

Group Work Recommendations

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

The four groups were set as follows:

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

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

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

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

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



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

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





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Capacity building	<p>Afghanistan, Bangladesh, Maldives and Pakistan</p> <p>Build Capacity to scale up/ expand coverage through:</p> <ol style="list-style-type: none"> 1) policy, 2) Programme, 3) Technical, 4) implementation 5) M&E 	<p>Fiji, Indonesia, Nepal, Lao PDR and Papua New Guinea</p> <p>Build capacity in the area of counseling (adequate and good quality) for all health care providers, managers etc. - at all levels.</p>	<p>Cambodia, Vietnam, Myanmar, Thailand and China</p>	<p>India</p> <p>Sensitization/ training of all the health care functionaries</p>
Integration of services	<p>Integrate PMTCT into MCH, FP, PHC, RH, STI and curative services.</p> <p>Mainstream HIV/AIDS prevention into education, labour, information and communication, health, religious affairs and women's development</p>	<p>Integration of prong 1 into existing services as e.g. MCH, STI</p>	<p>Include VCT services within the MCH service (ANC and FP)</p> <p>Multi-sectoral response</p>	<p>All RCH services to provide HIV services</p>
VCT	<p>Increase access to VCCT services</p>	<p>Innovative approach to VCT need to be found (e.g. group counseling, lay counselors)</p> <p>Acknowledge counselors as professionals (i.e. nurses, midwife, lay counselors are getting new roles)</p>	<p>Make use of couple counseling, waiting rooms for men and pre-marital counseling consultations</p>	

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Community/ male mobilization	Improve availability and quality of services to address unmet needs including e.g. male involvement, religious/community leaders and youth	Specific/ targeted approach to vulnerable and hard to reach groups needed (i.e. build on existing service such as immunization/vitamin A, CHWs, counselors)	Community mobilization - role of TBA (traditional birth attendant) to support the PMTCT programme	More adolescent friendly services
	Strengthening men's involvement			
Partnerships		Involvement of PLWAs (GIPA) as well as negative mothers and young people	Harmonization, collaboration, cooperation, coordination among partners and programmes including mass media	Involvement of private sector for delivery of PMTCT services: Need a strategy to be developed.
M & E	Establish data collection and analysis system for evidence based decision making	Strengthen/ establish good M&E of Prong 1 and 2 (regular programme review). Need to think about sustainable strategies and mechanisms	Monitoring, supervision, evaluation mechanisms	Comprehensive PMTCT reviews at the state level to develop a pronged strategy (including ART, GFATM).
Resource mobilization		Utilize new opportunities (GFATM funds) to strengthen HR gap in counseling	Resource mobilization - manpower, materials, money	





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

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

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Afghanistan, Bangladesh, Maldives and Pakistan	Fiji, Indonesia, Nepal, Lao PDR and Papua New Guinea	Cambodia, Vietnam, Myanmar, Thailand and China	India
	Strengthening the collaboration with NGOs and FBOs, civil societies and partners	Need to identify one coordination body within the government who will be coordinating	
Integration of services	Strengthening of the existing ANC/MCH/FP/PHC	Set up and improve health service for all people - if available then improve quality	
	Integrate of PMTCT services into routine MCH	VCCT and PMTCT should be integrated into existing services - counseling for pre-married couples, pregnant women and for couples. The important thing is to provide post-test counseling for both positive and negative.	
Community support and involvement	Improve and expand delivery of quality service	Put in place a comprehensive continuum of care with emphasis on community support	Community practices - improve awareness and HIV prevention
	Male involvement (multi-sectoral approach) - as well as involvement of religious leaders, community, labour, male youth groups and the Ministry of Education	Assessment of what is available in the country for care and support	Marriage counseling for newly wed couples





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	Afghanistan, Bangladesh, Maldives and Pakistan	Fiji, Indonesia, Nepal, Lao PDR and Papua New Guinea	Cambodia, Vietnam, Myanmar, Thailand and China	India
Resource mobilisation and supply	Resource mobilization and donor coordination	Develop and strengthen proposals to include/reinforce PMTCT component for Global fund		Harmonize funding/budgeting
		Continued supply of ARVs and OI treatment/prophylaxis as well as nutritional support		Inclusion of HIV test kits in RCH kits.
Regional support and knowledge base	Regional/ HQ support in national strategy formulation/plan of action	Pool of resource people to help other countries start up services	Need to be very well prepared before implementation is started - goal, strategy, scaling up process, selection of areas.	
	Country specific approaches	Learning hubs in the region (was promised last year), including E-web space		
M & E	M&E evaluation			State level reviews to define scaling up processes - capacity building, M&E

Presentation of scale-up framework

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

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

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

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



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

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



Example of a PMTCT scale-up framework
Group 2 - Low prevalence/ Initial phase of PMTCT programme

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



Annex 1: Agenda

Day One: 8 March 2005 (Tuesday)

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



Afternoon Session of Day One (Chairperson : Ivonne Camaroni)

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

Day Two: 9 March 2005 (Wednesday)

Morning Session of Day Two (Chairperson : Agatha Pratt)

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



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

Day Three: 10 March 2005 (Thursday)

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



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



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

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



Annex 2: List of Participants

Country Team	Participant	Organisation/Designation	Signature
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Annex 3: Evaluation Summary

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

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

The strengths of the meeting were found to be:

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

The weaknesses of the overall programme were pointed out as:

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

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

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

Programmatic issues:

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

Themes or topics:

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



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