Strategic Framework for the Prevention of HIV Infection in Infants in Europe

United Nations Population Fund

Joint United Nations Programme on HIV/AIDS
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WORLD HEALTH ORGANIZATION
EUROPE

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ABSTRACT

The European Region of WHO, and particularly the eastern part, is facing one of the fastest growing HIV/AIDS epidemics in the world. The number of HIV-infected women is steadily increasing, as is the transmission of the infection to newborns. Nevertheless, the high level of coverage with antenatal care, the availability of an extensive health care infrastructure, high literacy levels, the relatively low number of infections, and effective interventions to reduce mother-to-child transmission offer an opportunity to eliminate HIV infection in infants from the Region, and thus provide a model for the rest of the world. The challenge is to prepare health systems affected by economies in transition – and particularly maternal and child health services – to deal, in an integrated manner, with transmission of HIV infection to infants. This goes beyond clinical care and needs to include a range of care and protection issues, both in health institutions and in the community. The Strategic Framework for the Prevention of HIV Infection in Infants in Europe was developed by the UNAIDS cosponsors under the leadership of WHO, based on the experience of countries in the Region. The Strategic Framework outlines strategies for implementation at country level to achieve the global goals and those for Europe and Central Asia set out in the Dublin Declaration.

KEYWORDS

HIV INFECTIONS - prevention and control - transmission - in infancy
DISEASE TRANSMISSION, VERTICAL - prevention and control
MATERNAL HEALTH SERVICES - organization and administration
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DISCLAIMER

This document represents a common understanding among WHO, UNICEF, UNFPA and UNAIDS of key elements of the approach to preventing HIV infection in infants. The agencies cooperate closely in these efforts. The principles and policies of each agency are governed by the relevant decisions of each agency's governing body, and each agency supports the implementation of the interventions described in this document in accordance with these principles and policies and within the scope of its mandate.

PREFACE

The European Region of WHO, and particularly the eastern part, is facing one of the fastest growing HIV/AIDS epidemics in the world. The number of HIV-infected women is steadily increasing, as is the transmission of the infection to newborns. Nevertheless, the high level of coverage with antenatal care, the availability of an extensive health care infrastructure, high literacy levels, the relatively low number of infections, and effective interventions to reduce mother-to-child transmission offer an opportunity to eliminate HIV infection in infants from the Region, and thus provide a model for the rest of the world. The challenge is to prepare health systems affected by economies in transition – and particularly maternal and child health services – to deal, in an integrated manner, with transmission of HIV infection to infants. This goes beyond clinical care and needs to include a range of care and protection issues, both in health institutions and in the community.

At a meeting in December 2002 in Copenhagen, the Regional Directors of the UNAIDS cosponsors agreed to develop a strategic framework for preventing HIV infection in infants in Europe. This interagency initiative was undertaken to meet the goals set out in the Millennium Declaration by the United Nations General Assembly at its fifty-fifth session in September 2000 and the Declaration of Commitment on HIV/AIDS adopted by the General Assembly Special Session on HIV/AIDS on 27 June 2001.

The goal of eliminating HIV infection in infants in Europe and Central Asia was included in the Dublin Declaration adopted at the Conference on “Breaking the Barriers – Partnership to Fight HIV/AIDS in Europe and Central Asia”, organized under the Irish Presidency of the European Union in Dublin on 23 and 24 February 2004.

The Strategic Framework for the Prevention of HIV Infection in Infants in Europe was developed by the UNAIDS cosponsors under the leadership of WHO, based on the experience of countries in the Region. The Strategic Framework outlines strategies for implementation at country level to achieve the global goals and those for Europe and Central Asia set out in the Dublin Declaration.

ABBREVIATIONS AND DEFINITIONS

ACTG	AIDS Clinical Trial Group
AIDS	acquired immunodeficiency syndrome
CIS	Commonwealth of Independent States
HAART	highly active antiretroviral therapy
HIV	human immunodeficiency virus
IEC	information-education-communication
MCH	maternal and child health
NGO	nongovernmental organization
PCR	polymerase chain reaction
PMTCT	prevention of mother-to-child transmission
STI	sexually transmitted infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund

Mother-to-child transmission means transmission of HIV to a child from an HIV-infected woman during pregnancy, delivery or breastfeeding. The term is used in this document because the immediate source of the child's HIV infection is the pregnant woman or the mother. Another term used is “vertical transmission”. A woman can acquire HIV through unprotected sex with an infected partner, through receiving contaminated blood or through use of non-sterile instruments or medical procedures. Use of the term does not imply that the pregnant woman or mother is to blame.

Prevention of mother-to-child transmission (PMTCT) refers to specific interventions that prevent the transmission of HIV from an infected woman during pregnancy, delivery or breastfeeding. Currently the standard approach to reducing mother-to-child transmission of HIV in western Europe combines antiretroviral drug use during pregnancy, labour and the neonatal period, elective caesarean section delivery, and replacement feeding when it is affordable, feasible, acceptable, sustainable and safe.

Programmes to prevent HIV infection in infants comprise four interrelated elements: preventing HIV infection in women; preventing unintended pregnancies among HIV-infected women; preventing mother-to-child transmission of HIV; and providing care and support to HIV-infected women and their infants. PMTCT is thus just one element in a more comprehensive approach to preventing HIV infection in infants. The relative emphasis placed on each of these elements will depend on the epidemiological situation and the capacity of the health system to deliver services.

Contents

1 Introduction

The eastern part of the European Region of WHO is facing one of the most rapidly increasing HIV epidemics in the world. The number of HIV-infected women is increasing and transmission of the virus from infected women to their children is steadily rising. In western and central Europe, the epidemic is largely under control. Nevertheless, the difficulty of reaching certain marginalized populations and immigration from countries with a high prevalence of infection should preclude complacency. In this context, relatively low rates of HIV infection and well established health services provide an opportunity to prevent new infections in women and their children if countries act rapidly and decisively.

Why should countries invest in the prevention of HIV infection in infants? First and foremost, it should be considered a priority in terms of humanitarian principles and human rights, since it will protect children born to HIV-positive mothers from undue suffering and death. This is also in accordance with the obligation of the State Parties to the Convention on the Rights of the Child to “recognize that every child has the inherent right to life” and to “ensure to the maximum extent possible the survival and development of the child” (Article 6). There are also good economic reasons, as preventing HIV infection in infants will avoid a long-term drain on the health services.

Preventing paediatric cases is less costly than caring for children with HIV/AIDS, especially if highly active antiretroviral therapy (HAART) is used. There are also additional public health benefits. Programmes to prevent mother-to-child transmission of HIV will have a broader impact on the epidemic, since increased access to information and voluntary counselling and testing will strengthen primary prevention efforts, reduce denial, stigma and discrimination, and provide an excellent opportunity to reach young women (including those who inject drugs) who are at risk of HIV infection and other sexually transmitted infections (STIs). Preventing HIV infection in pregnant women can have a lasting impact on the woman, her partner and their children. Finally, diagnosing HIV infection during pregnancy can serve as an entry point to identifying the woman, her child and her partner as needing long-term care and support.

The main aim of the Strategic Framework for the European Region is to assist countries in stepping up their efforts to eliminate HIV infection in infants. It takes the global approach and applies it to the regional setting. The rapidly evolving epidemic in the Region has a number of important features that are unique, and the institutional setting for the response is very different from that in other parts of the world, although there are similarities in some areas.

The Strategic Framework has been developed through a consultative process involving focal points in ministries of health, UNAIDS cosponsors, technical experts, nongovernmental organizations (NGOs) and organizations concerned with preventing mother-to-child transmission in the countries of the Region. The target audience for the Framework comprises: health ministers, policy-makers and other decision-makers in the public health sector; NGOs working in the field of HIV prevention and/or care; professional associations involved in training health workers; and international agencies that wish to support national efforts to prevent HIV infection in infants, including aid agencies, bilateral donors and the United Nations system.

2 The regional context

2.1 The epidemiology of HIV infection

At the end of 2003, an estimated 1.8 million people were living with HIV/AIDS in the WHO European Region[1] and the number is growing. Eastern Europe and central Asia are experiencing the fastest growing HIV epidemic in the world: the number of HIV-positive people increased by an unprecedented 1300% in the five years between 1996 and 2001.

[1] The WHO European Region has 52 Member States in western, central and eastern Europe as well as central Asia.

Since 1996 in western Europe, the annual reported number of newly diagnosed HIV infections among adults has decreased slowly among homosexual and bisexual men and injecting drug users but has increased steadily the among the heterosexual population (a 59% increase between 1997 and 2001, Portugal excluded). Portugal has the highest rate of reported new infections, mainly associated with injecting drug use. This also remains the main mode of transmission in France and Spain. In Germany, and most notably in the United Kingdom, a significant proportion of new infections is associated with sexual transmission. Among infants and young children, 149 cases of new infections were reported in western Europe in 2002, about half of which occurred in the United Kingdom.

Central European countries have largely escaped the epidemic, with two exceptions. A cumulative total of 19 272 diagnosed HIV infections had been reported in central Europe by the end of 2002, with 48% (7880) and 33% (5464) of them reported from Poland and Romania, respectively. In Poland, HIV continues to spread among injecting drug users, with an estimated 31% infected with HIV in 2002, but so far has not gained a foothold in the population at large. The number of cases attributed to heterosexual transmission has remained low and stable (<25 cases per year). Romania has had the largest number of paediatric AIDS cases, owing to an outbreak of nosocomial infection among young children around 1990; thousands of young children in institutions were infected with HIV through microtransfusion of blood and multiple injections with contaminated equipment. In 2002, new cases of HIV infection in infants due to mother-to-child transmission were mainly reported from these two countries.

Eastern Europe and central Asia are confronted with explosive epidemics of drug use and HIV infection. The collapse of the USSR during the 1990s was followed by a huge increase in injecting drug use in the midst of a severe economic crisis. During the same period, the number of new HIV infections diagnosed increased dramatically, from 234 cases in 1994 to almost 100 000 in 2001, and remain high in 2002 (more than 60 000 cases). Some 40% of these were diagnosed among injecting drug users.

With few exceptions, very little is known about the spread of HIV among men who have sex with men in eastern Europe and central Asia. There is real concern that a hidden epidemic might be occurring among these communities. Young people are highly affected, as demonstrated by the fact that 84% of reported cases of HIV infection in the Russian Federation are among people under the age of 29. The number of new infections is growing in several countries in the European Region, with rates of new infections diagnosed reaching 660 per million population in Estonia, 350 per million in the Russian Federation and 226 per million in Latvia in 2002.[2] In Belarus and Ukraine, a shift in transmission patterns is being observed. The proportions of new HIV infections diagnosed that are attributed to heterosexual transmission increased steadily between 1996 and 2001, from 7% to 35% in Belarus and from 13% to 29% in Ukraine.

Central Asia has also reported increasing numbers of new cases of HIV infection, reaching rates of 43 per million in Kazakhstan, 31 per million in Kyrgyzstan, 4 per million in Tajikistan and 38 per million in Uzbekistan.

The prevalence of HIV infection among pregnant women remains relatively low throughout eastern Europe and central Asia with two exceptions. In Ukraine, women account for an increasing proportion of new cases of infection diagnosed, rising from 24% in 1996 to 38% in 2001. Reported HIV infections in pregnant women rose from 686 in 1998 to 2022 in 2002. The Russian Federation registered more than 3300 HIV-positive pregnant women in 2002. As a result, the number of infants born to HIV-infected mothers rose between 1998 and 2002 from 81 to 2777 in the Russian Federation and from 378 to 1334 in Ukraine. With the current rates of epidemic spread in the eastern part of the European Region, HIV prevalence in

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[2] It should be noted that there is a considerable difference between reported cases of new HIV infections and UNAIDS country estimates, particularly in eastern Europe and central Asia.

women is likely to increase sharply, leading to fears that large numbers of infants will become infected with HIV.

2.2 Lessons learned in the European Region

The HIV epidemic in western Europe initially resulted in large numbers of paediatric infections, until interventions became available to prevent mother-to-child transmission of HIV. The year 1994 was a turning point, the results of the ACTG 076 trial demonstrating for the first time the efficacy of antiretroviral drugs in preventing mother-to-child transmission of HIV. The demonstrated risk of the transmission of HIV through breastfeeding led to HIV-infected mothers being strongly advised to refrain from breastfeeding. In addition, it was shown that elective caesarean section could substantially reduce mother-to-child HIV transmission, even in women undergoing effective antiretroviral therapy. The standard approach to reducing mother-to-child transmission of HIV in western Europe and the United States thus became a combination of antiretroviral drug use (ACTG 076 prophylactic regimen or antiretroviral therapy for the mother), elective caesarean section and avoidance of breastfeeding. As a result, the rate of mother-to-child transmission of HIV has decreased in these countries from15–20% to 2% or less.

This success was due first and foremost to the fact that national programmes to prevent HIV infection had already gathered a large amount of information on HIV in the general population – and thus among pregnant women – before introducing specific interventions to prevent mother-to-child transmission of HIV. In addition, prevention programmes targeting injecting drug users and other vulnerable populations were already in place. Voluntary HIV testing and counselling was widely available, and was accepted as a standard procedure in antenatal care for all pregnant women. A well endowed clinical infrastructure with few resource constraints, a network of clinical experts on mother-to-child transmission of HIV, and a well trained cadre of midwives and obstetricians allowed these interventions to be rapidly and easily integrated into existing services. Finally, care and support services for infected mothers and infants were available.

Thanks to these favourable conditions, the HIV epidemic in infants is now largely under control in western European countries. HIV/AIDS has been mainstreamed throughout the health system, and in particular has become a normal feature of MCH service settings. Nevertheless, HIV infections in infants still occur, largely owing to the fact that some women come to antenatal care services too late to benefit from voluntary HIV testing and counselling and from specific interventions to prevent mother-to-child transmission of HIV. These are often women from marginalized groups such as injecting drug users, ethnic minorities and migrants (legal or illegal).

In eastern Europe, most countries adopted policies of mandatory HIV testing during pregnancy during the late 1980s, primarily for surveillance purposes. United Nations agencies have strongly advocated replacing these policies with a surveillance strategy based on sentinel surveillance sites, and many countries have now abandoned mandatory testing. Some countries, however, continue to test all pregnant women routinely, either nationwide or in areas with high levels of HIV prevalence.

Soon after the release of the ACTG076 study results, a number of central and eastern European countries adopted policies to provide the antiretroviral prophylactic regimen to HIV-infected pregnant women and mounted nationwide programmes. Other countries are still at an early stage of planning interventions or have undertaken some pilot activities. Access to comprehensive services to prevent HIV infection in infants remains limited for many HIV-infected women, and in particular highly vulnerable women such as injecting drug users.

In the coming years, western European countries need to adapt their strategy to reach those women not benefiting from current prevention efforts. Central and eastern European countries should quickly adopt lessons learned from western Europe and apply them to their own context in order to stay ahead of the impending HIV epidemic in infants.

2.3 Opportunities and challenges

In adapting, expanding or initiating programmes to prevent HIV infection in infants, countries in the European Region can take advantage of favourable preconditions but also face some particular challenges. The unique combination of well developed health systems and the relatively low numbers of HIV-infected women and children in central and eastern Europe – despite a rapidly evolving epidemic in certain countries – provides a special opportunity to drastically limit the number of HIV infections in infants in a manner similar to that achieved in most western European countries. The high level of coverage by antenatal care services, a large cadre of well trained professionals and almost universal literacy augur well for national programmes that aim to effectively apply knowledge on how to prevent HIV infection in infants.

While there are excellent opportunities, however, the challenges in mounting such programmes should not be underestimated. In many countries, preventing HIV infection among a relatively small number of children is not perceived as a priority by policy-makers. This may be due to difficulties in understanding the magnitude of the problem and its long-term consequences, to a low awareness of HIV/AIDS in general, or to the perception that this is mainly an issue for some marginalized groups. Advocacy is essential as a means of increasing awareness and creating commitment to take action.

Integrating HIV prevention and care, including specific interventions to prevent mother-to-child transmission of HIV, into existing maternal and child health (MCH) and reproductive health services is another major challenge. This is a major move away from the vertical structures through which HIV/AIDS programmes have often been organized, and may mean breaking up hierarchical and compartmentalized health systems. Vertical programmes have been shown not to work very well, with many women "missed" or lost to follow-up owing to poor access because of the distances involved or the stigma attached to such services. In addition, prejudice and discriminatory attitudes and practices militate against the success of services and treatment for groups with high risk-taking behaviour, marginalized groups and those affected or infected by HIV. Tackling discriminatory attitudes and practices from the perspective of human rights and medical ethics is essential if proper care is to be provided to everyone who needs it, without discrimination. This should be coupled with a system of accountability, by which clients have the opportunity to complain and to get redress.

In some countries, voluntary HIV testing and counselling are not widely available and/or are not routinely offered to all pregnant women but only to those believed to be at special risk, thus stigmatizing certain groups. Voluntary HIV testing and counselling need to be greatly expanded in ways that are non-stigmatizing and that encourage women to find out their HIV status and to learn about HIV/AIDS and ways to prevent it. It will be particularly challenging to design PMTCT interventions for women who are “missed” by the health services and arrive late for delivery. This calls for new approaches, including alliances with NGOs. Provision of care and support for women and children living with HIV/AIDS is still at a very early stage in some countries of the European Region.

3 The goal

The prevention of HIV infection in infants in Europe offers a unique opportunity to develop a model for eliminating HIV infection in infants. This model can then be adapted to other regions of the world. PMTCT also provides an opportunity to catalyse the different components of HIV prevention as a whole, and to introduce issues of quality and rights. Most of the countries in the Region have the capacity to do this in a short period of time.

Given the currently low numbers of women and infants infected with HIV and the capacity of most countries in the Region to rapidly implement or enhance interventions to prevent HIV infection in infants, the goal should be to eliminate HIV infection in infants.

The goal for the European Region

To eliminate HIV infection in infants by 2010 as indicated by:

– less than one HIV-infected infant per 100 000 live births; and
– less than 2% of infants born to HIV-infected women acquiring HIV infection.

This goal for the European Region is consistent with the global goal set at the United Nations General Assembly Special Session on HIV/AIDS in June 2001.[3]

> By 2005, reduce the proportion of infants infected with HIV by 20 per cent, and by 50 per cent by 2010, by: ensuring that 80 per cent of pregnant women accessing antenatal care have information, counselling and other HIV prevention services available to them, increasing the availability of and by providing access for HIV-infected women and babies to effective treatment to reduce mother-to-child transmission of HIV, as well as through effective interventions for HIV-infected women, including voluntary and confidential counselling and testing, access to treatment, especially anti-retroviral therapy and, where appropriate, breast milk substitutes and the provision of a continuum of care.

It is likely that the European contribution to the overall goal will be small in terms of numbers or proportions, since 90% of new HIV infections in infants currently occur in Africa. Nevertheless, the contribution can be important in demonstrating that a substantial reduction in HIV infections in infants is possible. If nothing is done, moreover, the increasing number of HIV-infected infants will add to the overall burden.

[3] Commitment 54. Declaration of Commitment on HIV/AIDS. United Nations General Assembly Special Session on HIV/AIDS, 25–27 June.

Combating HIV/AIDS is also one of the four overarching priorities in achieving the specific goals and targets adopted at the United Nations General Assembly Special Session on Children in May 2002. Also, reducing the number of HIV-infected infants will contribute to the Millennium Development Goal of combating HIV/AIDS.

Those countries in the Region that so far have had no or very few cases of HIV infection in infants should strive to maintain that situation. Those countries currently experiencing a rapid increase in HIV infection rates in pregnant women and infants should make every effort to reduce the proportion of infants infected.

In designing or reorienting national programmes to prevent HIV infection in infants, a number of key issues need to be addressed to ensure that specific interventions can be effectively implemented throughout the health system.

4 Key strategic issues

4.1 Integrating services for the prevention of HIV infection in infants into MCH and other reproductive health services

Experience has shown that efforts to prevent HIV infection in infants are most effective if they are fully integrated into existing services that cater to the needs of women and children. This implies that in particular family planning, antenatal care and obstetric and child health services have to address HIV/AIDS issues and be enabled to deliver interventions to prevent mother-to-child transmission of HIV. The involvement of male partners is also critical to the success of such programmes.

There is also a need to bring together specialists from different backgrounds – obstetricians, paediatricians, nutritionists and social workers – to decide which approaches will work best in the local circumstances. MCH and reproductive health services are central to the implementation of these approaches and may need to build new capacities and establish new links with other services.

✓ Priority actions

- Involve the MCH and reproductive health services actively and early in setting up programmes to prevent HIV infection in infants.
- Bring together all stakeholders to develop common approaches and establish referral linkages between services.
- Support the capacity-building of key providers of HIV/AIDS services, particularly on how to prevent mother-to-child transmission of HIV.

4.2 Reaching women who have limited or late access to services

Women who are "missed" by antenatal care and come late for delivery are often those who are at higher risk of becoming infected with HIV. In some areas, up to 30% of HIV-infected pregnant women present to the health services only at the time of delivery. For fear of action by child protection authorities, women who inject drugs frequently seek to conceal their drug use and present very late in pregnancy. Other groups that are equally difficult to reach include ethnic minorities, migrant women, refugees, sex workers, trafficked women and, in some settings, prisoners.

Strategies to ensure that such women do have early access to services and receive the support they need to care for themselves and their children become central challenges for PMTCT in the Region. Such strategies may include: creating links between antenatal care services and other (health) programmes targeting socially marginalized groups; involving these groups in the design of interventions; and developing special recommendations for women who come late for delivery, such as the use of rapid HIV tests and preventive antiretroviral regimens starting at labour or even after delivery (post-exposure prophylaxis for the child).

✓ **Priority actions**

- Create linkages between the mainstream health services, treatment for drug dependence, harm-reduction programmes and programmes targeted at marginalized groups, and promote outreach activities.
- Advocate for the rights of vulnerable groups, both on a broad public health basis and specifically to ensure that the benefits of MCH services are accessible to such women.
- Address procedural and legal constraints that impede the delivery of services to all women.

4.3 Expanding quality counselling and testing and developing linkages to other HIV prevention and care services

Women must have access to good quality voluntary counselling and testing to assess their HIV status, to discuss behaviour that may put them at risk, to involve their partner(s), to know how to protect themselves from HIV infection, to be provided with male and female condoms and, if pregnant, to decide early on about treatment options for themselves and their child. Making voluntary HIV testing and counselling widely available is thus essential to achieving the overall goal. This should be closely coordinated with other antenatal screening services, particularly that for maternal syphilis and the prevention of congenital syphilis.

An intensified effort to prevent HIV infection in infants in the Region should not be regarded as distracting attention and diverting resources from activities to strengthen and scale up other high priority interventions for HIV prevention and care. On the contrary, a well planned, comprehensive programme to prevent HIV infections in infants could provide additional impetus and support to other key HIV/AIDS programmes.

The rapid expansion of good quality testing and counselling services in reproductive health settings will contribute to increasing awareness and knowledge about HIV/AIDS, to supporting broader-based prevention efforts, especially among women, and to reducing stigma and discrimination. The confidentiality of HIV test results in health and social welfare settings must be protected. Respect for privacy and judicious use of information in the best interests of the client should be incorporated into standards for service providers.

Current low levels of HIV infection in many countries of the Region mean that only a small proportion of women will test positive. The appropriateness of offering voluntary HIV testing and counselling to all pregnant women may be questioned, as the costs of testing large numbers of women in order to identify the few who are infected with HIV may seem high. Nevertheless, creative options to reduce the costs of voluntary HIV testing and counselling can be used (e.g. by performing only one HIV test during pregnancy instead of multiple tests as required in some countries, using simple test technologies, or testing pooled samples). The benefits of increasing access to HIV testing are significant: HIV testing becomes a routine procedure in antenatal care, thus avoiding stigmatizing any particular group; and voluntary HIV testing and counselling is an excellent entry point to discussing potential risk behaviour and to helping those who are uninfected remain so.

The proposed approach to programme design and service delivery will allow HIV/AIDS to be addressed throughout a broader range of health services than is generally the case at present in eastern Europe. As a result, opportunities for HIV prevention and care will expand beyond a narrow set of highly specialized (and often stigmatized) services, and the capacity of all health workers will be extended to effectively and confidently deal with HIV/AIDS issues. This implies, however, overcoming barriers and building strong linkages between programme areas so that, for example: drug dependence treatment and other harm-reduction services are able to recognize the reproductive health concerns and needs of female drug users; MCH services build competencies in serving such users and their families; and referral systems are in place to facilitate effective linkages across departments and sectors so that they can converge and support each other.

The scaling up of services to prevent mother-to-child transmission of HIV will allow the health services to identify and reach out to large numbers of women living with HIV, and their partners and children, in good time for them to benefit from care, treatment and support. In the short term, until voluntary HIV testing and counselling become more widespread, these services may be the primary entry point to longer-term care for persons living with HIV/AIDS. They need to be designed in ways that optimize referral to health services that can offer care and treatment and to social services that can ensure support and protection for those in need.

✓ Priority actions

- Develop national policy and guidelines to normalize and integrate voluntary HIV testing and counselling services into MCH and reproductive health services. Establishing measures to prevent discrimination based on HIV status is important for effectiveness of care and support to HIV-infected women and their infants and families.
- Develop implementation guidelines, training and support to human resources for the provision of voluntary HIV testing and counselling for pregnant women, and IEC (information-education-communication) material targeting special groups.

5 Essential elements of a comprehensive approach to preventing HIV infection in infants

To address both the needs of pregnant women and mothers and of their infants, a comprehensive approach is recommended comprising the four interrelated elements described below. The relative emphasis placed on each of these elements will depend on the epidemiological situation and the capacity of the health system to deliver services.

1. Primary prevention of HIV infection

Avoiding HIV infection in women will contribute significantly to the prevention of HIV transmission to infants and young children. HIV prevention programmes thus need to be directed at a broad range of women at risk and their partners, with a particular focus on young people.

2. Prevention of unintended pregnancies among HIV-infected women

Women known to be infected with HIV should receive essential care and support services, including family planning and other reproductive health services, so that they can make informed decisions about their future reproductive lives.

3. Prevention of HIV transmission from HIV-infected women to their children

A package of specific interventions has been identified to prevent HIV transmission from an infected mother to her child. It includes antiretroviral drug use, safer delivery practices, and infant feeding counselling and support.

4. Provision of care and support to HIV-infected women, their infants and families

Strengthening the linkages among programmes for preventing HIV infection in infants and young children and care and support services for HIV-infected women and their infants and families will ensure that the women themselves get access to the services they need. With improvements in the mother's survival and quality of life, the child too will accrue important benefits.

5.1 Primary prevention of HIV infection

While all four elements of the Strategic Framework are important, primary prevention of HIV infection among women of childbearing age is crucial in the particular context of the European Region. The current low prevalence of HIV infection among pregnant women represents a unique opportunity to prevent the numbers of HIV-infected women and infants from rising. Unless the number of new HIV infections occurring among women is kept low or reduced to low levels, there will be a continuing flow of children who are infected through mother-to-child transmission of HIV. Only by preventing infection among women is it possible to stay ahead of the otherwise large numbers of infants who will become infected, who will need care and support and who risk becoming orphans. It is this emphasis on primary prevention that needs to be the distinguishing mark of the Region's Strategic Framework to prevent HIV infection in infants.

Programmes to prevent HIV infection in infants should not, however, take on the responsibility for all primary prevention efforts. Priorities for primary prevention within the context of mother-to-child transmission of HIV should specifically address the following areas:

- Specific advocacy efforts are required to emphasize the need to pay increased attention to women, especially young women and their partners, highlighting the strong and direct relationship between primary prevention activities (or the lack of them) and the number of infections in infants.

- All opportunities must be taken to integrate information and education on HIV prevention for young women into existing services, such as introducing preventive counselling into family planning services, antenatal care and child health clinics. Special attention should be paid to providing comprehensive HIV preventive services to all young women, including the provision of condoms and STI management.

- The HIV epidemic in the European Region has been characterized by an early concentration of HIV infection among injecting drug users and their partners. Thus women who inject drugs (or whose partners inject) are likely to constitute an important group of women at risk of giving birth to HIV-infected children. A particular effort should therefore be made to strengthen comprehensive HIV/AIDS prevention and care services for injecting drug users and their partners.

- More generally, preventive services need to be available to other hard-to-reach groups such as female sex workers, trafficked women, ethnic minorities, and legal and illegal immigrants. As these groups often experience difficulties in accessing health services, their specific needs should be taken into consideration.

- Voluntary HIV testing and counselling in general, and particularly during pregnancy, provide an excellent opportunity to address HIV prevention by appealing to the instinct of both men and women to protect their children. Given the low infection rates in the Region, most women will test negative. They should be counselled, encouraged to discuss and reflect on risk behaviour, and if necessary provided with condoms.

✓ Priority actions

- Advocate for the active and early involvement of MCH and reproductive health services in the planning of programmes to prevent HIV infection in infants.
- Integrate primary HIV prevention into programmes to prevent mother-to-child transmission of HIV, set-up linkages with other primary HIV prevention services, and intensify efforts to reach the most vulnerable women and those who "missed" antenatal care services.
- Address HIV-related gender and human rights concerns in programmes for the prevention of HIV infection in infants.
- Offer quality counselling and testing for all pregnant women, focusing on primary prevention.

5.2 Preventing unintended pregnancies among HIV-infected women

Women need to be able to assess their serostatus and, if found to be HIV-positive, to receive comprehensive care and support. This includes specific reproductive health information and counselling, incorporating information on the risk of HIV transmission to children and ways to reduce this risk. There are a number of opportunities for this before and during pregnancy that should not be missed.

All women, regardless of HIV status, have the right to make their own reproductive choices. Most HIV-infected women are unaware of their HIV status. Wider access to HIV testing and counselling within family planning services would enable more HIV-negative women to receive counselling to learn how to remain negative, and more HIV-positive women to learn about their status in time to plan their reproductive lives, including whether they wish to bear a child and, if so, when. While some women may opt to terminate their pregnancy, especially in settings where it is legal and safe, it should not be presented as a form of family planning; no woman (whether HIV-infected or not) should be coerced into terminating a pregnancy. For all women, including those whose HIV infection is first identified in early pregnancy, post-testing counselling should include full information about the risk of HIV transmission to their child and the interventions available to reduce this risk. In later pregnancy and after delivery, HIV-infected women should be provided with family planning counselling and services to enable them to make informed decisions about their future reproductive life.

In the European context, reproductive health services for drug-using women are of particular importance. Female injecting drug users are difficult to reach through the usual reproductive health services and may mistakenly perceive themselves as infertile because of drug-related amenorrhoea. This could be improved by making reproductive health services more client-friendly, especially toward marginalized and young women. Linkages should be created between HIV/AIDS services, reproductive health services and harm-reduction programmes, including the use of peer counsellors. All harm-reduction projects should establish linkages with reproductive health services.

✓ Priority actions

- Develop policies, guidelines and protocols on reproductive health services to be provided to HIV-infected women.
- Strengthen access to reproductive health services in the immediate post-partum period, especially for HIV-infected women.
- Sensitize health professionals in reproductive health services to the needs of HIV-positive women and also to the needs of drug-using and other marginalized women in the context of HIV/AIDS, and train them to care for this population without discrimination.

- Create linkages between reproductive health services and harm-reduction programmes.
- Create linkages between reproductive health services and care/support services for HIV-infected women.
- Create strong linkages between programme areas such as drug dependence treatment and harm-reduction services and referral systems.

5.3 Preventing HIV transmission from infected women to their infants

The package of specific interventions to prevent HIV transmission from an infected mother to her child includes antiretroviral drug use, safer delivery practices, and infant feeding counselling and support. Voluntary HIV testing and counselling play a key role, so that infected women can learn their status in good time to draw the full benefits of this package. In western Europe, the wide implementation of long-term antiretroviral prophylaxis or treatment, elective caesarean section and replacement feeding has reduced to very low levels the transmission of HIV from an HIV-positive woman to her infant.

To allow other countries in the Region to fully benefit from the lessons learned, the very detailed recommendations of the recent European consensus statement[4] on the management of pregnancy and HIV infection and the WHO recommendations on use of antiretroviral drugs for treating pregnant women and prevention of HIV infection in infants[5] have to be adapted to their needs and capacities. This could be done through regional and/or national

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[4] Newell ML, Rogers M. Pregnancy and HIV infection: a European consensus on management. *AIDS*, 2002, 16(Suppl. 2):S1–S18.
[5] *Antiretroviral drugs for treating pregnant women and prevention HIV infection in infants: guidelines on care, treatment and support for women living with HIV/AIDS and their children in resource-constrained settings*. Geneva, World Health Organization, 2004.

technical working groups that define and regularly update technical recommendations and clinical protocols regarding antiretroviral regimens, obstetrical procedures and infant feeding practices. In doing so, the following issues must be addressed.

- **Antiretroviral regimens**

Antiretroviral drugs can be used as prophylactic or treatment regimens. HIV-infected women should be assessed as to their need for antiretroviral treatment. If there is no clinical indication for the woman herself, antiretroviral prophylaxis to reduce the risk of mother-to-child transmission of HIV should be offered according to a recommended regimen appropriate to the circumstances.

Several antiretroviral prophylactic regimens have been demonstrated to be effective in large randomized clinical trials: zidovudine alone, nevirapine alone, and zidovudine in combination with lamivudine or nevirapine. All these regimens include an intrapartum component, with varying degrees of antepartum and/or postpartum prophylaxis. Although the longer, more complex regimens have a higher efficacy, the choice of regimen(s) should be determined by its feasibility, efficacy, acceptability and cost. Moreover, the availability of resources (health care infrastructure, human resources and drug availability), the health status of the woman, gestational age/timing of the intervention, history of prior or current antiretroviral therapy, availability and acceptability of supportive care services, and treatment for drug dependence should also be taken into account.

- **Safer delivery practices**

Labour and delivery management of HIV-infected pregnant women should be directed by the need to minimize the risk of mother-to-child transmission of HIV and to prevent neonatal and maternal complications.

An elective caesarean section delivery substantially reduces the risk of mother-to-child transmission of HIV, even in women with low viral load or those receiving combination antiretroviral therapy. HIV-infected women should thus be given the option of a caesarean section if it can be done safely. To ensure informed consent, HIV-infected pregnant women should be counselled on the potential benefits and adverse effects of the procedure, taking carefully into consideration the available health care infrastructure. If a woman decides to deliver through caesarean section, it should be performed before the onset of labour and rupture of membranes. Caesarean section deliveries carried out electively before labour and with intact membranes have a low risk of complications, whereas emergency procedures have a higher risk of complications. Universal precautions should be taken to reduce the risk of infective complications.

Invasive procedures such as artificial rupture of membranes, episiotomy and fetal scalp monitoring may increase the risk of transmission to the infant. They should not be performed routinely but only when absolutely necessary.

- **Infant feeding options**

Given the need to avoid HIV transmission to infants through breastfeeding, while at the same time avoiding putting them at increased risk of other morbidity and mortality, WHO, UNICEF, UNAIDS and UNFPA recommend that HIV-infected mothers do not breastfeed at all when replacement feeding is acceptable, feasible, affordable, sustainable and safe. Otherwise, exclusive breastfeeding is recommended during the first months of life and should then be discontinued as soon as feasible.

HIV-positive mothers should be helped to make the best choice according to their circumstances and to carry out their decision. They should thus receive counselling that includes information about the risks and benefits of various infant feeding options (based on local assessments) and guidance in selecting the most suitable option for their situation. Whatever the infant feeding option chosen, mothers should be supported to carry it out safely and appropriately. While commercial infant formula will be acceptable, feasible, affordable, sustainable and safe for many HIV-positive women in the Region, some women may choose other options depending on their personal circumstances.

To support HIV-positive women while protecting, promoting and supporting breastfeeding in the general population, countries in the Region are encouraged: to develop (or revise) a comprehensive national infant and young child feeding policy that includes the situation of HIV infection and infant feeding; to implement the International Code of Marketing of Breast-milk Substitutes and subsequent relevant World Health Assembly resolutions; to intensify efforts to protect, promote and support appropriate infant and young child feeding practices for the whole population in the context of HIV; and to provide adequate support to HIV-positive women to enable them to select the best feeding option for themselves and their babies and to successfully carry out their infant feeding decisions.

HIV and infant feeding activities should as far as possible build on existing infant and young child feeding activities in the Region. The Baby Friendly Hospital Initiative offers special opportunities for creating supportive environments, not only for breastfeeding women but also for HIV-positive women and children. A country's decision to provide free or subsidized commercial infant formula to HIV-positive women who make that choice after counselling should be consistent with the provisions of the International Code of Marketing of Breast-milk Substitutes and subsequent relevant World Health Assembly resolutions, and done in a manner that avoids unnecessary use of formula by women who could safely breastfeed.

✓ Priority actions

- Select clinical protocols according to the situation in the country.

- Set up mechanisms (e.g. working groups) to regularly update recommendations based on the latest evidence.
- Decide, at national level, how PMTCT services will be provided (e.g. all or only a few referral maternity units).
- Strengthen services for injecting drug users, such as drug dependence treatment and harm reduction, and create a strong link between these services and existing services such as reproductive health care for women, so as to prevent the spread to infants of HIV associated with drug use. Develop policies and procedures for the registration and procurement of antiretroviral drugs.
- Develop a comprehensive national policy on infant and young child feeding that also addresses HIV infection and infant feeding.
- Implement national legislation based on the International Code of Marketing of Breast-milk Substitutes and subsequent relevant World Health Assembly resolutions.
- Where appropriate, upgrade Baby Friendly Hospital Initiative hospitals to act as reference centres on HIV infection and infant feeding.
- Intensify efforts to protect, promote and support appropriate infant and young child feeding practices in general, while recognizing HIV as one of a number of exceptionally difficult circumstances.
- Provide adequate support to HIV-positive women to enable them to select the best feeding option for themselves and their babies and to successfully carry out their infant feeding decisions.

5.4 Providing care and support to HIV-infected women and their infants and families

HIV-infected women and their children are not given the same levels of care, support and protection in all countries of the Region. Nevertheless, the low numbers of HIV-infected women and children offer an opportunity to provide high-quality care and support even in settings with limited resources.

➢ **Diagnosis of HIV in infants born to HIV-infected women**

Maternal antibodies cross the placenta and can be present in the infant for up to 18 months. The early diagnosis of HIV infection in infants born to HIV-infected mothers thus depends on virological tests, most commonly DNA polymerase chain reaction (PCR). In a number of countries of the Region, the facilities to perform these complex and costly tests are not yet available. Nevertheless, making the PCR technique available would be very useful to allay fears of parents, to adapt child care and support to the needs of the individual infant, and to monitor the impact of PMTCT interventions. More generally, testing algorithms to diagnose HIV infection in children should be developed nationally based on the resources available.

➢ **Care of infants born to HIV-infected women**

An infant born to an HIV-infected mother should be closely followed until diagnosis is made. If HIV infection is confirmed, the infant needs specific medical care including clinical and biological monitoring of the immune status, prevention and treatment of opportunistic infections and antiretroviral treatment wherever available. In addition, usual medical procedures may need some modifications (e.g. treatment of common childhood infections, vaccinations). Each country will decide if HIV-infected infants and children are to be followed in specialized services or in general child health clinics. In any event evidence based national guidelines regarding all these issues should be developed and implemented.

➢ **Care for mothers**

There are at least three good reasons for providing care for HIV-infected mothers as an integral part of any PMTCT programme.

- On human rights and humanitarian grounds, it is difficult to defend giving antiretroviral drugs for a short period to save a child but then denying them to the mother.
- Treating an HIV-infected mother will increase the length and quality of her life, and thus allow her to take better care of her children and perhaps avoid their becoming orphans.
- Providing care for mothers may increase the uptake of testing and counselling services to prevent HIV infection among infants, and thus increase the impact of such programmes.

The care provided to an HIV-infected woman before and after delivery will depend on her immunological status. She should receive prophylaxis for opportunistic infections and, if immunocompromised and/or symptomatic, highly active antiretroviral therapy according to national guidelines to reduce her viral load. This may further reduce peripartum transmission and possibly transmission through breastfeeding.

It may not be the role of the reproductive health and obstetric services to provide care specifically for HIV-infected mothers. Moreover, the woman’s partner and children may also be in need of care. There should thus be close collaboration between MCH and reproductive health services and services that provide care for those with HIV/AIDS.

➢ **Mother and child protection**

General discrimination against and stigmatization of HIV-infected persons are still common in many countries of the Region. This is compounded by the fact that many HIV-infected people belong to socially marginalized groups, such as injecting drug users, sex workers, ethnic minorities, refugees and prisoners. They are often excluded or have very limited access to preventive and care services. In some countries, long-term monitoring of HIV-related immunodeficiency and antiretroviral treatment are not made available to such patients, who are "a priori" considered not to comply with medical prescriptions. Such stigmatization and discrimination may well be one of the major reasons that an important proportion of HIV-infected women do not attend antenatal care services or go to AIDS centres.

Another major issue is the abandonment or forced removal of children born to HIV-infected women. Although this problem is not specific to children born to HIV-infected mothers, anecdotal evidence points to the fact that children from poor and marginalized families, including drug users, have a very high risk of being abandoned or removed from the mother's care if the mother is also HIV-infected. In some countries, abandoned children remain for months or even years in paediatric hospital wards, because specialized child care institutions are overwhelmed or refuse to take children suspected to be HIV-infected. In addition, children born to HIV-infected women (whatever their own serological status) are refused by many institutions because of a greatly exaggerated fear of transmission between children.

To address issues of discrimination and abandonment health services need to work closely with a range of partners, including NGOs in the field of harm reduction and social protection. Decisions on the care of a child born to an HIV-infected mother must be guided by the right of the child to be cared for by the parents, and not to be separated from them except when necessary in the best interest of the child. Should the child become deprived of parental care, alternative (preferably permanent and family-based) care should be provided in the child's country of origin. Institutional care for abandoned children should be considered only as a last resort.

✓ **Priority actions**

- Create linkages between reproductive health and MCH services and care/support services.
- Develop guidelines for the diagnosis of HIV infection in infants and, if necessary, upgrade some reference laboratories with the PCR technique.
- Develop guidelines for the care and support of infants and adults, including HAART.
- Take measures to prevent the abandonment and forced institutional abduction of children.
- Offer referral to substance use treatment, legal, nutritional and psychosocial services, including support groups.
- Define new approaches to the care of abandoned/orphaned children, including children born to HIV-infected mothers.

6 Monitoring and evaluation

Close monitoring of interventions to prevent mother-to-child transmission of HIV is essential for guiding programme design and implementation and for adjusting, consolidating and further expanding the programme.

A manual entitled "National guide to monitoring and evaluation of programmes for prevention of HIV in women and in infants" is currently being developed by WHO in collaboration with other United Nations and key partner agencies. The manual presents a list of core and additional indicators. For each indicator, guidance is provided on its definition; the rationale for its use and what it measures; how to measure it; and its strengths and limitations. These indicators need to be adapted to the European Region, based on countries' actual needs and resources.

The following indicators are recommended for all countries:

- the existence of guidelines for preventing HIV infection in infants and young children;
- the number of health workers newly trained or retrained in the previous 24 months in interventions for preventing HIV infection in infants;
- the proportion of all possible public and private venues (family planning, primary health care, antenatal care/maternal and child health services, etc.) providing a minimum package of services for the prevention of HIV infection in infants in the previous 12 months;
- the percentage of pregnant women who access antenatal care services and counselling and testing, including: those attending for at least one antenatal care visit in a unit providing prevention of HIV infection in infants; those accepting testing for HIV infection; and those receiving HIV results and post-test counselling;
- the percentage of pregnant women receiving a complete course of antiretroviral prophylaxis to reduce mother-to-child transmission of HIV in accordance with a nationally approved treatment protocol in the previous 12 months; and
- the estimated percentage of HIV-infected infants born to HIV-infected mothers.

It is particularly important to understand why women are "missed" by services and to adjust services accordingly. Information should thus be gathered at certain points/activities where the system may fail or "gaps" occur. In particular, large maternity hospitals situated close to vulnerable populations and geographical areas where prevalence is high should be key areas for measuring progress in implementing the Strategic Framework for preventing HIV infection in infants. Assessment of qualitative aspects of the programme (such as reasons for low uptake of testing and counselling, inadequate uptake of antiretroviral treatment and difficulties in following advice on infant feeding) require specific instruments to be developed. Specific surveys and/or complementary databases will help identify population groups that are "missed" by the programmes and the reasons for not accessing services.

The compilation of these indicators will involve several types of data collection: surveys among key informants; reviews of administrative records; facility-based surveys; reviews of programme records; programme monitoring; and development of estimates based on gathered data. Audits of hospital records should provide follow-up data on identified HIV-infected women and their babies (including their HIV status).

A system of quality control, in particular for sensitive issues such as voluntary HIV testing and counselling, will need to be put in place. Evaluation of counselling would cover counselling skills, counselling content, client knowledge and client satisfaction.

6.1 Assessing achievement of the goal of eliminating HIV infection in infants and young children

Since the goal in the European Region of WHO is to eliminate HIV in infants, it is essential to estimate the percentage of HIV-infected infants born to HIV-infected mothers. It will be necessary to identify and test all children born to HIV-infected mothers (obtained through programmes for the prevention of HIV infection in infants, and other sources as appropriate in countries) and to ensure that cases are reported by health departments in cooperation with health care providers, hospitals and clinics through the routine completion of case reports. This demands that exposed infants are followed up until sufficient laboratory information is available to firmly establish their HIV status.

✓ Priority actions

- Establish national objectives and targets for the prevention of HIV infection in infants.

- Define a set of relevant monitoring and evaluation indicators that reflect national objectives and targets for the prevention of HIV infection in infants.
- Define data collection methods for each indicator (e.g. routine administrative/ policy/antenatal care document reviews, surveys, case reports, etc.). Priority should thus be given to setting up a reliable monitoring system before planning expensive surveys to assess HIV prevalence among pregnant women and newborns. Much could already be achieved if women testing positive for HIV during antenatal care and infants born to HIV-infected mothers were properly diagnosed and reported.

7 The way forward

7.1 Political commitment is essential

In endorsing the Declaration of Commitment on HIV/AIDS in 2001, every United Nations Member State in Europe has indicated its commitment to eliminate HIV infection in infants. Furthermore, in 2002 the ministers of health, heads of state and heads of government of the CIS countries endorsed the Programme of Urgent Response to the HIV/AIDS Epidemic, giving high priority to the prevention of mother-to-child transmission of HIV and access to voluntary HIV testing and counselling.

The first step in taking this Strategic Framework forward is for ministries of health to clearly reaffirm this commitment. Furthermore, the adequacy of current efforts to prevent HIV infection in infants needs to be examined and gaps identified. Based on this analysis, a comprehensive plan should be proposed. This would include setting national goals and objectives, developing policies, revising laws and regulations as needed, and ensuring that the health sector is enabled to effectively implement interventions to prevent HIV infection in infants. Strong national leadership is needed to guide these efforts.

7.2 Concerted action and collaboration across sectors

There is a need to join forces to achieve the overall goal of eliminating HIV infection in infants. Close coordination and collaboration between the different actors involved is an essential factor in implementing this Strategic Framework. National partnerships, within governments and with NGOs, should ensure that comparative advantages are optimally used and that gaps and failures are rapidly identified and remedied.

Within national governments, ministries of health are the major force in developing a coherent and effective effort to prevent HIV infection in infants, and the different actors within the ministry have to work together to bring the Strategic Framework into operation. This includes the national AIDS programme, family planning services, reproductive health services, MCH services, national statistical services and associations of health professionals (doctors, nurses, counsellors, etc.). To ensure a sense of ownership, the national programme to prevent HIV infection in infants should be developed jointly by all relevant actors in the ministry of health and in other ministries such as those concerned with social security, welfare, justice and education. Since implementation relies on collaboration at national, regional and local levels, it is important that decision-makers and health professionals, including social workers, be involved at all levels.

➢ **Action for national governments**

- Adapt the Strategic Framework to the national context.
- Revise and adjust laws and policies as needed, including the introduction of antidiscriminatory measures.
- Draft or adapt guidelines on the various elements of a comprehensive programme to prevent mother-to-child transmission of HIV.

- Implement the Strategic Framework through the public health services and through collaboration with other ministries, private sector services and NGOs.
- Strengthen health services by mainstreaming HIV/AIDS in all services, improving referrals and linkages, and ensuring a sustained supply of essential drugs and materials.
- Build human capacity by improving the knowledge, counselling skills and attitudes of health and social welfare workers.
- Assess epidemic trends and monitor the implementation and impact of the programme.
- Mobilize and allocate funds.

NGOs are crucial partners in working with vulnerable and marginalized groups. This includes preventing HIV and other STIs, advocacy and human rights issues, providing treatment, care and support for people living with HIV/AIDS, and participating in national HIV surveillance activities.

International and local NGOs have played an essential role in implementing harm-reduction programmes, in pilot testing innovative PMTCT approaches, and in advocating for access to treatment for HIV-infected people. Their fundamental role should be acknowledged in national PMTCT programmes.

➢ **Action for NGOs**

- Integrate information on mother-to-child transmission of HIV into harm-reduction programmes.
- Pilot test innovative PMTCT approaches, focusing particularly on vulnerable groups.
- Advocate for access to preventive and treatment services, particularly for marginalized and stigmatized women.

7.3 Mobilizing resources

Each government should determine the human, material and financial resources needed to implement the Strategic Framework, including funding to expand existing or create new services, to train health professionals and to support NGOs. For some countries, little extra investment may be necessary to implement the main elements of the Strategic Framework; for others, however, it may imply major investment in, for example, testing and counselling services and the provision of antiretroviral therapy. Countries will need to supplement government funds with those from other sources. It is essential that governments prepare a plan to coordinate funding assistance to cover all aspects of programmes to prevent HIV infections in infants and to sustain such programmes in the long term. Continuity is vital to building and maintaining trust in the programme.

7.4 Intercountry cooperation

Partnerships between countries can be particularly valuable in terms of learning from each other and sharing resources. Some countries in the Region are at the beginning of an HIV epidemic and have not yet developed a programme to prevent HIV infection in infants, while others can look back on almost a decade of experience with implementing most or all elements of the Strategic Framework. This provides a unique opportunity to strengthen national efforts to prevent HIV infection in infants by regional exchanges.

There are ample opportunities to build on lessons learned in western Europe adapting them to the epidemic situation and available resources in central and eastern European and central Asian countries. Sharing experiences between neighbouring countries is equally useful for learning about successes and difficulties in implementing programmes to prevent mother-to-child transmission of HIV in specific groups. Regional exchanges can take a variety of forms: bringing partners from different countries working in the same area together in a workshop; organizing visits by governmental and nongovernmental partners to successful programmes in nearby countries; and organizing regional conferences.

In addition, western European countries – bilaterally or through the European Union – can assist other countries in the Region by providing technical and financial support to introduce the necessary changes and scale up existing services.

7.5 The role of the United Nations

Given below is a summary of the role of each agency in preventing HIV infection in infants.

➢ **UNAIDS**

The prevention of mother-to-child transmission of HIV has been a priority for UNAIDS ever since its creation in 1996, and it has played a key role in establishing the extent of the problem, in finding ways to reduce it and in mobilizing action at international and national level. The role of the UNAIDS Secretariat in preventing HIV infection in infants comprises:

- continuing advocacy at the highest political levels and with communities and the general public;
- support for civil society and people living with HIV infection, including mothers and family members, to demand access to health and social services and medicines and other commodities for preventing and treating HIV infection;
- promotion of partnerships among all actors and the engagement of all sectors to prevent HIV infection in infants;
- support for the full engagement of people living with HIV infection at all stages of programme design, implementation and monitoring; and

- coordination of concerted actions of cosponsors and international partners in facilitating their efforts to support governments and civil society to deliver a comprehensive programme at country level.

➢ **WHO**

WHO is committed to providing support to countries in implementing and scaling up comprehensive programmes for the prevention of HIV infection in infants. WHO’s role focuses on primary prevention (especially among vulnerable groups), the integration of key interventions for the prevention of mother-to-child transmission of HIV within MCH services, and the provision of care, treatment and support to HIV-infected mothers, their children and their families. WHO has a particular role to play in:

- setting norms and standards for implementing programmes to prevention HIV infection in infants;
- providing technical support to countries in specific areas, such as surveillance, strategic planning, programme implementation, and monitoring and evaluation; and
- institutional and human capacity building, including training of MCH staff.

➢ **UNICEF**

Within the framework of the Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination against Women, and in the context of the organization’s Medium-term strategic plan for 2002–2005, UNICEF has a particular role in the following areas:

- advocacy for the development of national policies and actions and facilitation of national planning consistent with targets adopted by the United Nations General Assembly Special Sessions on HIV/AIDS and Children and the Millennium Development Goals;

- support for programmes to prevent the transmission of HIV infection from mother to child, as well as measures for the care of children born to HIV-infected mothers;
- addressing the protecting the rights of HIV-positive women and children through its commitment to strengthening the protective environment, including reform of social protection systems and promotion of family-based care for children;
- IEC and social mobilization activities to support families and communities in helping women to avoid HIV infection and in improving access to services;
- advocacy for expansion of access to and demand for voluntary and confidential counselling and testing, thus enabling pregnant women to discover their HIV status and be supported in decisions related to their own and their child's health; and
- addressing issues related to counselling and advice on appropriate feeding of infants born to HIV-positive mothers in particular, and support for activities related to the protection and promotion of breastfeeding in general.

➢ **UNFPA**

Within the broader context of its work in reproductive health, including safe motherhood, UNFPA contributes to preventing HIV transmission in pregnant women, their partners and children. UNFPA also addresses the reproductive health needs of HIV-positive women and their families. UNFPA supports a package of interventions integrated into reproductive health services that includes providing:

- access to voluntary HIV testing and counselling services;
- access to appropriate antenatal care (including information, counselling and related services on HIV/STI

prevention), screening and treatment for STIs, safe delivery and post-delivery care, and infant feeding counselling;

- reproductive health commodities, particularly those aimed at preventing HIV infection: male and female condoms, HIV testing kits, STI screening and diagnostic kits, equipment and supplies for safe childbirth, and drugs for the treatment of STIs;
- reproductive health information and services in the context of human rights, including information on the risk of HIV transmission to children, ways to reduce the risk of transmission, counselling and support on childbearing decisions, family planning services, and other reproductive health services;
- STI management;
- referrals for HIV-positive women for treatment, care and support services;
- technical support and capacity building for managers and service providers on HIV prevention, especially for young people, pregnant women and condom programming, and addressing the gender dimensions of HIV/AIDS; and
- advocacy for reproductive health rights and needs of HIV positive women, reduction of stigma and discrimination, and for greater involvement of men in reproductive health.