



Strategic Plan, 2009–2012

CAMPAIGN TO END PEDIATRIC HIV/AIDS (CEPA)

*Scaling up Prevention and
Treatment of Pediatric HIV/AIDS*

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GLOSSARY OF ACRONYMS

AIDS	Acquired immunodeficiency syndrome
ANC	Antenatal care
ANECCA	African Network for Care of Children Affected by HIV/AIDS
ART	Antiretroviral therapy
ARV	Antiretroviral
CCM	Country Coordinating Mechanism (Global Fund)
CDC	Centers for Disease Control and Prevention (U.S. Government)
CEPA	Campaign to End Pediatric HIV/AIDS
COP	Country Operational Plan (PEPFAR)
CHAI	Clinton Foundation HIV/AIDS Initiative
CIFF	Children's Investment Fund Foundation
CSO	Civil-society organization
EATAM	Eastern Africa Treatment Access Movement
EID	Early infant diagnosis
EIT	Early infant treatment
EMEA	European Medicines Agency
FDA	Food and Drug Administration (U.S. Government)
FDC	Fixed-dose combination
FHI	Family Health International
GAA	Global AIDS Alliance
Global Fund	Global Fund to Fight AIDS, TB and Malaria
HAART	Highly active antiretroviral therapy
HIV	Human immunodeficiency virus
ITPC	International Treatment Preparedness Coalition
KETAM	Kenya Treatment Action Movement
MoF	Ministry of Finance
MoH	Ministry of Health
NGO	Non-governmental organization
NSA	National Strategy Application (Global Fund)
OECD	Organization for Economic Co-operation and Development
OGAC	Office of the Global AIDS Coordinator (U.S. Government)
PAAP	Pre-Approval Access Permit
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PMTCT+	Prevention of Mother-to-Child Transmission of HIV
PATA	Paediatric AIDS Treatment for Africa
PATAM	Pan-African Treatment Access Movement
PPPPAT	Public-Private Partnership on Pediatric AIDS Treatment (PEPFAR)
SRH	Sexual and reproductive health
SATAMO	Southern Africa Treatment Africa Movement
TALC	Treatment Access Literacy Campaign
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
WHO	World Health Organization

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I. INTRODUCTION

Despite international commitments to achieve universal access to HIV/AIDS services by 2010, including 80% coverage for pediatric treatment and prevention of mother-to-child transmission (PMTCT+) services, progress toward these goals remains too slow, and pediatric HIV transmission remains unacceptably high, particularly in sub-Saharan Africa.

With support from The Children's Investment Fund Foundation (CIFF) and other funders, the Global AIDS Alliance and Africa-based partners are now moving forward with a three-year international Campaign to End Pediatric HIV/AIDS (CEPA). The campaign's primary goal is to increase coverage rates for prevention of mother-to-child transmission and pediatric treatment services from the current average of 30% to 40% to the globally agreed-upon target of 80% and ensure high-quality services. Specifically, the campaign is designed to overcome key policy and implementation bottlenecks to scaling up pediatric prevention, treatment, and care in sub-Saharan Africa. It will seek to leverage policy reforms at both the global and country levels, to expand and activate in-country advocacy networks, and to hold governments and decision-makers accountable for tangible progress toward their policy commitments. The expected outcomes are improved program delivery in the field and increased impact of ongoing investments from international donors and national governments.

The campaign will focus on seven high-burden countries in sub-Saharan Africa where large-scale PMTCT+ and pediatric HIV/AIDS programs are being implemented. These focus countries are Kenya, Tanzania, Uganda, Zambia, Nigeria, Mozambique, and Ethiopia. If universal PMTCT coverage (80%) had been achieved in these countries in 2007, an additional 337,740 women and families would have benefited. If universal pediatric treatment access (80%) had been achieved, an additional 693,001 children would have received antiretroviral treatment.

Campaign Design Reflects Expert Analysis and Input

The design of the Campaign to End Pediatric HIV/AIDS is based on extensive research, including a survey of 28 implementers and treatment activists in 15 African countries. GAA also undertook a thorough desk review of the latest data regarding pediatric HIV/AIDS services, including national and health sector plans and progress reports from ministries of health and national AIDS agencies. Finally, we consulted with numerous technical experts and continue to dialogue with key stakeholders, including the Clinton Foundation HIV/AIDS Initiative (Clinton Foundation/CHAI), United Nations Children's Fund (UNICEF), U.S. Agency for International Development (USAID), and World Health Organization (WHO). This research and analysis informed GAA's selection of focus countries, implementing partners, and other stakeholders needed to tackle key policy and implementation bottlenecks at the global and national levels.

Campaign to Leverage Critical Outcomes to Benefit Children

As described above, the primary goal of the Campaign to End Pediatric HIV/AIDS is to increase coverage rates for prevention of mother-to-child transmission and pediatric treatment services to the globally agreed-upon target of 80% and ensure high-quality services. Progress toward this goal will be leveraged through global and country-level advocacy to advance four core objectives:

1. Family-centered care and nutrition
2. Early infant diagnosis and treatment
3. Access to appropriate medications
4. Full funding to eliminate pediatric HIV/AIDS

As detailed in Section V of this strategic plan, CEPA's advocacy efforts are expected to leverage the following large-scale, sustainable impacts to improve the lives of children:

1. *WHO guidelines endorsing highly active antiretroviral therapy (HAART) as best practice for PMTCT are understood and implemented by key policymakers and service providers*
2. *Early initiation of diagnosis and treatment for all HIV-exposed infants and children, including administration of cotrimoxazole*
3. *Allocation of appropriate percentage of total HIV/AIDS resources to achieve 80% coverage rates for PMTCT+ and pediatric treatment and ensure high-quality services*
4. *Nutrition funded as key component of pediatric treatment, including micronutrients*
5. *New fixed dose combination drugs registered for use in focus countries*
6. *Increased task-shifting to allow trained non-physician clinicians to initiate PMTCT and pediatric treatment*
7. *Improved monitoring and capacity building of both local and global programs to ensure effective implementation of PMTCT+ and pediatric diagnosis and treatment guidelines*

II. CHALLENGES AND RECENT PROGRESS

Inadequate Prevention and Treatment. The vast majority of pediatric HIV infections occur through mother-to-child transmission, and antiretroviral therapy (ART) can reduce the incidence of MTCT to as low as 2%. But an estimated 370,000 children were infected with HIV in 2007 alone, approximately 17% of all new infections, primarily because pregnant, HIV-positive women lack access to PMTCT+ services. Treatment for children also lags far behind that of adults. Of the nearly 3 million people on treatment globally, only 200,000, or 6.7%, are children. Likewise, only one in seven (14%) of the 780,000 children in need of ART are receiving it. As a result, children accounted for 14% of all AIDS deaths in 2007. Worldwide, some 108 countries have programs to eliminate pediatric HIV/AIDS, but only 17 are on track to reach the United Nations General Assembly Special Session (UNGASS) goal for reducing HIV infections in children. Of the 2 million children under the age of 15 with HIV/AIDS worldwide, 1.8 million reside in sub-Saharan Africa.

During 2007, in the seven campaign focus countries, there were 683,000 pregnant women living with HIV, and 474,340 (69.4%) of them were not accessing prevention of mother-to-child transmission services. PMTCT coverage rates ranged from a low of 6% in Nigeria to a high of 70% in Kenya. If universal PMTCT coverage (80%) had been achieved, 546,400 pregnant women living with HIV would have received PMTCT services, enabling an additional 337,740 women and families to benefit from the scale-up of PMTCT services.

Also in 2007, 957,000 children were living with HIV/AIDS in the seven campaign focus countries. Of these, only 72,599 (7.58%) received antiretroviral medications. The percentage of children receiving ARVs as a percentage of the total number of people receiving treatment ranged from a low of 5% in Ethiopia to a high of 20% in Nigeria. If universal pediatric treatment access (80%) had been achieved, 765,600 children would have received ARVs, an additional 693,001 children.

Recent Progress. Though advances in pediatric prevention, treatment, and care have been unacceptably slow overall, PMTCT and pediatric AIDS treatment are beginning to receive increased attention from donors, implementing agencies, and national governments. For example, national pediatric treatment programs have seen recent growth due in part to an upsurge in donor resources dedicated to pediatric treatment. In 2005, UNICEF launched a Unite for Children, Unite Against AIDS campaign to urge the international community to protect children against the impacts of HIV/AIDS and eliminate AIDS among children and youth. The campaign aims to ensure that children's well-

being remains a focus of the global AIDS response, and has succeeded in encouraging and strengthening global and national efforts to scale up PMTCT programs, as well as protection, care, and support services for children affected by AIDS.

Rounds 6 and 7 of the Global Fund to Fight AIDS, TB and Malaria have contributed to the momentum to eliminate pediatric HIV/AIDS. In Round 6, 14 countries were granted funding for pediatric treatment programs. Fifteen successful grants mentioned PMTCT, including Burkina Faso, Djibouti, Guinea, Liberia, Mozambique, Rwanda, Senegal, and Sierra Leone, and ten successful grants mentioned pediatric treatment, including Burkina Faso, Djibouti, Guinea, Liberia, Mozambique, and Senegal. Eight grants proposed to provide both PMTCT and pediatric treatment.

The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) has also greatly increased the number of children on treatment through its programs in the last year. PEPFAR spent \$195 million in 2007 on PMTCT programs and through downstream support expanded access to treatment for children by reaching 85,900 children. As of September 2007, PEPFAR was providing ART to approximately 1.45 million people, of which PEPFAR reports 62% are women and 9% are children—up from 3% in 2004. In addition, PEPFAR has launched a public-private partnership that is catalyzing innovative solutions to scale up pediatric diagnosis and treatment.

Overall, a review of Global Fund and PEPFAR programs indicate progress toward reducing the proportion of infants with HIV by 50%, ensuring that 15% of all people on treatment are children, and increasing the number of pregnant women accessing PMTCT+ programs.

The Clinton HIV/AIDS Initiative is also galvanizing global demand for pediatric treatment, contributing to demand for increased funding, treatment scale-up, and lower costs. Through its activities, Clinton Foundation/CHAI has worked with national governments to expand the number of sites providing pediatric treatment and has succeeded in narrowing the gap between adult and pediatric access—with 25% of children in need now on ART, compared to 35% of adults.

Finally, innovative funding mechanisms such as the international drug purchase facility UNITAID are driving the fight against pediatric HIV/AIDS. UNITAID's initial budget for pediatric HIV commodities was \$35.9 million for 2007. UNITAID funding was recently extended to 2010, including \$58.6 million for 2008. UNITAID is also providing support for scale-up of PMTCT programs. In March 2007, UNITAID awarded UNICEF and WHO \$21 million over two years to support the acceleration of PMTCT programs in eight high-burden countries in Africa and Asia.

In tandem with progress at the international level, increasing numbers of sub-Saharan African nations have included expanding pediatric treatment programs as part of their formal national HIV/AIDS plans. For example:

- ◆ In Rwanda, the Commission Nationale de Lutte contre le Sida (CNLS) has partnered with UNICEF to organize an annual conference on care and treatment of children infected with and affected by HIV/AIDS since 2005. Overall coverage for pediatric treatment in 2006 was estimated at 41% of children in need of treatment; PCR testing coverage was approximately 60%; and PMTCT services reached 60% of confirmed HIV-positive women.
- ◆ Mozambique adopted a plan for pediatric treatment scale-up in 2006 and set pediatric treatment targets in its 2006-2009 Poverty Reduction Strategy. The number of children receiving ART increased from 3,443 in 2006 to 6,320 in 2007, about 8% of those in need.

- ◆ In May 2006, the Kenyan National Agency for the Control of AIDS introduced a national algorithm for early infant diagnosis (EID) that recommends PCR testing in all HIV-exposed infants from six weeks, with confirmatory antibody test at 18 months. That year 6,204 EID tests were performed within the national network, and the number of children receiving ART increased by 66% between 2006 and 2007.
- ◆ In Zambia, new policies and guidelines are being developed to track HIV-exposed infants and their mothers and increase the number of children tested for HIV infection using DNA PCR. A nationwide EID network consisting of two central laboratory sites and a distributed dried blood spot collection network is also under construction.
- ◆ In Nigeria, overall pediatric treatment coverage has increased from 5,279 children in 2006 to 15,345 children at the end of 2007.

Key Bottlenecks. As national and global organizations increase their investments in pediatric programs, there is significant opportunity to accelerate PMTCT+ and pediatric AIDS treatment. However, implementers are reporting key challenges that are threatening forward progress. Resources continue to lag behind needs estimates, and their sustainability remains uncertain. Beyond resource issues, GAA and our partners have identified two major types of bottlenecks that must be addressed urgently in order to leverage the opportunities described above and ensure that PMTCT+ and pediatric HIV/AIDS programs are scaled up successfully:

1. **Implementation bottlenecks**, such as inadequate health care worker training; lack of or insufficient transportation systems for health care commodities; problems with procurement and supply chain management; and inadequate adoption of international and national guidelines for PMTCT+ and pediatric treatment.
2. **Policy bottlenecks**, such as lack of long-term predictable financing; over-reliance on external funding for antiretroviral medications (ARVs); funding shortfalls and bottlenecks in disbursement from both domestic and international sources; limitations on task-shifting to trained non-physician clinicians; and the lack of or unclear national policies and targets for scaling up access to pediatric HIV/AIDS services.

There are both global and country-level challenges to addressing these bottlenecks to scaling up PMTCT+ and pediatric treatment programs.

Global Challenges. Despite international commitments to achieve universal access to HIV/AIDS services by 2010, including 80% coverage for pediatric treatment and PMTCT+ services, progress toward these goals remains slow, and pediatric HIV transmission remains unacceptably high, particularly in sub-Saharan Africa. Though there has been a proliferation in funding to combat pediatric HIV/AIDS over the past three years, the resources available continue to lag behind needs estimates, and their sustainability remains uncertain. As described below, the campaign's advocacy to overcome these challenges will focus on key global stakeholders:

- ◆ Both the **World Health Organization** and **UNICEF** must do more to provide the leadership and guidance needed to ensure up-to-date strategies are developed and disseminated and implemented at the country level. Failure to provide such leadership effectively and in a timely manner is slowing efforts to achieve agreed-upon goals for eliminating pediatric HIV/AIDS.

- ◆ The **Global Fund to Fight AIDS, TB and Malaria** is a critically important funding mechanism for HIV/AIDS prevention and treatment that must expand its commitment to ensuring country-level scale-up of pediatric HIV/AIDS programs. Moreover, the failure of donors to ensure full replenishment of the Global Fund hinders efforts to achieve universal access commitments, including 80% coverage for PMTCT+ and pediatric treatment.
- ◆ **PEPFAR** has contributed significant resources to scaling up global HIV prevention, treatment, and care; however, full funding for the next phase of the U.S. AIDS program remains uncertain, and PEPFAR needs to increase its investments in PMTCT+ and pediatric treatment and update its PMTCT guidelines to include HAART for all pregnant women through breast-feeding.
- ◆ **UNITAID** has provided funding for PMTCT and pediatric treatment programs, including the purchase of commodities and drugs, and has helped achieve significant price reductions for pediatric HIV/AIDS drugs. This is particularly important because health interventions such as pediatric treatment, second-line ARVs, PMTCT, and malaria combination therapy regimens are now being prioritized. Nonetheless, UNITAID's funding for programming is structured along project timelines, and it is unclear whether there is a long-term funding commitment to combating pediatric HIV/AIDS, or a commitment to take the lead in influencing the global health commodities market in order to help further lower prices.
- ◆ The **private sector** has mobilized to produce fixed-dose combination drugs (FDCs) and assist with logistics and the creation of early infant diagnostic systems. However, both the pharmaceutical and diagnostics industry need to do more in terms of accelerating research, development, and production of new technologies for early infant diagnosis, new FDCs, and second- and third-line antiretroviral medications.

Country-Level Challenges. Operational, systems, and policy bottlenecks exist in each of the seven focus countries, but to varying degrees. In order to overcome these bottlenecks, the Campaign to End Pediatric HIV/AIDS will target country-level mechanisms that can effect the policy changes needed to encourage scale-up of PMTCT + and pediatric treatment programs. Such mechanisms include national and district HIV/AIDS prevention and control councils, national AIDS plans, Global Fund country coordinating mechanisms (CCMs), national ARV procurement and supply chains, national legislative HIV/AIDS committees or associations, Ministry of Health national and district health management teams, local ARV manufacturers, and NGO service providers and implementers. Other stakeholders that can play a critical role in overcoming country-level bottlenecks include business coalitions, professional associations, and PEPFAR Country Operational Plan (COP) Committees.

See Appendix I for a summary of key bottlenecks in the campaign's focus countries.

III. CAMPAIGN GOALS AND OBJECTIVES

Over the next three years, the Campaign to End Pediatric HIV/AIDS will accelerate action to reduce the incidence of pediatric HIV/AIDS and measurably improve the delivery of treatment to children and mothers, with a focus on seven countries. The campaign's overall goal is:

To increase coverage rates for prevention of mother-to-child transmission and pediatric treatment services from the current average of 30% to 40% to the globally agreed-upon target of 80% and ensure high-quality services.

In order to achieve this goal, the campaign will seek to accelerate progress toward four core objectives, which comprise the CEPA Agenda for Action:

OBJECTIVE #1: Family-Centered Care and Nutrition. *Expand access to PMTCT+ and pediatric treatment, care, and support, including nutrition services, and integrate child and family services with other health services in order to improve survival rates and health outcomes for children, HIV-positive mothers, and their families. If successful, CEPA will persuade major global stakeholders to develop policies and guidelines that define and promote family-centered care and nutrition to better address the needs of children and families affected by or vulnerable to HIV/AIDS. At the country level, national governments and implementing organizations, including donors and NGOs, will prioritize developing national policies and guidelines that define and emphasize the provision of family-wide prevention, treatment, and care under one roof as part of their national AIDS programs. In particular, WHO guidelines endorsing highly active antiretroviral therapy (HAART) as best practice for PMTCT must be clearly understood and implemented by key policymakers and service providers alike.*

Most national HIV/AIDS programs do not provide PMTCT+ and pediatric treatment services in one location. But segmented service delivery to pregnant women and their children fails to take advantage of the benefits that comprehensive family-centered care can offer. In addition, service providers at the country level consistently complain that PMTCT+ and pediatric treatment programs are too often implemented in a parallel, uncoordinated manner, rather than effectively integrated.

A family-centered care approach to HIV that includes the provision of prevention, treatment, and care services to the entire family in one location is the best means to identify those in need, ensure services reach vulnerable groups such as women and children, and ultimately eliminate pediatric AIDS. In addition, family-focused programs have been shown to increase service uptake, make AIDS service delivery more complementary to horizontal improvements in health systems, and have higher chances of reaching populations in need and ensuring long-term treatment adherence.

The family-centered care package of services should, at a minimum, include:

1. Comprehensive PMTCT, including sexual and reproductive health (SRH) services;
2. Infant diagnosis and treatment;
3. Child survival interventions, including immunization and growth monitoring, nutritional support, access to and training in the correct use of insecticide-treated nets, and antibiotic cotrimoxazole prophylaxis;
4. Maternal HIV care;
5. Community-based care and support, including palliative care; and
6. Routine health interventions for the whole family.

Ultimately, an integrated, holistic approach to HIV/AIDS that incorporates a family-based approach to prevention, treatment and care at one location would ensure family-wide participation and benefits to HIV/AIDS programs and the health system in general.

Bottlenecks: The primary bottlenecks the campaign will seek to overcome are poor retention of patients in treatment programs due to fragmented service delivery structures; a lack of both trained health care providers and policies permitting non-physicians to initiate antiretroviral therapy (ART); and a lack of policies and guidelines that create linkages between antenatal care (ANC), sexual and reproductive health (SRH), including family planning, basic maternal and child health services, and PMTCT+ programs.

OBJECTIVE #2: Early Infant Diagnosis and Treatment. *Expand access to early infant diagnosis and earlier and improved pediatric treatment in order to improve survival rates and health outcomes for children. If successful, CEPA will persuade major global stakeholders to develop and implement policies and guidelines to promote national-level scale-up of early infant diagnosis and treatment programs. At the country level, national governments, donors, and NGOs will enhance and expand EID and EIT programs and support pediatric AIDS services within national AIDS plans and strategic frameworks.*

Pediatric AIDS has remained unchecked in sub-Saharan Africa partly due to the inability of health systems to track children exposed to HIV and perform timely, definitive diagnosis to identify those who are infected and need treatment. Indeed, most HIV-positive children die undiagnosed before their second birthday due to inadequate diagnostics infrastructure and personnel. In addition, treating infants is complicated and has been the subject of controversy. Infants are harder to treat in terms of dosing, formulations, adherence, and cultural bias. CD4 and viral load are poor criteria for judging disease progression in infants, and concerns have been raised about the initiation of lifelong ART in infants, since it raises the likelihood of eventual treatment failure and increases costs. Nonetheless, early treatment of HIV can reduce incidences of morbidity and mortality from opportunistic infections, malnutrition, and diarrhea. Indeed, treatment initiation in the first few months of life has proven to achieve health outcomes similar to those in adults and to considerably enhance child survival rates.

Bottlenecks: The primary bottlenecks CEPA will seek to overcome are insufficient infrastructure for diagnosis and treatment of children living with HIV; operational barriers such as the lengthy turnaround time from drawing test samples to reporting test results and difficulty enrolling and retaining children in the continuum of care; lack of health care workers trained in pediatric HIV treatment, clinical management of pediatric HIV, pediatric pain management and palliative care, and the use of diagnostic technologies; late initiation of infant HIV treatment due to failure to implement modified WHO infant treatment guidelines; the urgent need to develop new technologies; and the high cost of pediatric HIV diagnostics and treatment relative to the health resources available in most African countries.

OBJECTIVE #3: Access to Appropriate Medications. *Reduce distribution barriers and increase the global supply of high-quality, low-cost lifesaving medicines for children and their families, including ARVs, drugs to treat opportunistic infections, and first and second-line regimens to ease dosing and administration. If successful, CEPA will persuade major global stakeholders to prioritize expanded access to appropriate medications to prevent and treat pediatric HIV/AIDS, including making policy reforms to overcome procurement and supply chain management bottlenecks at the country level; increasing the quantity and availability of pediatric drug formulations; expanding efforts to secure price reductions for pediatric drugs and commodities; and developing global forecasts of supplies needed for PMTCT+ and pediatric treatment. At the country level, national governments will revise their policies and procedures to reduce country-level barriers and increase the supply and availability of pediatric medications, including ARVs and drugs to treat opportunistic infections.*

In the past two years, there has been an increase in the number of ARVs available in pediatric formulations, and prices for these formulations have decreased significantly. While this proliferation in pediatric formulations is vital to scaling up pediatric treatment and eliminating pediatric AIDS, pediatric formulations still lag behind their adult counterparts. In particular, access to pediatric ARV formulations is hindered by slow national pre-qualification and regulatory drug approval processes, weak national procurement and supply management guidelines and policies, and the high cost of pediatric drugs, which have made some countries hesitant to make pediatric formulations available. Without optimal HIV treatment and care for children, HIV infection progresses aggressively. Thus, HIV/AIDS accounts for 6% of deaths in children younger than five years of age and was the leading cause of death in six countries in eastern and southern Africa in 2000.

Bottlenecks: The primary bottlenecks the campaign will seek to overcome are slow national pre-qualification and regulatory drug approval processes, e.g., drug registration, the high cost of pediatric HIV drugs relative to adult ARVs; weak national procurement and supply management guidelines, policies, and systems that fail to maintain records of available medications, disseminate information on drug availability to providers, and ensure timely circulation; and lack of availability of second- and third-line pediatric ARV formulations and other essential drugs such as cotrimoxazole.

OBJECTIVE #4: Full Funding to Eliminate Pediatric AIDS. *Secure the financial resources needed to facilitate country-level scale-up of PMTCT+ and pediatric and maternal treatment programs. If successful, CEPA will persuade both global and national-level stakeholders commit the increased financial resources needed to effectively scale up PMTCT+ and pediatric treatment programs and eliminate pediatric AIDS morbidity and mortality. Importantly, increased donor spending will encourage national governments to prioritize pediatric treatment and care as part of national health and HIV/AIDS plans.*

Scale-up of pediatric diagnosis, treatment, and care has been disappointingly slow, partially due to inadequate funding. Pediatric HIV diagnosis, treatment, and care programs differ from adult services and require additional resources for equipment, training personnel, ARV formulations, communications, shipping, and reporting and storage networks. Ultimately, countries with more resources can establish better quality pediatric diagnosis and treatment programs that are able to identify children earlier and get more children on treatment.

Bottlenecks: The primary bottlenecks the campaign will seek to overcome are insufficient implementing and donor government commitment to achieving 80% coverage for pediatric treatment and PMTCT+ services; and inadequate allocation of resources to pediatric HIV diagnosis, treatment, and care, and PMTCT+ programs.

IV. EXPECTED ADVOCACY OUTCOMES

The overall goal of the Campaign to End Pediatric HIV/AIDS is to increase coverage rates for prevention of mother-to-child transmission and pediatric treatment services from the current average of 30% to 40% to the globally agreed-upon target of 80% and ensure high-quality services. Progress toward this goal will be leveraged through CEPA's efforts to advance its four core objectives of family-centered care and nutrition, early infant diagnosis and treatment, access to appropriate medications, and full funding to eliminate pediatric HIV/AIDS. The expected advocacy outcomes for these core objectives are as follows:

Family-Centered Care and Nutrition: Major global stakeholders develop policies and guidelines that define and promote family-centered care and nutrition to better address the needs of children and families affected by or vulnerable to HIV/AIDS. At the country level, national governments and implementing organizations, including donors and NGOs, prioritize developing national policies and guidelines that define and emphasize the provision of family-wide prevention, treatment, and care under one roof as part of their national AIDS programs.

Early Infant Diagnosis and Treatment: Major global stakeholders develop and implement policies and guidelines to promote national-level scale-up of early infant diagnosis and treatment programs. At the country level, national governments, donors, and NGOs enhance and expand EID and EIT programs and support pediatric AIDS services within national AIDS plans and strategic frameworks.

Access to Appropriate Medications: Major global stakeholders prioritize expanded access to appropriate medications to prevent and treat pediatric HIV/AIDS, including making policy reforms to overcome procurement and supply chain management bottlenecks at the country level; increasing the quantity and availability of pediatric drug formulations; expanding efforts to secure price reductions for pediatric drugs and commodities; and developing global forecasts of supplies needed for PMTCT+ and pediatric treatment. At the country level, national governments revise their policies and procedures to reduce country-level barriers and increase the supply and availability of pediatric medications, including ARVs and drugs to treat opportunistic infections.

Full Funding to Eliminate Pediatric HIV/AIDS: Both global and national-level stakeholders commit the increased financial resources needed to effectively scale up PMTCT+ and pediatric treatment programs and eliminate pediatric AIDS morbidity and mortality. Importantly, increased donor spending will encourage national governments to prioritize pediatric treatment and care as part of national health and HIV/AIDS plans.

At the global level, CEPA's primary advocacy targets will be the U.S. and other G8 governments, the Global Fund to Fight AIDS, TB and Malaria, the World Health Organization, UNICEF, and UNITAID. Importantly, GAA will continue to align our efforts with those of operational partners, such as the Clinton Foundation/CHAI, and to rely on their leadership in advancing specific operational outcomes. (UNAIDS AND UNITAID may be advocacy targets or advocacy partners, depending on the issue.)

The campaign's advocacy at the country level will target those responsible for ensuring effective funding and implementation of pediatric AIDS programs, including health and finance ministries, Global Fund CCMs, Global Fund and PEPFAR implementers, and Inter-Agency Task Team committees. The country-level outcomes will, of course, vary depending on opportunities and obstacles within specific focus countries, and specific outcomes will be prioritized within country-level Advocacy Action Plans based on consultations with local partners.

While the global-level advocacy objectives and outcomes of the Campaign to End Pediatric HIV/AIDS are fairly well-defined, specific elements may be revised based on input from core implementing partners and country-level stakeholders. Likewise, CEPA's country-level objectives and expected outcomes will be expanded and revised based on more intensive consultation with core partners and stakeholders during Phase #1 of the campaign. Appendix II provides a draft logframe of the campaign's initial global advocacy objectives and outcomes, based on an initial desk review. Appendix III provides a draft logframe of preliminary country-level objectives and expected outcomes based on GAA's research and feedback from our core implementing partners.

The following chart outlines the outcomes that the Campaign to End Pediatric HIV/AIDS is expected to achieve at both the global and country levels. While the work of the campaign will be organized around the four core objectives outlined above, the campaign will help leverage large-scale, sustainable impacts on two major fronts: prevention of mother-to-child HIV transmission and pediatric treatment. Of course, many of CEPA's advocacy efforts are expected to leverage policy changes that will positively affect both prevention and treatment of pediatric HIV/AIDS.

EXPECTED ADVOCACY OUTCOMES OF THE CAMPAIGN TO END PEDIATRIC HIV/AIDS

CEPA Agenda for Action			
<p>CEPA's efforts to advance progress toward these four core objectives will help achieve large-scale sustainable impacts for children:</p> <ol style="list-style-type: none"> 1. Family-centered care and nutrition 2. Early infant diagnosis and treatment 3. Access to appropriate medications 4. Full funding to eliminate pediatric HIV/AIDS 			
	Prevention Mother-to-Child HIV Transmission (PMTCT+)	Pediatric Treatment	Both Prevention & Treatment of Pediatric HIV/AIDS
Large-Scale, Sustainable Impacts for Children	<ol style="list-style-type: none"> 1. WHO guidelines articulating HAART as best practice for prevention of mother-to-child HIV transmission clearly understood and implemented by both policymakers and service providers 	<ol style="list-style-type: none"> 2. Early initiation of diagnosis and treatment for all HIV-exposed infants and children, including administration of cotrimoxazole 	<ol style="list-style-type: none"> 3. Allocation of appropriate percentage of total HIV/AIDS resources to achieve 80% coverage rates for PMTCT+ and pediatric treatment and ensure high-quality services 4. Nutrition funded as key component of both PMTCT and pediatric treatment, including micro- and macronutrients 5. New fixed dose combination drugs registered for use in focus countries 6. Increased task-shifting to allow trained non-physician clinicians to initiate PMTCT and pediatric treatment 7. Improved monitoring and capacity building of both local and global programs to ensure effective implementation of PMTCT+ and pediatric diagnosis and treatment guidelines

	Prevention Mother-to-Child HIV Transmission (PMTCT+)	Pediatric Treatment	Both Prevention & Treatment of Pediatric HIV/AIDS
Global-Level Advocacy Targets & Expected Outcomes	<p><u>United States & G8 Governments</u></p> <ul style="list-style-type: none"> ◆ Adopt and promote guidelines that include HAART for all pregnant women through breast-feeding, and prioritize increased funding for PMTCT+, development and dissemination of ART forecasting and supply chain for PMTCT commodities, provision of PMTCT at all ART sites and site networks, and harmonized M&E systems, including improved standard reporting requirements on women receiving HAART ◆ 80% of women at PEPFAR-funded PMTCT clinics receive prophylactic treatment to prevent HIV transmission and follow-up to ensure maternal and infant adherence, in accordance with latest guidelines from WHO and UNICEF, e.g., mix of nevirapine and HAART ◆ PEPFAR COPs address PMTCT and integrate PMTCT with other maternal, newborn, and child health services ◆ PEPFAR-funded PMTCT clinics offer family-centered care, e.g., opt-out counseling and testing, rapid testing, ART, infant feeding counseling and support, etc. 	<p><u>United States & G8 Governments</u></p> <ul style="list-style-type: none"> ◆ Adopt and promote guidelines that prioritize funding for pediatric treatment, use of point-of-care CD4 equipment at primary care level, nutritional services, and ensuring at least 15% of people in PEPFAR-funded treatment programs are children <15 ◆ PEPFAR COPs required to address pediatric treatment, including setting treatment targets, decentralizing services, and implementing health worker training and capacity building strategies ◆ PEPFAR incentivizes new early infant diagnosis (EID) technologies, new FDCs, and second- and third-line medications 	<p><u>United States & G8 Governments</u></p> <ul style="list-style-type: none"> ◆ PEPFAR promotes family-centered care approach, including use of point-of-care CD4 equipment at primary care level and nutritional services, through guidelines aligned with WHO and UNICEF ◆ Adopt and promote guidelines for infant feeding counselling and support ◆ Full funding for PEPFAR's next phase ◆ G8 communiqués highlight full funding for Global Fund and HIV/AIDS ◆ OECD tracking of HIV/AIDS funding ◆ Promote efforts to negotiate with manufacturers to lower costs and increase production, supply, and use of generic medications

	Prevention Mother-to-Child HIV Transmission (PMTCT+)	Pediatric Treatment	Both Prevention & Treatment of Pediatric HIV/AIDS
Global-Level Advocacy Targets & Expected Outcomes	<p><u>Global Fund to Fight AIDS</u></p> <ul style="list-style-type: none"> ◆ Increase support for HIV/AIDS proposals that include PMTCT+ ◆ Grant round system and National Strategies Application window launch prioritize PMTCT+ as part of broader demand creation strategy ◆ Issue procurement guidelines prioritizing PMTCT drugs and commodities <p><u>WHO and UNICEF</u></p> <ul style="list-style-type: none"> ◆ Update PMTCT guidelines to include HAART for all pregnant women through breast-feeding ◆ Promote use of 2007 guidelines for provider-initiated counseling and testing in health facilities ◆ Promote integration of PMTCT within routine MNCH and reproductive health care services ◆ Promote and encourage use of follow-up system to track maternal adherence, including enrolment of mothers into postpartum care 	<p><u>Global Fund to Fight AIDS</u></p> <ul style="list-style-type: none"> ◆ Increase support for HIV/AIDS proposals that include pediatric treatment and care, including nutrition and micronutrients ◆ Grant round system and National Strategies Application window prioritize pediatric HIV diagnosis and treatment as part of broader demand creation strategy ◆ Issue procurement guidelines prioritizing pediatric drugs and commodities ◆ Incentivize new EID technologies, FDCs, and second- and third-line medications <p><u>WHO and UNICEF</u></p> <ul style="list-style-type: none"> ◆ Disseminate revised pediatric treatment guidelines calling for earlier initiation of treatment and monitor to ensure country-level implementers initiate EID ◆ Consider adopting and promoting guidelines recommending country use of the Pre-Approval Access Permit (PAAP) 	<p><u>Global Fund to Fight AIDS</u></p> <ul style="list-style-type: none"> ◆ Establish process for extending grants in order to guarantee sustained, long-term funding and encourage national governments to scale up their own investments in the prevention and treatment of pediatric HIV/AIDS ◆ Adopt CEPA objectives as part of business plan to combat HIV/AIDS <p><u>WHO and UNICEF</u></p> <ul style="list-style-type: none"> ◆ Develop and disseminate estimates of global resources needed to scale up PMTCT+ and pediatric treatment ◆ Adopt and promote global definition and guidelines for family-centered care that stipulate minimum package of services ◆ Issue policy directives for adoption of family-centered care and use of point-of-care CD4 equipment at primary care level ◆ Promote follow-up to ensure adherence ◆ Help countries adopt WHO pre-qualification programs, standardize drug registration guidelines, and improve registration procedures ◆ Support country-level efforts to promote task-shifting for PMTCT and pediatric treatment ◆ Develop global forecasts for pediatric drugs and commodities and work to increase supply, lower prices, and improve distribution

	Prevention Mother-to-Child HIV Transmission (PMTCT+)	Pediatric Treatment	Both Prevention & Treatment of Pediatric HIV/AIDS
Global-Level Advocacy Targets & Expected Outcomes	<p><u>UNAIDS</u></p> <ul style="list-style-type: none"> ◆ Include PMTCT drugs and commodities in annual global resource needs estimates <p><u>UNITAID</u></p> <ul style="list-style-type: none"> ◆ Board resolution prioritizing funding for PMTCT drugs and commodities over next five years ◆ Allocate additional funding for PMTCT commodities 	<p><u>UNAIDS</u></p> <ul style="list-style-type: none"> ◆ Include early infant diagnostics in annual global resource needs estimates <p><u>UNITAID</u></p> <ul style="list-style-type: none"> ◆ Board resolution supporting countries' use of Pre-Approval Access Permit <p><u>Private Sector</u></p> <ul style="list-style-type: none"> ◆ Increased R&D of new pediatric diagnostics and medications, including FDCs and second- and third-line ARVs ◆ Engage with public-private partnerships to accelerate development of pediatric diagnostics and medications, including PEPFAR's Public-Private Partnership on Pediatric AIDS Treatment ◆ Support the UNITAID Patent Pool 	<p><u>UNAIDS</u></p> <ul style="list-style-type: none"> ◆ Board adopts CEPA objectives ◆ Prioritize and coordinate broader PMTCT and pediatric treatment efforts <p><u>UNITAID</u></p> <ul style="list-style-type: none"> ◆ Incorporate extension of project timelines for funding support of PMTCT and pediatric HIV medicines and diagnostics into UNITAID workplan and strategy to deliver on price reductions ◆ Board resolution operationalizing Patent Pool for Medicines without delay and efforts to secure support of pharmaceutical companies ◆ Improve coordination with partners by making process of accessing UNITAID priced medicines easier and more transparent ◆ Prioritize and lead efforts to impact global health commodities market in order to achieve further price reductions in PMTCT and pediatric HIV/AIDS drugs and commodities

	Prevention Mother-to-Child HIV Transmission (PMTCT+)	Pediatric Treatment	Both Prevention & Treatment of Pediatric HIV/AIDS
Country-Level Advocacy Targets & Expected Outcomes	<p><u>Nat'l Governments & Implementers</u></p> <ul style="list-style-type: none"> ◆ Nat'l AIDS and health plans create specific earmarks or treatment coverage goals for PMTCT+ and require all ART sites to provide PMTCT+ services ◆ Nat'l AIDS and health plans promote and monitor implementation of PMTCT+ services, including HAART for all pregnant women through breast-feeding and follow-up to ensure maternal adherence ◆ Nat'l AIDS and health plans promote and monitor integration of PMTCT+ with HIV, MNCH, and reproductive health services ◆ Nat'l health plans promote decentralization of antenatal care and PMTCT services and include strategies to increase ANC clinic visits and deliveries ◆ Adopt and implement guidelines for routine opt-out HIV counseling and testing for all pregnant women, rapid testing methods, follow-up to ensure receipt of PMTCT prophylaxis, and infant feeding counselling and support ◆ Establish MOH programs to train non-physician clinicians on PMTCT clinical management, including provision of HAART 	<p><u>Nat'l Governments & Implementers</u></p> <ul style="list-style-type: none"> ◆ Nat'l AIDS and health plans set pediatric treatment targets ◆ Nat'l AIDS and health plans incorporate implementation of WHO's 2006 pediatric treatment guidelines ◆ MOH guidelines for cotrimoxazole prophylaxis to all HIV-exposed children ◆ Nat'l system to transport blood samples and ensure PCR test results are delivered to all HIV-exposed infants' families ◆ Nat'l guidelines promote EID/EIT aligned with global evidence-based norms ◆ MOH recommendations for nationwide introduction and roll-out of EID/EIT infrastructure and services ◆ Require all adult treatment sites to provide pediatric treatment ◆ Establish MOH programs to train non-physician clinicians on EID/EIT and clinical management of pediatric HIV/AIDS ◆ Consider use of import waivers or PAAP 	<p><u>Nat'l Governments & Implementers</u></p> <ul style="list-style-type: none"> ◆ Nat'l HIV guidelines incorporate family-centered care and promote service delivery design changes and interventions to address continuum of care ◆ Nat'l AIDS and health plans decentralize HIV services, including PMTCT+ and pediatric treatment, through "district-wide" approach ◆ Allocate 15% of annual nat'l budgets to health care and increase funding for family-centered care programs, including nutritional services ◆ Allocate increased nat'l and donor funds to achieve national scale-up of PMTCT+ and pediatric treatment programs, including nutritional services ◆ Encourage PEPFAR COPs to include increased focus on PMTCT+ and pediatric treatment ◆ Nat'l guidelines authorize non-physicians to initiate PMTCT, pediatric treatment, and palliative care ◆ Support procurement mechanisms to negotiate lower prices on diagnostic tests and equipment ◆ Strengthen nat'l procurement, distribution, and supply chain management guidelines ◆ Revise pre-qualification and regulatory drug approval guidelines to accelerate registration ◆ Reform drug registration procedures and permit cross-border registration ◆ Amend national registration protocols to accept FDA or WHO pre-qualification ◆ Track prices and supplies of pediatric medicines and commodities ◆ Conduct public education campaigns to raise awareness of availability and impact of pediatric HIV programs and increase demand

V. CAMPAIGN MODEL AND APPROACH

A. Advocacy Approach

The Campaign to End Pediatric HIV/AIDS intends to support national-level models for effective advocacy—linked with the help of regional organizations and networks—and to strengthen African civil-society advocacy organizations. CEPA’s advocacy partners will target key decision-makers and those who can influence policies, funding, and program implementation to prevent and treat pediatric HIV/AIDS—with the goal of maximizing the impact of investments by national governments, Clinton Foundation/CHAI, PEPFAR, the Global Fund to Fight AIDS, TB and Malaria, UNITAID, and other NGOs. Our essential approach is to:

- ◆ Identify advocacy targets and engage partners at the country level that can influence key policy and implementation barriers;
- ◆ Monitor the impact of efforts to scale up pediatric HIV prevention and treatment; and
- ◆ Hold African governments and global stakeholders accountable for results, with a focus on developing standardized report cards of country-level progress and performance and independent country-level monitoring of implementers, e.g., Global Fund principal recipients and PEPFAR grantees.

Local to Global Advocacy Approach. CEPA partners will generate country-level Advocacy Action Plans linked to specific policy outcomes and to the campaign’s monitoring and evaluation (M&E) framework. Based on the priorities identified in these country-level plans, an annual global-level action plan will be developed. Interim regional meetings of country-level partners will be convened to ensure effective collaboration and promote shared learning among countries at different stages of scaling up pediatric HIV/AIDS programs. CEPA’s annual Advocacy Action Plans will identify specific country and global-level outcomes and track progress toward the campaign’s four core objectives.

Building a Network of Advocates. The campaign will engage indigenous African civil-society organizations (CSOs) and networks that can provide country-specific expertise and contacts, particularly to address diverse social, economic, cultural, and political contexts. Importantly, advocacy targeting national governments and implementing agencies will need to draw on the strengths of treatment activists, service providers, and technical experts on procurement and other implementation issues. Indeed, CEPA provides an important opportunity to leverage treatment activist organizations and networks into more active support of efforts to scale up pediatric AIDS services. Ultimately, CEPA will help build a network of advocates that can help ensure ongoing monitoring and accountability as prevention and treatment programs are scaled up at the national level across Africa. In doing so, the campaign will advance an advocacy model that can be implemented in other countries and potentially replicated in other regions worldwide.

CEPA partners will seek to establish linkages among African advocates, as well as between African advocates and those in donor countries. The initiative will enable in-country advocates to play a critical role in informing advocacy and shaping policy and funding decisions at the global level. This can strengthen and reinforce investments through global institutions and NGOs. At the same time, both donors and multilateral institutions can exert positive pressure on implementing country governments to scale up PMTCT+ and pediatric prevention programs.

Advocacy Action Plans. CEPA’s country-level partners will be convened periodically to develop and review progress in implementing annual Advocacy Action Plans that define country-specific outcomes, strategies and tactics, and M&E processes. Such activities could include (1) environmental mapping to identify advocacy opportunities; (2) national consultations to advance a policy initiative; (3) policy

analysis targeted to key policymakers; (4) media-based advocacy strategies; and (5) linking African advocates to U.S. and global policy dialogues. GAA will facilitate systematic communication to support the design and implementation of joint advocacy efforts, such as a standardized report card of country-level progress and performance.

B. Focus Countries

Based on an analysis of opportunities and obstacles to progress in scaling up PMTCT+ and pediatric and maternal treatment programs, the Campaign to End Pediatric HIV/AIDS will be launched in seven focus countries where key barriers can be addressed through effective advocacy at both the country and global levels. CEPA partners will concentrate our efforts in countries in which major global health financing initiatives are operating, i.e., PEPFAR, the Global Fund, and UNITAID. The campaign's country-level work will monitor whether donor and national government interventions are generating tangible results—and use this information to advocate for policy and program reforms and sustained and increased investments at both the country and global level.

The campaign's advocacy will focus on known barriers in countries at more advanced stages of programming, and also apply lessons learned to help address or avert bottlenecks in countries at earlier stages of program implementation. In each case, the high level of external investment creates an imperative for ensuring accountability. CEPA's strategy is to engage two groups of countries at different stages of scaling up pediatric and family AIDS services:

GROUP #1: "Tipping Point" Countries. The first country group CEPA will engage includes Kenya, Tanzania, Uganda, and Zambia, where scale-up of pediatric AIDS services is well under way. These countries are at a tipping point in terms of access to pediatric prevention and treatment, but more effective advocacy is needed to overcome key barriers. In addition, we selected countries whose experiences and challenges could benefit one another. For example, Uganda is one of the few countries that is increasing access to family-centered care and has taken concrete steps toward implementation.

GROUP #2: "Transition" Countries. The second country group CEPA will engage includes Ethiopia, Mozambique, and Nigeria—larger countries that are earlier in the process of scaling up pediatric AIDS services. Lessons from the East African "tipping point" countries will help provide a framework for translating best practices and applying lessons learned in countries at an earlier stage of scale-up. For example, strong national policy guidance and frameworks in Zambia could powerfully inform the work of Nigeria, where the lack of an effective policy framework has been identified as a bottleneck.

This approach is intended to facilitate the cross-pollination of best practices and South-to-South exchange of ideas and learnings both within the country groups and among countries at different stages. Such exchanges offer a critical vehicle for urging governments and implementers to accelerate progress according to best practices being implemented by neighboring countries.

As the campaign evolves, we may consider expanding to additional countries, such as Malawi, South Africa, and Zimbabwe, based on dialogue with other donors and partners.

Criteria for Focus Country Selection: In addition to major external funding for pediatric AIDS and PMTCT services and the stage of scale-up, GAA utilized the following additional criteria to select proposed focus countries:

- ◆ **Significant pediatric HIV/AIDS burden.** The number of children with HIV/AIDS living in each of the proposed focus countries ranges from 92,000 in Ethiopia to 220,000 in Nigeria, and together these focus countries accounted for 53% of the total number of children living with HIV/AIDS in sub-Saharan Africa in 2007. Similarly, the estimated number of pregnant women with HIV/AIDS ranges from 66,000 in Ethiopia to 190,000 in Nigeria, and the proposed CEPA focus countries accounted for 52% of the total number of HIV-positive, pregnant women in sub-Saharan Africa in 2007. While access to PMTCT services in the focus countries ranges widely, from 6% in Nigeria to 70% in Kenya, nearly 70% of the total number of pregnant, HIV-positive women in the seven CEPA focus countries were not receiving ARV treatment to prevent mother-to-child HIV transmission in 2007. Perhaps most important, according to WHO's 2008 report on progress toward universal access, children accessing antiretroviral treatment accounted for less than 10% of the total number of people on ARV treatment in 2007 in all of the CEPA focus countries except Nigeria.
- ◆ **High priority among global implementers.** Global initiatives such as CHAI's pediatric AIDS program, PEPFAR, the Global Fund, and UNICEF's "demand creation" strategy for PMTCT+ services have catalyzed direct implementation of scale-up and system-wide changes in the health sector. The proposed campaign will rely on the continued guidance and technical expertise of CHAI and UNICEF, as well as other stakeholders, including researchers, academics, service providers, PEPFAR, WHO, and UNAIDS.
- ◆ **Indigenous provider and activist networks.** Country-specific bottlenecks and interventions are best addressed by those living and working on the ground, and collaboration with partners in each of the focus countries will be critical to the campaign's success. Based on GAA's knowledge of existing networks and established working relationships, we have identified strong potential country-level implementation and advocacy partners in each of the focus countries.
- ◆ **Clear entry points for advocacy.** There are well-defined advocacy targets in the form of functioning decision-making bodies, such as national AIDS commissions, health ministries, and specialized task forces. In addition, each country has national frameworks, such as national AIDS, poverty reduction, children's well-being, and reproductive health plans, which will serve as vehicles for campaign advocacy and accountability.
- ◆ **Enabling environment for civil society advocacy.** Each focus country operates under democratic principles and has established processes for participatory decision-making, transparency, and accountability, albeit to greater or lesser degrees. While there may not be a longstanding tradition of civil-society participation in governance in some countries, we believe that establishing and strengthening such civic engagement is paramount to ensuring sustained results beyond the life of the Campaign to End Pediatric HIV/AIDS.

See Appendix IV for an outline of some of the selection criteria utilized to determine the focus countries for the proposed Campaign to End Pediatric HIV/AIDS.

VI. ESTIMATED IMPACT ON CHILDREN AND FAMILIES

The Campaign to End Pediatric HIV/AIDS could have an enormous impact in terms of increasing access to pediatric prevention, treatment, and care, including PMTCT+ and nutritional services. During 2007, in the seven CEPA focus countries, there were 683,000 pregnant women living with HIV, and 474,340 (69.4%) of them were not accessing prevention of mother-to-child transmission services. PMTCT coverage rates ranged from a low of 6% in Nigeria to a high of 70% in Kenya. If universal

PMTCT coverage (80%) had been achieved, 546,400 pregnant women living with HIV would have received PMTCT services, enabling an additional 337,740 women and families to benefit from the scale-up of PMTCT services.

Also in 2007, 957,000 children were living with HIV/AIDS in the seven CEPA focus countries. Of these, only 72,599 (7.58%) received antiretroviral medications. The percentage of children receiving ARVs as a percentage of the total number of people receiving treatment ranged from a low of 5% in Ethiopia to a high of 20% in Nigeria. If universal pediatric treatment access (80%) had been achieved, 765,600 children would have received ARVs, or an additional 693,001 children.

If the Campaign to End Pediatric HIV/AIDS achieves its goal of an 80% coverage rate for pediatric treatment services, approximately 700,000 more children are expected to receive antiretroviral medications.

See Appendix V for selected epidemiological data from the seven focus countries.

As part of Phase #1 of the campaign, GAA will work with our core implementing partners and other country-level stakeholders to establish baseline epidemiological data—and identify other key data that are not being adequately monitored or reported.

VII. PROVISIONAL OPERATIONAL PLAN

The Campaign to End Pediatric HIV/AIDS will be implemented in three phases over the course of three years. This phased-in approach will allow GAA to design and implement the campaign in accordance with the principles for partnership approved by our Board of Directors in June 2008 (Appendix VI), and is intended to facilitate continuous learning and program refinement. Based in part on a recognition of traditional power imbalances between organizations working in wealthy donor countries and those based in the “global south,” these principles are designed to promote partnerships based on equal footing, mutual transparency, and accountability.

In addition to global and country-specific Advocacy Action Plans, the campaign will undertake activities designed to leverage the expertise and experience of stakeholders across countries and sectors in order to accelerate national-level scale-up of PMTCT+ and pediatric treatment programs. These activities will include:

- ◆ Subgrants to core partners and country-level advocates;
- ◆ A secretariat to coordinate and support core team operations and country-level operations;
- ◆ A regional Advocacy Summit during of the first year of the campaign to identify new and emerging issues, share lessons learned, and foster community (with an interim summit planned 12 to 18 months after the first summit);
- ◆ Bi-annual meetings of the CEPA Advisory Group to provide a forum for participatory program development and mutual accountability;
- ◆ A technical support mechanism; and
- ◆ Monitoring and evaluation throughout implementation of the campaign’s three phases.

Appendix VII provides a detailed timeline for the Campaign to End Pediatric HIV/AIDS, and key milestones for each of the three major phases of the campaign are described below.

A. Proposed Program Phases and Key Milestones, Activities, and Oversight

PHASE #1: Laying the Foundation (Months 1–7)

As the campaign will be implemented using a team approach, CEPA's core partners will be to convened for a face-to-face strategic planning meeting. We will use this time to discuss and refine the campaign design; lay out a proposed management structure; and begin planning for the first CEPA Advocacy Summit, which will mark the official launch of the campaign and the culmination of Phase #1.

Establishing the Campaign Framework. A primary objective of Phase #1 will be to develop a management plan that effectively supports the campaign's goals, is responsive to core partners and their respective networks, establishes clear lines of accountability, and ensures rigorous joint accountability for meeting the campaign's goals. In addition to clarifying objectives, roles, and responsibilities, as well as expected outcomes and indicators for success, Phase #1 of the campaign is intended to:

- ◆ Establish a results-based approach by developing an evaluation framework at the outset of the campaign;
- ◆ Undertake participatory program planning that will encourage a sense of joint ownership and vested interest in the campaign's success;
- ◆ Produce a detailed workplan that will assist in holding the campaign's partners accountable for delivering on our objectives; and
- ◆ Conduct due diligence to ensure selection of subgrantees based on standardized criteria, including demonstrated performance and sound financial management systems.

During the initial planning meeting, we will request and share information on the financial condition of each member of the core team, i.e., financial records, relevant grant-making performance, etc. Key activities and management milestones during Phase #1 of the campaign will include:

- ◆ Global-level advocacy begins with U.S. government, Global Fund, WHO, and other key targets
- ◆ Management plan finalized by core team and management structure established
 1. CEPA staff hired
 2. Grants disbursed to regional partners and possibly to core partners in 3-5 focus countries based on mutually agreed-upon terms of reference (TORs) that specify roles and responsibilities, deliverables, and reporting and accountability requirements, including progress toward achieving Key Performance Indicators (KPIs)
 3. Grant-making procedures established for subgrants to country-level implementing partners
 4. Country implementing partners vetted and selected based on standard set of criteria, including demonstrated performance and sound financial management systems
 5. CEPA Advisory Group established
- ◆ Stakeholder briefings and/or consultations held in focus countries
- ◆ Country-level implementing partners identified and vetted
- ◆ Campaign M&E Plan finalized by core partners with participation by country-level implementing partners on timeline and indicators
- ◆ First Advocacy Summit and campaign kick-off
- ◆ Agenda for Action, including global and country-specific Advocacy Action Plans, adopted
- ◆ Campaign scorecard for tracking progress against key indicators developed

PHASE #2: Initial Implementation (Months 8–23)

During this phase, the campaign will become fully operational, as advocacy with global-level stakeholders continues and implementation of country-level Advocacy Action Plans begins in earnest. Progress toward expected outcomes will be assessed at six- to 12-month intervals, with an interim evaluation conducted in order to identify needed campaign refinements for Phase #3. Key activities and milestones during the second phase of the campaign will include:

- ◆ Grants to core partners renewed as appropriate
- ◆ Advocacy grants made to country-level partners based on mutually agreed upon TORs that specify deliverables, reporting, and accountability requirements, including progress toward achieving Key Performance Indicators
- ◆ Initial implementation of global and country-level Advocacy Action Plans
- ◆ Congressional delegation to selected campaign focus countries organized
- ◆ Country-level stakeholders mobilized and South-to-South learning facilitated through coalitions, working groups, etc.
- ◆ Expert resources identified, e.g., PSM consultants, etc., and dispatched
- ◆ Interim evaluation based on global and country-level Advocacy Action Plans
- ◆ Core team agrees upon needed program refinements, including revising scorecard
- ◆ CEPA Advisory Group meets
- ◆ Second Advocacy Summit (12 to 18 months after initial summit) focuses on interim lessons learned and ongoing implementation challenges

PHASE #3: Refinement, Full Implementation, and Evaluation (Months 24–36)

The third and final phase of the campaign will incorporate program refinements based on the interim evaluation in order to optimize implementation of the global and country-level Advocacy Action Plans. In addition, we will begin the process of developing plans for ensuring that the work of core partners and country-level implementing partners can be sustained. Key activities and milestones during the third and final phase of the campaign will include:

- ◆ Program adjustments made
- ◆ Grants to core partners renewed as appropriate
- ◆ Advocacy grants to country-level partners renewed as appropriate
- ◆ Final implementation of global and country-level Advocacy Action Plans
- ◆ CEPA Advisory Group meets
- ◆ Campaign outcomes documented and disseminated
- ◆ Complete final M&E evaluation

VIII. MONITORING AND EVALUATION

CEPA partners will develop a scorecard to track progress against the objectives of the Campaign to End Pediatric HIV/AIDS and determine what changes, if any, are needed in the campaign's design and implementation. The CEPA Advisory Group will use this scorecard to compare results across countries and evaluate the initiative's impact on scaling up pediatric AIDS services at six-month intervals. See Appendix VIII for a draft scorecard. Monitoring and evaluation of the campaign will be ongoing during implementation of CEPA's three phases. In addition, a mid-term review will be a key point for evaluating successes and continued obstacles and redirecting the initiative as needed.

APPENDIX I

Draft Summary of Focus Country Bottlenecks (based on initial desk review)

FOCUS COUNTRY	Family-Centered Care and Nutrition	Early Infant Diagnosis and Treatment	Access to Appropriate Medications	Full Funding to Eliminate Pediatric HIV/AIDS
GROUP #1: Tipping Point Countries				
KENYA	<ul style="list-style-type: none"> ◆ Widespread stigma and discrimination against PLWA limits demand for pediatric treatment and services ◆ Lack of support from male partners limits access to PMTCT services ◆ Limited geographic reach of quality PMTCT service in rural areas ◆ Loss to follow-up/retention 	<ul style="list-style-type: none"> ◆ Widespread stigma and discrimination against PLWA limits demand for pediatric treatment and services ◆ Limited demand creation or public knowledge of pediatric services ◆ Limited geographic reach of EID equipment and infrastructure; DBS-based DNA PCR testing in only four regions ◆ Long turnaround time for DNA PCR testing (2-6 weeks) ◆ Loss to follow-up/retention 	<ul style="list-style-type: none"> ◆ Slow, cumbersome drug registration approval process 	<ul style="list-style-type: none"> ◆ Limited funding from national government
UGANDA	<ul style="list-style-type: none"> ◆ Limited access to PMTCT services; services do not reach all women in need ◆ Widespread stigma and discrimination against PLWA limits demand for pediatric treatment and services ◆ Limited emphasis on family-centered care services in Global Fund grants ◆ Crowded partner landscape prevents use of available resources for pediatric treatment 	<ul style="list-style-type: none"> ◆ Widespread stigma and discrimination PLWA limits demand for pediatric treatment and services ◆ Inadequate government commitment to pediatric treatment; no national policy ◆ Inadequate access to ART for children ◆ Crowded partner landscape preventing use of resources available on pediatric treatment 	<ul style="list-style-type: none"> ◆ Slow, cumbersome drug registration approval process 	<ul style="list-style-type: none"> ◆ Global Fund Rounds 8-9

FOCUS COUNTRY	Family-Centered Care and Nutrition	Early Infant Diagnosis and Treatment	Access to Appropriate Medications	Full Funding to Eliminate Pediatric HIV/AIDS
GROUP #1: Tipping Point Countries				
ZAMBIA	<ul style="list-style-type: none"> ◆ Limited emphasis on FCC services in Global Fund grants ◆ Limited geographic roll-out of and implementation of family-centered care ◆ Insufficient participation of rural based organizations in national pediatric HIV/AIDS policy decision-making 	<ul style="list-style-type: none"> ◆ Limited availability and dispensing of quality ARV drugs, formulations, and commodities for pediatric treatment ◆ Costly pediatric drugs and commodities ◆ Poor national infrastructure to support the DBS collection network and lack of data collection of the number of tests performed or sites in operation ◆ Insufficient participation of rural-based organizations in national pediatric HIV/AIDS policy decision-making 	<ul style="list-style-type: none"> ◆ Limited availability and dispensing of quality ARV drugs, formulations, and pediatric commodities ◆ Costly drugs and commodities for pediatric treatment ◆ Slow, cumbersome drug registration approval process 	<ul style="list-style-type: none"> ◆ Global Fund Rounds 8-9
TANZANIA	<ul style="list-style-type: none"> ◆ Limited demand creation or public knowledge of pediatric services ◆ Widespread stigma and discrimination limits demand for pediatric services ◆ Loss to follow-up/retention ◆ Limited emphasis on FCC services in Global Fund grants 	<ul style="list-style-type: none"> ◆ Costly EID equipment and infrastructure ◆ Widespread stigma and discrimination limits demand for pediatric services ◆ Loss to follow-up/retention ◆ Limited access to pediatric treatment 	<ul style="list-style-type: none"> ◆ Slow, cumbersome drug registration approval process 	<ul style="list-style-type: none"> ◆ Global Fund Rounds 8-9
GROUP #2: Transition Countries				
ETHIOPIA	<ul style="list-style-type: none"> ◆ Loss to follow-up; inadequate retention of children on treatment ◆ Limited demand creation or public knowledge of PMTCT services ◆ Poor coordination at national/sub-national level affects accountability/service delivery ◆ Weak linkages between antenatal care and PMTCT services ◆ Shortage of HCWs trained in PMTCT/pediatric treatment ◆ Limited involvement of male partners in prevention, treatment, and care 	<ul style="list-style-type: none"> ◆ Insufficient infrastructure and equipment at health center level ◆ Limited roll-out and/or expansion of EID services nationwide ◆ Loss to follow-up 	<ul style="list-style-type: none"> ◆ Limited access to and provision of cotrimoxazole prophylaxis ◆ Slow, cumbersome drug registration approval process 	<ul style="list-style-type: none"> ◆ Limited funding for PMTCT services

FOCUS COUNTRY	Family-Centered Care and Nutrition	Early Infant Diagnosis and Treatment	Access to Appropriate Medications	Full Funding to Eliminate Pediatric HIV/AIDS
GROUP #2: Transition Countries				
NIGERIA	<ul style="list-style-type: none"> ◆ Limited access to treatment and rural vs. urban disparities ◆ Lack of political commitment from local actors ◆ Differing standards of care at government-supported and donor-supported ART facilities ◆ Shortage of HCWs trained in PMTCT and/or pediatric treatment ◆ Impractical national PMTCT guidelines¹ and lack of linkages between antenatal care and PMTCT services ◆ Limited involvement of male partners in prevention, treatment, and care services ◆ Lack of specific policies and guidelines supporting pediatric AIDS services ◆ Lack of service delivery at primary care level 	<ul style="list-style-type: none"> ◆ Limited access and rural vs. urban disparities ◆ Lack of political commitment from local actors ◆ Differing standards of care at government-supported and donor-supported ART facilities ◆ Limited geographic reach and availability of EID equipment and infrastructure, including DBS-based DNA PCR ◆ Lack of specific policies or guidelines supporting pediatric AIDS services ◆ Lack of service delivery at primary care level 	<ul style="list-style-type: none"> ◆ Multiple ARV supply chains and poor coordination and transparency among them ◆ Slow and cumbersome drug registration approval process 	<ul style="list-style-type: none"> ◆ Funding interruption; problems implementing Global Fund grant ◆ Global Fund Rounds 8-9
MOZAMBIQUE	<ul style="list-style-type: none"> ◆ Limited access to treatment and rural vs. urban disparities ◆ Limited access to PMTCT services; services do not reach all women in need ◆ Limited involvement of male partners ◆ Limited emphasis on FCC services in Global Fund grants 	<ul style="list-style-type: none"> ◆ Limited access to treatment and rural vs. urban disparities ◆ Limited geographic reach and availability of EID equipment and infrastructure ◆ Inadequate government commitment to pediatric treatment; no national policy 	<ul style="list-style-type: none"> ◆ Limited access to and provision of cotrimoxazole prophylaxis ◆ Slow, cumbersome drug registration approval process 	<ul style="list-style-type: none"> ◆ Unclear with PEPFAR and Global Fund Round 9

¹ This finding came from a single case study at a single hospital; it may not reflect the general country-level conclusion.

APPENDIX II

Draft Logframe for Global-Level Advocacy Strategy

Preliminary CEPA Objectives	Key Targets	Key Partners	Policy Outcomes	Illustrative Activities	Illustrative Outcome Indicators	Illustrative Impact Indicators
WORLD HEALTH ORGANIZATION AND UNICEF						
Family-Centered Care and Nutrition	AIDS, TB and Malaria Cluster Family Health Cluster HIV/AIDS Department	Implementing country partners CHAI PEPFAR UNICEF	<ul style="list-style-type: none"> ◆ Global definition and guidelines for family-centered care (FCC) ◆ Update PMTCT guidelines to include HAART for all pregnant women ◆ Establish policy directives for adoption of FCC ◆ Adopt guidelines promoting use of point-of-care CD4 equipment ◆ Support country efforts to promote task-shifting 	<ul style="list-style-type: none"> ◆ Advocacy to create global committee to adopt FCC approach, including WHO task-shifting recommendations ◆ Advocacy for WHO/UNICEF to issue directives to country offices to disseminate and implement FCC ◆ Department briefings on CD4 equipment and need for guidelines promoting use of point-of-care CD4 	<ul style="list-style-type: none"> ◆ Policy directive to focus countries ◆ Recommendations for use of point-of-care CD4 equipment in primary health care setting 	<ul style="list-style-type: none"> ◆ MTCT coverage rates
Early Infant Diagnosis and Treatment	HIV/AIDS Department	Implementing country partners CHAI PEPFAR UNICEF	<ul style="list-style-type: none"> ◆ Disseminate and advocate for adoption of revised pediatric treatment guidelines ◆ Work to increase supply of appropriate pediatric medications, lower prices, and improve distribution ◆ Develop and disseminate global forecasts of supplies ◆ Help countries adopt WHO pre-qualification programs and improve drug registration procedures 	<ul style="list-style-type: none"> ◆ Demand WHO/ UNICEF disseminate new treatment guidelines ◆ Advocate for guidelines that encourage use of point-of-care CD4 machines at primary care level 	<ul style="list-style-type: none"> ◆ WHO issues directive calling for dissemination and implementation of new treatment guidelines at country level ◆ Recommendations for use of point-of-care CD4 machines in primary health care settings 	<ul style="list-style-type: none"> ◆ Number of children on treatment

Preliminary CEPA Objectives	Key Targets	Key Partners	Policy Outcomes	Illustrative Activities	Illustrative Outcome Indicators	Illustrative Impact Indicators
WORLD HEALTH ORGANIZATION AND UNICEF						
Access to Appropriate Medications	WHO pre-qualification system	Implementing country partners African Union CHAI UNITAID UNICEF PEPFAR	<ul style="list-style-type: none"> ◆ Publish regulatory review and tentative drug approvals ◆ Adopt and promote guidelines recommending country use of Pre-Approval Access Permit (PAAP) ◆ Standardize drug registration guidelines ◆ Develop global forecasts for pediatric drugs and commodities 	<ul style="list-style-type: none"> ◆ Demand WHO publish global forecasts of needed supplies ◆ Engage with WHO/ UNICEF to encourage implementing countries to adopt WHO pre-qualification programs ◆ Pressure WHO system to create unified guidelines for African countries ◆ Advocate for increased WHO/ UNICEF engagement with public-private partnership 	<ul style="list-style-type: none"> ◆ Increased supply, lower prices, and improved distribution ◆ Wider acceptance of PAAP ◆ Procurement of PMTCT kits for providers 	<ul style="list-style-type: none"> ◆ Number of children and mothers on treatment ◆ Number of drugs approved
Full Funding to Eliminate Pediatric HIV/AIDS	UNAIDS WHO HIV/AIDS Department	Implementing country partners CHAI UNITAID UNICEF PEPFAR	<ul style="list-style-type: none"> ◆ Develop and disseminate estimates of resources needed to achieve CEPA objectives 	<ul style="list-style-type: none"> ◆ Demand for UNICEF/ WHO annual global resource estimates for pediatric HIV 	<ul style="list-style-type: none"> ◆ Global resource needs estimates to achieve universal access by 2010 	<ul style="list-style-type: none"> ◆ Resource allocations
GLOBAL FUND TO FIGHT AIDS, TB AND MALARIA						
Access to Appropriate Medications	Global Fund Board Procurement system	Implementing country partners CHAI UNITAID UNICEF PEPFAR	<ul style="list-style-type: none"> ◆ Issue procurement guidelines prioritizing CEPA commodities and drugs ◆ Incentivize new EID technologies, new FDCs, and second- and third-line drugs 	<ul style="list-style-type: none"> ◆ Hold CEPA briefings with Board members 	<ul style="list-style-type: none"> ◆ Board endorses CEPA objectives 	<ul style="list-style-type: none"> ◆ Increased procurement of PMTCT and pediatric HIV commodities

Preliminary CEPA Objectives	Key Targets	Key Partners	Policy Outcomes	Illustrative Activities	Illustrative Outcome Indicators	Illustrative Impact Indicators
GLOBAL FUND TO FIGHT AIDS, TB AND MALARIA						
Full Funding to Eliminate Pediatric HIV/AIDS	Global Fund Board	Implementing country partners CHAI UNITAID UNICEF PEPFAR	<ul style="list-style-type: none"> ◆ Increase grant support for PMTCT+ and pediatric HIV ◆ Adopt CEPA goals in global business plan to combat AIDS ◆ Round system and NSA window prioritize PMTCT+ and pediatric HIV as part of demand creation strategy ◆ Process for extending grants to provide long-term funding 	<ul style="list-style-type: none"> ◆ Advocate for Board to endorse, encourage, and fund country programs that prioritize PMTCT+ and pediatric HIV 	<ul style="list-style-type: none"> ◆ Board resolution adopting CEPA strategy 	<ul style="list-style-type: none"> ◆ Increased funding for programs devoted to ending pediatric HIV
UNITAID						
Access to Appropriate Medications	UNITAID Board	Implementing country partners CHAI UNITAID UNICEF PEPFAR	<ul style="list-style-type: none"> ◆ Ensure continued funding to strengthen WHO pre-qualification system ◆ Board resolution supporting countries use of PAAP ◆ Funds UNICEF procurement of PMTCT kits for providers 	<ul style="list-style-type: none"> ◆ Policy briefings on CEPA 	<ul style="list-style-type: none"> ◆ Board resolution to increase support for WHO prequalification system ◆ Ensure no interruption of pediatric drugs and commodities 	<ul style="list-style-type: none"> ◆ Number of children and mothers on treatment ◆ Supply and price of drugs
Full Funding to Eliminate Pediatric HIV/AIDS	UNITAID Board	Implementing country partners CHAI UNITAID UNICEF PEPFAR	<ul style="list-style-type: none"> ◆ Board resolution adopts CEPA objectives, extends project timelines, and allocates additional funding for PMTCT+ and pediatric HIV drugs 	<ul style="list-style-type: none"> ◆ Engage with Board to advocate for annual WHO/ UNICEF resource estimates for PMTCT+ and pediatric treatment ◆ Table CEPA strategy to the UNITAID Board 	<ul style="list-style-type: none"> ◆ Extension of project timelines for support of PMTCT+ and pediatric HIV treatment 	<ul style="list-style-type: none"> ◆ Resource allocations and expanded funding for PMTCT+ and pediatric HIV
U.S. GOVERNMENT, G8 GOVERNMENTS, AND PRIVATE SECTOR						
Family-Centered Care and Nutrition	PEPFAR	Implementing country partners CHAI UNITAID UNICEF PEPFAR	<ul style="list-style-type: none"> ◆ Promote FCC approach through policy and legislative guidelines aligned with WHO/UNICEF 	<ul style="list-style-type: none"> ◆ Briefings for PEPFAR implementers 	<ul style="list-style-type: none"> ◆ PMTCT clinics offering FCC 	<ul style="list-style-type: none"> ◆ MTCT coverage rates ◆ COPS promote FCC

Preliminary CEPA Objectives	Key Targets	Key Partners	Policy Outcomes	Illustrative Activities	Illustrative Outcome Indicators	Illustrative Impact Indicators
U.S. GOVERNMENT, G8 GOVERNMENTS, AND PRIVATE SECTOR						
Early Infant Diagnosis and Treatment	PEPFAR Public-Private Partnership on Pediatric AIDS Treatment (PPPPAT)	Implementing country partners CHAI UNITAID UNICEF PEPFAR	<ul style="list-style-type: none"> ◆ Policy directives for adoption of FCC ◆ Guidelines promoting point-of-care CD4 equipment at primary care level ◆ Policy and guidelines requiring COPs to include specific section on pediatric HIV ◆ Policy and guidelines for purchasing point-of-care CD4 equipment ◆ Increased R&D new pediatric diagnostics and drugs ◆ Engagement with public-private partnerships 	<ul style="list-style-type: none"> ◆ Advocate adoption of public-private partnership model to increase supply and reduce costs ◆ Policy brief on need to prioritize point-of-care CD4 at primary care level 	<ul style="list-style-type: none"> ◆ Incentivize procurement of new technologies ◆ Global forecasts for point-of-care CD4 equipment 	<ul style="list-style-type: none"> ◆ Number of children on treatment
Access to Appropriate Medications	USG PEPFAR FDA Pharmaceutical and diagnostic companies	Implementing country partners CHAI UNITAID UNICEF PEPFAR	<ul style="list-style-type: none"> ◆ Publish regulatory review and tentative drug approvals ◆ Negotiate with manufacturers to lower costs and increase production, supply, and use of generic s ◆ Incentivize new EID technologies, new FDCs, and second- and third-line medications ◆ Increased R&D FDCs and second- and third-line drugs ◆ Engagement with public-private partnerships 	<ul style="list-style-type: none"> ◆ Meet with and brief PEPFAR coordinator to accept WHO pre-qualification system ◆ Advocate for PEPFAR to support adoption of PAAP by countries ◆ Advocate for system to track prices of pediatric products 	<ul style="list-style-type: none"> ◆ Annual tracking of prices and supplies of pediatric commodities 	<ul style="list-style-type: none"> ◆ Number of children and mothers on treatment

Preliminary CEPA Objectives	Key Targets	Key Partners	Policy Outcomes	Illustrative Activities	Illustrative Outcome Indicators	Illustrative Impact Indicators
U.S. GOVERNMENT, G8 GOVERNMENTS, AND PRIVATE SECTOR						
Full Funding to Eliminate Pediatric HIV/AIDS	US Congress G8 Ministries of Finance	Implementing country partners UNAIDS UNICEF CHAI UNITAID PEPFAR	<ul style="list-style-type: none"> ◆ Adopt and promote policy guidelines that prioritize funding for PMTCT+ and pediatric treatment ◆ U.S. Congress fully funds second phase of PEPFAR ◆ OGAC ensures at least 15% of people on treatment through PEPFAR programs are children <15 ◆ Ensure full replenishment of Global Fund and make equitable contributions 	<ul style="list-style-type: none"> ◆ Watchdog earmarks for PMTCT+ and pediatric HIV funding ◆ Demand full replenishment of Global Fund 	<ul style="list-style-type: none"> ◆ G8 communiqués highlight full funding for Global Fund and HIV/AIDS ◆ OECD tracking of HIV/AIDS funding 	<ul style="list-style-type: none"> ◆ Increased resource allocations for PMTCT+ and pediatric HIV

APPENDIX III

Draft Logframe for Country-Level Advocacy Strategy

Preliminary CEPA Objectives	Key Targets	Key Partners	Policy Outcomes	Illustrative Activities	Illustrative Outcome Indicators	Illustrative Impact Indicators
Family-Centered Care and Nutrition	MoH National HIV/AIDS Prevention and Control Office	CHAI ANECCA PATA PATAM CEPA partners	<ul style="list-style-type: none"> ◆ Guidelines incorporate FCC and promote service delivery design changes to address continuum of care ◆ Guidelines authorize non-physician clinicians to initiate ART and pain management medication ◆ Earmarks and treatment coverage goals for pediatric HIV ◆ Health plans incorporate WHO's 2006 guidelines ◆ MoH guidelines on cotrimoxazole ◆ Encourage medical training reform 	<ul style="list-style-type: none"> ◆ Disseminate civil-society advocacy brief ◆ Establish media strategy for FCC 	<ul style="list-style-type: none"> ◆ Policy promulgated and disseminated to health units ◆ Increased funding for FCC programs 	<ul style="list-style-type: none"> ◆ Number of health units providing FCC ◆ Improved PMTCT rates ◆ Improved national and sub-national level coordination of service delivery ◆ Reduced loss to follow up
Early Infant Diagnosis and Treatment	MoH National HIV/AIDS Prevention and Control Office	CEPA partners	<ul style="list-style-type: none"> ◆ Guidelines promoting early testing and treatment ◆ MoH recommendations for roll-out EID/EIT Address transportation bottlenecks ◆ Procurement mechanisms to negotiate lower prices ◆ MoH health worker training programs ◆ Pediatric treatment targets 	<ul style="list-style-type: none"> ◆ Advocate for and help convene national public-private partnerships meetings on EID/T ◆ Encourage National Business Coalition on HIV/AIDS to hold annual forum 	<ul style="list-style-type: none"> ◆ EID/EIT access policies promulgated and disseminated 	<ul style="list-style-type: none"> ◆ Decentralization of pediatric services ◆ Increased HCW training in infant diagnostics and treatment ◆ Expansion of DBS testing sites ◆ Inclusion of EID/EIT in national HIV/AIDS guidelines

Preliminary CEPA Objectives	Key Targets	Key Partners	Policy Outcomes	Illustrative Activities	Illustrative Outcome Indicators	Illustrative Impact Indicators
Access to Appropriate Medications	MoH National HIV/AIDS Prevention and Control Office PEPFAR COPs National ARV supply chains	CEPA partners	<ul style="list-style-type: none"> ◆ Revise national pre-qualification and regulatory drug approval guidelines ◆ Adopt stronger national procurement, distribution, and supply chain management policies ◆ Consider use of import waivers or PAAP ◆ Reform drug registration procedures and permit cross-border registration ◆ Amend registration protocols to accept either FDA or WHO pre-qualification programs 	<ul style="list-style-type: none"> ◆ Advocate for national registration protocols to accept either FDA or WHO pre-qualification programs as proxies ◆ Conduct briefings with national stakeholders on PAAP and import waivers 	<ul style="list-style-type: none"> ◆ Annual national tracking of prices and supplies of pediatric commodities 	<ul style="list-style-type: none"> ◆ Increased children and mothers on treatment ◆ Registration protocols accept FDA or WHO pre-qualification programs as proxies
Full Funding to Eliminate Pediatric HIV/AIDS	MoH MoF PEPFAR Global Fund Rounds and NSA window	CEPA partners	<ul style="list-style-type: none"> ◆ Allocate 15% of annual budgets to health sector ◆ Allocate additional funds to achieve CEPA objectives ◆ Public education to raise awareness pediatric services ◆ Help ensure PEPFAR COPs focus on PMTCT+ and pediatric HIV 	<ul style="list-style-type: none"> ◆ Advocacy for increased funding for PMTCT+ and pediatric HIV ◆ Coordinated media and civil-society strategy to pressure governments to increase funding 	<ul style="list-style-type: none"> ◆ Gradual increase in annual health sector budgetary allocations 	<ul style="list-style-type: none"> ◆ 15% of annual national budgets allocated to health sector

APPENDIX IV

Focus Country Selection Criteria

The following chart is preliminary and is intended to indicate the type and level of analysis that GAA and our core implementing partners will undertake for each of the campaign focus countries.

FOCUS COUNTRY	Enabling Policy Environment and Clear Entry Points for Advocacy	Major Global Health Initiatives Operating	In-Country Partners or Networks	GAA Foundation Partner Focus Countries	Other Current or Planned GAA Initiatives
ETHIOPIA	<ul style="list-style-type: none"> ◆ Government, PEPFAR, and Global Fund signed MOU based on national plan for Accelerated Access to HIV/AIDS Care and Treatment, 2007-2010, including commitment to 80% treatment target by 2010 ◆ HIV-related commodities forecasting and costing estimates established through 2014 ◆ CCM approved two CSOs as principal recipients of Global Fund Round 7 HIV/AIDS proposal 	CHAI Global Fund PEPFAR UNICEF	ANECCA Eastern Africa Treatment Access Movement (EATAM) PATA	Children's Investment Fund Foundation Diana, Princess of Wales Memorial Fund	
KENYA		CHAI Global Fund PEPFAR UNICEF	ANECCA Kenya Treatment Access Movement EATAM PATA	CIFF Diana Fund Elton John AIDS Foundation (EJAF)	Positive Synergies for Health Systems Strengthening
MOZAMBIQUE	<ul style="list-style-type: none"> ◆ PRSP 2006-2009 includes specific targets for PMTCT and pediatric AIDS treatment ◆ Task forces on PMTCT and pediatric AIDS have been established ◆ MOH plays key role in managing basket health fund that includes contributions from 16 donors and merits transparency for accountability 	CHAI PEPFAR PMI UNITAID UNICEF World Food Programme	Mozambique Treatment Access Movement PATA works through CHAI/ Clinton Foundation	ELMA Philanthropies	Mobilizing for RH/HIV Integration

FOCUS COUNTRY	Enabling Policy Environment and Clear Entry Points for Advocacy	Major Global Health Initiatives Operating	In-Country Partners or Networks	GAA Foundation Partner Focus Countries	Other Current or Planned GAA Initiatives
NIGERIA	<ul style="list-style-type: none"> ◆ National government has allocated significant domestic resources ◆ PMTCT guidelines have been cited as needing review ◆ CHAI has goal of developing national pediatric plan 	CHAI Global Fund PEPFAR CDC FHI Global HIV/AIDS Initiative	ANECCA PATAM		Mobilizing for RH/HIV Integration
TANZANIA		CHAI Global Fund PEPFAR UNICEF	ANECCA EATAM PATA	CIFF EJAF Diana Fund	Mobilizing for RH/HIV Integration
UGANDA		CHAI Global Fund PEPFAR UNICEF	ANECCA EATAM PATA	EJAF Diana Fund	Positive Synergies for Health Systems Strengthening
ZAMBIA		CHAI Global Fund PEPFAR UNICEF	ANECCA Treatment Access Literacy Campaign (TALC) Southern Africa Treatment Africa Movement (SATAMO) PATA	ELMA EJAF Diana Fund	<p>Mobilizing for RH/HIV Integration</p> <p>Positive Synergies for Health Systems Strengthening</p>

APPENDIX V

Epidemiological Overview of Campaign Focus Countries

	Estimated # Pregnant Women Living with HIV/AIDS (2007)	# Pregnant Women Receiving ARVs (2007)	# Pregnant Women NOT Receiving ARVs (2007)	# Additional Pregnant Women on ARVs with Universal Access (80%) to PMTCT+ (2007)	Children Living with HIV/AIDS (2007)	Children (<15 yrs) Receiving ARVs (2007) **	Children (<15 yrs) Receiving ARVs as % Total Population Receiving Treatment (2007) **	Total Orphans Due to AIDS (2007)	Childhood Immunizations (2006) ***
KENYA	76,000	52,858 (70%)	23,142	7,942	180,000 *	15,090	9%	1,400,000 *	80%
TANZANIA	100,000	31,863 (32%)	68,137	48,137	140,000	11,176	8%	970,000	90%
UGANDA	78,000	26,484 (34%)	51,516	35,916	130,000	8,532	8%	1,200,000	80%
ZAMBIA	76,000	35,314 (46%)	40,686	25,486	95,000	11,602	8%	600,000	80%
ETHIOPIA	66,000	4,888 (7%)	61,112	47,912	92,000	4,534	5%	650,000	72%
MOZAMBIQUE	97,000	44,975 (46%)	52,025	32,625	100,000	6,320	7%	400,000	72%
NIGERIA	190,000	12,278 (6%)	177,722	139,722	220,000	15,345	20%	1,200,000	54%
TOTALS:	683,000	208,660	474,340	337,740	957,000	72,599		6,420,000	

Unless otherwise noted, all data is from the UNAIDS *2008 Report on the Global AIDS Epidemic*.

* No estimate of total number available; the high estimate is included in the table.

** Data from *Towards Universal Access Progress Report 2008* (WHO, UNAIDS, UNICEF).

*** Data from UNICEF and WHO, *Immunization Summary*, January 2008. This is the percentage of children per country who received the third dose of diphtheria and tetanus toxoid with pertussis vaccine (DTP3).

APPENDIX VI

Principles for Effective Partnerships

The following principles for effective partnerships were included in the Global Partnerships implementation strategy approved by GAA's Board of Directors in June 2008:

The term "partnership" is used to describe many relationships between and among different actors, often failing to acknowledge very real imbalances in resources and power between advocates in the north and global South. As such, GAA's commitment to authentic collaboration—defined by equality, mutual trust, reciprocity, and accountability—demands a conscious approach to working in partnership in order to break through "old" paradigms of North-South collaboration.

To that end, the Global Partnerships strategy is both a philosophical expression of solidarity and a strategic approach for advancing our objectives. In practical terms, GAA commits itself to:

- ◆ *Obtain early commitment from leaders and/or decision-makers of appropriate partners*
- ◆ *Establish early, direct involvement of staff of each respective partner*
- ◆ *Understand the partners' needs in relation to global health and AIDS priorities and regional and global policy frameworks*
- ◆ *Create a shared vision for the partnership and set clear expectations for what both partners hope to achieve*
- ◆ *Recognize and accommodate the different organizational cultures and structures of each partner*
- ◆ *Set realistic, concrete goals through a careful planning process.*
- ◆ *Integrate evaluation and ongoing planning into the partnership*
- ◆ *Allocate enough human and financial resources*
- ◆ *Define roles and responsibilities clearly*
- ◆ *Promote dialogue and open communication*
- ◆ *Provide real benefits that both partners can use*
- ◆ *Encourage flexibility creativity, and experimentation*
- ◆ *Seek wide range of stakeholder involvement*

APPENDIX VII

Campaign to End Pediatric HIV/AIDS Action Timeline

PHASE #1: Laying the foundation

Month 1

- ◆ **Begin rapid set up of management structure, e.g., hire staff, establish secretariat, formalize granting structures and procedures, etc.**
- ◆ **Disburse initial grants to core partners**
 - Develop TORs for each of the core partners (GAA, ANECCA, PATA, and PATAM)
 - Review and clarify division of labor and standard operating procedures among core partners, including overall campaign management, mutual accountability, communication protocols, coordination of activities, financial tracking, and donor reporting
- ◆ **Convene strategic planning meeting among core partners**
 - Translate Agenda for Action into preliminary Campaign Advocacy Action Plan
 - ✓ Map entry points for advocacy at the global, regional, and national levels
 - ✓ Map key stakeholders (beyond implementing partners), including advocacy targets, potential allies, technical experts, multilateral agencies, development partners, etc.
 - ✓ Outline basic framework for country-level Advocacy Action Plans within the context of CEPA Agenda for Action
 - Begin process of identifying and recruiting country-level implementing partners, including but not limited to core partners' networks
 - ✓ Develop criteria for identifying country-level implementing partners
 - ✓ Agree upon process for exercising due diligence in vetting potential country-level implementing partners, e.g., organizational capacity, management systems, financial oversight, etc.
 - ✓ Draft TOR for country-level implementing partners
 - Develop TOR for CEPA Advisory Group, including representation, membership criteria, governance, scope, etc.
 - Begin planning Advocacy Summit and campaign kick-off
 - ✓ Agree upon objectives, participants, and expected outcomes for Advocacy Summit, e.g., country-specific action plans developed
 - ✓ Agree upon date and location (minimum four months lead time)
 - ✓ Flesh out basic meeting format and proposed agenda
 - ✓ Begin compiling invitation list
 - ✓ Identify potential speakers
 - Begin developing Campaign M&E Plan
 - ✓ Review and discuss draft CEPA logframe
 - ✓ Identify core indicators for monitoring progress at national and global levels with specific indicators of success to demonstrate progress against objectives
 - ✓ Discuss M&E implementation and potential external support
- ◆ **Begin work on global advocacy targets, e.g., Office of US Global AIDS Coordinator, Global Fund Board of Directors, UNITAID Board of Directors, etc.**

Month 2

- ◆ **Identify and reach out to potential country-level implementing partners in each focus country**
 - Conduct initial outreach to establish interest
 - Brief potential partners on campaign
 - Identify existing capacities and resource needs
- ◆ **Recruit short-term meeting planner/events coordinator**
- ◆ **Continue planning for CEPA Advocacy Summit and campaign kick-off**
 - Develop and circulate working draft of Advocacy Summit agenda
 - Secure meeting venue
 - Invite speakers
 - Finalize invite list and send "save the date"
 - Arrange facilitation and translation services
- ◆ **Refine Campaign M&E Plan**
 - Update CEPA logframe, including timeline and indicators based on review and feedback from core partners

Months 3 - 4

- ◆ **Finalize country-level implementing partners in each focus country**
 - Name country-level leads to organize country action plan work and consultations to prepare for Advocacy Summit
 - Agree upon TORs leading up to campaign kick-off (agreement to cover travel and lodging expenses for country-level implementers to attend Advocacy Summit; not a subgrant)
 - Solicit feedback and input on Agenda for Action
 - Solicit feedback and input on Campaign Advocacy Action Plan
 - Solicit feedback and input on Campaign M&E Plan
 - Fund country-level consultations to prepare documentation for Advocacy Summit
 - Begin negotiating first-year country-level implementation grant agreements with advocacy partners
- ◆ **Finalize preparations for CEPA Advocacy Summit and campaign kick-off**
 - Send official meeting invites, visa letters, and preliminary agenda for Advocacy Summit
 - Meeting logistics, e.g., participant travel and lodging, visa letters, translation services, etc.
 - Finalize program
 - Brief speakers
 - Prepare meeting materials
 - Confirm logistics

Month 5

- ◆ **CEPA Advisory Group meeting**
 - Orientation
 - Finalize and agree upon TOR for CEPA Advisory Group
 - Adopt Agenda for Action

- ◆ **CEPA Advocacy Summit convening campaign implementers and external stakeholders**
 - State-of-the-art briefing on ending pediatric AIDS
 - Kick off campaign, i.e., disseminate Agenda for Action and develop and finalize local-to-global Campaign Advocacy Action Plan
 - Engage stakeholders in developing country-level Advocacy Action Plans with specific indicators of success to demonstrate progress against objectives
 - Finalize first-year country-level implementation grant agreements with advocacy partners
 - Promote campaign through U.S. and global media outreach efforts

Months 6

- ◆ **Meeting report and outcome documents finalized and circulated to Advocacy Summit participants**
- ◆ **Finalize campaign operational plan for Phases #2 and #3**
 - Implementation plan
 - Management plan
 - Budget and timeline
 - Campaign M&E Plan finalized based on input from core partners, country-level implementing partners, and country-level Advocacy Action Plans developed at Advocacy Summit
 - Scorecard for CEPA Advisory Group to track country-level progress
- ◆ **Country-level implementing partners disseminate campaign information and consult with other country-level stakeholders based on outcomes of Advocacy Summit**
- ◆ **Finalize outstanding country-level one-year grant agreements**
 - Include outcome indicators
 - Confirm granting structures with partners, ensure robust financial accountability mechanisms
 - Disburse subgrants at country-level
- ◆ **Finalize management and operating plan**

PHASE #2: Initial Implementation and Interim Evaluation

(timeline to be revised based on Phase #1 activities)

Months 7 - 12

- ◆ **Implementation of country-level Advocacy Action Plans begins**
- ◆ **CEPA listserv and communication platform established**
- ◆ **Arrange or facilitate technical support for country-level partners as needed through South-to-South exchanges, expert consultants, etc.**
- ◆ **Conduct mid-year progress review**
 - Review progress based on Campaign M&E Plan
 - Revise country-level Advocacy Action Plans as needed
- ◆ **Participate in international meetings and events as needed to support global-level advocacy agenda**

Months 13 - 18

- ◆ **Bi-annual CEPA Advisory Group meeting**
 - Report on initial outcomes, lessons learned, etc.
 - Share information on new developments, emerging issues and trends, etc.
 - Review progress based on Campaign Advocacy Action Plan and Campaign M&E Plan
 - Troubleshoot if necessary
 - Review scorecard tracking country-level progress
- ◆ **Arrange for technical support where needed or requested through South-to-South exchanges, consultants, etc.**
- ◆ **CEPA Second Annual Review and Advocacy Summit**
 - Countries convened to review progress on country-level Advocacy Action Plans
 - Begin negotiating and finalizing second-year country-level grant agreements with advocacy partners
 - Review scorecard tracking country-level progress
- ◆ **Organize Congressional delegation to selected focus countries**
- ◆ **Adjust Phase #4 implementation plan based on Phase #3 outcomes and lessons learned**
- ◆ **Arrange or facilitate technical support for country-level partners as needed through South-to-South exchanges, expert consultants, etc.**
- ◆ **Participate in international meetings and events as needed to support global-level advocacy agenda**
- ◆ **Document and disseminate lessons learned at international conferences and through publications and other media**
- ◆ **Interim independent evaluation completed as necessary**

PHASE #3: Refinement, full implementation, and evaluation (timeline to be revised based on Phase #1 and Phase #2 activities)

Months 19 - 24

- ◆ **Implement program refinements and adjustments to partnership structure as needed**
- ◆ **Renew grants to core partners as needed**
- ◆ **Bi-annual CEPA Advisory Group meeting**
 - Report on interim outcomes, lessons learned, etc.
 - Share information on new developments, emerging issues and trends, etc.
 - Review progress based on Campaign Advocacy Action Plan and Campaign M&E Plan
 - Troubleshoot if necessary
 - Review scorecard tracking country-level progress
- ◆ **Finalize outstanding second-year country-level grant agreements with advocacy partners**

- ◆ **Arrange or facilitate technical support for country-level partners as needed through South-to-South exchanges, expert consultants, etc.**
- ◆ **Conduct mid-year review of country-level progress and revise action plans as needed**
- ◆ **Participate in international meetings and events as needed to support global-level advocacy agenda**

Months 25 - 30

- ◆ **Bi-annual CEPA Advisory Group meeting**
 - Report on interim outcomes, lessons learned, etc.
 - Share information on new developments, emerging issues and trends, etc.
 - Review progress based on Campaign Advocacy Action Plan and Campaign M&E Plan
 - Troubleshoot if necessary
 - Review scorecard tracking country-level progress
 - Dialogue on next steps
- ◆ **CEPA Third Annual Review**
 - Take stock of campaign, i.e., achievements, lessons learned, remaining obstacles, etc.
 - Develop country-level sustainability plans
 - Review scorecard tracking country-level progress
 - Dialogue on next steps

Months 30 - 36

- ◆ **Finalize review and close-out of country-level grant agreements**
- ◆ **Finalize sustainability plans with country-level partners**
- ◆ **Finalize country-level reports**
- ◆ **Final independent evaluation**
- ◆ **Final grant report**
- ◆ **Document and disseminate lessons learned at international conferences and through publications and other media**

APPENDIX VIII

Draft Scorecard for Campaign to End Pediatric HIV/AIDS

The following scorecard would be used to track progress against specific indicators related to PMTCT+ and pediatric treatment services in the campaign's focus countries.

INDICATORS	Kenya	Tanzania	Uganda	Zambia	Ethiopia	Mozambique	Nigeria
Region / Province							
ARV treatment sites that treat children (%)							
Availability of fixed-dose combination (FDC) drugs (%)							
Access to free DNA PCR testing (%)							
Average turnaround time for DNA PCR testing							
Average cost of consultation							
# of sites that have less than 10% of the total population (under 15) on treatment							
# of sites that provide nutritional support							
# of sites that provide patient transportation							
# of sites that provide outreach workers							
# of sites that provide pediatric support groups							