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Two steps forward, one step back

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As the global community moves forward in implementing the 2030 Agenda for Sustainable Development, it is important that we learn from past challenges, especially those related to effectively reaching the people who are furthest behind.

We greatly appreciated the commentary by Drs. Wu and Hawkes (1) on our article on the *Global burden of maternal and congenital syphilis in 2008 and 2012: a health systems modelling study* (2) and fully agree that political will is instrumental in achieving dual elimination of mother-to-child transmission (MTCT) of HIV and syphilis. Our colleagues remarked on the “upsurge in global and national interest in controlling MTCT of syphilis that was spurred by its close alignment with the similar global goal of eliminating MTCT of HIV” (1). This interest and alignment was directly linked to evidence of continued congenital syphilis burden and the ability of countries to measure progress toward elimination. As is described in their commentary, inclusion of three core indicators into the Global AIDS Response Progress Reporting (GARPR) database in 2008 allowed, for the first time, measurement of outcomes and monitoring of national and regional progress in eliminating MTCT of syphilis, as has been done for many years in eliminating MTCT of HIV (2,3). That body of evidence, based upon country-reported data, allowed (quoting Wu and Hawkes) “accountability if national governments deem the global commitment as legitimate and comply with it” (1,4).

Our colleagues were particularly concerned about the marked disparity in progress in Sub-Saharan Africa, the region that is most affected by syphilis as well as HIV, compared with other regions of the world. From 2009 to 2013, in 21 prioritized African countries, coverage of antenatal care services increased to 83%, HIV testing coverage increased to 45%, and treatment coverage of pregnant women with HIV increased to 68% (5). However, syphilis testing coverage in pregnant women declined from 57% to 38% in these countries. Seeking a solution to this dilemma, Wu and Hawkes drew attention to the case of China, where in 2010

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the joint efforts of the policy communities working on HIV and syphilis were able to influence national decision makers to reframe the two infections, HIV and syphilis, together as “threatening the physical and mental health of a large number of women” (1,6). China’s approach, using program and cost-effectiveness data to influence decision makers, is one that could be used by other countries to achieve elimination of MTCT of HIV and syphilis (7). Based on success of this integrated model promoting quality antenatal services that support women and children’s health, China initiated prevention of MTCT of hepatitis B through an expanded program aimed at triple elimination of HIV, syphilis and hepatitis B (8).

It was therefore more than disheartening to learn—just as member states attending the June 2016 United Nations (UN) General Assembly High-Level Meeting on Ending AIDS committed to “taking all appropriate steps to eliminate new HIV infections among children… (and) dual elimination with congenital syphilis” (1,9)—that decision makers at UNAIDS have elected to discontinue collection of six critical indicators in the Global AIDS Monitoring (formerly GARPR) surveillance system that are needed to measure country and global progress toward elimination of MTCT of HIV (Table 1) (10,11). Lack of country-reported data on HIV testing in pregnancy and perinatal transmission will cripple the ability of the global health community and affected countries to measure ongoing progress in PMTCT, the flagship program that has forged the way to “Getting to Zero”. This lack of indicator data is anticipated to particularly affect Sub-Saharan Africa, which accounts for most MTCT transmission of HIV but has made such remarkable progress over the past decade. We worry that the disparities noted by Wu and Hawkes in program coverage for HIV and syphilis screening and treatment among pregnant women and infants may diminish further beyond already low levels.

The dual elimination of MTCT of HIV and syphilis specifically addresses Sustainable Development Goals (SDGs) 3 and 5 and has broad reaching impacts across all SDGs given their inherent focus on gender equality and the empowerment of women and girls. Integration of HIV and reproductive health services such as prenatal syphilis screening is a pragmatic and cost-effective approach to achieving maternal and child health goals, and has been found particularly effective in areas where access to health care may be limited (3,7). Lack of funding for reproductive health services (including prevention of sexually transmitted infections) greatly affects women and children. Losing critical MTCT of HIV indicators will inhibit realization of the dual elimination goals by making it more difficult to assess progress, identify areas that need improvement and demonstrate the cost-effectiveness of integrated approaches that have been proven effective in countries such as China. As pointed out by Wu and Hawkes, unification of efforts and alignment of global goals requires sustained political commitment, but this is unlikely to come without reliable data upon which to measure progress.

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Table 1

Mother-to-child transmission (MTCT) of HIV indicators in the Global AIDS Response Progress Reporting (GARPR) in 2016 compared with Global AIDS Monitoring (GAM, formerly GARPR) surveillance system in 2017

MTCT of HIV indicators	Indicator description	GARPR 2016	GAM 2017
Prevention of mother-to-child transmission of HIV	Percentage of HIV-positive pregnant women who received ARV medicine to reduce the risk of mother-to-child transmission	√	√
Early infant diagnosis	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	√	
Mother-to-child transmission of HIV	Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months	√	√
Programme-level mother-to-child transmission of HIV	Registered percentage of child HIV infections from HIV-positive women delivering in the past 12 months	√	
PMTCT testing coverage	Percentage of pregnant women with known HIV status	√	
Testing coverage of pregnant women's partners	Percentage of pregnant women attending ANC whose male partners were tested for HIV during pregnancy	√	
Coverage of infant ARV prophylaxis	Percentage of HIV-exposed infants who initiated ARV medicines prophylaxis	√	
CTX prophylaxis coverage	Percentage of HIV-exposed infants started on CTX prophylaxis within 2 months of birth	√	

Sources: UNAIDS. Global AIDS Response Progress Reporting 2016: construction of core indicators for monitoring the 2011 United Nations Political Declaration on HIV and AIDS. Joint United Nations Programme on HIV/AIDS (UNAIDS), Geneva (2016); UNAIDS. Global AIDS Monitoring 2017: indicators for monitoring the 2016 United Nations Political Declaration on HIV and AIDS. Joint United Nations Programme on HIV/AIDS (UNAIDS), Geneva (2016). CTX, co-trimoxazole; ARV, antiretroviral; ANC, antenatal clinics.