UKWIMYA LULU YAKUPWISHA AKASHISI KA HIV/AIDS MU BANA

CAMPAIGN TO END PEDIATRIC HIV/AIDS

CAMPAGNE POUR L'ÉLIMINATION DU VIH/SIDA PÉDIATRIQUE

OLUTALO OLWO KUMALAWO MUKENENYA MU BAANA

KUFARITSA KUSIRIDZA KALOMBA KA HIV NAMATENDA YA AIDS MUBANA BANGO'NO

CAMPANHA PARA A ELIMINAÇÃO DO VIH/SIDA PEDIÁTRICO

KAMPENI YA KUMALIZA MAAMBUKIZI YA VVU KWA WATOTO

ACCELERATING ACTION TO END PEDIATRIC HIV/AIDS BY 2015

A Status Report ▪ July 2010

ACKNOWLEDGEMENTS

The Global AIDS Alliance wishes to thank the many individuals, organizations, and networks that have contributed to this status report through their work with the Campaign to End Pediatric HIV/AIDS (CEPA).

We are particularly grateful to our partners in Africa—in the six CEPA initiating countries and elsewhere—for their engagement with the campaign, and their enormous commitment and efforts to advance CEPA's goals at the national, regional, and global levels.

- Pan African AIDS Treatment Access Movement (PATAM);
- African Network for the Care of Children Affected by HIV/AIDS (ANECCA) in Uganda;
- Kenya Treatment Access Movement (KETAM);
- Mozambique Treatment Access Movement (MATRAM);
- Positive Action for Treatment Access (PATA) in Nigeria;
- Human Development Trust (HDT) in Tanzania;
- Coalition for Health Promotion and Social Development (HEPS) in Uganda;
- Treatment Advocacy and Literacy Campaign (TALC) in Zambia; and
- CEPA local-to-global partner Health GAP.

In particular, we thank the following for their input on the country-level information presented in this report: James Kamau and John Kipchumbah of KETAM in Kenya; Gloria Nyamuzuwe of MATRAM and Luisa Brumana of UNICEF in Mozambique; Dr. Rolake Odetoyinbo of PATA in Nigeria; Dr. Peter Bujari, Simon Malanilo, and Jackline Jema Nusurupia of HDT and Dr. Juma Mwinula in Tanzania; Denis Kibira and Francis Tucungwirwe of HEPS and Franco Wandabwa of ANECCA in Uganda; Vivian Sakanga and Felix Mwanza of TALC and Henry Malumo in Zambia; and Tapiwanashe Kujinga of PATAM.

In addition, we wish to acknowledge the following individuals for their review and feedback on this status report: Fareed Abdullah of the Global Fund to Fight AIDS, TB and Malaria; Christa Cepuch of Health Action International—Africa in Kenya; Joan Holloway of the Office of the U.S. Global AIDS Coordinator; Samantha Salcedo of the Partnership for Supply Chain Management; Eric Friedman of Physicians for Human Rights; Labib El Ali and Paul Jensen of RESULTS; Sue Perez of the Treatment Action Group; Karusa Kiragu of UNAIDS; Shani Winterstein of UNICEF; and Mazuwa Andrew Banda of the World Health Organization.

Our special thanks go to The Children's Investment Fund Foundation for its generous support of the Campaign to End Pediatric HIV/AIDS.

Finally, we are grateful to Carol Bergman, Georgina Bukenya, Rachel Burton, Susannah Cernojevich, Susana Oguntoye, Lisa Schechtman, and Paul Zeitz of the Global AIDS Alliance for their invaluable input; and to Cathy Lemp of GAA for editing and production management.

Primary Author: Sarah Middleton-Lee.
Designer: KLD Design, Inc.
Photo Credits: Page 3 © 2005 Heather A. Lawrence, Courtesy of Photoshare; and Page 16 © 2007 Mary Atieno Otieno / Rural Kenya World Cultural Link, Courtesy of Photoshare

CAMPAIGN TO END PEDIATRIC HIV/AIDS

www.endpediatricaids.net

GLOBAL AIDS ALLIANCE

www.globalaidsalliance.org

CONTENTS

GLOSSARY

AIDS . . . . . Acquired Immune Deficiency Syndrome

ART . . . . . Antiretroviral therapy

ARV . . . . . Antiretroviral medication

AZT . . . . . Azidothymidine or zidovudine

AMDS . . . . . AIDS Medicines and Diagnostics Service (WHO)

CCM . . . . . Country Coordinating Mechanism (Global Fund)

CEPA . . . . . Campaign to End Pediatric HIV/AIDS

CHAI . . . . . Clinton Health Access Initiative

CPP . . . . . Coordinated Procurement Planning Program

CSO . . . . . Civil-society organization

EID . . . . . Early infant diagnosis

EIT . . . . . Early infant treatment

GHI . . . . . Global Health Initiative (U.S.)

Global Fund . . . Global Fund to Fight AIDS, Tuberculosis and Malaria

HIV . . . . . Human immunodeficiency virus

MDG . . . . . Millennium Development Goal

NGO . . . . . Nongovernmental organization

PEPFAR . . . . . President's Emergency Plan for AIDS Relief (U.S.)

PPTCT . . . . . Prevention of parent-to-child transmission (Note 1)

PPTCT+ . . . . . Comprehensive prevention of parent-to-child transmission (Note 2)

RCC . . . . . Rolling Continuation Channel

SMS . . . . . Short Message Service

TRP . . . . . Technical Review Panel

UNDP . . . . . United Nations Development Program

UNGASS . . . . . United Nations General Assembly Special Session on HIV/AIDS

UNICEF . . . . . United Nations Children's Fund

UNAIDS . . . . . Joint United Nations Programme on HIV/AIDS

WHO . . . . . World Health Organization

Note 1: As part of CEPA's advocacy strategy, the campaign is replacing the terminology ***prevention of mother-to-child transmission,*** which further stigmatizes mothers with HIV/AIDS, with ***prevention of parent-to-child transmission***, a usage that has already been adopted by the Indian government and is gaining currency with some U.N. agencies.

Note 2: Comprehensive prevention of parent-to-child transmission includes (1) prevention of primary HIV infection in women; (2) prevention of unintended pregnancies in women living with HIV, including provision of family planning services; (3) prevention of HIV transmission from a women living with HIV to her infant; and (4) provision of appropriate treatment, care, and support to mothers living with HIV and their children and families.

EXECUTIVE SUMMARY

This status report provides a SNAPSHOT OF PEDIATRIC HIV/AIDS GLOBALLY and in SIX KEY COUNTRIES IN SUB-SAHARAN AFRICA: Kenya, Mozambique, Nigeria, Tanzania, Uganda, and Zambia. It focuses on issues that are being prioritized by the Campaign to End Pediatric HIV/AIDS (CEPA), which—when reviewed together—PROVIDE A MEASURE OF PROGRESS TO DATE AND HIGHLIGHT ONGOING CHALLENGES.

CEPA is a three-year campaign that seeks to increase coverage rates for comprehensive prevention of parent-to-child transmission (PPTCT+) and high-quality pediatric treatment services from the current average of 45% to the globally agreed-upon target of 80%. Such action is critical to ensure universal access to HIV prevention, treatment, and care, and to achieve Millennium Development Goals 4, 5, and 6 by 2015.

This status report highlights concrete progress in both the quality and scale of responses to pediatric HIV/AIDS. For example:

- Kenya, Mozambique, and Zambia have already adopted the new World Health Organization guidelines issued in November 2009, which raise the standards for antiretroviral treatment, infant feeding, and PPTCT+ services, and Zambia is reviewing the guidelines to ensure improved implementation.
- All CEPA countries have adopted new WHO guidelines on early infant diagnosis and treatment, except for Tanzania, where adoption is under way. However, none of these countries has established systems for tracking the number of children being tested within two months—the timeframe critical for starting ARV treatment.
- All CEPA countries have some form of national budget for HIV/AIDS, except Mozambique. However, none of the national budgets includes a specific breakdown for expenditures on pediatric HIV/AIDS, which makes it difficult to track whether government spending is increasing.

The report also highlights a number of areas where significant bottlenecks continue to stymie progress. For example:

- None of the CEPA countries is currently meeting the Abuja Declaration commitment to allocate at least 15% of annual national budgets to health care.
- Stock-outs of essential drugs, commodities, and equipment for PPTCT+ and pediatric HIV/AIDS treatment remain common. Action is needed both globally—such as by the multilateral Coordinated Procurement Planning Program—and nationally to better track and address where and why these stock-outs are occurring.
- Stigma and discrimination is a major barrier to an effective response to pediatric HIV/AIDS, and major institutions such as PEPFAR and the Global Fund to Fight AIDS, TB and Malaria need to strengthen their technical expertise and monitoring on this issue. Moreover, the Stigma Index developed by the Global Network of People Living with HIV (GNP+) is being implemented in just four CEPA countries.
- While PEPFAR has set a target of training and retaining over 140,000 new health care workers by 2013, progress within most countries remains slow, and health care worker shortages are a reality in many hard-hit communities.

Finally, this status report highlights critical decisions related to pediatric HIV/AIDS that are currently being debated by national governments and donors. For example:

- New WHO treatment guidelines released in November 2009 give countries the option of choosing between triple or combination ARV therapy to prevent parent-to-child HIV transmission (Option B), or a less expensive and less efficacious version of PPTCT that includes AZT during pregnancy, delivery, and postpartum, as well as single-dose nevirapine at onset of labor and nevirapine (with or without AZT) during labor and postpartum (Option A). To date, Kenya, Mozambique, and Zambia have adopted Option A; Nigeria has chosen a combination of Options A and B; and Tanzania is still making a decision.
- The Global Fund to Fight AIDS, TB and Malaria, a multilateral funding mechanism that is critical to scaling up high-quality PPTCT+ and pediatric HIV/AIDS treatment services—has begun its 2011–2013 replenishment process and will require $20 million to continue its trajectory of growth over that period. Unfortunately, it remains unclear whether key donors will contribute their "fair share" of the resources needed.
- The Global Fund is also implementing a new reprogramming initiative to transition PPTCT services from single-dose nevirapine to dual or triple ARV therapy in 20 countries, including all six of the current CEPA countries. This initiative is an important sign of progress; however, there are concerns regarding whether the Fund is engaging civil society sufficiently, and advancing a comprehensive approach that includes all four prongs of PPTCT+ services, including family planning.

Finally, this status report concludes that we have the tools we need to eliminate pediatric HIV/AIDS. Effective treatments and technologies exist, and there are commitments in place at the country, regional, and global levels. Nevertheless, the number of children born with and dying of HIV/AIDS remains far too high. In order to achieve the agreed-upon target of 80% coverage for PPTCT+ and pediatric HIV/AIDS treatment—and save millions of lives—we must overcome key policy and implementation bottlenecks through accelerated and concerted action that involves a broad range of national and global stakeholders.

Our recommendations for accelerated action to eliminate pediatric HIV/AIDS are detailed on pages 17–18.

INTRODUCTION: What is this report?

"Children in Africa are living with this debilitating disease and DYING NEEDLESSLY—and this is both a TRAGEDY AND AN OUTRAGE. How can we stand back and watch the suffering of our children when we know that the world has the necessary means—medical, financial, intellectual—to END THE DESTRUCTION that is pediatric HIV and AIDS?"

—Graça Machel, Chair, CEPA Leadership Council

This report provides a snapshot of the status of pediatric HIV/AIDS globally and in six countries in sub-Saharan Africa: Kenya, Mozambique, Nigeria, Tanzania, Uganda, and Zambia. It focuses on selected advocacy goals that are being prioritized by the Campaign to End Pediatric HIV/AIDS, and that—when reviewed together—provide an important measure of progress to date and highlight ongoing challenges.

CEPA is a response to the unacceptable reality that, in developing countries, hundreds of thousands of infants continue to become infected with and die from HIV each year. And the majority of pregnant HIV-positive women still lack access to the services and commodities they need to protect their own health and that of their children.

CEPA is a three-year campaign that brings together the Global AIDS Alliance, UNICEF, Clinton Health Access Initiative, and national civil-society partners [Annex 1] in order to achieve a series of agreed-upon objectives [Annex 2]. It works to overcome policy and implementation bottlenecks to scaling up comprehensive prevention of parent-to-child transmission services, as recommended by the World Health Organization,[1] as well as pediatric HIV/AIDS diagnosis, treatment, and care.

CEPA aims to increase the coverage rate for PPTCT+ and pediatric treatment services from the current average of 45%[2] to the globally agreed-upon target of 80%.[3] It also seeks to ensure that services are high quality. These steps are critical to achieving key mandates set by the world's governments, including universal access to HIV prevention, treatment, care, and support by 2010[4] and Millennium Development Goals 4 (reduce child mortality), 5 (improve maternal health), and 6 (combat HIV/AIDS, malaria, and other diseases) by 2015.

THE NEED FOR ACCELERATED ACTION ON PEDIATRIC HIV/AIDS

- Without intervention, the risk of parent-to-child transmission of HIV is 20–45%. With intervention, it is reduced to 2–5%. [1]
- In 2008, less than half of all pregnant HIV-positive women received drugs for PPTCT. [2]
- That same year, 430,000 children were infected with HIV, about 90% through parent-to-child transmission and most of them in sub-Saharan Africa. [2]
- Without treatment, about half of those children will die before their second birthday. [3]
- Worldwide, of the over 4 million people on ARV treatment, just 275,700 are children. [2]
- In sub-Saharan Africa, only 35% of HIV-positive children who need ARV medications are receiving them. [2]

REFERENCES: [1] *PMTCT Strategic Vision 2010–2015,* WHO, February 2010; [2] *Children and AIDS: Fourth Stocktaking Report 2009,* UNICEF, November 2009; [3] *Scaling Up Early Infant Diagnosis and Linkages to Care and Treatment: Briefing Paper,* UNICEF, January 2009.

PROGRESS ON PPTCT+ AND ART FOR CHILDREN IN SIX CEPA COUNTRIES[5]

CEPA COUNTRY	PPTCT+			ART FOR CHILDREN		
	% of pregnant HIV-positive women receiving PPTCT+	Number of pregnant HIV-positive women receiving PPTCT+	*Additional* pregnant HIV-positive women who would receive PPTCT+ if target of 80% were achieved	% of children living with HIV receiving ART	Number of children living with HIV receiving ART	*Additional* children living with HIV who would receive ART if target of 80% were achieved
Kenya	72%	58,587	6,213	15%	28,370	118,872
Mozambique	53%	70,695	35,551	19%§§	13,510*	44,384§§
Nigeria	19%	45,578§	149,406§	26%§§	26,743	55,721§§
Tanzania	68%	58,883	9,971	10%	12,822^	102,576^
Uganda	52%	46,948§§§	25,852§§§	27%^	24,554§§§	71,446
Zambia	61%	47,176	14,796	65%§§	22,114	5,057
Total for six CEPA countries:			241,734	Total for six CEPA countries:		398,055

PRIORITY #1

Rapid adoption and implementation of new World Health Organization guidelines on antiretroviral therapy, PPTCT+ (Option B), and infant feeding by 2011

WHY IS THIS A PRIORITY?

Clear and agreed guidelines, based on evidence and good practice, are critical to ensuring effective action on pediatric HIV/AIDS. On November 30, 2009, WHO issued three sets of global guidelines: [6]

1. **Antiretroviral Therapy for HIV Infection in Adults and Adolescents,** which includes the recommendation that adults and adolescents should start taking antiretrovirals (ARVs) at an earlier stage.[7]
2. **Infant Feeding in the Context of HIV,** which includes the recommendation that HIV-positive mothers or their infants should take ARVs during breastfeeding to prevent HIV transmission.
3. **Use of Antiretroviral Drugs for Treating Pregnant Women and Preventing HIV Infection in Infants,** which includes a recommendation for prolonged use of ARVs to reduce the risk of parent-to-child transmission and provides two choices—Option A (maternal AZT)[8] and Option B (maternal triple ARV prophylaxis)—for HIV-positive women who do not need treatment themselves.[9]

These guidelines represent a significant step forward—clarifying and raising the standards of health care for HIV-positive women and their infants in developing countries. They also highlight critical decisions for countries, particularly in relation to the options for PPTCT+ services. Option A involves the use of first-line, older drugs such as nevirapine, which protect against transmission and are cheaper, but can cause severe side effects and induce resistance to ART. (Drug resistance can reduce future treatment options and potentially require patients to take more complex and expensive medications.)[10] As such, CEPA is advocating that **Option B is more efficacious for the health of women and their infants, and a better long-term choice from the perspective of national investment.**

WHAT IS BLOCKING PROGRESS?

- Slow processes for translating global guidelines into national policy and then national policy into practice.
- Concerns among donors and governments about the cost implications of Option B for PPTCT+ services, which vary from country to country.

WHAT IS THE STATUS? (see chart below)

WHAT ARE CEPA'S RECOMMENDATIONS?

1. **National governments** should rapidly adopt all three sets of new WHO guidelines within their national policies related to pediatric HIV/AIDS.
2. **National governments** should select Option B for their national policies on PPTCT+ services.

CEPA COUNTRY	ADOPTION OF NEW WHO GUIDELINES	SELECTION OF OPTION A OR B FOR PPTCT+
Kenya	New WHO guidelines adopted.[11]	Option A selected. The Technical Working Group met and revised the current PPTCT guidelines. Option B was previously agreed upon and actually adopted by all referral and district centers. The two national teaching referral hospitals were already using Option B and will continue to do so.[12]
Mozambique	New WHO guidelines adopted.[13]	Option A selected. Implementation has started in Maputo and will be rolled out nationwide.[14]
Nigeria	National treatment guidelines are currently under review.[15] A feasibility study is under way to assess the implications of adopting the WHO guidelines.[16]	Adopting a mix of Option A and B as suits the country context.[17]
Tanzania	New WHO guidelines not yet adopted. National AIDS Control Program, WHO, and CHAI are supporting the country to make an informed decision by doing a feasibility study on cost and program implications.[18]	A decision on Option A vs. Option B is expected to be finalized by the end of June 2010, pending completion of the feasibility study.[19]
Uganda	New WHO guidelines not yet adopted. National ART Committee is discussing their implications.[20]	Option A selected.[21]
Zambia	New WHO guidelines are being amended.[22]	Option A selected. Current guidelines under discussion.[23]

PRIORITY #2

Development and implementation of early infant diagnosis and treatment guidelines to increase testing of children within two months of birth by 2011

"HIV infection follows a more aggressive course among infants and children than among adults. WITHOUT ACCESS TO LIFESAVING DRUGS, including antiretroviral therapy and preventive interventions such as cotrimoxazole prophylaxis, ABOUT ONE-THIRD OF INFANTS WILL DIE BY AGE 1 YEAR, AND 50% BY AGE 2 YEARS."

—Early Infant Diagnosis Briefing Note 2009, Unite for Children, Unite Against AIDS, UNICEF

WHY IS THIS A PRIORITY?

If an infant is HIV-positive, **starting treatment early reduces their risk of death by 75%.**[24] So, it is vital to identify and help children who may be infected as early as possible, through accessible and high-quality early infant diagnosis and treatment (EID/T).[25]

In November 2009, WHO's new guidelines confirmed that all infants under one year of age who have been exposed to HIV should be tested and, wherever possible, **diagnosis should occur before six weeks of age.**[26] Also, all infants born to HIV-positive mothers or diagnosed with HIV should receive ART in their first year of life.[27]

In reality, many infants still do not receive early infant diagnosis and treatment and, where services exist, they are often not comprehensive and lag behind those of adults.

WHAT IS BLOCKING PROGRESS?

- Specific challenges related to HIV diagnosis and treatment for infants, such as the lack of appropriate ARV formulations, inadequate supply of ARVs, insufficient infrastructure, cost of equipment, and slow turnaround time for testing.[28]
- Low prioritization of EID/T by governments, in part due to the cost implications.
- Poor development and implementation of systems to collect data on EID/T, in particular the number of children tested before two months of age.

WHAT IS THE STATUS? (see chart below)

WHAT ARE CEPA'S RECOMMENDATIONS?

1. **National governments** should adopt WHO's guidelines within their national policies on early infant diagnosis and treatment.
2. **National governments** should implement and strengthen systems to track EID/T, in particular the number of infants being tested for HIV before two months of age.

CEPA COUNTRY	ADOPTION OF NEW WHO GUIDELINES ON EID/T	IMPLEMENTATION OF SYSTEM TO TRACK INFANTS BEING TESTED FOR HIV BEFORE TWO MONTHS
Kenya	New WHO guidelines adopted.[29]	Tracking system in place, but only records number of children tested before two years.[30]
Mozambique	New WHO guidelines adopted.[31]	Tracking system in place, but only records number of children tested before 18 months.[32]
Nigeria	New WHO guidelines adopted.[33]	Tracking system being established.[34] [Information not currently available to CEPA as to whether system will record number of children tested before two months].[35]
Tanzania	New WHO guidelines currently being adopted.[36]	Tracking system in place, but only records number of children tested before one year.[37] Reprogramming of $2.2 million in Global Fund grants will help ensure more efficient and timely transport of DBS test results.[38]
Uganda	New WHO guidelines adopted.[39]	Tracking system in place, but only records number of children tested between six weeks and 18 months.[40]
Zambia	New WHO guidelines adopted.[41]	Tracking system in place, but only tracks number of children tested before one year.[42]

PRIORITY #3

Effective policy and monitoring mechanisms in place to reduce point-of-care stock-outs of ART for adults and children, opportunistic infection drugs, and EID and family planning commodities by 2012

WHY IS THIS A PRIORITY?

Access to essential medicines, including those for HIV/AIDS, is a **human right and a cornerstone of effective primary health care.**[43] Strong policies and monitoring systems to ensure reliable, well-managed supplies of drugs, commodities, and equipment—from contraceptives to prophylaxis for opportunistic infections, such as cotrimoxazole for pneumonia—are critical to addressing pediatric HIV/AIDS. It is especially vital to ensure ongoing supplies of antiretroviral drugs, since interruptions increase the risk of resistance and can be life-threatening.

A number of global initiatives are supporting countries to address the affordability, procurement, and supply of relevant drugs and commodities. These include the AIDS Medicines and Diagnostics Service (AMDS),[44] UNITAID Patent Pool,[45] and Coordinated Procurement Planning (CPP) Program,[46] which streamlines mechanisms for drug supply across the Global Fund, UNAIDS, World Bank, PEPFAR, and WHO. However, **stock-outs, or situations in which drugs and commodities are not available at point of care, occur frequently.** This is often due to a range of factors, from inadequate budgeting to poor monitoring systems.

WHAT IS BLOCKING PROGRESS?

- Lack of global analysis about where and why stock-outs occur and what can be done to address them.
- Weak national systems for procurement and supply chain management of drugs and commodities, as well as poor systems to record the availability and distribution of medicines.
- Poor availability of second- and third-line pediatric ARVs, pediatric formulations, and other essential drugs.

WHAT IS THE STATUS? (see chart below)

WHAT ARE CEPA'S RECOMMENDATIONS?

1. **The Coordinated Procurement Planning Program** should develop a global tracking system to support countries to monitor and address stock-outs of HIV/AIDS-related drugs, commodities, and equipment.
2. **National governments** should implement effective supply chain management systems and engage with mechanisms such as the CPP Program, AMDS, and UNITAID Patent Pool in order to track and address stock-outs and ensure a reliable supply of drugs, commodities, and equipment for pediatric HIV/AIDS and family-centered care, including family planning.
3. **International donors** should prioritize affordable access to optimal drug regimens for all medically eligible individuals, including infants and children.

	DEVELOPMENT OF GLOBAL TRACKING SYSTEM FOR STOCK-OUTS BY COORDINATED PROCUREMENT PLANNING PROGRAM
GLOBAL	Global tracking system not developed. A study of partner funding streams is being implemented to identify gaps and issues relating to supply chain management and stock-outs, with follow-up planned to address country-specific issues.[47]
CEPA COUNTRY	**IMPLEMENTATION OF SUPPLY MANAGEMENT SYSTEM TO TRACK AND AVOID STOCK-OUTS**
Kenya	Weak supply management systems, with no central tracking of stock-outs. Interrupted supplies and drug stock-outs occur.[48] In 2009, SMS[49] Pill Check Week assessed over 150 health sites and found widespread stock-outs of essential medicines, including first-line ARVs and cotrimoxazole.[50]
Mozambique	Poorly functioning supply chain management and logistics systems, with no central tracking.[51] Stock-outs occur, causing unavailability of drugs and medications. Limited availability of cotrimoxazole exacerbated by supply chain problems.[52]
Nigeria	Weak procurement and supply management of essential commodities, with no tracking of stock-outs.[53]
Tanzania	Weak supply chain mechanism, with no tracking of stock-outs. Stock-outs for pediatric medications are common, with cotrimoxazole often not available.[54] U.S. government and PEPFAR are providing technical support to Medical Stores Department (MSD) to improve forecasting, stocking, and supply chain management.[55]
Uganda	Weak supply chain mechanism, with no tracking of stock-outs. Low availability of HIV drugs for infants and PPTCT+. Irregular supply of first-line ARVs.[56] In 2009, SMS Pill Check Week assessed 11 districts and found major stock-outs, especially of pediatric preparations.[57]
Zambia	Weak supply chain mechanism, with no tracking of stock-outs. Stock-outs at health facilities are common.[58] SMS Pill Check Week found widespread shortages of ARVs and cotrimoxazole.[59]

PRIORITY #4

Increased national budgets for PPTCT+ and pediatric treatment and services by 2012

WHY IS THIS A PRIORITY?

Adequate and well-spent funding is critical to ensuring the availability, quality, and sustainability of PPTCT+ and pediatric diagnosis, treatment, and care services, and to meeting the global target of 80% coverage. This is particularly true in high-impact countries with escalating needs.

To date, the **allocation of national resources to pediatric HIV/AIDS has often failed to keep pace with the need.** This has been exacerbated by national budget processes—both for health generally and for HIV/AIDS specifically—that make it difficult to identify precisely what resources are being allocated and where. However, national governments now have an unprecedented opportunity to benefit from global interest in supporting PPTCT+ and pediatric HIV diagnosis, treatment, and care, including interest among major donor countries.

WHAT IS BLOCKING PROGRESS?

- Lack of transparency and multisectoral involvement in the processes and decisions related to national budgets for overall health, for HIV/AIDS, and specifically, for pediatric HIV/AIDS.
- Decreasing or changing donor commitments threaten the sustainability of HIV/AIDS funding.

WHAT IS THE STATUS? (see chart below)

WHAT ARE CEPA'S RECOMMENDATIONS?

1. **National governments** should provide a clear budget for HIV/AIDS programming within their annual budgets for health, and a clear breakdown of allocations to PPTCT+ and pediatric HIV diagnosis, treatment, and care services within their annual budgets for HIV/AIDS.

CEPA COUNTRY	NATIONAL BUDGET FOR HIV/AIDS (U.S. DOLLARS)	ALLOCATIONS TO PPTCT+ AND PEDIATRIC DIAGNOSIS, TREATMENT, AND CARE IN NATIONAL HIV/AIDS BUDGET
Kenya	National AIDS Strategic Plan III has budget of $3.56 billion for 2009–2010 through 2012–2013. Allocated as $0.67 billion, $0.83 billion, $0.99 billion, and $1.05 billion per fiscal year.[60] Ministry of Medical Services and Ministry of Public Health and Sanitation allocated a total of $486,567,699 for 2009–2010.[61]	2010 health budget will have ARV provision budget line over $12,194,679.[62] KNASP indicates 57.9% of national HIV/AIDS budget will be allocated to treatment and care, with 38.3% for ART and 19.5% to prevention. PPTCT is 2.7% of total budget, increasing from $20 million in 2009–2010 to $97 million in 2012–2013.[63]
Mozambique	There is no dedicated budget line for HIV/AIDS, although the Global Fund has been given separate codes for their programs.[64]	[Information not currently available to CEPA.][65]
Nigeria	Budget for National HIV/AIDS Strategic Framework 2010–2015, with allocations for next five years. In 2008, approximately $394,963,881 spent on HIV/AIDS from domestic and international sources.[66]	[Information not currently available to CEPA.][67]
Tanzania	National budget for HIV/AIDS available.[68]	National budget for HIV/AIDS does not have designated budget line for PPTCT+ programs. [Information on budget for pediatric diagnosis, treatment, and care not currently available to CEPA.][69]
Uganda	Health Sector Budget Framework 2010–2011 has budget line for HIV/AIDS. Shows decline from previous financial year of approximately $7,555,555, largely due to reduced donor funding.[70]	National budget for HIV/AIDS lacks clear allocations for PPTCT+ or pediatric diagnosis, treatment, and care.[71]
Zambia	National budget for HIV/AIDS available.[72] In 2006, approximately $41,251,934 allocated to HIV/AIDS, with approximately $883,038 added for clinical care and $1,048,860 for ART.[73]	In 2007, budget line created for pediatric HIV/AIDS, with approximately $216,110 allocated for pediatric ART. In 2008, approximately $210,526 allocated under public health, and in 2009, $378,487 allocated, an increase of more than 60%.[74]

PRIORITY #5

Achieve the Abuja Declaration commitment by 2012

WHY IS THIS A PRIORITY?

In April 2001, the Heads of State of the Organization of African Unity signed the Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases, and pledged to "set a target of allocating at least 15% of our annual budget to the improvement of the health sector."

This 15% target is an important measure of a government's commitment to the health of its people, including its commitment to addressing pediatric HIV/AIDS and achieving the globally agreed-upon target of 80% coverage for PPTCT+ and pediatric treatment. Progress toward the Abuja Declaration also provides an important indicator of the extent to which a government is prioritizing health in comparison to other areas of expenditure.

To date, only six out of 54 countries in Africa have met their 15% commitment.[75]

WHAT IS BLOCKING PROGRESS?

- Low prioritization of health compared to other areas of national expenditure, due in part to pressures arising from the current global economic downturn.
- Poor transparency of processes and data for national budgets, which makes it difficult to assess allocations to health.
- Lack of active monitoring by civil society, due in part to limited capacity and engagement with budgetary processes.

WHAT IS THE STATUS? (see chart below)

WHAT ARE CEPA'S RECOMMENDATIONS?

1. **African national governments** should fulfill the Abuja Declaration commitment and allocate at least 15% of their annual national budgets to health.

CEPA COUNTRY	ALLOCATION OF NATIONAL EXPENDITURE TO HEALTH IN 2006 (AS COMPARED TO 2000)[76]
Kenya	9.7% (decrease from 11.6%)
Mozambique	12.5% (decrease from 13.9%)
Nigeria	3.5% (decrease from 4.2%)
Tanzania	13.7% (increase from 7.3%)
Uganda	8.9% (increase from 7.3%)
Zambia	16.4% (Abuja Declaration commitment achieved)

Note: This table uses WHO data that is consistent and comparable across countries. Additional, more recent data for individual countries indicate that Kenya spent 7% in 2009–2010,[77] a decrease from 2006; Tanzania spent 11% in 2007–2008,[78] a decrease from 2006; Uganda spent 10.2% in 2009–2010,[79] an increase from 2006; and Zambia spent 11.9% in 2009,[80] a decrease from 2006, and is no longer meeting the Abuja Declaration commitment.

PRIORITY #6

Full funding for the Global Fund to Fight AIDS, TB and Malaria and PEPFAR by 2012

Through Global Fund resources, 930,000 HIV-POSITIVE PREGNANT WOMEN have received ARVs for PPTCT, and 2.8 MILLION ADULTS AND CHILDREN are receiving ARV therapy—AN IMPRESSIVE RECORD OF SUCCESS.

WHY IS THIS A PRIORITY?

The Global Fund to Fight AIDS, TB and Malaria is a multilateral funding mechanism that has committed $19.3 billion to large-scale, performance-based, country-driven programs on AIDS, tuberculosis, and malaria in 144 countries since 2002.[81] As such, it provides a critical vehicle for accelerating progress toward 80% coverage for PPTCT+ and pediatric treatment services, as well as scaling up efforts to achieve the health-related MDGs 4, 5, and 6. In addition, the Global Fund's current reprogramming initiative to transition PPTCT services in 27 of the 34 countries receiving grants from single-dose nevirapine to dual or triple ARV therapy means that future resources will have an even greater impact.

The Global Fund is in the midst of its 2011–2013 replenishment cycle. To maintain its current trajectory of growth and keep its promise to fund all technically sound proposals, the Fund will need at least $20 billion over this three-year period. Together, Canada, France, Germany, Italy, Japan, the United Kingdom, the U.S., and the European Community account for 77% of the world's Gross National Income (GNI), and each has contributed to the Global Fund in the past. However, the current replenishment cycle is critically important given the 2015 deadline for achieving the MDGs and the growing momentum to end pediatric HIV/AIDS.

WHAT IS BLOCKING PROGRESS?

- Changing political priorities and budget pressures on donor governments, due in part to the global economic downturn.
- Competition among health issues continues to silo responses that can only succeed if linked at the donor and policy levels.
- Poor understanding among some donors of the value added of the Global Fund's model.

WHAT IS THE STATUS? (see chart below)

WHAT ARE CEPA'S RECOMMENDATIONS?

1. **Donor governments** should recognize the Global Fund's critical role in resourcing national PPTCT+ and pediatric HIV/AIDS programs, and contributing to MDGs 4, 5, and 6 through integrated services such as family-centered care, and should position the Global Fund as a primary multilateral mechanism for country-led responses to all three health-related MDGs.
2. **Donor governments** should make bold multi-year pledges to ensure that the Global Fund secures $20 million in funding during the 2011–2013 replenishment process.
3. **The U.S. government** should demonstrate its commitment to ending pediatric HIV/AIDS by providing full funding for PEPFAR, family planning, and the Global Health Initiative, including ensuring the resources needed to achieve PEPFAR's target of training and retaining 140,000 new health care workers.

	PLEDGES TO GLOBAL FUND DURING SECOND REPLENISHMENT CYCLE (2008–2010)	
DONORS	TOTAL 2008–2010 PLEDGES (U.S. DOLLARS)[82]	PERCENTAGE OF GNI[83]
Canada	$419,702,570	0.029
France	$1,229,326,538	0.046
Germany	$849,861,313	0.024
Italy	$531,033,552	0.025
Japan	$625,141,052	0.013
United Kingdom	$508,532,828	0.018
United States	$2,890,304,000	0.020
European Community	$417,808,524	0.003
Total	$7,471,710,377	0.017

PRIORITY #7

Global Fund programming opportunities include sufficient funding for all four prongs of PPTCT+, coverage targets, and pediatric treatment in CEPA countries by 2012

WHY IS THIS A PRIORITY?

In May 2009, the Global Fund's board of directors adopted Decision Point #34, which called for a review of the Fund's portfolio to identify countries with a high burden of pediatric HIV/AIDS and low coverage for PPTCT+ and pediatric treatment, and accelerated implementation of WHO guidelines recommending highly active ART as best practice for PPTCT+ services.[84] The decision point also called for social mobilization to increase the uptake of services.

In response, the Global Fund has now launched a reprogramming initiative to transition PPTCT services in 27 of the 34 countries receiving grants from single-dose nevirapine to dual or triple ARV therapy. This initiative has begun in 10 countries, including all six of the CEPA initiating countries, and represents a critical opportunity to accelerate progress toward the global target of 80% coverage for PPTCT+ and pediatric treatment. However, there is concern that the Global Fund's initiative has primarily focused on the third prong of PPTCT services, i.e., preventing HIV transmission from pregnant, HIV-positive women to their infants, rather than **promoting a comprehensive approach to PPTCT+ that includes prevention of unintended pregnancies and family planning, as well as ongoing treatment and care for women.** CEPA is also concerned that, in some contexts, the reprogramming process has lacked transparency and failed to engage multisectoral stakeholders sufficiently, particularly civil society.

WHAT IS BLOCKING PROGRESS?

- Inadequate understanding of the importance of a comprehensive approach to PPTCT, including among the Global Fund's Secretariat and Country Coordinating Mechanisms (CCMs).
- Concerns among national governments about the cost of implementing comprehensive PPTCT+ programming.
- Limited outreach and engagement of multisectoral stakeholders, including civil society, that have an important role to play in pediatric HIV/AIDS programming.

WHAT IS THE STATUS?

The chart on the following page outlines the status of the Global Fund's reprogramming initiative for PPTCT+ services in the six CEPA countries as of April 27, 2010.[85]

WHAT ARE CEPA'S RECOMMENDATIONS?

1. **The Global Fund** should fully implement Decision Point #34 and support countries in reprogramming their Global Fund grants to advance comprehensive programming that includes all four prongs of PPTCT+ services.
2. **The Global Fund** should work with Country Coordinating Mechanisms to ensure that the PPTCT reprogramming progress is transparent and involves all relevant stakeholders, including civil society.
3. **The Global Fund's Country Coordinating Mechanisms** should seek every opportunity to participate in reprogramming efforts, and should propose only comprehensive PPTCT services moving forward.

CEPA COUNTRY (Global Fund round and type of grant)	Is PPTCT+ a specific service delivery area within the grant?	STATUS OF REPROGRAMMING GLOBAL FUND GRANTS		
		Partners consultation led by CCM (Note 1)	Expected or actual grant signing	Comments
Mozambique (Round 2 HIV)	Yes		September 2010	
Nigeria (Round 8 Health Systems Strengthening)	No	January–March 2010	Signed	Reprogramming $3 million for PPTCT+ services. CCM request submitted and under review by Global Fund Secretariat.
Nigeria (Round 9 HIV)	Yes	January–March 2010	June 2010	Consolidation with Round 5 HIV grant. Operational plan to be finalized urgently.
Kenya	—	—	—	No active reprogramming opportunity.
Tanzania (Round 8 HIV)	Yes		October 2009	Reprogramming of $2.2 million for PPTCT+ services. Workplan and budget were due May 2010.
Tanzania (Round 9 Health Systems Strengthening)	No		August 2010	Linked to PPTCT service delivery.
Tanzania (Rolling Continuation Channel 1)	No	May–August 2010		Technical Review Panel did not recommend this proposal for funding, but encouraged the country to revise and resubmit as part of the final Rolling Continuation Channel wave. It is unclear whether the proposal has been resubmitted.
Uganda	—	—	—	No active reprogramming opportunity.
Zambia (Round 8 U.N. Development Programme)	Yes		September 2010	
Zambia (Round 8 Zambia National AIDS Council)	Yes	September–October 2010	October 2009	Submitted PPTCT plan.

Note 1: The CCM-led consultation with partners, e.g., WHO, UNAIDS, UNICEF, is aimed at developing a strategic focus and workplan for the country.

PRIORITY #8

Effective policies and guidelines to expand and improve human resources capacity to support scale-up of PPTCT+ and pediatric treatment services by 2012

WHY IS THIS A PRIORITY?

While funding and commodities are critical, it will not be possible to achieve the global target of 80% coverage for PPTCT+ and pediatric treatment services without sufficient human resources. At present, the inadequate number, skills, and retention of health care workers is a significant and persistent obstacle to mounting an effective HIV/AIDS response. This human resources problem can be particularly acute for pediatric HIV/AIDS services, which sometimes require specialized skills.

Human resources shortages are fueled by a variety of factors, including the loss of staff due to HIV-related illness and death, inadequate training infrastructure, and "brain drain," or the emigration of qualified health professionals to other countries. The shortages are often felt where support is needed most. Indeed, while sub-Saharan Africa has 11% of the world's population and 24% of the burden of disease, it has a mere 3% of the world's health workers.[86]

Globally, a number of initiatives are tracking and seeking to address human resources capacity. These focus on strategies such as target setting for task shifting[87] and capacity building. For example, **PEPFAR has set a target of training and retaining over 140,000 new health care workers by 2013.**[88]

WHAT IS BLOCKING PROGRESS?

- Lack of official government strategies and targets for task shifting, including in areas such as pediatric HIV/AIDS.
- Poor national tracking and data on the number of existing health workers, their capacity, and needs.
- The perception of pediatric HIV/AIDS as a specialized area that is not suitable for strategies such as task shifting.

WHAT IS THE STATUS? (see chart below)

WHAT ARE CEPA'S RECOMMENDATIONS?

1. **International donors, policymakers, and national governments** should collaborate to achieve the PEPFAR target of training and retaining 140,000 new health care workers by 2013.

CEPA COUNTRY	PROGRESS TO ACHIEVE THE PEPFAR TARGET OF TRAINING 140,000 NEW HEALTH WORKERS BY 2013 AND TO ADDRESS THE OVERALL HUMAN RESOURCES CRISIS
Kenya	PEPFAR targets within the Kenya National AIDS Strategic Plan III include involving at least 75,000 more community health care workers in HIV and deploying 30 new nurses and five new community health extension workers per district to support the Community Health Strategy.[89]
Mozambique	The PEPFAR Country Operational Plan for 2009 commits to training approximately 5,000 to 6,000 community health workers.[90]
Nigeria	[Information not currently available to CEPA.]
Tanzania	The Tanzania Health Sector Strategic Plan III 2009–2013 cites 35,202 professional health workers available and 90,722 needed.[91] UNGASS data indicates that by December 2009 the PMTCT Unit had trained 234 trainers and 8,003 health care workers from 3,626 PMTCT sites.[92]
Uganda	[Information not currently available to CEPA.]
Zambia	The National Health Strategic Plan 2006–2010 includes annual targets of (1) training 100 medical doctors, 500 nurses, and 250 midwives; and (2) recruiting 100 doctors, 300 nurses, and 100 clinical officers through a retainer package.[93]

PRIORITY #9

Effective policy and monitoring mechanisms to reduce stigma and discrimination to support scale-up of PPTCT+ and pediatric treatment services by 2012

WHY IS THIS A PRIORITY?

Stigma and discrimination—related both to HIV and to social status or behavior such as sex work or drug use—remains pervasive in many countries. In addition to its significant impact on individuals, families, and communities, stigma and discrimination is a powerful barrier to scaling up and increasing access to PPTCT+ and pediatric HIV diagnosis, treatment, and care, and achieving the 80% coverage target.

While felt most acutely at the local level, including within health care settings, stigma and discrimination is fueled by a variety of factors, from punitive legislation to cultural norms. Thus, **addressing stigma and discrimination requires strong national policies and monitoring mechanisms,** which should reflect the seriousness of the problem and put in place systems to both prevent incidents from occurring and respond to violations. A number of global initiatives—such as the Stigma Index[94] and monitoring indicators developed by PEPFAR and the Global Fund—provide tools to track stigma and discrimination. However, in many cases, these initiatives have yet to be rolled out systematically. In addition, existing efforts should be expanded, for example, to go beyond stigma against people living with HIV/AIDS and address broader social marginalization. More attention also needs to be focused on how stigma and discrimination affects access to PPTCT+ and pediatric HIV/AIDS services.

WHAT IS BLOCKING PROGRESS?

- National legislation and policies that encourage, rather than reduce, stigma and discrimination.
- Lack of programs and meaningful indicators to assess and address stigma and discrimination.
- Poor understanding and lack of information on how stigma and discrimination reduces access to pediatric HIV/AIDS services.
- Misinformation about pediatric HIV/AIDS that can fuel stigma among health care workers.

WHAT IS THE STATUS? (see chart below)

WHAT ARE CEPA'S RECOMMENDATIONS?

1. **PEPFAR** should scale up its programming and expertise on stigma and discrimination, including incorporating indicators on stigma and discrimination in its guidance for Country Operational Plans and Partnership Frameworks, and establishing a technical working group on stigma and discrimination.
2. **The Global Fund** should encourage proposals that address stigma and discrimination, including by developing a factsheet on the issue, incorporating stigma and discrimination in its proposal guidelines and forms, and leveraging Decision Point #34 to address stigma as part of social mobilization efforts to expand access to pediatric HIV/AIDS services.
3. **National governments** should adopt and implement the Stigma Index and eliminate discriminatory legal frameworks.

	PEPFAR INDICATORS AND EXPERTISE ON STIGMA AND DISCRIMINATION	GLOBAL FUND TECHNICAL GUIDANCE ON STIGMA AND DISCRIMINATION
GLOBAL	Stigma and discrimination indicators to be considered by the Monitoring and Evaluation Reference Group by end of September 2010.[95] No technical working group on stigma and discrimination.[96]	No factsheet on stigma and discrimination. Guidelines for proposals include but do not fully integrate stigma and discrimination. Proposal form for countries does not include stigma and discrimination.[97]
CEPA COUNTRY	**IMPLEMENTATION OF STIGMA INDEX**	
Kenya	Stigma Index being implemented.[98]	
Mozambique	[Information not currently available to CEPA.][99]	
Nigeria	Stigma Index being implemented.[100]	
Tanzania	Stigma Index being implemented in Dar es Salaam region, with findings to be shared in August 2010. UNAIDS has agreed to support implementation in four additional regions in order to better document stigma and discrimination nationwide.[101]	
Uganda	Stigma Index not being implemented.[102]	
Zambia	Stigma Index being implemented.[103]	

CONCLUSIONS: Where do we stand?

This status report demonstrates the following:

- **An end to pediatric HIV/AIDS is possible.** Effective treatments and technologies exist; there are commitments and guidelines in place at the country, regional, and global levels; and the Campaign to End Pediatric HIV/AIDS and other global and national initiatives have galvanized new momentum.

- **Progress is being made.** Globally, and in CEPA's six initiating countries, both the scale and quality of PPTCT+ and pediatric HIV/AIDS diagnosis, treatment, and care are increasing. For example, five of the CEPA countries have already adopted WHO's guidelines on early infant diagnosis and treatment, and all of them are reviewing and expanding coverage for PPTCT+ services.

WHY IS THE 80% TARGET IMPORTANT? In the six CEPA countries alone, achieving the 80% coverage target would mean that OVER 240,000 ADDITIONAL WOMEN would receive PPTCT+ services, and NEARLY 400,000 ADDITIONAL CHILDREN would receive antiretroviral therapy.

- **Much remains to be done.** Despite progress, critical areas of pediatric HIV/AIDS are still being neglected, and change is far too slow. As of 2010, the target date agreed to by the United Nations, none of the CEPA countries has achieved 80% coverage for PPTCT+ and pediatric treatment, and rates are as low as 19% and 10%, respectively, in some countries. As a result, hundreds of thousands of infants continue to be infected with HIV, and many die at an early age.

- **Major bottlenecks persist.** Both globally and, in particular, nationally, a range of policy and implementation obstacles continue to prevent progress on pediatric HIV/AIDS. For example, the lack of transparent budget allocations is a major obstacle to policy change, while the acute shortage of trained health care personnel is a critical barrier to progress at the implementation level. Persistent and systemic bottlenecks must be overcome in order to accelerate progress and meet agreed-upon targets.

- **A comprehensive approach is critical.** Expanded access to medicines, commodities, and equipment is essential to eliminating pediatric HIV/AIDS. But parallel efforts are needed to ensure strong health systems and address the socio-cultural issues that affect women and children living with HIV and limit their access to essential services, including gender inequality, gender-based violence, and stigma and discrimination.

- **Accelerated and concerted action is needed.** There are clear, agreed-upon goals: to eliminate pediatric HIV/AIDS; to ensure universal access to HIV/AIDS prevention, treatment, and care; and to achieve Millennium Development Goals 4, 5, and 6. At present, however, inadequate donor commitments are starving national responses of critical resources; weak government policies are restricting the quality of community-level services; and poor systems are failing to deliver lifesaving medicines and health commodities. To address these challenges and accelerate change, a broad range of stakeholders must work together more closely and more strategically.

RECOMMENDATIONS: Who needs to do what?

In order to accelerate action to eliminate pediatric HIV/AIDS by 2015, the CAMPAIGN TO END PEDIATRIC HIV/AIDS MAKES THE FOLLOWING RECOMMENDATIONS:

PRIORITY #1: Rapid adoption and implementation of new World Health Organization guidelines on antiretroviral therapy, PPTCT+ (Option B), and infant feeding by 2011

1. **National governments** should rapidly adopt all three sets of new WHO guidelines within their national policies related to pediatric HIV/AIDS.
2. **National governments** should select Option B for their national policies on PPTCT+ services.

PRIORITY #2: Development and implementation of early infant diagnosis and treatment guidelines to increase testing of children within two months of birth by 2011

3. **National governments** should adopt WHO's guidelines within their national policies on early infant diagnosis and treatment.
4. **National governments** should implement and strengthen systems to track EID/T, in particular the number of infants being tested for HIV before two months of age.

PRIORITY #3: Effective policy and monitoring mechanisms in place to reduce point-of-care stock-outs of ART for adults and children, opportunistic infection drugs, and EID and family planning commodities by 2012

5. **The Coordinated Procurement Planning Program** should develop a global tracking system to support countries to monitor and address stock-outs of HIV/AIDS-related drugs, commodities, and equipment.
6. **National governments** should implement effective supply chain management systems and track and address stock-outs to ensure the reliable supply of drugs, commodities, and equipment for pediatric HIV/AIDS and family-centered care, including family planning.
7. **International donors** should prioritize affordable access to optimal drug regimens for all medically eligible individuals, including infants and children.

PRIORITY #4: Increased national budgets for PPTCT+ and pediatric treatment and services by 2012

8. **National governments** should provide a clear budget for HIV/AIDS programming within their annual budgets for health, and a clear breakdown of allocations to PPTCT+ and pediatric HIV diagnosis, treatment, and care services within their annual budgets for HIV/AIDS.

PRIORITY #5: Achieve the Abuja Declaration commitment by 2012

9. **African national governments** should fulfill the Abuja Declaration commitment and allocate at least 15% of their annual national budgets to health.

PRIORITY #6: Full funding for the Global Fund to Fight AIDS, TB and Malaria and PEPFAR by 2012

10. **Donor governments** should recognize the Global Fund's critical role in resourcing national PPTCT+ and pediatric HIV/AIDS programs, and contributing to MDGs 4, 5, and 6 through integrated services such as family-centered care, and should position the Global Fund as a primary multilateral mechanism for country-led responses to all three health-related MDGs.
11. **Donor governments** should make bold multi-year pledges to ensure that the Global Fund secures $20 million in funding during the 2011–2013 replenishment process.

12. **The U.S. government** should demonstrate its commitment to ending pediatric HIV/AIDS by providing full funding for PEPFAR, family planning, and the Global Health Initiative, including ensuring the resources needed to achieve PEPFAR's target of training and retaining 140,000 new health care workers.

PRIORITY #7: Global Fund programming opportunities include sufficient funding for all four prongs of PPTCT+, coverage targets, and pediatric treatment in CEPA countries by 2012

13. **The Global Fund** should fully implement Decision Point #34 and support countries in reprogramming their Global Fund grants to advance comprehensive programming that includes all four prongs of PPTCT+ services.

14. **The Global Fund** should work with Country Coordinating Mechanisms to ensure that the PPTCT reprogramming progress is transparent and involves all relevant stakeholders, including civil society.

15. **The Global Fund's Country Coordinating Mechanisms** should seek every opportunity to participate in reprogramming efforts, and should propose only comprehensive PPTCT services moving forward.

PRIORITY #8: Effective policies and guidelines to expand and improve human resources capacity to support scale-up of PPTCT+ and pediatric treatment services by 2012

16. **International donors, policymakers, and national governments** should collaborate to achieve the PEPFAR target of training and retaining 140,000 new health care workers by 2013.

PRIORITY #9: Effective policy and monitoring mechanisms to reduce stigma and discrimination to support scale-up of PPTCT+ and pediatric treatment services by 2012

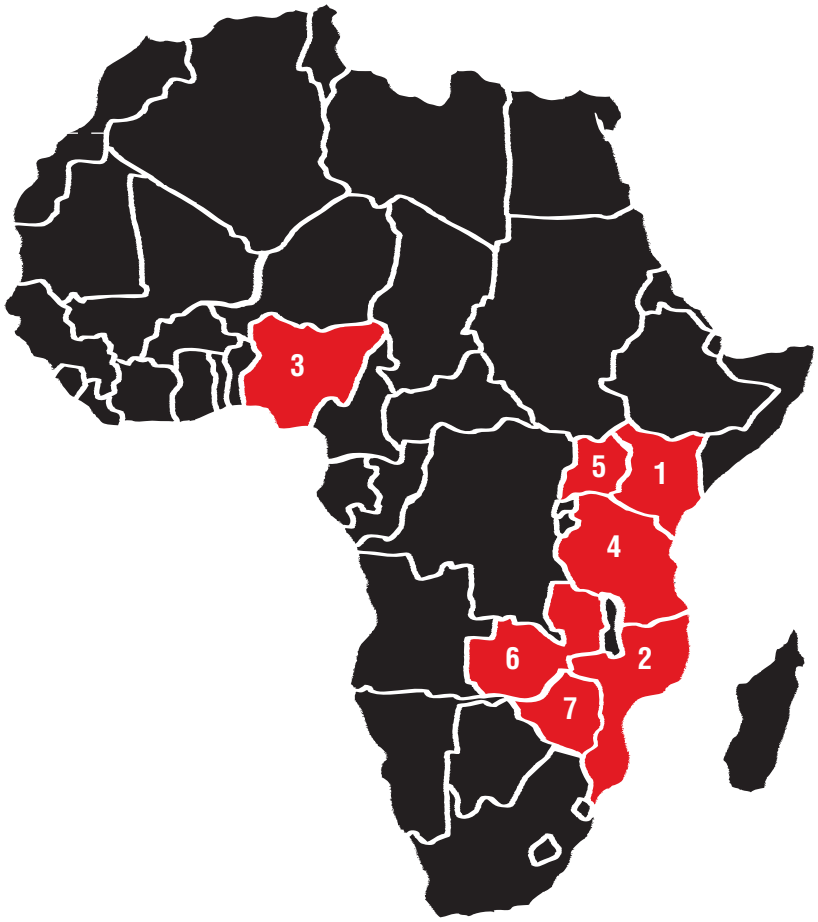
17. **PEPFAR** should scale up its programming and expertise on stigma and discrimination, including incorporating indicators on stigma and discrimination in its guidance for Country Operational Plans and Partnership Frameworks, and establishing a technical working group on stigma and discrimination.

18. **The Global Fund** should encourage proposals that address stigma and discrimination, including by developing a factsheet on the issue, incorporating stigma and discrimination in its proposal guidelines and forms, and leveraging Decision Point #34 to address stigma as part of social mobilization efforts to expand access to pediatric HIV/AIDS services.

19. **National governments** should adopt and implement the Stigma Index and eliminate discriminatory legal frameworks.

ANNEX 1: CEPA Countries and Partners

1. KENYA
CEPA country coordinating partner: Kenya Treatment Access Movement (KETAM), http://ketam.org
CEPA local-to-global partner: Health Global Access Project (Health GAP), USA and Kenya, http://www.healthgap.org
Population:[104] 39,002,772
Life expectancy:[105] 54
Adult HIV prevalence:[106] 7.2%
2. MOZAMBIQUE
CEPA country coordinating partner: Mozambique Treatment Access Movement (MATRAM)
Population: 21,669,278
Life expectancy: 48
Adult HIV prevalence: 15%
3. NIGERIA
CEPA country coordinating partner: Positive Action for Treatment Access (PATA), http://www.pata-nigeria.com
Population: 149,229,090
Life expectancy: 49
Adult HIV prevalence: 4.6%
4. TANZANIA
CEPA country coordinating partner: Human Development Trust (HDT), http://humandevelopmenttrust.org/hdt
Population: 41,048,532
Life expectancy: 52
Adult HIV prevalence: 6%
5. UGANDA
CEPA country coordinating partner: Coalition for Health Promotion and Social Development (HEPS), http://www.heps.or.ug
CEPA Africa regional coordinating partner: African Network for the Care of Children Affected by HIV/AIDS (ANECCA), http://www.anecca.org
Population: 32,369,558
Life expectancy: 48
Adult HIV prevalence: 6.4%



6. ZAMBIA
CEPA country coordinating partner: Treatment Advocacy and Literacy Campaign (TALC), http://www.talczambia.org
Population: 11,862,740
Life expectancy: 46
Adult HIV prevalence: 14.3%
7. ZIMBABWE
CEPA Africa regional coordinating partner: Pan African AIDS Treatment Access Movement (PATAM)
GLOBAL
CEPA global implementing partner: Global AIDS Alliance, USA, http://www.globalaidsalliance.org
CEPA local-to-global partner: Health Global Access Project (Health GAP), USA and Kenya, http://www.healthgap.org

ANNEX 2: CEPA Objectives and Priorities

OBJECTIVE #1: Family-centered care and nutrition

- **Priority 1.1:** Rapid adoption and implementation of new World Health Organization guidelines on antiretroviral therapy, PPTCT+ (Option B), and infant feeding by 2011.
- **Priority 1.2:** Development, adoption, and implementation of family-centered care and nutrition guidelines at country and global level by 2012.

OBJECTIVE #2: Early infant diagnosis and treatment

- **Priority 2.1**: Development and implementation of early infant diagnosis and treatment guidelines to increase testing of children within two months of birth by 2011.
- **Priority 2.2:** Effective policy and monitoring mechanisms in place to improve efficiency of polymerase chain reaction testing results in CEPA countries by 2012.

OBJECTIVE #3: Access to appropriate medicines and commodities

- **Priority 3.1:** Effective policy and monitoring mechanisms in place to reduce point-of-care stock-outs of ART for adults and children, opportunistic infection drugs, and EID and family planning commodities by 2012.
- **Priority 3.2:** Accelerated national registration, procurement, and distribution of pediatric first-line, fixed dose combination medicines by 2012.
- **Priority 3.3:** Increased number of pharmaceutical companies that produce ARTs for adults and children in UNITAID Patent Pool by 2011.

OBJECTIVE #4: Full funding to eliminate pediatric HIV/AIDS

- **Priority 4.1:** Increased national budgets for PPTCT+ and pediatric treatment and services by 2012.
- **Priority 4.2:** Achieve greater monitoring and accountability of CEPA-related funding by 2012.
- **Priority 4.3:** Achieve the Abuja Declaration commitment by 2012.
- **Priority 4.4:** Full funding for the Global Fund to Fight AIDS, TB and Malaria (Replenishment Cycle 2011–2013) and PEPFAR by 2012.

OBJECTIVE #5: Programming to achieve CEPA impact

- **Priority 5.1:** Political commitments and national plans and frameworks adopt CEPA goals and priorities and achieve those goals by 2012.
- **Priority 5.2:** Global Fund programming opportunities include sufficient funding for all four prongs of PPTCT+, coverage targets, and pediatric treatment in CEPA countries by 2012.
- **Priority 5.3:** GHI and PEPFAR programming opportunities include sufficient funding for all four prongs of PPTCT+, coverage targets, and pediatric treatment in CEPA countries by 2012.

OBJECTIVE #6: Overcome human resources crisis

- **Priority 6.1:** Effective policies and guidelines to expand and improve human resources capacity to support scale-up of PPTCT+ and pediatric treatment services by 2012.

OBJECTIVE #7: Overcome stigma and discrimination

- **Priority 7.1:** Effective policy and monitoring mechanisms to reduce stigma and discrimination to support scale-up of PPTCT+ and pediatric treatment services by 2012.

REFERENCES

1. PMTCT Strategic Vision 2010–2015, WHO, February 2010. The World Health Organization defines four prongs of comprehensive prevention of parent-to-child transmission services. Prong #1 is primary prevention of HIV infection among women of childbearing age; Prong #2 is prevention of unintended pregnancies among women living with HIV; Prong #3 is prevention of HIV transmission from a woman living with HIV to her infant; and Prong #4 is provision of appropriate treatment, care, and support to mothers living with HIV and their children and families.
2. Children and AIDS: Fourth Stocktaking Report 2009, UNICEF, November 2009.
3. Declaration of Commitment on HIV/AIDS, U.N. General Assembly Special Session on HIV/AIDS (UNGASS), June 2001.
4. Political Declaration on HIV/AIDS, U.N. General Assembly, 2006.
5. Unless otherwise stated, all data from national UNGASS Reports for 2010, http://www.unaids.org/en/KnowledgeCentre/HIVData/CountryProgress/2010CountryProgressAllCountries.asp, accessed May 19, 2010. Notes: §from estimates for 2010; §§calculated using estimates of children who have been identified as requiring ART because actual prevalence data not available; *from 2010 national data; §§§from 2009 national data; ^from 2008 national data.
6. Antiretroviral Therapy for HIV Infection in Adults and Adolescents, WHO, November 2009; Use of Antiretroviral Drugs for Treating Pregnant Women and Preventing HIV Infection in Infants, WHO, 2009; Infant feeding in the Context of HIV, WHO, 2009.
7. When they have a CD4 count of less than 350 cells/mm3.
8. AZT is azidothymidine, also called zidovudine, and is a medication used to delay the onset of AIDS in HIV-positive individuals.
9. Option A consists of antepartum daily AZT; single-dose nevirapine at onset of labor; AZT + 3TC during labor and delivery; and AZT + 3TC for seven days postpartum. Option B consists of triple ARV drugs starting from as early as 14 weeks of gestation until one week after all exposure to breast milk has ended, with recommended regimens including AZT + 3TC + LPV/r; AZT + 3TC + ABC; AZT + 3TC + EFV; and TDF + 3TC (or FTC) + EFV. Use of Antiretroviral Drugs for Treating Pregnant Women and Preventing HIV Infection in Infants, WHO, 2009. Notes: Option A can mean a single dose to mother and child at birth. AZT is zidovudine (sometimes also called ZDV); 3TC is lamivudine; sd-NVP is single-dose nevirapine; LPV/r is lipinovir; ABC is abacavir; EFV is efavirenz; and FTC is emtricitabine.
10. Hepatotoxicity Associated with Nevirapine Use, Journal of Acquired Immune Deficiency Syndromes, Baylor, M.S., Johann-Liang, R., 2004; Drug-Induced Liver Injury Associated with the Use of Non-Nucleoside Reverse-Transcriptase Inhibitors, Clinical Infectious Diseases, Dieterich, D.T., Robinson, P.A., Love, J., Stern, J.O., 2004; Appropriate Use of Nevirapine for Long-Term Therapy, Journal of Infectious Diseases, 38(Supplement 2):S80-9, Leith, J., Piliero, P., Storfer, S., et. al., 2005; Maternal Toxicity with Continuous Nevirapine in Pregnancy: Results from PACTG 1022, Journal of Acquired Immune Deficiency Syndromes, 192(3):545-6; Hitti, J., Frenkel, L.M., Stek, A.M., et. al., 2004; Treatment Interruption After Pregnancy: Effects on Disease Progression and Laboratory Findings, Infectious Disease in Obstetrics and Gynecology, 36(3):772-6, Watts, D.H., Lu, M., Thompson, B., et. al., 2009; and Emergence of Antiretroviral Resistance in HIV-Positive Women Receiving Combination Antiretroviral Therapy in Pregnancy, AIDS, 19(1):63-7, Lyons, F.E., Coughlan. S., Byrne, C.M., et. al., 2005.
11. Kenyan National HIV/AIDS Strategic Plan III, 2009, http://www.aidskenya.org/Programmes/Prevention/PMTCT, accessed May 5, 2010; and http://www.pepfar.gov/frameworks/kenyapf/137933.htm, accessed May 19, 2010.
12. Correspondence with CEPA Kenya team, June 7, 2010.
13. Correspondence with CEPA Mozambique team, February and May 2010.
14. Guidelines on Treatment of Adults and Adolescents and Pregnant Women, Mozambique, 2009.
15. CEPA Nigeria National Advocacy Action Plan, October 2009; and conversation with Dr. Rolake Odetoyinbo of PATA, June 2, 2010.
16. http://allafrica.com/stories/201005270556.html, accessed May 27, 2010.
17. Conversation with Dr. Rolake Odetoyinbo of PATA, June 2, 2010.
18. Correspondence with CEPA Tanzania team, May 2010.
19. Ibid.
20. Correspondence with CEPA Uganda team, May 2010.
21. Ibid.
22. Correspondence with CEPA Zambia team, May 2010.
23. Correspondence with CEPA Zambia team, May 18, 2010; and CHAI Laboratory Updates, Clinton Foundation, January 2010, received in missive from Kate Schroder of CHAI, April 27, 2010.
24. http://www.who.int/hiv/pub/tuapr_2009_en.pdf, last accessed April 26, 2010.
25. http://www.who.int/hiv/pub/mtct/rapid_advice_mtct.pdf, last accessed April 23, 2010.
26. Rapid Advice Document on MTCT, November 2009, http://www.who.int/hiv/pub/arv/advice/en/index.html.
27. http://www.who.int/hiv/pub/paediatric/WHO_Paediatric_ART_guideline_rev_mreport_2008.pdf, last accessed April 23, 2010.
28. As infants cannot be diagnosed using normal antibody tests (because they carry antibodies from their mother until they are roughly 18 months old), they have to be tested using DNA and RNA detection methods, which look for viral load rather than an immune response. This requires Polymerase Chain Reaction (PCR) testing. Although it is easy to take blood samples from a finger or toe of an infant, specialized PCR equipment has to be available to test for viral load. While all CEPA countries have PCR machines, most have only a few. And even where machines and staff are available, the turnaround time from taking the test to delivering the results is often too slow, which limits follow-up and retention of clients.

29. Correspondence with CEPA Kenya team, May 2010; and Guidelines for HIV Testing in Clinical Settings, 2nd ed., Nairobi: Ministry of Health, 2006.
30. Optimizing Paediatric HIV Care in Kenya: Challenges in Early Infant Diagnosis, Bulletin of the World Health Organization 2008; 86:155–160.
31. Correspondence with CEPA Mozambique team, May 2010.
32. UNGASS Country Progress Report—Mozambique: 2008–2009, Conselho Nacional de Combate ao HIV/SIDA, March 2010.
33. Correspondence with CEPA Nigeria team, 2009.
34. UNGASS Country Progress Report—Nigeria: January 2008–December 2009, National Agency for the Control of AIDS, Nigeria, March 2010.
35. Nigerian National Response Information Management System Operational Plan 2007–2010, NACA, 2007, http://www.naca.gov.ng/, last accessed June 2, 2010.
36. Correspondence with CEPA Tanzania team, June 2010.
37. UNGASS Country Progress Report—Tanzania: January 2008–December 2009, March 2010.
38. Correspondence with CEPA Tanzania team, June 2010.
39. Correspondence with CEPA Uganda team, May 2010.
40. UNGASS Country Progress Report—Uganda: January 2008–December 2009, March 2010.
41. Correspondence with CEPA Zambia team, June 2010.
42. Zambia Country Report: Monitoring the Declaration of Commitment on HIV and AIDS and the Universal Access Biennial Report: January 2008–December 2009, Ministry of Health and National AIDS Council, March 31, 2010.
43. Stop Stock-Outs Campaign, http://stopstockouts.org/, accessed May 21, 2010.
44. A network of technical partners, including NGOs, U.N. agencies, and the private sector, that supports countries in the procurement and supply management of HIV commodities, http://www.who.int/hiv/amds/about/en/index.html, last accessed April 26, 2010.
45. An international system to boost the availability of new and more patient-friendly medicines through a collective management structure that seeks to increase access to patents and foster the development and production of more affordable and appropriate medicines, http://www.unitaid.eu/images/projects/PATENT_POOL_ENGLISH_15_may_REVISED.pdf, last accessed April 23, 2010.
46. A global initiative to streamline mechanisms for drug supply across the Global Fund, UNAIDS, World Bank, PEPFAR, and WHO, which is being implemented in trial countries, http://www.who.int/hiv/amds/pfscm_cpp_initiative_2008.pdf, last accessed April 22, 2010.
47. Oral communication during meeting with Partnership for Supply Chain Management (PFSCM), May 2010.
48. CEPA Kenya National Advocacy Action Plan, February 2010.
49. SMS stands for Short Message Service, a form of text messaging on mobile phones enabled with third-generation or 3G technology.
50. http://stopstockouts.org/ushahidi/#, last accessed May 25, 2010.
51. CEPA Mozambique National Advocacy Action Plan, April 2010
52. UNGASS Country Progress Report–Mozambique: 2008–2009, Conselho Nacional de Combate ao HIV/SIDA, March 2010.
53. CEPA Nigeria National Advocacy Action Plan, October 2009.
54. CEPA Tanzania National Advocacy Action Plan, February 2010.
55. Correspondence with CEPA Tanzania team, June 2010.
56. Essential AIDS and TB Medicines and Diagnostics in Uganda: An Assessment of Availability and Management, HEPS Uganda, May 2009.
57. http://stopstockouts.org/ushahidi/#, last accessed May 25, 2010. The Stop Stock-Outs Campaign is a regional campaign in Kenya, Madagascar, Malawi, Uganda, Zambia, and Zimbabwe to stop continued stock-outs of essential medicines in public health facilities. In Uganda, a consortium of five CSOs (HEPS Uganda, AGHA, AIDE, ACFODE, and NAFOPAHU) is undertaking a one-year campaign. During the SMS Pill Check weekend in June 2009, these CSOs used SMS text messaging technology to check on 10 essential drugs: first-line anti-malarials (AMs); zinc 20mg tablet; benzathine penicillin; first-line ARVs; metronidazole 200mg tablet; ciprofloxacin 250mg or 500mg tablet; amoxicillin suspension; ceftriaxone 250mg or 1g vial; cotrimoxazole suspension; and ORS for diarrhea. A useful map of stock-outs in Kenya, Malawi, Zambia, and Uganda is available at http://stopstockouts.org/ushahidi/#.
58. CEPA Zambia National Advocacy Action Plan, February 2010.
59. http://stopstockouts.org/ushahidi/#, last accessed May 25, 2010.
60. Kenyan National HIV/AIDS Strategic Plan III, 2009, http://www.nacc.or.ke/2007/images/downloads/knasp_iii.pdf, accessed May 3, 2010.
61. Correspondence with CEPA Kenya team, June 7, 2010.
62. Ibid.
63. Kenyan National HIV/AIDS Strategic Plan III, 2009, http://www.nacc.or.ke/2007/images/downloads/knasp_iii.pdf, accessed May 3, 2010.
64. Correspondence with CEPA Mozambique team.
65. Ibid. Ministry of Health budgets were not accessible to review breakdown of budgets and allocations.

66. UNGASS Country Progress Report–Nigeria: January 2008–December 2009, National Agency for the Control of AIDS, March 2010. Specific information in the 2010 UNGASS report obtained from the National AIDS Spending Assessment.
67. No information available even after correspondence with CEPA Nigeria team in 2010.
68. Correspondence with CEPA Tanzania team, May 20, 2010.
69. Ibid.
70. Correspondence with CEPA Uganda team; information taken from the Health Sector Budget Framework Paper, 2010–2011.
71. Correspondence with CEPA Uganda team, May 2010.
72. Zambia Partnership Development Framework–Zero Draft, 2010.
73. Preliminary information from "Grave Negligence," a budget tracking review of the health budget from 2005 through 2009 by CEPA Zambia team consultant Henry Malumo, received May 18, 2010.
74. Ibid.
75. 2010 Africa Health Financing Scorecard, Africa Public Health Alliance and 15%+ Campaign, 2010.
76. Ibid.
77. Correspondence with CEPA Kenya team, June 7, 2010.
78. Figure refers to health budget share from government budget, including consolidated debt services, based on budget analysis by Human Development Trust.
79. Correspondence with CEPA Uganda team; information taken from the Health Sector Budget Framework Paper, 2010–2011.
80. Correspondence with CEPA Zambia team; figure refers to health sector budget and Ministry of Finance and National Planning budget speeches.
81. As of November 30, 2009, http://www.theglobalfund.org/en/fighting/, accessed May 19, 2010.
82. Global Fund pledges and contributions, www.theglobalfund.org/documents/pledges_contributions.xls.
83. Gross National Income (GNI) figures from the World Bank, http://siteresources.worldbank.org/DATASTATISTICS/Resources/GNI.pdf.
84. http://www.theglobalfund.org/documents/board/19/GF-BM19-DecisionPoints_en.pdf, last accessed April 26, 2010.
85. Correspondence with Mazuwa Andrew Banda of WHO, May 25, 2010.
86. World Health Report 2006: Working Together for Health, WHO, http://www.who.int/whr/2006/whr06_en.pdf, accessed April 23, 2010.
87. "Specific tasks are moved, where appropriate, from highly qualified health workers to health workers with shorter training and fewer qualifications in order to make more efficient use of the available human resources for health. Reorganization and decentralization of health services according to a task shifting approach can help to address shortages of health workers. Such shortages are particularly acute in countries that face a high HIV burden. However, task shifting alone is not expected to resolve the health workforce crisis. Task shifting is proposed as an efficient approach but one that will require significant investment and that should not be seen as a substitute for other investments in human resources for health." (Task shifting: Rational redistribution of tasks among health workforce teams: Global recommendations and guidelines, WHO, 2008, in collaboration with PEPFAR and UNAIDS.)
88. PEPFAR Contributions to GHI 2009: Human Resources for Health, http://www.pepfar.gov/strategy/ghi/134855.htm, accessed April 21, 2010.
89. Kenyan National HIV/AIDS Strategic Plan III, 2009, http://www.nacc.or.ke/2007/images/downloads/knasp_iii.pdf, accessed May 3, 2010.
90. Mozambique 2008 PEPFAR Country Operational Plan, http://www.pepfar.gov/documents/organization/140411.pdf.
91. Tanzania Health Sector Strategic Plan III, 2009–2013, 2009.
92. UNGASS Country Progress Report–Tanzania: January 2008–December 2009, March 2010.
93. Zambia National Health Strategic Plan, 2006–2010, 2006.
94. A tool developed by the Global Network of People Living with HIV (GNP+) to be used by and for people living with HIV, supporting the Greater Involvement of People living with HIV and AIDS (GIPA) principle by being driven by PLHIV and their networks, http://www.stigmaindex.org/9/aims-of-the-index/aims-of-the-index.html, last accessed April 14, 2010.
95. Oral communication at meeting with International Center for Research on Women, April 2010.
96. http://www.pepfar.gov/press/82130.htm, last accessed May 25, 2010.
97. http://www.theglobalfund.org/en/applicationmaterials/documentlistsingle/?lang=en, last accessed June 2, 2010.
98. www.stigmaindex.org, last accessed May 25, 2010: "The People Living with HIV Stigma Index provides a tool that will measure and detect changing trends in relation to stigma and discrimination experienced by people living with HIV. In the initiative, the process is just as important as the product. The initiative aims to address stigma relating to HIV while also advocating on the key barriers and issues perpetuating stigma—a key obstacle to HIV treatment, prevention, care and support."
99. Correspondence with CEPA Mozambique team and literature search did not result in any information on legislation or policies on stigma and discrimination.
100. www.stigmaindex.org, last accessed May 25, 2010.
101. CEPA Tanzania National Advocacy Action Plan, February 2010, and www.stigmaindex.org, last accessed May 25, 2010.

102. CEPA Uganda National Advocacy Action Plan, February 2010, and www.stigmaindex.org, last accessed May 25, 2010.

103. www.stigmaindex.org, last accessed May 25, 2010.

104. All population data from CIA World Factbook, https://www.cia.gov/library/publications/the-world-factbook/rankorder/2119rank.html.

105. All life expectancy data from World Health Statistics: Life Expectancy at Birth for Both Sexes (2007), WHO, http://www.who.int/whosis/whostat/EN_WHS09_Table1.pdf.

106. All adult HIV prevalence data from UNGASS 2010 Country Progress Reports, http://www.unaids.org/en/KnowledgeCentre/HIVData/CountryProgress/2010CountryProgressAllCountries.asp, accessed May 19, 2010.

Global AIDS Alliance
1121 14th Street NW, Suite 200
Washington, DC 20005

PH: +1 (202) 789-0432
www.globalaidsalliance.org