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

• UNICF 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 Uttarpradesh
- 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

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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
11. IMS Act – The Infant Milk Substitutes, Feeding Bottles and Infant Foods (Regulation of Production, Supply and Distribution) Act 1992 as amended in 2003
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 (AFASS) then exclusive breastfeeding is recommended during first months of life. These guidelines imply that till one can ensure all these 5 AFASS 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, profeesor 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 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.

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.

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, proessional 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 (10^{th} – 12^{th}) 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

Time	Topic	Speaker
08.30 - 09.00 AM	Registration of Participants	
09.00 - 11.30 AM	**Opening Session** Inauguration by: *Dr. Shanti Ghosh* Address by: *Dr. Prema Ramachandran, Director, NFI*	
	Sharing of district level action on IYCF	Presentations by BPNI District Coordinators
11.30 - 11.45 AM	Tea Break	
11.45 - 01.30 PM	**Session: HIV and Infant Feeding** ***Chair:*** *Prof. A.P. Dubey, MAMC, Delhi* • NACO' s PPTCT programme: An Overview with special reference to infant feeding *(15 mins)* • Issues related to Infant feeding in the context of HIV *(15 mins)* • Experience of training counselors in 'Infant Feeding and HIV' in Delhi. *(15 mins)* • State AIDS Control Society's initiatives in strengthening Infant Feeding in PPTCT programmes *(15 mins)*	Dr Inder Parkash, *Jt. Director (Training), NACO* Ms Vidhya Ganesh, *UNICEF, India* Prof. MMA Faridi, *UCMS, Delhi* Dr. Rajesh Gopal, *SACS Gujarat,*
01.30 - 2.30 PM	Lunch	
02.30 - 3.30 PM	Role of stakeholders in addressing Infant Feeding in the context of HIV Moderator: Dr J. P. Dadhich	Dr AP Dubey, IAP Dr S Salhan, FOGSI Dr NB Mathur, NNF Dr Dinesh Paul, *NIPCCD* Mrs Deepika Khaka, *TNAI* Ms. Deepa Venkatachalam, *JSA*
03.30 - 04.30 PM	**Group Work on Strengthening of infant feeding addressing** advocacy, training, communication, etc. a) Policy b) Programme	**Facilitator** Dr. M.M.A. Faridi Dr. J.P. Dadhich

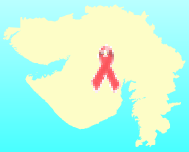
Day 2: Saturday, 10th Dec 2005

Theme: Infant and Young Child Feeding in Emergency Situations

Time	Topic	Speaker
09.00 - 09.30 AM	**Session: Infant and Young Child Feeding in Emergency Situations** Inaugural session *Chair:* **Dr K.K. Agarwal, *VC, IP University*** ***Objectives*: Dr Arun Gupta BPNI**	
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. Sangeeta Saxena, *ACCH, MOHFW* Dr. Anchita Patil /Dr. Arvind Mathur, *WHO (India)*
10.45 - 11.45 AM	o Mumbai (Floods) o Tamil Nadu (Tsunami) o Pondicherry (Tsunami) o Jammu & Kashmir (Earthquake) **Panel Discussion (Mainstreaming with current disaster preparedness)** **Moderator:** *Mr. N.M. Prusty, SPHERE*	Dr. Charu Suraiya Dr. J A Jayalal Dr. S Srinivasan Ms. Khalida Jabeen **Panel** (invited) Dr Deepika Nayar, CARE India, Dr Sangeeta Yadav, IAP Brigadier Khanna, NDMA, Red Cross, Save the Children
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

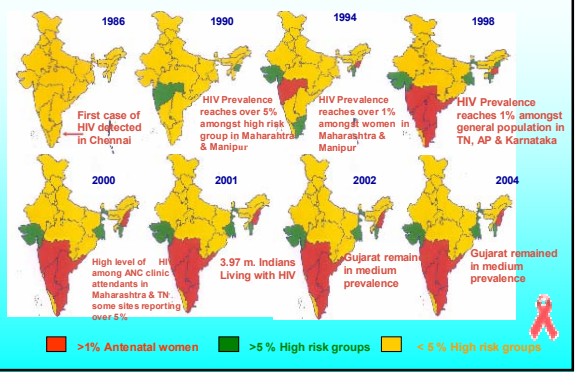
[National AIDS Committee(1986)
NACP(1987)]

NACP PHASE I (1992-1999)

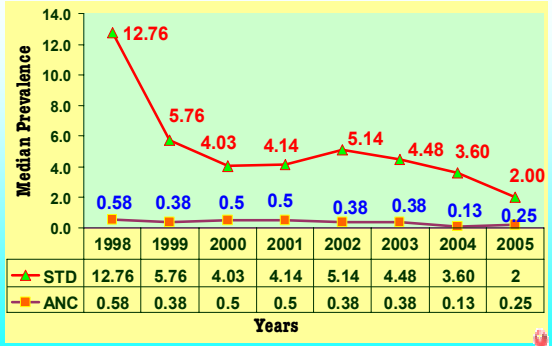
NACP PHASE II (1999-2006)

NACP PHASE III (2006-2011)

EVOLUTION OF HIV EPIDEMIC– INDIA 1986-2004



NACP Impact (Gujarat)….1998-2005



	1998	1999	2000	2001	2002	2003	2004	2005
STD	12.76	5.76	4.03	4.14	5.14	4.48	3.60	2
ANC	0.58	0.38	0.5	0.5	0.38	0.38	0.13	0.25

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 COUNSELLED &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, SURENDRANAGR**
- **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. Maskati Hospital, 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, Asarwa, 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

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

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

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 Gyanecology 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, Ped, 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/3days), WHO-Unicef 2000
4. Complementary Feeding counseling Training course (17 hr/3 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/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

Sr.No	Level of Knowledge acquired during training	N=9
I	**Infant feeding**	
	Exclusive Breastfeeding till 6 months	3
	Initiation of BF within half hour after delivery	2
	Positioning-most of the aeriolla part should be inside the baby's mouth	4
	Chin and nose should touch the breast	3
	Proper positioning & attachment help in reduction of HIV transmission	1

II	**Counselling**	N=9
	Breastfeeding counselling	5
	Use skills of counselling	3
	Counseling about HIV/AID	2
III	**Infant feeding**	
	EBF, formula milk, animal milk, wet nursing	1
	BF within half an hour, EBF till 6 months	4
	Proper positioning and good attachment	3

Post Training Assessment of PPTCT Counselors HIV +ve Woman

I	**Breastfeeding options**	N=9
	EBF for 6 months	6
	Expressed heat treated milk feeding	6
	Advise to breast positioning	8
	Nursing feeding	2
	No reply	1
II	**Precaution to be observed during breastfeeding**	
	Condition of nipples-no sore, cracked, mostities nipples	6
	Good positioning and attachment	4
	EBF only for 6 months, no mixed feeding	6
	Mother should avoid BF	2

PPTCT Counselors: RF For HIV Positive Woman

A.	Advantages & Disadvantages of replacement feeding	
I	**Advantage of replacement feeding**	N=9
	Easy availability	2
	Fresh and economic	1
	No risk of HIV transmission	6
II	**Disadvantages of replacement feeding**	
	Costly	4
	Not easily available	2
	More chances of diseases	7
	Risk of earlier pregnancy	1
	Social stigma	3
	Improper nutrients	2

PPTCT Counselors: AFASS- HIV Positive Woman

B.	Assessment & guidance in selection of Top Feeding option	
I	Acceptability	N=9
	Acceptability by family members	5
	By herself-fear of stigma	5
	No response	2
II	Affordability	
	Based on income	7
	Afford for a particular time-period	2
	Afford time in preparation	2
	No response	1

Post Training Assessment of PPTCT Counselors

B.	Assessment & guidance in selection of Top Feeding option	
III	Feasibility	N=9
	Easily obtainable	2
	Feasible to prepare	1
	Requirement for feeding artificially	1
	Adequate time	1
	Support of time	1
	No response	5
IV	Safety	
	Precautions during feeding for hygiene/cleanliness	2
	Hygiene/cleanliness of utensils	4
	Precautions in storage	3
	Must be used before expiry date	1
	Top feeding is best for HIV +ve mother	1
	No response	1

Post Training Assessment of PPTCT Counselors

B.	Assessment & guidance in selection of Top Feeding option	
V	Sustainability	N=9
	Sustainability in regard of duration	2
	Only top feeding(no mix feeding)	3
	Adequate supply, nearest source	2
	Commodities needed to feed the baby	1
	No response	3

Post Training Assessment of PPTCT Counselors

A.	Precautions while giving top feeding:	
I	Preparation and dilution	N=9
	Proper hygiene/cleanliness of utensils	3
	Proper measurement of milk, sugar	3
	No response	3
II	Measurement	
	Not too much, not too less proper diet	4
	No response	5
III	Feeding Mode	
	Cup catorie and spoon	7
	No response	2
IV	Hygiene in preparation and feeding	
	Clean hands, utensils and cover the milk	6
	No response	3

Post Training Assessment of PPTCT Counselors

B.	Suggestion to solve the problem when mother not enough milk	N=9
	More suckling by baby, more milk in breast	4
	Good positioning and attachment	4
	Mother should take good diet	1
	Mother should slightly massage her breast and give little press to nipple	1

Responses of Ante-Natal Mothers After Counseling

Know the topics discussed during counselling	N=45
Yes	93%
No	
Don't know/can't say	7%
Information provided	N=42
HIV infection	100%
Infant feeding	100%
Mother-to-child transmission of HIV infection	
Yes	53%
No	38%
Don't know/can't say	9%
Information provided	N=24
During pregnancy	100%
During delivery	100%
Breastfeeding	100%

Responses of Ante-Natal Mothers After Counseling

Mother-to-child transmission through breastfeeding	**N=45**
Yes	36%
No	60%
Don't know/can't say	4%
Information provided	N=16
Continue breastfeeding upto 3 months	100%
Infant feeding/Breastfeeding	
Yes	84%
No	4%
Don't know/can't say	12%
Information provided	N=38
Exclusive breastfeeding	100%

Lesson Learnt

1. All PPTCT/VCCTC Counselors need training in IF
2. Refresher course required 6-12 monthly for 1day
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

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.
- PMTCT programs provided opportunities for HIV prevention counseling and STI diagnosis and treatment for the 98-99% of pregnant women which were uninfected.

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 it is US $ 100 million
- The targets to reduce the prevalence of HIV infection in pregnant women from 1.4% to <1%.
- To reduce the transmission of HIV infection from mother to baby from 30% to 10%.
- To provide AIDS care to 70% of the eligible mothers by the year 2008.
- The programme envisages establishment of 444 PPTCT centers (315 government + 129 private) & 81 ART centers in the country in a phased manner (2004-2008)
- 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.

Expected outcome by the end of project period

Objective 1	Targets				
	Year 1	Year 2	Year 3	Year 4	Year 5
No. of health facilities providing HIV prevention services which include STI condom services etc.	125	331	400	420	444
No. of hospitals providing VCT services to pregnant women and their partners	125	331	400	420	444
No. of hospitals providing MTCT prevention to pregnant women	125	331	400	420	444
% of HIV+ pregnant women receiving nevirapine	70%	75%	80%	90%	95%

Objective 2	Targets				
	Year 1	Year 2	Year 3	Year 4	Year 5
Number of facilities with linkages for Treatment of OI	125	331	400	420	444
No. of health facilities providing the comprehensive package PMTCT, Care and ART	5	11	11	45	81
Number of HIV+ mother receiving ART	220*	650	1300	2800	4000

Objective 3	Targets				
	Year 2	Year 2	Year 3	Year 4	Year 5
Number of patients receiving ART at project sites	1000	2500	3000	6000	15000
Additional Number of patients in private sector (outside project sites) being treated with rational ART through regular monitoring of CD4	500	2000	3000	4500	6000
Number of Institutions with capacity to provide ART	20	40	60	120	200
Expand CD4 testing capacity in the private health facilities	15	25	35	55	80

Targets activities & achievements by end of the year 1

S. No	Activity	Targets	Achievements	% of achievements
1	Number of staff trained in PPTCT prevention	1000	3185	319%
2	Number of counselors and laboratory technicians trained on VCT	250	226	90.4%
3	Number of health facilities offering minimum package of PPTCT (including HIV prevention services, VCT, ARV prophylaxis to pregnant mothers, STI treatment, condom distribution, linkages for treatment of OIs)	125	113	90.4%
4	Percentage of HIV infected pregnant women and their babies receiving a complete course of ARV prophylaxis to reduce the risk of MTCT	70% (of those tested positive)	49% (3466/7081)	70%
5	Number of service providers trained in HIV/AIDS management	1300	1839	141.4%
6	Number of health facilities providing a comprehensive package of PPTCT, care and antiretroviral therapy and laboratories strengthened to support diagnosis of OI and monitoring ART	5	5	100%
7	No. of HIV positive women put on ART	220	589	267.7%
8	No. of partnerships established with pharmaceutical companies	4	0	0%
9	No. of health care workers trained in appropriate use of ARV therapy at 4 project sites	1066	542	50.8%
10	No. of project sites providing quality VCT services	14	18	128.6%
11	No. of NGOs linked to the health facilities providing ART involved in providing quality HIV/AIDS care and support services to PLWA	31	36	116.1%
12	No. of PLWA receiving ART through the four selected private hospitals including regular CD4 Monitoring	3850	3017	78.4%
13	No. of PLWA receiving ARV from Private sector, being monitored at project sites through subsidized CD4 counts	500	0	0%

Summary of overall PPTCT Centres Establishment

S.No.	States	PPTCT Units established			
		Baseline as on March,2005	Target for Phase-1	Units established during 2005	Total units established till Oct. 2005
1	High Prevalence States	238	222	69	307
2	Moderate Prevalence States	44	188	0	44
3	Low Prevalence States	18	177	2	20
4	North Eastern States	4	49	0	4
5	Union Territories	**3**	**20**	**0**	**3**
	Total	307	656	70	377

Summary of Service Delivery under PPTCT Programme

S. No.	States	Total no. of new registration	Number of women counselled	Number of persons tested	Number of persons found HIV+ve	Percent (%) found HIV +ve	Mother baby pairs given NVP Prophylaxis	% Coverage
1	High Preval.States	569997	512922	470469	4712	1.00	1982	42.06
2	Mod.Preval. states	124304	45258	28773	156	0.54	63	40.38
3	Low Preval. States	198	198	198	0	0.00	0	
4	N-E States	0	0	0	0	#DIV/0!	0	
5	Union Territories	10449	9831	9722	15	0.15	0	0.00
	Total	**704948**	**568209**	**509162**	**4883**	0.96	**2045**	41.88

Total Budget Available for GFATM-II

Budget Available for Phase-II & Phase-II under GFATM Round-2 US$ 000

Sl. No.	ACTIVITY	y1	y2	y3	y4	y5	total
1	Human Resources	300.00	540	590	590	450.00	1040
2	Infrastructure	500.00	650	590	90	30.00	120
3	Institutional Governance and Planning	1130.00	3395	2970	905	300.00	1205
4	Commodities	5512.00	10068	17700	19000	20000.00	39000
5	Drugs	53.00	315	675	875	1110.00	1985
6	Monitoring and Evaluation	743.00	1222	1500	1600	1800.00	3400
7	Administrative Costs	628.00	688	700	700	750.00	1450
8	Other/Technical Assistance	156.00	216	400	340	300.00	640
9	Committed expenditure	0.00					0
10	Committed expenditure - 2	0.00					0
	TOTAL	9022.00	17094	25125	24100	24740.00	100081

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-medical professionals.
- Husbands are either not allowed or they do not accompany their wives fro antenatal care services. It is necessary that this difference is gradually minimized in the public sector as well, enhancing the male envolvement 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.

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.**
- **Such a selective approach is likely to lead to sharing of antiretroviral drugs in HIV concordant couple-setting, may lead to power play for actual intake of these drugs in family setting and also require a huge budgetary; allocation.**
- **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. However, training of physicians, obstetricians and pediatricians in management of HIV disease using antiretroviral drug is crucial to meet the demand to institute a regimen and monitor patient, if they can afford these drugs themselves.**

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.

Strengthening of well baby clinics:

The well baby clinics run by department of Pediatrics should be strengthened in order to ensure regular follow-up of the babies and facilitating preventive, promotive and care & support services.

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, complementary feeding, infant feeding in 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

Budget plan for the year 2 (Phase-I				Budget plan for the year 3,4&5 (Phase-II)			
Sl. No.	Activity/Items	Year 1 & 2 (Phase-I)		Sl. No.	Activity/Items	Year 3, 4 & 5 (Phase-II)	
		US$	INR			US$	INR
1	Funds for Yr 1	902000	405990000	1	Funds for Yr 3	25125000	1130625000
2	Funds for Yr 2	17094000	769230000	2	Funds for Yr 4	24100000	1084500000
3	Total	26116000	1175220000	3	Funds for Yr 5	24740000	1113300000
							0
4	Funds Utilized in Yr 1	4205888.89	189265000	4	Total	73965000	3328425000
5	Saving from Yr 1	4816111.11	216725000				
		0		5	Saving from Phase-I	738043	332133443
6	Funds available for Yr 2	21910111.1	985955000				
		0					
7	Budgeted	14529367.9	653821557				
		0					
8	Saving	7380743.18	332133443	6	Budgeted	81345743	3660558443

Revised plan of action for Phase-II

Objective 1

Sl. No.	Outcome/coverage indicators	Original Targets	Revised Targets
1	No. of health facilities providing HIV prevention services which include STI condom services etc.	444	2329
2	No. of hospitals providing VCT services to pregnant women and their partners	444	2329
3	No. of hospitals providing MTCT prevention to pregnant women	444	2329
4	% of HIV+ pregnant women receiving nevirapine	95%	95%

Objective 2

S. No.	Outcome/coverage indicators	Original Targets	Revised Targets
5	Number of facilities with linkages for Treatment of OI	444	2329
6	No. of health facilities providing the comprehensive package PMTCT, Care and ART	81	81
7	Number of HIV+ mother receiving ART	4000	4000

Objective 3

S. No	Outcome/coverage indicators	Original Targets	Revised Targets
8	Number of patients receiving ART at project sites	15000	15000
9	Additional Number of patients in private sector (outside project sites) being treated with rational ART through regular monitoring of CD4	6000	6000
10	Number of Institutions with capacity to provide ART	200	200
11	Expand CD4 testing capacity in the private health facilities	80	80

Issues and Challenges

- Inadequate capacity of the SACS to identify NGO & PLHA Groups as well as assessment and identification of proper site for establishment of PPTCT centers.
- Availability of proper persons with the prescribed qualifications are not avialble for the job of counselors. This is because this particular discipline is very rare and very few schools are conducting this training in counselling and those who are conducting have very few admissions per annum. Thus in the near future there is a need to change in policy and neccessray qualification for the counselors.
- Training Strategy: During the project period a large number of trainings will be required. These trainings are conducted by mobile training teams for which experts are called from within or outside the state nod at time these experts may not be avialble. The programme as yet not involved the site level health arising institutions for seeking there support in NACP. Therefore there is strong need to strengthen the avialble healthy institutions that will in turn undertake the responsibility for training different aspects of training.
- Lack of Awareness among the community and clients: The programme is being implemented since long but the awareness about HIV/AIDS control programme and facilities available under the programme are not known even to most of the health care provaders.The awareness is still low in eth community and PLHAs so there is a need to strengthen the IEC activities appropriately.
- Management Information System: Although it is said that the performance report including financial report of the previous month should be made avialble by the 20th of the previous month, however this is not happening .Some of the states have delayed the submission of the quarters. This leads to compilation of the reports received at NACO.
- Financial Management: Delayed submission of SOEs from the states causes undue delay in the compilation at NACO. Further if the SOES are not received the funds cannot be released to the SACS. This also delay in submission of disbursement request from the Global Fund. Delays have also been observed due to bureaucratic and administrative procedures.
- Supervision of the programme is poor because the programme has large number of activities but does not have sufficient manpower to plan, implement, monitor and supervise the programme activities properly. This adds to further delays.
- Disparities in Salaries: The counselors and lab technicians at the grass root level have expressed that they are not getting the salaries which are at par with their counterparts in the public sector; Similar disparities are also observed for the TA/DA for the health staff attending the training programmes.
- Concerns about the role of Lead NGO: There is a lack of coordination among the NGO Consortium. The Lead NGO lacks the leadership that has caused isgnifiacnt delays with resets to finalization of partnership with pharmaceutical companies and delay in achieving the targets of ART to PLHAs by the NGO consortium. This has also caused slow pace of activity and utilization of funds

Budget Allocation and Utilization during year 1

Amount in INR (00,000)

	Budget	Actual	Variance	% Utilization
Human Resources	144.00	32.17	111.83	22.34
Infrastructure	240.00	12.80	227.20	5.33
Institutional Governance and Planning	970.08	25.10	944.98	2.59
Commodities	1840.49	312.13	1528.36	16.96
Drugs	38.12	0.00	38.12	0
Monitoring and Evaluation	212.48	9.19	203.29	4.33
Administrative Costs	208.07	35.08	172.99	16.86
Other/Technical Assistance	11.54	0.00	11.54	0
Committed expenditure	0.00	1444.62	-1444.62	
Committed expenditure -2	667.20	0.00	667.20	0
Grand Total	4331.98	1871.09	2460.89	43.19

State wise allocation and utilization of Budget during 2004-05

('00,000 Indian Rupees)

	Budget	Expenditure (Unaudited)*	Variance	% Utilization
States:				
Karnataka	464.28	199.44	264.84	43.0
Andhra Pradesh	596.13	370.22	225.91	62.1
Maharashtra	646.41	302.06	344.35	46.7
Nagaland	217.2	132.15	85.05	60.8
Tamil Nadu	581.25	316.48	264.77	54.4
Manipur	280.63	141.74	138.89	50.5
Total	2785.9	1462.09	1323.81	52.5
NGOs:				
ARCON	390.91	216.19	174.72	55.3
YRG	170.66	87.46	83.2	51.2
Freedom Foundation	317.31	126.91	190.4	40.0
Total	878.88	430.56	448.32	49.0
NACO**	667.20	0	667.20	0.0
Grand total	4331.98	1892.65	2439.33	43.7

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.

Revised plan of action for Phase-II

Objective 1

Sl. No.	Outcome/coverage indicators	Original Targets	Revised Targets
1	No. of health facilities providing HIV prevention services which include STI condom services etc.	444	2329
2	No. of hospitals providing VCT services to pregnant women and their partners	444	2329
3	No. of hospitals providing MTCT prevention to pregnant women	444	2329
4	% of HIV+ pregnant women receiving nevirapine	95%	95%

Objective 2

S. No.	Outcome/coverage indicators	Original Targets	Revised Targets
5	Number of facilities with linkages for Treatment of OI	444	2329
6	No. of health facilities providing the comprehensive package PMTCT, Care and ART	81	81
7	Number of HIV+ mother receiving ART	4000	4000

Objective 3

S. No	Outcome/coverage indicators	Original Targets	Revised Targets
8	Number of patients receiving ART at project sites	15000	15000
9	Additional Number of patients in private sector (outside project sites) being treated with rational ART through regular monitoring of CD4	6000	6000
10	Number of institutions with capacity to provide ART	200	200
11	Expand CD4 testing capacity in the private health facilities	80	80

Overall PPTCT Centers Established

S.No.	States	PPTCT Units established			
		Baseline as on March,2005	Target for Phase-1	Units established during 2005	Total units established till Oct. 2005
HIGH PREVALENT STATES					
1	Andhra Pradesh	37	57	0	37
2	Karnataka	45	37	0	45
3	Maharashtra	55	22	0	55
4	Manipur	9	5	0	9
5	Nagaland	9	10	0	9
6	Tamilnadu	65	60	69	134
7	Mumbai MACS	18	31	0	18
	Sub-total-1	**238**	**222**	**69**	**307**
MODRATELY PREVALENT STATES					
8	Gujarat	10	25	0	10
9	Goa	1	2	0	1
10	Pondicherry	2	3	0	2
11	Delhi	10	10	0	10
12	West Bengal	10	18	0	10
13	Orissa	3	29	0	3
14	Chennai MC		11		
15	Bihar	6	38	0	6
16	Jharkhand	0	1	0	0
17	Madhya Pradesh	2	49	0	2
18	CG				
19	Ahmadabad MC		2		
	Sub-total-2	**44**	**188**	**0**	**44**

Overall PPTCT Centers Established

S. No	States	Baseline as on March,2005	Target for Phase-1	Units established during 2005	Total established till Oct. 2005
LOW PREVALENT STATES					
20	Kerala	3	23	2	5
21	J&K	0	16	0	0
22	Himachal Pradesh	0	16	0	0
23	Punjab	6	17	0	6
24	Haryana	2	19	0	2
25	Rajasthan	6	32	0	6
26	Uttar Pradesh	0	48	0	0
27	Uttaranchal	1	6	0	1
	Subtotal-3	**18**	**177**	**2**	**20**
N-E STATES					
28	Assam	3	18	0	3
29	Sikkim	1	4	0	1
30	Meghalaya	0	7	0	0
31	Tripura	0	1	0	0
32	Arunachal Pradesh	0	12	0	0
33	Mizoram	0	7	0	0
	Sub-total 4	**4**	**49**	**0**	**4**
UNION TERRITORIES					
34	A&N Island	0	1		
35	Chandigarh	3	16	0	3
36	D&N Haveli	0	1		
37	D&D	0	1		
38	Lksdp	0	1		
	Sub-total 5	**3**	**20**	**0**	**3**
	Grant Total	307	656	70	377

Service Delivery under PPTCT Programme

S. No.	States	Total no. of new registration	Number of women counselled	Number of persons tested	Number of persons found HIV+ve	Percent (%) Found HIV +ve	Mother baby pairs given NVP Prophylaxis	% Coverage
HIGH PREVALENT STATES								
1	Andhra Pradesh	96807	91821	83108	1697	2.04	678	39.95
2	Karnataka	91409	76961	74025	870	1.18	360	41.38
3	Maharashtra	108727	88912	74768	804	1.08	311	38.68
4	Manipur	14914	7605	2181	96	4.40	13	13.54
5	Nagaland	2719	1776	1651	19	1.15	7	36.84
6	Tamilnadu	232289	223513	213912	917	0.43	476	51.91
7	Mumbai MACS	23132	22334	20824	309	1.48	137	44.34
	Sub-total-1	**569997**	**512922**	**470469**	**4712**	1.00	**1982**	42.06
MODRATELY PREVALENT STATES								
8	Gujarat	11968	7392	4302	55	1.28	18	32.73
9	Goa	3871	3794	3794	42	1.11	14	33.33
10	Pondicherry	17947	9576	4225	13	0.31	1	7.69
11	Delhi	86898	21646	14713	38	0.26	28	73.68
12	West Bengal							
13	Orissa							
14	Chennai MC							
15	Bihar	3620	2850	1739	8	0.46	2	25.00
16	Jharkhand					#DIV/0!		
17	Madhya Pradesh					#DIV/0!		
18	CG					#DIV/0!		
19	Ahmadabad MC					#DIV/0!		
	Sub-total-2	**124304**	**45258**	**28773**	**156**	0.54	**63**	40.38

Service Delivery under PPTCT Programme

S. No	States	Total no. of new registration	Number of women counselled	Number of persons tested	Number of persons found HIV+ve		Mother baby pairs given NVP Prophylaxis	% Coverage
LOW PREVALENT STATES								
20	Kerala					#DIV/0!		
21	J&K					#DIV/0!		
22	Himachal Pradesh					#DIV/0!		
23	Punjab					#DIV/0!		
24	Haryana					#DIV/0!		
25	Rajasthan					#DIV/0!		
26	Uttar Pradesh					#DIV/0!		
27	Uttaranchal	198	198	198	0	0.00	0	
	Subtotal-3	**198**	**198**	**198**	**0**	0.00		
N-E STATES								
28	Assam					#DIV/0!		
29	Sikkim					#DIV/0!		
30	Meghalaya					#DIV/0!		
31	Tripura					#DIV/0!		
32	Arunachal Pradesh					#DIV/0!		
33	Mizoram					#DIV/0!		
	Sub-total4	**0**	**0**	**0**	**0**	#DIV/0!		
UNION TERRITORIES								
34	A&N Island							
35	Chandigarh	10449	9831	9722	15	0.15	0	
36	D&N Haveli					#DIV/0!		
37	D&D					#DIV/0!		
38	Lksdp					#DIV/0!		
	Sub-total5	**10449**	**9831**	**9722**	**15**	0.15		

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
- Work shops

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 breastfed 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

MOTHER TO CHILD TRASMISSION OF HIV

Dr SUDHA SALHAN
CONSULTANT &
H.O.D.OBST.& GYNAE
VMMC &S.J.HOSP
NEW DELHI

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.

HIV IN WOMEN

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

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.

HIV/AIDS ESTIMATES IN **ASIA** PACIFIC

	Estimated number of people living with HIV					
	Adults and children, end 2003			Adults and children, end 2001		
Country	Estimate	Low Estmate	High Estimate	Estimate	Low Estmate	High Estimate
Afghanistan	-	-	-	-	-	-
Bangladesh	-	2500	15,000	-	2200	13,000
Bhutan	-	-	-	-	-	-
Cambodia	170,000	100,000	290,000	170,000	100,000	270,000
China	840,000	430,000	1,500,000	660,000	320,000	1,100,000
DPR Korea	-	-	-	-	-	-

HIV IN WOMEN

Age	Male	Female	Total
0-15yrs	825	523	1348
15-29yrs	8895	4071	12966
30-44yrs	14556	3499	18055
>45yrs	2197	562	2759
TOTAL	26473	8655	35168

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

FACTORS INCREASING VULNERABILITY

- 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

FACTORS INCREASING VULNERABILITY

- 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

FACTORS INCREASING VULNERABILITY

- 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

FACTORS INCREASING VULNERABILITY

- 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

DETERMINANTS OF VERTICAL TRANSMISSION

- 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

DETERMINANTS OF VERTICAL TRANSMISSION

- 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

DETERMINANTS OF VERTICAL TRANSMISSION

- 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

DETERMINANTS OF VERTICAL TRANSMISSION

- 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.

DETERMINANTS OF VERTICAL TRANSMISSION

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

DETERMINANTS OF VERTICAL TRANSMISSION

- 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

DETERMINANTS OF VERTICAL TRANSMISSION

- 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.

DETERMINANTS OF VERTICAL TRANSMISSION

- The newborn's immature gastro-intestinal 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

DETERMINANTS OF VERTICAL TRANSMISSION

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

DETERMINANTS OF VERTICAL TRANSMISSION

- 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.

DETERMINANTS OF VERTICAL TRANSMISSION

NEWBORN IMMUNE RESPONSE

- 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

DETERMINANTS OF VERTICAL TRANSMISSION

NEWBORN IMMUNE RESPONSE

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

HIV IN WOMEN

- TIMEING OF VERTICAL TRANSMISSION
- Intrauterine
- Intrapartum
- Lactation

INTERVENTIONS TO DECREASE RISK OF MTCT

Counseling

- Preferably early in pregnancy

General Measures

- Keep in good health . Treat malnutrition

INTERVENTIONS TO DECREASE RISK OF MTCT

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

- Early umbilical cord clamping is thought to decrease the chance of maternal blood containing HIV crossing over to the foetus

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[35]. 300mg 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 2mg./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.)

INTERVENTIONS TO DECREASE RISK OF MTCT

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.(contd.)

PRECAUTIONS

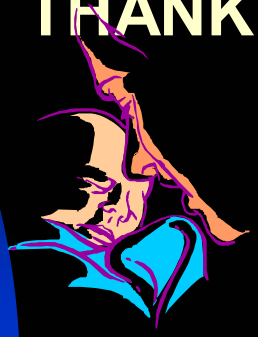
-Put placenta in a bag with bleaching powder and either burn or bury with bleaching powder in the soil.

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.
- Liason 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 & propogate 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

NB Mathur,
President, National Neonatology Forum,
Professor of Pediatrics,
Maulana Azad Medical College,
New Delhi

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 6months 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%**

- **Jones G, Steketee RW, Black RE, Bhutta ZA, Morris SS and the Bellaagio Child Survival Study. Lancet, 362, July 5, 2003, 65-71**

National Guidelines on IYCF: Optimal infant feeding Practices

- **Need Advocacy for**
- **Upgradation to the status 0f 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 Developements

- Developements
- 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
- Haider R, Ashworth A, Kadir I, Huttly SRA. Lancet 2000; 356: 1643-47

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 %).

- Bhandari N, Rajiv B, Sarmila M Jose M, Robert E B, Bhan M K. Lancet 2003; 361: 1418-1423.

Promotion of Exclusive Breastfeeding: Feasibility

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

Arifeen S, Black RE et. al. Exclusive breastfeeding reduces acute respiratory infections and diarrhoea deaths among infants in Dhaka slums. Pediatrics, 2001:108: E.67

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 targetted**
- **Skilled health workers must counsel all the mothers during prenatal, antenatal and postnatal period.**

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