

Towards universal access of PMTCT

Presentation to Funders Concerned About AIDS

May 21, 2010

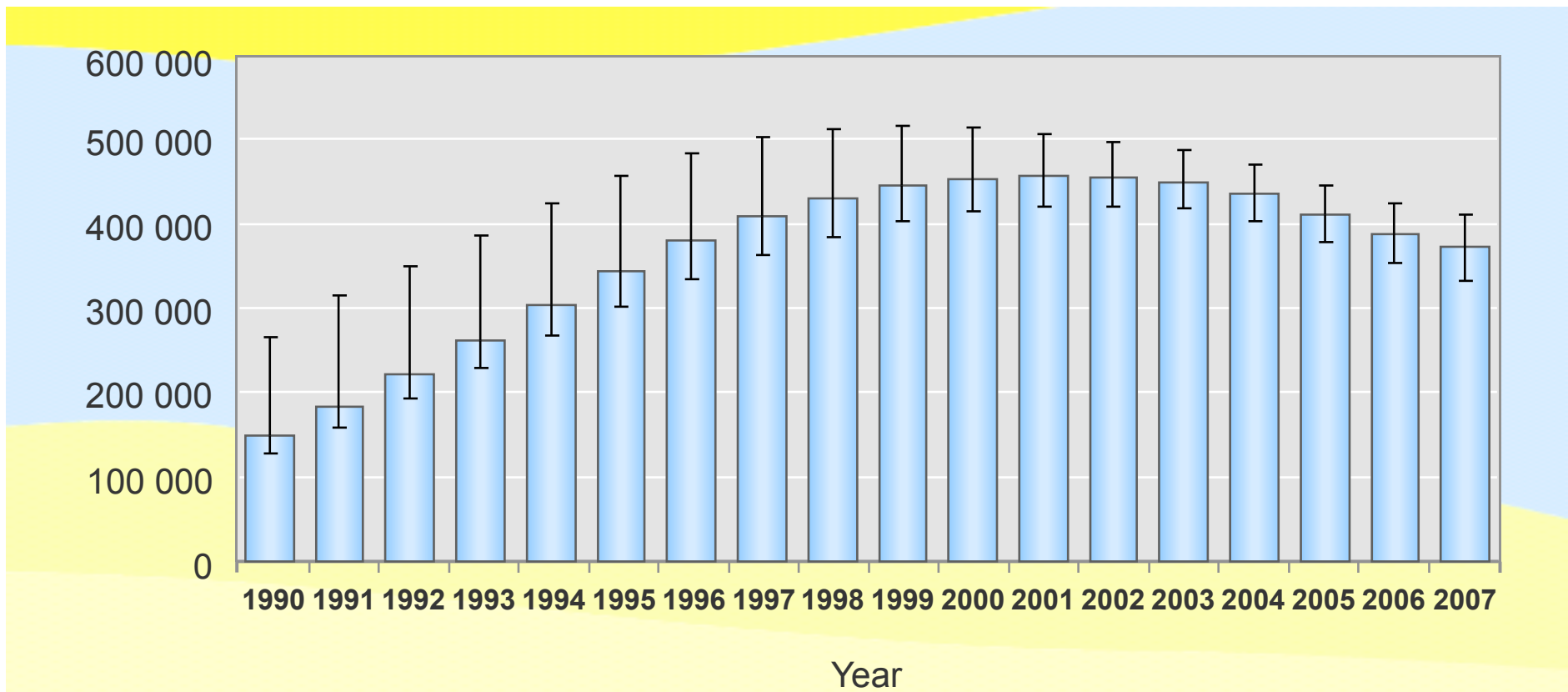


New HIV infections among children globally, 1990–2007



UNAIDS
JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS

UNICEF
WFP
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ILO
UNESCO
WHO
WORLD BANK



 *This bar indicates the range*

Each pediatric infection represents failure in prevention.

State of the Epidemic

- In 2008, 430,000 children were newly-infected with HIV, bringing to 2.1 million, the number of children under 15 living with HIV. 390,000 of the newly-infected children were in Africa.
- Globally 1.4m HIV+ pregnant women need PMTCT services. Nearly half are located in the following 4 countries: Nigeria, South Africa, Mozambique and Kenya. These 4 countries have more women needing PMTCT than the next 11 countries combined.
- Nigeria has overtaken South Africa as the country with the largest number of women in need of PMTCT services, 210,000 women. And India has joined the top 10 list of countries with the heaviest PMTCT burden.
- Globally, the number of new infections among children dropped by 80,000 from 2001 to 2008, in part due to greater access to prevention of mother-to-child transmission interventions.



Why PMTCT?

- 90% of children get HIV from mothers during pregnancy, childbirth and breastfeeding
- HIV infection is more aggressive among children than adults, half die by 2 yrs
- In highly-endemic areas, children present for care much later, as late as at ages 5-6 years
- Mortality for children born to HIV+ mothers higher than children born to HIV- mothers
- Some 200,000 new infections among children have been averted since 2001 due to the provision of ART prophylaxis to HIV-positive pregnant women



UNAIDS Outcome Framework: Virtual elimination of MTCT

- Without intervention, the risk of MTCT is 15-30% (and as high as 45% depending on duration of breastfeeding)
- The UN PMTCT Priority Area Working Group has defined “virtual elimination” as **<5% risk** of transmission at national level, and 90% reduction in new infections from 2010 to 2015



Full PMTCT: A range of services

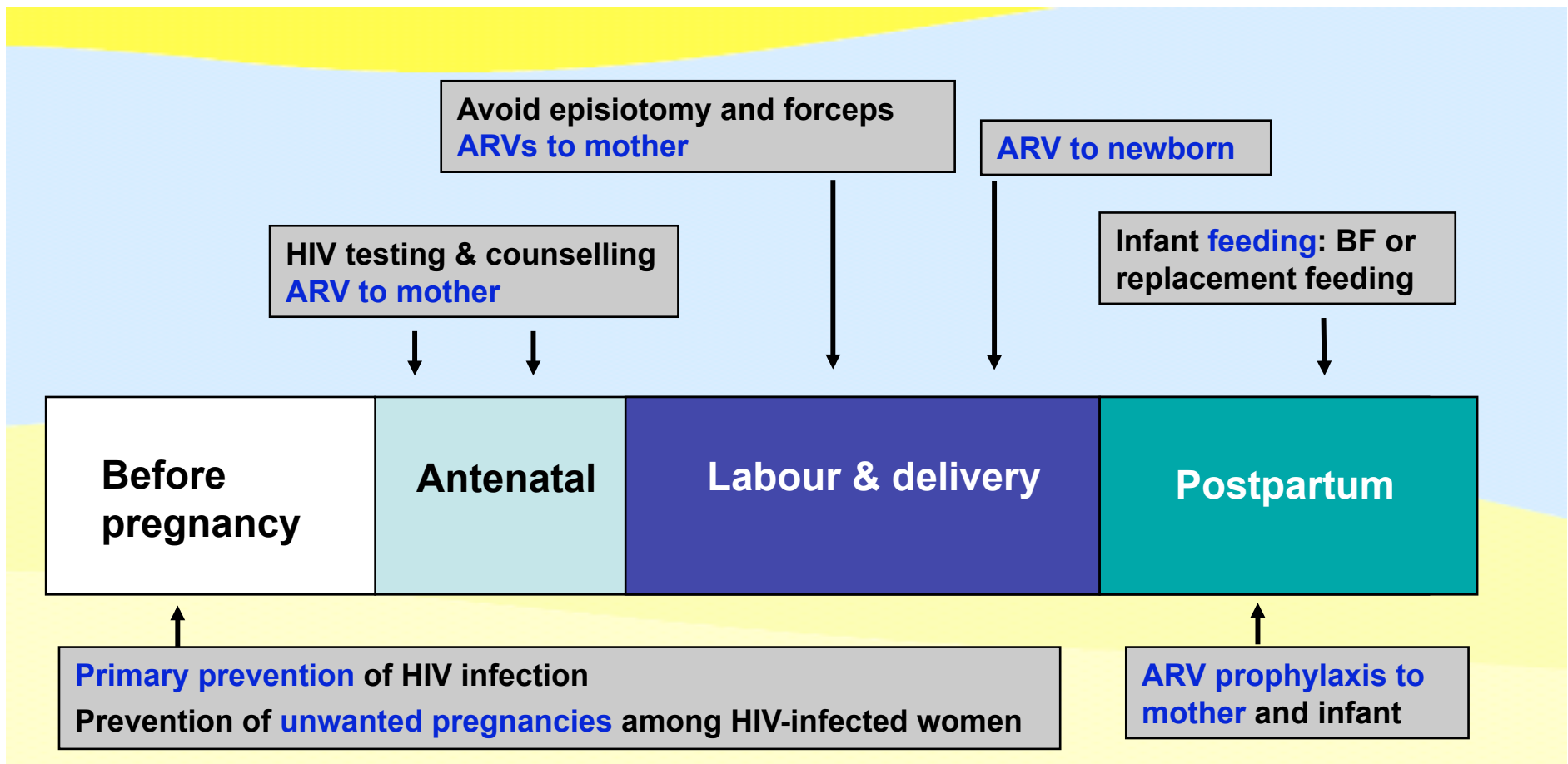
Prevention of mother-to-child transmission of HIV (PMTCT) comprises of a package of interventions summarized as 4 prongs, which must be implemented simultaneously. They are:

- **Prong 1:** Prevent HIV among women of reproductive age
- **Prong 2:** Prevent unwanted pregnancies among women living with HIV
- **Prong 3:** Prevent HIV transmission from women living with HIV to their infants using ARV prophylaxis, and
- **Prong 4:** Provide appropriate treatment, care and support to mothers living with HIV, their **children**, partners, and families



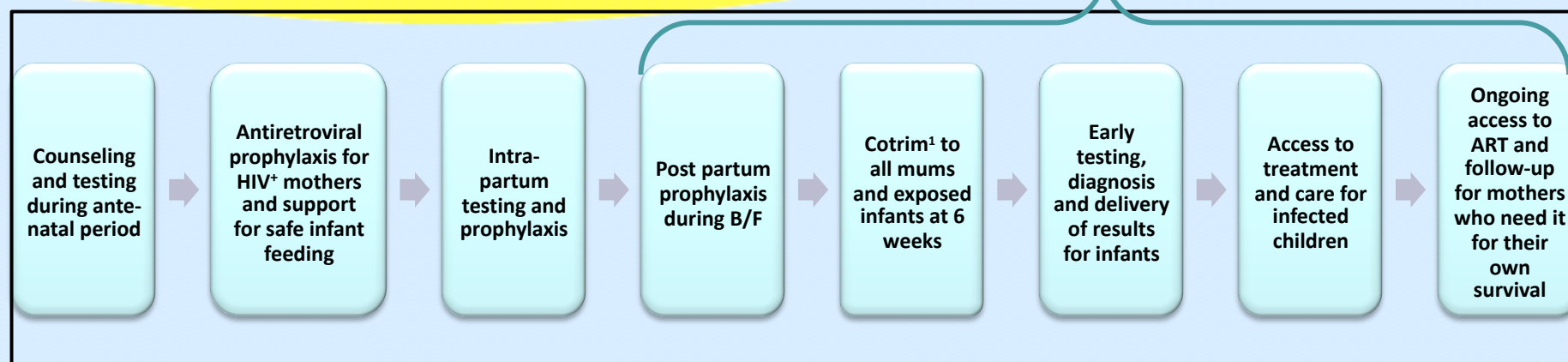
GUIDANCE ON GLOBAL SCALE-UP OF THE PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV
Towards universal access for women, infants and young children and eliminating HIV and AIDS among children

Interventions to prevent mother-infant HIV transmission, by timing



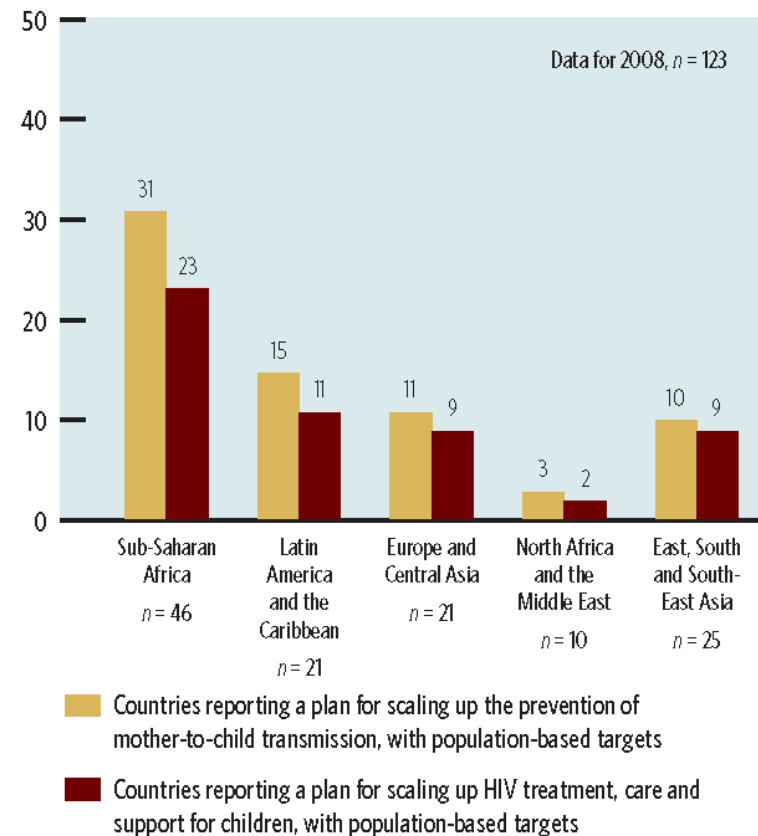
Integrated approach to PMTCT and Paediatric interventions and bottlenecks along the whole of the cascade

Interventions delivered to mother-baby pairs



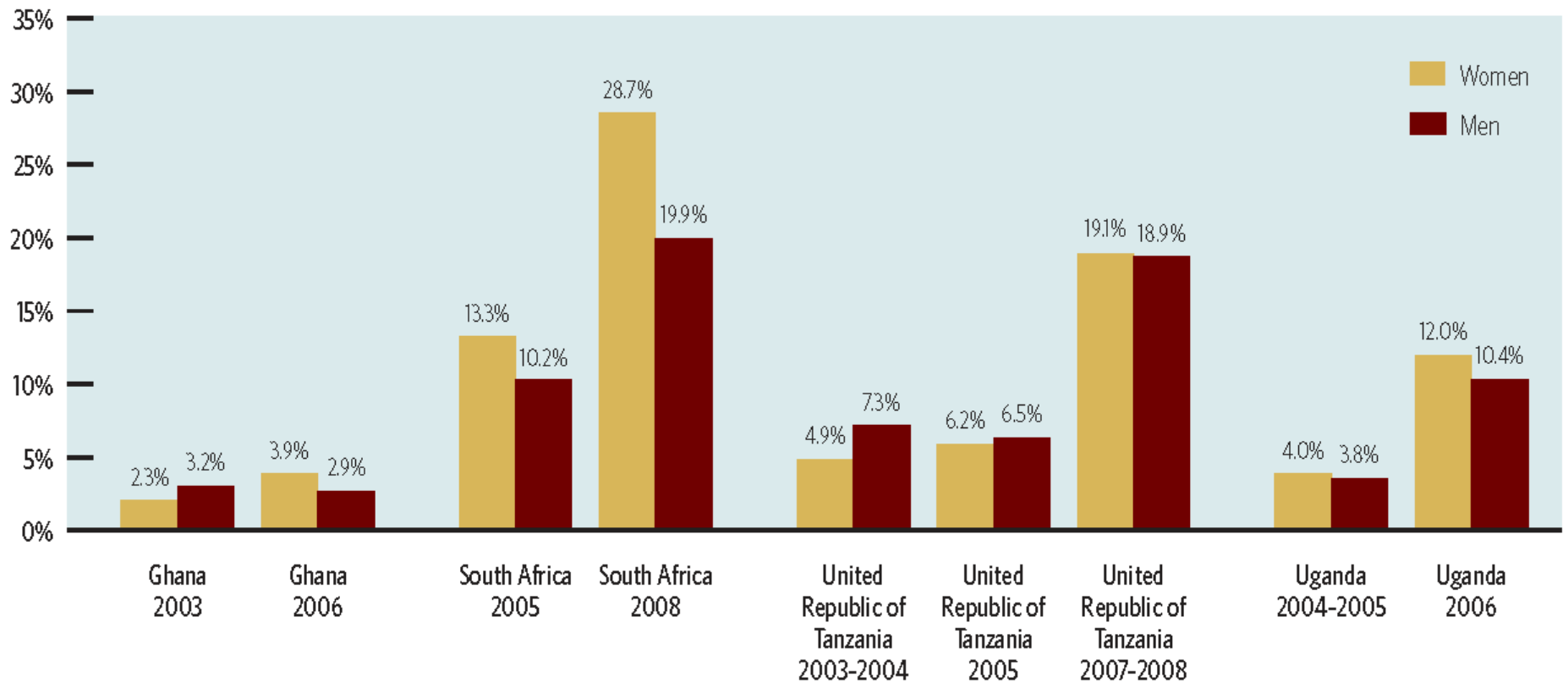
1. Given these linkages between PMTCT and pediatric interventions, it is important to identify and track all infected mother-baby pairs to ensure their completion of services along the cascade shown above.
2. Given the strong linkages between mother's and child's survival², it is possible to maximise the HIV free survival of the infants by keeping mums alive through PMTCT interventions.

Fig. 5.1. Number of low- and middle-income countries with national scale-up plans including population-based targets for preventing mother-to-child transmission and for HIV care and treatment for children, by region, 2008



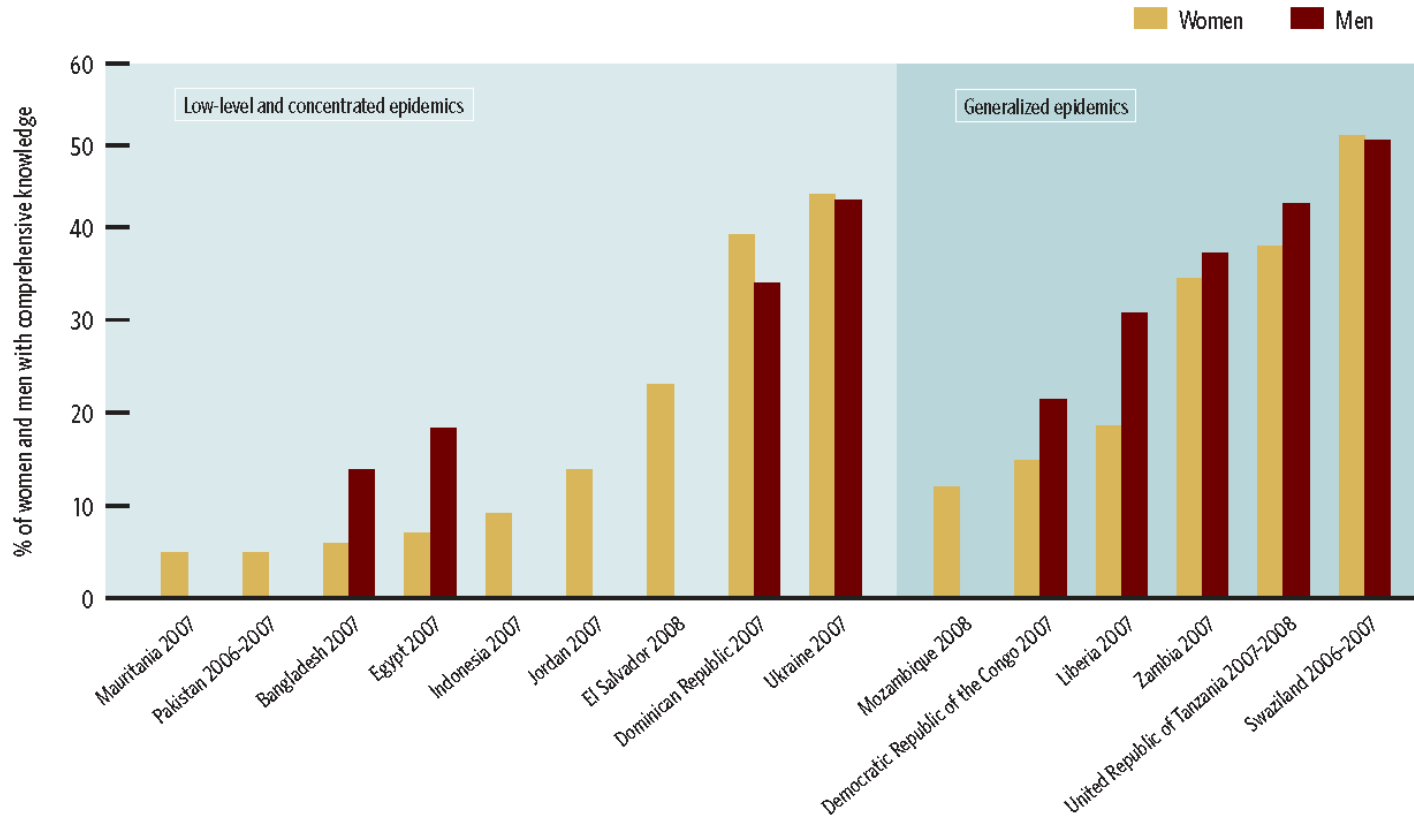
Source: Data reported by countries to WHO, UNICEF and UNAIDS in response to the annual reporting form for monitoring the health sector response to HIV/AIDS, 2009.

Fig. 2.4. Percentage of women and men receiving an HIV test and test results in the 12 months preceding the survey in countries with repeat population surveys, 2003–2008



Source: Demographic and Health Surveys.

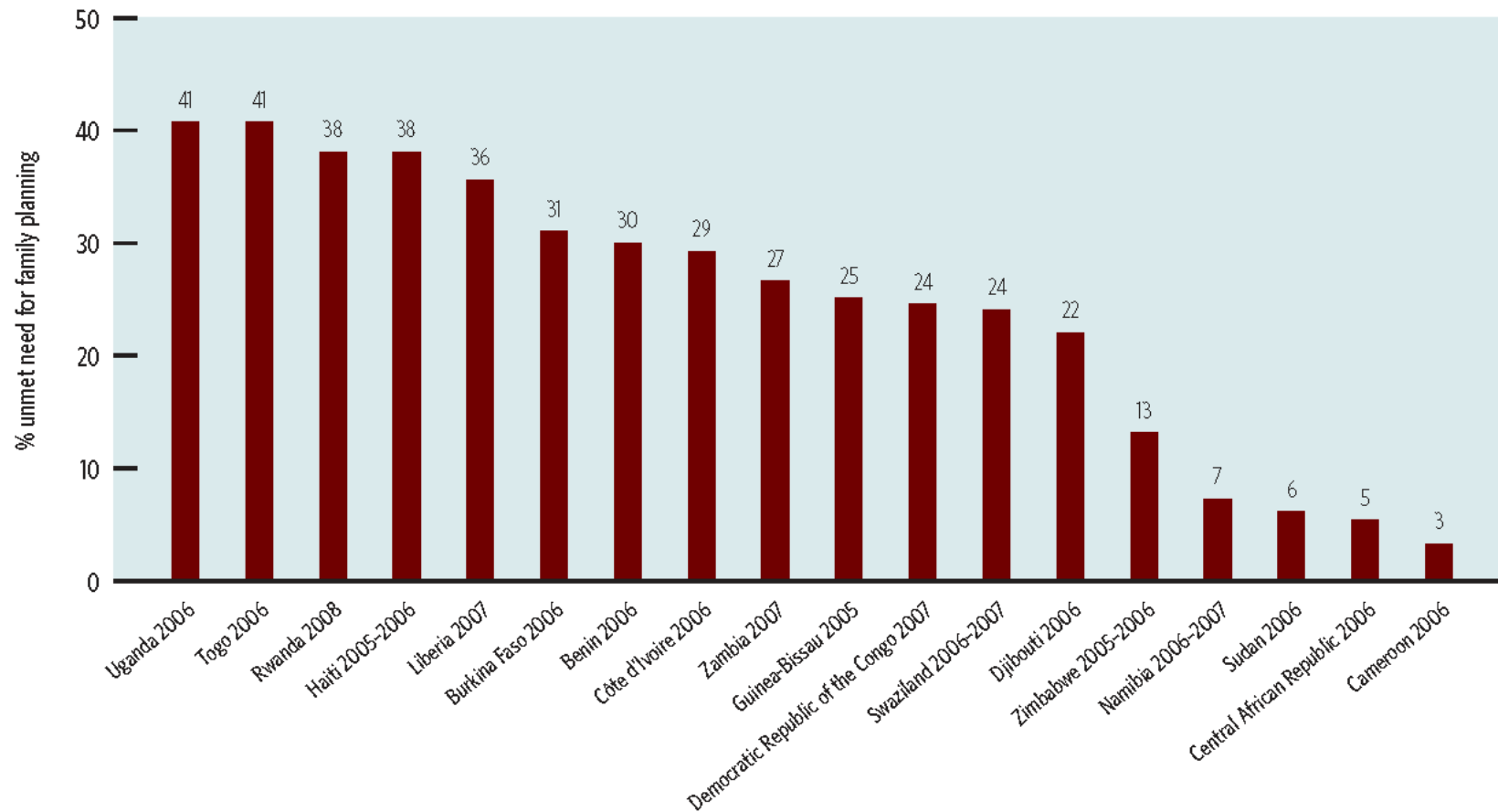
Fig. 5.2. Percentage of women and men aged 15–49 years with comprehensive knowledge^a of HIV in countries with recent population-based surveys (2007–2008)



* Comprehensive knowledge is defined as those who correctly identify the two major ways of preventing the sexual transmission of HIV (using condoms and limiting sex to one faithful, uninfected partner), who reject the two most common local misconceptions about HIV transmission, and who know that a healthy-looking person can transmit HIV.

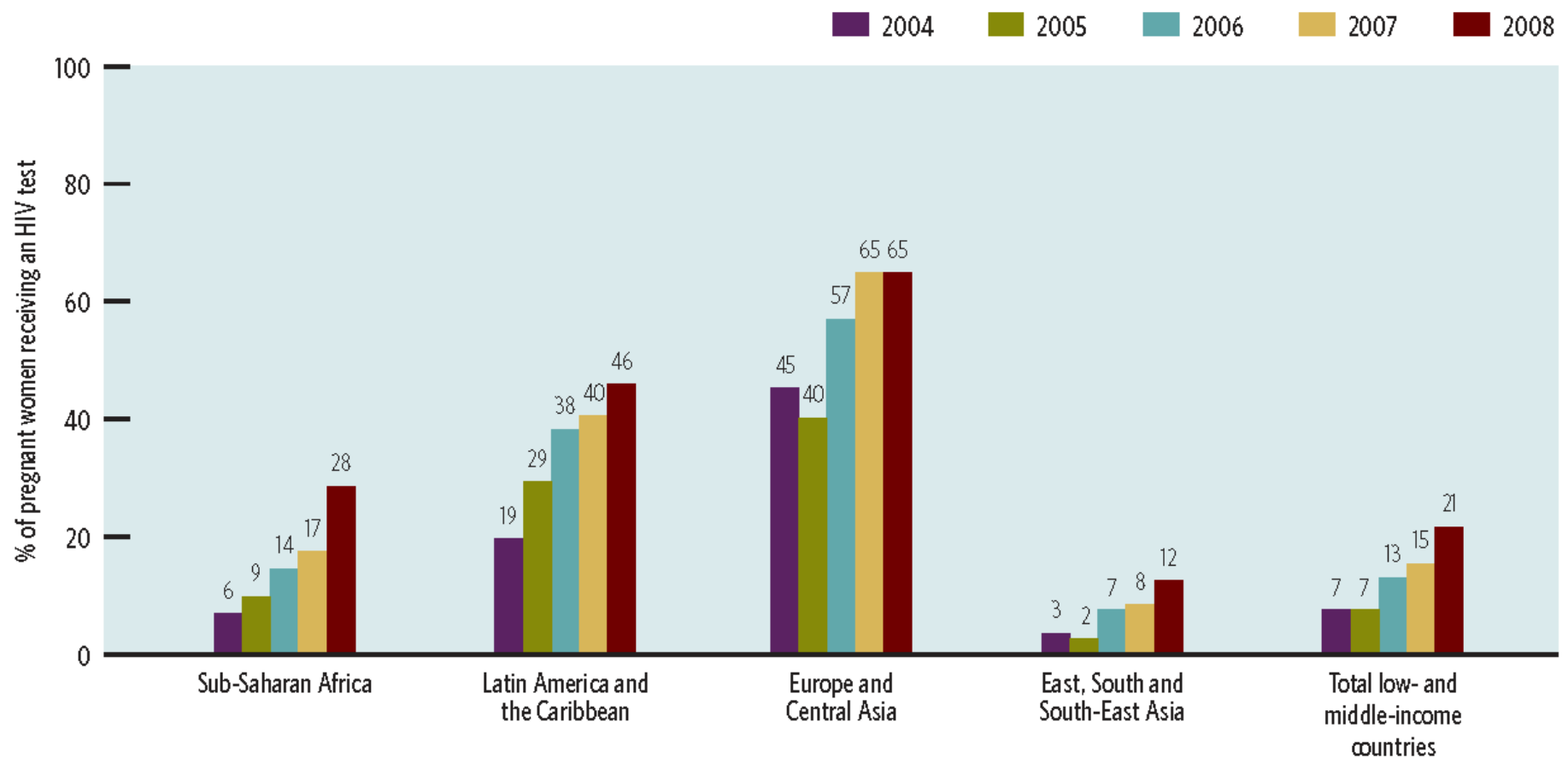
Source: AIS overview [web site]; DHS overview [web site]; Multiple Indicator Cluster Survey [web site], 2007-2008.

Fig. 5.4. Unmet need for family planning among married women 15–49 years old (%) in countries with a generalized epidemic, 2006–2008



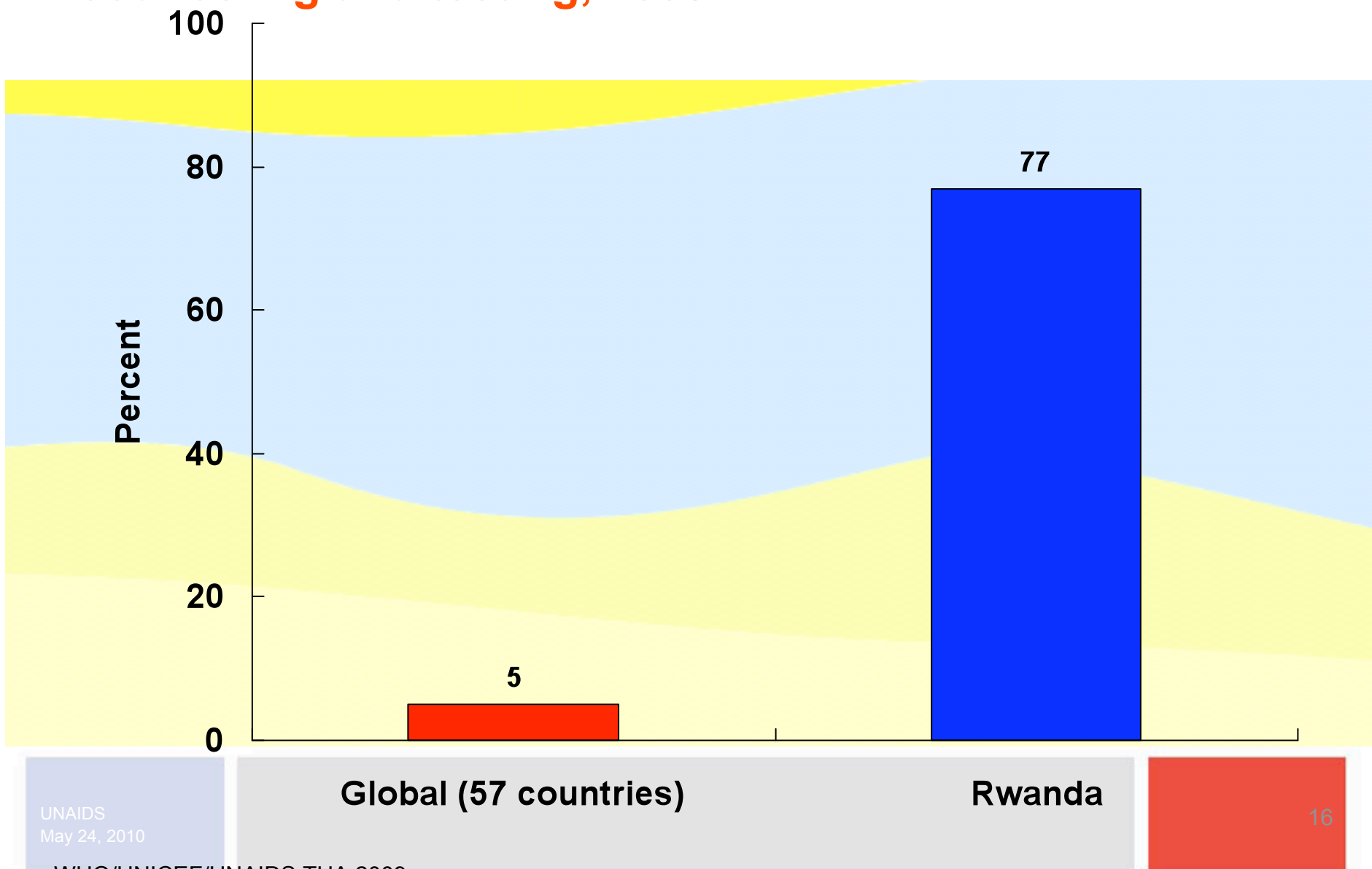
Source: DHS overview [web site]; Multiple Indicator Cluster Survey [web site]; Sudan Household Health Survey [web site].

Fig. 5.5. Percentage of pregnant women who received an HIV test in low- and middle-income countries by region, 2004–2008^a



^a Figures on the coverage of HIV testing among pregnant women were recalculated for previous years based on the revised estimates available.

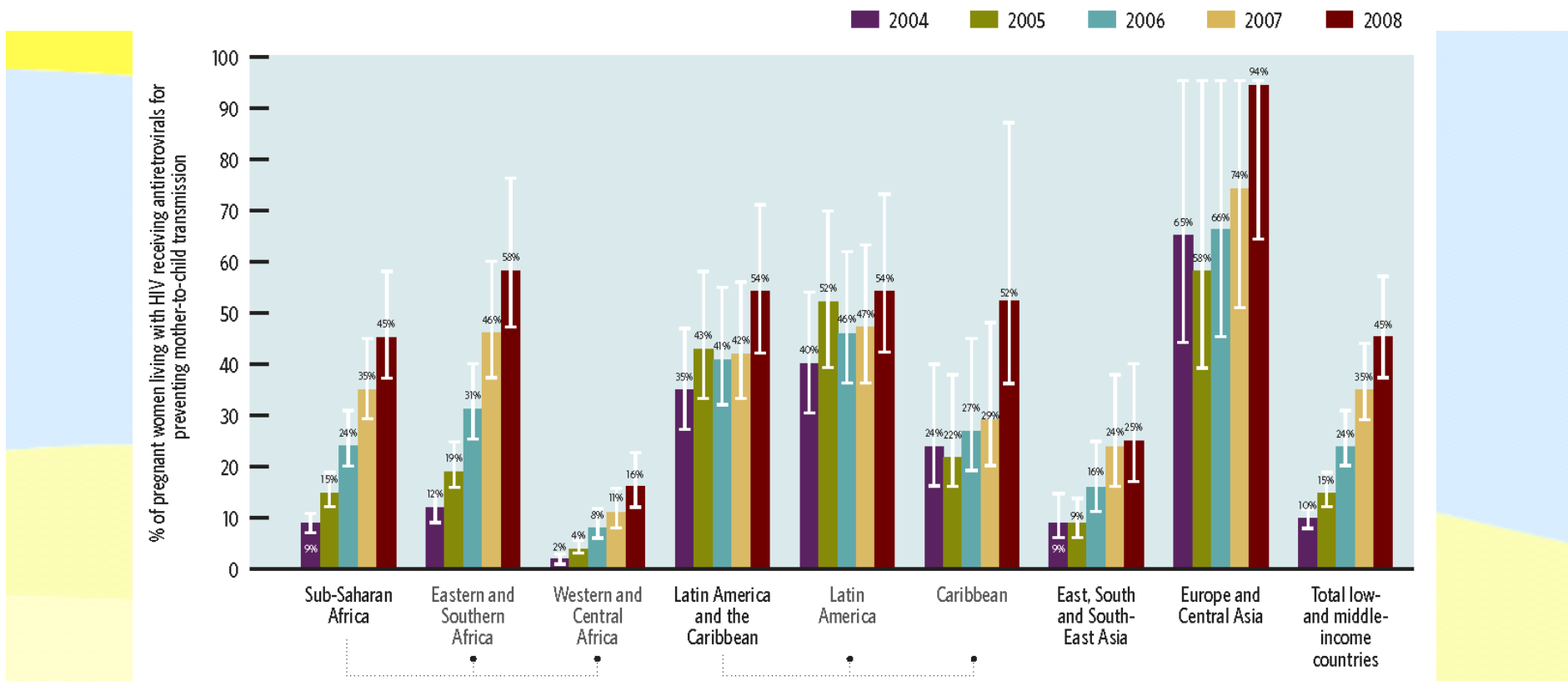
Percent of male partners who received counseling and testing, 2008



UNAIDS
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WHO/UNICEF/UNAIDS:TUA,2009

Fig. 5.7. Percentage of pregnant women with HIV receiving antiretrovirals for preventing mother-to-child transmission of HIV in low- and middle-income countries by region, 2004–2008



The bar indicates the uncertainty range around the estimate.

Source: Data reported by countries to WHO, UNICEF and UNAIDS in response to the annual reporting form for monitoring the health sector response to HIV/AIDS, 2009.

Fig. 5.9. Percentage of pregnant women living with HIV receiving antiretrovirals to prevent the mother-to-child transmission of HIV in 20 countries with the highest HIV disease burden among pregnant women, 2008

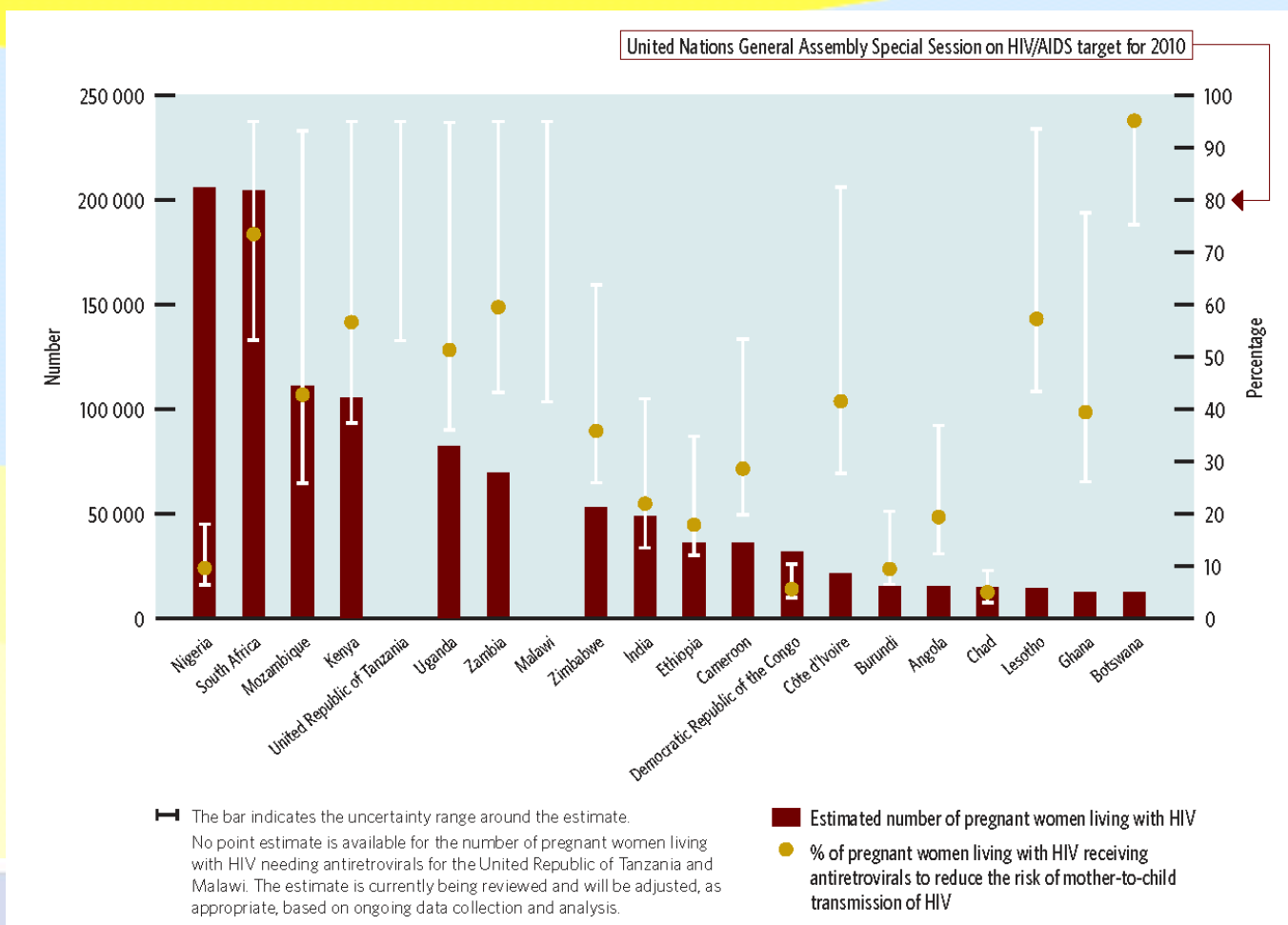


Fig. 5.11. Percentage distribution of various antiretroviral regimens provided to pregnant women in low- and medium-income countries in 2007 and 2008, based on available data

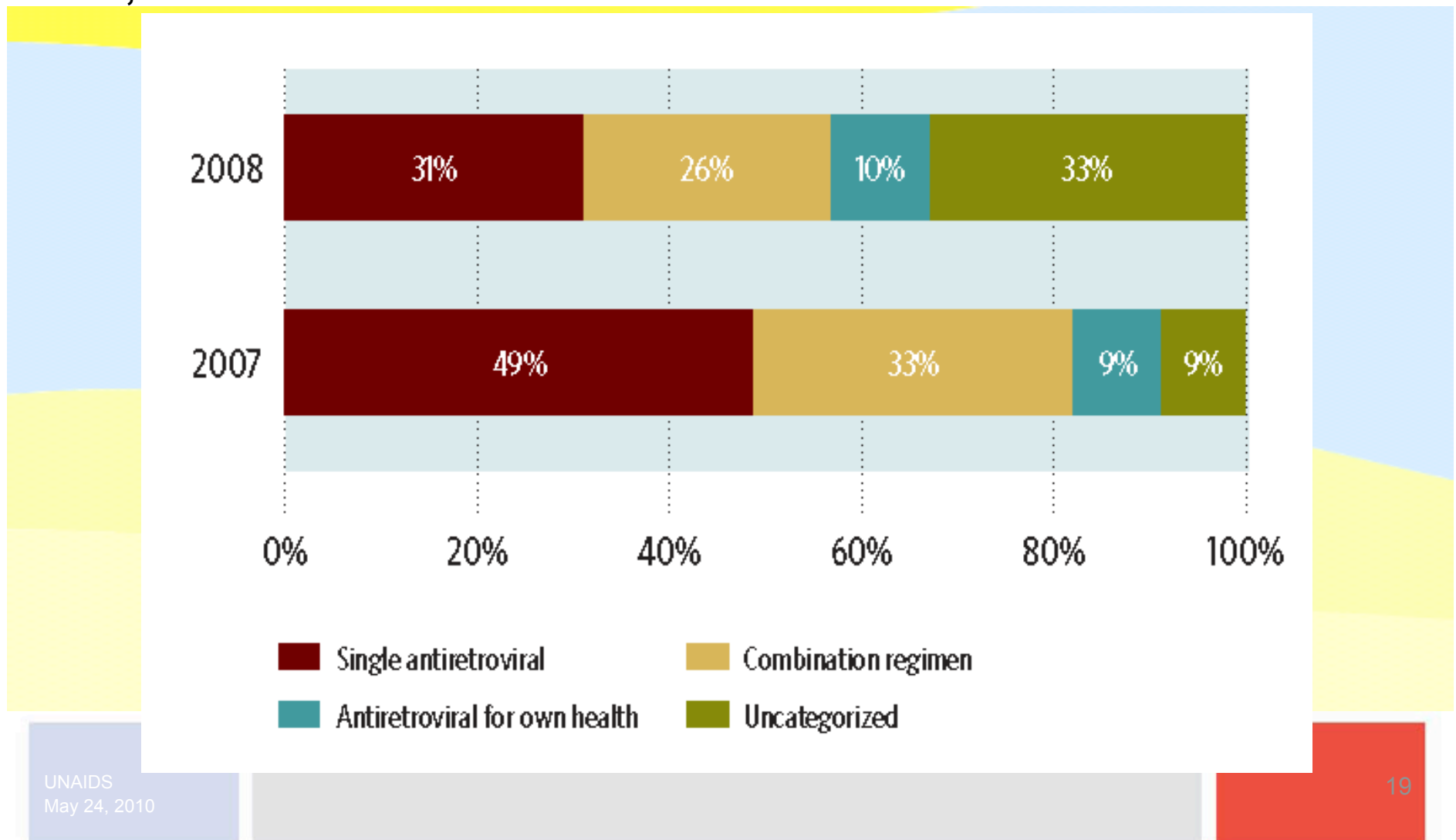
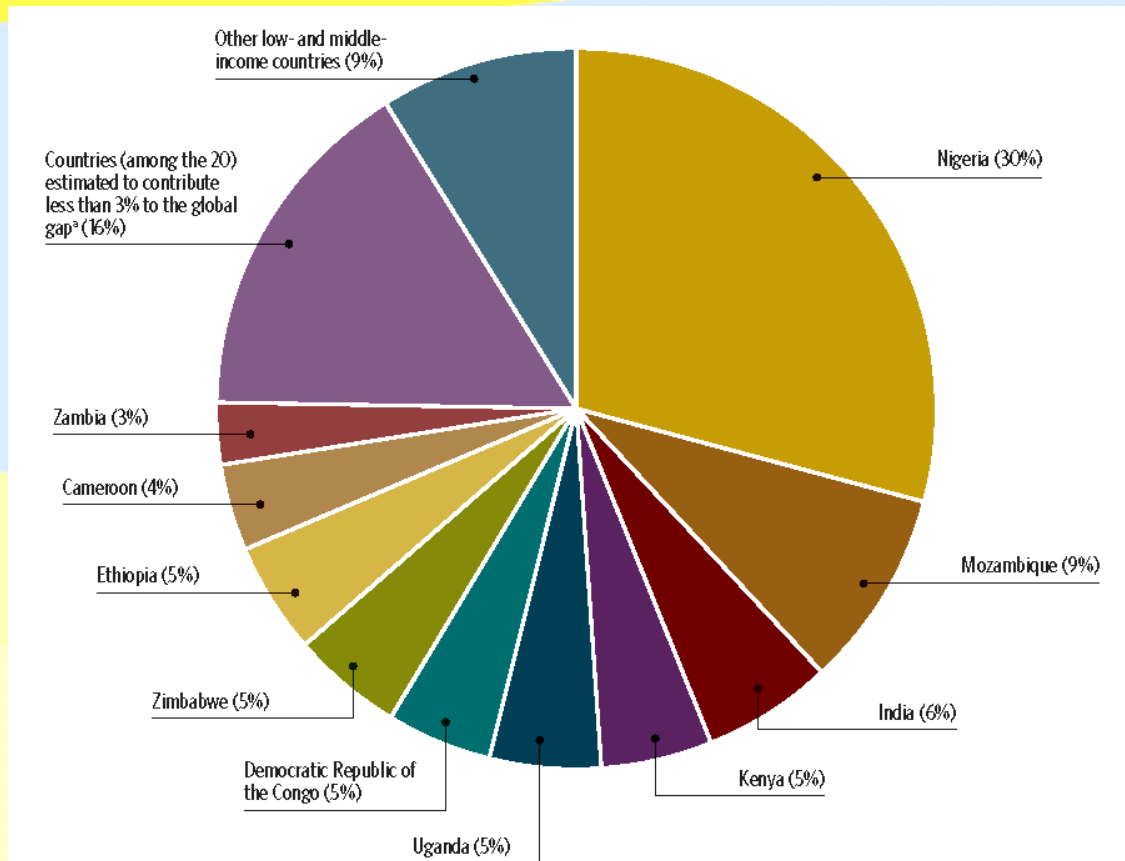


Fig. 5.12. Contribution of the 20 countries with the largest numbers of women needing antiretrovirals for preventing the mother-to-child transmission of HIV to the global gap to reach 80% of those in need, 2008



^a These countries include Angola, Botswana, Burundi, Chad, Côte d'Ivoire, Ghana, Lesotho, Malawi, South Africa and the United Republic of Tanzania.

Fig. 5.13. Coverage of antiretroviral prophylaxis among infants born to mothers living with HIV in low- and middle-income countries by region, 2008

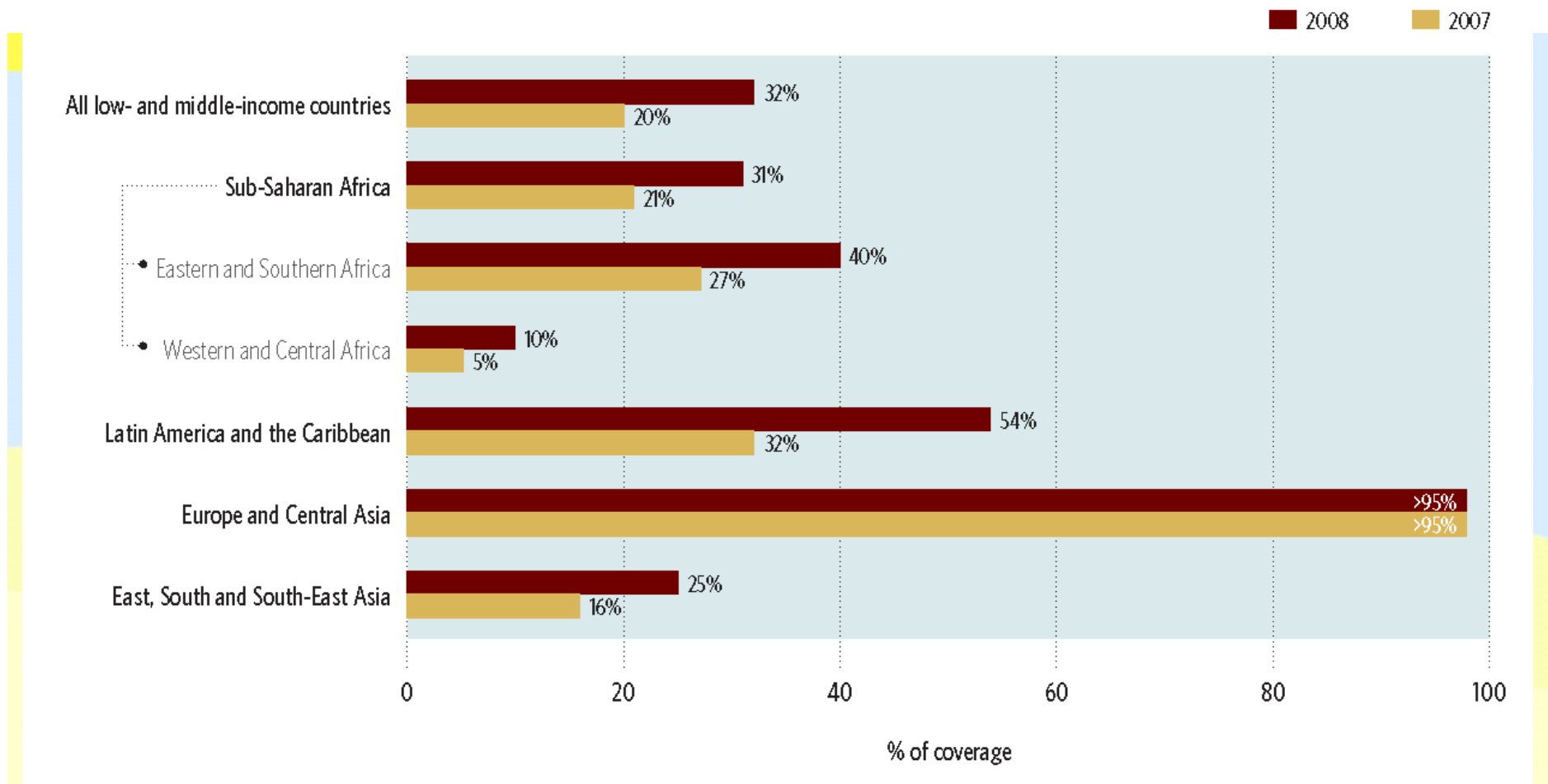
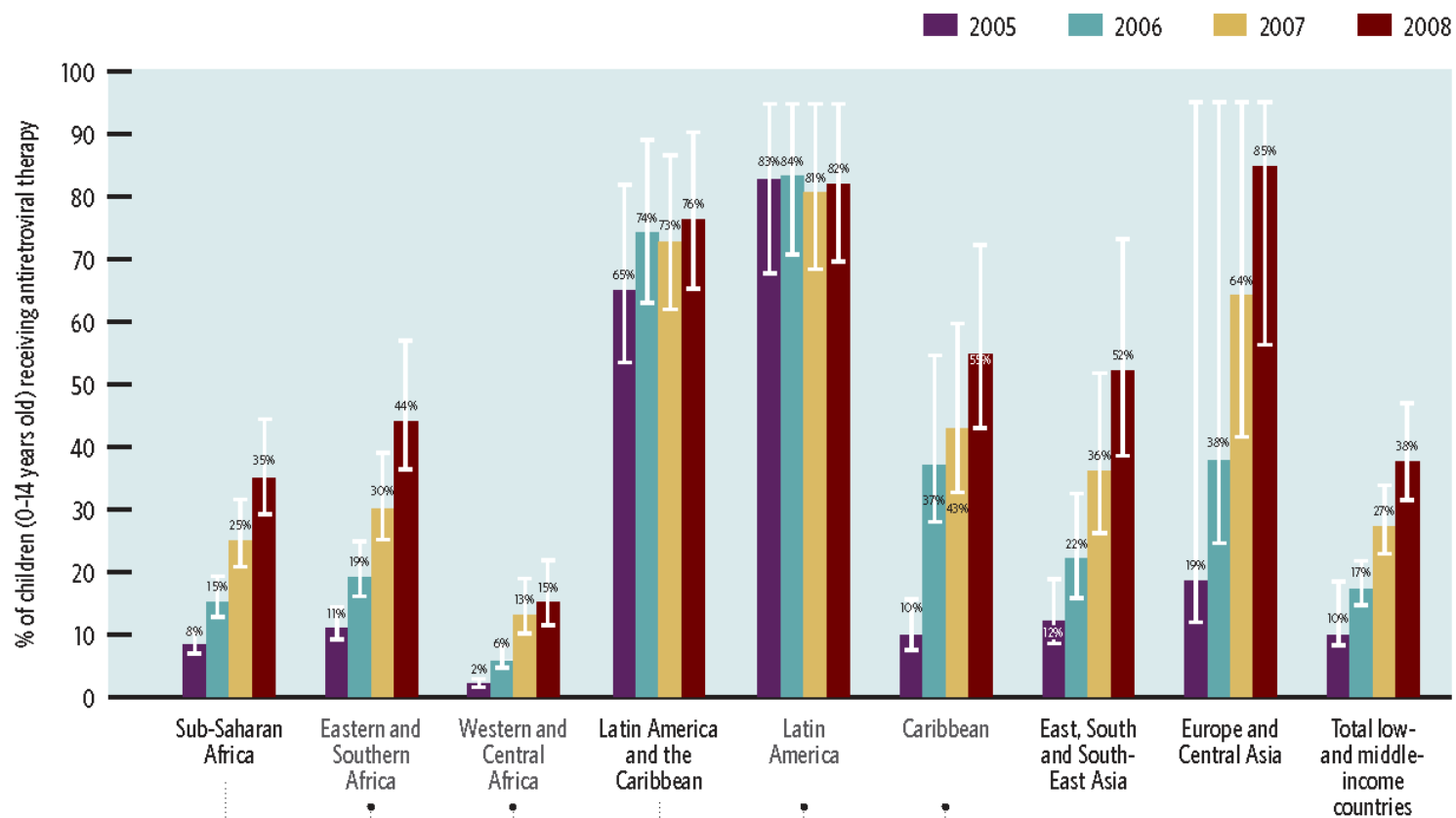


Fig. 5.16. Percentage of children receiving antiretroviral therapy in low- and middle-income countries, 2005–2008



The bar indicates the uncertainty range around the estimate.

Treatment, care and support



- 1. Prong 4 of PMTCT covers HIV treatment, care and support for women, children, and the family. In 2008, 38% of children in need of treatment, up from 10% in 2005. Children still lag behind adults; in 2008, 42% of adults who needed treatment were receiving it.**
- 2. In 2008, 34% of HIV+ mothers identified in antenatal clinics were assessed for their own ART needs, up from 12% in 2007.**
- 3. Basic antibiotics such as cotrimoxazole remain inaccessible to children, yet this is a highly efficacious medication, which has been shown to reduce opportunistic infections that lead to the illness and deaths of many children among exposed HIV- and HIV+ infants. In 2008, only 8% of infants born of HIV+ women received CTX, though this was up from 4% in 2007.**
- 4. The fourth prong of PMTCT also deals with infant feeding, in order to reduce the risk of HIV transmission during breastfeeding. However, the recommendations remain complicated and challenging , and many health care providers remain unsure about what guidance to give HIV+ mothers.**

Challenges

- 1. Insufficient global commitment and funding.**
- 2. Insufficient advocacy and political commitment at the country level.**
- 3. Programme fragmentation and parallel funding at the country level, with a concentration of services in urban settings.**
- 4. Insufficient integration and linkages within maternal, newborn and child health services and other sexual and reproductive health services, including family planning.**
- 5. Insufficient evidence base and monitoring and evaluation capabilities.**
- 6. Weak national health systems and programmes**

Virtual elimination action plan



UNAIDS has identified **21 countries** (13 high-burden countries and 8 other countries with specific constraints) where we can reduce the maternal HIV transmission to as close to zero by scaling up universal access to PMTCT by 2012, thereby contributing to the virtual elimination of this form of HIV transmission



The overall objective is to reach roughly 1 million HIV-infected pregnant women in the 21 countries concerned

Virtual elimination through 5 actions



1. INCREASE AND IMPROVE KNOWLEDGE ON PMTCT

2. STRENGTHENING COUNTRY OWNERSHIP

3. FACILITATE PROCUREMENT OF COMMODITIES AND TECHNOLOGIES

4. CAPACITY BUILDING AND HEALTH SYSTEMS STRENGTHENING

5. IMPROVE MONITORING AND MEASUREMENT OF RESULTS

6. SCALING UP TECHNICAL ASSISTANCE

Estimated Funding Required, 2010-2012 (US\$ 000s)

Budget Area	Year 1	Year 2	Year 3	Total
1. Situation assessment and review of plans				
Epidemiologic and PMTCT data collection and review	50	50	25	125
Analysis of gaps and bottlenecks at lowest level (e.g. dispensary)	50	50	25	125
Dissemination	10	10	5	25
Sub total	110	110	55	275
2. Government and Stakeholders Engagement				
Supporting demand generation activities via mass media, campaigns etc.	1,000	1,000	750	2,750
Strengthening advocacy to support PMTCT national ownership	600	600	200	1,400
Campaign for behaviour change and prevention among women of reproductive age,	1,500	1,500	700	3,700
Sub total	3,100	3,100	1,650	7,850
3. Commodities				
HIV tests, CD4 monitors and other equipment	1,500	1,500	1,500	4,500
ARVs for treatment and prevention	10,550	21,150	31,650	63,350
Early infant diagnosis's equipments and strengthening laboratories services	2,133	2,133	2,133	6,339
Other reproductive and child health supplies	4,500	4,500	4,500	13,500
Use of technological innovation for prevention and treatment (e.g., cell phones)	1,500	1,500	1,500	4,500
Sub total	16,550	27,150	37,650	92,249
4. Capacity building and health systems strengthening				
Helping countries to develop a system to assess the MTCT needs	50	50	0	100
Development of materials, strengthening service delivery infrastructure	250	125	75	450
Capacity building activities for doctors, nurses and health workers	1,350	1,350	1,000	3,700
Sub total	1,650	1,525	1,075	4,250
5. Monitoring and evaluation				
Strengthening data collection and M&E systems	135	135	50	320
Monitoring of PMTCT inputs and prevention activities	1,000	1,000	500	2,500
Surveillance of HIV and PMTCT	1,000	500	250	1,750
National AIDS spending assessments and setting up accountability systems	800	500	200	1,500
Studies on long term impact (output) of interventions (child survivals)	750	550	250	1,550
Sub total	3,685	2,685	1,250	7,620
6. Technical Support Facility				
Scale up of technical assistance funds in Africa, Asia and Europe and Central Asia	8,000	2,000	0	10,000
7. Global and programme support	1,655	1,829	2,084	5,568
TOTAL	34,750	38,399	43,764	127,812

- For this ambitious goal we estimated a financial need of \$ **127 millions over 3 years** (*This budget represent about 17% of the needs for PMTCT globally in 2010*)

- In a time of financial scarcity, every contribution can make a huge difference

Funders can contribute to the global project or to a single component or to one of the 21 countries





