

UKWIMYA LULU
YAKUPWISHA
AKASHISI KA
HIV/AIDS
MU BANA

CAMPAIGN
TO END
PEDIATRIC
HIV/AIDS

CAMPAGNE POUR
L'ÉLIMINATION
DU VIH/SIDA
PÉDIATRIQUE

OLUTALO OLWO
KUMALAWO
MUKENENYA
MU BAANA

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

CAMPAÑA PARA
A ELIMINAÇÃO
DO VIH/SIDA
PEDIATRICO

KAMPENI YA
KUMALIZA
MAAMBUKIZI
YA VVU KWA
WATOTO

CAMPAIGN TO END PEDIATRIC HIV/AIDS (CEPA) UPDATE AND PROGRESS REPORT May–September 2010

I. EXECUTIVE SUMMARY

Since May 2010, the Campaign to End Pediatric HIV/AIDS (CEPA) has continued to implement a complex and dynamic networked advocacy campaign to scale up prevention, treatment, and care of pediatric HIV/AIDS in Kenya, Tanzania, Uganda, Zambia, Nigeria, and Mozambique. In particular, the CEPA partners have successfully transitioned from developing advocacy action plans and M&E frameworks to advancing specific policy goals with stakeholders at the country, regional, and global levels. As detailed in Appendix I, we have achieved some key advocacy outcomes at both the country and global level since our last report in May 2010:

- ◆ The Kenyan government recently committed over \$11 million to purchase antiretroviral medications during the 2010-2011 fiscal year.
- ◆ Mozambique is piloting Option A of WHO's new PPTCT guidelines in Maputo and is planning to roll the guidelines out nationwide.
- ◆ Nigeria's new Round 10 proposal to the Global Fund to Fight AIDS, TB and Malaria focuses on all four prongs of comprehensive PPTCT+ services, and the Nigerian government has committed to covering 50% of the costs of providing HIV/AIDS services as part of the new PEPFAR Partnership Framework.
- ◆ In Uganda, treatment caps instituted by PEPFAR have been lifted, and members of the CEPA team in conjunction with the Ministry of Health played a key role in developing a focused early infant diagnosis strengthening program that aims to expand access and improve both quality of care for HIV-exposed infants and pediatric treatment, as well as reduce loss to follow-up for HIV diagnosis and treatment.
- ◆ The Zambian government has developed a national plan for scaling up PMTCT services from 2011 through 2015, with the goal of virtually eliminating vertical transmission by 2015.
- ◆ Five CEPA countries have submitted Round 10 proposals to the Global Fund to Fight AIDS, TB and Malaria, all of which contain a focus on PPTCT+ and pediatric treatment services.
- ◆ Thanks in part to advocacy by CEPA's regional and country partners, the African Union summit in July 2010 released a series of decisions reaffirming the commitment of African leaders to achieving the Abuja Declaration.
- ◆ In June 2010, the UNITAID board of directors approved the creation of a Medicines Patent Pool Foundation (MPPF) that will establish and manage the patent pool, with initial funding of approximately \$4.4 million.

Since May 1, 2009, CEPA's network partners have (1) produced and disseminated two new publications—the CEPA Status Report and CEPA Advocacy Toolkit—to promote and replicate the Campaign to End Pediatric HIV/AIDS; (2) hosted a series of events to mobilize support for CEPA's advocacy agenda during the XVIII International AIDS Conference in Vienna, including a Leadership Roundtable Dialogue and press conference co-hosted with UNICEF; (3) issued a Global Leadership Commitment to Action to End Pediatric HIV/AIDS, signed by UNAIDS Executive Director Michel Sidibé, UNICEF Executive Director Anthony Lake, and Global Fund Executive Director Michel Kazatchkine; (4) established and convened the inaugural meeting of the CEPA Leadership Council,

chaired by Mrs. Graça Machel; (5) scaled up implementation of CEPA's National Advocacy Action Plans (NAAPs), Regional Advocacy Action Plan (RAAP), and Global Advocacy Action Plan (GAAP); and (6) completed an initial assessment of the campaign's success, utilizing the Impact Planning, Assessment, Reporting and Learning (IPARL) framework.

CEPA's regional partners are the African Network for Care of Children Affected by HIV/AIDS (ANECCA); the Pan African AIDS Treatment Access Movement (PATAM); Health GAP; and Health Action International (HAI) Africa. Our country-level initiating partners include the Kenya Treatment Access Movement; Mozambique Treatment Access Movement; Positive Action for Treatment Access (Nigeria); Treatment Advocacy and Literacy Campaign (Zambia); Human Development Trust (Tanzania); and Coalition for Health Promotion and Social Development (Uganda). The Global AIDS Alliance (GAA) and Health GAP are implementing of CEPA's Global Advocacy Action Plan and local-to-global advocacy strategy, and CEPA is also working with the Open Society Institute South Africa.

III. CONTEXTUAL CHANGES AND LESSONS LEARNED

There have been a number of changes in the external environment that present opportunities—and potential obstacles—for the Campaign to End Pediatric HIV/AIDS.

- ◆ CEPA has played a key role in galvanizing increased momentum to eliminate pediatric AIDS by major stakeholders, including the World Health Organization (WHO), UNICEF, UNAIDS, PEPFAR, Global Fund to Fight AIDS, TB and Malaria, and African Union. In addition, major civil-society organizations have launched targeted campaigns to end vertical transmission, including the Elizabeth Glaser Pediatric AIDS Foundation and ONE Campaign. Moving forward, we hope to facilitate greater dialogue among these stakeholders and campaigns, particularly with respect to mobilizing accelerated action in key countries and at key global events, such as the 2012 International AIDS Conference in Washington, D.C.
- ◆ The Global Fund to Fight AIDS, TB and Malaria (Global Fund) has now reprogrammed \$66 million in eight countries to transition PMTCT services from single-dose nevirapine to dual or triple ARV therapy. While clearly aligned with CEPA's advocacy agenda, the Global Fund's implementation of its reprogramming initiative was very rapid and largely behind-the-scenes, which meant that CEPA's partners had little opportunity to shape country-level negotiations.
- ◆ Adoption of the new WHO treatment guidelines proceeded more quickly than expected; however, intensive advocacy will be needed to ensure that global normative agencies (and national governments) effectively support the development of tools and training programs that will be needed to support effective country-level implementation.
- ◆ UNICEF is rolling out its new Mother-Baby Pack, which provides HIV-positive, pregnant women with a pre-packaged set of drugs to prevent vertical transmission, and encourages both prenatal care and early infant testing and diagnosis. Unfortunately, the Mother-Baby Pack utilizes Option A of the new WHO treatment guidelines, and is thus misaligned with CEPA's endorsement of Option B as most efficacious for the health of women and their infants and the better long-term choice from the perspective of national investment. Nevertheless, CEPA has established a strong working partnership with UNICEF at the global and regional levels, and we hope to work more closely at the country level moving forward.
- ◆ On September 28, UNAIDS, UNICEF, and WHO released the fourth annual report tracking progress toward universal access to HIV/AIDS services by 2010. The report notes that 53% of pregnant women who need PMTCT services worldwide received them in 2009, but that many women and infants still lack access to timely interventions, including early infant diagnosis and pediatric AIDS treatment. Importantly, coverage rates for PPTCT are essentially the same in sub-

Saharan Africa as a whole and in the CEPA countries, at 53% and 52% respectively. However, there is a striking gap with respect to access to coverage rates for pediatric ART treatment, which is 28% worldwide and 26% across sub-Saharan Africa, but averages just 18% in the CEPA countries. This is likely due to very low coverage rates in Mozambique, Nigeria, Tanzania, and Uganda, which are all around or under 20%, while Zambia and Kenya have coverage rates of 36% and 32%, respectively, higher than either the global or African rates (Appendix II).

- ◆ WHO and UNICEF recently released new policy requirements for HIV testing and counselling of infants and young children, which could provide an opportunity for CEPA, since these guidelines allow accelerated integration of HIV testing services for children and mothers.
- ◆ The fiscal year 2011 budget for the President's Emergency Plan for AIDS Relief (PEPFAR) was essentially flat-lined; however, given the current political and economic climate, the success of CEPA network partners and other civil-society advocates in preventing significant cuts to the U.S. global AIDS budget represents a positive outcome. In addition, the new U.S. Global Health Initiative is prioritizing comprehensive prevention of mother-to-child transmission, which creates opportunities for joint programming with other maternal and child health programs.
- ◆ The global economic downturn continues to negatively impact the global AIDS response, with many CEPA partners reporting treatment cutbacks and ARV stock-outs.

IV. PROGRAM PROGRESS

Since May 2010, the Campaign to End Pediatric HIV/AIDS has successfully transitioned from laying the foundation for a coordinated advocacy campaign to implementing CEPA's National Advocacy Action Plans (NAAPs), Regional Advocacy Action Plan (RAAP), and Global Advocacy Action Plan (GAAP). As outlined in this section, we have achieved a number of key advocacy outcomes and outputs, and begun to operationalize CEPA's local-to-global advocacy approach.

A. Key Activities

INTERNATIONAL AIDS CONFERENCE

- ◆ In conjunction with the XVIII International AIDS Conference (IAC) in July 2010, CEPA released a status report that highlights progress toward CEPA's priority outcomes, and includes specific recommendations for key stakeholders, including national governments, the Coordinated Procurement Planning Program, donor governments, PEPFAR, and the Global Fund to Fight AIDS, TB and Malaria (http://aidsalliance.3cdn.net/c4448808bc953b94c7_3dm6vd8hq.pdf).
- ◆ In addition, we worked closely with iScale and our country partners to develop a CEPA Advocacy Toolkit that provides a detailed overview of CEPA's advocacy action planning process and is intended to help civil-society organizations and networks in other countries replicate the campaign (http://aidsalliance.3cdn.net/c872254846e2de92b1_uqm6vtak3.pdf).
- ◆ During the International AIDS Conference, CEPA hosted a panel discussion on family-centered care as part of a pre-conference symposium on children and HIV, which featured a video address from CEPA Leadership Council chair Mrs. Graça Machel.
- ◆ CEPA, UNICEF, UNAIDS, and the Global Fund to Fight AIDS, TB and Malaria co-hosted a roundtable dialogue and press conference, which included CEPA partners, U.N. representatives, and civil-society leaders, and provided an important opportunity to share lessons learned and identify strategic opportunities to eliminate pediatric HIV/AIDS. Importantly, the press conference highlighted the release of a Global Leadership Commitment to Action to End Pediatric HIV/AIDS, signed by UNAIDS Executive Director Michel Sidibé, UNICEF Executive Director Anthony Lake, and Global Fund Executive Director Michel Kazatchkine, among others.

- ◆ UNICEF funded Mrs. Machel's video address at the pre-conference on children and HIV, and is producing a longer video with Mrs. Machel that will include excerpts from the pre-conference presentation and will be released globally. CEPA's operational partnership with UNICEF was key to the success of the CEPA activities at the International AIDS Conference, and provides a strong foundation for ongoing collaboration.
- ◆ By the conclusion of the International AIDS Conference, the executive directors of UNICEF, UNAIDS, the Global Fund to Fight AIDS, TB and Malaria, and the International AIDS Society had all made public commitments to ending pediatric HIV/AIDS by December 2015, and CEPA played a role in galvanizing those commitments. In addition, Anthony Lake, Michel Sidibé, and Michel Kazatchkine all agreed to be collaborating partners of CEPA's Leadership Council.

CEPA LEADERSHIP COUNCIL

The Leadership Council members now include Mrs. Graça Machel, Chair; Ms. Angeline Siparo (Kenya); Dr. Avertino Barreto (Mozambique); Professor Kikelomo Osinusi (Nigeria); Professor Esther Mwaikambo and Ms. Joyce Mhaviile (Tanzania); Mr. Ronald Kamara and Professor Peter Mugenyi (Uganda); Dr. Veronica Mulenga (Zambia); and Rajat Gupta.

Mrs. Machel convened the inaugural meeting of the CEPA Leadership Council on September 9-10 in Johannesburg, where members finalized their goals for the coming year and committed to support both CEPA's local-to-global advocacy and the campaign's efforts in their respective countries. Specifically, the Leadership Council committed to (1) facilitate high-level advocacy to secure political commitments to the agreed-upon target of 80% coverage for PPTCT+ and pediatric treatment services; (2) exert leadership to promote dialogue with national governments to ensure accountability for accelerated funding and implementation of pediatric HIV/AIDS programs; (3) advocate for rapid adoption and implementation of WHO's new PMTCT guidelines; (4) develop strategic, consistent advocacy messaging to be used across the campaign; (5) support efforts to mobilize increased financial resources for CEPA; and (6) develop media partnerships to promote social mobilization and demand creation for PPTCT+ and pediatric treatment services.

The group adopted a draft Leadership Council Advocacy Action Plan that will serve as a 2010-2011 workplan. This plan includes a commitment to (1) produce a white paper that provides a clear rationale for CEPA's endorsement of Option B of WHO's new PMTCT guidelines, and articulates the importance of ethical funding for HIV/AIDS, e.g., preventing stock-outs or treatment stoppages; and (2) develop a collaborative media platform, including a partnership with the African Broadcast Media Partnership group and a new tag line to distinguish CEPA from other pediatric HIV/AIDS campaigns. The Leadership Council Advocacy Action Plan should be finalized by October 2010.

Several Leadership Council members conducted a briefing with a small group of journalists from print, television, and internet-based media, which focused on issues related to health systems, funding, and community engagement. Ms. Dorothy Mbori-Ngacha, the UNICEF Regional Advisor on PMTCT for Eastern and Southern Africa, also attended the briefing. Mrs. Machel highlighted the need for national governments to prioritize funding for health care and called for a greater focus on children as part of the global AIDS response. The media briefing—and subsequent one-on-one interviews—generated coverage by the Associated Press and Inter Press Service, among others (Appendix III).

Finally, prior to the Johannesburg meeting, the LC members met with selected CEPA partners to update them on the campaign's progress, and discuss how the LC can help leverage the campaign. Moving forward, individual LC members will continue to engage directly with CEPA's country teams to help accelerate progress toward key advocacy outcomes.

IMPACT PLANNING, ASSESSMENT, REPORTING AND LEARNING (IPARL)

In July 2010, Dr. Francis Bwambala of ANECCA's Regional Centre for Quality of Health Care and Viviane Sakanga of the Treatment Advocacy and Literacy Campaign (TALC) were engaged to provide peer-to-peer technical support to CEPA country partners related to CEPA's Impact Monitoring, Assessment, Reporting and Learning framework, and most of the CEPA partners have designated IPARL focal points. In addition, a new IPARL Outcomes Optimization Team was created to help bridge capacity gaps and optimize IPARL implementation. This team is comprised of CEPA Global Coordinator Georgina Bukonya, CEPA Advocacy Impact Officer Susana Oguntoye, Subarna Mathes of iScale, Dr. Francis Bwambale, Viviane Sakanga, and CEPA Director of African Partnerships Bonaventure Wakana. Team members conducted a series of country visits to provide hands-on support to address specific IPARL capacity gaps. These visits included Kenya (July 29-30), Tanzania (August 2-3), Mozambique (August 5-6), and Nigeria (August 31 to September 6).

Importantly, CEPA is being recognized as an important model by advocacy evaluation experts. The campaign's monitoring and evaluation framework was highlighted in the fall 2010 issue of the Advocacy Evaluation Update published by the Center for Evaluation Innovation and Innovation Network (http://evaluationinnovation.org/sites/default/files/AEU%20Issue10_0.pdf). In addition, the Hauser Center for Nonprofit Organizations at Harvard University highlighted the CEPA Advocacy Toolkit and the IPARL evaluation model on its blog for humanitarian and development NGOs (<http://hausercenter.org/iha/2010/07/22/evaluating-advocacy-start-from-the-beginning/>). Finally, CEPA's early experiences in evaluating a transnational campaign network were presented at an IANGO workshop in June (http://www.globalaidsalliance.org/page/-/PDFs/Early_Experiences_Evaluating_Transnational_Campaign_Network.pdf).

NETWORK COMMUNICATIONS AND MEDIA OUTREACH

- ◆ CEPA is in the final stages of selecting a vendor to manage the creation of a redesigned website that will feature a more interactive and accessible CEPA network communications platform. We expect to begin the redesign to begun by mid- to late October, with the goal of launching the new website by early 2011.
- ◆ As described above, CEPA's communications team organized press conferences and other media outreach activities in conjunction with both the XVIII International AIDS Conference in Vienna and the inaugural meeting of the CEPA Leadership Council in Johannesburg.
- ◆ PBS NewsHour, a nightly national U.S. news broadcast, will be filming in Mozambique during the week of October 16 on the topic of HIV/AIDS in southern Africa, with a focus on stock-outs of essential medicines and health commodities. This media opportunity was arranged by CEPA, and PBS will interview selected CEPA partners, including Cesar Mufanequico of the Movement for Treatment Access in Mozambique.

B. Key Accomplishments

Appendix I provides a detailed report on key advocacy outputs and outcomes achieved by the CEPA partners to advance the campaign's priority objectives over the past trimester. This report distills key learnings from the trimester reports submitted by CEPA's country and regional partners, which include data from the Key Performance Indicator tables, evidence of change journals, and other IPARL tools. Importantly, all of the IPARL data and more detailed reporting on progress toward CEPA's priority outcomes, as well as the traffic light coding, are available as part of the IPARL database that iScale has established online at <http://cepa.scalingimpact.net/iparl-system>.

The following analysis reflects CEPA's assessment of progress on 11 of the 16 nexus priorities where we have observed significant campaign-wide momentum. This analysis utilizes the traffic light color codification system, i.e., **GREEN** indicates achievement of outcome; **YELLOW** indicates good progress toward achievement of outcome, as evidenced by achievement of outputs toward that outcome; **ORANGE** indicates some progress toward originally defined advocacy outcome, but significant challenges exist and course correction under way; and **RED** indicates no progress to date or no achievement of outcome.

OBJECTIVE #1: FAMILY-CENTERED CARE AND NUTRITION

Priority 1.1: Rapid adoption and implementation of new World Health Organization guidelines on antiretroviral therapy, PPTCT+ (Option B), and infant feeding by 2011. All of the CEPA countries have rapidly adopted some version of the new WHO guidelines on PPTCT, but we remain concerned about the readiness of normative global agencies to develop tools and job aids to facilitate country-level implementation. Moving forward, CEPA's advocacy efforts will need to shift toward pushing both global and country-level stakeholders to facilitate effective on-the-ground implementation of WHO's guidelines. With several countries having selected Option A of WHO's guidelines, CEPA will also need to undertake some course correction in order to support countries in implementing Option A, while at the same time continuing to push for the eventual adoption of Option B. Indeed, CEPA's Leadership Council plans to produce a white paper articulating why Option B is more efficacious for the health of women and their children, and a better long-term choice from the perspective of national investment. Finally, several CEPA countries have adopted infant feeding guidelines, and we believe there is an opportunity to review the adoption and implementation of these guidelines and accelerate progress based on shared learnings. We assign a **GREEN** rating to CEPA's progress on rapid adoption of WHO's PPTCT+ guidelines, but an **ORANGE** rating to progress toward implementation of those guidelines. We assign a **YELLOW** rating to progress implementing of both the ARV therapy and infant feeding guidelines.

OBJECTIVE #2: EARLY INFANT DIAGNOSIS AND TREATMENT (EID/EIT)

Priority 2.1: Development and implementation of early infant diagnosis and treatment guidelines to increase testing of children within two months of birth by 2011. All CEPA countries have adopted WHO's guidelines calling for early initiation of infant diagnosis and treatment, and tracking systems are in place for testing before 24 months. However, more effective implementation is needed, including nationwide implementation of EID/EIT policies that are aligned with WHO's guidelines and ensure equitable access to services across urban and rural communities, and better systems for tracking the number of infants being tested for HIV before two months of age. Importantly, the CEPA Uganda team has worked with the Clinton Health Access Initiative and the Ministry of Health to develop an EID strengthening program that addresses referral issues and loss to follow-up. Indeed, this work in Uganda represents a new best practice for advocacy, and we hope to adapt the current peer mentoring process to help replicate this model in other CEPA countries. We assign an **ORANGE** rating to CEPA's progress toward this priority outcome.

OBJECTIVE #3: ACCESS TO APPROPRIATE MEDICINES AND COMMODITIES

Priority 3.1: Effective policy and monitoring mechanisms in place to reduce point-of-care stock-outs of ART for adults and children, opportunistic infection drugs, and EID and family planning commodities by 2012.

Priority 3.2: Accelerated national registration, procurement, and distribution of pediatric first-line, fixed dose combination medicines by 2012.

Most CEPA countries are showing progress on outputs and outcomes across both of these priorities. Importantly, Health Action International Africa's efforts to improve access to relevant pediatric medications and commodities did not get fully under way until September; however, HAI Africa did play a key role in working with the CEPA Kenya team to ensure the inclusion of pediatric formulations on Kenya's essential medicines list. We expect further progress based on an intensification of HAI's efforts, and we assign an **ORANGE** rating to progress toward both priorities 3.1 and 3.2.

OBJECTIVE #4: FULL FUNDING TO ELIMINATE PEDIATRIC HIV/AIDS

Priority 4.1: Increased national budgets for PPTCT+ and pediatric treatment and services by 2012. The first round of 2010 Network Transfer Agreements were disbursed too late to allow CEPA's partners to effectively influence FY2010 national budgets. Nevertheless, three of CEPA's country teams have secured favorable commitments from members of key parliamentary budget and finance committees for increased national spending on health and pediatric HIV/AIDS, and we anticipate that these outputs will translate into actual advocacy outcomes next year. In particular, the CEPA Kenya team's active engagement with national fiscal and technical working groups on HIV/AIDS, as well as direct advocacy with the Ministry of Finance, led directly to the inclusion of a designated line item for ARV medications in the national health budget, and exemplifies a best practice that could be replicated by other campaign partners. Importantly, we believe that the CEPA Leadership Council's call for increased national government funding of health budgets, particularly HIV/AIDS services, will provide essential support for CEPA's country-level efforts to leverage increased spending during the FY2011 and FY2012 budget cycles. We assign an **ORANGE** rating to progress toward this priority outcome.

Priority 4.3: Achieve the Abuja Declaration commitment by 2012. In response to backtracking by a number of African Ministries of Finance, CEPA's regional and national partners worked together to help organize a two-day civil-society meeting at the African Union summit in late July, which released a communiqué that focused on the failure of most African governments to devote an adequate percentage of their national budgets to health care, as well as low per capita spending on health. In response, the African Union explicitly extended the Abuja Declaration commitment to allocate 15% of annual national budget to improving the health sector, as well as the Abuja call for accelerated action to achieve universal access to HIV/AIDS services. In addition, the CEPA Status Report identified new baseline information for tracking national expenditures toward health. Specifically, our data indicate that Kenya spent 7% of its national budget on health in 2009-2010, a decrease from 2006; Tanzania spent 11% in 2007-2008, a decrease from 2006; Uganda spent 10.2% in 2009-2010, an increase from 2006; and Zambia spent 11.9% in 2009, a decrease from 2006, and is no longer meeting the Abuja Declaration commitment. We assign an **ORANGE** rating to progress toward this priority outcome.

Priority 4.4: Full funding for the Global Fund to Fight AIDS, TB and Malaria (2011-2013 Replenishment Cycle) and PEPFAR by 2012. The 2011-2013 Global Fund replenishment process will conclude next week at the Global Fund Replenishment Conference in New York City. We anticipate that the U.S. government will make a multi-year commitment, which will be a positive outcome, and CEPA continues to advocate for a significant increase in the U.S. contribution to the Fund. Overall, however, it appears unlikely that the Fund will be replenished at the level needed to effectively accelerate progress toward 80% coverage for PPTCT+ and pediatric treatment. We assign an **ORANGE** rating to CEPA's progress toward this priority outcome.

OBJECTIVE #5: PROGRAMMING TO ACHIEVE CEPA IMPACT

Priority 5.1: Political commitments and national plans and frameworks adopt CEPA goals and priorities and achieve those goals by 2012. CEPA's advocacy has helped generate a high level of political commitment to eliminating pediatric HIV/AIDS at the global, regional, and national levels, as evidenced by the targeted campaigns and initiatives being implemented by stakeholders such as UNICEF, UNAIDS, and the Global Fund, as well as the willingness of key stakeholders to endorse CEPA's Global Leadership Commitment to Action to End Pediatric HIV/AIDS. Moving forward, CEPA will maintain pressure on national governments to adopt effective plans and frameworks by 2012, while at the same time realigning our advocacy around the 2015 timetable of the broader Millennium Development Goal and universal access movements, as well as other multilateral and NGO campaigns on pediatric AIDS. Thus, CEPA will focus increased efforts on translating positive rhetoric into concrete action. For example, we will seek to ensure that the elimination of pediatric HIV/AIDS is included in the updated document that will emerge from next year's review of the UNGASS Declaration. We assign a **GREEN** rating to CEPA's progress in securing political commitments to achieve CEPA's goals and priorities, and a **YELLOW** rating to progress toward the creation of national plans and frameworks.

Priority 5.2 and Priority 5.3: Global Fund, Global Health Initiative, and PEPFAR programming opportunities include sufficient funding for all four prongs of PPTCT+, coverage targets, and pediatric treatment in CEPA countries by 2012. Five CEPA countries have submitted Round 10 proposals to the Global Fund to Fight AIDS, TB and Malaria, which include a focus on PPTCT+ and pediatric treatment services. Likewise, the Global Fund's reprogramming initiative has been implemented in all six CEPA countries, although the Fund's implementation process did not involve civil-society, and continued monitoring will be needed to ensure that this initiative is effectively advancing CEPA's priorities. In addition, CEPA partners worked with local civil-society groups in both Nigeria and Zambia to shape the PEPFAR Partnership Framework development process, and we have successfully leveraged the inclusion of CEPA priorities in the draft framework documents. All six CEPA countries have succeeded in leveraging either Global Fund or PEPFAR support for CEPA's agenda. Thus, we assign a **YELLOW** rating to progress toward this priority outcome.

OBJECTIVE #6: OVERCOME HUMAN RESOURCES CRISIS

Priority Outcome 6.1: Effective policies and guidelines to expand and improve human resources capacity to support scale-up of PPTCT+ and pediatric treatment services by 2012. About half of the CEPA country partners have undertaken some initial efforts to improve human resources capacity, and the CEPA Uganda team has developed simplified algorithms and job aids and other technical tools on EID, EIT, and PMTCT services for use by health care workers. These tools will be launched at the National Pediatric HIV/AIDS Conference being held this week in Kampala, and we anticipate accelerated progress on this front during 2011. We assign an **ORANGE** rating to CEPA's progress toward this priority outcome.

OBJECTIVE #7: OVERCOME STIGMA AND DISCRIMINATION

Priority Outcome 7.1: Effective policy and monitoring mechanisms to reduce stigma and discrimination to support scale-up of PPTCT+ and pediatric treatment services by 2012. Both the CEPA Nigeria and Tanzania teams are actively exploring opportunities to leverage progress in reducing stigma and discrimination, and four of the CEPA countries (Kenya, Nigeria, Tanzania, and Zambia) are implementing the Stigma Index. We expect further progress on this front in late 2010 and 2011, and assign an **ORANGE** rating to progress toward this priority outcome.

APPENDIX I

CEPA Advocacy Impact Report (May through August 2010)

OBJECTIVE #1: FAMILY-CENTERED CARE AND NUTRITION	
Priority 1.1: Rapid adoption and implementation of new World Health Organization guidelines on antiretroviral therapy, PPTCT+ (Option B), and infant feeding by 2011.	
Kenya	<p>ADVOCACY OUTCOME: The Kenyan government has adopted the new 2009 WHO guidelines for PMTCT and selected Option A.</p> <p>ADVOCACY OUTPUT: Consensus on recommendations to revise infant feeding guidelines in line with new WHO guidance in 2009 has been reached by CEPA and Technical Working Groups.</p>
Mozambique	<p>ADVOCACY OUTCOME: The Mozambique government has adopted Option A of WHO's new PMTCT guidelines, and implementation is being initiated in Maputo Province, with the goal of rolling out nationwide.</p> <p>ADVOCACY OUTCOME: Government has adopted the new 2009 WHO infant feeding guidelines.</p>
Nigeria	<p>ADVOCACY OUTPUT: The national Technical Working Group on HIV/AIDS in conjunction with the national Technical Working Group on Pediatrics (a CEPA core partner) have finalized a draft of new 2009 WHO guidelines for PMTCT, proposing a hybrid of Options A and B. Delivery of Option A or B will depend on the capacity of the health care center to deliver the services. The guidelines are pending approval from the the Federal Ministry of Health (FMOH).</p> <p>ADVOCACY OUTCOME: Lagos State and the Federal Capital Territory/Abuja (FCT) have adopted the new 2009 WHO PMTCT guidelines. States are waiting for FMOH approval before implementation. (*) (+)</p> <p>ADVOCACY OUTCOME: Resolutions of the National Consultative Forum on Infant Feeding recommends that HIV-positive mothers (1) exclusively breastfeed infants for the first six months; (2) introduce complementary feeds at six months; and (3) continue breastfeeding until 12 months, and also highlights the need to promote, and where possible, support improved complementary feeding of all infants, especially those born to HIV-infected mothers. (+)</p>
Tanzania	<p>ADVOCACY OUTPUT: A feasibility and costing study of the new 2009 WHO PMTCT guidelines has been finalized and submitted to the Ministry of Health by an MOH-procured consultant. CEPA continues to advocate for immediate adoption of these guidelines, and the government is leaning toward Option A.</p> <p>ADVOCACY OUTPUT: The feasibility and costing study of the new 2009 WHO infant feeding guidelines has been finalized and submitted to the Ministry of Health by an MOH-procured consultant, and CEPA continues to advocate for immediate adoption of these guidelines.</p>
Uganda	<p>ADVOCACY OUTCOME: The Ugandan Ministry of Health has drafted new guidelines based on the WHO's 2009 PMTCT guidelines, and these were likely to be adopted at the final adoption process meeting in late September. The National ART Committee is leaning toward Option B.</p> <p>ADVOCACY OUTCOME: In April 2009, the Ugandan government launched new guidelines that address most of the recommendations for infant feeding in the 2009 WHO guidelines, and a five-year 2010-2015 action plan has been developed to incorporate these recommendations.</p>
Zambia	<p>ADVOCACY OUTPUT: CEPA Zambia has produced a report recommending the rapid adoption of the new 2009 WHO infant feeding guidelines, PPTCT, and other pediatric AIDS policy issues.</p> <p>ADVOCACY OUTPUT: The Zambian Ministry of Health has recommended comprehensive pediatric treatment in the National 2011-2015 PMTCT scale-up plan.</p> <p>ADVOCACY OUTCOME: The Zambian Ministry of Health has adopted Option A of WHO's new 2009 PMTCT guidelines.</p>
Regional	<p>ADVOCACY OUTPUT: In June 2010, regional partners PATAM and ANECCA presented a communiqué highlighting CEPA's advocacy priorities on PPTCT and early infant diagnosis and treatment at a WHO-convened meeting on the new WHO guidelines in Harare, Zimbabwe. PATAM and ANECCA urged WHO, UNICEF, and PEPFAR representatives to provide technical support and guidance to countries currently adopting and implementing the new WHO guidelines on PPTCT, ART, and infant feeding.</p>

OBJECTIVE #2: EARLY INFANT DIAGNOSIS AND TREATMENT	
Priority 2.1: <i>Development and implementation of early infant diagnosis and treatment (EID/EIT) guidelines to increase testing of children within two months of birth by 2011.</i>	
Tanzania	ADVOCACY OUTPUT: CEPA has developed a proposal for an addendum to the national CTC-2 form, which monitors child development, in order to include specific pediatric HIV/AIDS parameters, and the proposed addendum has been forwarded to the Tanzanian Ministry of Health for approval.
Uganda	ADVOCACY OUTPUT: CEPA partners conducted an EID courier services desk review and produced a report that will be released publicly in mid-October 2010. ADVOCACY OUTCOME: CEPA partners UPA and Baylor-Uganda, together with CHAI, have worked with the Ministry of Health on an EID strengthening program. To date the pilot has run in seven centers across the country, and has improved referral systems and reduced loss to follow-up. ¹

OBJECTIVE #3: ACCESS TO APPROPRIATE MEDICINES AND COMMODITIES	
Priority 3.1: <i>Effective policy and monitoring mechanisms in place to reduce point-of-care stock-outs of ART for adults and children, opportunistic infection (OI) drugs, EID and family planning commodities by 2012.</i>	
Mozambique	ADVOCACY OUTPUT: As part of Ministry of Health efforts to improve supply and distribution, logistics management of ARVs and HIV/AIDS commodities has been transferred to the Centre for Medicines and Medical Articles, which should improve supply chain management. (+)
Uganda	ADVOCACY OUTCOME: PEPFAR has reversed funding caps on ART provision for Uganda in response to pressure from civil-society organizations (CSOs), including CEPA partners in Uganda and across the campaign. In addition, the U.S. government pledged to return to the rate of new patient enrollment taking place before treatment caps were put in place, which means that approximately 3,000 new patients will be treated each month until 2013.
Zambia	ADVOCACY OUTPUT: CEPA Zambia has produced and disseminated a report on current supply chain management status and existing guidelines. ADVOCACY OUTCOME: The Zambian Ministry of Health has included the strengthening of supply chain management in the national PMTCT scale-up plan. (*)
Global	ADVOCACY OUTCOME: In June 2010, the UNITAID board of directors approved the creation of a Medicines Patent Pool Foundation (MPPF) that will establish and manage the patent pool. The board also approved approximately \$4.4 million in initial funding, and both UNITAID and the MPPF are now finalizing a memorandum of understanding and establishing a secretariat. Later this year, the MPPF will begin negotiating with relevant pharmaceutical companies to join the patent pool.

¹ Ugandan MOH developed and piloted “EID strengthening program” in response to EID review by CEPA. The objectives for this are to (1) increase the number of HIV-exposed infants accessing PCR testing; (2) increase the percentage of tested infants that receive results and either (a) complete the infant testing algorithm (if negative), or (b) access care and treatment at the ART clinic (if positive); and (3) improve the quality of care provided to HIV-exposed infants by shifting EID services from the lab to a clinic-based program with sufficient staff and basic resources. It is a package of six complementary initiatives, including (1) establish EID ‘Care Point’ within either MCH or ART clinic where all exposed infant care/follow-up is centralized; (2).integrate routine care into EID process and establish regular visit schedule; (3) improve tracking tools to centralize data and follow infants longitudinally; (4) establish referral system for DBS testing and follow-up at EID care point; (5) establish referral system for care and treatment at ART clinic; and (6) strengthen and standardize counseling for caregivers of exposed infants. To date the MOH has (1) conducted EID review at seven health facilities; (2) developed initiatives to strengthen EID programs; (3) implemented “EID strengthening pilot” at 21 health centers; and (4) is assessing pilot and guiding national scale-up.

Priority 3.2: Accelerated national registration, procurement, and distribution of pediatric first-line fixed dose combination (FDC) medicines by 2012.	
Kenya	ADVOCACY OUTPUT: CEPA Kenya in conjunction with HAI Africa, a CEPA regional partner, produced a review of the essential medicines list. ADVOCACY OUTCOME: CEPA Kenya used this review to leverage the inclusion of pediatric formulations on the essential medicines list, and pediatric formulations are now included.
Nigeria	ADVOCACY OUTCOME: The Federal Ministry of Health issued a directive to states to adopt fixed dose combinations for pediatric treatment while guidelines are being revised. (*) (+) ADVOCACY OUTCOME: Lagos State and the Federal Capital Territory have included FDCs for pediatric HIV/AIDS in their treatment protocols. (*) (+).

OBJECTIVE #4: FULL FUNDING TO ELIMINATE PEDIATRIC HIV/AIDS	
Priority 4.1: Increased national budgets for PPTCT+ and, pediatric treatment, and services by 2012.	
Kenya	ADVOCACY OUTPUT: CEPA presented a scenario of funding for ARV medications and treatments to the national finance working group and recommended the inclusion of an ARVs line item in the national budget at the level of roughly 900 million Ksh (US \$11.25 million). ADVOCACY OUTCOME: The Kenyan government has included an ARV line item and made a commitment of 900 million Ksh (US \$11.25 million) for ARVs in the FY2011 national budget.
Nigeria	ADVOCACY OUTPUT: CEPA catalyzed a national civil-society mobilization and championed specific demands that align with campaign priorities, including calling for a commitment of 50% by the federal government of Nigeria within the PEPFAR Partnership Framework. A leaked draft indicates that the Nigerian government has committed to this 50% target.
Zambia	ADVOCACY OUTPUT: The CEPA Zambia team has produced a report titled Grave Negligence that tracks government spending on health and HIV/AIDS from 2005 through 2009 and the impact of suspending aid to the Ministry of Health. CEPA will seek to use this report to leverage increased resources for expanded access to PPTCT+ and pediatric AIDS treatment. ADVOCACY OUTPUT: CEPA partners worked with regional partner PATAM to engage in the development process for Zambia's National AIDS Strategic Framework, which is linked to the PEPFAR Partnership Framework, and the preliminary draft includes some CEPA recommendations, e.g., increase domestic spending to meet 50% of the HIV/AIDS need.
Regional	ADVOCACY OUTPUT: Regional and national CEPA partners, including ANECCA, Health GAP, and CEPA partners in Kenya and Uganda, participated in a two-day civil-society meeting in July in Kampala to develop a communiqué to the Ambassadors to the African Union, African Ministers, Heads of State, and Organization of African First Ladies Against HIV/AIDS at the African Union (AU) summit. ADVOCACY OUTCOME: The African Union summit on maternal and child health resulted in decisions that aligned with civil-society demands, including a decision to "Provide sustainable financing by enhancing domestic resources mobilization including meeting the 15% Abuja target, as well as, mobilizing resources through public-private partnerships and by reducing out-of-pocket payments through initiatives such as waiving of user fees for pregnant women and children under five and by instituting national health insurance." ²

² Assembly of the African Union, Fifteenth Ordinary Session, 25–27 July 2010, Kampala, Uganda. Actions on Maternal, Newborn and Child Health and Development in Africa by 2015.

Priority 4.3: Achieve the Abuja Declaration commitment by 2012.	
Regional	ADVOCACY OUTCOME: Regional and national CEPA partners, including ANECCA, Health GAP, and CEPA partners in Kenya and Uganda, participated in a two-day civil-society meeting in July in Kampala to develop a communiqué to the Ambassadors to the African Union, African Ministers, Heads of State, and Organization of African First Ladies Against HIV/AIDS at the African Union (AU) summit. At the conclusion of the summit, the African Union issued a series of decisions, including one that reaffirms the commitment to “provide sustainable financing by enhancing domestic resources mobilization, including meeting the 15% Abuja target.” Given the fact that AU Ministers of Finance were actively trying to distance their governments from the Abuja Declaration commitment as recently as May 2010, when they described the declaration as a “colossal mistake,” this recommitment to the 15% target represents a major win for civil society and CEPA’s partners.
Priority 4.4: Full funding for the Global Fund to Fight AIDS, TB and Malaria (Replenishment Cycle 2011-2013) and PEPFAR by 2012.	
Global	ADVOCACY OUTPUT: The White House FY2011 budget request reflected cuts across the board, and CEPA worked with a broad civil-society coalition to lobby Congress. Current House and Senate legislation calls for \$5.25 billion and \$5.5 billion for PEPFAR, respectively, and \$825 million and \$800 million for the Global Fund to Fight AIDS, TB and Malaria. ADVOCACY OUTPUT: GAA launched a “3 x 6” campaign at the XVIII International AIDS Conference in July, calling for a U.S. commitment to the Global Fund of \$6 billion over three years. As a result of extensive advocacy efforts, including a letter to President Obama signed by 101 Members of Congress, the White House is seriously considering a multi-year pledge to the Global Fund. The significance of this cannot be underestimated, given the fact that the U.S. Congress only appropriates funds on an annual basis and has historically been unwilling to consider multi-year pledges for anything.

OBJECTIVE #5: PROGRAMMING TO ACHIEVE CEPA IMPACT	
Priority 5.1: Political commitments and national plans and frameworks adopt CEPA goals and priorities, and achieve those goals by 2012.	
Mozambique	ADVOCACY OUTCOME: The government of Mozambique has approved new PMTCT and pediatric HIV/AIDS treatment and general ART targets. While these targets have not been released, previous government targets include 58% coverage by 2014, and the Ministry of Health’s 2008 PMTCT coverage target was 33.7%. CEPA is advocating for the government to set more ambitious 80% coverage targets for both PPTCT and pediatric treatment.
Uganda	ADVOCACY OUTPUT: The CEPA Uganda team, with regional partner Health GAP, coordinated a consultation of 115 CSOs from across the country to develop core demands on PPTCT and pediatric HIV/AIDS for inclusion in the Health Sector Strategic Plan III for Uganda.
Zambia	ADVOCACY OUTPUT: CEPA partners, in collaboration with regional partner PATAM, engaged in the development process for the National AIDS Strategic Framework for Zambia, which is linked to the PEPFAR Partnership Framework, and a preliminary draft includes some CEPA recommendations, e.g., eliminate pediatric HIV / AIDS, achieve universal access to testing and treatment, and improve laboratory infrastructure and health information systems. ADVOCACY OUTCOME: The Zambian government has confirmed new PPTCT+ and pediatric treatment targets, including 80% coverage by 2010, and CEPA Zambia is advocating for full implementation by 2012. ADVOCACY OUTCOME: The Zambian government has developed a national 2011-2015 PMTCT scale-up plan that seeks the virtual elimination of vertical HIV transmission by 2015. ADVOCACY OUTCOME: The Zambian Ministry of Health has included equitable distribution of PPTCT+ services in its national PMTCT scale-up plan, and CEPA is advocating for the development and dissemination of national implementation guidelines.

Regional	<p>ADVOCACY OUTCOME: The July 2010 African Union summit issued the following decisions on maternal, newborn, and child health, health financing, universal access, and PPTCT:</p> <ol style="list-style-type: none"> 1. Strengthen the health systems to provide comprehensive, integrated, maternal, newborn and child health care services, in particular through primary health care, repositioning of family planning including reproductive health commodities security, infrastructure development and skilled human resources for health. 2. Reaffirm the commitments undertaken at the Special Summits on HIV/AIDS, TB and Malaria in 2000, 2001, and 2006. 3. Extend the Abuja Call for Accelerated Action Towards Universal Access to HIV/AIDS, Tuberculosis and Malaria Services in Africa to 2015 to coincide with the MDGs. 4. Underscore the need to promote throughout the continent, programs for the total eradication of mother to child transmission so that no child is born with HIV/AIDS.
Global	<p>ADVOCACY OUTCOME: At the XVIII International AIDS Conference, CEPA released a Global Leadership Commitment to Action to End Pediatric HIV/AIDS by December 31, 2015, which was signed by UNAIDS Executive Director Michel Sidibé, UNICEF Executive Director Anthony Lake, Global Fund Executive Director Michel Kazatchkine, and International AIDS Society President-Elect Dr. Elly Kabira, among others.</p> <p>ADVOCACY OUTPUT: Also at the International AIDS Conference, CEPA released a status report that highlights progress toward CEPA's priority advocacy outcomes, and includes specific recommendations for key stakeholders, including national governments, the Coordinated Procurement Planning Program, donor governments, PEPFAR, and the Global Fund to Fight AIDS, TB and Malaria.</p>
Priority 5.2: Global Fund programming opportunities include sufficient funding for all four prongs of PPTCT+, coverage targets, and pediatric treatment in CEPA countries by 2012.	
Mozambique	ADVOCACY OUTPUT: Round 10 Global Fund proposal submitted. (*) (+)
Nigeria	ADVOCACY OUTPUT: Round 10 Global Fund proposal submitted, which focuses on all four prongs of PPTCT+ services and names a CEPA partner as a potential sub-recipient.
Tanzania	ADVOCACY OUTPUT: Round 10 Global Fund proposal submitted, and CEPA coordinating partner HDT is named as a potential sub-recipient for work on social mobilization and demand creation for PPTCT and pediatric HIV/AIDS services.
Uganda	<p>ADVOCACY OUTPUT: CEPA partner NACWOLA is part of the Global Fund's Country Coordinating Mechanism in Uganda, and a Round 10 proposal was submitted with NACWOLA named as a potential sub-recipient.</p> <p>ADVOCACY OUTPUT: CEPA partners advocated for the Round 10 Global Fund proposal to include funding to implement Option B, and this was included in the final proposal.</p>
Priority 5.3: Global Health Initiative and PEPFAR programming opportunities include sufficient funding for all four prongs of PPTCT+, coverage targets, and pediatric treatment in CEPA countries by 2012.	
Tanzania	ADVOCACY OUTPUT: CEPA Tanzania is engaged in the PEPFAR Partnership Framework development process and has championed a set of core demands.
Uganda	ADVOCACY OUTPUT: CEPA Zambia partners worked with Health GAP to help galvanize a joint civil-society demand for a PEPFAR Partnership Framework for Uganda, but the Ugandan government remains hesitant to enter into a five-year framework.
Nigeria	ADVOCACY OUTPUT: CEPA catalyzed a national civil-society mobilization and championed specific demands that align with campaign priorities, including calling for a commitment of 50% by the federal government of Nigeria within the PEPFAR Partnership Framework. A leaked draft indicates that the Nigerian government has committed to this 50% target.
Zambia	ADVOCACY OUTPUT: CEPA partners, in collaboration with regional partner PATAM, engaged in the development process for Zambia's National AIDS Strategic Framework, which is linked to the PEPFAR Partnership Framework, and a preliminary draft includes some CEPA recommendations, e.g., commitments to eliminate pediatric HIV/AIDS, achieve universal access to testing and treatment, and improve laboratory infrastructure and health information systems.

OBJECTIVE #6: OVERCOME HUMAN RESOURCES CRISIS	
Priority 6.1: <i>Effective policies and guidelines to expand and improve human resources capacity to support scale up of PPTCT+ and pediatric treatment services by 2012.</i>	
Mozambique	<p>ADVOCACY OUTPUT: Lack of engagement of the Ministry of Health has affected CEPA partners working with the MOH to raise awareness and jointly train community, religious, and traditional leaders, traditional healers, and community activists on pediatric HIV/AIDS, PMTCT, and stigma and discrimination. Working with the MOH has been challenging.</p> <p>ADVOCACY OUTCOME: Non-physician clinicians (e.g., medical technicians) can now prescribe antiretroviral therapy for children. (*) (+)</p> <p>ADVOCACY OUTCOME: Training for non-clinical health care workers (HCWs) began in the second half of 2010. (*) (+)</p>
Uganda	<p>ADVOCACY OUTPUT: CEPA partners and CHAI have developed simplified pediatric treatment and diagnosis algorithms, job aids, and other technical tools for healthcare workers, which were launched at the 4th National Paediatric HIV/AIDS Conference, September 28-30, 2010.</p>
Zambia	<p>ADVOCACY OUTPUT: CEPA Zambia produced a report titled Grave Negligence, which includes a review of health workforce financing and employment in Zambia (Health Space Fiscal Study review).</p> <p>ADVOCACY OUTPUT: CEPA partners, in collaboration with regional partner PATAM, engaged in the development process for the National AIDS Strategic Framework for Zambia, which is linked to the PEPFAR Partnership Framework, and a preliminary draft includes some CEPA recommendations, e.g., recruitment, retention, and training of health workers to achieve a ratio of 2.3 HCWs per 1,000 population, accreditation of community health workers, etc.</p> <p>ADVOCACY OUTPUT: CEPA has produced a review of the national Nurse's and Midwives Drug Formulary and Prescribing Guidelines and Curriculum to push the Zambian government for inclusion of pediatric ART in these guidelines.</p>

OBJECTIVE #7: OVERCOME STIGMA AND DISCRIMINATION	
Priority 7.1: <i>Effective policy and monitoring mechanisms to reduce stigma and discrimination to support scale-up of PPTCT+ and pediatric treatment services by 2012.</i>	
Nigeria	<p>ADVOCACY OUTCOME: A national stigma and discrimination bill has passed both houses of the national assembly and is awaiting Presidential approval.</p>
Tanzania	<p>ADVOCACY OUTPUT: The Stigma Index is being piloted in the Dar Es Salaam region by the National Council for People Living with AIDS (NACOPA) and the African Medical and Research Foundation, and the Tanzania AIDS Forum and NACOPA will be receiving funds from UNAIDS to expand this initiative to three additional regions nationwide.</p>
Global	<p>ADVOCACY OUTPUT: In the FY2011 State and Foreign Operations Appropriations bill, the Senate included this report language on stigma and discrimination: "The Committee welcomes the emphasis in PEPFAR's five-year strategy on addressing stigma and discrimination against most-at-risk populations and violations of the rights of women, and directs OGAC to address the needs for legal and policy reform and the enforcement of such policies in Partnership Frameworks, Partnership Framework Implementation Plans, and Country Operational Plans." GAA submitted a FY2011 wish list to the U.S. House and Senate that included this language.</p>

(*) Denotes advocacy outputs or outcomes that were unanticipated.

(+) Further assessment required to determine attribution to CEPA's advocacy efforts.

APPENDIX II

2010 Progress on PPTCT+ and ART for children in six CEPA countries ³								
	Pregnant women living with HIV/AIDS	Pregnant women receiving ARVs	% pregnant women receiving ARVs	Pregnant women that would receive PPTCT at 80% coverage	Children in need (estimate)	Children receiving ARVs	% children on ARVs for PTCT	Children that would receive ARVs at 80% coverage
Kenya	81,000	58,591	72	6,213	89,000	28,370	32	42,830
Mozambique	97,000	68,248	70	35,551	66,000	13,510	20	39,290
Nigeria	210,000	44,723	21	149,406	180,000	25,200	14	118,800
Tanzania	84,000	58,883	70	9,917	75,000	10,500	17	102,576
Uganda	88,000	46,948	53	25,852	76,000	10,640	18	50,160
Zambia	68,000	47,175	69	14,796	59,000	8,260	36	38,940
Total (#) /average (%) for six CEPA countries	628,000	324,568	52	241,734	545,000	96,480	18	392,596

2009 Progress on PPTCT+ and ART for children in six CEPA countries ⁴								
	Pregnant women living with HIV/AIDS	Pregnant women receiving ARVs	% pregnant women receiving ARVs	Pregnant women that would receive PPTCT at 80% coverage	Children living with HIV/AIDS	Children receiving ARVs	% children receiving ARVs	Children that would receive ART at 80% coverage
Kenya	81,000	58,587	72	6,213	184,052	28,370	15	118,872
Mozambique	132,807*	70,695*	53	35,551	72,367 ^{§§}	13,510 ^{§§§}	19	44,384
Nigeria	243,730 [§]	45,578 [§]	19	149,406	103,080 ^{§§}	26,743	26	55,721
Tanzania	86,000	58,883	68	9,917	144,248	12,822 [^]	10	102,576
Uganda	91,000*	46,948*	52	25,852	120,000 [^]	24,554*	27	71,446
Zambia	77,465	47,176	61	14,796	33,964 ^{§§}	22,114	65	5,057
Total (#) /average (%) for six CEPA countries	712,002	327,867	46	241,734	657,711	128,113	19	398,055

³ Unless otherwise stated, all data from WHO, UNICEF, UNAIDS Universal Access Progress Report 2010, http://www.who.int/hiv/pub/2010progressreport/full_report_en.pdf, accessed September 30, 2010.

⁴ Unless otherwise stated, all data from national UNGASS Reports for 2010, <http://www.unaids.org/en/KnowledgeCentre/HIVData/CountryProgress/2010CountryProgressAllCountries.asp>, accessed May 19, 2010.

Notes: §from estimates for 2010; §§calculated using estimates of children who have been identified as requiring ART because actual prevalence data not available; §§§from 2010 national data; *from 2009 national data; ^from 2008 national data.

APPENDIX III

Governments Failing to Take the Threat of HIV Seriously

by Chris Stein

JOHANNESBURG, Sep, 10, 2010 (Inter Press Service)—Experts worry that African governments are failing to take the threat of HIV seriously enough by not dedicating enough of their resources to prevention of mother-to-child transmission (PMTCT) efforts.

For Graça Machel, Chair of the Campaign to End Pediatric AIDS (CEPA) Council, the struggle to stop the spread of the disease is a matter of inequality.

“A child born in a developed country has all the chances for having a full, healthy, long life,” Machel said at a CEPA press conference on Sep. 10. “In Africa and Asia, they have much less of a chance.”

Machel and other East African council members of CEPA spoke about the challenge of stopping the spread of paediatric AIDS in the continent, which accounts for 90 percent of the world’s population of children born with HIV.

While funding remains a key issue in terms of combating paediatric AIDS, the experts were concerned about the lack of progress made on the Abuja Declaration, an agreement signed by African Union member nations to allocate at least 15 percent of their budgets to the improvement of their healthcare systems.

So far only six African countries have met that pledge, according to CEPA.

But while African Union countries have fallen short of their pledge, Machel said the issues to curbing the spread of the disease are systemic.

“I think we need to reprioritise,” Machel said. “We need to solve the problem of the health system.”

Avertino Barreto, CEPA Council member and current deputy national director for health in Mozambique, said though his government had adopted a program of distributing antiretrovirals used in PMTCT for its population, the country’s underdeveloped supply chain was unable to get the drugs to the people who needed them.

“Mozambique has poor supply chain management, and our health budget allocation is far from 15 percent,” Barreto said. “There is no need for everyone who takes drugs to have to travel a long distance.”

Thrifty nations need to be reminded that fighting AIDS will save money in the long term, said Peter Mugenyi, a specialist in HIV/AIDS and a member of the CEPA Council.

“[Preventing HIV/AIDS] is not a program that is taking money away,” Mugenyi said. “It is saving huge amounts of money.”

With only five years left to meet the Millennium Development Goals, Machel said progress over the last ten years had been modest, but that was no reason to back down.



Graça Machel says the struggle to stop the spread of HIV is a matter of inequality. Credit: Chris Stein/IPS

"We cannot pledge to do this then five years down the road say we did not," Machel said.

Community Roles

In the face of the inadequate healthcare system in many African countries, Dorothy Mbori-Ngacha, UNICEF Regional Advisor on prevention of mother-to-child transmission for Eastern and Southern Africa, said it was important for local communities to play a role in promoting the use of medication.

"We need to partner with mothers, fathers and the community as a whole," Mbori-Ngacha said. "When a health system is ineffective, the community is crucial."

Another obstacle to getting expecting mothers to take antiretrovirals is stigma, Mugenyi said. Education and community are key to ending the stigma of HIV/AIDS, Mugenyi said. "The crisis is that one of the biggest drivers of stigma is fear of death," Mugenyi said. "When people know that the death rate can be reduced, it reduces stigma."

Another player in the struggle against the virus is civil society organisations, which provide important ways to access communities, Mbori-Ngacha said.

"We know now what to do to end paediatric AIDS," Mbori-Ngacha said. "We require that apart from seeing communities, that unless we support civil society, we are going to fail."

There was reason to be optimistic, Mugenyi said: for the first time in history, recent advances in preventative medicine make it possible for a future generation to be free from HIV/AIDS.

"There was no possibility of having an AIDS-free generation in the past," Mugenyi said. "Now it is here."