



**PMTCT High-Level
Global Partners Forum 2007**

**Achieving Universal Access to
Comprehensive PMTCT Services
26-27 November 2007
Johannesburg, South Africa
Meeting Report**

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ABBREVIATIONS

AED	Academy for Educational Development
ANC	Antenatal Care
ART	Anti-retroviral therapy
ARVs	Anti-retroviral drugs
BIPAI	Baylor International Pediatric AIDS Institute
CHAI	Clinton Foundation HIV/AIDS Initiative
CDC	Centers for Disease Control and Prevention
CMMB	Catholic Medical Mission Board
CST	Care Support and Treatment
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
FHI	Family Health International
HIV	Human immunodeficiency virus
IATT	Inter-Agency Task Team
ICAP	International Center for AIDS Care and Treatment Programs
ICRH	International Centre for Reproductive Health
ICW	International Community of Women Living with HIV
IEC	Information, Education and Communication
IPPF	International Planned Parenthood Federation
MDGs	Millennium Development Goals
MNCH	Maternal, Newborn and Child Health
MTCT	Mother-to-Child Transmission of HIV
PEPFAR	President's Emergency Plan for AIDS Relief.
PLWHA	People living with HIV/AIDS
PMTCT	Prevention of Mother-to-Child Transmission of HIV
STI	Sexually transmitted infections
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNGASS	UN General Assembly Special Session on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	US Agency for International Development
WHO	World Health Organization

Executive Summary

Globally, about half of the roughly 33 million people living with HIV are women. But in sub-Saharan Africa, home to almost 70 per cent of infected people, more women (61 per cent) than men are living with HIV.¹

Most children acquire HIV infection through mother-to-child transmission (MTCT), during pregnancy, labour and delivery or breastfeeding. In the absence of any intervention, the risk of HIV transmission from mother to child is 15–30 per cent if the mother does not breastfeed. Poor breastfeeding practices may increase the risk by 5–20 per cent to a total of 20–45 per cent.²

Every day, about one thousand two hundred children under the age of 15 years become infected with the HIV virus¹, 90 per cent of them through MTCT.³ Comprehensive delivery of proven interventions can reduce the risk of MTCT of HIV to less than 2 per cent^{4,5,6}, and

institutionalisation of these interventions as the standard of care has already led to the virtual elimination of new paediatric HIV infections in most high income countries. These intervention packages—broadly known as Prevention of Mother-to-Child Transmission (PMTCT) services—are becoming increasingly available and affordable even in low and middle income countries. Thus, the majority of HIV-related child deaths are now avoidable everywhere.

UN recommendations for comprehensive PMTCT programming are based on a four pronged approach which includes:

Prong (1): Primary prevention of HIV infection among women;

Prong (2): Prevention of unintended pregnancies among women living with HIV;

Prong (3): Prevention of HIV transmission from women living with HIV to their children; and

Prong (4): Provision of care, treatment and support to mothers living with HIV their children and families.

In 1998, an Inter-agency Task Team (IATT) on prevention of mother to child transmission (PMTCT), comprising representatives from

¹UNAIDS/WHO AIDS Epidemic Update 2007.

² De Cock KM, et al. Prevention of mother-to-child HIV transmission in resource-poor countries: translating research into policy and practice. *Journal of the American Medical Association*, 2000, 283(9):1175–1182.

³ UNAIDS/WHO AIDS Epidemic Update 2006.

⁴ Read J et al. A prospective cohort study of HIV-1-infected pregnant women and their infants in Latin America and the Caribbean: the NICHD International Site Development Initiative Perinata Study. *12th Conference on Retroviruses and Opportunistic Infections*. Boston, MA, USA. 22–25 February 2005 (Abstract 790).

⁵ European Collaborative Study. Mother-to-child transmission of HIV infection in the era of highly active antiretroviral therapy. *Clinical Infectious Diseases*, 2005, 40(3):458–465.

⁶ Dorenbaum A et al. Two-dose intrapartum/newborn nevirapine and standard antiretroviral therapy to reduce perinatal HIV transmission: a randomized trial. *Journal of the American Medical Association*, 2002, 288(2):189–198.

UNAIDS, UNFPA, UNICEF, and WHO, was established to create a platform for guiding and supporting country level action. The name later changed to the IATT on prevention of HIV infection in pregnant women, mothers and their children and with the expansion of the number of key implementing partners at country level, the membership of the IATT grew to 20 partners, including AED/Linkages, CDC, BIPAI, Clinton Foundation, CMMB, Columbia University, EGPAF, ESTHER, FHI, Global Fund, HORIZONS, ICRH, ICW, IPPF, USAID, UNAIDS, UNICEF, UNFPA, WHO and the World Bank.

In 2001, at the UN General Assembly Special Session on AIDS (UNGASS), national governments pledged to reduce risk of MTCT HIV infection by at least half by 2010, by ensuring that 80 per cent of pregnant women attending antenatal care had access to PMTCT services. Today, over 100 countries in low and middle income countries are fulfilling this commitment by integrating PMTCT services in maternal and child health programmes and the number of women receiving the services has been increasing. However, most of these countries are mainly implementing the third prong of the comprehensive UN approach, “reducing the risk of transmission during pregnancy and delivery”, and have paid scanty attention to: improving infant feeding practices; integrating primary prevention interventions and services

for prevention of unintended pregnancies among women living with HIV and to improving access to antiretroviral treatment (ART) for women for their own health and to prevent orphaning.

At the end of 2006, 23 per cent of pregnant women living with HIV in low and middle income countries received antiretrovirals (ARVs) for PMTCT. Regional estimates indicated higher coverage rates in Latin America and the Caribbean as well as Central and Eastern Europe, where PMTCT ARV coverage levels reached 40 and 80 per cent respectively. Some improvements are also being observed in Africa. In East and Southern Africa, some 31 per cent of women had access to PMTCT ARVs in 2006 up from 11 per cent in 2004 whereas in West and Central Africa, 7 per cent did, up from 2 per cent in 2004.

Despite these positive developments, many countries are still not on track to achieving the UNGASS targets by 2010. This slow progress was not initially predicted. PMTCT was at first envisaged as a time-limited service, governed by relatively simple guidelines that would be easily delivered to a select group of women through existing maternal and child health services.

International organizations and initiatives, including the UN, the Global Fund for AIDS, Tuberculosis and Malaria (GFATM) and the

President's Emergency Plan for AIDS Relief (PEPFAR) are providing considerable amounts of money and expertise in support of national government PMTCT scale up efforts worldwide. However, they have had to contend with a number of obstacles, including the poor national health care systems, especially in the poorest parts of the countries and particularly in the area of Maternal, Newborn and Child Health (MNCH); high levels of stigma, denial and discrimination and the fact that those who stand to benefit most from the services—women and children—often have a weak political voice.

Concerned by the limited progress and motivated by successful scale-up experiences in some of the middle and low-income countries, UNICEF and WHO, in collaboration with the IATT, convened the first High-Level PMTCT Global Partners Forum in Abuja in December 2005. The high-level delegates representing national governments, civil society, international organizations and donor countries adopted and issued a Call to Action, pledging to

“...commit to the goal of elimination of HIV infections in infants and young children, paving the way towards an HIV-free and AIDS-free generation”.

The deliberations from the Abuja meeting resulted in the IATT drafting of the drafting of a new guidance document, the “Global

Scale up of the Prevention of Mother-to-Child Transmission of HIV”. This document is a synthesis of critical elements needed for scaling up PMTCT services based on lessons learnt to date.

As a follow up to the Abuja declarations and acknowledging the urgent need for continued high level political advocacy to accelerate PMTCT service scale up, UNICEF, WHO, the IATT and the South African Ministry of Health convened the 2nd High-Level PMTCT Global Partners Forum on 27-28 November 2007, Johannesburg, South Africa. The Forum brought together health ministers, policy makers and technical experts from 27 countries as well as chief executives and senior managers of IATT partner organizations to review implementation progress since the Abuja Call to Action; share lessons learnt; discuss remaining gaps and challenges and to seek endorsement of the elements outlined in the IATT document on “Global Scale up of the Prevention of Mother-to-Child Transmission of HIV”. The presentations and discussions focused mainly on service-related challenges, such as health worker shortages, supply chain issues, patient follow-up, breastfeeding guidance and the introduction of new technologies such as Dried-Blood Spot-PCR HIV testing of infants. Community issues—including male involvement, stigma and discrimination, gender based violence and disclosure, HIV prevention and health worker attitudes, were

also raised and will likely remain an important focus of research in the future.

At the end of the deliberations, Health Ministers and country heads of delegations issued a Forum Statement, outlining nine key actions (*Appendix 1*):

1. Sustain political commitment and translating it into meaningful and visible support of programme implementation;
2. Support by partners of comprehensive and costed country-driven plans with long term sustainable and predictable financing;
3. Ensure adherence to all components of the Paris Declaration, including the principle of country ownership and leadership, and harmonisation and alignment of all partners behind national plans;
4. Strengthen coordination and ensure accountability among all partners in line with the 3 Ones principle, including developing and strengthening NGO capacity to respond in a coordinated manner.
5. Document lessons learnt and strengthen monitoring and evaluation with quality data;

6. Support of regular reviews and reporting of country level progress towards meeting PMTCT targets;
7. Adopt or adapt strategic directions laid out in the Guidance on global scale-up of PMTCT of HIV;
8. Place prevention of mother-to-child transmission of HIV in a broader spectrum and position it as "women, newborn, child and family-centered HIV prevention and care", and support integrated, not vertical programming;
9. Ensure meaningful participation of people living with HIV and people infected and affected by HIV and AIDS, in all policy discussions and in programme implementation.

The large attendance, the high-level commitment from national governments and partners, the IAT^T Guidance on Global Scale up of PMTCT, and the growing clarity on country specific programme needs will undoubtedly accelerate momentum for rolling out of PMTCT in the years to come. The major conclusion of the meeting was that PMTCT service implementation must no longer be addressed through vertical programming, but as an integral part of national health services and the overall response to AIDS.

1. Introduction

The HIV epidemic has had a major impact on maternal and child health and survival worldwide. At the end of 2007, an estimated 15 million women and 2.1 million children were estimated to be living with HIV, and about 1,200 children under the age of 15 were newly infected each day, largely through mother-to-child transmission⁷. Regional data from UNAIDS indicates that sub-Saharan Africa is the most severely affected region, accounting for nearly 70 per cent of all new HIV infections and roughly 90 per cent of infections in children.

These infections continue to occur, despite the existence of medical tools that can sharply reduce the likelihood of mother to child transmission (MTCT). In 1994, it was shown that a course of the anti-retroviral drug zidovudine, administered early in pregnancy and to the infant for a few weeks after delivery can sharply reduce the chances that the child will become infected⁸. Since then, shorter and simpler courses of ARVs have also been shown to be effective.^{9,10} However,

the most recent studies suggest even greater impact with two ARV drug combinations.¹¹

In recent years, these technical advances have run in parallel with political mobilization. In 2000, United Nations member states agreed to a set of Millennium Development Goals (MDGs), including the reduction of child mortality, the improvement of maternal health and the reversal of the AIDS epidemic and it was recognized that PMTCT programmes contribute to the achievement of all three. When UN members and other actors came together again in 2001 for the UN General Assembly Special Session (UNGASS) on AIDS, they set a target for the coverage of PMTCT. Specifically, the Declaration of Commitment pledges to reduce the fraction of children infected with HIV by half by 2010, by ensuring that 80 per cent of all pregnant women have access to PMTCT services.

By the end of 2004, over 100 low- and middle- income countries had established PMTCT programmes, although only 10 per cent of the pregnant women living with HIV in these countries were accessing ARVs for PMTCT.¹¹ Further, most programmes have focused on integrating PMTCT interventions in ANC and delivery settings, and have been limited to HIV testing and counseling and delivery of antiretroviral (ARV) drug preventive treatment. Few programmes have defined interventions for the other “three

⁷ UNAIDS/WHO AIDS Epidemic Update 2007.

⁸ Reduction of maternal-infant transmission of human immunodeficiency virus type 1 with zidovudine treatment. Pediatric AIDS Clinical Trials Group Protocol 076 Study Group', Connor et al, NEJM 331(18), 3 November 1994.

⁹ Intrapartum and neonatal single-dose nevirapine compared with zidovudine for prevention of mother-to-child transmission of HIV-1 in Kampala, Uganda: HIVNET 012 randomised trial', Guay et al, The Lancet 354(9181), 4 September 1999.

¹⁰ *Antiretroviral drugs for treating pregnant women and preventing HIV infection in infants: towards universal access. Recommendations for a public health approach.* Geneva, World Health Organization, 2006.

(www.who.int/hiv/pub/guidelines/pmtctguidelines2.pdf, accessed 13 June 2007).

¹¹ UNICEF, UNAIDS, WHO: Children and AIDS: Second Stocktaking Report, April 2008.

prongs” that the UN recommends should be part of any PMTCT programme: primary prevention of infection, prevention of unintended pregnancies and HIV/AIDS care and treatment. This is partly due to the lack of clear policy and operational guidance on how primary prevention and family planning should be implemented in the context of PMTCT and within the framework of national HIV prevention programmes.

In addition, most national PMTCT programmes lacked focused plans and targets for going to scale, and local and global resources have not been optimally mobilized and coordinated with one another to support the bold commitments made at the UNGASS.

At the first High-Level PMTCT Global Partner’s Forum meeting held in Abuja, Nigeria in 2005, national governments and partners pledged to commit to scaling up PMTCT in order to achieve an AIDS-free generation by 2015. This goal has also been endorsed by the G8 and also by the *Unite for Children, Unite against AIDS* initiative, launched by a wide partnership of UN, bilateral and non-governmental agencies in 2005.

At the end of 2006, 23 per cent of pregnant women living with HIV in low and middle income countries had ARVs for PMTCT, Regional estimates indicated higher coverage in Latin America and the Caribbean as well as Central and Eastern Europe where some 40

and 80 per cent of pregnant women living with HIV were reported to have received PMTCT ARVs.¹² Unfortunately, service provision tends to be especially low in some of the African countries most severely affected by AIDS.

That such an apparently technologically simple intervention is not more widely available puts the lives of millions of children at risk of HIV infection. The 2006 data indicated some improvements in coverage in sub-Saharan Africa, although only a few countries were on target to meet the UNGASS goal of 80 per cent coverage by 2010. According to the Children and AIDS: Second Stocktaking Report, in Eastern and Southern Africa, 31 per cent of pregnant HIV positive mothers received ARVs for PMTCT in 2006, up from 11 per cent in 2004, and in Western and Central Africa, some 7 per cent received the services, up from 2 per cent in 2004.

PMTCT services are important not only for those mothers and children who benefit directly from the services, but for the wellbeing of all those affected by HIV/AIDS, and for the broader fight against the epidemic. Even in the poorest countries, most women come into contact with the health care system at some point during their pregnancies. For HIV positive women, PMTCT services can be

¹² UNICEF, UNAIDS, WHO: Children and AIDS: Second Stocktaking Report, April 2008.

an entry-point for HIV-related care for the entire family, and for HIV negative women, as well as HIV positive ones, PMTCT services offer vital prevention counseling opportunities for women and their partners. Acceleration of efforts, however, requires political will and support as well as development of multi-sectoral programme management structures that have adequate linkage to community efforts and activities.

In 1998, an Inter-agency Task Team (IATT) on PMTCT, comprising representatives from UNAIDS, UNFPA, UNICEF, and WHO, was established to create a platform for country level action. The number of IATT partners has since grown to 20, including other key implementing partners: AED/Linkages, CDC, BIPAI, CHAI, CMMB, Columbia University, EGPAF, ESTHER, FHI, GFATM, HORIZONS, ICRH, ICW, IPPF, USAID, UNAIDS, UNICEF, UNFPA, WHO and the World Bank. The IATT is responsible for coordinating developing policy and operational guidance in addition to providing technical and financial assistance to national governments to scale up their efforts.

Since 2005, the IATT has conducted joint technical missions to countries across sub-Saharan Africa and Asia to foster in-country dialogue and galvanise political commitment and support to institute the necessary strategic shifts to accelerate scale of efforts. The

missions have focused on intensive review of PMTCT and Paediatric HIV care and treatment service delivery implementation status as well as the programme strategies and implementation bottlenecks. Based on the lessons learnt to date, the IATT has recently produced a document on “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.*”

This Global Guidance document provides recommendations to governments and key implementing partners for accelerating PMTCT programme scale up. The Guidance supports implementation of all four “prongs” of the UN comprehensive approach and operationalisation of the Three Ones¹³ 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.

¹³ Three Ones Principles envisage:

- one agreed HIV/AIDS action framework;
- one agreed AIDS coordinating authority, and
- one agreed monitoring and evaluation system.

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

2. Rationale for the High Level Global Partners Forum

Acknowledging the urgent need for continued high level advocacy and renewed political commitment and support to PMTCT efforts and to ensure these commitments translate into accelerated action, UNICEF, WHO and the Global IATT convened the Second Global Partners Forum on Prevention of Mother to Child Transmission of HIV Infection:

- 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.

The meeting was officially opened and adjourned by the Minister of Health of South Africa and attended by 241 Delegates from 27 countries that bear over 80 per cent of the pediatric HIV disease burden globally.

The country delegations included high-level government representatives and national programme managers and technical experts from the ministries as well as civil society representatives.

Among the high-level participants were four health Ministers of Health from Kenya, Mozambique, South Africa and Zimbabwe; vice ministers and/or permanent secretaries from Cameroon, Guatemala, Malawi and Thailand, and Chief Executives and senior officials from IATT partner organizations and agencies, BIPAI, CHI, CMMB, Columbia University’s ICAP, EGPAF, FHI, UNFPA, UNICEF, WHO, the World Bank.¹⁴ (*Please refer to Appendix 2 for the full list of participants*).

¹⁴ The IATT was led by two Assistant Director Generals of the WHO, the Vice President of the Human Development Network of The World Bank, Chief Executive Officers from other IATT members including EGPAF, FHI, Horizon, ICW), Deputy CEOs (BIPAI, CMMB), Senior Directors (UNICEF, UNFPA, UNAIDS, WHO, ICRH) and senior advisors. CEOs and senior officials from non-IATT partner agencies engaged in global PMTCT response included DFID and UNITAID.

3. Structure of the Forum

The two-day forum held from 26 through 27 November consisted of four main sessions:

Session 1: Global Trends, Lessons Learned, New Evidence;

Session 2: Comparative analysis and lessons learned from country experiences;

Session 3: Closed High level meeting with heads of delegation and group sessions on Building Partnerships and Technical Co-operation with technical representatives from countries and IATT representatives (Parallel Sessions); and

Session 4: Discussions on the way forward. The formal meeting was preceded by technical pre-meeting sessions on November 25th with key technical resource people from the country delegations and selected IATT partner agencies to review and share country PMTCT implementation experiences. The countries were divided into four working groups according to population sizes; HIV epidemic type (whether generalized or concentrated) and government administrative and management structure (whether decentralized or not):

Group 1: **High population countries with decentralized governments**¹⁵

Brazil, China, the Democratic Republic of Congo, Ethiopia, India, Nigeria and South Africa.

Group 2: **Countries with generalized epidemics**¹⁶

Cameroon, Central African Republic, Cote D'Ivoire, Haiti, Malawi, Mozambique, Rwanda, Tanzania and Uganda.

Group 3: **Countries with generalized epidemics and high mortality**

Botswana, Kenya, Lesotho, Namibia, Swaziland, Zambia and Zimbabwe.

Group 4: **Countries with concentrated/low epidemics**

Cambodia, Guatemala, Honduras, Russian Federation, Thailand and Ukraine.

Each country presented a progress report on its national PMTCT programme to the group, based on a template distributed prior to the meeting. Countries were asked to report on the political commitment will and support in delivering on the goal of universal access to PMTCT and Paediatric HIV care, support and treatment (CST) services and to describe their national policies and strategies. They were also asked to describe how the programmers were operating in their countries, including a) the roles and responsibilities of regional, district and other sub national levels in scaling up national programmes; b) efforts to implement provider-initiated testing and counseling in maternal, newborn and child health services; c) HIV prevention programming in the context of PMTCT; the integration of HIV care into maternal, newborn and child health settings and linking these services to sexual and reproductive health services; d) increasing access to more effective ARV regimens for women who need treatment during pregnancy and for their families in the longer term; e) efforts to clarify counseling on infant nutrition; and f) efforts to mobilize communities to support PMTCT programmes. Based on the discussions in the group, each group summarized their

¹⁵ The final group did not include Dominican Republic and India.

¹⁶ The final group did not include Haiti delegation.

discussions in a synthesis presentation that was shared as part of the lessons learnt session on the second day.

4. Proceedings

4.1. Opening and key note addresses

On behalf of Dr. Margaret Chan, the Director-General of the World Health Organization (WHO), Dr Hiroki Nakatani, the Assistant Director General AIDS, TB and Malaria of WHO expressed his sincere gratitude to the Government of South Africa for hosting the PMTCT High-Level Global Partners Forum 2007 in Johannesburg. He noted that although HIV transmission from HIV-infected mothers to their children can be reduced down to less than 2-3 per cent and paediatric HIV infection has virtually been eliminated in high income countries, there were still 2.5 million children under 15 years living with HIV globally and that over 90 per cent were infected through MTCT. He also noted that more than 85 per cent of these children were living in the African region.

He called for concerted action to meeting Millennium Development Goals 4, 5 6 to reduce by two-thirds the 'under-five' mortality rate; to reduce by three-quarters the maternal mortality ratio and to halt and reverse the HIV epidemic respectively.

The South African Health Minister Manto Tshabala-Msimang's highlighted the continued struggle to curb the epidemic and

the urgent need to focus HIV prevention and the parallel epidemic of gender violence. She acknowledged the complexity of the AIDS crisis, the history of South Africa's response, the disappointing results of recent clinical trials of vaccines and microbicides, the poor state of South Africa's health services and the persistently high levels of discrimination against people living with HIV. Despite all these problems, she noted that South Africa was making progress and that according to UNICEF and WHO, South Africa was on track to meet the UNGASS target of 80 per cent PMTCT service coverage by 2010. She pledged that the government was more committed than ever to scaling up PMTCT and AIDS treatment programmes in general.

The Health Minister's address was followed by four brief key note speeches. **Joy Phumaphi**, Vice President of the Human Development Network of the World Bank described the economic impact of the epidemic, which is especially severe in communities in Africa. She also warned that in the most severely affected countries, increasing health service demands are likely slow economic growth overall in the years to come. She described the essential package of services of which PMTCT must be an essential part, including family planning, pre- and post-natal care, HIV prevention counseling, testing and treatment and improved Maternal, Newborn and Child Health services.

Alan Rosenfield, Dean of the School of Public Health at Columbia University and a pioneer in expanding and improving PMTCT services to include AIDS treatment for women, children and extended families, even in the poorest countries, in a brief video address proposed that the name PMTCT be changed to Women and Children-Centered Care, or WCCC, to reflect the need for comprehensive, integrated services that place particular emphasis on the needs of women.

Pamela Barnes, President and CEO of EGPAF highlighted the contribution of her Foundation in the provision of HIV prevention, care and treatment services to thousands of women and children in eighteen countries, even in the most difficult circumstances, and **Florence Ngoben Allen** of IPPF discussed the importance of listening to women affected by HIV when planning PMTCT programmes. She reminded the audience that stigma and discrimination, by communities and by health workers themselves, still discouraged women from seeking out services and testing for HIV. She also stressed the need for health services to be more youth friendly, in terms of physically and psychologically accessibility and support.

4.2. Session 1 - Global Trends, Lessons Learned, New Evidence

To update participants on program implementation status; emerging new

evidence and the new IATT global guidance, four plenary presentations were made on:

- a. Global Progress in Scaling up the PMTCT Response;
- b. Lessons Learned from PMTCT Scale-up efforts;
- c. Emerging Evidence, Current Interventions and Promises for the Future; and
- d. Presentation of Guidance on Global Scale-up of PMTCT.

4.2.a. Global progress in scaling up the PMTCT response

Highlights of the findings reported in the forthcoming 2006 PMTCT and Paediatric Care Report Card were presented by Jimmy Kolker, Chief of HIV Section and Associate Director, Programme Division at UNICEF Headquarters in New York. He highlighted that at present, there are 2.5 million children living with HIV globally; 420,000 were newly infected last year, and 330,000 died of AIDS. One hundred and eight countries, representing 99 per cent of the estimated 1.5 million HIV positive pregnant women in low and middle income countries, reported progress data on PMTCT and paediatric care services in 2006. Most of these countries have national strategic plans to expand these services, and while coverage is still low, HIV testing and ARV treatment for PMTCT is increasing, particularly in Eastern and Southern Africa, as well as Western and Central Africa, although coverage levels are still very low. In all, 16 per cent of all pregnant women in low and middle income countries, and 21 per cent of those who attended at least one antenatal visit were

tested for HIV in 2006. Coverage of ARVs for PMTCT was greatest in Central and Eastern Europe—roughly 79 per cent¹⁷-- but the expansion of coverage has been most rapid in Eastern and Southern Africa, where 31 per cent¹⁸ of pregnant women living with HIV received PMTCT ARVs in 2006, compared to only 11 per cent¹⁹ in 2004. Twenty-one²⁰ countries are on track to reach the UNGASS target of 80 per cent ARV PMTCT coverage by 2010, including Rwanda, Kenya, Swaziland South Africa, Botswana and Namibia, where the proportion of women living with HIV is high.

Some 85 per cent of all HIV-positive children live in East and Southern Africa. In 2006, nearly 85,000 children in this region received ART, nearly double the number in 2005. Overall in low and middle income countries that reported, 127,300 children under 15 received ART in 2006 compared with 75,000

in 2005, an increase of 70 percent²¹. In all regions, more children were getting ART in 2006 than they were in the in 2005. While the scale-up of these programmes need to accelerated, roll out efforts underway with the help of partners and global initiatives including the GFATM, CHAI, PEPFAR and UNITAID. Of major concern however, is the fact that only 2 per cent of infants born to HIV positive mothers received co-trimoxazole preventive therapy, an inexpensive and simple antibiotic recommended for HIV exposed and infected children to reduce the incidence of and probability of dying from opportunistic infections.

4.2.b. Lessons Learned

Dr Elaine Abrams, Professor of Pediatrics and Epidemiology and Director of the MTCT-Plus Initiative at the International Center for AIDS Care and Treatment Programs at Columbia University Mailman School of Public Health in New York presented a new paradigm for the scale-up of PMTCT. She described the successes of the scale-up of HIV Care and Treatment services in low resources settings and suggested that the basic lessons of the ART roll-out be applied in the arena of PMTCT. To date, this has not been done and PMTCT has been established as a vertical program focused on a

¹⁷ Presentation reported 70 per cent coverage using then available UNAIDS/WHO need estimates of HIV infected pregnant women. Recalculated coverage rates above are found in *Children and AIDS: Second Stocktaking Report, UNAIDS/UNICEF/WHO, 2008*

¹⁸ Presentation reported 27 per cent coverage using then available UNAIDS/WHO need estimates of HIV infected pregnant women. Recalculated coverage rates above are found in *Children and AIDS: Second Stocktaking Report, UNAIDS/UNICEF/WHO, 2008*.

¹⁹ Presentation reported 9 per cent coverage using then available UNAIDS/WHO need estimates of HIV infected pregnant women. Recalculated coverage rates above are found in *Children and AIDS: Second Stocktaking Report, UNAIDS/UNICEF/WHO, 2008*

²⁰ Presentation reported 17 countries on track to reach 2010 UNGASS targets using then available UNAIDS/WHO need estimates of HIV infected pregnant women. Recalculated coverage rates and list of countries above are found in *Children and AIDS: Second Stocktaking Report, UNAIDS/UNICEF/WHO, 2008*

²¹ Presentation reported paediatric ART coverage rates using then available UNAIDS/WHO need estimates of HIV infected children in need of treatment. Current estimates are being revised and thus not available.

simplified intervention. Dr. Abrams provided a new framework which optimizes the opportunity provided by pregnancy and maternal child health services in identifying and engaging women, children and families in HIV care and treatment, maximising opportunities to provide potent PMTCT prophylaxis ARV regimens and to identify women and children in need of ART.

Dr. Abrams also provided examples of successes and challenges from the field in the various aspects of PMTCT care for women and children. Multiple countries have demonstrated the success of the “opt-out” approach in HIV testing and counseling within the ANC. In Rwanda, ICAP supported programmes have successfully integrated CD4 testing of all pregnant women and initiation of HAART for women with advanced disease and dual ARV therapy for those women only requiring prophylaxis. In multiple countries infant diagnostic technology is becoming available using dried blood spots for DNA PCR and programmes are facing challenges around linkages between PMTCT services for the mother and ongoing follow-up for the child.

An exemplary PMTCT programme being implemented in Rwanda was described. The programme is linked to care and treatment services. All participating HIV-positive women get a CD4 test, which are analyzed in a central location at the district level. The

results then determine whether the woman is referred right away for treatment for her own health. One difficulty in linking PMTCT and treatment services is that ART is usually dispensed by doctors, often at large tertiary hospitals, whereas antenatal services are usually staffed by nurses at the dispensary or health center level. Linking these services will require policy changes and task shifting within the health sector.

Finally, the challenges associated with infant diagnosis and follow up care were raised. It is known that early infant diagnosis is crucial, because HIV disease is so aggressive in children, making early treatment essential. Dried blood spot-PCR technology makes early diagnosis feasible, in theory, even in very poor clinics. However, in practice, the maternal, newborn and child health clinics where most infants and children generally receive care are often beset with staff shortages, and supply chain and infrastructure problems. It is essential that these services be improved because children with HIV—like all children--- need a range of services, including routine immunizations, co-trimoxazole prophylaxis and growth monitoring as well as ART.

4.2.c. Emerging Evidence, Current Interventions and Promises for the Future

Kevin De Cock, the Director for the Department of HIV at WHO in Geneva, addressed research challenges in the field of

PMTCT. He noted that the Guidance document recommends that health systems address PMTCT using a “four pronged” approach, which links PMTCT to primary HIV prevention, family planning to prevent unwanted pregnancies and treatment and care for women and their partners and children.

Various guidelines are now available from WHO on provider-initiated testing and counseling, ART formulations for children and other technical issues. WHO has also issued guidance on infant feeding, but the decision-making process for women is still complex, and depends upon their particular circumstances.

There are several ongoing studies of antiretroviral therapy for mothers during pregnancy and early weaning. One such study, based on Mozambique’s DREAM programme reduced MTCT to 2.7 per cent at six months in a breastfeeding population. The longer term effects of ART exposure in utero are unknown however, so ART during pregnancy is not yet routinely recommended.

4.2d. Presentation of new Guidance for Global Scale-up of PMTCT

At the end of the Session, Lynn Collins, Technical Adviser, HIV/AIDS at UNFPA in New York, presented the new “Guidance on the Global Scale up of the Prevention of Mother-to-Child Transmission of HIV.” The guidance document was developed by the

IATT based on the emerging programmatic evidence and experiences from seven years’ of PMTCT service implementation in low and middle income countries. It is meant for health ministries and their NGO partners aiming to scale up and integrate PMTCT into national Maternal, Newborn and Child Health programmes. It recognizes that for years PMTCT was addressed through “projects” and “pilots” but that comprehensive, ministry-driven national programmes are now called for. While acknowledging that the details of particular approaches will depend upon local conditions, the document outlines eight strategies that need to be part of any comprehensive, national approach to PMTCT:

- 1) Government leadership, commitment and accountability to deliver on the goal of universal access.
- 2) District driven responses focused on the delivery of a standard package of comprehensive services.
- 3) Institutionalizing provider-initiated HIV testing and counseling in maternal, newborn and child health settings.
- 4) Institutionalizing longitudinal HIV care management in MNCH settings.
- 5) Strengthening infant feeding and nutrition advice, counseling and support.
- 6) Increased access to ART.

- 7) Operationalising linkages between PMTCT and sexual and reproductive health services.
- 8) Empowering and linking with communities.

She emphasized that the document provides details about issues related to health education for pregnant women in ANC; provider initiated testing and counseling; condom provision; screening for gender violence; nutritional support for pregnant women and their infants, family planning and the recommended regimens of ART for PMTCT and paediatric care.

She noted that particularly complex are social issues that complicate service delivery, such as lack of health staff capacity for counseling, lack of male involvement, domestic violence associated with HIV diagnosis and treatment, loss to follow-up, discriminatory attitudes of health staff and stigma in communities. The document does not provide guidance on these issues but they must be addressed according to local norms and mechanisms.

4.3. Session 2: Comparative analysis and lessons learned from countries

During this session, the four country groups presented in plenary the reports they prepared from their deliberations during the Sunday pre-meeting. Despite the diversity of the countries represented at the meeting,

concerns, challenges and recommendations raised were remarkably similar. Common to all groups were the following challenges: the need to transform vertical, donor driven pilot services into programmes that are integrated within existing national health systems; the need to strengthen existing health systems; the need to clarify infant feeding recommendations, especially at the time of weaning particularly in settings where formula feeding is not safe and finally the need to increase community engagement and male involvement in PMTCT programmes.

The groups also identified common factors that contribute to strong PMTCT implementation as political commitment; decentralized systems of governance and service delivery; rapid adoption of new technology and the use of trained lay counselors and village health workers.

Group 1 comprised Brazil, China, DRC, Ethiopia, Nigeria and South Africa.²²

These countries all have large populations and even though HIV infection rates are low and the epidemic highly concentrated in most group 1 countries (except in South Africa), each of the countries is home of millions of HIV positive people, just because their populations are so large. These countries also have decentralized health systems that are governed at provincial or state levels. In

²² A civil society representative from India also contributed to the discussion.

addition they are characterized by vast inequalities in distribution of wealth, especially amongst women.

The challenges to scaling up PMTCT in these large populous countries included inadequate funding; weak health systems and poor infrastructure; insufficient staff; gaps in supply chain and lack of technology for early infant diagnosis. Existing programmes were said to be poorly coordinated, donor driven and sometimes insufficiently integrated into existing health care systems. This was especially true of family planning and HIV-related services. Additional problems included stigma and discrimination in communities, limited of accountability and commitment at both national and local levels, and the fact that in some countries, antenatal and child health services are not free.

Successful features of programmes included elements of political commitment including Brazil's universal access policy; the strong national coordination mechanisms of South Africa, China and Brazil, and the use of community health workers and lay counselors in South Africa and Nigeria.

Technical interventions, such as provider initiated testing and counseling, rapid HIV testing, CD4 testing of pregnant women and early infant diagnosis using DBS DNA PCR technology were also seen as important for

success, as were strong monitoring and evaluation systems.

Community engagement had been achieved in some communities through programmes such as "Mothers 2 Mothers 2 Be" in South Africa, networks of PLHWA groups in India, Nigeria and Brazil and female health extension workers in Ethiopia.

The group agreed that vertical programmes and incentives for government health workers hired by NGOs were to be avoided. The group also recognized that each country and region is different, and the complexities surrounding infant feeding decisions, relationships to NGO partners, the generation of political will and programme evaluation need to be worked out locally. For these reasons, the group emphasized that partners need to support country driven initiatives with technical know how, commodity and equipment procurement and research into outstanding issues such as infant feeding, maternal ART and etc.

Group 2 comprised Cameroon, Cote D'Ivoire, Mozambique, Tanzania, Uganda and Rwanda. All of these countries have generalized epidemics with relatively high rates of infection among women of childbearing age. All of them have high levels of political commitment, and advanced national policies and plans that recognize the

importance of integrated service delivery coordinated at the district level.

In addition to the challenges encountered by Group 1, Group 2 requested partners to help with monitoring and evaluation of services, health system strengthening, and for improved guidance on how to mobilize communities and involve men.

Group 3 consisted of Botswana, Kenya, Lesotho, Swaziland, Zambia and Zimbabwe. These countries have generalized HIV epidemics and high infant and child mortality rates and they have made considerable strides in recent years in scaling up access to services. In Zimbabwe, 96 per cent of ANC facilities offer PMTCT interventions; in Zambia 85 per cent of hospitalized children at the University Teaching Hospital are now tested for HIV since institutionalization of the provider-initiated testing and counseling, and in Kenya, many pregnant women identified as living with HIV through PMTCT services are subsequently enrolled in ART treatment, a triumph for integration. In Botswana, PMTCT services are a routine part of antenatal care and as a result the fraction of children born to HIV-positive mothers who are themselves positive has fallen from nearly 30 per cent to 7 per cent. However, Botswana has had less success in recruiting men to join their partners in being tested: only 6 per cent agreed to do so.

In addition to the recommendations noted by group 1 and 2, **Group 3** highlighted the importance of aggressive community involvement of PLWHAs and the need to make sure women and children are followed up as a continuum throughout the health care system.

Group 4 consisted of Cambodia, Ukraine, Russia, Thailand, Honduras, Guatemala, and the Dominican Republic. These countries have epidemics that are concentrated in especially high risk, often marginalized populations.

The group noted that in these countries, efforts to scale up PMTCT services must be linked not only to other health services, but also to social programmes addressing those groups most at risk of infection, including commercial sex workers, men who have sex with men and injecting drug users.

The group also highlighted that the programmes must also be informed by a commitment to uphold the rights of all those affected, including women, children and vulnerable populations.

4.4. Session 3 – Parallel Sessions on building partnerships and technical cooperation:

- Group work with technical experts from countries on Building Partnerships;
- High level meeting of ministers and other heads of delegation; and

- IATT meeting on Technical Co-operation in support of country efforts.

After the country groups presented their technical support needs (*annex 1*), the IATT met to discuss how to improve technical cooperation and coordination (*annex 2*). At the same time, Ministers and other heads of delegation met to draw up the Forum Statement (*Appendix 1*).

Guidance on infant feeding including IEC materials and counseling guidelines were considered a priority by all country technical groups. In addition, all groups also requested guidance on reducing stigma and on approaches for effective engagement of men and civil society. To effectively scale up services, all countries called for service integration and an end to what was perceived as donor-driven pilot projects. Monitoring and evaluation was also seen as a priority complemented by methods for ongoing quality control and assurance. Groups 1, 2 and 3 expressed great concern over human resource issues, especially the shortage of health professionals and emphasized the need to shift tasks such as dispensing ART to lower level health providers, and to explore ways for increasing the capabilities of traditional birth attendants and other community health workers. Groups 1 and 2 stressed the need for enhanced technical capacity, especially in the areas of CD4 testing and early infant HIV diagnosis. There was

also a wide-ranging debate about primary HIV prevention, including the ongoing controversies surrounding the “ABC’s” and the recent finding of the protective effect of male circumcision.

4.5. Session 4 – The Way Forward: Renewing Commitment

During session 4, health ministers and other heads of delegation presented the Forum Statement (*Appendix 1*). The Statement commits governments to sustained leadership to PMTCT scale up. Specific actions highlighted included: Developing costed plans in line with the Paris Declaration; developing structures and systems for better coordination, in line with the 3-ones principle and for working with affected communities on both policy and implementation issues; integration of PMTCT services into existing Maternal, Newborn and Child Health services; improving monitoring and evaluation to assist health workers and improving the supply chain for drugs and other commodities.

In partnership with IATT members, governments also pledged to advocate for increased funding, especially from the Global Fund for AIDS, Tuberculosis and Malaria. Governments also agreed to work with partners to strengthen family planning and HIV prevention for all women and to develop locally appropriate infant feeding guidelines.

5. Conclusions

The commitment of political will at the Global Partner's Forum, along with increased funding for PMTCT programmes, will inevitably generate momentum for greater PMTCT service coverage in the years to come. However, as many participants noted, expansion of services must be balanced with the need to maintain quality and to increase the capacity of health systems to cope. Problems such as inadequate counseling by harassed health workers, lack of gloves and other infection control commodities, as well as other supply chain and laboratory glitches could undermine faith in these life-saving programmes.

Remedying these problems may require not just funding and political will, but also broad legislative and policy changes. Health worker shortages in Africa, in particular, are not just caused by lack of personnel, but by the lack of posts for the many trained people who remain in their countries. The departure of African doctors and nurses for greener pastures in the West is part of the problem; but so are hiring constraints imposed by Ministries of Finance and International Financial Institutions. These

are some restrictions preventing lower level health workers from dispensing ARVs may also contribute to unnecessary staff shortages.

Finally, the issue of male involvement posed a conundrum for many participants. It is known that women are much more likely to adhere to PMTCT regimens if they are tested and counseled along with their partners. But programmes encouraging couple testing has had mixed results.

Within one programme in Rwanda, 40 per cent of the male partners of PMTCT clients agreed to be tested, whereas in Botswana, only 6 per cent did. There was considerable discussion about how to boost these rates, but it is important to bear in mind that while couple testing may be a good measure of male involvement, building a supportive household and community atmosphere for women living with HIV involves far more than this.

Making PMTCT programmes work will require an end to stigma, denial, discrimination and domestic violence, and greater openness about the reality of HIV.

Appendix 1: Consensus Statement

CONSENSUS STATEMENT

ACHIEVING UNIVERSAL ACCESS TO COMPREHENSIVE PREVENTION OF MOTHER-TO-CHILD TRANSMISSION SERVICES

27 NOVEMBER 2007

We, the participants of the High Level Global Partners' Forum met to review progress and achievements since the meeting in Abuja in 2005 and we noted the following:

- Increased availability of funding for HIV programmes from government budgets and international sources and further international commitments;
- The diversity of HIV epidemics and of the capacity of countries to respond, with regard to disparities in health system capacity, including financial and human resources;
- Progress made in scaling up programmes for HIV prevention and care especially among women and children at country level: with some notable achievements and good results, including in very resource-constrained, high HIV burden settings and in conflict/crisis situations;
- 108 countries have programmes and, notably, 17 countries are on track to reach the UNGASS goal for reducing HIV infections in children; however, progress overall is uneven;
- Important factors of success, including:
 - high level national political commitment
 - coordinated national policies with targets and plans (according to the "3 ones" principle)
 - movement from vertical to integrated approaches, in the context of decentralization and district level implementation.

We identified challenges to scaling up quality, comprehensive programmes at all levels, from the community to the global level, as follows:

- Inadequate financial resources, which are often narrowly earmarked by donors;
- Inadequate human resources;
- Poor partner and sectoral coordination and donor support resulting in verticalisation of programmes and poor implementation of national policies;
- Stigma and discrimination;
- Inadequate support for infant feeding which remains a complex issue, requiring further research;
- Unequal emphasis on the needs of women, their children, partners and families, and insufficient follow up within a continuum of care and assurance of adequate care, treatment and diagnosis of exposed infants;
- Insufficient integration of prevention of mother-to-child transmission services and insufficient linkages with other health and social services;
- The need to decentralize implementation and service delivery, and focus on developing and strengthening of community structures and systems to include prevention of mother-to-child transmission services;

- Insufficient attention to, and services for primary prevention and prevention of unintended pregnancies, including access to reproductive health commodities;
- Programme monitoring, recording and reporting;
- Quality assurance and impact assessment;
- Inadequate efforts to ensure male engagement;
- Impact of gender inequality and of gender-based violence;
- Lack of capacity to cost plans;
- Slow scale-up of provider-initiated testing and counselling services, where appropriate, and the limited creation of demand for these services.

In order for us to meet these commitments and address these concerns, we agree to the following priority actions at the political level:

- Sustain political commitment and translating it into meaningful and visible support of programme implementation;
- Support by partners of comprehensive and costed country-driven plans with long term sustainable and predictable financing;
- Ensure adherence to all components of the Paris Declaration, including the principle of country ownership and leadership, and harmonisation and alignment of all partners behind national plans;
- Strengthen coordination and ensure accountability among all partners in line with the 3 Ones principle, including developing and strengthening NGO capacity to respond in a coordinated manner.
- Document lessons learnt and strengthen monitoring and evaluation with quality data;
- Support of regular reviews and reporting of country level progress towards meeting prevention of mother-to-child transmission targets;
- Adopt or adapt strategic directions laid out in the Guidance on global scale-up of the prevention of mother-to-child transmission of HIV;
- Place prevention of mother-to-child transmission of HIV in a broader spectrum and position it as "women, newborn, child and family-centred HIV prevention and care", and support integrated, not vertical programming;
- Ensure meaningful participation of people living with HIV and people infected and affected by HIV and AIDS, in all policy discussions and in programme implementation.

This consensus statement was prepared by delegates at the Global Partners Forum, 26-27 November 2007, Johannesburg, South Africa. Delegates included Ministers who identified priority actions to be taken at the political level.

Annex 1: Summary of priority programmatic and technical support needs prepared by representatives of national programmes, NGOs, and technical agencies working at country level

1. Technical support for the development, revision, finalization of national policies, guidelines and national scale-up plans;
2. Resource mobilization and leveraging for implementation of national scale-up plans and specifically to support the above activities;
3. Integrated human resource planning, including pre-service training and capacity development to support scale-up efforts;
4. Guidance and support on how to operationalize the integration of prevention of mother-to-child transmission services with maternal, newborn and child health services at all levels (policies, planning, funding, service delivery and monitoring and evaluation);
5. Support rapid scale up of capacity building on infant feeding at health facility and community levels, and country level consultative meetings on infant feeding
6. Operational guidance on the implementation of primary prevention and linkages between PMTCT and sexual and reproductive health (SRH) for people living with HIV, including prevention of unintended pregnancies and prevention with positives;
7. Technical support to set up well-functioning systems for the provision, quality follow-up care to HIV-exposed and HIV-infected infants, including co-trimoxazole prophylaxis and early infant diagnosis;
8. Development and implementation of integrated community strategies;
9. Technical support for establishing well functioning M&E and quality improvement systems; and
10. Technical support for reviewing and improving supply chain management systems to support scale-up efforts.

Annex 2: Summary of joint activities from the expanded Interagency Task Team on Prevention of HIV infection in Pregnant Women, Mothers and their Children and other implementing partners

1. Global advocacy for increase in funding directed to comprehensive services aligned to the guidance document for global scale up of prevention of mother-to-child transmission of HIV;
2. Resource leveraging – Include PMTCT elements in global health initiatives
 - a. Advocacy and lobbying for the inclusion of PMTCT and paediatric HIV care, support and treatment (CST) in global financing mechanisms at global level;
 - b. Support to development of appropriate proposals for different financing mechanisms, including GFATM proposals;
3. Development and implementation of national costed population-based scale-up plan;
4. Development/strengthening of regional and country coordination mechanisms (e.g. regional configurations of the global IATT)
 - a. Joint frameworks, joint planning;
 - b. Building strengthening of technical assistance on existing regional structures such as the UNAIDS/WHO and other technical support facilities/hubs;
 - c. Integration of PMTCT principles from the Global guidance into existing regional frameworks;
 - d. Support regional adaptation and country level implementation of the guidance on global scale-up of PMTCT (key roles of PLWHA to be defined);
 - e. Link global efforts with regional and country efforts
5. Providing technical guidance to strengthen programme monitoring, review, quality assurance and operational research in line with agreed upon monitoring indicators as part of the global PMTCT monitoring guidance and WHO framework for monitoring progress towards universal access in the health sector;
6. Advocating for the joint country teams to include PMTCT in their technical support plans;
7. Supporting country level consultative meetings on infant feeding and rapid scale up of capacity building on infant feeding at health facility and community levels;
8. Providing policy and operational guidance on the implementation of primary prevention and prevention of unintended pregnancies among women including access to reproductive health commodities;
9. Providing technical support for establishing well functioning M&E and quality improvement systems; and
10. Providing technical support for reviewing and improving supply chain management systems to support scale-up efforts.

Appendix 2: List of Participants

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Appendix 3: Agenda

GLOBAL PARTNERS FORUM ACHIEVING UNIVERSAL ACCESS TO COMPREHENSIVE PMTCT SERVICES

SANDTON SUN HOTEL AND CONFERENCE CENTRE
JOHANNESBURG, SOUTH AFRICA
26- 27 NOVEMBER 2007

PRE-MEETING DISCUSSIONS ON PANEL PRESENTATIONS SUNDAY, 25 NOVEMBER 2007

TIME	AGENDA
16:00 – 18:00	<p>SYNTHESIS OF THE COUNTRY PRESENTATIONS FOR SESSION 2 OF DAY 1 “WHAT HAVE WE LEARNED AT COUNTRY LEVEL?”</p> <p>The National Programme Managers and/or other technical resource persons from the invited countries will work in 4 groups to discuss and finalize the panel presentations for Day 1 (Session 2). The four groups are clustered based on epidemic and demographic typologies of the countries.</p> <p>Each working group will be facilitated by senior advisors/technical resource persons from the partner agencies of the Global Inter-Agency Task Team (IATT) on Prevention of HIV Infection in Pregnant Women, Mother and their Children.</p>
Group 1	<p>High population countries with decentralized governments – Brazil, China, Democratic Republic of Congo, Ethiopia, India, Nigeria, South Africa.</p> <p>Discussions facilitated by UNICEF and IPPF</p>
Group 2	<p>Countries with generalized epidemics - Cameroon, Central African Republic, Cote d’Ivoire, Haiti, Malawi, Mozambique, Rwanda, Tanzania, Uganda</p> <p>Discussions facilitated by WHO and ESTHER</p>
Group 3	<p>Countries with generalized epidemics and high mortality - Botswana, Kenya, Lesotho, Namibia, Swaziland, Zambia, Zimbabwe.</p> <p>Discussions facilitated by UNAIDS and EGPAF</p>
Group 4	<p>Countries with concentrated/low epidemics – Cambodia, Dominican Republic, Guatemala, Honduras, Russian Federation, Thailand, Ukraine</p> <p>Discussions facilitated by UNFPA and FHI</p>

DAY 1 - MONDAY, 26 NOVEMBER 2007

TIME	AGENDA
8:00 – 9:00	REGISTRATION
	MASTERS OF CEREMONY Co-chairs: Macharia Kamau - UNICEF Representative to South Africa Stella Anyangwe - WHO Representative to South Africa
9:00 – 9:30	OFFICIAL OPENING AND WELCOME Hiroki Nakatani - Assistant Director General, WHO HQ Jimmy Kolker – Chief of HIV/AIDS Section, UNICEF HQ Honourable Manto Tshabalala-Msimang - Minister of Health, South Africa
9:30 – 10:30	KEY NOTE ADDRESSES Joy Phumaphi - Vice President, Human Development Network, the World Bank Allen Rosenfield - Dean, Mailman School of Public Health, Columbia University Pamela W. Barnes - President and Chief Executive Officer, EGPAF Florence Ngubeni, IPPF/ICW, South Africa
10:30 – 10:50	NATIONAL RESPONSE TO PMTCT IN SOUTH AFRICA Department of Health, South Africa
10:50 – 11:10	BREAK
SESSION 1	GLOBAL TRENDS, LESSONS LEARNED, NEW EVIDENCE Co-chairs: Honourable David Parirenyatwa, Minister of Health and Child Welfare, Zimbabwe Barbara O. de Zaluondo - Associate Director, Evidence and Partnerships Department UNAIDS HQ
11:10– 11:30	GLOBAL PROGRESS IN SCALING UP THE PMTCT RESPONSE Jimmy Kolker – Chief of HIV/AIDS Section, UNICEF HQ
11:30– 11:45	DISCUSSION
11:45 – 12:05	LESSONS LEARNED FROM SCALING-UP Elaine Abrams - Professor of Pediatrics and Epidemiology, The International Center for AIDS Care and Treatment Programmes, Columbia University Mailman School of Public Health
12:05 – 12:20	DISCUSSION
12:20 – 12:40	EMERGING EVIDENCE, CURRENT INTERVENTIONS AND PROMISES FOR THE FUTURE Kevin De Cock – Director, Department of HIV/AIDS, WHO HQ
12:40 – 13:00	DISCUSSION
13:00 – 14:00	LUNCH

SESSION 2 14:00 – 15:50	WHAT HAVE WE LEARNED AT COUNTRY LEVEL? COMPARATIVE ANALYSIS AND LESSONS LEARNED FROM COUNTRIES Co-chairs: Michael A. Tolle, Family medicine Service Director, Baylor International Paediatric AIDS Initiative (BIPAI)
14:00 – 14:20	GUIDANCE FOR GLOBAL SCALE-UP OF PMTCT Lynn Collins – Technical Adviser, HIV/AIDS, UNFPA HQ
14:20 – 14:35	Group 1. High population countries with decentralized governments – Brazil, China, Democratic Republic of Congo, Ethiopia, India, Nigeria, South Africa
14:35 – 14:50	Group 2. Countries with generalized epidemics - Cameroon, Central African Republic, Côte d'Ivoire, Haiti, Malawi, Mozambique, Rwanda, Tanzania, Uganda
14:35 – 15:50	Discussion
15:50 - 16:10	BREAK
16:10 - 17:40	Co-chairs: Siripon Kanshana - Deputy Permanent Secretary, Ministry of Public Health, Thailand Peter Lamptey - President, Public Health Programmes, Family Health International (FHI)
16:10 – 16:25	Group 3. Countries with generalized epidemics and high mortality - Botswana, Kenya, Lesotho, Namibia, Swaziland, Zambia, Zimbabwe
16:25 – 16:40	Group 4. Countries with concentrated/low epidemics – Cambodia, Guatemala, Honduras, Russian Federation, Thailand, Ukraine
16:40 – 17:40	Discussion
17:40	END OF DAY 1
19:00	GALA DINNER HOSTED BY THE MINISTER OF HEALTH, SOUTH AFRICA

DAY 2 - TUESDAY, 27 NOVEMBER 2007

TIME	AGENDA
8:30 – 9:00	Co-chairs: Koffi -Koumi Marcel - Director, Cabinet of the Minister Ministry of Health, Côte d'Ivoire Olivia Yambi – UNICEF Representative of Kenya
	HIGHLIGHTS OF DAY 1 Mitch Besser - Founder and Medical Director, Mothers2Mothers Introduction to Group Work Chewe Luo – Senior Programme Advisor HIV/AIDS & Health, UNICEF NY
SESSION 3	GROUP WORK ON BUILDING PARTNERSHIPS, TECHNICAL CO-OPERATION PARALLEL SESSIONS
9:00 – 10:45	Ministerial and Heads of Country Delegations Closed Meeting
9:00 – 10:45	Group 1. High population countries with decentralized governments – Brazil, China, Democratic Republic of Congo, Ethiopia, India, Nigeria, South Africa
	Group 2. Countries with generalized epidemics - Cameroon, Central African Republic, Cote d'Ivoire, Haiti, Malawi, Mozambique, Rwanda, Tanzania, Uganda
	Group 3. Countries with generalized epidemics and high mortality - Botswana, Kenya, Lesotho, Namibia, Swaziland, Zambia, Zimbabwe
	Group 4. Countries with concentrated/low epidemics – Cambodia, Guatemala, Honduras, Russian Federation, Thailand, Ukraine
10:45 – 11:00	BREAK
11:00 – 12:00	REPORT BACK FROM GROUPS - 4 PRESENTATIONS
12:00 – 13:00	DISCUSSION
13:00 – 15:00	LUNCH WORKING LUNCH FOR IATT PARTNERS
14:00 – 15:00	Ministerial and Heads of Country Delegations Closed Meeting (reconvened)
SESSION 4	WAY FORWARD Co-chairs: Honourable KM Sang - Minister of Health, Kenya Daisy Mafubelu -Assistant Director General, WHO HQ
15:00 – 15:30	REPORT BACK FROM MINISTERIAL LEVEL AND HEADS OF COUNTRY DELEGATIONS
15:30 – 16:00	REPORT BACK FROM IATT PARTNERS Doreen Mulenga - Senior Adviser, HIV/AIDS, UNICEF HQ
16:30 – 17:00	NEXT STEPS - CHAIR PERSONS
17:00	OFFICIAL CLOSURE OF THE MEETING Daisy Mafubelu - Assistant Director General, WHO HQ Honourable Manto Tshabalala-Msimang - Minister of Health, South Africa