AFRICAN PLAN TOWARDS THE ELIMINATION OF NEW HIV INFECTIONS AMONG CHILDREN BY 2015 AND KEEPING THEIR MOTHERS ALIVE

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FOREWORD

The African Union Commission facilitated the process to develop an African Plan towards Elimination of New HIV Infections among Children by 2015 and Keeping their Mothers Alive. The African Plan is an accountability framework that outlines the responsibilities of stakeholders for tracking progress towards achieving the set goals of the African Union policy instruments on health. It domesticates the Global plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive. By achieving the goals of the existing policy instruments, Africa hopes to significantly contribute towards achieving the goals of the Global Plan.

The African Union Commission recognises the importance of addressing the issue of Prevention of Mother to Child Transmission of HIV. To that end, African leaders, at their Special Summit on HIV, TB and other Related Infectious Diseases in 2001 committed themselves to reducing the disease burden on the Continent. In order to build on the achievements and to keep HIV, TB and other related infectious diseases high on the agenda, they met again in 2006 in Abuja and adopted the "Call for Accelerated Actions towards Universal Access" and also met in 2010 and 2013 to review progress and renewed the commitments to 2015.

Women are particularly vulnerable to HIV/AIDS and biological factors are a major contributor to this. Most cultural and traditional practices continue to put less value on the lives of women and children. Women are still far less educated than men across Africa, and are often forced into marriage at a very young age with their fundamental sexual rights denied. High maternal and child mortality is therefore a manifestation of these conditions, and one that cannot be dealt with unless these conditions are addressed along with the improvement of health systems. Evidence shows HIV is a major contributor to maternal mortality especially in Southern Africa.

In response to the challenges of maternal and child health, the African Union Commission, in collaboration with its partners, initiated a Campaign for Accelerated Reduction of Maternal, Newborn and Child Mortality in Africa (CARMMA) which has received overwhelming response from AU Member States.

The CARMMA can be used as a vehicle to link the interventions against HIV/AIDS and maternal & child health, during the process of implementing the African Plan.

I call upon all stakeholders to play an active role in implementing the "African Plan towards Elimination of New Infections among Children by 2015 and Keeping their Mothers Alive", as this is in line with the Decision of the AU Heads of State and Government on Eradication of mother to child transmission of HIV, passed during the July 2010 Summit.

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List of abbreviations and acronyms

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ARV	Antiretroviral
AU	African Union
AUC	African Union Commission
CARMMA	Campaign on Accelerated Reduction of Maternal, Newborn and Child Mortality in Africa
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDG	Millennium Development Goals
PMTCT	Prevention of Mother to Child Transmission of HIV
PoA	Plan of Action
REC	Regional Economic Community
RHO	Regional Health Organisation
SRHR	Sexual and Reproductive Health and Rights
UN	United Nations

Introduction

Background

The year 2011 marked the 30 years of AIDS epidemic and ten years of high level commitments made by African leaders which have led to a turning point in the continental response to the disease.

The African leadership resolved to speak as one voice in addressing the HIV epidemic.

In 2006, the African Union Heads of State and Government articulated a common position on the epidemic that was submitted to the High Level Meeting (HLM) of the UN General Assembly Special Session on AIDS (UNGASS).

In April 2011, an *African Common Position on HIV/AIDS to the UN High Level Meeting on AIDS* was adopted by the 5th Session of the AU Conference of the Ministers of Health (CAMH5), and endorsed by the AU summit in Malabo, in July 2011. It urged AU Member States to implement the AU initiatives, decisions and to step up leadership and ownership by enhancing appropriate responses to HIV through implementing the campaign for zero new infection, zero discrimination and zero AIDS- related deaths.

On 9 June 2011, World leaders gathered in New York for the 2011 United Nations High Level Meeting on AIDS and launched a Global Plan that would make significant strides towards eliminating new HIV infections among children by 2015 and keeping their mothers alive. This plan covers all low and middle-income countries, but focuses on 21 countries with the highest estimated number of pregnant women living with HIV. Exceptional global and national efforts are needed in these countries that are home to nearly 90% of pregnant women living with HIV in need of services. Intensified efforts are also needed to support countries with low HIV prevalence and concentrated epidemics to reach out to all women and children who are at risk of HIV with services that they need. The Global Plan supports and reinforces the development of costed country-driven national plans.

Rationale

The objectives of the African Plan is to domesticate the Global Plan in order to create ownership for the elimination of the mother to child transmission initiative particularly in the 21 high burden countries. While reinforcing the Global Plan, the African Plan responds to the specific African situations and challenges. The African Plan reinforces the various health policy instruments of the African Union including the Africa Health Strategy, the Maputo Plan of Action on Sexual and Reproductive Health and Rights, the Abuja Call for Accelerated Action Towards Universal Access to HIV/AIDS, TB and Malaria Services by 2015 and the Campaign on Accelerated Reduction of Maternal, Newborn and Child Mortality in Africa (CARMMA). It is an accountability framework that outlines the responsibilities for tracking progress toward achieving the set goals of the AU policy instruments on health. By achieving the goals of the policy instruments, Africa shall make a significant contribution towards achieving the goals of the Global Plan.

Mandate and principles for success

The African Plan is guided by various decisions and declarations of the African Union (AU) Executive Council and Assembly. During the 15th Ordinary Session of the AU Assembly held in Kampala in July 2010, the AU Heads of States and Government adopted decisions Assembly/AU/Dec.291 (XV) and Assembly/AU/Dec.320 (XV) on the Five-year Review of the Abuja Call and elimination of mother to child transmission of HIV respectively. At this Assembly, the AU Heads of State and Government debated on the theme and later adopted a declaration of Actions on Maternal, Newborn and Child Health and Development In Africa by 2015 [Assembly/Au/Decl.1 (Xi)]. The Executive Council also extended the Maputo Plan of Action up to 2015 ([EX.CL/Dec.568 (XVII)]).

Challenges

Despite opportunities to overcome scaling up demand and provision of treatment for HIV positive pregnant women and mothers of infants, significant challenges still remain.

The major challenges identified in responding to paediatric HIV infections in Africa include the following:

- Inadequate response from countries to health issues in their central development frameworks.
- Weak health systems including inadequate infrastructure, equipment, human resources and supplies remain a major barrier to implementing disease control programmes, although progress has been made towards universal coverage and access to health services.
- Limited health financing is hampering response to the epidemic. Although the available resources have generally increased, this has been mainly from international sources and there is still inadequate domestic investment in health. Moreover, disbursement of funds, access to funds at operational levels, inadequate absorptive capacity, tracking and accountability of funding still remain major challenges. Most countries have not yet established sustainable financing mechanisms for health services or regular supplies.
- Coordination and harmonisation of partnerships at all levels remain inadequate. Inadequate government oversight and supervision remains a challenge including for the private sector in Africa.
- There are specific challenges facing the implementation of respective programmes for each disease as well as HIV/TB co-infection, in addition to the above. Development of drug resistance or its threat, are added problems many countries face.
- Monitoring and evaluation systems are still weak in countries, making reporting difficult.

Programme framework

The implementation framework for the elimination of new HIV infections among children and keeping their mothers alive will be based on a four-pronged strategy for PMTCT in line with the Global Plan. This strategy provides the foundation from which national plans will be developed and implemented and encompasses a range

of HIV prevention and treatment measures for mothers and their children together with essential maternal, new-born and child health services as an integral part to achieve Millennium Development Goals 4, 5 and 6.

Prong 1:

Prevention of HIV among women of reproductive age within services related to reproductive health such as antenatal care, postpartum and postnatal care, family planning and other health and HIV service delivery points.

Prong 2:

Providing appropriate counseling and support and contraceptives to women living with HIV to address their unmet needs for family planning, spacing of births and to optimise health outcomes for women and their children.

Prong 3:

For pregnant women living with HIV, ensure that HIV testing and counseling and access to antiretroviral drugs needed to prevent HIV infection from being passed on to their babies during pregnancy, delivery and breastfeeding.

Prong 4:

HIV care, treatment and support for women, children living with HIV and their families.

Advocacy

Advocacy should be strengthened at all levels. More effort should be put to promote and reach communities at the national level. This includes soliciting support from traditional and religious leaders and providing communities with information and services, laying emphasis on the most vulnerable groups, particularly pregnant women. Governments, private sector and development partners are urged to ensure universal access to affordable and timely services. The media and civil society should be mobilised to play their role in the promotion of Information, Education and Communication (IEC).

At the regional level, the Regional Economic Communities (RECs) and Regional Health Organizations (RHOs) should be part of the advocacy campaign through their regular meetings. They should also provide specific resources towards special regional advocacy efforts.

At continental and international levels the African Union (AU) should advocate for the effective implementation of the commitments.

Leadership

While technical capacity to support programmes for elimination of new HIV infections among children and keeping their mothers alive is largely in place, managerial and political leadership must be strengthened to ensure programme ownership, problem solving and accountability. Leadership must focus on ensuring clarity in messaging, direction and priority action, in ways that are recognised at all levels and by all stakeholders.

Leadership in health in Africa face a number of challenges that include ministers' diverse backgrounds, limited orientation and limited tenure of office.

Roles and responsibilities in leadership

The leadership roles and responsibilities of stakeholders at continental, regional and national levels should be well articulated and allocated.

Continental actions

1. Continental leaders will mobilise resources from development partners and the private sector to support the funding of the implementation of the African Plan in countries.
2. Continental leaders will build and enhance the capacities of countries
3. Continental leaders will develop, resource and sustain mechanisms for coordinating the rapid provision of technical assistance and capacity building based on national driven needs.
4. Continental leaders will promote and support synergies and strategic integration between programmes for preventing HIV infection among children and programmes for maternal, newborn, child and reproductive health;
5. Leaders at continental level will build coalitions and reinforce support of integration of initiatives to eliminate new HIV infections in children and keep their mothers alive with the "Abuja Call" and the Maputo Plan of Action (PoA) on Sexual and Reproductive Health and Rights (SRHR) with a view to contribute to the global strategy for women and children's health and the MDGs 4, 5 and 6.
6. Continental leaders will commit to accountability.

Regional actions

7. Regional leaders will create partnerships to support the implementation of the African Plan.
8. Leaders will ensure policy harmonisation and integration of the African Plan into the regional development agendas and support the mobilisation of domestic resources.
9. Regional leaders will promote south-to-south exchange of good practices.
10. RECs and RHOs will raise awareness of the African Plan, attract resources to it and promote collaboration around its goals.

Resources mobilisation

The actions needed to mobilise resources are outlined below. These actions are guided by the core principles of country ownership and shared responsibility.

11. Costing national plans: the RECs and RHOs will assist countries to cost their resource needs for eliminating new HIV infections among children by 2015 and keeping their mothers alive.

12. Increasing domestic investments: the RECs and RHOs will assist countries to meet the target of allocating at least 15% of domestic budgets for health as agreed at the 2001 AU Special Summit on HIV/AIDS, TB and other related infectious diseases in Abuja Behavior change communication

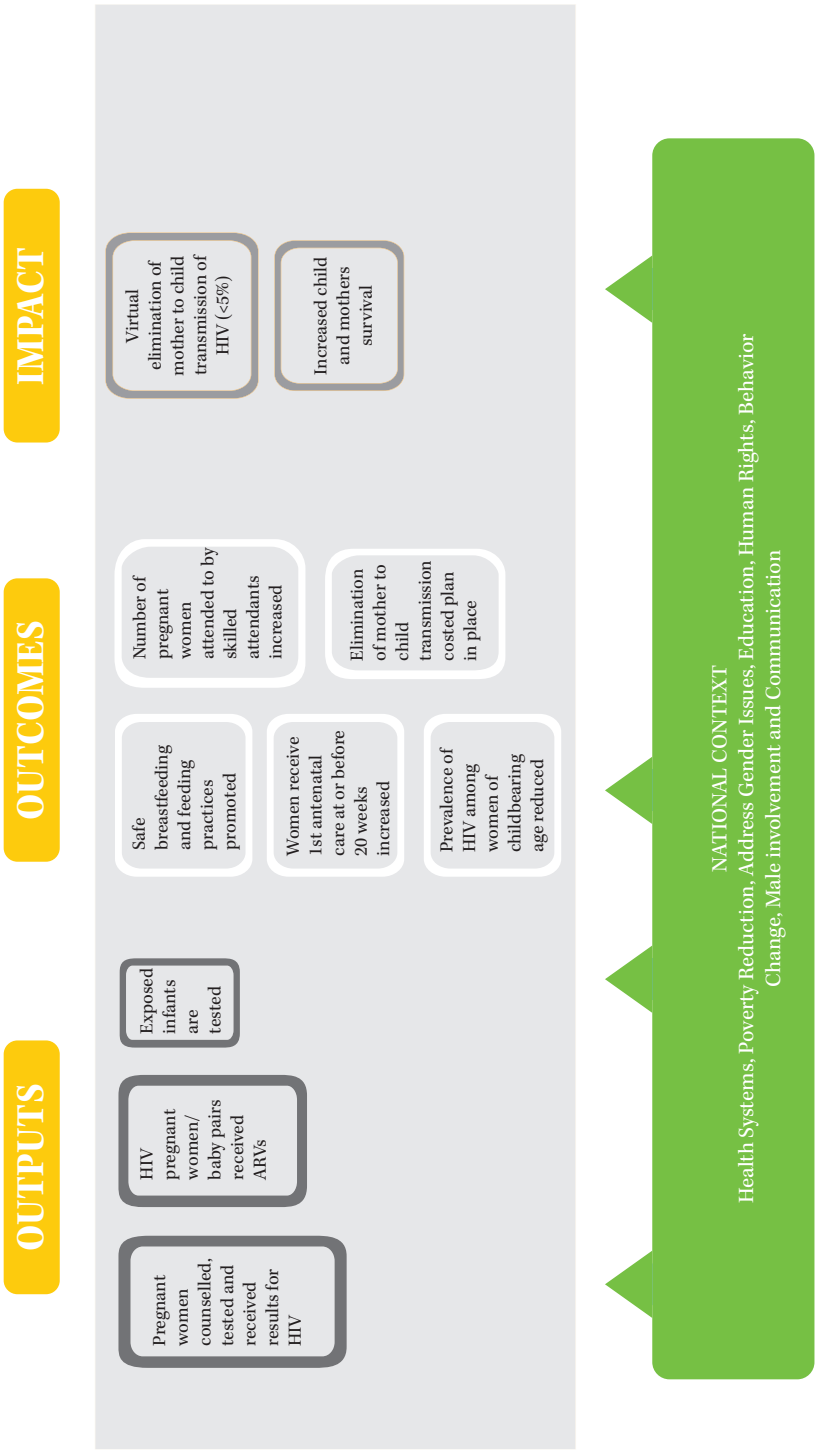
13. To promote the goal of elimination on new HIV infections among children and keeping their mothers alive, education and mobilization will be undertaken by countries at the continental level (social change mobilisation to ensure demand creation and uptake of services).

The continental campaign will be launched to promote the goal of eliminating new HIV infections among children and keeping their mothers alive. These efforts will increase interest and support behind the African Plan and provide a communication framework for all partners to use in promoting their individual programmes. Some of the goals will include advocacy around the African Plan, accountability and resources.

Implementation

Depending on specific needs, specific actions need to be undertaken at country level towards elimination of new HIV infections among children and keeping their mothers alive. The African Plan proposes the implementation framework below.

Figure 1: IMPLEMENTATION FRAMEWORK OF THE AFRICAN PLAN



African Union Commission, Department of Social Affairs, 2011

Focused actions for countries based on typologies

The 21 priority countries in Africa have diverse epidemics, contexts, conditions and are at different stages in progress in implementing PMTCT. In this sense, they have been identified as having different 'typologies' for response based on epidemiology, need and coverage for ARVs and PMTCT services, quality antenatal care (4 ANC visits), skilled birth attendance and post natal care coverage/access. Given these differences, it is critical that specific response actions are appropriately tailored according to each typology. Typologies have been developed based on two key indicators: 1) PMTCT, using maternal ARV coverage as the marker of access and uptake; 2) MCH quality, using the proportion of women accessing 4 ANC visits as the marker of quality of services.

Countries should identify their typology and use this as a basis to plan priority and focused actions to facilitate reaching elimination targets.

Typology A

These are countries where maternal ARV coverage for PMTCT is over 80%. If ANC coverage for 4 ANC visits is less than 60% (noted as Typology A-), priority actions should include improvement of the quality of ANC services.

Typology B

These are countries where maternal ARV coverage for PMTCT is between 60-79%. If ANC coverage for 4 ANC visits is less than 60% (B-), priority actions should include improvement of the quality of ANC services.

Typology C

These are countries where maternal ARV coverage for PMTCT is between 30-59%.

If ANC coverage for 4 ANC visits is less than 60% (C-), priority actions should include improvement of the quality of ANC services.

Typology D

These are countries where maternal ARV coverage for PMTCT is less than 30% and low to moderate ANC coverage. Priority actions should include improvement of the quality of ANC services.

Priority actions should be based on improving coverage and outreach/ community based approaches (See Annex 1).

Accountability priorities

Good governance must promote transparency, interaction and accountability. The African Plan focuses on the following priorities:

1. Strengthening linkages with existing accountability initiatives.
2. Developing structures for shared responsibility and accountability.
3. Building national capacity to monitor progress.

Monitoring and evaluation

The African Union Commission and partners have developed a series of indicators to support countries to improve information related to the quality, coverage, outcome and impact of HIV services. The African Plan focuses on the following priority areas for M&E:

1. Outputs

- Counselling and testing pregnant women for HIV.
- HIV pregnant women's access to ARVs.
- Testing of exposed infants.

2. Outcomes

- Promotion of safe breastfeeding and infant feeding practices.
- Measuring access to antenatal care for pregnant women at or before 20 weeks.
- Measuring prevalence of HIV among women of childbearing age.
- Pregnant women attended to by skilled attendants in labour.
- Availability of policies/plans for elimination of mother to child transmission.

3. Impact

- Virtual elimination of mother to child transmission of HIV (<5%).
- Improved child and mother survival.

The indicators for measuring the success of the African Plan are available in the African Union's Monitoring & Evaluation Indicator Reference Guide (July, 2011).

- Indicator 1: HIV prevalence among population aged 15-49 years.
- Abuja Call- Indicator 1: HIV prevalence among population aged 15-24 years.
- Abuja Call- Indicator 4: Percentage of HIV-positive pregnant women who received antiretroviral drugs to reduce the risk of mother-to-child transmission of HIV.
- Abuja Call- Indicator 5: Percentage of pregnant women attending ANC who were tested for HIV and know their results.

- Abuja Call- Indicator 6: Percentage of infants born to HIV-positive mothers who are infected.
- Abuja Call- Indicator 9: Percentage of women and men aged 15–49 who received an HIV test in the last 12 months and who know their results.
- Maputo PoA- Indicator 19: Proportion of births attended by skilled health personnel.

Roadmap

2011	2012	2013	2014	2015
Consensus on draft African Plan achieved	RHOs and RECs will have support from countries in conducting rapid assessment of their status in elimination of new HIV infections. RECs and RHOs will have developed and activated mechanism for technical assistance to meet country needs for support towards elimination of new infections among children by 2015 and keeping their mothers alive. Regional Framework for eliminating new HIV infections among children and keeping their mothers alive will have been finalised or revised. Regional strategies for south-to-south cooperation will have been developed.	Progress report on the review of the implementation on the Abuja Call will have been completed.	Speed up implementation of the Abuja Call in line with recommendations of the 2013 progress report.	Final review of the implementation of the Abuja call will have been completed. Assessment of attainment of the targets of the African Plan.

ANNEX 1

The table below shows the different features defining typology in countries including HIV prevalence among women 15-49, burden of HIV positive pregnant women, unmet need for FP, proportion of women and infants receiving ARVs to prevent MTCT, and new infections among children and women. These variations call for focus on interventions specific to country typologies.

TABLE: Typology features of 21 High Burden Countries in Africa

COUNTRY	ESTIMATED HIV PREVALENCE AMONG WOMEN 15-49	Estimated NUMBER OF HIV+ PREGNANT Women	UNMET NEED FOR FAMILY PLANNING %	PERCENTAGE OF WOMEN RECEIVING ARVS (EXCL SDNVP) TO PREVENT MTCT	PERCENT OF WOMEN OR INFANTS RECEIVING ARVS DURING BREASTFEEDING TO PREVENT MTCT	NUMBER OF NEW CHILD INFECTIONS	NEW HIV INFECTIONS AMONG WOMEN 15-49
ANGOLA	2.7 [2.2-3.3]	15,000 [12,00-19,000]	NA	17 [14-22]	NA	5,100 [4,000-6,600]	12,000 [9,100-17,000]
BOTSWANA	26.6 [25.2-28.2]	13,000 [11,000-14,000]	NA	96 [86->95]	69 [62-75]	<500 [<500-<1,000]	6,200 [5,300-7,300]
BURUNDI	1.5 [1.2-1.8]	5,100 [3,900-6,500]	32 (2010)	54 [41-69]	20 [16-26]	1,300 [<1,000-1,800]	1,800 [<1,000-3,300]
CAMEROON	5.3 [4.8-5.7]	27,000 [23,000-31,000]	24 (2011)	64 [56-73]	18 [16-21]	5,800 [4,600-7,100]	21,000 [18,000-25,000]
CHAD	3.2 [2.7-4.1]	12,000 [10,000-16,000]	21 (2004)	14 [11-18]	24 [19-31]	4,100 [3,200-5,500]	6,300 [4,500-8,900]
COTE D'IVOIRE	3.8 [3.3-4.5]	20,000 [16,000-24,000]	NA	68 [55-84]	14 [12-17]	4,700 [3,400-6,400]	13,000 [9,800-18,000]
DEMOCRATIC REPUBLIC OF THE CONGO	1.3 [1.2-1.4]	(32,000 [28,000-37,000]	27 (2007)	13-11-15]	6 [6-7]	11,000 [9,300-12,000]	14,000 [12,000-16,000]
ETHIOPIA	1.7 [1.6-1.9]	38,000 [32,000-46,000]	26 (2011)	41 [35-49]	21 [18-25]	9,500 [7,300-12,000]	6,200 [2,800-10,000]
GHANA	1.6 [1.4-1.9]	9,500 [7,800-11,000]	36 (2008)	95 [77->95]	95 [77->95]	<1,000 [<1,000-1,500]	3,800 [2,100-5,500]
KENYA	7.2 [7.0-7.4]	86,000 [76,000-97,000]	36 (2008)	53 [47-60]	22 [19-25]	13,000 [10,000-17,000]	46,000 [43,000-50,000]

LESOTHO	26.9 [25.3-28.7]	16,000 [14,000-17,000]	28 (2008-2009	58 [52-64]	21 [19-23]	3,700 [3,100-4,300]	12,000 [10,000-14,000]
MALAWI	12.8 [12.0-13.5]	68,000 [61,000-75,000]	26 (2010)	60 [54-67]	57 [51-64]	11,000 [8,200-14,000]	29,000 [26,000-34,000]
MOZAMBIQUE	12.8 [11.4-14.9]	94,000 [81,000-110,000]	29 (2011)	86 [74->95]	86 [74->95]	14,000 [11,000-20,000]	55,000 [44,000-73,000]
NAMIBIA	15.7 [13.5-18.0]	8,100 [6,700-9,700]	21 (2006-2007)	94 [78->95]	56 [47-67]	<1,000 [<1,000-1,200]	5,100 [3,800-6,600]
NIGERIA	3.7 [3.3-4.1]	200,000 [170,000-230,000]	20 (2008)	17 [15-19]	15 [13-17]	59,000 [49,000-70,000]	110,000 [87,000-130,000]
SOUTH AFRICA	21.8 [21.2-22.5]	280,000 [260,000-310,000]	NA	83 [75-90]	83 [75-90]	21,000 [19,000-32,000]	180,000 [170,000-190,000]
SWAZILAND	31.1 [28.9-33.2]	12,000 [11,000-13,000]	25 (2006-2007)	83 [75-92]	34 [30-37]	1,600 [1,300-2,000]	5,600 [4,500-6,700]
UGANDA	8.4 [7.5-9.7]	100,000 [88,000-120,000]	NA	72 [62-86]	67 [57-79]	15,000 [10,000-22,000]	67,000 [54,000-82,000]
UNITED REPUBLIC OF TANZANIA	6.1 [5.5-6.8]	97,000 [83,000-110,000]	25 (2010)	77 [66-89]	77 [66-89]	14,000 [8,600-21,000]	38,000 [32,000-48,000]
ZAMBIA	13.2 [12.3-14.1]	79,000 [71,000-88,000]	27 (2007)	>95 [87->95]	55 [49-61]	9,400 [8,300-11,000]	22,000 [19,000-25,000]
ZIMBABWE	17.3 [16.2-18.4]	68,000 [60,000-76,000]	15 (2010-2011	82 [72-91]	52 [46-58]	9,300 [7,000-12,000]	32,000 [27,000-38,000]

Source: UNAIDS 2012 Estimates

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