Meeting Report

2011 Annual Meeting of the Interagency Task Team on Prevention and Treatment of HIV Infection in Pregnant Women, Mothers and their Children*

Geneva, Switzerland
May 2 - 3, 2011

** Note: At the annual meeting, it was recommended that the name of the IATT be changed to include "treatment".*

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The meeting report was prepared for WHO by Peggy Henderson, an independent consultant, and reviewed and finalized by Julia Samuelson and Nathan Shaffer (WHO).

Availability of meeting report and related documents
This meeting report is being posted on the WHO website, and is not being printed in hard copy. Please see:
www.who.int/hiv
www.who.int/hiv/topics/mtct

The meeting presentations and the agenda are also available at:
http://www.unicef.org/aids/index_58520.html

Meeting materials will also be posted on the new IATT website, which is expected to be available by August 2011: *www.pmtctpaediatrics.org*.

ABBREVIATIONS AND ACRONYMS

AIDS	Acquired immunodeficiency syndrome
ANC	Antenatal care
ART	Antiretroviral therapy
ARVs	Antiretrovirals
EID	Early infant diagnosis
eMTCT	Elimination of mother-to-child transmission of HIV
GTT	Global Task Team for the elimination of new HIV infections among children by 2015 and keeping their mothers alive
HIV	Human immunodeficiency virus
IATT	Interagency Task Team
Global Fund	Global Fund to Fight AIDS,Tuberculosis and Malaria
MCH	Maternal and child health
MDGs	Millennium Development Goals
MNCH	Maternal, newborn and child health
MTCT	Mother-to-child transmission of HIV
OGAC	Office of the United States Global AIDS Coordinator
PEPFAR	President's Emergency Plan for AIDS Relief
PMTCT	Prevention of mother-to-child transmission of HIV
PNMCH	Partnership for Newborn, Maternal and Child Health
RMNCH	Reproductive, maternal, newborn and child health
SRH	Sexual and reproductive health
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNITAID	International organization to scale-up access to treatment for HIV/AIDS, malaria and tuberculosis, by leveraging price reductions for quality diagnostics and medicines
WHO	World Health Organization

EXECUTIVE SUMMARY

The 2011 Annual Meeting of the *Interagency Task Team (IATT) on Prevention of HIV Infection In Pregnant Women, Mothers and their Children*[1] was co-convened by WHO and UNICEF and hosted by WHO on 2-3 May 2011 at WHO Headquarters in Geneva, Switzerland. The objectives of the meeting were to:

- Review achievements and progress made on prevention of mother-to-child transmission of HIV (PMTCT);
- Provide an update on the elimination of new paediatric HIV infections (eMTCT), and introduce the Global Task Team for the *Elimination of New HIV Infections among Children by 2015 and Keeping their Mothers Alive* (GTT);
- Discuss new global initiatives and synergies working towards eMTCT and improving maternal and child health (MCH) and survival;
- Review progress on regional frameworks for eMTCT, with country perspectives;
- Review mechanisms, including the IATT and the GTT, to optimize support towards eMTCT.

The IATT meeting, which included 73 participants from the 23 member agencies, and additional participants from countries and from the GTT, was an important opportunity to review progress and planning on eMTCT and to inform the discussion of the GTT. The meeting reviewed an overall Global Action Framework for the Elimination of Mother To Child Transmission of HIV, and key draft background documents developed to support a global action plan, including**:** 1) Leadership, 2) Targets, monitoring and evaluation, 3) Role of civil society , 4) Resources and costing, 5) Implementation and country support, 6) Laboratory and diagnostics, and 7) Integration/linkages with MNCH, with the aim of presenting key issues and recommendations to the GTT.

The meeting was held at an important strategic moment, in light of the formation of the GTT and the launching of the initiative on the *Elimination of New HIV Infections among Children by 2015 and Keeping their Mothers Alive.* It is also a time when much progress has been made on the key indicators related to PMTCT, and many activities led by the IATT or its members are in progress, but accelerated action in many countries is necessary to achieve the ambitious goals of 2015. Many other initiatives aimed at improving MCH and survival have been newly launched or are in progress, such as the United Nations Secretary General's Global Strategy for Women's and Children's Health and work on the MDGs.

Conclusions and Recommendations:

Based on the presentations and discussions, the meeting participants agreed on the following recommendations to inform the GTT and guide the IATT's future work.

Key Products to Inform the GTT

1. Action Framework

This provides a common and coordinated approach on priority actions and support for global and country-level efforts towards eMTCT, including: accelerating momentum on eMTCT in support of the MDGs, providing a framework on goals and targets, prioritizing evidence-based solutions to overcome bottlenecks, and mobilizing, leveraging and synergizing partners and resources for more effective country level action.
Recommendation: Action Framework was endorsed and recommended to the GTT.

[1] At the meeting, it was recommended to change the name to: *Interagency Task Team (IATT) on Prevention and Treatment of HIV Infection In Pregnant Women, Mothers and their Children*

2. Results and M&E Framework

A global monitoring plan was outlined, with targets, baseline estimates, support for regional and country review and reporting, and an active and visible plan for regular global reporting as part of a countdown on progress and accountability. Progress towards achieving targets will be based on modelled estimates of infections and infections averted, based on improved country coverage data, surveys and field studies on transmission rates and survival. Key coverage indicators need to be strengthened to better support outcome estimates (eg. types of ARV regimens received). In addition to expanded global reporting, there will be a special focus to report on progress of the 25 highest burden countries.
Recommendation: General endorsement of M&E framework, with additional work and review, *and specifically to agree on global target (see section below)*. Intensified efforts are needed to strengthen M&E systems at country level and better harmonize national data.

3. Implementation and Country Support

Two complementary draft papers, IATT Technical Support Plan and an outline 10-Point plan (OGAC) for country implementation, were discussed in detail. Key elements and principles include: country ownership, capacity-building and in-country sustained, harmonized ("three ones") support, intensified support and focus on high burden countries with the weakest MNCH systems (typology "D"), and special emphasis on synergizing PEPFAR and Global Fund support.
Recommendation: Synthesize the background papers and finalize an implementation and country support plan.

4. Resource Estimation

A draft Global Investment Framework for the Countdown to Zero was presented, showing that the estimated additional investment needed to eliminate new HIV infections among children and keeping their mothers alive is USD 2.5 billion for the 22 priority countries for the 2011-2015 period (approximately 0.5 billion/ year). The sense of the group was that further work was needed, but that the overall estimates were very much on target. There was strong country input raising questions of access and coordination of current and potential new resources at country level.
Recommendation: Endorsement of the resources estimates, with some further clarifications needed.

Additional Key Issues

Global Targets

The global targets, based on the November consultation, and now endorsed by most of the regions, were presented and reviewed, and form the basis of the proposed results and M&E framework. The proposed overall eMTCT initiative goals are:

- **i)** Reduce the number of new paediatric HIV infections by 90%, from 2009 baseline estimates (from about 400,000 to 40,000); and
- **ii)** Reduce population-level mother-to-child transmission rate (MTCT) to <5%

There are also specific goals and related indicators for each of the 4 prongs. As recognized at the November meeting, and again at the IATT, these goals are recognized to be aspirational, towards significantly lowering MTCT as a public health problem and aligning with the MDG focus for 2015.

The USG partners raised concerns about the 90% target and proposed 85% as an alternative. The IATT group was very sensitive to the questions raised on the overall target, impressed by the strong USG commitment to support the initiative, and considered several alternatives in the language towards a consensus, including wording of "at least 85% reduction" in new infections, as well as “towards elimination of new infections” (shile maintaining the definition of elimination being 90%). While there was not enough time to resolve this issue, there was clear commitment to identify a consensus solution for a shared target .

Recommendation: The GTT should consider further and seek the appropriate wording towards a shared and ambitious global goal on eMTCT.

Language and Branding

Strong concerns were raised, particularly by civil society, on the use of language around "elimination" and that the term "elimination" should not be used as a short-hand or slogan for the initiative. One alternative proposal was: eMTCT -- ending mother-to-child transmission (replacing "elimination of" by "ending") . There are several important issues around language: not stigmatizing mothers living with HIV, that it was acceptable to focus on mode of transmission, having language that includes the goal not only of stopping transmission and new paediatric infections but also emphasizing the health of the mother and child (HIV-free survival). There was appreciation that there may be a need for a technical term for the initiative and also a short, public term suitable to support the campaign. The meeting did not have time to fully discuss or conclude on suitable terminology, but recognized the critical importance of resolving this in a short period of time.

Recommendation: Alert the GTT to the problematic nature of "Elimination" and the need to rapidly agree on technical and public/campaign terminology for the initiative.

New Name for the IATT

In light of the increasing overlap between prevention and treatment, and the comprehensive nature of PMTCT, it was recommended to rename the IATT to include both prevention and treatment: *Interagency Task Team (IATT) on Prevention and Treatment of HIV Infection in Pregnant Women, Mothers and their Children*

Other Key Issues and Recommendations

Integration and linkages with MNCH and SG Women and Children's Initiative

The background paper and discussion highlighted the importance of linking the eMTCT initiative with broader MNCH global initiatives such as the H4+ and the Secretary General's Initiative on Women's and Children's Health, and the need to support integrated and systems strengthening approaches at country level. Key opportunities were highlighted with the USG Gobal Health Initiative and the Global Fund commitment to systems strengthening and MNCH. The IATT is working towards a joint event of key stakeholders from both constituencies to harmonize ongoing work on eMTCT and MNCH.

Recommendation**:** The GTT should strongly emphasize the importance of linkages with broader MNCH inititaves and strengthen synergies.

Lab and Diagnostics

There are several key technical issues, related to both quality and access of key diagnostics at primary care level, that are critical to the success of the eMTCT initiative. The 3 key issues were: better quality control of rapid HIV testing; development and access to point of care CD4 screening (the key determinant for eligibility to ART/treatment); and development of point of care diagnostics for early infant diagnosis (EID). The IATT lab working group, with leadership from both CDC and CHAI, will expand its portfolio to address these critical issues, and work closely with the diagnostics workstream in Treatment 2.0.

Recommendation: Recognize that there are key diagnostic and lab issues that need to be addressed, especially with regard to quality and point of care testing at primary care level, to support the initiative.

Treatment 2.0

The new Treatment 2.0 initiative was reviewed and discussed, based on the key principles of simplified earlier treatment, lower cost, less monitoring and decentralized access. These key principles are directly applicable to PMTCT - and progress on moving the treatment 2.0 agenda will directly benefit PMTCT and the ability to achieve eMTCT goals.

Recommendation: Treatment 2.0 should actively include PMTCT and goal of simplified and expanded treatment and related ARVs for pregnant and reproductive age women. The PMTCT IATT should work closely with Treatment 2.0.

IATT structure and roles in relation to GTT

The structure and roles of the IATT need to be reconsidered and defined particularly after clarifications on the structure and ongoing role of the GTT and how the GTT proposes to work with the IATT. There was general agreement that priority needs to be given to support the Elimination Initiative, and to focus on country support and monitoring in the 22 high burden countries.

Recommendation: The IATT Secretariat agreed to take this up as a priority and present recommendations to the larger group.

Update from the IATT Technical Working Groups:

Atlhough the IATT meeting had a much smaller amount of time available for review of the working groups, brief summaries on progress and plans for the coming year were shared:

- ***Primary prevention and prevention of unintended pregnancies;*** is finalizing a programming framework setting out strategies for work on Prongs 1 and 2 of PMTCT and a case study, including a film, on Swaziland, and will continue pilot testing an indicator for family planning.
- ***Paediatrics:*** has developed an advocacy toolkit for paediatric testing and treatment, and a paediatric retention in care analysis to help identify barriers and solutions and illustrate in-country experiences. Future work includes a formulary for paediatric antiretroviral drugs (ARVs), with ongoing advocacy with industry to expedite better paediatric ARVs.
- ***Monitoring and evaluation:*** is finalizing a guide to harmonize indicators, drafting a data quality document and training module, helping to develop harmonized transmission rates for modeling, and developing guidance on different approaches to measure impact. It will work to improve data quality, analysis and use, finalize the guide for impact assessments, and provide coordinated technical support to countries.
- ***Scale up working group:*** supported the development of the UNAIDS business case, the Global Fund reprogramming initiative and regional elimination efforts. Current projects include revising the 2007 guidance on PMTCT scale-up, finalizing the Global Action Framework, drafting a technical support plan and establishing the MTCT website.
- ***Laboratory (EID):*** has compiled recommended actions for EID service improvement and continued development of EID site supervision tools for improving quality of service delivery and infant health outcomes. Priorities for next year include development of a document on EID point of care, working on commodity issues with UNITAID, and completing and piloting site supervision tools.
- ***HIV and infant feeding:*** has participated in national decision-making processes and developed tools for adapting WHO guidelines and guidance for implementation. Future work will include updating of the Framework for Priority Action on HIV and Infant Feeding; advocacy and communication strategies; technical support for funding applications; and implementation research.

A. INTRODUCTION

The 2011 Annual Meeting of the expanded *IATT on Prevention of HIV Infection Among Pregnant Women, Mothers And Their Children*[2] was convened by WHO and UNICEF on 2-3 May 2011 and hosted by WHO in Geneva, Switzerland. The objectives of the meeting were to:

- Review achievements and progress made on PMTCT;
- Provide an update on eMTCT and introduce the GTT;
- Discuss new global initiatives and synergies working towards eMTCT and improving MCH and survival;
- Review progress on regional frameworks for eMTCT, with country perspectives;
- Review mechanisms, including the IATT and GTT, to optimize support towards eMTCT.

To further these objectives, background papers on key issues were prepared for discussion on: leadership; targets, monitoring and evaluation; resources and costing; implementation and country support; laboratory and diagnostics; and integration and linkages.

The meeting brought together 73 participants, including representatives of the 23 IATT member agencies, regional advisors of WHO and UNICEF for Central and Eastern Europe and the Commonwealth of Independent States, Eastern and Southern Africa, Latin America and the Caribbean and Western and Central Africa; and additional participants invited in the context of the GTT including country representatives from 9 high-burden countries[3], and additional GTT partners including the Earth Institute, the PMNCH, and UNITAID.

The meeting was held at an important strategic moment, with a changing global landscape. Following the success of a high level, multilateral heads of agency meeting in June 2010 which endorsed the goal of eMTCT by 2015, there is a strong global commitment for the general concept and overall goal of eMTCT and improving MNCH and survival. WHO, UNICEF, UNFPA and UNAIDS consulted global partners at the end of 2010 to define elimination of MTCT and agree on targets and indicators for monitoring progress. This momentum is now complemented by the establishment of a high-level GTT on eMTCT. The IATT will participate in the GTT meeting in Johannesburg later this week, which will focus on the development of a Global Action Plan for eMTCT to be presented at a high level meeting in conjunction with the United Nations General Assembly Special Session on HIV/AIDS in June.

Much progress has been made since 2005 towards the targets set for PMTCT, but accelerated action in many countries will be necessary between now and 2015 in order to make significant progress towards eMTCT. In addition, at this time, many other related global initiatives aimed at improving MCH and survival have been newly launched or are in progress, such as the United Nations Secretary General's Global Strategy for Women's and Children's Health, the H4+ Initiative and the commitment to the MDGs. These initiatives provide opportunities for important synergies that will contribute to optimized outcomes.

Following the IATT annual meeting, the IATT working groups for monitoring and evaluation, and paediatrics met. Other working groups will plan follow-up teleconferences

[2] At the meeting, it was recommended to change the name to: *Interagency Task Team (IATT) on Prevention and Treatment of HIV Infection In Pregnant Women, Mothers and their Children*

[3] Botswana, Kenya, Lesotho, Mozambique, Nigeria, South Africa, Tanzania, Uganda, Zimbabwe

and separate face-to-face meetings. In addition, UNICEF convened an all-day meeting (an External Technical Advisors Group/ ETAG) after the IATT to review the concept, issues and current experience of the Mother-Baby Pack.

B. PROCEEDINGS OF THE MEETING

The IATT's 2011 Annual Meeting was structured into five sessions in the form of plenary presentations, group work and discussion:

Session 1: Introduction and overview of progress on PMTCT
Session 2: Elimination of new paediatric HIV infections and new global initiatives
Session 3: Implementation: Global synergies, regional frameworks and IATT working groups
Session 4: Developing an action plan: Background papers to support the elimination initiative
Session 5: Leadership and accountability: Mechanisms, including the IATT/GTT, to reach elimination

Session 1: Introduction and overview of progress on prevention of mother-to-child transmission of HIV

OPENING

The meeting was opened by the United Nations PMTCT co-convening agencies, Gottfried Hirnschall, Director, Department of HIV/AIDS, WHO; and Jimmy Kolker, Chief HIV and AIDS, Associate Director, UNICEF. In addition, Paul De Lay, Deputy Executive Director, UNAIDS, provided opening remarks. Together they welcomed the participants and highlighted recent important developments related to PMTCT and eMTCT. Some of these developments included the technical consultation on eMTCT in November 2010 which led to the drafting of a Global Action Framework for the Elimination of Mother-to-Child Transmission of HIV, the inputs into the Women Deliver conference, and the drive for synergy and increased collaboration with other relevant global initiatives on MNCH. They noted the measurable progress on scale up in many countries, although the 2010 UNGASS coverage target of 80% for PMTCT has only been met in a few countries, and there is a strong need to move to a more active scaling-up mode with more effective regimens and interventions. This progress and call to action is taking place against a background of challenges, including the global financial crisis and the shift of HIV/AIDS from a pandemic to an endemic state.

Nathan Shaffer, Department of HIV/AIDS, WHO, and René Ekpini, Health Section, UNICEF, as co-chairs of the IATT, also welcomed the participants. They highlighted to the IATT the strong technical expertise and implementation support of its member organizations and recent successes to date. With the formation of the GTT on eMTCT, however, the structure and function of the IATT needs to be re-considered, particularly how to best position the IATT to support the GTT and eMTCT. Because of the new emergence of the GTT, the usual format of an IATT meeting was revised to include many key aspects related to the GTT, and to use much of the meeting to define issues and review background papers that could be used to inform the GTT.

GLOBAL PROGRESS ON PMTCT AND THE IATT

Towards Universal Access and elimination of mother-to-child transmission: Scaling up HIV/AIDS interventions for women and children

Yves Souteyrand, WHO; Priscilla Akwara, UNICEF

Much progress is being made on scaling up PMTCT interventions. Data to monitor progress is collected with reporting tools agreed upon by United Nations agencies and disseminated in global reports. In 2009, 53% of pregnant women living with HIV received ARVs (note: "any" ARV) to reduce the risk of transmitting HIV to their infants, up from 45% in 2008 and 15% in 2005, although progress varies greatly between countries and regions. Fifteen low and middle income countries reached over 80% coverage. However, about 30% of women receiving ARVs received the less-efficacious single-dose nevirapine. Only 35% of HIV-exposed infants received any ARVs as part of PMTCT prophylaxis. It is important also to consider that the coverage and regimen data reported for 2009 represent interventions based on the 2006 WHO PMTCT guidelines, and do not reflect the more efficacious regimens now being introduced, based on the 2010 WHO PMTCT and infant feeding guidelines. Coverage of ART (treatment) for children eligible for treatment rose from 22% in 2008 to 28% in 2009 with 14 countries reaching over 80% coverage.

Many challenges in monitoring and evaluation remain: current data quality is uneven and lacking in critical areas; in some countries there are parallel and uncoordinated monitoring systems; and difficulties in moving from monitoring coverage to monitoring outcomes and evaluating impact. Enhanced global monitoring will be critical to support eMTCT; between now and 2015 there will be expanded annual reporting on eMTCT with more focus on impact.

In the discussion, participants wondered how to address the issue of coverage of testing of pregnant women in low-prevalence settings where universal testing is not the norm. No data were presented on HIV prevention or family planning (Prongs 1 and 2 of the comprehensive approach to PMTCT[4]), but work is ongoing on indicators and baselines.

The Interagency Task Team on Prevention of HIV Infection in Pregnant Women, Mothers and their Children: Evolution of the IATT from 1999-2011

Chewe Luo, UNICEF

The functions of the IATT have evolved from overseeing a pilot response to MTCT, to support for scale-up and the development of national programmes, to support for more effective interventions and active support towards eMTCT. The establishment of technical working groups was an important step to develop normative and operational guidance and to provide technical support, with a more coordinated approach among the many IATT organizations. IATT technical working groups were created to focus in depth in specific areas including: paediatric care and treatment; prevention and family planning; laboratory; infant feeding; monitoring and evaluation; and scale up. The IATT is currently poised to continue to provide global technical leadership and harmonize efforts. It will do this by helping to set country-level goals and targets, while prioritizing actions and tracking progress; to assess barriers to access and utilization; to facilitate bringing services closer to populations with unmet needs; to strengthen the MNCH platform through innovations and quality improvement; and to partner with individuals, families and communities. To assist in prioritizing actions, a typology of countries according to current coverage of maternal ARVs (indicative in many places of the integration of PMTCT into MCH and the status of MCH systems) has been developed with different scenarios for defining effective

[4] The four prongs of the comprehensive strategy on PMTCT include: 1: primary prevention of HIV among women of child-bearing age; 2: prevention of unintended pregnancies among women living with HIV; 3: prevention of HIV from a woman living with HIV to her infant; 4: provision of appropriate treatment, care and support to women living with HIV and their children and families.

programming approaches and investments, and particularly to address different issues among the high burden countries.

With regard to the relationship of the IATT to the GTT, the IATT has been the technical and advocacy arm for the PMTCT global effort, has established an effective interagency collaboration framework, and is well-positioned to respond to the call for eMTCT. The GTT has political representation and is a broader partnership. How the IATT can maintain and strengthen its technical and implementation support focus, while most effectively supporting the GTT, needs to be clarified.

Questions from participants focused on the barrier of access to CD4 cell count testing for HIV-infected women, and the difficulties of initiating treatment in rural settings. An issue was raised on the language of "elimination", with caution that this phrase not be used indiscriminately, and inadvertently perpetuate stigma and discrimination against HIV-infected pregnant women.

Session 2: Elimination of new paediatric HIV infections and new global initiatives

THE GLOBAL INITIATIVE, FRAMEWORK AND TASK TEAM ON ELIMINATION OF NEW PAEDIATRIC HIV INFECTIONS

Elimination of mother-to-child transmission of HIV: Vision, progress, next steps
Nathan Shaffer, WHO

Advocacy and political will for eMTCT have increased rapidly in the past year, supported by various initiatives and priorities as well as revised guidance, such as the 2010 WHO guidelines on ARVs for treating pregnant women and preventing HIV infection in infants and on HIV and infant feeding[5]. As defined in the November 2010 consultation on elimination, the goal of the new initiative is "to eliminate new paediatric HIV infections and improve maternal, newborn and child survival and health in the context of HIV". The targets proposed included a 90% global reduction in new infections from the 2009 baseline, and to achieve less than 5% population-based transmission rates (or less than 2% at 6 weeks of age). Prong-specific targets were also identified: 1) reduce new infections in women by 50%; 2) meet all unmet family planning needs; 3) achieve less than 5% transmission rates (or less than 2% in the absence of breastfeeding or if measured at 6 weeks ; 4) reduce HIV-related maternal and child mortality. There was broad consensus on the goal and targets, although discussion on precise terminology and how to better represent the need to improve maternal survival is ongoing. Modelling shows that combined action on Prongs 1, 2 and 3 will be necessary if the 2015 targets are to be achieved.

The general principles of the elimination initiative are:
- targets need to be clear, simple, bold and aspirational but plausible;
- position within the context of the MDGs, since the success of eMTCT and the health of the child are directly linked to the health of the mother;
- the focus on elimination needs to be at population level;
- the perspective of civil society is important to support the health and rights of individual women;
- clear baselines, clear annual targets and clear measures of progress are needed, with an adequate monitoring and evaluation system;
- strong leadership at global, regional and country levels is needed.

[5] WHO. *Antiretroviral drugs for treating pregnant women and preventing HIV infection in infants: Recommendations for a public health approach*. Geneva, 2010; WHO. *Guidelines on HIV and infant feeding: Principles and recommendations for infant feeding in the context of HIV and a sumary of evidence.* Geneva, WHO, 2010.

Global Action Framework for the elimination of mother-to-child transmission of HIV
René Ekpini, UNICEF

The *Global Action Framework* was developed by the IATT and is proposed as an updated framework for guiding coordinated work. Its purpose is to provide a common and well-coordinated approach to supporting country-level efforts toward eMTCT in the broader context of global health; and to galvanize and harmonize support for the implementation of the eMTCT agenda among national government, development and implementing partners and civil society. The four strategic areas include:

- keeping the momentum on eMTCT as a critical priority for reaching MDGs 4, 5 and 6;
- setting goals and targets, and tracking progress;
- mobilizing, leveraging and synergizing partners and resources to support country-level implementation;
- identifying key bottlenecks and prioritizing strategies to overcome them.

The Global Task Team for the elimination of new HIV infections among children by 2015 and keeping their mothers alive: development of a global plan
Paul De Lay, UNAIDS

The GTT was formed recently and a global plan is in development because, despite considerable achievements, progress towards current targets is insufficient. There is a need to shift the focus to prevention and treatment for mothers and their children, to more fully integrate with MNCH, as well as reproductive health; and sustain leadership at all levels with strong accountability. The GTT has 67 partners, including governments from high-burden countries; bilateral and multi-lateral donors, civil society, the private sector and the United Nations. The GTT will produce a results-based, time-specific global plan for eliminating new HIV paediatric infections based on four elements, described as 'Frame It'; 'Campaign for it'; 'Do it'; and 'Account for it'. A meeting will take place in South Africa later this week (following the IATT), and will be followed by a high level meeting in June in conjunction with the United Nations General Assembly Special Session on HIV/AIDS in New York, during which the GTT Global Action Plan will be launched.

The discussion centred on how the IATT relates to the GTT and the intended life-span and structure of the GTT. The general thinking is that the IATT should continue to provide normative and operational guidance, technical support, coordinate approaches among implementing partners, and support the translation of global action plans into national and sub-national ones.

SELECTED KEY ISSUES FOR ELIMINATION

Leadership and accountability
Sigrun Møgedal, UNAIDS

Making something extraordinary happen, such as eMTCT, requires leaders at many levels and in different roles to work in concert, and requires exceptional leadership. They need to have clear and simple joint messages and targets for achievement that maximize the contribution of each, while also recognizing their different roles, drives, opportunities and limitations. Where PMTCT has not moved as quickly as it could have, one of the reasons relates to the quality of leadership. There is an expressed need for a global leadership strategy to sustain and advance eMTCT. In formulating this strategy, issues include whether there is a need for a campaign (with more global and national advocacy) or a strategy that focuses on scale-up, accountability and results. Other issues being discussed include finding national champions, maximizing funding opportunities, innovation and simplification where possible, and building and keeping momentum after the push of the upcoming high-level meeting.

Global Monitoring Framework for the elimination of new paediatric HIV infections
Chika Hayashi, WHO

In light of eMTCT, the focus for monitoring has shifted from coverage targets to assessing impact and results, particularly new paediatric infections and transmission rates. There is a renewed emphasis on the link with relevant MDGs and the critical links with MCH. The Global Monitoring Framework is being finalized to summarize elimination targets, indicators and monitoring strategy as well as an annual reporting and progress review plan. Targets and indicators will need to be adapted for regions and countries. Working together, there needs to be a joint monitoring and evaluation plan, owned and committed to by all partners; systematic country support; and a coordinated technical support plan. In addition to an eMTCT monitoring framework, a PMTCT Impact Assessment Guide is under development.

Cost estimation for preventing new child infections: investment needs and resource gap
Karl-Lorenz Dehne, UNAIDS

An estimation of investment needs and resource gaps for PMTCT scale-up and eMTCT has been developed, taking into account costs for HIV screening, scaling-up family planning and ARV prophylaxis and treatment, CD4 cell count testing, co-trimoxazole prophylaxis for mothers, early infant diagnosis and community mobilization activities. The estimated additional investment needed for eMTCT is US$ 2.5 billion for the 22 priority countries for the 2011-2015 period (approximately US$ 0.5 billion/ year). Available expenditure data show about $300 million in these countries per year, but because of data gaps it is more likely to be around US$500 million. There is a need for better expenditure tracking and to develop costed plans for each country which can then be used to mobilize resources to bridge the investment gap. Further work is needed, but the overall estimates appear to be very much on target. There was strong country input into the discussion, raising questions of access and coordination of current and potential new resources at country level.

Elimination of mother-to-child transmission: country-level implementation
Stephen Spector, University of California and OGAC

A proposed ten-point plan for accelerated PMTCT country support and action was presented as:

1. Establish a well-costed, nationally-owned PMTCT implementation plan;
2. Assess resources for PMTCT and unmet needs;
3. Establish a plan to strengthen synergies between PMTCT and other inter-related services;
4. Develop a plan for EID and follow-up;
5. Strengthen and expand the capacity of national health systems to deliver coordinated, high-quality PMTCT services;
6. Address human resources necessary to implement effective PMTCT;
7. Evaluate and improve supply chain operations for expanding PMTCT;
8. Strengthen community and male partner involvement;
9. Better coordinate and technically assist PMTCT service delivery;
10. Improve PMTCT outcomes, data quality and impact assessment.

Elimination of MTCT by 2015 will require a coordinated commitment to such a plan at the country level.

Technical support plan for the elimination of new paediatric HIV infections and keeping mothers alive
Matthew Barnhart, UNICEF

An IATT Technical Support Plan has been developed, building on the comparative advantages of the IATT and its technical expertise. The key themes are a focus on the highest-burden countries, country leadership, linkages to the Global Action Framework, and accountability with clear, time-bound deliverables. These will involve ensuring appropriate structures for accelerating eMTCT; providing support to align country policies, plans and resources with the elimination initiative; and regular reviews, continuous improvement and accountability. Some of this work is already ongoing in countries. It will be important to synthesize the IATT technical support plan with the country support principles from the OGAC presentation (above) and to strengthen effective mechanisms of support under both the IATT and the GTT.

Laboratory needs for elimination of mother-to-child transmission
Shaffiq Essajee, WHO

To achieve the targets for eMTCT, a number of health system elements need to be strengthened, including laboratory systems. Four key laboratory and diagnostic issues include expanding access and quality of: HIV testing within antenatal care (ANC); CD4 cell count testing for HIV-infected women; early infant diagnosis (EID); and innovation to more effectively link eMTCT to other programmes. Not all programmes use rapid testing in ANC, and thus women are lost to follow-up before accessing PMTCT and HIV care. Seroconversion later in pregnancy or during breastfeeding is an important driver of new paediatric infections, and strategies for re-testing need consideration. Access to CD4 cell count testing within ANC settings is currently a major barrier to decisions on treatment versus prophylaxis for HIV-infected pregnant women, especially at primary care level, and could be improved by using either point-of-care testing and/or simplified sample transport systems. While there has been major progress introducing dried blood spot-based PCR testing for EID, only 15% of exposed infants currently receive an early diagnostic test. Increasing EID coverage for exposed infants will require more funding, new and simpler technologies, as well as increased emphasis on rapid return of results and appropriate follow up and treatment based on the infant test results. The experience with using SMS printers for providing a hard copy of results outside of laboratories in Mozambique was mentioned as one innovate approach. Addressing laboratory bottlenecks is critical to achieving MTCT targets and harmonizing Treatment 2.0 work with diagnostics.

Nonhlanhla Dlamini, Department of Health, South Africa, and Ado Sabo Uba, Federal Ministry of Health, Nigeria, provided insights on these issues from their country perspectives. Both noted the commitment that exists in their countries to improved access to diagnostics, the importance of phasing in point-of-care testing, and involving community health workers and mobilizers. They are implementing task shifting, but in South Africa, despite a push to a nurse-centred model, nurses still lack confidence in some of their new tasks.

TREATMENT 2.0

Treatment 2.0
Craig McClure, WHO; Mariangela Simao, UNAIDS
commentary by Elaine Abrams, ICAP

The public health approach to treatment has rapidly evolved from that set out in the “3x5” strategy. There are now over 5 million people receiving ART, but the estimated treatment gap in resource-limited countries is 10 million. Various challenges exist for narrowing this

gap, including financing, the complexity of treatment regimens, inefficiencies in and fragmentation of service delivery, difficulties in initiating treatment early, and the transition from an emergency response to sustained chronic care. Treatment 2.0, an initiative of UNAIDS and WHO, hopes to address these issues by optimizing drug regimens, ensuring point-of-care diagnostics, reducing costs, adapting service delivery systems and mobilizing communities.

With regards to eMTCT, Treatment 2.0 envisions: ensuring that the preferred first- and second-line regimens are safe to use during pregnancy; integrating HIV testing, counselling and treatment with ANC and MCH services; and increasing access to point-of-care diagnosis and monitoring tools. An important concept underlying Treatment 2.0 is simplifying regimens and protocols. An additional point raised was that family planning should be available at all points of contact with HIV-infected individuals, including in ART programmes. It was noted that there is more to care and support than the priority work streams mentioned, and that 2.0 is above all about simplification of treatment. New formulations and simplification of treatment regimens are needed, as well as new tools for diagnostics for peripheral levels. Some participants suggested that PMTCT could be simplified if all countries used Option B for PMTCT, but many countries have chosen Option A because of cost differences and the lack of access of triple ARVs at primary care level. Caution was raised to avoid oversimplification with inadequate treatment in the midst of seeking to simplify treatment.

Session 3: Implementation: Global synergies, regional frameworks and IATT working groups

INTEGRATION WITH OTHER GLOBAL INITIATIVES

Working together for enhancing linkages and integration between RMNCH and HIV/AIDS programmes
Viviana Mangiaterra, WHO; Luc De Bernis, UNFPA; the HIV/Reproductive, Maternal, Newborn and Child Health (RMNCH) teams of WHO, UNFPA, UNICEF

The IATT is developing a concept paper on integration to highlight the relationship between RMNCH and HIV/AIDS programmes in the context of PMTCT; to identify areas of synergies between elimination of new paediatric HIV infections and other global initiatives on RMNCH; and to suggest collaborative activities for improved MNCH and HIV prevention. There is a global momentum to build on and a collaborative framework was proposed that envisions 6 critical areas of work:

- Strengthen effective coordinating bodies for RMNCH/HIV activities at all levels;
- Joint RMNCH and HIV programme planning;
- Joint resource mobilisation for RMNCH/PMTCT;
- Advocacy and social mobilization;
- Operational research; and
- Monitoring and evaluation that includes RMNCH outcomes beyond HIV transmission.

Perspectives on these global initiatives and partnerships were shared from the three agencies and one country.

Integration and synergies with global initiatives
Andrés de Francisco, Partnership for Maternal, Newborn and Child Health

Some global initiatives that offer opportunities for linkages include: the United Nations Secretary General's Global Strategy for Women's and Children's Health, the H4+

mechanism, and the PMNCH. The Global Strategy is the first comprehensive roadmap to accelerate progress, deliver results and ensure accountability for women's and children's health. The PMNCH, hosted by WHO, has over 400 partners from countries, donors and foundations, professional associations, multilateral agencies, civil society, and academic, research and training institutes. These constituencies are working together on the continuum of care. The PMNCH has documented commitments to this Global Strategy made by governments, bilaterals, foundations, non-governmental organizations and the private sector. These commitments by agencies include ensuring that health centres offer PMTCT, increasing coverage, providing free services, increasing the number of at-risk babies born HIV-free, creating centres for treatment and new investments in PMTCT and peer education programmes. WHO, UNFPA, UNICEF, UNAIDS and the World Bank have joined together under the H4+ initiative to bring greater focus, integration, and resources to the task of reducing maternal and child deaths. The H4+ initiative seeks to significantly reduce maternal and newborn mortality in countries with the highest burdens of maternal and newborn illness and death.

PEPFAR Global Health Initiative, integration and linkages to PMTCT
Omotayo Bolu, Centers for Disease Control and Prevention

PMTCT is a strong priority of PEPFAR, which operates in 30 countries, focusing primarily on Prongs 3 and 4. Current strategies are shifting to country ownership, health services strengthening and integration. The Global Health Initiative is the new, broader framework for the United States support for global health, as it goes beyond HIV to reproductive, maternal and child health and other areas.

Global Fund perspectives
Ade Fakoya, Global Fund

The Global Fund is committed to initiatives to both eliminate new paediatric HIV infections and improve MNCH. It has developed guidance to help countries integrate interventions to control HIV/AIDS, tuberculosis and malaria. Round 11 will have a particular focus on PMTCT. A Technical Guidance Note for Global Fund proposals on PMTCT was developed in 2010 by WHO and UN partners, and a shorter programming guidance note was developed by the Global Fund. These will be updated for 2011.

Case study on integrating PMTCT into MNCH
Leonardo Chavane, Ministry of Health, Mozambique

At the country level, there is a need to deliver comprehensive services, but the challenge is how to move from a complex intervention to a simple yet comprehensive one. The primary health care context, which incorporates integration, has to be maintained. There is also an issue on how to monitor the programme, without putting more pressure on the health system.

The discussion highlighted "smart" integration, that is, optimizing investments by combining various closely related interventions, e.g. syphilis and PMTCT. The participants wanted to ensure that the GTT be given clear and adequate information on the importance of integrating PMTCT and MNCH.

Discussion
Issues that arose in discussions included:

- The value of revisiting the work that was done on integration in countries some years ago in order to look at the lessons learned.
- Integration generally works better at the local level, but not at national level because of resource issues, and donors tend not to fund in an integrated way.
- How coordination should be managed at the various levels, and the importance of not duplicating structures, as there are already many mechanisms in countries.

- Calls for simplifying PMTCT, including options for ARV regimens, were strongly expressed. While the need to simplify regimens was acknowledged, others cautioned not to rush to oversimplify without a review of key evidence and experience.
- One reason for the call for simplification was that comprehensive plans including all aspects of PMTCT can be difficult to manage.
- There was a request for more work on Prongs 1 and 2, human rights issues, and links with social protection.

UPDATE ON REGIONAL ELIMINATION STRATEGIES, FRAMEWORKS AND PROGRESS

All regions (except the Middle East) are planning for the elimination of new paediatric HIV infections, but the status of plans and progress vary greatly.

Progress towards HIV MTCT elimination in Europe
Irina Eramova, WHO Regional Office for Europe

In Europe, the goal of virtual elimination of HIV infection in infants by 2010 was endorsed by an Inter-ministerial Conference in Dublin in 2004, with elimination defined as less than one HIV-infected infant per 100 000 live births and less than 2% of infants born to HIV-infected women acquiring HIV infections. Many countries in the region have met these targets, except for some Eastern European states. However, the number of new HIV paediatric infections has increased from 3000 in 2001 to 3700 in 2008, reflecting an increasing number of HIV-infected women delivering. A major challenge is that the women who are HIV-infected are mostly from high-risk groups and are difficult to access and maintain in follow up. However, there is a strong link between ANC and HIV services, and 85-100% of HIV-infected pregnant women in the different countries in the region receive at least some ARV prophylaxis.

Regional initiative for the elimination of mother-to-child transmission of HIV and congenital syphilis in Latin America and the Caribbean
Raúl González, WHO Regional Office for the Americas

In Latin America and the Caribbean, eMTCT is linked to the elimination of congenital syphilis, defined as reduction of MTCT of HIV from HIV-infected women to infants to less than or equal to 2% and reduction of incidence of HIV infections in infants to less than or equal to 0.3 cases and congenital syphilis to less than or equal to 0.5 cases per 1000 live births. Testing has increased over recent years, but coverage of ARVs has not. Countries are at various stages in developing strategic plans, guidelines and establishing baselines. Priorities include scaling up quality of ANC, HIV and syphilis testing in pregnant women and infant diagnosis. Several proposals will be submitted to the Global Fund from the region.

Asia-Pacific Task Force on the prevention of parent-to-child transmission towards elimination of new paediatric HIV infection and congenital syphilis
Ying-Ru Lo, WHO, presenting for Teodora Wi and Iyanthi Abeyewickreme, WHO Regional Offices for South-East Asia and Western Pacific

Elimination of new paediatric infections is possible in the Asia-Pacific Region, as demonstrated by progress in Thailand. A regional framework has been developed. Targets are to reduce new paediatric HIV infections by 90%; reduce MTCT to less than 5% in breastfed populations and reduce congenital syphilis to less than 0.5 per 1000 live births. Next steps include finalization of a monitoring and evaluation framework, endorsement of the framework by the WHO Regional Committee, and country adaptation and resource mobilization, especially through the Global Fund.

Pathway towards elimination of new paediatric HIV: African Region
Dorothy Mbori-Ngacha, Claude Kamenga and Macoura Oulare, UNICEF; Isseu Diop Touré, WHO

Africa is the region with most of the global burden of MTCT, with 95% of the unmet need for services. Progress has been made in decreasing prevalence and increasing coverage, but this progress varies widely between countries and many challenges remain. In the past 2 months, major regional meetings were held for both East and Southern Africa and for West and Central Africa to develop and endorse e-MTCT frameworks. Next steps include finalizing the regional framework, the joint regional action plan and countries' action plans. The regional framework and plans will be disseminated with advocacy and communication, as well as support for capacity building and monitoring progress. Many countries have requested technical assistance for specific areas of action.

Koona Keapoletswe, Ministry of Health, Botswana, pointed out that her country needed strategies from the regional office to strengthen country work in some areas, notably Prongs 1 and 2. The country expected to receive funding for sexual and reproductive health which would help accelerate work in these areas. It would also be working on strengthening testing and counseling. Angela Mushavi, Ministry of Health and Child Welfare, Zimbabwe, said coverage was increasing but there were many challenges, including community sensitivities and limited involvement of males, and the major change of introducing more effective regimens. The country saw an opportunity for the regional framework to be used as a catalyst when working with ministers and policy-makers. Zimbabwe is aligning its targets with the global and regional targets.

IATT WORKING GROUPS: ACHIEVEMENTS, CURRENT WORK, NEW PLANS AND ISSUES, KEY PRODUCTS

All the working groups have carried out many activities since the 2010 IATT meeting. Brief updates were provided by the current IATT working groups (because of the change in agenda for this IATT meeting, full reports and review of workplans from the working groups were not possible).

Primary prevention and prevention of unintended pregnancies among women living with HIV
Lynn Collins, UNFPA

The working group on ***primary prevention and prevention of unintended pregnancies*** is currently finalizing a programming framework setting out strategies for work on Prongs 1 and 2 and a case study, including a film, on Swaziland. A rapid assessment tool for sexual and reproductive health and HIV linkages is aimed at identifying current critical gaps in policies and programmes, and contributing to the development of country-specific action plans to forge and strengthen these linkages. Future work includes continuing with pilot testing of an indicator for family planning.

Paediatrics
Shaffiq Essajee, WHO

The past five years have seen improvements in paediatric access, but coverage remains low and few infants are accessing EID or ART, with paediatric coverage lagging behind adult ART coverage. To help overcome this, the ***paediatric working group*** has developed an advocacy toolkit for scale up of paediatric testing and treatment, highlighting key programme and policy interventions. A paediatric retention in care analysis has also been developed to help identify barriers to retention, identify solutions and illustrate in-country experiences. To address the problem of fragmentation of the market for paediatric ARV

formulations because of an increased number of products, a formulary will be developed, and advocacy with industry to expedite better paediatric ARVs is ongoing (linked to activities in Treatment 2.0). IATT partners are also actively working on guidance on issues for adolescents living with HIV.

Monitoring and evaluation
Chika Hayashi, WHO; Priscilla Akwara, UNICEF

The ***monitoring and evaluation working group*** now has 19 organizations as members, holds monthly teleconferences and an annual meeting. It is finalizing a guide to harmonize indicators, drafting a data quality document and training module, helping to develop harmonized transmission rates for modeling for Option A and Option B, and developing guidance on different approaches to measure impact. For monitoring eMTCT, the working group will assist to strengthen capacity and improve data quality, analysis and use, including for MCH, finalize the guide for impact assessments, and provide coordinated technical support to countries. Some concerns included that while there is strong interest in monitoring and evaluation among the individuals in the group, there is a need for more organizational commitment. In addition, many organizations support facility-level monitoring and evaluation for their own projects, but not national systems.

Scale up
Christian Pitter, EGPAF

The ***scale up working group*** supported the development of the UNAIDS business case, participated in joint technical missions, supported the Global Fund reprogramming initiative and regional elimination efforts. Current projects to guide and support eMTCT include revising the 2007 guidance on global scale-up of PMTCT, finalizing the Global Action Framework, drafting a technical support plan and establishing the IATT website. Current issues include defining the appropriate role in the GTT and follow-on structures; how to optimize provision of technical support at country level, how to develop synergies with PEPFAR, the Global Fund and IATT implementing partners; how to best harmonize IATT working groups and their potential role with regional IATTs; and finding appropriate resources for the work.

Early infant diagnosis (EID) / laboratory
Molly Rivadeneira, Centers for Disease Control and Prevention

The ***working group on EID and laboratory*** has compiled recommended actions for EID service improvement; continued development of EID site supervision tools for improving quality of service delivery and infant health outcomes; and liaised with the monitoring and evaluation team on EID indicators. Priorities for next year include development of a scoping document for EID point of care, working on commodity issues with UNITAID, completing and piloting site supervision tools, and sharing materials via the web, including cost-effectiveness analysis for investment in laboratory infrastructure. There was further discussion about whether the lab working group should continue to focus only on EID, or also focus on HIV rapid testing and point of care CD4 testing (general consensus was to expand the focus).

HIV and infant feeding
Nigel Rollins, WHO

The ***HIV and infant feeding working group*** has provided country support though participation in national decision-making processes and developing tools for adapting WHO guidelines and guidance for implementation. It has also supported implementation research. Future work will include updating the Framework for Priority Action on HIV and Infant Feeding; advocacy and communication strategies; technical support for funding applications to PEPFAR and the Global Fund for improving infant feeding practices; and

further implementation research on improved infant feeding practices in the context of HIV as part of integrated MNCH services.

General discussion on IATT workgroups
In the discussion, several issues were raised:

- There is a new global landscape for HIV/AIDS and a new focus on eliminating new paediatric HIV infections, and thus a need to reflect on whether IATT's existing modalities are the best ones for this environment. Specifically, questions were raised about the current focus of the IATT working groups, if gaps are being addressed and whether adequate country support can be provided by the IATT as structured.
- The activities of the IATT working groups are currently based on joint work plans and the good will of member agencies to work together, without specific funding or specified commitments. Some participants thought the lack of funding was a problem, while in response it was pointed out that the institutions in the working groups have committed to the plans with the understanding that they should provide funds from within their own agencies. Working groups should define what they need to do, and the resources needed, and then collectively find the resources and/or commit to support the joint workplans and products. There is a need for commitment and accountability from the member agencies of the working groups.
- It was questioned whether the working groups should continue indefinitely or whether a process is needed to review and reconfigure the workgroups.
- On monitoring and evaluation, the working group can provide a set of core indicators, but often agencies want more information and ask for more indicators in the facilities where they work.

While there was only very limited time to review the brief work plans of the IATT working groups and to discuss whether the working groups adequately "fit" the needs of a focus on eMTCT and country support, it was recommended that these issues be part of the review to be undertaken by the Secretariat.

Session 4: Developing an action plan: background papers to support the elimination initiative

IATT WEBSITE

Introduction to the IATT website
Braeden Rogers, UNICEF

A commitment was made at the 2010 annual IATT meeting to develop a joint website, for which UNICEF has taken the lead. The mockup for the website was introduced. The proposed IATT website will have a public section, and a section with access only to IATT members. Pages will show a calendar of events, background and membership of the IATT, information on eMTCT, including progress toward the targets, and a resource hub. Participants emphasized that it was important to have information on regional and country frameworks, working groups and other activities. The website is a work in progress, so it can be revised and updated. In the context of the website, modifying the name of the IATT to reflect its broader mandate was proposed. It is expected that the internal website will be available for posting materials from this annual meeting, and, in the near future, will be available more broadly.

FEEDBACK ON GROUP WORK ON BACKGROUND PAPERS

The participants divided into six groups according to themes to discuss the different background papers. The objectives of the discussion were to: identify key

points/recommendations on each group's issue; and identify the next three to five key actions needed towards eMTCT. Each group then presented their key points in plenary.

Issue note on leadership and accountability (group on leadership)

Leadership is critical to achieving elimination of new paediatric infections. The IATT Global Action Framework should be included as part of the technical basis for the GTT. The group suggested key messages that should be shared with the GTT:

- There is interdependence between MNCH and the eMTCT strategy, and there must be cooperation between the two.
- PMTCT could be the bridge between the push to reduce maternal mortality and the HIV response;
- There is an opportunity to achieve three MDGs (4, 5 and 6) with one unified strategy;
- The initiative is not just about prevention, but also treatment.

Leadership depends on champions at various levels, each with their own roles. At community level, this involves leading actions against stigma and encouraging positive behavior change; at national levels, leaders need to prioritize PMTCT, drive scale-up, provide domestic financing and increase ANC coverage and institutional deliveries. At the global level, champions should advocate for additional resources, improve coordination between agencies and donors and strengthen managerial and technical capacity.

In this context, the IATT should use evidence to inform plans and scale up; strengthen implementation and technical support work, and strengthen its normative work and simplification agenda.

Enhancing linkages and integration between reproductive, maternal, newborn and child health and HIV/AIDS programmes: towards elimination of mother-to-child transmission of HIV (draft outline) (group on integration and linkages)

Comments from the group on the background paper included:

- Ensure that definitions on integration and linkages are consistent with agreed United Nations language;
- Include references to the linkages systematic review and key gaps;
- Acknowledge the importance of contextualization;
- Share accountability from HIV and sexual and reproductive health (SRH) constituencies towards eMTCT;
- Strengthen community aspects;
- HIV and SRH departments need to coordinate/collaborate, as structures at the country policy level are important to success;
- Address systems constraints which are critical, e.g. human resources.

Key actions at the global level should include making a visible HIV-MCH coalition; encouraging flexible funding to enable integrated planning; working with other key stakeholders such as midwives and nursing organizations as these are the main service providers; use the Roll Back Malaria/maternal-newborn health model as an approach; and develop integration indicators to assess progress.

Key messages to the GTT related to leadership include the need for bi-directional linkages at the global level and commitment to a visible global coalition; ensure the eMTCT agenda is part of the work of the Commission on Information and Accountability for Women's and Children's Health; and include the MCH perspective in the eMTCT GTT action plan. Participants stressed the need for strong linkages with the current efforts on reducing maternal mortality and the need for the IATT to be strategic in selecting countries for learning from integration efforts.

Towards a framework for community engagement : Every woman able to protect herself from HIV infection; choose when, and if to have a child, protect them from HIV infection in the first year of life; and live to raise them well – this is our hope and it can be our reality (group on role of civil society)

The group raised the question of whether eMTCT can be achieved without civil society's meaningful participation. The role of civil society in the IATT is informing the IATT work though consultations with communities; human rights and people-centred approaches based on expertise; linking with broader civil society; and supporting framework development for services that parents living with HIV will access. At community level, civil society often has direct experience in accessing and providing PMTCT services and contact with those who need the services; partnership in developing culturally sensitive and human rights-based programmes and services; and experience with social networking technology for health.

The group recommended that the GTT and IATT develop guidance for meaningful involvement of civil society and networks of people living with HIV in the Global Action Plan and Action Framework; that the IATT provide space and support for consultations with civil society and its inclusion in the work of the IATT; that the IATT advocate for civil society engagement in PMTCT; and develop good policy and practice on the role of civil society in PMTCT.

Participants pointed out that tools for community engagement in Making Pregnancy Safer exist, and could be used for PMTCT. A World Bank document including a costing component has also looked at the role of civil society in taking forward services. Various country representatives noted that civil society has been active in related work at various levels, but one pointed out that the term "civil society" may mean many different types of actors.

The issue of branding the eMTCT initiative with the short-hand term "elimination" was discussed, because of possible negative implications. There was concern that no action on terminology has been taken since a similar recommendation in November; suggestions for other terms were requested to be received in the very near future.

Global monitoring and evaluation framework strategy for the elimination of new paediatric HIV infections (group on targets and monitoring and evaluation)

The group reviewed the indicators and targets contained in the monitoring and evaluation framework. They discussed the number of indicators, and proposed to reduce them. They also proposed that there should be region-specific options where circumstances indicated.

With regard to the overall target for decreasing new infections by 90%, there was discussion on whether this should be reduced to 85%. Some participants felt that 90% was both too ambitious and not supported by the modeling work that had been done. The point was made that the target was aspirational, but also needed to be realistic. If some partners were not comfortable with the 90% target, then possible compromises could be moving back the target year to 2020, or stating "at least 85%" or "close to 90%", or "make serious efforts to scale up towards the goal of 90%". It was pointed out that elimination is a public health term with a specific definition, and that the target of 90% was developed with this in mind-- to reduce the number of new paediatric HIV infections to a significantly lower level and thereby reduce MTCT as a major public health problem. It was also noted that it would be difficult to change the overall 90% target when it has already been incorporated into most regional and country frameworks. However, some countries were concerned that even with their best efforts, it might not be possible to achieve the targets, and the issue of maintaining quality would become critical when scaling up. Whatever is agreed, the target applies to the population level, and not just women who use services; however it was

noted that it is challenging to follow up women through the whole PMTCT process, even when services are fully integrated.

The discussion also pointed out the difficulty of monitoring when different countries are using different regimens, and the need for better measures than just modeling to track progress. Trying out different methodologies can be part of the process of refining monitoring and evaluation systems. Another issue of concern was tracking not just HIV infections, but also HIV-free survival.

Laboratory needs for elimination of mother-to-child transmission (group on laboratory and diagnostics)

The group examined the delivery of diagnostic services across all four prongs of comprehensive MTCT:

Prong 1: identify women who are HIV-positive and help HIV-negative women to stay negative;
Prong 2: Ensure availability of HIV testing (during pregnancy, in ART clinics, and in family planning clinics, so that women who are HIV-positive are able to make informed choices about contraception methods;
Prong 3: Increase access to HIV testing for pregnant women and provide accessible CD4 cell count testing for HIV-positive pregnant women to identify women in need of treatment and facilitate delivery of efficacious prophylaxis and treatment;
Prong 4: Provide early infant diagnosis for all HIV-exposed infants at 6 weeks (for the future, goal is point of care EID) and final diagnosis after 15 months or cessation of breastfeeding.

Proposed messages to be communicated to the GTT included:

- Promote a basic package of diagnostic services for pregnant women which includes, but is not limited to, HIV diagnosis;
- Provide access to timely and reliable CD4 cell count testing as an essential component of PMTCT, but do not let lack of access to diagnostic services prevent clinical decisions or impede patient care;
- Improve the management of HIV-exposed infants with EID and immediate initiation of ART for positive infants;
- Develop automated EID data management and sharing systems to monitor progress of eMTCT and improve PMTCT services in real time;
- Decentralize integrated HIV diagnostic services (rapid testing, CD4, EID) in parallel to ART services for mother and baby;
- Support integration of services through coordinated national plans for eMTCT and laboratory services.

Discussion brought up the issue of including safe blood transfusions in the laboratory package, as a good point for integration. Some participants raised questions on quality of HIV test kits, and lack of quality assurance for decentralized rapid testing, as there is reportedly 30-40% disagreement of results in some field settings.

Technical Support Plan of the Global Inter-Agency Task Team on prevention of HIV infection in pregnant women, mothers and their children for the elimination of new paediatric HIV infections and keeping mothers alive (group on implementation and country support)

In addition to the draft Technical Support Plan, the group also considered the OGAC presentation on the ten-point plan for accelerated PMTCT action.

The group began by considering relevant questions, such as:

- How do we restructure the IATT to be able to offer more effective and harmonized support to the 22 high-burden countries, and how do we ensure country buy-in?
- Who within the IATT will support the process at country level and what resources are needed?
- What does the IATT bring to the table to address technical assistance needs?

The group noted that many countries had recently gone through a process of identifying their technical assistance needs. However, there was a need to prioritize IATT assistance to countries, in part using the typology of countries that was presented earlier.

The group in general endorsed both the IATT Technical Support Plan and the Ten-point Plan, and suggested that the whole IATT also do so. The scale-up working group was proposed as the appropriate arm to coordinate IATT technical support to countries, with the IATT being the technical implementation arm of the GTT.

Other recommendations included:

- Add an additional technical person to the global IATT secretariat to facilitate communication between global and regional IATTs as well as countries;
- Maintain a database of experts on costing, procurement and supply management, and other key issues, with perhaps the UNAIDS-supported Technical Support Function taking on this responsibility
- Track progress towards eMTCT with a focus on HIV-free survival by including infant feeding and other MNCH indicators, and include these issues in the costing model presented earlier.
- Develop a toolkit for facilitating feedback of IATT members to their constituencies.
- Develop a resource mobilization plan for each of the 22 high-burden countries.
- Explore including IATT technical assistance costs in country funding proposals.

Discussion points included asking that counselling and support of women for the recommended infant feeding option and adherence to ARVs be included in the costing model. This is important if the model is to include HIV-free survival, and not only prevention of HIV.

Some concerns were expressed as to whether the IATT has the capacity and is the appropriate mechanism to have a lead role in technical assistance to countries, and whether other mechanisms at country level already exist. In response, it was agreed that arranging technical support should be a country-led process, since all partners are represented on local working groups.

It was observed that some programmatic issues were covered in the Ten-point Plan but not in the Technical Support Plan. Others expressed concern that the group was looking at PMTCT in a more isolated way than the drive to integration envisions. It was pointed out that countries in Africa had already identified technical support needs in regional meetings.

Session 5: Leadership and accountability: mechanisms including IATT/GTT to reach elimination

C. CONCLUSIONS AND RECOMMENDATIONS

Conclusions

In the final session, the major issues discussed were the IATT's structure and mandate, the key products and messages that the IATT should ensure reach the GTT, including

during its upcoming meeting in South Africa, and the terminology around eMTCT. Other conclusions are derived from presentations and discussions from earlier sessions.

The group recognized that the IATT has a unique value in drawing together key agencies that share PMTCT goals. However, differing viewpoints exist regarding the structure and mandate of the IATT. There was some consensus that the working groups should be reviewed, with an effort to refocus on deliverables to focus on eMTCT and direct country support. In particular, the issue remains around its capacity and the mechanisms to provide direct technical support to countries, as well as the resources to continue the increasing activities of the working groups.

Several documents have been developed which spell out the vision for global eMTCT, or outline future actions. The Global Action Framework, Global Monitoring and Evaluation Framework, IATT Technical Support Plan and an outline Ten-Point Plan (from OGAC) for country implementation were all generally endorsed by the IATT as a group. However, it will be important to have a consolidated document rather than multiple documents.

The U.S. government partners raised concerns about the target to reduce the number of new paediatric HIV infections by 90%, from 2009 baseline estimates (from about 400,000 to 40,000); and proposed 85% as an alternative. The IATT group considered several alternatives in language with the hopes of building a consensus. While there was not enough time to resolve this issue, there was a clear commitment to maintain the current 90% target as the overall "elimination" goal, while accepting variations in the language with the idea of aspiring towards a 90% reduction. This key issue will be referred to the GTT for further consideration and resolution.

Strong concerns were raised, particularly by civil society, on the use of language around eMTCT and that ”elimination” alone should not be used as a short-hand or slogan for the initiative. There may be a need for a technical term for the initiative and also a short, public term suitable to support the campaign. The meeting did not have time to fully discuss or conclude on suitable terminology, but recognized the critical importance of resolving this in a short period of time. This key issue will also be referred to the GTT.

The importance of linking the eMTCT initiative with broader MNCH global initiatives and the need to support integrated and systems strengthening approaches at country level were stressed. The IATT must work to shift in this direction; it is working towards a joint event of key stakeholders from both constituencies to harmonize ongoing work on eMTCT and MNCH.

Several key laboratory issues, related to both quality and access of key diagnostics at primary care level, are critical to the success of the eMTCT initiative. The IATT lab working group, with leadership from both CDC and CHAI, will expand its portfolio to address these issues, and work closely with the diagnostics work stream in Treatment 2.0. The principles of the new Treatment 2.0 initiative are directly applicable to PMTCT - and progress on moving the Treatment 2.0 agenda will directly benefit PMTCT and the ability to achieve eMTCT goals.

Recommendations

The IATT agreed on the following recommendations to inform the GTT and guide its future work.

Key products to inform the GTT

The following IATT documents were identified to be provided to the GTT later the same week to help inform the development of the GTT Global Action Plan:
1. *A Global Action Framework for the elimination of Mother-to-child transmission of HIV.*
This *Global Action Framework* was endorsed and recommended to the GTT.

2. *Global Monitoring Framework and Strategy for the Elimination of New Paediatric HIV Infections by 2015.* There was general endorsement of the monitoring framework, recognizing that additional work is needed, including to agree on the language used for the global target (see below). Intensified efforts are needed to strengthen monitoring and evaluation systems at country level and better harmonize national data.

3. Implementation and Country Support. These background papers should be synthesized to finalize an implementation and country support plan.

4. Resource Estimation. The resource estimates were endorsed with request for further revisions/clarifications, including how to incorporate HIV-free survival issues and the limited inclusion of service delivery and systems issues that will need to be addressed to achieve the goals, and the importance of making clear the assumptions behind the costing estimates.

Global Targets

The IATT recommended that the GTT should consider further and seek the appropriate wording towards a shared, aspirational global goal of 90% reduction in new paediatric infections as the basis for eMTCT.

Language and Branding

The IATT should alert the GTT to the problematic nature of the short-hand term "elimination" and the need to rapidly agree on technical and public/campaign terminology for the initiative.

Other Key Issues

- ***Integration and linkages with MNCH*** and the United Nations Secretary General's Initiative on Women's and Children's Health. The GTT should strongly emphasize the importance of linkages with broader MNCH initiatives and strengthen synergies.

- ***Laboratory and Diagnostics.*** Key diagnostic and laboratory issues need to be addressed, especially with regard to quality and point-of-care testing at primary care level, to support the initiative.

- ***Treatment 2.0.*** Treatment 2.0 should actively include PMTCT issues and the goal of simplified and expanded treatment and related ARVs for pregnant and reproductive age women. The PMTCT IATT should work closely with Treatment 2.0.

IATT structure and roles

The structure and roles of the IATT need to be reconsidered and defined particularly after clarifications on the GTT. The IATT Secretariat agreed to review the current structure in light of the new goals and the need to focus strongly to support elimination of new paediatric infections in the 22 high burden countries, and will make recommendations to the general IATT.

Renaming of the IATT
It was recommended to rename the IATT to include both prevention and treatment: *Interagency Task Team (IATT) on Prevention and Treatment of HIV Infection in Pregnant Women, Mothers and their Children.* The IATT should formally endorse this suggestion during the next general IATT meeting call.

Appendix A: Agenda of the IATT 2011 Annual Meeting

Interagency Task Team (IATT) on Prevention of HIV Infection in Pregnant Women, Mothers and their Children

ANNUAL MEETING

2-3 May 2011

Salle B - WHO/HQ Main Building

Geneva, Switzerland

DRAFT AGENDA

Day 1: Monday, 2 May 2011

Session 1: Introduction and overview of progress on PMTCT Chair: Ying-Ru Lo		
Time	**Topic**	**Presenter**
09:00 - 09:30	Welcome remarks Introductions including new IATT members	Gottfried Hirnschall (WHO) Jimmy Kolker (UNICEF)
09:30 - 09:45	Objectives of the meeting	Julie Samuelson (WHO)
09:45 - 10:00	Global progress on PMTCT Presentation (10 min) and discussion	Yves Souteyrand (WHO)
10:00 - 10:15	The PMTCT IATT - background, progress, key focus and issues Presentation (10 min) and discussion	Chewe Luo (UNICEF)
10:15 - 10:45	*Coffee break*	

Session 2: Elimination of new paediatric HIV infections and new global initiatives Chair: Christian Pitter and Dorothy Mbori-Ngacha		
10:45 - 11:15	The Elimination Initiative Presentation (10 min) Elimination Global Action Framework Presentation (10 min) Discussion (10 min)	Nathan Shaffer (WHO) René Ekpini (UNICEF)

Time	Topic	Presenter
11:15 - 11:30	Global Task Team (GTT) on Elimination: Overview Presentation (15 min)	Paul de Lay (UNAIDS)
11:30 - 12:30	Selected key issues for elimination Presentations (10 min each) • Leadership and accountability • Targets, monitoring and reporting • Costing and resource needs • Implementation and country support • Laboratory Country programme: Commentary (5 min each)	Sigrun Mogedal Chika Hayashi (WHO) Carlos Avila (UNAIDS) TBC (OGAC) Shaffiq Essajee (WHO) Nonhlanhla Dlamini (S Afr) Ado Sabo Uba (Nigeria)
12:30 - 13:00	Treatment 2.0 - Presentation (10 min) - Commentary from IATT partner (5 min) - Discussion (10 min)	Craig McClure (WHO) Mariangela Simao (UNAIDS) Elaine Abrams (ICAP)
13:00 - 14:00	*Lunch break*	

Session 3: IMPLEMENTATION: Global synergies, regional frameworks and IATT workgroups Chair: George Tembo		
Time	**Topic**	**Presenter**
14:00 - 14:45	Integration and synergies with other global initiatives: MNCH, H4, SCG Women and Children Health Initiative and Congenital Syphilis Elimination Presentation (10 minutes) Panel (5 minute statements each): • UN Secretary General's Global Strategy on Women's and Children's Health and opportunities for elimination • PEPFAR Global Health Initiative, integration and linkages to PMTCT • Global Fund perspectives • Case study on integrating PMTCT into MNCH Discussion (15 min)	Viviana Mangiaterra (WHO) Panellists: Andres de Francisco (Global Partnership) Omotayo Bolu (CDC/PEPFAR) Ade Fakoya (Global Fund) Achamyelehe Alebachew (Ethiopia)
14:45 - 16:00	Update on regional elimination strategies, frameworks and progress (presentations 7-10 min each) • Progress towards elimination in Europe • Progress towards elimination in Latin America	Regional Representatives Irina Eramova (WHO) Raul Gonzalez (WHO)

Time	Topic	Presenter
	• Eastern and Southern Africa • West Africa Country panel comments (20 min) Discussion (15 min)	Dorothy Mbori-Ngacha (UNICEF) Isseu Diop Toure (WHO) Claude Kamenga (UNICEF) Panellists TBC
16:00 - 16:30	*Coffee break*	
16:30 - 17:30	IATT Working Group: achievements, current work, new plans and issues, key products. Presentations (5 min each) followed by discussion (5 min each) • Primary prevention & family planning • Paediatrics • Monitoring & evaluation • Scale up • Laboratory • Infant feeding	Working group co-chairs Lynn Collins (UNFPA) Shaffiq Essajee (WHO) Priscilla Akwara (UNICEF) Christian Pitter (EGPAF) Molly Rivadeneira (CDC) Nigel Rollins (WHO)
17:30 - 18:00	Wrap up of day 1 and introduction to day 2 break out groups	TBC
18:00	Reception	Restaurant, main building

Day 2: Tuesday, 3 May 2011

Session 4: DEVELOPING AN ACTION PLAN: Background papers to support elimination Chair: Karl Dehne and Sostena Romano		
Time	**Topic**	**Presenter**
09:00 - 09:15	Review of day 1 and plan for day 2	Secretariat
09:15 - 09:30	Introduction to the IATT website	Braeden Rogers (UNICEF)
09:30 - 09:45	Introduction to group work	Secretariat
09:45 - 11:00	Group work break-out sessions: 1. Leadership 2. Targets and monitoring 3. Role of civil society 4. Resources and costing 5. Implementation & country support 6. Laboratory and diagnostics 7. Integration/linkages	
10:30 - 11:00	*Coffee break* *(take coffee and continue working groups)*	
11:00 - 11:30	Finalize group work and presentations	
11:30 - 12:30	Plenary: report back from group work (5 - 10 min presentation + 10 - 15 min discussion each) 1. Leadership 2. Targets and M&E 3. Role of civil society	Working group representatives
12:30 - 13:30	*Lunch break*	
13:30 - 15:00	Continue plenary report back and discussion (5 - 10 min presentation + 10 - 15 min discussion each) 4. Resources and costing 5. Implementation & country support 6. Laboratory and diagnostics 7. Integration/Linkages	Working group representatives
15:00 - 15:30	*Coffee break*	
Session 5: Leadership and accountability: Mechanisms including IATT/GTT to reach elimination Chairs: Jimmy Kolker and Gottfried Hirnschall		
Time	**Topic**	**Presenter**
15:30 - 17:00	Strengthening mechanisms including IATT/GTT towards reaching elimination Raising the visibility of elimination	Facilitated discussion
17:00 - 17:30	Next steps and wrap up	Nathan Shaffer, René Ekpini
17:30	Closing of the meeting	

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Infant feeding	Nigel Rollins, WHO; UNICEF (tbd)
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Scale up	Christian Pitter, EGPAF; Omotayo Bolu, CDC; René Ekpini, UNICEF; Nathan Shaffer, WHO
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