The Global plan to eliminate mother to child transmission (eMTCT) of HIV: challenges in integration and of therapeutic strategies

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Global Context

• The international agreements such as the ICPD 1994, the MDGs, the Maputo Plan of Action on SRH, the Global Strategy on Women and Children of the Secretary General, and the summit on FP recognise need for synergies between MNCH, SRH and HIV and call for integration

• The Global Plan for EMTCT also underlines:
  “HIV, maternal health, newborn and child health, and family planning programmes should work together to deliver quality results and lead to improved health outcomes”

• These commitments have been translated into country specific health sector strategic plans advocating for integrated, accessible and effective health service delivery

• The need for implementation of the new WHO guidelines
The Global Context: opportunities for optimizing strategies across MDG 4-5 and collaboration

COUNTDOWN TO ZERO

The Joint Action Plan For Women’s And Children’s Health
10 Point Plan for Country Level Action

The Global **10 Point Plan** is as follows:

1. To conduct a strategic assessment of key barriers to elimination of new HIV infections and keeping mothers alive
2. To develop or revise costs, nationally-owned MTCT elimination plans
3. To assess available resources for EMTCT and develop a strategy to address unmet needs.
4. To implement a comprehensive, integrated package of HIV prevention and treatment interventions and services
5. To strengthen synergies and integration fit to context between PMTCT and related health services to improve MCH outcomes
6. To enhance the supply and utilization of human resources for health (HRH)
7. To evaluate and improve access to essential medicines and diagnostics and strengthen supply chain operations
8. To strengthen community involvement and communication
9. Better coordinate technical support to enhance PMTCT service delivery
10. To improve PMTCT outcomes assessment, data quality, and impact assessment
- **Overseeing implementation of the Global Plan:**
  - Focus on goals
  - Oversight responsibility for overall implementation of the plan

- **Promote high-level engagement**
  1. Country-led
  2. Resource mobilization
  3. Communications and high-level advocacy
  4. Monitoring and accountability
The total gap in treatment coverage is unevenly spread among low and middle-income countries.

The share of each low and middle-income country in the total shortfall in providing antiretroviral medication to HIV-positive pregnant women to prevent new HIV infections among children.

Source: UNAIDS 2012
Slight decline in new HIV infections among women 15-49, 21 priority countries

Source: UNAIDS Estimates 2012
Reduction in unmet need for family planning is slow (countries with available data)

Source: Demographic and Health Surveys 2000-2011
As a result, the number of women in need of PMTCT services remains constant.
New HIV infections among children (0–14 years old), 2001–2011 and the target for 2015
### New HIV infections among children, 2009–2011

<table>
<thead>
<tr>
<th>Rapid decline</th>
<th>Moderate decline</th>
<th>Slow or no decline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will reach the target if the 2009–2011 decline of more than 30% continues through 2015.</td>
<td>Can reach the target if the decline in 2009–2011 of 20–30% is accelerated.</td>
<td>In danger of not reaching the target, with a decline in 2009–2011 of less than 20%.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Country</th>
<th>Rapid decline</th>
<th>Moderate decline</th>
<th>Slow or no decline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethiopia</td>
<td>31%</td>
<td></td>
<td>Angola</td>
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<tr>
<td>Ghana</td>
<td>31%</td>
<td></td>
<td>Chad</td>
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<tr>
<td>Kenya</td>
<td>43%</td>
<td></td>
<td>Democratic Republic of the Congo</td>
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<tr>
<td>Namibia</td>
<td>60%</td>
<td></td>
<td>Mozambique</td>
</tr>
<tr>
<td>South Africa</td>
<td>49%</td>
<td></td>
<td>Nigeria</td>
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<tr>
<td>Swaziland</td>
<td>39%</td>
<td></td>
<td>United Republic of Tanzania</td>
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<tr>
<td>Zambia</td>
<td>55%</td>
<td></td>
<td>India</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>45%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Botswana</td>
<td>22%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Burundi</td>
<td>30%</td>
<td></td>
<td></td>
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<tr>
<td>Cameroon</td>
<td>24%</td>
<td></td>
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<tr>
<td>Côte d’Ivoire</td>
<td>20%</td>
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<tr>
<td>Lesotho</td>
<td>21%</td>
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<tr>
<td>Malawi</td>
<td>26%</td>
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<tr>
<td>Uganda</td>
<td>24%</td>
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</table>

**Note:** The baseline year for the Global Plan is 2009. Some countries had already made important progress in reducing the number of new HIV infections among children in the years before 2009, notably Botswana which by 2009 already had 92% coverage of antiretroviral regimens among pregnant women and a transmission rate of 5% (see table pp122–123). In countries with high coverage, further declines are much harder to achieve.
New child HIV infections and PMTCT coverage, 21 priority countries

Before the Global Plan

Source: UNAIDS Estimates 2012
Prophylaxis coverage: the other half of the picture……

Number of women/infant pairs receiving prophylaxis, 2011, 21 priority countries

Source: UNAIDS Estimates 2012
As a result, MTCT transmission rates are still high.

Source: UNAIDS Estimates 2012
WHAT TO DO?
(when to start or switch, how to monitor, which regimen to use)

HOW TO DO IT?
(diagnostics, service delivery)

HOW TO DECIDE?
(prioritization, equity and ethics, M&E)
New Recommendations in WHO ART guidelines (2013)

1) Immediate ART for children below 5 years

2) Harmonization of ART across populations (e.g., adults and pregnant women, B/B+) and age groups

3) Simplified, fewer, and less toxic 1\textsuperscript{st} line regimens (TDF/XTC/EFV)

4) Improved patient monitoring to support adherence and detect failure (increased use of VL)

5) Recommend task shifting, decentralization, and integration
• Review of all WHO guidelines on the use of ARVs – Treatment 2.0 (2012-2013)

<table>
<thead>
<tr>
<th>HIV positive women CD4&lt;350</th>
<th>HIV positive women CD4&gt;350</th>
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<tbody>
<tr>
<td></td>
<td>Antenatal ARV interventions</td>
</tr>
<tr>
<td>Option A</td>
<td>mART</td>
</tr>
<tr>
<td>Option B</td>
<td>mART</td>
</tr>
<tr>
<td>Option B+</td>
<td>mART</td>
</tr>
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Q. How to support countries anticipate, and respond to more changes in ARV recommendations and scale up interventions?
HIV and Infant feeding

- ARV interventions resolve many of the dilemmas facing mothers and health workers re. HIV & IF.
- Little experience on how best to implement extended interventions during postnatal period, including how to monitor them?
- Planned AFRO regional consultation on promoting optimal infant feeding practices in the context of HIV (with UNICEF)

Questions and Answers on infant feeding in the context of HIV

Q. How to support the development and implementation of country work plans to scale up ARVs and optimising IFPs?
Percentage of those eligible receiving ART for their own health

Source: UNAIDS estimates 2012

ART coverage (percent)

- Adults: 58%
- Children: 28%

Source: UNAIDS estimates 2012
Simpler drugs

Point of care diagnostics

Delivery models
Key actions needed to reach the Global Plan goals

- Strengthen all efforts but pay special attention to the lagging countries
- Strengthen efforts to reduce unmet need for family planning. Limited data on unmet need among women living with HIV
- Increase coverage of prophylaxis during breastfeeding
- Ensure eligible children receive ART
  - Increasing early infant diagnosis from 35% to higher levels will improve ART uptake
  - Ensure diagnosis is linked to treatment
BUT: what can be done to address the challenges of implementation?

INTEGRATION: the overarching principle
Rationale for integrated RMNCH/PMTCT

- Common goals are to keep the women and children healthy and alive
- Women of reproductive age and their children require both services
- Facilities are invariably the same and the same provider deliver services
- Simplifies and cuts cost care for the patient
- Supports continuity of care, minimizes dropout and reduces missed opportunities
Many bottle necks making integration a reality

- National guidelines, implementation manuals and standard operating procedures
- Skilled and adequate numbers of health care providers
- Adapted infrastructures to support integrated services
- Sustainable supply chain to address the issue of frequent stock-outs of essential commodities and supplies
- Strengthened referral system for continuity of care for women and children, especially those living with HIV
- Integrated training approaches into existing pre and in service training
- Strengthen and simplify information systems to support routine monitoring of integrated service delivery
1. Implement package of services within stigma-free integrated SRH and HIV services
2. Utilize key entry points to integrate HIV and SRH
3. Strengthen national programme implementation
Highlight: Rapid Assessment Tool Implementation – to date

2008-2012
37 (7) countries

Impact Interviews
20 Countries

21 (13) Rapid Assessment Summaries
Policy brief:

- Technical statement to continue use of HC by PLHIV, advice on condom use.
- Programmatic and research issues
HIV and FP linkages and integration tools

- Counseling for FP in HIV clinics
- Counseling on testing in FP clinics

Reproductive Choices and Family Planning for People Living with HIV Counselling Tool

Module on Provider Initiated
- HIV testing and counselling (PITC)
Repositioning Family Planning Advocacy toolkit

- Aims to help those working in family planning across Africa to effectively advocate for renewed emphasis on family planning.

- It aims to enhance the visibility, availability, and quality of family planning services for increased contraceptive use and healthy timing and spacing of births, ultimately, improved quality of life across the region.

- It was developed in response to requests from several countries to assist them in accelerating their family planning advocacy efforts.
IMAI-IMPAC primary level tools

Based on WHO normative guidelines, translating guidelines into simplified, operational tools to be applied for service provision.

IMAI-IMCI tools build clinical teams.
IMAI/IMPAC clinical course on PMTCT

- Modular course
  - Module I: Covers PMTCT during Pregnancy
  - Module II: Covers PMTCT during Labour
  - Module III: Covers PMTCT during Postnatal Period

- To equip the health workers to provide integrated PMTCT as part of routine maternal health services
We would continue to:

- Integrate PMTCT and ART into MNCH and SRH, and have a MNCH training manual for all providers
- Offer a super-market approach for services
- Allow task shifting
- Give midwives opportunity to: 1) own and lead in PMTCT implementation; and 2) manage HIV positive women
- Integrate EID into immunization services
What we will improve:

- Focus on all 4 prongs: but would focus on them equally, instead of mainly focusing on prong 3
- Provide family planning at all service delivery points
- Provide wellness services to encourage male involvement
- Integrate Peds HIV into IMNCI services
- Harmonize PMTCT and MCH data, and reporting at all levels
What we would not repeat:

- Implement PMTCT and MNCH/RH as separate programs
- Have PMTCT managed/coordinated by 2-3 departments or units of MOH
- Separate the child from her mother by putting pediatric HIV in a different directorate
- Focus on selected prongs, instead of all PMTCT prongs
- Have a parallel systems for supplying HIV related commodities
Lessons learned

• Tools are useful but do not solve the systemic problems

• Integration needs to begin with the “Right integrated mind-set” of all players

• Proper planning is critical for effective implementation (joint planning, establishing baselines, bottleneck/gaps analysis, adapting infrastructure, joint monitoring)

• Define and prioritize the package of integration based on set goals, space, and HR
Lessons learned

• Need for continuous support supervision, mentoring and coaching

• Successful integration requires a committed and proactive focal person/team

• Integration needs to go hand in hand with quality insurance initiatives

• Adequacy of HR (Nos & skills) & Task shifting critical

• Partner coordination key to integration
Conclusion

Programs for women’s health should mainly consider their holistic needs:

• Think “integration” at all levels-Funding, training, supervision and reporting.

• Optimal models of integration still need to be conceptualized and shaped country by country

• Develop a consensus on standards of evidence for integration implementation and dissemination of current research findings on what works in terms of effectiveness, cost efficiency, quality etc.

• There is no “One size-fit all” integration solution, innovative ideas are there: work with your country context
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