



PMTCT High-Level Global Partners Forum 2007

Building Political Momentum Towards Universal Access

**Sandton Sun Hotel, Johannesburg, South Africa
26 - 27 November 2007**



CONCEPT NOTE

1. BACKGROUND AND RATIONALE

PROMISING PROGRESS – PERSISTING EMERGENCY

National governments through the Millennium Development Goals agenda (2000) and the UNGASS Declaration of Commitment (2001) have pledged high level commitments towards improving maternal and child survival by 2015 and to halving HIV infections among infants by 2010, respectively. The HIV commitments re-affirmed by the G8 Gleneagles Summit (2005), the Abuja Call to Action towards an HIV and AIDS free generation (2005), the Political Declaration of the UN High-Level Meeting (2006) and the G8 Communiqué (2007) call for provision of integrated and effective PMTCT and Paediatric HIV services to at least 80% of pregnant women and their infants through family centred approaches.

The efforts towards prevention of HIV infection among infants are guided by UN recommendations for a comprehensive four-element strategy, envisaging:

1. Primary prevention of HIV infection;
2. Preventing unintended pregnancies among HIV-infected women;
3. Preventing HIV transmission from HIV-infected women to their children, and
4. Providing care, treatment and support to HIV-infected mothers, their children and families.

In support of national efforts to scale up HIV prevention, treatment, care and support programmes, the international community has launched a number of global partnerships and resource mobilization initiatives: The Expanded Inter-agency Task Team on Prevention of HIV Infections in Pregnant Women, Mothers and their Children, The Global Fund to Fight AIDS, TB and Malaria (GFATM), the President's Emergency Fund for AIDS Relief (PEPFAR), UNITAID drug procurement initiative, and the Global Campaign Unite for Children, Unite against AIDS. These initiatives and partnerships have helped maintain resource flows and technical assistance to countries for

a strengthened HIV/AIDS response, including the response to prevention of HIV infections among infants.

The momentum by these initiatives is slowly beginning to translate into improved national actions in both middle and low income countries:

- Over 100 countries implementing national PMTCT programmes have developed PMTCT policies and strategies. Some of these countries have also elaborated national scale-up plans with clearly defined population-based targets and time-bound benchmarks to direct programming.
- Although uptake of PMTCT intervention remains low, routine programme data from 71 countries indicate increased coverage of both HIV testing and anti-retroviral (ARV) preventive treatment for prevention of Mother-To-Child-Transmission of HIV. Coverage of HIV testing and counselling among women in antenatal care increased from 8.2% to 9.2% during the 2004-2005 period, while in the same period coverage of ARV prophylaxis among HIV infected pregnant women and their exposed babies increased from 8% to 11% and from 5% to 8%, respectively. Furthermore the 2006 data from the 15 countries supported by PEPFAR has shown continued improvements* in the coverage of the PMTCT interventions.
- The slow but promising progress reported over 2004-2005 is documented across geographic regions, specifically in regard to coverage of ARV prophylaxis among pregnant women living with HIV: a. East and Southern Africa has increased the coverage from 9% to 14%, with South Africa having doubled their coverage, and Botswana being on track to achieve the UNGASS 2010 target. b. West and Central Africa with the lowest regional coverage rates (2%) demonstrated 200% increase in coverage in Congo and Togo; c. Central and South American countries reported 30% coverage for ARV prophylaxis with 4 countries (Argentina, Belize, Brazil and

* These data are expected to be confirmed upon receipt of UNICEF/WHO joint report data as part of the PMTCT and Paediatric HIV Care and Treatment Report Card

Jamaica) being on track to UNGASS targets; d. Central and Eastern Europe and the Commonwealth of Independent States (CEE/CIS) region continues to demonstrate high ARV coverage both among HIV positive pregnant women and exposed children (up to 80%). e. East Asia and Pacific with low PMTCT service coverage in most countries has demonstrated a success story in Thailand, the single country on track with UNGASS; Myanmar has also made a major progress – doubling ARV prophylaxis among pregnant women living with HIV.

However despite the recent encouraging trends the pandemic continues to affect the lives of 17.5 million women and 2.3 million children living with HIV. UNAIDS and WHO Epidemic Updates estimated 530,000 children to be newly infected and 380,000 children to have died due to HIV and AIDS related causes in 2006 alone.

URGENCY OF STRENGTHENED NATIONAL COMMITMENT

1,400 children under age of 15 years become infected by HIV infection every day, with 90% of the infections contracted through mother-to-child transmission. Comprehensive evidence-based PMTCT interventions can reduce the risk of mother-to-child transmission of HIV infection to less than 2% compared to 20% to 45% risk of transmission without any interventions. Thus the majority of the infections and the child deaths related to HIV are avoidable with effective delivery of the evidence-based PMTCT packages that are increasingly affordable. Furthermore it is feasible to provide antiretroviral therapy to pregnant women in need of care for their own health in resource limited settings. This will lower the risk of transmission to the child, prolong the life of the mother, and avoid orphaning to HIV.

Institutionalization of the evidence-based PMTCT interventions as the standard of care has led to virtual elimination of new paediatric HIV infections in most of the industrialized countries.

However, progress in scaling-up the effective and comprehensive PMTCT programmes is lagging far behind in most middle and low income countries. By end of 2006 only 8 out of 71 countries, where data exists, were on track to meet UNGASS Declaration targets for ARV prophylaxis uptake among pregnant women living with HIV.

Furthermore most national programmes have focused on prevention of HIV transmission during pregnancy, delivery and breastfeeding (prong 3 of the UN comprehensive strategy)

and paid much less attention to primary prevention, prevention of unintended pregnancies among women living with HIV, and access to antiretroviral treatment (ART) for women.

It is therefore imperative for national governments to critically analyse current contexts, the policies and programmes in place and to identify the key barriers, opportunities and immediate steps to accelerate scale up of comprehensive PMTCT programmes to universal levels of service coverage.

LESSONS LEARNED

The cumulative scientific evidence and analysis of the global and country-level PMTCT response over the last seven years has resulted in critical lessons learned to fuel future dialogue and action towards accelerating comprehensive programme scale up.

- Existence of a strong governmental commitment and ownership of the PMTCT programme is critical for development of one national programme and alignment of the country-level partnerships to the unified action framework. Botswana with exemplary governmental commitment has demonstrated programme scale up despite the persistence of systemic bottlenecks (i.e. human resource crisis).
- Existence of a strong national management team and a well functioning national coordination mechanism is essential to guide programme design, implementation and monitoring. Establishment of annual progress review mechanisms on children and AIDS in Rwanda was a demonstration of a concerted political commitment for accountability.
- Successful programmes are built on strengthened health systems and quality maternal, neonatal and child health (MNCH) and other sexual and reproductive health services (SRH). Full integration of PMTCT into MNCH packages and the high coverage of antenatal and skilled delivery attendance is key to success of PMTCT scale-up in CEE/CIS countries. Meanwhile the low coverage of skilled attendance in other countries remains as a major barrier towards PMTCT scaling up efforts (e.g. India, Haiti).
- Efforts to reduce HIV transmission through breastfeeding have been undertaken successfully alongside efforts to promote, protect and support breastfeeding in the general population.

- Successful programmes are built on linkages with HIV care and treatment services. Viewing PMTCT as a gateway to engage women, their babies and their families in continuous HIV care and treatment services enables women with advanced disease to receive antiretroviral treatment for their own health thus preventing maternal morbidity and mortality and significantly reducing MTCT risk.
- Countries with high coverage of PMTCT and Paediatric HIV services have introduced an enabling policy environment for testing – i.e. institutionalization of provider-initiated HIV testing and counselling within the standard MNCH packages at antenatal and perinatal services.
- Modelling studies demonstrate that increasing access to family planning is cost-effective in decreasing HIV infection in infants. Modern contraceptive prevalence rates are very low (<25%) and unmet need for family planning is very high (13-35%) in many high burden countries in sub-Saharan Africa. Meeting the unmet needs represents an opportunity to decrease number of infants exposed to HIV.
- Establishment of systems to identify and track exposed and infected children is a common challenge, between PMTCT, paediatric and ART services for pregnant women and their exposed infants. Zimbabwe has been among the few countries to address the issue through revision of the national child health registries and cards.
- Innovative solutions to address the shortage of the HIV/AIDS service workforce are important, especially in resource-limited and high disease burden settings. Introduction of lay counsellors in Botswana is one of the human resource management models proven to be successful in PMTCT programme scale up. The innovative solutions need to strengthen competences in midwifery and infant feeding in the context of PMTCT.
- Involving families and communities is vital in creating demand, improving adherence to treatment and provision of a wide variety of necessary support (e.g. psycho-social, nutrition) often not available through public health services. Successful family-centered models are available from community-based projects in Ethiopia, South Africa (Mothers 2 Mothers), Kenya (Speaking for Children), Mozambique (Child & Caregiver camps).

NEW GLOBAL SCALE UP GUIDANCE - A WAY FORWARD

The Inter-Agency Task Team (IATT) on Prevention of HIV Infection in Pregnant Women, Mothers and their Children has translated the lessons learnt from the last 7 years of PMTCT programme implementation into Guidance for Global Scale Up of the Prevention of Mother-to-Child Transmission of HIV - Towards Universal Access for women, infants and young children and eliminating HIV and AIDS in Women, Children.

The Global Guidance document is intended to provide recommendations to the governments and key implementing partners on accelerating PMTCT programme scale up. The Guidance supports implementation of all four components of the UN comprehensive approach and operationalisation of the Three Ones** principles for more effective, efficient and coordinated response at the country level.

The Global Guidance defines the minimum standard of care for PMTCT in antenatal, perinatal, postnatal and paediatric services and recommends integration of PMTCT interventions within maternal, newborn and child health, nutrition, family planning, STI, and HIV care and treatment services with clearly defined operational linkages.

Implementation of the recommendations proposed in the Global Guidance will enable national governments and development partners to harmonise scaling up of comprehensive PMTCT programmes, within a broader framework of maternal and child survival and health.

2. SCOPE OF THE GLOBAL PARTNERS FORUM

Acknowledging the urgent need for a renewed political movement to advance the PMTCT agenda and to ensure translation of pledged commitments into accelerated action at country level, the Global Inter-agency Task Team, represented by 20 partner agencies will convene the 2nd Global Partners Forum on Prevention of Mother to Child Transmission of HIV Infection.

The 2nd Global Partners Forum will be held on 26 and 27 November in Johannesburg, South Africa.

** Three Ones Principles envisage:
- one agreed HIV/AIDS action framework;
- one agreed AIDS coordinating authority, and
- One agreed monitoring and evaluation system.

OBJECTIVES OF THE GLOBAL PARTNERS FORUM

- To analyse and document progress made by national governments since the endorsement of the “Abuja PMTCT Call to Action towards an HIV and AIDS free generation” in 2005.
- To review and share lessons learned and remaining gaps and challenges to scaling up PMTCT from the evidence & experiences at the global and regional levels and selected countries.
- To present the new IATT Guidance for Global Scale Up of PMTCT, and
- To secure high level endorsement of the Global Guidance for Scale Up of PMTCT as the new strategic vision from national governments and key implementing partners, by endorsing the Forum Declaration.

EXPECTED OUTCOMES OF THE GLOBAL PARTNERS FORUM

- The Guidance for Global Scale Up of PMTCT endorsed by National Governments as the new strategic vision for PMTCT scale up, and
- The national Governments and key implementing partners endorse and commit to the Global Partners Forum Declaration for renewed focus and action for PMTCT

STRUCTURE OF THE MEETING

The Global Partners Forum will be organized into two days (26 and 27 November), preceded by a technical preparatory meeting on November 25.

The **pre-meeting discussions on November 25** will be organized for national programme managers and technical resource persons from the invited countries to synthesize the panel presentations for Day 1 (session 2). The participants will work in 4 groups based on epidemic and demographic typologies of the countries.

The meeting agenda for **Day 1, November 26** will be structured around:

- a. Plenary session and discussions on the global and regional trends for PMTCT, documented lessons and emerging evidence for PMTCT

- b. Presentation of the new Guidance for Global Scale-up of PMTCT
- c. Panel sessions to discuss the lessons and experiences from the countries in scaling up PMTCT response within the different demographic and epidemic contexts, and
- d. A High Level Panel with the Ministers of Health, Heads of the Country delegations and CEOs/Senior officials from the Global IATT agencies to focus on the political commitment and resource mobilization for PMTCT scale up.

The meeting on **Day 2, November 27** will cover:

- a. Plenary sessions on Partnership and Technical co-operation vis-à-vis global scale up of PMTCT
- b. High level discussions and endorsement of the Global Partners Forum Declaration (Statement) on the Global Guidance as new strategic vision for PMTCT scale up, and
- c. Discussion and agreement on the follow-up actions to the Global Partners Forum

MEETING PARTICIPANTS

The Global Partners Forum intends to involve national governments and partners in the renewed political movement for global PMTCT Scale up. The meeting will focus on 30 countries across geographic regions of the world, accounting for over 80% of the maternal HIV infections and the global MTCT burden. The 30 focus countries to be invited to the Global Partners Forum include countries from the following regions:

- Eastern and Southern Africa: Botswana, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, Swaziland, Uganda, United Republic of Tanzania, Zambia, and Zimbabwe
- Western and central Africa: Cameroon, Central African Republic, Democratic Republic of the Congo, Côte d'Ivoire, and Nigeria
- Asia and the Pacific: Cambodia, China, India, Thailand
- Central and Eastern Europe: Russian Federation and Ukraine
- Latin America and the Caribbean: Brazil, Dominican Republic, Haiti, Honduras and Guatemala

TARGET AUDIENCES

- a. Ministers of Health
- b. Heads or senior advisers of IATT member agencies at global, regional and country level
- c. Country Technical experts - up to 4 national partners, government or NGO representatives playing a lead role in the country-level scale up of the PMTCT / Paediatric HIV programmes. These may include:
 - The National PMTCT /Paediatric HIV programme coordinator,
 - The National ARV programme coordinator,
 - The National reproductive health programme coordinator, or
 - A representative of an NGO with a proven record of leadership in program scale up
- d. Non-IATT partners actively engaged in PMTCT /Paediatric HIV responses, including financing institutions