

# Possible support for PMTCT from German Development Cooperation

Theme Group on Health, Working Group SRHR and Working Group AIDS 25 Jan 2011

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## 1. Background

### 1.1. Current status of implementation

Since 1998, when clinical studies proved that the short-term administration of antiretroviral medication reduces the mother-to-child transmission of HIV by 50 %, drug prophylaxis to prevent mother-to-child HIV transmission has been introduced as an important and effective prevention strategy in partner countries in Africa, Asia, Latin America and Eastern Europe as well.

However, PMTCT (Prevention of Mother-to-Child Transmission) involves more than drug prophylaxis to prevent HIV transmission from mother to child, and can make an effective contribution to improving the health of mothers, newborn infants and children. PMTCT also encompasses HIV prevention, sexual and reproductive health, maternal and child health and antiretroviral therapy, and should only be implemented in this comprehensive context. It includes:

- primary prevention of HIV infection in young women,
- the prevention of unwanted pregnancy in women infected with HIV
- the prevention of vertical transmission and
- care and treatment for HIV-positive women, their partners and children.

Unfortunately, PMTCT is often limited to vertical transmission and no consideration is given to integrating it into or linking it with sexual and reproductive health services, maternal and child health and antiretroviral therapy. It is a well-known fact that at the same cost, family planning is able to prevent 30 % more infections in children than the administration of a single dose of nevirapine.<sup>1</sup>

Some 90 % of all HIV infections in children worldwide are transmitted by the mother. Although the drug regime has been substantially improved since 1998, this has made it very complicated to administer. And although transmission could theoretically be reduced to 2 %, 430,000 children were infected with HIV in 2008. This number represents 17 % of all new HIV infections worldwide.<sup>2</sup>

The number of women who received antiretroviral drugs to prevent vertical transmission has risen markedly.

In 2008, 45 % of pregnant women infected with HIV in low- to medium-income countries had access to drugs that prevent vertical transmission, as compared with only 11 % in 2005. That included the administration of various drug regimes of differing effectiveness, starting with a single dose of nevirapine up to regimes involving the long-term administration of several antiretroviral drugs. However, only 20 % of the children born to these women received the necessary medication.

Children born with an HIV infection are rarely treated in time, leading to the deaths of 270,000 children from the infection throughout the world in 2007. That corresponds to 14 % of all AIDS-related deaths.<sup>3</sup>

This was attributed to the following main causes:

- inadequate access for pregnant women to advice and HIV testing
- inadequate access for pregnant women to CD4 cell determination
- High drop-out rates of mothers and children (between the time of testing and childbirth an neonatal care)

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<sup>1</sup> Reynolds HW et al; the value of contraception to prevent perinatal HIV transmission; Sex Transm Dis., 2006 June; 33(6): 350-6

<sup>2</sup> PMTCT Strategic Vision 2010-2015; Preventing mother-to-child transmission of HIV to reach the UNGASS and MDGs; WHO, Geneva, 2010

<sup>3</sup> The Global Fund; Nineteenth Board Meeting, Geneva, 5-6 May 2009

- Inadequate involvement of male partners in antenatal care, birth, care of newborn babies and antiretroviral therapy (ART) for their female partners (one of the reasons for -out rates)
- Insufficient capacity at the Ministry of Health to adjust national directives in accordance with WHO recommendations
- Lack of capacity and commitment to a holistic understanding of PMTCT and its family orientation, and to creating the corresponding linkages with and between sexual and treatment and care of people with HIV
- Inadequate primary prevention, since young women who have not yet given birth have only limited access to health services that are principally tailored to maternal and child care.
- Inadequate advice to HIV-infected women with regard to their reproductive options<sup>4</sup>
- Disregard of the right to health and access to medical services

## 1.2 International commitments

G8 countries including Germany committed in 2005, and again in 2007, to contribute to improved access to PMTCT. During their June 2010 summit in Canada, the G8 member states launched the Muskoka Initiative that aims to improve maternal, newborn and under-fives child health. The final document underlines that maternal and child health can only be improved by integrated services including antenatal and postnatal care, and by sexual and reproductive health services that include family planning and PMTCT.<sup>5</sup>

In 2010, WHO once again committed with greater emphasis to achieving the objective of the United Nations General Assembly (UNGASS), i.e. access to PMTCT for 80 % of pregnant women. However, it will focus its support on the 10 countries with the highest prevalence of HIV.<sup>6</sup>

GFATM also decided at its Board Meeting in May 2009 to comprehensively step up its support for measures to improve access to PMTCT, or to consider it in applications.

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<sup>4</sup> *ibid*

<sup>5</sup> G8 Muskoka Declaration Recovery and New Beginnings, Muskoka, Canada, 25-26 June 2010

<sup>6</sup> PMTCT Strategic Vision 2010-2015; Preventing mother-to-child transmission of HIV to reach the UNGASS objective and MDGs; WHO, Geneva, 2010

## **2. Possible support within the scope of German development cooperation (DC)**

Changes to improve the situation described above can take place at the level of policy and strategy development and of implementation in the partner countries.

### **2.1 Policy advice and support for implementation in the field**

#### **2.1.1 Policy advice**

German DC programmes (financial cooperation and technical cooperation) advise ministries in all countries where health is a priority area, in close and continuous coordination with other supporting partners. This advice can be used to introduce important approaches into the dialogue, with the aim of modifying and adapting national SRH and HIV/AIDS strategies. In some countries, particularly in Africa, officers responsible for SRH call for better linkages between SRH and HIV services as one of the foremost requirements.

The ministry staff who are responsible for the strategies relevant to HIV and some of the international partners who support them, however, do not see the same necessity to move towards conducting horizontal rather than vertical programmes.

Hence the importance of underlining the relevance of linkages between the different services especially in the bodies that are responsible for discussing strategies relevant to HIV.

In addition, continuous dialogue should be encouraged and promoted between the officers responsible for SRH and HIV strategies and policy.

Representatives of German DC should foster dialogue in the following areas:

- PMTCT is no longer to be seen as merely preventing vertical HIV transmission but should be linked with sexual and reproductive health services and the treatment and care of people infected with HIV. Strategies must be adapted correspondingly.
- Primary prevention of HIV infection in women of reproductive age is improved by better access for young women to preventive services and counselling inside and outside health institutions.
- Family planning is increasingly included in counselling for HIV-infected women, thus helping to prevent unwanted pregnancies.
- Training measures are integrated and curricula are correspondingly adapted to promote the linkages identified.
- National PMTCT guidelines are adapted in line with WHO directives, also with regard to integrating PMTCT, sexual and reproductive health and HAART (Highly Active Anti-Retroviral Therapy). This offers an opportunity to enhance the effectiveness with which

HIV transmission is prevented, but also involves the risk of asking too much of the existing system and having a counterproductive effect.<sup>7</sup>

- Making HIV testing and counselling an integral part of antenatal care. (At present, only half of health institutions offer testing and counselling).
- Male partners are included in antenatal care, birth and neonatal care, and in ART for their female partners. This leads to increased advice and HIV testing and treatment of men too, and promotes more understanding and support for female partners receiving ART.

Advice on implementation should be offered and provided in addition to encouraging continuous dialogue on these highly complex areas.

Partner countries in which health is a priority area, and which have a high prevalence of HIV and a correspondingly high number of women infected with HIV and a great need for PMTCT (Tanzania, Malawi, Kenya, Rwanda and Cameroon), are suitable for this approach.

The Asia-Pacific Operational Framework for Linking HIV/STI Services with Reproductive, Adolescent, Maternal, Newborn and Child Health Services was developed for the Asian region. Health programmes in Nepal, Viet Nam and Cambodia, countries with a low prevalence of HIV and less need for PMTCT, should concentrate on implementing this framework. Linking has been introduced at all levels in Cambodia. The experience gained in this way should be evaluated and made available to neighbouring countries.

### 2.1.2 Implementation level

While developing and adapting strategies is important, this is only one way of achieving improvements.

The **real challenge** is **practical implementation of linkages** between PMTCT and SRH services, and with the treatment and care of people infected with HIV, as well as linkages between the latter and SRH.

A) Since PMTCT and HAART were initially designed as vertical (stand-alone) programmes, this is reflected in the strategies, in the way the health institutions' services are organised and in the understanding of health institution staff (e.g. no coordination between SRH-R and HIV-related services, no mutual information or transferral, health staff often have expertise in SRH-R or HIV, but not in both areas, etc.).

B) Some strategies are appropriately worded but not operationalised. National strategies do in fact envisage the provision of advice on family planning for HIV-infected women, but staff at the HAART clinic are not trained for this, nor are those staff who are responsible for family planning at the same health institution involved in counselling women and their partners.

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<sup>7</sup> PMTCT Strategic Vision 2010-2015; Preventing mother-to-child transmission of HIV to reach the UNGASS objective and MDGs; WHO, Geneva, 2010

C) Furthermore, the entire organisation of the health institutions is mainly geared to the problems and needs of mothers and children. This means that services are not organised in such a way as to ensure the constructive involvement of male partners. Nor is enough consideration given to making sure that young women who have not yet had children make use of services.

Introducing care and treatment for HIV-positive people, including women, men and children, calls for health services that are accessible on an equitable basis to everyone, irrespective of gender and age. This offers a chance to restructure the services to meet these needs.

Linkages between the above-named services and organisational adjustment at the health institutions have not yet been successfully or comprehensively operationalised.

### **2.1.3 Proposals for a plan of action**

We therefore propose:

- devising specific models for the complex linkage and reorganisation of services for PMTCT, HAART and SRH, and support for their pilot implementation, flanked by process and results monitoring and evaluation. A study of this kind can show the extent to which linkages are possible and necessary to improve health care for the women and children involved and their health. The health programmes in Tanzania, Kenya, Malawi and Cameroon (countries with a high prevalence of HIV) are suitable for this purpose.
- devising a model for organising youth-friendly reproductive health and HIV prevention services, and support for implementing pilot projects, flanked by process and results monitoring and evaluation. A study of this kind can show that organising youth-friendly services increases the number of young women who take advantage of such services and who have not yet had children. Again, the health programmes in Tanzania, Kenya, Malawi and Cameroon are suitable for this.
- producing a manual on introducing measures that promote male participation in antenatal care and PMTCT, based on the experience so far. This manual should be widely distributed so that such measures can be put into practice. The experience gained in cooperation with the sector project on AIDS and the health programme in Tanzania offers a good basis for such efforts.

The programmes supported by financial cooperation to improve the health of mothers and newborn infants based on social franchising, results-based financing (RBF) and voucher systems can also take PMTCT into account.

## **2.2 Operational research**

With the exception of producing the manual, all of the proposed measures need to be flanked by operational research to verify the assumed results. Operational research can be directly initiated and carried out by the programme, or with support from the operational research sector project. This project invites candidates to submit a research project, based for example

on the competitive bidding procedure for the EU Framework Programme for Research and Technological Development.

Cooperation with other partners involved in implementing PMTCT might also be sought to carry out joint studies on **other relevant questions**. These might include:

- examining the reasons (and their relevance) for the high drop-out rate of HIV-positive women, after they have been identified during antenatal and neonatal care. Although we are aware of reasons such as a lack of involvement by male partners, limited access to health services due to poverty and cultural norms, we do not know about the relevance of individual factors. Appropriate planning of the most effective measures is not possible without this information
- examining the causes of death of newborn infants of HIV-positive mothers receiving preventive ART, who do not or do not exclusively breastfeed their babies. The theory is that most of these infants do not die as a result of the HIV infection, but from other illnesses such as diarrhoea.
- examining the effect that involving male partners in antenatal care and PMTCT has on reducing the drop-out rate, the number of deliveries at a health institution and the health of newborn babies. Although we know which measures encourage greater involvement of male partners, we do not know whether they achieve the desired results.

The health programmes in Tanzania, Kenya and Malawi, where there is a high prevalence of HIV and a great need for PMTCT, are suitable for conducting this research.

### **2.3 ESTHER hospital partnerships**

Hospital partnerships could be formed to improve PMTCT and the care and treatment of HIV-infected children. They could be used to implement model projects with enhanced approaches and services and to integrate these at national level to improve evidence-based strategies.

### **2.4 Possible support from the sector projects Population Dynamics (PD)+SRHR and HIV/AIDS, to implement the listed measures**

After ART was also introduced in developing countries, PMTCT was often seen more as a component of ART than as an important part of SRH or a linkage between the two areas.

Since financial and technical support for introducing ART and the related activities was mainly assumed by other international partners, the German health programmes withdrew from this field, and subsequently tended to lose sight of just how important PMTCT was for SRH-R and for maternal and child health.

Knowing that 270,000 children around the world died from HIV infection in 2007, we should make PMTCT a firm component of efforts to reduce newborn and child mortality. This can make a significant contribution to achieving the aims of the Muskoka Initiative, of which Germany is also a signatory.

### 2.4.1 Proposals for support

- > Employees of the sector projects support policy dialogue on this theme, e.g. at government negotiations on bilateral cooperation
- > Employees of the sector projects approach programme managers of the health programmes to foster discussion of this thematic area and point out its importance for their work.
- > Draw up a policy brief on PMTCT together with BMZ's Division 315, the sector projects HIV/AIDS and PD+SRGR, regional divisions and implementing organisations, and develop an implementation strategy and offer advice to the health programmes on implementation.
- > Conduct a survey of the health programmes to establish which measures have already been supported to link PMTCT with SRH and HAART, which are already being carried out in the country, and what results have been achieved.
- > Provide experts to develop practical models for linking PMTCT with ART and SRH and youth-friendly services together with partners in the relevant countries, and for monitoring implementation and conducting operational research.
- > Support operational research on the issues named in Section 2.2
- > Address the theme in the sector networks
- > Take this theme into account when conducting PPRs and designing new projects/programmes where expedient, and where suitable objectives are in place.