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Oral report background note

UNICEF follow-up to recommendations and decisions of the Joint United Nations Programme on HIV/AIDS 37th and 38th Programme Coordination Board meetings

Introduction

1. This report presents an overview of key recommendations and decisions of the Joint United Nations Programme on HIV/AIDS (UNAIDS) Programme Coordinating Board (PCB) that are relevant to UNICEF, as well as an update on UNICEF HIV and AIDS programming activities in 2016 across the two decades of childhood (see annex). The report was produced in follow-up to the 37th and 38th meetings of the UNAIDS PCB, which took place from 26 to 28 October 2015 and 28 to 30 June 2016, respectively.

2. The report highlights the current work of UNICEF and its follow-up to activities relating to four key issues discussed at the meetings:

(a) The AIDS response in the context of the 2030 Agenda for Sustainable Development;

(b) The UNAIDS 2016-2021 Strategy: On the fast-track to end AIDS;

(c) The funding for the 2016-2021 Unified Budget, Results and Accountability Framework (UBRAF);

(d) The role of communities in ending AIDS by 2030.

3. The annex details the status of the HIV epidemic in children and adolescents and the key achievements of and challenges for UNICEF HIV programming for children in the period 2015-2016.

* E/ICEF/2017/1.

Issue 1: AIDS response in the context of the 2030 Agenda for Sustainable Development

4. At the high-level meeting on HIV/AIDS, organized by the General Assembly of the United Nations and held in New York from 8 to 10 June 2016, Member States took stock of the progress made since the first Declaration of Commitment on HIV/AIDS in 2001, and committed to implementing a bold agenda to end the AIDS epidemic by 2030.

5. In order to foster political momentum regarding the global AIDS response, Member States adopted the Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030 (General Assembly resolution 70/266, annex, adopted on 8 June 2016). The Declaration spells out targets that must be achieved by 2020, within the framework of the Sustainable Development Goals, in order to end the AIDS epidemic by 2030.

6. The participants in the high-level meeting acknowledged the progress made since the launch of the Global Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping Their Mothers Alive: 2011-2015. The plan led to an acceleration in efforts aimed at the prevention of mother-to-child transmission of HIV (PMTCT) and an increase in access to antiretroviral treatment (ART) in pregnant women, with an estimated 85 countries now within reach of their elimination targets.

7. While acknowledging progress in PMTCT, Member States, including the meeting co-facilitators, Switzerland and Zambia, and representatives of civil society, in dialogue with UNICEF, expressed concern about the low rates of HIV testing and treatment coverage among children and adolescents living with HIV and the slow reduction in the rate of new HIV infections among adolescents. To address these gaps, they proposed the following specific targets relating to children and adolescents, including young women, for incorporation into the Political Declaration:

(a) Eliminate new infections among children by 2020, while ensuring that 1.6 million children have access to HIV treatment by 2018;

(b) Ensure access to combination prevention options for at least 90 per cent of people, especially adolescent girls and young women in high-prevalence countries and among key populations;

(c) Eliminate gender inequalities and end all forms of discrimination against women and girls, people living with HIV and other key populations by 2020;

(d) Ensure that 90 per cent of young people have the knowledge, skills and capacity to protect themselves from HIV and have access to sexual and reproductive health services by 2020, in order to reduce the number of new infections among adolescent girls and young women to below 100,000 by 2020;

(e) Ensure that 75 per cent of people living with and affected by HIV benefit from HIV-sensitive social protection and ensure that at least 30 per cent of all service delivery is community-led.

8. In order to reinforce the provisions of the Political Declaration on children and adolescents, and to guide country-level action for children and adolescents, UNICEF and WHO convened three high-level side events during the high-level meeting in New York:

A. High-level meeting on ending paediatric AIDS

9. During the meeting, convened as a direct follow-up to the ministerial meeting on the theme "Towards ending paediatric AIDS: catalyzing global action to close the HIV treatment gap for children", held in Abidjan, Côte d'Ivoire, in May 2016, under the leadership of the First Lady of Côte d'Ivoire, the Executive Directors of UNICEF and UNAIDS, the Chief Executive of the ELMA Philanthropies and the Government of Luxembourg emphasized the urgency of increasing ART coverage to 95 per cent of pregnant women living with HIV by 2018 in order to reduce the number of new paediatric HIV infections to 20,000 by 2020. Participants at the high-level meeting also called for an urgent focus on increasing HIV treatment among children living with HIV, which remains critically low, at 49 per cent.

B. Validation of the elimination of new infections in Armenia, Belarus and Thailand

10. In 2015, in collaboration with UNAIDS, the President's Emergency Plan for AIDS Relief (PEPFAR) of the United States and WHO, a final report was released on progress made since the launch of the Global Plan. The report highlighted the impressive decline of 60 per cent between 2009 and 2015 in new infections in children acquired through mother-to-child transmission in the 21 Global Plan priority countries[1] in sub-Saharan Africa. During the high-level meeting, three countries that UNICEF has been supporting (Armenia, Belarus and Thailand), received WHO validation certificates for the elimination of mother-to-child transmission of HIV at a ceremony organized by WHO, UNICEF and partners. Thailand is the first country with a major HIV epidemic (440,000 people living with HIV in 2015) to receive global recognition for the elimination mother-to-child transmission.

C. Launch of the Three Frees Framework (Start Free. Stay Free. AIDS Free.)

11. The principals of UNICEF, UNAIDS, PEPFAR, WHO and the Elizabeth Glaser Pediatric AIDS Foundation convened a high-level side event, which highlighted the treatment gaps in children. That consultation led to the development of the Three Frees Framework (Start Free. Stay Free. AIDS Free), which highlights the fast-track targets for 2018 and 2020 agreed at the high-level meeting to:

(a) Eliminate mother-to-child transmission of HIV (Start Free);

(b) Reduce the rate of new HIV infections among adolescents and young women (Stay Free);

(c) Increase HIV treatment for both children and adolescents (AIDS Free).

12. In the governance structure for the Three Frees Framework, UNICEF is co-leader of the Stay Free pillar, together with PEPFAR, and will work as a core partner on the Start Free and AIDS Free pillars. The Stay Free pillar will build upon current global initiatives, including the UNICEF-UNAIDS-led All In initiative[2] for adolescents and the PEPFAR DREAMS[3] project for adolescent

[1] See http://emtct-iatt.org/priority-countries.
[2] See http://www.unaids.org/en/resources/campaigns/all-in.
[3] See http://www.pepfar.gov//partnerships/ppp/dreams/.

girls and young women and Accelerating Children's HIV/AIDS Treatment Initiative.[4] Other initiatives include UNICEF projects, funded by the United Nations International Drug Purchase Facility (UNITAID), on (a) innovative point-of-care HIV diagnostics for the early identification of children with HIV and the monitoring of treatment response; and (b) the use of pre-exposure prophylaxis (PrEP) as an additional HIV prevention option for older adolescents at substantial risk of HIV acquisition.

13. In July 2016, the Executive Director of UNICEF participated in the 21st International AIDS Conference, held in Durban, South Africa. The conference provided an opportunity for UNICEF to showcase its use of such innovations as the introduction of point-of-care initiatives in child health platforms and the use of mobile technologies (U-Report[5]) in the HIV response for children and adolescents. The Durban meeting also served as a platform to remind the 12,000 participants about the stagnation in recent years of the global efforts to reduce new HIV infections, especially among adolescents.

Issue 2: UNAIDS 2016-2021 Strategy: On the fast-track to end AIDS

14. UNICEF worked closely with the UNAIDS secretariat and the other 11 co-sponsoring agencies to draft the UNAIDS 2016-2021 Strategy and the UBRAF to ensure that both documents contained targets for women, children and adolescents. The analyses, advocacy and technical engagement of UNICEF contributed to several multi-country efforts that generated key operational evidence and strategic reports[6] and informed the formulation of the following priority strategies to improve results in women, children and adolescents:

(a) *The scale-up of testing, knowledge of HIV status and access to ART*. In women, children and adolescents, the achievement of this target will be supported by means of improved access to HIV testing services for people at the greatest risk for infection as well as intensified early infant diagnosis, ensuring immediate linkage to ART;

(b) *The elimination of new HIV infections among children and the improved health and well-being of their mothers*. This will be driven by immediate treatment for all pregnant women living with HIV (option B+), improved access to sexual and reproductive health services (including family planning) and better integration of tuberculosis care within maternal and child health services;

(c) *Improved access to combination HIV prevention and opportunities for the empowerment of young people, especially adolescent girls and young women*. Key to this target is the expansion of voluntary medical male circumcision and integrated sexual and reproductive health services for an additional 27 million adolescent boys and men in high-HIV-prevalence settings as well as quality comprehensive sexuality education, demand creation for HIV testing and prevention services and the meaningful engagement of adolescents;

[4] See http://www.pepfar.gov/partnerships/ppp/234538.htm.
[5] See https://ureport.in.
[6] These included the multi-country bottleneck analyses on PMTCT; country projects to optimize access to HIV services for PMTCT in four countries; assessments on adolescents and HIV in multiple countries; and the following reports: (a) South Africa Medical Research Council, "Report on the external mid-term, formative evaluation of the optimizing HIV treatment access (OHTA) for pregnant and breastfeeding women initiative in Uganda, Malawi, Ivory Coast and the Democratic Republic of Congo" (October 2015) and (b) UNICEF, "All In: synthesis report of the rapid assessment of adolescent and HIV programme context in five countries: Botswana, Cameroon, Jamaica, Swaziland and Zimbabwe" (2015).

(d) *The effective and targeted delivery of biomedical, behavioural and structural prevention services for key populations, including people who sell sex, men who have sex with men, people who inject drugs, transgender people and prisoners, as well as migrants*. Key to this target is the recognition of adolescents among these population groups and their unique needs, and the implications for programme focus and adjustments in new implementation strategies, such as the use of new media for outreach as well as prevention technologies, such as PrEP;

(e) *The engagement and empowerment of communities to promote and establish healthy gender norms*. Key priorities for this target include the commitment to end sexual and gender-based violence as well as expanded opportunities to ensure that women are meaningfully engaged in decision-making and the implementation of the AIDS response;

(f) *The strengthening of health and community systems to ensure the delivery of HIV services as part of a more integrated programme that addresses the broader needs of women, children and adolescents*. Essential to this target is support to the empowerment of women, adolescents and households affected by HIV by means of HIV-sensitive national social protection programmes, including cash transfers. In addition, this work will prioritize investments in the integration of community service delivery within formal health systems.

Issue 3: Funding for the 2016-2021 Unified Budget, Results and Accountability Framework

15. The UBRAF operationalizes the UNAIDS 2016-2021 Strategy by means of the implementation of 27 outputs. UNICEF is engaged in 16 of the 27 outputs.

16. The Strategy and the UBRAF were approved by the PCB at its 37th meeting.[7] The UBRAF includes a $485 million core budget for the 2016-2017 biennium as well as budget allocations for the co-sponsors and the secretariat at the same levels as those for the 2014-2015 biennium (UNICEF received $24 million for that biennium). Furthermore, the PCB urged the full funding of the 2016-2021 UBRAF and the allocation of sufficient funding for the UNAIDS secretariat.

17. In spite of the budget recommendations of the PCB, ongoing fundraising challenges affected the UBRAF funding allocations to UNICEF and other co-sponsors in 2016, with allocations reduced by 50 per cent. The PCB also recommended further cuts, to 75 per cent against funds raised for 2017. At a November 2016 meeting with co-sponsor principals, the UNAIDS Executive Director made the commitment to maintain the 2016 co-sponsor allocation (a reduction of 50 per cent) as a result of the savings achieved following reductions in both staffing levels in the secretariat and 2016 activity budgets.

18. The 2015 expenditure level ($107 million, including $12 million from the UBRAF) for HIV programming in UNICEF is the lowest across all the UNICEF result areas and reflects a decline of 43 per cent from the peak level in 2009 ($189 million). About half of the HIV expenditures in 2015 were from earmarked resources (e.g., the Global Fund for commodities and emergency settings) ; special catalytic projects; and initiatives of UNITAID, the MAC AIDS Fund, Sweden and Norway) to implement selected projects in a limited number of countries. The proportion of funds that are non-earmarked and used to provide high-quality technical assistance for implementation has decreased, with serious implications for future UNICEF HIV programming.

[7] See http://www.unaids.org/sites/default/files/media_asset/20151028_UNAIDS_PCB37_Decisions.pdf.

19. In order to mitigate the UBRAF reductions and to reorient the UNICEF response towards the new global strategies, partnerships and changes in funding, UNICEF undertook three actions:

(a) The review and update of the UNICEF Programme Strategy on HIV and AIDS, with a focus on ending the global AIDS epidemic among mothers, children and adolescents. The new Programme Strategy is aligned with the Sustainable Development Goals, regarding health (Goal 3); gender equality (Goal 5); reduced inequality (Goal 10); and partnerships (Goal 17). The objectives and targets of the new Programme Strategy are also aligned with the UNAIDS 2016-2021 Strategy; the All In initiative; and the Three Frees Framework. Details of the revised UNICEF Programme Strategy on HIV and AIDS are outlined in the annex;

(b) *The finalizing of an analysis of HIV resource requirements for the period 2016-2021, using the expenditure trends for the period 2007-2015.* The analysis, modelled on the current budget level and potential future declines in resources, is expected to show gaps in funding for programming and staff capacity across countries, regions and headquarters. Preliminary findings indicate that UNICEF has been successful in attracting earmarked project funding for selected countries, particularly for the introduction of innovations, including HIV diagnostics, as well as for ART commodity security during emergencies. UNICEF has also attracted earmarked Global Fund resources as the principal recipient or subrecipient. While such earmarked responses have greatly facilitated UNICEF programming around targeted initiatives and innovations, they lack the flexibility to support much of the organization's ongoing programmatic accountabilities on HIV. UNICEF will use the information from the cost analysis to develop a fundraising strategy for HIV programming and staffing, the aim of which is to ensure adequate financing for the UNICEF Programme Strategy on HIV and AIDS through the next strategic plan cycle (2018-2021);

(c) *An assessment by UNICEF, in collaboration with UNAIDS and co-sponsors, of the impacts of the UBRAF cuts and the projected shortfalls for 2016 and 2017 on the delivery of the UNAIDS 2016-2021 Strategy*. The financial crisis has immediate and far reaching implications for the work of UNICEF:

(i) The decrease in funding will impact the ability to support the multiple verification assessments that are part of the validation of the elimination of mother-to-child transmission of HIV, a role that UNICEF plays as a member of the Global Validation Advocacy Group. In countries that are on the way to achieving that goal, reduced funding could result in an inability to eliminate new paediatric HIV infections by limiting the reach of their PMTCT HIV programming or negatively impacting service quality. In Eastern and Southern Africa, where PMTCT coverage has been significantly increasing, reduced funding will delay the work on strengthening the use of data for programme course corrections, as well as restrict support to the retention in care of pregnant women and mothers. In West and Central Africa, given the low PMTCT ART coverage levels, reduced funding will prevent improvement in the identification and treatment of pregnant and lactating women living with HIV. UNICEF work to accelerate and sustain access to paediatric and adolescent ART will be limited to countries with the highest number of HIV infections in children and adolescents. Technical support to low-level and concentrated epidemics will be limited to the tracking of the response to HIV programming and advocacy;

(ii) In light of the current discussions on the Three Frees Framework and the All In initiative, UNICEF will prioritize prevention in adolescents and young women in all regions.

However, the organization will not be able to provide the intensified implementation support needed to close the programming gaps in all 25 lead countries;

(iii) UNICEF will reduce its advocacy efforts and its support to civil society for its work on reducing inequalities in access to HIV prevention and treatment services, particularly for marginalized and key populations in various regions, especially in the Middle East and North Africa and Central and Eastern Europe and the Commonwealth of Independent States, where the epidemic is more hidden than in other regions and the affected populations are highly stigmatized;

(iv) The number of UNICEF staff members dedicated to HIV programming at the country, regional and headquarters levels will be seriously affected. In 2016, UNICEF had 111 full-time staff members on fixed-term contracts working in HIV programming compared with 173 in 2015, a decrease of 36 per cent. Only four out of the seven regions have maintained a regional adviser at the senior level compared with seven regions in 2014. Headquarters reduced its staffing levels by 50 per cent in 2016.

20. Despite the immediate effects of the reduction in resources in 2016 and the outlook for the next few years, UNICEF is committed to addressing the resource gaps and will continue to contribute to the HIV response. For example, the Executive Director has undertaken exceptional measures to maintain critical staff capacity at headquarters in 2017. The Global Management Team met to discuss the future of the Programme Strategy on HIV and AIDS in June 2016 and agreed unanimously that UNICEF would not abandon its responsibilities regarding HIV programming. Both Private Fundraising and Partnerships and the Public Partnerships Division are committed to facilitating fundraising efforts around HIV programming and exploring new partnerships for innovative work.

Issue 4: Role of communities in ending AIDS by 2030

21. In June 2016, UNICEF worked with the UNAIDS secretariat and partners to organize the thematic segment of the 38th meeting of the PCB, on the role of communities in ending AIDS by 2030. In that segment, UNICEF showcased the findings from the Optimizing HIV Treatment Access for Pregnant Women (OHTA)[8] Initiative, funded by Norway and Sweden, to highlight the essential role played by communities in the delivery of care and support services for pregnant and lactating women who are accessing PMTCT services that follow the "test and start" approach. Côte d'Ivoire, the Democratic Republic of the Congo, Malawi and Uganda participated in OHTA Initiative.

22. The 2015 midterm evaluation[9] of the OHTA Initiative concluded that OHTA funding at the facility and community levels improved community involvement in both demand and service delivery. Key results that informed this positive conclusion include:

(a) Technical and material support provided to the peer support of mothers in health facilities and communities as well as to community support groups increased the number of pregnant women reached with antenatal services and ART and who were retained in care. Standard indicators to track community and facility services and accountability were developed to inform the

[8] See http://childrenandaids.org/partnership/optimizing-hiv-treatment-access.
[9] https://www.unicef.org/evaldatabase/files/HQ-PD_Final_OHTA_report_October_2015.pdf.

scale of community activities in Côte d'Ivoire. Male involvement activities also increased the number of partners tested for HIV;

(b) Improved district- and facility-level monitoring systems helped to diminish inequities in service delivery through the better tracking of defaulters; the local ownership of the issues; and the understanding of data for service improvement. These health system-strengthening outcomes were important to both the PMTCT programme and the broader maternal, newborn and child health services.

23. At the 38th meeting of the PCB, the thematic segment on communities provided important evidence in support of community engagement and the strengthening of community systems for HIV prevention, care and treatment and for the broader development results.

Annex

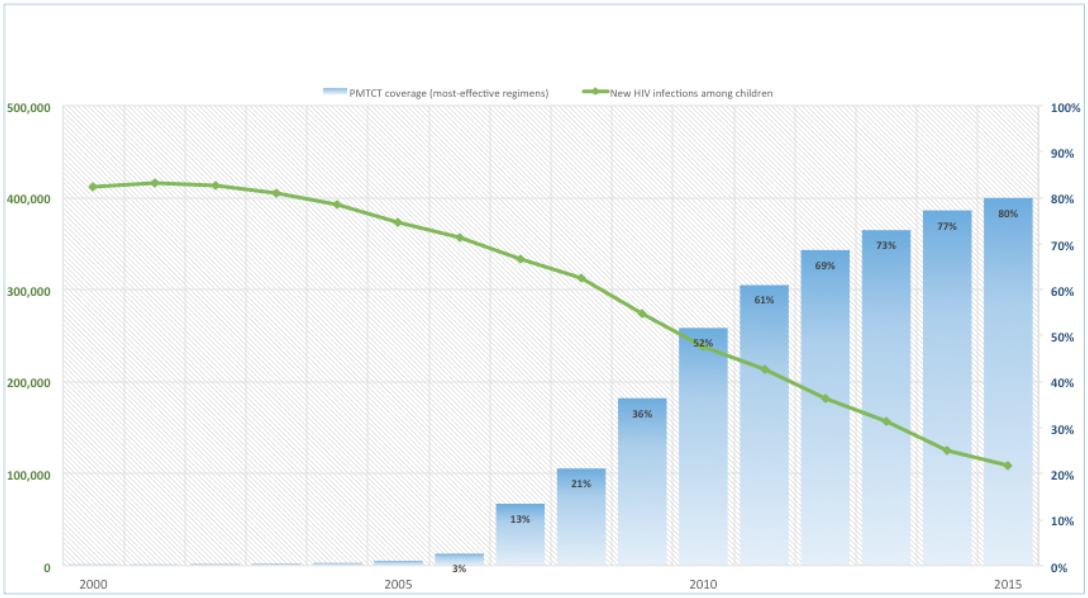
UNICEF HIV programming in the period 2015-2016 across the two decades of childhood

Status of the epidemic

1. For children, the success story of increased antiretroviral therapy (ART) access for people living with HIV is limited mainly to the prevention of mother-to-child transmission of HIV (PMTCT) services, and challenges remain for children and adolescents living with HIV.

Figure 1

Percentage of pregnant women living with HIV receiving the most effective antiretroviral treatment for the prevention of mother-to-child transmission of HIV and number of new HIV infections among children (aged 0-14 years) in 21 Global Plan countries in sub-Saharan Africa, 2000-2015



Abbreviation: PMTCT – prevention of mother-to-child transmission of HIV
Source: UNICEF analysis of Joint United Nations Programme on HIV/AIDS (UNAIDS) 2016 estimates.

2. Lifelong ART for pregnant women living with HIV increased globally to 70 per cent in 2015 compared with only 49 per cent in children (0-14 years).[1]

3. Coverage is worse in adolescents aged 10 to 19 years, on the basis of data from the few countries that report age-disaggregated data. AIDS is the leading cause of death among adolescents

[1] Joint United Nations Programme on HIV/AIDS (UNAIDS) 2016 estimates.

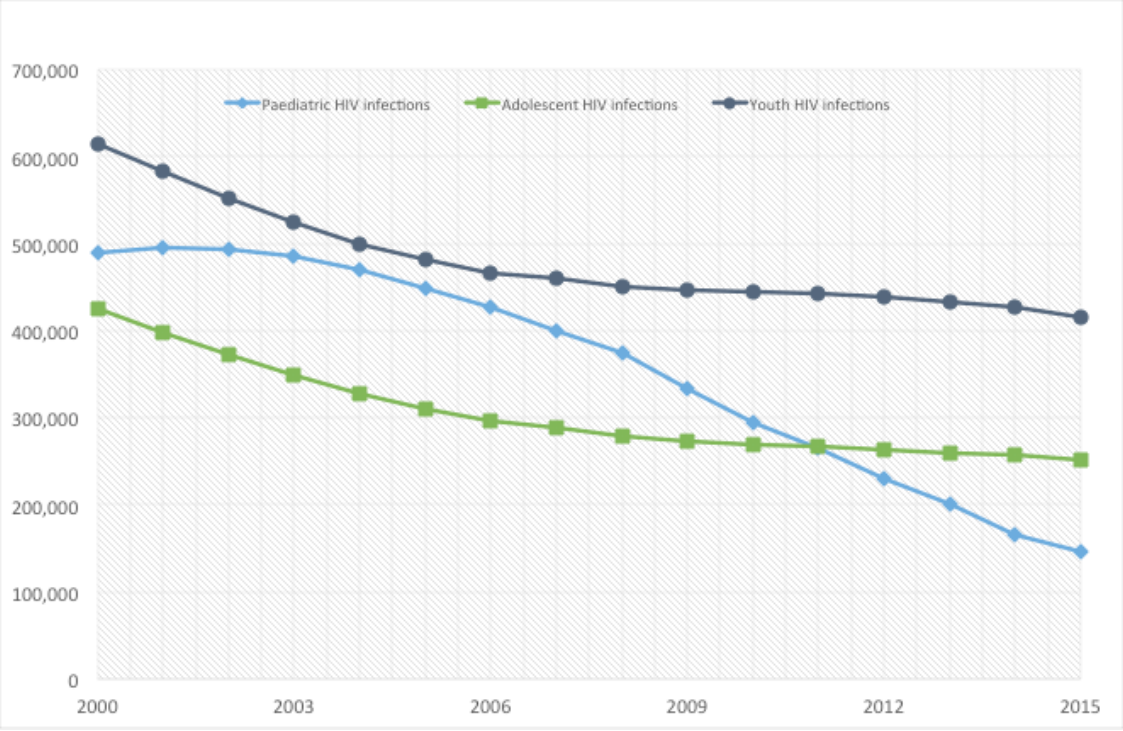
aged 10-14 years globally and the leading cause of death in adolescents in sub-Saharan Africa.[2,3] In fact, nearly 90 per cent of all AIDS-related deaths among adolescents in 2015 were in sub-Saharan Africa.[4]

4. The quality of services for adolescents varies greatly between settings. A lack of health-care provider skills; restrictive age-of-consent laws that affect access to HIV testing; high levels of stigma surrounding HIV, including in health-care settings and schools; and inadequate adolescent-focused health education and communications contribute to limiting access to information and services for HIV prevention as well as access to treatment among adolescents.

5. Three out of four new infections among adolescents aged 15 to 19 years in sub-Saharan Africa were in girls in 2015.[5] As mentioned in the 2016 UNAIDS "Prevention gap report", new HIV infections in adolescents and adults aged 15 years and above stagnated at 1.9 million between 2010 and 2015. In the same period, infections in adolescents aged 15 to 19 years declined only minimally, from 270,000 to 250,000, compared with the much greater decline in children aged 0 to 14 years, from 290,000 to 150,000.

Figure 2

Number of new HIV infections globally among children (0-14 years), adolescents (15-19 years) and youth (20-24 years), 2000-2015



Source: UNAIDS 2016 estimates.

[2] Mokdad, Ali H. et al, "Global burden of diseases, injuries, and risk factors for young people's health during 1990-2013: a systematic analysis for the Global Burden of Disease Study 2013", *The Lancet*, vol. 387, No. 10036 (11 June 2016), pp. 2383-401.
[3] World Health Organization, "Health for the world's adolescents: A second chance in the second decade", May 2014. Available from http://apps.who.int/adolescent/second-decade.
[4] UNAIDS estimates.
[5] Ibid.

6. Investments in HIV prevention have focused on PMTCT, medical male circumcision and, increasingly, on HIV treatment for prevention through ART to discordant couples. However, other components of "combination prevention", such as condom programming; behaviour change communication and demand creation; social protection, such as cash transfers; and efforts to prevent and respond to sexual and gender-based violence, have not been adequately funded.

7. In all regions, men who have sex with men, transgender people, people who sell sex and people who inject drugs are disproportionally affected by HIV. These vulnerable and socially excluded populations are key to halting the spread of the HIV epidemic. Reducing vulnerability and HIV infection in these populations requires an understanding of epidemiological factors and structural drivers, in addition to supportive laws and protective policies that enable service delivery and access. There is also a need for broader multi-sectoral investment in adolescent programming and empowerment as well as in improved service provider capacity.

8. Building social inclusion and respect for gender equality and diversity for all adolescents, improving the quality of services and expanding opportunities for the empowerment of adolescents will become even more important as the absolute size of the adolescent population continues to grow rapidly, particularly in sub-Saharan Africa.

Achievements and challenges

9. In early 2016, stimulated by declines in HIV funding and seeking to better align UNICEF HIV work with the Sustainable Development Goals[6] and the UNAIDS 2016-2021 Strategy, UNICEF revised its Programme Strategy on HIV and AIDS. The new strategy, which will inform the UNICEF Strategic Plan, 2018-2021, has the following overarching goals:

(a) Fast-track the HIV response by 2020 for pregnant women, mothers, children and adolescents;

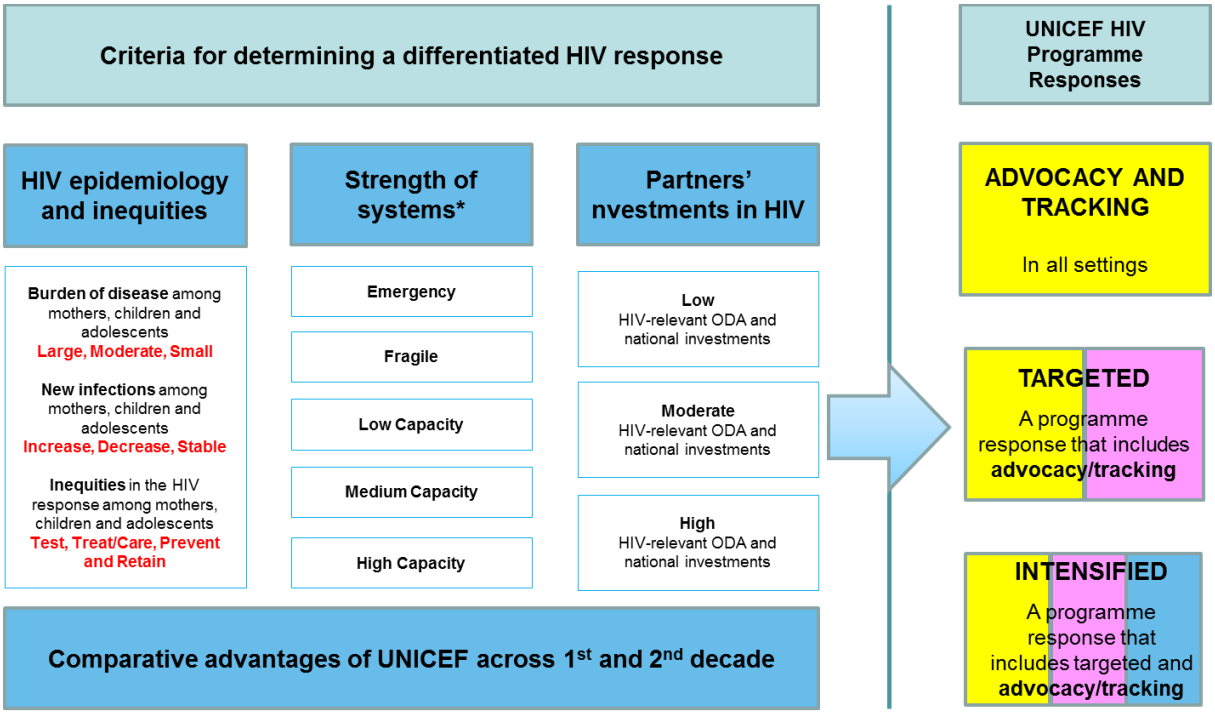
(b) Build resilient government and community systems to decrease inequities in HIV services among pregnant women, mothers, children and adolescents.

10. The new strategy proposes a programming framework with differentiated country response at its core. It takes into account three main criteria: (a) the evolving epidemiology of HIV; (b) the strength of systems; and (c) available investments. Figure 3 provides an overview of how programming can be differentiated to suit the country context and focus HIV resources accordingly. The strategy proposes: (a) advocacy and tracking in all settings; (b) targeted programming combined with advocacy; and (c) an intensified approach in settings with high burden, low capacity and insufficient resources.

[6] Health (Goal 3); gender equality (Goal 5); reduced inequality (Goal 10); and partnerships (Goal 17).

Figure 3

Differentiated response for country programme prioritization



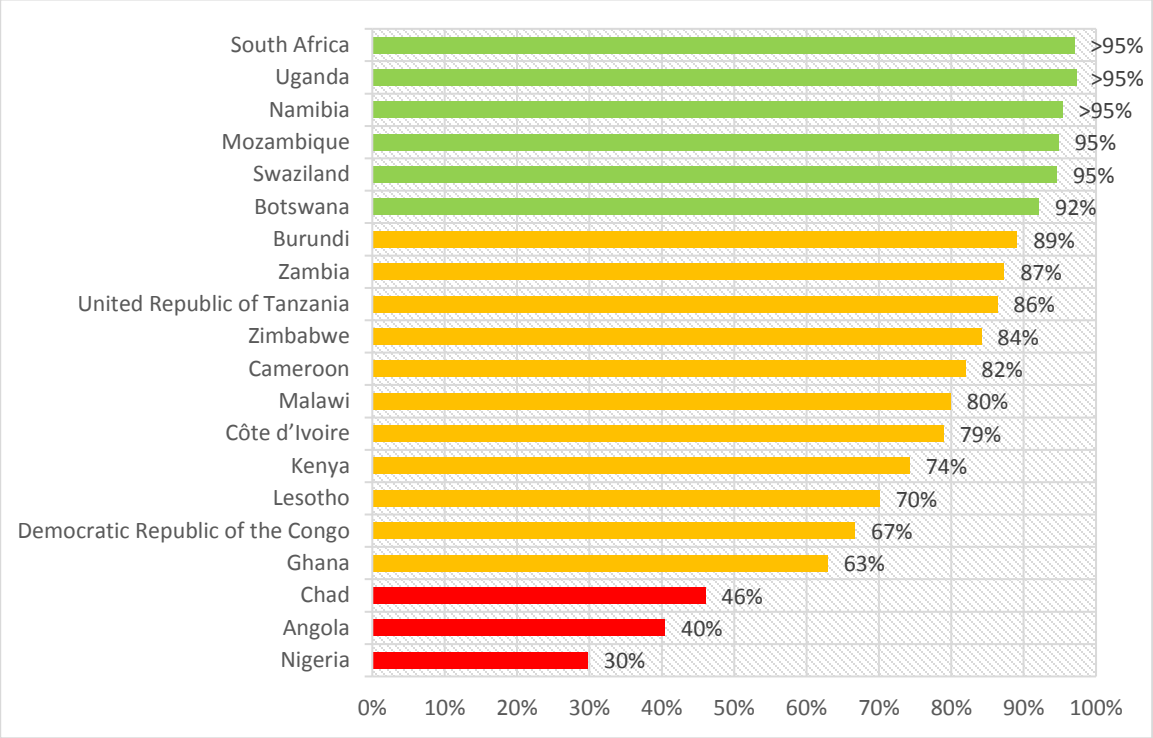
* UNICEF Health Strategy, 2016-2030.

Results of programming for decade one of childhood (0-10 years)

11. UNICEF has been supporting countries to scale up the "test and start" approach for pregnant and lactating women using option B+. By June 2016, all 21 Global Plan countries in sub-Saharan Africa had fully transitioned to providing ART treatment for life for all pregnant women living with HIV, bringing about a massive scale-up of access to ART. In 2015, 7 countries (Botswana, Burundi, Mozambique, Namibia, South Africa, Swaziland and Uganda) out of the 21 countries had achieved PMTCT ART coverage of over 90 per cent (see figure 4).

Figure 4

Percentage of pregnant women living with HIV receiving the most effective antiretroviral treatment for the prevention of mother-to-child transmission of HIV in 21 Global Plan countries in sub-Saharan Africa, 2015.



Note: Excludes single-dose nevirapine; statistics for Ethiopia not available.
Source: UNAIDS 2016 estimates.

12. The secretariat of the Inter-Agency Task Team on Prevention and Treatment of HIV Infection in Pregnant Women, Mothers and their Children (IATT) at UNICEF headquarters and the UNICEF focal points in country offices coordinated the provision of technical assistance upon country request and supported the tracking of the achievement of key milestones; the strengthening of longitudinal monitoring and tracking systems for mother-infant pairs; and the timely sharing of tools and lessons learned to catalyse global, regional and country action.

13. UNICEF country offices, with support from regional offices, continued to support bottleneck analyses for improved data-driven planning. In the Democratic Republic of the Congo, Ghana and South Africa, monitoring systems for the timely removal of barriers have contributed to the scale up of PMTCT and paediatric HIV services.

14. In 2012, UNICEF, together with Norway and Sweden, signed a three-year agreement to adopt and scale up the "test and start" approach (option B+ or ART for life) in Côte d'Ivoire, the Democratic Republic of the Congo, Malawi and Uganda. This involved the strengthening of community capacity and linkages to health-care facilities in order to improve demand for PMTCT services and HIV treatment as well as retention in the care of pregnant and breastfeeding women on

ART for life. In 2016, Norway and Sweden extended their support to UNICEF for an extra year so that countries could consolidate gains and share knowledge for wider uptake.

15. UNICEF has been supporting countries to improve paediatric HIV case finding and ART uptake and retention. In the Democratic Republic of the Congo, Nigeria and Zimbabwe, this work has included family-centered testing of children in households by using an "index HIV case" (either a child or a parent found to be HIV positive) to promote the testing of all the children in the family.

16. Since 2012, with funding from UNITAID, UNICEF and the Clinton Health Access Initiative have been supporting the introduction of point-of-care diagnostics to include CD4. By 2016, the initial seven countries (Ethiopia, Kenya, Malawi, Mozambique, Uganda, the United Republic of Tanzania and Zimbabwe) had made significant progress in developing point-of-care policies; site-selection criteria for deploying CD4 point-of-care diagnostics; and quality assurance mechanisms.

17. In 2016, the Executive Board of UNITAID approved $95 million in additional funding for four years to UNICEF and the Clinton Health Access Initiative to expand access to point-of-care diagnostics for early infant HIV diagnosis and HIV treatment monitoring (viral load). Experiences with point-of-care testing indicate that it can speed up clinical decision-making and reduce turnaround time, substantially increasing ART initiation rates, reducing morbidity and saving lives. The funding will expand access to point-of-care diagnostics and coverage of HIV testing by means of new technologies and the strengthening of conventional lab systems. The funding will also enable the expansion of programming from the seven countries in Eastern and Southern Africa to three countries in Western and Central Africa (Cameroon, the Democratic Republic of the Congo and Senegal).

18. In collaboration with the Elizabeth Glaser Pediatric AIDS Foundation, the Clinton Health Access Initiative and WHO, UNICEF supported the IATT paediatric working group to finalize operational guidance on the use of a new paediatric formulation of the drugs lopinavir and ritonavir in the form of oral pellets, recommended by WHO for the youngest infants.

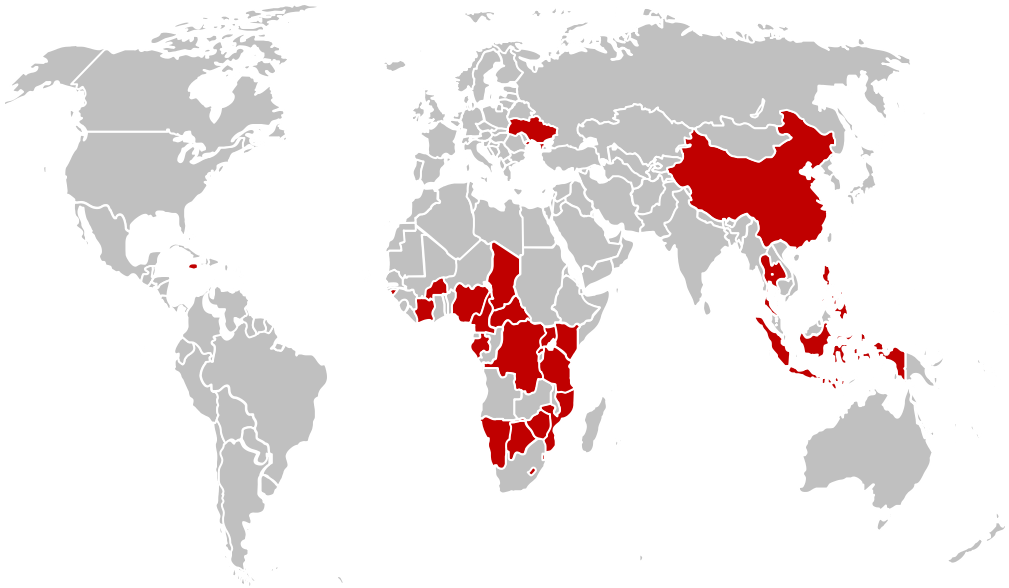
Results of programming for decade two of childhood (10-19 years)

19. In February 2015, UNICEF and UNAIDS launched the All In initiative to fast-track global and country efforts to end the AIDS epidemic among adolescents. The multi-stakeholder effort, which includes United Nations partners, the Global Fund, Governments, the World Bank, civil society, private sector partners and adolescent and youth networks, brought the crisis of adolescents and AIDS to the attention of global policymakers and promoted the goals to achieve by 2020 of (a) a reduction of 65 per cent in AIDS-related mortality; (b) a reduction of 75 per cent in new infections among adolescents; and (c) the elimination of stigma and discrimination. Better information is now available to inform HIV programmes for adolescents in the 25 countries that have undertaken All In assessments.

20. UNICEF has provided technical assistance to multiple countries across all regions to mobilize national partners and identify key implementation bottlenecks for high-impact HIV interventions for adolescents. These multi-sectoral efforts have been supported in over 25 countries, which are now better positioned to strengthen their adolescent response.

Figure 5

The 25 countries that have completed All In adolescent assessments on HIV, as of November 2016



Note: The boundaries shown do not imply official endorsement or acceptance by the United Nations.

21. Following their All In assessments, some countries (Botswana, Jamaica, Lesotho, Namibia, the Philippines and Swaziland) negotiated the reprogramming of Global Fund resources towards more strategic priorities, such as community-based targeting; the engagement and empowerment of the most vulnerable adolescent populations; and targeted subnational assessments on equity-based planning across the country.

22. Other countries have used the exercise to strengthen action plans. In the Philippines, for example, local governments in counties with highest burden have used the All In assessment to design an HIV prevention programme for gay and bisexual adolescent boys. The programme includes the use of social media and mobile health to improve access to information, ensure adolescent-friendly support from available prevention services and collect better age-disaggregated data for planning.

23. The All In assessment in Nigeria is being used to operationalize the national strategy on adolescents and young people and to leverage national and partner resources to improve allocations for adolescent programming. To ensure clear accountability and coordinated action to address the identified gaps and bottlenecks, action plans have been developed by 17 local governments in two high-burden states.

24. In Côte d'Ivoire and Zimbabwe, the adolescent assessment led to the targeted promotion of adolescent HIV testing, resulting in the provision of counselling to a total of 200,000 adolescents.

The process led to the diagnosis of HIV for nearly 7,700 adolescents, who were subsequently linked to care.[7]

25. New evidence released in 2015 on the effectiveness of pre-exposure prophylaxis (PrEP) paved the way for increased support from UNICEF to countries for the inclusion within national strategies of that prevention tool for adolescents. In September 2016, UNITAID approved $38 million for UNICEF to provide PrEP to sexually active older adolescents at highest risk of HIV infection in Brazil, South Africa and Thailand. It will be the first multi-country oral PrEP project to be implemented in a public health setting in the three countries, whose experience will help to provide global lessons, as each captures various aspects of the HIV epidemic within diverse sociocultural contexts.

26. The goal of the project is to contribute to a decrease in the incidence of HIV among adolescents for whom PrEP is recommended. The project will also collect critical information for the development of global guidance on the implementation of combination HIV prevention that includes PrEP for sexually active older adolescents aged 15 to 19 years who are at substantial risk of HIV acquisition. The outcomes are to: (a) increase access to PrEP for eligible adolescents, including by improving the legal, ethical and regulatory environment; (b) demonstrate the effective use of PrEP in adolescents; and (c) generate knowledge on PrEP use among eligible adolescents to foster the expansion of PrEP in the focus countries as well as in other countries.

27. The MAC AIDS Fund has provided more than $2.4 million to support innovations and enhance service delivery for adolescents for one year, ending in 2016, in seven focus countries: Brazil, China, India, Indonesia, South Africa, Thailand and Ukraine. The funding has enabled the development of innovative technologies and approaches, including (a) telemedicine in the state of Maharashtra, India, to provide paediatric clinical expertise in rural areas; (b) the MomConnect mobile phone texting application, which helps reduce loss to follow-up in maternal, newborn and child health services for pregnant women and mothers living with HIV in South Africa; and (c) mobile clinic HIV testing conducted by young people living with HIV in Brazil and Ukraine.

28. UNICEF is working in partnership with the Praekelt Foundation in Nigeria to strengthen the national use of mobile health applications to identify and reach vulnerable adolescents and link them to services and retain them in care. A pilot experience working with the National Call Centre on HIV/AIDS and Related Diseases in Nigeria was used to develop a blueprint for the integration of mobile health applications in national systems for HIV outreach, empowerment and data gathering. The call centre is aimed at providing easy access for all people to information on HIV/AIDS and other health issues. The centre currently provides operator-assisted responses to 46,000 calls a year. The upgrades recommended in the blueprint would immediately expand its reach to 53 million people, 11 million of whom would be adolescents. Further proposed upgrades would expand its reach to 110 million people, doubling the number of adolescents reached to 23 million and accelerating improvements in knowledge, demand and linkage to services.

29. In collaboration with the Southern African AIDS Trust, and with support from law firms affiliated with the Thomson Reuters Foundation, UNICEF has supported a legal review of consent

[7] UNICEF, "Annual results report 2015: HIV and AIDS". Available from https://www.unicef.org/publicpartnerships/files/2015ARR_HIVAIDS.pdf.

laws and policies in 22 countries[8] and complemented this with a review of ethical, social and cultural barriers in 11 countries[9] to understand the context behind their laws, policies and practices. The legal review looked at consent in relation to sexual activity; contraception; ART; post-exposure prophylaxis; PrEP; abortion; antenatal care; the human papillomavirus vaccine and cervical cancer screening and treatment; and HIV testing. The ethical, social and cultural review used three frames of reference to understand the context for the legal provisions and general practices around consent for adolescents in relation to the above-mentioned issues: (a) contradictions between ethics (what ought be done on the basis of universal human rights standards) and morality (what people generally think should be done on the basis of individual values and beliefs); (b) social factors (the way communities organize themselves and acquire identity); and (c) cultural factors (both modern and traditional customs, traditions, practices, representation, expressions and values).

Across decades one and two of childhood

30. Disease outbreaks, conflict, natural disasters, economic and political crises and other hazards can disrupt HIV services. UNICEF includes HIV services in its Core Commitments for Children in Humanitarian Action to improve access to HIV prevention and treatment for children, adolescents, pregnant women and mothers in risk-prone and emergency settings. Access to and the availability of food is critical for adherence to HIV treatment and retention in care. Mortality is two to six times higher for children living with HIV who begin treatment when they are severely malnourished than for those who are not malnourished. A 2014 study of 18 countries in sub-Saharan Africa, including Lesotho, Malawi, Mozambique, Swaziland, Zambia and Zimbabwe, among the El Niño-affected countries in Southern Africa, found that infection rates in HIV-endemic rural areas increased by 11 per cent for every recent drought. Income shocks further explained up to 20 per cent of the variation in HIV prevalence across African countries. UNICEF developed the HIV and El Niño study and supported the affected countries in its implementation.

31. The UNICEF nutrition and HIV sections, together with WHO and the Emergency Nutrition Network, organized a technical consultation in Geneva, with the participation of the United Nations, Governments, non-governmental organizations working in nutrition and HIV and other stakeholders, to clarify programmatic issues and implementation strategies and to develop a framework and key principles around infant feeding and HIV in emergencies in the context of the WHO and UNICEF 2016 publication *Guideline: Updates on HIV and Infant Feeding.*

32. A guidance note on ordering supplies to address the clinical management of sexual assault against women and children is now being finalized.

33. As a response to the emergency in Ukraine, UNICEF has been working with the Global Fund to ensure the continued supply of antiretroviral drugs. In 2016, UNICEF documented approaches, assessments and lessons learned on risk-informed programming, resilience and HIV in emergencies.

34. Eastern and Southern Africa carry the highest burden of HIV and AIDS among children, adolescents and their families. In 2014, in collaboration with Governments in four countries in those

[8] Botswana, Brazil, Canada, Côte d'Ivoire, France, India, Indonesia, Jamaica, Kenya, Malawi, Morocco, Nigeria, South Africa, Swaziland, Sweden, Thailand, Ukraine, United Kingdom of Great Britain and Northern Ireland (England and Wales), United Republic of Tanzania, Viet Nam, Zambia and Zimbabwe.
[9] Brazil, India, Indonesia, Jamaica, Nigeria, Philippines, South Africa, Thailand, Uganda, Ukraine and United Kingdom.

regions, UNICEF conceived the "Cash Plus Care" intervention to strengthen the linkages between HIV/AIDS services and national social protection programmes. The project, funded by the Government of the Netherlands, is being implemented in Malawi, Mozambique, Zambia and Zimbabwe. As of 2016, all four countries have made considerable progress in combining HIV services with cash transfer provisions.[10] In Zimbabwe, the project was undertaken in two districts and has reached 23,000 children. Community partnerships were established between the Department of Child Welfare and Social Services and community volunteers to enhance referral and linkage to services for families receiving cash transfers. Through this partnership, community volunteers provide psychosocial support to HIV-positive adolescents and assist them with referrals to health services, while the Department of Child Welfare distributes cash transfers to the adolescents and their households through pay-points. There are plans to introduce Internal Savings and Lending systems to help households overcome economic barriers that prevent them from accessing health services.

[10] See http://childrenandaids.org/publication/building-hiv-sensitive-social-protection-systems-through-%E2%80%98cash-plus-care%E2%80%99-model-findings.