Report of
Symposium on HIV and Infant Feeding

9th December, 2005

Organised by:

Breastfeeding Promotion Network of India (BPNI)

Supported by:

- Planning Commission, Government of India
- UNICEF India
Collaborating Partners

- CARE - India
- Concerned citizens for community health and development, Jaipur
- Department of Women and Child Development, Govt. of India
- Directorate of Family Welfare, Govt. of Uttar Pradesh
- Food and Nutrition Board, Govt. of India
- Federation of Gynecology and Obstetrics Societies of India (FOGSI)
- Gujarat State AIDS Control Organization
- Indian Council of Medical Research (ICMR)
- Indian Academy of Pediatrics (IAP)
- Jan Swasthya Abhiyan
- Life Foundation, Bhopal
- National AIDS Control Organization (NACO)
- National Institute of Public Cooperation and Child Development (NIPCCD)
- Nutrition Foundation of India
- National Neonatology Forum (NNF)
- Planning Commission, Govt. of India
- Trained Nurses Association of India (TNAI)
- UNICEF India
Report of
Symposium on HIV and Infant Feeding
9th December, 2005

Written by:
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HIV & Infant Feeding

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Acknowledgement

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Abbreviations

1. AFASS- Affordable, Feasible, Acceptable, Sustainable and Safe
2. AIDS – Acquired Immunodeficiency Syndrome
3. AIIMS – All India Institute of Medical Sciences
4. ART – Anti Retroviral Therapy
5. BPNI – Breastfeeding Promotion Network of India
6. FOGSI – Federation of Obstetric and Gynecological Societies of India
7. GSACS – Gujarat State AIDS Control Society
8. HIV – Human Immunodeficiency Virus
9. IAP – Indian Academy of Pediatrics
10. ICDS – Integrated Child Development Scheme
12. IYCF- Infant and Young Child Feeding
13. JSA – Jan Swasthya Abhiyan
14. MCH – Mother and Child Health
15. MTCT – Mother to Child Transmission
16. NACO - National AIDS Control Organization
17. NHRC – National Human Rights Commission
18. NIPCCD – National Institute of Public Cooperation and Child Development
19. NNF – National Neonatology Forum
20. NRHM – National Rural Health Mission
21. PPTCT – Prevention of Parent to Child Transmission
22. RCH – Reproductive and Child Health
23. RCH II – Reproductive and Child Health II
24. TNAI – Trained Nurses Association of India
25. UN – United Nations
26. UNAIDS- United Nations Programme on HIV/AIDS
27. UNICEF – United Nations Children’s Fund
28. VCTC – Voluntary Counseling and Testing Centre
Introduction
Breastfeeding Promotion Network of India (BPNI) organized its National Convention in Delhi on 9th and 10th December 2005 in collaboration with the Planning Commission, Government of India, UNICEF and national breastfeeding partners. The meeting had two key themes ‘HIV & infant feeding’ and ‘Infant feeding during emergencies’ for discussion.

The themes were based on the report of “Assessment of Status of Infant and young child feeding (IYCF) Practice, Policy and Program: Achievements and Gaps” by a team of 4 core partners- Breastfeeding Promotion Network of India (BPNI), National Neonatology Forum (NNF), AIIMS – Department of Pediatrics and Center for Community Medicine. The report found major gaps on these two issues. Discussions during the convention were designed in such a manner so as to develop certain recommendations, which may be utilized into the process of developing national action plans on infant feeding.

This is the report on the theme ‘HIV and Infant feeding’. In the paragraphs that follow, you will find relevant background information, brief proceedings of the sessions including views of various stakeholders, brief description of the process of group discussions to formulate recommendations and finally recommendations which were presented in a plenary session to the participants for their concurrence and finally agreed upon.

Background
According to UNAIDS, in 2005, some 8.3 million people were living with HIV in Asia, including 1.1 million people who became newly infected in the past year. AIDS claimed 520,000 lives in 2005.

2004 report on the global AIDS epidemic by UNAIDS says that at the end of 2003, the estimated number of adults of children living with HIV in India was 5,100,000; out of this 1,900,000 were women between 15-49 years of age and 120,000 were children between 0-14 years of age.

According to the estimates, more than 30,000 babies are infected vertically with HIV each year in India. In this scenario, it becomes imperative to look at the situation of parent to child transmission of HIV more closely and explore ways and means to minimize it and also ensure HIV free child survival.

Optimal infant and young child feeding i.e. exclusive breastfeeding for the first six months and continued breastfeeding for two years or beyond along with adequate and appropriate complementary feeding contributes to infant and child survival more than any other intervention singly, making it most critical factor in reducing infant mortality. New studies have reconfirmed that young child nutrition is a major determinant of survival; exclusive breastfeeding if universal, could save 13% of under 5 deaths. Appropriate complementary feeding could save 6% deaths whereas intervention like Nivarapine and artificial feeding will save 2% deaths only. Malnutrition accounts for more than 50% of child mortality worldwide, making it’s impact on child mortality much greater than that of any single disease.

The Global Strategy for Infant and Young Child Feeding and the National Guidelines for Infant and Young Child Feeding call for actions to achieve optimal infant and young child feeding practices. Today, the most important challenge to the promotion of exclusive breastfeeding is the knowledge that there is a possibility of HIV transmission from mother to the child. Such transmission can occur during pregnancy, at the time of delivery, and after birth through breastfeeding.

There are indications from new data that exclusive breastfeeding carries much smaller risk than ‘mixed-feeding’ (breastfeeding plus alternate feeding) when it comes to analyzing the risk factors for transmission of HIV from mother to baby. Also, it is well understood that benefits of achieving close to 90% exclusive breastfeeding in terms of ensuring HIV free child survival are tremendous.
Considering these, the UN guidelines on HIV and Infant Feeding and the National guidelines clearly provide for promoting optimal feeding practices among all communities for all babies. These guidelines advocate that if artificial feeding is NOT affordable, feasible, acceptable, safe and sustainable (AFAS) then exclusive breastfeeding is recommended during first months of life. These guidelines imply that till one can ensure all these 5 AFAS factors it would not be safe to provide artificial feeding even in HIV positive mothers.

For all populations and for mothers who are not positive and whose status is not known, promoting exclusive breastfeeding for the first six months should continue as a norm.

Risk factors during breastfeeding that increase transmission includes breast pathology like sore nipples or even sub clinical mastitis, are preventable problems through good breastfeeding and lactation management support to mothers. Unfortunately, such knowledge and skills to prevent or solve these problems as well as building confidence skills to ensure exclusive breastfeeding is found missing among PPTCT counselors.

Counseling on infant feeding options, or skills to make breastfeeding safer either don’t exist or are very weak. Currently NACO has taken up revision of training of NACO’s counselors that addresses the issues of infant feeding also. Challenge is how to mainstream and implement this component given widespread lack of interest and knowledge to solve the problem.

To facilitate a better understanding among all the stakeholders on the issue and to generate a plan for action, a session on HIV and infant feeding session was incorporated in the national convention of BPNI.

Objectives
1. To share experiences in the PPTCT program of our country and experience of state level actions in dealing with the infant feeding issues.
2. To share experiences of various stakeholders including Government agencies, UN agencies, Professional bodies and NGOs.
3. Discuss programmatic and policy issues related with infant feeding component in context with HIV and to evolve recommendations to strengthen actions on this issue at state and national level.

Proceedings
Three separate sessions dealt with the issue in a comprehensive manner.

Session on HIV and Infant Feeding
Professor AP Dubey, profesor of pediatrics at Maulana Azad Medical College, New Delhi chaired the session. Dr. JP Dadhich, Senior Pediatrician and Project Coordinator, HIV and Infant Feeding, BPNI acted as session coordinator.

Government agencies including National AIDS Control Organization (NACO), Gujarat State AIDS Control Society (GSACS), UNICEF and Breastfeeding Promotion Network of India (BPNI) presented their views on existing situation regarding HIV and infant feeding in the country. Action taken and future activities were shared with the participants.

Dr. Inder Parkash, Joint Director (Training), National AIDS Control Organization of India spoke on Prevention of Parent to Child Transmission (PPTCT). He described the latest situation about the magnitude of the problem in the country. He informed about the objectives of phase II of PPTCT program which has been launched with a goal to reduce the spread of HIV infection in women, their partners and infants and provide care including ART. He also highlighted the strategies to enhance acceptance of antenatal services & make the clinics-husband-friendly; Care & support for HIV infected persons especially women & children; Integration of HIV/AIDS in RCH & MCH programmes and interventions to reduce MTCT including antiretroviral drugs. Regarding the infant feeding policies of NACO, he explained that

• Best practices as recommended by UNICEF and supported by NACO will be disseminated. Clear advice and support of feeding options should be given to HIV positive women.
• This will need appropriate training of the counselors and health care workers. Training will include breastfeeding counseling, complementary feeding, infant feeding in PPTCT, and replacement feeding options.
• Messages will be consistent with the related programme of Reproductive and Child Health (RCH) of the department of Family Welfare.
• The aim of such a counseling should be not just the giving of information, but to empower the mother to assess the appropriateness of the alternatives to her specific situation.
• Every effort should be made to promote exclusive breastfeeding up to four months in HIV positive mothers followed by weaning and complete stoppage of breastfeeding at 6 months in order to restrict transmission through breastfeeding.
• However, such mothers will be informed about risk of transmission of HIV through breastmilk and its consequences and would be helped for making informed choice regarding infant feeding.

Professor M.M.A. Faridi, Head of department, Department of Pediatrics at University College of Medical Sciences, New Delhi, shared the experience of training counselors in Infant Feeding and HIV in the PPTCT centers of Delhi, which BPNI conducted in collaboration with Delhi State AIDS Control Society. He described the process of developing a training tool and shared pre training assessment, training workshop and post training assessment. Training brought about a significant improvement in the approach of counselors towards the issue of infant feeding and HIV.

Dr. Vidhya Ganesh, Chief of HIV section at UNICEF, India, highlighted various issues and risk factors related with transmission of HIV from the mother to the child. She described available UN guidelines on the subject and stressed a need to avoid mixed feeding in HIV positive mothers.

Dr. Rajesh Gopal, Additional Project Director (i/c), Gujarat State AIDS Control Society (GSACS), spoke about various interventions being undertaken for PPTCT (nicknamed MAMTA) in the state of Gujarat. In Gujarat, Medical colleges and district hospitals has been designated as MAMTA centers to spearhead various activities for PPTCT in their area. Various activities like training of PPTCT teams, Infrastructure support to PPTCT clinics, monitoring & evaluation of the program and capacity building workshops for the counselors are an essential part of the program. However, Infant feeding issues are covered in all these activities in a limited way. He stressed on some actionable points like

• Capacity building of the PPTCT teams in general and PPTCT counselors in particular about promotion of exclusive breastfeeding in the first months of life in a clear and concise manner for all the mothers.
• Capacity building for ensuring safety of artificial feeding with emphasis of the five AFASS factors (affordability, feasibility, acceptability, safety and sustainability).
• Capacity building for addressing the gaps in establishment of proper infant and young child feeding practices.
• Dangers of ‘mixed-feeding’ must be very obvious to the entire PPTCT team and the counselor must ensure regular follow-up and effectively counsel and empower the mothers for the same.
• A separate training of all the PPTCT counselors and VCTC counselors may be organized for enhancement of their capacities in dealing with the issues of infant and young child feeding practices besides the provision of psycho-social support.
• NACO’s efforts for training of counselors for ensuring capacity enhancement through improved knowledge and development of skills for tackling the vitally important issues of breastfeeding in the context of HIV must be sustained and strengthened.

Role of stakeholders in addressing Infant Feeding in the context of HIV
In this session various stakeholders presented their views and actions being undertaken by them on HIV and Infant feeding. Dr. JP Dadhich moderated the session.

Professor Sudha Salhan from Federation of Obstetric and Gynecological Societies of India (FOGSI), dealt in detail with maternal HIV and risk factors in mother for mother to child transmission.
Professor AP Dubey, representing Indian Academy of Pediatrics (IAP), highlighted various initiatives undertaken by IAP in advocacy, training and communication to address the issue of mother to child transmission.

Ms. Deepika Khaka from Trained Nurses Association of India (TNAI), stressed the need for technical assistance regarding program development, evaluation and agency infrastructure to enhance the capacity of community-based organizations to provide targeted HIV prevention services.

Ms. Deepa Venkatachalam from the Jan Swasthya Abhiyan (JSA), which is the Indian circle of the People’s Health Movement, a worldwide movement to establish health and equitable development as top priorities through comprehensive Primary Health Care; spoke about the role and activities of the organization in the area of HIV. JSA has participated in the process of the HIV/AIDS bill. Public Hearings on Right to Healthcare organized by National Human Rights Commission (NHRC) & JSA-National-Action-Plan recommends National Public Services Act to recognize and legally protect health rights of populations that have special health needs - women, children, persons affected by HIV/AIDS.

Professor NB Mathur from National Neonatology Forum (NNF) of India stressed the need for universalized exclusive breastfeeding in the community looking in to the recent evidence citing child survival benefits.

Dr. Dinesh Paul, Additional Director, NIPCCD stressed the need for capacity building of grass root level workers to strengthen the efforts to universalize exclusive breastfeeding.

Group A dealt with policy issues in the advocacy addressing need for a comprehensive policy at national level on infant and young child feeding that includes infant feeding and HIV and gives effect to the national legislation, the Infant Milk Substitutes, Feeding Bottles and Infant Foods (Regulation of Production, Supply and Distribution) Act, 1992 as amended in 2003 (IMS Act). It also discussed ways to incorporate HIV and Infant feeding in the child health programs like NRHM/RCHII/ICDS. Policy issues in training like universalization of training of counselors were discussed.

Group discussion in this group was moderated by Prof. MMA Faridi and chaired by Prof. CR Banapurmath.

Group B dealt with programmatic issues in advocacy emphasizing need for implementation of the national policy and guidelines on infant feeding and HIV at grass root level, ensuring guidance to hospital administrators and staff in settings on how to assess the needs and provide support to HIV positive mothers, ensuring on-going monitoring to determine the effects of interventions to prevent HIV transmission, on infant feeding practices and health outcomes for mothers and infants, including those who are HIV negative or of unknown status.

Programmatic issues were discussed in detail. It included, ensuring training of health staff and community workers on HIV and infant feeding policies and the risks associated with various feeding options for infants of HIV-positive mothers. How to train training of counselors for locally appropriate infant feeding counseling in line with current international recommendations so as to enable them to support mothers in their infant feeding decisions was also discussed.

Programmatic issues in communications like efforts to counter misinformation on HIV and infant feeding and to promote, protect and support breastfeeding in the general population were also discussed.

Group discussion in this group was moderated by Dr. JP Dadhich and chaired by Prof. Kaiser Ahmed.

Group Work on Strengthening of infant feeding addressing advocacy, training, communication in policy and planning

After thoroughly discussing the subject in first two sessions, a group discussion was undertaken on strengthening of infant feeding in terms of addressing advocacy, training, communication in policy and programming. The participants were divided into two groups.
Conclusions and Recommendations

The meeting provided a unique opportunity to understand the existing challenge of parent to child transmission of HIV and prevention of it by addressing the issue of infant feeding. Valuable discussion and recommendations were generated which will prove an important step towards development of a comprehensive response on this important issue. One of the action ideas, which have emerged consistently during the discussions, is capacity building of the counselors of PPTCT program at grass root level in counseling skills with greater understanding of AFASS criteria. Ultimate target is to help the mother to make a choice of feeding method and assist her to implement her decision appropriately.

The groups came out with following recommendations, which were presented, to a plenary session by Dr. JP Dadhich, coordinator for HIV and Infant feeding for the convention. Participants provided their inputs and finally a consensus was achieved.

1. Advocacy
   • There should be a greater cooperation among both sectors, HIV and Infant Feeding, at state level.
   • There should be a national policy about HIV and Infant feeding
   • The existing national guidelines on feeding of babies born to HIV positive mothers are adequate and acceptable and may be implemented
   • Research component and socioeconomic problems pertinent to our country should be given due consideration
   • Appropriate infant feeding component should be incorporated in the training modules of the PPTCT counselors
   • State AIDS control societies should organize a forum of all the stakeholders including NGOs, professional organizations, government agencies at the state level for networking to take forward these actions.
   • Simple guidelines on IYCF should be prepared in local language at state level
   • Sensitization of all health workers / persons working around counselors should be ensured
   • Infant feeding indicators should be included in the existing monitoring framework of HIV/AIDS programme.

2. Training
   • Training of all frontline health care workers and stakeholders and teachers (10th – 12th) to be incorporated
   • Identify a standard/core curriculum for imparting training on infant feeding counseling, NIPCCD should take lead in this involving other related institutions.
   • Universalize training in HIV and Infant feeding for all health workers, doctors, nursing personnel, frontline workers etc.
   • In-service training of existing counselors in HIV and Infant feeding should be strengthened addressing AFASS, and provided with decision-making algorithm to facilitate.

3. Communication
   • Intensifying communication efforts to universalize exclusive breastfeeding in all populations using services of all frontline workers in the ICDS, NRHM, and RCH II
   • To continue existing policy of communication in HIV transmission
## Programme

### Day 1: Friday, 9th Dec 2005
**Theme: HIV and Infant Feeding**

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Speaker</th>
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<tbody>
<tr>
<td>08.30 - 09.00 AM</td>
<td>Registration of Participants</td>
<td></td>
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<tr>
<td>09.00 - 11.30 AM</td>
<td><strong>Opening Session</strong>&lt;br&gt;Inauguration by: <em>Dr. Shanti Ghosh</em>&lt;br&gt;Address by: <em>Dr. Prema Ramachandran, Director, NFI</em></td>
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<td></td>
<td>Sharing of district level action on IYCF</td>
<td>Presentations by BPNI District Coordinators</td>
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<td>11.30 - 11.45 AM</td>
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<td>01.30 - 2.30 PM</td>
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<td>02.30 - 3.30 PM</td>
<td>Role of stakeholders in addressing Infant Feeding in the context of HIV&lt;br&gt;Moderator: Dr J. P. Dadhich</td>
<td>Dr AP Dubey, <em>IAP</em>&lt;br&gt;Dr S Salhan, <em>FOGSI</em>&lt;br&gt;Dr NB Mathur, <em>NNF</em>&lt;br&gt;Dr Dinesh Paul, <em>NIPCCD</em>&lt;br&gt;Mrs Deepika Khaka, <em>TNAI</em>&lt;br&gt;Ms. Deepa Venkatachalam, <em>JSA</em></td>
</tr>
<tr>
<td>03.30 - 04.30 PM</td>
<td><strong>Group Work on Strengthening of infant feeding</strong>&lt;br&gt;addressing advocacy, training, communication, etc.&lt;br&gt;a) Policy&lt;br&gt;b) Programme</td>
<td>Facilitator&lt;br&gt;Dr. M.M.A. Faridi&lt;br&gt;Dr. J.P. Dadhich</td>
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Day 2: Saturday, 10th Dec 2005  
Theme: Infant and Young Child Feeding in Emergency Situations

<table>
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<tr>
<th>Time</th>
<th>Topic</th>
<th>Speaker</th>
</tr>
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| 09.00 - 09.30 AM | Inaugural session  
Chair: Dr K.K. Agarwal, VC, IP University  
Objectives: Dr Arun Gupta BPNI | Dr. Sangeeta Saxena, ACCH, MOHFW  
Dr. Anchita Patil/Dr. Arvind Mathur, WHO (India)                                                |
| 09.30 - 10.45 AM | Inauguration and address: Mr. Vinod Menon, Member, National Disaster Management Authority  
Sharing technical information and field data  
Chair: Dr Shashi Prabha Gupta, Tech Advisor, FNB, DWCD,GOI  
- Defining the Problem (10 mins.)  
- Infant Feeding in Emergencies (WHO Guidelines) (15 mins.)  
- Current observations on Status of Infant feeding in Emergencies in: (10 mins. each) | Dr. Charu Suraiya  
Dr. J A Jayalal  
Dr. S Srinivasan  
Ms. Khalida Jabeen  
Dr. Sangeeta Yadav, IAP  
Brigadier Khanna, NDMA, WHO (invited) |
| 10.45 - 11.45 AM | Panel Discussion (Mainstreaming with current disaster preparedness)  
Moderator: Mr. N.M. Prusty, SPHERE | Dr Deepika Nayar, CARE India, Dr Neelam Bhatia, Dr Tarsem Jindal |
| 11.45 - 12.00 PM | Tea                                                                   |                                                                                                |
| 12.00 - 12.45 PM | Working groups for recommendations both at National and State/Local level for  
a) Policies  
b) Programmes | Dr. Neelam Bhatia  
Dr. Tarsem Jindal |
| 12.45 - 01.15 PM | Presentation of Group Reports                                        |                                                                                                |
| 01.15 - 02.15 PM | Lunch                                                                |                                                                                                |
| 02.15 - 04.00 PM | Closing Ceremony  
Chair Dr. Shanti Ghosh, Dr. Tarsem Jindal  
- Final Recommendations:  
  - Day 1 (HIV and Infant Feeding)  
  - Day 2 (IYCF in Emergency Situations)  
  - World Breastfeeding Week Awards | Dr. JP Dadhich  
Dr. Arun Gupta |
Presentations
GUJARAT’S RESPONSE TO HIV/AIDS EPIDEMIC

Dr. Rajesh Gopal
Addl. Project Director (i/c)
Gujarat SACS

IMPLEMENTING AGENCIES OF NACP- PHASE II

• NATIONAL LEVEL
  National AIDS Control Organisation (NACO)

• STATE LEVEL
  State/UT AIDS Control Society (e.g. GSACS)

• CITY LEVEL
  Municipal Corporation AIDS Control Society (e.g. AMCACS)

LEADERS OF THE TEAMS

NATIONAL LEVEL
Ms. K. Sujatha Rao, IAS
AS & Director General, NACO, New Delhi
Websites: www.nacoonline.org
             www.nacoindia.org

STATE LEVEL
Dr. Amarjit Singh, IAS
Project Director
Gujarat State AIDS Control Society (GSACS)
Ahmedabad
Website: www.gsacsonline.org

IMPLEMENTATION OF THE NATIONAL AIDS CONTROL
[National AIDS Committee(1986)
    NACP(1987)]

NACP PHASE I  (1992-1999)

NACP PHASE II  (1999-2006)

NACP PHASE III (2006-2011)

EVOLUTION OF HIV EPIDEMIC– INDIA
1986-2004

NACP Impact (Gujarat)….1998-2005
PRESENT STATUS
Being on the verge of completion of phase II of the NACP, the GSACS is about to finalize its project implementation plan (PIP) developed through a participatory and consultative process in a bottom up approach for the phase III going to commence in June, 2006.

AN OVERVIEW OF PPTCT ACTIVITIES CARRIED OUT BY THE GSACS AS A PART OF THE EFFORTS FOR THE CONTAINMENT OF DUAL EPIDEMICS –
A. HIV/AIDS PANDEMIC
B. STIGMA AND DISCRIMINATION FACED BY THE PLWHA

PREVENTION OF PARENT TO CHILD TRANSMISSION

PPTCT
- TEN PPTCT CENTRES (Mamta Clinics) ARE FUNCTIONING WHERE PREGNANT WOMEN ARE COUNSELED & TESTED, NEVIRAPINE SUSPENSION AND TABLETS ARE BEING PROVIDED TO HIV +VE WOMEN.
- ELEVEN MAMTA CLINICS ARE BEING ESTABLISHED IN THE DISTRICT HOSPITALS

Existing Ten Mamta Clinics (PPTCT)
- Professor & Head, Dept. of Obstetrics & Gynecology, Govt. Medical College, RAJKOT
- Professor & Head, Dept. of Obstetrics & Gynecology, Govt. Medical College, JAMNAGAR
- Professor & Head, Dept. of Obstetrics & Gynecology, Govt. Medical College, BHAVNAGAR
- Professor & Head, Dept. of Obstetrics & Gynecology, Govt. Medical College, SURENDRANAGAR
- Professor & Head, Dept. of Obstetrics & Gynecology, Govt. Medical College, BARODA
- Professor & Head, Dept. of Obstetrics & Gynecology, Govt. Medical College, SURAT
- Professor & Head, Dept. of Obstetrics & Gynecology, Govt. Medical College, SMIMER, SURAT
- Professor & Head, Dept. of Obstetrics & Gynecology, Govt. Medical College, ANAND

Managed By Ahmedabad Municipal Corporation AIDS Control Society
- The Superintendent, V.S. Hospital, Ellisbridge, AHMEDABAD
- The Medical Superintendent, Civil Hospital, Anarwa, AHMEDABAD

Eleven New Mamta Clinics (PPTCT)
- CDMO Cum Civil Surgeon, District Gen. Hospital, Amreli
- CDMO Cum Civil Surgeon, District Gen. Hospital, Palanpur
- CDMO Cum Civil Surgeon, District Gen. Hospital, Bharuch
- CDMO Cum Civil Surgeon, District Gen. Hospital, Godhra
- CDMO Cum Civil Surgeon, District Gen. Hospital, Gandhinagar
- CDMO Cum Civil Surgeon, District Gen. Hospital, Junagadh
- CDMO Cum Civil Surgeon, District Gen. Hospital, Bhuj
- CDMO Cum Civil Surgeon, District Gen. Hospital, Valsad
- CDMO Cum Civil Surgeon, District Gen. Hospital, Mehsana
- CDMO Cum Civil Surgeon, District Gen. Hospital, Himmatnagar
- CDMO Cum Civil Surgeon, District Gen. Hospital, Ahwa
PPTCT Services

<table>
<thead>
<tr>
<th>Sr. No.</th>
<th>Topic</th>
<th>Year - 2004</th>
<th>Jan. to July'05</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No. of women counselled</td>
<td>22781</td>
<td>14718</td>
</tr>
<tr>
<td>2</td>
<td>No. of women accepting HIV test</td>
<td>18545</td>
<td>8204</td>
</tr>
<tr>
<td>3</td>
<td>No. of women found HIV +ve</td>
<td>153</td>
<td>100</td>
</tr>
<tr>
<td>4</td>
<td>Percentage of positivity</td>
<td>0.83</td>
<td>1.22</td>
</tr>
<tr>
<td>5</td>
<td>No. of babies who received NVP</td>
<td>57</td>
<td>42</td>
</tr>
<tr>
<td>6</td>
<td>No. of PPTCT Centres getting free ARV drug (Nevirapine)</td>
<td>10</td>
<td>10</td>
</tr>
</tbody>
</table>

Training of PPTCT Teams

- Training of 10 PPTCT teams was carried out at the two centres of excellence at
  a) J.J. Hospital, Mumbai
  b) KEM, Hospital, Mumbai

Issues of infant and young child feeding practices were included in the curriculum in a limited manner.

Support to the PPTCT Centres

- Infrastructural support is provided to all the 10 PPTCT Centres (Mamta Clinics) as per the provisions under the NACO guidelines.
- Consumables (HIV testing kits & Nevirapine) are provided in accordance with the arrangements with the UNICEF, NACO and GSACS.

Monitoring & Evaluation

- Monitoring & Evaluation through field visits, interactions with PPTCT team members and reports in the CMIS formats or otherwise.
- The feedback on the CMIS reports are provided to the members of the PPTCT teams telephonically & through personal interactions during their visits to the GSACS for the collection of Nevirapine & HIV testing kits.
- The departments of social work & psychology of the MS University, Baroda to monitor & evaluate all the VCTCs & PPTCT Centres through extensive field visits and facilitation of training of the counselors.

Capacity Building Workshops

- The medical colleges have ensured the hands on training and sensitization of the PPTCT staff & other staff respectively.
- Training of some of the counsellors of the PPTCT centres on counselling issues was carried out at a central level.
- UNICEF-GSACS workshop for the states of Gujarat & Sikkim was organised at Ahmedabad, Gujarat on 6th & 7th December, 2005.

Addressing infant feeding issues in PPTCT programme of Gujarat

- The medical colleges have ensured the hands on training and sensitization of the PPTCT staff & other staff respectively.
- Training of some of the counsellors of the PPTCT centres on counselling issues was carried out at a central level.
- UNICEF-GSACS workshop for the states of Gujarat & Sikkim was organised at Ahmedabad, Gujarat on 6th & 7th December, 2005.
**Actionable Points - I**
- Capacity building of the PPTCT teams in general and PPTCT counsellor in particular about promotion of exclusive breast feeding in the first months of life in a clear and concise manner for all the mothers.
- Capacity building for ensuring safety of artificial feeding with emphasis of the five AFASS factors (affordability, feasibility, acceptability, safety and sustainability).
- Capacity building for addressing the gaps in establishment of proper infant and young child feeding practices.

**Actionable Points - II**
- Dangers of mixed feeding must be very obvious to the entire PPTCT team and the counsellor must ensure regular follow up and effectively counsel and empower the mothers for the same.
- A separate training of all the PPTCT counsellors, VCTC counsellors and also the TI counsellors may be organized for enhancement of their capacities in dealing with the issues of infant and young child feeding practices besides the provision of psycho-social support.

**Actionable Points - III**
- NACO’s efforts for training of counsellors for ensuring capacity enhancement through improved knowledge and development of skills for tackling the vitally important issues of breast feeding in the context of HIV must be sustained and strengthened.
- Senior Professors of Gynecology and Obstetrics have requested the GSACS to be included in the training on counselling as the entire team has the responsibility of ensuring strong counselling services in the PPTCT programme.

**Future Needs of the PPTCT Activities**
- We have to sustain and strengthen the efforts.
- There is need to develop strong linkages with the peripheral healthcare infrastructure to ensure involvement of antenatal women from the rural areas also in the PPTCT services till we have services at the sub-district levels/CHCs in the Phase III of NACP.
- Need to address the gaps in the capacities and facilities available for effective PPTCT services for majority of the antenatal women of the state.
- Involvement of other departments of the government and different sectors for strengthening the services.
Experience Of Training Counselors In Infant Feeding And HIV

Dr. M.M.A. FARIDI
MD, DCH, MNAMS, FIAP
Professor and Head, Dept of Pediatrics
University College of Medical Sciences, Delhi and
Coordinator, BPNI Task Force on IF & HIV

PPTCT Program, NACO, GOI

• Low HIV prevalent areas-2002
• PPTCT established in 9 hospitals
• Obst, Pod, Micro, Nurse, PRO trained at Pune
• Counselors PPTCT/VCCTC appointed n=54
• Pre/Post test counseling of antenatal mothers.

PPTCT Program, NACO-Delhi, 2002

# Vertical transmission:
  • Via placenta (5-10%)
  • During delivery (10-20%)
  • Through Breastfeeding (10-20%)
# Intervention:
  • Nevirapine Therapy
  • Minimal intervention during labor
# No focus on Infant feeding

What Do We Expect From PPTCT Counselors

Counselors should be able to:
1) Motivate pregnant women for HIV test
2) Convince them for hospital delivery
3) Empower them to practice Infant Feeding choice safely & exclusively

IF Counseling & HIV Training

AIMS: HIV free Survival
The counselor will be able to-
1) Describe vertical transmission
2) Enlist IF options for HIV+ve mother
3) Describe relative merit of BF & RF
4) Discuss AFASS to help mother to arrive at IF option
5) Help mother to practice exclusive IF option
6) Empower mother to do safe BF/RF

What Was Needed For Training

1) Demand by PPTCT program managers
2) Trainers of HIV & IF Counseling
3) Training tools
  • Trainer’s guide, Participants manual, Counseling aid
4) Availability of Counselor-trainees
5) Finances
6) Place for training
7) Pre/Post training evaluation
What Was Available

1. Breastfeeding counseling: A Training course (40 hr/5 days), WHO-Unicef 1993
2. Breastfeeding and complementary feeding counseling Training course (45 hr/6 days), BPNI-2001
3. HIV and Infant feeding Counseling- A Training Course (18 hr/3 days), WHO-Unicef 2000
4. Complementary Feeding counseling Training course (17 hr/5 days), WHO 2002

Limitations Of Existing Courses

- Breastfeeding counseling course a prerequisite
- HIV and IF counseling course spans 5+3 days
- Courses were not updated
- Complementary feeding counseling component not integrated

Planning For Training

- Constitution of Core Committee
- Workshop of BPNI National Trainers
- Orientation of BPNI Trainers in HIV & IF
- Topics- BF, CF, HIV & IF, IMS act, BFHI Counseling skills
- Pre/Post training evaluation of counselors
- Duration of the course- 6 days

Planning: Contd.

- 3 days orientation of the existing National Trainers of BPNI
- All topics related to HIV & IF prepared, read, discussed
- Practical aspects rehearsed
- BF and HIV & IF counseling courses combined
- Trainer’s guide, participant’s manual & counseling aids developed

Pre-Training Assessment of VCCTC / PPTCT Counselors

- April 2004: BPNI, NACO, IBFAN, UNICEF
- 25% counseled HIV -ve mother for BF
- 25% counseled HIV +ve mother for BF
- 25% counseled HIV +ve mother for BF/RF
- 25% counseled HIV +ve mother for BF if can’t afford artificial feed

Pre-Training Assessment of VCCTC / PPTCT Counselors

- None: Knew about AFASS
- None: Knew about Ten Steps for Successful BF
- None: knew about national recommendation on optimal infant feeding
- None: Perceived training for skill improvement
- 30% had knowledge about complementary feeding
Pre-Training Assessment of VCCTC / PPTCT Counselors

- 12.5% refer HIV +ve mother to pediatrician for IF
- 12.5% give option to HIV +ve mother for BF/RF
- 25% advised top feeding, none explained preparation
- 50% expressed lack of skills for counseling in HIV and AIDS
- 100% expressed lack of skills in counseling for IF

Training of Counselors in HIV&IF

- Two sessions of 6 days each
- 28 participants per session
- BPNI National Trainers involved
- One course director
- Trainer: Counselor ratio 1:6
- Venue: GTB Hospital

Post Training Assessment of PPTCT Counselors

<table>
<thead>
<tr>
<th>Sr.No</th>
<th>Level of Knowledge acquired during training</th>
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<tbody>
<tr>
<td>I</td>
<td>Infant feeding</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Exclusive Breastfeeding till 6 months</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Initiation of BF within half hour after delivery</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Positioning - most of the areola part should be inside the baby’s mouth</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Chin and nose should touch the breast</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Proper positioning &amp; attachment help in reduction of HIV transmission</td>
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</tr>
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Post Training Assessment of PPTCT Counselors HIV +ve Woman

<table>
<thead>
<tr>
<th>Sr.No</th>
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<tr>
<td>I</td>
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</tr>
<tr>
<td></td>
<td>BF for 6 months</td>
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</tr>
<tr>
<td></td>
<td>Expressed breast milk feeding</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Advise to breast positioning</td>
<td>8</td>
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<tr>
<td></td>
<td>Nursing feeding</td>
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<tr>
<td></td>
<td>No reply</td>
<td>1</td>
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<tr>
<td>II</td>
<td>Precaution to be observed during breastfeeding</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Condition of nipples - sore, cracked, moisture nipples</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Good positioning and attachment</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>BF only first 6 months, no mixed feeding</td>
<td>6</td>
</tr>
<tr>
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<td>Mother should avoid BF</td>
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PPTCT Counselors: RF For HIV Positive Woman

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<thead>
<tr>
<th>A.</th>
<th>Advantage &amp; Disadvantages of replacement feeding</th>
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<td>Easy availability</td>
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<td>Fresh and economic</td>
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<td>No risk of HIV transmission</td>
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<td>More chances of disease</td>
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<td>Risk of early pregnancy</td>
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<tr>
<td></td>
<td>Social stigma</td>
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<td>Improper nutrition</td>
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### Post Training Assessment of PPTCT Counselors

#### B. Assessment & guidance in selection of Top Feeding option

<table>
<thead>
<tr>
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<tbody>
<tr>
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<tr>
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<tr>
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<td>Support of time</td>
</tr>
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<tr>
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<tr>
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<td></td>
<td>Afford for a particular time-period</td>
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### Responses of Ante-Natal Mothers After Counseling

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<tr>
<th>Information provided</th>
<th>N=42</th>
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<tbody>
<tr>
<td>100%</td>
<td>Breastfeeding</td>
</tr>
<tr>
<td>100%</td>
<td>During pregnancy</td>
</tr>
<tr>
<td>100%</td>
<td>During delivery</td>
</tr>
<tr>
<td>100%</td>
<td>Infant feeding</td>
</tr>
<tr>
<td>100%</td>
<td>Infants healthcare</td>
</tr>
<tr>
<td>7%</td>
<td>Don't know/ can't say</td>
</tr>
<tr>
<td>Information provided</td>
<td>93%</td>
</tr>
<tr>
<td>HIV infection</td>
<td>100%</td>
</tr>
<tr>
<td>93%</td>
<td>Yes</td>
</tr>
<tr>
<td>93%</td>
<td>No</td>
</tr>
<tr>
<td>Mother-to-child transmission of HIV infection</td>
<td>100%</td>
</tr>
<tr>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>100%</td>
<td>No</td>
</tr>
<tr>
<td>100%</td>
<td>Don't know/ can't say</td>
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</table>
Responses of Ante-Natal Mothers After Counseling

<table>
<thead>
<tr>
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</tr>
<tr>
<td>No</td>
<td>65%</td>
</tr>
<tr>
<td>Don’t know/can’t say</td>
<td>0%</td>
</tr>
<tr>
<td>Information provided</td>
<td>100%</td>
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</table>

<table>
<thead>
<tr>
<th>Infant Feeding/Breastfeeding</th>
<th>N=38</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>12%</td>
</tr>
<tr>
<td>No</td>
<td>88%</td>
</tr>
<tr>
<td>Don’t know/can’t say</td>
<td>0%</td>
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<tr>
<td>Information provided</td>
<td>100%</td>
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</tbody>
</table>

Lesson Learnt

1. All PPTCT/VCTC Counselors need training in IF
2. Refresher course required 6-12 monthly for 1 day
3. Conflicting messages by OBG, Ped 1/c of the case
4. Availability of trained counselor in LR for unbooked mothers

IF Training Component in HIV/AIDS Module NACO

1. Significant role of IF in vertical transmission of HIV
2. Need of trained counselors for HIV & IF
3. Three days training in IF counseling incorporated in the NACO module on HIV/AIDS in children

Urgent Need

All Obstetrician and Pediatrician need to be trained so that they can counsel HIV +ve mother after delivery

in

Infant Feeding

Thank You
Prevention of Parent to Child Transmission

Dr. Inder Parkash
Joint Director (Training)
National AIDS Control Organization

BACKGROUND

- GFATM-II awarded to NACO in Feb 04 with a goal to reduce the spread of HIV infection in women, their partners and infants & provide care including ART.
- The duration of the project is for five years (2004-’09) and overall cost of the project is US $ 100 million.
- The targets to reduce the prevalence of HIV infection in pregnant women from 1.4% to <1%.
- To provide AIDS care to 70% of the eligible mothers by the year 2008.
- The programme envisages establishment of 444 PPTCT centers (315 public & 129 private) & 81 ART centers in the country in a phased manner (2004-2006).
- Program to be implemented in (medical colleges, district hospitals and private hospital) in a phased manner through public & private sector involvement.

Objectives

1. To scale up prevention and care interventions among women of child bearing age and their families through providing a package of primary prevention, family planning, voluntary counseling and testing (VCT), ARV prophylaxis and counseling on infant feeding.
2. To implement a comprehensive HIV/AIDS care package including antiretroviral treatment for HIV infected mothers their infants and partners.
3. To enhance access to antiretroviral therapy through public/ private partnership.

Magnitude of Problem

- HIV prevalence exceeds 1% and is as high as 5% in some areas in 6 states which have a combine population of 291 million. Almost 90% of all PLWHA in India live in these states.
- More that 7 million women, including 92,000 HIV infected women, give birth every year in the 6 high prevalence states.
- UNAIDS has estimated that there are already 170,000 HIV infected infants in India, and that many more (340,000) are, or will soon be orphans.
- The impact of the epidemic is now being seen in children due to vertical transmission of HIV, with increasing under- 5 mortality rates.
- PPTCT programs provided opportunities for HIV prevention counseling and STI diagnosis and treatment for the 98-99% of pregnant women which were uninfected.

Expected outcome by the end of project period

Objectives

<table>
<thead>
<tr>
<th>No.</th>
<th>Objective</th>
<th>Targets</th>
<th>Achievements</th>
<th>% of achievements</th>
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<tbody>
<tr>
<td>1</td>
<td>Number of health facilities providing PMTCT services</td>
<td>350</td>
<td>340</td>
<td>97.1%</td>
</tr>
<tr>
<td>2</td>
<td>Number of health facilities providing VCT services</td>
<td>400</td>
<td>340</td>
<td>85%</td>
</tr>
<tr>
<td>3</td>
<td>Number of health facilities providing ART services</td>
<td>300</td>
<td>250</td>
<td>83.3%</td>
</tr>
<tr>
<td>4</td>
<td>Number of health facilities providing ARV prophylaxis</td>
<td>250</td>
<td>200</td>
<td>80%</td>
</tr>
<tr>
<td>5</td>
<td>Number of health facilities providing STI prevention services</td>
<td>200</td>
<td>180</td>
<td>90%</td>
</tr>
<tr>
<td>6</td>
<td>Number of health facilities providing family planning services</td>
<td>150</td>
<td>130</td>
<td>86.6%</td>
</tr>
</tbody>
</table>

Targets activities & achievements by end of the year 1

<table>
<thead>
<tr>
<th>No.</th>
<th>Activity</th>
<th>Targets</th>
<th>Achievements</th>
<th>% of achievements</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>No. of staff trained in ART medication</td>
<td>1200</td>
<td>1100</td>
<td>91.7%</td>
</tr>
<tr>
<td>2</td>
<td>No. of staff trained in VCT counseling</td>
<td>250</td>
<td>225</td>
<td>90%</td>
</tr>
<tr>
<td>3</td>
<td>No. of health facilities offering comprehensive package of PMTCT services</td>
<td>340</td>
<td>300</td>
<td>90%</td>
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<tr>
<td>4</td>
<td>No. of health facilities providing ARV prophylaxis</td>
<td>250</td>
<td>220</td>
<td>88%</td>
</tr>
<tr>
<td>5</td>
<td>No. of health facilities providing ART services</td>
<td>200</td>
<td>180</td>
<td>90%</td>
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<tr>
<td>6</td>
<td>No. of health facilities providing STI prevention services</td>
<td>150</td>
<td>130</td>
<td>86.6%</td>
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<tr>
<td>7</td>
<td>No. of health facilities providing family planning services</td>
<td>100</td>
<td>90</td>
<td>90%</td>
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</table>
Summary of overall PPTCT Centres Establishment

<table>
<thead>
<tr>
<th>High Prevalence States</th>
<th>Moderate Prevalence States</th>
<th>Low Prevalence States</th>
<th>Union Territories</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>60</td>
<td>72</td>
<td>32</td>
<td>4</td>
<td>107</td>
</tr>
</tbody>
</table>

Union Territories: 60
Moderate Prevalence States: 72
Low Prevalence States: 32
High Prevalence States: 4
Total units established till Oct. 2005: 107

Summary of Service Delivery under PPTCT Programme

<table>
<thead>
<tr>
<th>High Prevalence States</th>
<th>Moderate Prevalence States</th>
<th>Low Prevalence States</th>
<th>Union Territories</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>60</td>
<td>72</td>
<td>32</td>
<td>4</td>
<td>107</td>
</tr>
</tbody>
</table>

Union Territories: 60
Moderate Prevalence States: 72
Low Prevalence States: 32
High Prevalence States: 4
Total units established during 2005: 107

Total Budget Available for GFATM-II

<table>
<thead>
<tr>
<th>Activity</th>
<th>Budget Available for Phase-I &amp; Phase-II under GFATM Round-2</th>
<th>US$ 000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drugs</td>
<td>39000000</td>
<td>10000000</td>
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<tr>
<td>Commodity</td>
<td>1205300</td>
<td>3000000</td>
</tr>
<tr>
<td>Institutional Governance and Planning</td>
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<td>2000000</td>
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<tr>
<td>Infrastructure</td>
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<td>5400000</td>
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<td>Human Resources</td>
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<td>1500000</td>
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<tr>
<td>Monitoring and Evaluation</td>
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<td>6750000</td>
</tr>
<tr>
<td>Drugs</td>
<td>3900020000</td>
<td>1900017700</td>
</tr>
<tr>
<td>Commodity</td>
<td>1205300</td>
<td>905297033</td>
</tr>
</tbody>
</table>

Care & support for HIV infected persons especially women & children:

- Any PMTCT programme limiting itself to provision of interventions to reduce MTCT along will not complete unless offer of high quality care as per the prevailing standards of care in the country is also include in the package.
- Though there is a demand of including combination antiretroviral therapy in the package to ensure longer maternal & child survival and reduction of likelihood of children becoming orphans through selective offer to HIV infected mothers and children, it is felt that such a decision needs to be taken at a national level in view of the challenges that it may pose.
- Selective approach may also be seen as a discriminatory approach and may prove counterproductive through creation of indifference towards HIV prevention programmatic strategies among males and sometimes may force women to become pregnant to receive these otherwise unaffordable drugs for them. Hence it is felt that offer of chemoprophylaxis and drugs for prompt and effective treatment of opportunistic infections should be the mainstay of the package.

Strategies to enhance acceptance of antenatal services & make the clinics-husband-friendly:

- Efforts to strengthen the antenatal services are not sufficient in isolation, but implementing strategies to enhance their acceptance in the community are critical. A comprehensive intervention should envisage male involvement in MCH services that is abysmally low at present.
- Husbands, by and large, tend to go along with their wives in any private antenatal clinic setting, but in public sector antenatal clinics, it is the pregnant women who interacts with the medical and para-professionals.
- Husbands are either not allowed or they do not accompany their wives for antenatal care services. It is necessary that this difference is gradually minimized in the public sector as well, enhancing the male involvement and providing opportunity to implement various reproductive health-related interventions in couple-setting.

Provision of services to counsel on birth-spacing methods:

- Prevention of unintended pregnancies is an overall objective of any family welfare programme.
- It assumes importance in PMTCT programmes as it reduces the cumulative risk of transmitting HIV infection to the progeny in a family setting where HIV infection has made an entry.
Integration of HIV/AIDS in RCH & MCH programmes

- PMTCT is currently implemented in project mode. Integration of this programme into existent RCH and MCH service is critical in enhancing cost-efficiency and also the sustainability.
- Use of infrastructure in post-partum programme and in primary health care and also in Integrated Child Development Scheme by clearly identifying non-overlapping tasks appropriate to their level of expertise is envisaged in this scaling up.
- The capacity building of these health care personnel through training is given a high priority.

Interventions to reduce MTCT including antiretroviral drugs:

- Currently this intervention is available in select eleven centers in areas where HIV prevalence rate among pregnant mothers is more than 1.
- In the initial stages of scaling up, these interventions shall be offered through existent infrastructure of tertiary care centers such as medical colleges and then through district hospitals.
- In order to enhance cost-efficiency, provision of referral for HIV testing and offer of antiretroviral is envisaged for low prevalence States. Additionally, minimally invasive conduct of labour and offer of services for medical termination of pregnancy should also be included in the package.

Nevirapine Prophylaxis

Dosage for mother
- Tab. Nevirapine 200 mg stat
- To be taken between the start of labour pains upto 72 hours after delivery.

Dosage for newborn
- Syrup. 2 mg per kg body weight.
- To be given within 72 hours after birth.
- Informed choice on infant feeding.

Infant Feeding

- Best practice as recommended by UNICEF and supported by NACO will be disseminated. Clear advice and support of feeding options should be given to HIV positive women.
- This will need appropriate training of the counselors and health care workers. Training will include breastfeeding counseling, complimentary feeding, infant feeding to MTCT, and replacement feeding options.
- Messages will be consistent with the related programme of Reproductive and Child Health (RCH) of the Department of Family Welfare.
- The aim of such a counseling should be not just the giving of information, but to empower the mother to assess the appropriateness of the alternatives to her specific situation.
- Every effort should be made to promote exclusive breast feeding up to four months in HIV positive mothers followed by weaning and complete stoppage of breast feeding at 6 months in order to restrict transmission through breast feeding.
- However, such mothers will be informed about risk of transmission of HIV through breast milk and its consequences and would be helped for making informed choice regarding infant feeding.

Offering comprehensive health education including nutrition, exclusive breast feeding, RTIs/STIs, HIV/AIDS:

- Provision of critical information about various reproductive health related issues in a simple, easily understandable, acceptable manner in local language is important.
- It is necessary to give primacy to infant practices and nutrition including exclusive breastfeeding in view of their importance in reducing morbidity and, therefore, mortality in childhood as well as reducing transmission of HIV infection.
- The health education to pregnant women should aim at discussing HIV/AIDS as a component of RTIs universally (irrespective of the level of HIV epidemic in the area).
Implementing peer-based strategies (community participation) for promoting exclusive breastfeeding, reduction of stigma & preventive measures for STI/AIDS:

- Community participation health related interventions is a crucial component for not only its sustainability but acceptance as well. Use of peer-based strategies to promote exclusive breastfeeding has been shown to efficacious in countries like Bangladesh.
- Additionally, the community participation can be utilized to implement effective strategies to reduce stigma about HIV/AIDS as well as sexually transmitted diseases in general.
- An effective intervention of this kind can create an enabling environment and a HIV- sensitive ambience to effectively reach the preventive messages about HIV and also providing care and support to HIV infected individuals, involvement of NGOs CBOs and other community opinion leaders is crucial for the success of the programme.

Thank you

Availability of funds during Phase I & II

<table>
<thead>
<tr>
<th>Objective 1</th>
<th>Budget plan for the year 1 (Phase I)</th>
<th>Revised plan of action for Phase-II</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of health facilities providing the comprehensive package PMTCT, Care and ART</td>
<td>15000</td>
<td>15000</td>
</tr>
<tr>
<td>No. of hospitals providing MTCT prevention to pregnant women</td>
<td>2329</td>
<td>2329</td>
</tr>
<tr>
<td>No. of hospitals providing VCT services to pregnant women and their partners</td>
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<td>2329</td>
</tr>
<tr>
<td>No. of health facilities providing HIV prevention services which include STI condom services etc.</td>
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<td>4000</td>
</tr>
<tr>
<td>Objective 2</td>
<td>Budget plan for the year 3,4 &amp; 5 (Phase-II)</td>
<td>Revised plan of action for Phase-II</td>
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<td>No. of patients receiving ART at project sites</td>
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<td>95%</td>
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<tr>
<td>Number of HIV+ mother receiving ART</td>
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<td>Additional Number of patients in private sector (outside project sites) being treated with rational ART treatment</td>
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<tr>
<td>Objective 3</td>
<td>Revised plan of action for Phase-II</td>
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<td>No. of health facilities providing comprehensive package ART, Care and ART</td>
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<tr>
<td>No. of health facilities providing VCT services to pregnant women and their partners</td>
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<tr>
<td>No. of health facilities providing HIV prevention services which include STI condom services etc.</td>
<td>4000</td>
<td>4000</td>
</tr>
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</table>

Issues and Challenges

- Inadequate capacity of the SACS to identify NGO & PLHA Groups as well as assessment and identification of people for establishment of PPTCT centres.
- Availability of proper persons with the prescribed qualifications are not available for the job of monitoring. This is because this particular discipline is very rare and very few organizations are conducting this training in counselling and there are no proper training institutions which train people in counselling, which is very much needed in the health sector.
- Inadequate capacity of the SACS to identify NGO & PLHA Groups as well as assessment and identification of proper persons with the prescribed qualifications are not available for the job of counselors. This is very much needed in the health sector.
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Revised plan of action for Phase-II

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<tr>
<th>Objective 1</th>
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</thead>
<tbody>
<tr>
<td>1. No. of health facilities providing the comprehensive package PMTCT, Care and ART</td>
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<tr>
<td>2. No. of hospitals providing MTCT prevention to pregnant women</td>
<td>2329</td>
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<tr>
<td>3. No. of hospitals providing VCT services to pregnant women</td>
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<tr>
<td>Objective 2</td>
<td>Revised plan of action for Phase-II</td>
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<tr>
<td>4. No. of health facilities providing HIV prevention services which include STI condom services etc.</td>
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Budget Allocation and Utilization during year 1

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<th>Account (in INR</th>
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<td>Administrative</td>
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Thank you
### Revised plan of action for Phase-II

#### Objective 1

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Dataset/country indicators</th>
<th>Original Targets</th>
<th>Revised Targets</th>
</tr>
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<td>No. of hospitals providing ART services</td>
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<td>No. of health facilities providing comprehensive package PPTCT, Care and ART</td>
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<td>4</td>
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<tr>
<td>5</td>
<td>Number of patients receiving ART at project site</td>
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<tr>
<td>6</td>
<td>Total number of patients receiving ART at project site</td>
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<td>7</td>
<td>Total number of patients receiving ART at project site</td>
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#### Objective 2

<table>
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<th>Dataset/country indicators</th>
<th>Original Targets</th>
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<td>Number of patients involving ART in project site</td>
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<tr>
<td>11</td>
<td>Number of patients involving ART in project site</td>
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<td>10000</td>
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</table>

### Overall PPTCT Centers Established

#### States

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>States</th>
<th>Revised Plan</th>
<th>Revised Total</th>
</tr>
</thead>
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#### Revised Plan

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<th>Revised Total</th>
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<tr>
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### Service Delivery under PPTCT Programme

#### States

<table>
<thead>
<tr>
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<th>States</th>
<th>Service Delivery</th>
<th>Service Delivery</th>
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<tr>
<td>11</td>
<td>Uttrakhand</td>
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</tbody>
</table>

### Reason for saving of funds

- Estimates made for drugs and laboratory logistics were very high at the planning stage. Where as procurements were low.
- The cost of the drugs and laboratory logistics were reduced by twenty times than the estimates.
- The estimated cost of the training programme was made on WHO/UNICEF rates but utilization was made at GOI rates.
- Non availability of appropriate NGO and PLHA Networks as a result less no. of NGOs were engaged.
- Misunderstanding and conflicts among NGO’s consortium which resulted in low utilization of fund.
- Recruitment of necessary sanctioned staff has not been made.
- The drugs was used from already exiting staff under NACP and booked for accounts to the World Bank, as such GFATM funds for procurement of drugs were not used were not accounted in GFATM funds.
- Some activities (research studies) were not undertaken by the states.
<table>
<thead>
<tr>
<th>No.</th>
<th>States</th>
<th>Total no. of state departments</th>
<th>Number of sessions conducted</th>
<th>Number of persons tested</th>
<th>Number of persons found HIV+ve</th>
<th>Number of persons counselled</th>
<th>Mothers tested</th>
<th>Mothers found HIV+ve</th>
<th>Mothers counselled</th>
<th>% Coverage</th>
<th>Mother baby pairs given NVP Prophylaxis</th>
<th>Number of women counselled</th>
<th>Total no. of new registration</th>
</tr>
</thead>
<tbody>
<tr>
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HIV Prevention & plan for future activities

Deepika Khakha
TNAI

HIV Prevention

Levels
- Individual
- Family
- Community
- Medical
- Legal

Individual level
- Prevention program help individuals change risky behavior
  - VCTC
  - Assess risk behavior
  - Enhance sexual communication
  - Understand substance abuse
  - Recognize triggers to unsafe sex

Family level
- Health & safe sex education
- Family & individual counseling
- Relapse prevention for the parent
- Drug awareness
- Prevention for children
- Support for each family member

Community level
- Can reach to large number of people therefore is more cost effective
  - Outreach programs
  - Using social events & peer leaders nominated for training & team building
  - Workshops

Community level
- Focusing decision-making at state and local levels
- Involving affected communities at decision making
- Using community risk profiles and research prevention strategies to inform decision-making
Medical level

- ART to treat HIV has helped to prevent PPTCT
- Prevent transmission after accidental exposure (PEP)
- Viral load is greatly reduced after ART thereby could decrease the risk of sexual transmission

Most at risk population vulnerable to HIV infection

- Injection drug users who share HIV contaminated drug injection equipment
- Individuals who abuse other substance such as non-injection drugs & alcohol
- Commercial sex workers & their partners
- Youth & street children
- Persons detained in corrections facilities
- Men who have sex with men

HIV prevention strategy

- In resource limited settings multi-component targeted intervention approach
- Evidence based intervention
- Supportive policies to prevent spread of HIV infection
- Provide comprehensive treatment for persons who become HIV infected

HIV prevention interventions

- Outreach to populations most at risk for HIV
- VCTC
- Education to prevent transmission of HIV through sex or needle sharing
- Treatment of STI (which can facilitate transmission of HIV infection)
- Treatment of HIV/AIDS including counseling to prevent further spread to partners

Prevention services for HIV positive persons

- HIV counseling
- Partner counseling
- Access timely medical & support services
- Referral services

Infant feeding choices for HIV positive mothers

- Resource poor settings
- Infant morbidity/mortality is high
- Babies already infected with HIV at birth for whom breast feeding is likely prolong life
Mother to child transmission
- Pregnancy
- Labor
- Breast feeding

Advantages of Breast feeding
- Nutritional
- Immunological
- Emotional

Risk during breast feeding
- 14% risk of transmission via breast feeding
- Rate of transmission dependent on
  - Maternal viremia
  - Breast feeding patterns
  - Timing of infection
  - Maternal health
  - Nutrition

What should be done?
- A diagnosis of HIV infection in mother requires her to make a very difficult decision on how to feed her baby
- HIV positive mother have a right to make informed decisions on how to feed their babies & health care workers should support and assist them in whatever decision they make

What can HCP do?
- Support women to make and carry out their own informed infant feeding decision
- Help HIV positive women obtain accurate and complete information regarding infant feeding options
- Encourage appropriate research regarding HIV, breastfeeding and Human milk

Should mothers with HIV choose not to breastfeed?
- If breast milk substitute is affordable
- Can be fed safely
- If adequate health care is available and affordable

Then might seem logical for a mother with HIV to choose not to breastfeed
How can a mother reduce risk of transmission if she breastfeeds?

- Safest way to breastfeed in the first six months is exclusively
- Not to add other foods which may cause gut infections that could increase the risk of HIV infection
- Death due to replacement feeding is greatest in the first few months

Future activities for HIV

- Leadership summits to identify stakeholders and leaders, and to increase awareness and mobilize communities to reduce spread of HIV
- Capacity building efforts aimed at enhancing the ability of agencies in communities

Future planning for HIV

- Coalition-building efforts to utilize faith-based institutions to disseminate HIV prevention messages
- Technical assistance regarding program development, evaluation and agency infrastructure to enhance the capacity of community-based organizations to provide targeted HIV prevention services

Thank you
HIV IN WOMEN

- In 1981 the first Human Immunodeficiency Virus infected case was seen in USA. At that time it was considered a disease of males.
- Currently, almost half of new HIV infections in the reproductive age group are women.

HIV IN WOMEN

- From an exclusive male disease HIV/AIDS is now almost equally distributed in both sex in new cases.

FACTORS INCREASING VULNERABILITY

- Heterosexual exposure is the primary risk factor for HIV infection in adolescent and adult females
- Sexual relationships of women are often with older men, who are more likely to be HIV infected and at an advance stage of the disease.

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<th>Adults and children, end 2001 (Low)</th>
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HIV/AIDS ESTIMATES IN ASIA PACIFIC

- 9 out of 10 infected women live in a developing country
- Black women have a disparately increased infection rate.
HIV IN WOMEN

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FACTORS INCREASING VULNERABILITY

- Male to Female transmission of HIV is 2 to 17 times higher as reported by different workers than vice versa.
- The custom of selecting significantly younger woman as wives makes them culturally vulnerable to HIV infection at an early age.

- Before 18 - 20 years of age the vagina is lined by a single columnar layer, which offers only minimal protection against HIV infection.
- Females have a large surface area of mucosa exposed during intercourse to their partner's sexual secretions, which also stay there for a long time.

- Younger women's immature cervix (cervical ectopy) and relatively low vaginal mucus production presents less of a barrier to HIV, making them biologically more susceptible to infection.
- Sex during menstruation and anal sex also favour male to female transmission.

- Semen infected with HIV typically contains a higher concentration of the virus than women's sexual secretions.
- STD and RTI causing ulcers and discharge increase the chances of HIV transmission.

- The chance of women reaching a health facility, where proper treatment is available, is low.
- Women are economically dependent on men. Hence they cannot insist on safe sexual practices.
FACTORS INCREASING VULNERABILITY

- Women receive blood transfusions more often than men because of anaemia and complications of pregnancy and childbirth (including unsafe abortions).

HIV IN CHILDREN

- HIV-1 is expected to infect 10 million children worldwide by the year 2000 and a majority of these children have acquired their infection as a result of mother-to-child transmission (MTCT).

HIV IN CHILDREN

- Since women infected with HIV are the major source of infection for infants, trends in HIV infection among women forecast the impact of HIV in children.

DETERMINANTS OF VERTICAL TRANSMISSION

MATERNAL

- Viral load maximal immediately after infection and in the advanced stage of the disease
- Concurrent STI also strongly associated
- Unprotected sexual intercourse

- A high frequency during pregnancy associated with an increased risk

DETERMINANTS OF VERTICAL TRANSMISSION

- Maternal CD-4 & lymphocyte count an independent predictor
- Mother's neutralizing antibody monoclonal HIV-3 may be a protective association.
- A correlation between the time elapsed from rupture of membranes to actual delivery and an increased risk of transmission

DETERMINANTS OF VERTICAL TRANSMISSION

- Nutritional Status
- Micronutrient deficiencies weaken epithelial integrity of the placenta & the genital tract and are associated with accelerated HIV disease progression. A number of trace elements including zinc are involved in many immunologic impairments.
DETERMINANTS OF VERTICAL TRANSMISSION

Nutritional Status (contd)
Low vitamin A levels during pregnancy were associated with an increased transmission of HIV
The Viral biological phenotype may influence the transmission risk

Breaches in the placental barrier could lead to a mixing of maternal and foetal cells.
Presence and amount of virus in the genital tract may affect the transmission risk.

DETERMINANTS OF VERTICAL TRANSMISSION

FOETAL FACTORS
Genetic differences in host cell susceptibility to HIV infection of foetal cells have been reported
Susceptibility to infection could vary with gestational age

Intensive exposure of the infant's thin skin and mucosal surfaces to maternal blood and secretions during the birth process could provide a significant route for viral transmission.
A possible route of HIV 1 transmission is by oral exposure

Invasive procedures that breach the infant's skin barriers could provide another mechanism for viral entry
External cephalic version, episiotomy and operative vaginal delivery also increase intrapartum transmission to the foetus

A more than two fold risk of infection of the first-born twin as compared to second
DETERMINANTS OF VERTICAL TRANSMISSION

**BREAST MILK**
- Transmission via breast milk supported by known transmission of other retroviruses, the detection of HIV-1 in the cellular & acellular compartments of BM and reports of transmission from mothers infected during the postpartum period or from infected wet nurse.

**Appears to result from the coexistence of HIV-1 & an inadequate humoral response in milk**
- Complete avoidance of breast-feeding is the surest way to avoid MTCT of HIV through breast-feeding.

**In underdeveloped countries, formula feeding may be impractical & associated with increased mortality from diarrhoea & respiratory infection**
- WHO & UNICEF (1998) have recommended exclusive breast-feeding, as malnutrition is the primary cause of infant death in many developing countries.

**The risk of transmission varies with the period of breast-feeding, amount of exposure, infectivity of milk and specific susceptibility of the infant**
- It is recommended exclusively breast feed the baby for 4-6 months only.

The newborn’s immature gastrointestinal tract may facilitate transmission but is not essential to transmission.
- The potential value of nevirapine used for a longer duration in the breast-feeding population is under trial.

**CAESAREAN DELIVERY**
- American college of Obstetrician & Gynecologists conclude that scheduled caesarean delivery should be discussed & recommended for HIV-infected women with an HIV-1 RNA load of greater than 1000 copies/ml.
Some obstetricians concluded that combined antiretroviral therapy (ART) may reduce the risk of vertical transmission to as low as 2% or less. According to them prophylactic caesarean delivery would be of benefit for only a small number ART treated women.

The newborn immune response to HIV-1 exposure may have a role in averting MTCT of HIV. Cell-mediated immunity in the foetus or newborn may have a crucial role in protection or clearance of infection.

Preterm foetus
Foetal ingestion of virus
Duration of exposure of maternal secretion
Period of breast feeding

Counseling
Preferably early in pregnancy
General Measures
Keep in good health. Treat malnutrition

Obstetric Measures
Prevention and treatment of chorioamnionitis and discontinuation of cigarette smoking and illicit drug use during pregnancy
Systematic birth canal cleaning has been attempted.
INTERVENTIONS TO DECREASE RISK OF MTCT

- Invasive procedures on the foetus like foetal scalp electrode or foetal scalp blood sampling, umbilical cord blood sampling etc. are to be avoided during labour.
- Avoid episiotomy & vaginal operative delivery, if possible.

INTERVENTIONS TO DECREASE RISK OF MTCT

Giving a bath to the baby immediately after birth with mild disinfectants or baby soap and plain running water.

INTERVENTIONS TO DECREASE RISK OF MTCT

Immunological
- Are based on the assumption that more transmission occurs at or around the time of delivery and that a combination of passive and active immunization will be effective in the transmission.

INTERVENTIONS TO DECREASE RISK OF MTCT

Passive protection using HIV IgG is presently under investigation (ATGT, 185).
- Of hyperimmune anti-HIV immunoglobulin
- Protocols to test neutralizing monoclonal antibodies are in the developmental stage.

INTERVENTIONS TO DECREASE RISK OF MTCT

Antiretroviral Drugs
- ZIDOVUDINE:
  - In trial ACTG 076- HIV transmission rate was reduced by approximately 2/3rd. At 14 weeks of gestations zidovudine 100 mg 5 times a day is given until labour. (contd.)
INTERVENTIONS TO DECREASE RISK OF MTCT

During labour a loading dose of 2 mg/kg over the first hour is given followed by a maintenance dose of 1 mg/kg/hr until delivery. In the neonatal period oral zidovudine syrup 2 mg/kg orally four times a day for 6 weeks is given. (contd.)

INTERVENTIONS TO DECREASE RISK OF MTCT

In a trial conducted in Thailand a "short course" of Zidovudine regimen given from 36 weeks of pregnancy and during labour is compared with no treatment. 300 mg of zidovudine is given orally twice a day from 3 weeks of gestation until onset of labour.

INTERVENTIONS TO DECREASE RISK OF MTCT

Then 300 mg is given every 3 hours from onset of labour to delivery. The newborn is given zidovudine syrup 2 mg./Kg for one week. All women are provided with infant formula and are counseled against breast-feeding.

INTERVENTIONS TO DECREASE RISK OF MTCT

NEVIRAPINE - (HIV/NET 0/2)

It is given to pregnant women as a single dose (200 mg tablets) at the onset of labour, within 4 hours of delivery & to the baby (2 mg/kg) as a single dose within 72 hrs of birth. (contd.)

This has been shown to be more effective than an intrapartum & postpartum regimen of Zidovudine.

But when nevirapine is given to mothers already receiving standard antiretroviral therapy (for their HIV infection), there appears to be no additional advantage.

PRECAUTIONS

Precautions Taken During MTP or Delivery

- **Barrier:** disposable gloving, hand washing, special gown or suit, mask, boot, eyeglass, eye shield, automatic water tap
PRECAUTIONS

- **Disinfectant Solution:**
  - 0.5% Sodium hypochlorite or household bleach for cleaning.
  - 10% Lysol for cleaning metallic table and chairs.
  - Dip all linen in household bleach (1%) for half an hour before sending to laundry.

PRECAUTIONS

- Put placenta in a bag with bleaching powder and either burn or bury with bleaching powder in the soil.

PRECAUTIONS

Precaution during operation

- Double gloving -(Special puncture- resistant gloves if available)
- Untouched technique
- Using eyeglasses, shield, special gowns & boots.

THANKYOU
INFANT FEEDING & HIV

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ADVOCACY

- Formulating & promoting the policy of exclusive breast feeding in all children.
- Counseling mothers about benefits of EBF.
- Discourage the use of mixed feeding.
- Support mothers in her decision of infant feeding practices.
- Liaison with other National & International agencies.

Training

- Training of all health workers in appropriate IYCF practices.
- Training of trainers (MOs, Specialists)
- Preparation of training modules.
- Organize training workshops.

Communication

- Prepare & publish IEC material.
- Develop a communication channel through news letters, articles in journals etc.
- Participate in various radio, TV programmes.
- Communicate & co-ordinate with different agencies, NGOs to formulate & propagate these feeding practices.
- Discuss these issues and sensitize the members.
Role of Stakeholders in addressing Infant Feeding in the context of HIV

Jan Swasthya Abhiyan

The Jan Swasthya Abhiyan is the Indian circle of the People’s Health Movement, a worldwide movement to establish health and equitable development as top priorities through comprehensive Primary Health Care and action on the social determinants of health.

It is a growing coalition of people’s organizations, NGOs, social activists, health professionals, academics and researchers that are working consistently towards the goal of “Health for All”.

These organizations and movements involved in healthcare delivery and health policy in the country, who made themselves a part of the People’s Health Assembly campaign in 2000, and have continued to participate in this process. BPNI is one of the networks that is part of the NCC of JSA.

JSA does not engage with health issues in a vertical paradigm

JSA’s role
- has been involved in shaping – for example, participated in the process of the HIV/AIDS bill
- has been involved in discussing /critiquing National Health policy, National policy on pharmaceuticals, rational drug policy
- has been raising the issue of health rights and emphasizing the recognition of health rights as human rights
- JSA HUNGER WATCH group consisting of public health and nutrition experts, formed in 2003 - prepared protocol to investigate hunger-related and starvation deaths
JSA’s role (contd.)

- Has been involved in the Right to Food campaign in several states. For eg, in Rajasthan, PIL filed by PUCL in the SC, BGVS initiated action on mid day meal schemes, conventions on RTF in some states.
- Right to Healthcare campaign, which is ongoing. This campaign was initiated in 2003. Public Hearings on Right to Healthcare organised by NHRC & JSA - National Action Plan. Recommends National Public Services Act to recognise and legally protect health rights of populations that have special health needs - women, children, persons affected by HIV/AIDS, persons with mental health problems, disability, conflict situations etc.

JSA’s COMMITMENT to Partnership with BPNI

THANK YOU
IYCF And HIV

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Developements

• National Breastfeeding Committee
• RCH-II Program
• IMNCI
• National Rural Health Mission
• ASHA
• NACO Plans
• Research: Inclen Study

NNF Activities

Neonatal Care and Breastfeeding
• High Priority area
• Care of the Sick New Born
• Comprehensive Neonatal Care

10th Five Year Plan: National Goals

• Exclusive breastfeeding during first 6 Mo 41.2 % to 80 %
• Initiation of breastfeeding within one hour: 15.8 % to 50 %
• Complementary feeding for 6 months old 33.5 % to 75 %

State Specific Goals

Breastfeeding & Child Survival

• Universal exclusive breastfeeding for the first six months reduces under-5 mortality by 13%


National Guidelines on IYCF: Optimal infant feeding Practices

• Need Advocacy for
• Upgradation to the status of Policy
### Action Plan

Massive action on the issue of infant and young child feeding required at State levels
- Need for a State Infant and Young Child Committee of all Stakeholders
- To formulate and implement action plan at State level to achieve Optimal Infant Feeding Practices.
- Strengthen core training resources and enhance capacity

### Action Strengthening Developments

- Developments
  - National Bf Committee
  - RCH-II Program
  - IMNCI
  - National Rural Health Mission
  - ASHA
  - NACO Plans
- Actions
  - All Partners on board
  - Planning/ Review
  - Training
  - Operational Research
  - Public Pvt Partnership
  - Urban Slum

### National Aids Control Organisation (NACO) : Plans

- Creating district level Voluntary and Confidential Counselling and Testing Centres (VCCTC) & Prevention of Parent to Child Transmission Centres (PPTCT),
- would lead to an increased demand of skilled counsellors on infant and young child feeding in the context of HIV.

### Mortality and IYCF Practices

- Worldwide 10.9 million children under five years of age die every year,
- of which 2.42 million deaths occur in India alone.
- Two-thirds of these deaths (16 lac) occur during the first year and is related to inappropriate infant feeding practices.
  
  World Health Assembly

### Multiple Indicator Cluster Survey UNICEF India 2000

- ‘True’ exclusive breastfeed Rate (0-3 m) is even lower than NFHS 2 figure
- INCLEN study results

### The Promotion of Early and Exclusive Breastfeeding: Feasibility

- Feasibility of increasing exclusive BF through trained home-based community peer counsellors
- The programme achieved 70 percent exclusive breastfeeding in five months
The Promotion of Early and Exclusive Breastfeeding: Feasibility

- Exclusive breastfeeding till six months is feasible through training in existing primary health-care services.
- Exclusive breastfeeding at 3 months was higher in the intervention group (79%) Vs the control group (48%).

Promotion of Exclusive Breastfeeding: Feasibility

- Increase in exclusive breastfeeding rates from 39 percent to 70 percent
- Reductions in infant mortality by 32 %,


Commitment of GOI to Improve Infant Young Child Feeding (IYCF) Practices

International Instruments

- India is first to harmonize global recommendations on IYCF in its National policy
- APPAR Tool for advocacy- Tracking IYCF status at National and State level

Recommendations: For Achieving Optimal Feeding Practices

- Training must be given to the health worker and community workers.
- Launch BCC campaigns for discontinuing pre-lacteal feeds.
- Family members/ mother-in-law, must be targeted.
- Skilled health workers must counsel all the mothers during prenatal, antenatal and postnatal period.

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