

**ICAP Collaborative PMTCT and Pediatric HIV Strategic Planning Workshop  
In Partnership with Tygerberg Children's Hospital, South Africa and S2S**

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| Title:                            | <b>CROI Updates: Findings from recent studies: ART for the prevention of <i>postnatal</i> MTCT</b>  |
| Country:                          | New York  |
| Host Name/Title:                  | Elaine Abrams, MTCT-Plus Director   |
| Session Goal:                     | To discuss and synthesize relevant CROI 2008 conference information, including new research findings that have programmatic and policy implications ( <i>for a program and non clinical audience</i> )  |
| Learning Objectives:              | <ol style="list-style-type: none"> <li>1. To describe the results of recently completed studies for the prevention of postnatal mother-to-child transmission.</li> <li>2. To estimate the potential benefits and risks of extended daily nevirapine to infants for prevention of postnatal MTCT.</li> <li>3. To estimate the potential benefits and risks of HAART to mothers during breast feeding for prevention of postnatal MTCT.</li> <li>4. To examine the implications of these study findings on the implementation of programs</li> <li>5. To assess the feasibility of introducing ART regimes for mother and/or baby in PMTCT programs.</li> <li>6. To propose strategies to introduce new PMTCT regimens on a national and program level</li> </ol>   |
| Instructional Method(s):          | <ul style="list-style-type: none"> <li>● Lecture format with open-ended question and answer period</li> <li>● Compare and contrast</li> <li>● Problem solving (creative and reflective)</li> </ul>  |
| Session Description (with times): | <p><b>0-30 minutes</b></p> <ul style="list-style-type: none"> <li>● Dr. Abrams will provide a review of key findings presented at the 15<sup>th</sup> annual CROI conference in February 2008.</li> <li>● The review will focus on three studies (SWEN, PEPI, KIBS) of antiretroviral agents for the prevention of PMTCT during breast feeding.</li> <li>● During the talk participants will be able to ask questions to clarify scientific and technical points.</li> </ul> <p><b>31-45 minutes:</b> An open-ended question and answer section to address questions prompted by the lecture.</p> <p><b>45-70 minutes:</b> Participants will be divided into 3 groups to develop optimal approaches to the following scenario:</p> <ul style="list-style-type: none"> <li>● Assuming that WHO recommends the use of ART for postnatal prevention of MTCT what are the steps that will need to be taken to implement these interventions? <ol style="list-style-type: none"> <li>1. on a national level</li> <li>2. on a program level in the field</li> <li>3. on a community level</li> </ol> </li> <li>● Each group will be asked to identify barriers and challenges as well as proposed solutions and strategies.</li> </ul> <p><b>71-90 minutes</b></p> <ul style="list-style-type: none"> <li>● Each group will provide a bullet list summarizing steps identified during the problem solving activity. Activities will be tied together to develop a matrix for program implementation.</li> <li>● Host will summarize and close the session.</li> </ul> |

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| Equipment Needed: | <ul style="list-style-type: none"> <li>● Computer projector</li> <li>● Flipcharts</li> <li>● Mobility of seating to accommodate different activities</li> </ul> |
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### Session Notes and Summary

**Session name:** CROI update for the non clinical participant

**Note taker name:** Ruby Fayorsey

#### Major Discussion Points and/or Conclusions:

After the lecture by Dr Abrams, participants spent the rest of the time asking questions. There was no group activity as originally planned due to time constraints.

1. Extended prophylaxis for infants is safe and effective in reducing postnatal transmission via BF however there are concerns about resistance.
2. Women at highest risk of PN transmission are those with low CD4 count. Women with CD4 < 350 account for 82 percent of transmission and of PNT. Can we lower threshold for pregnant women to initiate HAART?
3. There were high rates of transmission after 6 months despite encouraging mothers to wean at 6 months in both PEPI and SWEN. May be mothers still continued to BF and like in ZEBS if they weaned and put the child back to the breast there may be an increased risk in PNT.
4. How can we identify postpartum women in need of ART and start them on treatment? Have mothers get repeat CD 4 at 6 weeks post partum, when infant gets the first DNA PCR and repeat again at 6 months post partum. Post partum women identified at the immunization clinics etc, should be expedited for HAART if they are eligible.
5. Since both interventions have about same efficacy which is programmatically more easy to adopt and implement? Maternal HAART is easier programmatically. However need to monitor for toxicity? There still issues around how long should you treat them? For the duration of BF? Most studies advised mothers to wean early, all the studies adhered to the old WHO recommendations on infant feeding.
6. Why does exclusive breastfeeding decrease MTCT of HIV? Complex proteins found in formula and solids cause gut inflammation in infants which makes the gut wall leaky and as such increase the risk of passage of HIV present in BM if mother mix feeds. Exclusive BF in the first 6 months of life protects the gut mucosa and decreases rick of PNT because there are less breast problems such as mastitis, breast abscesses and cracked nipples which are associated with increased PNT. Around 6 months of age the gut is more mature and can handle complex proteins
7. In PEPI and SWEN were mothers given HAART? It varied considerably. May be in India and Uganda women were given HAART later on in the study, not in Ethiopia and Malawi.

8. Infant feeding counseling messages usually reflect the HCW biases. In SA most HC workers realize that the government does not provide enough formula for women and their infants. The same amount of formula is provided each month, despite the fact that infants are growing and need more formula. Because of stock out HCW are now advising mothers to EBF. Is it possible in situations where formula is provided to keep the formula and provide it after 6 months, when mothers need to add complementary foods?

9. What was the cause of infant death? Most were not HIV related. Infants who were determined to be HIV infected were given treatment if they were eligible. All infants received CPT which was standard of care.

**Remaining Questions/Parking Lot Items:**

When can you safely stop HAART in a woman who is breast feeding?

Are there any studies looking at maternal outcomes?

What will it take to implement postnatal prophylaxis in the field?

What treatment options for infants who become infected despite maternal HAART?

**Agreed Upon Next Steps:**

Participants agreed that at all sites

- Sick pregnant and postpartum women should be prioritized for HAART
- Check CD 4 in postpartum women who are breast feeding and place them on HAART if eligible, programmatically this can be attached to the infant PCR at 6 weeks
- Continue encouraging EBF for infants