PMTCT counseling, gender disparities in pediatric treatment and around HIV more generally, and reaching MARPs are other topics that were suggested for inclusion in the next meeting. Operational research and context-specific indicators could also be addressed.

Meeting likes

When asked what they liked most about the meeting, many people mentioned sharing experiences and learning from other countries' experiences. The group work was also viewed favorably by many survey respondents. Other positive aspects of the meeting included the talks by people living with HIV, discussions on male involvement and the linkages between RH and HIV. Respondents also mentioned that there was a good mix of countries represented and the country presentations and plenary discussions were also described as positive.

Meeting dislikes

When asked to share what they disliked about the meeting, participants indicated the absence of UN agency HQ representative, differing views from different agencies and a lack of "experts." Also, too much of a focus on Prong 3 and a lack of opportunity to discuss harmonization/alignment of M&E were mentioned. Logistically, in some presentations and a lack of opportunities to speak, short group activity sessions, very long days, the absence of a field visit and no choice of which group discussion to participate in were listed as "dislikes."

Logistics

Many people felt the logistics were well done. However, there were people who felt that the hotel (particularly the airport pickup, check in and check out) and food arrangements could have been better. The issue of per diem was raised, as people felt that they should have had a choice in where to take their meals, and that the hotel was too expensive. The visit to Fisherman's Cove was positively received. More time to discuss the final recommendations in the plenary sessions was suggested. Also, IT support was appreciated.

Technical

A lot of respondents felt that the technical aspects of the meeting were well organized. Some suggestions include the need for more scientific presentations during the meeting, and the need to concentrate on all four prongs of the approach to PMTCT. Also, topics such as multi- and single-drug regimens, fundraising strategies and policy effectiveness could have been included. The presence of OB/GYNs could have been valuable during the meeting.

