** **

**Sub-Regional PMTCT Capacity Building Meeting**

**On**

**Primary Prevention of HIV**

**&**

**Prevention of Unintended Pregnancies**

**Conference Report**

Lilongwe, Malawi

**May 16-19, 2011**

# Table of Contents

[List of Acronyms 3](#_Toc296941972)

[Acknowledgements 4](#_Toc296941973)

[Executive Summary 5](#_Toc296941974)

[Key Recommendations 6](#_Toc296941975)

[Background 8](#_Toc296941976)

[Day One [16th May, 2011] 9](#_Toc296941977)

[Field Visits 9](#_Toc296941978)

[Day Two [17th May, 2011] 10](#_Toc296941979)

[Introductory Session 10](#_Toc296941980)

[Session 1: Background 11](#_Toc296941981)

[Session 2: Framework on Prongs 1 & 2 17](#_Toc296941982)

[Session 3: Barriers and Challenges to Service Delivery 19](#_Toc296941983)

[Official Opening Ceremony 20](#_Toc296941984)

[Day Three [18th May, 2011] 24](#_Toc296941985)

[Session 4: Data, Indicators and Reporting 24](#_Toc296941986)

[Session 5: Building Partnerships 26](#_Toc296941987)

[Session 6: Country Lessons Learnt 31](#_Toc296941988)

[Day Four [18th May, 2011] 34](#_Toc296941989)

[Session 7: Specialized Programming 34](#_Toc296941990)

[Session 8: Specialized Services 39](#_Toc296941991)

[Session 9: Service Challenges and Resource Mobilization 42](#_Toc296941992)

[Country Plans 45](#_Toc296941993)

[Reception 48](#_Toc296941994)

[Annex 1: Program 49](#_Toc296941995)

[Annex 2: Background to Field Visits 54](#_Toc296941996)

[Annex 3: Conference Evaluation 55](#_Toc296941997)

[Annex 4: Speeches 57](#_Toc296941998)

[Annex 5: Logistics Report 65](#_Toc296941999)

[Annex 6: List of Facilitators 67](#_Toc296942000)

[Annex 7: List of Participants 69](#_Toc296942001)

[Annex 8: References 73](#_Toc296942002)

# List of Acronyms

|  |  |
| --- | --- |
| AIDSART | Acquired Immunodeficiency Syndrome.Antiretroviral Therapy  |
| ARV | Antiretroviral |
| CHAM | Christian Health Association of Malawi |
| CIDA | Canadian International Development Agency |
| CSOs | Civil Society Organizations |
| DFID | Department for International Development |
| DRC | Democratic Republic of Congo |
| FP | Family Planning |
| FPAM | Family Planning Association of Malawi |
| GBV | Gender-Based Violence |
| GF | Global Fund |
| GTT | Global Task Team |
| HTC | HIV Testing and Counselling |
| ICASA | [International Conference on AIDS and STIs in Africa](http://www.google.com/url?sa=t&source=web&cd=6&sqi=2&ved=0CFQQFjAF&url=http%3A%2F%2Fwww.icasa2011addis.org%2F&ei=nOXvTejtBtCr8AOrzKWpBw&usg=AFQjCNHXzIwbnT8feo3TjIv4KQ1o2kcPYQ)  |
| ICPD | International Conference on Population and Development, |
| IPPF | International Planned Parenthood Federation |
| MANET+ | Malawi Network of People Living With HIV.  |
| MCP | Multiple Concurrent Partnership  |
| MDGs | Millennium Development Goals |
| MoH | Ministry of Health |
| MTCT | Mother-to-Child Transmission |
| MVP | Millennium Village Project |
| NGO | Non-Governmental Organizations |
| NPO | National Programme Officer  |
| PAC | Post Abortion Care |
| PEPFAR | President's Emergency Plan for AIDS Relief |
| PLHIV | People Living With HIV |
| PLWA | People Living With Aids |
| PMTCT | Prevention of Mother-To-Child-Transmission |
| RH | Reproductive Health |
| SRH | Sexual and Reproductive Health |
| STI | Sexually Transmitted Infection |
| TB | Tuberculosis  |
| UN | United Nations |
| UNAIDS | Joint United Nations Programme on HIV/AIDS |
| UNFPA | United National Population Fund |
| UNGASS | United Nations General Assembly Special Session |
| UNICEF | United Nations Children Fund  |
| UNDP | United Nations Development Programme  |
| UNPFA | United Nations Population Fund  |
| USAID | United States Aid Agency |
| VAW | Violence against women |
| VCT | Voluntary Counseling and Testing  |
| WHO | World Health Organization  |

# Acknowledgements

We would like to thank the many individuals and organizations that contributed to the success of this meeting. We gratefully acknowledge the participation of partners, including government officials and representatives; national and international NGOs as well as UN Agencies. Special appreciation goes to the UNFPA Malawi Country Office for hosting and organizing this conference.

We are also appreciative of the presentations and active participation of UNFPA staff from 16 country offices including Angola, Botswana, Burundi, Democratic Republic of Congo, Ethiopia, Kenya, Lesotho, Malawi, Namibia, Rwanda, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe. Representatives from UNFPA headquarters, Africa Regional Office should also receive our appreciation. Additional gratitude goes to the Global Fund who made significant contribution during the meeting.

Finally, special thanks to the Chief Rapporteur, Rev Patrick Semphere of Dawn Consulting for providing daily conference recaps and preparation of this report with assistance from representatives of Angola, Democratic Republic of Congo, Ethiopia, Zambia, Namibia and South Africa.



# Executive Summary

The Eastern and Southern African sub-region has more than 60% of the global PMTCT burden and has 15 of the 25 high burden countries. Additionally, HIV-related conditions have become the leading cause of maternal and child mortality. Remarkable progress has been made in the implementation of PMTCT strategies to reduce the risk of mother-to-infant transmission from nearly 40% to under 5%. However, much more needs to be done in the area of primary prevention of HIV and prevention of unintended pregnancies among women living with HIV where UNFPA is expected to provide leadership.

Since comprehensive and widely available PMTCT programmes could substantially move the sub-region towards preventing new infections through primary prevention and supporting women living with HIV to prevent unwanted pregnancies, concerted efforts of governments and their partners can maximize the utilization of limited expertise and resources.

Against this backdrop, the UNFPA Sub-Regional Office for Eastern and Southern Africa – Johannesburg, South Africa hosted a meeting of sixteen African countries in Lilongwe Malawi from May 16-19, 2011 towards the strengthening of the first two prongs of PMTCT. The conference brought together over 60 participants including government officials, non-governmental organizations, UNFPA staff, other UN agencies and other partners.

The general objective of the meeting was to contribute to the scale-up comprehensive PMTCT services by strengthening policy and programming to implement the first two prongs of PMTCT:

1. Primary prevention of HIV for women of child-bearing age, and
2. Prevention of unintended pregnancies among women living with HIV (as part of rights-based sexual and reproductive health of people living with HIV).

The specific objectives of the meeting were:

1. To orient participants on the new guidelines of Prongs One and Two.
2. To share experiences on the barriers and challenges of programming and implementing Prongs One and Two.
3. To discuss data collection methodologies, available indicators and reporting challenges.
4. To highlight the service delivery challenges and share experiences on how to address them through resource mobilization.
5. To identify technical assistance needs and build partnerships.

The meeting had ten sessions and was highly participatory, with resource persons utilizing interactive methods of knowledge sharing and transfer which included presentations, plenary discussions and dialogue.

# Key Recommendations

In the course of plenary discussions that followed presentations, several recommendations were advanced which are summarized as follows:-

|  | **TOPIC** | **KEY RECOMMENDATIONS** |
| --- | --- | --- |
|  | Elimination of Mother to Child Transmission | * Review monitoring frameworks and programme implementation in order to accelerate progress targeting a 90% reduction in new paediatric infections, less than 5% vertical transmission rate, and improvement in HIV-related maternal mortality by supporting a more comprehensive 4-pronged approach
 |
|  | Overview of the implementation of prongs one and two as a component of comprehensive PMTCT | * *Devise programmes that will focus on country-level opportunities which include policy support.*
* *Explore interventions that will ensure an urgent shift to a women-centred approach instead of focusing only on HIV positive women.*
 |
|  | Rationale of prongs one and two as a component of comprehensive PMTCT. | * *Explore more innovative strategies for effective integration of SRH and HIV Services at all level which will lead to improved SRH services for people living with HIV.*
 |
|  | Prongs one and two frameworks | * *Engage in creative discussion that will promote prongs one and two as marketable initiatives through creation of multi-sectoral synergy.*
 |
|  | A client perspective: Defining PMTCT (Prongs One and Two) services for clients | * *Ensure continued dialogue with cultural, faith-based and civic opinion leaders to help demolish gender imbalances that retard progress in PMTCT.*
* *Accelerate programming that will raise awareness to improve client access to integrated SRH and HIV services.*
 |
|  | Modelling and costing for PMTCT-Prongs one and two | * *Devise clear-cut strategies and activities which will help reduce incidence by 50%.*
* *Explore new approaches and strategies that will improve modelling, measurement and data collection.*
 |
|  | Indicators/Data Collection and Reporting | * *Ensure constant flow of non-technical information on indicators to relevant government agencies.*
 |
|  | Resource Mobilization—The Global Fund | * *UNFPA needs to support technical assistance for proposal writing, with strong integration of SRH/HIV-AIDS*
 |
|  | Building partnerships and developing strategy for comprehensive PMTCT | * *Undertake periodic appraisal, joint planning, and dissemination of research findings with partners to ensure quality control of interventions.*
 |
|  | Integrated Strategy development in SRH/HIV-addressing Prongs One and Two as part of an SRH/HIV policy | * *Formulate a comprehensive integration strategy that will synchronize HIV and SRH interventions.*
* *Leverage partner funding to ensure that both HIV and SRH programmes get adequate attention.*
* *Identify key allies for policy dialogue and advocacy for integration of HIV and SRH programming.*
* *Ensure vigilant tracking of national UNDAF provisions towards a comprehensive and well coordinated PMTCT programme that will impact on the new infections especially among women and children.*
 |
|  | SRH of people living with HIV | * *Undertake lobbying and advocacy activities to uphold the sexual reproductive rights of people living with HIV.*
 |
|  | Programming for adolescents/young people and MARPs | * *Undertake multi-sectoral consultations with youth-based agencies at national level to formulate long-term youth-friendly interventions that will promote SRH issues among the youth.*
 |
|  | Engaging men in PMTCT | * *Devise a strategic inquiry into the social environment of male involvement in SRH and PMTCT to ensure culturally appropriate engagement.*
* *Formulate and promote family-centred interventions that will accelerate SRH well-being at the family level.*
 |
|  | Mobilizing Technical Assistance | * *UNFPA should invest in capacity building of its partners in proposal writing, project and financial management.*
 |
|  | STI Management and Treatment | * *Access to services for STI care should be improved at all levels and outlets of the health-care system*
 |
|  | Post Abortion Care (PAC) - Malawi | * *PAC programmes should devote more attention in training, monitoring, mentoring and supervision to ensure high-quality family planning and HTC services*
 |
|  | Management of cervical cancers - Zambia | * *Research should be undertaken to explore the effect of ART on disease progression and treatment outcomes*
 |
|  | GBV as a component of Prongs One and Two | * *Mass media and community mobilization should be employed to increase awareness and change behaviours.*
 |

# Background

HIV has significantly impacted upon the developmental milestones of Sub-Saharan African countries, such that health indicators like maternal, infant and child health gains made in the immediate post-independent era are being threatened. While the global HIV proportion of women living with HIV has remained stable around 50%, in Sub-Saharan Africa HIV has increasingly become feminised with an estimated 60% of PLHIV being female. The Eastern and Southern Africa sub-region has more than 60% of the global PMTCT burden and has 15 of the 25 high burden countries. South Africa, Mozambique, Uganda, Tanzania, Kenya, Zambia, Malawi, Zimbabwe and Ethiopia account for 55% of pregnant women living with HIV. Consequently, HIV-related conditions have become the leading cause of mortality in women of reproductive age in the sub-region.

Significant progress has been in Prevention of Mother to Child Transmission (PMTCT) in the sub-region for antiretoviral prophylaxis during pregnancy, treatment and support (Prongs 3 & 4), but HIV infection among childbearing women remains the main source of HIV infection among children. More than 90% of infant and young child infections occur through mother-to-child transmission, either during pregnancy, labour, or through breastfeeding. Without any intervention, about one in three children born to HIV-positive mothers will be infected. In 2008, 430 000 children were newly infected with HIV, 90% of whom lived in sub-Saharan Africa[[1]](#footnote-1). In contrast, mother-to-child transmission of HIV has almost been eliminated in high income countries through primary prevention including HIV testing and counselling and access to effective antiretroviral prophylaxis and treatment; safer delivery practices, family planning, and safe use of replacement feeding. In Sub-Saharan Africa most children born with HIV die within their first two years of life, while children born to mothers with advanced AIDS disease are also more likely to die, even if they are not infected.[[2]](#footnote-2)

The 2001 Declaration of Commitment on HIV/AIDS at the UN General Assembly Special Session on HIV/AIDS (UNGASS) committed to reduce the proportion of infants infected withHIV by 50% by 2010, by ensuring that 80 per cent of pregnant women accessing antenatal care have information, counselling and HIV-prevention services available to them, as well as through effective interventions for HIV-infected women, including voluntary and confidential counselling and testing.

This global goal has not been achieved by the end of 2010, while considerable progress is being made towards the national scale-up of prongs 3 and 4, like the introduction of more efficacious regimens, with the primary prevention of new infant infections and unintended pregnancies still being under-served, such that in the hardest-hit countries of sub-Saharan Africa, women, infants and young children account for more than 60% of all new HIV infections[[3]](#footnote-3).

An Interagency Task Team (IATT) on Prevention of HIV Infection in Pregnant Women, Mothers and their Children review showed that the scale-up of PMTCT has been slow and very uneven between countries and did not meet the initial five-year UNGASS targets. This is in contrast to many antiretroviral therapy programmes that have had focused plans and targets for scaling up with designated resources. Due partly to lack of commitment and policy and operational guidance on primary prevention of HIV among women of childbearing age and prevention of unintended pregnancies including how it should be implemented in the context of PMTCT and within the framework of the overall national HIV prevention programmes most PMTCT activities focused mostly on ART interventions to prevent transmission from pregnant women living with HIV to their infants primarily in antenatal care and delivery settings.

The 2005 Abuja Call to Action towards an HIV-free and AIDS-free generation urged “… governments, development partners, civil society and the private sector to commit to the

goal of elimination of HIV infections in infants and young children, paving the way towards an HIV-free and AIDS free generation” by providing a comprehensive set of services including not only a continuum of family-centred HIV care and treatment services, but also a broader array of maternal, newborn and child health services and other sexual and reproductive health care, including family planning, management of sexually transmitted infections and nutritional support.[[4]](#footnote-4)

The IATT further recommends ten principles, that among other things, urge countries to emphasise delivering a comprehensive package of services, including links between services and integration with maternal, newborn and child health services; the participation of people living with HIV and communities; strong, coordinated and sustained partnerships; the importance of male involvement; and improving maternal and child survival to attain both impact and equity.

Please refer to the next section **Overview of the Global Landscape for the Elimination of MTCT** for an update on recent commitments in eliminating new paediatric HIV infections and improving maternal health.

# *Day One [16th May, 2011]*

# Field Visits

Upon arrival in the country, participants undertook field visits to two sites to add to their understanding of PMTCT programming in prongs one and two. They visited the Family Planning Association of Malawi (FPAM) SRH/FP Clinic and Youth Centre in Kawale and the Government Health Centre both situated in Lilongwe.

At the FPAM Clinic, participants were taken round the clinic from the time clients are received to when they get services and referrals. They were also introduced to young adolescents who are living positively with the virus.

The visit to the Government Health centre gave participants an appreciation of progress being made in primary prevention and Family Planning for positive women and girls.

The following observations were made after the visit:-

* There are weaknesses in primary prevention programmes in the PMTCT service that is provided at the hospital.
* Unwanted pregnancies in women living with HIV are not adequately addressed.
* The strength of addressing mother to child transmission in the context of PMTCT
* A narrow focus of PMTCT evidenced by the absence of prongs one and two and a strong emphasis on prong three.
* There is need to address primary prevention of HIV and prevention of unwanted pregnancies in adolescents and young people some of whom:
	+ Were born with HIV
	+ Are already in high risk activities like sex work
	+ Are dealing with issues of sexuality.

# *Day Two [17th May, 2011]*

# Introductory Session

**Welcome Remarks***Dr Margaret Agama, HIV/AIDS Advisor for UNFPA, Eastern and Southern Africa. Johannesburg, South Africa*

Dr Margaret Agama welcomed the participants on behalf of UNFPA Sub-Regional Office for Eastern and Southern Africa. She acknowledged the presence of government officials, other UN agencies; non-governmental organizations and other related partners. She appreciated all the countries for making it to the workshop which she said was a demonstration of how seriously they considered issues relating to PMTCT.

She singled our certain individuals for their value-adding role to the workshop:-

* Mr Edwin Huizing, SRO-J Director
* Dr George Tembo, Chief HAB
* Dr Kanyanta Sunkutu, Programme Specialist, SRO-J
* Ms Pumla Golimpi, Programme Assistant, SRO-J

Dr Agama also made special recognition to the Malawi office for working very hard to organize and host the conference.

**Purpose of the Orientation***Dr Florence Ebanyat, Technical Advisor, RH/MH – UNFPA ESA SRO- Johannesburg.*

She welcomed the participants on behalf of Mr. Edwin Huizing, Director at the UNFPA Sub Regional Office, for East and Southern Africa.

The Eastern and Southern African Sub-Region has more that 60% of the global PMTCT burden and has 15 of the 25 high burden countries. Additionally, HIV-related conditions have become the leading cause of maternal and child mortality. While progress has been made in the implementation of PMTCT strategies to reduce the risk of mother-to-infant transmission from nearly 40% to under 5%, much more needs to be done in the area of Primary Prevention of HIV infection and prevention of unintended pregnancies among women living with HIV where UNFPA is expected to provide leadership.

The “four-pronged approach” to PMTCT recognizes that an integrated and comprehensive approach is needed to address the problem. In addition, interventions that focus on antiretroviral drugs for HIV-positive women and their children must be augmented by a broader approach that addresses primary prevention and family planning. The prevention of new infections in women and men is an important goal both for comprehensive PMTCT and for the prevention of maternal mortality. The provision of rights-based planning services for HIV-positive women is another important component for the strategy, linked to universal access to sexual and reproductive health.

Proven interventions such as the integration of HIV information and education into maternal and Child Health and family planning services, increased access to VCT, the provision of counseling on safer sexual behavior should all be integrated into comprehensive PTCT services. The same applies for male and female condom provision for dual protection, diagnosis and treatment of sexually transmitted infections and for providing information on HIV and the risk of prenatal HIV transmission.

#  Session 1: Background

**Overview of the Global Landscape for the Elimination of MTCT***Dr Lynn Collins, Technical Advisor in HIV/AIDS and Health, UNFPA, NY*

Eliminating new paediatric HIV infections and improving maternal health requires that **SRH and HIV join forces** – delivering the lifesaving **HIV interventions integrated** **with the** **SRH platform**, particularly **MNCH** and family planning (**FP**).

For most women, **pregnancy is the key entry point to the health system**, and offers an **opportunity to address synergistically both maternal health, family planning and HIV**.

**HIV** is the **leading cause of death** among women of child bearing age and contributes significantly to **maternal mortality**.

A **mother’s death** can **increase** by more than **four times** her **child’s own risk of death**.

This means we need to **finally deliver on the four prongs which are inter-connected**:

* **Greater emphasis should be placed on the first two prongs of PMTCT since together they contribute 13% to the 90% reduction target for new HIV infections in children; and have additional benefits to the women themselves.**
* **Prong 1 - prevent HIV in pregnant women**
	+ Alarming HIV **sero-conversion rates during pregnancy** (5 – 10%)
	+ Programming is required to increase partners’ awareness of their HIV status through **HIV counselling and testing**, improve access to **ARVs** and **condoms**; prevent and treat **STIs, and eliminate gender-based violence (GBV)**.
* **Prong 2 - offer rights-based family planning**

.

* An estimated **27% of maternal deaths can be prevented by meeting unmet need for family planning**.
* Yet, **family planning has not been sufficiently integrated into antenatal and postpartum care—the backbone of PMTCT programmes - and into HIV treatment programmes**. This under-programming is despite the high level of unmet need for family planning; an estimated **38% of pregnancies globally are unintended.**
* In the enthusiasm to attain the bold PMTCT goals, we must ensure that the **rights of women living with HIV are respected**. Preventing unintended pregnancies does not mean preventing women living with HIV from having children. **Reproductive choice is a basic human right**. **Yet women living with HIV are reporting human rights violations such as coerced abortion and sterilization, or denial of the right to be sexually active and have children. This is unconscionable, and more needs to be done to eliminate stigma and discrimination, including in health services**
* **We also need to continue to deliver interventions for Prongs 3 and 4** sustainable **ART and safer infant feeding**– to prevent transmission to infants and save the lives of children, women, and men.

The **landscape** has changed markedly:

* On the technology front:
	+ new recommendations for **more effective ARV regimens** started earlier
	+ evidence of **treatment for prevention**.
* But technology alone will not eliminate paediatric HIV infections and keep women alive. That requires:
* **elimination of stigma and discrimination** (key barrier to access to services), including through sensitising health providers and the community to rights
* **better coordination between MNCH programmes and HIV**; especially the SG’s *The Global Strategy for Women’s and Children’s Health* – a roadmap to save the lives of over 16 million women and children, taking maternal and child health to a new level, and
* **full engagement of the community, including people living with HIV, key populations, and men, and**
* **Going beyond the health sector response:**
* **Supporting community programmes linked to health services**
* **Education, especially sexuality education**
* **Poverty reduction/income generation.**

Various initiatives are underway from UNAIDS; PEPFAR II; WHO/partner ART PMTCT and infant feeding Guidelines; Global Fund Priorities; IATT technical reviews and operational guidelines, and the Global Task Team (GTT) global plan for eliminating new HIV infections in children and keeping their mothers alive. These include:

* + MDGs: <5 years to realise the goals
	+ UN Secretary General's Global Strategy for Women's and Children's Health (*Commission on accountability)*
	+ H4+: WHO, UNICEF, UNFPA, World Bank + UNAIDS
	+ Global Fund: strengthen linkages in future proposals
	+ Elimination of congenital syphilis
	+ Elimination of paediatric HIV
		- *To eliminate new paediatric HIV infections and improve maternal, newborn and child survival and health in the context of HIV*
	+ Prioritisation among bilateral agencies and other funders
		- *Muskoka Initiative, GHI (PMI and PEPFAR)*
	+ Integration recognised as a priority by malaria and immunization programs and for operational research
		- *1st Global Symposium on Health Systems Research*

Global MTCT Elimination goals are as follows:

***To eliminate new paediatric HIV infections and improve maternal, newborn and child survival and health in the context of HIV (IATT)***

**Elimination of new HIV infections among children by 2015 and keeping their mothers alive (GTT)**

Global MTCT Elimination Targets have been set as follows:-

* 90% reduction in new paediatric HIV infections.
* Less that 5% *transmission rate (2% at 6 weeks).*

Prong 1: Reduce infections in women by 50%
Prong 2: Meet unmet FP needs
Prong 3: Less than 5% transmission rate
Prong 4: Reduce HIV-related maternal and child mortality

**Challenges:**

* Implementing the programmes through integrated HIV and SRH services
* Delineating what interventions for primary prevention can be carried out within the health services through HIV interventions and linked to the community
* Ensuring rights-based SRH services for women living with HIV, including but not limited to family planning
* There is also need to be attention paid to all for prongs, since as modelling has demonstrated, prongs 1 and 2 together contribute 13% toward the 90% reduction target.

**Overview of the Implementation of Prongs One and Two within the Sub region***Dr Margaret Agama*

**Issues**

* Like a good car, PMTCTneeds all four wheels in order to achieve satisfactory results. PMTCTcomprises a package of interventions summarized as 4 prongs, which must be implemented simultaneously.
* The sexual health triad (a portrayal of the overlap that exists among three elements--unintended pregnancies; STIs and HIV/AIDS) demonstrates the need for integration as we seek to deal with each of these areas of need.
* A number of issues related to HIV demand our attention:-
* HIV is a chronic disease that people can live with for a long time. ;
* HIV is the leading cause of death for people in the reproductive age and a major cause to infant mortality;
* Sexual and Reproductive Health needs should be tailored to meet the needs of people living with HIV.
* There is need to address unintended pregnancies among HIV+ women.
* HIV-born children are surviving into adolescence so their sexual and reproductive health need to be addressed.
* Men and women need space to discuss their fertility intentions (sexual and reproductive health rights).
* Cost benefits and health for efficacy and effectiveness
* Golden rule of prevention: Beyond the facility; reaching and involving the community

**Challenges**

* While elimination of mother-to-child transmission is possible in view of the gains that have been made, new infections which continue to occur pose a challenge to progress.
* Another bottleneck relates to the unmet need for family planning among married women 15–49 years old.
* Other challenges are as follows:
	+ Stakeholder commitment is low.
	+ Poor programme management & supervision.
	+ Inadequate infrastructure.
	+ Inadequate equipment and commodity supply.
	+ Barriers to client service utilization.
	+ Lack of women's empowerment to make SRH decisions.

**Opportunities**

The scaling up of Prong One and Two could take advantage of a number of opportunities as follows:-

* Emerging policy support for development of the strategy for the integration of FP and VCTServices (Kenya; Uganda; Tanzania) as well as High priority FP strategies (Mozambique, Rwanda).
* Country-specific funded programmes on integration (Botswana, Lesotho, Malawi, Namibia, Swaziland, Zambia, Zimbabwe).
* Increasing number of integrated RH/HIV bilateral programmes (Botswana, Kenya,Malawi, Rwanda, Zambia, and Zimbabwe).

**Rationale of Prongs One and Two as a Component of Comprehensive PMTCT***Dr Dorothy Mbori-Ngacha, Senior HIV Specialist at UNICEF ESARO- Johannesburg, South Africa*

**Issues**

* In Sub-Saharan Africa 60% of adults and 75% of youth living with HIV are women.
* Female youth are at disproportionally high risk of acquiring HIV, with —three to five times greater prevalence among girls than boys.

**Challenges**

* For women living in countries with generalized epidemics, the greatest risk of acquiring HIV infection is through marriage.
* 60% - 95% of new heterosexually acquired infections are estimated to occur within marriage or cohabitation.
* Gender and power inequity put women at increased risk for HIV acquisition.
* Incidence of HIV infection significantly higher in women who report history of physical or intimate sexual violence:

**Opportunities:**

* Prevention of unintended pregnancies among women living with HIV—already averts around 170 000 new infections. If all women in the region who did not wish to get pregnant accessed contraceptive services as many as an additional 160 000 HIV-positive births could be averted every year.
* New findings of effective structural intervention for prevention of HIV infection in young girls in Malawi. Cash payments lead to improved school attendance and lower HIV prevalence.

**Recommendations:**

* Inclusion of non-reactive women in PMTCT programming.
* Involvement of men is key to reduced transmission and saved marriages***.***

**PMTCT (Prongs One and Two) as a Component of SRH/MCH Services***Dr Florence Oryem-Ebanyat*

**Issues:**

* Integration of HIV and SRH is not a new concept as it had been promoted since the conference on Primary Health Care (PHC) in Alma-Ata (1978). Also when health was declared as a fundamental human right and when PHC was identified as the mechanism to realize health.
* In addition, subsequent platforms on which integration has been championed include ICPD (1994) ; UNGASS (2000); New York Call (2004) and Maputo Call to Action (2004).
* The 2005 World Summit Declaration states as follows:-

*That all individuals - women as well as men and adolescents - have universal access to comprehensive sexual and reproductive health services that meet their changing reproductive health needs throughout the life cycle.*

 Against this backdrop, 50% of the 40 million people are living with HIV are women

**Challenges**

Integration of Family Planning (FP) and HIV or vice versa

* Many HIV-infected women need FP.
* Unmet need for FP greatest in high HIV prevalence countries.
* Need can be met if FP services are offered to women who access HIV or other services.
* Clients accessing FP services may be in need for HIV prevention, diagnosis and treatment services.

**Opportunities for HIV prevention within SRH**

* Review of SRH policy and guidelines for Integrated SRH package;
* Policy and legal reform to remove barriers for unmarried & young people’s access to HIV testing and counseling;
* Policies on confidentiality and disclosure of HIV status and for dual protection.

**Recommendation (for SRH Providers)**

* Routinely offer STI/HIV prevention information to all SRH/MH clients, including people living with HIV;
* Provide basic information on family planning, dual protection and the importance of correct and consistent condom use; provision of male and female condoms;
* Routinely offer STI/HIV testing, counseling , diagnosis and appropriate treatment in family planning , ANC, PNC, PAC & during screening for RH tract cancers ;
* Provide non-directive, non-judgmental and confidential counseling on SRH for people living with HIV;
* Provide counseling on fertility desires and reproductive choices for PLWA and their partners;
* Provide related services and commodities;
* Referral for prenatal care, high quality obstetrical services and post-natal care.

# Session 2: Framework on Prongs 1 & 2

**Prongs 1 and 2 Framework***Dr Lynn Collins*

**Issues**

* Focusing on comprehensive approach, including prongs one and two contributes to the elimination of MTCT (modeling has demonstrated a 13% reduction in new paediatric HIV infections).
* A community focus improves service delivery as each segment of the community is treated in context.
* There is increased commitment to having guidelines for implementing Prongs 1 & 2, dependent on integration of SRH and HIV services.
* Reproductive rights issues underpin prong 2; women living with HIV are facing violations of their reproductive rights (forced abortion and sterilization).
* In terms of primary prevention, the new finding that ART can reduce onward HIV transmission by 96% is highly significant.

**Challenges**

A number of factors have led to the neglect of Prongs One and Two:-

* Perceived to be relatively non-priority areas compared to prong 3; but recent modeling has proven otherwise..
* Lack of understanding that there are interventions that can be undertaken for primary prevention in the context of heath services (HIV counselling and testing, ART for prevention; condoms, STI management, GBV elimination, etc.); aside from what is already taking place in general HIV prevention programming
* Insufficient multi-sectoral synergy at planning level
* Lack of understanding of SRH, especially family planning among HIV practitioners, including lack of awareness of intrinsic benefits of HIV to the women themselves, and its contribution to elimination of MTCT goals.

**Recommendations**

* There is need to understand linkages between facility-based and community based approaches.
* We should move towards integration of SRH and HIV services.
* Coordination mechanisms are required between maternal health, other SRH areas and HIV.
* Addressing stigma and discrimination against people living with HIV and key populations and addressing gender-based violence is essential for achieving the human rights and public health goals should promote innovative men-inclusive programmes e.g. Workplace outreach programs, couples counselling and testing as appropriate.
* Urgent progress to be made in prongs 1 and 2 to achieve the MTCT elimination targeting of 90% reduction in new paediatric HiV infections and a ess than 5% vertical transmission rate.

#

# Session 3: Barriers and Challenges to Service Delivery

**A Client-Perspective: Defining PMTCT services (Prongs One and Two) for Clients***Mr & Mrs Sitolo*

A married couple living with HIV shared their life experience with the participants. They had three health children prior to Mr Sitolo discovering that he was HIV positive. When he discovered his status, he did not disclose to his wife, who only discovered during her fourth pregnancy during routine PMTCT screening. Following successful prong 3 interventions she delivered an HIV negative baby who later died from malaria.

The couple do not use condoms as they want to have more children. Currently the wife is pregnant with the fifth child. The husband is on ART while the wife is not yet eligible.

**Observations and Discussion**

* Non-disclosure of HIV status to his wife meant violation of her human rights.
* In the absence of full disclosure of the HIV status of the couple, decision-making was highly compromised.
* Issues of ethical disclosure of HIV status come into play.
* The fact that the lady could not speak for herself reflects power imbalance and disempowerment of the woman.
* Workshop participants did not fully engage with the couple. Could this be a reflection of difficulties of discussing sex and sexuality in our culture?

**Providing (Prongs One and two) services for clients—Malawi:***Ms. F Chavula (Matron, Bwaila Hospital).*

Bwaila maternity wing is situated at the centre of the city of Lilongwe district and it caters for a population of 163,089 people. It falls under Bwaila health area which comprises of four health facilities such as Bwaila itself, Kawale, Area18 and Kang’oma. Its location in the centre of the city places a huge burden upon it as it caters for clients and patients from a vast catchment area.

* The following services are provided at this centre: antenatal care; postnatal checks; family planning; early infant diagnosis; under-five clinic and nutrition clinic.
* Under prong three, antenatal services include
* health education on different health topics including HIV prevention and PMTCT
* counselling and testing
* haemoglobin check, syphilis testing
* Prophylaxis treatment such as SP, iron and de-worming drugs

**Issues**

* The city has the highest annual population growth rate of 6.1% as it continues to face an influx of migrants from both within and outside the country.
* The district’s health services are mostly catered for by the Ministry of Health (MOH) and some by hospitals under the Christian Hospital Association of Malawi (CHAM) and other private facilities.
* Outlined services provided at the hospital include antenatal care; postnatal checks; family planning; early infant diagnosis; under-five clinic and nutrition clinic.

**Challenges**

* Inconsistent supply of HIV testing kits and syphilis test reagents.
* Shortage of staff: the ones on duty being overwhelmed with work.
* Not enough space for all the integrated services rendered since the facility offers teaching services for students from Kamuzu College of Nursing; College of Health Sciences and CHAM colleges.
* No proper coordination between ANC attendance and those delivering at the labour ward, as many deliver and attend postnatal checkups and family planning services elsewhere.
* Lack of follow-up on EID defaulters as many keep on moving houses and locations.

**Opportunities**

* Support for staff training and materials for PMTCT by partners such as UNC, EGPAF, CCDC, UNICEF.
* The support and use of CD4 count machine by UNC.
* Bwaila health centre has a vast opportunity for prongs one and two as it has just a big captive audience. Unfortunately, this is not happening.

## *Official Opening Ceremony*

The conference was officially opened by Dr Mary Shawa, Principal Secretary in the Office of the President and Cabinet, Department of Nutrition & HIV/AIDS. She was flanked by other dignitaries from the UN and NGO sector.

**Keynote Address:***Dr Mary Shawa, Principal Secretary, Office of the President and Cabinet, Department of Nutrition & HIV/AIDS.*

Mitigating the impact of HIV/AIDS faces several challenges. One of them is that we often operate in our own little corners whereby we do collaborate with others. The other challenge is the compartmentalization of HIV. HIV is in all MDGs and in this regard, each and every sector of the economy must be involved in PMTCT.

Sub-Sahara Africa is the epicentre of the epidemic. The unanswered question is, “Why?” Among other reasons, sex has no borders. 90% of HIV transmission is though sex. In addition, we need to do much at household level where most of the infections are happening. 55 new infections are occurring through MTCT.

In Malawi, we need to focus on proper and family-centred services that will focus on a comprehensive set of interventions e.g. nutrition support; treatment and care. There is also need to package our communication so that there is clarity both among ourselves as well as to our political masters.

The legal framework will also have to be revisited to take care of trends in our society that are retarding our progress in the fight against HIV/AIDS. For instances, there are religious sectors who claim that prayer and ARVs are mutually exclusive thereby jeopardizing the lives of their faithful.

There is also need to pay attention to nutritional support as it relates to HIV/AIDS. If we can work on a comprehensive HIV/AIDS strategy that includes nutritional support, we will go a long way towards winning the battle against HIV/AIDS.

It is evident that our leaders are committed to the fight against HIV/AIDS and SRH service delivery. However, there is need for policy guidelines that are communicated in user-friendly language to enable them to clearly understand the expectations and it is imperative for the conference to come up with clear recommendations in this regard.

**Message from Civil Society:***Ms Annie Banda (MANET +)*

The opening of this conference coincided with the International AIDS Candlelight Memorial under the theme—“Touch Lives”. The day falls three weeks before the UN General Assembly High Level Meeting on AIDS. In June 2011, member states will meet to review progress of the HIV/AIDS response. Civil Society and People Living With HIV wish to urge governments of member states to commit themselves to:-

* Achieving universal access to HIV prevention, treatment, care and support by 2015.
* Respecting, protecting and fulfilling the human rights of the people living with and those affected by HIV.
* Introducing and promoting laws to protect the rights of people living with and those most affected by HIV.
* Involving people living with HIV meaningfully at key decision-making levels.
* Ensure that country-level HIV responses are transparent, accountable and inclusive of those most affected by HIV.

**Message from UNICEF Sub-Regional Office (PMTCT):***Dr Dorothy Mbori-Ngacha*

90% of all new HIV infections in children worldwide occur in Sub-Saharan Africa. The majority of these infections are caused by vertical transmission from mother-to-child. Both the UN Secretary General and the UN’s joint programme on AIDS have called for the elimination of mother-to-child transmission of HIV by 2015.

Remarkable progress has been made in increasing access to PMTCT services with the main focus on delivering ARVs. However it is clear that to realise the goal of E-MTCT and the Millennium Development Goals, we will need to have a more comprehensive approach including primary prevention of unintended pregnancies which is the focus of the meeting.

Programme focus should be on the equity lens in order to reach unreached women including pregnant adolescents. It also means disaggregating data to identify gaps in coverage, access and utilization of services.

At Regional level, UNICEF is proud to partner with UNFPA, WHO and UNAIDS in jointly supporting countries through technical advice and financial support; helping governments in setting standards, modelling successful programmes and documenting both gaps and results on the road to MTCT elimination.

**Welcome Remarks:***Mr. Athanase Nzokirishaka, Country Representative for UNFPA, Malawi Office.*

HIV significantly impacts upon developmental milestones of Sub\-Saharan African countries thus threatening health indicators made in the post-independence era. About 60% of HIV infections in Malawi are among women, mostly of child-bearing age.

HIV infections among child-bearing women remain the main cause of HIV infection among children. More than 90% of infant and child infections occur through mother-to-child transmission, either during pregnancy or through breast-feeding. Without any intervention, about one in three children born to HIV mothers will be infected.

Therefore comprehensive and widely available PMTCT programmes could help turn the tide.

Sincere appreciation to our Sub-Regional Office in Johannesburg and our HIV/AIDS Branch in New York for choosing Malawi to host this meeting.

**Statement:***Mr Richard Dictus, UNPD Malawi Resident Coordinator*

HIV/AIDS remains a major threat in the attainment of MDGs by 2015, especially MDG 3, 4 and 5. For Malawi, it is becoming increasingly clear that we have a long way to go to achieving MDG 3, 4 and 5. Thus this workshop is timely and relevant.

In the context of the challenges in PMTCT programming, we in the UN system in Malawi wish to create an enabling environment for interventions to take place. This meeting will help us build our own internal capacities within UNFPA with which to support government and civil counterparts in these highly technical areas.

Delightfully, the new UNDAF which we are currently finalising has made great efforts and investments to ensure provision for a comprehensive and well coordinated PMTCT program that impacts on new infections especially among women and children.

# *Day Three [18th May, 2011]*

#  Session 4: Data, Indicators and Reporting

**Modelling and Costing for PMTCT**

*By Erica Kufa, Data Manager, WHO-IST/ESA, Harare, Zimbabwe.*

**Issues:**

There is global impetus towards achieving virtual elimination of new child infections PMTCT. The goal is to reduce new infections in children by 90% between 2009 and 2015 and reduce MTCT to less that 5%. This goal hinges on the comprehensive coverage of all the four prongs in PMTCT.

In early years, regional and global estimates were made using a simple epidemiological programme (EPIMODEL) for the calculation of estimates on incidence and mortality from this epidemic curve. Country-specific estimates were made every two years since 1998 (end-1997 estimates) and more data was available and new methods and tools have been developed since 2001.

A suite of easy to use policy models (EPP/Spectrum) provide policymakers with an analytical tool to support the decision making process based on recommendations of the UNAIDS Reference Group on Estimates, Modeling and Projections. This Spectrum also includes a PMTCT and FP module

**Modelling**

The modeling framework displays the following realities:-

* Reduction of transmission rate is based on clinical evidence.
* No data for HIV positive breast-feeding women is available.
* It is an ambitious target.
* There is inadequate resource mobilization.
* ART coverage is not enough.
* The current indicators are not measuring the desired outcome

**Costing**

* Significant resources and commitment will be needed to reach target.
* Strategies have not clearly defined.
* As 2015 is not far, there is urgent need to accelerate efforts in order not to miss the target.

**Challenges:**

* Time running out: 2015 just around the corner!
* UNFPA was not involved in initial development of models and this may pose problems in the roll-out process of the same.

**Recommendations:**

* We need clear definition of strategies and activities which will help reduce incidence by 50%.
* New approaches and strategies which have service delivery implications need to be adopted (for example: couples’ testing; ART treatment for prevention and re-testing).
* There is need to strengthen health systems to enable them to cope the ever increasing demands.
* More work has to be done with modeling to accurately project rates for prong one.
* Improving measurements and data collection quality will make modeling work better.

**Indicators/Data Collection & Reporting for PMTCT:**

*By Erica Kufa.*

**Issues**

A new focus on programme impact has emerged. This underlines linkages and improvements in maternal and child health and survival.

A draft global monitoring framework has been devised to support one monitoring and evaluation system for the initiative. The proposed indicators for each prong are being finalized while no new indicators have emerged so far.

**Challenges**

* No existing data for FP for unmet needs for HIV positive women (Prong 2).
* Lack of service delivery packages for prong 1 and 2.
* Global setting of targets does not seem to take into account local realities.

**Recommendations**

* Indicators for prong 1 need to be refined.
* Changes in definition of indicators need to be communicated to governments.
* Countries should repackage evidence in a simplified way for policy makers to understand.
* Better indicators for prong 1 should be formulated.
* We need continuous capacity building to ensure effective service delivery.

#  Session 5: Building Partnerships

**Angola***Dr Nzoi Mpoio Lusaia UNFPA NPO-SRH*

**Issues**

For eight years now, Angola is at peace after a long devastating civil war. National development is making good progress. Generally speaking, Angola has a low HIV/AIDS Prevalence. However the characteristic of the epidemic needs particular watch because of neighbouring countries with high HIV prevalence. Reviewing estimated prevalence by province shows significantly higher rates along the southern and northern borders; which are key geographic areas with “hotspots”, or high HIV prevalence areas.

In Angola, there has been a scale up of PMTCT services since 2004. HIV/AIDS services provided in the country include VCT and antiretroviral prophylaxis to prevent MTCT. SRH services including HIV prevention for in-school and out-of-school youth are being rolled out at both facility and community levels.

**Progress made**

* Implementation of CARMMA (Campanha para a Redução da Mortalidade Materno Infantil) has been effective.
* There has been progressive scale-up of PMTCT and SRH services to all municipalities.
* Inclusion of contraceptives in the list of essential medicines.
* Implementation of the National Strategic Plan for the accelerated reduction of maternal- infant mortality.
* National wide Implementation of Strategic Plan for Revitalization.
* Inclusion of SRH, HIV and STI Prevention into the strategic plan and action plan of equality and empowerment of women in the Portuguese Speaking Community: CPLP (Comunidade de Pais da Lingua Portuguesa).
* LUANDA Declaration of May 2011: It expressed the conviction that there can be no sustainable development unless there is effective gender equality and equity and empowerment of women towards their full enjoyment of their civil, political, economic, cultural, social, sexual and reproductive rights.

**Challenges and Constraints**

* Demotivated and insufficient human resource to some extent has slowed down the scale- up of PMTCT services
* Limited community and leadership involvement.
* Limitation in communication and difficulties in reaching out to some communities.
* Difficulty in integration of SRH and PMTCT programming and implementation.
* Insufficient community mobilization.
* Need to scale up of PMTCT.
* Need to Strengthen M&E at national and provincial levels.
* Mobilization of funds by NGOs.

**Rwanda***Amadou Senk, UNICEF*

**Issues**

In Rwanda, 2.2% of heterosexual couples are HIV sero-discordant (around 60 000 couples), putting the HIV-negative members of these discordant couples at high risk of HIV infection.

Furthermore, it was predicted in the elaboration of the new National Strategic Plan (NSP) on HIV and AIDS (2009-2012) that sero-discordant couples in stable relationships will be the major contributor of new infections, accounting to 27-53% of new HIV infections depending on the specific scenario. In spite of this, very few programmes exist that aim to identify and work with discordant couples for HIV prevention.

The country has achieved remarkable National PMTCT programme milestones (1999-2011).

**Partnership Model—Bugesera District has a good**

* With about 400 HIV+ (3%) pregnant women expected per year, if no intervention is implemented to prevent MTCT, about 140 new born infected by HIV (35% of MTCT).
* The district has achieved 100% coverage of PMTCT and VCT services in all health facilities services, approximately 10,731 (82.5%) pregnant women tested for HIV in 2009.
* Among the existing PMTCT sites, 6 (50%) are offering highly active antiretroviral therapy (HAART).
* In September 2009, a high level consultative meeting between UNAIDS and MVP project and Presidents of 8 selected countries including Rwanda charted a partnership arrangement.

**The managerial structure for the partnership is reflected in following areas:**

* NACC will ensure the role of coordination and partnership development towards an effective alignment to national priorities.
* EGPAF, Columbia University and other clinical partners will provide medical treatment, nutrition counseling data collection system, testing and task shifting for ARV initiation to nurses.
* Imbuto Foundation and other stakeholders ensured support to accelerate primary prevention interventions through continued awareness sessions, access to RH services package and ensuring male involvement.
* WHO, UNICEF, UNFPA, and UNAIDS provided catalytic technical and financial assistance and overall advocacy based on agency’s comparative advantages.

**Kenya***Kjetil Bordvik, RH Programme Officer.*

In 2004 Kenya undertook a pilot integration programme in some selected public health facilities (Family Planning Association of Kenya). The Pilot was limited to integrating HIV/FP and FP/HIV. The lessons learnt informed the development of the integration strategy and rollout of a national programme. The rationale for the integration was as follows:-

* Both FP and HIV interventions serve the same target population – the sexually active men and women
* Integration leads to better-utilized services
* Integrated programmes make better use of limited human resources
* Missed opportunities are minimized.
* We build on existing programmes and institutions
* There is greater convenience for clients

This process was facilitated by a number of factors which included the availability of the Reproductive Health Policy 2007; the RH/HIV Integration Strategy 2009; Draft RH and Communication Strategy and the three year Quantification for RH Commodity Strategy for both HIV and SRH.

Critical success factors included

* Supportive Policy environment
* National RH/HIV Integration Strategy
* Broad-based RH/HIV Integration Committee
* Service provision guidelines in the areas of FP, CT/PICT, PMTCT, ART and Adolescent RH.

Persistent challenges have been encountered in this process, and they include:-

* Resource constraints: Financial, Human, Infrastructure
* Training (Segmented VS Integrated).
* Shortage and distribution bottlenecks in RH Commodities.
* Lack of sustained advocacy/consensus Building
* Scope of services which is not comprehensive.
* Lack of Integrated Reporting Tools.

**Key points & lessons leant in this process**

* Ministry of Health ownership and involvement is critical: When policymakers understand the savings and benefits of integrating FP and HIV services, they are more likely to support it.
* Consensus building among stakeholders is also important.
* Inbuilt Monitoring and Evaluation makes a big difference.

**Tanzania***Dr Deborah Kajoka, National PMTCT Coordinator*

**Issues**

At the lower level of facilities such as dispensary and health centers, services like PMTCT, SRHs are provided under one roof and in dispensaries, it may be carried out by the same provider. At regional and district level, Regional & Council Health Management Teams are responsible while at national level, RCH section and NACP/ZACP are two separate institutions under one directorate (Preventive).

Policy review was undertaken in 2007 : Several HIV and FP policies were integrated.

In Zanzibar, a task force on SRH/HIV integration was established in 2010 and an assessment on SRH/HIV integration using the Rapid Assessment tool has started in May 2011.

In 2008, the country began to coordinate and move ahead in a strategic and systematic way to address issues at the policy, system and service delivery levels

An enabling policy environment also made a big difference. Among others, In 2009, the FPHIV TWG (Technical Working Group) was established in 2009, co-chaired by the NACP and RCHS unit of the MoHSW (secretariat – partner rotation). In addition, advocacy was also strengthened.

**Challenges:**

* Limitations in scaling up.
* Moving forward within the overburdened system.
* In Zanzibar advocacy on SRH/HIV integration is still needed particularly between Inter-Ministerial level and among CSOs.

 **Future Plans**

* Support implementation of the Zanzibar Rapid assessment recommendations.
* Partner with EGPAF to support integration of FP into HIV care and treatment at policy, planning and service delivery levels.
* Continue with policy dialogue and advocacy for integration at all levels and specifically at regional and district levels.

**Plenary Discussions**

**Considering unique national contexts, the following points of consideration were advanced:-**

* Leveraging partner funding ensures that both HIV and SRH programme get adequate attention.
* Religious communities have good potential of partnership.
* When donors are part of the sector-wide approach, consistent funding is ensured.
* Integration should be pursued beyond provincial/district levels to higher/national level.
* We need to formulate mechanism that will ensure that integration is running in synch with relevant guidelines.
* Integration at UN level is an issue that impacts how we deliver our services.

#  Session 6: Country Lessons Learnt

**Round Table Discussions**(Botswana, Lesotho, Malawi, Namibia, Swaziland, Zambia and Zimbabwe)*.**Moderated by Mr Kevin Osborne, Senior HIV Adviser, International Planned Parenthood Federation ( IPPF).*

**Key Issue: Rapid Assessment Tool (RAT) for SRH and HIV Linkages**

The discussions involved countries that completed the Rapid Assessment for the SRH and HIV linkages. They shared their experience on how they undertook the assessment, challenges faced, successes registered and the impact achieved.

***Overview of RAT***

* Assess HIV and SRH bi-directional linkages at policy, systems and service-delivery levels.
* Identify current critical gaps in policies and programmes.
* Contribute to the development of country-specific action plans to forge and strengthen these linkages.
* Focus primarily on the health sector.
* Stand-alone activity or part of a larger review of national response.
* Includes desk reviews and individual/group interviews
* Ensure at a minimum the assessment team includes:
	+ national government SRH and HIV units
	+ networks of people living with HIV
	+ key populations
	+ civil society
	+ UN organizations
	+ Donors

**What has the RAT accomplished in your country?**

* Creates understanding of the situation of SRH and HIV.
* Assists in the assessment of existing linkages between SRH and HIV.
* Helps us identify gaps and challenges at policy, service delivery and health system levels.
* Facilitates advocacy at various levels.
* Provide an opportunity for MOH to take the leadership role.

**Describe the leadership options/tension on process drivers?**

* Varied from country to country. Options include:-
	+ UNFPA
	+ Technical committees
	+ Hired consultants
	+ WHO
* MOH and the civil society not actively involved in some countries
* No tension between SRH and HIV people if one took a lead role
* Donors were involved in consensus meetings and dissemination.
* GTZ,USAID,CIDA,DFID etc

**What is the one result that you can think of as “amazing” ?**

* High level commitment by policymakers, stakeholders
* Existing integration of services by default
* Interest and motivation to push agenda forward
* Existing guidelines and protocols in some while the need to develop these has been identified
* Finance mobilization
* Joint planning and budgeting
* Joint monitoring and supervision (strengthen M&E)
* Development of clear linkages between SRH and HIV
* Better coordination of activities to avoid duplication of activities
* Translation of policies at lower levels

**General Recommendations**

* MOH must be involved and if possible lead the process
* Adequate planning is critical for the success of the process
* Civil society should not only be included at stakeholder meetings but also in the process
* Hiring of consultants should take into consideration the following factors:-
	+ International and local perspectives
	+ Health expertise
* Other aspects of integration to be included on our agenda:
	+ The perspective of health service providers
	+ Integration of donors
	+ Community involvement
* Donor involvement should be at policy level
* Linkages vs. integration: We need to pay attention to those elements that can be a barrier to progress.

**Sexual and Reproductive Rights of people living with HIV***Mr Kevin Osborne*

HIV positive persons have the same SRH rights as HIV negative persons. While certain interventions uphold SRH rights for HIV-positive persons, some suppress these rights. For example:

* Criminalization of HIV transmission
* Gender based Violence
* HIV related stigma and discrimination
* Health care providers

Each HIV person is a different individual with specific sexual health needs and influences.

A guide has been developed on prevention strategies for people living with HIV.

**Briefing on forthcoming ICASA Brief: “Own, Scale up and sustain”***Dr Margaret Agama*

Preparation is underway to host the 16th International Conference on HIV/AIDS and STI in Africa (ICASA 2011) to be held in Addis Ababa on 4-8 December, 2011. Details of the conference are available on <http://www.icasa2011addis.org/>. Submission of abstracts has been announced.

Participants outlined the following priority areas for UNFPA which could be discussed during the conference:-

* Integration: Cost effectiveness (website on linkages exists)
* Adolescent health; At-risk groups: Policy and barriers.
* Argument for good governance and leadership on Prong 1 and 2
* Prong 1 and 2 strategy and delivery modes
* Partnerships: How do we work with others to scale up.
* Documentation of best practices
* Support for stakeholders
* Start looking in at what recommendations and resolutions that need to come out of ICASA and mobilize resources to enforce the outcomes
* Raise awareness on UNFPA activities
	+ How does UNFPA position itself on virtual elimination of PMTCT. How do we bring prominence to issues that may not be brought up by others
* Community health system strengthening
* Link with maternal mortality
* Comprehensive PMTCT including Prong 1 & 2
	+ Adolescents and prong 1 and 2
	+ Maputo Plan of Action
	+ Treatment for prevention: Needs clarity to avoid negation of other existing programmes.

# *Day Four [18th May, 2011]*

# Session 7: Specialized Programming

**Programming for Adolescents/Young People and MARPs***Mathias Chatuluka, Family Planning Association of Malawi (FPAM).*

**Issues:**

The Priority (Focus) areas for Family Planning Association of Malawi are as follows:-

* Adolescent/young people
* Access to Information and services
* HIV/AIDS
* Post Abortion Care
* Advocacy

A number of issues affect young people. These range from social, health, physical and psychological needs. Key areas include the following:-

* Social and physiological
* Sex and Sexuality
* Access to health and in particular SRH information and services
* Rights, safety and protection
* Employment and social security

Key programming principles are as follows:-

* Need to focus on rights based approach
* Understanding young people better
* Consider issues such as age, sex, socio-economic status,
* Consider young people’s rights
* Participation of the target group (active in planning monitoring etc)
* Other factors – gender, partnerships and stakeholders, community acceptance, vulnerability of young people,
* Targeting: Young people are not homogeneous and thus cannot be reached with one intervention.

Strategies and interventions in programming for young people

* Information services without monotony
* Recreation and entertainment
* Innovation and creativity
* Safe space
* Delivering youth friendly services
* Peer education
* Alternative opportunities
* Integration of services
* Young people appreciate to be included.
* Young married women should be included in the MARPS group.

**Engaging men in PMTCT***Ms. Vestine Mutarabayire Wibabara:* *NPO, HIV/AIDS Prevention***,** *Rwanda*

**Issues**

Rwanda has made great milestones in the roll-out of PMTCT at national level. Key strategies to strengthen male involvement in PMTCT programme have been made as follows:-

*At National level*

* Commitment by high level leaders (HE President of Republic launched the first meeting on Couple VCT).
* Promotion of Couple HIV counseling and testing.
* Performance-based financing (PBF); integrating couples’ HIV counseling and testing indicators at health facilities and community level

*Involvement of local authorities/leaders:*

* CVCT in performance contract of Mayor
* Family Testing with an introduction of a follow up tool tracking of the HIV status for all family ( at VCT and PMTCT programme)

*Health Facilities*

* Invitation letters for partners of unaccompanied pregnant women
* VCT session on the week-end for partners not available during the week.
* TOT on CVCT for Health care providers
* Fast- tracking of women attending ANC with their spouses

*Community Mobilization*

* Community health workers involvement in mobilizing male partners

**Challenges**

* How do we reach the remaining 15-20% male?
* Management of discordant couples.
* Ensuring that male participation translates into optimum uptake to all the package of PMTCT
	+ ANC services
	+ ARV prophylaxis
	+ Safe practices delivery
	+ Infant feeding support
	+ Family planning services

**Male involvement in PMTCT in Mwandama***Ms Thandiwe Mijoya: Millennium Village Project, Malawi*

**Millennium Villages Project (MVP).**

MVP is a partnership between UNDP, Millennium Promise and The Earth Institute in New York. It uses a bottom up approach to lifting developing country villages out of poverty trap and aims at providing successful evidence on how to achieve MDGs by offering an integrated package of interventions at village level

**What is offered in PMTCT prong one and two**

* Condoms are distributed for both HIV prevention and family planning methods.
* Awareness campaigns are done on HIV/AIDS prevention, transmission, treatment and drug compliance
* Counseling and Testing in outreach clinics as well as at the VCT at the referral clinics
* Collection of CD4 count and dry blood samples and transportation of samples to Zomba Central hospital

**Lessons Learnt**

* Hard to involve men in PMTCT/hard to implement PMTCT without men involvement;
* Stigma and discrimination – no disclosure among couples leading to:
	+ Women not coming for CD4 count results
	+ No drugs compliance among women
	+ No baby feeding compliance and post natal follow up
* Community leaders need to take lead for men to be involved
* Deep rooted cultural norms need to be dealt with – e.g. women do not share information because they cannot tell a man what to do – that is why knowledge and action is different
* Ante-natal Clinics still being looked as an arena for women
* Outreach clinics not proving enough privacy – there is need for permanent buildings
* Acceptance of female condoms very low, therefore still rely on male condoms – this still gives power to a man

**Recommendations**

* There is need for partnerships for resource mobilisation
	+ In July 2010, MVP signed an MOU with UNAIDS to make MVPs, HIV/AIDS free zones
	+ MVP had a grant of US$52,000 for PMTCT interventions
	+ In Sep. 2010 MVP signed an MOU with UNFPA to strengthen SRHR in MVP.
	+ Strengthened working relationship with of Banja La Mtsogolo ( Marie stopes) in the impact area
* There is need to Intensify on the community mobilization
* Have built clinics – to help in privacy
* Conducting door to door visits providing the intervention

**Gender-Based Violence as a Component of Prongs One and two**

 *Dr.Lynn Collins*

**Issues**

The UN defines violence against women (VAW) as any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.

Violence against women includes sexual, physical, or emotional abuse by an intimate partner; physical or sexual abuse by family members or others; sexual harassment and abuse by authority figures (such as teachers, police officers or employers) and trafficking for forced labor or sex.

Systematic sexual abuse in conflict situations is another form of VAW.

Women’s experience (or threat or fear) of violence may lead to HIV infection as well as create barriers to women’s access to HIV services

**Challenges**

Gender inequalities are drivers of VAW, HIV, and barriers to services as follows:-

* Social, political, and economic gender inequalities
* Gender norms and roles that promote inequalities
* Cultural practices that shape and sustain inequalities
* Gender discriminatory policies, laws, and services
* Poor implementation of policies, laws, and services that promote gender equality
* The Global Fund has not been keen to fund GBV, but a review undertaken by some UN agencies revealed the link between GBV and HIV.

 **Recommendations**

* There is need to engage in risk reduction counseling.
* Mass media and community mobilization should be employed to increase awareness and change behaviours.
* Engage in Impact mitigation: HIV PEP & post-rape care services
* Increase capacity of health providers to
	+ understand clients’ rights and eliminate stigma
	+ identify VAW among clients and offer support
* Establish support groups or refer clients to those that exist
* Strengthen and link to programmes that engage men (facilitate access to services, etc.)
* A good model used in several countries include the linking of social, legal and law enforcement
* There needs to be an emergency preparedness for women during conflict situation
* Health workers should be trained to recognize GBV cases and clinical guidelines should be developed to assist health workers on dealing with GBV.

# Session 8: Specialized Services

**STI epidemiology, Prevention, Treatment and Management: An Overview***Dr Brian Pazvakavambwa, AIDS Team Leader, WHO.*

The main aims of STI control are as follows:-

* To interrupt the transmission of sexually acquired infections
* To prevent the development of diseases, complications and sequelae
* To reduce the risk of HIV infection
* **Major constraints/obstacles?**
* Stigma, discrimination and violation of human rights in relation to STI are still hampering a supportive and energetic response.
* A Global Strategy for the prevention and control of Sexually Transmitted Diseases was Adopted by the 192 Member states during the World Health Assembly in May 2006
* **Preventive Measures that are applicable**
* Take note of social and cultural environment
* Promote safer sexual behaviour
* Raise awareness of availability of vaccines
* Promote Other barrier/chemical methods
* **Recommendations**
* Prevention education and information to prevent acquisition & transmission of STIs
* Improve access to services for STI care at all levels and outlets of the health-care system
* Improve quality of care for STIs
* Promote early health-care seeking behaviour
* Promote effective partner notification and management
* Pursue a policy of integrated service delivery
* Explore strategies for case finding and screening for STIs, especially in women and adolescent males and females
* Enhance STI surveillance

**DISCUSSIONS**

* As STI seem to have gone off the radar, there is need to intensify advocacy initiatives.
* The challenge of MCP in STI control – interventions under development to address MCP
* There is need to incorporate STIs in HIV surveillance.

**Post-Abortion Care (Malawi)***Juliana Lunguzi, NPO, RH.*

**Issues**

Each year in the developing world, an estimated 210 million women become pregnant. Approximately 15 to 20 percent of these pregnancies will end in miscarriage, and 67,000 women will die from complications related to unsafe abortion. This represents 13 percent of all pregnancy-related deaths. Millions more women suffer serious illness and infertility.

Three core componentsof post-abortion care:

* Emergency treatment for complications of spontaneous or induced abortion
* Family planning counseling and services: depending on disease prevalence and available resources, sexually transmitted infection evaluation and treatment, and HIV counseling and/or referral for testing.
* Community empowerment through community awareness and mobilization.

**Challenges**

* Malawi—just like many countries with a high burden of mortality have no PAC activities—equipment and trained personnel remain a challenge.
* Non-availability of back-up services.
* PAC activities have not reached the majority of the population.
* PAC has been largely a medical model: community demand for high-quality post-abortion care is almost non-existence.
* There is a critical need for data for efficient and effective planning and for assessing impact. Data are necessary for demonstrating the unique contribution of PAC on maternal morbidity and mortality—a demonstration that is increasingly important given the high opportunity costs of any programme in developing countries.

**Recommendations**

* PAC programmes should devote more attention in training, monitoring, mentoring and supervision to ensure high-quality family planning and HTC services
* Knowledge, attitude and skills in family planning (FP), HTC; organization of FP and HTC services (physical location and space),
* Counseling services for FP and HTC within PAC services
* IEC materials linking PAC, HTC and FP-contraceptive supply and method mix,
* Privacy and integration with providers of FP/HTC services
* Community mobilization and male involvement.

**Management of Cervical Cancer**

*Dr Christine Kaseba-Sata,Consultant Obstetrician, Zambia*

**Issues**

Cervical cancer ranks as the most frequent cancer among women in Zambia. Annual new cases add up to about 1650 while annual deaths are estimated at 1340.

80% of the cases are at advanced stage at presentation. Cervical Cancer is heavily impacted by HIV/AIDS pandemic. Cervical screening coverage is at 3.1%. Smoking in women contributes 3.5% of the cases.

**Successes**

* Established a functional referral system within Lusaka
* Established see and treat approach
* Trained over 70 medical personnel
* PEPFAR sponsored site visits by African countries
* Established computer-based consultation for all trainees both local and abroad.
* Integrated STI screening and treatment
* From small beginnings of screening HIV positive women, this service has grown to a nationwide facility that is providing lessons to other countries as well.

**Challenges**

* Low screening coverage of the services.
* Late presentation of cases for treatment.
* Delay in processing specimens
* Data Inconsistencies.
* Long waiting time for radiotherapy.
* Inadequate linkages to ART
* High loss to follow up rates
* Only 49% referred to UTH keep appointment
* High equipment maintenance costs
* Inadequate human resource

**Recommendations**

* Adherence to follow-up visits is a challenge and requires significant investment
* Research should be undertaken to explore the effect of ART on disease progression and treatment outcomes
* ‘Screen and treat’ infrastructure is potential platform for implementation of HPV-based screening and vaccination programmes
* There is need to invest in development of appropriate HPV vaccines.

#  Session 9: Service Challenges and Resource Mobilization

**Resource Mobilization—The Global Fund***Dr Brian Pazvakavambwa*

The Global Fund (GF) is a partnership of the public sector (governments); civil society; the private sector and technical partners who have different roles to play. The GF recommends integrated approaches to achieve Millennium Development Goals (MDGs) 4 (reducing child mortality), 5 (improving maternal health) and 6 (combating HIV, malaria and other diseases) and improve health outcomes for women and children.

* Proposal Development - Overview
	+ - There are 4 months to develop & submit proposals
		- Proposal development is a country-led process
		- GF does not advise countries on precise contents of proposals
		- Technical Assistance is provided by partners (WHO, UNAIDS)
* In developing proposals, GF policy states that all 'Coordinating Mechanisms' must:
	+ - Ensure the input of a broad range of stakeholders
		- Have documented/transparent processes to:
			* solicit and review submissions of proposals for possible integration into a consolidated national proposal;
			* nominate the Principal Recipient(s)
* Key Issues for the CCM (and TRP!)
	+ - Is the Work Plan and Budget aligned with the strategy of the proposal and with each other?
		- Is the proposal consistent with existing grants and/or does it link to previous submissions?
		- Does the proposal anticipate future programme realities?
		- Who will implement programme? Is the PR known?
		- Are there any needs for technical and management assistance & are these clear?
* Service delivery areas supported by GFATM include:
	+ - HIV, TB and malaria prevention and care for women and children
		- Health and community systems
		- Gender equality and an enabling environment of women and girls
		- Any MNCH interventions directly or indirectly contributing to mitigation of the impact of HIV, TB and Malaria supported
* Interventions not currently supported include building hospitals, immunizations, nutritional supplements (e.g. Vitamin A, zinc, other micronutrients).
* How to Develop a Strong Proposal
	+ - Start early
		- Consult broadly and inclusively
		- Select PRs early
		- Identify barriers and develop solutions
		- Share potential priorities
		- Invite contributions
		- Finalize the application
		- Review the application

**Discussions**

* Need for greater involvement of UNFPA at Country Office and Regional level
* Need for UNFPA to fund Technical Assistance for proposal writing, with strong integration of SRH/HIV-AIDS
* Allocations are given according to Country specific needs and absorption capacity
* Countries to request Technical Support to drive implementation where required

**Session** **10: Mobilizing Technical Assistance**

**Mobilizing Technical Assistance**

*Dr Anthony Kinghorn: TSF Southern Africa*

*Ms Angeline Siparo: TSF Eastern Africa*

**TSF Southern Africa**

The Southern Africa Technical Support Facility (TSF) has been established to improve access to timely, high quality short-term technical assistance (TA) for scaling up national HIV and AIDS responses. TSF services are available to National AIDS Commissions, Health and other Ministries, as well as their international and national partners in the HIV and AIDS response.

The TSF is being supported by UNAIDS and UN Cosponsors as part of their strategies to help to strengthen co-ordination and capacity for effective HIV and AIDS responses at country level.

The TSF has a capacity development programme for consultants and country partners which builds capacity particularly in relation to new developments and emerging issues in the HIV and AIDS response.

The TSF is being managed by Health and Development Africa (Pty) Ltd. Consultants are sourced from a network of organisations and consultants throughout Southern Africa.

**TSF Eastern Africa**

The Technical Support Facility (TSF) for Eastern Africa has been established to respond to the growing demand for quality short term technical assistance (STTA) in strategic areas of planning and management for scaling up HIV and AIDS responses across Eastern Africa. The TSF is managed by CAFS and funded by UNAIDS as part of its strategy to help strengthen co-ordination and capacity for effective HIV and AIDS interventions in line with national priorities and plans. The TSF offers the following four main services:

* Provision of quality assured STTA under defined priority areas
* Capacity strengthening of country partners to plan and manage STTA
* Professional development of national and regional consultants
* Support to Global Fund recipients to enhance performance of grant implementation

**Areas of Technical Assistance**

The TSF can be accessed for client-focused technical assistance at no additional cost (UNAIDS covers operational costs) in any of the following areas:

* Monitoring and evaluation
* Resource tracking
* Strategic and operational planning
* Costing and budgeting
* Management, including financial management
* Organizational development
* Partnership development
* Gender & Mainstreaming of HIV and AIDS
* Prevention
* Other Thematic Areas

The TSFs encourages partners to do technical support planning and involve the TSFs early in order to facilitate effective planning, sourcing and management of consultancies for better results, as well as build capacity in emerging areas of need when necessary. However the TSFs can often respond quickly to urgent requests for TS and help to reduce the burden on partners in relation to sourcing and contracting

# *Country Plans*

Each country went into a brief planning session to outline possible implementation that would require technical support:-

**Angola**

* Disseminate the information from this conference, putting emphasis on Prong 1 and 2 as well as the integration of SRH and HIV/AIDS services.
* Finalise UNFPA projects plans and budgets of three more additional NGOs in order to scale up SRH and HIV prevention in Youth including young women in others 3 provinces.
* Continue to lobby with MOH to strengthen coordination of the M&E of the PMTCT programme –this is an ongoing process.
* Ministry of interior and Ministry of Family have an MoU (Memorandum of Understanding) with the UN to strengthen intervention on GBV on GBV, VIH/SIDA and SRH in the 5 provinces bordering countries of high HIV/AIDS prevalence.

**Botswana**

* Support government for development of SRH/HIV integration strategy
* Review of data collection tool to be harmonized for M&E of SRH and HIV
* Support intensification and expansion of use of visual inspection method for cervical cancer screening and management

**DRC**

* Rapid assessment
* Elaborate Road map for integration
* Submit proposal for Round 11 Global Fund –Maternal Health and Prong 1 and 2 to be inserted

**Ethiopia**

* For Prong 1 we want to do advocacy for partner testing, couple testing and male involvement
* Inclusion of indicator for Prong 2 at national level
* Include intervention on FP for HIV-positive women in CO CPD
* Rolling out of GBV service provision protocol – advocacy for scale up of the training for service providers

**Kenya**

* Government at steering wheel in support for phase 1 and 2 of the implementation plan
* Continuous M&E plan
* Support government in training care providers on comprehensive PMTCT

**Lesotho**

* Intensify integration and linkages
* Involve males in SRH and HIV
* Intensifying couple counselling and testing

**Malawi**

* Another round of rapid assessment – districts dissemination
* Community mobilization in 3 selected districts – Prong 1 and 2 advocacy
* CB of family planning providers on Prong 2, not enough follow-up after delivery

 **Namibia**

* SRH /HIV rapid assessment finalization: this will ensure that target gaps are identified
* PMTCT programme to reflect all 4 prongs, especially Prongs 1 and 2
* MTCT Elimination strategy

**Rwanda**

* A challenge for SRH/HIV integration is that technical working groups do not work integrated –e.g. FP; HIV
* Rapid Assessment on linkages –strategy not yet
* Global Fund – WHO in CCM—advocacy and participation in TWG for integration of linkages

**South Africa**

* Will do assessment – target identified for possible implementation of linkages
* Strengthen community mobilization, especially on Prong 1 and 2
* On Policy: Integration of Prong 1 and 2 into school health policy to address high teenage pregnancy.
* CB of health care professionals on Prong 1 and 2—curricula reviewed already

**Swaziland**

* Disseminate assessment to stakeholders
* Mid-term review of integrated SRH strategy – prongs 1 and 2 reflection
* Develop a package or service guidance for prong 1 and 2.

**Tanzania**

* Task force with MOH different branches and partners to share results of this meeting
* ToR bottleneck analysis for implementation are being developed
* Identify issues for developing MTCT elimination plan
* Stakeholder meeting in July – feedback on issues discussed here
* Review of updated PMTCT guidelines– all 4 prongs to be addressed
* SRH/ HIV integration activities – scale up initiatives Prong 2
* Identify internal capacity + external support needed for implementation plan

**Zanzibar**

* Provide feedback from meeting here
* Expand task force from assessment – more people needed to include Prong 1 and 2
* Integration strategy
* Develop package with essential services for both areas
* Necessity to carry issues to community –guideline or plan on communication and advocacy, especially Prong 1 and 2
* CB for sex workers including all prongs.
* Young people integration into UNDAP: YFS with comprehensive integration services, at least 1 model

**Uganda**

* Strategy on integration to be disseminated
* Implementation of guidelines on P1 and 2
* (Advocacy for) integration of indicators for P1 and 2 into other systems

 **Zambia**

* Finalize assessment – support development of service guideline
* Advocacy for strengthening PMTCT, esp. Prong 1 and 2 to support integration
* Cancer screening in two provinces supported by UNFPA

**Zimbabwe**

* Finalize draft service package Prong 1 and 2
* Finalize indicators for the service package
* Proposal development Round 11 GFATM –insert Maternal Health

# *Reception*

On the last day of the conference, the Malawi country office hosted a reception for the participants. During the reception, the UNFPA Malawi Country Representative thanked the participants for their dedication to the task at hand over the four days they were in the country.

He also expressed his sincere appreciation to SRO/RO for having confidence in Malawi to host this conference. He was hopeful that this conference will yield positive results in PMTCT programming especially around prongs one and two within UNFPA in this region. He was optimistic that with this training, countries will start seeing changes in the number of new cases among women of child bearing age and their children as well as seeing HIV pregnant women having access to Family Planning services.

He finally thanked the country team colleagues for working so hard in making the workshop successful. He then wished the participants a safe trip back to their respective countries and further extended his greetings to all the Representatives of the countries that had attended the meeting.

The reception was spiced by the Zikomo Cultural Troupe who entertained the participants with Malawian traditional dances.

# Annex 1: Program

|  |
| --- |
| **AGENDA****UNFPA sub-regional capacity building meeting on PMTCT** **FOCUSING ON** **PRIMARY PREVENTION OF HIV AND PREVENTION OF UNINTENDED PREGNANCIES** **16th to 19th of may 2011****LILONGWE, malawi** |
| **DAY ONE 16 May: Pre-meeting** | **Responsibility** | **Facilitator** |
| **15:30** | **Field Trip** | **Malawi CO to organise** | **Family Planning Association of Malawi Clinic/Kawale Health Centre**  |
| **DAY TWO 17 May****Rapporteurs:****Morning: Democratic Republic of the Congo****Afternoon: Swaziland** | **Responsibility** | **Facilitator** |
| **08:00 - 08:30** | **Registration** |
|  | **INTRODUCTORY SESSION**  | **Purpose, introductions, and logistics**  | **Mr. Humphrey Shumba** |
| **08:30 - 8:40** | **Welcome Remarks** | **Dr Margaret Agama** |  |
| **Purpose of the orientation**  | **Mr. Edwin Huizing, DirectorSRO/J** | **Dr. Florence Ebanyat** |
| **08:40 - 8:50** | **Overview and acceptance of the agenda** | **Mr. Humphrey Shumba** |  |
| **08:50 - 09:00** | **Rules/Norms of the workshop** | **Mr. Humphrey Shumba** |  |
| **09:00 - 09:10** | **Introductions** | **Mr. Humphrey Shumba** |  |
| **09:10 - 09:20** | **Administrative/Logistic Information and security briefing** | **Ms. Rose Khonje****Mr. Saleh Tembo** |  |
|  | **SESSION ONE** | **Background** | **Ms. Gift Malunga** |
| **09:20 - 10:10** | **Overview of the Global Landscape for the elimination of MTCT; and** **Overview of the implementation of Prongs One and Two within the sub-region** | **Dr. Lynn Collins****Dr. Margaret Agama** | **UNFPA** |
| **10:10 - 10:30** |  **HEALTH BREAK** |
|  | **SESSION ONE cont.**  | **Background** | **Ms. Gift Malunga** |
| **10:30 - 11:00** | **Discussion** |  |  |
| **11:00 - 11:20** | **Rationale of Prongs one and Two as a component of comprehensive PMTCT** | **Dr. Dorothy Mbori-Ngacha** | **UNICEF** |
| **11:20 - 11:40** | **PMTCT (Prongs One and Two) as a component of SRH/MCH services** | **Dr. Florence Ebanyat** | **UNFPA** |
| **11:40 - 12:00** | **Discussion** |  |  |
|  | **SESSION TWO**  | **Framework on Prongs 1 and 2** | **Ms. Gift Malunga** |
| **12:00 - 13:00** | **Prongs One and Two Framework** | **Dr. Lynn Collins** | **UNPFA HAB** |
| **13:00 - 14:00** | **LUNCH** |
|  | **SESSION TWO cont.** | **Framework on Prongs 1 and 2** | **Dr. Margaret Agama** |
| **14:00 - 14:40** | **Prongs One and Two Framework cont.** | **Dr. Lynn Collins** | **UNFPA-HAB** |
|  | **SESSION THREE** | **Barriers and challenges to service delivery** |  |
| **14:40 - 15:00** | **A clients perspective: Defining PMTCT(Prongs One and Two) services for clients** | **Mr. and Mrs. Sitolo** |  |
| **15:00 - 15:20** | **Providing (Prongs One and Two) services for clients-Malawi** | **Ms. F Chavula (Matron Bwaila Hospital)** |  |
| **15:20 - 16:00** | **Plenary discussion of country experiences and challenges around Prongs One and Two**  |  |  |
| **OPENING CEREMONY** | **Government Protocol** |
| **16:00 - 16:10** | **Message from Civil Society** | **Ms. Annie Banda (MANET+)** |  |
| **16:10 - 16:20** | **Message from UNICEF Sub-Regional Office (PMTCT)** | **Dr. Dorothy Mbori-Ngacha, PMTCT Advisor, UNICEF Sub-Regional Office** |  |
| **16:20 - 16:35** | **Welcoming Remarks**  | **Mr. Athanase Nzokirishaka, Representative of the Malawian UNFPA County Office**  |  |
| **16:35 - 16:50** | **Statement** | **Mr. Richard Dictus Malawi Resident Coordinator**  |  |
| **16:50 - 17:10** | **Keynote Address** | **Dr. Mary Shawa, Principal Secretary, Office of the President and Cabinet Office, Department of Nutrition, HIV/AIDS** |  |
| **OPENING CEREMONY TEA** |
| **17:30 - 18:00** | **Facilitators meeting** | **Facilitators & country office team** |  |
| **DAY THREE 18 May****Rapporteurs:****Morning: Ethiopia****Afternoon: Zambia** |  |  |
|  | **OVERVIEW DAY TWO** |  |  |
| **08:30 - 08:45** | **Overview day TWO** |  | **General Rapporteur** |
|  | **SESSION FOUR** | **Data, indicators and reporting** | **Dr. Lynn Collins** |
| **08:45 - 09:30** | **Modelling and costing for PMTCT-Prongs One and Two** | **Miss Erica Kufa** | **WHO – IST/ESA** |
| **09:30 - 10:20** | **Indicators/Data collection and reporting** | **Miss Erica Kufa** | **WHO – IST/ESA** |
| **10:20 – 10:45** | **HEALTH BREAK** |
|  | **SESSION FIVE** | **Building partnership and developing strategies** | **Dr. Dorothy Mbori-Ngacha** |
| **10:45 – 13.00** | **Country report**  |  | **UNFPA Angola** |
| **Building partnerships developing strategy for comprehensive PMTCT** |  | **UNFPA Rwanda** |
| **Integrated strategy development SRH/HIV-addressing Prongs One and Two as part of an SRH/HIV policy.** | **Examples from Kenya, Tanzania and Uganda** | **Kenya/Uganda/Tanzania Cos** |
| **13.00-14.00** | **LUNCH** |
|  | **SESSION 6** | **Country : Lessons Learnt** | **Mr. Kevin Osborne, IPPF** |
| **14.00-15.15** | **Country lead round table discussion on SRH and HIV linkages** | **Botswana, Lesotho, Malawi, Namibia, Swaziland, Zambia and Zimbabwe** | **Mr. Kevin Osborne, IPPF****(Discussion to include results of rapid assessment)** |
| **SRH of people living with HIV** | **Mr. Kevin Osborne, IPPF** |  |
| **15.15-15.40** | **HEALTH BREAK** |
| **15.40-16.00** | **Discussion session 5 and 6** |  | **Dr Dorothy Mbori-Ngacha** |
| **16.00-17.30** | **Briefing in ICASA** | **Dr Dorothy Agama** |  |
| **17.30-18.00** | **Facilitators’ Meeting**  |  |  |
| **DAY FOUR 19 May****Rapporteurs:****Morning: Nambia****Afternoon: South Africa** |  |  |
|  | **OVERVIEW OF DAY 3** |  |  |
| **08:30 - 08:45** | **Overview of day three** |  | **General Rapporteur** |
|  | **SESSION SEVEN** | **Specialized Programming** | **Dr. Cleverb, WHO** |
| **08:45 - 09:15** | **Programming for adolescents/young people and MARPs** | **Mr Matthias Chatuluka, Family Planning Association of Malawi** |  |
| **09:15 - 09:45** | **Engaging men in PMTCT** | **Vestine Mutarabayire Wibabara****Ms Thandie Mijoya** | **Rwanda Country Office/MVP(Malawi)** |
| **09:45 - 10:20** | **Discussion** |  |  |
| **10:20 - 10:45** | **HEALTH BREAK** |
|  | **SESSION EIGHT** | **Specialized Services** | **Dr. Florence Ebanyat** |
| **10:45 - 11:00** | **STI Management and Treatment** | **Dr Brian Pazvakavamba** | **WHO – IST/ESA** |
| **11:00 - 11:15** | **Post Abortion Care - Malawi** | **Ms Juliana Lunguzi** | **Malawi Country Office** |
| **11:15 - 11:30** | **Management of cervical cancers - Zambia** | **Dr Christine Kuseba-Sata** |  |
| **11:30 - 12:00** | **Discussion** |  |  |
| **12:00 - 12:30** | **GBV as a component of Prongs One and Two** | **Dr. Lynn Collins** |  |
| **12:30 - 13:00** | **Discussion** |  |  |
| **13:00 - 14:00** | **LUNCH** |
|  | **SESSION NINE** | **Service Challenges and Resource Mobilization**  |  |
|  | **Resource Mobilization—the Global Fund** | **Dr Brian Pazvakavamba** | **WHO – IST/ESA** |
|  | **SESSION TEN** | **Technical Assistance and Planning** | **Dr. Margaret Agama and Dr. Lynn Collins** |
| **14:00 - 14:45** | **Mobilizing Technical Assistance** | **Dr Anthony Kinghorn and Ms. Angeline Siparo** | **TSF-Eastern and Southern Africa** |
| **14:45 - 15:20** | **Country Planning**  | **Dr Margaret Agama****Dr. Lynn Collins**  |  |
| **15:20 - 15:45** | **HEALTH BREAK** |
| **15:45 – 17.0017:30** | **Country planning feedback** | **Dr Margaret Agama****NNMMMMMMMNNN** | **Dr**  |
| **Evaluation**  | **MMMMMMM** |
| **Closing**  |  |
| **18.00-20.00** | **Reception**  | **Malawi Country Office**  |
| **DAY FIVE 20 May** |  |  |
| **08:30**  | **Departure**  | **TBTBDDTTBD** | **Malawi Country office to organise** |

# Annex 2: Background to Field Visits

UNFPA Malawi Country Office will from 16-20th May 2011 host a Sub-Regional Capacity Building workshop on Prongs 1 & 2. As part of the programme activities, the Country Office in conjunction with the Sub-Regional Office and indeed national counterparts agreed to arrange field visits for the delegation to the workshop. The site visits are in support of the workshop overall objective and will add to the understanding of PMTCT programming in prongs 1 & 2.

**Proposed Sites**

Two sites have been identified. These are Family Planning Association of Malawi (FPAM) SRH/FP Clinic and Youth Centre in Kawale and the Government Health Centre just a few metres from the FPAM clinic both situated in Lilongwe (just a few kilometers from the hotel).

**What programmes will be visited**

At the FPAM Clinic, you will be taken around the clinic from the time clients are received to when they get services and referrals. You will also be introduced to young adolescents who are living positively with the virus. Meeting the young adolescents and hearing their stories will afford you the opportunity to reflect on how best and where we can intervene and come up with programmes within the continuum of the PMTCT prongs of care.

The visit to the Government Health centre is meant to give you an appreciation of progress being made in primary prevention and Family Planning for positive women and girls. It may also be interesting to see how referrals are made between the Family Planning clinic and the government facility.

**When is the visit**

The visit has been planned for the first day of your arrival. It is anticipated that most of the guests will have settled down and have relaxed (after check in at the hotel) by at least 2.00pm on 16th May 2011. The field visit is therefore expected to take place from 3.00pm to 5.00pm on arrival date.

**How will the visit be conducted?**

There will two teams. The first one will go to the Family Planning Clinic and the second team will start with the Health Centre. The two teams will then swap places allowing both teams to have a feel of the services being offered by both facilities. Time management will be of the essence and therefore punctuality is a must. Two buses will be available to ferry the guests to the two sites.

**Who are your contact persons for this field visit**

Your primary contact person is Humphreys Shumba – NPO – HIV Prevention (+265 888 865 316)

He will be assisted by Rose Khonje- Programme Associate (+265 888 201 146)

TAKULANDIRANI…..!!!!!

# Annex 3: Conference Evaluation

|  |  |
| --- | --- |
| RECOMMENDATIONS |  |
|  | **FREQUENCY** |
|  | Clear guidelines for implementation of prongs 1 & 2 should be developed and communicated to country offices | XXXXXXXXX |
|  | SRO needs to follow up on country progress | XXXXXXX |
|  | Background reading should have been provided beforehand.  | XXXXX |
|  | Annual meetings for monitoring & evaluation should be organized. | XXX |
|  | We needed time to see the city during daytime | XXX |
|  | Country experiences should have been given more time | XX |
|  | Next time consider a five-day meeting | XX |
|  | More time should be allocated to PMTCT and integration of RH and HIV | XX |
|  | Global guidelines to be completed and forwarded to countries soon | XX |
|  | UNFPA should have invited representatives from both SRH and HIV (PMTCT) departments especially from countries where prongs 1 & 2 are not part of PMTCT | XX |
|  | Clear indicators should be formulated | X |
|  | Provide more time for discussions |  |
|  | Similar workshop to be organised for MOH and national Aids commissions | X |
|  | SRO to help country offices on resource mobilization | X |

|  |
| --- |
| STRENGTHS |
|  |  | **FREQUENCY** |
| Design of Meeting | Well structured meetings | XXXXXXXXXXXXXX |
|  | Good and informative presentations | XXXXXXXX |
|  | Country participation was great | XXX |
|  | Country participation was great | XX |
|  | Involvement of different partners and other UN agencies | X |
| Field Visits | Good and informative | XXXXXXXXXXX |
|  | FPAM was well prepared and presented | XXXXXXXX |

|  |
| --- |
| WEAKNESSES |
|  | **FREQUENCY** |
| Design of Meeting | * Program overloaded
 | XXXXXXXXXXX |
|  | * Inadequate time to share experiences
 | XXXXXXX |
|  | * Inadequate focus on more concrete activities to implement prongs 1 & 2.
 | XXXXXX |
|  | * Limited Time
 | XXXXX |
|  | * Some presentations too generic
 | XXX |
|  | * Presenters seemingly not adequately briefed on expectations
 | XX |
|  | * Few participants from MOH
 | X |
|  |  |  |
| Field Visits | * Kawale clinic not well prepared
 | XXXXXXX |
|  | * Poorly scheduled (participants were tired)
 | XXXX |
|  | * Prior communication not adequate.
 | XX |

# Annex 4: Speeches

**Message from Civil Society:***Ms Annie Banda (MANET +)*

Distinguished participants;

On Sunday 15 May 2011, tens of thousands of people worldwide will light a candle on occasion of the 28th International AIDS Candlelight Memorial. In Malawi this is happening today. This year again on this occasion, community-based organizations in some 115 countries will use the event to remember those who have lost their lives to AIDS-related illnesses, to support those living with HIV and affected by its impact and to spur calls to action for greater awareness.

“The International AIDS Candlelight Memorial is an essential platform that allows the global health community to advocate for needed change,” said Global Health Council president and CEO Jeffrey L. Sturchio. “The Candlelight Memorial brings new voices to the fight against HIV/AIDS at an important time in the trajectory of the epidemic.” Important time in the trajectory indeed as new innovations are coming and better understanding of the epidemic is growing.

With the theme “Touching Lives…” the Candlelight Memorial is highlighting how HIV has touched the lives of many people. “Touching Lives…” also refers to how an improved HIV response with more treatment access, better prevention methods and respect for human rights and dignity touches the lives of people living with and affected by HIV.

I must say that I find this meeting a striking coincidence; coming hot on the heels of the Candle Light Memorial celebrations. As the theme suggests…Touching Lives…. ! I am hoping that so many lives here and beyond will be touched come Friday as a result of your resolve after this meeting.

“The Candlelight Memorial is therefore important to people living with HIV,” as Kevin Moody, CEO of the Global Network of People living with HIV said. “The memorial is more than a moment to remember our loved ones. It is a moment to look forward to the future of the HIV.”

“The only way to honor those who have passed away, is to do everything to improve the lives of people living with HIV,” he said.

We long for the future where poverty will be eradicated, and where every pregnancy is wanted, every birth is safe, every young person is free from HIV/AIDS and every girl and woman is treated with dignity and respect. Isn’t this why we are here today?

Distinguished delegates you may want to know that this year, the Candlelight Memorial falls three weeks before the United Nations General Assembly High Level Meeting on AIDS (HLM). Ten years ago, UN member states committed to achieving universal access to treatment, prevention, care and support by 2010. Universal access has not been achieved, but HIV treatment is working to slow down the HIV epidemic. HIV treatment keeps people living with HIV healthy, more productive and lowers the risk of transmitting HIV to others. To improve the lives of people living with HIV, a successful High Level Meeting will be important.

In June 2011, the member states are coming together again to review progress and chart the future course of the HIV response. Civil society and people living with HIV want the governments of the member states to commit to:

1. Achieving universal access to HIV prevention, treatment, care and support by 2015;
2. Respecting, protecting and fulfilling the human rights of people living with, and those most affected by HIV;
3. Introducing and promoting laws to protect the rights of people living with, and those most affected by HIV. Governments should review their laws, practices and policies and amend any that cause barriers to accessing HIV prevention, treatment, care and support services;
4. Involving people living with HIV meaningfully in decisions on national, regional and global levels of the HIV response;
5. Ensuring that country level HIV responses are transparent, accountable and inclusive of those most affected by HIV, particularly women and girls, young people, men who have sex with men, transgender people, sex workers and people who use drugs.

On behalf of MANET + and many of our gallant colleagues (living & fallen) in the fight against HIV/AIDS I would like to wish you all the best as you meet here in Lilongwe over this important topic of PMTCT.

I THANK YOU.

**Message from UNICEF Sub-Regional Office (PMTCT):***Dr Dorothy Mbori-Ngacha*

* All Protocol observed
* Ladies and gentlemen.
1. It is an honour and privilege for me to be here with you today at this important meeting.
2. I would like first and foremost to thank my colleague Margaret Agama for inviting me and I would also like to express my appreciation for being allowed to say a few words. I bring greetings from UNICEF ESAR Regional Office.
3. Ladies and Gentlemen, 90% of all new HIV infections in children worldwide occur in Sub-Saharan Africa. The majority of these infections are caused by vertical transmission from mother to child.
4. As you know, both the UN Secretary General and the UN’s joint programme on AIDS have called for the elimination of mother to child transmission of HIV by 2015.
5. We have made remarkable progress increasing access to PMTCT services with the main focus on delivering ARVs. However it is clear that to realise the goal of E-MTCT and the Millennium Development Goals, most notably, to reduce mortality (MDG 4), improve maternal health (MDG 5), and combat AIDS, malaria and other diseases (MDG 6) we will need to have a more comprehensive approach including primary prevention and prevention of unintended pregnancy which is the focus of this meeting.
6. To make this elimination a reality, it will also be important to refocus programs and services through an “equity lens”, thereby reaching those women who have thus far not been reached, including pregnant adolescents. It also means disaggregating data to identify gaps in coverage, access and utilization, as well as in removing bottlenecks so that inequities in supply and demand can be dealt with. And finally it means engaging communities to make sure that every pregnant woman goes to a health centre where MCH and PMTCT programmes are integrated.
7. At regional level, UNICEF is proud to partner with UNFPA, WHO and UNAIDS in jointly supporting countries through technical advice and financial support helping governments in setting standards,, modelling successful programmes and documenting both gaps ad results on the road to MTCT elimination.
8. The timing of this meeting could not be more perfect. Not only is MTCT elimination a possibility by 2015, but I am confident that with our collective hard work it will be a reality.
9. There is an Africa proverb that I love that says, “If you want to go FAST go alone but if you want to go FAR go together with others. I look forward to us working together on this journey towards MTCT elimination.

Thank You.

**Welcome Remarks:***Mr. Athanase Nzokirishaka, Country Representative for UNFPA, Malawi Office.*

The Principal Secretary in the Office Of the President and Cabinet Dr. Mary Shawa

The PS in the Ministry of Health

The UN Resident Coordinator Mr. Richard Dictus

Dorothy Mbori-Ngacha from UNICEF Sub-Regional Office (PMTCT)

Colleagues from the UN

Our Implementing Partners

Distinguished participants

Ladies and Gentlemen

Takulandirani- Welcome to Malawi !!!

It gives me great pleasure to be present at an opening ceremony of this important workshop for UNFPA whose aim is to strengthen policy and programming in PMTCT with particular focus in implementing the first two prongs of PMTCT; namely Primary prevention of HIV in women of childbearing age; Prevention of unintended pregnancies in women living with HIV (as part of rights-based sexual and reproductive health of people living with HIV).

As you all may be aware, HIV significantly impacts upon the developmental milestones of sub-Saharan African countries, such that health indicators like maternal, infant and child health gains made in the immediate post-independent era are constantly being threatened. About 60% of HIV infections in Malawi are among women (mostly of child bearing age). This picture is mirrored throughout the region where HIV has increasingly become feminised with an estimated 60% of PLHIV being female. The Eastern and Southern Africa sub-region has more than 60% of the global PMTCT burden and has 15 of the 25 high burden countries. South Africa, Mozambique, Uganda, Tanzania, Kenya, Zambia, Malawi, Zimbabwe and Ethiopia account for 55% of pregnant women living with HIV. Consequently, HIV-related conditions have become the leading cause of mortality in women of reproductive age in the sub-region. Something needs to be done and done with urgency!!!

Again as experts in this field, you are aware that HIV infection among childbearing women remains the main cause of HIV infection among children. More than 90% of infant and child infections occur through mother-to-child transmission, either during pregnancy, labour, or through breastfeeding. Without any intervention, about one in three children born to HIV-infected mothers will be infected. Therefore, comprehensive and widely available PMTCT programmes could substantially move the sub-Region towards preventing new infections through primary prevention and supporting women living with HIV prevent unwanted pregnancies through concerted efforts of governments and their partners to maximize the utilization of limited expertise and resources. I guess this why this meeting is being held here in Malawi at this critical and seemingly optune moment in the fight against HIV/AIDS.

It is therefore once again a great pleasure for me to be able to welcome you on behalf of my colleagues in UNFPA Country Office and indeed on my own behalf. We all look forward to the outcome of this meeting with great expectations. From the programme I find it well compacted and focused. I therefore have no doubt that this meeting being held here in Lilongwe for next four days will usher in a new era in our PMTCT programming especially on prongs 1 &2 where our niche lies as UNFPA.

I wish you all the best and enjoy the warmth of the people and the beautiful sceneries from the WARM HEART OF AFRICA.

Zikomo Kwambiri

Merci

Thank you !!!

**Statement:***Mr Richard Dictus, UNDP Malawi Resident Coordinator*

The Principal Secretary in the Office Of the President and Cabinet Dr. Mary Shawa

The PS in the Ministry of Health

The UNFPA Resident Representative Mr. Athanase Nzokirishaka

Madame Dorothy Mbori-Ngacha from UNICEF Sub-Regional Office (PMTCT)

Colleagues from the UN

Our Implementing Partners

Distinguished participants

Ladies and Gentle men

I am delighted and honored to have the opportunity to make this speech at this very important and timely workshop on PMTCT. As you are all aware, HIV/AIDS remains a major threat in the attainment of the MDGs by 2015 especially MDG 3 4and 5. For Malawi it is increasingly becoming clear that we have a long way to go to achieving MDG 3, 4 and 5. It is all the more reason why any efforts directed at realizing this goal are not only welcome but also encouraged. I therefore find this workshop which UNFPA has organized timely and relevant in the broader context of attaining several of the lagging MDG such as MDG 3, 4 and 5 as these are always inter-linked.

Of immediate concern for us now, today and this week is the PMTCT programming issues especially for prongs 1 and 2 aimed at addressing Primary prevention of HIV in women of childbearing age; Prevention of unintended pregnancies in women living with HIV. The challenges in PMTCT programming have been well articulated by my colleagues in their speeches before but what is important for us as the UN system in Malawi is the creation of an enabling environment for such interventions to effectively take place. Our Government counterparts often look up to us for technical support and guidance in these matters. That is why I find this meeting very relevant as a way of building our own internal capacities within UNFPA with which to support our Government and Civil counterparts in these highly technical areas.

One way of supporting our counterparts is to ensure that we have appropriate structures and frameworks that can be used to convey our support to Government. In this regard, you will be delighted to note that we are currently finalizing our new UNDAF for 2011-2016. I am pleased to inform you that in this new UNDAF tremendous efforts and huge investments have been made to ensure provisions for a comprehensive and well coordinated PMTCT programme that impacts on the new infections especially among women and children.

Just recently the UNAIDS Executive Director Michel Sidibé and United States Global AIDS Coordinator Eric Goosby co-chaired the first meeting of the Global Task Team to prepare the Global plan for the elimination of new HIV infections among children and keeping their Mothers Alive (GTT) via teleconference. More than a hundred participants joined the call covering 21 countries and 23 participating organizations. This high level of participation from all constituencies, including UN member states countries, donors, civil society, the private sector, foundations and international organisations, demonstrates the collective commitment to the virtual elimination of new HIV infections among children by 2015.

This meeting clearly showed the shared commitment of participants to contribute to the development of the plan and address the barriers at country level through coordinated action, collaborative problem solving and mutual commitment to progress. The meeting also called on countries to use new and sustainable models for innovation in leadership and governance to achieve the goal of elimination of new HIV infections among children and keeping their mothers alive.

There were several themes that emerged from the meeting and I would like to draw your attention to the theme on **New models of collaboration to achieve elimination.** The theme calls for **r**enewed focus on mothers, family planning and primary prevention of HIV among women of reproductive age. This is exactly what this gathering is trying to develop. This should therefore act as an encouragement to you all in knowing that our priorities as defined in this workshop have full international backing and are high on the agenda. I am convinced that eliminating new HIV infections among children and keeping their mothers alive are both extremely essential and achievable. Through renewed and more focused engagement, purposeful design and leadership, I believe we all can generate tangible results. This workshop is therefore an extremely huge opportunity to transform our programming in PMTCT as well as contributing to laying global foundation for a healthy HIV free generation.

I certainly did not plan to talk much but I guess it was important for me to share my understanding on these issues and indeed to also assure you of my support to this workshop. Please enjoy your time here in Malawi.

Thank you

Dankie

Zikomo

**CLOSING RECEPTION***Mr. Athanase Nzokirishaka, Country Representative for UNFPA, Malawi Office.*

The PS, OPC, distinguished guests, Colleagues from the UN, our esteemed implementing partners, dear participants to this workshop, Ladies and Gentlemen.

I am extremely delighted to hear that the workshop on PMTCT Prongs 1 & 2 which was being held here in Lilongwe went on so well and achieved its intended goals. When we took a decision to accept hosting this workshop, we had no clue whatsoever as to how it would go. And hearing that it has been an excellent workshop, it gives me all the reason to celebrate. And as you may all appreciate, this has been made possible because of the dedication and tireless efforts that so many of you put in, in making this a success. That is why I would like at this point to invite you to join me in thanking those us that were heavily involved in planning and making sure that this workshop was a hit.

Please let’s put our hands together for such people as Humpreys, Rose, Madalo, Veronique, Gloria, Frank and indeed the entire country office for making us proud in successfully hosting this workshop. Let me also thank our Sub Regional Office and the Regional Office for having confidence in us that we could do it, and indeed we have done it. YES, TOGETHER WE CAN.

Talking about this conference, we can not emphasize the importance of this conference. This is clearly echoed in your sentiments expressed by representatives from each country. I would like to read you some of the sentiments that were passed on to me. And indeed they express the mood and aspiration that we all hold after going through this conference.

Quotes:

Ethiopia: “The meeting was timely and dealt with critical issues on PMTCT Prongs 1 & 2 to make a difference in the lives of women and children”.

Kenya: “We all have been inspired by the presentations so so that we can continue to work even better towards integration of RH & HIV”.

Zambia: “Comprehensive PMTCT with special emphasis on Prongs 1 & 2 is a key to elimination of MTCT”.

Uganda: “The workshop comes at a time when we are developing an HIV Prevention Strategy in which issues of integration are featuring very high”.

These are just some of the sentiments from the countries represented here as to how they saw the conference and I think they are right in their assessment. But let me also add a quote from Malawi as it really summarises how we feel about the conference, and I quote:

“We feel greatly honoured to have hosted this important meeting here in Lilongwe, Malawi on PMTCT focusing on Prongs 1 & 2”.

Ladies and gentlemen, as I said this is not time to make speeches, but rather to interact after four days of hard work. Once again let me thank our regional office, all the Representatives of various offices who agreed and accepted to release you to attend this conference, please pass my greetings and those of my colleagues from Malawi, to all your Representatives. You have been such a wonderful group of people.

Thank you very much and Bon Voyage.

# Annex 5: Logistics Report

UNFPA Malawi accepted to host the above conference which took place at Crossroad Hotel, Lilongwe from 16-20 May 2011. A task force was instituted to work with the Sub- Region Office in ensuring that necessary arrangements are done to make the conference a success. The following people were selected in the task force:

1. Humphreys Shumba – Programme Focal Person
2. Rose Khonje – Logistical Focal Person
3. Madalo Khoza – IT Support
4. Gloria Mpelembe - Member
5. Veronique Omar - Member
6. Frank Gondwe - Transport Assistant
7. Joseph Mabutao – Transport Assistant

The task force was in touch with the Sub Regional Office to ensure all necessary requirements were in place. This was done through e-mails, telephone calls and tele-conferences. The following issues were agreed to take place:

* Participants to pay for their own accommodation bills only
* Hire coasters to felly participants to and from the airport
* Provide a separate room for secretarial services where participants would access internet
* Hire a Cultural Troup to perfume during the Reception
* All presentations and background documents to be copied to memory sticks that could be distributed to all participants
* Local presenters coming from outside Lilongwe to receive an allowance

Below is a summary of expenses incurred during the conference:

| **Req. No.** | **Vendor** | **Amount****MWK** | **Details** |
| --- | --- | --- | --- |
| 2749 | Cash refund for visa applications. DRC & Rwanda | 20,000.00 | The CO paid to the Immigration office and it was processing visa for participants from DRC and Rwanda. Need to refund cash to Paul Makwinja |
| 2753 | Local DSAs, Manet+, Couple Living +, Hospital Matron, MVP, Independent Consultant, Mr. Bridget Chibwana | 209300.00 | Local presenters on various topics. These include: Matron from Bwaila Hospital, couple living positive, and MVP representative |
| 2760 | Planet Car Hire | 86,247.10 | Provided two coasters: ferried participant from the airport on arrival and on return. One coaster was also used to transport dance troupe member (13 people) to their various destinations within the city. |
| 2762 | Zikomo Cultural Troupe | 40,000.00 | Hired to perfume during the Reception on 19.5.2011 |
| 2763 | Stationery supply | 217,437.49 | Stationery used during the entire period. Note the memory sticks were purchased by the Sub-Regional office  |
| 2764 | IT Support by AH Networks  | 600,500.00 | Provided 6 computers for internet access. |
| 2768 | Consultancy fee for the Chief Rapportuer, Rev Patrick Semphere (Dawn Consultants) | 208,800.00 | Amount to be paid in two trucks. 30% upon signing of a contract, and 70% upon submission of the conference report |
| 2775 | Overtime worked by the task force  | 147,329.14 | Rose, Gloria, Madalo, Veronique, Frank |
| 2776 | Payment to Crossroads Hotel | 1,818,931.00 | Conference facilities, Reception |

# Annex 6: List of Facilitators

| **Country** | **Name of Facilitator**  | **Title/Organisation**  | **Email address** |
| --- | --- | --- | --- |
| 1. Angola
 | 1. Dr. Frank Mpoyo Lusaia
 | NPO for RH/HIV/AIDSUNFPA | *lusaia@unfpa.org* |
| 1. England
 | 1. Kevin Osborne
 | Senior HIV Adviser, International Planned Parenthood Federation ( IPPF).  | KOsborne@ippf.org |
| 1. Kenya
 | 1. Kjetil Bordvik
 | RH Programme OfficerUNFPA  | *bordivik@unfpa.org* |
| 1. Angeline Siparo
 | TSF Eastern Africa | *asiparo@cafs.org* |
| 1. Malawi
 | 1. Ms. Thandie Mijoya
 | Health Coordinator, Millenium Village Project | *thandiwe.mijoya@mvp.org.mw* |
| 1. Ms. Juliana Lunguzi
 | NPO (RH) UNFPA Malawi  | *jlunguzi@unfpa.org* |
| 1. Ms. F Chavula
 | Matron, Bwaila Clinic. |  |
| 1. Mr Matthew Chatuluka
 | Director of Programmes, Family Planning Association of Malawi | *fpam@fpamalawi.org* |
| 1. Patrick Semphere
 | Chief Rapporteur | *psemphere@hotmail.com* |
| 1. Rwanda
 | 1. Amadou Seck
 | Youth/Adolescent Specialist, UNICEF | *aseck@unicef.org* |
| 1. Vestine Mutarabayire
 | UNFPA, NPO - HIV/AIDS Prevention | *mutarabayire@unfpa.org* |
| 1. South Africa
 | 1. Dr Dorothy Mbori–Ngacha
 | Snr. HIV/AIDS Specialist (UNICEF) | *dmboyingacha@unicef.org* |
| 1. Dr. Margret Agama
 | HIV/AIDS Advisor, SRO | *agama@unfpa.org* |
| 1. Dr. Ebanyat
 | RH/MH Technical Advisor, SRO | *ebanyat@unfpa.org* |
| 1. Dr Anthony Kinghorn
 | TSF Southern Africa | *akinghorn@hda.co.za* |
| 1. Tanzania
 | 1. Dr. Deborah Kajoka
 | National PMTCT Coordinator | *dkajoka@yahoo.com* |
| 1. USA
 | 1. Dr. Lynn Collins
 | HIV Technical Advisor | *collins@unfpa.org* |
| 1. Zambia
 | 1. Christine Kaseba Sata
 | Consultant Obstetrician | *cmkaseba@yahoo.com* |
| 1. Zimbabwe
 | 1. Dr. Brian Pazvakavambwa
 | AIDS Team Leader, WHO | *pazvakavambwab@who.int* |
| 1. Ms. Erica Kufa
 | Data Manager, WHO | *kufae@zw.afro.who.int* |

# Annex 7: List of Participants

| **Country** | **Name of Participant** | **Title** | **Email address** |
| --- | --- | --- | --- |
| 1. Angola
 | 1. Dr. Ana Leitão
 | UNFPA NPO for RH/HIV/AIDS | *Leitao@unfpa.org* |
| 1. Antonia Ngueve Manuel Pedro
 | PMTCT Focal point MIINSA (Enfermeira). | *to.**pedro76@hotmail.com* |
| 1. Botswana
 | 1. Ms. Chipo Petlo
 | Regional Coordinator, PMTCT (North) | *cpetlo@yahoo.com* |
| 1. Kabo Tautona
 | NPO, SRH | *tautona@unfpa.org* |
| 1. Sarah Masale
 | Assistant Representative | *masale@unfpa.org* |
| 1. DRC
 | 1. Dr. Bora Kawende
 | NPO SRH/FP | *bora@unfpa.org* |
| 1. Dr. Alphonse Matondo
 | NPO HIV/AIDS  | *matondo@unfpa.org* |
| 1. Ethiopia
 | 1. Dr. Beyeberu Assefa
 | NPO—SRH/HIV | *bassefa@unfpa.org* |
| 1. Fikir Melesse
 | NPO—SRH/HIV | *fikirm@et.afro.who.int* |
| 1. Kenya
 | 1. Dr. Geoffrey Okumu
 | NPO RH/HIV prevention | *okumu@unfpa.org* |
| 1. Lesotho
 | 1. Seipati Matsepeli Nchepe
 | PMTCT Programme Officer | *simotsei@yahoo.co.uk* |
| 1. Anna Makapa Kampong
 | HIV Prevention Programme Manager | *kampongannamakapa@gmail.com* |
| 1. Mamorao Mable Khaebana
 | NPO HIV Prevention  | *khaebana@unfpa.org* |
| 1. Malawi
 | 1. Dorothy Nyasulu
 | Assistant Representative | *Nyasulu@unfpa.org* |
| 1. Humphreys Shumba
 | HIV Prevention Officer | *Shumba@unfpa.org* |
| 1. Bridget Chibwana
 | Independent Consultant (HIV/AIDS) | *chibwanab@gmail.com* |
| 1. Gloria Mpelembe
 | Fin/Admin. Associate | *Mpelembe@unfpa.org* |
| 1. Hans Katengeza
 | RH, Programme Officer | *hansrobertkatengeza@yahoo.co.uk* |
| 1. Rose Khonje
 | Programme Associate | *Kamanga@unfpa.org* |
| 1. Grace Hiwa
 | NPO, RH | *hiwa@unfpa.org* |
| 1. Namibia
 | 1. Dr. Tomas Zapata-Lopez
 | SRH/HIV Programme Analyst | *tlopez@unfpa.org* |
| 1. Ms. Grace Hidinua
 | HIV Programme Officer | *hidinua@unfpa.org* |
| 1. Dr. Florence Soroses
 | PMTCT Project Coordinator; MoHSS | *fsoroses@globalfund.com.na* |
| 1. Rwanda
 | 1. Alphonse Munyakazi
 | UNFPA, Assistant representative/SRH | *munyakazi@unfpa.org* |
| 1. South Africa
 | 1. Ms. Josephine Sithole
 | PMTCT Training Coordinator  | *SitholP@health.gov.za* |
| 1. Ms. Meisie Lerutla
 | UNFPA NPO-RH  | *lerutla@unfpa.org* |
| 1. Ms. Linda Naidoo
 | UNFPA NPO-Kwazulu Natal  | *naidoo@unfpa.org* |
| 1. Christine Schuster
 | JPO HIV/AIDS | *cschuster@unfpa.org* |
| 1. Swaziland

  | 1. Margaret Thwale-Tembe
 | Programme Specialist-SRH | *thwala-tembe@unfpa.org* |
| 1. Sanelisiwe Tsela
 | HIV Prevention Analyst | *tsela@unfpa.org* |
| 1. Thembesile Dlamini
 | Social Mobilization & Partnership Advisor | *dlaminit@unaids.org* |
| 1. Dr. Chilanga Asmani
 | UNFPA Programme Specialist – HIV | *asmani@unfpa.org* |
| 1. Ms. Felister Bwana
 | UNFPA Programme Analyst SRH/HIV Zanzibar | *bwana@unfpa.org* |
| 1. Hamida Omar Bungalah
 | PMTCT Coordinator, Zanzibar/Tanzania | *nami\_bungalah@yahoo.co.uk* |
| 1. Uganda
 | 1. Rhoda Wanyenze
 | Lecturer/Programme Manager School of Public Health | *rwanyenze@hotmail.com* |
| 1. Dr. Godfrey Esiru
 | PMTCT Manager, MoH | *godfreyesiru@gmail.com* |
| 1. Rosemary Kindyomunda
 | NPO, HIV/AIDS | *kindyomunda@unfpa.org* |
| 1. Zambia
 | 1. Dr. Salai Bvulani Malumo
 | NPO, RH | *malumo@unfpa.org* |
| 1. Elizabeth Kalunga
 | Midwifery Advisor | *kalunga@unfpa.org* |
| 1. Zimbabwe
 | 1. Daisy Nyamukapa
 | HIV Prevention Services Officer | *nyamukapa@unfpa.org* |
| 1. Edwin Mpeta
 | NPO, RH | *mpeta@unfpa.org* |

# Annex 8: References

1. IATT: Guidance on Global Scale Up of the Prevention of Mother to Child Transmission of HIV, 2007.
2. IPPF, UNFPA, WHO, UNAIDS, GNP +, ICW and Young Positives, Rapid Assessment Tool for Sexual & Reproductive Health and HIV Linkages: A Generic Guide, 2009.
3. UNAIDS, UNAIDS Outcome Framework: Business Case Preventing Mother-to-Child Transmission of HIV, 2010.
4. WHO, Guidelines on HIV and infant feeding: Principles and recommendations for infant feeding in the context of HIV and a summary of evidence, 2010.
5. \_\_­­\_\_, Antiretroviral Therapy for HIV infection in Adults and Adolescents: Recommendations for a Public Health Approach, 2010 revision.
6. \_\_­­\_\_, Priority Interventions HIV/AIDS Prevention, Treatment and Care in the Health Sector, 2010.
7. \_\_­­\_\_, Antiretroviral Therapy for HIV infection in Adults and Adolescents Recommendations for a Public Health Approach, 2010
8. \_\_­­\_\_, Antiretroviral Therapy for HIV Infection and Children: Towards Universal Access. Recommendations for a Public Health Approach, 2010 Revision.
9. \_\_­­\_\_, PMTCT Strategic Vision 2010 – 2015.
10. \_\_­­\_\_, Call to Action: Towards an HIV-free and AIDS-free Generation. Prevention of Mother to Child Transmission (PMTCT) High Level Global Partners Forum, Abuja, Nigeria, December 3, 2005.
1. WHO PMTCT Strategic Vision 2010 - 2015 [↑](#footnote-ref-1)
2. UNAIDS Outcome Framework: Business Case Preventing Mother-to-Child Transmission of HIV, 2010 [↑](#footnote-ref-2)
3. IATT (2007): Guidance on Global Scale Up of the Prevention of Mother to Child Transmission of HIV [↑](#footnote-ref-3)
4. Call to Action: Towards an HIV-free and AIDS-free generation. Prevention of Mother to Child Transmission

(PMTCT) High Level Global Partners Forum, Abuja, Nigeria, December 3, 2005. Geneva, World Health

Organization, 2005 (http://www.who.int/hiv/mtct/pmtct\_calltoaction.pdf, accessed 13 June 2007). [↑](#footnote-ref-4)