Thematic discussion on results and lessons learned in the medium-term strategic plan focus area 3: Children and AIDS

I. Children and AIDS: a commitment to an AIDS free generation

1. The international community can achieve an AIDS-free generation. UNICEF, governments and other stakeholders have access to scientific evidence, years of implementation experience, and are committed to attaining the goals of Getting to Zero, the Joint United Nations Programme on HIV/AIDS (UNAIDS) 2011-2015 Strategy. The UNICEF AIDS response contributes to the UNAIDS strategy and consists of the “four P’s”:

   (a) Prevention of HIV among adolescents and young people;
   (b) Prevention of mother-to-child transmission (PMTCT);
   (c) Paediatric HIV treatment;
   (d) Protection of children affected by AIDS.

2. This paper provides a background to the thematic discussion on results and lessons learned in the medium-term strategic plan focus area 3: Children and AIDS. It offers an overview with examples of results and lessons learned over the past five years, and charts a way forward for ‘doing more and doing better with less’. Further, it explores the application of the UNICEF agency-wide equity approach to scale up HIV and AIDS-specific outcomes, building upon new science and evidence: (a) the advent of more effective paediatric and PMTCT drug regimens; (b) treatment as prevention; (c) the potential of cell phone short message service; and (d) the co-packaging of PMTCT commodities - and other exciting opportunities in a new era of responding to HIV and AIDS.

II. Overview of children and AIDS response and challenges

A scaled-up response to children and AIDS

* E/ICEF/2012/1.
3. UNICEF investments in the global AIDS response have positively affected the trajectory of the pandemic and contributed to mitigating the impact AIDS has on children and their families. The Unite for Children, Unite against AIDS campaign has influenced global, national and local discourse to prevent children from “falling through the cracks” by working with partners, including UNAIDS and Co-sponsors, the Global Fund for AIDS, Tuberculosis and Malaria, the United States President’s Emergency Plan for AIDS Relief (PEPFAR), the International Drug Purchase Facility – UNITAID1, as well as people living with HIV and AIDS and others. Central to the UNICEF HIV mandate has been the drive to achieve the goals of the Political Declaration on HIV and AIDS (2011), Millennium Development Goals 4, 5 and 6, and contribute to Goals 1, 2 and 3.2

4. UNICEF is providing leadership at global, regional and country levels in the implementation of the United Nations Secretary-General’s Global Strategy for Women and Children’s Health and the Global Plan to Eliminate New HIV Infections in Children by 2015 and Keep Their Mothers Alive (eMTCT), in line with the new UNAIDS ‘Division of Labour’.3 UNICEF and partners have been working towards the development of national, costed eMTCT scale-up plans. UNICEF and our partners have been championing the integration of PMTCT and maternal, newborn and child health (MNCH) services, and the promotion of decentralized facility level planning. At the centre of this effort is the organization’s work with communities – specifically community-based health workers – to deliver solutions to alleviate health-system bottlenecks to accessing MTCT services by women and their infants. UNICEF, along with the World Health Organization (WHO) and other PMTCT partners, has also made progress in improving access to HIV testing for the partners of pregnant women, improving access to antibiotics to prevent AIDS-related deaths in children and supporting mothers to exclusively breastfeed when appropriate.

5. In 2005, only 14 per cent of HIV-positive pregnant women in low- and middle-income countries received antiretroviral drugs for PMTCT, while in 2010 that figure had risen to 48 per cent. UNICEF, along with national partners planned a critical role in developing national eMTCT scale-up plans and leveraged funding from PEPFAR, the Global Fund and others. UNICEF has also been instrumental in supporting governments to reflect the new WHO guidelines in national eMTCT strategies. This work is being coordinated by UNICEF and WHO with over 27 partners of the Inter-Agency Task Team on PMTCT in 22 countries with the highest burden of mother-to-child transmission of HIV.4

6. As access PMTCT services increased, the annual number of children acquiring HIV infection stabilized in the early 2000s before decreasing steeply in the past few years. An estimated 390,000 children were newly infected with HIV in 2010, 30 per cent fewer than the peak of 560,000 children newly infected annually in 2002 and 2003. The number of children (younger than 15 years) living with HIV globally has levelled off in the past few years and

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1 The International Drug Purchase Facility is better known as UNITAID.
2 There are six relevant Millennium Development Goals: Eradicate extreme poverty and hunger (Goal 1); Achieve universal primary education (Goal 2); Promote gender equality and empower women (Goal 3); Reduce child mortality (Goal 4); Improve maternal health (Goal 5); and Combat HIV/AIDS, malaria and other diseases (Goal 6).
3 Building on the UNAIDS Outcome Framework for 2009–2011, the Division of Labour consolidates UNAIDS support to countries on HIV in 15 areas. Each area has one or two convening agencies – each with relevant mandates and technical expertise – to both facilitate the contributions of broader UNAIDS family partners and ensure the quality of overall results in the respective area.
4 Angola, Botswana, Burundi, Cameroon, Chad, Côte d’Ivoire, Democratic Republic of the Congo, Ethiopia, Ghana, India, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, South Africa, Swaziland, United Republic of Tanzania, Uganda, Zambia and Zimbabwe.
totalled 3.4 million in 2010; more than 90 per cent were living in sub-Saharan Africa. Deaths among children younger than 15 years are declining. The estimated 250,000 children who died from AIDS-related illnesses in 2010 were 20 per cent fewer than the estimated 320,000 who died in 2005. This trend reflects the steady expansion of services to prevent HIV from being transmitted to infants and, to a lesser degree, the expansion of access to treatment for children.

7. Treatment for children has increased, but at an unacceptably low rate, from 21 per cent in 2009 to 23 per cent in 2010. UNICEF has been a strong advocate for getting infants tested for HIV early and promoting access for infants living with HIV to appropriate paediatric AIDS drug formulations. Working with UNITAID, the Clinton Foundation and others, low-cost paediatric formulations have been produced by pharmaceutical companies and made available to children who need it. UNICEF partnerships with the private industry and academic institutions are utilizing new HIV testing equipment that is easier for mothers and their infants to access and provides more timely results (point of care diagnostics). UNICEF is also working to capitalize on cell-phone technology and other innovative communications to retain mothers and their infants in HIV services, and secure their access to AIDS treatment, care and support.

8. In 2010, an estimated 35 per cent of pregnant women in low-and middle-income countries (approximately 123 million) received an HIV test, up from 7 per cent in 2005. Increases were observed in almost all regions, with the percentage of pregnant women testing for HIV growing by around 10 per cent or more between 2009 and 2010 in three regions. During 2010, in 65 low- and middle-income countries, 28 per cent of infants were reported to have been tested for HIV within the first two months of birth, versus 6 per cent in 2009.

9. Encouraging trends are evident among young people in several countries with a high burden of HIV. Data from antenatal clinics from 2000 to 2010 showed that the HIV prevalence declined among women 15–24 years old in 22 of the 24 countries with a national HIV prevalence of 1 per cent or higher and with data available.

10. UNICEF and our partners have agreed to implement a combination of simultaneous HIV prevention interventions over the life cycle of an adolescent and young person’s life. These interventions include access to comprehensive HIV knowledge, condoms, HIV testing and counselling, treatment, harm reduction for young people who use drugs in concentrated epidemics and male circumcision in generalized epidemic settings. UNICEF has worked with young people in many regions to determine how best to increase HIV knowledge and skills to promote healthy behaviour while working with leaders to create policies that reflect science and experience. UNICEF has led efforts to compile state-of-the-art science on which interventions are most applicable in different epidemic settings and advocated for their implementation in collaboration with young people themselves.

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5 Eastern and Southern Africa (from 52 per cent to 61 per cent); Central Asia (from 73 per cent to 84 per cent); and East, South and South-East Asia (from 18 per cent to 30 per cent).

6 Angola, Bahamas, Burkina Faso, Botswana, Democratic Republic of the Congo, Chad, Ethiopia, Gabon, Ghana, Haiti, Kenya, Lesotho, Malawi, Mali, Mozambique, Nigeria, Namibia, South Africa, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.

7 Generalized HIV Epidemic: The HIV prevalence rate is >1% in the general population. Concentrated HIV Epidemic: The HIV prevalence rate is <1% in the general population, but >5% in at least one high-risk subpopulation, such as men who have sex with men (MSM), injection drug users (IDUs), commercial sex workers (CSWs), or the clients of CSWs.
11. Globally, an estimated 5 million young people aged 15-24 years were living with HIV in 2009, a 12 per cent reduction since 2001. UNICEF has intensified its efforts in recent years to increase access and coverage of adolescent antiretroviral treatment (ART) through working with the Global Network of People living with HIV (GNP+) and WHO to develop treatment, care and support guidelines.

12. Most countries in sub-Saharan Africa have made significant progress towards parity in school attendance for orphans and non-orphans 10-14 years old. In 27 out of 31 countries in sub-Saharan Africa that report data, school attendance among children who have lost both parents, including parents who have died of AIDS, has increased.

13. AIDS and child-sensitive social protection efforts led and supported by UNICEF have been catalysts for broader initiatives that have affected health and development outcomes. Kenya, Malawi, Namibia, South Africa and Zambia, motivated in part by the severity of the AIDS epidemic, have several large national cash-transfer programmes that benefit AIDS-affected individuals and households without explicitly targeting them. There has been a demonstrable impact on nutrition, education and health-seeking behaviours for children affected by AIDS. UNICEF worked with the Joint Learning Initiative on Children Affected by AIDS to review the science and provide guidance to faith-based groups, community-based organizations, organizations of people living with AIDS and others to more effectively mitigate the impacts of the epidemic on children and families.

Remaining challenges – addressing inequities in the AIDS response

14. Inequities in the AIDS response span age, gender, geography and economic status; these are well documented among socially marginalized populations.® Globally, in 2009, young people aged 15-24 years accounted for 41 per cent of new infections among adults aged 15 and older. An estimated 890,000 young people aged 15-24 years were newly infected with HIV in 2009, with 79 per cent of these new infections occurring in sub-Saharan Africa. In 9 countries in Southern Africa, at least 1 in 20 young people is living with HIV. Some 4.9 million of the 5 million young people aged 15-24 years living with HIV in 2009 were in low- and middle-income countries and 3.2 million were female. Globally, young women make up more than 60 per cent of all young people living with HIV; in sub-Saharan Africa, their share jumps to 72 per cent, and young women face their greatest burden of infection before the age of 25.

15. Levels of HIV knowledge and skills among adolescents and young people remain insufficient. In most high-burden countries in sub-Saharan Africa, HIV knowledge disparities are reported by wealth quintile, residence and gender. Accurate HIV knowledge among young people in sub-Saharan Africa is lowest among the poorest households and in rural areas; young women are less likely than young men to have accurate knowledge about HIV and AIDS. Only 47 per cent of young men (aged 15-24 years) and 32 per cent of young women (aged 15-24 years) who reported having sex with multiple partners during the previous 12 months indicated they had used condoms at their last intercourse.9 Adding to the complexity of HIV prevention in sub-Saharan Africa is intimate-partner violence; this is an indirect and disturbing cause of HIV transmission, with an estimated 11-45 per cent of girls aged 15 years or younger experiencing their first sexual experience as forced.

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® Socially marginalized populations vary by setting, but science has demonstrated increased risk for HIV infection among certain populations across cultural settings: IDUs, MSM and CSWs.

9 Data on sub-Saharan Africa refer to the most recent year available for 2005-2010.
16. In most countries with low-level or concentrated epidemics, infection is spread primarily by people (many of them adolescents and young people) who engage in behaviours contrary to accepted cultural norms and may even be illegal. In Central and Eastern Europe and the Commonwealth of Independent States, HIV prevalence is on the rise, largely because of soaring levels of unsafe injecting drug use. Four out of five people living with HIV in countries of this region are under age 30, and one out of every three new HIV infections occurs among young people aged 15-24 years. Young men who have sex with other young men often have higher rates of infection. A young man in the suburbs of Cape Town, South Africa, or Lilongwe, Malawi, who has sex with other men has about a 20 per cent risk of becoming infected with HIV by the age of 24, whereas the risk in the general population in either country is much lower: 4.5 per cent in South Africa and 3.1 per cent in Malawi.

17. These disparities in access also reflect disparities in access to HIV testing, treatment, care and support. Only 40 per cent of people globally know their HIV status, and that figure is even smaller for young people. In developing countries, only 8 per cent of adolescents aged 15-24 years had undergone HIV tests and received results, and among young people in sub-Saharan Africa, only 10 per cent of young men and 15 per cent of young women (aged 15-24 years) know their HIV status.

18. In 2010, while women have more entry points to testing via MNCH services, including antenatal care, only 35 per cent of pregnant women in low- and middle-income countries had been tested for HIV, and only 28 per cent of children born to HIV-positive mothers received an HIV test within the first two months of life. Globally, in 2010, some 22 countries accounted for nearly 90 per cent of pregnant women living with HIV (see footnote 4). The same countries are also home to approximately 90 per cent of children under 15 years in need of antiretroviral therapy.

19. In 2010, treatment coverage was notably lower for children aged 0-14 years (23 per cent) than for adults aged 15-49 years (51 per cent). Treatment statistics for adolescents and young people are not available globally. Adults and children living with HIV and AIDS require 20 to 30 per cent more nutrition (energy intake) than the general population; and cotrimoxazole prophylaxis, an inexpensive drug regimen that prevents common infections in children, remains low (23 per cent).

20. For children and families affected by AIDS, there is still a great deal to do to keep parents alive and protect children from the impacts of HIV on the household. At the end of 2010, despite the millions of dollars invested in programmes for orphans and vulnerable children, many remain underserved. In 25 countries where household surveys were conducted between 2005 and 2009, a median of 11 per cent of households were receiving external support. Many HIV-affected children, especially girls, are taken out of school, putting them at risk of early sexual debut and abuse and diminished access to health services, which in turn makes them more susceptible to HIV infection. Many studies indicate that children affected by AIDS, especially older adolescents, may be more frequently absent or drop out of school due to increased economic pressures and caregiving responsibilities. Women and girls account for 66-90 per cent of all caregivers for people living with HIV in Africa, with similar trends across the developing world.

21. A main driver of inequities in the HIV response is stigma and discrimination. About 3 in 10 countries worldwide still lack laws prohibiting HIV-related discrimination. In 6 of 24 countries surveyed by the United Nations Development Programme Commission on HIV and the Law, the evolving capacity of children to seek health services and exercise their right to health go unrecognized until they reach the legal age of adulthood and therefore the age of consent to medical treatment.
III. Lessons learned: programme integration to achieve AIDS and other development sector results

22. The synergies between the UNICEF AIDS response and other health and development priorities offer a great deal of opportunity to achieve increased results across a number of agendas. In 2009, HIV was a key factor in an estimated 20 per cent of all maternal deaths. In some African countries, HIV has resulted in an up to tenfold increase in tuberculosis incidence. It is the leading cause of death among women of reproductive age worldwide and associated with almost half of pregnancy-related maternal and child deaths in some countries in southern Africa. The burden of HIV-related illness and death on households undermines their resilience and threatens hard won development gains in relation to poverty reduction, access to education, gender equality and health-systems strengthening. Integration of HIV with the MNCH platform and mitigating the effects of HIV on families and children is therefore essential for making a major contribution to Millennium Development Goals 1 to 6.

23. UNICEF efforts to support the implementation of the Global Plan on the elimination of mother to child transmission of HIV and keeping mothers alive will build on the organization’s experience of implementing PMTCT programmes at decentralized levels. Decentralized planning of MNCH and PMTCT services brings services closer to the people for which they are designed, and UNICEF will be increasing investments in this area, including enhanced field-level monitoring and documentation. Infant and maternal nutrition programming will be integrated into the MNCH and PMTCT services, as they use a cost-effective way of reducing maternal and child deaths among populations living with HIV.

24. Many countries with low-level or concentrated HIV epidemics are now moving towards integrated frameworks for MNCH and sexual and reproductive health outcomes. UNICEF offices in South Asia and East Asia and the Pacific have promoted integration and linkages between HIV, MNCH and sexual and reproductive health services, developing guidance with partners, reflecting and supporting government efforts in Cambodia and Thailand. UNICEF will continue to support this work to document best practices and lessons learned on how to best integrate HIV prevention, treatment and care for children and adolescents.

25. The United Nations Secretary-General called for the international community to leverage the HIV experience to accelerate the non-communicable disease response. UNICEF support of partners’ efforts to promote the health of adolescents living with HIV has identified specific chronic-care support needs, including psychosocial and community-based support that extends beyond clinical, emergency services. UNICEF will support governments and national implementers to efficiently and effectively implement community based strategies for improving AIDS specific long term care and support for children and adolescents living with HIV.

26. UNICEF will work to integrate HIV programming and emergency responses. Many countries with high burdens of HIV are experiencing on-going emergencies requiring the integration of humanitarian and development responses. Of the 22 mother-to-child transmission high-burden countries, for example, many of which are the focus of HIV prevention and social protection, more than half are experiencing humanitarian emergencies (conflict, food crises, drought and other emergencies). UNICEF, in strong collaboration with partners, has played a critical role in a number of emergencies. Antiretroviral (ARV) redistribution, nutritional support and provision of post-exposure prophylaxis were provided in Côte d’Ivoire. Maternal and child health clinics were strengthened to provide PMTCT and ART services in Haiti and in the Horn of Africa.

27. UNICEF has learned that integration is only effective if there are well-functioning monitoring and surveillance systems to measure AIDS specific outcomes at national and
decentralized levels. UNICEF will work with partners to ensure integration leads to efficient and effective use of resources that affect the trajectory and scope of the HIV epidemic while supporting the work of other development sectors.

IV. Lesson learned: bridging the gap between research and practice to improve the efficiency and effectiveness of HIV and AIDS programmes

28. While collective successes have resulted in placing children front and centre in the global AIDS response, there is insufficient experience in bridging the gap between research and the ‘real life’ problems faced by implementers in applying new science to local-level programmes. Recent groundbreaking research is providing new evidence that promises to reduce new HIV infections significantly – the challenge is to apply this new knowledge equitably.

29. Recently, scientists have proven for the first time that antiretroviral medicines can prevent sexual transmission of HIV: (a) the HIV Prevention Trials Network (HPTN 052) trial demonstrated in 2011 that early ART taken by the HIV-positive partner in a serodiscordant relationship\(^ {10} \) provided 96 per cent protection against HIV acquisition by the HIV-negative partner; (b) in the I-PrEX trial, once-daily oral truvada (tenofovir plus emtricitabine) taken by at risk, HIV-negative men who have sex with men and transgender persons in six countries resulted in a 44 per cent reduction in incidence; and (c) in a trial called CAPRISA, 1 per cent tenofovir vaginal gel, when used before and after sex, demonstrated a 39 per cent reduction in HIV incidence in women (2010), although efficacy was not shown in a subsequent trial where the gel was used once-daily (VOICE - 2011).

30. Medical male circumcision has been shown to lower HIV incidence in men by up to 76 per cent. UNICEF has been working with WHO and UNAIDS to apply this research to generalized epidemic settings, specifically by providing information to men and by promoting neonatal circumcision. Swaziland is leading the way in integrating neonatal circumcision as part of its neonatal care services with support from UNICEF.

31. UNICEF has reviewed the research with global experts in relation to the implications of the results for adolescents and young people, and the UNICEF-authored publication, *Opportunity in Crises: Preventing HIV from early adolescence to young adulthood*, summarizes this evidence for programmers and policy makers. Issues for UNICEF and partners to consider include the legal and ethical framework around prevention of sexual transmission of HIV among adolescents, in particular laws about age of consent. UNICEF is working with national-level researchers, young people and policymakers to understand how this new science can benefit adolescents and young people.

32. New WHO PMTCT guidelines issued in 2010 promote the use of combination and more effective ARVs for PMTCT and strongly advise against the use of previously recommended single-dose nevirapine. UNICEF has been advocating and supporting the transition to more efficacious PMTCT regimens. Since 2007, UNICEF, with financial resources from UNITAID, has been providing both diagnostic commodities and efficacious PMTCT ARV regimens in 17 countries in Asia and sub-Saharan Africa to facilitate this transition. In September 2009, the Executive Director for the Global Fund announced a special PMTCT reprogramming project in collaboration with UNICEF and other partners, which has mobilized over $80 million to date. Today, over 80 per cent of HIV-positive pregnant women who received ARVs for PMTCT were provided efficacious regimens, including antiretroviral therapy for their own health. UNICEF

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\(^ {10} \) Researchers use ‘serodiscordant’ to describe couples where one individual is HIV-positive and the other is HIV-negative.
and the Global Fund are reviewing the operational experiences and challenges as well as compliance to the 2010 WHO guidelines at implementation level in five countries.

33. New research authored by UNICEF on child vulnerability in the context of HIV has helped to better target scarce resources for the most ‘at need’ children affected by AIDS. The landmark UNICEF publication, *Taking evidence to impact: Making a difference for vulnerable children living in a world with HIV and AIDS*, reviews the state of the evidence of social protection as an HIV response. This review and other support have helped governments design social protection and health systems that are HIV and child-sensitive. This evidence helped inform the nine-country Children and AIDS Regional Initiative (CARI), which has scaled up HIV-sensitive social protection and child protection programmes and mitigated the impact of AIDS on the neediest children and households.\(^\text{11}\)

**Scale-up of high-impact HIV investments and critical enablers**

34. UNICEF has worked with the Interagency Task Team on Prevention of Infection in Pregnant Women, Mothers and Children, the Inter-Agency Task Team on children affected by AIDS and HIV-prevention partners to publish definitive resources on global research priorities across the four P’s in the coming years. Implementation research priorities will focus on defining context-specific methods for scaling up high-impact, evidence-informed interventions and supporting a set of context-specific enabling factors and development sector synergies to improve efficiency.

35. Between 2002 and 2008, as indicated in UNICEF country office annual reports, there were 427 studies and 155 evaluations related to HIV and AIDS conducted or supported by UNICEF. UNICEF, in collaboration with *Médecins Sans Frontières* and other partners, compiled evidence on how best to integrate implementation and operational research into programme offices. UNICEF work in Zimbabwe with the Collaborating Centre on Operational Research and Evaluation initiative provides an example of how researchers and programmers can work together to design research questions and how research findings can feed directly into programmes for improved efficiency and effectiveness on investments.

**V. Lesson learned: optimizing partnerships to leverage impact, resources and mutual accountability**

36. International and domestic partners are the major funders and implementers of the children and AIDS response, and hence it is critical that UNICEF strengthen and foster effective partnerships, especially in times of economic austerity. Our partnership goals will be to: (a) accelerate the scale-up of high-impact HIV investments and critical enablers; (b) diversify international and domestic funding for the children and AIDS response; and (c) advocate for AIDS and child-sensitive responses in health, protection, education, gender and human rights.

**UNAIDS Secretariat and the Cosponsors**

37. Collaboration with UNAIDS is central in UNICEF efforts to advocate for and demonstrate how to achieve the 2011 United Nations General Assembly’s Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS. Under the revised UNAIDS Division of Labour, UNICEF has an accountability to co-convene UNAIDS Cosponsors and partners in the following areas: (a) PMTCT, including paediatric care, treatment and support,

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11 The CARI programme was implemented in Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland and United Republic of Tanzania.
with WHO; (b) provision of care and support to children affected by AIDS, with the World Bank; and (c) prevention of HIV among adolescents and young people, with the United Nations Population Fund.

**The Global Fund for AIDS, Tuberculosis and Malaria and UNITAID**

38. A global partnership with the Global Fund has been critical in leveraging action and results for children. In Namibia, for example, an investment of $30,000 from the Government of Luxembourg recuperated $2.8 million from previous Global Fund grants for PMTCT programmes. In 2009, UNICEF was reported to be actively engaged in 70 out of 106 (66 per cent) Global Fund Country Coordinating Mechanisms (CCMs) that were eligible to receive Global Fund resources; the UNICEF Supply Division has been procuring increasing amounts of AIDS commodities (funded by some governments’ Global Fund resources) – approximately $100 million in 65 countries during 2010.

**The United States President’s Emergency Plan for AIDS Relief (PEPFAR)**

39. In 2010, the United States Government provided $6.8 billion for PEPFAR, of which $1 billion was for the Global Fund. UNICEF has engaged PEPFAR countries though their partnership frameworks and country operational plans. In 2011, the UNICEF Eastern and Southern Africa Regional Office and country offices were essential to leveraging specific financial commitments for children in Ethiopia, Swaziland, and Tanzania, and PEPFAR remains a main technical and financing partner for the children and AIDS response.

**The private sector and innovators**

40. The response to HIV has been a leading force in public health innovation; with the advent of new scientific evidence, UNICEF will collaborate with the private sector to equitably scale up innovative means of implementing evidence-informed investments. The Unite for Children, Unite against AIDS campaign has a strong partnership with MTV Networks in Kenya, Trinidad and Tobago and Ukraine through the Staying Alive campaign, and The Think Wise campaign of the International Cricket Council, supported by UNICEF and UNAIDS, which both aim to reduce HIV stigma and increase knowledge about HIV.

**Civil society, including women, children and adolescents living with HIV and AIDS**

41. The partnership with civil society and people living with HIV and AIDS will focus on operational research to demonstrate how to work with families and communities and to bring HIV interventions to scale for all mothers, children and young people. In Zimbabwe, UNICEF support to the Male Plus PMTCT Champions (M+PC) improved PMTCT utilization among pregnant women and testing among their male partners. In India, UNICEF support to women living with HIV in Madhya Pradesh, Uttar Pradesh and Delhi helped enable them to provide inputs into state policy regarding treatment of women living with HIV and other issues.

**VI. Way forward: high-impact, equitable investments**

42. Inequities are driving the epidemic: inequities between adults and children; boys and girls; rural and urban residents; and the poorest and richest families. These inequities, if not addressed, will increase long-term economic and social consequences of AIDS. UNICEF, along with the international community and national stakeholders, must invest in the following high-impact HIV prevention and treatment interventions.\(^\text{12}\)

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(a) Prevention of mother to child transmission of HIV;
(b) HIV testing for infants, adolescents and pregnant women as a gateway to treatment and prevention;
(c) Treatment;
(d) Voluntary male medical circumcision in generalized epidemics;
(e) Condoms;
(f) Harm reduction for people who use drugs;
(g) Support to households affected by HIV and AIDS.

43. UNICEF will scale up a set of social and programmatic enablers, grounded in child rights, including supportive legal and policy environments, community design and delivery of services, and operations research, to maximize the impact of investments for women and children.

44. HIV and AIDS programmes are not implemented in isolation and should not be planned in isolation. UNICEF will align planning across its own programmes, along with supporting governments and other partners to align national HIV and development objectives, and thereby support the strengthening of social, legal, and health systems to enable an efficient, effective and integrated children and AIDS response.