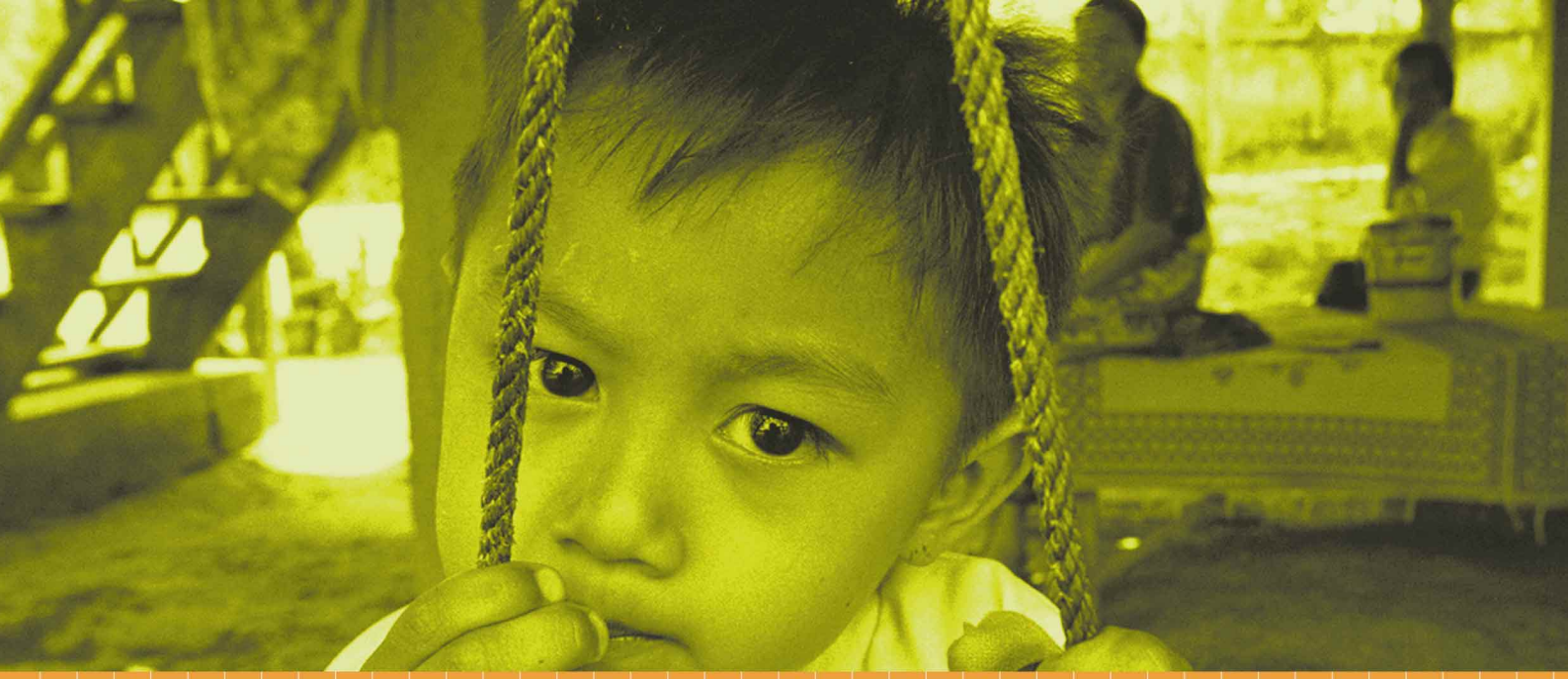

REPORT OF THE UN REGIONAL TASKFORCE ON

PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV

SOUTH, EAST ASIA AND THE PACIFIC

MAY 2004, BANGKOK, THAILAND

Convened by :
UNICEF East Asia and Pacific Regional Office (EAPRO)

Joint United Nations Programme on HIV/AIDS
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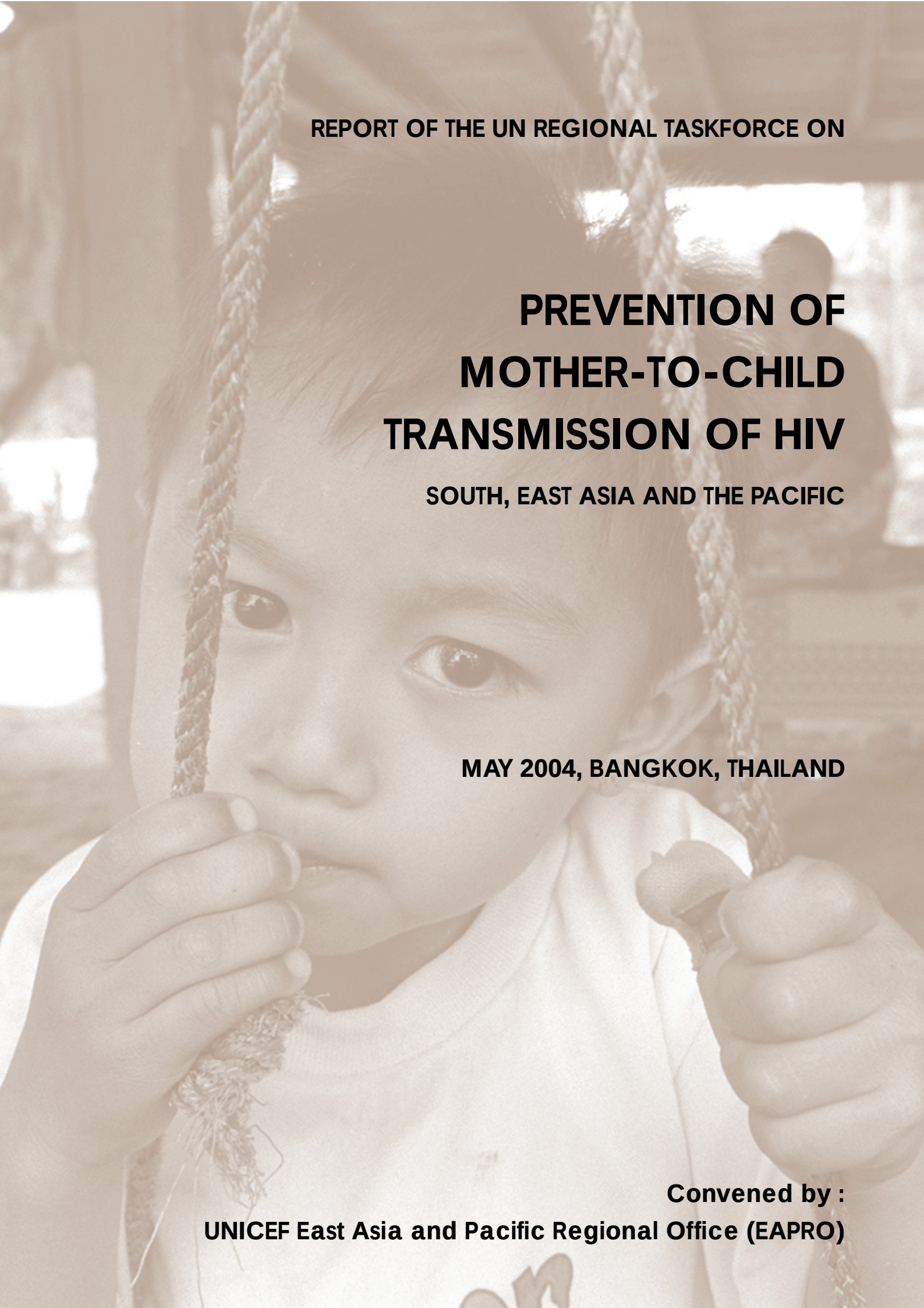

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ACKNOWLEDGEMENTS

On behalf of the Taskforce UNICEF acknowledges and expresses appreciation to WHO and CDC for their continuing support to the convening of the Taskforce. UNICEF also thanks all resource persons and country participants who have contributed to the Taskforce meeting [names listed in Annex II]

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EXECUTIVE SUMMARY

The United Nations Regional Taskforce on Prevention of Mother-to-Child Transmission of HIV met from 11-13 May 2004 in Bangkok, involving countries from East and South Asia and the Pacific.

The meeting aimed to strengthen communication and cooperation among those working on PMTCT in Asia and the Pacific through sharing country experiences and technical updates from global experts. Specific attention was also given to issues related to increasing access to antiretroviral treatment.

During the opening session it was emphasized that the response to the HIV/AIDS epidemic in the Asia-Pacific region will be a litmus test for how the epidemic will progress globally and that a continued focus on prevention is essential to stop the increase in HIV prevalence in many countries. In particular, countries with low HIV prevalence and low populations should keep their major focus on primary prevention.

During the update on HIV in the region it was shown that HIV is increasingly spreading from high-risk behaviour groups including injecting drug users and sex workers, to populations with low risk behaviour and who are in risk situations such as women whose husbands/partners engage in risky sex or injecting drug use, or the unborn children of these women. As a consequence the number of children infected with HIV is increasing. Prevalence rates among populations with high-risk behaviour; how much the epidemic has spread into the lower-risk/ risk situation populations; and occurrence of risky behaviors among certain population groups vary between and even within countries and one standard PMTCT approach for the whole region is therefore not suitable.

A mother living with HIV, also a member of the Thai Network for people living with HIV, gave a presentation on her personal experience of finding out she was infected and how to deal with her HIV status during subsequent pregnancies. The involvement of people living with HIV/AIDS during these kinds of meetings is important for participants to get exposure to the reality of the people they are planning programs for, as well as the participation of women affected.

Several presentations criticized the fact that many PMTCT programs have a narrow focus on voluntary confidential counseling and testing (VCCT) and anti-retroviral (ARV) provision. Participants were urged to support more comprehensive programs that also address primary prevention (such as through counseling all HIV-negative women on HIV prevention), assisting HIV-positive women to make an informed decision about future pregnancies, infant feeding counseling for HIV-positive and -negative women, and support and treatment for women and children affected by HIV/AIDS.

While provision of anti-retroviral therapy (ART) is receiving increasing attention, care, support and treatment for mothers and children as part of PMTCT should go beyond ART and also

include prevention and treatment of opportunistic infections, psychosocial support, nutritional support and support for orphans and other children made vulnerable by HIV/AIDS. Countries are encouraged to adapt international WHO guidelines for ARV prophylaxis and treatment based on local circumstances such as funding availability and health care capacity.

Several speakers voiced concern about treatment for children. Disease progression in children is normally faster than in adults. Treatment guidelines for children are not widely available and pediatric formulations of many of the ARVs do not exist. Participants were therefore requested to support the development of national pediatric guidelines. The Regional PMTCT Taskforce should advocate for increased availability of pediatric drug formulations.

An essential component of a comprehensive PMTCT program is community mobilization. Creating awareness on HIV/AIDS and PMTCT among the population at large will reduce fear, stigma and discrimination; support the quality of counseling of pregnant women on PMTCT, and increase uptake and demand for PMTCT services. While the importance of community mobilization has been recognized in many reports and meetings, services and coverage remain limited.

Many PMTCT programs in the region face inadequate funding. To increase funding for PMTCT programs, program managers and others working on PMTCT should be more proactive in trying to influence national HIV/AIDS project proposals to the Global Fund for HIV/AIDS, Tuberculosis and Malaria (GFATM) and other funding sources including funding for HIV/AIDS activities by their own governments.

On the future of the Regional PMTCT Taskforce it was agreed to continue the representation of the East Asia, South Asia and Pacific regions, to meet approximately three times every two years and to ensure that other UN agencies and NGOs are involved in planning and attending meetings, as well as representatives of women affected by and living with HIV/AIDS.

INTRODUCTION

The meeting of the United Nations Regional Taskforce on Prevention of Mother-to-Child Transmission of HIV was held from 11-13 May 2004 in Bangkok. It was convened by UNICEF and involved participants from the East Asia and Pacific regions, along with participants from South Asia, who were attending in a formal capacity for the first time.

A total of 40 representatives from 14 countries attended, along with 15 representatives of 11 national and supranational organizations (see Annex II). Representatives from CDC and WHO, strong supporters of the Taskforce, could not attend the meeting because of conflicting commitments.

The meeting aimed to strengthen communication and cooperation among those working on PMTCT in Asia and the Pacific through sharing country experiences and technical updates from global experts. Within the context of PMTCT programs, the broader issue of increasing access to antiretroviral treatment (including the "3 by 5" Initiative) was also highlighted, along with:

- Infant feeding
- A wider framework for care and support
- Advocacy for attention to pediatric formulations
- Counseling quality and support to counselors

The meeting agreed that the Taskforce should continue as a "joint" regional initiative, including countries from East Asia, the Pacific and South Asia. The meeting agreed that this should be formalized at the next UNAIDS Regional Theme Group Meeting.

OPENING REMARKS

"By 2007, it is quite likely we will have 40 million more people living under the poverty line as a result of HIV/AIDS, excluding the major countries of Indonesia, China and India."
- Tony Lisle

The meeting began with remarks from UNAIDS Intercountry Team Leader Tony Lisle and UNICEF Deputy Regional Director Richard Bridle, both of whom stressed that, while much has been accomplished in PMTCT across the region, much more remains to be done. They agreed that the response to the HIV/AIDS epidemic in the Asia-Pacific region will be a litmus test for how the epidemic will progress globally and that the key to reining in the explosive growth of the disease is to keep efforts and resources focused on prevention.

Other major points made by Mr. Lisle were:

- Vibrant responses to the epidemic among some countries in the region have started to wane.
- Commitment from political leaders is essential to keeping national responses strong.
- The ability of young people to receive meaningful services is absolutely critical to response; but in many cases they are unable to do so.
- Women are disproportionately affected by the HIV/AIDS epidemic.
- Only 20% of the resources needed to effectively battle the epidemic in the region have been mobilized.
- Public/private partnerships will be critical for an effective response.

Major points made by Mr. Bridle included:

- The region is facing three major threats: growing gross inequalities of wealth and resources, increasing internal conflicts and the threat of HIV/AIDS.
- The growth of the HIV/AIDS epidemic is related to inequalities and conflicts.
- The epidemic, if unchecked, will rob countries of their new-found prosperity and prevent poorer nations from achieving prosperity.
- While political commitment is still lacking, some countries have made significant progress, for instance, China has made a dramatic turnaround in public health issues largely because of SARS.
- While prevention is crucial, care must not be neglected nor efforts to reduce the stigma associated with the disease.

1. The Epidemic in Asia - Dynamics and Projections

Presented by Gregory Carl of EAPRO on behalf of Dr. Tim Brown of East West Centre/ UNAIDS/Thai Red Cross AIDS Research Centre.

"HIV growth is not inevitable... We know how to interrupt the chain of transmission in Asia."
- Dr. Tim Brown.

A study conducted by Dr. Tim Brown that mapped the progress of the HIV/AIDS epidemic in the Asia-Pacific region concluded that the numbers of those engaged in risky behaviors in different countries varies, explaining different levels and intensities of the epidemic in various countries. He expressed concerns that the high levels of HIV prevalence among high-risk groups like intravenous drug users and commercial sex workers could result in the virus spreading more widely among the general population and ultimately through mother-to-child transmission to infants. Data shown from several countries in the region already indicate that this trend has started. Despite some notable successes in stemming the growth of the epidemic, the response in Asia has flat-lined. With today's level of response, the epidemic in this region will not be contained.

Dr. Brown outlined several solutions to blunt the growth of the epidemic. Among his key points were:

- The most effective way to control generalized epidemics in Asia is to protect high-risk populations such as intravenous drug users, commercial sex workers and their clients.
- Prevention programs should be expanded and refocused to ensure the availability of condoms as well as new needles for intravenous drug users.
- Prevention programs must be carried out on a national scale.

Participants agreed that because of the varying levels and intensities of the disease in different countries, Asia was facing several HIV/AIDS epidemics, not just one. Several noted that critical data on young people and the epidemic are lacking, and that young people must be engaged in the prevention process. Care must also be available, for without hope for care, few people at risk will submit to testing. One participant added that unless the general population could be shown the benefits of funneling resources to the marginalized groups that make up the at-risk population, societies will not be willing to shoulder the cost of care and prevention programs.

2. The perspective of HIV-positive pregnant women

Presented by Khun Junsuda Suwanjundee of the NGO/CBO Network for HIV-positive women.

"When I learned I had HIV everything in my life was lost." - Junsuda Suwanjundee

In a poignant and highly personal presentation, Junsuda Suwanjundee recounted her experience of teenage intravenous drug use, learning she was HIV positive and dealing with despair and rejection by family members, friends and society. She also explained her decision to have a child despite being HIV positive and the risks, fears and joy of bringing a new life into the world. The cornerstone of her ability to cope with the disease was finding others who were in the same position, underscoring the absolutely crucial role that communities and support groups play in assisting people living with HIV/AIDS.

Among key points made by Junsuda were:

- HIV is not just a biological but also a cultural issue.
- Governments, NGOs, support groups and HIV-infected people need to work together for prevention to be successful.
- HIV-infected women want to make their own choices when it comes to having children.
- Quality pre-test and post-test counseling is vital.

All who heard Junsuda's tale agreed that it succeeded in personalizing a subject that at times can become coldly scientific. People such as Junsuda should be an integral part of Taskforce meetings and any other meetings on HIV/AIDS to bring home the human element of the work. Interpreters, if needed, should be provided on such occasions so that people living with HIV/AIDS can express their feelings and experiences with as much eloquence as possible. Junsuda's story can encourage others to learn how to live with the disease. In conclusion, Junsuda stressed the importance of family support in coping with HIV/AIDS and that it is always better for a family to stay together.

3. Primary prevention during pregnancy and post-partum

Presented by Dr. Wendy Holmes, Health Specialist, International Centre for Health, MacFarlane Burnet Institute for Medical Research and Public Health.

"The question of whether women are especially vulnerable to HIV during pregnancy has been neglected." - Dr. Wendy Holmes

Dr. Wendy Holmes' findings suggested that women may indeed be more vulnerable to infection during certain periods of pregnancy, delivery and thereafter. The reasons for this are varied, including changes to a woman's immune system during pregnancy, the quality of care a woman receives while pregnant and a tendency for husbands to pursue extra-marital sex during their wives' pregnancies. Since people infected with HIV maintain an especially

high viral load in the period following infection, pregnant women are at particular risk of infection from husbands who become infected during extra-marital sex and then return to sex within the marriage after delivery of a child. Dr. Holmes concluded that it is essential to step up levels of counseling and involve men in the counseling process to protect women from infection during pregnancy.

Other key points made by Dr. Holmes were:

- Women are more likely to receive a blood transfusion when pregnant or soon after delivery.
- Women may be more likely to receive a possibly unsafe injection during ante-natal care.
- During pregnancy there are changes in the immune system to accommodate the 'alien' fetus during gestation. Reproductive immunologists should work to increase our understanding of these complex changes.
- Community PMTCT education programs should appeal to men's sense of responsibility towards the protection of their families.

Participants agreed that increased counseling for couples both during pregnancy and after is vital for preventing HIV infections during those periods. However, many cultural roadblocks remain, including taboos on discussing sexual practices and educating and encouraging women to take control of condom use in their marriages. Responding to queries, Dr. Holmes said this complex subject could be reduced to a simple message to husbands: that if you have sex outside your marriage while your wife is pregnant or breastfeeding you risk the lives of your wife and baby. She also stressed that counseling should be available even when testing is not.

4. Revised UN ARV guidelines for PMTCT

Presented by Dr. Ngashi Ngongo, Health Advisor, HIV Care and Support, UNICEF NewYork.

"When a woman is in labor, it's not the appropriate time for counseling." - Dr. Ngashi Ngongo

In a technical presentation, Dr. Ngashi Ngongo of UNICEF New York updated and reviewed the latest United Nations guidelines for antiretroviral treatments and regimens for pregnant women to prevent mother-to-child transmission of HIV. A range of treatment options were presented and analyzed for efficacy as well as subsequent resistance to ARV therapies. A total of eight clinical scenarios were presented and discussed along with the current recommended treatments for each.

Among the key findings raised by Dr. Ngongo were:

- Up to 50% of women with HIV/AIDS can pass on infection to their babies.
- Short course zidovudine for PMTCT is not associated with short-term clinical or lab toxicities, altered disease progression or increased risk of congenital malformations.

- The major short-term toxicity in infants is anemia, usually mild and reversible after discontinuation of treatment.
- Severe neonatal anemia and neutropenia were observed with prolonged use of AZT + 3TC (more than one month).

Three treatments were analyzed for ARV resistance following a short-course PMTCT prophylaxis:

- Zidovudine: Multiple mutations required to confer resistance. Very low prevalence of resistance reported, unlikely to impact of future Zidovudine treatment options.
- 3TC: Requires only one mutation to confer resistance. This occurs in up to 20% of cases of treatment for longer one month (even when given in combination with Zidovudine) and in up to 50% of cases where treatment is given for more than two months.
- Nevirapine: Requires only one mutation to confer resistance. There is a high prevalence of Nevirapine resistance, even when used in combination with Zidovudine, and this risk increases with multiple dosing (SA with single dose 39% and 67% with double dose).

Participants noted that the guidelines are now more in line with those used in industrialized countries. They also raised concerns that the nevirapine resistance is too high to warrant its use as part of ART. It should be realized that any guidelines issued by WHO are always conservative guidelines based on scientific empirical evidence. It will not issue guidelines if the evidence is not available or convincing. Several people related experiences where they had used different treatment regimens and claimed to have better success. It was agreed that it is up to countries to develop their national protocol based on, but not necessarily copying, WHO guidelines.

5. Consultation on new UK Government HIV/AIDS strategy

Presented by Elizabeth Smith, Health and Population Adviser, Department for International Development.

"What role should the government Her Majesty's Government should play in the global fight against HIV/AIDS?" - Elizabeth Smith

Smith stressed that the proposals she was putting forward were an opportunity for those in the field to give feedback. They have yet to be adopted as policy. She stressed, however, that Prime Minister Tony Blair and his government are deeply committed to supporting the global effort to combat the spread of HIV/AIDS as the disease is a major threat to development.

Some of the components of the strategy outlined by Ms. Smith were:

- Focusing on the poor
- Scaling-up evidence-based interventions

- Building effective national responses
- Improving the efficiency and effectiveness of the international response
- Investing in long-term solutions

6. Introduction to HIV-NAT and Update of PMCT clinical trials

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

"How do we see that people still get treatment when trials are done?" - Dr. Chris Duncombe

Dr. Chris Duncombe explained the role and activities of HIV-NAT, the latest World Health Organization guidelines along with which combinations of anti-retrovirals are most effective for infants and adults and when to administer them. He also updated participants on ongoing and upcoming PMTCT trials and the new WHO guidelines on the use of ARVs in PMTCT. The various trials highlighted by Dr. Duncombe all concluded that the more potent the ARV regimen the lower the transmission rate from mother to child.

Other points made by Dr. Duncombe included:

- Concerns remain about drug safety, the safety of early weaning and drug resistance.
- SIMBA study results on the use of ARVs during the breastfeeding period are encouraging but there are still many questions.
- Single-dose nevirapine programs should continue and be expanded, but at the same time programs should also plan to introduce other ARV regimens.
- Recognize that single-dose nevirapine is the simplest regimen to deliver.
- The new WHO guidelines on the use of ARVs for PMTCT in resource-poor settings will be available soon. National PMTCT teams are encouraged to familiarize themselves with these guidelines (for more details see the Power-Point presentation in Annex IV)

A major issue raised by those who attended Dr. Duncombe's presentation was what ethical standards should be used in trials involving countries of different levels of development and wealth. Dr. Duncombe agreed that ethics was a significant and complex issue. He explained that in local studies in Thailand international standards according to the Helsinki Convention were employed. The WHO guidelines are just guidelines. Ultimately, what regimens a country follows depends upon what is feasible and affordable for that country.

7. Results of study, PHPT-2 and the links between PMTCT and PMTCT Plus

Presented by Dr. Gonzague Jourdain, MD, Harvard School of Public Health.

"High viral load is a risk factor for the selection of resistance mutations." - Dr. Gonzague Jourdain.

The results of a recent study conducted by PHPT, an international consortium of

researchers from France, the United States and Thailand, regarding the efficacy of Zidovudine (ZDV) and Nevirapine (NVP) was presented by Dr. Gonzague Jourdain of Harvard University. The study asked, among other questions, whether a single dose of Nevirapine will compromise the response to a subsequent NNRTI-based regimen. One of the main conclusions of the research was that where or when Highly Active Antiretroviral Treatment (HAART) during pregnancy is not feasible or desirable, Zidovudine and Nevirapine is the only regimen which matches the efficacy of HAART during pregnancy to prevent vertical transmission. Some of the important points made by Dr. Jourdain were:

- Maternal and infant zidovudine (28 weeks' gestation) combined with intrapartum Nevirapine decreases the risk of HIV perinatal transmission to levels comparable to HAART during pregnancy (in settings where, in addition, elective C-Section is commonly used to prevent transmission).
- Six months after initiation of therapy, median CD4 increase was similar among previous nevirapine exposed and unexposed women.
- However women who initiated a regimen containing Nevirapine in the postpartum period were less likely to achieve virological suppression (<50 copies/ml) at six months of treatment if they had previously been exposed to a single dose of Nevirapine.
- Highly Active Antiretroviral Treatment (HAART) and prevention of opportunistic infections, particularly PCP, should be proposed wherever possible if pregnant women are immuno-compromised (CD4 count below 250-200 cells/mm3).

Attendees asked whether the regimens most commonly used in their countries, which differed from the regimen advocated by Dr. Jourdain, are as efficacious. Dr. Jourdain replied that he believed they weren't. Nonetheless, he stressed that the structure for providing care was more important than the specific regimen. The goal is to give the best regimen available and to be flexible in what is prescribed because all women are not alike.

8. Impact of '3 x 5' for parent-to-child transmission prevention and care

Presented by Dr. Wendy Holmes, Health Specialist, Centre for International Health, Macfarlane Burnet Institute for Medical Research and Public Health, Melbourne, Australia.

"Women are the ones most vulnerable and affected by the impact of the stigma of AIDS."
- Dr. Wendy Holmes

With the World Health Organization's goal of providing 3 million people living with HIV/AIDS in developing countries with antiretroviral treatments by 2005 just around the corner, Dr. Wendy Holmes reviewed the progress made towards achieving that target, what remains to be done and what the program means for PMTCT. The need to reduce stigma and the role poorly-trained health care workers play in increasing stigma was highlighted. Dr. Holmes urged caution in rapidly implementing programs still being designed because of potential, unseen side effects. She also urged that cynicism be guarded against because the goals of "3 x 5" are unlikely to be met by the program's deadline.

Dr. Holmes made several important points, including:

- Health care staff and counselors need training and guidelines to help them to respond to questions and to manage HIV-positive women that become pregnant.
- There are hazards associated with introducing new, not well-tested programs without sufficient preparation.
- "3 by 5" may divert resources and attention from efforts to prevent women becoming infected during pregnancy and post-partum.
- "3 by 5" may divert resources and staff from mother and child health/reproductive health services that help to reduce the risk of MTCT when we don't know which mothers are infected.
- We need to harness the energy generated by the "3 by 5" initiative.
- We shouldn't pretend that countries can expand access without increasing their health care budget.
- Resist too hasty introduction and expansion of hospital or clinic-based PMTCT - prepare carefully.

While agreeing with Dr. Holmes' call for caution, most participants also expressed the absolute need to take action now on HIV, whether or not meeting a certain program's particular goals is realistic or not. They believed the goals were useful in presenting a challenge to scale up and accelerate national programs. "It's a matter of human rights," said one. "We have to do something today."

9. Component four of the UN PMTCT strategy - care, support and treatment of women, children and their families

Presented by Dr. Ngashi Ngongo, Health Advisor on HIV Care and Support for UNICEF New York and Arjan de Wagt, Regional Project Officer - PMCT Plus, UNICEF EAPRO.

"Services are not all provided at one level. We need to see that people with HIV get access to interventions wherever they are." - Dr. Ngashi Ngongo

In a dual presentation, Dr. Ngashi Ngongo and Arjan de Wagt focused on the goals and current difficulties of programs aimed at women, children and their families. Their major message was that care and support for people living with HIV/AIDS should go beyond the provision of treatment. Psychosocial care, health care and nutrition support are as important. Dr. Ngongo concentrated on the link between PMTCT programs with overall HIV strategies, and de Wagt raised issues of nutrition for those taking ARVs. Dr. Ngongo concluded that most PMTCT programs are not linked to care and support strategies and that to be effective they need to be. De Wagt showed that malnutrition and disease are locked in a vicious cycle, and that he was particularly concerned about the effects of ARVs on people who are already malnourished.

Other points stressed by Dr. Ngongo were:

- It is not sufficient to focus only on PMTCT.
- It is not sufficient to focus on ART as the only component of care and support for people living with HIV/AIDS.
- Service delivery has to be available at the household, community and health facility levels.
- Care must be provided in a continuum.
- HIV-infected women and children born to HIV-infected women have particular health care needs.
- PMTCT programmes can serve as an entry point to care for HIV-infected women and their children, and a rallying point for enhanced prevention and care.

Key issues included in Mr. de Wagt's presentation were:

- Certain micronutrients such as selenium given at four or five times the daily recommended allowances seem to have a positive effect.
- At last stages of the disease, nutritional interventions can actually make the person more comfortable.
- Practically nothing is known about the impact of ARV use in nutrition - compromised populations and on the impact of ARVs on micronutrient status.
- No WHO recommendations are available yet on micronutrient supplementation and therefore recommendations for micronutrient supplements for people living with HIV/AIDS are the same as those who are not HIV infected.
- Limited scientific evidence (e.g. very few placebo controlled trials) results in difficulties making evidence-based recommendations.

Participants raised a number of questions regarding the tendency for patients to demand ART treatment as soon as they know they are HIV positive, even though their CD4 counts are still low. Dr. Ngongo and de Wagt stressed that the toxicity associated with ARVs can have harmful effects upon patients and so ART must be prescribed later in the development of the disease. This needs to be clearly explained to patients. Other patients don't want to take the medicines because they fear the side effects. Mr. de Wagt responded that any decision on when to initiate treatment requires a balance between the risk of opportunistic infection and the side effects of the drugs. Proper information must be provided. The discussion concluded with a consensus that more resources were needed to train health care workers to deal with these dilemmas.

10. The PMTCT-Plus Initiative and global support

Presented by Dr. Katherine Bond, Associate Director of Health Equity for the Rockefeller Foundation.

"We have to take [programs] from hospitals to the farms." - Dr. Katherine Bond.

Dr. Katherine Bond used the Taskforce meeting to unveil to those in attendance the PMTCT-Plus Initiative, a more integrated approach to dealing with HIV/AIDS prevention, care and treatment. The program focuses on resource-limited settings and provides long-term HIV primary care services for women diagnosed with HIV in the context of perinatal prevention programs, their HIV-infected infants and children, and family/household members. The program is designed to be comprehensive and consists of antiretroviral therapy; family-centered care; attention to clinical, psychosocial, and environmental issues; and an emphasis on involvement of people with HIV and outreach to community resources.

Among the conclusions gained from the program, Dr. Bond cited:

- Multidisciplinary care works.
- Family-focused care works.
- Loss to follow-up is negligible (so far).
- ARV adherence is excellent (so far).
- Health care systems are strengthened, health care workers are enthusiastic.
- Stigma and discrimination are powerful barriers to care and treatment.

While praising the program, some Taskforce members questioned whether other health care services might suffer because of the increased emphasis and funding of PMTCT-Plus because in resource-poor environments overworked doctors and health care workers may choose to treat the diseases for which they have the most funds. Questions were also raised about control and sustainability of programs funded by overseas organizations. The concerns were legitimate, Dr. Bond responded, and the program's efficacy would be proven in its implementation. Lastly, it was agreed that the role of religious leaders in promoting awareness and reducing stigma would be of great value.

11. Voluntary counseling and testing (VCT) specific to the needs of pregnant women - WHO standardized modules for VCT

Presented by Dr. Prawate Tantipiwatanaskul MD, Bureau of Mental Health Technical Development, Department of Mental Health, Ministry of Public Health, Thailand.

"In some countries there are less than ten, in some only one psychiatrist for the whole country." - Dr. Prawate Tantipiwatanaskul

Thailand has long been a leader in the fight against HIV/AIDS and Dr. Prawate used the occasion of the Taskforce meeting to outline his country's program for Voluntary Counseling and Testing as it relates to PMTCT. Dr. Prawate discussed the origins of the program, its implementation, what has been learned and how other nations, particularly those without a highly-developed health and mental health infrastructure, might learn from the Thai experience.

Key points raised by Dr. Prawate included:

- There is an increased demand for VCT.
- It is necessary to highlight the issues specific to the objectives and epidemiology of local areas.
- It is imperative to include strategies for reducing disclosure related violence.

Meeting participants asked how the program was progressing and wondered how effective it would be in settings where seeking or receiving mental health counseling stigmatizes the individual. Dr. Prawate responded that if community leaders can be brought on board then the reaction to mental health care changes and stigma is reduced. This has already happened, he said, in northern Thailand. Well-trained and quality counselors, however, are essential. Counselors should have a willingness to help, be good communicators and be generally liked by patients.

12. PMTCT and PMTCT Plus - experiences from Thailand

Presented by Dr. Praphan Phanupak, Thai Red Cross AIDS Research Centre.

"You have to be committed. The country has to be committed. The process of commitment is probably more important, because while the regimen is important, it keeps changing." - Dr. Praphan Phanupak

Thailand first established a limited PMTCT campaign in 1996 and it went national in 1999. Dr. Praphan explained how Thailand implemented its programs, what it has learned and where it is going. To date, more than 5,500 women have received Zidovudine and the program is being extended into PMTCT-Plus. Its slogan is Treat the Parents, Prevent the Orphans and among its aims are to enable women to inform their husbands and to get them tested and treated; to get public acceptance that HIV patients need ART, it works and is cost-effective; and to prepare more hospitals for ARV use.

Other observations made by Dr. Praphan included:

- A vital element missing from the program is the restoration of the psychosocial status of the infected individuals and their affected families.
- Poverty should not be a barrier or used as an excuse to do placebo-controlled trials.
- Maximal viral suppression or HAART should be ideal in preventing vertical transmission and resistance.
- Patients should not be forced to have therapeutic abortions.

Admirable though Thailand's program is, participants still wondered if adherence is a problem, as it has proven to be in other countries. Dr. Praphan responded that indeed it is, but Thai doctors and nurses are constantly talking to the patients to try and keep them in the program and coming for treatment. That kind of effort requires a lot of money and personnel, and so the UN should be making a bigger investment. Even poor countries can progress, Dr. Praphan

said, by lobbying rich people and corporations to contribute. Even if only one child could be included in the program, he said, that's one child saved.

13. Issues of pediatric treatment

Presented by Dr. Jintanat Ananworanich, Pediatrician, Clinical Trials Coordinator, HIV-NAT.

"All children said they knew already they had HIV and no one told them. And that's a very bad thing, not to be ale to trust the caregiver." - Dr. Jintanat Ananworanich

In treating children for HIV/AIDS Thai pediatricians have observed that the disease progresses more rapidly in children, and that they have a higher viral load but better immune recovery in response to HAART. If getting adults to adhere to therapy is difficult, Dr. Jintanat said it's even harder for children to cope with taking a large number of pills on a daily basis, so it is incumbent upon caregivers to give positive reinforcement and come up with the best treatments requiring the fewest number of pills taken the least amount of times. Despite advances in treating the disease, poor attitudes and knowledge among health care workers and non-acceptance by society are still the most difficult things facing children infected with HIV/AIDS in Thailand, Dr. Jintanat said.

Other developments noted by Dr. Jintanat included:

- When it comes to telling children they have HIV, parents and caregivers are not well prepared and often lie.
- Pediatricians have had very little experience with HIV-positive children surviving into teen years. As more do survive, they are not sure what to do as far as treatment is concerned.
- Starting ARV is not always urgent, but opportunistic infections prophylaxis is.

Participants commented that treating HIV-infected children is a new challenge for most countries. Some wondered why few countries have guidelines for various opportunistic infections prophylaxes and why no drugs had been developed specifically for children with HIV. One asked if any Thai children had died from drug toxicity. None have to date. Responding to a question, Dr. Jintanat said the program's policy was to tell children if they have HIV, even though that may disclose the mother's status in the process. While the revelation can be emotional and involve a lot of crying, most said afterwards they were happier that they knew.

14. Infant feeding and HIV - technical and program update

Presented by Mr. Arjan de Wagt, UNICEF EAPRO Regional Project Officer - PMTCT Plus.

"There is no way we're going to reach our PMTCT goals if we don't address the issue of HIV transmission through breastfeeding." - Mr. Arjan de Wagt

Breastfeeding saves lives. When it comes to PMTCT, that's the conclusion reached by Mr. Arjan

de Wagt in his presentation on infant feeding and HIV. One of the reasons for this is that not all mothers receiving formula have enough time or resources for proper preparation, such as sterilizing utensils or access to clean water, resulting in increased disease and mortality. A study by Ruth Nduati in 2001 showed that breastfeeding increases the risk of mortality among HIV-infected mothers, however study results including a recently published study from Tanzania show that these findings are not confirmed and that breastfeeding does not have an increased mortality risk for HIV-infected mothers.

Other points made by Mr. de Wagt included:

- Formula feeding can be done in poor countries, but some children will die because they have been formula fed. Therefore it is necessary to compare the risk of formula feeding with that of HIV transmission.
- Total risk reduction is not possible.
- Studies show that exclusive breastfeeding reduces risk of transmission compared to mixed feeding.
- If you promote exclusive breast feeding in the general population then all children benefit, not just HIV positive children.
- It is possible to promote exclusive breastfeeding on a large scale.

Stigma as an issue also came up in the discussion on breastfeeding, with one participant asking if mothers who formula feed their children would be stigmatized. The possibility is there, de Wagt noted, and so more needs to be done as far as counseling is concerned. Most agreed that hygiene and sanitation should be recognized components of HIV interventions. But the primary conclusion is that there is no one solution. The final decision is the mother's after understanding what it requires to breastfeed or formula feed. The most important thing is that these women need support from health care workers and the community.

Bangladesh

Presented by Dr. Ivonne Camaroni, Project Officer, HIV/AIDS, UNICEF Dhaka.

Bangladesh has an estimated 13,000 cases of HIV/AIDS with 300 children infected, but updated estimates are expected at the end of this year. Furthermore, increased funding from the World Bank and the GFATM indicates increasing commitment from the international community to help Bangladesh combat the disease despite the country's limited resources.

Among other points made by Dr. Camaroni were:

- A low percentage of women attend antenatal care sessions.
- The challenge is how to reach pregnant women in vulnerable groups, such as sex workers and intravenous drug users.
- Reaching pregnant migrant workers is also a major challenge.
- There are only two VCCT centers in Dhaka and almost none in the rest of the country.
- The country's health infrastructure is still undeveloped.
- A UNICEF consultant carried out a feasibility study in December 2003 to guide the country towards what PMTCT it can reasonably expect to undertake in the near future.
- Working guidelines are being developed for PMTCT and antenatal care programs scheduled to be launched next year.

Cambodia

Dr. Koum Kanal, Director of the Ministry of Health and Chairperson of the PMTCT Working Group delivered Cambodia's country presentation.

Dr. Kanal related the following developments:

- HIV remains a serious national concern with 3% of adult males and 2% of females currently living with the virus.
- Between the first appearance of the virus and 2002, the latest year for which statistics are available, 259,000 people were infected and 94,000 died.
- At the current level of intervention, 20,000 people will die of AIDS each year, meaning major care needs will continue throughout the next decade.
- By 2005, 12 operational districts among 68 functioning ones will have at least one facility offering a full package of PMTCT services.
- PMTCT services will be scaled up to 25 operational districts by 2007.

Cambodia has had enormous success in getting husbands to participate in PMTCT counseling and several participants asked what strategies had been used to achieve this. Dr. Kanal said

that radio and television advertisements played a significant role, but also providing men with the choice of being counseled together with their wives or having the option of seeing a different counselor made a difference. Cambodia is also fortunate, he said, in that there are few cultural barriers among men as far as talking about these issues.

China

The presentation on China was delivered by Dr. Linhong Wang, Deputy Director of the National Centre for Women and Children's Health, China Centre for Disease Control.

Key points made by Dr. Wang included:

- In 2003, China recorded 840,000 cases of people living with HIV/AIDS and 84,000 cases of full-blown AIDS.
- Intravenous drug use accounts for the highest percentage of infections (61.6%) while transmission from mother to child accounts for the lowest (0.3%).
- HIV/AIDS prevalence in China is increasing dramatically
- There is a lack of effective strategies on prevention and control
- The proportion of females living with HIV/AIDS is increasing.
- Traditional culture and discrimination affect the likelihood that a person will seek medical services.
- Some of the constraints faced by China include poor awareness among local government and target populations, low coverage of PMTCT (low antenatal care and hospital delivery rates), a lack of high-quality counseling and the weakness of information systems.
- Goals for 2004-5 include scaling up PMTCT activity to 127 sites as part of the National Project of Comprehensive AIDS Response and improving social awareness on PMTCT through community mobilization, information and education capacity building.

India

The report was presented by Dr. Ranjit Singh Virk, MD Advisor HIV/AIDS, and Consultant PPTCT, Epidemiologist and Specialist in Public Health & Nutrition.

Important points made by Dr. Ranjit were:

- Eleven percent of the world's HIV-infected population is in India.
- Less than 50% of women aged 15-49 have heard of HIV/AIDS.
- India is ready to scale up PMTCT to a national program.
- Components of a scaled-up Indian program include primary prevention of HIV infection in young women through information/education, family planning to prevent unwanted pregnancies, voluntary counseling and testing, ARV prophylaxis and counseling on infant feeding for informed choice.

- Some of the challenges India faces in scaling up are maintaining quality, completing the 'PMTCT package', addressing discrimination and stigma, reaching out to all women, addressing infant feeding issues and integrating with the RCH program.

Responding to queries, Dr. Ranjit noted that 55% of Indian women breastfeed their babies and that rapid testing for HIV has been implemented for more than a year. He added that only 26% of men attend counseling sessions, as many are daily wage earners and can't leave work.

Indonesia

Presented by Ida Bagus Putu Widiarsa, Ministry of Health, and Husein Habsyi, Vice President of Yayasan Pelita Ilmu.

The presenters made the following points:

- With a population of 214 million spread across 13,000 islands, very little hard data about HIV/AIDS is available in Indonesia.
- There were 2,746 cases of HIV and 1,413 AIDS cases as of March 2004.
- However, there are an estimated 90,000 to 130,000 people living with HIV/AIDS in Indonesia.
- As far as transmission is concerned, 55% of HIV/AIDS cases were transmitted by sexual contact in 2003, while 30% were transmitted by intravenous drug use.
- From 1999 through 2001, more than 600 women attended HIV/AIDS and safe-motherhood education courses, 574 attended pre-test counseling and 558 voluntary tested for HIV.
- Inadequate data on the magnitude of MTCT continues to undermine the design of appropriate interventions to effectively address this program area.

Malaysia

Presented by Dr. Mahanim Md Yusof, MD, Ministry of Public Health and Dr. Rohani Ismail, MD, Ministry of Public Health.

Since 1998, 1,425,918 mothers attending antenatal clinics have been screened for HIV/AIDS with 450 testing positive. A total of 419 babies were tested with 17 showing up positive.

Strategies outlined for Malaysia's PMTCT program by Dr. Yusof and Dr. Ismail included:

- Early detection of HIV through screening using rapid test kits for antenatal mothers.
- Provision of counseling to infected mothers and partners.
- Institution of ARV to infected mothers and their babies.
- Early detection of HIV infection among babies born to HIV-infected mothers.
- Contact tracing of partners of HIV-infected mothers.

Myanmar

Myanmar's presentation was delivered by Dr. May Hla Nwe, Assistant Director of the AIDS/STD program of the Department of Health.

With limited resources, Myanmar is working hard to deal with HIV/AIDS. As of March 2003, there were 45,968 people who had tested HIV positive and 6,727 reported AIDS cases. Nonetheless, there were an estimated 177,279 HIV-positive people in Myanmar as of March 2002. To date, PMTCT is only available in a limited number of townships in the country.

Other points raised by Dr. May Hla Nwe included:

- In 2004, services will be expanded to an additional 10 townships with UNFPA support from an existing total of 32 townships as part of a community-based PMTCT program.
- In 2003, institutional-based PMTCT started in five townships with support from WHO and there are plans to expand to Yangon and Mandalay Division in 2004 with UNICEF support.
- There are plans to expand to a total of 57 townships with FHAM (Fund for HIV/AIDS in Myanmar) funding during 2004-2006.
- Constraints faced by Myanmar include high acceptance for VCCT but low acceptance for testing, problems with reaching pregnant women among mobile populations and that fact that about 70% of Myanmar's citizens live in rural areas.

Nepal

Presented by Dr. Sushila Shrestha, Senior Gynaecologist, Ministry of Health.

Due to security problems and the difficulty of obtaining accurate data, the Kingdom of Nepal has so far produced only policy and operational guidelines to launch a PMTCT program in the country. It is hoped that with the results obtained from a situation assessment planned during the year, a well-defined program will become operational. There is very close working collaboration between WHO and UNICEF in the country. Opportunities that exist in the country include:

- Increase in service outlets.
- Partnership.
- Availability of funds.
- Support groups.
- Interest groups.

Among the needs cited were:

- Experts to work with nationals.
- Equipment/drugs and reagents.
- IEC materials.

- Trained counselors.
- Service providers.

Papua New Guinea

The country report for Papua New Guinea was delivered by Joseph Kwaru Anang, HIV/AIDS Consultant, UNICEF Papua New Guinea.

There are about 170,000 births per year in Papua New Guinea, and the rate of antenatal coverage has reached 50%. It has been estimated that there are anywhere from 5,000 to 22,000 cases of HIV infection in Papua New Guinea, but the country has no formal death notification system so reliable data are almost non-existent. Heterosexual transmission accounts for most cases followed by perinatal transmission.

Other points included in Mr. Anang's presentation were:

- Thirty to forty babies in Port Moresby General Hospital die each year from HIV/AIDS.
- Only three hospitals are currently implementing PMTCT.
- Four regional hospitals and 22 minor hospitals and health centers will initiate PMTCT by the end of 2004.
- UNICEF is the only funding agent for PMTCT.
- Sixty patients will be on ARV by the end of 2004, and this will be scaled up to cover 3,000 patients by 2005.
- All pregnant women testing positive to HIV and meeting other criteria will receive ART under the '3 by 5' initiative.

Sri Lanka

Presented by Dr. Sarathchandra Wijemanne, Consultant Obstetrician & Gynaecologist, Family Health Bureau.

Sri Lanka is a low prevalence country. Nonetheless, it understands the need to set up programs to combat the disease before an epidemic emerges. To that end, in March 2003 it set up a National Working Group on PMTCT.

The proposed interventions the working group is recommending in pilot project areas include:

- Strengthening of maternal and child health services.
- Intensifying advocacy and awareness on HIV/AIDS.
- Training of health care workers.
- Providing VCT.
- Using of ARV drugs for PMTCT.
- Maternal STI screening and treatment.
- Improved Obstetric Care.

Thailand

Presented by Dr. Boonsang Boonamnuaykij, The 12th Health Promotion Center, Yala Province, Department of Health, Ministry of Public Health.

Thailand's campaign against HIV/AIDS has long been held up as a model for how developing nations can successfully tackle the spread of this deadly disease. Nonetheless, there is a constant need for vigilance. When it comes to PMTCT the magnitude of the problem is still great. There are 900,000 women who give birth annually in Thailand, and 13,000 children born at risk for HIV each year. Without intervention, 4,000 of these will contract HIV. This is despite the fact that Thailand's program has scaled up to national level.

To improve Thailand's approach to PMTCT, Dr. Boonsang made the following recommendations:

- Enhance HIV prevention in antenatal and postpartum settings for HIV-negative women/partners.
- Improve care of HIV-positive women and children.
- Meet the needs of orphans.
- Support research on better interventions.
- Share experiences with and learn from other countries.

GROUP WORK

To foster closer cooperation and exchange of ideas and to identify recommendation to assist scaling up PMTCT interventions, meeting participants were divided into three groups and given three aspects of PMTCT to work on as mini-Task Forces. Group 1 tackled the community component of PMTCT, Group 2 addressed the issue of quality counseling and Group 3 looked at strategies for low prevalence countries. Their recommendations were as follows:

Group 1
Strengthening the Community Component of PMTCT

- Use an integrated approach to community engagement.
- Identify resources/structures within the community.
- Create an enabling environment through involvement of political/community leaders.
- Increase access to appropriate information.
- Empower/build the capacity of communities.

Group 2
Quality Counseling

- Training needs to be continuous.
- Continued networking is important.

- A standard curriculum for training is required.
- Clear counseling guidelines need to be in place.
- Training should include counseling of illiterate mothers.
- Job security for trainers is needed.

Group 3

Strategies for Low-prevalence Countries

- Focus on primary and secondary prevention.
- Strengthen and integrate existing health systems – at all levels.
- Reduce discrimination and stigma – especially among health care workers.
- Lobby political leaders to understand that they can take action on PMTCT that is not (only) ARV related.

FUTURE OF THE REGIONAL PMTCT TASK FORCE

In a final discussion moderated by Mr. Ian Macleod, participants discussed what the meeting had accomplished and what they would like to see on the agenda for future meetings, as well as how the role of the Taskforce should evolve in the foreseeable future. They noted that at present the Taskforce involves countries from two regions – South Asia and East Asia and the Pacific – and countries at varying levels of PMTCT program development. There is also currently little involvement of other UN agencies and key NGO partners. The field is also rapidly evolving on technical levels.

Little agreement was reached on how to maintain communications and share knowledge and experiences between Taskforce meetings. Some favored a website, others an e-mail forum, yet some said existing mechanisms were sufficient and doctors and health care workers were already extremely busy and had little time to devote to new information systems. Most agreed, however, that the Taskforce should engage with other regional PMTCT networks and link up with the Asia Pacific AIDS Conference.

Proposals put forward at the conclusion of the meeting were:

- Maintain the Taskforce as a two-region network.
- Break into two sub-networks: (a) countries with established PMTCT programs that are being scaled up are scheduled to be scaled up; and (b) countries with new or developing PMTCT programs. While some sessions could be held jointly for both groups (such as technical updates), other sessions (particularly those designed to share experience or examine program planning) could be in held in separate groups.
- Meet approximately three times per two years.
- Ensure WHO, UNAIDS and key NGO participation.
- Meetings should be a balance of expert technical updates; detailed program interventions/guided discussions on one or two issues (with country presentations focusing on these); and a study tour/site visit.
- Ensure key advocacy statements and plans emerge from the network.

SUMMARY

A number of recurrent issues and themes were raised by participants during presentations and discussion sessions. They all centered on the need to do more. Among the areas that require further action were:

- **Services for Low-prevalence Countries –** One issue that was discussed at several points during the meeting was what PMTCT services to provide in low HIV prevalence countries. There seemed to be consensus that while in many countries in the region the numbers of children living with HIV is increasing, this does not necessarily mean that all countries should start setting up full-scale PMTCT services. In particular, countries with a low prevalence might want to focus their human and financial resources on primary prevention (including primary prevention and support on reproductive health to HIV-positive women) instead of the provision of VCCT and ARV services in all health facilities. The setting up of regional facilities providing these full PMTCT services, or targeting the provision of these services in areas with high-risk groups, could be more cost-effective interventions. What package of services is provided will not only depend on the HIV prevalence in the countries, but also on the human and financial resources that can be mobilized.

- **Scaling Up Programs to National Levels –** Programs need to be urgently scaled up to national levels and planning for scaled-up interventions should be discussed even at the onset of short-term pilot interventions.

- **Reducing Stigma and Discrimination –** More efforts need to be made to reduce stigma and discrimination, whether this directed against breastfeeding, testing, counseling or those living with HIV/AIDS. This will require more intensive community mobilization efforts and involvement of male partners. Counseling of HIV positive women should cover how to deal with stigma and the fear of stigma. While reduction of stigma and discrimination have been mentioned for years as major obstacles for providing PMTCT services, so far PMTCT programs have still not adequately addressed this issue.

- **Quality Counseling –** While in the past the emphasis was on making counseling and testing services available, experience shows that more attention must be paid to the quality of counseling and not just availability. Adequate and appropriate training, counseling aids, job security and other incentives for counselors are required.

- **Primary Prevention and Support on Reproductive Health for HIV-Positive Women –** With increasing attention to ART, Prong Four of PMTCT (care, support and treatment) is also getting increasing attention. However, in particular, primary prevention and support on reproductive health to HIV-positive women are still inadequately included in PMTCT programs. More must be done to reach young people and make links between primary prevention and existing PMTCT interventions

- **Pediatric Formulations of ART –** An increasing number of countries are planning or have

already started to roll out provision of anti- retroviral therapy for people living with HIV/AIDS. There is a risk that the initiatives will not adequately target highly vulnerable population groups like children. Members of the PMTCT Taskforce are encouraged to advocate at country and regional level for the production of pediatric formulations of ARVs as at the moment these are often not available.

- **Comprehensive Care, Support and Treatment Initiatives –** Where ARV treatment is provided this should be part of a comprehensive package of care for all women and children infected/affected by HIV/AIDS. Such initiatives should also be linked to program initiatives for orphans and vulnerable children, which will require additional partnerships with governments, NGOs and CBOs.

- **Political Commitment and Leadership –** While there seems to be an increasing political commitment in the region towards dealing with HIV/AIDS, including the issue of PMTCT, further strengthening of the political commitment and leadership from national and religious leaders is required.

- **Funding and Resources –** More funds and resources must be mobilized if the epidemic is to be contained. PMTCT country teams should ensure that PMTCT is adequately included in national HIV/AIDS project proposals for GFATM and other funding.

ANNEX I : AGENDA

UN Regional Taskforce on Prevention of Mother to Child Transmission
Bangkok, 11-13 May 2004

DAY ONE (11 May, Tuesday) - Progress on PMCT	
08:30 - 09:00	Registration
09:00 - 09:30	Welcome and opening of the meeting, Richard Bridle UNICEF Deputy Regional Director, and Tony Lisle, Team Leader, UNAIDS Intercountry Team
09:30 - 09:40	Self-introduction by participants
09:40 - 09:50	Review meeting agenda & logistics, Robert Bennoun & Arjan de Wagt
09:50 - 10:00	Group photograph
10:00 - 10:30	**Morning break**
10:30- 11:20	**Chair : Ian Macleod** **The epidemic in Asia – dynamics and projections** Gregory Carl, EAPRO [presenting on behalf of Dr. Tim Brown, East West Centre/UNAIDS/Thai Red Cross AIDS Research Centre (30 minutes presentation, 20 minutes Q&A and discussion) **Objective : update**
11:20 - 12:00	**Perspective of HIV+ pregnant women,** Khun Junsuda Suwanjundee, NGO/CBO Network for HIV+ women 20 minutes presentation, 20 minutes Q&A and discussion) **Objective : Sharing experiences of key people affected**
12:00 - 13:30	**Lunch**
13:30 - 14:20	**Chair: Prof. Dr. Praphan Phanuphak** **Primary prevention during pregnancy and post-partum** - Dr. Wendy Holmes, Health Specialist, International Centre for Health, Burnet Institute. (20 minutes presentation followed by 30 minutes discussion) **Objective : Strengthen integration of prong 1 and 2 into PMTCT programs. Identify programmatic approaches for better linkages between primary prevention and PMTCT programs**

continue : Day One

14:20 - 15:10	**Revised UN ARV guidelines for PMCT** – Dr. Ngashi Ngongo, Health Advisor, HIV Care and Support, UNICEF New York (25 minutes presentation followed by 25 minutes discussion) **Objective : Technical update**
15:10 - 15:40	**Afternoon break**
	Chair : Rachel Odede **Country presentations:** "Update on implementation – changes since 2003 Taskforce presentation, scale / coverage, role of different funding sources – i.e. GFATM, impact / activities by 3 x 5 Initiative, sources of / action by key technical assistance – national, UN and other" **Objective : Assessment of country experiences, program successes and challenges in establishing and planning for scaling up interventions and required support needs (technical and financial)**
15:40 - 16:30	**Countries with established PMCT programmes** (Panel presentation - 3 x 10 minutes presentation followed by 20 minutes Q&A and discussion) - Sri Lanka - Malaysia - Myanmar Q&A and discussion
16:30 - 17:00	**Countries establishing PMTCT activities (summary oral comment – "where we are and where we want to be in 12 months"; "what are the major challenges to achieving this?" "what – if any – support is needed?"** 3 x 3 minutes followed by 20 minutes Q&A and discussion) - Nepal - Lao PDR - Viet Nam
17:00 - 17:30	**DFID draft HIV/AIDS strategy** – Elizabeth Smith (15 minutes presentation followed by 15 minutes Q&A and discussion) **Objective : Update on new strategy from key donor**
17:30 - 17:45	Synthesis of Day 1 - end of Day 1 - Rapporteur
17:45 - 18:15	Coordination meeting [Robert Bennoun, Ian Macleod, Arjan de Wagt, Ngashi Ngongo, Wassana]

DAY TWO (12 May, Wednesday) - Issues & challenges	
	Chair: Dr. Koum Kanal
08:30 - 09:10	**Introduction to HIV-NAT & Update of PMCT clinical trials,** Dr. Chris Duncombe, HIV-NAT (20 minutes presentation followed by 20 minutes discussion) **Objective : Update**
09:10- 10:00	**Countries moving to national scale PMCT programmes** (3 x 10 minutes presentation followed by 20 minutes Q&A and discussion) - Thailand - China - India Q&A and discussion **Objective : Assessment of country experiences, program successes and challenges in scaling up interventions and required support needs (technical and financial)**
10:00 - 10:40	**Results of study, PHPT-2, and the links between PMTCT and PMTCT+** including issues related to Nevirapine resistance and further antiretroviral treatments - Dr. Gonzague Jourdain (20 minutes presentation followed by 20 minutes Q&A and discussion) **Objective : Technical update**
10:40- 11:00	**Morning break**
	Chair : Dr. Scott Bamber
11:00 - 11:40	**Continued : countries with established PMCT programmes** (Panel presentation – 2 x 10 minutes presentation followed by 20 minutes Q&A and discussion) - Cambodia - Papua New Guinea Q&A and discussion
11:40 - 12:30	**Implications of "3 by 5" for parent to child transmission prevention and care** – Dr. Wendy Holmes, Health Specialist, International Centre for Health, Burnet Institute. (25 minutes presentation followed by 25 minutes discussion) **Objective : Identifying opportunities and roles of partners and UNICEF in integration of 3 by 5 into PMTCT**
12:30 - 14:00	**Lunch**

continue : Day Two

	Chair: Dr. Wendy Holmes
14:00 - 15:15	**Component 4 of the UN PMTCT strategy - care, support and treatment of women,** children and their families - Dr. Ngashi Ngongo & Arjan de Wagt (40 minutes presentation followed by 35 minutes discussion) **Objective : Update and identification of strategic actions with regards to ART and other care and support activities for people living with HIV/AIDS**
15:15 - 15:30	**Global support to PMCT – Dr. Kate Bond, Rockefeller Foundation** **Objective : Summary update of support to PMTCT Plus**
15:30 - 16:00	**Afternoon break**
	Chair: Dr. Sarathchandra Wijemanne
16:00 - 16:45	**VCCT specific to the needs of pregnant women / women of reproductive age** – WHO standardized modules for VCCT - Dr. Prawate Tantipwantanaskul, Bureau of Mental Health Technical Development, MoPH (25 minutes followed by 20 minutes discussion) **Objective : Technical and programmatic update**
16:45 - 17:00	Synthesis of Day 2- end of Day 2
17:00 - 17:30	Coordination meeting [Robert Bennoun, Ian Macleod, Arjan de Wagt, Ngashi Ngongo, Wassana]

DAY THREE (13 May, Thursday) - PMTCT Plus, Pediatric Care, Scaling Up	
	Chair: Dr. Ivonne Camaroni
08:30 - 09:15	**PMCT Plus - experiences from Thailand** – Thai Red Cross AIDS Research Centre, Dr. Praphan Phanupak, (25 minutes followed by 20 minutes discussion) **Objective : Sharing experiences**
09:15 - 09:35	**Countries establishing PMTCT activities (summary oral comment – "where we are and where we want to be in 12 months"; "what are the major challenges to achieving this?" "what – if any – support is needed?"** 2 x 3 minutes followed by 10 minutes Q&A and discussion) - Indonesia - Bangladesh
09:35 - 10:30	**Pediatric treatment** - Dr. Jintanat Ananworanich, Pediatrician, Clinical Trials Co-ordinator, HIV-NAT (25 minutes presentation followed by 30 minutes Q&A and discussion) **Objective : Identifying opportunities for ensuring adequate attention for pediatric treatment in 3 by 5 and other treatment initiatives.**
10:30 - 11:00	**Morning break**
	Chair: Dr. Ngashi Ngongo
11:00 - 12:15	**Infant Feeding** Arjan de Wagt (30 minutes presentation followed by 30 minutes discussion) **Objective : Technical and programmatic update on opportunities for strengthening prevention of MTCT through breastfeeding**
12:15 - 12:30	Discussion and preparation for Group Work
12:30 - 14:00	**Lunch**
	Chair: Dr. Scott Bamber
14:00 - 15:30	**Group Work** [1] Key action to get effective participation of women affected into PMCT Plus planning and programming [2] Key actions to effectively improve pediatric treatment **Objectives : Identify key country level interventions for the integration of ART and other care into PMTCT**

continue : Day Three

15:30 - 16:00 Afternoon break	
	Chair: Mr. Arjan de Wagt
16:00 - 16:30	Group summary reporting & discussion
16:30 - 17:00	Synthesis of meeting, key agreements, next meeting Closure of meeting

ANNEX II : LIST OF PARTICIPANTS

UN Regional Taskforce on Prevention of Mother-to-Child Transmission of HIV
11 - 13 May 2004 - Bangkok, Thailand

Country Team	Name of participants	Agency/Organizations
Bangladesh	1. Dr. Ivonne Camaroni	Project Officer, HIV and AIDS, UNICEF Dhaka
	2. Dr. Ruhul Amin	Professor of Paediatrics, Dhaka Shishu Hospital
Cambodia	3. Dr. Kazuhiro Kakimoto	Chief Advisor, JICA Maternal and Child Health Project in Cambodia
	4. Dr. Etienne Poirot	Project Officer - HIV/AIDS, UNICEF Phnom Penh
	5. Prof. Koum Kanal M.D.	Director, National Maternal and Child Health Center
	6. Ms. Elizabeth Smith	Health and Population Adviser, Department for International Development (DFID)
China	7. Dr. Koenraad Vanormelingen	Chief, Health & Nutrition, UNICEF Beijing
	8. Ms. Wang Linhong	Deputy Director, National Centre for Women and Children's Health, China CDC
	9. Wang Kerang	Program Officer, Ministry of Helath
India	10. Dr. Ranjit Singh Virk	Advisor HIV/AIDS Training and Consultant PPTCT & Senior Specialist in Public Health and Nutrition, National AIDS Council Organization
	11. Dr. Bir Singh	Project Officer, Prevention of Parent to Child Transmission of HIV, UNICEF India
Indonesia	12. Husein Habsyi	Vice President, Yayasan Pelita Ilmu
	13. Ms. Rachel Odede	Project Officer - HIV/AIDS, UNICEF Indonesia
	14. Ida Bagus Putu Widiarsa	Responsible for Obstretics & Gynaecologic Care in "Sulianti Saroso" including ANC & PMTCT, Ministry of Health
Japan	15. Dr. Yumi Mukoyama	Medical Officer, Bureau of International Cooperation, International Medical Center of Japan, Ministry of Health, Labor & Welfare
Lao PDR	16. Dr. Sivixay Thammalangsy	PMCT Focal Point, Medical Administrative Manager, MCH Hospital, Ministry of Health
Malaysia	17. Dr. Mahanim Md Yusof	AIDS Officer, Pejabat Pengarah Kesihatan Negeri
	18. Dr. Rohani Hj Ismail	AIDS Officer, Jabatan Kesihatan Negeri Kedah

Country Team	Name of participants	Agency/Organizations
Myanmar	19. Dr. Aye Aye Mon	Project Officer, UNICEF Yangon
	20. Dr. May Hla Nwe	Assistant Director, AIDS/STD, the NAP, DOH
	21. Dr. Aung Sein	Medical Officer, AIDS/STD, the NAP
ROSA	22. Mr. Ian MaCleod	Regional HIV/AIDS Adviser, UNICEF Regional Office for South Asia (ROSA)
Nepal	23. Dr. Sushila Shrestha	Senior Gynaecologist, Ministry of Health
	24. Dr. Debendra Karki	National Operations Officer, World Health Organization
	25. Ms. Agatha Pratt	Chief of Health Programme, UNICEF Nepal
Papua New Guinea	26. Mr. Joseph Kwaru Anang	HIV/AIDS Consultant, UNICEF Papua New Guinea
Sri Lanka	27. Dr. Sudarshina Fernandopulle	Programme Officer, Child Health, Ministry of Health
	28. Dr. Sarath Nihal	Medical Officer in charge of STD/HIV/AIDS Control Programme, Southern Province, Ministry of Public Health
	29. Dr. Aberra Bekele	Head of Early Childhood Programme, UNICEF Colombo
Thailand	30. Ms. Junsuda Suwanjundee	Founder and chairperson of Power of Life Organization Bangkok Thailand
	31. Ms. Wonthong Rattanasongkram	Power of Life Organization
	32. Ms. Sumalee Jodsam	Power of Life Organization
	33. Dr. Scott Bamber Project	Officer - HIV/AIDS, UNICEF Office for Thailand
	34. Ms. Jarunee Jaturapornperm	Technical Officer, Health Promotion Centre, Region 4 - Ratchaburi
	35. Dr. Gonzague Jourdain	Technical Expert, Perinatal, HIV Prevention Trial
	36. Ms. Patchara Rumakom	HIV/AIDS Program Specialist, USAID Regional Development Mission/Asia
	37. Dr. Boonsang Boonumnuaykij	Paediatrician, Health Promotion Centre, Region 12 - Yala
	38. Dr. Katherine Bond Associate	Director, Health Equity, The Rockefeller Foundation
	39. Ms. Somsong Teerapakulpisarn	Nurse Coordinator, PMCT Plus Project, Thai Red Cross AIDS Research Centre
Viet Nam	40. Dr. Pham Bich Ha	Project Officer PMTCT, UNICEF Hanoi
	41. Ms. Duong Lan Dung	Obstetrician, Central Hospital of Obstetrics & Gynaecology
	42. Prof. Tran Thi Phuong Mai	Deputy Director, Department of Reproductive Health & Director of PMTCT Project, Ministry of Health

Country Team	Name of participants	Agency/Organizations
Resource Team		
EAPRO	43. Mr. Robert Bennoun	Regional Adviser - HIV/AIDS, UNICEF EAPRO
	44. Mr. Arjan De Wagt	Regional Project Officer - PMCT Plus, UNICEF EAPRO
	45. Mr. Gregory Carl	Regional Project Officer - Behaviour Development & change/Lifeskills, UNICEF EAPRO
	46. Ms. Wanda Krekel	Regional Adviser, Supply Division, UNICEF EAPRO
	47. Ms. Phongpan Vannakit	Consultant, UNICEF EAPRO
UNAIDS SEAPICT	48. Mr. Tony Lisle	Team Leader, UNAIDS South East Asia and Pacific Intercountry Team
Macfarlane Burnet	49. Dr. Wendy Holmes	Deputy Director, Macfarlane Burnet Institute for Medical Research and Public Health
UNICEF New York	50. Dr. Ngashi Ngongo	Health Advisor, HIV Care and Support, UNICEF New York
TRC	51. Prof. Dr. Praphan Phanupak	Director, Thai Red Cross AIDS Research Centre
Ministry of Public Health	52. Dr. Prawate Tantipiwattanaskul	Director, Department of Mental Health,
HIV-NAT	53. Dr. Chris Duncombe	Senior Trial Physician/Clinical Trials Co-ordinator HIV Netherlands Australia Thailand Research, Collaboration
	54. Dr. Jintanat Ananworanich	Pediatrician, Clinical Trials Co-ordinator, HIV Netherlands Australia Thailand Research, Collaboration
Rapporteur	55. Mr. Robert Horn	Consultant, UNICEF EAPRO
Secretariat	56. Ms. Wassana Kulpisitthicharoen	Project Assistant, UNICEF EAPRO

ANNEX III : TERMS OF REFERENCE

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

Objectives:

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

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

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

   (a) Situation Assessment

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

   (b) Technical Support

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

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

(c) Coordination and Communication

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

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

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

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

(f) Resource Mobilization

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

(g) External Relations

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

i) Documentation and dissemination of MCT operational researches, cost-effective and feasibility studies as well as best practices;
ii) Advocate policy changes to reduce MCT. This includes analysis of social-economic impact of existing policies, alternate policies to cushion the effects, and what changes are needed at policy level;
iii) Draw on resources of the UN system, regional offices and committees of various co-sponsors, to solicit political and institutional support for MCT interventions.

Membership:

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

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

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

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

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

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

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

Organization:

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

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

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

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

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

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

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

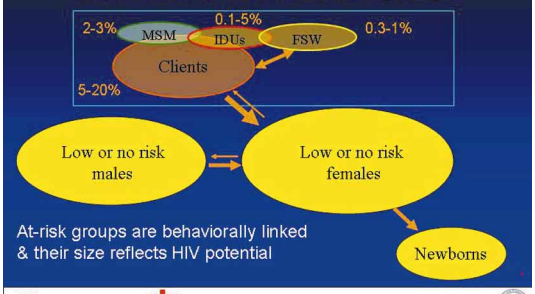
1. The Epidemic in Asia - Dynamics and Projects - Gregory Carl

The Epidemic in Asia – Dynamics and Projections

Compilation of presentations by Dr. Tim Brown
East West Centre / UNAIDS / Thai Red Cross AIDS Research Centre

Asian epidemic dynamics – What do Asian epidemics look like?

Early infections are strongly focused in behaviorally linked at-risk groups



At-risk groups are behaviorally linked & their size reflects HIV potential

But if they all basically look like this, why do they differ so much in severity and rate of growth?

Explaining the differences 1

- HIV is a "behaviorally transmitted" disease, and….
- The level and intensity of HIV risk behaviors vary around the region

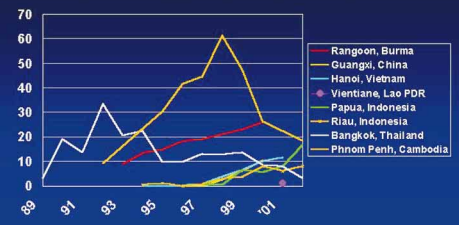
The number at risk varies…

Percent adult male clients in various Asian countries

Country	% clients	Number	Year
Thailand	22% / 10%	4 / 1.8 million	1990/1997
Cambodia	13%	0.5 million	2000
Japan	11%	3.2 million	1999
China	9%	34.0 million	2000
Philippines	7%	1.6 million	2000
Hong Kong/ Singapore	5%	0.1 million	Early 1990s

5 to 20% of adult males visit sex workers

…and this seems to relate to how quickly an epidemic takes off



Source: US Bureau of the Census HIV Surveillance Database and national surveillance systems

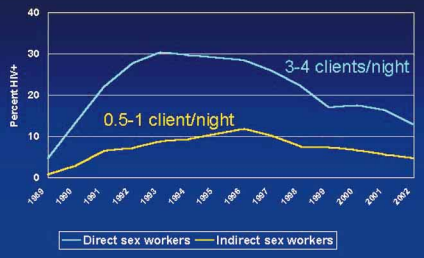
The frequency of risk varies…

Clients per week in different locations and types of sex work

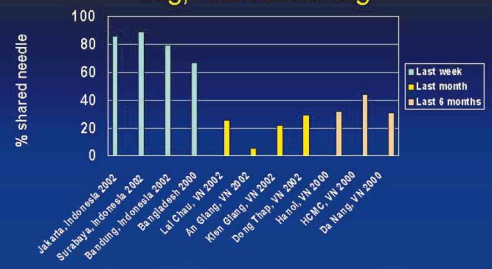
Sources: Pisani et al 2001, Rogers et al 2002, Bangladesh BSS, Boonchalaksi & Guest 1994

And frequency of risk relates to HIV

Comparative HIV in direct & indirect Thai sex workers



And other behaviors vary, e.g, needle sharing

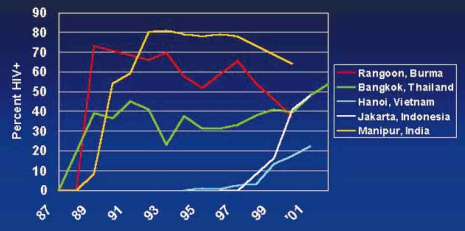


Sources: Tuan et al 2002, Bangladesh, Indonesia and Vietnam BSS

Explaining the differences 2

- Epidemics grow at different rates and to different levels in different sub-groups
  - Some transmission modes are more efficient
  - The contribution of different sub-populations varies from place to place

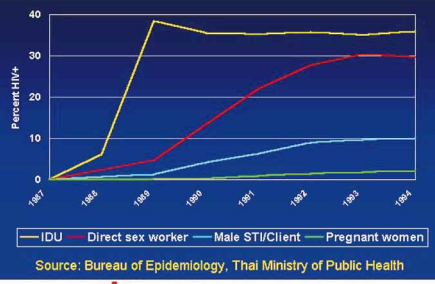
HIV in IDUs takes off fast to hi levels…



Source: US Bureau of the Census HIV Surveillance Database and national surveillance systems

And other groups follow after…

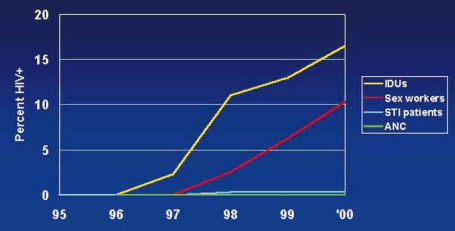
"Waves" in the early Thai epidemic



Source: Bureau of Epidemiology, Thai Ministry of Public Health

…and this pattern is seen repeatedly

IDUs come up first, followed by other groups



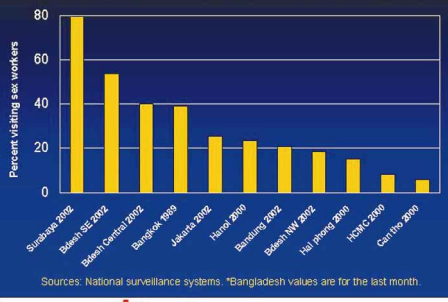
Source: US Bureau of the Census HIV Surveillance Database

Explaining the differences 3

- The links between the different sub-epidemics vary in strength around the region

IDUs visit sex workers…

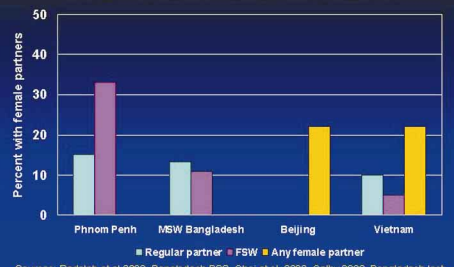
Percent of injectors visiting sex workers in last year*



Sources: National surveillance systems. *Bangladesh values are for the last month.

MSM also have sex with women…

Percent of MSM reporting female partners



Sources: Rodolph et al 2002, Bangladesh BSS, Choi et al, 2002, Colby 2003. Bangladesh last month, Cambodia last 6 months, Beijing and Vietnam last year

EAST-WEST CENTER

…and furthermore

- Some sex workers inject drugs
- Some male sex workers visit female sex workers
- Many high risk men and women have lower risk partners

EAST-WEST CENTER

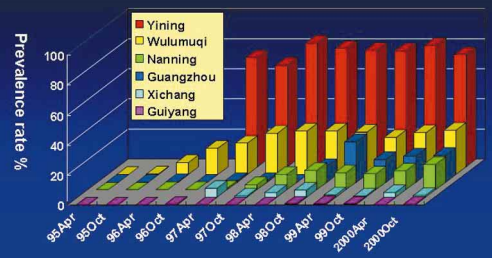
Explaining the differences 4

- Epidemics don't take off until HIV is introduced….
- And HIV is introduced at different times, even within the same country

EAST-WEST CENTER

HIV "introductions" at different times

HIV among IDUs in different Chinese provinces



Source: Zheng Xiwen MAP Meeting Melbourne 2002

EAST-WEST CENTER

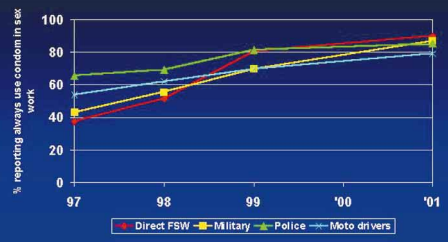
Explaining the differences 5

- Behaviors are changing in the region

EAST-WEST CENTER

In some places condom use climbs…

Consistent condom use in Cambodia over time



Source: Cambodian Behavioral Surveillance System

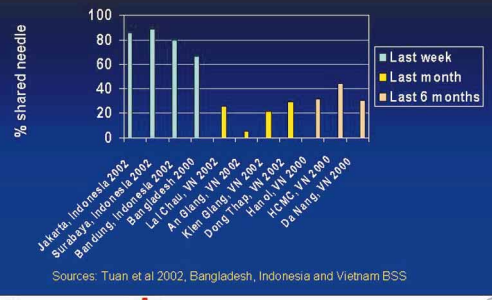
EAST-WEST CENTER

But in others it remains low…

Consistent condom use in various populations

EAST-WEST CENTER

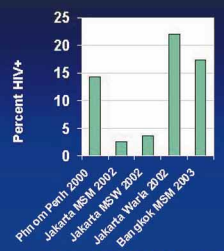
Needle sharing remains high…



Sources: Tuan et al 2002, Bangladesh, Indonesia and Vietnam BSS

EAST-WEST CENTER

And programs for MSM are almost non-existent despite high HIV



And risk remains high:

- HCMC 60% no condom at last anal sex
- Bangkok 21% no condom with last casual partner
- Jakarta 53% unprotected anal sex last month
- Phnom Penh 67% in last month had not used condom with a non-regular partner
- Bangladesh 96.5% no condom at last anal sex with non-paying partner

Sources: van Griensven et al 2003, Pisani et al 2004, Girault et al 2002, Colby et al. 2003, Bangladesh BSS

EAST-WEST CENTER

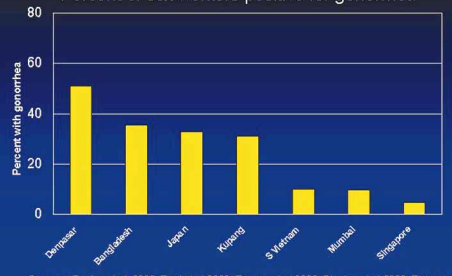
Explaining the differences 6

- Other biological factors vary
  - Circumcision in the male population
  - STIs vary around the region and we know this can increase HIV transmission

EAST-WEST CENTER

STIs occur at various levels…

Percent of sex workers positive for gonorrhea



Sources: Davies et al. 2003, Ford et al 2002, Tsunoe et al 2000, Divekar et al 2000, Thuy et al 1999, Goh and Chan 1995, Rahman et al 2000

EAST-WEST CENTER

Clearly all Asian epidemics are NOT alike

- Substantial diversity from country to country
  - Level of risk & rate of growth
  - Relative contribution of different at-risk pops
  - Linkages among the sub-epidemics
  - Time of HIV entry into at-risk pops
  - Evolution of risks over time and effectiveness of responses
  - Other biological factors (STI and circumcision)
- Country-specific assessments needed, but current knowledge is limited

EAST-WEST CENTER

However, Epi evidence shows many lower risk Asian countries are today entering the faster growth period…

…and in most places the IDU epidemics that may seed sex work epidemics are well underway

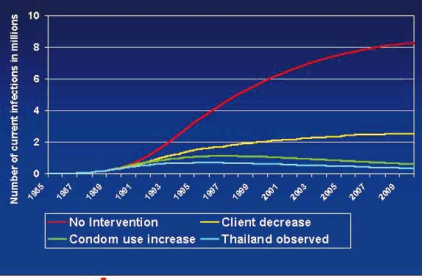
EAST-WEST CENTER

But HIV growth is not inevitable…

We know how to interrupt the chain of transmission in Asia…

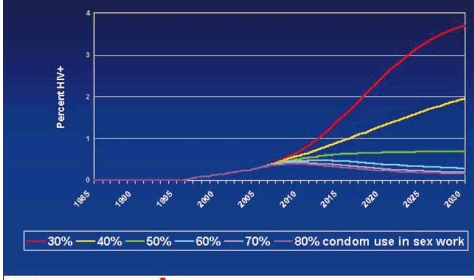
EAST-WEST CENTER

Thailand shows that the course of Asian epidemics can be changed



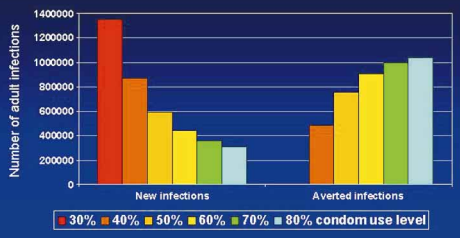
EAST-WEST CENTER

Impact of increasing condom use 40%, 50%, 60%, 70% and 80% starting in 2005



EAST-WEST CENTER

Impact of increasing condom use in infections averted by 2015



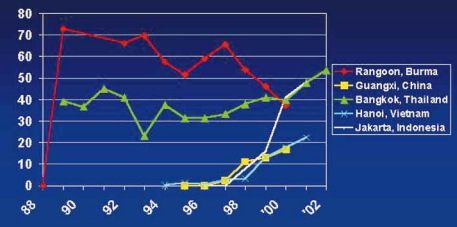
EAST-WEST CENTER

But, despite these notable successes, the response to HIV in Asia today is flatlined….

the epidemic is alive and well…

EAST-WEST CENTER

HIV among IDUs remains high and new IDU epidemics are emerging…

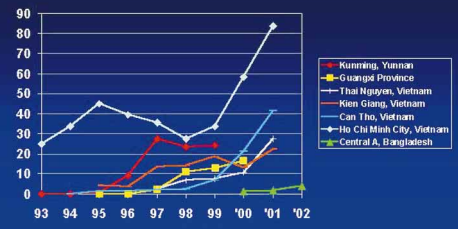


Source: US Bureau of the Census HIV Surveillance Database and Indonesia national surveillance

EAST-WEST CENTER

…emerging around the region

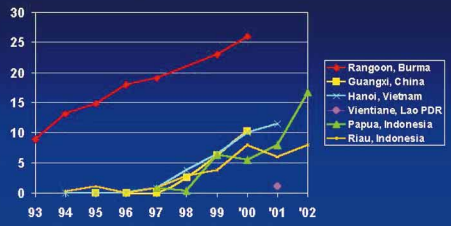
New IDU epidemics in many places



Source: US Bureau of the Census HIV Surveillance Database

EAST-WEST CENTER

Outside of Thailand and Cambodia HIV among sex workers increases…

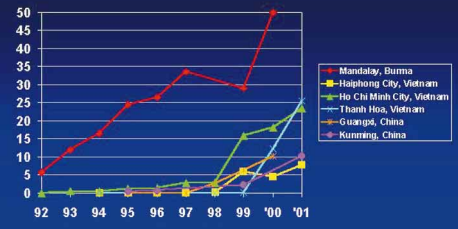


Source: US Bureau of the Census HIV Surveillance Database

EAST-WEST CENTER

And not in just a few places…

Continuing HIV increases among sex workers



Source: US Bureau of the Census HIV Surveillance Database

EAST-WEST CENTER

And with so many clients in Asia…

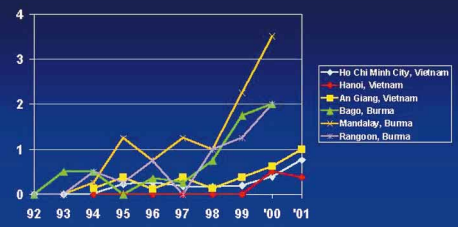
Country	% clients	Number	Year
Thailand	22% / 10%	4 / 1.8 million	1990/1997
Cambodia	13%	0.5 million	2000
Japan	11%	3.2 million	1999
China	9%	34.0 million	2000
Philippines	7%	1.6 million	2000
Hong Kong/ Singapore	5%	0.1 million	Early 1990s

5 to 20% of adult males visit sex workers

EAST-WEST CENTER

…ultimately HIV finds wives & children

Growing ANC prevalence around the region

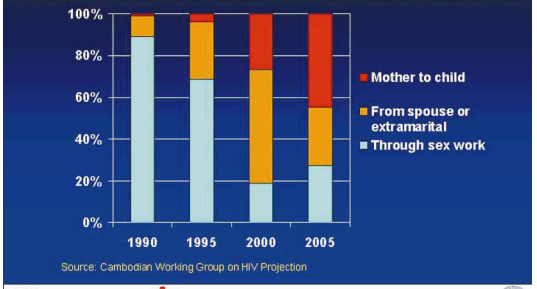


Source: US Bureau of the Census HIV Surveillance Database

EAST-WEST CENTER

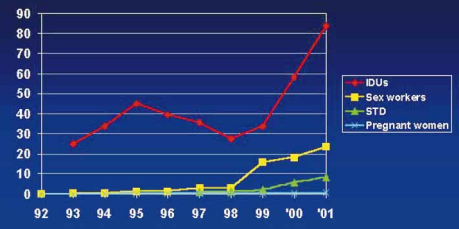
Infections in at-risk groups eventually reach lower risk women and children…

Percent of new infections in Cambodia through different routes



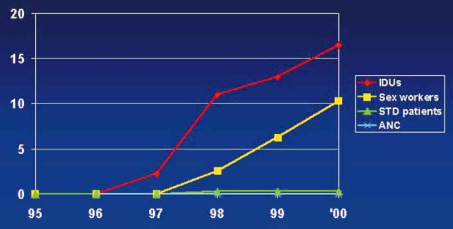
Source: Cambodian Working Group on HIV Projection

We see this chain around the region in the data from Ho Chi Minh City…



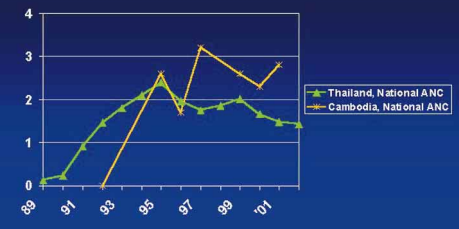
Source: US Bureau of the Census HIV Surveillance Database

…and we see it in Guangxi, China…



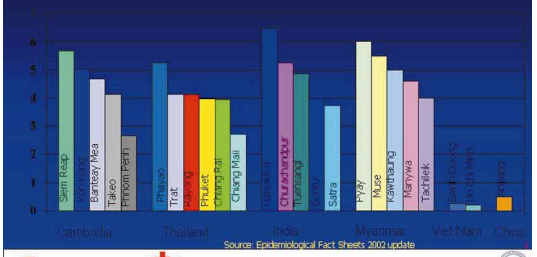
Source: US Bureau of the Census HIV Surveillance Database

Even in Thailand & Cambodia, wives & children are still being infected…



Source: US Bureau of the Census HIV Surveillance Database

National seroprevalence obscures localized epidemics (line showing national; 2 or 3 bars to show local hot spots: Prevalence among ANC)



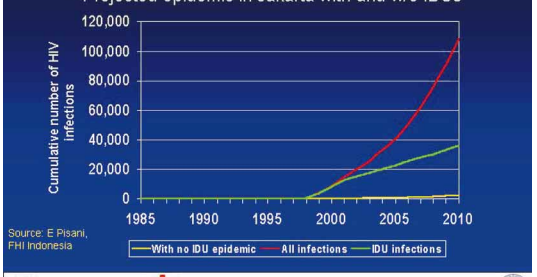
Source: Epidemiological Fact Sheets 2002 update

We understand the way Asian epidemics play out….

Thus the most effective way to control population-at-large epidemics in Asia is protecting at-risk populations ….

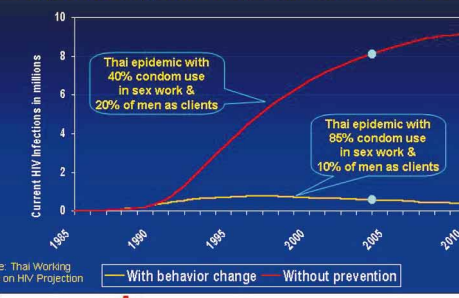
Preventing an IDU epidemic slows or averts a sex work epidemic…

Projected epidemic in Jakarta with and w/o IDUs



Source: E Pisani, FHI Indonesia

Promoting safer sex for clients and FSW with high coverage turns epidemics around…



Source: Thai Working Group on HIV Projection

With behavior change — Without prevention

But high coverage is essential if this is to succeed….

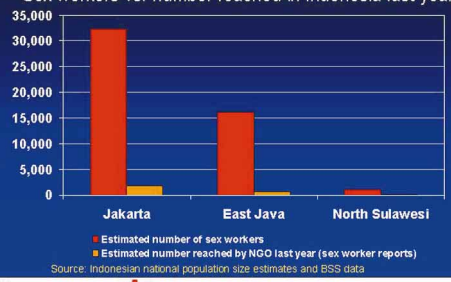
In a country with 10% clients and an IDU epidemic in 1990, epidemic course depends on % condom use in sex work

Source: T Brown, EWC

EAST-WEST CENTER

…and yet high coverage is sorely lacking in Asia…

Sex workers vs. number reached in Indonesia last year

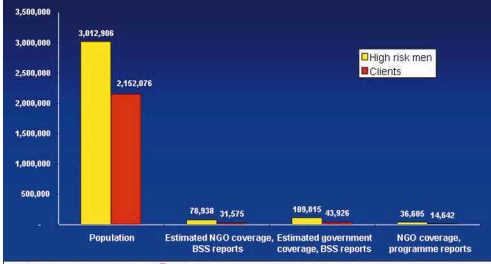


Source: Indonesian national population size estimates and BSS data

EAST-WEST CENTER

Even when government coverage is factored in, coverage remains low…

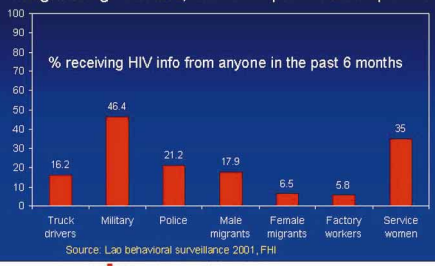
Coverage of high risk males and clients in Indonesia



EAST-WEST CENTER

And it's not just Indonesia, coverage in many Asian countries remains critically low…

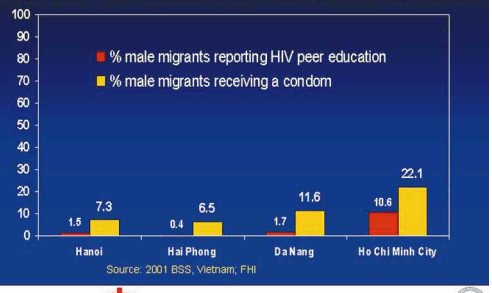
In Laos, several groups, including migrants traveling to neighboring Thailand, have little prevention exposure



Source: Lao behavioral surveillance 2001, FHI

EAST-WEST CENTER

In Vietnam, where HIV is rising fast, coverage of migrants is dangerously low…



Source: 2001 BSS, Vietnam; FHI

EAST-WEST CENTER

Truckers & sex workers have high STI exposure, but low use of services…

Source: 2001 BSS, Vietnam; FHI

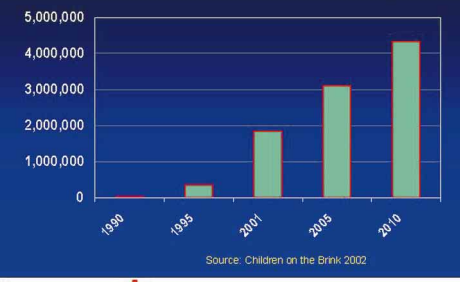
EAST-WEST CENTER

But with today's coverage, we will NOT contain most epidemics in this region….

We are failing to apply lessons learned, and the consequences are serious….

EAST-WEST CENTER

The number of children orphaned by AIDS in the region is growing…



Source: Children on the Brink 2002

EAST-WEST CENTER

And every percentage point in the larger countries of Asia is serious…

Country	Adult population	1% adds this to global pandemic
China	733 million	7.3 million
India	567 million	5.7 million
Indonesia	132 million	1.3 million
Bangladesh	78 million	780,000
Pakistan	76 million	760,000
Vietnam	47 million	470,000

Source: US Bureau of the Census 15-49 populations for 2004

But this will not happen in other Asian countries unless we achieve better focus and greater coverage…

So what should we do?

Expand & refocus prevention programs

Emphasize CNN

- Keep the focus in Asia on prevention with two key priorities (CNN)
  - Condoms (for clients & sex workers, MSM, IDUs)
  - New needles (harm reduction)
- Early prevention with high coverage for IDUs and MSM buys time for sex work programs
- Programs for sex workers AND clients must be brought to national scale ASAP
  - Main reason for non-use of condoms is the clients

Refocus some international resources to leverage substantial coverage

- Use some resources to
  - Critically evaluate current national responses
  - Determine where impact is largest
  - Advocate for better focus, more resources & higher coverage
- Redirect international resources where they'll have maximal impact
  - Appropriate populations
  - Narrower country focus

Move beyond boutique projects…

Mobilize the resources for good coverage

- We need national coverage, not just the cities
  - Work with governments, not just NGOs
  - Expand for full geographic coverage…starting from highest prevalence areas
- Achieving coverage requires more resources
  - National & community resources needed
  - Insist on local resource mobilization as condition for international assistance
- This is not the time to be scaling back in Asia

Source Presentations

- Why Are Asian HIV Epidemics Different? Exploring Program & Policy Implications of HIV Diversity, March 2004
- Why Do HIV Epidemics in the Countries of Asia Differ? Possibilities and alternatives, March 2004
- What Drives Asian Epidemics? The Asian Epidemic Model – a tool for exploring national epidemics, March 2004
- What Really Matters? Exploring the dynamics of Asian HIV epidemics, March 2004
- I Heard That It's Over! Where are Asian epidemics going in the future? March 2004
- Flatlined…The Asian Response to HIV, February 2004

2. The Perspective of HIV - positive pregnant woman - Khun Junsuda Suwanjundee

The Importance of VCT from a positive women's perspective

Omm Junsuda

Founder and chairperson of Power of Life Organization Bangkok Thailand

FHI Satellite on VCT — Barcelona World AIDS Conference July 2002

My Background – A Tough Time

- A drug injecting rebellious youth
- tested for HIV against my knowledge aged 18
- my serostatus was made common knowledge to those in the hospital
- I lost my job and got kicked out of my home and for a time was literally living on the street and sleeping rough

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Moving Forward

- Since being involved with PWA peer support group in Bangkok my life has changed completely
- I now head an organisation called Power of Life which has a number of ongoing pwa driven projects in Thailand

FHI Satellite on VCT — Barcelona World AIDS Conference July 2002

Voices & Choices

An ongoing project in conjunction with Raks Thai foundation and ICW

- In 1999 around 2% of women receiving anti natal care tested positive for HIV in Thailand
- The V & C project provides clear information on related issues to help these women
- Health care works attitudes need much room for improvement

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Whistle Baby Home

- Provides a supportive environment for positive women and their children
- Child care and support services for children under 3 years old
- Peer support groups
- Health Advice and counseling
- Referral and advice concerning presenting problems

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Issues surrounding VCT

We know that VCT is proven to be effective in changing behavior however:

- Mandatory testing is happening more than ever in my country including schools, universities and even the temples!
- People have a lack information about their human rights
- Children and being turned away from schools because of their HIV status
- Men cannot ordain as a monk after testing positive for HIV

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Confidentiality is essential

- Information must be put across in a language that is easily understood
- Often women attending ANC have poor levels of education
- Attitudes of health care workers have a direct impact on the client's decision making
- Must listen and learn from PWA make us a part of the solution not the problem

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A Way Forward

- Encourage more people living with HIV to put a face to AIDS
- Involve us in policy decisions, project implementation, education and care
- All sectors of civil society involved as equal players in the response to AIDS
- Requires time, strong commitment and a great deal of support and encouragement

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Necessary Conditions

- good quality pre- & post-test counselling
- early referral to peer support
- help with disclosure to family members
- fulfil physical and emotional needs
- encouragement to remain productive
- provided with skills:
  - counselling, public speaking
  - writing funding proposals
  - managing own organisations

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Capacity Building

- more people to put a face to AIDS
- human rights violations reduce
- society takes on greater responsibility
- generates enabling environment for families of HIV-positive people

- more people speak out
- AIDS-competent communities increase

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"We just happen to have HIV"

- Give women equal choice and rights to make their own decisions
- Being a positive woman doesn't mean your life is worthless or than you cant lead a normal life like everyone else

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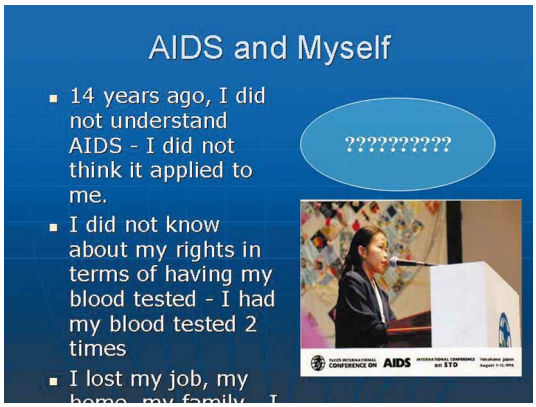
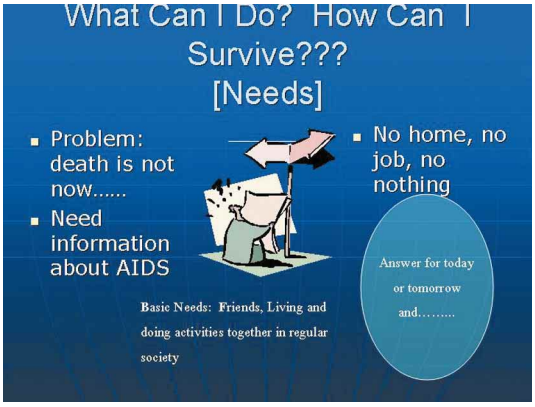
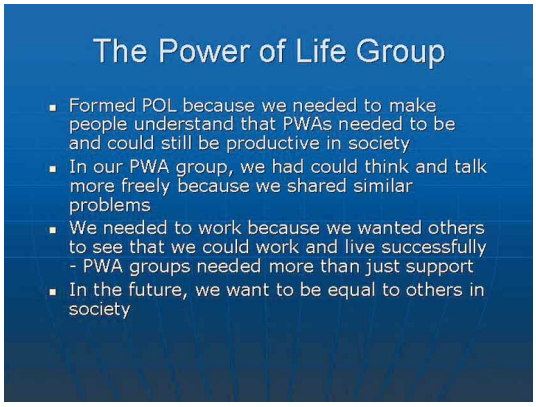
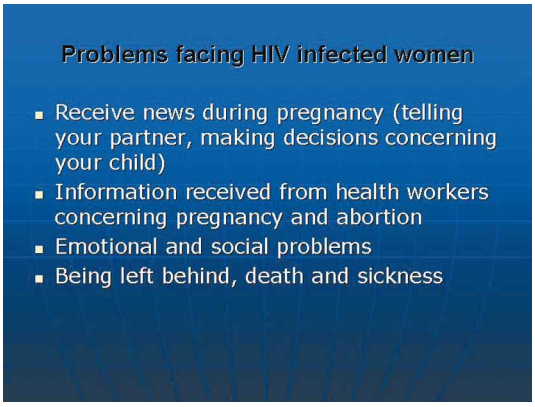
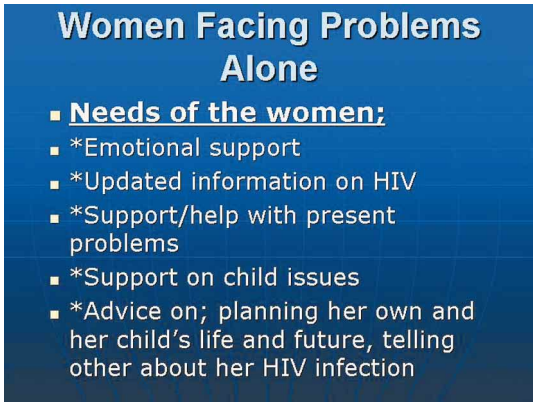
WHISTLE HOME
Power Of Life
Power of Life Group
www.thaicities.net/whistle

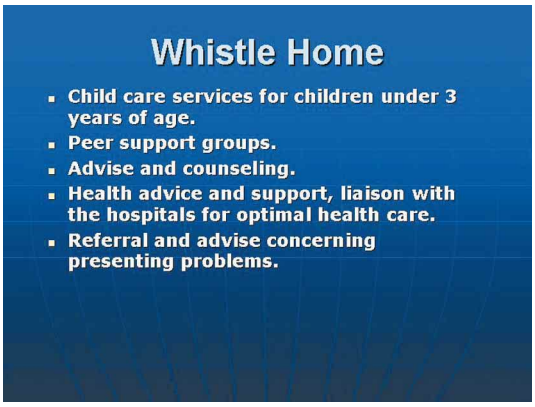

AIDS and Myself
14 years ago, I did not understand AIDS - I did not think it applied to me.
I did not know about my rights in terms of having my blood tested - I had my blood tested 2 times
I lost my job, my
??????????
AIDS

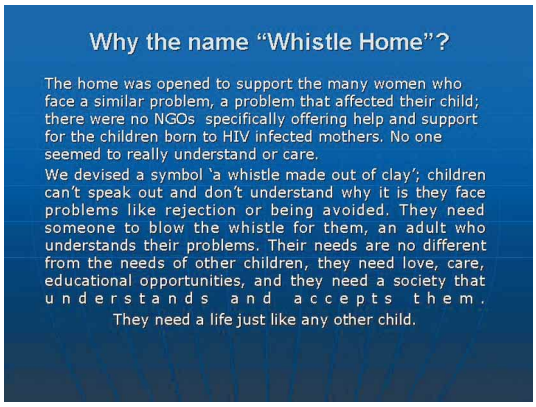

What Can I Do? How Can I Survive??? [Needs]
Problem: death is not now.....
Need information about AIDS
No home, no job, no nothing
Answer for today or tomorrow and.....
Basic Needs: Friends, Living and doing activities together in regular society


The Power of Life Group
Formed POL because we needed to make people understand that PWAs needed to be and could still be productive in society
In our PWA group, we had could think and talk more freely because we shared similar problems
We needed to work because we wanted others to see that we could work and live successfully - PWA groups needed more than just support
In the future, we want to be equal to others in society


Problems facing HIV infected women
Receive news during pregnancy (telling your partner, making decisions concerning your child)
Information received from health workers concerning pregnancy and abortion
Emotional and social problems
Being left behind, death and sickness


Women Facing Problems Alone
Needs of the women;
*Emotional support
*Updated information on HIV
*Support/help with present problems
*Support on child issues
*Advice on; planning her own and her child's life and future, telling other about her HIV infection


Whistle Home
Child care services for children under 3 years of age.
Peer support groups.
Advise and counseling.
Health advice and support, liaison with the hospitals for optimal health care.
Referral and advise concerning presenting problems.


Why the name "Whistle Home"?
The home was opened to support the many women who face a similar problem, a problem that affected their child; there were no NGOs specifically offering help and support for the children born to HIV infected mothers. No one seemed to really understand or care.
We devised a symbol 'a whistle made out of clay'; children can't speak out and don't understand why it is they face problems like rejection or being avoided. They need someone to blow the whistle for them, an adult who understands their problems. Their needs are no different from the needs of other children, they need love, care, educational opportunities, and they need a society that understands and accepts them.
They need a life just like any other child.

Voices & Choices

Voices and Choices

- Did survey in 3 regions: Chiang Rai, Khon Kaen, and Bangkok
- Trained female PWAs to do junior research
- Did 2 group discussions with HIV+ men
- Did 100 surveys and 20 interviews with HIV+ women
- Asked questions about their lives, sicknesses, who and where they go when they need help, access to

MEETING THE NEEDS OF CLINICAL TRIAL PARTICIPANTS: A SURVEY OF CLINICAL TRIAL PARTICIPANTS CONDUCTED BY HIV SUPPORT GROUP LEADERS

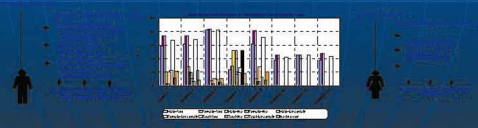
Issue

HIV positive persons enrolled in clinical trials for drug therapies are raising questions concerning the lack of information provided to them and inadequate follow-up after the completion of drug trials.

Project Description

Twenty interviews were conducted and 100 questionnaires were answered among HIV positive persons who had been enrolled in clinical trials. Questions examined their level of satisfaction with information provided prior, during and after the trials, as well as the enrollee's degree of involvement in decision making.

Questionnaire



Results

A significant number of clinical trial participants expressed dissatisfaction with the information they received. They felt that the drug therapy offered through clinical trials was their only choice in order to prolong their life. They particularly felt there were limited treatment options available on a continual basis, and therefore were willing to take the drug therapy for the limited time period. Problems arose when drug trials were completed and participants had to continue taking these costly drugs at their own expense. Some of the participants had their periods of therapy reduced without explanation. They felt the drug companies should be responsible in supplying the drug therapies throughout their life, since clinical trial participants were relatively few in number and were risking their health to participate in the drug trial. They were also aware of drug trials being conducted in developed countries where trial participants were provided the drugs on a life-long bases, even after the trial was completed. Pregnant women in the study felt that they should receive equal attention as that given to their unborn children because they wish to spend their lives with their children.

PWAs want the same happiness as other people

WHISTLE HOME

POWER OF LIFE

Power of Life Group

www.thaicities.net/whistle

3. Primary prevention during pregnancy and post-partum - Dr. Wendy Holmes

PMTCT of HIV - Primary Prevention

Wendy Holmes

Centre for International Health
Macfarlane Burnet Institute
for Medical Research and Public Health

May 2004

PMTCT of HIV - Primary Prevention

The best way to stop children getting HIV is to stop men and women getting infected.

Preventing women becoming infected late in pregnancy and post-partum is especially important.

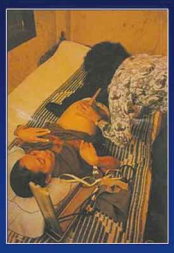
PMTCT of HIV - Primary Prevention

- Why might women be especially vulnerable to infection when pregnant and post-partum?
- Why are such infections especially significant in relation to mother-to-child transmission?
- What strategies can we implement to prevent women becoming infected during pregnancy and the post-partum period?

PMTCT of HIV - Primary Prevention

Attention has been focussed on interventions that depend on knowledge of a woman's HIV status:

- Antiretroviral prophylaxis
- Replacement of breastfeeding
- Elective caesarean section



PMTCT of HIV - Primary Prevention

Clinical vs population perspective

Policy has been influenced primarily by clinical trial researchers and clinicians.

Naturally they tend to focus on how best to reduce the risk of MTCT for the HIV positive pregnant woman.

PMTCT of HIV - Primary Prevention

Interagency Task Team on Preventing HIV in Pregnant Women, Mothers and their Children.

Four-prong approach to prevent HIV infection in babies:

1. Primary prevention of HIV in young people and women of childbearing age
2. Prevention of unintended pregnancies among HIV infected women
3. Prevention of transmission of HIV from an infected woman to her infant
4. Care and support for HIV-infected women, their infants and their families

www.unaids.org/publications/documents/mtct/mtct_TU4.ppt

PMTCT of HIV - Primary Prevention

There are studies that explore:

- impact of HIV infection on the fertility of women
- effect of HIV infection on pregnancy outcome
- impact of pregnancy on the natural history of HIV infection
- relationship between results of sero-surveillance surveys of pregnant women and rates of HIV prevalence in general population
- susceptibility of HIV positive pregnant women to other infections, such as bacterial vaginosis, STIs and malaria

But the question of whether women are especially vulnerable to HIV during pregnancy has been neglected.

PMTCT of HIV - Primary Prevention

Most studies in Africa show that HIV prevalence is higher in women without children

- but HIV infection lowers fertility in women
- and there are confounding factors

Judith R. Glynna JR, Buveb A, et al. Factors influencing the difference in HIV prevalence between antenatal clinic and general population in sub-Saharan Africa. AIDS 2001, 15:1717-1725.

PMTCT of HIV - Primary Prevention

Cohort studies – such as:

- Senkoro et al; Mwanza, Tanzania
- Carpenter L et al; Masaka, Uganda
- Gray et al; Rakai, Uganda
- Quinn TC et al; Rakai, Uganda
- Nelson K et al; Northern Thailand

examine variables such as:
- frequency and type of sex
- evidence of STDs / discharge
- viral load
- CD4 counts
- circumcision
- age

but don't mention pregnancy…

Burnet Institute

PMTCT of HIV - Primary Prevention

But Miotti et al noted:

"The observation that seroconversion was highest during the first year of enrollment with a declining trend in subsequent years suggests that women are at highest risk during the postpartum period."

Miotti P, et al. Rate of new HIV infection in a cohort of women of childbearing age in Malawi. AIDS Res Hum Retroviruses 1994, 10 (suppl 2):S239-S241.

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PMTCT of HIV - Primary Prevention

In a paper that asks "Why do young women have a much higher prevalence of HIV than young men?" the authors note that

"marriage was a risk factor for HIV" and that

"HIV prevalence was very high even among women reporting one lifetime partner and few episodes of sexual intercourse"

But the paper does not contain the word 'pregnancy'.

Glynn, J. R.; Caraël, M.; Auvert, B. et al the Study Group on the Heterogeneity of HIV Epidemics in African Cities. "Why do young women have a much higher prevalence of HIV than young men? A study in Kisumu, Kenya and Ndola, Zambia" [The Multicentre Study of Factors Determining the Different Prevalences of HIV in sub-Saharan Africa] *AIDS*. 2001 Aug;15 Suppl 4:S51-60.

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PMTCT of HIV - Primary Prevention

Results of prospective studies of HIV negative women

Location and year of study	HIV neg women	Incidence observed (per 100 person-years)	Max expected Incidence (per 100 p-yrs)
Blantyre, Malawi, 1990-95	>1,000	**21** during ANC and PP in 1990 **12** during ANC and PP in 1991 **8.0** during ANC 1990-93	2.2 - 3.3
Harare, Zimbabwe, 1990-94	372	**17** during ANC **>13** during 0-6 months PP	2.4 - 3.0
Durban, South Africa, 1993	178	**9.0** during ANC	0.7
Nairobi, Kenya, 1986-91	353	**6.2** during 0-6 months PP	0.27 - 1.6
Kigali, Rwanda, 1988-90	216	**7.2** during 0-6 months PP **4.2** during 7-18 months PP	3.0 - 3.2
Rakai, Uganda, 1994-96	1,305	**3.2** during pregnancy	1.4
Lusaka, Zambia, 1987-88	634	**3.0** during first year PP	1.2

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Gisselquist et al. International Journal of STD & AIDS 2002;13(10):657-666

PMTCT of HIV - Primary Prevention

Why might women be especially vulnerable to infection when pregnant and post-partum?

There are social, medical and physiological reasons

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Increased likelihood of **exposure** to HIV:

- Men may be more likely to have sex outside the marriage when their wife is in late pregnancy or post-partum. They then have a post infection peak in viral load so that they are very infectious when they resume sex with their wives.
- Women are more likely to receive a blood transfusion when pregnant or soon after delivery
- Women may be more likely to receive an unsafe injection during ante-natal care

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Physiological changes may increase susceptibility:

During pregnancy cervical ectopy is more common, which is associated with increased transmission of HIV [1].

There is a higher concentration of SIV-infected cells in the cervical sub-mucosa compared to the vaginal sub-mucosa following vaginal innoculation of SIV in monkeys[2].

[1] Moss GB et al. Association of cervical ectopy with heterosexual transmission of human immunodeficiency virus: results of a study of couples in Nairobi, Kenya. J Infect Dis. 1991;164:588-591

[2] Zhang Z-Q, et al. Sexual transmission and propagation of simian and human immunodeficiency viruses in two distinguishable populations of CD4+ T cells. Science 1999;286:1353-7

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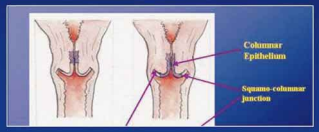
PMTCT of HIV - Primary Prevention

The single layer of cervical columnar cells of the endocervix is more easily crossed by the virus than the several layers of cells of the squamous vaginal endothelium.



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Increased blood flow and hormonal effects may make it easier for HIV to cross the mucosal lining of the vagina or cervix.

There is a change to non-keratinizing squamous epithelium in the vagina during pregnancy.[3]

Progesterone and estrogen affect HIV vaginal transmission[4]. Postmenopausal women and women who use injectable, progestin-based contraceptives are at increased risk of HIV infection.

It seems likely that progesterone increases risk, while estrogen decreases risk[5]. What happens during pregnancy?

[3] Schaller G. Changes in keratin expression of human vaginal epithelium during different female generation phases. Polyclonal antibody studies. Gynecol Obstet Invest. 1990;29(4):278-81.

[4] Smith SM, et al. Estrogen protects against vaginal transmission of simian immunodeficiency virus. *J Infect Dis.* 2000 Sep;182(3):708-15.

[5] Marx PA, et al. Progesterone implants enhance SIV vaginal transmission and early virus load. *.Nat Med.* 1996 Oct;2(10):1084-9.

PMTCT of HIV – Primary Prevention

Bacterial vaginosis and candidiasis increase vulnerability to infection[6],[7], and are more common during pregnancy[8].

BV associated with higher levels of pro-inflammatory cytokines in the cervical secretions[10].

BV and candidiasis cause micro-ulcerations in the epithelium, which could expose susceptible target cells in the submucosa to the virus[11].

[6] Taha TE, et al. Bacterial vaginosis and disturbances of vaginal flora: association with increased acquisition of HIV. AIDS. 1998 Sep 10;12(13):1699-706

[7] Cauci S, et al Correlation of local interleukin-8 with immunoglobulin A against Gardnerella vaginalis hemolysin and with prolidase and sialidase levels in women with bacterial vaginosis. J Infect Dis. 2002 Jun 1;185(11):1614-20.

[8] Galask RP. Vaginal colonization by bacteria and yeast. Am J Obstet Gynecol. 1988 Apr;158(4):993-5.

[9] Sturm-Ramirez K, et al. High levels of tumor necrosis factor-alpha and interleukin-1beta in bacterial vaginosis may increase susceptibility to human immunodeficiency virus. J Infect Dis. 2000 Aug;182(2):467-73.

[10] Pope M, et al. Transmission, Acute HIV-1 infection and the quest for strategies to prevent infection. Nature medicine 2003;9(7):847-852

PMTCT of HIV - Primary Prevention

The incidence and severity of Donovanosis and other STIs may be increased in late pregnancy[12], increasing susceptibility to HIV [13].

Pregnancy increases reactivation of CMV – it is not known whether this happens with other herpes viruses such as herpes simplex. Herpes simplex seems to increase susceptibility to HIV. [14]

[12] O'Farrell N. Donovanosis (granuloma inguinale) in pregnancy. Int J STD AIDS. 1991 Nov-Dec;2(6):447-8.

[13] Brabin BJ. Epidemiology of infection in pregnancy. Rev Infect Dis 1985;7(5):579-603

[14] Glynn, J. R.; Caraël, M.; Auvert, B. et al "Why do young women have a much higher prevalence of HIV than young men? A study in Kisumu, Kenya and Ndola, Zambia" *AIDS.* 2001 Aug;15 Suppl 4:S51-60.

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Pregnancy decreases immunity to malaria, and possibly other parasitic infections [13] . Might malaria or helminthic infections increase susceptibility to HIV infection?[15]

Tissue damage to cervix and vagina associated with delivery may increase susceptibility post-partum.

[13] Brabin BJ. Epidemiology of infection in pregnancy. Rev Infect Dis 1985;7(5):579-603

[15] Harms G, Feldmeier H. HIV infection and tropical parasitic diseases – deleterious interactions in both directions? Trop Med Int Health. 2002 Jun;7(6):479-88.

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PMTCT of HIV - Primary Prevention

Shifts in the maternal immune system

During pregnancy there are changes in the immune system to accommodate the 'alien' fetus during gestation

Increasing our understanding of these complex changes is a fertile field for reproductive immunologists

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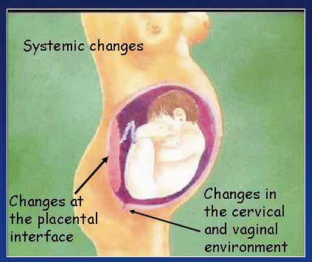
PMTCT of HIV - Primary Prevention

There are changes in the immune system at different levels



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There are changes at different stages of gestation

– from implantation, growth and development of the fetus, through to onset of labour and expulsion of the baby.

Th1 CD4 -> Th 1 type cytokines – proinflammatory – kill intracellular parasites
Th2 CD4 -> Th 2 type cytokines – anti-inflammatory

During pregnancy there is a skewing towards the TH2 response
- with some suppression of cell-mediated immunity

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Might the shift to Th-2 type responses (if it is real) increase susceptibility to HIV?

Bentwich et al investigated immune responses of helminth-infected Ethiopian migrants to Israel. [16] They also have a predominantly Th-2-type immune response.

PBMC from HIV negative Ethiopians showed increased susceptibility to HIV infection.

[16] Bentwich Z, Weisman Z, Borkow G, Galai N, Kalinkovich A. Helminthic infections and pathogenesis of AIDS. Conf Retroviruses Opportunistic Infect. 1999 Jan 31-Feb 4;6th:81 (abstract no. 74).

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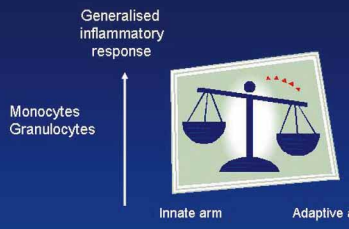
PMTCT of HIV - Primary Prevention

Complex changes in the immune system during pregnancy



Luppi P. How immune mechanisms are affected by pregnancy Vaccine 2003;21:3352-3357

PMTCT of HIV - Primary Prevention

Pro-inflammatory cytokine concentrations in cervico-vaginal fluids increase exponentially as gestational age increases, and are especially high in labour.[17]

This may increase susceptibility to HIV because they can up-regulate local HIV replication. [18]

[17] Tanaka Y; Narahara H; Takai N; Yoshimatsu J; Anai T; Miyakawa I. Interleukin-1beta and interleukin-8 in cervicovaginal fluid during pregnancy American Journal of Obstetrics & Gynecology. 179(3 Pt 1):644-9, 1998 Sep.

[18] Sturm-Ramirez K, Gaye-Diallo A, Eisen G, Mboup S, Kanki PJ. High levels of tumor necrosis factor-alpha and interleukin-1beta in bacterial vaginosis may increase susceptibility to human immunodeficiency virus. J Infect Dis. 2000 Aug;182(2):467-73.

PMTCT of HIV - Primary Prevention

What are the implications of the changes in immune function for susceptibility to HIV?

HIV can pass through the cells of the intact mucosa to infect susceptible CD4+ T cells and dendritic cells in the sub-mucosa.[10]

These cells facilitate production of virus and its rapid dissemination within the host.

Local changes in function of immune cells and cytokine production in the vagina and cervix may increase the likelihood that HIV will reach target host immune cells.

We don't know whether activation of the immune system, which might cause more rapid dissemination of the virus, would increase the risk of infection with HIV.

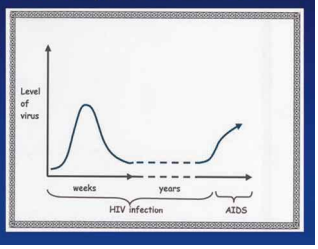
[10] Pope M, Haase A. Transmission, acute HIV-1 infection and the quest for strategies to prevent infection. Nature Medicine 2003;9(7):847-852.

PMTCT of HIV - Primary Prevention

Why are such infections especially significant in relation to mother-to-child transmission?

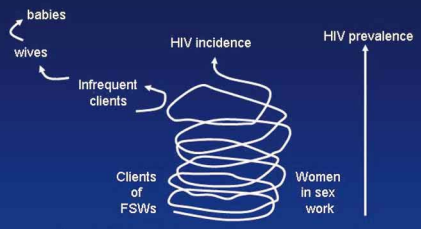
Maternal viral load is the most important influence on risk of transmission

Viral load is high soon after infection and again, often years later, when the woman develops HIV-related signs and symptoms

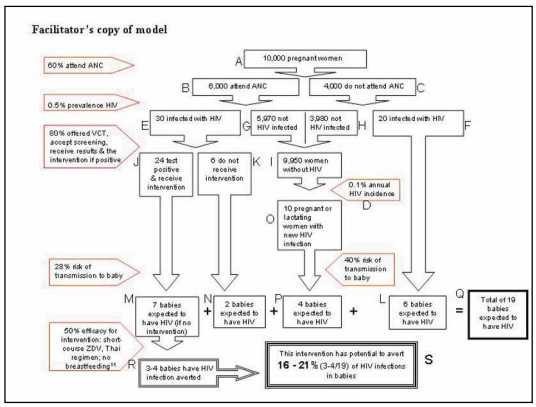


PMTCT of HIV - Primary Prevention

Role of primary infection important for PTCT early in the epidemic?

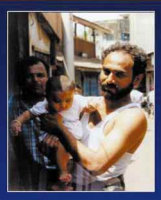


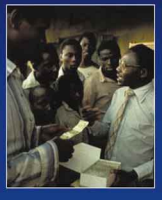
Jacquez J, et al. Role of primary infection in epidemics of HIV infection in gay cohorts. J Acquir Immune Defic Syndr 1994;7:1169-84. Koopman J, et al. The role of early HIV infection in the spread of HIV through populations. J Acquir Immune Defic Syndr 1997;14:249-58.



PMTCT of HIV - Primary Prevention

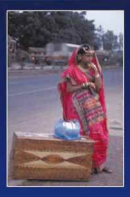
Community education about PTCT - appeal to men's sense of responsibility to protect their family





Provide condoms in the workplace – and explain how to use them

PMTCT of HIV - Primary Prevention

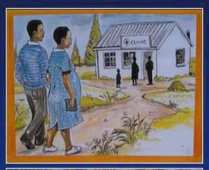


- Counsel men pre-marriage
- Encourage planning for pregnancy
- Counsel discordant couples

PMTCT of HIV - Primary Prevention

Introduce a routine 'couple visit' as the second ante-natal visit:

- Discuss and test for TB and STIs
- Discuss warning signs in labour, and plans for emergency transport
- Counsel the father about the risk to his baby if he has unprotected sex now or after the birth
- Provide condoms



Burnet Institute

PMTCT of HIV - Primary Prevention

- Counsel fathers after delivery, and provide condoms
- Train midwives/drs to reduce need for transfusions, use strict transfusion criteria and safe injection practice

Counsel women / couples when they test negative for HIV during pregnancy

Burnet Institute

PMTCT of HIV - Primary Prevention

Teach women how to talk about and use condoms

Tamil Nadu, India

Phongsali, Lao PDR

Burnet Institute

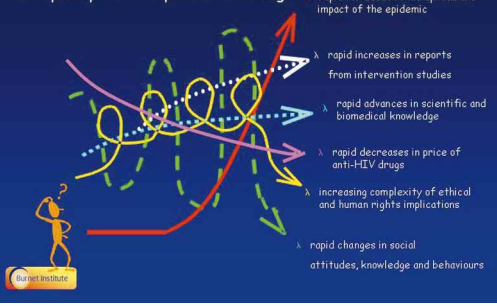
Parent to child transmission of HIV: prevention and care

Primary prevention (prevent infection of women and men)		Secondary prevention (prevent HIV passing from positive women to infants)	
Non-specific interventions (Prevent transmission between men and women) • Reduce stigma • Increase community resilience & capacity for behaviour change • Provide access to quality VCT • Peer education • Promote and distribute condoms • Improve treatment of STIs • Behaviour change communication with youth • Address problem of child sexual abuse	**Specific interventions** (Prevent new infections during pregnancy, at delivery, and during lactation) • Introduce as routine an evening "couple" visit as the second ante-natal visit, • Counsel fathers after delivery, and provide condoms • Train midwives/drs to reduce need for transfusions, implement strict transfusion criteria and safe injection practice • Community education about PTCT, especially addressing men • Counsel discordant couples •Counsel women / couples when a woman tests neg for HIV during pregnancy	**Population-based interventions** (Do not depend on testing during pregnancy) • Prevent unwanted pregnancies • Encourage women with any chronic illness to avoid pregnancy until well for 6 months • Improve health of pregnant women • Reduce risk of MTCT at delivery • Reduce risk of transmission through breastfeeding - promote exclusive breastfeeding, train health workers	**Test-dependent interventions** (depend on knowledge of women's HIV status) Assist HIV positive women to avoid unwanted pregnancy Provide VCT for pregnant women. For those HIV positive offer: • Antiretroviral prophylaxis • Counselling to assist women to make a choice between exclusive breast or replacement feeding, and follow up support • Elective Caesarean section (if feasible) • Counselling re termination of pregnancy (if legal) • Post-partum counselling re contraception choices

Plus - care and follow up support for infected mothers, sick babies, and carers of orphaned babies

PMTCT of HIV - Primary Prevention

The policy landscape is confusing



Burnet Institute

4. Revised UN ARV guidelines for PMTCT
- Dr. Ngashi Ngongo

Revised ARV guidelines for treatment in pregnant women and for preventing mother to child transmission of HIV

Dr Ngashi Ngongo
UNICEF HQ
Bangkok May 2004

For every child
Health, Education, Equality, Protection
ADVANCE HUMANITY

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Outline of the presentation

- Background
  - Global goals
  - Efficacy of current regimens
- Safety of ARV drugs in pregnancy
- Concerns about resistance
- Recommended guidelines

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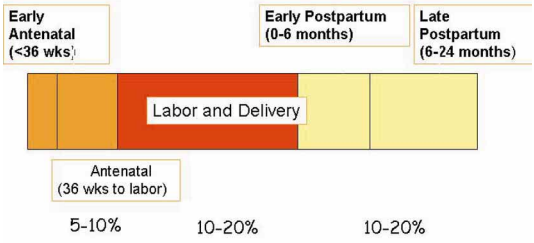
Magnitude of the problem: Up to 50% of women with HIV/AIDS can pass on infection to their babies



adapted from de Cock et, 2000

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Efficacy of current ARV regimens

Study	Drug Regimen	Mean CD4	Efficacy
Thai CDC short-course ZDV trial, **No breastfeeding**	ZDV from 34 weeks. No PP dose (mother only)	411, 427	At 6 months: **50.1% efficacy**
DITRAME / ANRS 049a trial, Côte d'Ivoire, Burkina Faso(16, 17) **Breastfeeding**	ZDV from 34 weeks plus 1-week PP (mother only)	535, 568	At 6 months: **38% efficacy;** At 15 months: **30% efficacy** At 24 months: **26% efficacy**
PETRA trial, South Africa, Tanzania and Uganda(9) **Breastfeeding**	ANC/IP/PP ZDV+3TC vs. IP/PP ZDV+3TC vs. IP ZDV+3TC vs. placebo	445, 475, 440, 435 (placebo)	At 6-8weeks: **63%, 42% and 0%, respectively** At 18months: **34%, 18% and 0%, respectively**
HIVNET 012 trial, Uganda(7, 8) **Breastfeeding**	NVP vs. ZDV	426, 461	At 14-16 weeks: **47% efficacy** At 18 months: 41% efficacy

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Global goals

PMTCT Targets	Expected Coverage
20% reduction by 2005	50% of pregnant women having access to PMTCT services
50% reduction by 2010	80% of pregnant women having access to PMTCT services

Sources: UNGASS on HIV/AIDS 2001 and Interim report of Millennium Project task force 5

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Two are better than one

Study	Drug Regimen	Mean CD4	Efficacy
Thai Perinatal HIV Prevention trial, Thailand (PHPT-2) **No breastfeeding**	ZDV from 28 weeks, IP and 1-week PP to both mother and infant plus a) NVP-NVP OR b) NVP-Placebo OR c) Placebo-Placebo	N/A	VTR as follows: Group a: 2.0% Group b: 2.8% Group c: 6.3% (Stopped because of high VTR)
DITRAME Plus / ANRS 1201.0 trial Abidjan, Côte d'Ivoire(23) **Breastfeeding**	ZDV from 36 weeks, NVP one dose at onset of labour Infant: SD NVP plus 1-week ZDV	378	VTR at 6 weeks: 6.4%
NVAZ trial Malawi(25) **Breastfeeding**	Mothers: late comers Infants: NVP + 1-week ZDV versus NVP alone.	N/A	VTR at 6-8 weeks 15.3% vs. 20.9% with ZDV only (26% efficacy). VTR at 6-8 weeks in infants who were negative at birth 7.7% and 12.1%, respectively (36% efficacy)
French AZT+3TC / ANRS 075 trial France(21) **Breastfeeding**	Mother: ZDV+3TC from 32 weeks and IP. No PP. Infant: 6-week ZDV+3TC	426	VTR 1.6% [437 infants]; 5-fold lower than in historical controls receiving ZDV only

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Safety of ARV drugs in pregnancy
Nucleoside Reverse Transcriptase Inhibitors

- Short course ZDV for MTCT not associated with short-term clinical or lab toxicities, altered disease progression or increased risk of congenital malformations
- Major short-term toxicity in infants is anemia, usually mild and reversible after discontinuation of treatment
- Severe neonatal anemia and neutropenia were observed with prolonged use of AZT + 3TC (>1month)

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ARV resistance following short course MTCT prophylaxis
Nucleoside Reverse Transcriptase Inhibitors

- ZDV:
  - Multiple mutations required to confer resistance. Very low prevalence of resistance reported, unlikely to impact of future ZDV treatment options
- 3TC:
  - Requires only one mutation to confer resistance
  - Frequent with treatment above month (up to 20%) even when given in combination with ZDV, and more (up to 50%) if used for more than 2 months

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ARV resistance following short course MTCT prophylaxis

Non Nucleoside Reverse Transcriptase Inhibitors

- NVP:
  - Requires only one mutation to confer resistance
  - High prevalence of NVP resistance, even when used in combination with ZDV: 17-39% in mothers and 33-53% in infants (CI 33%, Thai 17%, Uganda 36%)
  - Risk increases with multiple dosing (SA with single dose 39% & 67% with double dose)

ARV resistance following short course MTCT prophylaxis

Non Nucleoside Reverse Transcriptase Inhibitors

	VL<400 Copies/mL	VL<50 Copies/mL
Exposed with Resistance	68%	38%
Exposed without Resistance	80%	50%
Not exposed	85%	74%

Conclusion: **a) Median CD4 increase in the three groups similar (100/mL)**

b) Viral response reduced if treatment started within 6 months after delivery

Source: The Thai Perinatal HIV Prevention trial,PHPT-2 Study

Revised ARV guidelines for PMTCT

Eight (8) clinical scenarios

Scenario 1: Non-pregnant women of child bearing age

HIV-infected women With indications for initiating ARV treatment (Non-pregnant women who may become pregnant)	First-line regimens: **ZDV/d4T+3TC+NVP** (EFV should be avoided)

Scenario 2: Women on treatment who become pregnant

HIV-infected Women receiving ARV treatment who become pregnant	**Women** • Continue current ARV regimen • If contains EFV, substitute with NVP or PI if in the first trimester. • Continue same during/after delivery **Infants** • single-dose NVP + 1-week ZDV OR • 1-week ZDV OR • single-dose NVP

Scenario 3: Pregnant women who have indications for ARV treatment

HIV-infected pregnant women with indications for ARV treatment	**Women** • First-line: ZDV/d4T +3TC+NVP • No EFV if during first trimester • If possible, consider delaying initiating ARV treatment until after first trimester, **Infants** • single-dose NVP + 1-week ZDV OR • 1-week ZDV OR • single-dose NVP

Scenario 4: Pregnant women who have NO indications for ARV treatment

HIV-infected pregnant women without indications for ARV treatment	**Women** • First line: ZDV starting at 28 weeks + single-dose NVP at onset of labour **Infants** • Single-dose NVP plus 1-week ZDV [3] **Alternative regimens:** • ZDV alone (Mother: from 28 weeks, Infant: 1-week) • ZDV+3TC (Mother: from 36 weeks + 1-week PP, Infant: 1-week) • Single-dose NVP to mother and Infant

Scenario 5: Pregnant women who have indications for ART where there is no treatment

HIV-infected pregnant women with indications for ARV Treatment, BUT ART is not available	Same as Scenario D Give the most potent ARV regimen available

Scenario 6: Pregnant women who have indications for ART where there is no treatment

Pregnant women of unknown HIV status at the time of labour or known HIV-infected women in labour who did not receive ARV	• If there is time, offer VCT • if positive initiate intrapartum ARV prophylaxis. • If there is no time for VCT, offer it as possible postpartum and follow the recommendations in Situation H. **Recommended regimens** • Single-dose NVP: if imminent delivery is expected do not give the mother dose • ZDV+3TC to mother (in labour and 1-week PP) and infant 1-week ZDV+3TC

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Scenario 7: Infants born to women who did not receive any ARV

Infants born to HIV-infected women who did not receive ARV during ANC and delivery	**Infants** •Single-dose NVP as soon as possible after birth **PLUS** •1-week ZDV (preferably within 2 days after birth)

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Scenario 8: Women with indications for treatment who did not initiate it during pregnancy

HIV-infected women with indications for ARV treatment who did not initiate therapy during pregnancy.	•Initiate ART as soon as possible •Follow recommended guidelines •short-course ARV MTCT-prophylaxis does not affect the choice of first-line regimen.

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Way forward

- Initiate national dialogue with key stakeholders to review current national guidelines

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Thank you and God bless

unicef

5. Consultation on new UK Governmnet HIV/AIDS strategy - Elizabeth Smith

Consultation on new UK Government HIV/AIDS Strategy

UNICEF Regional Taskforce on Prevention of Mother to Child Transmission
Bangkok 11 – 13 May 2004

UK Department for International Development

New UK Government strategy on HIV/AIDS

- Significant developments since last DFID HIV/AIDS strategy in 2001
- Call for Action was the first step in an intensification of effort by HMG
- New strategy will set out how the UK will work with international and developing country partners in the global fight against HIV/AIDS
- Consultation Document is not a statement of Government policy but rather opportunity to encourage feedback and ideas on what should become policy
- Primary question being asked is what role should HMG be playing in the global fight against HIV/AIDS ?

UK Department for International Development

A major threat to development

- The global response to date has been inadequate; we are not on track to achieve the MDGs or contain the epidemic
- No region of the world is unaffected – both advanced and emerging epidemics pose a significant threat
- Prime Minister has declared his strong commitment and the whole of the UK Government is geared to support the global effort
- The UK is committed to continue working within the international framework for action and towards the UNGASS and MDG targets

UK Department for International Development

Five key themes

. Focusing on the poor

. Scaling-up evidence based interventions

. Building effective national responses

. Improving the efficiency and effectiveness of the international response

. Investing in long-term solutions

UK Department for International Development

1. Focusing on the poor

- Support HIV/AIDS programmes that help reduce the causes and effects of poverty
- Scale up efforts to address gender inequalities caused by HIV/AIDS
- Support strategies that promote an equitable response to HIV/AIDS
- Work to reduce stigma and discrimination related to HIV/AIDS

UK Department for International Development

2. Scaling-up evidence based interventions

- Strengthen the effectiveness and coverage of prevention efforts, including:
  - •focused and targeted interventions, e.g. sex workers, men who have sex with men
  - •increased access to confidential voluntary counselling and testing
- Support efforts to provide increased - and eventually universal - access to treatment and care
- Develop strategies to address the socio-economic impacts of HIV/AIDS on:
  - •young people affected by AIDS
  - •the labour force
  - •orphans and children made vulnerable by AIDS
  - •social stability, conflict and security
  - •food security
  - •environment and natural resource management.

UK Department for International Development

3. Building effective national responses

- Adopt a range of approaches to delivering HIV/AIDS aid
- Work with country governments to strengthen and improve access to health services
- Mainstream HIV/AIDS programmes into all sectors, e.g. education, agriculture
- Strengthen human capacity for service delivery
- Work with civil society and private sector to support their role within multi-sectoral strategies
- Adapt to the challenge of working in difficult environments

UK Department for International Development

4. Improving the efficiency and effectiveness of the international response

- Take a lead in promoting better harmonisation
  - •working with UNAIDS, we will mobilise support for implementing the "Three Ones" principles
- Ensure that macroeconomic policies support effective responses
- Increase the capacity of countries to absorb new funding

UK Department for International Development

5. Investing in longer-term solutions

- Ensure stability and sustainability of commitment and resources for scaled up responses
- Support research aimed at developing best-practice and better HIV treatments and diagnostics for poor people, children and women
- Accelerate progress towards developing new technologies for prevention and treatment – including vaccines and microbicides

UK Department for International Development

DFID in Asia – responding to HIV/AIDS

- Commitments in:

- Bangladesh
- Burma
- Cambodia
- China
- India
- Nepal
- Pakistan
- Vietnam

- Asia Regional

UK Department for International Development

6. Introduction to HIV-NAT and Update of PMCT clinic trials - Dr. Chris Duncombe

Introduction to HIV-NAT & Update on PMCT Clinical Trials

Chris Duncombe

HIV-NAT
The Netherlands, Australia, Thailand Research Collaboration
May 2004

chris.d@chula.ac.th

Overview

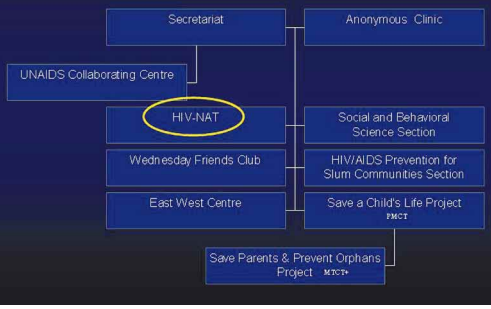
- HIV-NAT
- Update on antiretrovirals
- Ongoing and planned PMCT trials
- New WHO guidelines for PMTCT

Thai Red Cross AIDS Research Centre
National Centre in HIV Epidemiology and Clinical Research
International Antiviral Therapy Evaluation Centre

HIV-NAT
The Netherlands Australia Thailand Research Collaboration

www.hivnat.org

Thai Red Cross AIDS Research Centre



Mission and Objectives

- Conduct clinical studies according to international good clinical practice (GCP) guidelines
- Improve access to antiretroviral therapy for PLHA in Thailand
- Educate and train healthcare workers

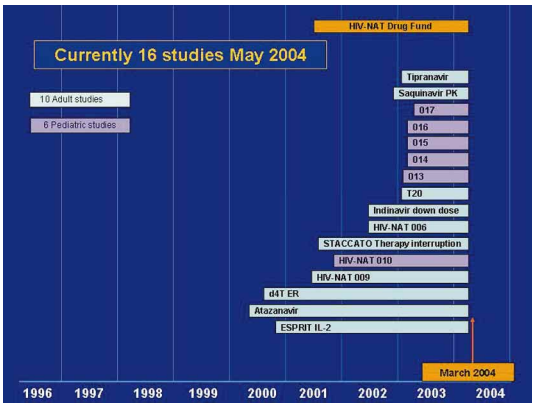
Milestones

1995	HIV-NAT concept
1996	start of operations
	1st patients enrolled on study
1997	1st presentations at international meetings
1998	1st Bangkok symposium in HIV medicine
	UNAIDS collaborating centre
1999	new building and facilities
2000	1st publications
2004	More than 1,800 adults & children on 16 studies

HIV-NAT Study Sites

Bangkok
10 sites

9 Provincial sites



HIV-NAT studies

- New drug development
  - US FDA registrational studies of atazanavir, d4T and T20
- Investigator-initiated studies
  - Relevant to Thailand
  - Down dosing of indinavir
- Pharmacokinetic studies
- Vaccine program

Adult Research

- Structured therapy interruption
  - Can ARV be given on/off?
- Interleukin-2
  - Does immunotherapy work?
- Dose reductions of ARV in Asian populations
- Vaccine for A/E strain HIV (Thailand)

Pediatric Research

- Optimum time to start ARV in children
- ARV resistance in children
- Effect of ARV on behavioral and cognitive function
- Treatment outcomes in children receiving HAART
- PK of nelfinavir in children
- Salvage therapy in children failing first line ARV

Overview

- HIV-NAT
- **Update on antiretrovirals**
- Ongoing and planned PMCT trials
- New WHO guidelines for PMTCT

Antiretroviral Drugs – 2004

Nucleoside RTIs	Non nucleoside RTIs	Protease inhibitors
zidovudine (ZDV)	nevirapine (NVP)	saquinavir (SQV)
didanosine (ddI)	efavirenz (EFV)	ritonavir (RTV)*
zalcitabine (ddC)	delavirdine (DLV)	indinavir (IDV)
stavudine (d4T)	**Nucleotide RTIs**	nelfinavir (NFV)
lamivudine (3TC)	Tenofovir (TDF)	amprenavir (APV)
abacavir (ABC)*	**Fusion inhibitors**	lopinavir/r (LPV/r)
emtricitabine (FTC)	Enfuvirtide (T20)	atazanavir (ATZ)
Triple therapy (HAART) for all		fosamprenavir

WHO Adult Guidelines Revision December 2003 Key changes

No longer recommended

- Triple nucleoside combination with abacavir
- ddI as first line drug
- d4T+ddI combination
- Protease inhibitor regimen as first line

How to Start WHO December 2003

- First line regimen
- 5-drug "formulary" approach
- (d4T or ZDV) + 3TC + (NVP or EFZ)

- Choice based on cost, availability, side effects, fixed dose combinations

When to start - Adults

If CD4 testing available

- AIDS
- Anyone with CD4 count < 200/mm^3
- Consider starting if WHO stage III and CD4 count < 350

If CD4 testing unavailable

- AIDS
- HIV-related symptoms and total lymphocyte count < 1200

Overview

- HIV-NAT
- Update on antiretrovirals
- **Ongoing and planned PMCT trials**
- New WHO guidelines for PMTCT

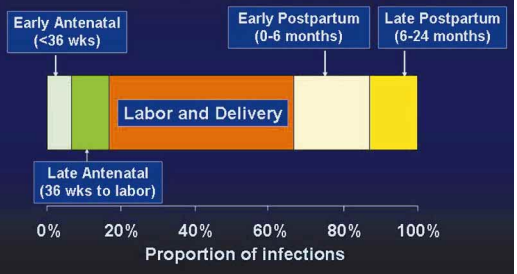
PMCT Trials

Ongoing and Planned Studies

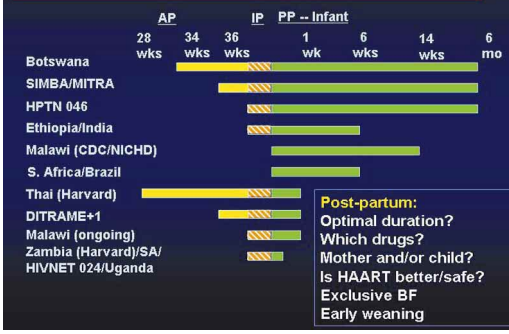
Lynne M. Mofenson
National Institute of Child Health and Human Development
National Institutes of Health
www.womenandaids.gov

Philippe Gaillard
World Health Organization
www.GhanaGroup.org

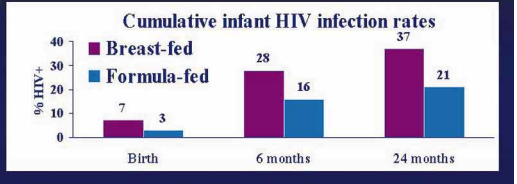
Timing of Transmission (with Breastfeeding and No ARV)



Antiretroviral Prophylaxis Trials



Nairobi Feeding Study



- Infant HIV-free survival at 24 months
- 58% in breast fed
- 70% in formula fed

Nduati. JAMA 2000; 283:1167-74

Risk factors for transmission through breastfeeding

- Maternal HIV status (CD4 count)
- Maternal plasma and milk viral load
- Duration of breastfeeding
- Mode of feeding: EBF or MBF (early weaning)
- Breast health (mastitis)
- Infant factors (oral thrush)
- Antiretroviral interventions

Interventions to prevent breast milk transmission

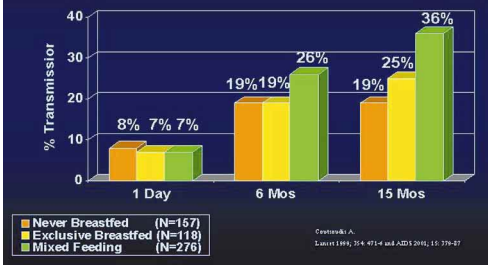
Studies on:

- Infant feeding practices
- Prophylaxis using ARVs
  - to the child
  - to the mother

Modifying infant feeding practices

- Exclusive breastfeeding *vs* mixed feeding
- Early weaning
- Ongoing studies
  - Breastfeeding study - Kwazulu Natal, South Africa (ongoing)
  - ZEBS - Lusaka, Zambia (ongoing)
  - ZVITAMBO - Harare, Zimbabwe (recruitment completed)
  - DITRAME Plus - Abidjan, Côte d'Ivoire (ongoing)

Type of Feeding
Exclusive breast milk vs mixed feeding



Coutsoudis A.
Lancet 1999; 354: 471-4 and AIDS 2001; 15: 379-87

Antiretroviral Infant Prophylaxis

Rationale

- Post exposure prophylaxis with ARV given to infant can reduce transmission of HIV (SIMBA trial)
- Single ARV therapy given to the uninfected infant does not expose the infected mother to the risk of developing ARV resistance
- ARV to the infant during the time of breast feeding may be a safer option for both

SIMBA: Infant Prophylaxis

Arm 1:

AZT +ddI start 36 wks | AZT +ddI | Mother: AZT + ddI x 1 wk

Infant: 3TC x 6 months

Birth-14 days, 2 mg/kg bid; then 4 mg/kg bid

Arm 2:

AZT +ddI start 36 wks | AZT +ddI | Mother: AZT + ddI x 1 wk

Infant: NVP x 6 months

Birth-14 days, 2 mg/kg once/d; then 2 mg/kg bid

Vyankandondera J et al.
IAS Meeting, Paris France
2003

SIMBA "Package" of Interventions

1) Maternal dual ARV (AZT +ddI)
2) High rate exclusive BF (87%)
3) Early weaning median duration BF 3.3-3.5 months
4) Infant prophylaxis while breast feeding (NVP or 3TC)

- Overall 30 cases of infant HIV infection
- 7.6% transmission
- Median follow-up 100 days
- 3TC group
  - 2 of 179 infants (1.1%)
- nevirapine group
  - 1 of 179 infants (0.6%)

SIMBA: Infant Prophylaxis

- Issues remain about:
  - drug safety
  - safety of early weaning
  - drug resistance
- SIMBA results encouraging but still many questions
- Phase III studies ongoing

Duration of therapy to infant

	IP	PP	
HPTN 046	NVP x1	Infant NVP x1	Infant: NVP x 6 months
	NVP x1	Infant NVP x1	Infant: Placebo x 6 months
Ethiopia Uganda India	NVP x1	Infant NVP x1	Infant: NVP x 6 wks
	NVP x1	Infant NVP x1	Infant Placebo x 6 wks

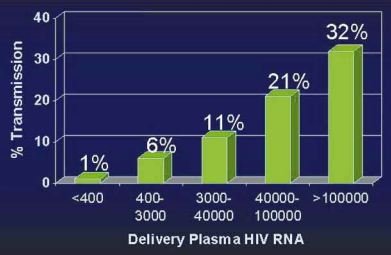
Are two drugs better than one?

IP	PP	
NVP x1	Infant NVP x1	Infant AZT x1 wk
NVP x1	Infant NVP x1	Infant: AZT x 16 wks
NVP x1	Infant NVP x1	Infant: NVP + AZT x 16 wks

Maternal Antiretroviral Prophylaxis Trials

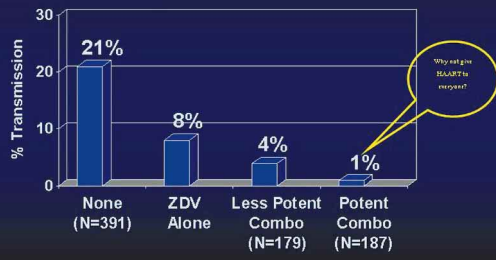
- Goals
- Improve maternal health and survival
- Lower maternal viral load and decrease perinatal transmission
- Prevent resistance
  - 3TC and nevirapine
  - limit future maternal treatment options
- Prevent breast milk transmission

Delivery Plasma Viral Load



Women & Infants Transmission Study, 1990-1999
Cooper E et al. JAIDS 2002;29:484-94

The More Potent the ARV Regimen The Lower the Transmission Rate



Women & Infants Transmission Study, 1990-1999
Cooper E et al. JAIDS 2002;29:484-94

Maternal Antiretroviral Toxicity

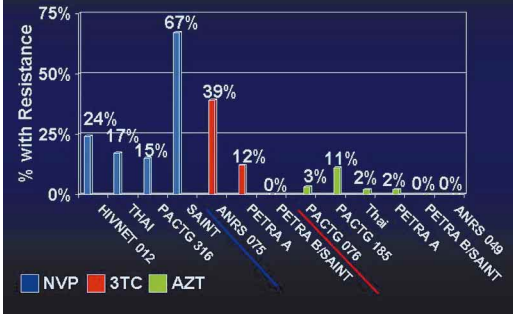
- Due to efficacy, cost and availability in developing countries
- Use NNRTI-based triple therapy
- Hepatic toxicity/severe rash with NVP
  - More common in women than men (3-7 times)
  - More common women with CD4 >250
- d4T/ddI lactic acidosis deaths
  - 3 deaths late pregnancy in women (with 2 fetal deaths) who received d4T/ddI throughout pregnancy

Maternal Antiretroviral Toxicity

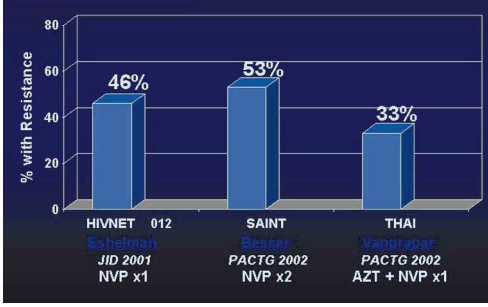
- 139 pregnant women started NVP-based regimen (89% started during pregnancy)
- 2 women (1.4%) died hepatic failure
- Serious rash -1.4%
- Moderate-severe ↑ liver enzymes - 8%

Lyons et al. 2nd IAS Conf, Paris, July 2003

Resistance in Women Following PMTCT Antiretroviral Prophylaxis

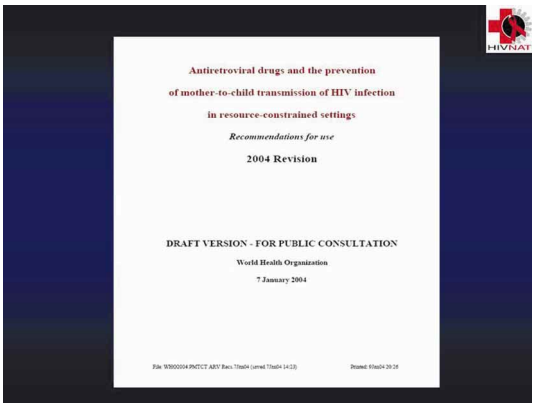


Nevirapine Resistance in Infected Infants at 6 Weeks Postpartum



Overview

- HIV-NAT
- Update on antiretrovirals
- Ongoing and planned PMCT trials
- **New WHO guidelines for PMCT**


Antiretroviral drugs and the prevention
of mother-to-child transmission of HIV infection
in resource-constrained settings
Recommendations for use
2004 Revision
DRAFT VERSION - FOR PUBLIC CONSULTATION
World Health Organization
7 January 2004

WHO guidelines May 2004 Key points

- Recognise that single-dose NVP is the simplest regimen to deliver
- Single-dose NVP programs should continue and be expanded
- Programs should plan to introduce other ARV regimens
- Health systems improved
- Enable the delivery of more complex ARV regimens

First-choice regimen

- Women
  - AZT starting at 28 weeks or as soon as possible thereafter
  - continue AZT during labour
  - single-dose NVP at the onset of labour
- Infants
  - Single-dose NVP plus one week of AZT

Alternative regimens

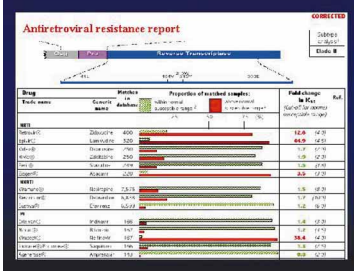
- Women
  - AZT +3TC from 28 weeks or as soon as possible
  - continued during labour
- Infants
  - one week AZT +3TC

- Women
  - single-dose NVP
- Infants
  - single-dose NVP

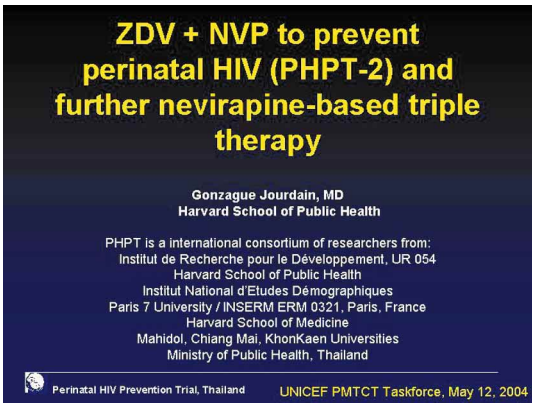
Alternative regimens

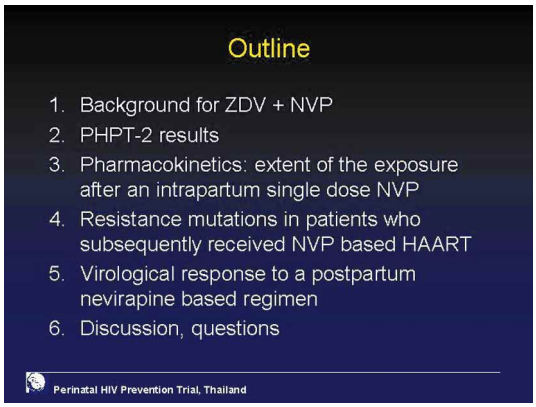
- If triple-combination regimens are used
- MTCT prevention only
- Women without indications for ARV treatment
- Recommended regimens
  - AZT+3TC+SQV/r
  - AZT+3TC+NFV
- third trimester of pregnancy
  - AZT+3TC+EFV could be considered

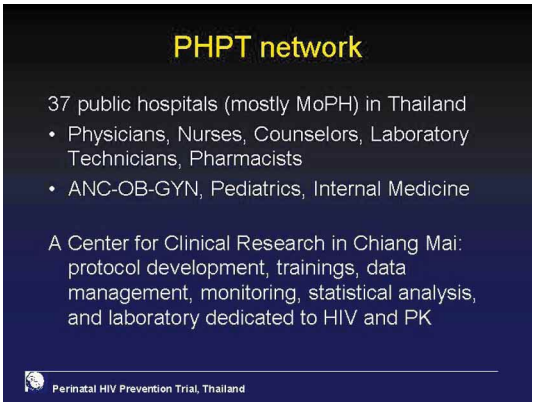
Research Next Steps

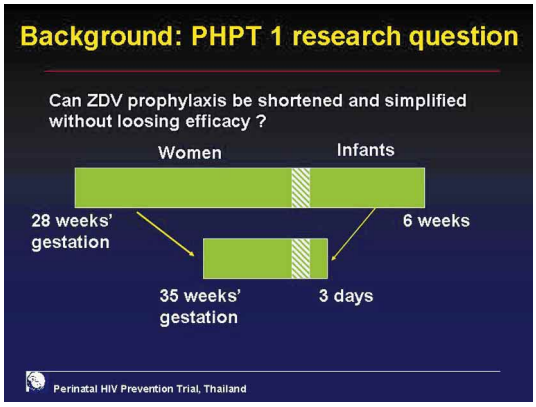


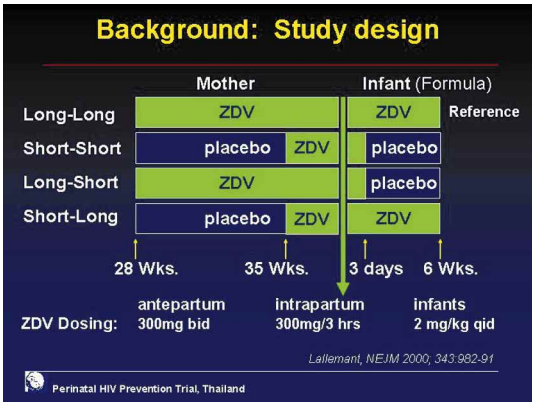
7. Results of study, PHPT-2 and the links between PMTCT and PMTCT Plus
- Dr. Gonzague Jourdain

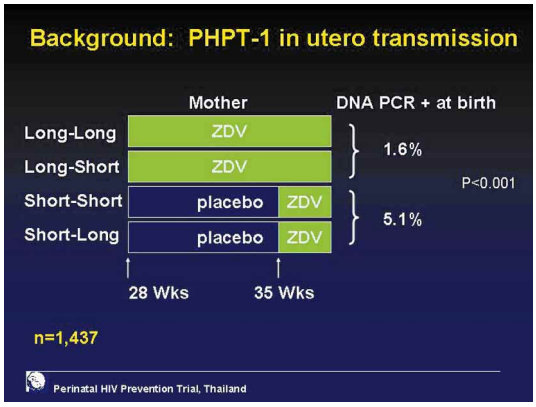


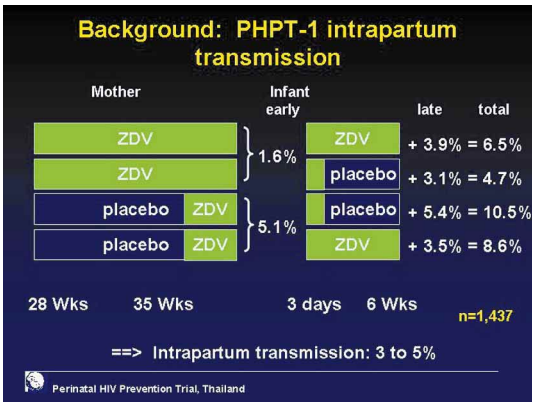


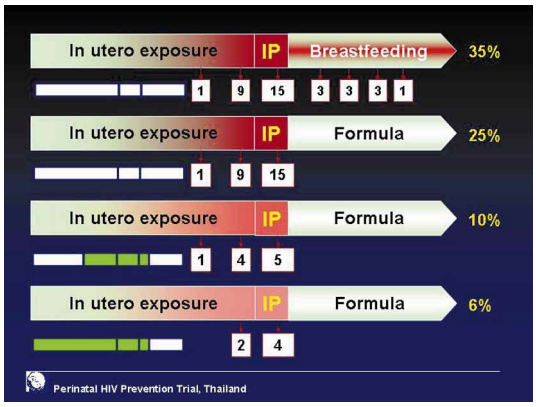




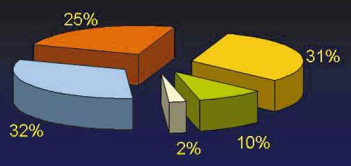








Distribution of intervention costs



- Counseling
- HIV testing
- Prenatal/intrapartum ZDV
- Infant's ZDV
- Formula

Perinatal HIV Prevention Trial, Thailand

HIVNET 012: Efficacy

Guay, Lancet 1999; 354:795-802

Perinatal HIV Prevention Trial, Thailand

Reducing Intrapartum Exposure and Increasing PEP

Transmission Period	In utero Pregnancy	Intrapartum Labor and delivery	Postpartum Infant
Antiretrovirals	Zidovudine	Zidovudine + Nevirapine	Zidovudine + Nevirapine
Others			Formula

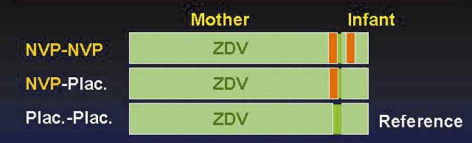
Nevirapine: long half-life, immediate and potent antiretroviral action

To decrease exposure

To block replication

Perinatal HIV Prevention Trial, Thailand

A randomized, double blind trial



NVP dosing: Mother = 200 mg po at onset of labor
Infant = 6 mg po 48-72 hours after birth

ZDV regimen: Pregnancy = 300 mg bid from 28 wks' gestation or as soon as possible thereafter
Labor = 300 mg po every 3 hours
Infant = 2 mg/kg qid for 1 wk (6 wks if <4 wks in mother)

No breastfeeding
1,844 women and their infants (one year follow-up)

Perinatal HIV Prevention Trial, Thailand

Methods

- Counseling and written Informed Consent
- ZDV prophylaxis from 28 weeks' gestation or as soon as possible thereafter

Women were not randomized if they had received less than 2 weeks of ZDV or had initiated HAART
These women were followed separately

- PCP prophylaxis to all infants from 6 weeks until proven uninfected
- Symptomatic infected infants and immunocompromised mothers offered ARV

Perinatal HIV Prevention Trial, Thailand

Endpoint

Method

- Blood draw at birth, 6 weeks, 4 and 6 months
- HIV DNA-PCR performed on Dried Blood Spots (Roche Amplicor 1.5)

Diagnosis criteria

- *Infected*: two positive DNA-PCR on separate occasions
- *Uninfected*: two negative DNA-PCR on separate occasions after 1 month of age

Twins considered a single entity: discordant twins counted as a single infected infant

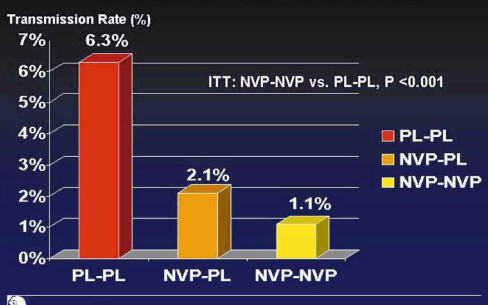
Perinatal HIV Prevention Trial, Thailand

Characteristics of Mothers, Deliveries and Infants

- Similar between groups

Perinatal HIV Prevention Trial, Thailand

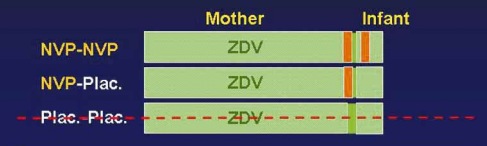
Transmission Rates: Deliveries before May 2, 2002



Perinatal HIV Prevention Trial, Thailand

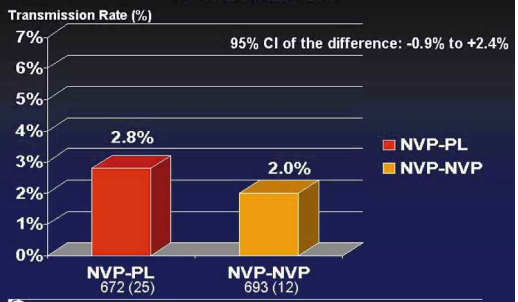
First Interim Analysis

On May 2, 2002, the DSMB recommended that enrolment in the PL-PL arm be terminated and the target sample size increased to 695 per arm (test for non-inferiority between NVP-PL and NVP-NVP; 0.8 power, delta value = 2.5%).



Perinatal HIV Prevention Trial, Thailand

Transmission Rates: Final analysis



Perinatal HIV Prevention Trial, Thailand

Conclusion

- Maternal and infant ZDV (28 weeks' gestation)+ intrapartum NVP decreases the risk of HIV perinatal transmission to levels comparable to HAART during pregnancy (in settings where, in addition, elective C-Section is commonly used to prevent transmission)

Perinatal HIV Prevention Trial, Thailand

Intrapartum exposure to single dose nevirapine and subsequent maternal 6-month response to a nevirapine based antiretroviral regimen

Perinatal HIV Prevention Trial, Thailand

Background

- ZDV from 28 weeks' gestation + intrapartum nevirapine highly efficacious and safe (PHPT-2)
- Intrapartum NVP has been associated with the emergence of NNRTI drug resistance mutations (HIVNET 012, PACTG 316). Rates vary depending on techniques, definitions of resistance mutations, and number of intrapartum doses
- In PHPT-2, 25% of pregnant women needed HAART (CD4 <250)
- Thai « GPOvir » (d4T–3TC–NVP): US$ 30/month
- WHO recommendations for women of childbearing potential

Question

Is the response to a subsequent NNRTI-based regimen compromised by SD NVP?

Perinatal HIV Prevention Trial, Thailand

Measurement of NVP exposure in the postpartum period

- Measurement of postpartum NVP plasma levels
- Technique: HPLC: sensitivity of the NVP assay used was 50 ng/ml (NVP IC_{50} =10-100 nM or 3-30 ng/mL)
- Nevirapine was detected up to three weeks after intrapartum intake in some women

Perinatal HIV Prevention Trial, Thailand

Response to a NNRTI based regimen following intrapartum NVP exposure

Patients

- 269 immunocompromised women started nevirapine based regimen in the postpartum period between June 2002 and August 2003:
  - 48 not exposed to intrapartum NVP
  - 221 exposed to intrapartum NVP
- NVP was switched to EFV if adverse event (6%)

Perinatal HIV Prevention Trial, Thailand

Viral loads and Genotyping

- VL assayed at baseline (or during pregnancy), 3 and 6 (± 1.5) months (Cobas Amplicor HIV-1 Monitor v1.5 Roche Diagnostics)
- ViroSeq HIV-1 Genotyping system
- 12-day postpartum samples
- Definition of NNRTI resistance associated mutations according to IAS-USA tables (Oct. 2003)
- Genotyping performed blindly to intrapartum intake of NVP

Perinatal HIV Prevention Trial, Thailand

Patients with NNRTI resistance mutations (IAS) at median 12 days (10-14) postpartum

- High viral load is a risk factor for teh selection of resistance mutations
- In this group of women who needed treatment and therefore had high viral loads (4.6 log10 copies/ml) NNRTI resistance mutations were found in about 30 percent of the women who had been exposed to intrapartum nevirapine

Perinatal HIV Prevention Trial, Thailand

Results

- Six months after initiation of therapy, median CD4 increase was similar among NVP exposed and unexposed women
- However women who initiated a nevirapine containing regimen in the postpartum period were less likely to achieve virological suppression (<50 copies/ml) at 6 months of treatment if they had previously been exposed to a single dose of nevirapine.

Perinatal HIV Prevention Trial, Thailand

Need for more studies

- Sustainability of the response at 12 months?
- Relationship between time to treatment initiation and virological response?
- Can we prevent the selection of resistance mutations?
- Other antiretroviral drugs for PMTCT?
- Alternatives?

Perinatal HIV Prevention Trial, Thailand

HAART during pregnancy in women who require therapy for their own health

Highly Active Antiretroviral Treatment (HAART) and prevention of opportunistic infections (OIs) in particular prevention of PCP should be proposed wherever possible if pregnant women are immunocompromised (CD4 below 250-200 cells/mm^3):

- Minimize the risk of vertical transmission
- Minimize the risk of adverse event during pregnancy
- Need coordination with Internal Medicine (long term treatment)

Perinatal HIV Prevention Trial, Thailand

HAART during pregnancy in women who do not require therapy for their own health?

- Good efficacy, but data from settings where C-section is extensively used for PMTCT (PACTG 316)
- Safety concerns (hepatic toxicities) regarding the use of nevirapine based HAART in **women** with **CD4 > 250** cells/mm^3 (patients on NNRTIs were not included in PACTG 316) especially in populations with high prevalence of Hepatitis B
- Use of 3TC for a few months and Hepatitis B: risk of HBV rebound after 3TC discontinuation?
- Pharmacokinetics of PIs modified during pregnancy, adherence to complex regimens during pregnancy: risk of resistance mutations?
- Implementation: a medical intervention which requires specific training
- HAART during pregnancy in women who do not require therapy for their own health has never been directly compared to simpler regimens

Conclusion

- Where or when HAART during pregnancy is not feasible or desirable, ZDV + NVP is the only regimen which matches the efficacy of HAART during pregnancy to prevent vertical transmission

Perinatal HIV Prevention Trial, Thailand

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23 Bhumibhol Adulyadej Hospital
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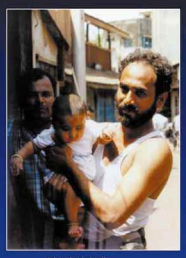
• Institut National d'Etudes Démographiques, France
• Fogarty international, USA
• Glaxo-Smith-Kline, Boehringer-Ingelheim and Roche Molecular Systems
Perinatal HIV Prevention Trial, Thailand

8. Impact of '3 x 5' for parent-to-child transmission prevention and care
- Dr. Wendy Holmes

The impact of '3 by 5' on parent-to-child transmission prevention and care



Mumbai, India

Regional consultation, Bangkok

Wendy Holmes

Centre for International Health, Macfarlane Burnet Institute for Medical Research and Public Health, Melbourne, Australia

holmes@burnet.edu.au

May 2004

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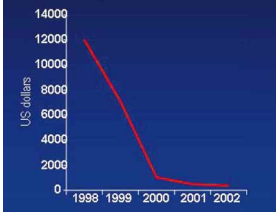
The impact of '3 by 5' on prevention of parent-to-child transmission of HIV

Cost (per year) of antiretroviral drugs has dropped dramatically

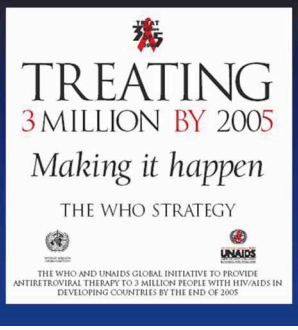


Sources of data: UNAIDS

The impact of '3 by 5' on parent-to-child transmission prevention and care

On World AIDS Day last year, December 1st – WHO announced a new advocacy initiative –

An emergency response to the disaster of AIDS



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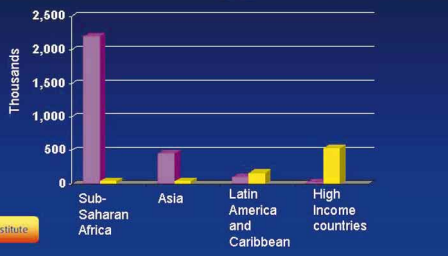
The impact of '3 by 5' on parent-to-child transmission prevention and care

ARVs have not been available where the need is greatest



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The impact of '3 by 5' on parent-to-child transmission prevention and care

Countries in Asia and the Pacific, as well as in Africa, have requested assistance from WHO, including India, China, Indonesia, Papua New Guinea and Vietnam.

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The impact of '3 by 5' on parent-to-child transmission prevention and care

Many potential benefits:

- More people (including parents) with HIV receive treatment – live longer, happier, productive lives
- Reduced viral load contributes to prevention
- People may be more willing to be tested – contributes to prevention
- Stigma reduced – more pregnant women willing to take up prophylaxis
- Greater engagement by governments with general responses to the epidemic
- Increased resources for health care systems

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The impact of '3 by 5' on parent-to-child transmission prevention and care

Why has the '3 by 5' initiative been taken up so rapidly by national governments?

Reich described a useful framework to analyse the politics of agenda setting in international health.

He classifies the streams of influence as

- symbolic
- organisational
- scientific
- economic and
- political

Reich M. The Politics of agenda setting in international health: child health versus adult health in developing countries. J Int Development 1995; 7(3):489-502.

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The impact of '3 by 5' on parent-to-child transmission prevention and care

Influence of 'symbolic politics'

Individuals and organisations employ images and language as symbols for advocacy and fundraising.

The DOTS campaign for tuberculosis showed how successful 'branding' a policy could be for mobilising resources.

Concept of delivering potent new medicines to the sick is a more ready source of positive symbols to attract funds.

E.g. 'Before and after' pictures from WHO web-site. Joseph Jeune. Patient, Lascahobas Clinic, Haiti. *Top*: Before therapy for TB and AIDS, February/March 2003. *Right*: After therapy for TB and AIDS, September 2003 –

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The impact of '3 by 5' on parent-to-child transmission prevention and care

Influence of 'organisational politics'

World Bank / WHO - setting the international health agenda

'3 by 5' taken up by bilateral donors, and by the new large funding bodies, such as the Global Fund, Bill and Melinda Gates Foundation, Bush Initiative.

The priorities of these donor agencies inevitably influence the policy agendas of developing country governments, and of their smaller partner organisations.

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The impact of '3 by 5' on parent-to-child transmission prevention and care

Influence of 'scientific politics'

Evaluating the impact of prevention efforts problematic - pace and pattern of spread of HIV difficult to predict in any setting

Evaluating comprehensive continuum of care problematic - can seem a vague ideal

But measuring increased numbers on ARVs is conceptually simple

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The impact of '3 by 5' on parent-to-child transmission prevention and care

Influence of 'economic politics'

Extending life of productive adults lessens economic impact on families, communities and nations.

Treatment with ARVs may reduce other health care costs.

The multi-national pharmaceutical companies also now have an economic interest in rapid expansion of a long-term treatment for millions of people.

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The impact of '3 by 5' on parent-to-child transmission prevention and care

Influence of 'political politics'

Debates about promotion of condoms and needle exchange programs unpopular with politicians – 'treating sick people' less politically threatening.

'3 by 5' presented as an important contribution towards achieving UNGASS targets, and to the Millennium Development Goals

Security concerns prominent - both donor and recipient governments are aware that armies often have high rates of HIV infection.

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The impact of '3 by 5' on parent-to-child transmission prevention and care

What's needed for '3 by 5'?

- Wide availability of VCT
- Quality control for tests – ordering and storage
- Laboratory technicians trained
- Quality control for drugs – ordering and storage
- Referral mechanisms in place
- Trained health staff
- Adherence support mechanisms
- Social and emotional support
- Community knowledge and acceptance…. and…

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The impact of '3 by 5' on parent-to-child transmission prevention and care

WHO have urged that we need to be:

"sailing the ship at the same time that it is being built"….

A precautionary metaphor -

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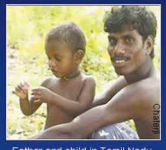
The impact of '3 by 5' on parent-to-child transmission prevention and care

Ternate, Indonesia

What are the implications for prevention and care in relation to parent to child transmission of HIV?

There are opportunities and concerns – if we recognise and discuss these we can try to avoid and minimise adverse effects



Father and child in Tamil Nadu

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The impact of '3 by 5' on parent-to-child transmission prevention and care

Countries have set targets that are greater than the numbers yet identified with HIV

Many Asian countries are still in the early stages of establishing VCCT services. VCCT plays an important role in prevention, as well as being an entry point to care. But the pressure to identify those eligible for ARVs threatens to skew VCT towards screening those with symptoms.

The impact of '3 by 5' on parent-to-child transmission prevention and care

Recently Richard Holbrooke suggested in the NY Times that testing should be 'required' at marriage, before childbirth and upon any visit to a hospital

Stephen Lewis, UN special envoy, urged that routine testing be required

"whenever someone presents at a medical facility, with the option of course to opt out."

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The impact of '3 by 5' on parent-to-child transmission prevention and care

The Asia Pacific Network of People Living with HIV/AIDS conducted a study of 764 HIV positive people in four Asian countries (India, Indonesia, Thailand and the Philippines)

More than half experienced discrimination in the health sector

This was more likely among those who were unprepared or coerced into taking a test. Breaches of confidentiality were common

Documentation of AIDS-Related Discrimination in Asia: Final report of the APN+ Human Rights Initiative. December 2003

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The impact of '3 by 5' on parent-to-child transmission prevention and care

When treatment is available people are encouraged to come forward for HIV testing

Reproduction is an important part of life – people with HIV have needs and concerns in relation to:

- contraception
- pregnancy
- childbirth
- infant feeding and
- baby care

Health care staff and counsellors need training and guidelines to help them to respond to questions and to manage HIV positive women that become pregnant

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The impact of '3 by 5' on parent-to-child transmission prevention and care

In some places ARVs are becoming available where pregnant women are not yet routinely offered HIV testing in the ante-natal clinic.

This can add to pressure to introduce rapidly an ANC-based PMTCT of HIV program.

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The impact of '3 by 5' on parent-to-child transmission prevention and care

There are hazards associated with introducing such programs without sufficient preparation:

- anxiety about testing
- discrimination if confidentiality is breached
- rejection by husband or family – male suicide
- missing out on ANC, delivery and PP care to avoid hearing the results
- unwanted sterilisation
- unsafe infant feeding practices

The poorest and most marginalised are at greatest risk

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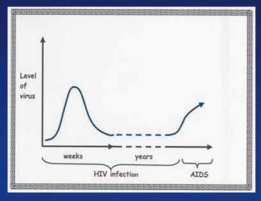
The impact of '3 by 5' on parent-to-child transmission prevention and care

'3 by 5' may divert resources and attention from efforts to prevent women becoming infected during pregnancy and post-partum



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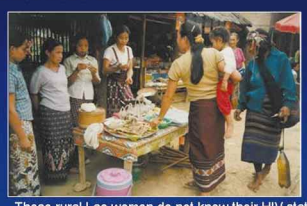
The impact of '3 by 5' on parent-to-child transmission prevention and care

'3 by 5' may divert resources and staff from MCH, and RH services that help to reduce the risk of MTCT of HIV when we don't know which mothers are infected.



These rural Lao women do not know their HIV status

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The impact of '3 by 5' on parent-to-child transmission prevention and care

Secondary prevention – population-based

Strategies to reduce risk of HIV passing from infected mothers to babies when we don't know which women have HIV

- Prevent unwanted pregnancies
- Improve health of pregnant women
- Strengthen STI treatment and control
- Encourage women with any chronic illness to avoid pregnancy until well for 6 months
- Train midwives to reduce interventions at delivery
- Promote exclusive BF; train health workers

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The impact of '3 by 5' on parent-to-child transmission prevention and care

Increased inequality of access to health care services – rural / urban divide

Attention and resources diverted from other HIV prevention and care activities – "honey pot" effect

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The impact of '3 by 5' on parent-to-child transmission prevention and care

Community-based approaches to HIV treatment in resource-poor settings
Paul Farmer et al Lancet 2001;358:404 -409

The Brazilian HIV/AIDS success story – can others do it?
Oliveira-Cruz V et al. Tropical Medicine and International Health, 2004;9:292-297

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The impact of '3 by 5' on parent-to-child transmission prevention and care

Country	Total spent on health % of GDP	Govt $ for health as % of total $ on health	Govt $ on health as % of total govt $
Brazil	7.6	41.6	8.8
India	5.1	17.9	3.1
Indonesia	2.4	25.1	3

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The impact of '3 by 5' on parent-to-child transmission prevention and care

'PMTCT-Plus' – the ANC as the starting point for introducing ART

Ethical issues

Husband, children, should receive treatment too if they meet lab / clinical criteria

- needs to be thought of as a life-long commitment

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The impact of '3 by 5' on parent-to-child transmission prevention and care

Problem of selective access

If access to free or subsidized ART only through ANC – risk that women may become pregnant, or be pressured to become pregnant, in order to access ART for herself and her family

ART should be available to all infected with HIV who meet the clinical / laboratory criteria

VCT for HIV should be available both outside and within the ANC setting.

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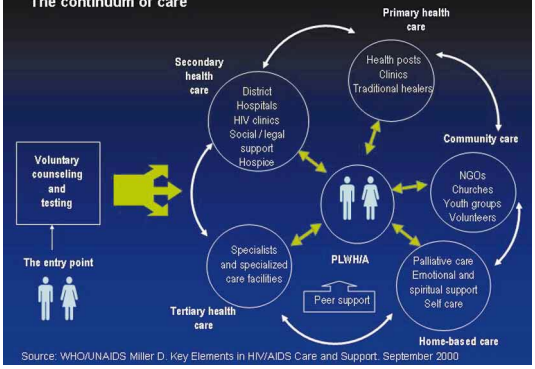
The continuum of care



Source: WHO/UNAIDS Miller D. Key Elements in HIV/AIDS Care and Support. September 2000

The impact of '3 by 5' on parent-to-child transmission prevention and care

- We need to develop adherence strategies for pregnant women and new mothers – and research the barriers to adherence
- Important to form links with supportive community based NGOs and CBOs
- Support the development of support groups
- Actively seek to counter stigma – starting in the health care system
- Document and publish experiences

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The impact of '3 by 5' on parent-to-child transmission prevention and care

Problems with resistance

There are interactions both ways to consider:

- '3 by 5' may increase resistance and make it difficult to provide effective prophylaxis to pregnant women
- PMTCT programs may cause resistance to develop rapidly to first line ARVs because of use of single and double drug regimens

Where VCT with ARV prophylaxis has been available for some time there will be increasing numbers of women attending ANC who are not naïve to ARVs. Recent studies show that resistance is a greater problem than expected

Martinson M, et al. HIV resistance and transmission following single-dose nevirapine in a PMTCT cohort. Conf Retroviruses Opportunistic Infect. 2004 Feb 8-11;11th: Abstract No. 38.

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The impact of '3 by 5' on parent-to-child transmission prevention and care

South Africa - single dose NVP to mother and baby; 455 mothers

- Median baseline: CD4: 392 cells/mm3; viral load: 28,700 copies/mL; no resistance to NVP
- At median 7 week follow up: Resistance to NVP: 38.8% of mothers, 42.4% of infants
- At 10 weeks: overall MTCT rate: 8.6%

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The impact of '3 by 5' on parent-to-child transmission prevention and care

Thai study - PHPT-2

Placebo-placebo arm discontinued after interim analysis showed 80% reduction using NVP-NVP arm

Interim analysis - MTCT rate:	NVP-NVP arm:	1.1%
	Placebo-placebo:	6.3%
Final results - MTCT rate:	NVP-NVP arm:	2.0%
	NVP-placebo:	2.8%

The effect of addition of NVP was much greater than expected.

Lallemant M, Jourdain G, Le Coeur S et al. A randomised, double-blind trial assessing the efficacy of single-dose perinatal nevirapine added to a standard zidovudine regimen for the prevention of mother-to-child transmission of HIV-1 in Thailand. Conf Retroviruses Opportunistic Infect. 2004 Feb 8-11; 11th: Abstract No. 40LB.

The impact of '3 by 5' on parent-to-child transmission prevention and care

25% (255) of the women needed treatment and received an NNRTI-containing regimen - NVP/3TC/d4T

At 6 months, percentage with viral load below 50 copies:

Unexposed:	75%
Exposed but with no detectable mutations:	53%
Exposed and with mutations:	34%

conclusions:

- NVP has a long half-life
- Even a single dose may cause a high rate of resistance
- The resistance often results in treatment failure

Jourdain G, Ngo-Giang-Huong N,Tungyai P et al. Exposure to intrapartum single-dose nevirapine and subsequent maternal six-month response to NNRTI-based regimens. Conf Retroviruses Opportunistic Infect. 2004 Feb 8-11; 11th: Abstract No. 41LB.

The impact of '3 by 5' on parent-to-child transmission prevention and care

Has the time come to abolish the use of suboptimal regimens and use generic HAART?

3 studies are underway in Africa to investigate efficacy and safety of giving HAART (ZDV + 3TC + NVP) to all HIV positive pregnant women during pregnancy and for 6 months during breastfeeding for those who do not meet treatment criteria (with ongoing HAART for those with clinical or laboratory treatment criteria).

Concerns re resistance - the baby receives sub-therapeutic levels of ARVs for a long period.

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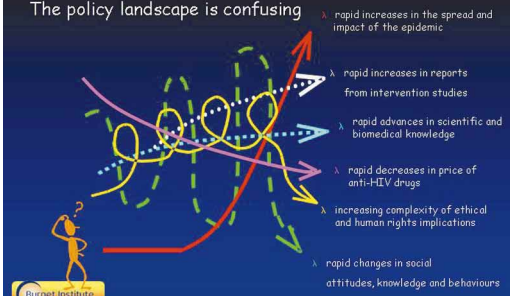
The impact of '3 by 5' on parent-to-child transmission prevention and care

The policy landscape is confusing



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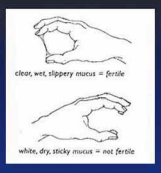
The impact of '3 by 5' on parent-to-child transmission prevention and care

Discordant couples that want to have a baby

Rather than have unprotected sex all through the month it is preferable for the couple to have unprotected sex only once a month at the time when the woman is more likely to ovulate.

She can be taught to recognise when this occurs from changes in her cervical mucus.



The risk can be lowered further by giving the woman pre or post-exposure ARV prophylaxis once a month. If the man is on HAART his viral load will be greatly reduced and the risk to the woman will be lower.

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The impact of '3 by 5' on parent-to-child transmission prevention and care

Conclusions:

We need to harness the energy generated by the '3 by 5' initiative

WHO has urged: "This is not the time for hesitation or doubt" -- but we do need to discuss the potential problems

We need to argue that with a strong health care system it is possible to deliver ARVs safely

We shouldn't pretend that countries can expand access without increasing their health care budget

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The impact of '3 by 5' on parent-to-child transmission prevention and care

- Prepare first to respond to the reproductive health needs of those who already know they are infected with HIV
- Resist too hasty introduction and expansion of hospital or clinic-based PMTCT - prepare carefully
- Pay attention to specific primary prevention
- Pay attention to strengthening MCH and RH services
- Pay attention to equitable allocation of resources
- Guard against cynicism

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The impact of '3 by 5' on parent-to-child transmission prevention and care
Burnet Institute

9. Component four of the UN PMTCT strategy - care, support and treatment of woman, children and their families - Dr. Ngashi Ngongo

Prong four of the UN PMTCT strategy: - care, support and treatment of women, children and their families -

Ngashi Ngongo & Arjan de Wagt

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Presentation outline

- Rationale
- Care needs of PLWHA
- Recommended interventions
- Conclusion

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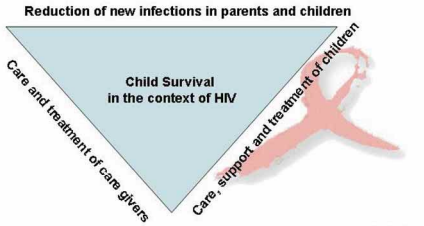
Rationale: HIV/AIDS and child survival



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However….

Most PMTCT programs not linked to HIV care, support and treatment

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Rationale (Cont'd): Why care, support and treatment?

- Health care for PLHA is human right
- Prolongs life and reduce AIDS deaths
- Reduce the number of orphans
- Reduce infant and young child mortality and improve child survival
- Strengthen prevention efforts
- Contribute to stigma reduction
- Reduce spread of TB and STIs

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Needs of PLHA

- To be diagnosed and supported to accept and cope with their serostatus
- Clinical Care: ART, OIs.
- Psychosocial support
- Nutritional support
- Legal support
- Social support for their orphans

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MTCT Prevention: A unique entry point to care for HIV-infected women and their children

International commitments:

"…by 2010, reduce the proportion of infants infected with HIV by 50%…"

"…by 2005, develop and make significant progress in implementing comprehensive care strategies…

Narrow focus on prevention of transmission insufficient

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UN recommended package of care, support and treatment interventions

- WHO and partners (UNICEF, UNFPA, UNAIDS, World Bank, Family Health International, CDC)
- Presents key interventions and recommendations that address the health needs of HIV-infected women and their children, building on existing recommendations

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UN recommended package of care, support and treatment interventions (2)

- Aim:
  - Assist policy-makers and managers of national HIV/AIDS programmes as well as clinical services and reproductive health programmes to make informed decisions, draw up country-specific norms and standards, develop operational policies and guidelines for the treatment, care and support of HIV-infected women and their children.

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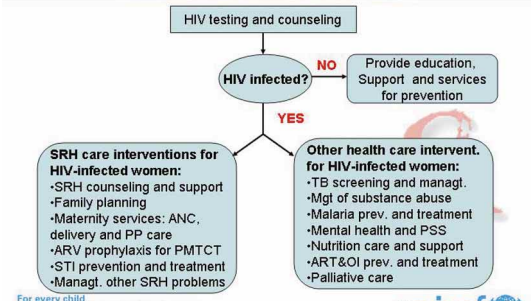
Key health care interventions for HIV-infected women



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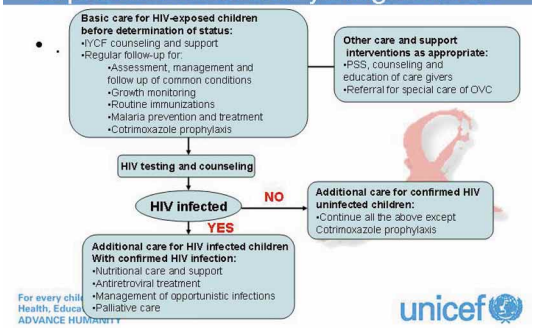
Key health care interventions for HIV-exposed infants and young children



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Continuum of care

- Different levels of service delivery:
  - Household level
  - Community level
  - Health facility:
    - Primary health facility level
    - Secondary health facility level
    - Tertiary health facility level
- Care must be provided in a continuum:
  - Linkages between service providers and
  - Referrals of PLHA between different levels

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Source: WHO/UNAIDS December 2000

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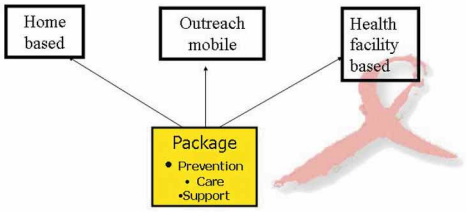
Health services delivery strategies



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Conclusion

- HIV infected women and children born to HIV-infected women have particular health care needs.
- PMTCT programmes can serve as an entry point to care of HIV infected women and their children, and a rallying point for enhanced prevention and care.

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Source: WHO/UNAIDS December 2000

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Nutrition care and support for people living with HIV/AIDS - Mr. Arjan de Wagt

Nutrition care and support for people living with HIV/AIDS

Arjan de Wagt
UNICEF EAPRO

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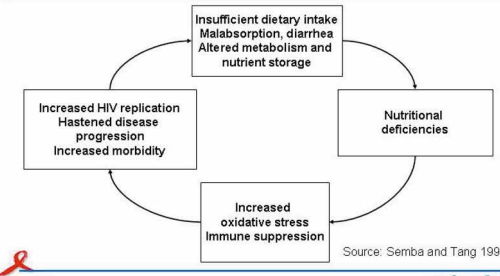
The Vicious Cycle of Malnutrition and HIV



Source: Semba and Tang 1999.

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Summary micronutrients and HIV infection

(Modified from Fris H, ed. *Micronutrients and HIV infection*, CRC Press, 2001)

	Viral load	Progression	Transmission
A	≈	↓ (↑)	≈ / ↑
B		(↓)	
C	(↓)		
E	(↓)		
Fe	Low dose ≈/ high dose?	(↑)	
Zn		(↑)	
Se	(≈)	(↓)	

No effect: ≈ Decrease: ↓ Increase: ↑ (Weak data)

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Stages of HIV Disease and Nutrition

- **Early - no symptoms, stable weight:**
  - Promote a diet adequate in energy, protein, and other essential nutrients
  - Maintain physical activity
- **Middle - weight loss:** "minimize consequences"
  - Maintain intake during periods of acute illness and depressed appetite, increase intake to promote weight gain and recovery
  - Continue physical activity as able
  - Manage the symptoms that affect food intake immediately
- **Late - symptomatic AIDS, wasting** " provide comfort"
  - Treat infections affecting appetite, ability to eat, retention of nutrients
  - Maintain intake during periods of acute illness
  - Modify diet according to symptoms
  - Encourage physical activity as able

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WHO expert consultation on nutrient requirements for PLWHA - May 2003

- Limited evidence resulting in difficulties making evidence recommendations
- Energy: 10% increase in RDA when HIV+, 30% increase when AIDS
- Protein: possible increase, not yet quantified
- Micronutrients:
  - existing iron, folate and vitamin A supplementation guidelines to be followed independent of HIV status. Not less, not more
  - Normal fortification levels not expected to give problems
  - PLWHA need at least 100%RDA and possibly more. Based on present evidence not possible to provide guidelines for composition of and micronutrient levels in supplement

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Nutrition / ARV interactions

- Food affects medication absorption, metabolism, distribution, excretion
- medication affects nutrition absorption, metabolism, distribution, excretion
- Medication side effects affect food consumption, nutrient absorption
- medication and certain foods can give unhealthy side effects

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Food and ARVs

- Some ARVs should be taken with food (2-3 times per day)
- Some ARVs should be taken without food (Indinavir: food not be taken within 2 hour before, 1 hour after taking medication (2-3 times daily)

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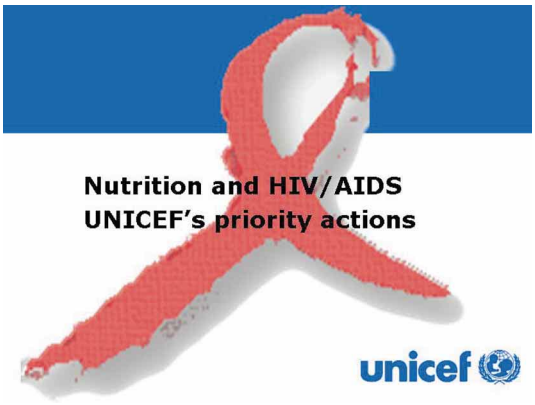
Common Side effects of ARVs

- Diarrhea, nausea, reduced appetite
- Fat metabolism:
  - Lypodistrophy
  - cholesterol
- Liver / kidney problems

Basically nothing known about impact of ARV use in nutrition compromised populations and on impact of ARVs on micronutrient status

Arjan de Wagt UNICEF EAPRO | Bangkok, Thailand, May 2004 | unicef



UNICEF priority actions in nutrition and HIV

- **Advocacy for commitment from national Government, NGOs, CBOs and donors**
- **Situation assessment and analysis**
- **Develop or reorient national policies and strategies**
- **Support to women and children infected with or affected by HIV/AIDS**
  - **monitor nutrition status**
  - **provide dietary guidance**
  - **support micronutrient supplementation**
  - **advocate for and support child supplementary feeding and therapeutic feeding in cases of severe malnutrition in high HIV-prevalence areas**
- **Research, monitor evaluate, document and share experiences**

4a. monitoring the nutrition situation of PLWHA

- Community based and health center based growth monitoring and monitoring of nutrition status of PLWHA and others who are chronically ill
- Referral system in place
- Strengthen community information systems

4b. Dietary guidance

- Develop national guidelines for nutritional care and support for PLWHA
- Disseminate dietary guidelines:
  - training of counselors, volunteers, support groups, families, homes based care providers (pre- and in-service)
  - communication strategy

4c. Micronutrient supplementation

- No WHO recommendations yet

4D. Support TF and CSF in cases of severe malnutrition likely confounded by HIV/AIDS

- Support nutrition surveillance and identify specific groups of women and children affected by HIV, assess how best they can be targeted and identify what other supply/resource needs besides food they might have
- collaborate with WFP to support interventions assisting these groups.
- monitor coverage and adequacy
- explore potential to scale up TF in areas with high PEM and HIV/AIDS
- explore opportunities to provide community based TF

Operational approach

- Integrate into PMTCT plus
- Integrate into support for OVCs (<12 months, 1-5 years, 5+ years)
- Integrate with VCT and care and support for PLWHA
- Integrate into emergency responses
- Integrate into non-HIV programs like IECD, IMCI, IYCF

10. The PMTCT-Plus Initiative and global support
- Dr. Katherine Bond

MTCT PLUS

Columbia University Mailman School of Public Health

The MTCT-Plus Initiative

www.mtctplus.org

Support

- Bill & Melinda Gates Foundation
- William and Flora Hewlett Foundation
- Robert Wood Johnson Foundation
- Henry J. Kaiser Family Foundation
- John D. and Catherine T. MacArthur Foundation
- David and Lucile Packard Foundation
- Rockefeller Foundation
- Starr Foundation
- United Nations Foundation
- United States Agency for International Development
- Centers for Disease Control & Prevention

The MTCT - Plus Initiative

What is the MTCT-Plus Initiative?

- HIV/AIDS care and treatment program, focusing on resource-limited settings
  - 11 program sites in Africa, one in Thailand
- Foundation-funded
  - Now a "public-private partnership" w/support of USAID, CDC
- Leadership at Columbia's Mailman School of Public Health
  - Program development informed by international External Advisory Committees

The MTCT - Plus Initiative

MTCT-Plus Secretariat

- Elaine Abrams
- Alan Berkman
- Pamela Collins
- **Wafaa El-Sadr**
- Scott Hammer
- Tom Hardy
- David Hoos
- Louis Kuhn
- Marita Murrman
- Landon Myer
- Richard Parker
- Miriam Rabkin
- **Allan Rosenfield**
- Nomi Rotbard
- Robert Sember
- Ezra Susser
- Andrew Thompson
- Joshua Zivin

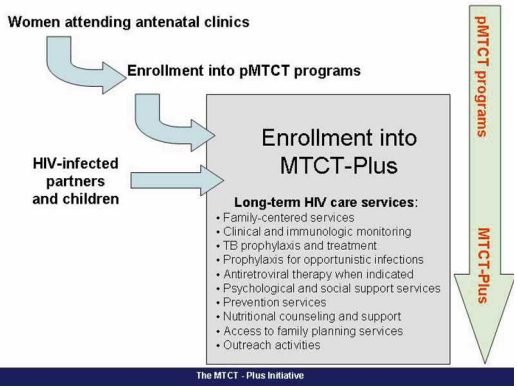
The MTCT - Plus Initiative

What is the MTCT-Plus Initiative?

MTCT-Plus provides long-term HIV primary care services for

- **women diagnosed with HIV in the context of perinatal prevention programs ("pMTCT" programs)**
- **their HIV-infected infants and children**
- **family/household members**

The MTCT - Plus Initiative



The MTCT - Plus Initiative

Fundamentals of MTCT-Plus

- Comprehensive HIV primary care that includes antiretroviral therapy
- Family-centered care
- Attention to clinical, psychosocial, and environmental issues
- Emphasis on involvement of people with HIV and outreach to community resources

The MTCT - Plus Initiative

What are the Goals of MTCT-Plus?

- Longer parental survival to take care of children and families
- Wellness and quality of life to facilitate continuing employment
- Healthier individuals, families and communities

The MTCT - Plus Initiative

Why Was this Model of HIV Care Selected?

- Rapid global expansion of pMTCT programs
- Recognition of the impact of loss of mothers on health of the child, the family and the community
- Appeal of linking a treatment intervention (MTCT-Plus) to a prevention intervention (pMTCT)

What can MTCT-Plus Accomplish?

- A decrease in morbidity and mortality
- Further reduction in MTCT
- Strengthened local health care capacity
- Empowerment of patients
- Promotion of VCT and other HIV prevention strategies
- Decrease in stigma and enhanced support to persons with HIV in the community
- A generalizable model for HIV care in resource-limited settings

Building the Program

- Staffing
- Training
- Clinical procedures and tools
- Procurement
- Patient record keeping
- Implementation and quality assistance
- Evaluation

Multidisciplinary Care

- Care provided by diverse team of providers across disciplines to enhance the quality of services provided to patient/family
- Coordination of care for adults and children
- On-site team of providers linked to those conducting outreach activities and supportive services

Early Training Decisions:

- Training of teams > training of individuals
  - on-site whole-team training, rather than a train-the-trainer model
- Skills transfer > "information update"
  - "competency-based" training
- Utilization of local expertise & experience

The Elements of HIV Care in MTCT-Plus

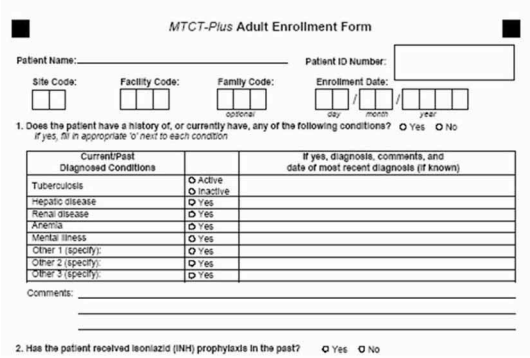
- **Medical care for HIV infected adults and children** *(750 people/site)*
- **Early diagnosis of infant infection status**
- **Clinical and immune monitoring**
- **Prevention of opportunistic infections**
- **Antiretroviral therapy**
- **Patient education, counseling, adherence support**
- **Social and psychological support**
- **Outreach and community linkage**
- **Retention in long term care**
- **Prevention of transmission to others**

Choosing ARV regimens

- **Local / national treatment guidelines** (and patents, registration, procurement issues)
- **WHO guidelines**
- **Toxicity / teratogenicity** (women of child-bearing age)
- **Adherence considerations** (pill count)
- **Cost**
- **Storage requirements** (refrigeration)
- **Sequencing of 1st and 2nd regimens** (resistance !)
- **Prevalence of tuberculosis**

Procurement of Medications

- Central purchasing and distribution of medications and supplies through UNICEF
- Use of medications on WHO pre-qualified list (including generics)
- Development of system to ensure secure medication supply



MTCT-Plus Adult Enrollment Form

Patient Name: _____ Patient ID Number:

Site Code: Facility Code: Family Code: (optional) Enrollment Date: day / month / year

1. Does the patient have a history of, or currently have, any of the following conditions? O Yes O No
If yes, fill in appropriate 'o' next to each condition

Current/Past Diagnosed Conditions		If yes, diagnosis, comments, and date of most recent diagnosis (if known)
Tuberculosis	O Active O Inactive	
Hepatic disease	O Yes	
Renal disease	O Yes	
Anemia	O Yes	
Mental illness	O Yes	
Other 1 (specify):	O Yes	
Other 2 (specify):	O Yes	
Other 3 (specify):	O Yes	

Comments: _____

2. Has the patient received isoniazid (INH) prophylaxis in the past? O Yes O No

Implementation and Quality Assistance

- On-site assistance in preparation and implementation
- Identification of training needs
- Enhancement of quality of care
- Ongoing sharing of experiences at various programs
- Quarterly site visits by IQA team (JSI)
- Ongoing communication with NY-based "desk officer"

Program Evaluation

- Identification of key programmatic outcomes
- Rapid feedback to sites
- Cross-site evaluation and assessment of key parameters
- Evaluation of overall Initiative impact

How is this different from other programs?

Emphasis on

- Prevention of illness
- Adherence to care and treatment
- Family-focused care
- Children
- Secondary prevention

Lessons Learned

- Multidisciplinary care works
- Family-focused care works
- Loss to follow-up is negligible (so far)
- ARV adherence is excellent (so far)
- Health care system is strengthened, health care workers are enthusiastic
- Stigma and discrimination are powerful barriers to care and treatment

Challenges to Scaling-Up

- Mobilizing resources - $125 million from US Government
- 15,000 patients in 12 locations, add others
- Engaging the communities
- Taking it from the hospital to the farm
- Ensuring on-going compliance

11. Voluntary counseling and testing (VCT) specific to the needs of pregnant woman - WHO standardized modules for VCT - Dr. Prawate Tantipiwatanaskul

VCT specific to the needs of pregnant women - WHO standardized modules for VCT

Prawate Tantipiwatanaskul MD.,MPH.
Bureau of Mental Health Technical Development, Department of Mental Health,
Ministry of Public Health

Scope of presentation

- ✓ Why did we develop WHO standardized training program in VCT ?
- ✓ What are the key components ?
- ✓ How did we develop it ?
- ✓ How can you make use of it?

WHY?

- Increased demand on VCT
- Regional training program from Thailand → Regional standardized training program

What are the key components?

- ✓ Background information on HIV & VCT : 1 d.
- ✓ VCT for HIV : 4 ½ d.
- ✓ Targeted VCT intervention : 1 ½ d.
- ✓ Psychosocial care : 1 d.
- ✓ Establishment and management of VCT services : 1 ½ d. + 1 ½ d. field visit

What are the key components?

Targeted VCT intervention : 1 ½ d.

- ✓ IDU
- ✓ Sex workers
- ✓ Youth and children
- ✓ MSM
- ✓ PMTCT (2 hours)

PMTCT

Epidemiological data
Current strategy for the PMTCT
Importance of VCT on PMTCT program
Concepts and skills needed
Strategies for reducing disclosure related violence
Integration of PMTCT counseling into MCH system

HOW did we develop it?

Context:
Limited mental health resources
Mental health system focused on psychiatric care
In some places, lack of health infrastructure

Process of development:
Update information from project consultant (Ms.Kathleen Casey)
Relevancy and case examples from member countries thru series of meetings

HOW to make use of it?

Service protocol / procedures for counselors to follow (linked with other service components)
→Skills they require
→Relevant competencies
→Development of training program

HOW to make use of it?

Highlight the issues specific to the objectives and epidemiology of local area

Core modules should be included

Activities and case studies selected

Sawasdee

12. PMTCT and PMTCT Plus - experiences from Thailand - Dr. Praphan Phanupak

PMTCT & MTCT-Plus: Experiences from Thailand

Praphan Phanuphak, M.D., Ph.D.

The Thai Red Cross AIDS Research Centre

Bangkok

Issues to be addressed

- Is the country genuinely committed to PMTCT?
  - *Not because of UNICEF, Global Fund, etc*
- If yes, country needs to prepare VCT facility, de-stigmatization and ARV plans.
- If yes, what ARV regimen to be used and how about bottle feeding?
  - *Is it really true that country cannot afford the more efficacious regimen?*
- If yes, how about the orphans? How about the MTCT-Plus and ARV for the rest of the population?
- If yes, who can help?

Cost of ARV in PMTCT

US$ per mother

	Proprietary	Generic
• Single-dose NVP	None	Almost none
• AZT 4 weeks	208	30
• AZT 6 weeks	312	43
• AZT/3TC/NVP	684	150

Why not using generic drugs?

Objectives of PMTCT & MTCT-Plus

- Preventing the vertical transmission of HIV
- Maintaining the health and quality life of infected individuals
- Maintaining good family life of the entire family, both infected and uninfected
- What not included is ***the restoration of the psychosocial status of the infected individuals and their affected families***

Principles of PMTCT

- Reduce viral load in blood and breast milk
- Minimize the exposure to infected blood and breast milk
- Post-exposure chemoprophylaxis

The Thai Red Cross PMTCT Project

- **A donation campaign to provide free AZT for PMTCT**
- **Established February 1996**
- **Under the patronage of HRH Princess Soamsawali**
- **Over 5,500 women from 40 provinces have received AZT**
- **UNAIDS Best Practice series showing public mobilization**
- **Extension into MTCT-Plus**

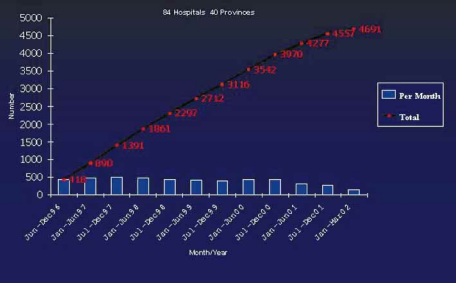
Rationale

- AZT should be used to prevent mother-to-child HIV transmission
- Patient should not be forced to have therapeutic abortion
- **Poverty should not be a barrier or being used as an excuse to do placebo-controlled trials**
- Money can be raised and used for PMTCT
- A pilot project to demonstrate need and feasibility as well as to drive government policy

TRCS AZT regimens

- **Initially, ACTG076 regimen, resulting in 5.8% transmission rate**
- **Later, only 8 week antepartum AZT was given because of similar efficacy**
- **Then, single-dose NVP was added to mother & newborn**
- **Now, triple therapy for all**
- **No breast feeding**

Number of Pregnant Women Receiving AZT from the program



MOPH PMTCT program

- Initially based on the short-course (4-week) antepartum AZT which had a transmission rate of 9.8%
- Later, 6-week antepartum AZT plus 1-week AZT to newborns or 6-week AZT to newborns if mother receives less than 4 weeks of AZT.
- Now, 12 weeks AZT plus single dose NVP to mother and newborn
- Nationwide PMTCT program since 1999

Problem of single-dose NVP

- High rate of NVP resistance (up to 20%) due to incomplete viral suppression and the long half -life of NVP
- This may jeopardize future use of NVP-containing regimens in mothers and infants
- Therefore, maximal viral suppression or HAART should be ideal in preventing vertical transmission and resistance

Current TRCS PMTCT regimen

- Any pregnant women with known CD4 count
- For those with CD4>200, start AZT/3TC/NVP from Week 28 until delivery, AZT 300 mg q 3 hrs during labor, AZT/3TC 1 week after delivery, 6 week AZT to newborn and bottle feeding
- For those with CD4<200, start ARV after Week 14 or sooner and patient must be able to access to national ARV program after delivery
- SGOT/SGPT q 2 weeks until 8 weeks, then q month and hospital must have experts to treat side effects & to change ARV

Objectives of TRCS MTCT-Plus

- To maximize the use of the donated fund
- To prevent orphans and to have a happy family *(Treat the Parents, Prevent the Orphans)*
- To enable women to inform their husbands and to get their husbands tested and treated and even the husband is negative, he will not leave the family
- To get public acceptance that HIV patients need ART, it works and is cost-effective
- To prepare more hospitals for ARV use

TRCS MTCT-Plus Project

- Extension of TRCS PMTCT donation project to women after delivery and their families (N=250) using d4T/3TC/NVP
- Supplemented by Columbia University MTCT Plus Initiative (N=250) using AZT/3TC/NVP
- Four hospitals (Chula, Sriracha, Police, Thammasat) participate, both NEW & OLD mothers
- Started in February 2003
- ARV will be provided life-long

Columbia University MTCT-Plus Initiative

- Initiated by Professor Allan Rosenfield, Dean of the Mailman School of Public Health, Columbia University who believes in woman-based family center program
- Totally funded by public donation
- Proposals reviewed by independent international experts based on the existing PMTCT activities, expertise & need
- 9 countries (13 sites) selected from 48 countries applied

Columbia MTCT-Plus (II)

- Thailand (TRCS) is one of the 9 countries
- 250 patients per year X 3 years (750 total)
- Starting from ANC and continue for life, estimating that only 15% of patients will need ARV at entry
- Monitored by clinical and CD4 only
- A demonstration, operational research, not a clinical trial
- Hope to be picked up and expanded by Global Fund

Components of Columbia MTCT-Plus

- Clinical care of adults (women & men), infants & children (OI & ARV)
- Psychosocial care
- Nutrition
- Adherence
- Patient education and 2ry prevention

Components of MTCT-Plus (II)

- Family care coordination
- Active case finding for TB
- Community outreach and mobilization
- Care of the care givers

The concept of one-stop clinic

- **OB clinic** for pre-partum & post-partum OB care
- **Medical clinic** for post-partum women & husbands
- **Newborn clinic** for:- early Dx (DNA-PCR at 8 weeks)
  - PCP prophylaxis for at least 6 months
  - early CD4 & ARV
- **Counselors, nutritionist, support group, etc**

Similarities & Differences of Columbia Univ. vs. TRCS MTCT-Plus

	Columbia	TRCS
• N (1st Yr)	250	250
• N (2nd, 3rd Yr)	250	?250
• Life-long ARV	+	+
• Funding	corporates donation	individual donation
• Eligibility of mothers	<6 Mo post-partum	as long as 7 years

Similarities & differences (II)

	Columbia	TRCS
• ARV (1st line)		
- Antepartum	AZT/3TC/NVP	AZT/3TC/NVP
- Postpartum	AZT/3TC/NVP	d4T/3TC/NVP
• Copayment for husbands	No/Yes	Yes/No
• Copayment for CD4	No/Yes	Yes/No

Similarities & Differences (III)

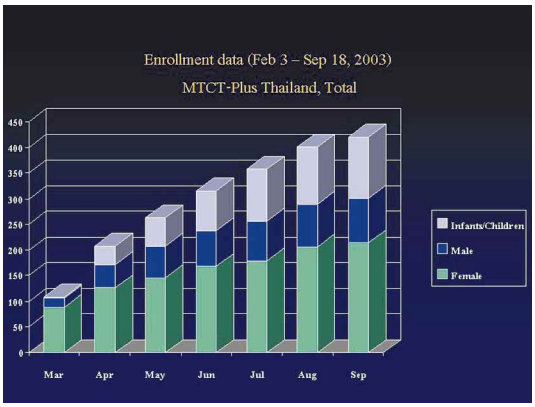
	Columbia	TRCS
• Financial support for infrastructure	Yes	No >>>Yes
• Record keeping	+++	+>>>+++
• One-stop care	++	+/->>>++
• Holistic care approach	+++	+>>>+++
• Socioeconomic support	None	Hopefully ++
• TB/HIV integration	+++	+>>>+++

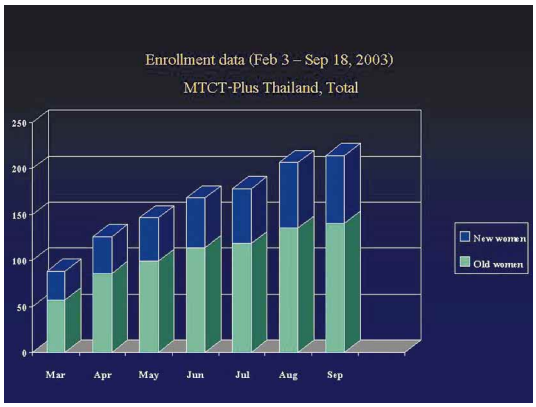
Unique features of TRCS/CU MTCT-Plus program

- Whole family comes on same day
- Many non-medical services & PWA in clinic as support group
- Latent TB detection
- Early ART for adults and newborns
- Team meeting
- Good record keeping & central data entry
- Continuous update, monitoring & training

Enrollment data (Feb 3 – Sep 18, 2003)

MTCT-Plus Thailand, Total


Enrollment data (Feb 3 – Sep 18, 2003)
MTCT-Plus Thailand, Total
450
400
350
300
250
200
150
100
50
0
Mar
Apr
May
Jun
Jul
Aug
Sep
Infants/Children
Male
Female


Enrollment data (Feb 3 – Sep 18, 2003)
MTCT-Plus Thailand, Total
250
200
150
100
50
0
Mar
Apr
May
Jun
Jul
Aug
Sep
New women
Old women

13. Issues of pediatric treatment
- Dr. Jintanat Ananworanich

Issues of Pediatric Treatment

UN Regional Taskforce on Prevention of Mother to Child Transmission
May 13, 2004

Jintanat Ananworanich, M.D.
The HIV Netherlands Australia Thailand Research Collaboration (HIV-NAT),
The Thai Red Cross AIDS Research Center
Bangkok, Thailand
Email: jintanat.a@chula.ac.th

1

Children (<15 years) estimated to be living with HIV/AIDS as of end 2002

Total: 3.2 million

UNAIDS

World Health Organization

HIV/AIDS in Thailand at Year-end 2002 (Population 60 million)

- Cumulative HIV/AIDS in children 32,961
- Current children living with HIV/AIDS 20,052
- New HIV-positive infants per year 600 - 800

Siraprapasiri T. Bureau of AIDS, TB and STI, Department of Disease Control, Ministry of Public Health, Thailand 3

Pediatric Treatment

Medical Issues

- Understanding Pediatric HIV disease
- Diagnosis of HIV
- Disease monitoring
- Immunization
- OI
- ARV

Coping and Living Issues

- Discrimination
- Disclosure
- Neuropsychological Development
- Adherence
- School
- Orphans
- Family support
- Teenagers
- Jobs
- Many more

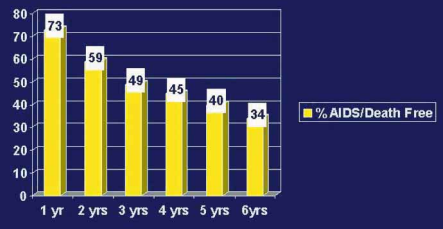
4

Children when compared to adults

- More rapid disease progression
- Higher viral load
- Better immune recovery in response to HAART

5

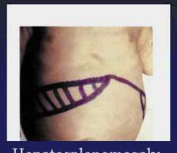
Survival Time Free of AIDS or Death in Thai Children (N = 68)



Ref. Chearskul S, et al. Pediatrics. 2002 Aug;110(2 Pt 1):e25

6

CDC Clinical Class A (Mild)

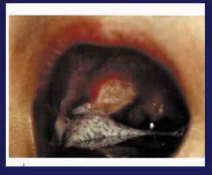


Hepatosplenomegaly

Parotitis

Dermatitis

CDC Clinical Class B (Moderate)



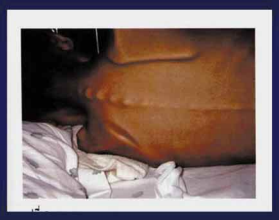
Oral candidiasis

Recurrent HSV

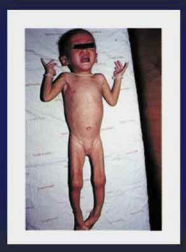
Pulmonary TB

Pancharoen C, ed. 2002

CDC Clinical Class C (Severe)



Wasting



Encephalopathy

Pancharoen C, ed. 2002

TABLE 3. Class C Clinical Conditions Among HIV-Infected Children (n = 21)

Condition	N	Median Age (Months)	Number Died (%)	Median Time From Diagnosis to Death (Months)
Recurrent serious bacterial infections	13	11	8 (62%)	10.5
Wasting syndrome	8	26	7 (88%)	0.5
Encephalopathy	5	11	4 (80%)	17.0
PCP	4	7	4 (100%)	0.5
Candidal esophagitis	4	20.5	4 (100%)	5.0
First Class C condition	21	12	14 (67%)	3.0

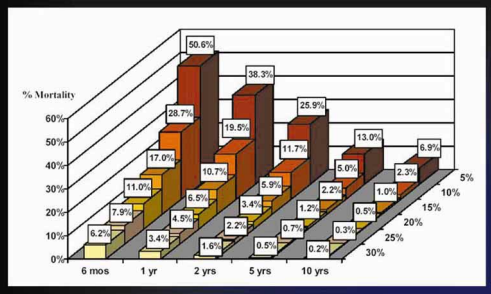
Ref: Chearskul S, et alPediatrics. 2002 Aug;110(2 Pt 1):e25

CDC Immune Classification

	< 12 mos		1–5 yrs		6–12 yrs	
Immune category	No./mm^3	(%)	No./ mm^3	(%)	No./ mm^3	(%)
Category 1: No suppression	≥ 1,500	(≥25%)	≥ 1,000	(≥25%)	≥500	(≥25 %)
Category 2 : Moderate suppression	750–1,499	(15%–24%)	500–999	(15%–24%)	200–499	(15%–24%)
Category 3: Severe suppression	<750	(<15%)	<500	(<15%)	<200	(<15%)

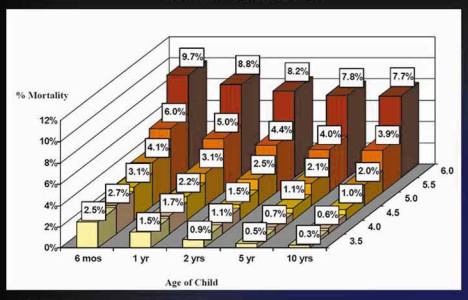
www.aidsinfo.nih.gov. January 20, 2004 11

CD4% and Probability of Death within 12 Months



www.aidsinfo.nih.gov. January 20, 2004 12

Viral Load and Probability of Death within 12 Months



www.aidsinfo.nih.gov. January 20, 2004 13

Care for HIV-infected infants in Thailand

- Diagnosis
  - HIV ELISA at 15 to 18 months
- Pneumocystis carinii pneumonia prophylaxis
  - At least to age 6 months in all
  - Longer if symptomatic or CD4 < 15%

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Antiretroviral Treatment Guidelines

- Individual country guidelines
  - Thailand (Ministry of Public Health, 2002)
- USA
  - www.aidsinfo.nih.gov (last updated on January 20, 2004)
- Pediatric European Network for the Treatment of AIDS or PENTA
  - http://www.ctu.mrc.ac.uk/penta/guidelines.htm
- World Health Organization
  - http://www.who.int/docstore/hiv/scaling/guidelines.pdf

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Factors to Consider

- Readiness of family and child
- Age
- Clinical staging
- CD4 staging
- Viral load

Starting ARV is not urgent

But OI prophylaxis is urgent

16

Thai Guidelines (2002)

- Age < 12 months
- Age >/= 12 months
  - Symptoms: CDC B (moderate) or C (severe)
  - CD4 < 20%

17

What to Start?

Principles of ARV Combinations

2 Nucleoside RT Inhibitors + NNRTI or PI

Thymidine Analog	+	Non-Thymidine Analog	+	•NNRTI •PI
AZT or d4T		3TC or ddI		

Quadruple therapy: 2NRTI + 1NNRTI + 1PI

Most used in resource-limited countries: 2 NRTI+NVP or EFV

Modified from the slide collection of Dr. Kiat Ruxrungtham

Ideal Regimen

- Good efficacy
- No or few side effects
- Few pills, no bad taste
- Few times, no food requirements
- Readily available
- Inexpensive

20

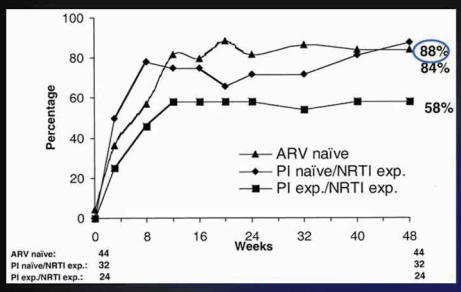
ARVs available through the Thai MOPH Access to Care Program

- Nucleoside Reverse Transcriptase Inhibitors (NRTI)
  - AZT, 3TC
  - d4T, ddI
- Non-NRTI (NNRTI)
  - Nevirapine (NVP)
  - Efavirenz (EFV)
  - GPO-vir (d4T/3TC/NVP)
- Protease inhibitors (PI)
  - Ritonavir (RTV), Indinavir (IDV)
  - Likely soon: Nelfinavir (NFV), Saquinavir (SQV)

Approprite dosing & formulation for children

21

VL < 400 copies/ml in almost 90% of ARV-naïve children on LPV/r



Ref: PIDJ 2003; 22(3):216-224

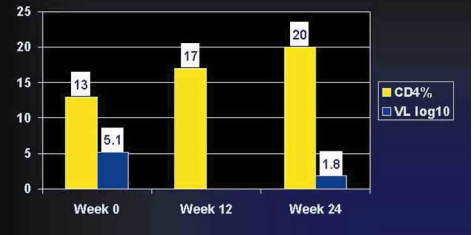
22

Nevirapine-based HAART

- Puthanakit T, et al. Chiangmai University (Abstract no.1081. Second IAS Conference, Paris, 2003)
  - Treated 30 children with baseline CD4 < 15% with GPO-vir (d4T/3TC/NVP) for 24 weeks
    - Median HIV viral load reduction was 2.88 log10 copies/ml
    - Median %CD4 change from baseline was 7%

23

Outcome of children on NNRTI-based HAART at HIV-NAT (n = 32)



At week 24

VL < 400 = 82%
VL < 50 = 60%

24

Helping children adhere to therapy

25

Understand the difficulty

- An 18-month old boy takes
  - 1 cap + 3 ml of AZT, 1/2 tablet of 3TC, 1/2 tablet of NVP TWICE per day
  - Equals to 4 pills + 6 ml per day
- A 6 year old girl takes
  - 5 capsules of Saquinavir, 1 capsule + 0.7 ml of Kaletra and 1 tablet of 3TC TWICE per day
  - Equals to 14 pills + 1.4 ml per day

26

Team work

- Children
  - Child's willingness (~ 4-5 yrs and up)
  - Activities and pill box especially at the beginning
  - Show results of tests to family and child
  - Older children: diary
  - Understanding of disease
- Caretaker(s)
  - Understanding of disease
  - Caretakers' responsibility to give the child his/her medicines
- Health care providers
  - Give positive reinforcement
  - Best possible formulations, fewest times, smallest amount

27

What is treatment failure and what to do?

28

The order of failure

Viral load failure

↓

CD_4 failure

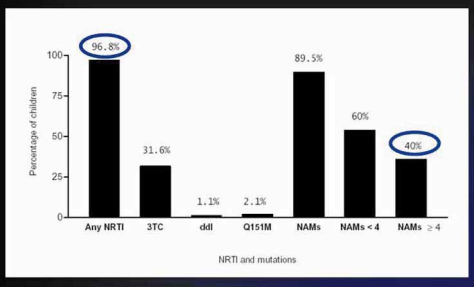
↓

Clinical failure

Poor adherence
Sub-optimal regimen
Infected with resistance virus

29

Prevalence of NRTI resistance in 95 children on dual NRTI for at least 6 months



Lolekha R, et al. Submitted to CID

30

Next Regimen? New Class, New Drugs

2 NRTI failure →
- •2 new NRTI + NNRTI (Likely will not work)
- •2 new NRTI + PI
- •NNRTI + PI
- •2PI

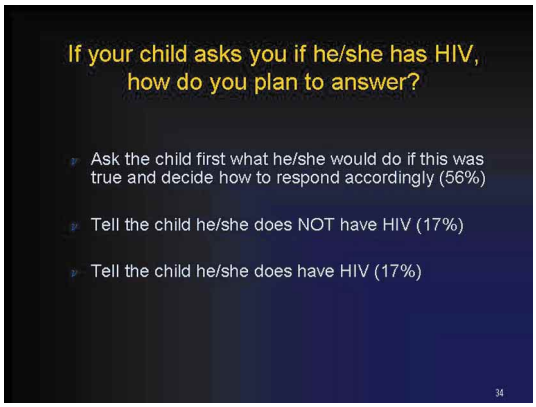
2 NRTI + NVP failure →
- •2 new NRTI + PI
- •2 PI

31

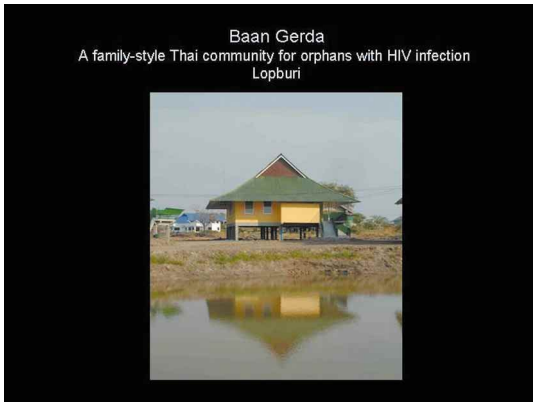
Telling children they have HIV

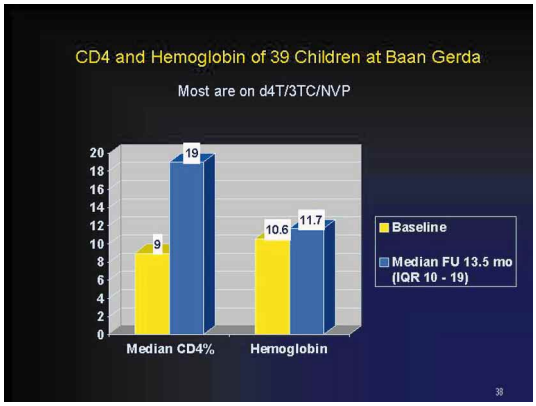
32

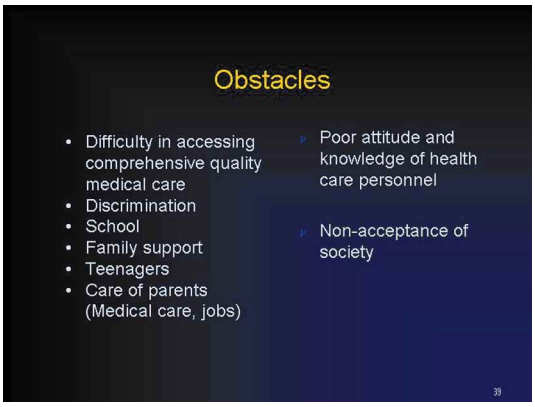

70
60
50
40
30
20
10
0
63
37
Yes
No
Do you intend to tell your child He/she has HIV infection?
80
70
60
50
40
30
20
10
0
73
58
46
31
0
Mental health
Secrecy
Immaturity
Don't know how
Reject mother
What are your reasons for not disclosing?
33


If your child asks you if he/she has HIV, how do you plan to answer?
Ask the child first what he/she would do if this was true and decide how to respond accordingly (56%)
Tell the child he/she does NOT have HIV (17%)
Tell the child he/she does have HIV (17%)
34


Orphans


Baan Gerda
A family-style Thai community for orphans with HIV infection
Lopburi


CD4 and Hemoglobin of 39 Children at Baan Gerda
Most are on d4T/3TC/NVP
20
18
16
14
12
10
8
6
4
2
0
9
19
10.6
11.7
Median CD4%
Hemoglobin
Baseline
Median FU 13.5 mo (IQR 10 - 19)
38


Obstacles
Difficulty in accessing comprehensive quality medical care
Discrimination
School
Family support
Teenagers
Care of parents (Medical care, jobs)
Poor attitude and knowledge of health care personnel
Non-acceptance of society
39

14. Infant feeding and HIV - technical and program update
- Mr. Arjan de Wagt

Infant Feeding and HIV: Technical and Programme Update

unicef

Arjan de Wagt
UNICEF EAPRO

Overview

- Brief technical update
- Experiences with free formula
- UN Framework
- New guidelines and tools

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Global Commitment to Action. UNGASS Goal

During the UN special session on HIV/AIDS in June 2001, 189 countries agreed on the following commitment:

"By 2005, reduce the proportion of infants infected with HIV by 20 per cent, and by 50 per cent by 2010... "

To reach this objective we will have to adequately focus on HIV and infant feeding!

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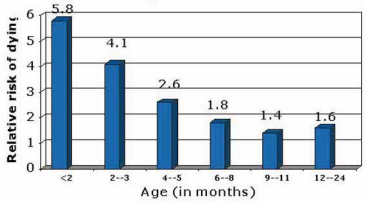
Duration of breastfeeding: Breastfeeding Saves Lives

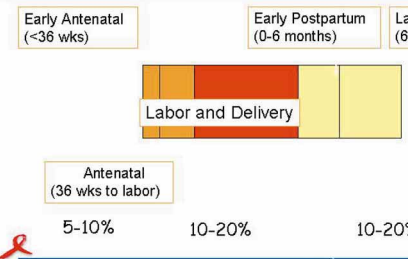
Risk of dying from infectious diseases for non-breastfed infants compared to breastfed infants



Source: WHO. *The Lancet* Vol. 355, 5 Feb 2000, pp 451-455

Arjan de Wagt UNICEF EAPRO | UN Regional Task force on PMTCT Bangkok, Thailand, 12 May 2004 | unicef

Timing of Mother-to-Child HIV Transmission with Breastfeeding and No ARV



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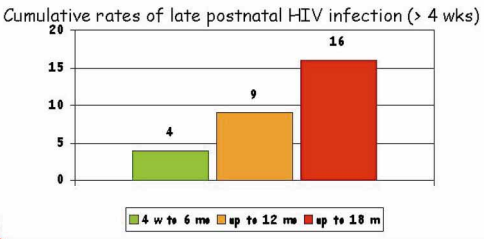
BF transmission of HIV: Ghent meta-analysis (Read et al, 2002). - Early cessation can reduce BF transmission with about 60% (even when MF)



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MTCT risk 0- 4 weeks

Comparison of several studies:

- Between 1.8 and 4.5%
- Median: 2.3%

(Ellen Piwoz, in press)

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Early cessation is possible but:

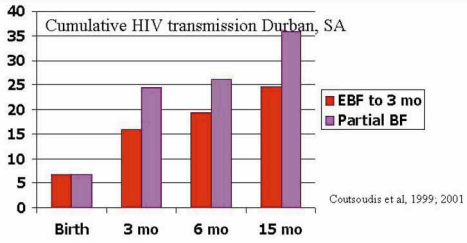
- Early, rapid cessation is possible (Uganda, Zambia, Botswana)
- Problems encountered
  - breast engorgement; mastitis; babies crying, trouble sleeping, appetite loss, diarrhea; financial constraints with replacement feeding; family objections
  - more problems when cessation < 6 months (Botswana)
- Trained counselors were able to help mothers overcome problems
- Provision of replacement feeds, family support facilitated process
- **Impact on HIV transmission, survival not yet known**
- **Early Transition not Abrupt Cessation!**

Arjan de Wagt UNICEF EAPRO | UN Regional Task force on PMTCT Bangkok, Thailand, 12 May 2004 | unicef

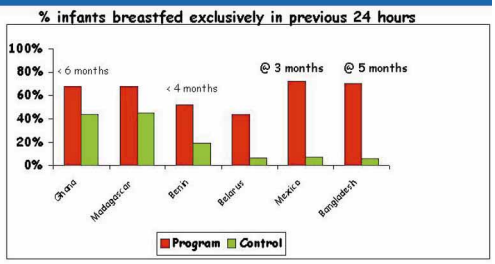
Duration of Exclusive Breastfeeding HIV Positive Mothers

"when replacement feeding is acceptable, feasible, affordable, sustainable and safe, avoidance of all breastfeeding by HIV-infected mothers is recommended. Otherwise, exclusive breastfeeding is recommended during the first months of life" and should then be discontinued as soon as the above conditions are met"

Impact of Exclusive Breastfeeding - the only intervention to reduce MTCT among mothers with unknown HIV status?



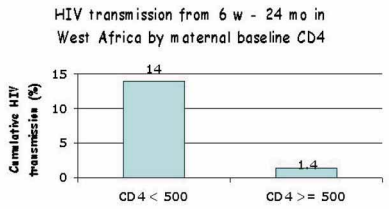
What do we know about the feasibility of exclusive breastfeeding? BFHI/MCH/IMCI) -1



Breastfeeding and maternal mortality

- Nduati (Lancet, 2001): breastfeeding HIV-positive mothers have an increased risk of mortality
- WHO statement, not enough evidence for policy change, more research needed, mothers need to receive nutritional support
- Ghent Group (Paris 2003): draft meta analysis: no negative impact
- Sedgh et al (AIDS, 2004): "there is insufficient evidence to support the hypothesis that Breastfeeding is detrimental to the health of HIV-infected women"

Risk factors for postnatal transmission: Maternal immune status



Leroy et al 2002

ART and Infant feeding

- "...there are many planned or ongoing studies to assess the impact of ARV use during breastfeeding, but no evidence is yet available on its impact on the health of infants or mothers. Where mothers are using combinations of ARV drugs for treatment, the infant feeding recommendations in this document still apply"

Questions remaining to be answered include:

- Can the use of ARVs reduce risk of postnatal HIV transmission?
- Should drugs be given to the mother or the infant or both?
- What may be long- and short-term consequences for health of the baby of ARV use by either the mother or the baby?
- What is the long-term impact on the mother's health of ARV use for prevention of postnatal transmission only?"

Use of Free Formula - Lessons Learned

- **Limited UNICEF resources were used to support "free" formula for women for whom this option was "feasible, safe, acceptable and sustainable". This did not address the needs of poorer women.**
  - **AFASS needs to be operationalised locally**
- **Not all mothers receiving formula have enough time or resources for proper preparation, resulting in increased disease and mortality,** e.g. in India (Sarna, 2002) higher mortality was reported among formula group, several mothers reported not having the means for sterilizing utensils

Lessons learned - Continued

- **In some cases the result of formula distribution to HIV+ women was mixed feeding** with its expected higher MTCT and mortality risks (Botswana 20% (Rollins 2001), Nairobi 30% (Nduati)), Thailand 6% (CDC, 2001).
- **Logistical challenges -** risk of running out of formula (in Botswana (Rollins, 2001) 40% of mothers ever ran out of formula; in Uganda (Matovu 2002), 35% did not turn up for supply of formula after 6 weeks
- **Risk of "Spillover":** e.g., in Botswana (Rollins 2001) 20% of HIV- mothers in program EBF, while 37% in non-program group EBF; formula shared with other children in South Africa (McCoy, 2002)

Lessons learned - Continued

- **Poor risk assessment resulted in unsafe use of formula,** e.g, In Honduras (Baek, 2002) it was reported that providers have preference for formula and inadequate knowledge about risks; In RSA (Rollins 2002) 66% of women who gave formula did not have adequate conditions (water, fridge, fuel); in Zambia (Kankasa, 2002) the risk assessment and counseling was poor

Lessons learned - Continued

- **Many women do not live in conditions where formula is safe,** e.g.
  - although the better option in Nairobi (Nduati, 2000), women had at least primary school, access to safe water and good access to health facilities these are not common conditions

Considerations for Distribution and Procurement of Free Formula
(WHO/UNICEF/UNAIDS/UNFPA, 2004)

- Only if RF is **acceptable, feasible, sustainable and safe.**
- Ensure **uninterrupted supply**
- Governments should procure formula through normal channels to **ensure sustainability,** don't accept donations
- Before formula is available **counselors to be adequately trained**. They need to be skilled in providing non-biased counseling and support all mothers.
- **Guidelines** specifying which HIV-positive women will receive it, under what conditions, how frequently and for how long, etc. need to be in place.
- Information on the health and nutrition status to be collected and analyzed to enable the **monitoring of health outcomes**
- Infant formula for at least the first 6 months, then formula or other milk **up to at least 1 year**, and preferably 2yrs.
- Consider some type of support to HIV-positive women who choose other options in the interests of **equity**.

HIV and Infant Feeding Framework: Purpose

To recommend key priority actions, related to infant and young child feeding, that cover the special circumstances associated with HIV/AIDS. The aim is to create and sustain an environment that encourages appropriate feeding practices for all infants, while scaling-up interventions to reduce HIV transmission.

HIV & Infant Feeding Framework: Priority action areas

- **Develop a comprehensive national infant and young child feeding (IYCF) policy, including HIV and infant feeding**
- **Implement the Code of Marketing (& subsequent relevant WHA resolutions)**
- **Protect, promote and support appropriate IYCF practices in context of HIV**
- **Provide support to HIV+ women in their chosen infant feeding method**
- **Promote research on HIV and infant feeding, monitoring and evaluation**

So what is new?

An integrated approach

- The strategy recognizes that HIV-positive mothers are a special group needing special support
- The framework recognizes that support to HIV-positive mothers requires an environment in which breastfeeding is promoted, supported and protected so: PMTCT includes HIV and infant feeding which supports the overall goals on infant and young child feeding for all children.
- Consequently project proposals on PMTCT should include activities as outlined in the Framework including support to infant feeding of all children (30% of budget?)

Technical and programmatic guidance

New **Global Strategy on Infant and Young Child Feeding** (2002)

New **HIV & Infant Feeding: Framework for Priority Action**
(WHO/UNICEF/UNFPA/UNAIDS/World Bank/UNHCR/WFP/FAO/IAEA)

Revised **HIV & Infant Feeding: Guidelines for decision-makers**
(WHO/UNICEF/UNFPA/UNAIDS)

Revised **HIV & Infant Feeding: A Guide for Health Care Managers and Supervisors**
(WHO/UNICEF/UNFPA/UNAIDS)

Major revisions

- Incorporates recommendations from 2000 Technical Consultation
- Within context of Global Strategy on IYCF
- Inclusion of recent research findings
- Programmatic experience
- Organisation around HIV & IF Framework

unicef

CAMBODIA

PMTCT in CAMBODIA

Presented by
Prof.KOUM KANAL
Chairperson of PMTCT Working group
Director of NMCHC

Cambodia Health Information

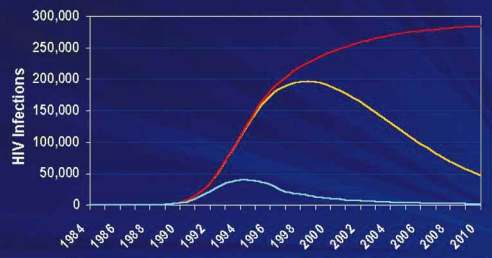
Indicators	Year	Estimate	Source
Total Population (thousands)	2001	13,441	UNPOP
Population Aged 15-49 (thousands)	1999	6,314	UNPOP
GNP Per Capita (US$)	2001	260	World Bank
Maternal Mortality Rate (per 100,000 live births)	2001	437	WHO
Life Expectancy at Birth	2001	54	UNICEF/UNPO
Total Fertility Rate	1998	4.6	UNPOP
U-5 Mortality Rate	2001	122	UNICEF/UNPOP
Infant Mortality Rate (per 1,000 live births)	2001	95	WHO
HIV/AIDS prevalence among reproductive age	2002	2.6%	
HIV/AIDS prevalence Among pregnant women Attending ANC clinic	2002	2.8%	

The Current Status of the Cambodian HIV Epidemic

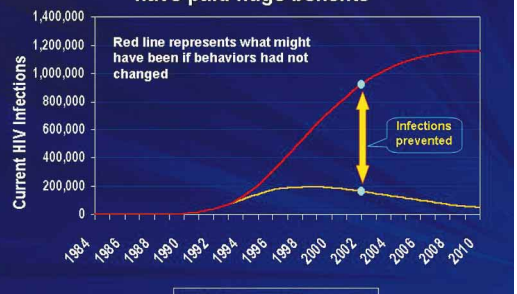
- For the year 2002
  - 259,000 have been infected since start
  - 94,000 have died of AIDS
  - 164,000 currently living with HIV or AIDS
  - 7,300 new infections will occur this year
  - 22,400 will develop serious illness and die this year.
- HIV remains a serious national concern
  - Potential for epidemic relapse is high, 3% of adult men and 2% of women are currently living with HIV
- Even if interventions are kept at current levels, major care needs will continue through the next decade as roughly 20,000 people a year die of AIDS

HIV Infection in Cambodia over time

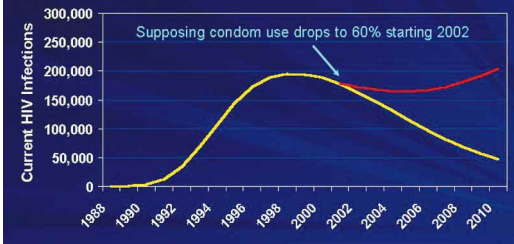
New, cumulative and current HIV infections



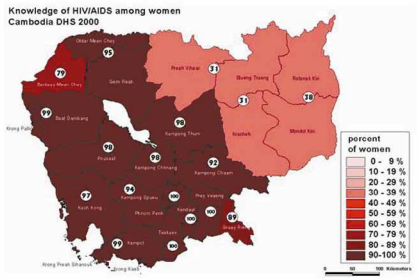
Prevention efforts in Cambodia have paid huge benefits



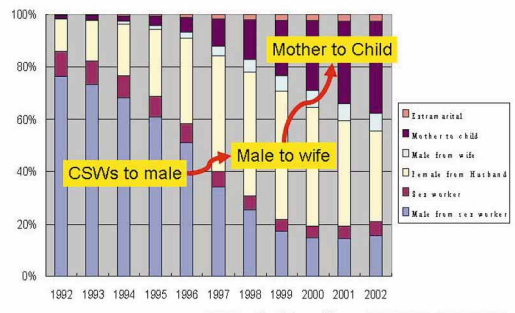
Sustaining past successes in sex work is essential to keeping HIV under control. If condom use in direct sex work were to fall to 60% in 2002, the epidemic would re-establish itself.



Counseling and Testing in HIV Prevention and Care



Change of HIV transmission mode by year



HIV Sentinel Surveillance, NCHADS, MOH 2003

PMTCT history

- 1999 PMTCT working group
- 2000 PMTCT national policy and Pilots
- 2001 PMTCT curriculum
- 2002 PMTCT guidelines for impl.
- 2003/4 Scaling up
  Participate in testing the CDC/WHO guideline.

POLICY GUIDELINES

PMTCT strategies will be integrated into existing MCH/RH/IMCI/STIs programs within Ministry of Health ,other related Ministries,International Organizations, Bilateral agencies , Non-Government Organizations and the Private sector.

OBJECTIVES OF PMTCT PROGRAM IN CAMBODIA

- To enable women to **avoid HIV infection through counseling** especially pregnant women.
- To enable HIV sero positive women to **avoid unwanted pregnancies**
- To **protect** HIV-infected women and children **from stigmatization and discrimination**; and
- To **prevent Vertical transmission** in HIV infected pregnant women through prophylactic means.

Target population and prioritization

- Couple and youth will be targeted
- Pregnant women will be actively promoting
- ANC Client will be referred to VCT/PMTCT sites for VCCT
- HIV infected pregnant women will receive Nevirapine at the delivery site and be referred to CoC
- Newborn from HIV infected women

Site selection and prioritization

PMTCT program efforts focus on ODs which have :

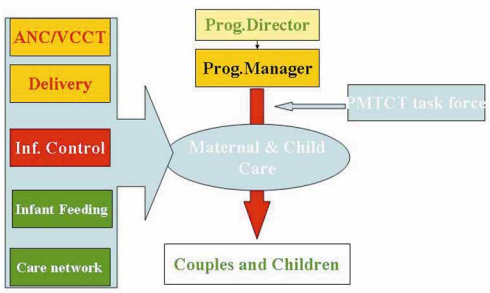
- High HIV prevalence or increasing trends
- Existing VCCT
- Accessibility to ANC/delivery services
- Full package of CoC activities for AIDS/PLWA patients

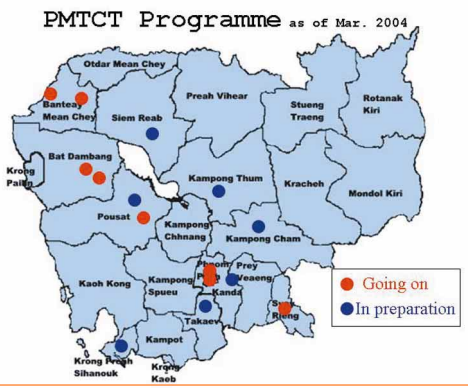
The expansion program

Targets

- By 2005,12 ODs among 68 functioning ODs will have at least one facility offering full package of PMTCT services
- Scaling up of PMTCT services to 25 ODs by 2007

Implementation of PMTCT in NMCHC





PMTCT Counsellor Training Curriculum and Expansion Guidelines

Group Counseling in Mothers' Class

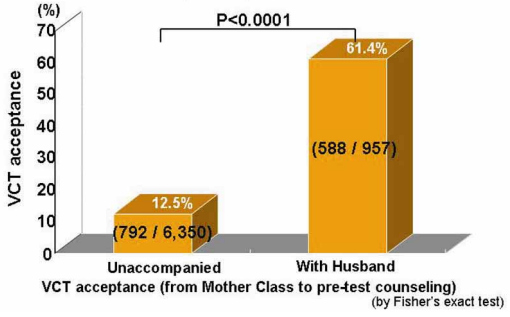
Individual Counseling

IEC materials for PMTCT

PMTCT activities in 2003

	NMCHC, Battambang, Svay Rieng Pursat, Mong Russey (5 sites)
ANC first attendants [a]	11,875
Pre-test counseling [b] (b) / a))	3,037 (25.6%)
HIV tested [c] (c) / b))	3,029 (99.7%)
Post-test counseling [d] (d) / c))	2,422 (80.0%)
HIV positives [e] (e) / d))	78 (3.2%)
NVP received	43
Deliveries	9,018
Unknown HIV status cases	8,325 (92.3%)

Difference of VCT acceptance rate with Husband participation (since July 2002)



Conclusion

- Introducing PMTCT into existing maternal/child health services
- PMTCT has the potential not only to protect exposed baby from becoming infected with HIV
- As the programme is scaling up, greater attention to the prevention needs of HIV negative women, more support for providers should take center stage

CHINA

Program for Prevention of Mother to Child Transmission of HIV/AIDS in China

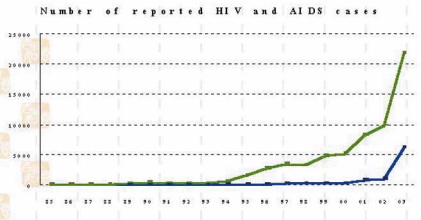
Linhong Wang, MD, professor

China

1

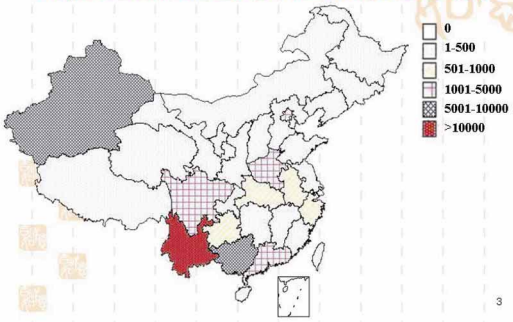
HIV/AIDS in China

- **Prevalence:** In 2003,according to a China CDC survey supported by WHO, UNAIDS and US CDC, China has 840,000 people having with HIV/AIDS, among with 80,000 are AIDS patients.



2

Geographic Distribution of Cumulative Reported HIV Infections in China (1985- 2002)



3

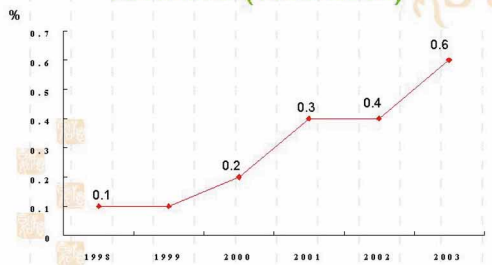
Proportion of different transmit ways (1985-2003)

- IDU 61.6%
- Commercial Blood Donation 9.4%
- Blood Transmission 1.6%
- Sexual Transmission 8.4%
- Mother to Child Transmission 0.3%

(2003: 0.6%)

4

Proportion of MTCT in Reported HIV/AIDS (1998-2003)



5

The Challenge for Control of HIV/AIDS

- HIV/AIDS prevalence in China is increasing dramatically
- Lake of effective strategies on prevention and control
- Poor effective surveillance network
- Multifactor effect (social, economic, culture)
- Provenance from high risk population to general population
- More HIV/AIDS in rural areas
- Proportion of female is increasing
- Traditional culture and discrimination affect the behavior of seeking medical services

6

Progress on Prevention and Control

- Setup State Council working committee for HIV/AIDS prevention and control
- Middle-long Term Planning (1998~2010)
- Five Years Action Plan (2001-2005)
- New Five Commitments
- New principles: "4 free's and 1 care"
- Increased financial support from national and provincial governments

7

Primary Wen jiabao visited AIDS patients in Ditan hospital

Vice-primary Wu Yi visited AIDS patients in Shangcai Country, Henan province

8

Five Commitments on HIV/AIDS Prevention and Control

- Strengthening government efforts by clarifying targets, identifying responsibilities and improving evaluation, supervision and monitoring:
- Providing free ARV medicines to low-income HIV/AIDS patients in urban areas and all patients in rural areas;
- Improving laws and regulations, intensifying intervention, launching public awareness campaigns, promoting drug-free communities;
- protecting the legitimate rights of HIV/AIDS patients and opposing social discrimination against them;
- Increasing international cooperation on HIV/AIDS.

9

"4 free's and 1 care"

- Free antiviral treatment to groups with financial difficulties in rural, township and urban areas.
- Free anonymous blood test in the highly affected areas.
- Free schooling for the orphans who parents suffered HIV/ADIS
- Free counseling, testing, and treatment to HIV positive pregnant women
- Provide special relief to AIDS patients who have financial difficulties.

10

PMCT Project in China

2003-2004

11

Background

- The government has made remarkable progress over the last year in political commitment and implementation of MTCT control interventions.
- PMTCT is lagging behind other prevention and controls of HIV/AIDS in the country.
- Pilot PMTCT project in Shangcai county of Henan province, supported by UNICEF (2001-2003)
- MCH Department of MOH initiated a national PMTCT expanding pilot project, covering eight counties/cities as parts of national HIV/ADIS Control Programme in 2003.

12

Objectives

- To explore the epidemiological characteristics of mother to child HIV transmission in China;
- To find out the suitable ways and model to provide related services so as to build up the capacity of preventing HIV/AIDS and PMTCT;
- To ultimately reduce the occurrence of HIV infections caused by mother-to-child transmission.

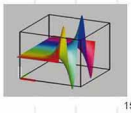
13

8 pilot city/county project of PMTCT

14

Methods

- VCT for pre-marriage couples and pregnant women
- Provision of free HIV testing kits
- Provision of free NVP to HIV+ mother and infant
- Intervention during delivery
- Provision of free formula to infant



15

Activities (1)

- Develop implementation protocol
- Training for MCH workers, FP workers and managers
- Utilizing MCH service network
- Follow the implementation flowchart
- Health education and counseling
- VCT in pre-marriage health care
- VCT in prenatal health care

16

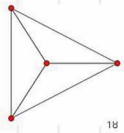
Activities (2)

- Following up pregnant women
- VCT for emergency delivery women (no prenatal health care)
- NVP use during delivery for HIV (+)
- Avoiding injury during delivery
- Infant feeding counseling
- Follow up infant

17

Follow up

- Routine follow up mothers and infants
- First HIV test for baby with a positive mother at 9th □12nd month
- Second HIV test at 18th month



18

Outcome

- Enhanced awareness in project areas
- Government Participation and support
- PMTCT management protocol
- Comprehensive service provided
- Cooperative mechanism developed (MCH, FP, CDC)
- Data collection and report
- Getting some experiences from PMCT program
- Training materials developed
- Health education materials and activities

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Result from 8 PMTCT pilot areas(2003)
VCT on pre-marriage couple

	Premarriage women	HIV Counseling	HIVtesting	Proportion . . .	HIV(+)	HIV(+) . ‰ .	Time
Guangxi	127	109	91	71.69	1	10.99	Oct.-Dec
Yunnan	--	--	--	--	--	--	Nov.-Dec
Xinjiang	180	180	180	100	9	50.0	Oct.-Dec
Shangcai	6932	6932	6932	100	14	2.02	Jan.-Dec.
Total	7239	7231 (99.9%)	7203 (99.6%)	99.45	24	3.33	

20

Result from 8 PMTCT pilot areas(2003)
VCT on pregnant women

	Pregnant women	HIV Counseling	HIVtesting	Proportion . . .	HIV(+)	HIV(+) . ‰ .	Time
Guangxi	5317	4716	2231	41.96	19	8.50	Oct.-Dec
Yunnan	2347	912	664	28.29	4	6.02	Nov.-Dec
Xinjiang	4910	4375	4375	89.10	7	1.60	Oct.-Dec
Shangcai	9799	9308	7924	80.87	35	4.42	Jan.-Dec.
Shenzhen	124203	116751	116751	94.00	10	0.09	Jan.-Dec.
Total	146,576	136,060 (93%)	131,945 (97%)		75		

21

Results (2003 project)

- No. of giving birth with HIV test: 3130
- No. of HIV positive : 29
- NVP use during delivery for HIV (+) 24
- No. of positive infant: under following up

22

Constraints

- Poor awareness among local government and target population
- Low coverage of PMCT (low antenatal care and hospital delivery rate)
- Weakness of high quality counseling
- Weakness of information system
- Need further expanded
- Lake of financial support
- Lack of harmonious cooperation between different sections

23

National Plan of PMCT (2004□2005)

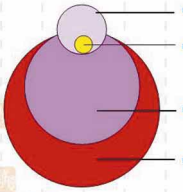
24

Future Plan

- Scale up PMCT activity to 127 sites in National Project of Comprehensive AIDS Response
- Improve social awareness on PMCT through community mobilization, information and education capacity building
- Benefit more people in project areas

25

PMTCT in China



- 8 PMTCT pilot areas by MOH
- Pilot county of Shangcai, Henan (UNICEF support from 2001)
- 85 counties of high prevalence areas (15 provinces)
- 127 counties of "Comprehensive HIV/AIDS Response" in China

26

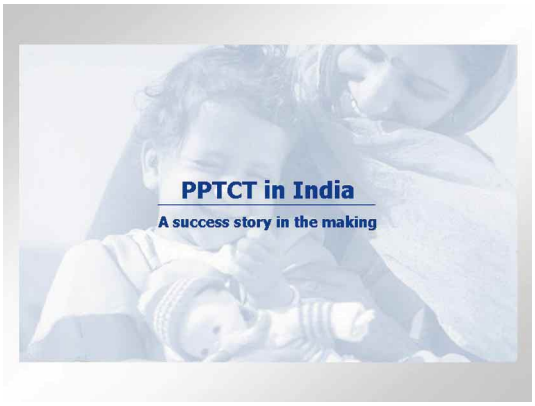
- Capacity building and training
- Follow the implementation flowchart
- Monitor and evaluation
- Strengthening information system
- Developing comprehensive care package
- Provide comprehensive service
- Learning more experiences
- Cooperating with and within other sections and programs

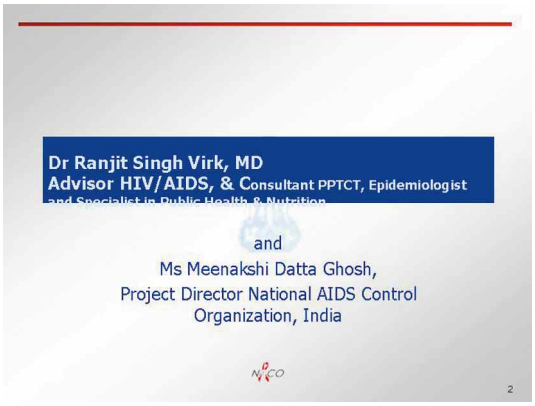
27

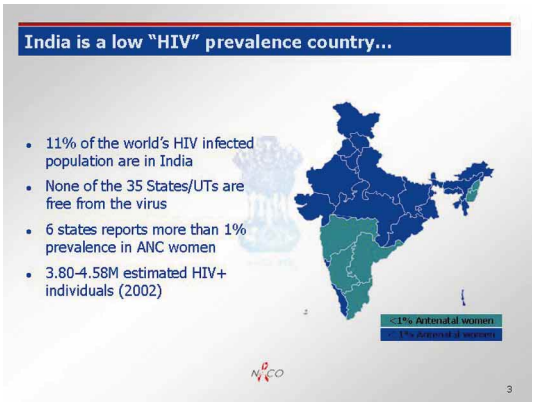
Thank You !

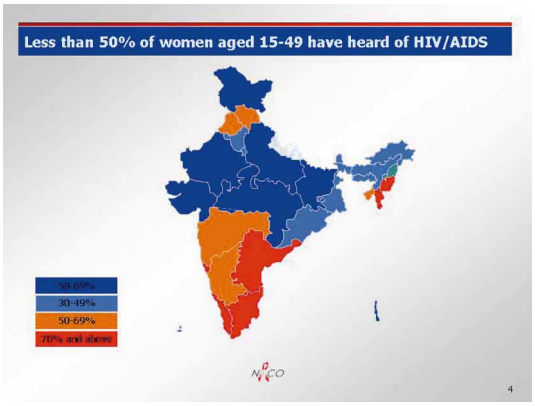
28

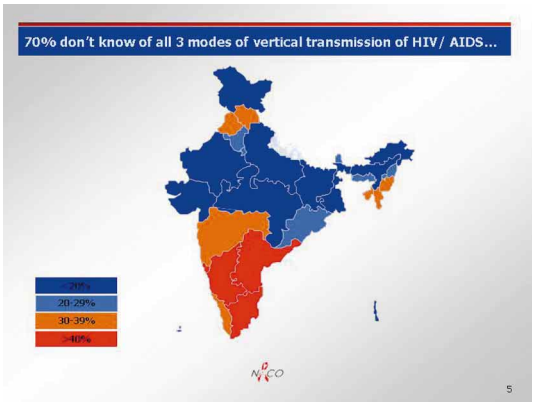
INDIA

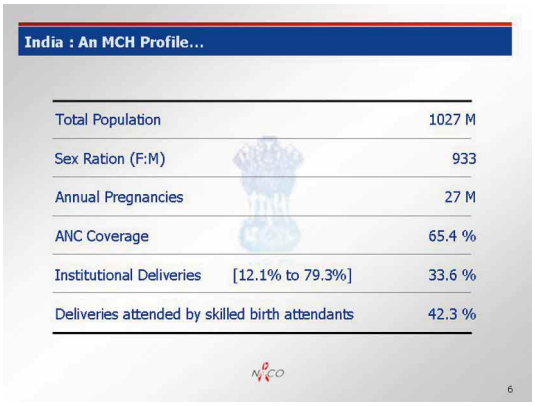

PPTCT in India
A success story in the making

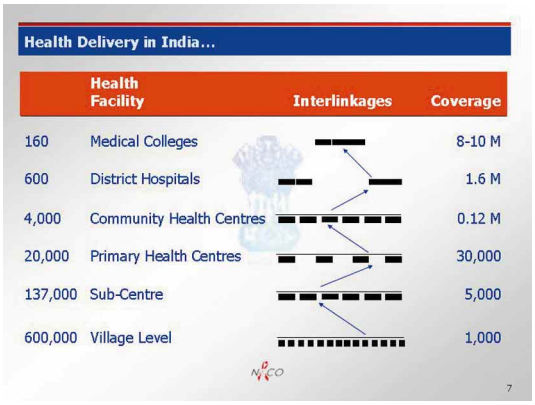

Dr Ranjit Singh Virk, MD
Advisor HIV/AIDS, & Consultant PPTCT, Epidemiologist
and Specialist in Public Health & Nutrition
and
Ms Meenakshi Datta Ghosh,
Project Director National AIDS Control
Organization, India
2

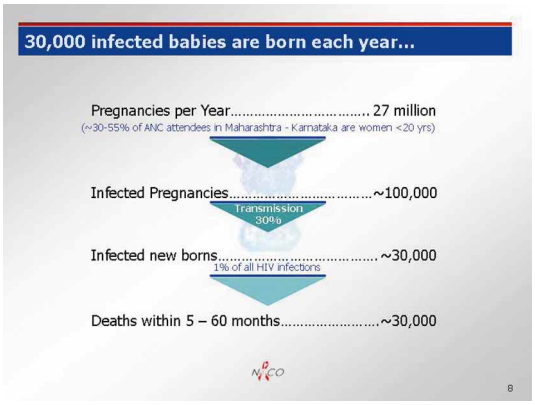

India is a low "HIV" prevalence country...
11% of the world's HIV infected population are in India
None of the 35 States/UTs are free from the virus
6 states reports more than 1% prevalence in ANC women
3.80-4.58M estimated HIV+ individuals (2002)
<1% Antenatal women
3


Less than 50% of women aged 15-49 have heard of HIV/AIDS
30-49%
50-69%
70% and above
4


70% don't know of all 3 modes of vertical transmission of HIV/ AIDS...
20-29%
30-39%
5


India : An MCH Profile...
Total Population 1027 M
Sex Ration (F:M) 933
Annual Pregnancies 27 M
ANC Coverage 65.4 %
Institutional Deliveries [12.1% to 79.3%] 33.6 %
Deliveries attended by skilled birth attendants 42.3 %
6


Health Delivery in India...
Health Facility
Interlinkages
Coverage
160 Medical Colleges 8-10 M
600 District Hospitals 1.6 M
4,000 Community Health Centres 0.12 M
20,000 Primary Health Centres 30,000
137,000 Sub-Centre 5,000
600,000 Village Level 1,000
7

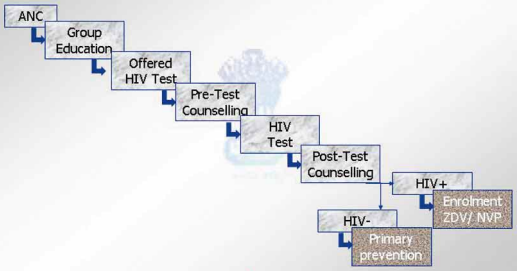

30,000 infected babies are born each year...
Pregnancies per Year..... 27 million
(~30-55% of ANC attendees in Maharashtra - Karnataka are women <20 yrs)
Infected Pregnancies.....~100,000
Transmission 30%
Infected new borns..... ~30,000
1% of all HIV infections
Deaths within 5 – 60 months.....~30,000
8

We are ready to scale up to a national level...

Time	Activity	Σ Medical Centres Participating
2000-02 (Pilot)	11 Centres of Excellence	11
Dec 2002	81 Medical Colleges in High Prevalence States	92
Jun 2003	159 District Hospitals - Maternity Hospitals in High Prevalence States	242
Dec 2003	Medical Colleges in Low Prevalence States	301
2004	450+ District Hospitals - Maternity Hospitals in Low Prevalence States	780+

9

Steps in Enrollment...



10

PPTCT was implemented in 11 medical colleges for 2 years...

- Implemented within the existing in RCH programme
- Implemented in 5 high prevalence states
  (Karnataka, AP, Maharashtra, Tamil Nadu & Manipur)
- The counselling in the 2 phases led to "Informed Choice" on
  1. HIV testing
  2. Infant feeding

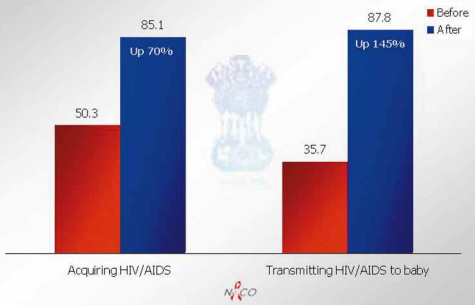
11

As we scale up : Infrastructure...

- Cubicals for 1-to-1 counselling
- Upgrade lab facilities
- Linkages with Dept of Medicine & Paediatrics

12

Today there is an increased knowledge about AIDS prevention...



13

When we look at Phase II (NVP) vs Phase I (AZT) we see...

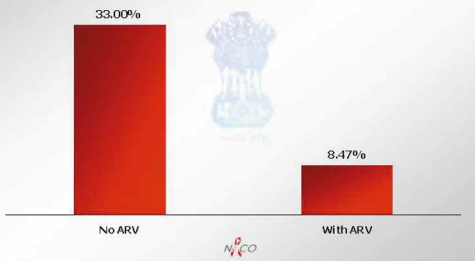
	From	To
Intervention Uptake increased by 66%	42%	70%
BF Rate increased by 157%	21%	54%

VCT acceptance rate for all tested women was 55%
VCT acceptance rate was higher by 25% for HIV+ women at 69%
Drop out Rate was 45% (from # ANC → # Women getting rest results)

14

And 75% reduced transmission of HIV from mother to infant...

Proportion of infants of HIV+ mothers who acquired HIV



15

As we scale up : Components...

- Primary Prevention of HIV infection in young women by information / education
- Family planning to prevent unwanted pregnancies
- Voluntary counselling and testing
- ARV prophylaxis
- Counselling on infant feeding for informed choice

16

As we scale up : Issues...

- Identification and training of PPTCT teams
- Appointment and training of cousellors
- Appointment and training of lab technicians
- Making rapid HIV tests available
- Ensuring availability of tab & syrup NVP
- Linkages with NGOs for care and support

17

As we scale up we face the challenge of ...

- ... Maintaining quality
- ... Completing the 'PPTCT package'
- ... Addressing discrimination and stigma
- ... Reaching out to all women
- ... Addressing infant feeding
- ... Integrating with RCH programme

18

Success Mantra ?

- Visionary (& indigenous) approach
- Leadership (& ownership)
- Mobilization of diverse partnerships
  (Public, Private, NGO and UN)
- Significant investment
- Project Prioritization
- Transparency in implementation
- Strong Monitoring and Evaluation

19

The Way Forward...

- Advocacy
- Strengthening of MCH services
- Posting of counselors & continuous supervision
- Provision of rapid testing kits, ARV and drugs
- Continuum of Care
- Communication Strategy/IEC
- Monitoring & Evaluation

20

As we scale up : Monitoring...

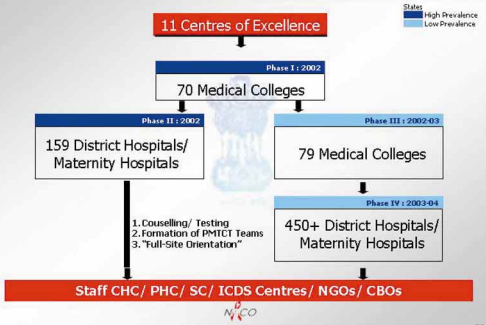
- 42 indicators
- 11 indicators for monthly reports
- Detailed quarterly reports – gaps/ lessons/ suggestions

21

National Objectives & Goals...

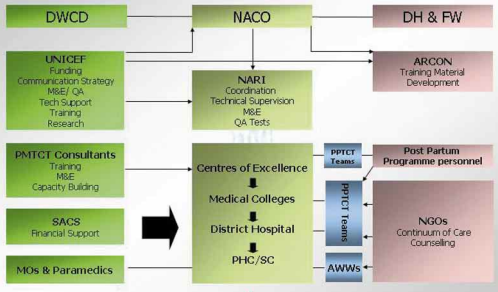
22

As we scale up : The Training Component...



23

As we scale up : The Collaborative Strategy...



24

Status as on 31 December 2003...

Medical Colleges	81+47=128
District Hospitals	132
Total Trained	260
Number providing services	225
Reports received from	202

25

Role of Consultants...

- Supplies & Logistics
- VCT
- Care and Support
- Testing and quality Assurance
- Infant Feeding
- ARVT
- Monitoring and Evaluations
- Communication and Advocacy

26

As we scale up : Issues that need to be addressed...

- Difficulty in completing 11 indicators
- Irregular supply of test kits
- One counsellor inadequate ??
- Follow up needs strengthening
- 20-30% are un-booked
- Collection of test results continues to remain low
- 20-30% of mothers do not come for institutional deliveries

27

Lessons learnt : SACSs

1. Counselling increases knowledge and awareness
2. Possible to mainstream PPTCT into existing ANC services with little additional resources
3. PPTCT does reduce transmission from mother to baby
4. Involvement of husband and family is key to acceptance
5. For cost effectiveness all 4 components must be implemented
6. Community must play a critical role
7. Women in general are at risk

28

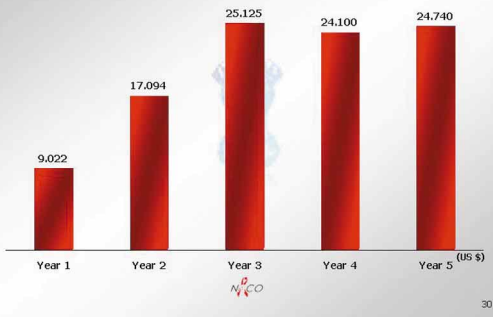
Funds Utilized...

Costs	Total	Recurring	Non-Secured
2000-01	1.74	1.24	0.50
2001-02	1.24	1.24	0.00
2002-03	3.79	3.69	0.10
2003-04	7.74	7.50	0.24

(Figures in Rs. Cr)

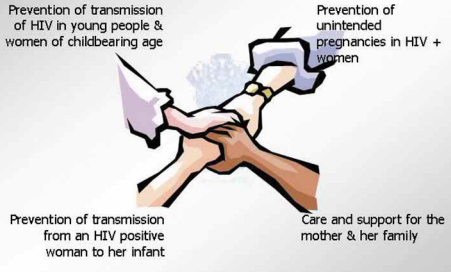
29

Global Funding...



30

The PPTCT Strategy...

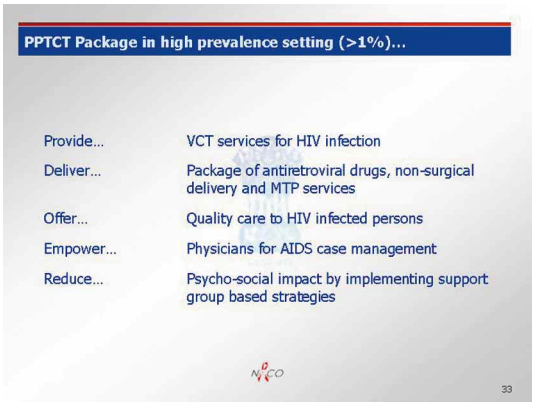


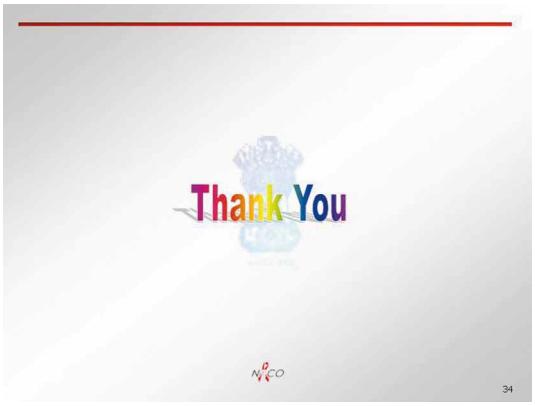
31

PPTCT Package in low prevalence setting (<1%)...

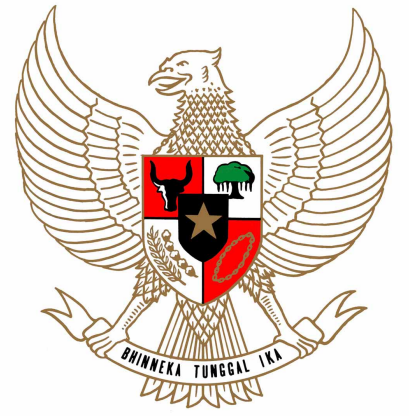
Strengthen...	Quality of antenatal services
Enhance...	Acceptance of antenatal services
Make...	Clinics husband-friendly
Offer...	Comprehensive health education
Implement...	Peer based strategies
Emphasize...	Rational use of blood
Counselling...	Birth-spacing methods
Provide...	Referral services for VCT for HIV infection
Integrate...	HIV/AIDS in RCH/MCH

32


PPTCT Package in high prevalence setting (>1%)...
Provide... VCT services for HIV infection
Deliver... Package of antiretroviral drugs, non-surgical delivery and MTP services
Offer... Quality care to HIV infected persons
Empower... Physicians for AIDS case management
Reduce... Psycho-social impact by implementing support group based strategies
33


Thank You
34

Indonesia Response to Mother to Child Transmission of HIV



By :

Dr. Ida Bagus Putu Widiarsa (Ministry of Health)

Husein Habsyi, Grad.PH (Yayasan Pelita Ilmu)

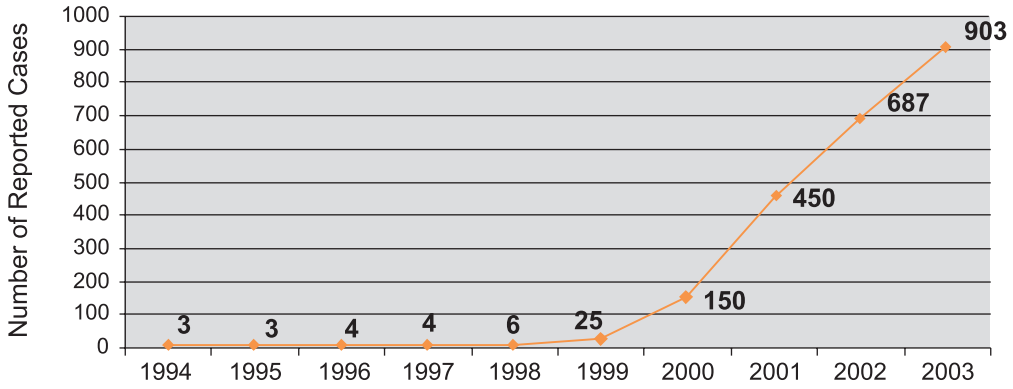
11 – 13 May 2004

Bangkok, Thailand

A. Country Situation

Indonesia has a total population estimated at 214 million people (UNPOP 2001 estimates). The HIV/AIDS epidemic is a concentrated epidemic in high risk groups. Initially related to sexual transmission, parenteral transmission in IDUs has shown an eightfold increase in the last 6 years. In surveys among IDUs in selected populations, seroprevalence has reached as high as 90% in Jakarta and 53% in Denpasar, Bali. In female sex workers, the highest prevalence rates were observed in Merauke, Papua (27%). As of March 2004, a total of 2746 HIV positive cases, 1413 AIDS cases and 493 AIDS-related deaths have been reported to the Ministry of Health (MoH). Among the total number of AIDS cases, 78% were male, heterosexual transmission accounted for 51% of AIDS cases, IVDUs for 26% and MSM for 9%. As a consequence of limitations in the national HIV/AIDS surveillance system, there is good reason to believe that the actual numbers are significantly higher. In August 2002, A National Consultation estimated the total number of PLWHA between 90,000 – 130,000 persons.

Cummulative Number of Reported HIV-IVDV Cases in Indonesia



Source : CDC Ministry of Health

In December 2003, shortly after the launch of the global 3x5 initiative, the Minister of Health requested WHO assistance to plan to provide antiretroviral treatment to 10,000 Indonesians by 2005. Currently it is estimated that up to 15,000 people are in need of ART, and about 1,500 persons are receiving ART. The initiative will be undertaken in six most affected provinces of Jakarta, Papua, East Java, Bali, Riau, and West Java.

With regards to PMTCT in Indonesia limited data is available. The limited information available is from the Ministry of Health that indicate that between 2000 -2001, the HIV prevalence of pregnant women, through voluntary and confidential counseling and HIV testing (VCCT) moved from 1.5% - 2.7% in Jakarta. The Government also reported that prevalence among pregnant women in Papua and Riau was 0.25%-0.35% (GoI, 2002). Little is known about HIV prevalence rates among antenatal women in other provinces. According to the Ministry of Health (MoH 2002) and National Family Planning Board (2002) 13 pediatric AIDS cases have been reported so far in Indonesia. This may be under-estimation as no large scale studies have been conducted in this area.

The majority of Indonesians, including pregnant women, are unaware of their HIV status due to lack of access to and utilization of VCCT services. Understanding of HIV transmission modes, including Mother-to-Child Transmission (MTCT), and prevention methods is still lacking among many (Indonesian National AIDS Commission, 2001). Inadequate data on the magnitude of MTCT continues to undermine design of appropriate interventions to effectively address this programme area. In addition, lack of clear policy and guidelines, trained counselors for PMTCT, health workers limited knowledge about PMTCT and lack of community support groups for people living with HIV/AIDS are major contributing factors to the slow pace of establishing a PMTCT programme.

Limited access to antiretroviral drugs in general can also impact negatively on effort to implement PMTCT in Indonesia. High levels of HIV/AIDS stigma and discrimination, including fear of rejection among people living with HIV/AIDS, continue to undermine efforts aimed at increasing use of VCCT services, an entry point for PMTCT. The VCCT sites in Indonesia are few and currently in several of the major urban areas. HIV testing including pre and posttest counseling in other urban areas has been mainly via specific health care professionals or addiction treatment facilities.

UNICEF Indonesia cognizant of the deficiency of information on current factors that may contribute to MTCT of HIV and the potential for its prevention is proposing to conduct a rapidly

situation assessment and analysis in six GoI priority HIV/AIDS provinces. This will be done within the context of "3X5" initiative with PAF funds from UNAIDS.

B. Progress in PMTCT related interventions

Political Climate : The government of Indonesia (GoI) recognizes PMTCT as one of the prevention priority for HIV/AIDS. This is reflected in the National Report on monitoring follow-up to the Declaration of Commitment on HIV/AIDS which further endorses the country's commitment to initiate and expand PMTCT. PMTCT is included as part of the national HIV/AIDS prevention and care strategy in the government's application for GFATM funds. The Ministry of Health and the National AIDS Commission have clearly stated their commitment to move PMTCT into the national HIV/AIDS prevention plan.

Despite the above limitations, Indonesia has been preparing ground for PMTCT. Two pilot interventions in Jakarta and Merauke district in Papua were conducted between 1997-2001 by a local NGO (Yayasan Pelita Ilmu) and WHO respectively. With the modest support from WHO (US$ 30,000 for 3 years), a pilot PMTCT project was initiated in Papua (high HIV prevalence area) from 1997 to 2000. A few health care providers were said to be trained on counseling techniques. The project faced a number of logistic problems including limited documentation of the experience.

Pelita Ilmu PMTCT pilot project : Started in 1999 with a grant of US$ 29,300 from Becton Dickinson to implement a pilot PMTCT project "Counselling and HIV Testing for Pregnant Women in Drop-in Centres in Jakarta" for a period of two years (1999 – 2001). The project experience is well documented. The PMTCT services were integrated into the existing safe motherhood services in 8 districts of Jakarta, two locations at each site – drop-in centres and through mobile approach. The project strategies included information and education to pregnant women and families through IEC materials, telephone hotline service and through motivation workers, HIV Counselling and testing, support and care services – mainly perinatal care through safe motherhood services, referrals to support mothers and babies. The project also ensured collaboration with wide range of partners - public and private health care system (hospitals, community health centres, private maternity clinics, midwives, pharmacies etc), NGOs, counselors, community workers, mothers, child care workers, medical faculty, provincial and district HIV/AIDS committees.

Key programme components consisted of antenatal care through routine safe motherhood services, HIV counseling and testing, safe delivery – by women's option - normal and caesarean section, universal precaution procedures in the health care settings, infant feeding for HIV-infected women – provision of free infant formula, by option EBF for 4-6 months and referrals to PMTCT and maternity related services.

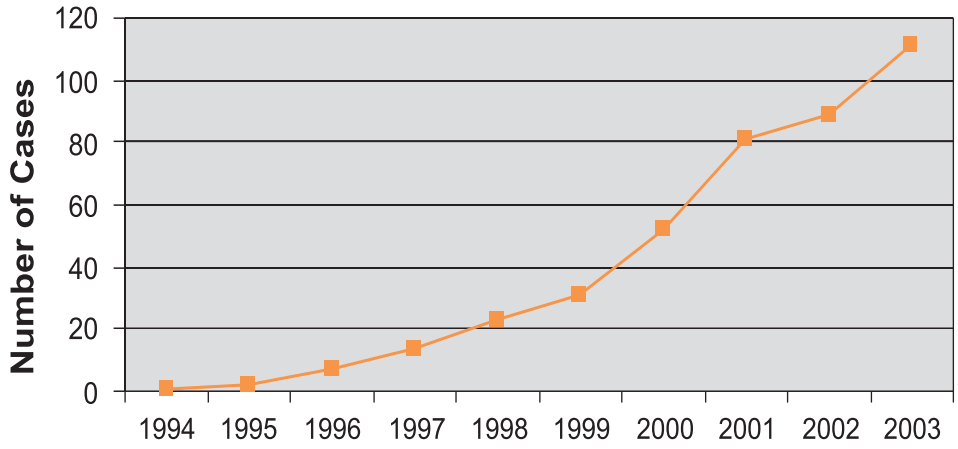
At the end of the two years Pelita Ilmu reported the following results:

- Increased interest by the community and pregnant women on PMTCT services. The project managed to reach and mobilize an expanded group of people beyond the pregnant women.
- Of targeted 574 women attended pre-test counseling, 558 voluntarily tested for HIV (97.2%), 16 were found HIV positive (2.86%).
- Of 11 women who gave birth, 6 were through caesarian section and 5 chose normal delivery.

- 9 of 11 HIV-infected women received AZT and all opted for formula feeding. Free formula was provided to 6 mothers who could not afford it.
- Regarding the spouses of 16 HIV-infected women, 5 are known HIV positive, 1 is negative and 10 have not been/no desire to be tested.

With funding from Global Fund the GoI in October 2003 commissioned Pelita Ilmu a local NGO with experience in PMTCT to implement the PMTCT component of the GFATM first round in some locations within slums of Jakarta. The locations are Bukit Duri, Rawa Bunga, Jatinegara, Tanah Abang and Petamburan with the possibility of expansion to other slum areas of Jakarta. The two year intervention (2003-2005) is expected to reach 2000 pregnant women with total funding of US$ 44,800 for the first year. Of 414 clients attended to since October 2003, 411 received pretest counseling for HIV and 373 got post test counseling. No HIV case was found among this group. In addition to the Jakarta slum-based intervention and with funding from GFATM Pelita Ilmu also provides services to cases from referral around Jakarta such as from Kramat 128 Hospital, RSPI – Infectious Disease Hospital, Dharmais National Cancer Hospital and MSF Clinic in Jakarta. Seven (7) HIV positive cases have been identified from these referral centers. The cost for two caesarian sections and infant formula has been borne by GFATM funds. The project is expected to continue until 2005 during which experienced gained here will be replicated in other parts of the country.

Cummulative Number of HIV Woman Contacted to Pelita Ilmu



Source : Pelita Limu

Another notable progress is that the Government with support from WHO and USAID/FHI developed national guideline on care, support and treatment for PLWHA. The issue of PMTCT is extensively covered in the guidelines. In December 2003 GoI also facilitated a high level advocacy meeting in Jakarta on PMTCT targeting key government ministries at national and provincial levels – Ministry of Health, Food and Drug Administration, National Coordinating Board of Family Planning programme (BKKBN), Ministry of Social Affairs, National Planning Board (Bappenas), National AIDS Commission, 4 Provincial Health Services, Provincial Hospitals, NGOs and religious leaders. Pelita Ilmu is assisting these provinces to explore feasibility for implementation of PMTCT interventions. With the commitment to "3X5" initiative the GoI with financial support from AusAID has recently engaged in an aggressive training programme for counselors to support VCCT activities in Jakarta, Bali and Papua.

The issue of PMTCT features prominently in the National Guideline on World Campaign 2004 theme "Women, Girls, HIV, and AIDS". The Ministry of Women Empowerment the lead Government sector for this campaign has adapted for its logo for this campaign a mother and baby.

C. Future Programming

Favourable Conditions

- PMTCT is included as one of the prevention priorities in the National AIDS Strategy 2003-2007
- GoI has began implementation of the plans to provide PMTCT services through public health care delivery system with support from the first GFATM round proposal.
- PMTCT national taskforce with the clear terms of reference has been established with representation from various departments of Ministry of Health, Food and Drug Administration, National Coordinating Board of Family Planning programme (BKKBN), Ministry of Social Affairs, NGOs – Pelita Ilmu, Yayasan Mitra Indonesia, Spiritia, Family Health International, WHO, UNICEF, UNAIDS and UNFPA. The group provides guidance on PMTCT related issues.
- In the area of service delivery it is reported that 88% of pregnant women have at least one ANC visit. 69% have at least 4 AN visits. 75% households – access to safe water while 61% household - safe sanitation. Percent of child deaths due to diarrhea is also declining. 52% are practicing family planning.

Challenging Issues

The challenge for PMTCT in Indonesia is therefore to sensitise, mobilise and commit an array of stakeholders and communities to create a supportive and enabling environment that facilitates the implementation of interventions aimed at PMTCT. The development of technical and organizational capacity of national counterparts to implement PMTCT intervention is another challenge to be addressed if Indonesia is to expand the current interventions on PMTCT. In order to implement effective PMTCT intervention, Indonesia will also need to address the following challenges: low levels of condom use rate (10%); high levels of needle sharing among IDUs. In some areas, over 85% of IDUs are already infected with HIV; limited technical knowledge and experience on PMTCT among national counterparts.

D. Recommendations and Way Forward

Services General

- Consolidate and expand experience gained from Jakarta pilot to selected provinces with high HIV prevalence.
- Conduct situation assessment and analysis in the selected locations in high prevalence provinces to design PMTCT interventions.
- Develop clear plan of action, including all prongs: primary prevention, prevention of unintended pregnancies, PMTCT core interventions and care and support.
- Review of existing policies, infant feeding (code of marketing of BMS, BFHI), VCCT etc. to determine relevance of PMTCT. Health and Nutrition unit of UNICEF will support this activity in 2004.
- Support development of training curriculum (PMTCT inclusive of VCCT, Infant feeding etc.) and train health and social workers at national, provincial and district levels.
- Develop a communication strategy on PMTCT and roll out plan. Technical and financial assistance are required to carry out the above recommendations.

INDONESIA

Indonesia Response to Mother to Child Transmission of HIV

Ida Bagus Putu Widiarsa
Husein Habsyi
Bangkok, 11 – 13 May 2004

Indonesia Situation

- Country Population : 210,000,000
- 30 provinces
- > 13,000 islands

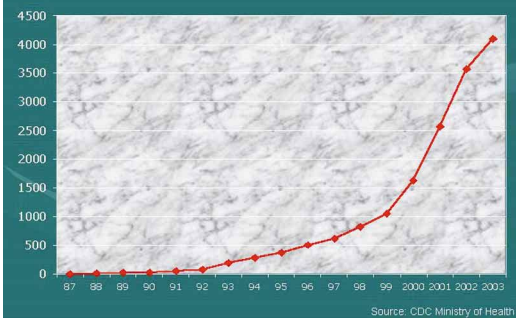
Indonesia Situation

- First case of AIDS : 1987
- Registered cases (March 2004) :
  - HIV = 2,746
  - AIDS = 1,413
- Main mode of transmission :
  - Sexual transmission
  - Injecting drug user

- For many years, very few HIV infection were found but in the last three years, this has begun to change.
- 2000 : Indonesia

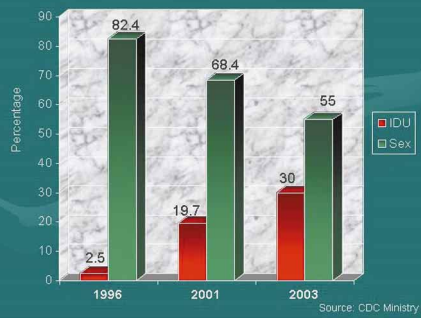
  low prevalence level ⇨ concentrated level (Jakarta, Papua, Bali, Riau)
  - IDUs : 47% in DKI Jakarta, 53 % in Bali
  - CSWs: >5% in Papua, Riau
- In the year 2002, estimation of PLHA in Indonesia was 90,000 – 130,000.

Trend of Registered HIV/AIDS Cases in Indonesia (1987 – 2003)



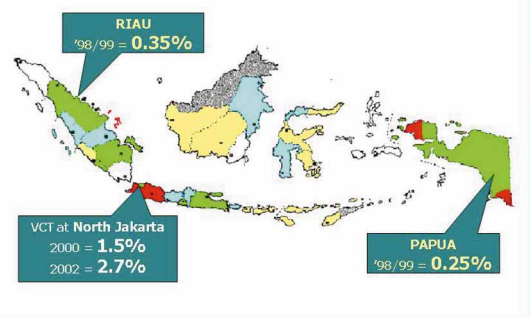
Source: CDC Ministry of Health

HIV/AIDS Cases According to Mode of Transmission



Source: CDC Ministry of Health

HIV Prevalence Study Among Pregnant Women



PMTCT Issues

- The government committed to initiate and expand PMTCT, included in National HIV/AIDS Strategy.
- A pilot PMTCT project was initiated in Papua, support from WHO (US$ 30,000 in 1997 - 2000)
- Pilot initiative by NGO (Yayasan Pelita Ilmu): "Counselling and HIV testing for Pregnant Women in Drop-in Centres in Jakarta", support from Becton Dickinson (US$ 29,300 in 1999 – 2001)

Components of PMTCT - YPI

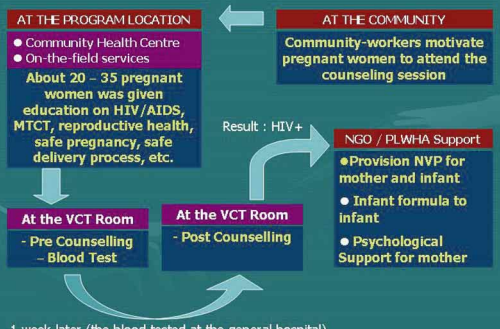
- Information Dissemination:
  IEC, hotline ● Motivate pregnant women to attend counseling session.
- ANC through routine MCH services
- Voluntary counseling and testing
- ARV prophylaxis
- Safe delivery by women's option
- Universal precaution in the health care settings
- Infant feeding – promote/provide formula
- Psychological and social support for HIV+ mothers.

PMTCT – YPI
(1999 – 2001)

Target	: 1.000 pregnant women in Jakarta
Location	: 8 sites of slum areas / crowded population
Counselor	: 15
Nurse	: 4
Staf	: 8
VCT Sites	: - at Community Health Centre - at Schools, Community Unit Post
Funded	: Becton Dicksonson

Preparation: Training for counselor & motivator ● Providing VCT Equipment ● Distributing poster/brochures on HIV and Pregnancy ● Lobbying to health centers, community-cadres, hospitals, and NGOs ●

Program Strategies



Result of PMTCT – YPI
(1999 – 2001)

- **> 600** attended HIV/AIDS and safe-motherhood education
- **574** attended pre-test counseling
- **558** voluntary tested for HIV (97.2%)
- **16** HIV positive (2.86%)
- **11** gave birth:
  - 6 caesarian
  - 5 normal delivery
- **9** receive AZT in the last month of pregnancy
- **6** opted for formula feeding

PMTCT – YPI
(2003 – 2005)

Target : 2.000 pregnant women in the slum areas in Jakarta

Funded : Global Fund

Temporary Result of PMTCT - YPI 2003 – 2005
(up to May 2004)

Location	Client	Pre-test	Post	HIV +
Bukit Duri (1x)	25	25	22	0
Rawa Bunga (2x)	61	58	43	0
Jatinegara (1x)	21	21	19	0
Tanah Abang (4x)	167	167	167	0
Petamburan (3x)	140	140	122	0
Total	**414**	**411**	**373**	**0**

Seven (7) HIV positive mother come from referral centers have been provided services by the project.

Progress in PMTCT Related Interventions

- **PMTCT as One of the Prevention Priority for HIV/AIDS** (National Commitment)
- **National Guideline on Care, Support & Treatment for PLWHA** was developed by government (2003). The issue of **PMTCT** is extensively covered in the guidelines.
- **High Level Advocacy Meeting in Jakarta on PMTCT** was facilitated by government (Dec 2003).
- **Training Programme for Counselor to Support VCCT Activities** in Jakarta, Bali, Papua (commitment to "3 by 5" initiative).
- **PMTCT at the National Guideline on World Campaign 2004** theme "women, girls, HIV, and AIDS".
- **PMTCT Pilot Project** (2003 – 2005)
  GoI commissioned Yayasan Pelita Ilmu to implement the PMTCT component of the GFATM first round.

Future Programming

Favorable Condition

- PMTCT is included as one of the prevention priorities in the National AIDS Strategy.
- Government Planning to provide PMTCT services through public health care delivery system (support from the first GFATM round proposal)

- PMTCT National Taskforce has been established with representation from various departments. The group provides guidance on PMTCT related issues.

- ARV are getting more acceptable and affordable.
  - generic drug has been manufactured by a national pharmacy
  - The price of triple drug combination < US$ 50 a month
  - The Minister of Health promised to subsidies ARV for 2000 PLWHA (commitment to "3 by 5" initiative)

Challenging Issues

- To sensitise, mobilise and commit an array of stakeholders and communities to create a supportive and enabling environment that facilitates the implementation of interventions aimed at PMTCT;
- The development of technical and organizational capacity of national counterparts to implement PMTCT intervention;
- Low levels of condom use rate (10%);
- high levels of needle sharing among IDUs;
- Very few VCCT sites, trained counselor and health worker;
- Inadequate data on the magnitude of MTCT continues to undermine design of appropriate interventions to effectively address this programme area.

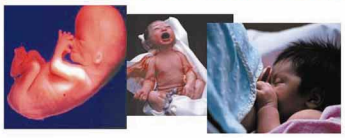
Recommendation

Will be conducted by GoI supported by UNICEF

- Consolidate and expand experience gained from Jakarta pilot to selected provinces with high HIV prevalence.
- Conduct situation assessment and analysis in 6 (six) high prevalence provinces: Jakarta, Papua, East Jawa, Bali, Riau, West Jawa (start July 2004)
- Develop and publish a national guidelines and best practice on PMTCT. (June – Dec 2004)
- Develop clear plan of action, including all prongs: primary prevention, prevention of unintended pregnancies, PMTCT core interventions and care and support.
- Define the composition, roles and responsibilities for PMTCT coordination committee at central and provincial.
- Review of existing policies, infant feeding, VCCT etc.
- Support development of training curriculum
- Support training of health workers at national, provincial and district levels.
- Develop a communication strategy on PMTCT and roll out plan.

MALAYSIA

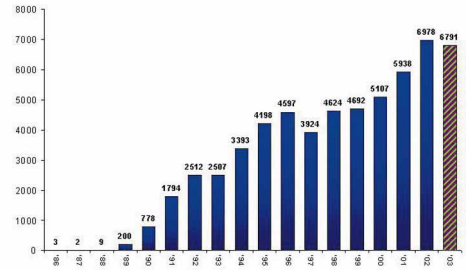
PREVENTION OF MTCT PROGRAMME IN MALAYSIA



Mahanim Md Yusof, MD, MPH
Rohani Ismail, MD, MPH

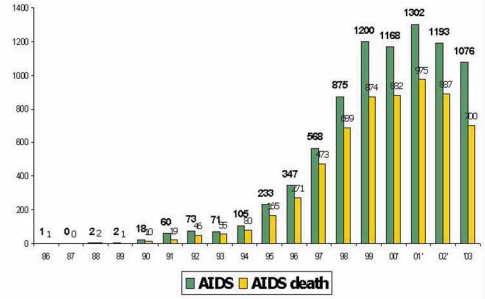
Page 1

Reported HIV infections in Malaysia 1986 – 2003



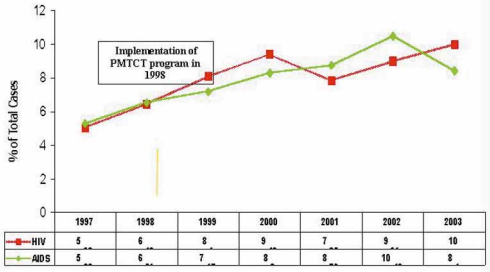
Page 2

Reported AIDS Cases in Malaysia, 1986 – 2003



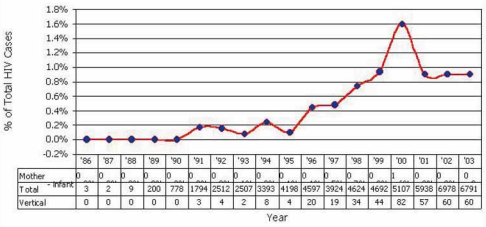
Page 3

Proportion of HIV and AIDS Cases by Female Gender, Malaysia, 1990 - 2003



Page 4

Proportion of HIV cases attributed to vertical route, Malaysia 1986 – 2003



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PREVENTION of MOTHER-TO-CHILD TRANSMISSION (MTCT) PROGRAM

- **OBJECTIVE**
  - To reduce the risk of HIV transmission from mothers to child
- **TARGET GROUPS**
  - All pregnant women attending antenatal clinics at health clinics/hospitals under MOH

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PREVENTION of MOTHER-TO-CHILD TRANSMISSION (MTCT) PROGRAM

- **STRATEGIES**
  - Early detection of HIV through screening using rapid test kit for antenatal mothers.
  - Provision of counseling to infected mothers and partners.
  - Institution of ARV to infected mothers and their babies.
  - Early detection of HIV infection among babies born to HIV-infected mothers.
  - Contact tracing of partners of HIV-infected mothers.

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HIV TEST in Malaysia

- **Screening tests (61 centers)**
  - ELISA in 32 centres
  - PA in 31 centres (19 Sarawak & 12 Sabah)
  - Rapid test (mostly for MTCT & Serenti/Prisons)
- **Supplementary tests**
  - Immunoblot (only at IMR KL) e.g western-blot or line immuno-assay
  - PCR (only at IMR KL and mostly for children < 18 months of age)
- **Confirmation**
  - Positive screening + supplementary (at least one)

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HIV DIAGNOSIS in MTCT

- Antenatal
  - Screening
    - Rapid Test (currently is Acon®)
  - Confirmation (2nd sample)
    - ELISA + PA then LIA
- Child < 18 months
  - Screening
    - ELISA + PA
  - Confirmation
    - PCR test

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PREVENTION of MOTHER-TO-CHILD TRANSMISSION (MTCT) PROGRAM

- Program launched nationwide in 1998.
- Coverage improves – more than 90%.
- As of 2003, 597 mothers detected positive out of 1,759,869 screened.
- Prevalence of positive mothers < 0.04 %
- 18 babies confirmed PCR+ve out of 442 deliveries (until Dec 2003),
  - ✓ successfully reduced the vertical transmission from estimated 25-30% to 4.06%.

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CHARACTERISTICS of POSITIVE MOTHERS (Ethnic/Mode of Exposure), 1998 - 2002

	No. (n=450)	%
• Ethnicity		
– Malays	271	60.2
– Chinese	38	8.4
– Indians	29	6.4
– Other Malaysians	9	2.0
– Foreigners	118	23.0
• Mode of exposure		
– Heterosexual contact	392	87.1
– Injection drug use	10	2.2
– Unknown	48	10.7

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CHARACTERISTICS of POSITIVE MOTHERS in MTCT (age and gravida), 1998 - 2002

	No. (n=450)	(%)
• Age groups		
– < 20	15	3.3
– 20 - 29	285	63.3
– 30 - 39	144	32.0
– 40 & above	3	1.4
• No. of Gravida		
– 1	141	31.3
– 2 – 4	275	61.1
– > 5	23	5.1
– No data	11	

Page 12

CHARACTERISTICS of POSITIVE MOTHERS in MTCT, 1998 - 2002

	No. (n=450)	(%)
• Age groups		
– < 20	15	3.3
– 20 - 29	285	63.3
– 30 - 39	144	32.0
– 40 & above	3	1.4
• No. of Gravida		
– 1	141	31.3
– 2 – 4	275	61.1
– > 5	23	5.1
– No data	11	2.5

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SUMMARY OF MTCT PROGRAMME, 1998 – 2002

YEAR	1998	1999	2000	2001	2002	TOTAL
No. of Attendance of ANC Mothers	323,902	416,400	347,979	392,139	387,200	1,867,620
No. of ANC Screened	161,087	276,000	286,390	343,030	359,411	1,425,918
Percentages Screened	49.7	66.3	82.3	87.5	92.8	76.4
No. of ANC Mothers HIV Positive	56	89	85	79	141	450
Percentages of Mothers' Positive	0.0348	0.0322	0.0296	0.0230	0.0392	0.0316
Babies delivered (31 Dec '02)	56	89	85	79	110	419
No. of Babies HIV Positive (31 Dec '02)	3	5	3	1	5	17
Percentages of Babies Positive	5.35	5.62	3.53	1.26	4.55	4.06

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Progress …

A. Review of PMTCT programme, includes

Protocols on management of HIV infected mothers

Protocols on management of babies born to HIV mothers

B. Scale up care and treatment which include treatment and care given by Family Medicine Physicians at clinic level.

Page 15

Future…..

- More innovative and responsive multi-sectoral team work efforts, proposed futher program
- · Pre-marital and pre-pregnancy screening for women.
- · Treatment to husband of HIV infected mothers
- . Providing care and support for the orphaned or affected child from the HIV infected mothers.

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TERIMA KASIH

Page 17

Rapid Test Kit

- Started in 1996 and 1997 as pilot in 5 states
  - HemaStrip® by Serodia Diagnostic
- First tender for 1998 to 2000 (3 years)
  - UniGold® by TrinityBiotech (www.trinitybiotech.com)
- Second tender for 2001 to 2002 (2 years)
  - JNQC® spot
- Third tender for 2003 to 2004 (2 years)
  - Acon® by Acon Laboratories (www.aconlabs.com)

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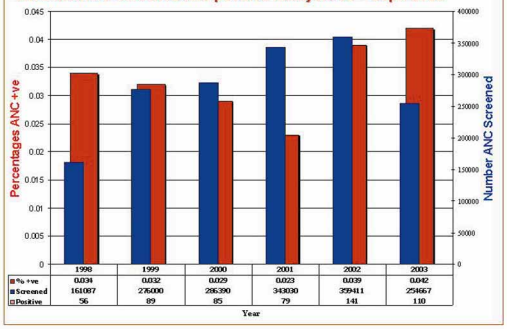
ANC Mothers screened and positive Malaysia 98 – Sept. 2003



	1998	1999	2000	2001	2002	2003
% +ve	0.034	0.032	0.029	0.023	0.039	0.042
Screened	161087	276000	286390	343030	359411	254667
Positive	56	89	85	79	141	110

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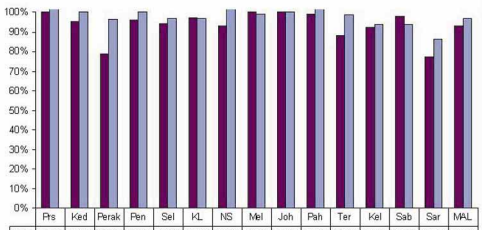
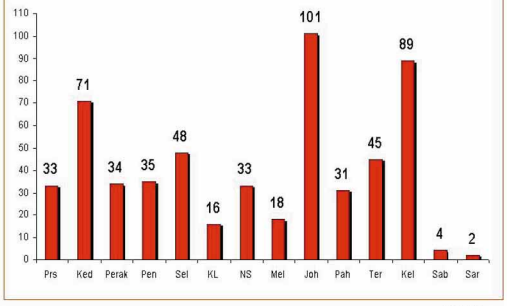
Proportion of Eligible Antenatal Mothers Screened by State, Malaysia 2002 and September 2003



	Prs	Ked	Perak	Pen	Sel	KL	NS	Mel	Joh	Pah	Ter	Kel	Sab	Sar	MAL
2002	99.9%	95.0%	78.6%	95.9%	94.2%	97.5%	93.0%	100.0	99.8%	99.3%	88.1%	92.3%	97.7%	77.4%	92.8%
2003	101.6	99.9%	96.4%	100.0	96.9%	96.8%	101.6	98.9%	100.1	108.0	98.5%	93.7%	93.7%	86.3%	96.9%

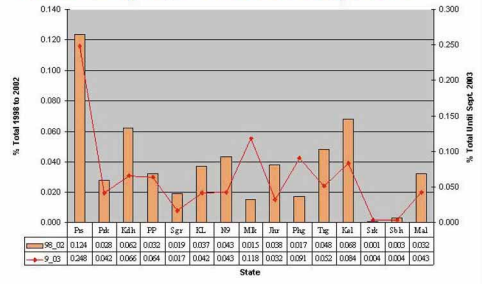
Page 20

HIV Infected ANC Mothers by states, 1998 – Sept. 2003



Page 21

% Antenatal Mothers detected HIV positive by states: Malaysia, 1998 to 2002 vs. Sept. 2003



	Ps	Pak	Kdh	PP	Sgr	KL	N9	Mk	Jhr	Phg	Trg	Kel	Sak	Sbh	Mal
98_02	0.124	0.028	0.062	0.032	0.019	0.037	0.043	0.015	0.038	0.017	0.048	0.068	0.001	0.003	0.032
9_03	0.248	0.042	0.066	0.064	0.017	0.042	0.043	0.118	0.032	0.091	0.022	0.084	0.004	0.004	0.043

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MYANMAR

Prevention of Mother to Child Transmission of HIV (PMCT) Programme

Myanmar

11-13 May 2004 (Bangkok)

Country profile

- 14 states and divisions, 63 districts and 324 townships
- Population in 2002 was about 52.17 million
- 70% of the population residing in rural areas
- Population growth rate was 2.02 (2000)
- Average life expectancy

Urban: 61.1 years (male), 65.1 years (female)

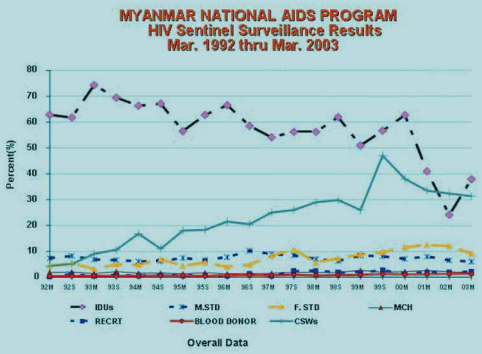
Rural: 60.4 years (male), 62.8 years (female)

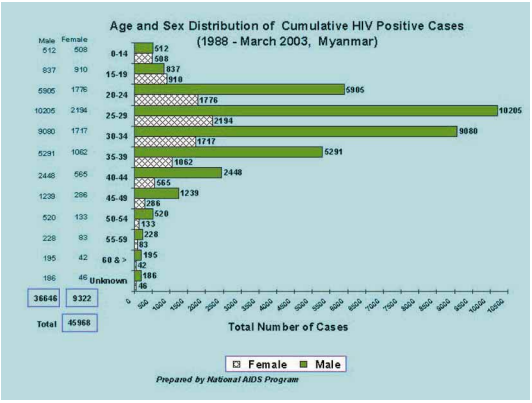
HIV/AIDS SITUATION IN MYANMAR

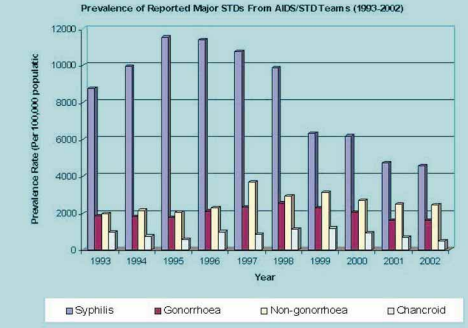
Total HIV +ve detected	45968 (Mar. 31, 2003)
Total Reported AIDS Cases	6727 (Mar. 31, 2003)
Reported Deaths of AIDS Cases	2843 (Mar. 31, 2003)

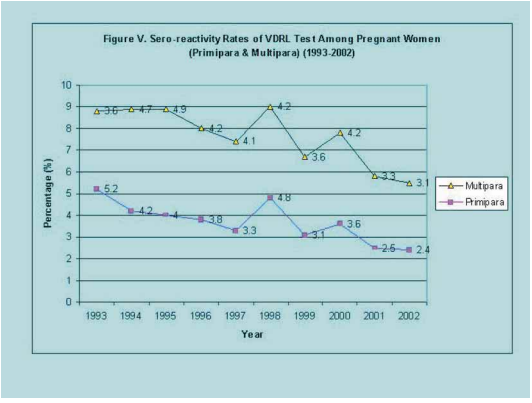
Year	HIV (+) Cases	AIDS Cases
1988	----- 1	
1989	----- 323	
1991	----- 2152	6
1992	----- 1641	41
1993	----- 2001	142
1994	----- 2361	286
1995	----- 2055	618
1996	----- 2971	690
1997	----- 3307	554
1998	----- 3689	517
1999	----- 5201	802
2000	----- 4717	816
2001	----- 8013	668
2002	----- 5567	1298
2003 (Mar)	----- 935	289

HIV/AIDS estimates in March, 2002 = 177,279









Background and Progress of PMCT in Myanmar

- Initial discussions & preliminary preparation in 1998
- Achieved high level support from MOH in 1999
- Assessments in 2000
- implemented in 2 pilot townships during 2000
- Expanded to 5 more townships in 2001
- Further expanded into 5 more tsp in 2002 and 10 more tsp in 2003
- Jointly implemented by Department of Health and UNICEF for above 22 tsps

- In 2004 expand additional 10 townships with UNFPA and till now total 32 townships as community based PMTCT programme
- In 2003 Institutional based PMCT started in 5townships with support from WHO and planned to expand Yangon and Mandalay Division in 2004 with UNICEF
- Planned to expand total 57 townships by FHAM (Fund for HIV/AIDS in Myanmar),2004-2006

Map of Myanmar showing locations of Prevention of Mother to Child Transmission of HIV programme (22 in *2003*)

PMCT Townships

Provision of counselling training for PMTCT programme in a district area

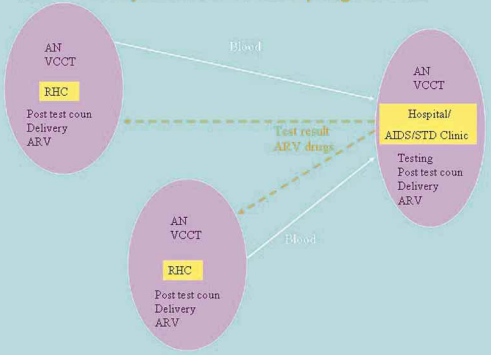
Approach

- To be start with areas where
  - potential of target population exist: evidenced by epidemiological data
  - existing infrastructure and manpower is feasible to implement the PMTCT programme
- In the initial stage, start with one to two sites and later on to expand accordingly

Uniqueness of community-based PMCT in Myanmar

- 70 % of population live in rural areas
- most of pregnant women in Myanmar receive AN care in RHC
- Assess to hospitals is not always easy because of limited transport feasibilities and resources

Community based PMTCT programme



Drug regimen used in Myanmar

- For mother
  - Tab Nevirapine 200 mg at the onset of labor
- For infant
  - Syrup Nevirapine 2 mg/kg body weight within 72 hours after delivery

Activities

- Advocacy
- Training
  - VCCT
  - PMCT package
  - Safe Delivery and Universal Precaution
  - Infant feeding option/ Counselling
  - Home care and Management of opportunistic infection
  - Lab: technician training for HIV testing
- Community mobilization

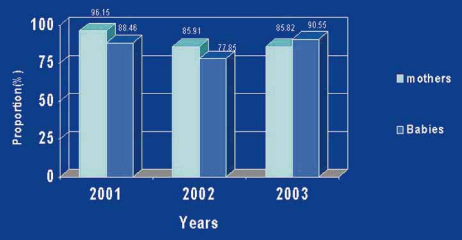
- Provision of supplies and equipments
  - instruments for safe delivery at the township hospital
  - clean delivery kits for MWs + LHVs
  - HIV test kits and lab: equipments
  - ARV deugs (NVP)
- Monitoring and Evaluation

Results - Service utilization

PMTCT at a glance:
service utilization rate increased,
seroprevalence rate reduced

Results –ARV therapy

PMTCT at a glance: most of the deliveries of HIV infected pregnant women were covered by Nevirapine



Problems and constraints

- high acceptance for VC but low acceptance for testing
- problems with pregnant women of mobile population
- coverage of PMTCT is very limited (22/324)
- Breast feeding is a traditional norms

Map of Myanmar showing locations of VCCT service and HIV sentinel surveillance activity (30 in 2003)

VCCT services in Myanmar

- conduct at 36 townships where AIDS/STD teams exist.
- improve services for provision of VCCT in the MCH clinics, TB centre and drug treatment centre as WHO 3 by 5 goal
- expand in NGOS and INGOS and supervise continuously by National AIDS Control Programme.
- Develop The National Guideline on Voluntary Confidential Counselling and testing (VCCT)

ARV therapy in Myanmar

- Provide ARV therapy in 2003 for selected 100 AIDS patients in Waibargi Specialist Hospital in cooperation with one INGO (AZG) and expands to AIDS patients in Lashio Hospital
- Provide standard anti retroviral therapy for 150 AIDS patients in Yangon and Mandalay by FHAM Round I Budget (2003-2004).
- Plan to give ARV therapy for 1500 patients by FHAM Round II Budget (2004-2006) in selected sites and institution using the national guideline.

- build capacity for voluntary confidential counseling and HIV testing (VCCT) and care and support services by Global fund for AIDS/TB/Malaria – (Round III))
- propose to expand ARV therapy programme according to WHO goal 3 by 5 and scaling up ARV therapy by Global Fund (Round IV).
- Publish Guidelines for the clinical management of HIV/AIDS in 2002

NEPAL

UN REGIONAL TASKFORCE ON PMTCT
11-13 MAY 2004

NEPAL

DR SUSHILA SHRESTHA
SENIOR GYNAECOLOGIST
MINISTRY OF HEALTH
NEPAL

SITUATION

- 900,000 pregnancies per year
- Prevalence .3%
- Infected – 180 p/y
- Cohort approx 200

SITUATION

- NEED ASSESSMENT
  - Planned for July 2004
- POLICY/GUIDELINES
  - Standard Operating Procedures for Implementation of ARV (Adults & Children)
  - National Guidelines for ARV Therapy 2003
  - Policy in place since 2003
  - A single dose treatment for PMTCT – Dec. 2003

PROGRAMME IMPLEMENTATION STATUS

- In process

FUTURE PLANS

- Selection of focus sites – 3 proposed
- Activities planned:
  - Training of doctors/nurses
  - Continue awareness program
  - Counselling – pre and post
  - HIV lab testing
  - Universal precaution
  - Drugs/supplies – ARVs & reagents
  - Infant feeding

FUTURE PLANS contd.

- Site selection
- Build partnership – Nurses Association
  - SNEHA (people living with AIDS)
  - MAITI NEPAL
  - Grassroots NGOs

Adaptation of training modules to Nepalese context

Training of trainers

Operationalise selected sites

Community mobilisation

CHALLENGES

- Instability/insecurity
- Lack of skilled human resource
- Involvement of male partners & family members
- Supervision/Monitoring
- Surveillance system
- Social & cultural issues/stigma/discrimination
- Dissemination of information

SUPPORT REQUIREMENTS

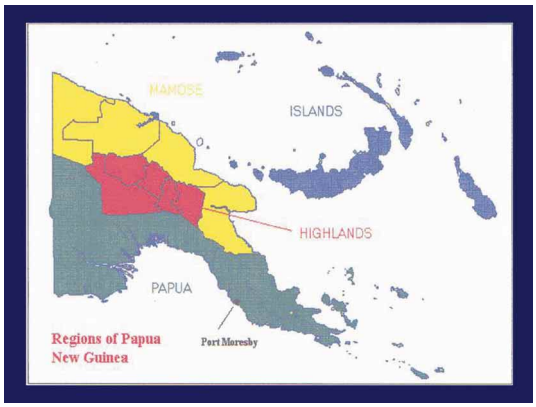
- Experts to work with nationals
- Equipment/drugs & reagents
- IEC materials
- Trained counselors
- Service providers

OPPORTUNITIES

- Increase in service outlets
- Partnership
- Availability of funds
- Support groups
- Interest Groups

PAPUA NEW GUINEA

Prevention of Mother To Child Transmission of HIV in PNG. May 2004



Papua New Guinea (July 2000)

- Total population 5, 130, 365
- Male 2,661, 091 (51.9%)
- Female 2,469,274 (48.1%)
- Annual growth rate 3.1%
- Antenatal coverage rate 50%
- 170 000 births/year

HIV/AIDS in PNG

- First case 1987
- 8202 HIV/AIDS (30/9/03)
- 50% male, 46% female, 4% unknown gender
- No formal death notification system
- Estimates 10, 000 – 15,000 (5,500 – 22,000) HIV infected in PNG (National consensus workshop January 2000)

HIV/AIDS IN PNG

- No province is spared
- Heterosexual transmission accounts for most cases followed by Perinatal transmission.
- Other modes of transmission reported are between MSM

PMTC IN Papua New Guinea

Mother-to-child transmission, a major public health problem

- heterosexual transmission
- prognosis of HIV infection in infants very poor
- infant mortality rate
- Most mother-to-child transmission can be prevented and is cost-effective

For the Children

National Capital District

- Population 252, 469 (4.9% of total pop.)
- Male 138,182
- Female 114,287
- Antenatal coverage rate:
- PMGH: ANC books 5,000 mothers/yr & does 10, 000 deliveries/yr (37/day).
- The other 5,000 are booked at the urban clinics in NCD.

Port Moresby General Hospital

- PMGH 10 000 deliveries/yr or 37/day, 2002 – 10 192 deliveries
- 5000 mothers ANC at PMGH
- 5000 mothers other clinics in NCD/CP
- Sero surveillance rate (PMGH) 2002: 0.8% , 2003: 0.9%, 2004 Jan – April: 1.35%
- 80 - 100 babies a year born to HIV positive mothers

Cont..

- 30 – 40 babies IN PMGH die each year from HIV/AIDS.

Age Group Distribution of Pregnant Women who tested positive for HIV in Port Moresby General Hospital
2000 – March 2004

Year	% Seropositive 15 – 19 years	% Seropositive 20 – 24 years	% Seropositive 25 – 49 years	Total Seropositives 15 – 49 years
2000	16.7% (5)	53.3% (16)	30.0% (9)	30
2001	16.7% (6)	50.0% (18)	33.3% (12)	36
2002	10.8% (4)	56.8% (21)	32.4% (12)	37
2003	21.7%(10)	41.3% (19)	37.0% (17)	46
2004 March	25.0% (3)	50.0% (6)	25.0% (3)	12
Total	17.4% (28)	49.7% (80)	32.9% (53)	161

HIV Sero surveillance in other Antenatal Clinics in the country – September 2003

ANC Site	No of Pregnant women	No of HIV Positive	Prevalence Rate (%)
Port Moresby General Hosp	1187	16	1.35
Goroka	451	4	0.89
Lae	480	12	2.50
Daru	150	1	0.66

IMPLEMENTATION OF PMTC IN PNG

- 3 Hospitals are currently implementing PMTC:
- St Mary's Hospital Port Moresby
- Mingendi Hospital
- St Mary's Hospital Vunapope

Steps Involved in PMTC Implementation in PNG

- Voluntary Pre –Test Counseling in AN clinics (Group or Individual counseling)
- HIV Testing (Rapid Test)
- Post Test Counseling for both +ve & -ve mothers
- Optimal obstetric care
- ARV during delivery
- Counseling for Infant Feeding Option
- ARV treatment (PMTC+)

PMTC Current Situation in the 3 Hospitals December 2003 – March 2004

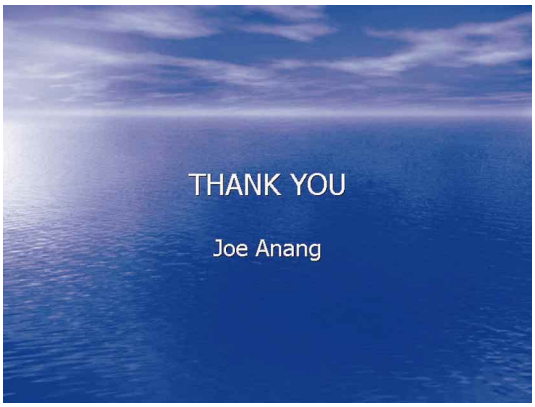
- Total ANC women: 227
- Total group counseling & education: 207
- Total Individual counseling: 227
- # women who refused HIV Test : 88 (38.8%)
- # Women who tested positive for HIV: 4 (2.88%)
- # women who delivered: 150
- # HIV + women who delivered: 3
- # HIV + women who received ARV (Nevirapine: 3
- # Babies who received Nevirapine: 3
- # women who received counseling on infant feeding options: 3

Plans to scale up PMTC in PNG

- UNICEF is the only funding agent for PMTC in PNG
- PNG was not successful in securing funding from GFATM in the 2nd & 3rd rounds proposals (PMTC was not addressed in those proposals)
- Successful in securing funds for Malaria eradication: US$ 20 million
- PMTC and ARV treatment had been included in the 4th GFATM Proposal
- Total GFATM for HIV/AIDS: US$ 29 Million
- Country is implementing 3 x 5 initiative (Feb 2004) WHO & ADB
- 60 patients will be on ARV by the end of 2004, and this will be scaled up to cover 3000 patients by 2005
- All pregnant women testing positive to HIV receive ARV under the 3 x 5 initiative.

Plans to scale up PMTC in PNG

- 4 Regional Hospitals and 22 minor hospitals and Health Centers will initiate PMTC by the end of 2004
- TBAs will be involved initially in PMTC as advocators for VCT in rural PNG.
- Pregnant Women aged 15 – 24 years will be targeted under the PMTC program in PNG.


THANK YOU
Joe Anang

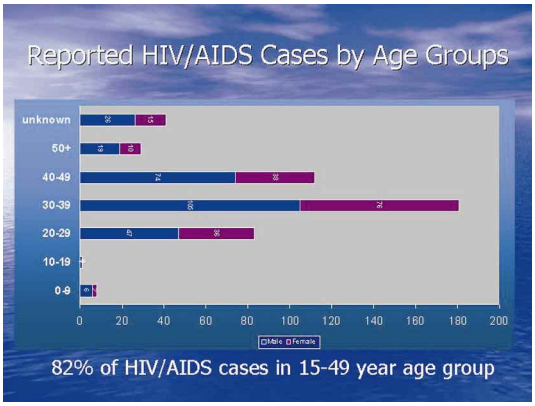
SRI LANKA

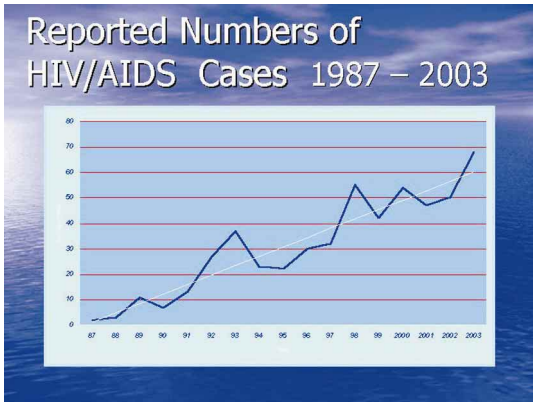
HIV/AIDS Estimates For Sri-Lanka

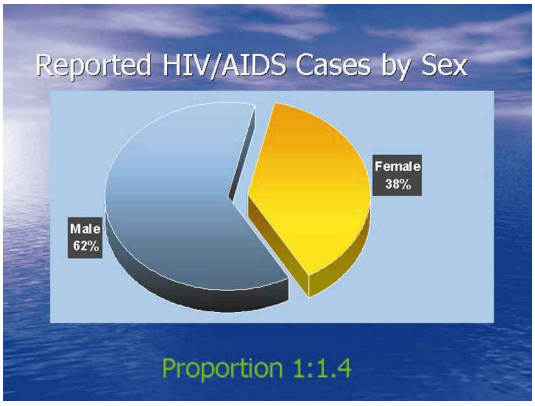
By UNAIDS/WHO as of end 2003

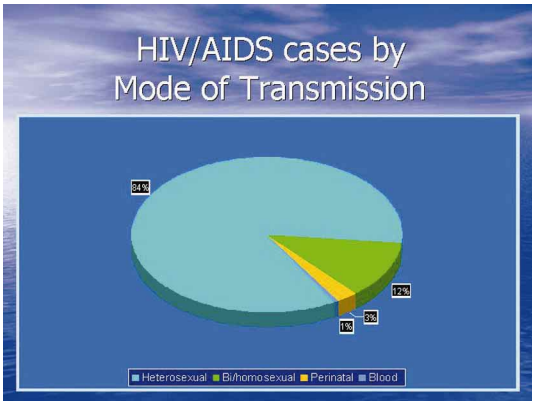
- People living with HIV/AIDS
  - Adults(15-49 years) -3500
  - Children(<15) -<100
- Deaths in 2003 -<100
- Adult Prevalence(15-49 years)-<0.1%

Year	# of AN Mothers Screened for HIV	Number positive
1999	14,901	0
2000	30,906	3
2001	20,409	0
2002	17,601	0
2003	20,236	1









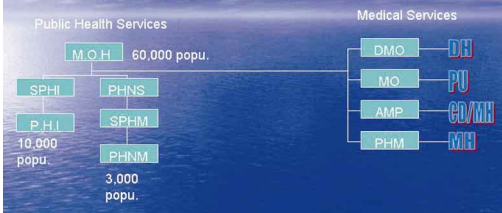
Planning for PPTCT In Sri Lanka

- Formation of National Working Group on PPTCT in Mar 2003
- Members of the National Working Group included MOH,UNICEF,WHO, UNFPA & NGOs
- Development of guidelines on PPTCT in Sri Lanka
- Piloting of Plan of Action in one district

Objective of the pilot project

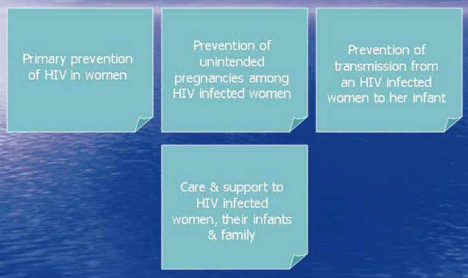
To demonstrate the feasibility of implementing PPTCT interventions using the existing PHC infrastructure

Primary Health Care Infrastructure in Sri Lanka



Primary Health Care Infrastructure in Sri Lanka

Four – Pronged Strategies for PPTCT



Proposed interventions in the project areas (1)

- Strengthening of maternal and child health services
- Intensify advocacy and awareness on HIV/AIDs
- Training of health care workers
- Provide Voluntary Counseling and Testing
- Use of ARV drugs
- Maternal STI screening & treatment
- Improved Obstetric Care

Proposed interventions in the project areas (2)

- Infant feeding counseling
- Promotion, protection and Supporting BF in the general population including the Code for BMS
- Strengthen postpartum care including family planning services
- Involvement of the male partner
- Monitoring and evaluation

Sri-Lanka is bound by the United Nations General Assembly Special Session (UNGASS) Declaration of Commitment

This pilot project is an important step in achieving the target set at UNGASS.

"We must prevent the cruelest, most unjust infections of all – those that pass from mother to child"

United Nations Secretary General - Kofi Annan

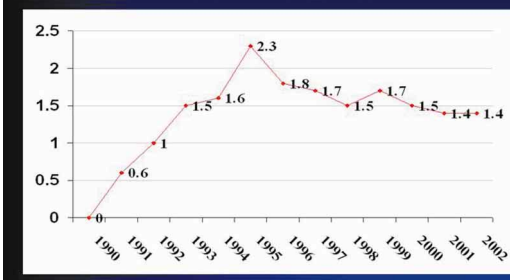

THANK YOU !

THAILAND

Implementing a National Mother-Child HIV Prevention Program in Thailand

Dr. Boonsang Boonamnuaykij
The 12 th Health Promotuion Center, Yala
Department of Health
Ministry of Public Health, Thailand

Sentinel Surveillance Median HIV Seroprevalence (in percent) for Women Attending Clinics in Thailand 1990-2002



Source : Division of Epidemiology, MOPH, 2003

Number of AIDS Cases of Children 0 – 4 years from Vertical Transmission

Source: Monthly Epidemiological Surveillance Report/ Dec. 2002

Magnitude of The Problem
Mother to Child HIV Infection in Thailand

900,000 women give birth annually

↓

13,000 children born at risk for HIV annually

↓

4,000 HIV-infected children born annually without intervention

Background

1994	Voluntary counseling and HIV testing in antenatal care clinics (ANC)
	Formula feeding for infants of HIV-infected mothers
1996 -	MOPH and World Bank re-evaluate ARV use: AZT in pregnant women is most cost-effective use of ARV
1998	Bangkok regimen (short-course ZDV) found to reduce transmission by 50%
1997-8	MOPH pilot program providing short-course ZDV to pregnant women in Region 10, 7
2000	National PMTCT program providing ZDV short-course starting from 34 wks gestation and infant ZDV 1 or 6 wks depending on duration of ZDV received by mothers

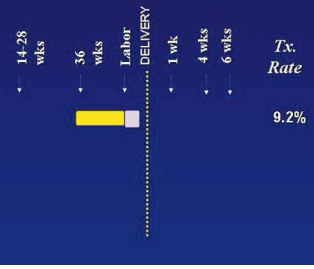
Clinical PMTCT Training Program

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
1997-98	MOPH begins pilot programs providing short-course AZT to pregnant women in Regions 10 and 7
1998 -	Bangkok trial shows effectiveness of short-course AZT
1999 -	National PMTCT guidelines reviewed
2000 -	National regimen of AZT for HIV+ women/infants

Clinical PMTCT Training Program — *Ministry of Public Health, Thailand*

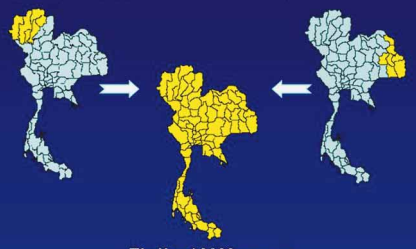
Bangkok Study Short Course AZT Thailand,



Pilot Program Evaluation To National Implementation

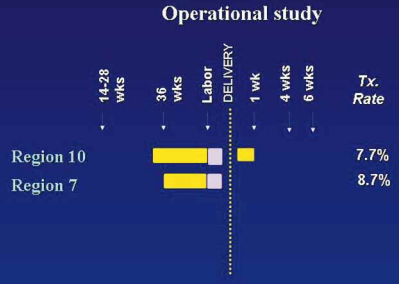
Region 10: 1997-1999

Region 7: 1998-2000



Thailand 2000-present

Overall HIV Transmission Risk in PMTCT Pilot Regions, Thailand, 1997-2000



Major Components of PMTCT Program in Thailand

- Antenatal/intrapartum HIV testing
- Counseling
- Short-course ZDV
- Formula feeding

Major Components of PMTCT National Program

- Integration of PMTCT to existing MCH system
- Provide VCT during antenatal care
- Supply HIV testing: EIA and Rapid test
- Provide short-course ZDV
- Supply formula feeding with counseling
- Convene program monitoring and supervision

Nationally-Supported Mother-Child HIV Prevention Program, Thailand, 1999

- VCT for all pregnant women
- ZDV for all HIV+ pregnant women from 34 wks
- ZDV for all children born to HIV+ women:
  - 1 wk if mother's treatment is □4 wks
  - 6 wks if mother's treatment is <4 wks
- Infant formula for 12 mos to replace breastfeeding
- HIV test for infant at 12 mos; if +, re-test at 18 mos
- Appropriate care for mothers and children

Nationally-Supported Mother-Child HIV Prevention Program, Thailand, 2004

- VCT for all pregnant women
- ZDV for all HIV+ pregnant women from 28 wks
- NVP single dose intrapartum and newborn infant
- ZDV for all children born to HIV+ women:
  - 1 wk if mother's treatment is □4 wks
  - 6 wks if mother's treatment is <4 wks
- Infant formula for 12 mos to replace breastfeeding
- HIV test for infant at 12 mos; if +, re-test at 18 mos
- Appropriate care for mothers and children

Monitoring National PMTCT Program Thailand

- MOPH collaborating with CDC in establishing a national system to monitor PMTCT implementation:
  - each hospital completes 44-item report monthly
  - standard reports generated at provincial, regional, and national levels
- System implemented in 2000

Monitoring and Evaluation for PMTCT

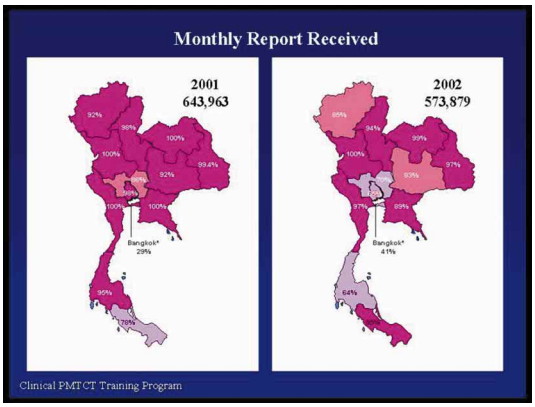
- Process Monitoring and Evaluation
  - Perinatal HIV Monitoring System (PHIMS)

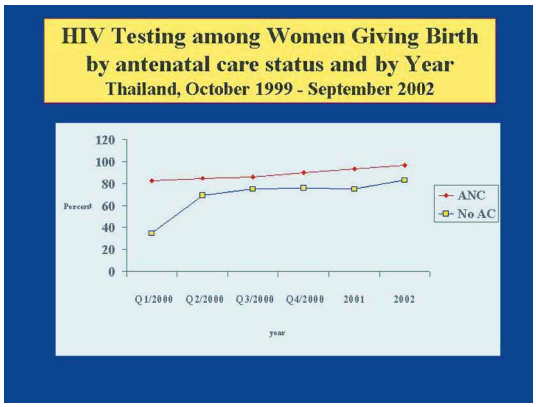
    Data system to monitor national implementation of perinatal AZT
- Outcome Monitoring and Evaluation

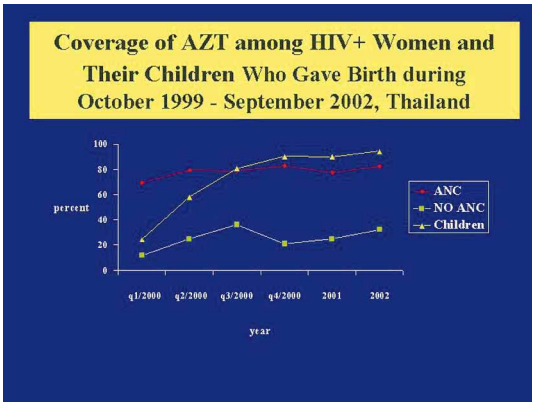
Monitoring and Evaluation for PMTCT

Process Monitoring and Evaluation

- % ANC
- % VCT among pregnant women
- % received ZDV of mothers and infants affected by HIV
- % ZDV adherence
- % used formula substituted breast-fed
- % HIV testing to diagnose perinatal HIV transmission

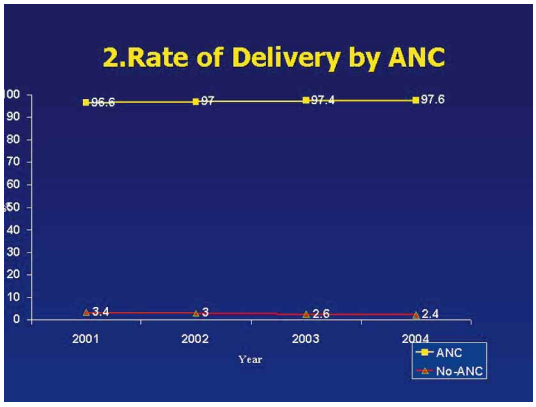






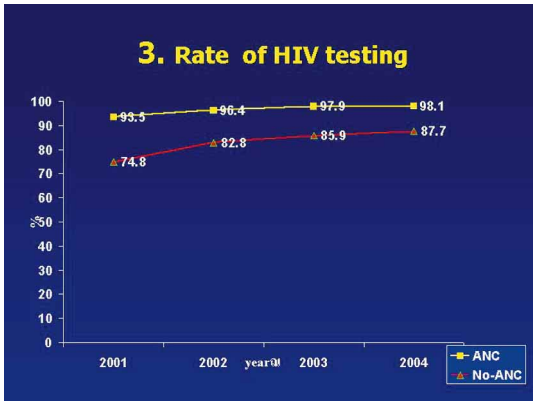
1. Rate of report receieved

	2001	2002	2003	2004 (March)
percent	96.5	97.5	97.6	56.2

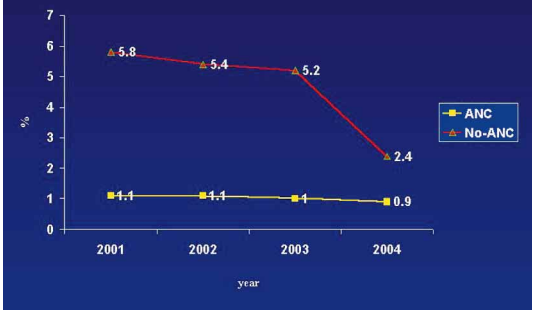


3. Rate of HIV testing

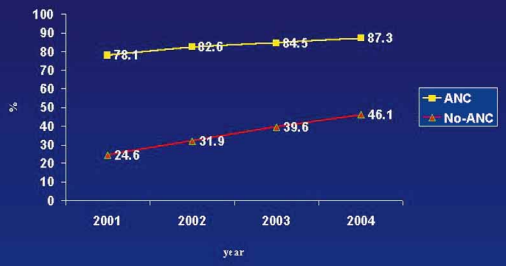
	2001	2002	2003)	2004
ANC	93.5	96.4	97.9	98.1
No-ANC	74.8	82.8	85.9	87.7



4.Rate of Infection



5 Rate of ARV given to pregnant mother



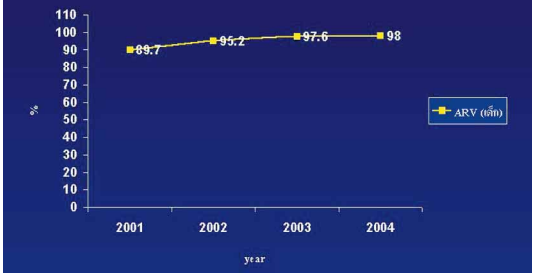
6. AZT in Pregnant Mother

	2001	2002	2003	2004
≥ 4 week	70.5	71.6	71.1	73.8
< 4 week	29.5	28.4	28.9	26.2

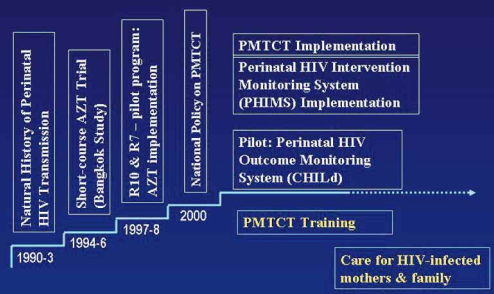
7. ARV in Newborn infants

	2001	2002	2003	2004
percent	89.7	95.2	97.6	98.0

7. ARV in Newborn infants



Conclusion of PMTCT in Thailand



Thailand's National PMTCT Program
Lessons Learned

- Surveillance, research, pilots, monitoring, evaluation provide useful information.
- Research and NGO projects provide early program experience.
- Integrating PMTCT into MCH simplifies program.
- Counseling plays central role in PMTCT.
- Training is needed to prepare staff; team-building is needed to maintain communication.

Thailand's National PMTCT Program

Future Challenges (1)

Sustainability of PMTCT program requires:

- **using monitoring and evaluation data to improving programs and policies.**
- **ongoing clinical, counseling, management training.**
- **continued political and budgetary support.**

Thailand's National PMTCT Program

Future Challenges (2)

To improve PMTCT program:

- enhance HIV prevention in antenatal and postpartum settings for HIV- women/partners
- improve care of HIV+ women and children
- meet needs of orphans
- support research on better interventions
- share experiences with and learn from other countries

ARV regimens for HIV +ve adult:

Regimen 1 ;	d4T+3TC+NVP
Regimen 2 ;	d4T+3TC+EFV
Regimen 3 ;	d4T+3TC+(IDV+RTV)

ARV regimens for HIV positive children

1. **AZT+3TC+NVP OR d4T+3TC+NVP**
2. **AZT+3TC+EFV OR d4T+3TC+EFV**

In case of sevsere side effect from NVP and EFV change to Dual therapy

1. **AZT+3TC**
2. **d4T+3TC**

ANNEX VI : GROUP WORK

Group 1 : Strengtheing the community component of PMTCT

Strengthening the community component of PMTCT

Group I:
G. Jourdain
Agatha Pratt
Husein Habsyi
Scott Bamber
Aye Aye Moa
Rohani Ismail
Koum Kanal
Ngashi Ngongo

Aim of the community-based PMTCT-Plus

- Strengthen HIV prevention
- Increase acceptance of services through stigma reduction and creation of conducive environment
- Provision of home-based care: Psychosocial support, nutrition care etc...
- Enhance adherence through improved follow-up

Resources

- Human:
  - Community and religious leaders
  - Traditional groups: women & men's groups...
  - Community/village workers
  - Community/village facilitators
  - PLWHA etc...
- Financial
- Communication media: Radio, TV, traditional ...

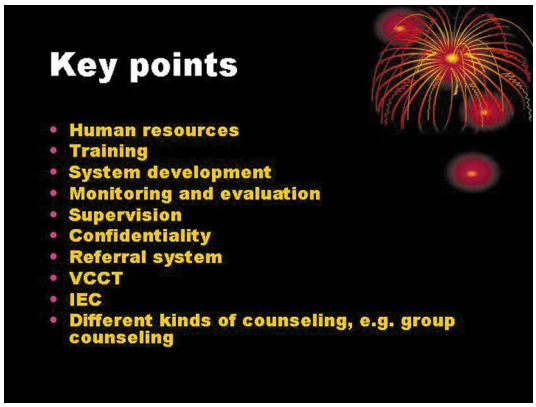
Constraints

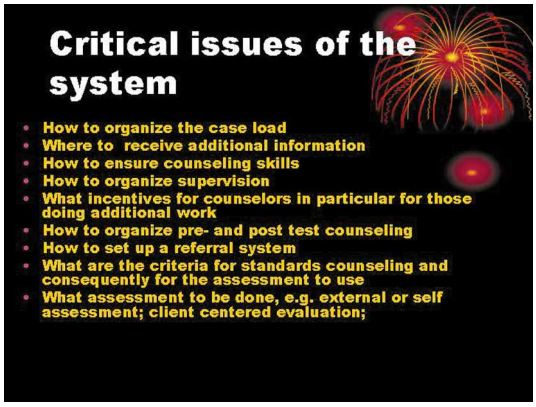
- Language
- Migration
- Logistics: telephone, etc...
- Poverty
- Geographical accessibility

Key Issues

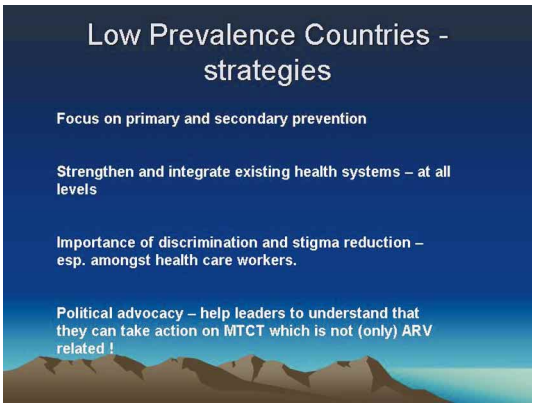
- Using an integrated approach to community engagement
- Identifying resources/structures within the community
- Create an enabling environment through involvement of political/community leaders
- Increase access to appropriate information
- Empowerment/Capacity building of communities

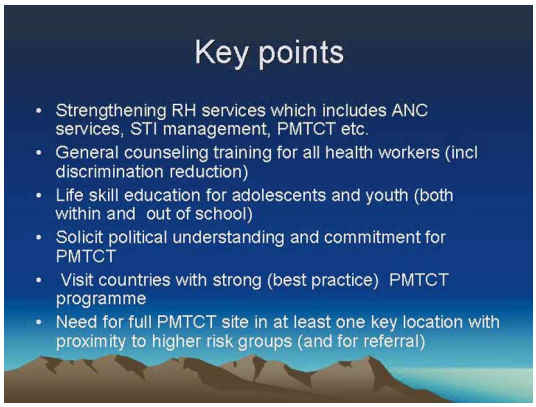
Group 2 : Quality Counseling





Group 3 : Low Prevalence Countries strategies





ANNEX VII : FUTURE OF REGIONAL PMTCT TASK FORCE

Future of the Taskforce

Issues:

- The Taskforce now involves a greater number of countries across two regions – South and Southeast Asia and the Pacific; previously it was Southeast Asia and the Pacific and India.
- Countries are at different levels of programming scope on PMTCT.
- Additional involvement is to be sought of other UN agencies and key NGO+ partners.
- This is a rapidly evolving technical field.

6. Ensure key advocacy statements and plans emerge from Network

   E.g. – statement of concern of the Taskforce meeting on the need for greater emphasis to be given to paediatric formulations for infants.

- Review options for the establishment of Technical Working Group/s or Advisory Teams ….. from the Network on key programme issues for the purpose of specific technical assistance.

- Information sharing between meetings:
  - Set up an Email forum (not moderated)
  - Website – either new or directed to key sites & discussion groups
  - Join global PMTCT electronic network
  - Involve – engage with other regional networks
  - Link this Taskforce to Asia Pacific AIDS Conference

The Future - a Proposal

1. Maintain as a two-region Network
2. Break into two sub Networks: (to be reviewed)
   - Countries with established PMTCT programmes looking to or are scaling up
   - Countries with new, nascent or developing PMTCT programme
3. Meet approximately 3 times per 2 years
4. Ensure WHO, UNAIDS, CDC and key NGO participation
5. Meetings to be a a balance of:
   - Expert technical updates – both sub networks
   - Detailed programme interventions/guidance discussions on one or two issues (i.e. country presentations focus on that issue/issues)
   - Include study tour/site visit within meeting schedule

UN Regional Taskforce on PMTCT

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