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List of Abbreviations

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



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



Executive Summary and Recommendations

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

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

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

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

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

The major conclusions and recommendations of the meeting were:

1. Vertical transmission has been the primary focus on PMTCT

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

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

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



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

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

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

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

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

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

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

5. **Reaching the UNGASS PMTCT target**

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

6. **Challenges**

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

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

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

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



8. Routine VCT

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

9. Resources

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

10. Supply chain management

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

11. Global guidelines

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

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

12. Monitoring and evaluation

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



13. Adapting national guidelines and regimens

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

14. Linking PMTCT to Care, Support and Treatment

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

15. Involvement of men in PMTCT

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

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

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

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

17. Cotrimoxazole prophylaxis

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

18. Next meeting

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



Background, Conceptual Framework and Objectives

Background

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

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

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

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

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

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



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

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

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

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

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

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



Conceptual Framework for Comprehensive PMTCT

Four Prongs of the Comprehensive PMTCT Approach

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

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

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

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

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

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



Table 1: Conceptual Framework for Comprehensive PMTCT

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

Task Force Meeting Objectives

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

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

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

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

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

Session Objectives:

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



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

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

Session Objectives:

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

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

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

Session Objectives:

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



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

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

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

Session Objectives:

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

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

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

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

Session Objectives:

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



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

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

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

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

