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

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INTRODUCTION

On behalf of the UN Regional Taskforce on Prevention of Mother-to-Child Transmission of HIV, UNICEF EAPRO convened the 3rd Regional Taskforce meeting on 7-8 March 2001 in Bangkok. The objectives of the meeting were to:

1. Update country situations on PMCT
2. Update and share the latest technical and scientific data on the use of ARV, infant feeding options and existing guidelines, role of UNFPA in PMTCT and the evaluation results of VCT in Thailand
3. Amend the Terms of Reference of the Regional Taskforce and
4. Discuss upcoming PMCT global and regional events

Participants

12 participants from 7 countries (Cambodia, China, India, Myanmar, Papua New Guinea, Thailand, Viet Nam) consisting of programme managers and UN staff, 6 technical staff from regional UN agencies (WHO, UNFPA, UNAIDS and UNICEF). 3 technical experts from - CDC Atlanta, Thai-Red-Cross AIDS Research Centre and CDC Region 10- Chiang Mai chaired half-day session each. Please see the full list of participants in **Annex-2**.

Outcomes are as follows:

Summary of action across the region

While Thailand continues to be the only country to have taken PMCT services to scale nationally, Myanmar and Cambodia are currently developing lead initiatives in selected locations to work out an effective model and process for nationwide expansion. PNG is still in early stages, but there is strong government commitment to moving ahead quickly given the 9% infection rate accorded to perinatal transmission. India has important lessons for all other countries given scale of lead initiatives, the widespread use of cow's milk, and the use of low/no cost Nevirapine from a generic producer. Viet Nam and China are in the process of discussion to develop PMCT pilot initiatives.

COUNTRY SPECIFIC PMCT SITUATIONS

Each country reported the epidemiological situation of PMCT and progress made since the last Taskforce meeting (Please also refer the attached presentations in the **annex -4**).

Cambodia

Dr. Sent Sut Wantha, Vice Chairperson of the PMTCT Sub-committee reported as follows:

- HIV epidemic in Cambodia moving very fast - one of the most serious in Asia. 3.2% of adults or 170,000 people are infected with HIV. 100 new infections occur every day with a total of 35,000 new infections over the last year.

- 2.6% of pregnant women are HIV infected.

- Estimated 3,500 HIV positive babies will be born each year if there is no intervention. Necessary preparations on-going to initiate pilot PMCT projects in two sites, National Maternal and Child Health Centre (NMCHC) in Phnom Penh and one provincial hospital in Battambang.

To date, the following have been achieved:

- Technical working group on PMCT established
- Rapid assessment on PMCT conducted
- National policy on PMCT developed and approved by Ministry of Health
- Proposal to start the pilot project developed and submitted to MOH for approval

Activities planned for two pilot sites in the coming few months are to:
- Train health staff
- Provide VCT services for all pregnant women with pre and post test counselling
- Administer Anti-retroviral therapy (nevirapine) to HIV positive mothers who opted and their infants
- Counsel on infant feeding and family planning

The monthly monitoring and reporting mechanism on PMCT has been developed. The duration of the pilot phase is 2 years.

China

Dr. Yuzhen Cao, from China reported the history of HIV situation.

- From 1985 to 1988, few HIV cases were detected. Limited epidemic among IDUs from 1989 to 1993. In 1994, large number of HIV infections reported from a number of different geographic regions.
- As of December 2000, 22,517 HIV and 880 AIDS reported while as many as 600,000 people are estimated to be HIV positive in the country.
- STI infection indicates the potential threat of HIV. Reported STI infection in women in 1998 was 268,112, and is 12 times higher compared to STI situation of 1988.
- PMCT - not much has been done yet; the following activities were carried out in selected geographical locations, namely Yunnan, Xinjiang and Liaoning:
  - Conducting HIV/AIDS clinical training course for doctors and nurses
  - Screening of high-risk populations in Xinjiang, Yunnan, Guangdong, Guangxi, Sichuan and Henan.
  - Provide Nevirapine and AZT to HIV positive mothers in Yunnan, Xinjiang and Liaoning.

India

Dr. Anne Vincent from UNICEF India and Dr. Joshi from National AIDS Control Organization (NACO) reported as follows:

- India is facing a rapidly evolve HIV/AIDS epidemic with an estimation of 3.6 millions infected with HIV. Of this, 21.4% (800,000) are women.
- Based on the surveillance data 1999 of NACO, the generalized epidemic has now spread to eight States where 300 million people are residing.

- Internal migration as a transmission belt is on a massive scale: 1.19 million to 18.84 million people are on the move between one State to the other and this move is occurring in 12 States.
- HIV sero-prevalence rate among antenatal clinic attendees varies from State to State. In high epidemic States, the rate was from 1% in Karnataka to over 2.5% in AP, in 1999.
- 0.73% of HIV infection occurs through vertical transmission, with an approximate 32,000 children infected each year.
- With 27 million pregnancies per year with a national prevalence of 0.4% among pregnant women and 30% transmission, it was estimated that 25,000 to 50,000 child deaths would be the outcome within 1-8 years, with no intervention.
- Due to the above factors, PMCT was initiated by first conducting a feasibility study in March 2000.
- 11 medical colleges in the five most affected States enrolled to be in the study.
- Routine antenatal VCT, Bangkok short course AZT regimen, provision of iron folic acid and vitamin A, counselling on infant feeding practices are the components of the PMCT program.
- As of 28 February 2000:
  - 147,262 pregnant women were reached
  - 74% received pre-test counselling
  - 59% opted for testing
  - 1.9% were HIV positive
  - 38.4% were provided with AZT

Major constraints defined by the program were - late AN coverage with low rate of institutional deliveries, counselling still being a very new concept among clients and service providers, issue of confidentiality, social stigmatization, low rate of exclusive breastfeeding, and no linkages between PTCT and communities.

Future Plans include developing a district level PMTCT model and the communication strategy. By the end of 2003, plans are underway for National PTCT Policy to be in-place and to integrate PMCT into the existing national reproductive and child health programs.

Myanmar

Dr. Pirkko Heinonen from Myanmar presented the PMCT country report.

- September 1999 sentinel surveillance data shows that nearly 2.7% of pregnant women at 14 sentinel surveillance tested positive.
- To address this, PMCT needs assessment carried out in two project sites (Tachileik and Kawthaung), during 2000.
- With Ministry of Health/National AIDS Programme endorsement, PMCT activities carried out in the two sites since November/December 2000.
- Among UN agencies, UNICEF is chairing the UNAIDS sub-group on Care, Counselling and Support and is responsible for PMCT pilot project in Myanmar.

UNICEF support ranges from provision of voluntary HIV counselling and testing kits, development of guidelines and counselling manuals with MOH, financial and technical support in conducting counselling training to health staff and procuring of Nevirapine for HIV positive PW and infants. PMCT is also implemented in conjunction with women's health and EPI projects addressing safe-delivery in these two townships.

UNICEF providing Emergency Obstetric Care instruments for township hospitals and clean delivery kits to basic health staff in the context of Japanese Grant AID assistance for MCH activities. Primary prevention is also emphasized and focused by linking with other on-going HIV/AIDS activities, such as Lifeskills training for in-and-out of school children and youth, initiating and strengthening the community support group for HIV infected and affected families.

From January – February 2001, 69 health staff, mainly midwives from MCH and Rural Health Centre and nurses from the two township hospitals were trained on counselling skills specifically tailored for PMCT. In addition, 9 auxiliary midwives, who have been working in remote, inaccessible areas, also trained in the counselling.

From January to March 2001, 3 out of 137 (1.8%) and 3 out of 29 (32%) pregnant women in Kawthaung and Tachileik tested positive respectively. As the pilot projects are at very early stages, many structural adjustments are being made while implementing the activities. The team has reported that intensive efforts are needed to address the birthing practices and infant feeding issues. At present, only 16% of mothers are exclusively breastfeeding their babies while the rest are practising mixed feeding. Discussions are already underway with UNFPA to link with family planning services to address the future contraceptive needs of women who tested positive.

Papua New Guinea (PNG)

Dr. Clement Malau of the National AIDS Council presented briefly on the major health problems, the basic demographic data, the organogram of the NAC, and its committees, and the HIV/AIDS situation.

- As of December 2000, there were 3,428 HIV positive cases with the national estimates of 10 – 15 thousand people being infected. 91% were transmitted through sexual intercourse. In 2000, 9% were of peri-natal transmission, a more than two-fold increase from the 4% figure of 1998.
- Major strategic interventions defined for 2001-2002 was also presented.
- PMCT component was not included in the national medium term plan (MTP) of 1998-2002, because mother to child transmission (MTC) data was not available at the time of MTP preparation in 1997. However, due to the recent available data of high peri-natal transmission rate, the country is now preparing to initiate the PMCT program as soon as possible.
- Four major hospitals have been selected for PMCT pilot initiatives.
- Recently, the medical expert advisory committee has endorsed the protocol of PMCT.
- Workshops on assessment of antenatal and post-natal care have been conducted.
- Preparations are being made to develop the counselling training manual for health staff/counsellors and a series of counselling training will be conducted in the next few months. Guidelines and procedures for hospital management (ANC and delivery) are now being reviewed to adjust the integration of PMCT into ANC care.

Thailand

The Thailand PMCT programme has been cited as one of the PMCT success stories in the region and globally.

- Khun Pornsinee Amornwichit MOH reported how antenatal HIV seroprevalence peaked in 1995 at 2.3%, and how far it has progressed, from 1994 - the stage of ACTG 076 clinical trial to pilot programs in 1997, and then the declaration of national PMCT implementation in 1999.

- Further presentation of the components of Thailand PMCT national programme and the guidelines on overall PMTCT management guidelines and specific management guidelines on ANC, and at Hospital for labor/delivery, postpartum mothers and newborn.
- From October 1999 to September 2000, of 417,400 deliveries:
  - 98% have access to ANC services
  - 88% consented to HIV testing
  - 88% collected the test result
  - 1.6% of pregnant women tested HIV positive and 57% took AZT
- In 2000, it was estimated that over 3,000 infants were protected from HIV infection by PMCT national programme.

In summary, Khun Pornsinee concluded that the success of PMCT programme in Thailand was due to the following factors:

- Early policy response
- Support to PMCT specific research/clinical trials
- Pilot projects leading to programs
- Use of research, pilot data for crafting the national policy
- Specific attention given to training and counselling
- Integration of PMCT into strong MCH system
- Engagement of international community

Requirements to sustain PMCT programs were also presented. Thailand plans to form proactive PMCT committee for policy, and PMCT technical committee in the near future. The following plans are in the pipeline to carry out before the end of this year:

- Conduct research on AZT and Nevirapine
- Strengthen the care for postpartum mothers
- Establish self-care component to prevent mothers and women from HIV infection
- Strengthen community participation in PMCT
- Strengthen MCH data management system
- Conduct PMCT counselling training for health personnel at health centres level
- Develop PMCT evaluation package

Vietnam

Professor Tran Thi Phuong Mai and Dr. Enzo Falcone presented the country report.

It is estimated that by end 2000, 160,000 adults and children are living with HIV in Vietnam. Out of two millions pregnant women each year, 0.1% might be infected with HIV. Although the rate of HIV infection among pregnant women is still low, it is inevitable that more and more pregnant women will be effected in the coming years as HIV/AIDS is a growing problem.

UNAIDS initiative, launched in February 2000 address PMCT on the access of drug issue only. At present, the capacity of health system is also not ready to address the full-scale PMCT program yet. Therefore, by initiating a PMCT project will be an opportunity of piloting different mechanisms before the problem has become huge.

Keeping these factors in mind, the government has endorsed PMCT as a priority and has clearly included in the agenda of the newly developed “National Strategy AIDS Prevention and Control in Viet Nam for 2000-2005”. To address this, UN Theme Group meeting of 15 March 2001 and the

UN Working Group Meeting on PMCT in April have agreed to develop a joint PMCT plan.

- Pilot project will be implemented in 2 urban and 2 rural areas where UN-supported health projects relating to PMCT are in existence.
- Primary prevention will be reinforced through:
    - Implement lifeskills program for in-school/out-of-school children and young people
    - Prevent women of reproductive age from being infected with HIV by providing family planning, reproductive health and STI control and introduce HIV Voluntary counselling and testing services
    - Promote condom availability and the optimum utilization in high-risk behaviour groups and
- VCT will be integrated into ANC at district and commune levels
- Strengthen health care delivery system through:
    - Providing short course ARV therapy
    - Modifying obstetric services to reduce PMCT
    - Counselling on infant feeding options
    - Linking with Integrated Management of Children Illness initiative
    - Counselling on family planning choices and use of condoms
- Involvement of private sector

Viet Nam team also presented in-detail the planned activities the role and responsibility of each agency (MOH, WHO, UNICEF, UNFPA, UNAIDS) against each defined activity.

UPDATE ON ARV FOR PMCT (WHO)

Dr. Ying Ru-Lo, Medical Officer (STD/AIDS). WHO Thailand provided an update on new data on the use of ARV medicines for PMCT. She presented the various ARV regimens in non-breastfeeding HIV+ women and the on-going clinical trials. She concluded her presentation by stating that "Benefits of ARV in reducing mother-to-child HIV transmission greatly outweigh any potential adverse effects of drug exposure and any concerns related to development of drug resistance. Thus, PMCT should be part of the minimum standard package of care for HIV+ women. Participants further discussed the different ARV regimens that will be feasible in their country settings (Please see detailed presentation in **annex -4**).

FAMILY PLANNING IN THE CONTEXT OF MTCT (UNFPA)

Dr. Katherine Ba-Thike, Technical Expert, UNFPA Country Support Team presented on how family planning plays an important role in PMCT. She also touched upon the type of contraceptives/devices such as male and female condoms, microbicidal products and other non-barrier methods of contraception to prevent HIV transmission. Further presentations was made on how UNFPA contribute to the comprehensive PMCT activities at the country level by:

- Strengthening support for primary prevention of HIV
- Providing support to country implementation of MTCT interventions
- Promoting good quality counselling as part of Reproductive Health Care

She also presented on the efforts of UNFPA to involve youth and men and the impact of gender roles in VCT and MTCT at the country level.

Participants discussed on the window of opportunity for UNFPA-support at the country level. Discussion focused on UNFPA support not only to address the primary prevention components, but also to strategically position to provide family planning services to HIV-positive pregnant women who come to know their HIV status after going through VCCT.

Discussion was also focussed around the situation of pregnant women who become positive in the course of pregnancy after first testing negative. Also for lactating women who opted for breastfeeding due to their negative status, but become infected while still breast-feeding their babies. As the viral load was very high for these newly infected pregnant/lactating women, the risk of transmission to their infants either through intra-partum or breast-feeding is high. The participants agreed that post-test counselling to women and couples who tested negative should emphasize on using condoms even in pregnancy and while lactating to stay negative. UNFPA training program on reproductive health and family planning to counsellors and health staff should incorporate this message to address PMCT effectively.

INFANT FEEDING OPTIONS (UNICEF)

Ms. Karen Codling from EAPRO, presented on current knowledge and infant feeding options, and the pros and cons of different options in the context of PMCT. She also discussed UNICEF, WHO and UNAIDS HIV/Infant Feeding guidelines and emphasis on the human rights approach.

The ranking of different infant feeding options based on the risk of HIV transmission and nutritional value was discussed. However, after considering the feasibility and cultural acceptability, she reported on the three options:

- Commercial infant formula.
- Home prepared formula, including modified animal milk and unmodified cow's milk.
- Exclusive breastfeeding with early cessation of breastfeeding in this region.

All participants agreed that at the country level, the package of options must be adapted to the local situation, giving emphasis to the most feasible, culturally acceptable options. To be able to do this formative research is essential, and outcomes of some formative research on infant feeding from Africa were further discussed.

Pros and cons of the most two feasible infant feeding options, replacement feeding usually with formula and modified breastfeeding was presented and discussed by participants in detail. Depending on each country situation, in Thailand, HIV positive mothers opted for formula feeding while in Cambodia and Myanmar, the choice was exclusive breastfeeding. In India, cow's milk was the most feasible feeding option for HIV positive mothers.

EVALUATION OF PMTCT PROGRAMME IN REGION 3 & 6 OF THAILAND

Dr. Siripon Kanshana, Director, Bureau of Health Promotion, MOH Thailand presented the results of evaluation on PMCT carried out in region 3 & 6. Following are some of the summary results of the evaluation:

Service provision:

- 89% disclose result only to the person tested
- 58% had a written policy on confidentiality
- 53% of service providers reported workload increase since PMTCT services began.
- Over 50% of the staff have not received on-going training and supervision is not satisfactory. 36% of staff have moved from the original posting.

Counsellors

- 74% are professional nurses while 17% are technical nurses.
- They spend on average 1.8 hours per day counselling and have 5 clients per day. Although 73% of them have received general HIV counselling, only 45% were trained on PMTCT counselling specifically.
- Half of the counsellors have been trained on HIV/MCH counselling.
- Over half of the counsellors felt that clients valued them and that make their job worthwhile.

Client perspective

- 91% of HIV positive women and 80% of HIV negative women learned about their HIV status during current pregnancy.
- Over 80 to 90% of clients were satisfied with the information received and only 1-7 per cent of clients were not happy with their counsellors.
- 46% of HIV positive women stated that they wanted to ask more questions to their counsellors.
- Nearly 90% of pregnant women discussed HIV testing with their partner and over half of the partners also opted for testing showing that the stigma and discrimination by men towards women is not as big an issue in Thailand as in Africa.
- Over 95% of HIV positive mothers opted for formula feeding while nearly 60% of HIV negative women breastfeed their babies.
- Mixed feeding practiced by nearly 30% of HIV negative mothers.
- Nearly half of HIV positive women have undergone tubal ligation as their choice of family planning followed by injection as the second choice (27%).
- Problems encountered by HIV positive women following VCT/PMCT intervention - financial difficulties cited as the biggest issue for 60% of women.
- Quality of health care support was said to be not sufficient for them.

For participants from other countries, it provided them with a valuable insight to the Thailand PMCT program, and many interesting questions were raised on the process of conducting the evaluation, the tools and methodologies used.

AMENDMENT ON TERMS OF REFERENCE (TOR) OF PMCT TASKFORCE

In line with the new UN Regional Coordination Mechanism and UNAIDS-SEAPICT structure, from 1 January 2001, the UN Regional Taskforce was convened by UNICEF-EAPRO. As endorsed by Regional Taskforce members, India was added as a member country. TOR was amended accordingly to reflect the changes (**Annex- 3**).

NEXT TASKFORCE MEETING

Participants discussed on the dates and possible venue of the next taskforce meeting. Myanmar offered to organize the coming taskforce inYangon. The possibility of combining the forthcoming Taskforce meeting with the International Conference on Care and Support, Chiang Mai from 17-20 December 2001, was also discussed. As most Taskforce members will be participating in this conference, there will be added value to organize the Taskforce meeting in Chiang Mai. UNICEF Regional Office and WHO – SEARO are also planning to organize one satellite session on PMCT in the Southeast Asia Region. Taskforce members will be informed.

ANNEX1: AGENDA OF THE MEETING

AGENDA

Regional Taskforce and Technical Exchange Meeting on Prevention of Mother-to-Child-Transmission Royal Princess Hotel, 7 - 8 March 2001

7th March (Wednesday)

8:00 - 9:00	**Registration**
Chairperson:	**Dr. Praphan Phanuphak**
9:00 - 9:10	**Introduction to the meeting and agreement on the agenda, Thazin Oo**
9:10	**Country Report on the Situation and Responses Analysis on PMTCT (15 minutes presentation, 15 minutes discussion)**
9:10 - 9:40	**Papua New Guinea**
9:40 - 10:10	**Vietnam**
10:10- 10:40	**China**
10:40 - 11:00	**Coffee/Tea Break**
11:00 - 11:30	**India**
11:30 - 12:00	**Myanmar**
12:00 - 12:30	**Cambodia**
12:30 - 13:30	**Lunch**
Chairperson	**Dr. Chawalit Natpratan**
13:30 - 14:00	**Continue country presentation. Thailand**
14:00 - 14:20	**New data on the use of anti-retroviral medicines for the prevention of Mother-to-Child-Transmission of HIV and their policy implications Dr. Ying-Ru-Lo, Medical Officer, WHO Thailand**
14:20 - 14:30	**Q & A**
14:30 - 14:50	**Amendment on the TOR of PMCT taskforce Thazin Oo, UNICEF EAPRO**
14:50 - 15:05	**Family Planning Services in the context of PMCT Dr. Katherine Ba Thike, UNFPA, Country Support Team**
15:05 - 15:15	**Q & A**
15:15 - 15:35	**Coffee/Tea Break**
15:35 - 15:55	**Vouluntary Counselling and Testing in the context of the National Prevention of Mother-to-Child-Transmission Programme: Implementation, monitoring and evaluation Dr. Siripon Kanshana, Bureau of Health Promotion, Dept of Public Health, Thailand**
15:55 - 16:15	**Q & A**

8th March (Thursday)

Chairperson:	**Dr. R. J. Simonds**
9:00 - 9:20	**Infant Feeding Options. Karen Codling, UNICEF EAPRO**
9:20 - 10:20	**Discussion and Issues**
10:20 - 10:40	**Coffee/Tea Break**
10:40- 11:10	**What are the next steps for the countries in the stage of developing PMCT programs? Country Workplan (feasible, practical plans from March - December 2001 Support requested by countries to regional entities Thazin Oo**
11:10 - 11:30	**Recommendation and decision on next taskforce meeting**
12:00	**Lunch**

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ANNEX 2: LIST OF PARTICIPANTS

UN Regional Taskforce and Technical Exchange on PMTCT
7-8 March 2001 - Bangkok, Thailand

Country Team	Name of participants	Agency/Organizations
1. Cambodia	1. Dr. Seng Sutwantha	Deputy Director, NCHADS
	2. Dr. Tiv Say	National Mother & Child Health Centre
	3. Dr. Etienne Poirot	HIV/AIDS Coordinator, UNICEF
2. China	4. Prof. Cao Yunzhen	National Centre for AIDS Prevention and Control
3. Myanmar	5. Dr. Pirkko Heinonen	Chief, H/N, UNICEF
4. Papua New Guinea	6. Dr. Clement Malau	Director, National AIDS Council Secretariat
5. Thailand	7. Khun Pornsinee Amornwichit 8. Dr. Siripon Kanchana	Bureau of Health Promotion, MOPH
	9. Dr. Usa Thisyakorn	Thai Red Cross AIDS Research Centre
6. Vietnam	10. Prof. Tran Thi Phuong Mai	Deputy Director, MCH/FP Dept. Ministry of Health
	11. Dr. Enzo Falcone	Project Officer, Health Section, UNICEF Hanoi
7. India	12. Dr. Anne Vincent	Health Officer, UNICEF, India
	13. Dr. P.L. Joshi	Joint Director, National AIDS Control Organization, New Delhi
Regional Teams		
EAPRO	14.Thazin Oo	Regional Project Officer, HIV/AIDS/PMCT
	15. Karen Codling	Regional Project Officer, Nutrition
WHO, Thailand	16. Dr. Ying-Ru-Lo	Medical Officer STD/AIDS
UNAIDS/APICT	17. Dr. A. Chatterjee	Advisor on HIV and Drug Vulnerability
UNFPA, CST	18. Dr. Katherine Ba Thike	Specialist on Reproductive Health, Family Planning
	19. Dr. Chaiyos Kunanusont	Specialist on HIV/AIDS and STD
Ext. Res. Persons	20. Dr. Praphan Phanuphak	Director, Thai Red Cross AIDS Research Centre
	21. Dr. R. J. Simonds	CDC Atlanta, Bangkok
	22. Dr. Chawalit Natpratan	Director, CDC Region 10, Chiang Mai
Observer	23.Dr. Bernard Fabre-Teste,	FAC, Cambodia
	24. Ms. Tipawadee Emavardhana	Psychology Department, Thammasat University
Secretariat	25. Khun Wassana Kulpisitthicharoen	UNICEF EAPRO

ANNEX 3: TERMS OF REFERENCE OF PMCT TASKFORCE

Terms of Reference

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

Objectives:

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

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

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

(a) Situation Assessment

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

(b) Technical Support

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

i) Identifying country-specific needs;
ii) Identifying areas of MCT that require policy and technical advice, and interventions;
iii) Providing technical support to the planning, management and implementation of MCT interventions;
iv) Developing regional guidelines, adapting global guidelines to conditions unique to the region, and monitoring implementation in collaboration with the UN Theme Groups, governments and NGOs
v) Proposing surveys and applied research plans on unresolved strategic and technical issues. The tasks can entail assisting research institutions to assess funding needs, and utilizing findings to guide policy adjustments.

(c) Coordination and Communication

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

i) Ensuring regular communications between the UN Theme Groups, co-sponsors, technical resources, country programmes and agencies interested in MCT issues.

ii) Maintaining close liaison with the Global MCT Task Force and MCT Steering Committee, perhaps, through a joint membership. That is, participation in the global and regional discussions from both ends. This will include communicating data and findings to the global MCT forums and ensuring the exchanges of information between the MCT Task Forces are in place.

iii) Making periodic reports to the RCM Sub-committee on HIV/AIDS and other regional organizations such as ASEAN to mobilize regional support for MCT reduction and prevention.

iv) To promote communication of knowledge and learning outside meetings, the Task Force should:

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

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

(f) Resource Mobilization

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

(g) External Relations

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

i) Documentation and dissemination of MCT operational researches, cost-effective and feasibility studies as well as best practices;

ii) Advocate policy changes to reduce MCT. This includes analysis of social-economic impact of existing policies, alternate policies to cushion the effects, and what changes are needed at policy level;

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

Membership:

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

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

6. Members of the Task Force are selected from three categories:

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

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

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

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

Organization:

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

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

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

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

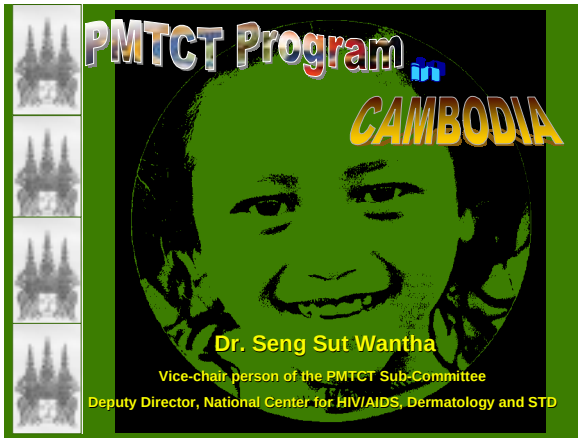
14. The UNICEF-EAPRO shall recommend to the Task Force, a suitable and qualified person as Chairperson.

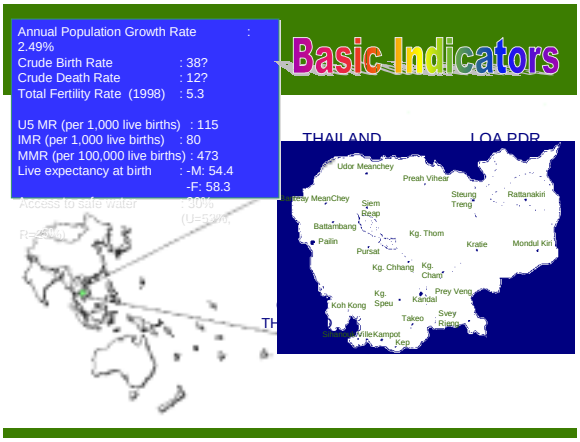
15. The UNICEF-EAPRO in consultation with the regional core members shall propose agenda of the Task Force meetings. UNICEF-EAPRO will invite members to the meeting and furnish invitation with appropriate annotations and background documents.

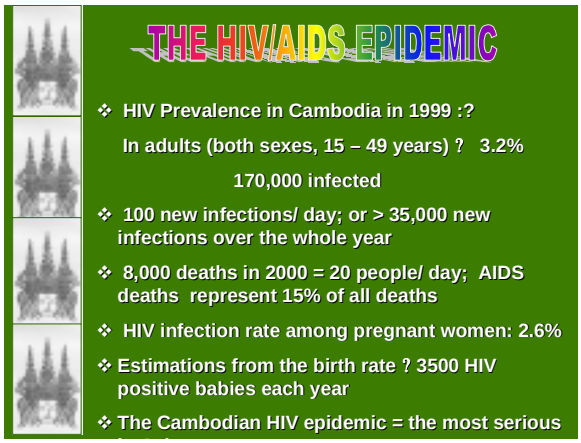
16. The UNICEF-EAPRO/Secretariat will be requested to document the Task Force meeting and if necessary, supported by seconded staff and consultants. The report of the meeting shall be circulated to each member of the Task Force as soon as possible, and shall be made available to other concerned parties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

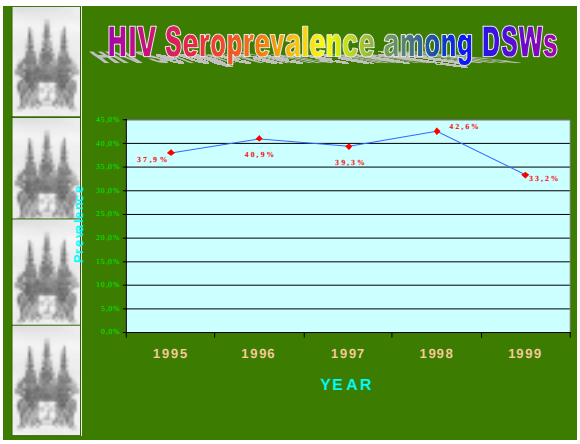
ANNEX 4: PRESENTATIONS

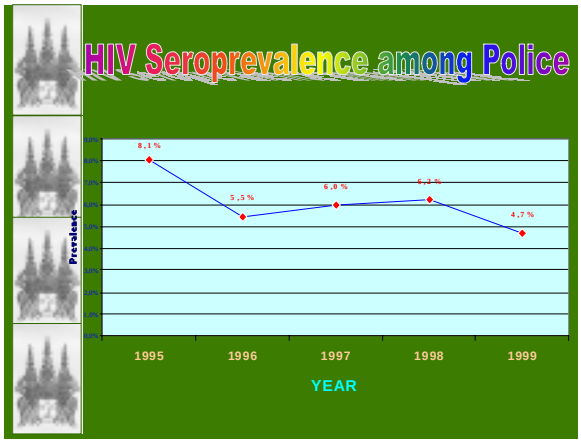
Cambodia

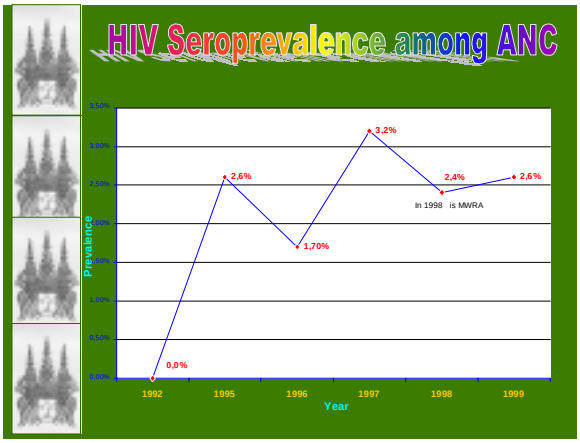

PMTCT Program in
CAMBODIA
Dr. Seng Sut Wantha
Vice-chair person of the PMTCT Sub-Committee
Deputy Director, National Center for HIV/AIDS, Dermatology and STD


Basic Indicators
Annual Population Growth Rate : 2.49%
Crude Birth Rate : 38?
Crude Death Rate : 12?
Total Fertility Rate (1998) : 5.3
U5 MR (per 1,000 live births) : 115
IMR (per 1,000 live births) : 80
MMR (per 100,000 live births) : 473
Live expectancy at birth : -M: 54.4
-F: 58.3
THAILAND
LAO PDR
Udor Meanchey
Preah Vihear
Steung Treng
Ratanakiri
Siem Reap
Battambang
Kg. Thom
Pailin
Kratie
Mondul Kiri
Pursat
Kg. Chhang
Kg. Cham
Prey Veng
Kandal
Koh Kong
Takeo
Svey Rieng
Kep

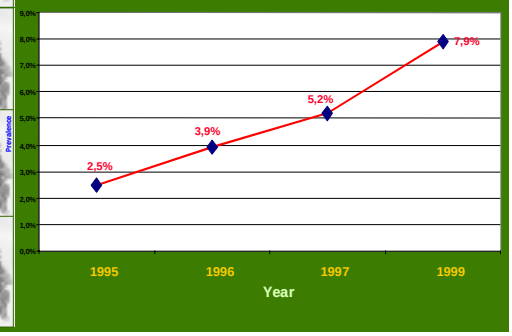

THE HIV/AIDS EPIDEMIC
❖ HIV Prevalence in Cambodia in 1999 :?
In adults (both sexes, 15 – 49 years) ? 3.2%
170,000 infected
❖ 100 new infections/ day; or > 35,000 new infections over the whole year
❖ 8,000 deaths in 2000 = 20 people/ day; AIDS deaths represent 15% of all deaths
❖ HIV infection rate among pregnant women: 2.6%
❖ Estimations from the birth rate ? 3500 HIV positive babies each year
❖ The Cambodian HIV epidemic = the most serious


HIV Seroprevalence among DSWs
37,9%
40,9%
39,3%
42,6%
33,2%
1995
1996
1997
1998
1999
YEAR


HIV Seroprevalence among Police
8,1%
5,5%
6,8%
6,2%
4,7%
Prevalence
1995
1996
1997
1998
1999
YEAR


HIV Seroprevalence among ANC
0,0%
2,6%
1,70%
3,2%
2,4%
2,6%
In 1998 is MWRA
Prevalence
1992
1995
1996
1997
1998
1999
Year

HIV Seroprevalence among TB patients

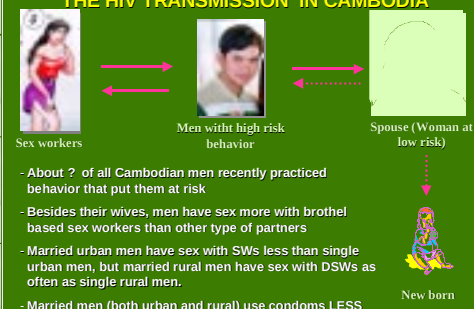


THE NATURE OF THE EPIDEMIC

HIV/ AIDS TRANSMISSION

THE NATURE OF THE EPIDEMIC

THE HIV TRANSMISSION IN CAMBODIA



- About ? of all Cambodian men recently practiced behavior that put them at risk
- Besides their wives, men have sex more with brothel based sex workers than other type of partners
- Married urban men have sex with SWs less than single urban men, but married rural men have sex with DSWs as often as single rural men.
- Married men (both urban and rural) use condoms LESS with DFSWs than single men (BSS 2000)

THE RESPONSE

8 AREAS OF PRIMARY FOCUS

2001- 2005

?

- HIV/AIDS and STI Awareness and Education Campaigns; which include both IEC and Outreach activities for high risk situations
- 100% Condom Use in high risk situations
- STI Management
- Blood Safety
- Preventing Mother-to-Child-Transmission
- AIDS Care; which includes Institutional and Home-based Care and help-self group, Testing and Counseling and Universal Precautions
- HIV/AIDS and STI Surveillance and Research
- Multi-sectoral Collaboration and Support; which include both horizontal support for other sectors and institutions and vertical support for decentralization to Provinces, and integration within the health sector

THE RESPONSE

Preventing Mother-to-Child-Transmission

1999:

- TWG on PMTCT established
- Rapid assessment conducted: specific assessment of 3 sites

2000:

- National Policy on PMTCT of HIV developed and approved by the MOH
- Proposal of a pilot project on PMTCT developed and submitted to the MOH

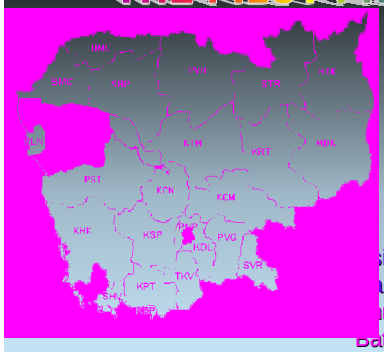
THE PILOT PROJECT

Project objectives

To investigate, through a pilot project in two sites, the acceptability and feasibility of providing:

- Counseling and testing services to women visiting ante-natal services, as well as to their sexual partners;
- Identifying and referring women in need of PMTCT services
- Counseling to HIV positive women before and after delivery about infant feeding options
- Nevirapine to HIV positive women during labour, and to their newborns
- Follow-up and support to HIV positive mothers and their neonates
- Primary prevention activities focusing on young people, women and their families, and community at the pilot sites

THE PILOT PROJECT



Pilot sites

Pregnant Women
iting the Antenatal
re in NMCHC in
nom Penh and
Battambang

THE PILOT PROJECT

Battambang

- 15% of births in the hospital ?67% use TBA services
- 47% ANC coverage = 1500 visits/month
- VTC with 2 trained counselors
- Project focus:
  - ✍ Improving the hospital's referral systems
  - ✍ integration of primary prevention strategies into reproductive health and STI issues

THE PILOT PROJECT

Phnom Penh

NMCHC = main public center for obstetric care

- 19,000 ante-natal visits / year
  - ? 36% for 1st visits
  - ? 20% for 2nd visits
- 6,000 deliveries/year
- Full range of ante-natal, obstetric, family planning, STI and other reproductive health services offered
- No VTC but is 500 meters from Pasteur Institute

THE PILOT PROJECT

Activities

✍Training of staff

✍Voluntary HIV Testing and Counseling for all pregnant women

- *Pre-test group counseling performed with mother class of ANC*
- *Pre-test individual counseling*
- *HIV testing*
- *Post-test counseling*
- *Family counseling*

THE PILOT PROJECT

Activities

✍Anti-retroviral therapy: Nevirapine

- *Mothers: single dose of 200mg at onset of labour*
- *Neonate: single dose of 2mg/kg within 72 hours after birth*

✍Infant feeding

- *Exclusive breastfeeding for HIV positive mother*

THE PILOT PROJECT

Elements of monthly report

✍ANC

- *# women visiting ANC, % tested, % HIV+*

✍Delivery

- *# women delivering*
- *% with ANC, % tested, % HIV+, % getting ARV*
- *# HIV+ exposed children born, % getting ARV*

✍Ped, OPD

- *# HIV exposed children with exclusive breastfeeding*

THE PILOT PROJECT

Project Duration:

2 Years

Estimated Project costs:

270,000 USD

THE PILOT PROJECT

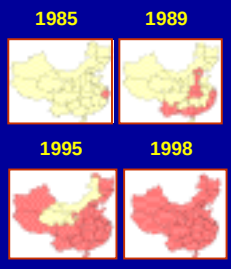
Financial & Technical Support

- MOH / NCHADS / NMCHC
- UN co-sponsors
- JICA
- French Cooperation

Thank yo

Prevention of prenatal HIV-1 infection
Update from China

Yunzhen Cao M.D.
National Center for AIDS Prevention and Control
Beijing China



- 1985-1988 was marked by a small number of cases imported by overseas travelers
- 1989-1993, a limited endemic, was defined by the identification of HIV infection in drug users in southwest Yunnan Province
- began in late 1994 when large number of HIV infections were reported from a number of different geographic regions

Cumulative reported cases

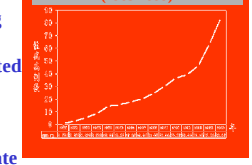
Dec 30, 20000	HIV(+)	22,517
	AIDS	880
	Die	496

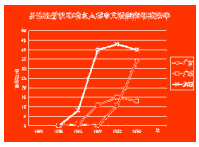
Covered 31 provinces regions
Estimated prevalence 600,000 HIV positive

Women

- Women everywhere are increasingly at risk of contracting STDs and HIV infection.
- STD infection in women Reported cases in 1998- 268,112, 12 times increase comparing with 1988
- Number of prostitutes and their clients around 3 million by estimate

Reported cases of STD in China (1985-1999)

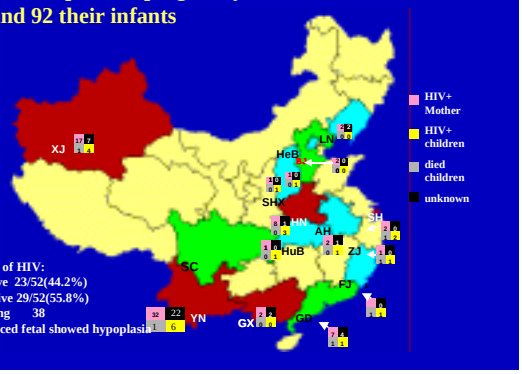




HIV incidence in spouse of IVDU and pregnancy womerf at Yunnan province

Year	IVDUs wife (%)	pregnancy women (%)
1990	2/53 (3.8)	ND
1991	0/7 (0)	1/492 (0.2)
1992	5/100 (5)	0/1234 (0)
1993	7/146 (4.8)	1/2387 (0.04)
1994	3/48 (6.25)	4/3567 (0.11)
1997	11/83 (13.3)	0.3-0.6

85 HIV positive pregnancy women and 92 their infants

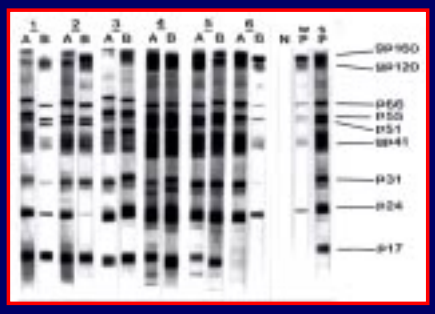


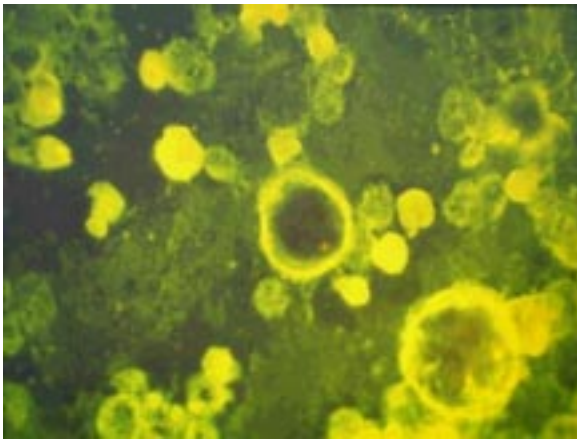
Status of HIV:
Positive 23/52(44.2%)
Negative 29/52(55.8%)
Pending 38
2 induced fetal showed hypoplasia

The project for to reduce MTCT of HIV-1 in China

- HIV/AIDS Clinical Training Course for Doctors and Nurses
- Screening of high risk population: Xinjiag, Yunnan, Guangdong , Guangxi ,Sichuan , Henan
- Nevirapine and AZT has used for reduce MFT of HIV-1. Yunnan, Xinjiag, Liaoning

Western blot assay for blood (A) and urine(B)





Reference

Cao Yunzhen, Friedman-Kien, AE, et al. IgG antibodies to HIV-1 in urine of HIV-1 seropositive individuals. Lancet, 1988; ii:831-832.

Cao Yunzhen, Friedman-Kien, AE , et al. Antibodies to human immunodeficiency virus type 1 (HIV-1) in the urine specimens of HIV-1 seropositive individuals. AIDS Res Human Retroviruses, 1989; 5:311-319.

Cao Yunzhen, Friedman-Kien, AE, Ho, DD. HIV-1 neutralizing antibodies in urine from seropositive individuals. J. AIDS, 1990; 3:195-199.

J, Li Friedman-Kien, Cao Yunzhen. Detection of HIV-1 in DNA of urine pellets from HIV-1 seropositive persons. Lancet, 1990; ii: 1590-1591.

Calypte™ HIV-1Urine EIA

Sensitivity: 98.7-99.0%
Specificity: false negative Rate of 1.3% (combined Population of AIDS patients and other HIV-1 seropositive individuals

Dick Van Maanen
Director, Sales & Marketing
Calypte Biomedical Corporation
1265 Harbor Bay Parkway
Alaneda, CA 94502?USA

Tel: 510-749-5153
Fax: 510-814-8408
WEB:?www.calypte.com
E-mail:
dvanmaanen@calypte.com

Comparison of the results for HIV-1 blood and urine assay from pregnancy women in Yunna

Samples	NO	POS No	Prevalence ?%?
Serum	800	3	0.38
Urine	800	3	0.38
Total	800	3	0.38

Goals for AIDS Control

To keep the prevalence of HIV infection in China at a relatively low level for the global context

2002 Focus on: Blocking HIV transmission through blood and blood products;
Controlling the annual increase of STD patients below 15%

2010 Control HIV infection among adult at low level.

India

Prevention of Parent-To-Child Transmission of HIV: India Experience

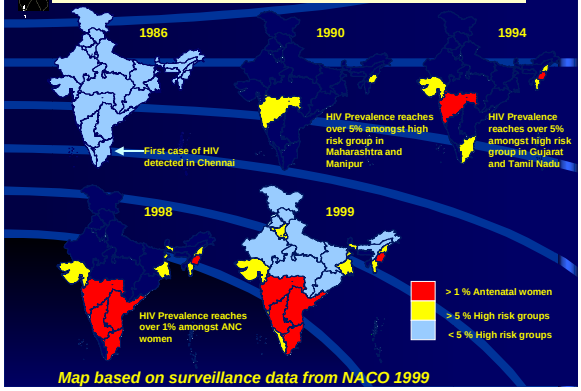
Dr. Anne H. Vincent, Project Officer Safe Motherhood/Women's Health/PTCT - UNICEF India

HIV/AIDS in India

- A rapidly evolving HIV epidemic
- Eight States facing a generalized epidemic:
  - Maharashtra
  - Andhra Pradesh
  - Karnataka
  - Tamil Nadu
  - Manipur/Mizoram/Tripura/Nagaland

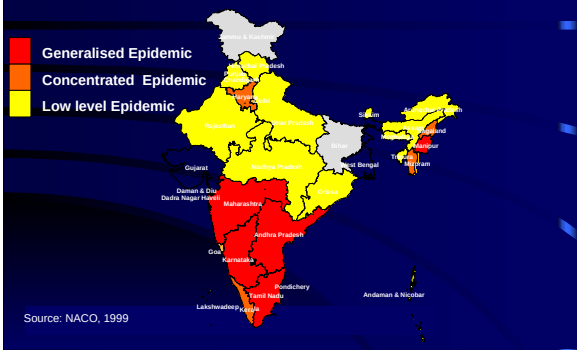
Total Population: 300 million

INDIA - A RAPIDLY EVOLVING HIV EPIDEMIC 3.6 MILLIONS INFECTED



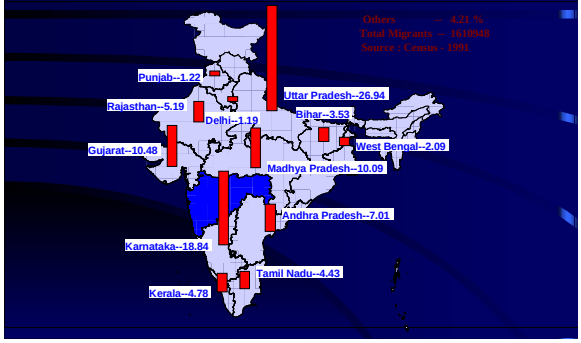
Map based on surveillance data from NACO 1999

State of the epidemic

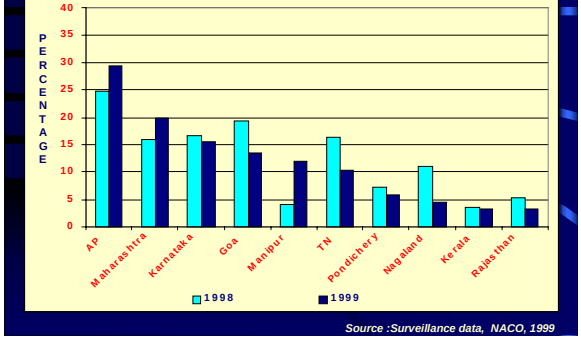


Source: NACO, 1999

MIGRATION AS A TRANSMISSION BELT ACROSS THE STATES - MAHARASHTRA

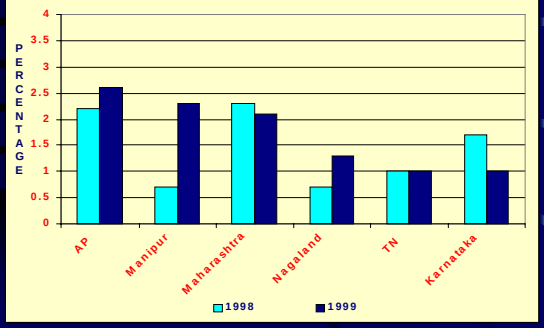


HIV PREVALENCE RATE IN STD CLINIC ATTENDEES MAJOR STATES 1998-1999



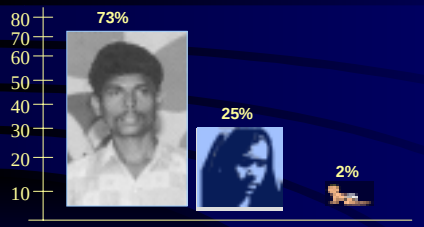
Source :Surveillance data, NACO, 1999

HIV PREVALENCE RATE AMONG ANTENATAL CLINIC ATTENDEES - HIGH EPIDEMIC STATES 1998-1999



Source :Surveillance data, NACO, 1999

BREAKUP OF NEW INFECTIONS - 1998



(in Lacs per year)

UNICEF HIV/AIDS PRIORITIES IN INDIA

Children

0.72% of HIV infection occurs through vertical transmission, translating in approximately 32,000 children infected every year

UNICEF HIV/AIDS PRIORITIES IN INDIA

Women

out of 3.8 million people infected in India

21,4% are women

More than 800,000 women infected

UNICEF HIV/AIDS PRIORITIES IN INDIA

	Epidemic Status
1. Advocacy	Nat./L/C/H
2. Youths: Primary Prevention	L/C/H
• Life Skills	
• Adolescent Friendly H1ealth Services	
3. Parent-To-Child Transmission	C/H
4. Children Affected	C/H

RATIONALE FOR PTCT IN INDIA

27 million pregnancies per year

↓ 0.4% prevalence

108,000 infected pregnancies

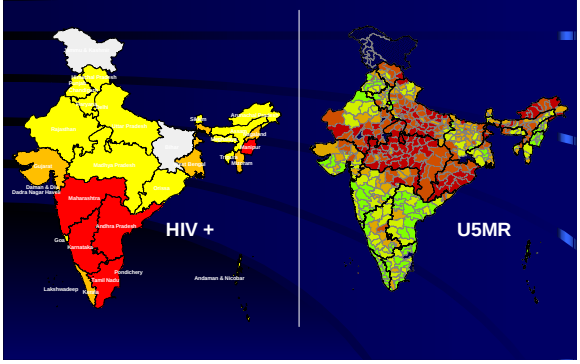
↓ 30% transmission

25,000 - NAGO Annual Cohort of 32,000 infected newborns 30,000 - NNF

↓

25,000-50,000 deaths within 1-8 years

Child Mortality as an Indicator of Vulnerability



Status of PTCT in India (1)

- March 2000: beginning of a Feasibility Study
- 11 Medical Colleges in the five most affected States (1,000 expected infected pregnancies over a twelve-month period)
- Based on the Bangkok regimen:
  - routine antenatal VCT
  - provision of IFA and vitamin A to all
  - counseling on infant feeding practices

Status of PTCT in India (2)

- short-course of AZT and AZT during delivery in HIV positive women
- no AZT to infant
- 18-month follow-up for infant

- Aiming at: 1) identifying strengths and weaknesses of the Indian Public Health System in implementing PTCT; 2) identifying the optimal protocol for a National Policy; 3) integrating PTCT in the RCH Program

STATUS OF PTCT IN INDIA AS OF 28th FEB. 2000

# of pregnant women in ANC	147,262
# of pregnant women counseled (pre-test)	108,799 (74%)
# of pregnant women screened for HIV	64,243 (59%)
# of pregnant women found HIV (+)	1,203 (1.9%)
# of pregnant women provided with AZT	462 (38.4%)
# of live births to HIV (+) women	562
# of births after provision of AZT	457 (81%)

Constraints

- Only 40% of pregnant women attend ANC and mostly in the third trimester/Low rate of institutional deliveries
- Counseling is a new concept
- Confidentiality
- High risk of social stigmatization
- All Indian women breastfeed (but the actual rate of exclusive breastfeeding is very low)
- Poor NGO coordination
- No link between Health system (PTCT at tertiary level only) and communities
- Limited resources

Opportunities

- Some political commitment (PM's Independence Day Address, 15 August '00)
- A good network of health institutions
- A network of State AIDS Control Societies (SACS) under the National AIDS Control Organization (NACO)
- ARV are produced in India
- Donors interest

NEXT STEPS FOR PTCT IN INDIA

For 2001

1. Inception of NACO Feasibility Study Phase 2
   - Nevirapine/Rapid Tests
   - Continuum of Care for both mother and child
   - Strengthening of counseling services
2. O.R. on Infant Feeding Practices in the context of the HIV Epidemic in India
3. Development of a District Model for PMTCT
4. Communication strategy for low prevalence States

NEXT STEPS FOR PTCT IN INDIA

And by end of 2003

1. National Policy on PTCT
2. Integration into the National Reproductive & Child Health Programme

Myanmar

Myanmar PMCT Country Profile

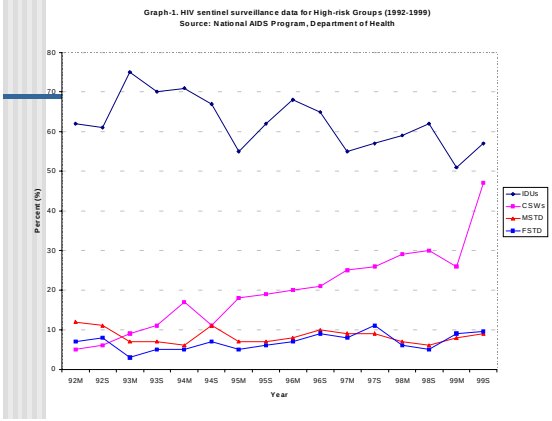
Regional Task Force on PMCT

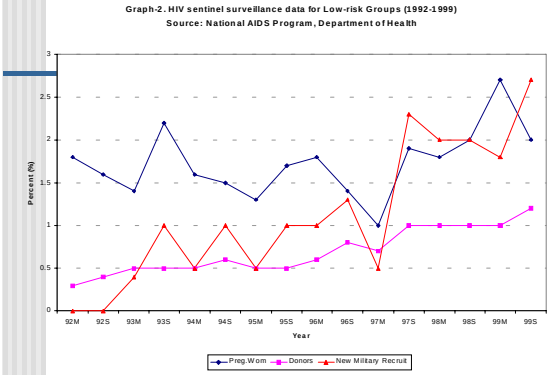
7-8 March 2001

Bangkok

Myanmar PMCT Situation

- Assessment in Tachileik and Kawthaung 2000
- Pilot activities started in November 2000 in Tachileik and December in Kawthaung
- PMCT activities guided by the UNAIDS sub-group Care, Counseling and Support
- Chaired by UNICEF
- Advocacy at the central level





Myanmar PMCT Situation (2)

- Selection of ARV
- Advocacy at the township level
- Development of the guidelines and training manuals
- Training of midwives, other PHC staff
- Training of Township hospital Ob/Gyn
- Training of lab workers
- Social mobilization at the community level

Myanmar PMCT Situation (3)

- Provision of test kits, nevirapine, EOC instruments and clean delivery kits
- Linking with other HIV/AIDS activities such as SHAPE, Care Counseling & Support and Youth Friendly Services
- Linking with Women's Health, EPI

Myanmar PMCT Situation(4)

- Tachileik
- 3 positive out of 29 tested pregnant women
- Care and Support activities ongoing by INGO
- Kawthaung
- 3 positive out of 137 tested pregnant women
- Care and Support activities ongoing by INGO

Myanmar PMCT Situation(5)

- Birthing practices to be addressed
- Infant Feeding policy; exclusive BF for 4 months (current rate 16%)
- Family Planning, very limited
- Funding is a major concern

Papua New Guinea

Dr. Clement Malau

Mother to Child Transmission Task Force Meeting Bangkok, 7-8 March

"I have a dream to contain HIV/AIDS in Papua New Guinea"

Major Health Problems in PNG

- **Infant Mortality**
- **Maternal Mortality**
- **Infectious Diseases**
- **Emerging Problems**
- **Social Change**
- **Smoking**
- **Drugs and Alcohol**

National Policies

- **National Health Plan 2001 - 2010**
- **National AIDS Council Act**
- **National HIV/AIDS MTP 1998 - 2001**

Vital Statistics

? Total Population - 4.9 Million,
? Life expectancy at birth 54 years
? Infant Mortality Ration 73 per 1,000 births
? Total Fertility Rate 4.8
? Maternal Mortality Ratio 370 per 100, 000 pop
? Total Women 15 - 44 years - 2.2 Million
? 1, 506 Health Facilities (46% Church run)
? 26% of all admissions are obstetrical
? Antenatal Coverage 66%
? Percentage of supervised deliveries 44%

OUR NATIONAL RESPONSE

HEALTH SECTORAL

↓

MULTI-SECTORAL

Major Challenges

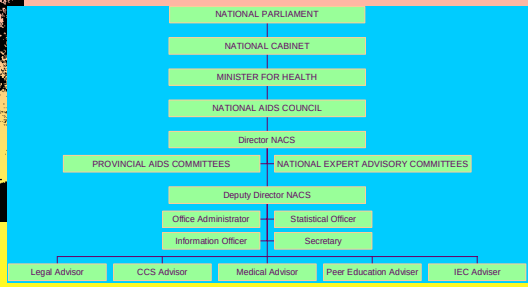
- **Diversity of Culture**
- **Cultures in transition**
- **Poverty**
- **Economic Development and urban development**
- **Imposition of Diverse philosophies**
- **Youth full population and population control**
- **Poor Infrastructure**
- **Poor literacy rates**
- **Lack of accountability for peoples well being**
- **Violence in general & Gender based violence**
- **Youth and employment**

Medium Term Plan

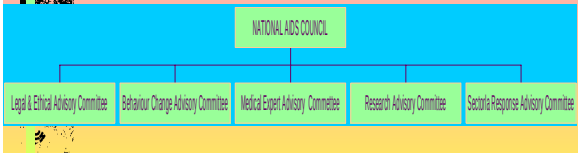
the six components

- **Information, Education and Communication;**
- **Counselling, Care and Support;**
- **Legal and Ethical;**
- **Social and Economic Impact;**
- **Monitoring, Evaluation and Research;**
- **Medical and Laboratory (PMTCT needs Attention).**

Organizational Chart of the PNG National AIDS Council and Secretariat



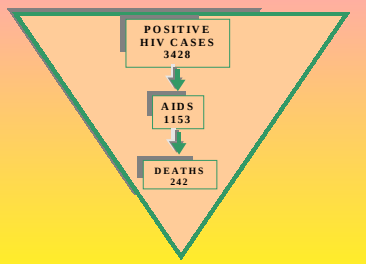
Organizational Chart of the PNG National AIDS Council Committees

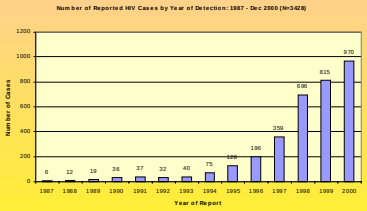


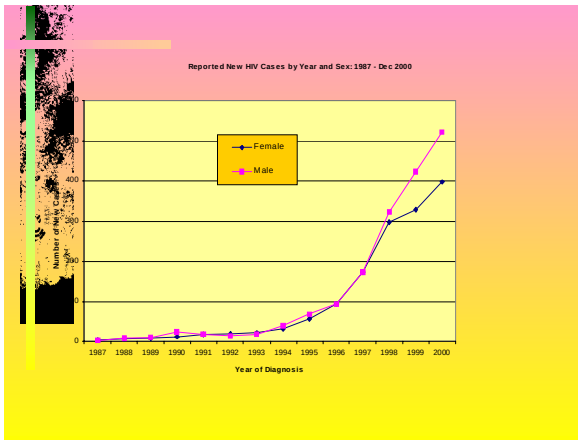
Current Situation

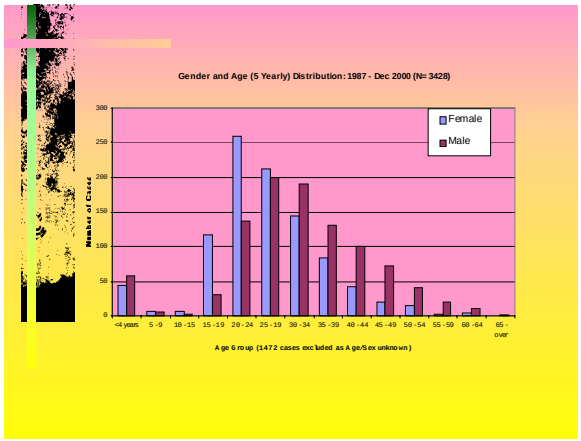
- **December 2000, 3, 428 HIV cases**
- **National estimates 10 - 15 thousand cases**
- **51% male, 45% female**
- **91% Heterosexual intercourse**
- **9% peri- natal transmission (up from 4% in 1998)**
- **BTS POM 1997- 0.038%, 1999 - 0.255%**
- **Simbu, Western, Enga & Manus recorded sharp increases in the past 18 months**
- **Close to 1 in every 5 individuals being affected in high risk setting**
- **Gulf, North Solomons and Sundaun no comprehensive testing**

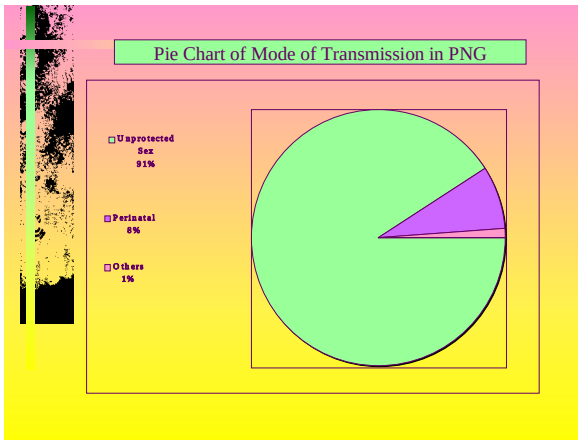
Cumulative Numbers up to December 2000

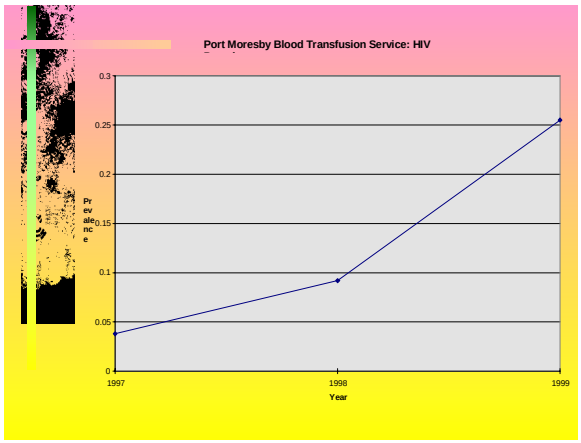












Major Goals for 2001 - 2001

- Keep prevalence rate below 0.5% in low risk settings
- Keep prevalence rate below 20% in high risk settings

Major Strategic Interventions

- Prevention and proper treatment of all STIs
- 100% condom use strategy (after definition)
- Desensitization of HIV/AIDS through public campaigns, counseling and peer education
- Introduction and full implementation of PMTC initiatives (including improvement in antenatal and post natal care)
- Through the multi-sectoral response in PNG
- Improve surveillance

Mother to Child Initiatives

- Medical expert advisory committee to look at and confirm protocol on PMTC
- K99,000 grant from UNICEF for workshops
- Workshop to focus on antenatal care and post natal care
- Introduction of chemotherapy based on experiences elsewhere.
- Four major hospitals to be involved
- Review of MTP

Support Needed

- Protocol development and drug supplies to at least 4 hospitals to commence chemotherapy
- Facilitator to assist in workshops
- Review of MTP
- Support to HIV & Development Study

Acknowledgement

- European Union
- AusAID
- UNICEF
- WHO
- UNFPA
- UNDP
- UNAIDS
- Our Political leaders

PREVENTION OF MOTEHR TO CHILD TRANSMISSIN WILL ENABLE US TO REDUCE THE OVERALL BURDEN OF HIV/AIDS IN THE COUNTRY PARTICULARLY THE TOLL ON CHILDREN.

Thank You

Thailand

Implementing Mother to Child HIV Prevention Program in Thailand

Thailand's National Policy on HIV/AIDS

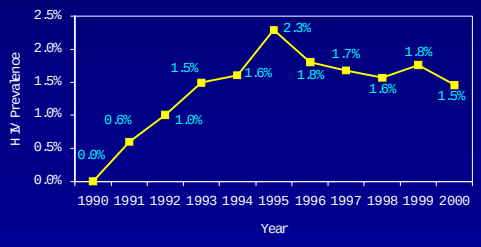
1985 - First national committee for prevention and control of HIV/AIDS
- Systematic screening of blood supply

1993 - "100% condom use" campaign

1994 - Importance of PMTCT recognized:
- Voluntary counseling and HIV testing in ANC
- Formula feeding for infants of HIV+ mothers

Ministry of Public Health, Thailand

Median Provincial Antenatal HIV Seroprevalence, Thailand



Ministry of Public Health, Thailand

AIDS Cases in Children 0-4 Years from Mother-Child Transmission, Thailand, 1984-1999

Ministry of Public Health, Thailand

National Policy on HIV/AIDS

1994 - Importance of HIV/AIDS in children recognized

MOPH begins
- Voluntary Counselling and HIV Testing for pregnant women
- Recommends formula feeding for infants of HIV+ mothers

Thailand's National Policy on HIV/AIDS--PMTCT

1994 - Results of ACTG 076: AZT decreases mother-to-child transmission by 2/3

1996 - MOPH and World Bank re-evaluate ARV use: AZT in pregnant women is most cost-effective use of ARV

1997 MOPH begins pilot programs providing short-course AZT to pregnant women in Regions 10

1998 - Bangkok trial shows effectiveness of short-course AZT

1998 MOPH begins pilot programs providing short-course AZT to pregnant women in Regions 7

Thailand's National Policy on HIV/AIDS--PMTCT

1998 - National PMTCT guidelines reviewed

1999 - National PMTCT policy and PMTCT guideline declared

Thailand MOPH Nationally-Supported Perinatal HIV Prevention Program

- Voluntary HIV testing and counseling for all pregnant women
- AZT for all HIV+ pregnant women starting at 34 weeks' gestation
  - start at 34 week GA
  - AZT 300 mg b.i.d until onset of labor
  - AZT 300 mg every 3 hours during labor
- AZT for all children born to HIV+ women:
  - 1 week if mother's treatment is ? 4 weeks
  - 6 weeks if mother's treatment is <4 weeks

Ministry of Public Health, Thailand

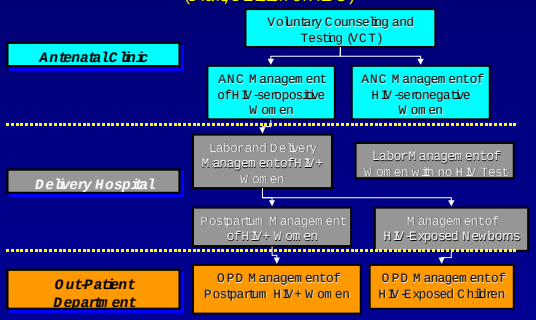
Thailand MOPH Nationally-Supported Perinatal HIV Prevention Program

- Infant formula for 12 months to replace breastfeeding
- HIV test for infant at 12 months; if positive re-test at 18 months
- Appropriate care for mothers and children

Ministry of Public Health, Thailand

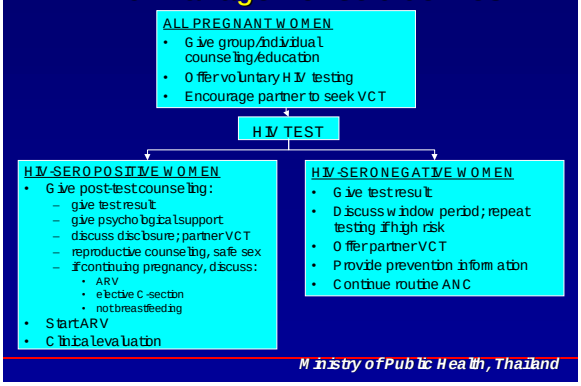
Overview of PMTCT Management Guidelines

(Draft, Division of AIDS)



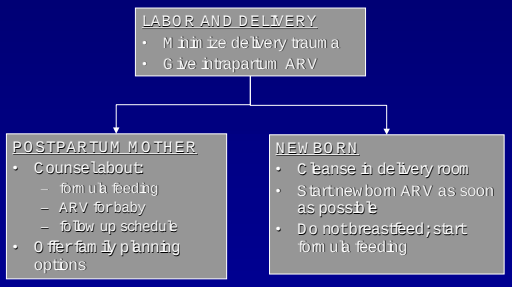
Ministry of Public Health, Thailand

ANC Management Guidelines



Ministry of Public Health, Thailand

Hospital Management Guidelines



Ministry of Public Health, Thailand

Monitoring and Evaluation

- Department of Health national monthly report on PMTCT implementation indicators
- Division of Epidemiology pilot perinatal infection surveillance system in 4 provinces
- Department of Health pilot in perinatal infection monitor system in 8 provinces
- Evaluation activities:
  - Cost-effectiveness
  - Counseling
  - Surveys of clients, providers

Ministry of Public Health, Thailand

Expansion of AZT Programs, Oct99-Sept00

Number of women who gave birth : 417,436

--with ANC 400,307 (98%)

--with HIV test result 350,400 (88%)

--HIV positive 5,588 (1.6%)

--took AZT 3,188 (57%)

Reports from 11 out of 12

Ministry of Public Health, Thailand

Target number of Preventable Infections Averted by PMTCT Program,2000

Annual Births	900,000
Seroprevalence Among Pregnant Women	1.5%
Birth to HIV infected Women	13,500
Number of Infants Infected	
-with no intervention TR=33%	4,0508
-with MOPH Program	
TR=8%,85%women received AZT	918
Estimated Infected Averted	3,132

Summary (1)

Success of PMTCT program in Thailand:

- early policy response
- support of Thailand-specific research
- early use of pibt projects to set programs
- use of research, pibt data for policy
- attention to training, counseling
- integration into strong MCH system
- engagement of international community

Ministry of Public Health, Thailand

Summary (2)

Sustainability of PMTCT program requires:

- continued political and budgetary support
- ongoing training of health care workers
- attention to monitoring and evaluation data for improving programs and policies
- improving program components
  - better regimens
  - improved counseling (eg, couples)
  - primary prevention opportunities
  - care for women and children after PMTCT program

Ministry of Public Health, Thailand

Future Plan

- **PMTCT committee for Policy**
- **PMTCT Technical committee**

Ministry of Public Health, Thailand

Future Plan

- Research on AZT and Nevirapine
- Care for Postpartum mothers
- Self care to prevent mothers and women from HIV infection
  - community participation in PMTCT
  - MCH data management system
  - PMTCT counselling training for health personel at Health centers level

Future Plan

- Develop PMTCT evaluation package

Update on ARV for PMCT (WHO)

New Data on the Use of Anti-retroviral Medicines for the Prevention of Mother to Child Transmission (PMTCT) of HIV

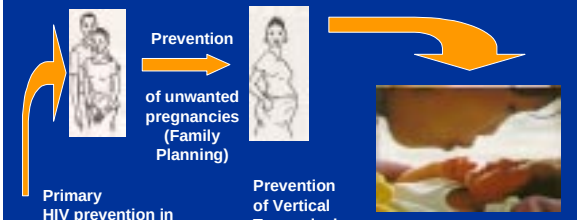
Dr Ying-Ru Lo
Medical Officer STD/AIDS
WHO Thailand

Regional Task Force on the Prevention of Mother-to-Child Transmission
7-8 March, Bangkok, Thailand

End-2000 global estimates Children (<15 years)

- Children living with HIV/AIDS ---------- 1.4 million
- New HIV infections in 2000 ---------- 600 000
- Deaths due to HIV/AIDS in 2000 ---------- 500 000
- Cumulative number of deaths due to HIV/AIDS ---------- 4.3 million

Three Integrated Strategies to Reduce Paediatric AIDS



Prevention

of unwanted pregnancies (Family Planning)

Primary HIV prevention in parents to be

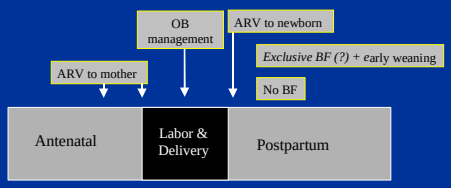
Prevention of Vertical Transmission

- Antiretrovirals during pregnancy
- Antiretrovirals during labor and to newborn
- Obstetric management during labor
- Breastfeeding management

Knowledge Strategies for Preventing Mother-Infant HIV Transmission

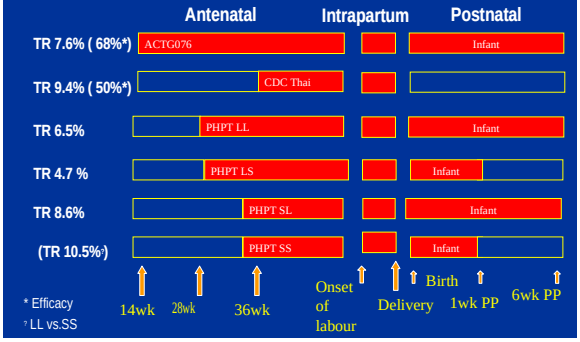
- Reduce concentration of HIV in maternal fluids and tissues
- Reduce exposure of fetus/infant to maternal fluids and tissues
- Reduce chance of infection in infants exposed to HIV

Interventions to Prevent Mother-Infant HIV Transmission, by Timing

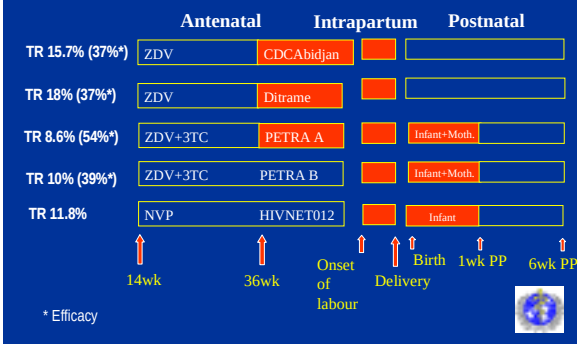


Adapted from Simonds RJ, 2000

ZDV regimens for PMTCT in non- breastfeeding HIV+ women



ARV regimen for PMTCT in breastfeeding HIV+ women

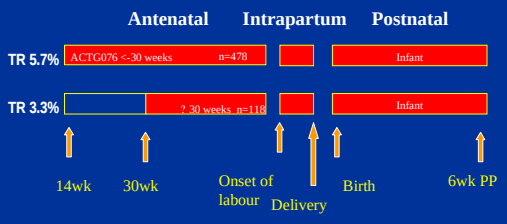


* Efficacy

Thai Red Cross zidovudine donation program

n=2891, n=726 evaluable

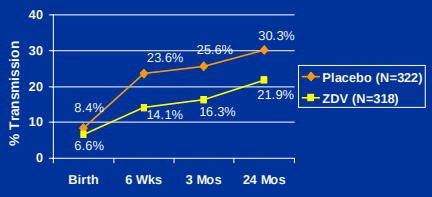
Observational retrospective evaluation



Source: Thisayakorn U, et al, AIDS 2000

Ivory Coast Short-Course ZDV Trials: Combined Analysis Through 24 Months

Witkor S. XIII AIDS Conf, July 2000, Durban S Africa (TuOrB354)



Risk Difference: 6 Wks: 9.5%
24 Mos: 8.4% (95% CI 2.0% -15.4%)

HIVNET 012: Trial Design

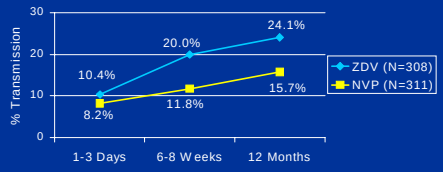
- Population: HIV-infected pregnant Ugandan women enrolled at 36+ weeks gestation
- Study size: 609 mother-infant pairs

NVP
- 200 mg at labor onset
- 2 mg/kg to baby at 2-3 days of life

ZDV
- 600 mg at labor onset; then 300 mg q 3hrs
- 4 mg/kg BID for 7 days

HIVNET 012: Intrapartum/Postpartum Nevirapine vs 1 Week ZDV

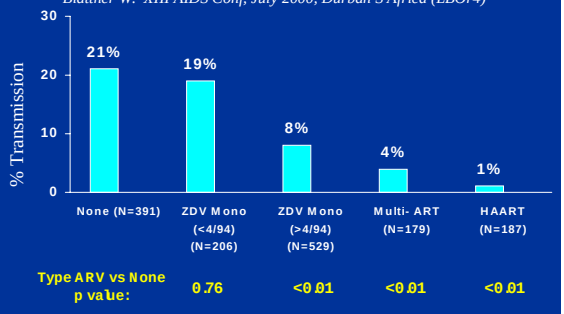
Owen M. XIII AIDS Conf, July 2000, Durban S Africa (LbOr01)



Risk Difference: 6 Wks: 8.2%
12 Mos: 8.4%

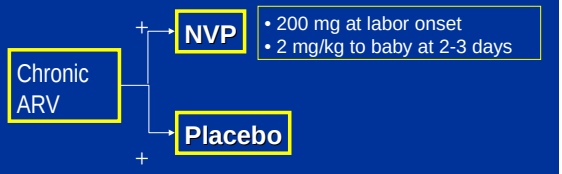
Antenatal Antiretroviral Treatment and Perinatal Transmission in WITS, 1990-1999

Blattner W. XIII AIDS Conf, July 2000, Durban S Africa (LBOr4)



PACTG 316: Trial design

Population enrolled was ARV experienced (except NNRTI)
Study size 1506/ 2000 pairs
1267 received NVP/placebo



Nielsen K, et al, 8th conference on Retroviruses and Opportunistic Infections, 2001

PACTG 316: Results

ARV regimens
- 41% PI +NVP
- 28% ZDV+3TC +NVP
- 21-24% ZDV + NVP
- 1-2% NVP only

- 45% Vaginal delivery
- > 34% C-section
- No breastfeeding

- TR 1.5%
- No benefit of adding NVP

Nielsen K, et al, 8th conference on Retroviruses and Opportunistic Infections, 2001

ARV - Issues (1)

ARV safety

- Short-term safety and tolerance of the effective antiretroviral prophylactic regimens has been demonstrated in all the controlled clinical trials
- Collection of long-term safety data is ongoing
- Mild transient anemia in infants receiving ZDV-containing regimens (contraindicated in Hb <8g/L)
- Mitochondrial dysfunction not confirmed in an review of 16,000 infants exposed in the US nor in the PETRA study

WHO 2000

ARV - Issues (2)

IMPORTANT DRUG WARNING

Bristol-Myers Squibb Company

Fatal lactic acidosis has been reported in pregnant women who received the combination of didanosine and stavudine with other antiretroviral agents

- 3 maternal deaths (2/3 pancreatitis)

Nevirapine and PEP

- Severe hepatotoxicity in post-exposure prophylaxis
  - Not recommended for PEP
  - Outweigh risk in health health worker with risk of serious adverse event
- Safety data from > 1,000 mother/infant pairs (US, SA, Uganda)
  - No severe adverse reactions with single dose NVP

Source: MMWR Jan 2001

Nevirapine for PMTCT: resistance

- PACTG 316
  - 5/ 64 (8%) of had new/ preexisting resistance mutations in NVP arm 6 weeks post partum
- HIVNET 012
  - Women
    - 21/111 (19%) had resistance mutations in NVP arm 6-8 weeks post partum
    - Resistance mutations disappeared after 12-24 months in 11/11 specimens
  - Infants
    - 11/24 (46%) had resistance mutations
    - Resistance mutations disappeared after 12 months
  - 1/12 transmission of NVP resistance during breastfeeding

8th conference on Retroviruses and Opportunistic Infections, 2001

ARV - Issues (4)

ARV drug resistance

Not fully suppressed viral replication

- Selection for pre-existing resistant viral populations or
- Development of new mutations
- More likely to occur with drugs in which a single mutation is associated with development of drug resistance (3TC, nevirapine)
- Drug resistance mutation decreases when ARV is discontinued
- Mutant virus may persist at very low levels

WHO 2000

ARV - Issues (5)

ARV drug resistance

- What could happen?
  - Effectiveness of chronic ARV decreased
- No evidence
  - Effect on the use of same drug or class of ARV in subsequent pregnancy
  - Drug-resistant more transmissible
  - Drug-resistant virus more virulent

WHO 2000

ARV - Issues (5)

Sub-optimal antepartum regimen

Sub-optimal antepartum regimen

At least 1-2 weeks of treatment for reduction in maternal viral load required

< 2 weeks ZDV antepartum consider

- ➡ 6 weeks infant ZDV
- ➡ or 6 weeks ZDV+3TC
- ➡ or two-dose NVP

WHO 2000

Phase 4 ARV - Conclusions (1)

Short term efficacy* of ARV prophylactic regimens

- Antiretroviral prophylaxis regimens evaluated included zidovudine (ZDV) alone, ZDV+lamivudine (3TC), or nevirapine
- All regimens include an intrapartum component, with varying durations of antepartum and/or postpartum treatment
- The most complex effective regimen includes antepartum/intrapartum/postpartum ZDV, while the simplest effective regimen included single dose intrapartum/postpartum nevirapine

* Infant infection status at 6-8 weeks

WHO 2000

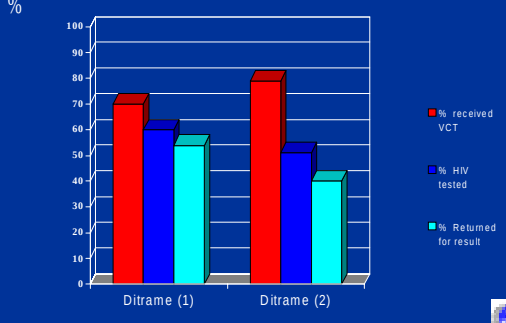
Phase 4 ARV - Conclusions (2)

Long term efficacy of ARV prophylactic regimens

- Short-course ZDV, ZDV+3TC, and nevirapine have been evaluated in breastfeeding populations.
- Long-term efficacy as measured by infant infection status through 12 to 24 months has been demonstrated for short-course ZDV and nevirapine regimens.
- Analysis of long-term efficacy of the ZDV+3TC regimens are in progress.

WHO 2000

% of HIV Tested from New ANC Women



(1) Research (2) Implementation

ARV - Conclusions & recommendations

Conclusion

Benefits of ARVs in reducing mother to child HIV transmission greatly outweigh any potential adverse effects of drug exposure and any concerns related to development of drug resistance

Recommendations

Local choice of ARV regimen should be determined by
- efficacy
- feasibility
- affordability

PMTCT should be part of the minimum standard package of care for HIV+ women

WHO 2000

Family Planning In the Context of MTCT (UNFPA)

Family Planning in the context of MTCT

The role of FP is

•To prevent unwanted pregnancy

•To delay subsequent pregnancy

•To replace contraceptive effect of BF

Male Condom

female barrier methods involve use of a spermicidal product, either alone or in conjunction with a physical barrier such as a diaphragm, cervical cap or contraceptive sponge

female condom

difficulty with use, such as problems with insertion, discomfort during sex and excess lubrication

Microbicidal products

vaginal products that would prevent STIs and be still under a woman's control

less effective than condoms on a "per use" basis in preventing HIV/STDs

women can use by themselves, if necessary without the knowledge or co-operation of their male partner

a microbicide that does not kill sperm and prevent conception would be helpful to millions of couples worldwide

Non-barrier methods of contraception

•**Sterilization**

•**Implants (Norplants)**

•**Oral contraceptive pills**

•**Injectables**

•**IUDs**

•**Others**

Primary prevention

The best means of reducing mother-to-child transmission remains primary prevention- making sure that women of childbearing age do not get infected in the first place and FP- making sure that parents have children if and when they wish.

information of FP and access to FP services.

promoting safe and responsible sexual behaviour in couples, (full information on HIV/AIDS and how to prevent infection, and ensuring the personal skills and access to condoms

Service Delivery

Health personnel need a thorough understanding of how HIV is transmitted, familiarity with universal precautions, knowledge of locally available models of care, and awareness of the importance of confidentiality.

Ideally, health providers should have a grounding in counselling and support skills, an appreciation for the wider socio-cultural issues related to HIV, and the ability to refer HIV positive people to a variety of psycho-social, welfare and care services

Integrating STI control with services provided at primary care level

Incorporating men into RH programmes

Youth interventions

Outreach Interventions

Community outreach programmes

Informing women is essential, but the real challenge is empowering women to avoid exposure to infection and supporting them to cope with AIDS

Financial dependence on men and traditional gender roles may deprive HIV positive women of the ability to make decisions about childbearing and health.

Structural problems

Socio-cultural factors that promote the spread of HIV among women

The role of men and how to enable men to change their sexual behaviour and responsibilities is seen as a priority

UNFPA's role

Strengthen support for primary prevention of HIV

Provide support to country implementation of MTCT interventions

Promote good quality counselling as part of RH care

Ensure and support effective management of logistics procurement and supplies

Improve access and quality of FP care

Strengthen advocacy, education and information dissemination

Participate in monitoring and evaluation activities

UNFPA assistance for preventing HIV infection includes

•Information, education and communication campaigns and materials to raise awareness and encourage behaviour change, including interventions specifically targeted at youth and men

•Counselling on how to prevent the sexual transmission of HIV/AIDS and other STIs, MTCT and the impact of gender roles as well as counselling related to VCT

•Provision of male and female condoms and social marketing interventions to promote condom use

•Training to upgrade the skills of RH service providers, and training for teachers, students and leaders of women's & community groups

•Research into gender issues, integrating HIV prevention within RH programmes, consequences of the epidemic, and interventions specifically for women

•Activities for youth and adolescents

•Advocacy for sexual and reproductive rights, especially for empowerment of women to protect themselves, and to promote tolerance and care for PWHA

Infant Feeding Options (UNICEF)

Infant Feeding Options

Regional Taskforce & Technical Exchange Meeting on PMCT
Bangkok 7-8 March 2001

Objectives:

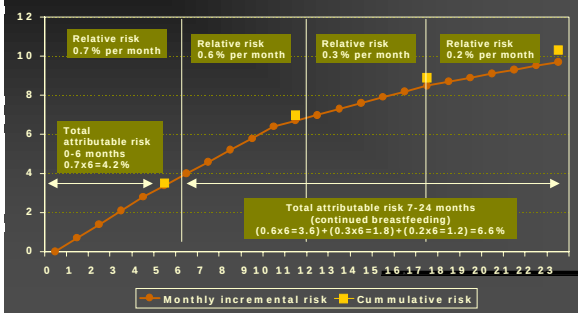
- Current knowledge
- Infant feeding options
- Pros, cons and suggestions for key options
- Context of infant feeding options
- Conclusions

HIV Transmission through Breastfeeding

- Total risk of transmission of HIV through breastfeeding if it continues after the first year is 10-20%
- Risk depends on clinical & viralogical factors
- Vary according to pattern & duration of breastfeeding
- Half of infections occur after six months if continued breastfeeding into the second year of life

HIV Transmission through BF, Malawi

Miotti et al. JAMA 1999 Vol.282 No. 8



HIV Transmission through Breastfeeding

- Exclusive breastfeeding – significantly lower risk of transmission than mixed feeding
- Exclusive breastfeeding up to three months – no excess risk over replacement feeding
- Due to protection of integrity of mucosal surfaces in gut

Avoid any mixed feeding

Infant feeding options……..

Infant Feeding Options

UNICEF, UNAIDS, WHO "HIV and Infant Feeding: A Guide for health care managers and supervisors"

- Breastmilk Substitutes
  - Commercial infant formula
  - Home prepared formula
    - Modified animal milks
    - Dried milk powder and evaporated milk
    - Unmodified cow's milk
- Modified Breastfeeding
  - Early cessation of breastfeeding
  - Expressed and heat treated breastmilk
- Other Breastmilk
  - Breastmilk banks
  - Wet nursing

HIV and Infant Feeding Guidelines UNICEF, WHO, UNAIDS

- Based on human rights approach
- Policy is to "*offer as much (infant feeding) choice as possible to women who are HIV positive, enabling them to decide what is most appropriate for their circumstances and supporting them in their choice*"
- "*no attempt to favour any one of these options over the others*"

Infant Feeding Options

ranked by risk of HIV transmission & nutritional value

- Wet nursing
- Breastmilk banks
- Commercial infant formula
- Expressed and heat treated breastmilk
- Home prepared formula
  - Modified animal milks
  - Dried milk powder and evaporated milk
  - Unmodified cow's milk
- Early cessation of breastfeeding

(exclusive breastfeeding & quick cessation)

HIV and Infant Feeding Guidelines UNICEF, WHO, UNAIDS

However at the country level,

we must adapt the package of options to the local situation, giving emphasis to most feasible, culturally-acceptable options

Undertake formative research

Formative research from Africa: infant feeding

- Breastfeeding is common. Hard not to breastfeed.
- Exclusive breastfeeding is not common
- No quick cessation
- Exclusive formula feeding is not common
- Cost of formula & inappropriate mixing

Formative research from Africa: infant feeding

- Expressing and boiling breastmilk not common
- Wet nursing not common
- Milk banks virtually unknown
- Some feeding of cow's milk, but not diluted
- Other milks not given

Formative research from Africa: HIV transmission

- People believe all babies will be infected
- Know that HIV can be transmitted through breastfeeding
- Hard to believe exclusive breastfeeding will reduce transmission
- Try to reduce amount of breastfeeding ✝ mixed feeding

Infant Feeding Options

ranked by risk of HIV transmission & nutritional value

- Wet nursing
- Breastmilk banks
- Commercial infant formula
- Expressed and heat treated breastmilk
- Home prepared formula
  - Modified animal milks
  - Dried milk powder and evaporated milk
  - Unmodified cow's milk
- Early cessation of breastfeeding

(exclusive breastfeeding & quick cessation)

Infant Feeding Options

ranked by risk of HIV transmission & nutritional value and considering feasiblity & cultural acceptablity

- Wet nursing
- Breastmilk banks
- **Commercial infant formula**
- Expressed and heat treated breastmilk
- **Home prepared formula**
  - **Modified animal milks**
  - Dried milk powder and evaporated milk
  - **Unmodified cow's milk**
- **Early cessation of breastfeeding**

(exclusive breastfeeding & quick cessation)

Real Infant Feeding Options

In effect, chose between replacement feeding, usually with formula, and modified breastfeeding

Review of the real infant feeding options

- Pros and Cons
- Recommendations for implementation

Formula Feeding: Pros

- Replacement feeding – only way to completely avoid post-natal transmission
- Nutritionally – not too bad

Formula Feeding: Cons

- Requires: female literacy/education, clean water, fuel for boiling water…… ✝ hard to do safely
- Increased risk of disease (diarrhoea, infectious diseases due to reduced immunity, malnutrition)
- Cost…….subsidization/distribution
- Exclusivity
- Stigmatization in breastfeeding cultures
- 'Keepability' in hot climates

Formula Feeding: Suggestions

- Guarantee adequate supplies
- Monitor distribution and use
- Labels in local language/pictures
- Education in preparation
- Promote hygenic practices
- Family planning
- Prevent spill-over
- Monitor impact

Modified Breastfeeding

- Relatively low risk of transmission
- More acceptable/feasible

- Exclusive
- For first few months – greatest benefit
- Prevent breast problems
- Quick cessation

Exclusive Breastfeeding: Pros

- Optimum nutrition
- Protection against disease
- Promotes bonding
- Birth spacing effect
- Free & always available

Exclusive Breastfeeding: Cons

- Some risk of transmission
- Exclusive is hard to do
- Difficulty if mother is working
- Requires strong health sector and community support
- Cost to the mother's health

Exclusive Breastfeeding: Suggestions

- High quality counselling to explain benefits
- Ensure correct positioning and attachment
- Teach expression
- Provide follow up support
- Growth monitoring
- Treat breast problems/oral thrush
- Special support for working women
- Monitor impact

Exclusive Breastfeeding: Overall suggestion

Overall, promote, support & protect exclusive breastfeeding to ALL women

- EBF in mixed feeding culture ↑ stigmatization/lack of confidence
- Must see EBF is possible
- EBF message reinforced

Quick cessation

- Abrupt stopping of breastfeeding ↑ reduce risk of transmission
- Possibility of malnutrition, psychological trauma
- Unhappy baby and engorged breasts may lead to mixed feeding
- When? Before 6 months. Maybe earlier rather than later. Not before 3 months

Quick cessation: Suggestions

- **Expressed BM fed from a cup prior to cessation**
- **Expressed and heat treated BM after introduction of other foods**
- **Finger sucking or other means of comfort**
- **Skin-to-skin contact and massage for comfort**
- **Temporary/short term separation**
- **Prevention/treatment of breast problems**
- **Support to mother**
- **Family planning services**

Adequate Infant Feeding

- BM traditionally provides substantial proportion of calories and nutrient well into the 2nd year of infant's life
- Need to ensure very good quality (nutrient dense) infant food to make up for lack of BM
- Alternative milk source also needed if possible

Adequate Complementary Feeding: Suggestions

- Distribution/subsidization of fortified commercial complementary food eg. Indonesia
- Distribution of micronutrient sprinkles/fat spread to add to home prepared CF
- Distribution/subsidization of BMS/other milk
- Growth monitoring

Counseling

- Fully explain all feasible options – reduce bias
- Counellors have strong breastfeeding knowledge
- Guide decision making ("what would you do?")
- Simplify message
- Support decision and follow up
- Involve families
- Intergrate with HIV pre & post-test counselling

Context

- Code of Marketing of Breastmilk Substitues
  - Prevent mis-use of substitutes
  - Prevent spill over
  - Not to block access to formula
- HIV and Infant Feeding Policy
  - Consistency between HIV/AIDS and nutrition & breastfeeding policies

While between 1.1-1.7 million children have been infected with HIV/AIDS through breastfeeding in the last 20 years,

WHO estimates that 1.5 million infants *die each year* because of lack of breastfeeding

and

In developing countries formula-fed infants are 4-6 times more likely to die from infectious diseases than breastfed infants

Conclusions

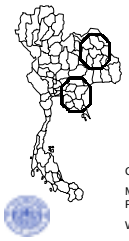
- Define the most appropriate infant feeding options
- Recognize EBF with rapid cessation and good complementary feeding as a possible option
- Ensure good counselling, follow up and monitoring

Conclusions

- Continue BF promotion to all, esp. EBF
- Strengthen infant feeding
- Link infant feeding counseling and VCCT
- Strengthen health systems and interface with the community
- Share experiences with other countries

The Evaluation of Voluntary Counselling and Testing

Voluntary Counselling and Testing in the Context of the National Prevention of Mother to Child Transmission Programme: Evaluation in Region 3 and Region 6, Thailand



Dr. Siripon Kanshana
Director, Bureau of Health Promotion
Department of Health, Ministry of Public Health, Thailand

Regional Task Force Meeting on the
Prevention of Mother to Child Transmission
7-8 March 2001, Bangkok, Thailand

Collaborators:

Ministry of Public Health (Department of Mental Health, Health Promotion Centers Region 3 and Region 6),

WHO, UNAIDS, The HIV/AIDS Collaboration (HAC)

Region 3 and Region 6

Region 3

- 7 provinces in central Thailand
- Population 3.8 million
- 2.98% HIV prevalence in ANC
- Births per year: 50-60,000

Region 6

- 7 provinces in north-eastern Thailand
- Population 7,3 million
- 1.4% HIV prevalence in ANC
- Births per year: 90,000-100,000

Adaptation of HIV counselling to the requirements of the National PMTCT Programme

- 1990 Voluntary Couselling & Testing (VCT) in STD clinics, anonymous clinics, hospitals
- 1994 VCT in ANC and counselling on formula feeding
- 1998 Counselling for zidovudine (AZT) in ANC
- 2000 Integrated curriculum for VCT, antenatal care for HIV infected pregnant women, AZT and formula feeding

Counselling curriculum for PMTCT

- Pre- & post test counselling
  + Vertical HIV transmission
  + Encourage partner for HIV testing
- ARV counselling
- Infant feeding counselling

Evaluation of the PMTCT programme Region 3 & 6

Goal

- To Improve HIV related counseling services in MCH setting

Objectives

- To evaluate
  - implementation
  - effectiveness
  - acceptability
  - quality

of HIV counselling services in antenatal care and maternal child health services in Region 3 & 6

Evaluation of the PMTCT programme Region 3 & 6

Methodology

- 3 hospitals selected randomly (1provincial,2districts) in each of 3 provinces, plus 1 regional MCH
- 3 types of data collection
  - interviews with person responsible for HIV/MCH (n=19)
  - interviews with counselor (n = 48)
  - interviews with women: - **pregnant women at ANC** (n=51)
    - HIV - ve post partum (n= 75)
    - HIV +ve post partum (n=54)

Evaluation of the PMTCT programme Region 3 & 6

***HIV Counseling and testing*: (n=19)**

Pre-test counseling
- individual 42 %
- Group 58 %

post-test counseling
- individual if negative result - 37 %
  if positive result - 84%

Evaluation of the PMTCT programme Region 3 & 6

Results (Service provision)

HIV Counseling and testing

during labour for women without ANC:

- counseling 63 %
- testing 68 %

Evaluation of the PMTCT programme Region 3 & 6 HIV testing methods

Type of test used :
- **ELISA 8**
- **GPA 16**
- **Rapid test 14**

Number of test types used :
- **1 type 2**
- **2 type 14**
- **3 type 4**

Evaluation of the PMTCT programme Region 3 & 6

Results (Service provision)

Disclosure and confidentiality

89 % disclose result only to person tested

58 % had a written policy on confidentiality

Evaluation of the PMTCT programme Region 3 & 6

Results (Service provision)

Problems and Challenges

53 % increase workload since PMTCT

58 % lack of on going training

53 % lack of supervision

36 % staff moved

Evaluation of the PMTCT programme Region 3 & 6

Results : Counselor interviews

Characteristics of Counselors :
74 % professional nurse
17 % technical nurse

	Mean	Range
Time as counseling	**30 months**	**2 m - 8 years**
Hours/day counseling	**1.8**	**1-8**
Clients/day	**5**	**1-30**

Evaluation of the PMTCT programme Region 3 & 6

Results : Counselor Interviews

Counseling Training Received :

- general HIV counseling 73 %
- HIV/MCH counseling 49 %
- PMTCT counseling 45 %

Evaluation of the PMTCT programme Region 3 & 6

Results : Counselor interviews

Support and supervision :

- had technical support 22 %
- had emotional support provided by colleagues 38 %

Feel valued:

- by colleagues 39 %
- by supervisors 23 %
- by clients 56 %

Evaluation of the PMTCT programme Region 3 & 6

Results : Client interviews

- HIV positive women learned about their HIV status during current pregnancy 91 %
- HIV negative women learned about their HIV status during current pregnancy 80 %

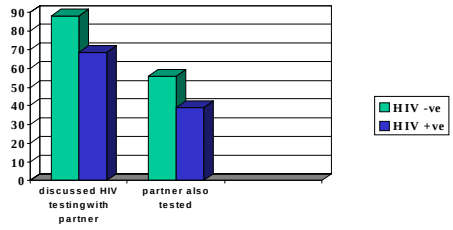
Evaluation of the PMTCT programme Region 3 & 6

Results : Client interviews

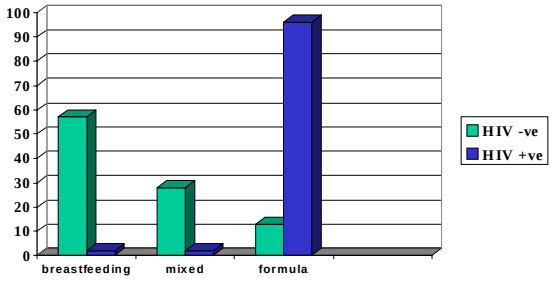
	ANC.	HIV-ve PP	HIV +ve PP
Adequate information	88 %	82 %	96 %
Adequate time	84 %	87 %	87 %
Wanted to ask more question	31 %	35 %	46 %
Not satisfied with counselor	11 %	7 %	1 %

Evaluation of the PMTCT programme
Region 3 & 6
Results : Client interviews

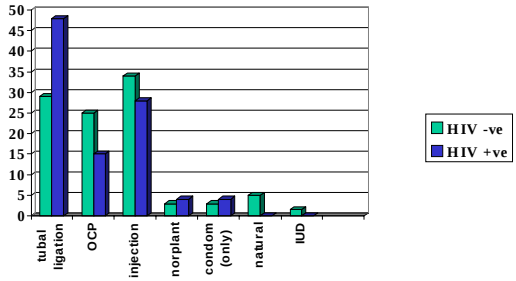
Disclosure and partner testing



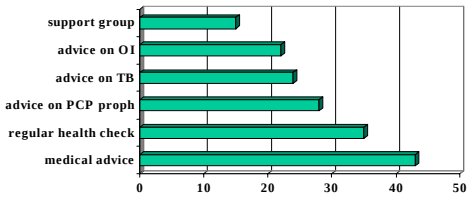
Evaluation of the PMTCT programme Region 3 & 6
Infant feeding
Results : Client interviews



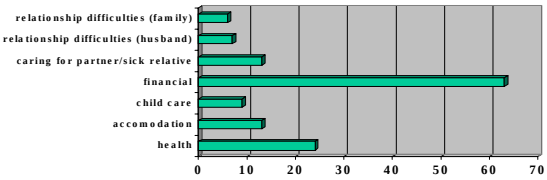
Evaluation of the PMTCT programme Region 3 & 6
Family planning
Results : Client interviews



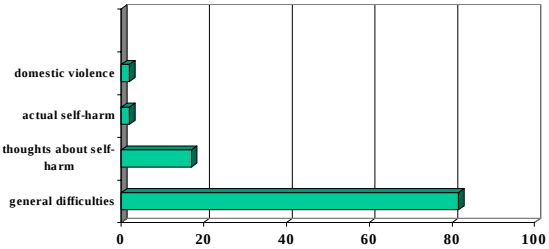
Evaluation of the PMTCT programme Region 3 & 6
Care and support services used by +ve women following VCT



Evaluation of the PMTCT programme Region 3 & 6
Problems encountered by +ve women following VCT/PMTCT intervention (%)



Evaluation of the PMTCT programme Region 3 & 6
Coping by +ve women following VCT/PMTCT intervention (%)



Evaluation of the PMTCT programme Region 3 & 6
Conclusions (1)

Service provision
- in the majority of sites
  - Individual post-test counselling
  - HIV counselling during labour for women without ANC followed by intrapartum AZT/ infant AZT
  - Disclosure of test results only to person tested
- problems
  - lack of ongoing training
  - lack of ongoing supervision

Evaluation of the PMTCT programme Region 3 & 6
Conclusions (2)

Counsellor perspective
- majority were trained in general HIV counselling
- lack of
  - MCH and PMTCT counselling training
  - support and supervision
  - feeling valued

Client perspective
- adequate time and information
- majority had discussed testing with partner
- around half of partners tested
- financial problems the biggest issue
- lack of referral to care & support

Evaluation of the PMTCT programme Region 3 & 6
Recommendations

Counselling is the core component for the successful implementation of the PMTCT programme

UN Regional Taskforce on PMCT

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