THE DOUBLE DIVIDEND

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

The "Double Dividend" is intended to catalyse accelerated action toward the dual goals of ending paediatric HIV and AIDS and improving child survival. Around the world, countries are recognizing the need for alignment between management, messaging and services for maternal and child HIV and broader maternal, newborn and child health (MNCH). This kind of alignment is also endorsed by the Secretary General’s Global Strategy for Women’s and Children’s Health and the Global Plan to Eliminate New HIV Infections Among Children by 2015 and Keeping Their Mothers Alive (Global Plan)1 and A Promise Renewed (2012). The 2013 African Union Declaration on Abuja Actions Toward the Elimination of HIV and AIDS, Tuberculosis and Malaria in Africa by 2030 also calls for support through mobilization of governments, private sector and other stakeholders. Several initiatives currently call for effective integration of HIV within sexual and reproductive health (SRH) and MNCH services to increase maternal and paediatric HIV intervention coverage and to strengthen systems for provision of more comprehensive, effective and efficient health and HIV services.2-4 Expansion of these efforts could significantly improve overall survival of women and children and accelerate progress toward reaching MDGs 4, 5 and 6 by 2015.

RATIONALE

In 2012, there were an estimated 1.5 million pregnant women living with HIV globally.5 Without intervention, up to half of these women will transmit HIV infection to their children either during pregnancy, childbirth or through breastfeeding.6 The launch of the Global Plan 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 Africa by the end of 2012. New infections in children dropped to 260,000 in 2012, a decline of 52% since 2001; and a decline of 64% in paediatric AIDS-related mortality.7 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 treatment and demonstrated 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 and the US President’s Emergency Plan for AIDS Relief. National political leadership has been central to this success, most notably in the scale up of prevention and treatment programmes and the drive for integration of HIV services for children and families within routine SRH and MNCH services. The push from civil society to “move the needle” has also been critical for success. A dramatic acceleration in reduction of child mortality has occurred in parallel to this, but not enough to reach the MDG 4 goal of a two-thirds reduction by 2015. The movements A Promise Renewed and Every Woman Every Child have accelerated political, global and civil society momentum to achieve MDGs 4 and 5.

While there has been significant progress with increased

activities and focus on women’s access to family planning, SRH, MNCH and PMTCT services, challenges remain.

Putting the health of mothers first through simplified approaches

A large proportion of pregnant women living with HIV still does not receive ARVs and many who start ARVs are lost to follow up after delivery. Early identification, initiation of ARVs and retention of pregnant women living with HIV are critical to reducing maternal and child mortality. Infants ‘exposed’ to HIV and children (both HIV infected and uninfected) whose mothers become ill or die are at significantly increased risk of mortality.5,9 Maternal antiretroviral treatment (ART) and access to family planning have been shown to reduce maternal mortality. Yet in 2012, while 65% of pregnant women with HIV were reached with ART, loss-to-follow up was as high as 89% among those reached.10 Providing ART to all pregnant and breastfeeding women living with HIV is expected to simplify and improve this situation, along with expanded access to family planning. Furthermore, decentralization of services to lower level antenatal care settings can result in earlier initiation of maternal and child ART, improved retention in care and improved 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 children 'exposed' to HIV. HIV disease progression is much faster in children than adults - without treatment, half of children born with HIV die by the age of two, and 80% by age five.12 However, in 2012, only 35% of children 'exposed' to HIV received a test by the recommended two months of age that would permit early initiation of lifesaving treatment among those identified; and only a minority of these was linked into care.5

In September 2000, building upon a decade of major United Nations conferences and summits, world leaders came together at United Nations Headquarters in New York to adopt the United Nations Millennium Declaration – which committed to a new global partnership, and a deadline of 2015 with time-bound targets which became known as the eight Millennium Development Goals (MDGs). The "Double Dividend" relates mostly to the following MDGs:

**GOAL 4:** Reduce child mortality: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate

**GOAL 5:** Improve maternal health: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio

**GOAL 6:** Combat HIV and AIDS, malaria and other diseases: Have halted by 2015 and begun to reverse the spread of HIV and AIDS; Achieve, by 2010, universal access to treatment for HIV and AIDS for all those who need it.
Children under five years of age who have been 'exposed' to HIV - both HIV infected and uninfected - have higher rates of morbidity and mortality than children who are not 'exposed' to HIV.

A recent study suggested that a higher rate of HIV infection was found among children who were tested in regular paediatric service points such as paediatric wards and nutrition clinics than in PMTCT paediatric testing settings. In high prevalence settings, integrating HIV testing into existing child health settings such as the expanded programme on immunization, paediatric wards, nutrition clinics, under-five and community-based health programmes can greatly improve earlier identification of HIV 'exposed' children, and speedier linkage to care and treatment.13

Linking all HIV-'exposed' children under five to treatment and care

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 and AIDS.14

The median age of initiation of ART for children living with HIV in many countries is 4.6 years of age.15 Most children living with HIV do not receive ART and an estimated 210,000 children died last year due to HIV.16 There are 3.3 million children under 15 years of age living with HIV worldwide; 1.8 million of these children are eligible for ART according to 2010 WHO guidelines, but only 34% of those who are eligible had access to treatment in 2012.5

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.15,17

Even with ART, mortality rates for children living with HIV are estimated to be 30 times higher than mortality among children not 'exposed' to HIV, 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 who remain HIV-free. Some gaps in our understanding of the long-term consequences of exposure to ARVs as part of PMTCT remain, but we know that HIV-'exposed' uninfected children may have slower early growth, and are more likely to die and experience more illness than children who are not 'exposed' to HIV.19,20,21 The health of the child’s mother is also a critical factor in the child’s health.

Untapped opportunities

The new WHO guidelines (2013) recommend the treatment for all HIV-positive children under five, and provide ways to optimise and simplify paediatric ART. Efforts to expand availability of suitable drug formulations must be continued. Decentralization of ART for pregnant and breastfeeding women living with HIV into MNCH settings has been the cornerstone of scale up and increased overall PMTCT coverage. Decentralization of paediatric ART into MNCH is the next step in high burden countries.

Integration of HIV elements in child survival programmes, such as integrated management of childhood illness, integrated community case management and nutrition rehabilitation centers, has the potential to reinforce paediatric HIV care and treatment as well as other child health outcomes and improve overall child survival. Consistent messaging on exclusive breastfeeding and later, introduction of nutritional foods has the potential to dramatically increase overall child survival as well as decrease the number of new paediatric 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

ACTION

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 the Elizabeth Glaser Pediatric AIDS Foundation 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 in Africa with the greatest burden of paediatric HIV infection and mortality. We hope to build on the growing momentum to improve the health and wellbeing of women and children living with HIV 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 governments strive to further integrate HIV services into MNCH platforms to eliminate new paediatric HIV infections, keep mothers who have HIV alive, ensure all infants and children with HIV are on treatment, and ultimately improve child survival so that by 2015 we 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).

At ICASA 2013, we renewed a promise to refocus our energies on women living with HIV and their children - regardless of the child's HIV status - in the wider context of improved survival and health outcomes for all in the 21 most affected countries in Africa.7 Today we call for refocused energy, urgency and global and national political leadership to make these HIV and maternal and child mortality targets a reality by the end of 2015.

This can be achieved through collaborative efforts focused on reducing child mortality and inequities in infant and child HIV outcomes, as well as re-invigorating political, technical
and financial support for the care of children 'exposed' to HIV and their mothers.

The Double Dividend calls for countries and partners to:

- Mobilize global, political and community leadership and key actors including funders, civil society and child survival actors including through:
  - global partners harmonizing and leveraging their vertical programmes to create unified approaches with guidance, technical and financial synergies and efficiencies
  - strengthening global and national awareness about the goal of a two-thirds reduction in child mortality and inequities in infant and child HIV outcomes and generating public and leadership support for this effort
  - recruiting and engaging advocates, such as networks of people living with HIV (especially women), to bring strong client perspectives to government initiatives linking HIV with MNCH efforts
  - identifying alternative financial models to address gaps and complement those that already exist

- Review current child-specific health plans and develop a roadmap that articulates the specific goals, opportunities and action steps needed to change how national programmes approach paediatric and maternal HIV, including through:
  - measuring paediatric HIV disease burden with a focus on children living with HIV and children 'exposed', but not infected
  - identifying existing strategic platforms in HIV, MNCH, and child health strategies where synergies can be leveraged to increase programmatic reach and impact
  - aligning and scaling up evidence-based interventions within national plans and strategies, including through innovative technologies and new innovative service delivery models
  - effectively integrating HIV related services across child health platforms, for example:
    - paediatric HIV testing can be integrated into a wide range of routine health services. In addition to the initial virological test before two months of age, for all HIV-'exposed' children, periodic testing should continue through the breastfeeding period or if the clinician suspects HIV in pursuit of an early diagnosis, quickly followed by appropriate treatment and support
    - decentralized systems bring services closer to the communities that need them and facilitate follow up to optimise retention in care and treatment

- Monitor progress on the roadmap and evaluate impact on maternal and paediatric health outcomes, including:
  - specific national targets, timelines and accountabilities with clear benchmarks
  - streamlining the tracking of programme performance across platforms and entry points
  - reviewing processes regularly and using data to inform decisions about programme improvements including at local levels

ENDNOTES

3. Lassi Z S et al., Community-Based intervention packages for reducing maternal and neonatal morbidity and mortality and improving neonatal outcomes, 2010.
7. 21 high burden priority countries included in the Global Plan are: Angola, Botswana, Burundi, Cameroon, Chad, Cote d’Ivoire, DR Congo, Ethiopia, Ghana, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, South Africa, Swaziland, Uganda, Tanzania, Zambia, Zimbabwe.