THE DOUBLE DIVIDEND

Action to improve survival of HIV exposed infected and uninfected children in the era of eMTCT and renewed child survival campaigns
OPENING NOTE

This framework is intended to be a catalyst for accelerated action toward ending Pediatric HIV and AIDS, keeping mothers alive and improving child survival. The Secretary General’s Global Strategy for Women’s and Children’s Health and the Global Plan to eliminate new pediatric HIV infections and keeping mothers alive (2011) and A Promise Renewed (2012), reflected in the recent Abuja Declaration on the Elimination of HIV and AIDS, Tuberculosis and Malaria in Africa by 2030, have called for mobilization of governments and other stakeholders toward these goals by 2015. Around the world, countries are recognizing the need for alignment between management, messaging and services for maternal and child HIV and maternal, newborn and child health (MNCH). Several initiatives currently call for effective integration of HIV within general SRH/MNCH services to increase maternal and pediatric HIV intervention coverage and to provide support to strengthen systems for provision of more comprehensive, effective and efficient health and HIV services.1,2,3 Expansion of these efforts could significantly improve overall survival of women and children and accelerate progress toward reaching MDG 4, 5 and 6 by 2015 (See Box).

RATIONALE

In 2012, there were an estimated 1.5 million HIV positive pregnant women globally.4 Without intervention, up to half of these women will pass on HIV infection to their children either during pregnancy, birth or through breastfeeding.5 The launch of the Global Plan to Eliminate New HIV Infections among Children and Keeping Mothers Alive (Global Plan)6 has had a significant impact on coverage of services to prevent mother to child transmission (PMTCT) of HIV, reaching 65 % of pregnant women living with HIV in the 21 priority countries in sub-Saharan Africa7 by the end of 2012. New infections in children dropped to 260,000 in 2012, a decline of 52% since 2001; 64% decline in pediatric AIDS-related mortality.8 Treatment initiatives such as WHO’s “3 by 5” and more recently Treatment 2.0, accompanied by evidence-based guidance, have substantially increased access to HIV treatment8 and demonstrate that dramatic results can be achieved with sustained investments from domestic sources and international partners, including the Global Fund to Fight AIDS, TB and Malaria (GFATM) and the US President’s Emergency Plan for AIDS Relief (PEPFAR). National political leadership has been central to this success, most notably in the areas of the scale up of prevention and treatment programs and driving for integration of HIV services for children and families within routine SRH/MNCH services, as well as the push from civil society to “move the needle”. In parallel to this has been a dramatic acceleration in reduction in child mortality but not enough to reach the MDG 4 goal of 2/3 reduction by 2015. The movements “A Promise Renewed” and “Every Woman Every Child” have accelerated political, global and civil society momentum to push toward MDGs 4 and 5. While there has been significant progress to date with increased activities and focus on women’s access to SRH/FP/MNCH and PMTCT services challenges remain.

Putting the Health of Mothers through simplified approaches at the heart of PMTCT

A large proportion of HIV-positive pregnant women still do not receive ARVs and many that start ARVs are lost to follow up after delivery: Early identification, initiation and retention of HIV positive pregnant women is critical to reduce maternal and child mortality. Maternal antiretroviral treatment (ART) and access to family planning has been shown to reduce maternal and child mortality and HIV-exposed infants and children (both HIV infected and uninfected) whose mothers become ill or die are at significantly increased risk of mortality.8,9 Yet in 2012, while 65% of HIV positive pregnant women were reached with ART, lost-to-follow up (LTFU) was as high as 89.4% among those reached.10 Providing ART and family planning for all pregnant women

1 Examples include the WHO IMCI, WHO IMAPC, USAID’s Minimum Activities for Mothers and Newborns – MAMAN, the UN Millennium Project task force on child and maternal health 2005 World Health Report
2 Lassi Z S et al. Community-Based intervention packages for reducing maternal and neonatal morbidity and mortality and improving neonatal outcomes
4 WHO and UNICEF. Global update on HIV treatment 2013: results, impact and opportunities. June 2013
7 21 high burden priority countries included in the Global Plan are: South Africa, Swaziland, Namibia, Lesotho, Zambia, Kenya, Botswana, Mozambique, Cameroon, Zimbabwe, Uganda, Tanzania, Ethiopia, Ghana, Burundi, Angola, DR Congo, Nigeria, Malawi, Cote d’ Chad
9 Larder et al. Mortality and health outcomes of HIV exposed and unexposed children in a PMTCT cohort in Malawi. Plos 2012; 7(10): e17
living with HIV in lower level antenatal care settings can result in greater, earlier and regular care which would serve to identify and initiate early maternal and child ART, improve retention in ANC, maternity and post-nataly as well as improve overall birth outcomes and child survival.11

Providing early infant testing for all HIV-exposed children

Early infant testing of HIV is available to only a minority of HIV-exposed children: HIV disease progression is much faster in children than adults - without HIV treatment, half of children born with HIV die by the age of two, and 80% die by age five.12 However, in 2012, only 35% of HIV exposed children received an early infant testing with dried blood spot (DBS) by 2 months of age that would permit early initiation of lifesaving treatment among those identified; only a minority has been quickly linked into care. Increased utilization of routine child health services, such as immunization clinics and community-based maternal and sick child programs provide opportunities for timely identification of HIV infected/exposed children. Additionally, a recent survey suggested that a higher rate of HIV infection was found among children who were tested in pediatric service points like pediatric wards and nutrition clinics than in PMTCT pediatric testing settings. In high prevalence settings, integrating HIV testing into existing child health settings such as EPI, pediatric wards, nutrition clinics, under-5 and community-based health programs can greatly improve earlier identification of HIV exposed children, and speedier linkage to care and treatment, ensuring improved child survival.13

Linking all HIV-infected children under five to treatment and care

Most children living with HIV do not receive ART: The new WHO guidelines (2013) recommend treatment for all HIV-positive children under five years old. Despite this, among the 3.3 million children under 15 years of age currently living with HIV worldwide, only 34% of the 1.8 million children in need of ART according to 2010 eligibility criteria had access to treatment in 2012.4 The median age of initiation of ART for children living with HIV in many countries is 4.6 years of age 14 and 210,000 children were estimated to die last year due to HIV.4 The new WHO guidelines provide ways to advance on optimization and simplification of pediatric ART and many efforts to expand availability of suitable drug formulations are in progress; these efforts must be continued. Decentralization of ART for HIV infected pregnant and lactating women into MNCH settings has been the cornerstone of scale up and increased overall PMTCT coverage. Decentralization of pediatric ART into MNCH needs to be the next step in high burden countries.

Children under 5 years of age that have been exposed to HIV (both HIV infected and uninfected) do not receive the services and support they need, resulting in unnecessary illness and death: In 2013, UNICEF and WHO reported that 6.6 million children under five died in 2012, with nearly 75% of all the deaths attributable to six conditions: neonatal causes, pneumonia, diarrhea, malaria, measles, and HIV/AIDS.15 Furthermore:

- The majority of children living with HIV live in areas with high prevalence of other conditions, including malaria and malnutrition. While AIDS accounted for 4% of child mortality in sub-Saharan Africa, in many high HIV burden countries, HIV accounts for between one in ten to more than one in four child deaths.16,17

- Even with ART, mortality rates for HIV positive children are estimated to be 30 times higher than mortality among HIV unexposed children, largely due to opportunistic infections as well as common childhood illnesses such as diarrhea, pneumonia, malaria and malnutrition.18

- As more pregnant women living with HIV gain access to ARVs to prevent mother-to-child transmission and for their own health, there will continue to be a ballooning number of infants exposed to HIV and remain HIV-free through end of exposure during breastfeeding. Some gaps in our understanding of the long-term consequences of exposure to ARVs as part of PMTCT still remain, but what is known is that HIV-exposed uninfected children may have slower early growth and higher morbidity/mortality as a result of several factors, including the health of the child’s mother and persistent diarrhoea and malnutrition.19,20,21

- Consistent messaging on exclusive breastfeeding and introduction of nutritional foods has the potential to dramatically increase overall child survival as well as decrease the number of new pediatric HIV infections. Additionally, community-based interventions on diarrhea and pneumonia have been shown to be scalable and effective in reducing childhood morbidity and mortality associated diarrhea and pneumonia.22

There are untapped opportunities to reach more children in need of HIV services through integrated program approaches: Integration of HIV elements in child survival

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13 Chamilia D et al. Evidence from the field: missed opportunities for identifying and linking HIV-infected children for early initiation of ART. AIDS 2013; 27 (In publication)
15 Estimates Developed by the UN interagency Group for Child Mortality Estimation. Levels and trends in Child Mortality 2013
18 Modi S et al. Contribution of common childhood illnesses and opportunistic infections to morbidity and mortality in children living with HIV in resource-limited setting. AIDS 2013, 27 (In publication)
programs, such as integrated management of childhood illness (IMCI), integrated community case management (iCCM) and nutrition rehabilitation centers has the potential to reinforce pediatric HIV care and treatment as well as other child health outcomes and improve overall child survival.

The time to act is now; there is an opportunity to accelerate the fight against HIV and improve maternal and child survival. UNICEF, WHO and EGPAF have come together to highlight the need for concerted stakeholder action and to engage the leadership and commitment of the Ministers of Health from the 21 countries with the greatest burden of pediatric HIV infection and mortality. We hope to build on the growing momentum to improve the health and wellbeing of HIV positive women and children started through the actions of the Global Plan, and the overall child survival agenda outlined in the A Promise Renewed Pledge. Through political, technical and global leadership, this group of UN agencies, partners and ministries strive to further HIV services into MNCH platforms to eliminate new paediatric HIV infections, keep HIV positive mothers alive, ensure all infected infants/children are on treatment, and improve child survival so that by 2015 we can see a two-thirds reduction in child mortality and a 50% reduction in HIV-related child and maternal mortality (MDGs 4, 5, 6; Global Plan to eliminate new HIV infections among children and Keeping mothers alive).

ACTION

We are here today to renew our promise and refocus our energies on the HIV infected and HIV-exposed but uninfected infants and children and their mothers, and expand our scope to envision improved survival and health outcomes for all in the 21 most affected countries. There has been and continues to be significant scientific, technological and programmatic data that can be leveraged to reach our common goals of an AIDS – Free Generation through the Global Plan and A Promise Renewed. However, today we call for refocussed energy, urgency and global and national political leadership to make these HIV and maternal and child mortality targets a reality in the next 18 months. This can be achieved with all of our collaborative efforts.

We should work together; to be challenged and motivated to take the work forward to reduce child mortality and inequities in infant and child HIV outcomes; to re-invigorate political, technical and financial support for the care of HIV exposed children.

This framework calls for countries and partners to:

- Mobilize global, political and community leadership and key actors including funders, civil society and child survival actors:
  - All Global Partners work to harmonize and leverage their vertical programs to create guidance, technical and financial synergies and efficiencies;
  - Strengthen global and national awareness about the goal of 2/3 reduction of child mortality and inequities in infant and child HIV outcomes and generate public and leadership support for this effort;
- Recruit and engage advocates, including networks of people and women living with HIV, to bring strong client perspectives to government initiatives linking HIV with MNCH efforts;
- Identify alternative financial models to complement current existing ones to cover existing gaps.
- Review current child specific health plans; develop a Roadmap that articulates the specific goals, opportunities and action steps needed to change how national programs approach paediatric and maternal HIV:
  - Identify existing strategic platforms in HIV, MNCH, Child Health strategies where synergies can be leveraged and built upon to increase programmatic reach and impact - delivery as one:
  - Align and scale-up evidence-based interventions within national plans and strategies by:
    - Measuring Paediatric HIV disease burden with a focus on both HIV exposed uninfected children and infected children;
    - Defining goals, identifying country-level gaps and setting targets and benchmarks to address those gaps;
    - Identifying and implementing evidence-based interventions and innovative technologies to accelerate progress and address infant/child health and treatment gaps.
- Effective integration across common HIV and child-survival health platforms including:
  - Pediatric HIV testing means more than EID alone – Pediatric HIV testing is PCR testing in the first months of life and a combination of provider initiated testing and virologic testing to optimise identification of HIV exposure and infection among infants and children;
  - Decentralized systems that link facilities with communities to better follow up mothers living with HIV and their infants and children to optimize care and treatment;
  - Develop innovative service delivery models, to serve the health needs of families affected by HIV;
- Monitor progress on the Roadmap and evaluate impact on maternal and pediatric health outcomes:
  - Include timelines and accountabilities for the implementation benchmarks;
  - Move to streamline tracking of program performance across platforms;
  - Review processes regularly and change paths to maximize achievements and outputs.