

## IATT Webinar: The Path to Elimination

March 17, 2016

A total of **72 participants** from China, Côte d'Ivoire, Djibouti, Madagascar, Mozambique, Namibia, Nepal, Panama, Senegal, South Africa, Zimbabwe and many other countries attended the webinar to learn about the validation criteria for elimination of mother-to-child transmission (MTCT) of HIV and syphilis, as well as pre-elimination criteria, from World Health Organization (WHO) representatives. The main message was that achieving elimination and qualifying for the validation process will require more than reducing the proportion of HIV-positive children who are born to women living with HIV. In high burden countries, it will require reducing the HIV case rate to  $\leq 50$  per 100,000 live births. This essentially means reducing HIV incidence among young girls and pregnant women and reducing the unmet need for family planning (FP), increasing partner testing, etc in order to reduce the case rate along with the declines in MTCT of HIV seen in many countries. The recording of the webinar can be found [here](#).

### Main Discussion Points from Presentations

#### 1. Elimination and Pre-Elimination - An overview of the rationale and criteria

Dr. Shaffiq Essajee, WHO (Geneva)

- Cuba was the first country to be certified as having reached elimination MTCT of HIV and syphilis.
- Elimination certification is contingent on reaching impact and process indicators for HIV and syphilis (e.g., HIV case rate of  $\leq 50$  per 100,000 live births and syphilis case rate of  $\leq 50$  per 100,000 live births).
- Many (10+) countries in Asia, Europe and South America are close to being validated for EMTCT of HIV, but none are in Sub-Saharan Africa (SSA), which accounts for 90% of the global burden of MTCT of HIV.
- Some SSA countries are close to achieving elimination criteria (e.g., South Africa, Namibia, Botswana), but have a case rate well above the elimination criteria.
- "Pre-elimination" is an attempt to recognize the progress that has been made in PMTCT of HIV in high burden countries.
- The paediatric HIV case rate is a function of maternal prevalence and population MTCT rate, so FP, prevention and retention are all key to achieving a case rate of  $\leq 50$  per 100,000 live births for HIV and syphilis (elimination targets).
- It may take a country years to move from "pre-elimination" to elimination of MTCT of HIV and syphilis.

#### 2. The process of validation and an introduction to the validation tools

Dr. Innocent Nuwagira, WHO (Eastern & Southern Africa Region)

- Review of the National, regional and global validation structures and processes :
  - National EMTCT validation structure
    - National validation secretariat (WHO country office):
      - 1<sup>st</sup> point of contact with national stakeholders
      - Provide technical support to the country for the report development

- Receives the validation report request and sends to the regional director
  - National validation committee (NVC):
    - Established by each MOH
    - Coordinates data collection and writing of the country report
    - Works with regional groups (secretariat, validation committee, and validation team) to plan for and implement country validation
  - Regional EMTCT validation structure
    - Regional validation secretariat:
      - Managed by WHO
      - Supports the RVC/RVT (regional validation team)
    - Regional validation committee (RVC)
      - Evaluate a EMTCT report from a candidate country for validation assessment
      - *If there is no RVC, the WHO regional office will serve the function of the RVC*
  - Global EMTCT validation structure
    - Global validation secretariat:
      - Managed by WHO
      - Coordinates with the GVAC
      - Provides official notification of EMTCT of HIV and syphilis validation
      - Monitors the maintenance of status
    - Global validation advisory committee:
      - Formed in mid-2015
      - Provides independent review and advice to WHO regarding validation of candidate countries (and did so for Cuba)
- Operational tools have been revised and will soon be available as a consolidated implementation guide to provide guidance to teams at the national and regional levels.

### 3. Upholding human rights during the elimination validation process

Miriam Chipimo, UNAIDS

- Human rights is a key consideration for validation.
- Part of the documentation required from countries includes questions about the legal environment, consent, confidentiality, civil society engagement, gender norms, violence against women and mechanisms for addressing grievances.
- The team that visits the country will be validating what was written in the country elimination request report, rather than carrying out their own assessment (e.g.,

validate that policies passed by the government are understood and implemented at the facility- and community-levels).

## Q&A

### 1. Which countries can apply for pre-elimination – only the countries which implemented the Global Plan?

- All countries are eligible for pre-elimination, not just Global Plan countries.
- Pre-Elimination certification would only be available for countries with a higher prevalence of HIV (>2%), as this is what is holding back some of the higher burden countries from achieving the elimination targets.
- Countries with a low prevalence should be actively seeking elimination certification.

### 2. Is Rwanda currently in the Elimination process?

- Yes, they are in the process of pulling together a team to submit a report to the WHO to start the Elimination process.

### 3. Previous documents included two elements of criteria for pre-elimination related to MTCT rate: MTCT rate of <2% (at 6 weeks), and a final MTCT rate <5% (18 months). This did not come out clearly in the presentation. Has that been modified or changed?

- No this has not been modified. The 2% population MTCT rate at 6 weeks is for countries that provide and support formula feeding and the 5% population MTCT rate at the end of breastfeeding is for countries where the national policy for HIV positive women to breastfeed

### 4. Is there now a regional validation team (RVT) for Africa? Who is on the team apart from Innocent?

→ I understand WHO will officially communicate to countries that do qualify for pre-elimination. When will this be done - timelines?

→ Could you please send to us the ToR of the NVC, RVC...?

- The AFRO regional validation team has not been put in place, so as yet it is not known who will be on it. An Elimination Secretariat will be established at the regional level by WHO AFRO, potentially with the involvement of other UN agencies as well as partners.
- The Regional Validation Committee is **optional**. If there is no RVC in place, the WHO convened Elimination Secretariat would perform this function.
- If there is a country that needs to be validated or pre-validated, the regional office will review the report (from the country) through the secretariat.
- A policy brief is slated to be released in the 1<sup>st</sup> week in April about Pre-Elimination and the criteria.
- Some criteria are set in stone already (e.g., MTCT rate), while other criteria (e.g. process indicator criteria) are still being finalised, but there is nothing preventing country teams from gathering this data in anticipation of submitting their report.

### 5. Why link EMTCT to Syphilis and not to another disease? I am wondering why linking EMTCT to syphilis?

- We have long had dual-elimination initiatives for MTCT of syphilis and HIV in the AFRO region, but these have not consistently been taken up.

- Globally, congenital syphilis accounts for more perinatal mortality and morbidity than HIV. Also – treating mothers for syphilis and preventing congenital syphilis is so simple (a single dose of penicillin), we wanted to take advantage of the PMTCT efforts around HIV.

**6. From Cuba's experience and from spectrum estimates; is it possible to estimate the years between "pre-elimination" to elimination?**

- This will vary from country to country. If the infection case rate is high, it may take many years, even a decade. For example, a country like South Africa, which has been very successful at implementing services for pregnant women still has a case rate much above the Elimination threshold, largely due the high prevalence of HIV in ANC. It will likely take many years for the case rate to fall below 50 per 100,000 live births.
- An important aspect of the pre Elimination criteria is for countries to submit an elimination plan which emphasizes the things that need to be done and the timeline to get to goal. We specifically did not put in a requirement for the duration of the plan in order to allow countries to come up with a feasible estimate in their own context.
- WHO is developing a tool to let countries input their background information, and then toggle different interventions, over specific time periods. The model will be able to tell you what case rate a country will be able to achieve over a certain time period. This would then be built into each country's plan to receive recognition for pre-elimination.

**7. Can Shaffiq or others elaborate on what is expected around PrEP and uninfected pregnant women?**

- We do not feel that there is rationale to not use PrEP in HIV negative pregnant women (if they otherwise meet the criteria for PrEP) . However, there are concerns around giving pregnant women ARVs if they do not need it to treat their HIV infection. There are other strategies that can be used (e.g., partner testing to get serodiscordant partners on ART) to ensure pregnant women stay HIV-free, so it is important that countries that are considering implementing PrEP in ANC settings should also consider additional prevention elements.
- There is ongoing and planned work to discuss whether PrEP is appropriate for pregnant or breastfeeding women to ensure they stay negative, and do not seroconvert while there is still risk of vertical transmission.