

Lifelong ART for Pregnant Women: Benefits, trade-offs,
and the research needed to optimize maternal, perinatal,
and community health outcomes

Resource and programmatic considerations



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UNAIDS Secretariat, Geneva
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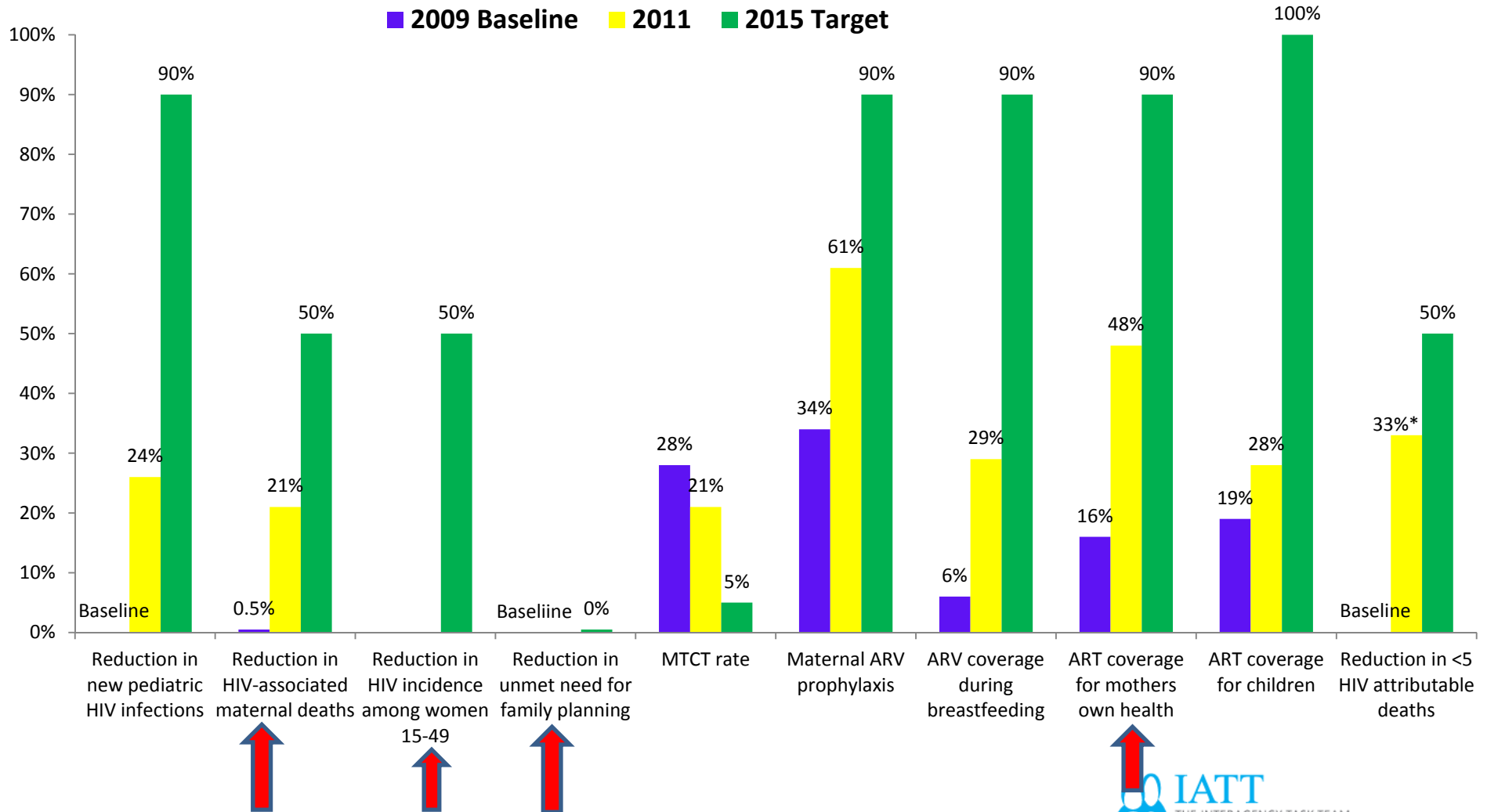


The creation of the Global Plan to eliminate new HIV infections among children by 2015 and keep mothers alive

- ▶ High Level Global Task Team co-chaired by Michel Sidibé and Ambassador Eric Goosby
- ▶ Membership of 40 countries, 30 civil society and private sector organizations, and 15 international and regional bodies/organizations.
- ▶ Global Plan launched at UN High Level Meeting on AIDS in the presence of UN Secretary General Ban Ki-moon, President Goodluck Jonathan of Nigeria, Former United States President Bill Clinton
- ▶ Member states set target to eliminate new HIV infections among children and reduce AIDS related maternal mortality by half in the **Political Declaration on AIDS** adopted at UN High Level Meeting on AIDS.



Progress Toward Global Plan Targets

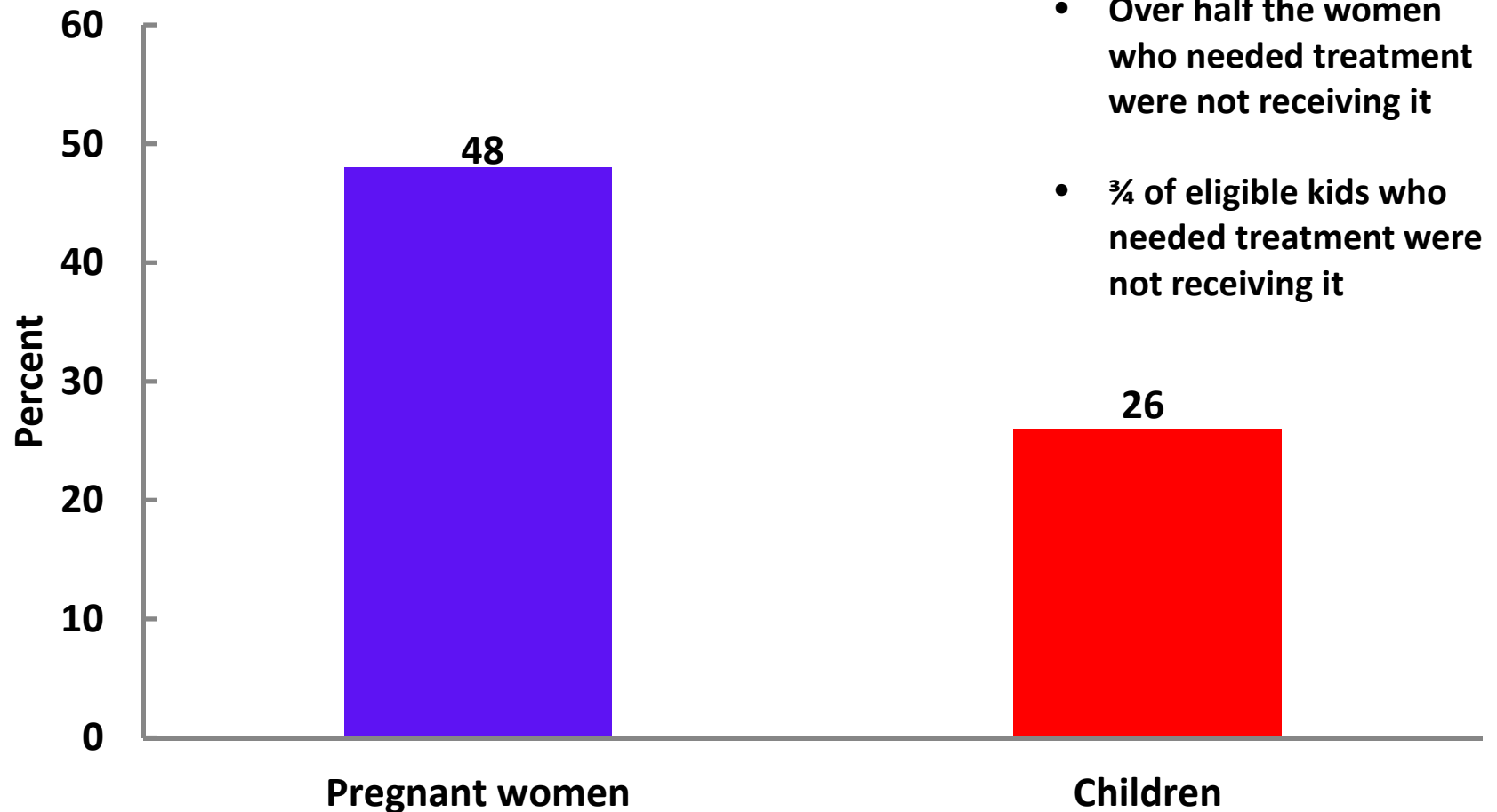


Source: *Towards the Elimination of Mother-to-child Transmission of HIV and Keeping Their Mothers Alive Abbreviated Progress Report 2012; UNAIDS*



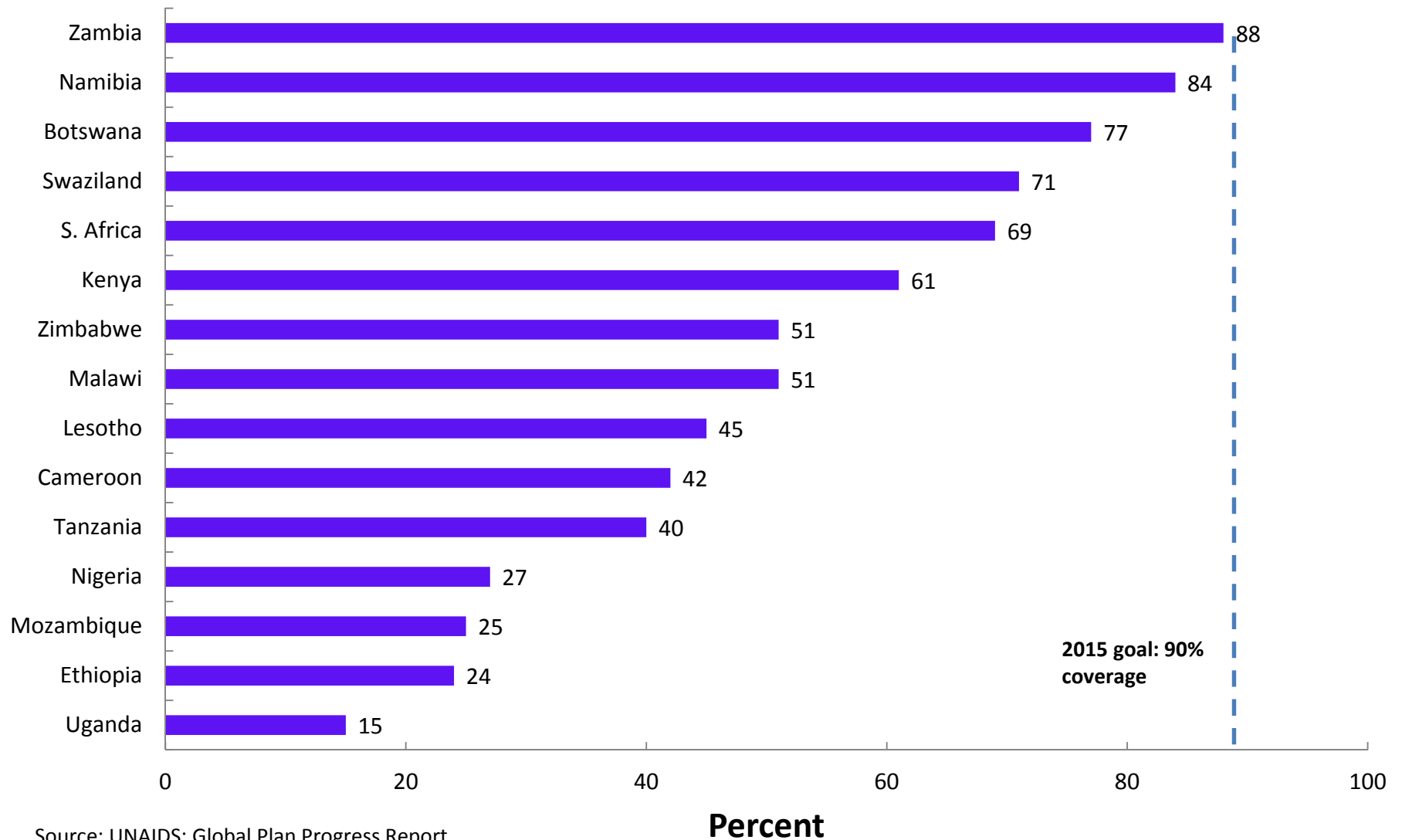
Rationale:

Percent of eligible receiving ART for their own health, 21 priority countries, 2011



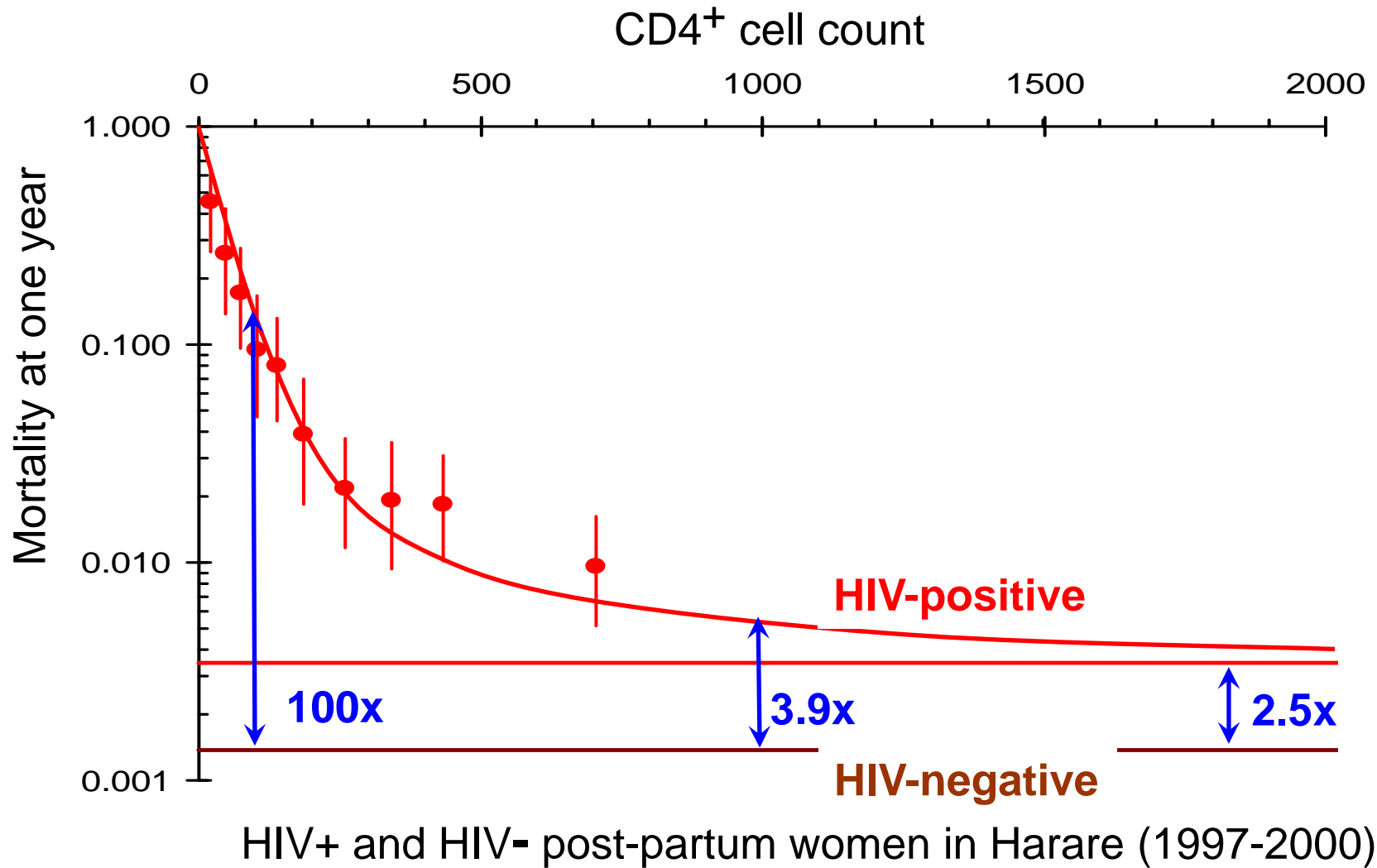
Rationale:

Percent of pregnant women eligible for treatment receiving it, 2011

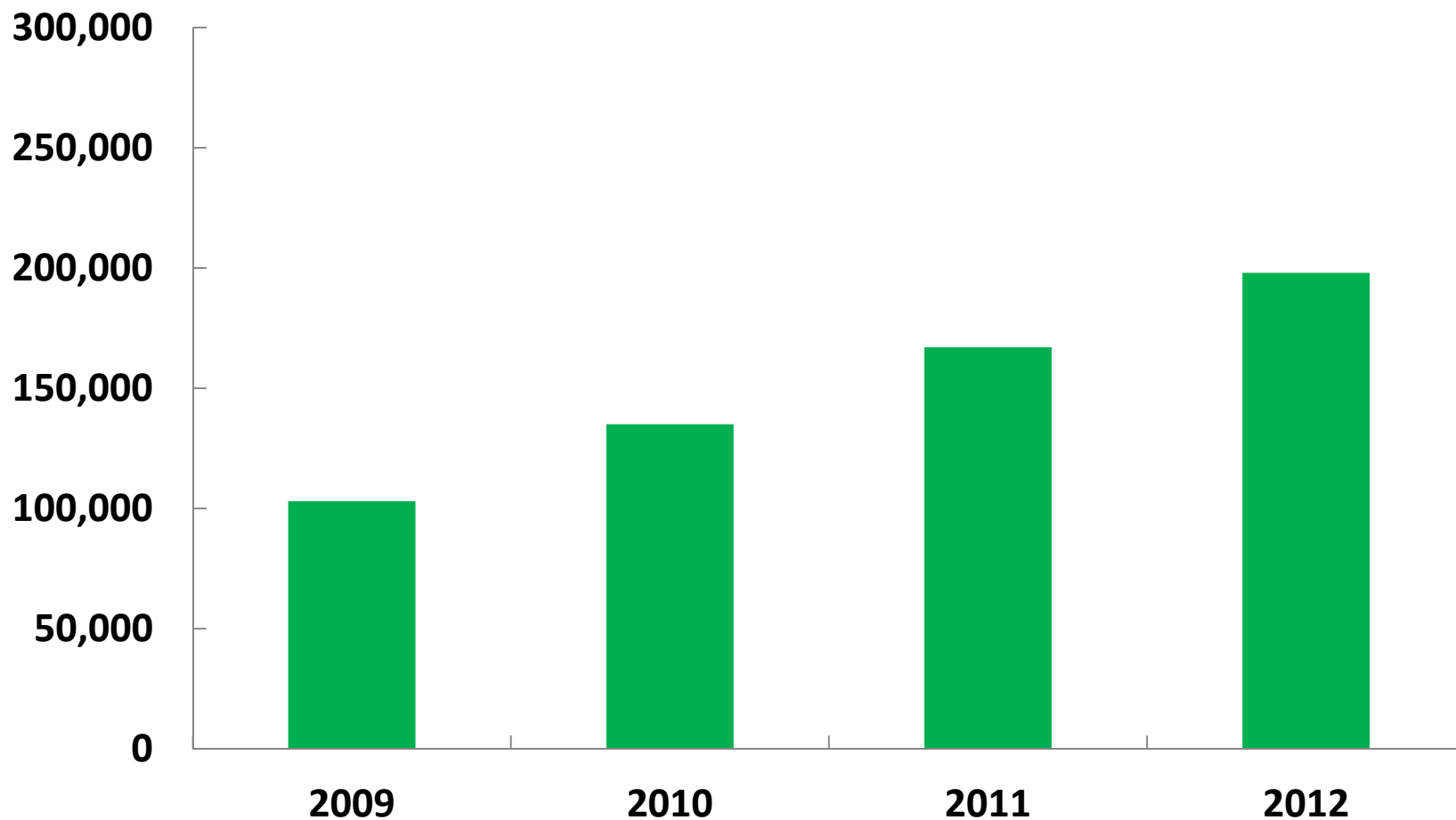


Source: UNAIDS: Global Plan Progress Report,

Excess mortality for mothers in Zimbabwe even when CD4 cell counts are at higher level (ZIVTAMBO study)



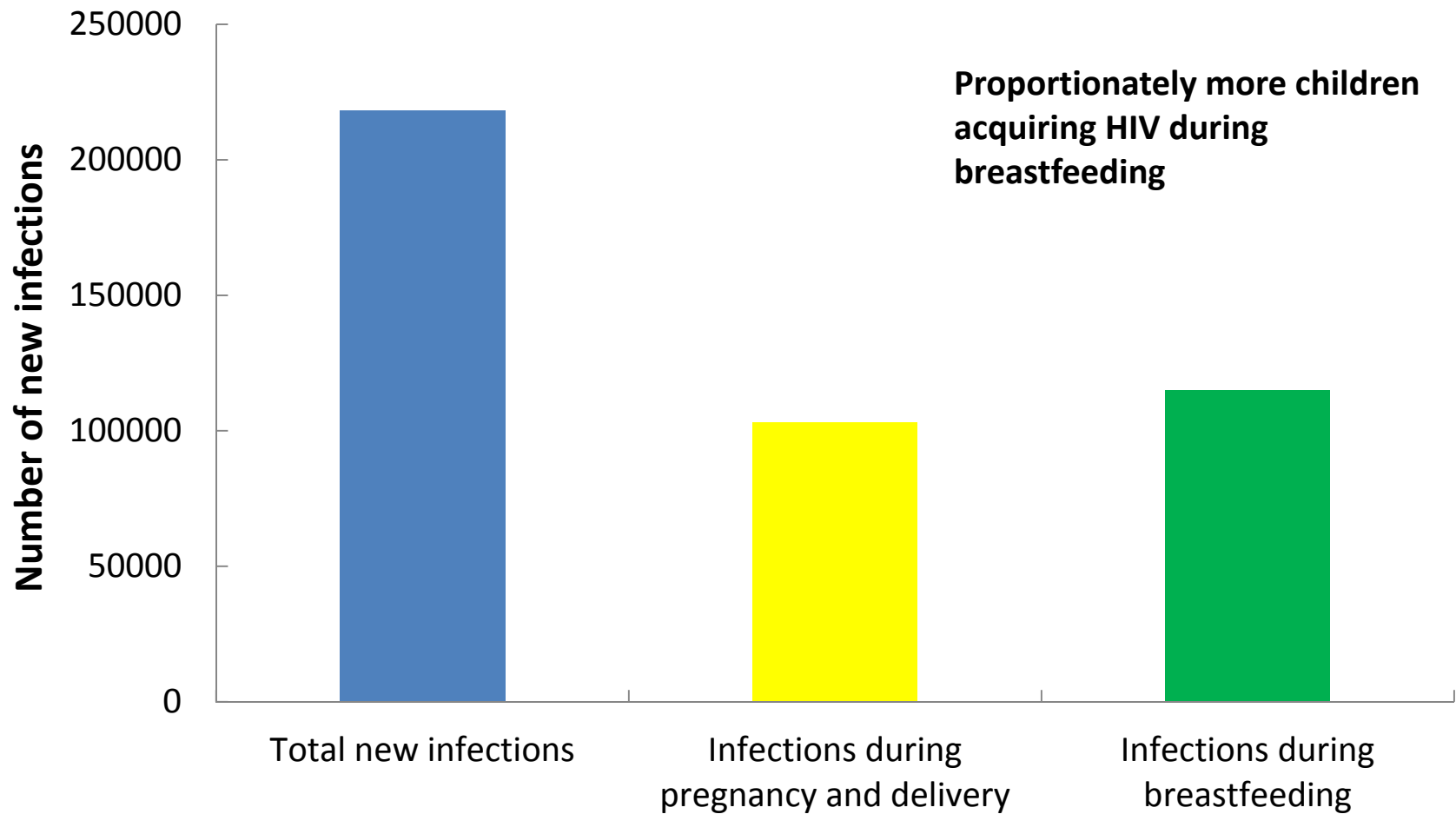
Number of childhood infections averted because of ARVs since 2009



UNAIDS estimates, 2013

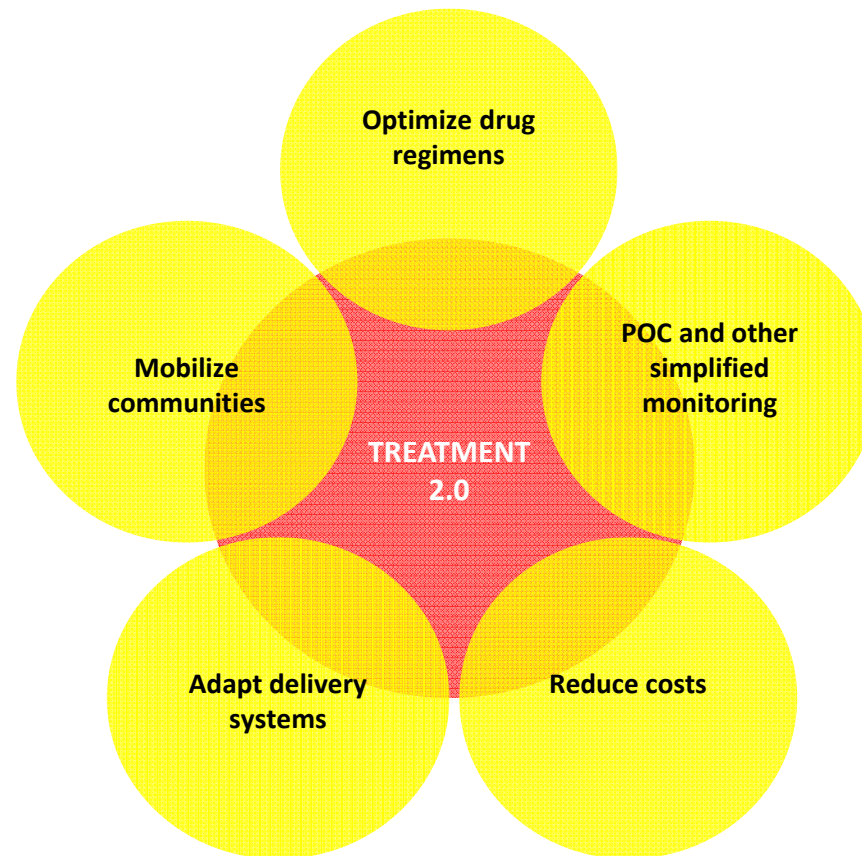
Rationale:

New child infections in 2012 by mode of transmission, 21 priority countries, preliminary



Simplicity

5 Pillars of Treatment 2.0



2013 WHO Guidelines Development Groups

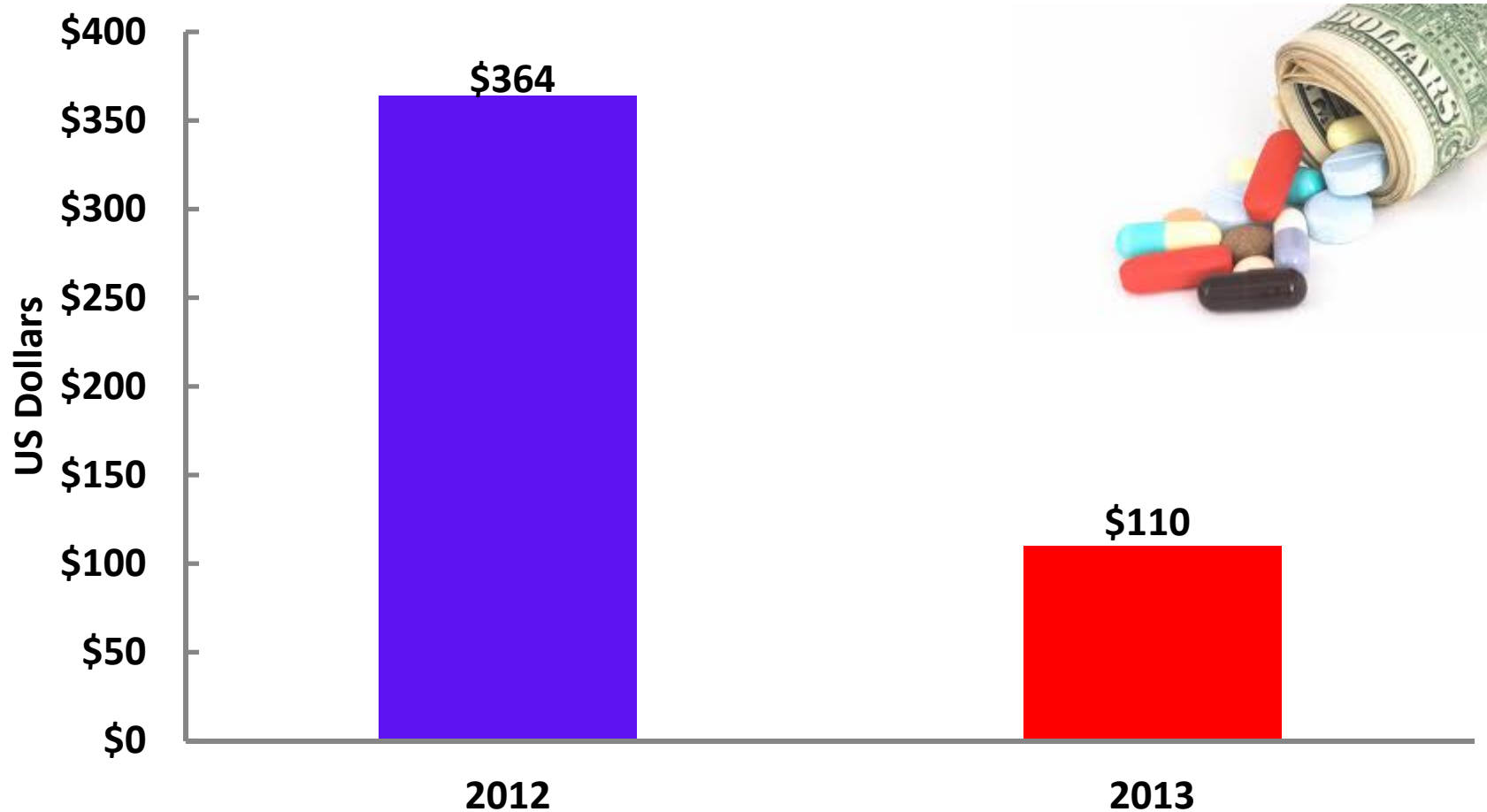
GDG (n)	Adult (n=37)	MCH (n=41)	Operational (n=38)	Programmatic (n=36)
WHO Facilitator	Marco Vitoria	Nathan Shaffer/Lulu Muhe	Eyerusalem Negussie	Joseph Perriens
Co-chairs	Stefano Vella Serge Ehoile	Elaine Abrams Denis Tindyebwa	Kevin de Cock Yogan Pillay	Irene Mukui Adeeba bte Kamarulzaman
Community	Gisela Schneider, Luis Adrieon Quiroz	Evgenia Maron, Babalwa Mbono	Anupam K. Pathni, Anna Zakowicz, Kenly Sikwese	Kenly Sikwese, Asia Russell, Sergey Filippovych
Methodologist	Elie Akl	Jörg Meerpohl	Holger J Schünemann	
WHO HQ	6 WHO staff	5 WHO staff	6 WHO staff	8 WHO staff
WHO RO	4 WHO staff	5 WHO staff	3 WHO staff	3 WHO staff

Current ARV Regimen for PMTCT, April 2013

Option A	Option B	Option B+ (life-long ARVs for pregnant women)		
		High level Discussions	MOH approved	Implementing
Cameroon	Cote d'Ivoire	Kenya	Namibia	Malawi
Ghana	Botswana		Tanzania	Uganda
Nigeria*	Burundi		Angola	
Swaziland*	India		Mozambique	
	Chad		Zambia	
	South Africa		Ethiopia	
			Lesotho	
			Zimbabwe	
			DRC	

* Piloting Option B+ in some regions or districts

Approximate cost of 12-month supply of life-long ART

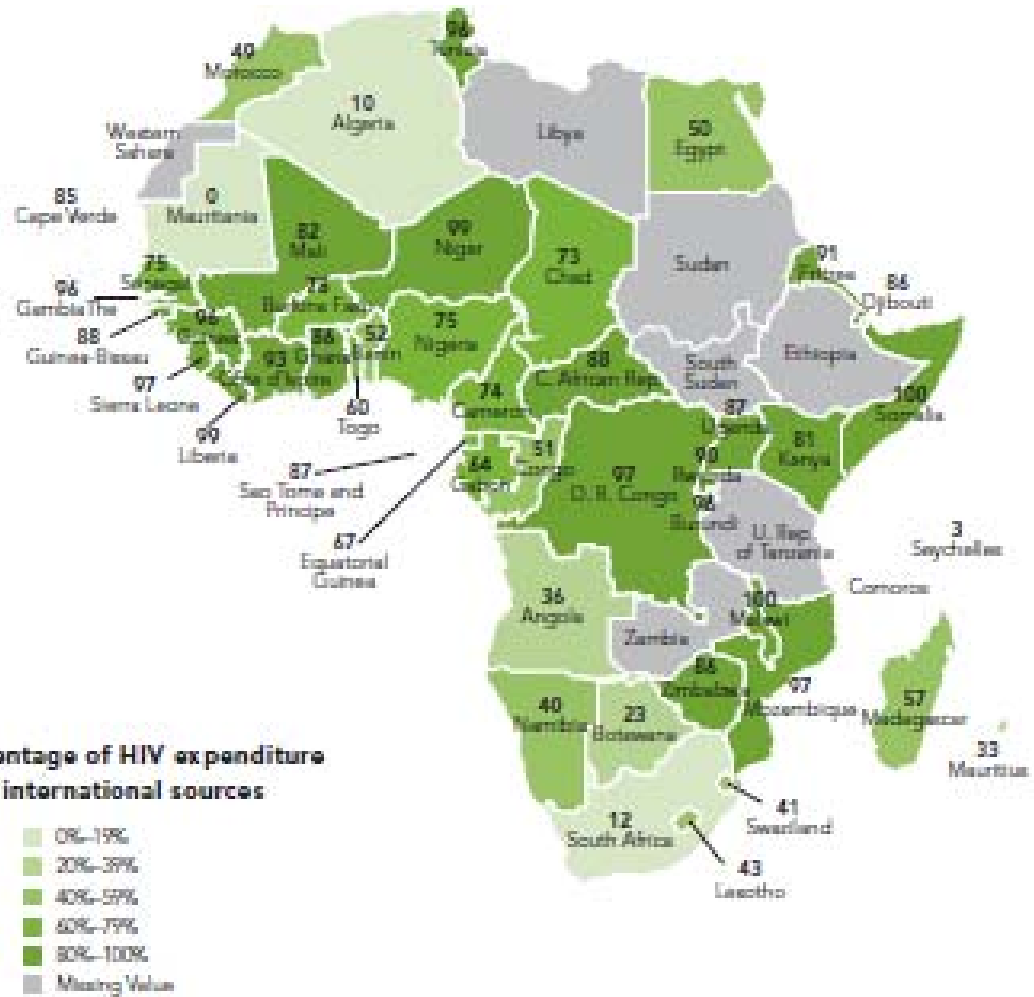


TDF/3TC (or FTC)/EFV

International transaction prices, and not those paid by end-users at country level

Source: WHO 2013 Global Price Reporting Mechanism

Over-reliance on Aid for AIDS

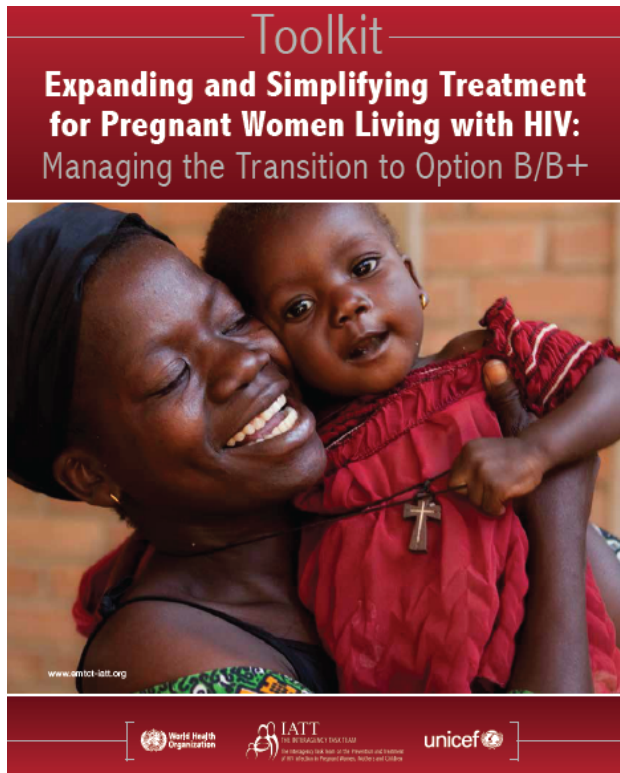


In 35% of countries, donor support accounts for >50% of the AIDS response

Lifelong ART for Pregnant Women

Women

Benefits, trade-offs, and
research needed



Benefits of Life-long Treatment

- Treatment benefits for women
- Simpler regimen – one pill, once a day
- Simpler message – treatment for life
- Simpler determination of eligibility – only voluntary and confidential HCT
- Prevention benefits for child and partner
- Simpler supply chain
- Integration: Opportunity for better platform

Operational issues

- Planning and preparation of the MNCH system
 - Infrastructure, HRH including task sharing, supply chain, community systems
- Expansion and decentralization to primary services
- Integration (MNCH clinics into ART clinics)
 - Services integration (e.g. TB, ANC/MCH and IDU settings, FP, pediatric HIV)
- Monitoring for toxicity and resistance
- Quality assurance
- Client retention
- ART Adherence

Research gaps to improve efficiency and effectiveness

- Impact of earlier ART initiation
- Optimal monitoring of ART response
- B+ feasibility, acceptability, field efficacy, and safety especially long-term use
- Toxicity and resistance monitoring (what, how and frequency)
- Strategies to improve retention and adherence
- Implementation on service delivery models – linkage to care, service integration, decentralisation, retention
- Optimizing partnerships with community

Acknowledgements

- Mary Mahy
- Reuben Granich
- Patrick Brenny
- Mitch Besser
- Bernhard Schwartlander

For more information:

Global Plan: zero-HIV.org

IATT: emtct-iatt.org

