Investing in our future

The Global Fund

To Fight AIDS, Tuberculosis and Malaria

The Global Fund's role as a strategic and responsible investor in HIV/AIDS: Paediatrics and PMTCT

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The Children's Investment Fund Foundation

Investment Criteria

- Measurable..... change beyond the immediate impact
- Scaleable..... or able to be replicated
- Sustainable..... durable beyond CIFF's investment
- Value for money...cost effective and "affordable"

- Leverage.....indirect impact form the onset

Strategic GFATM investments can increase the impact of PMTCT and paediatrics programs and reduce future costs

- Significantly reducing maternal and infant mortality/morbidity thereby significantly accelerating progress towards Universal Access/MDGs
- Increasing primary prevention as well as prevention of vertical transmission
- Comprehensive family centred four pronged approach provides an entry point to integrate HIV/AIDS further into ANC/MNCH/SRH and strengthen health systems more generally optimising use of resources
- Reducing HIV/AIDS treatment and costs by significantly reducing new infections.
- Reducing costs of care of orphaning by keeping mother/parents alive

AIDS Epidemic: Global summary 2007

Number of people living with HIV in 2007	Total	33 million [30 – 36 million]
	Adults	30.8 million [28.2 – 34.0 million]
	Women	15.5 million [14.2 – 16.9 million]
	Children under 15 years	**2.0 million [1.9 – 2.3 million]**
People newly infected with HIV in 2007	Total	2.7 million [2.2 – 3.2 million]
	Adults	2.3 million [1.9 – 2.8 million]
	Children under 15 years	370 000 [330 000 – 410 000]
	Children in Sub Saharan Africa	**330 000** 89% of new child infections
AIDS deaths in 2007	Total	2.0 million [1.8 – 2.3 million]
	Adults	1.8 million [1.6 – 2.1 million]
	Children under 15 years	270 000 [250 000 – 290 000]
	Children in Sub Saharan Africa	**240 000** 89% of child deaths

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Source: UNAIDS 2008

The Global Fund should invest in overcoming key barriers and promote best practices in PMTCT and Paediatric care and treatment interventions

	Common barriers	Best practices
Counseling and testing during pregnancy	• Poor quality of ANC infrastructure • Stigma and fear of rejection by family • **Reliance on "opt-in" testing model, resulting in sub-optimal uptake** • **HIV testing technology slow, highly laboratory-dependent**	• Community based approaches • **"Opt-out" testing** • **Rapid HIV test kits to allow same-day results** • Task shifting among staff
Antiretroviral prophylaxis for HIV+ mothers and support for safe infant feeding	•Logistical difficulties in delivering the most efficacious ARV regimens •ARV stock outs •**Introducing new regimens requires revising guidelines, issuing policies, ensuring supply systems, retraining staff, etc.** •Insufficiently rigorous counseling about feeding options	• Repeat drug dispensation and recurrent counseling • **Referral mechanisms between laboratory, ANC and ART clinics** • improve training on infant feeding for health workers • **use infant immunization services for postnatal infant feeding assessment, counselling and follow-up nutrition support**
Intra partum testing and prophylaxis Prophylaxis to reduce exposure during B/F?	• Unaffordability of facility based delivery • **No access to testing in labour for untested women delivering at home** • HIV+ women in delivery wards not offered ARV prophylaxis	• **Incentives for women to deliver in facilities including subsidized delivery fees, transport subsidies, nutrition supplements** • Links with safe motherhood programmes • Traditional birth attendants trained and linked to health facilities and trained midwives
Cotrim to all exposed infants at 6 weeks Early testing, diagnosis and delivery of results for infants Access to treatment and care for infected children	• Missing linkages between PMTCT and ART such that exposed infants are missed once their mothers drop out • Limited number of PCR machines at a country level • **Delays in communicating results to the parent/caregiver** • **Missing referral networks with other services including nutrition, neonatal health, IMCI, immunization, malaria and TB** • Limited lab and clinic human resources, as well as training in paediatric-specific skills • Restricted expansion of paediatric ART access points from urban/tertiary to rural/primary • Paediatric-friendly drug formulations are needed sooner and at lower prices to address major dosing and supply-chain constraints	• **Leveraging 6-week immunization visit to follow up for other HIV services** • **Child health cards in Malawi and Rwanda revised to track HIV related information** • Child health days which integrate HIV testing with delivering other health and nutrition services to children on a large scale • Provider initiated testing and counselling • **Establish family-centred services that treat adults and children together, to better assure follow-up** • **Provide RUF through ART sites to increase retention and improve outcomes, while integrating HIV-testing at CMAM (community-managed acute malnutrition) service sites to identify older children**
Continued access to ART for mothers who need it for their own survival	• ART largely unavailable to women accessing PMTCT • **ANC, delivery, and postpartum health services are vertical and uncoordinated**	• Institute measures to follow-up HIV+ pregnant women after delivery are essential -- mobilize community leaders for follow-up • **Adopt a family-centered approach to HIV care and treatment**

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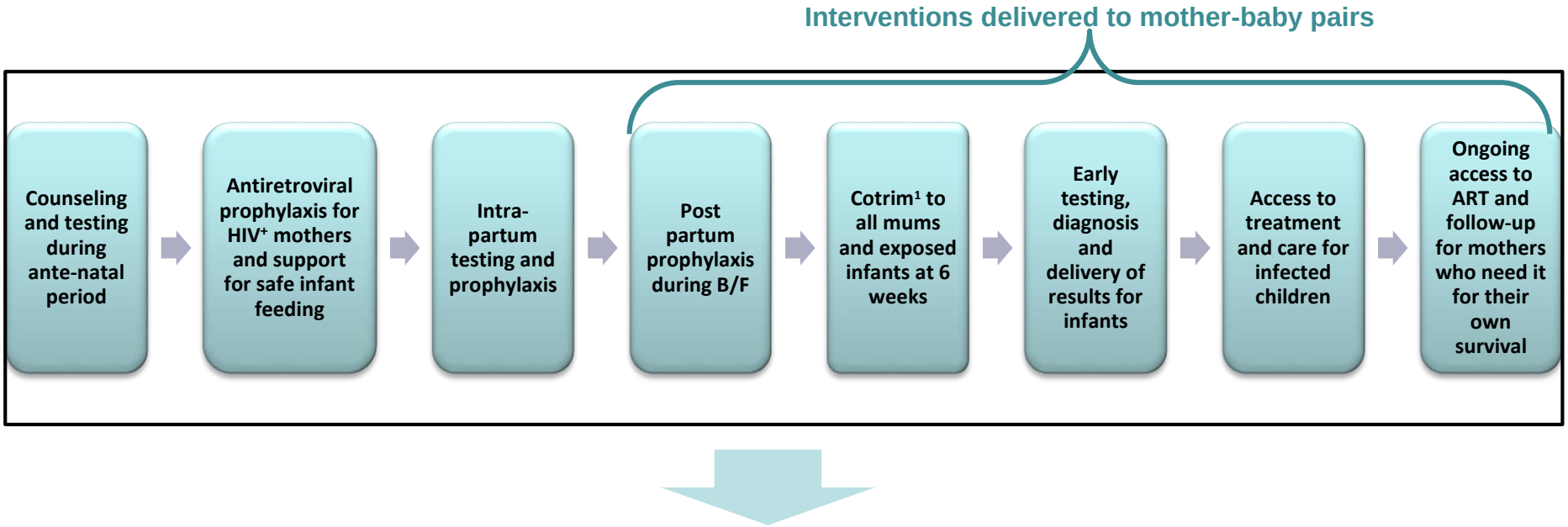
The Global Fund should fund an integrated approach to PMTCT and Paediatric interventions and bottlenecks along the whole of the cascade



1. Given these linkages between PMTCT and pediatric interventions, it is important to identify and track all infected mother-baby pairs to ensure their completion of services along the cascade shown above.
2. Given the strong linkages between mother's and child's survival[2], it is possible to maximise the HIV free survival of the infants by keeping mums alive through PMTCT interventions.

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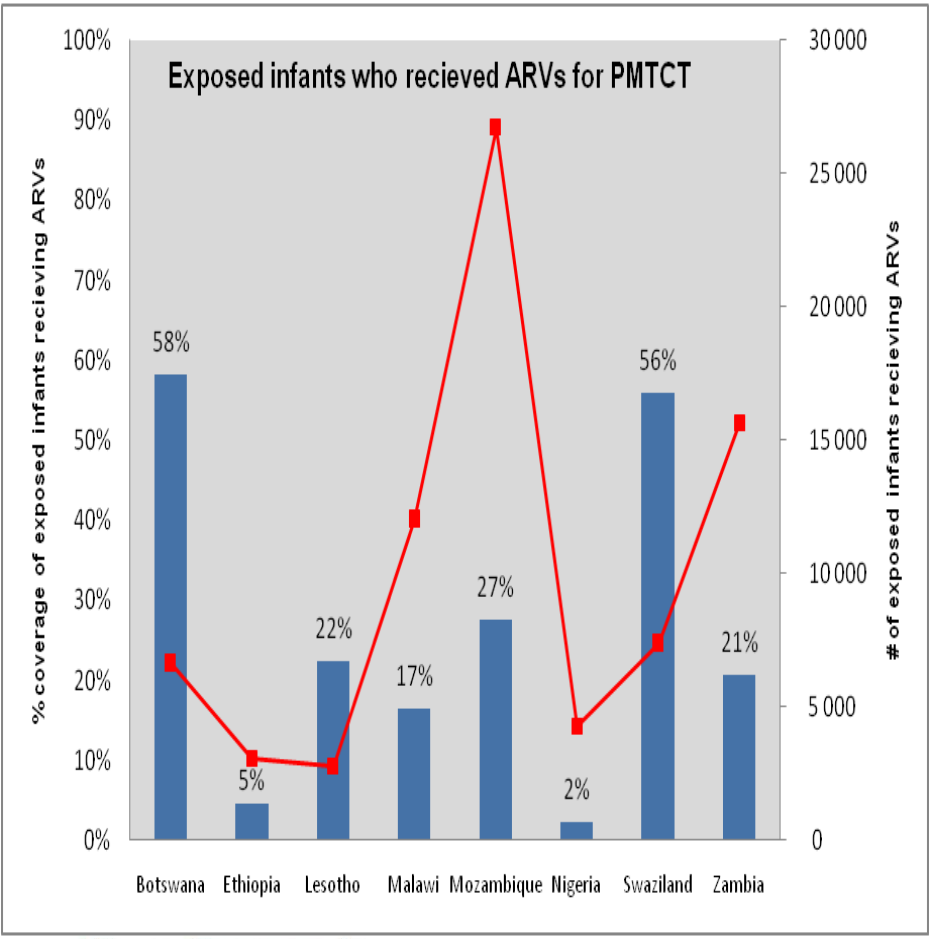
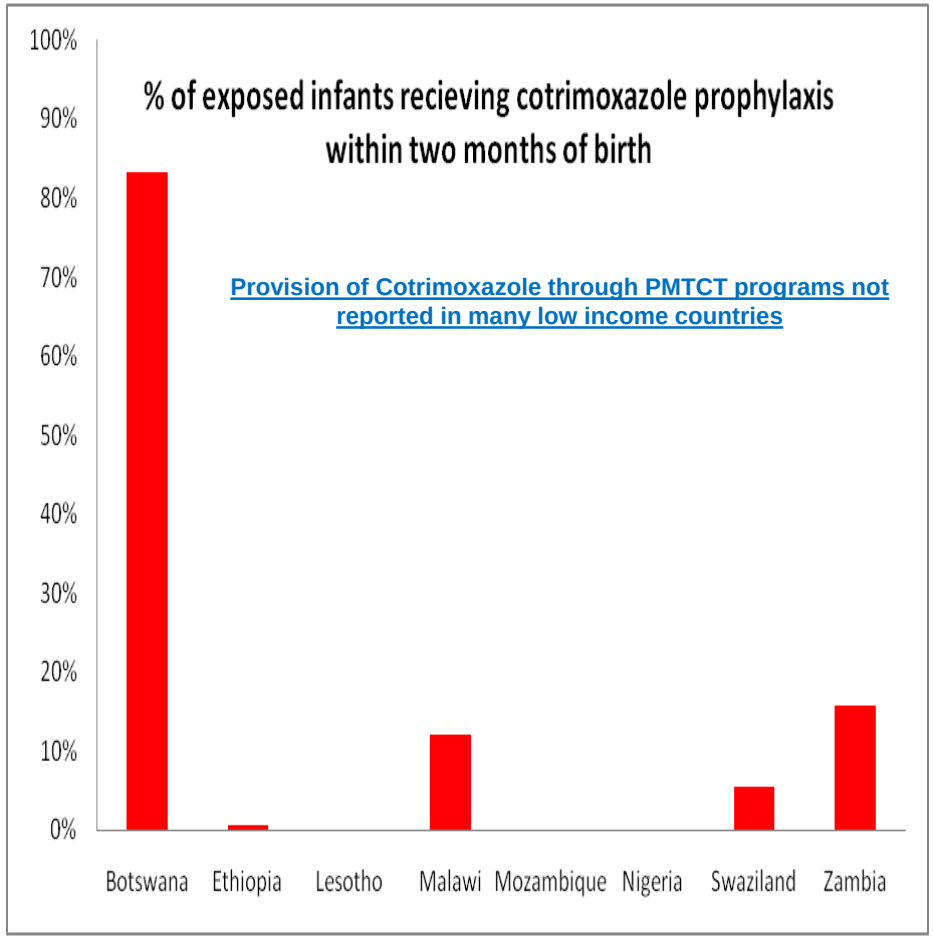
1. Cotrim or Cotrimoxazole is a widely available, low cost drug that can reduce the occurrence of opportunistic infections that are a leading cause of illness and death in adults and children living with HIV.
2. Watt et al., 2005; Masmas et al, 2004

Proven interventions not being scaled up .Majority of HIV exposed infants not receiving Cotrimoxazole prophylaxis and ARVs for PMTCT





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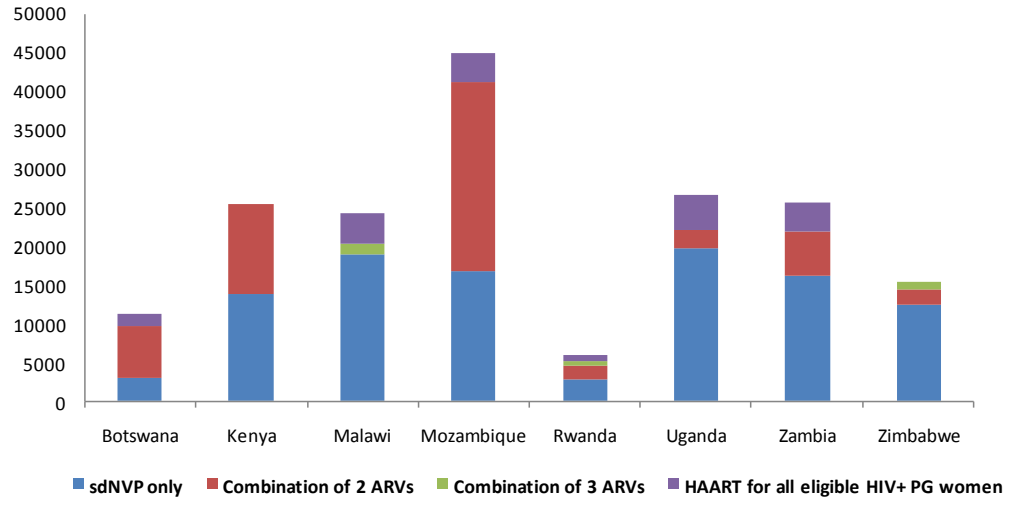
Source: WHO UNICEF data on Preventing mother to child transmission of HIV in low and middle income countries, 2007

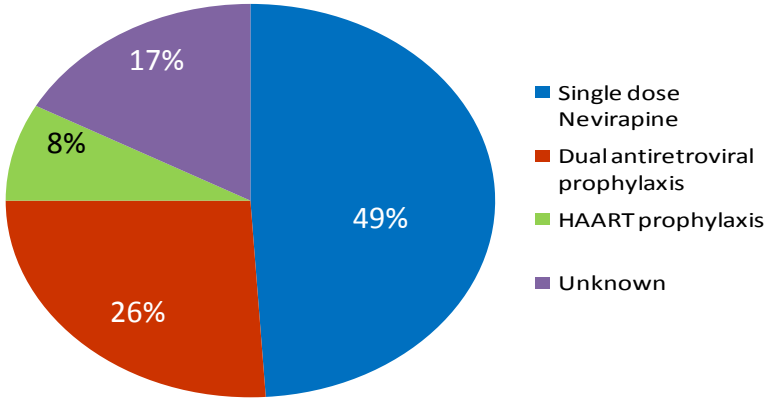
Limited access, ART assessment and suboptimal antiretroviral regimens are the norm for mothers in low and middle income countries

Only 12% of pregnant women living with HIV were assessed for ART eligibility and of those only 9% received ART

Number of HIV+ Pregnant Women Receiving Different ARV Regimens[1]



Distribution of antiretroviral regimens received by pregnant women living with HIV, 2007[2]



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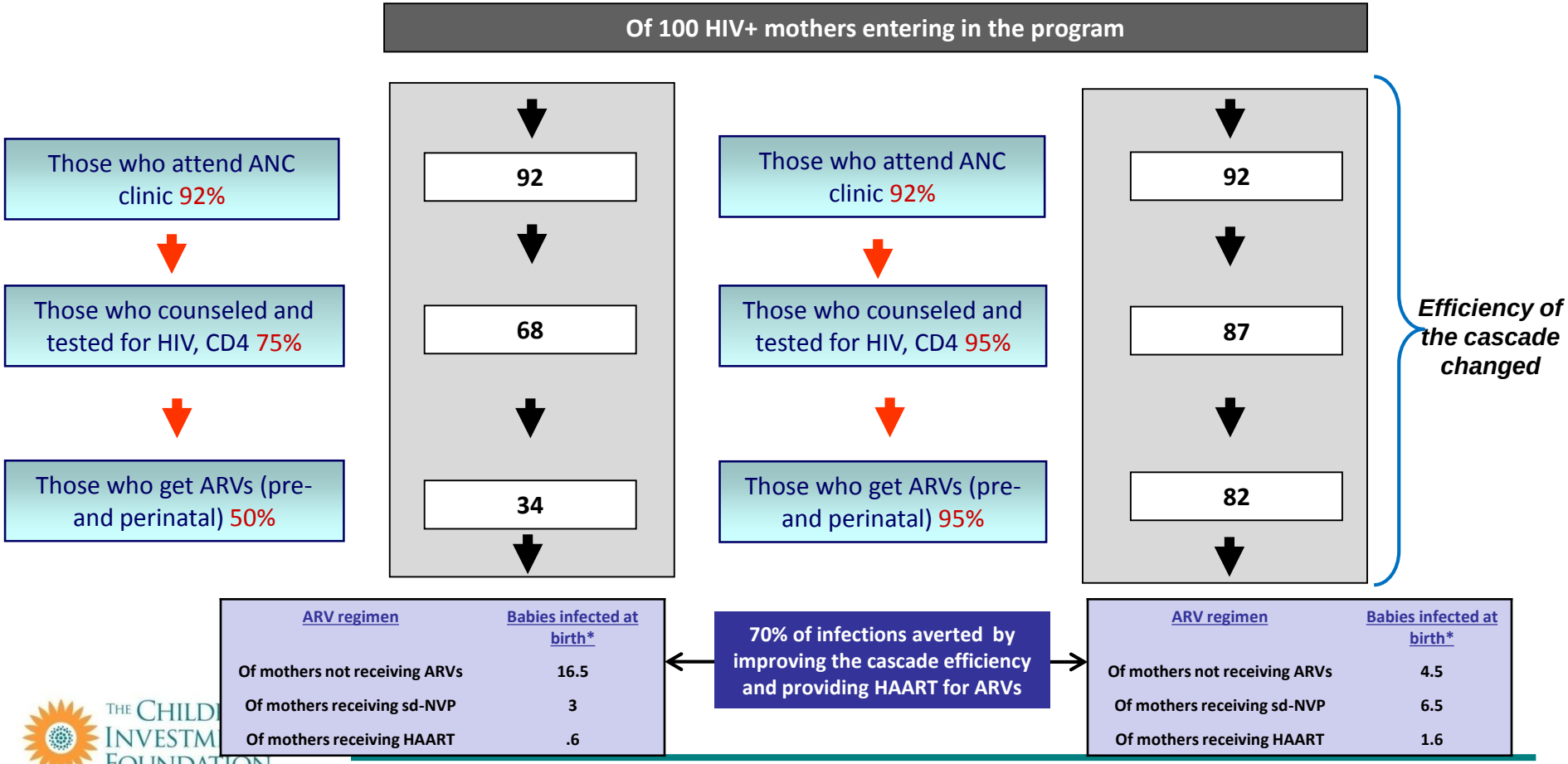
Source: [1]ARK analysis. PMTCT Annual Report Card, 2007. [2] Dr Ying-Ru Lo, WHO, August 2008 (Data from 60 countries)

PMTCT cascade: potential to avert 70% of child infections by driving both access and effective treatment

- **By improving mothers' access to testing and basic ARV regimens, 44% of child infections can be averted**
- **It is possible to avert an additional 25% of child infections by providing mothers with more efficacious regimens such as HAART**



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Source: CIFF analysis based on the presentation by P. Barker at WHO PMTCT consultation meeting Nov 2008

* **Excludes the # of infants infected after birth during breast feeding**

Recommendations to Global Fund

- Undertake portfolio reviews of PMTCT and paediatrics
- Revise TRP/ proposal/ renewal forms and guidelines to focus on PMTCT and paediatric outcomes/impact and set performance metrics
- Develop/fund a costing framework for PMTCT, fundamental to determine Value for money, relative value and return on investment , provides comparability measure
- Increase program efficiency by funding the implementation of best practices not " more of the same", address drop off along the PMTCT cascade and loss to follow up
- Focus investments on both increasing access to services and regimen changes, including scaling up of early infant diagnosis, CD4 cell counts and ART for infants
- Expedite development of technical guidance and implementation at country level
- Develop/fund operational research on scaling up in different contexts, improve data