Elizabeth Glaser Pediatric AIDS Foundation

Investment Case

Three infections. One platform. A generation born free.

Ending mother-to-child transmission of HIV, syphilis and hepatitis B by 2030: what it will cost, what it will save and who must act.

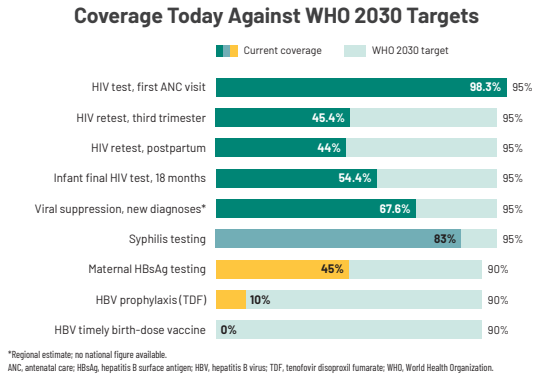
Nine in ten pregnant women in Tanzania make a first antenatal visit, and 98% of them are tested for HIV.[1] That single contact is the strongest platform the health system has. With stronger retesting, treatment and follow-up through breastfeeding, it can protect mother and baby for the whole journey and put Tanzania on the path to WHO validation of triple elimination by 2030.[2]

What Full Investment Will Deliver, 2027-2030

11,401 infections in babies prevented	**4,928** fetal deaths averted	**131 → 36** HIV infections per 100,000 live births, below the WHO threshold of 50	**78 → 25** congenital syphilis cases per 100,000 live births

Infections prevented: 6,110 HIV, 3,403 congenital syphilis and 1,888 hepatitis B, compared with keeping today's coverage. By 2030, yearly infant infections will be 57–72% lower.[1]

Where Mothers and Babies are Being Missed

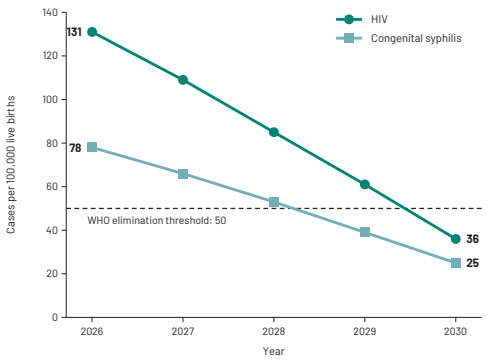


Protection too often stops after the first visit:

- **Retesting is low:** only 45% of women are retested for HIV in late pregnancy, and 44% after birth.
- **Infants are lost to follow-up:** only 54% of HIV-exposed infants have a final HIV test at 18 months.
- **Newly diagnosed women are not yet suppressed:** an estimated 68% reach viral suppression (regional data).
- **Hepatitis B is under-served:** 45% are screened, 10% of those eligible receive prophylaxis, and the birth-dose vaccine is not yet delivered.

Tanzania's gaps mirror a regional crisis: 120,000 children acquired HIV worldwide in 2024[3] and only 17% of newborns in the WHO African Region received a timely hepatitis B birth dose.[4]

Elimination of HIV and Syphilis Is Within Reach; Hepatitis B Is Not Yet



Hepatitis B: the critical gap

7.5% → 3.2%

of exposed infants infected, 2026 to 2030. Even at WHO coverage targets, transmission will remain above the WHO 2% target.[2]
What closes the gap: a universal, timely hepatitis B birth dose, alongside maternal HBsAg screening and tenofovir prophylaxis, with HBV indicators in routine reporting.

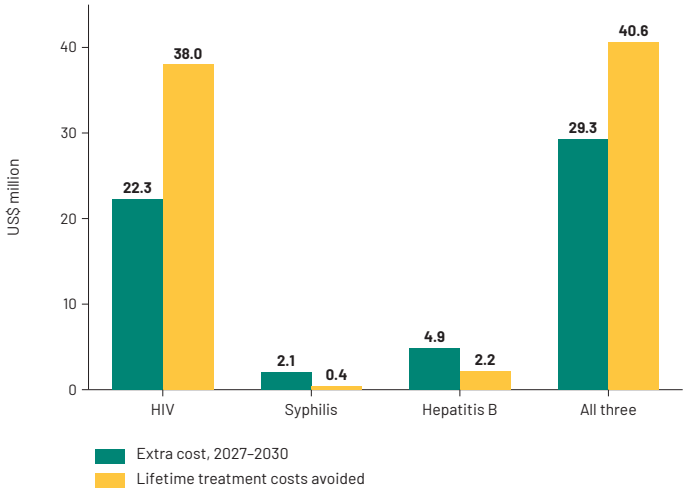
A Modest Investment with a Lasting Return

US$46.2m
annual testing and treatment cost by 2030, up from US$33.4m in 2026

+US$29.3m
added over four years (2027–2030) to reach the WHO targets, plus US$4.3m for demand creation

US$40.6m
treatment costs avoided for the 11,401 infections averted, 2027–2030 (lifetime, undiscounted)

US$1.38
avoided in future treatment costs for every US$1 spent



Why it is a smart investment

- **Prevention costs less than lifelong care.** Preventing one infant HIV infection costs about US$3,650 in testing, treatment and prophylaxis, against an estimated US$6,223 to treat one child for life, a conservative figure.[1]
- **Screening is cheap.** A dual HIV/syphilis test costs about US$2 per woman and hepatitis B screening US$1.12.[1]
- **Syphilis and hepatitis B add little cost**. They account for less than a quarter of the extra cost but almost half of the infections prevented.[1]
- **Savings accrue over decades.** Treatment costs avoided are a long-term economic gain, not an immediate budget saving.
- **External funding is falling.** UNAIDS warns of up to 6 million extra HIV infections by 2029 if US-supported services collapse; domestic ownership protects the gains.[5]

Four Priorities That Close the Gaps

1. Find and treat infections early
Integrated HIV, syphilis and hepatitis B testing in antenatal care, with repeat HIV testing in late pregnancy and after birth.

2. Protect treatment continuity
Maternal ART, syphilis treatment and HBV prophylaxis with an assured supply of medicines and tests.

3. Protect infants beyond delivery
Hepatitis B birth dose, infant HIV prophylaxis and testing, and follow-up to 18 months.

4. Reach the women who are missed
Community mobilisation, mother peer support, tracking and data systems that link mother and baby.

What Each Partner Can Do

Governments & Ministries of Finance

- Adopt triple elimination as one costed package in the national budget
- Validate the full package cost and funding gap
- Set a predictable domestic financing pathway, starting with commodities

Development Partners & Donors

- Align catalytic support with national priorities
- Co-finance tests, medicines, workforce and community follow-up
- Back data systems that track mothers and infants

African Union, WHO, & UN Agencies

- Champion triple elimination as a continental priority
- Provide technical review and hepatitis B data support
- Share Tanzania's approach with other countries

The Call to Action

Fund One Plan, Stop Three Infections: Commit to Tanzania's Investment Case

1. Finalise
the national investment requirement and the validated funding gap

2. Finance
a phased response, with commodity security and the hepatitis B birth dose first

3. Track
progress together towards validation of triple elimination by 2030

Notes. Figures are model projections, not observed results. Infections prevented and extra costs are cumulative for 2027–2030 compared with keeping 2026 coverage; treatment costs avoided are lifetime, undiscounted costs and are not budget savings. **References:** (1) Elizabeth Glaser Pediatric AIDS Foundation, Ministry of Health Tanzania. Investing to end vertical transmission of HIV, syphilis and hepatitis B in Tanzania: technical report. November 2026. (2) WHO. Global guidance on criteria and processes for validation: elimination of mother-to-child transmission of HIV, syphilis and hepatitis B virus. Geneva: WHO; 2021. (3) UNAIDS. 2025 Global AIDS Update. Geneva: UNAIDS; 2025. (4) WHO. Global hepatitis report 2026. Geneva: WHO; 2026. (5) UNAIDS. Press release, 10 July 2025.