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2014 UBRAF thematic report

Eliminating new HIV infections among children

CONTENTS

ACHIEVEMENTS

Transmission of HIV from Mother-to-child (MTCT) is highly preventable and has been virtually eliminated in the developed world, with many countries reporting rates of less than 1%. Elsewhere, limited access to HIV diagnostics and treatment for pregnant or breastfeeding women and to family planning services for women of reproductive age and women living with HIV, results in thousands of new HIV infections in babies each year.

The Global Plan for the Elimination of New Infections in Children and Keeping their Mothers Alive launched in 2011 and since then has helped to galvanize action for achieving an AIDS-free generation and preventing HIV-associated maternal mortality.

Over the past year the global community has made remarkable progress towards the goals of the Global Plan. At the end of 2014 the estimated number of children newly infected with HIV globally has fallen to 220,000 [190,000-260,000] and 73% [68-79%] of HIV positive pregnant women now receive highly effective antiretroviral regimens to prevent vertical transmission. All of the 22 Global Plan target countries now report adoption of “Option B+”- the WHO recommendation to maintain women living with HIV on ART for life. Although access to paediatric antiretroviral therapy (ART) continues to lag behind, almost 1 in 3 children worldwide are now on lifesaving treatment.

Supported by funding under the UBRAF agreement, the UN family has continued to play a critical role in:

- Developing and disseminating normative and operational guidance that has transformed implementation efforts;
- Mobilizing resources for scale- up from the Global Fund, PEPFAR and other partners;
- Providing in country technical assistance and fostering south to south sharing of experiences and research into novel approaches to optimize drugs, diagnostics and integrated service delivery models and
- Working within a broader community of stakeholders and civil society to coordinate and support field implementation.

Specific examples of this work include:

1. Catalysing B+ roll out: UNICEF and partners are helping address key health and community systems constraints in the roll-out of Option B+ in DR Congo, Côte d’Ivoire, Malawi and Uganda in maternal and newborn child health programmes.

2. Improving coverage of paediatric ART and child survival: the Ministry of Health and Social Services (MoHSS) of Zimbabwe in collaboration with UNICEF, WHO and EGPAF developed a plan to accelerate efforts to integrate paediatric HIV testing and treatment in child health programmes to double access to ART and improve child survival (the double Dividend).

3. Memorandum of Understanding (MOU) with the Global Fund in support of integration of maternal Health and PMTCT: Following the signing of a MOU with the Global Fund, UNICEF and WHO have provided support to 14 countries to effectively integrate maternal health interventions and PMTCT services in Global Fund grants at the various stages of the grant cycle. A related joint UNICEF/UNFPA/Global Fund communique was issued on procurement and supply chain management to increase provision of life-saving HIV and Sexual Reproductive Health (SRH) commodities.

4. Mobilizing resources from the Global Fund in 2014 to leverage AIDS, TB and malaria specific funding in over 20 countries in Africa.

5. UNITAID support to catalyse introduction of point of care diagnostics for CD4, viral load and infant HIV diagnosis: UNICEF and Clinton Health Access Initiative with funding from UNITAID provided support to seven countries in Eastern and Southern Africa to evaluate new products for in-country licencing and registration as well as piloting them for routine use. CD4 data from these countries indicate cost savings have been made as a result of more patients receiving results and having been initiated on ART. Interagency Task Team (IATT) on the Prevention and Treatment of Pregnant Women, Mothers and Children: WHO and UNICEF as co-conveners facilitated the work of the IATT - Major contributions of the IATT in 2014 included:

    - The $200M PEPFAR/Children Investment Fund Foundation (CIFF) commitment to double the number of children accessing ART in 9 countries (Cameroon, Côte d'Ivoire, DRC, Kenya, Lesotho, Malawi, Mozambique, Tanzania and Zambia).
    - Bottleneck analysis of both PMTCT and MNCH programmes in Chad, Guinea Bissau, Liberia, Mali and Senegal: UNICEF provided bottleneck analyses field support, in support of PMTCT planning and performance monitoring of integration of PMTCT in MNCH, and other SRH services.
    - Technical support to dual elimination of HIV and syphilis in the Caribbean, Latin America, Eastern Europe and Asia: UNAIDS, UNFPA, UNICEF and WHO continued to provide technical assistance to develop tools and support efforts for dual elimination of vertical transmission of HIV and syphilis. In 2015, Cuba was the first country to be certified by WHO.

World Food Program (WFP) provided food and nutrition support to pregnant and lactating women (including PMTCT clients) and their children. In Ethiopia, WFP supported community-level nutrition assessment, counselling and support for PMTCT mothers; 99% of their infants were born HIV-free in health facilities.

Working together, UN agencies mobilized governments and partners to secure and deliver additional MCH commodities - such as iron and folic acid, tetanus vaccines and medications for syphilis and treatments for pneumonia and diarrhoea in children.

Overall, in 2014, maternal and child health systems and services continued to benefit from the global, regional and country level activities of UN partner agencies. Aside from promotion of the best formulations for paediatric ART - through the Global Fund paediatric ARV procurement working group - UN partners have also worked to improve access to paediatric HIV diagnosis, with new technologies and service delivery approaches such as birth testing to improve early identification infants born with HIV and at the highest risk of early mortality, and targeted integrated paediatric HIV and child health services to improve rates of loss-to-follow-up.

MAJOR CHALLENGES AND HOW THESE WERE ADDRESSED

Several challenges have emerged in the past year:

- Continued weak procurement and supply systems have resulted in commodity insecurity in some of the high-burden countries.
- Early “Option B+” implementation experiences in Malawi and Tanzania indicate high loss to follow-up in women initiated on ART in the post-partum/natal period - in many settings the risk of loss-to-follow-up may be five times more than for other clients on ART.
- Weak routine monitoring and evaluation systems resulting in gaps in data need for elimination validation.
- Underlying weakness in MNCH and other SRH services (family planning, STIs, gender based violence) continue to compromise delivery of comprehensive integrated PMTCT services. The number of trained health workers and lack of task-shifting policies and/or implementation of the policies are the most significant of these weaknesses, compounded by poor primary health infrastructure. Fully integrating family planning into EMTCT programming, including for preventing unintended pregnancies in adolescents and young women living with HIV is also not receiving adequate programming attention.
- With decreases of HIV funding, countries with low HIV prevalence are struggling to secure the resources needed to support PMTCT and paediatric interventions, especially as the cost of identifying positive cases is proportionately higher.
- In all regions, but especially in concentrated epidemics, there is a need to identify hard-to-reach populations. A key challenge remains to ensure that those most vulnerable (migrants, prisoners, drug users, sex workers and the female partners of men who have sex with men) have full access to effective services to prevent HIV and unintended pregnancies. These populations are not well-served by traditional health services and greater involvement with the community is needed. The level of male partner engagement in MTCT continues to be very low.
- Stigma, discrimination and violence are still barriers preventing clients from seeking and getting the rights-based services they need.
- Early infant diagnosis of HIV remains low, with long turnaround time for results and low rates of ART initiation in infants. Additionally, there continues to be little

data on sequential HIV testing of exposed infants throughout the breastfeeding exposure period which results in little information on the impact of PMTCT services and poor linkage to treatment in infants acquiring infection during breast feeding.

- Sero-conversion during pregnancy and breastfeeding is a significant contributor to vertical transmission, especially in high-prevalence settings. HIV re-testing (for mothers and their exposed infants/children) and couples testing coupled with provision of HIV prevention commodities (condoms, STI drugs, ART as "treatment as prevention") during pregnancy and breastfeeding would help address the incident infections.

These challenges can be remedied. Increasingly pregnant women, HIV positive women, and their children are benefitting from MNCH programmes that include integrated reproductive health, PMTCT and paediatric HIV services.

Point-of-care early infant diagnosis is being evaluated in several countries with the promise of early registration/uptake of this technology.

Finally the launch of several global initiatives - Double Dividend, ACT, All In and DREAMS – have brought a renewed focus on children affected by HIV and adolescents and young people at risk of acquiring HIV.

KEY FUTURE INTERVENTIONS

- New WHO operational guidelines on strategies to improve post-partum/natal retention in women on ART will help to reduce HIV transmission during breastfeeding.
- New operational guidance on HIV re-testing and counselling will provide specific recommendations to prevent and/or identify HIV sero-conversion in pregnant and breastfeeding women.
- Future work of the IATT will focus on the small number of countries that represent the majority of unmet need - in terms of MTCT, family planning and paediatric ART access - by offering targeted technical assistance in the areas of gap analysis, sub-national monitoring systems and integration of paediatric HIV and child health services.
- Inequities in services for key populations will be addressed by advocating to governments and partners to increase access to quality services and to prioritize locations that are home to the most vulnerable communities.
- Countries in the Americas and Eastern Europe that are close to elimination will be supported to develop monitoring and evaluation systems to validate elimination of HIV and syphilis.
- Community involvement will be prioritized in several ways:
    - by expanding operational research in this area to strengthen the evidence base;

    - by advocating for greater involvement of the community groups and civil society as part of the national response;
    - by providing direct support to community organizations and providers.
- Investment will be made in operational research, using new and existing research programmes such as WHO's Inspire Initiative to address barriers and identify solutions for scale up.
- Adolescents, youth and key populations will be included in programme design and implementation to improve accountability, including through links with current initiatives such as All In!, DREAMS and UNFPA's Strategy for Adolescents and Youth.
- EMTCT programming will be linked with strategies to eliminate violence, stigma and discrimination, including through analysis using the Stigma Index and linking to related initiatives for decriminalization.
- Health systems will be strengthened to deliver rights-based, integrated HIV and RMNCAH services in line with the Secretary General's agenda on Every Woman Every Child.
- Linkages between food and nutrition, social protection and economic strengthening activities will be strengthened for longer-term sustainability of integrated MNCH/EMTCT programmes.

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