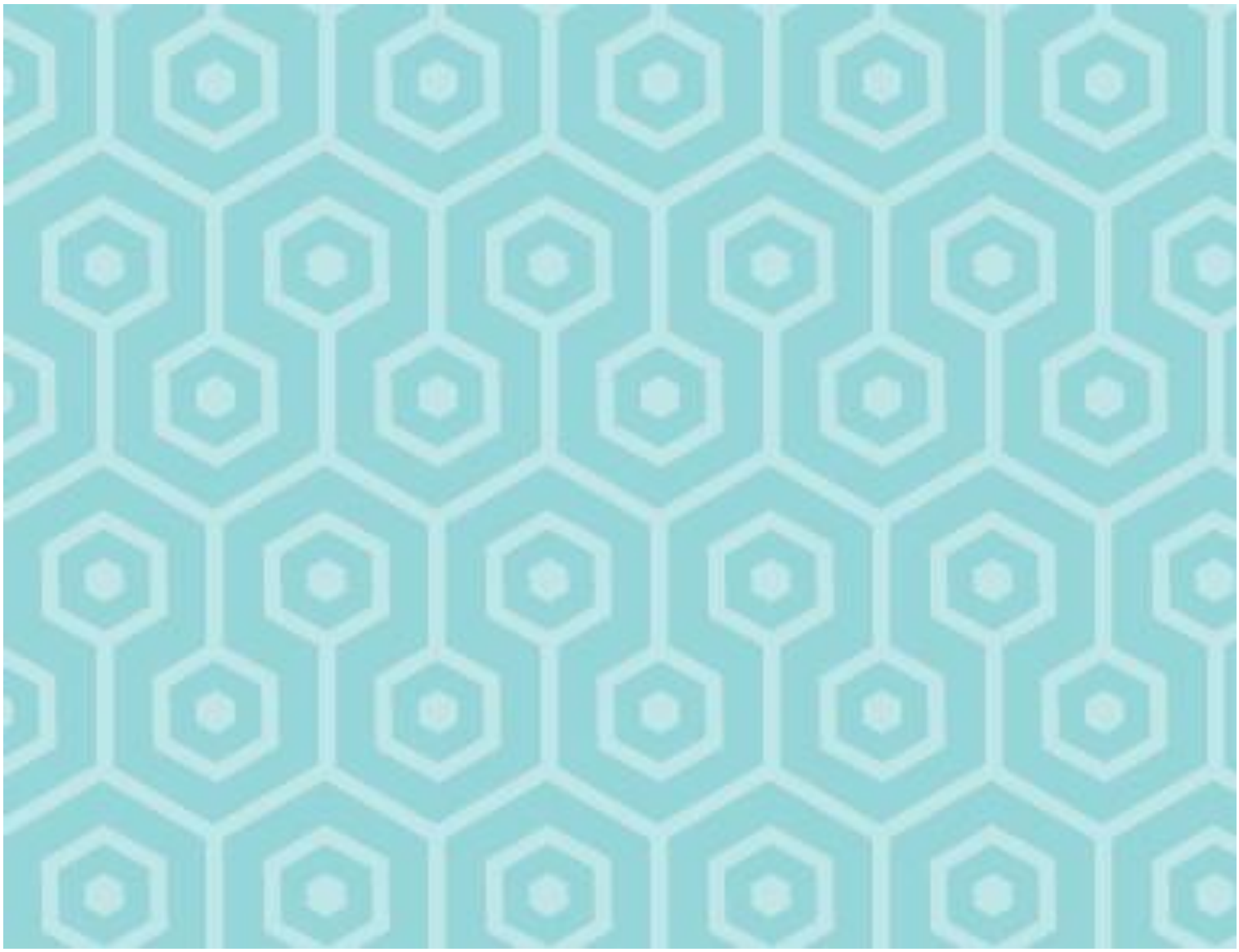
Elimination of mother-to-child transmission

UBRAF 2016-2021 Strategy Result Area 2



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Strategy Result Area 2: New HIV infection among children eliminated and their mothers' health and well-being is sustained

Comprehensive eMTCT services

The scale-up of prevention of mother-to-child (PMTCT) services is one of the greatest global public health achievements of the last decade. In 2016, 76% of pregnant women living with HIV received effective antiretroviral medicines (ARVs), up from 74% in 2015 and from a baseline of 36% in 2009 . The eastern and southern Africa (ESA) region, home to 50% of new HIV infections in children aged 0–14, had 88% of pregnant women receiving effective ARVs, the highest proportion, followed by 75% in Latin America and the Caribbean, and 54% in east Asia and the Pacific. Of concern is the low coverage in west and central Africa (49%), the region with the second highest burden of new HIV infections in children.

To build on the inspirational Global Plan, and ensure the sustainability of gains made, an eMTCT last mile agenda was adopted by the Joint Programme that includes integrating services using different service delivery platforms to close gaps in coverage. Building on the relatively high utilization of antenatal care in many regions and countries, UNICEF supported maternal, newborn and child health (MNCH) programmes to integrate PMTCT within national policies, guidelines and standard packages of services at all levels. Effective integration often entailed routine HIV testing of pregnant and breastfeeding women, offer of male partner testing as part of the package of care, provision of effective ARVs, monitoring retention in care, providing adherence support for pregnant and breastfeeding women diagnosed with HIV, infant HIV diagnosis, ARV prophylaxis for HIV exposed children and infant feeding support. In 2017, UNICEF and WHO supported the eMTCT last mile agenda, promoting the use of data at decentralized levels to further reduce infections by implementing differentiated eMTCT responses. Examples include: introducing subnational data dashboards and performance reviews to address remaining programme bottlenecks in poor performing areas; improving retention of pregnant and breastfeeding women initiated on ART through reminders for clinic appointments (the remind me SMS platform); and community-based support strategies.

WHO together with UNICEF hosted a community consultation to strengthen the dialogue between governments and civil society and propose concrete actions to improve service utilization, retention, adherence and quality of care for women, adolescents and children with HIV. WHO finalized implementation of science projects under the INSPIRE project and gathered lessons learned in a journal supplement launched in July 2017. Additionally, UNFPA

worked to strengthen the delivery of family planning services to the last mile by strengthening the reproductive health commodity supply chain, including in humanitarian settings, and ensuring a choice of contraceptive options, including those that can be safely used by women living with HIV, was available at all service delivery points.

WFP worked with partners to integrate food and nutrition support in PMTCT programmes and MNCH services provided to pregnant malnourished women. This was mainly done through technical assistance to governments, including by supporting the development of guidelines and educational materials. In many contexts, WFP targets pregnant and lactating women, PMTCT clients and children in its food and nutrition support. This can have an impact on adherence to PMTCT, as well as better health outcomes for newborns. For example, WFP supported Liberia's Government to develop an Essential Package of Health Services in 2011, which emphasized maternal and child health services. In 2017, through the intervention, WFP reached 822 PMTCT clients and supported 1610 PMTCT household members by providing food assistance to support treatment adherence. In Ethiopia, 99.8% of PMTCT clients receiving WFP food assistance attended all their clinical appointments and 99.6% of newborn babies were negative

In the biennium 2016-2017, the World Bank placed strong emphasis on the integration of HIV maternal and child health programmes, using two innovative financing initiatives. The Global Financing Facility (GFF) and the results-based financing (RBF) programme supported more than 35 maternal and child health projects around the world to improve the health of women, children and adolescents by financing high-impact, evidence- and rights-based interventions, and building resilient systems to increase the use of primary maternal and child health services at facility and community level and the integration of sexual and reproductive health (SRH) and HIV services.

The implementation process was country-led and the interventions context specific to address barriers, thereby resulting in increased provision of reproductive, maternal, newborn, child and adolescent health (RMNCAH) information and greater coverage of equitable, high-quality services. For example, in Zimbabwe, the World Bank RBF grant is increasing coverage of key maternal and child health interventions, including for HIV positive mothers and children, and covering a total population of approximately 4.1 million people. Additionally, through its allocative efficiency studies, the World Bank helped governments in target countries to identify priority funding needs, including: analysis of PMTCT programmes; evaluation of costs, quality and impact of expanding coverage of integrated HIV, PMTCT and SRH services to rural and semi-rural locations, improving HIV testing and counselling (HTC) among

pregnant women; and improving access to family planning and antenatal care for women living with HIV.

UNHCR played a pivotal role in ensuring equity in programming, advocating for refugees, asylum seekers and other populations affected by humanitarian emergencies to have the same access to eMTCT services as host communities, for urban and out-of-camp populations, and those in camps. In 2017, UNHCR conducted a review of HIV prevention policies and practices in 10 operations from different regions, with a focus on eMTCT in humanitarian settings. UNHCR achieved a global PMTCT coverage (proportion of first time ANC visits who were pre-test counselled) of 86% in humanitarian settings, both in and out of camp operations. Recognising that elimination goals are hampered by low rates of retention in care, UNHCR established mother support groups to improve rates and mobilise community support in camp settings and supported implementing partners to provide eMTCT services.

The Inter-Agency Task Team (IATT) on HIV in Emergencies, convened by WFP and UNHCR, completed an online Distance Learning Module on PMTCT in emergency contexts in 2017. This Module will be rolled out to UNHCR staff and other humanitarian partners in 2018. In Somalia, WFP and UNICEF held a sensitization workshop on PMTCT, training HIV peer educators on nutritional assessments and providing education and counselling to clients in the Puntland area where they are currently serving as community nutrition workers. In collaboration with UNHCR, UNICEF and WHO, and NGO partners, the World Bank facilitated access to eMTCT services in humanitarian emergencies. In the biennium, through the International Development Association (IDA), the Bank doubled its overall resources for fragility conflict and violence-affected countries to some US$ 14 billion.

In 2017, UN joint work on elimination of mother-to child transmission of HIV and syphilis as a public health problem continued to gain momentum. Since 2015, WHO, at its headquarters and regional offices, with support from UNAIDS and UNICEF, has led a global validation process. WHO serves as the secretariat for the Global Validation Advisory Committee (GVAC), a group of international experts in eMTCT, including community representatives and human rights experts, and convenes regular meetings to determine whether countries have met criteria for validation of elimination, or steps to elimination. By the end 2017, 11 countries had been validated for eMTCT of HIV and/or syphilis and all regions had established validation structures. The two WHO regions of Western Pacific and the Americas have committed to the triple elimination of mother-to-child transmission of HIV, syphilis and hepatitis B.

Additionally, the UNAIDS Secretariat supported the International Community of Women living with HIV (ICW) and Global Network of People Living with HIV/AIDS (GNP+) to develop a framework and criteria, under the aegis of the GVAC, to evaluate how national efforts to end vertical transmission were meeting human rights, gender equality and community engagement standards. An assessment tool, which has been included in the second edition of the eMTCT global validation guidance, measures readiness for the validation and progress towards a human rights-based approach to the prevention of mother-to-child transmission of HIV and syphilis. It also assesses implementation of good practices regarding gender equality and community engagement. The tool is a collection of human rights issues identified by women living with HIV as the main barriers to achieving eMTCT of HIV and syphilis. Non-negotiable issues include grave or systematic human rights abuses, including forced sterilizations, contraception or abortion and mandatory testing, and lack of government due diligence in redressing abuses. No country can be validated if there are grave or systematic human rights violations in the context of eMTCT. This is the first time a WHO disease elimination validation process considered measures for human rights, gender equality and community engagement as a key factor in evaluating whether a country should receive validation.

The Secretariat continued to play a pivotal advocacy role to maintain momentum towards achieving eMTCT goals by 2020, raising the visibility of the eMTCT agenda through high-profile initiatives such as engaging the First Ladies of Côte d'Ivoire, Kenya, Namibia and Panama; strategic and catalytic investments made with Luxembourg and Gala funds to all 21 Global Plan focus countries in sub-Saharan Africa including fast-track cities; and mobilization and engagement of communities to improve uptake and retention of pregnant and breastfeeding women in antenatal and postnatal care. The Secretariat also led the analysis and publication of a supplement in the Journal of Acquired Immune Deficiency Syndromes (JAIDS) in May 2017, on the living legacy of the Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive. The Secretariat with U.S. PEPFAR launched the follow-on initiative to the Global Plan, Start Free Stay Free AIDS Free to further galvanize global momentum around a shared and ambitious agenda.

Start Free Stay Free AIDS Free seeks to reach the super-fast track targets and end AIDS in children and adolescents. WHO and UNICEF are co-leading in two work streams, AIDS Free and Stay Free, respectively. WHO worked with the Elisabeth Glaser Pediatric AIDS Foundation and provided enhanced technical assistance on treatment and care of children and adolescents living with HIV in 21 priority countries. WHO and its AIDS Free partners launched a global action plan in December 2017 to accelerate development and introduction of new paediatric formulations. UNICEF and PEPFAR lead the Stay Free work stream, which

focuses on preventing HIV in adolescent girls in 23 countries. WHO and UNICEF are active members of the Stay Free working group to sustain and further expand global and country efforts in preventing mother-to-child transmission. The Secretariat leads the Start Free Work Group, together with ICAP, and broadly supports coordination across all three work streams. Global and country acceleration is being promoted in a more holistic way, with coordinated action across the different work streams in the context of a strong life-cycle approach.

Challenges

In some of the highest burden countries in sub Saharan Africa, the high HIV prevalence in women of reproductive age makes it difficult to achieve elimination despite high ART coverage. In west and central Africa, particularly outside the bigger cities, fragile health systems characterized by limited numbers of trained health workers, weak procurement and supply management systems, and barriers to service utilization among the most vulnerable have hampered progress. Several countries face challenges in their operating environments, such as weak governance, poor access to health services and human-made or natural crises that impinge on effective delivery of PMTCT services. In some regions, improved decentralized data is needed to reach women who are still being left behind. To understand who these women are, where they are and how they can be located and linked to antenatal care and PMTCT is crucial, either through better integration of HIV testing and treatment in routine health systems or other targeted approaches.

128. In 2017, an estimated 214 million women and adolescent girls (aged 15–49) in developing countries were unable to exercise their right to freely decide whether or when to start a family because they were not using or had no access to modern contraception. Unmet demand for family planning translates into more than 65 million unintended pregnancies annually in developing countries. There is also a large resource gap for family planning among the 135 low- and middle-income countries. By 2020, an additional US$ 173.2 million will be needed every year for procuring contraceptives alone, and costs to deliver quality services including to marginalized populations will be notably higher.

129. With the roll-out of test and treat for PMTCT, there are concerns about suboptimal adherence post-initiation. Addressing issues such as stock-outs of ARVs and other commodities, poor adherence and retention in care in the peripartum period as well as the postnatal, stigma, fear of disclosure, user fees and other costs, and socioeconomic factors such as poverty is essential to support lifelong treatment. Decentralized capacity for viral load monitoring, limited task-shifting and poor scale-up of early infant diagnosis also hampers service delivery to children even when they are receiving the most effective ARVs in age-appropriate formulations.

130. Demand-side barriers to access and adherence to PMTCT services include food insecurity. Comprehensive services that integrate food assistance enable more women to

start and adhere to PMTCT programmes. Due to funding reductions at global level, some UN agencies such as WFP have limited capacity to address the specific needs of people living with HIV. This negatively impacts on integrating food and nutrition into PMTCT programmes and MNCH services, which in turn can be harmful for nutrition and HIV outcomes of women living with HIV. Data on access to PMTCT services in humanitarian emergencies, such as on the number of patients who require ART in the immediate aftermath of an emergency, is often limited or not available. Inclusion of HIV-related data in rapid assessments is not always possible. Insecurity and conflict can often prevent services from being established or continued.

Key future actions

The Joint Programme will continue prioritizing eMTCT based on the mandate and comparative advantage of UN sponsor agencies.

UNHCR is working to strengthen data management systems through the revision of health information systems, including updating eMTCT indicators in line with the Global AIDS Monitoring report. Monitoring systems are being strengthened at all levels – facility, camp, country and HQ – by scaling up the use of mobile phones/tablets and PCs to enable real time and accurate data collection and analysis of eMTCT indicator data. The quality of eMTCT services in humanitarian settings will be enhanced by scaling up mother-to-mother support groups, and access to PCR testing for HIV-exposed infants will be improved.

WFP in collaboration with UNICEF will continue to support people living with HIV, PMTCT clients and children through its food and nutrition support activities, specifically targeting these groups where possible and relevant.

UNICEF's critical role in leading the global eMTCT agenda, and in scaling up national programmes in resource-limited settings is ongoing. In eastern and southern Africa, UNICEF will focus on retaining mother-infant pairs after childbirth, increasing coverage of early infant diagnosis, keeping women who test negative HIV-free, and enhancing services for adolescent PMTCT clients. It will also leverage partnerships, programmes and greater domestic investments at decentralized levels to support capacity development, health system strengthening, policy, tool development, promotion of methods to expand access to HIV testing and counselling through better integration in broader MCH services, and efficient procurement of ARVs. In west and central Africa, emphasis will be placed on high-impact changes in service delivery, including innovations to improve PMTCT coverage and retention in care.

WHO will continue to take the lead in developing the normative elements required by the eMTCT agenda. In doing so, it will support countries to adapt and adopt national guidelines and ensure access to best treatment and diagnostics for pregnant and breastfeeding women, infants, children and adolescents. It will continue contributing to UN joint work on validating elimination of mother-to-child transmission of HIV and syphilis, and further facilitate it by serving on the Global Validation Advisory Committee.

With UNAIDS it will continue to support country, regional and global validation of eMTCT and the path to elimination by:

- providing updated HIV strategic information for policy development and implementation of evidence-based programmes;

- empowering communities and women living with HIV to participate in validation exercises by identifying rights violations, gaps in implementation and realization of rights protections, gender equality and community engagement;

- coordinating with partners to support national strategies achieve fast-track targets by 2020.

As key contributor of the Start Free Stay Free AIDS Free framework, WHO will foster collaboration with partners to increase access to critical commodities for age-appropriate testing and treatment of children and adolescents living with HIV.

UNFPA's work with programme countries, particularly those with the highest unmet need for family planning, is ongoing to develop sustainable human rights-based family planning programmes, including through integrated sexual and reproductive health and rights delivery platforms that meet the needs of all populations. UNFPA will monitor key sexual, reproductive, maternal and newborn health indicators to better implement responses that address gaps in availability and quality of care and also sharpen focus on increasing domestic financing so countries can transition from donor support. UNFPA will work with governments to develop family planning business cases that set out what works, how much is needed and where efficiencies can be made, and identifying potential sources of funds, for example from International Development Association loans or taxation schemes. It will look at ways to expand the financing base to ensure predictable and sustainable resources, at global, regional and national levels. UNFPA has begun scoping out innovative and blended financing mechanisms that will attract new investors to family planning.

The World Bank will continue to support countries in the elimination of mother-to-child transmission of HIV. The GFF is in the process of a major replenishment and will keep providing catalytic funding for the expansion of access to essential HIV services. The projects will continue to focus on the integration of SRH and HIV services, the scale-up of existing RBF programmes to cover larger geographical areas for greater reach and impact, and enhanced collaboration with partners such as the Global Fund to ensure a more effective supply chain for essential health commodities that reach populations most in need.

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