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Children and AIDS

Fourth Stocktaking Report 2009

Summary

UNITE FOR CHILDREN
UNITE AGAINST AIDS

The *Fourth Stocktaking Report*, produced by UNICEF, in partnership with UNAIDS, WHO and UNFPA, is an annual report that examines current knowledge on the global response for children, progress, emerging evidence and case studies of best practices as they relate to four programme areas known as the 'Four Ps':

- **Preventing mother-to-child transmission of HIV**
- **Paediatric HIV care and treatment**
- **Preventing HIV infection among adolescents and young people**
- **Protecting and supporting children affected by HIV and AIDS**

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A generation of children free from AIDS is not impossible. Years ago, when the devastating impact of the AIDS epidemic on children was just becoming apparent, there was no way to imagine an AIDS-free generation in the foreseeable future.

Since 2005, many lives have been saved or improved as national governments, non-governmental organizations, local communities and international organizations have examined the evidence and responded with tailored and effective responses. Interventions such as the prevention of HIV infections through a combination approach with young people, early infant diagnosis of HIV and the provision of antiretrovirals (ARVs) for the prevention of mother-to-child transmission of HIV (PMTCT) are now an integral part of the global HIV response.

But the world is not yet on track to meet targets for prevention, treatment, care and support.

There remains uneven progress to date that underscores gaps in service coverage and inequities in access. Improving the delivery and uptake of HIV and AIDS-related interventions requires enhancing the broad systems that deliver services – health, political, legal and social welfare –and linking them with communities.

Wise investment is needed to ensure sustainable services and systems. The economic crisis raises concerns about sustaining current assistance for women and children, as well as questions about expanding coverage and access to reach universal access targets in a climate of contracting resources. If economic constraints were to suddenly put a halt to extending antiretroviral therapy (ART) to new recipients, this would *mean no infants would receive treatment* and *no mothers receiving PMTCT services would start treatment for their own health*.

In 2005, UNICEF, the Joint United Nations Programme on HIV/AIDS (UNAIDS) and other partners launched *Unite for Children, Unite against AIDS* to focus attention and resources on mitigating the worst effects of HIV and AIDS on children and young people.

A rights-based approach to children and AIDS means addressing issues of equity of access.

Universality and equity are cornerstones of child rights and must be re-emphasized in this 20th anniversary year of the Convention on the Rights of the Child. This means using an 'equity lens' to review progress towards universal access goals, upholding a standard of care and treatment for all and working towards an equitable distribution of resources. We must strive to meet universal access targets, while ensuring that the most-at-risk and vulnerable children and families do not fall through the cracks in the system.

Families, local communities, national governments, non-governmental organizations and international institutions have shown they have the will and capacity to reverse the epidemic. It is now time to follow through on these commitments.

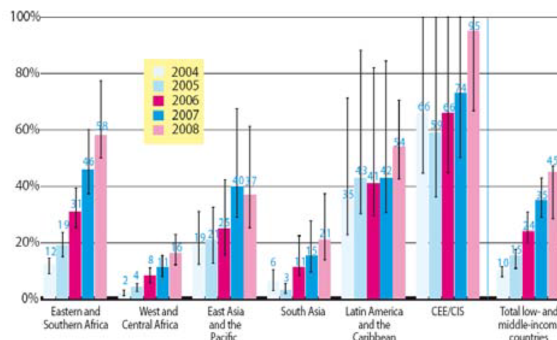
unicef UNAIDS World Health Organization UNFPA

P1 – Prevention of Mother to Child Transmission (PMTCT)

Elimination of mother-to child transmission is now a global objective

Coverage of services for PMTCT has increased: in 2008, 19 countries had reached the UN General Assembly Special Session on HIV/AIDS (UNGASS) goal of reaching 80 per cent of pregnant women living with HIV with ARVs to prevent transmission of HIV to their infants. In 2008, some 45 per cent of pregnant women living with HIV received antiretroviral drugs to prevent the transmission of the virus to their infants, compared with 24 per cent in 2006. On average in low- and middle-income countries, 32 per cent of infants born to HIV positive mothers were given ARV prophylaxis for PMTCT at birth in 2008, up from 18 per cent in 2006. Even with this excellent progress, too few HIV-positive women are receiving therapy for their own health, and the majority of pregnant women and children do not yet have access to basic PMTCT services, including HIV testing and counselling, family planning, infant feeding counselling and support, and ARV prophylaxis.

Trends in percentage of pregnant women with HIV receiving ARV prophylaxis for PMTCT, by region, 2004–2008



Note: The lines on the bars indicate the uncertainty bounds for the estimates.
Source: UNICEF calculations based on data collected through the PMTCT and Paediatric HIV Care and Treatment Report Card process and reported in Towards Universal Access: Scaling up HIV services for women and children in the health sector – Progress Report 2009 (WHO, UNAIDS, UNICEF).

Main issues:
Experience in resource-limited countries that have made significant progress show that PMTCT programmes can be scaled up using strategic approaches including:

- Decentralizing programmes using the sub-national level as the unit of planning, coordination, implementation, and monitoring and evaluation.
- Building capacity and harmonizing actions, goals and outcomes within maternal, newborn and child health services.
- Scaling up innovations to service delivery.
- Making community-based interventions integral to national scale-up plans.

P2 - Paediatric HIV care and treatment

Significant progress in expanding access to early infant diagnosis is not matched by progress in linking it to early treatment.

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The number of children under 15 living with HIV that receive antiretroviral therapy has increased from 75,000 children in 2005 to 275,700 out of an estimated 730,000 children in need of ARTs in 2008 (approximately 38% coverage). There is increased support for early testing and initiation of treatment of infants- this is critical given that evidence suggests that peak AIDS mortality in infants may come at the age of two to three months. Co-trimoxazole prophylaxis is an important intervention for children, and if initiated among HIV-exposed infants within two months of age, can save lives. However, coverage in low and middle-income countries only increased from 4 per cent in 2007 to 8 per cent at the end of 2008.

Main Issues:

- Many countries have improved access to early infant diagnosis. A positive diagnosis of HIV though, does not guara*ntee access to life-saving treatment.*
- Loss to follow-up of mothers and children (following birth) results in otherwise preventable deaths among children and a massive loss in public health investments. A Clinton Foundation study from eight countries estimated loss to follow-up after testing positive of about 53 per cent.
- To be effective, paediatric HIV care and treatment need to become an integral part of infant and child survival and health programmes.
- Young people living with HIV have particular challenges related to treatment and adherence, and it is important to address safer sex behaviours as these young people grapple with their emerging sexuality.

P3 – Preventing infections among adolescents and young people

The basis for effective prevention actions is a better understanding of the local epidemic and its drivers

In 2008, it was estimated that 4.9 million young people (aged 15-24) were living with HIV globally, with 60% of that number in Eastern and Southern Africa and 23% in West and Central Africa. This age group accounts for 45% of all new adult infections. Modest improvements are noted in a limited number of countries in knowledge and self-reported behaviours such as early initiation of sex, sex with multiple partners and unprotected sex. Data disaggregated by sex, age and region highlight great diversity in the epidemic both in intensity and in the causes of vulnerability.

Young people aged 15–24 living with HIV, 2008

Region	Female	Male	Total
Eastern and Southern Africa	2,000,000	850,000	2,900,000
West and Central Africa	770,000	320,000	1,100,000
South Asia	120,000	130,000	250,000
Latin America and the Caribbean	130,000	170,000	300,000
East Asia and the Pacific	120,000	93,000	210,000
CEE/CIS	41,000	29,000	70,000
Middle East and North Africa	45,000	44,000	89,000
Total	3,230,000	1,640,000	4,900,000

Note: The estimates are provided in rounded numbers but unrounded numbers were used in the calculations, thus there may be discrepancies between the totals.
Source: Unpublished estimates from Joint United Nations Programme on HIV/AIDS and World Health Organization, 2009 AIDS Epidemic Update, UNAIDS and WHO, Geneva (forthcoming).

In sub-Saharan Africa and particularly southern Africa, where extremely high levels of HIV are prevalent, many young women are exceptionally vulnerable to infection in the context of strong social, cultural and economic forces that influence exposure to risk of infection. Girls in sub-Saharan Africa account for nearly 75% of all infections in young people. In South Asia, Latin America and the Caribbean, more young men than women are infected with HIV. In low or concentrated epidemics, young people who are selling sex, men having sex with men and injecting drug users face multiple structural and social barriers to receiving HIV and AIDS services. In all regions, gender-based discrimination and gender-based violence significantly hamper access to services and negatively affect people's ability to exercise choices that reduce risk of infection.

Main issues:

- A clear understanding of adolescent sexual relations and gender dynamics is necessary to understand how best to intervene to prevent new infections.
- School attendance is a protective factor against HIV, especially for vulnerable girls. Schools are also an effective platform through which to raise HIV-related knowledge, sensitize young people and help them develop positive life-skills. A major barrier to using schools effectively to prevent HIV infections is the lack of evidence-informed national frameworks with specific application at the local level.
- Interventions that engage young men and boys are necessary to reduce HIV incidence among both males and females.
- The AIDS epidemic will not be halted until prevention services are more effectively designed and targeted to address the behaviours that marginalize and place adolescents and young people at risk for infection.

P4 – Protection care and support for children affected by HIV and AIDS

Strengthening social protection in economic hard times is necessary to support families and communities in caring for children affected by AIDS.

Poverty is a key factor negatively affecting children's wellbeing. It increases the impact of AIDS on children by reducing households' ability to cope with additional stress. The current economic crisis, if prolonged, is likely to worsen such outcomes unless efforts are undertaken to mitigate its impact. Evidence from 2008 shows that very few households caring for orphans or vulnerable children were receiving basic external support: a median of 12 per cent. Scaling up support for children affected by AIDS remains an urgent priority.

Child-sensitive social protection for children affected by AIDS includes social transfers (including cash and in-kind transfers and vouchers), social insurance, social services (including social welfare services such as legal support, social work and alternative-care services), and social policies and legislation designed to be AIDS sensitive.

Child-sensitive social protection is a key intervention to reaching children affected by AIDS. It can support poor households unable to cope with the growing number of vulnerable children as a result of HIV and AIDS. Integrated social protection can reduce the risk of chronic poverty which drives children into orphanages, can prevent hazardous child labour and other forms of abuse, as well as support greater access to health and education.

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Main issues:

- Community- and faith-based organizations will continue to have an important role in delivering social protection services for children in communities affected by AIDS.
- Building the capacity of national social welfare systems is urgently needed to scale up support for vulnerable children affected by AIDS.
- Underfunded social welfare ministries and lack of social workers results in little support for the most vulnerable children, including those living outside of families.

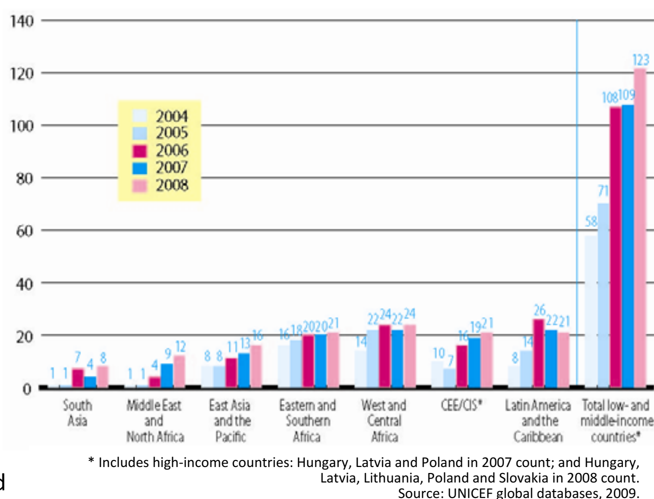
Programme Monitoring and Evaluation

Monitoring and evaluating programmes on HIV and AIDS is critical to providing evidence for what works and where to make improvements.

Monitoring and evaluation (M&E) is crucial for tracking progress in meeting HIV and AIDS commitments and goals. At the global level, great strides have been made in the past year towards strengthening M&E capacity in all four priority areas of the *Unite for Children, Unite against AIDS* campaign.

The implementation of national M&E frameworks is a tremendous challenge. Furthermore, development of national systems which monitor progress for children affected by HIV and AIDS and young people is weak, as are the links between facility-based and community-based M&E activities. Most importantly, evidence of the impact of HIV and AIDS interventions on the health of women and children needs to be strengthened.

Number of low- and middle-income countries reporting on key data on PMTCT and paediatric HIV care and treatment, 2004–2008



* Includes high-income countries: Hungary, Latvia and Poland in 2007 count; and Hungary, Latvia, Lithuania, Poland and Slovakia in 2008 count.
Source: UNICEF global databases, 2009.

Main issues:

- Monitoring and evaluation of PMTCT and paediatric HIV programmes must keep pace with advances in science and programming.
- Efforts to capture prevention data at the community level are still weak.
- M&E indicators to gauge the status of children affected by HIV and AIDS need to be revised.
- The implications of the shift from AIDS-exclusive to AIDS-sensitive programming are still unclear in terms of monitoring and evaluation of these efforts.

Investment: What Women and Children Need

"A mother should not have to choose between continuing AIDS treatment and feeding her children." – Michel Sidibé, UNAIDS Executive Director

In 2008, an estimated US$ 13.7 billion was invested in the AIDS response. To achieve the 2010 UNGASS targets of universal access, UNAIDS estimates that a US$25.1 billion investment is needed in 2010. Most upper middle-income countries will continue to finance their own national AIDS responses, but in low-income countries, especially in sub- Saharan Africa, roughly two thirds of national AIDS responses will require international support. UNICEF and UNAIDS have determined that about US$5.9 billion is needed specifically to meet universal access targets for women and children. Wise investment in HIV and AIDS programmes for children at the country level will require us to 'know the epidemic,' how to respond appropriately and the associated costs of that response, and how that response is affecting the health and wellbeing of women and children.

Estimates of investment needed to meeting universal access goals:

Preventing mother-to-child transmission of HIV	US$605 million
Providing paediatric treatment and care:	US$649 million
Preventing infection among adolescents and young people	US$1.4 billion
Protection and care for children affected by AIDS	US$2.5 billion
Prevention of violence against women	US$326 million
Programme support costs for women and children	US$406million

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Call to Action:

UNITE FOR CHILDREN
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Now is the time to follow through on our commitments

The progress described in the report represents steps along a continuum of evidence, action and results. It is clear that targets can be reached – but also obvious that in most places, universal access goals are not yet being achieved. Evidence for programming is improving, but needs to be better. Investment needs to be bolstered, but must also be used more wisely.

Amid global economic difficulties, it is important that sights remain fixed on the long-term and that commitments to act in the short-term are kept. The following actions must be prioritized if women, children and young people are to have opportunities to live and thrive in a world free of AIDS:

1. ***Accelerate the scale-up of PMTCT services and early infant diagnosis to contribute to the elimination of HIV transmission to young children.***
2. ***Continually seek out new evidence to inform HIV prevention.***
3. ***Support and empower adolescents, particularly girls, to identify and respond to their own vulnerabilities.***
4. ***Protect the rights of adolescents and young people living with HIV to receive good-quality support and services.***
5. ***Ensure that adolescents who are in situations of the greatest risk are reached by HIV prevention, treatment, care and support services.***
6. ***Make sexual violence against girls and women socially unacceptable.***
7. ***Scale up child-sensitive social protection, a necessary part of the response for children affected by AIDS.***
8. ***Strengthen community capacity to respond to the needs of children affected by AIDS by preventing the separation of families and improving the quality of alternative care.***
9. ***Strengthen whole systems so that gains made on behalf of women and children affected by AIDS can be extended and sustained.***
10. ***Improve data gathering and analysis to achieve results for children, and identify gaps in equitable coverage of and access to services.***

Ultimately, investment will not be used wisely and the many gaps that exist in coverage, quality and equity will not be closed if knowledge is not turned into practice. We must follow through – on our commitments, on closing the gaps in the global knowledge base, and in honestly acknowledging where efforts fall short so that work may be improved.

For the full Fourth Stocktaking Report, visit http://www.uniteforchildren.org/

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