Current State of AIDS Epidemic in Nigeria: Role of ARVs on PMTCT

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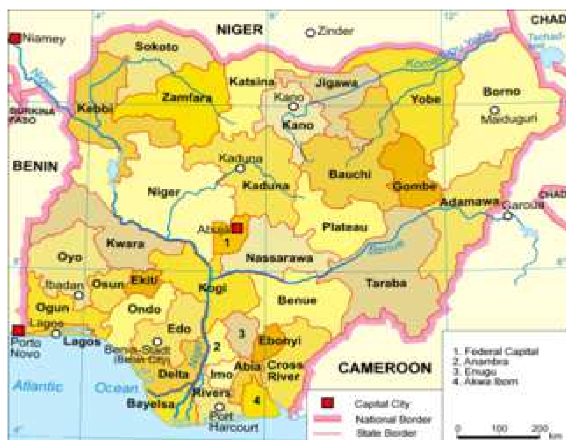
OUTLINE

- Introduction
- Adoption of Global e-MTCT Plan
- What Nigeria planned to do / Projections
- Achievements by end 2012
- What is the way forward?

Introduction 1



HIV positive persons: 3.1million
Annual Births: ~6 million
HIV prevalence (ANC): 4.1% (2010)
HIV+ pregnant women(annual): ~229,480

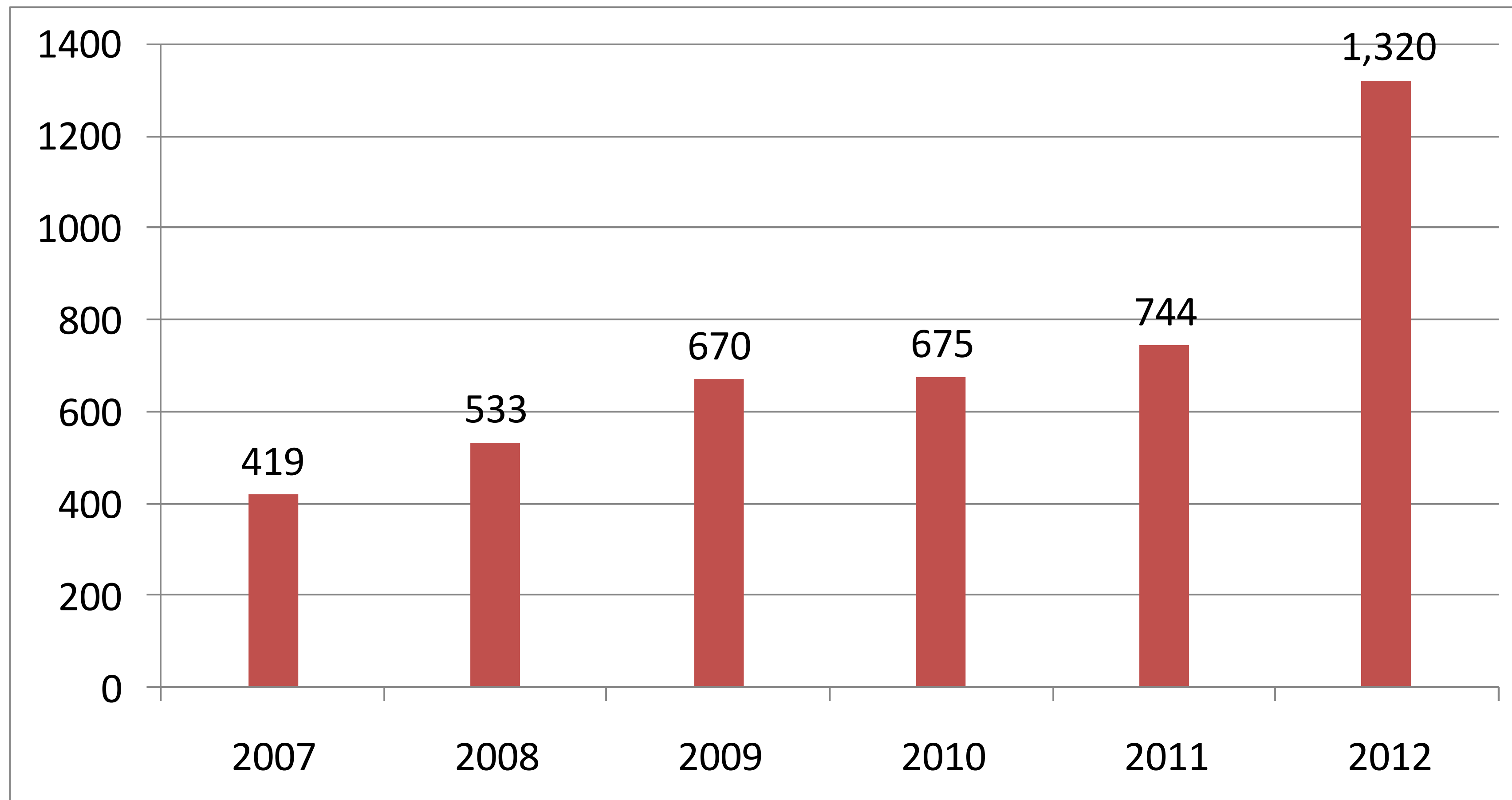
- 58% of pregnant women attend ANC at least once
- 45% attend at least 4 times
- 35% of births occur in health facilities
- 39% deliveries by Skilled Birth Attendants
- HIV+ Babies (annual) : 50,000 – 80,000

Introduction 2

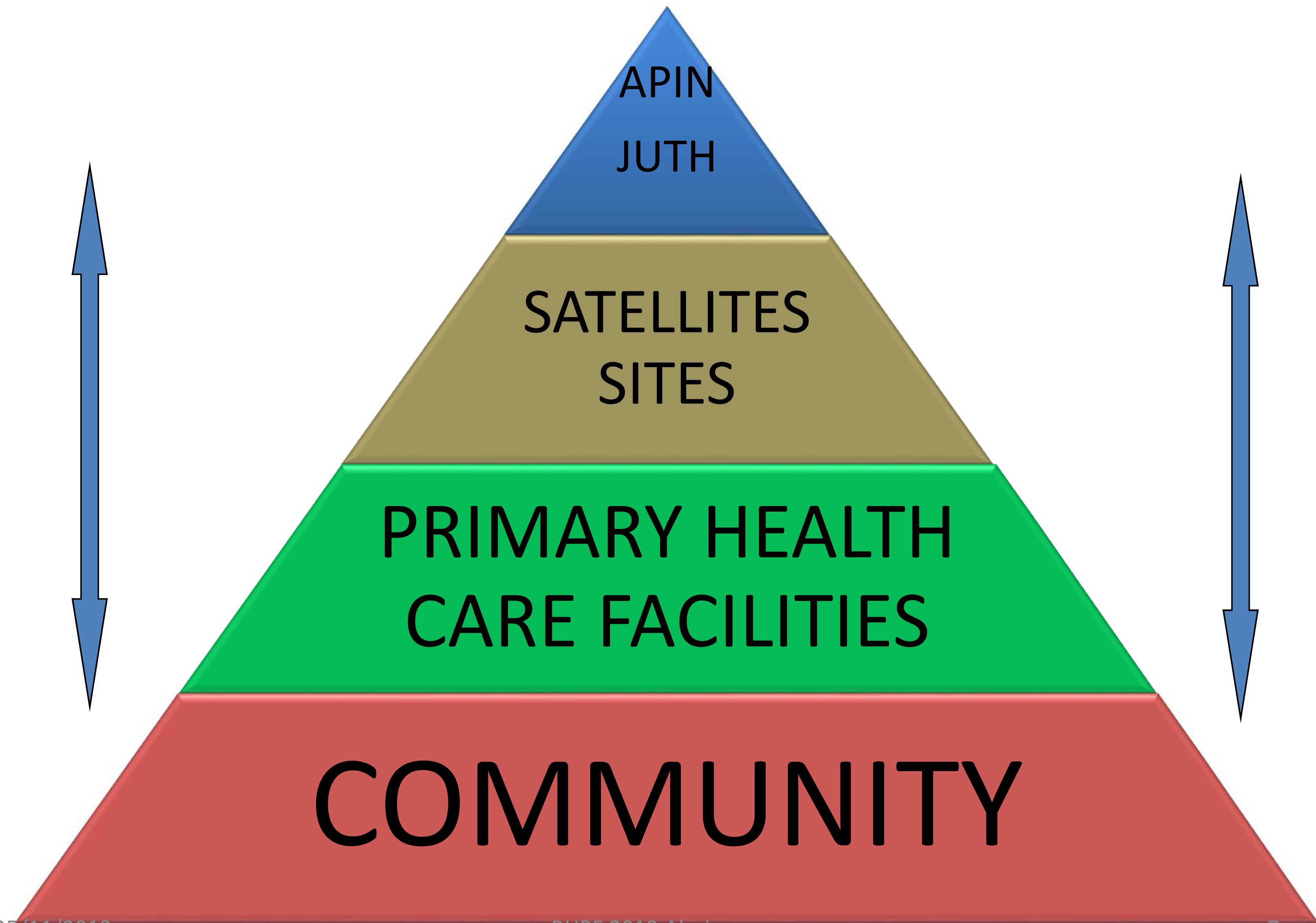
- Nigeria has the 2nd highest burden of HIV globally
- About 3.4m PLHIV (spectrum 2012)
- 270,000 new infections occurred in 2012
  - Adults 210,000
    - 58% Women
    - 42% Men
  - **Children 60,000 (Highest annual new cases globally)**
- Rate of MTCT in Nigeria - 30% (modeling 2012)
- 70% of HIV infection concentrated in 12 + 1 out of 36 states of the country
- Nigeria accounts for about 30% global MTCT

The Nigerian PMTCT program started in 6 Tertiary Hospitals in 2002

Number of facilities offering PMTCT services nationally



HIV Treatment / PMTCT in Plateau State



Score Board after nearly One Decade of Implementation

	Nigeria	South Africa
HIV+ pregnant women:	210,000	210,000
Coverage of ARV/ART for PMTCT:	22%	88%
Estimated HIV incidence (modelled):	0.39%	1.68%
Contraceptive prevalence:	20%	62%
Unmet need for FP:	20%	14%
ANC at least 1 visit:	58%	92%
Median duration of BF:	19 m	16 m
MTCT rate in 2009:	32%	19%
New child infections 2009:	64,700	40,500

Sources: WHO Universal access report 2010, Nigeria DHS 2008, South Africa DHS 2003, UNAIDS analysis

Paediatric HIV Epidemic in Nigeria

- Flourishing on innocent little lives
- Entirely preventable
- We know what to do
- We know how to do it
- Stakeholders are willing and supportive
- ....Hope is not lost but where are the actors?

Nigeria endorses global plan for e-MTCT

Launch of the Global Plan 2011

Two Global Targets:

- Reduce new HIV infections among children by 90%
- Reduce number of AIDS related Maternal deaths by 50%

A 4-Point Plan:

- Frame it
- Advocate for it
- Do it
- Account for it

Nov. 2010 Geneva Consultation on Elimination

Goal: *"To eliminate new paediatric HIV infections and improve maternal, newborn and child survival and health in the context of HIV."*

Overall Targets

1. Reduce new paediatric HIV infections by 90%
2. Reduce mother-to-child transmission rate (MTCT) to <5%

Prong Targets and Indicators

Prong 1: 50% reduction in HIV incidence **(+3 indicators)**

Prong 2: Unmet FP to ZERO **(+1 indicator)**

Prong 3: Vertical transmission < 5% (<2% around 6 weeks) (+9 indicators)

Prong 4: 90% reduction in HIV-related maternal and infant and child deaths (**+4 indicators)**

Towards Elimination of MTCT in Nigeria

- **Renewed Commitment for Elimination of MTCT**
  - Commitment to fully implement New Scale up (e-MTCT) Plan (2011-2015)

- **Equity-focused strategic analysis** of current program performance to identify and overcome bottlenecks (routine program data, effectiveness study, etc..)

- **Strengthened emphasis on Prongs 1&2** through better collaboration and integration of SRH, MNCH and HIV programs.
  - Programming for E-MTCT will not occur in isolation and calls us to get out of our comfort (Prong 3&4) zone

- **Sustained funding for cost-effective interventions** to support elimination of MTCT and contribute to maternal health and child survival.

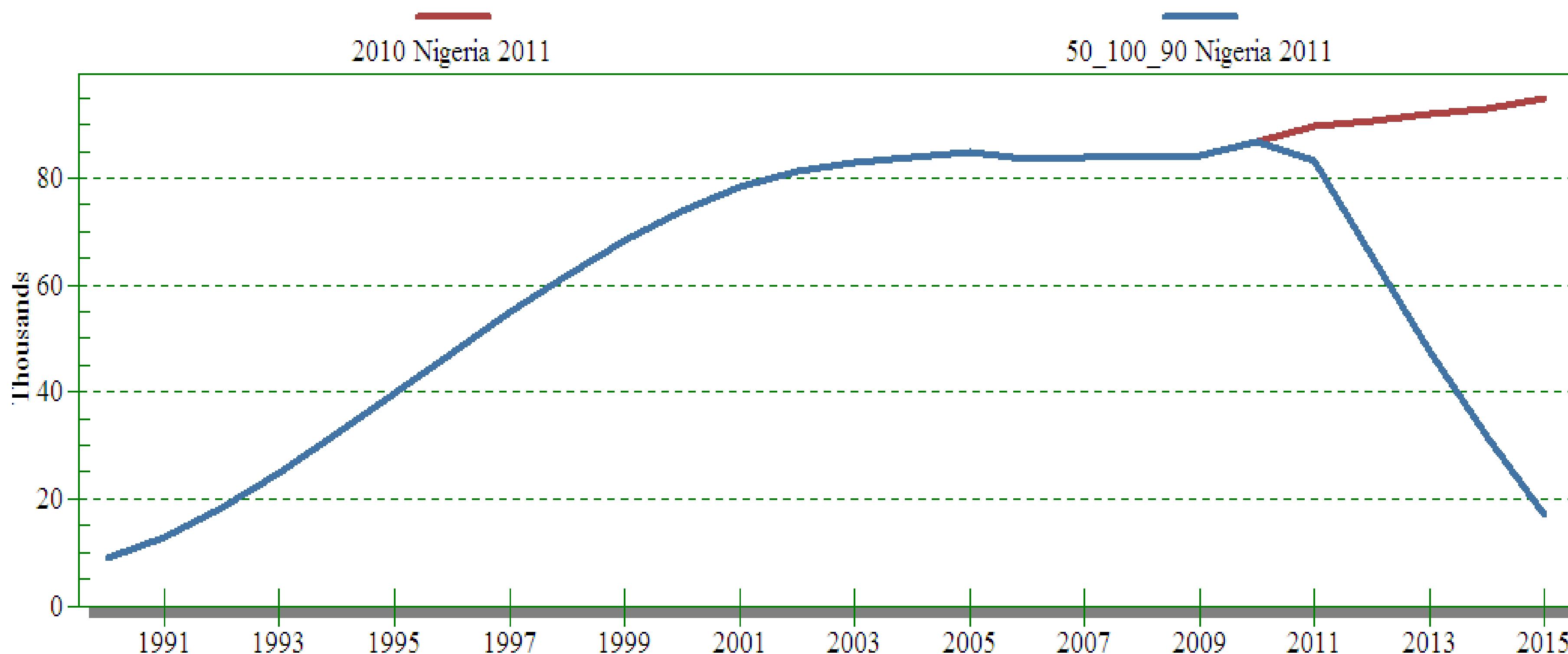
- **National leadership, States and LGA buy-in**, accountability and ownership (communities).

What did Nigeria plan to do?

Nigeria: 2011-2015 e-MTCT Targets

- Reduce HIV incidence among women of reproductive age by 50% between 2011 and 2015
- Reduce unmet need for family planning by 100% between 2011 and 2015
- Reach 90% of HIV-positive women and infants with ART or ARV prophylaxis according to National PMTCT guidelines

Number of new child HIV infections due to mother to child transmission, by scenario, Nigeria



2010 – base scenario: 2009 programme coverage maintained through 2015

50_100_90 – intervention scenario: 50% reduction in HIV incidence, eliminate unmet need for family planning, provide ARVs or ART to 90% of women in need

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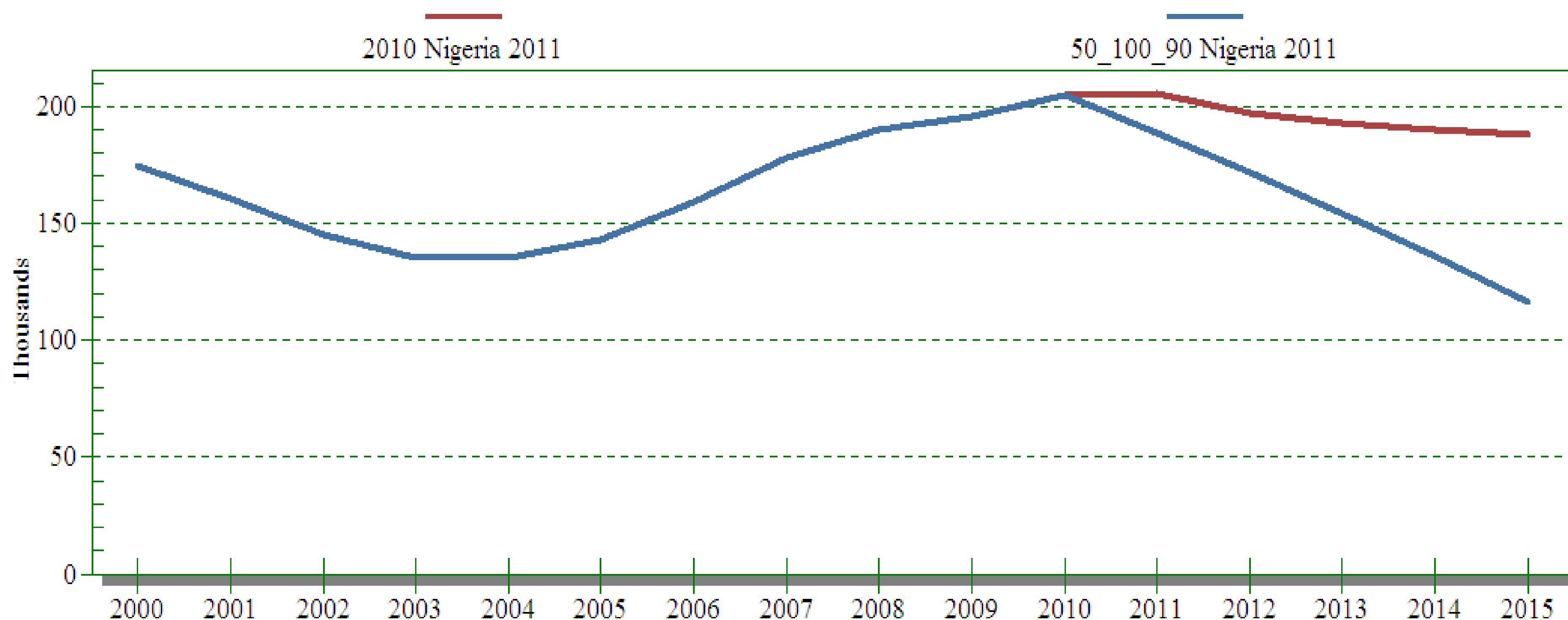
Number of new HIV infections among reproductive age women, by scenario, Nigeria



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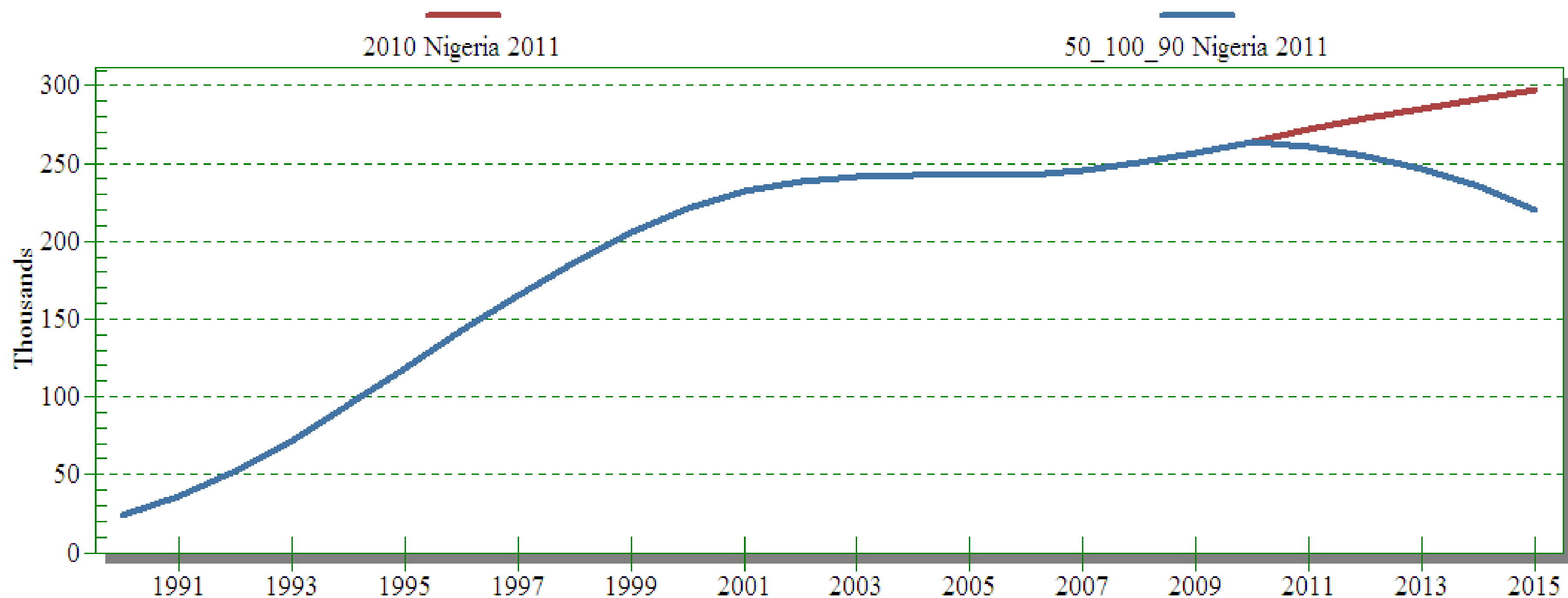
Number of women living with HIV giving birth (women in need of PMTCT services), by scenario, Nigeria



2010 – base scenario: 2009 programme coverage maintained through 2015

50_100 intervention scenario: 50% reduction in HIV incidence, eliminate unmet need for family planning.

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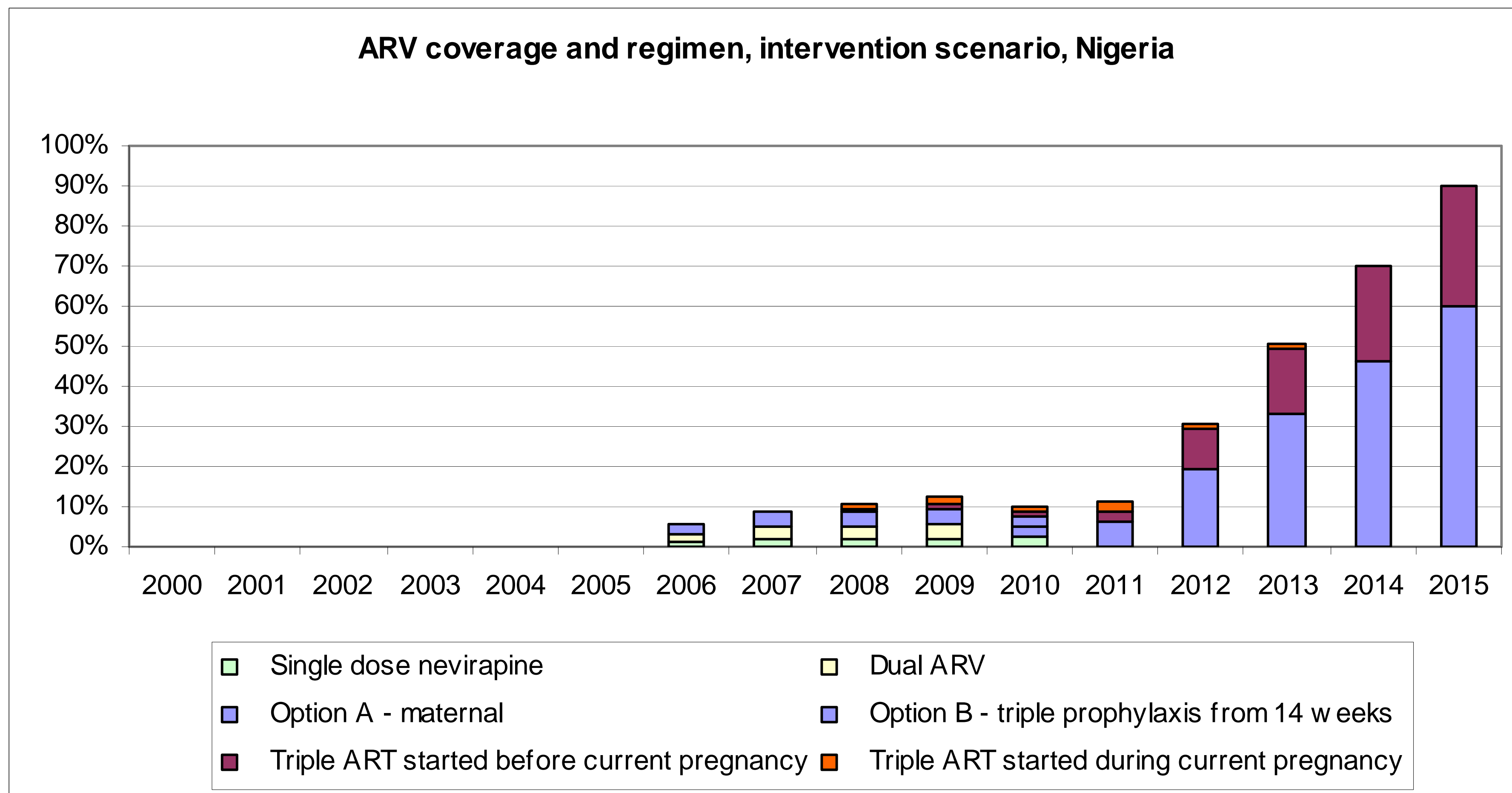
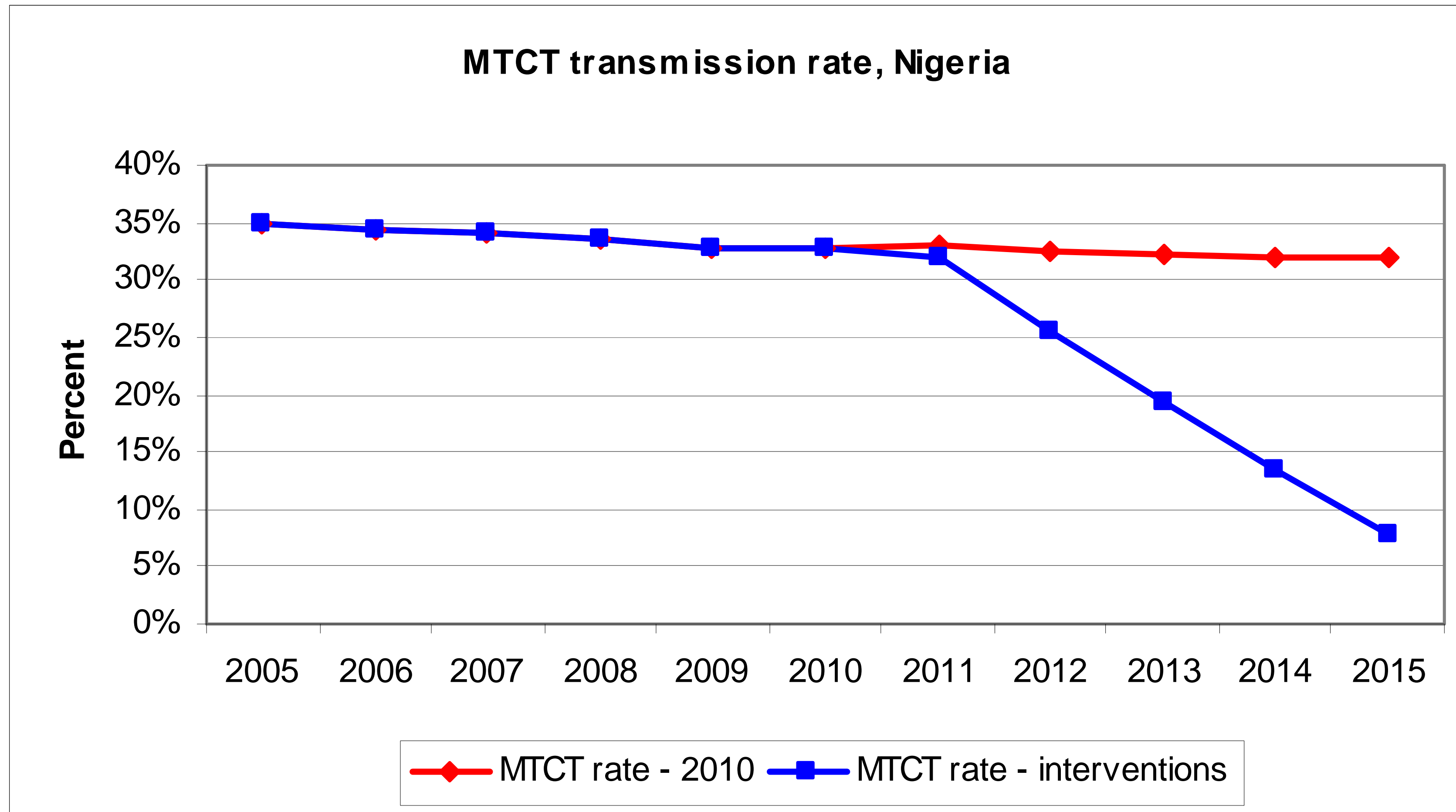
Percent of women receiving ARV or ART by regimen, by scenario, Nigeria



In this scenario the 2015 regimen and coverage will result in 8% transmission rate

Estimated mother to child transmission rate (including transmission during pregnancy, delivery and breastfeeding), by scenario, Nigeria



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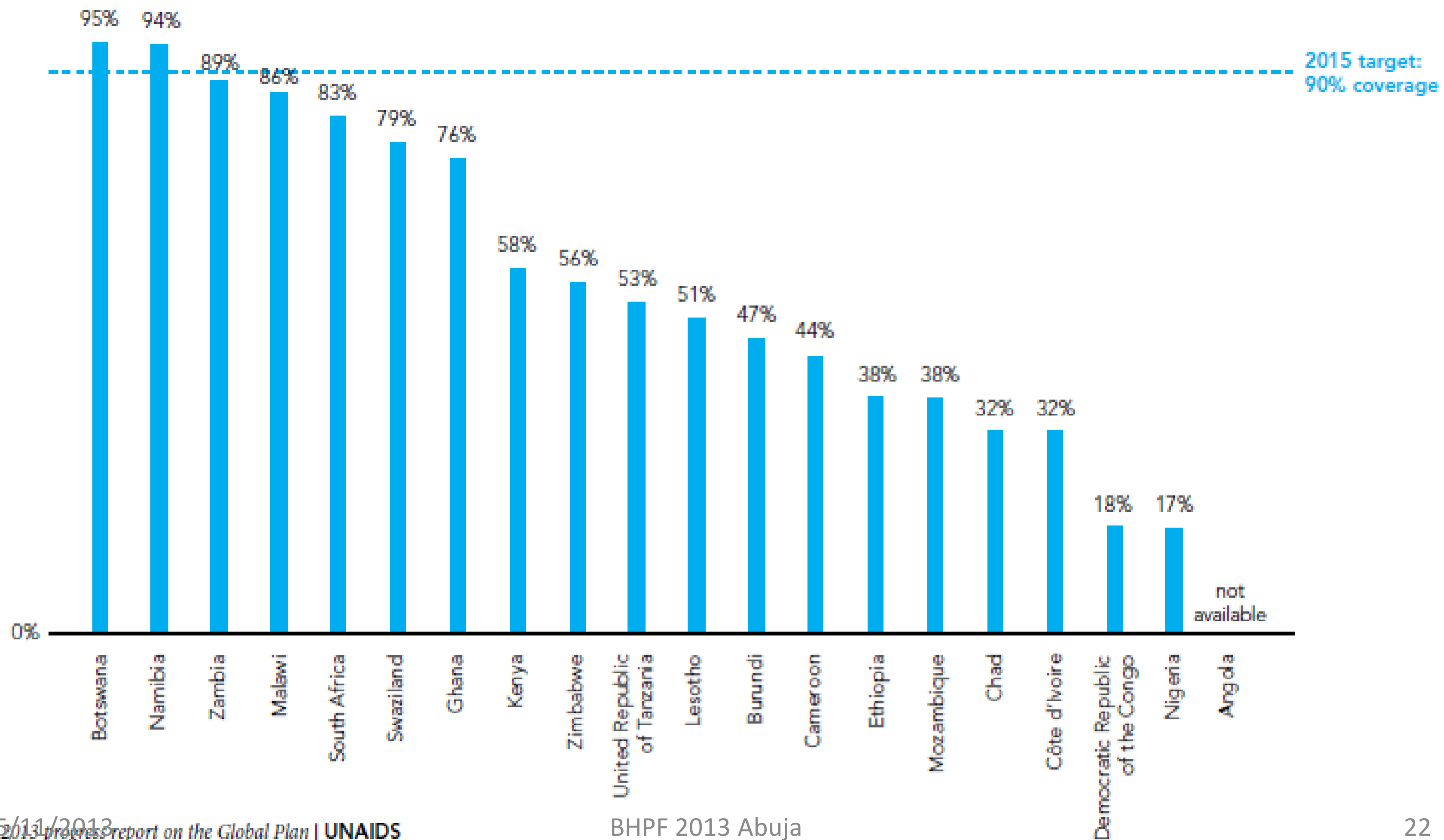
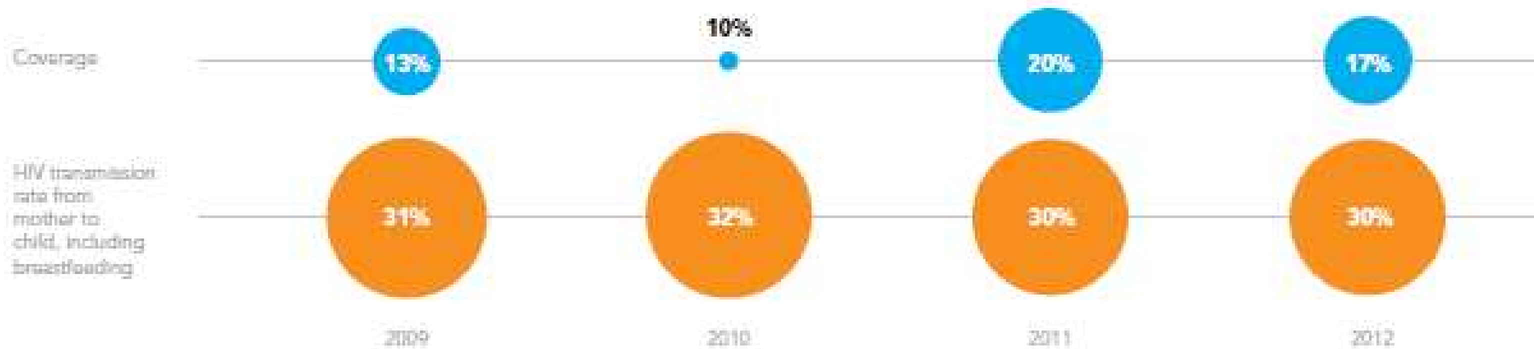
Achievements by end 2012

ART Coverage in Pregnancy By Country



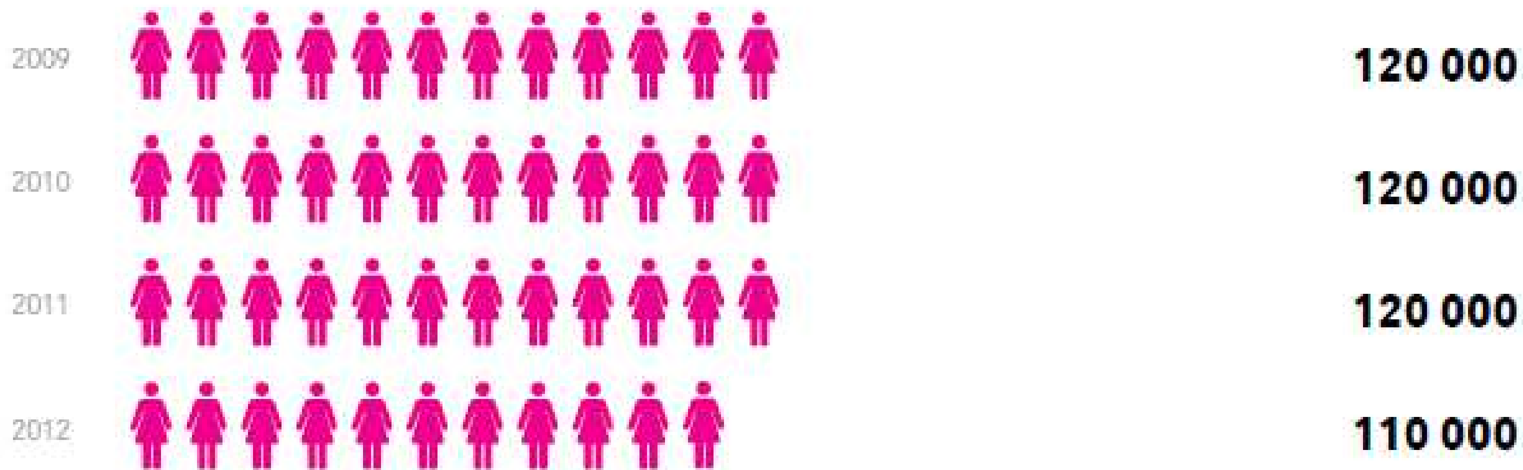
Nigeria: ARV Coverage/ MTCT Rates/New HIV in Women (2009-2012)

Significantly reducing HIV transmission rates requires rapidly scaling up the coverage of antiretroviral medicines



The number of women acquiring HIV infection has not changed substantially

Women acquiring HIV infection (15–49 years old), 2009–2012



2013 progress report on the Global Plan | **UNAIDS**

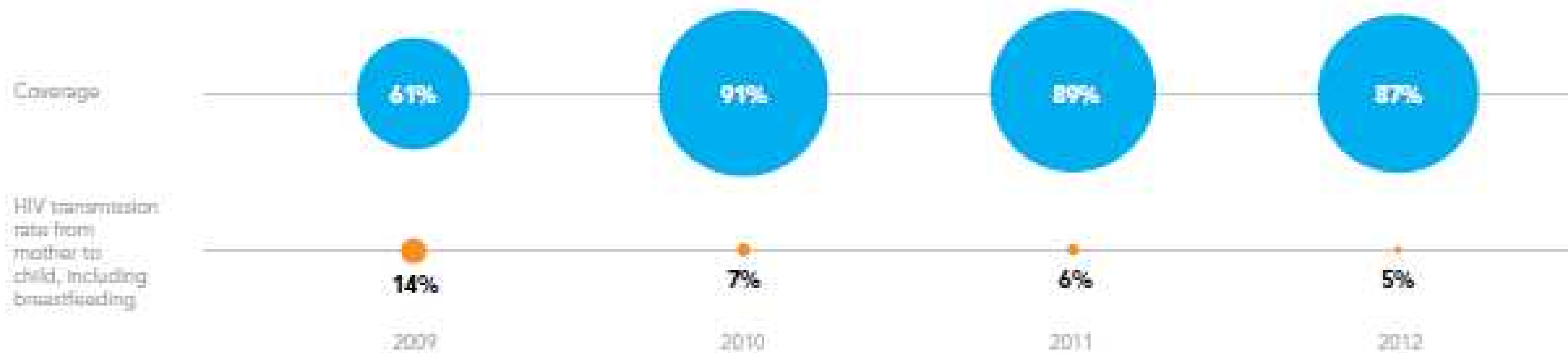
Nigeria: HIV Global Plan Achievements: 2009-2012

The number of new HIV infections among children has declined very slowly

Nearly 9 out of 10 eligible children are not receiving HIV treatment

2013 progress report on the Global Plan | **UNAIDS**

South Africa: ARV Coverage/ MTCT Rates/New HIV in Women (2009-2012)



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South Africa: HIV Global Plan Achievements: 2009-2012

The number of new HIV infections among children continues to decline rapidly

New HIV infections among children (0–14 years old)

The number of eligible children who are receiving HIV treatment has increased rapidly, to nearly 7 out of 10

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E-MTCT in Nigeria: The Worry

- Progress in Nigeria is critical to eliminating new HIV infections among children globally.
- Nearly all indicators assessed show stagnation and suggest that Nigeria is facing significant hurdles.
- Meeting the 2015 targets requires massive effort.

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What is the way forward?

E-MTCT in Nigeria: On-going Efforts

- Government has taken a bold step to focus on the 12+1 states with the highest burden of HIV, which account for about 70% of new HIV infections.
- In addition, it is rapidly scaling up service delivery to stop new HIV infections among children
- Govt. has embarked on an intensive state-focused data-driven decentralization initiative.

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National Focus

- Saturation of PMTCT services in the 12+1 states with highest HIV/AIDS burden
- Improved Ownership and Coordination at State level
- Intensive state-focused data-driven decentralization initiative.
- Increased involvement of the Organised Private Sector and Private Health facilities
- Strengthening MCH services and RH/HIV integration
- All PMTCT sites to provide EID services

2013 WHO Recommendations

"Option B+"

"Option B"

All pregnant and breastfeeding women infected with HIV should initiate triple ARVs (ART), which should be maintained at least for the duration of mother-to-child transmission risk. Women meeting treatment eligibility criteria should continue lifelong ART .

(strong recommendation, moderate-quality evidence)

For programmatic and operational reasons, particularly in generalized epidemics, all pregnant and breastfeeding women infected with HIV should initiate ART as lifelong treatment.

(conditional recommendation, low-quality evidence)

In some countries, for women who are not eligible for ART for their own health, consideration can be given to stopping the ARV regimen after the period of mother-to-child transmission risk has ceased.

(conditional recommendation, low-quality evidence)

Rationale: Shift from Option A to B+ or B

BENEFITS FOR MOTHER AND CHILD	BENEFITS FOR PROGRAM DELIVERY & PUBLIC HEALTH
Ensures all ART eligible women initiate treatment	Reduction in number of steps along PMTCT cascade
Prevents MTCT in future pregnancies	Same regimen for all adults (including pregnant women)
Potential health benefits of early ART for non-eligible women	Simplification of services for all adults
Reduces potential risks from treatment interruption	Simplification of messaging
Improves adherence with once daily, single pill regimen	Protects against transmission in discordant couples
Reduces sexual transmission of HIV	Cost effective

Major issue now is not "when to start" or "what to start" but "whether to stop"

Summary of Changes in WHO Recommendations: What to Start in Adults

FIRST-LINE REGIMENS (PREFERRED ARV REGIMENS)			
TARGET POPULATION	**2010 ART GUIDELINES**	**2013 ART GUIDELINES**	**STRENGTH & QUALITY OF EVIDENCE**
HIV+ ARV-NAIVE ADULTS	AZT or TDF + 3TC (or FTC) + EFV or NVP	**TDF + 3TC (or FTC) + EFV** (as fixed-dose combination)	***Strong, moderate-quality evidence*** NEW
HIV+ ARV-NAIVE PREGNANT WOMEN	AZT + 3TC + NVP or EFV		
HIV/TB CO-INFECTION	AZT or TDF + 3TC (or FTC) + EFV		
HIV/HBV CO-INFECTION	TDF + 3TC (or FTC) + EFV		

Key research questions: Pregnant Women

ARV toxicity surveillance:

- Safety of early, lifelong ART for pregnant and breastfeeding women?
- Maternal toxicity, pregnancy toxicity (stillbirth, low birth weight, prematurity, birth defects) and infant toxicity?

Mother-to-child transmission and mother and child health impact:

- Impact on overall HIV-free survival and and overall MTCT rate (*at the end of breastfeeding* as well as at 6-weeks)?
- Impact on maternal morbidity and mortality, sexual transmission, and the long-term success of first-line ART?

Adherence and retention:

- Acceptability of ART to women, especially those who initiate lifelong ART before they meet «adult eligibility» criteria»
- Adherence and retention rates for women with both low and high CD4?
- Health systems and community interventions needed to achieve high levels of adherence and retention in setting of universal ART?

STEPS TO HIV-FREE GENERATION IN NIGERIA

HIV-free Generation

TasP	Option B+	EID	Paed ART

Male Involvement	Family Planning (LAPMs)

Combination Prevention

Task-Shifting	Decentralization : HIV/MCH/RH	Private Sector Engagement

Community engagement for participation and action

Conclusion

- Eliminating mother-to-child transmission of HIV requires a solid foundation in community partnership
- Although antiretroviral drugs (ARVS) alone cannot achieve this goal, without ARVs there will be very little movement
- The key is to address all strategies concurrently

Acknowledgements

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THANK YOU FOR LISTENING