Oral report background note

UNICEF follow-up to the recommendations and decisions of the thirty-ninth and fortieth Joint United Nations Programme on HIV/AIDS Programme Coordinating Board meetings

Introduction

1. This report presents an update of progress made on and the UNICEF response to the discussions and decisions of the thirty-ninth and fortieth Joint United Nations Programme on HIV/AIDS (UNAIDS) Programme Coordinating Board (PCB) meetings, in accordance with the requirement of the PCB. The PCB meetings took place from 6 to 8 December 2016 and from 27 to 29 June 2017.

2. The report highlights three issues raised by the PCB that are relevant to UNICEF work:

(a) Decisions arising from the updated gap analysis on paediatric HIV prevention, treatment, care and support and the need to accelerate efforts to achieve targets set out in the Sustainable Development Goals; the 2016 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); the UNAIDS Strategy 2016–2021; and the Three Frees Framework (Start Free. Stay Free. AIDS Free);

(b) The intensification of collaboration with communities to end AIDS by 2030;

(c) The mitigation of the budgetary shortfall for the 2016–2021 Unified Budget, Results and Accountability Framework (UBRAF) and joint resource mobilization for a fully funded framework.

3. The annex details the status of the HIV epidemic in children and adolescents, including key achievements and challenges.

* E/ICEF/2018/1.
Issue 1: Decisions on the updated gap analysis on paediatric HIV prevention, treatment, care and support

4. At the thirty-ninth UNAIDS PCB meeting, the Board called upon the members of the joint programme and its co-sponsors to support country efforts to achieve (a) the elimination of mother-to-child transmission of HIV (EMTCT) and (b) World Health Organization (WHO) certification of EMTCT.

5. EMTCT was a priority area in the UNICEF Strategic Plan, 2014–2017 and will remain so under Goal Area 1 of the UNICEF Strategic Plan, 2018–2021 (Every child survives and thrives), with specific results at the impact level (reduction of new infections in children) and the outcome level (increased access of pregnant women to antiretroviral therapy (ART)). UNICEF acknowledges the urgency of ending AIDS among children and accordingly has aligned its results with the 2016 Political Declaration and the Three Frees Framework super-fast-track targets for 2018 and 2020.

6. The scale-up of the prevention of mother-to-child transmission of HIV (PMTCT) services globally is one of the greatest public health achievements of the last decade. Across all regions, the latest UNAIDS/UNICEF/WHO data (2017) show continued improvements in the proportion of pregnant women living with HIV who are receiving effective antiretroviral (ARV) medicines to keep them alive and to prevent them from transmitting HIV to their children. In 2016, 76 per cent of pregnant women living with HIV globally received effective ARV medicines, a marginal increase from 74 per cent in 2015. The Eastern and Southern Africa region, home to 50 per cent of new HIV infections in children aged 0 to 14 years, had the highest proportion of pregnant women receiving effective ARV medicines (88 per cent); followed by 75 per cent in Latin America and Caribbean and 54 per cent in East Asia and the Pacific. Of concern is the low coverage in West and Central Africa (49 per cent), the region with the second-highest burden of new HIV infections in children.

7. In 2016, Armenia, Belarus and Thailand received WHO validation certificates for the elimination of new HIV infections in children, joining Cuba, the first country to receive such certification. In 2017, Anguilla, Antigua and Barbuda, Bermuda, Cayman Islands and Montserrat in Latin America and Caribbean, with support from UNICEF and WHO, were newly validated by the WHO regional and global validation advisory committees. In China and India, UNICEF is supporting the strengthening of subnational data to inform the validation of provinces and states.

8. Globally, there were 160,000 new infections in children aged 0 to 14 years in 2016, a 47 and 8 per cent reduction since 2010 and 2015, respectively. In order to super-fast-track ending AIDS in children, the UNAIDS Three Frees Framework proposes reductions in the number of new HIV infections in children globally to fewer than 40,000 annually in 2018 and fewer than 20,000 annually in 2020, and reaching and sustaining 95 per cent of pregnant women living with HIV with lifelong ARV medicines by 2018. UNICEF and partners are supporting 23 high-burden countries in sub-Saharan Africa as well as India and Indonesia to align national targets with the global targets, and to define how to reach them.

9. In response to this renewed effort, UNICEF and partners are supporting national Governments to strengthen the use of data at the decentralized level to further draw down infections by implementing differentiated PMTCT responses. For example, in South Africa, where over 95 per cent of pregnant women living with HIV were receiving effective PMTCT ART in 2016, UNICEF, with assistance from the Government of the United States of America, is supporting the district-level monitoring of key PMTCT indicators through the introduction of data dashboards and performance reviews, particularly in low-performing districts, to address programme bottlenecks. To improve the retention of women in care, UNICEF is also supporting the use of text-message reminders (MomConnect) for antenatal-care clinic appointments in South Africa.
10. In Côte d’Ivoire, the Democratic Republic of the Congo, Malawi and Uganda, UNICEF and partners, with assistance from Norway and Sweden, are supporting demand creation and the follow-up of mother-infant pairs by intensifying peer support and defaulter tracing through community mentor mothers and other community-based strategies. These include the formation of peer support groups of mothers living with HIV to strengthen the care continuum between primary care facilities and communities. These efforts have resulted in an increased uptake of services and better retention in care. A formal evaluation of these approaches is underway, as part of the transition plan for expanded adoption.

11. In Eastern Europe and Central Asia, UNICEF and partners are working through community networks to increase the access of pregnant women living with HIV to PMTCT and other services. In Nepal, to increase the access of pregnant women to HIV testing, UNICEF and partners have been advocating the expansion of HIV testing in all antenatal care facilities in the country. With support from UNICEF and the Global Fund to Fight AIDS, Tuberculosis and Malaria, HIV testing has been instituted in all health facilities and PMTCT service access has been expanded to remote villages.

12. The gap analysis highlighted the slower progress in the access of children to life-saving ART. In 2016, globally, 54 per cent of adults living with HIV received ART compared with only 43 per cent of children (0-14 years), a slight increase from 38 per cent in 2015. Latin America and Caribbean had the highest proportion of children on ART (53 per cent) in 2016, followed by Eastern and Southern Africa (51 per cent) and East Asia and the Pacific (47 per cent). Key bottlenecks include limited (a) access to the HIV testing of infants; (b) paediatric treatment access points; and (c) financing.

13. Improving the coverage of ART in children is linked to timely access to HIV testing. UNICEF continues to find new ways to decentralize and improve access to HIV testing in order to link children to ART early, given the high mortality rate related to HIV in infancy and early childhood. With support from UNITAID, the international drug purchase facility, and in collaboration with the Clinton Health Access Initiative and the African Society for Laboratory Medicine, UNICEF continues to support seven countries in Eastern and Southern Africa (Ethiopia, Kenya, Malawi, Mozambique, Uganda, the United Republic of Tanzania and Zimbabwe) and three countries in West and Central Africa (Cameroon, the Democratic Republic of the Congo and Senegal) to pilot and scale up new point-of-care HIV diagnostic technologies for early infant diagnosis.

14. Early adopters of point-of-care technologies in Eastern and Southern Africa have demonstrated that, compared with conventional laboratories, point-of-care platforms can reduce the turnaround time for results and substantially increase both ART initiation rates and the retention of patients in care. The analysis of the point-of-care pilot programme to institute same-day results for infant HIV testing has demonstrated improved and early linkage to treatment, counteracting the early peak mortality associated with HIV at 2 to 3 months of age in HIV-infected infants. Countries are at different stages of implementation, with most countries in Eastern and Southern Africa transitioning from pilot to scale-up, while those in West and Central Africa are in the pilot phase. Malawi, Mozambique and Zimbabwe, the early adopters, are also piloting the integration of HIV and tuberculosis testing, using point-of-care platforms capable of multiplexing.

15. UNICEF is integrating health and nutrition interventions for children, including in emergency settings. For example, the Malawi country office is supporting the institutionalization of HIV testing and linkage to HIV treatment in community nutrition rehabilitation centres. In Lesotho and South Africa, work is ongoing to adapt and roll out the updated WHO HIV and infant feeding guidance to promote optimal feeding practices, including (a) exclusive breastfeeding; (b) appropriate complementary feeding; and (c) enhanced maternal ART-adherence counselling during the breastfeeding period.

16. Other child-focussed interventions include:
(a) The integration of HIV and tuberculosis elements in the guidance and tools for the integrated community case management of childhood illnesses. These have now been piloted and are ready for systematic roll-out;

(b) The identification of the optimal entry points for locating children with HIV. As the prevention of vertical transmission improves, the greatest yield for the identification of children with HIV is no longer through the testing of known HIV-exposed infants. Rather, emerging data from testing programmes in paediatric wards, malnutrition units and tuberculosis clinics suggest a much higher yield from routine HIV testing in these settings, as it enables the identification of children living with HIV whose mothers were never tested or did not receive PMTCT interventions, or children who acquired HIV during breastfeeding;

(c) The dissemination of promising results from programmes. UNICEF has been working with the President’s Emergency Plan for AIDS Relief (PEPFAR) to highlight key findings from the two-year multi-country Accelerating Children’s HIV/AIDS Treatment Initiative, led by PEPFAR and the Children’s Investment Fund Foundation, using the community of practice, a virtual global forum for the discussion of issues and the dissemination of information related to the prevention, care and treatment of children and adolescents. Of concern is the poor progress in West and Central Africa in scaling up both PMTCT and paediatric ART. The region accounts for 33 per cent of new infections in children and 25 per cent of children living with HIV, second to Eastern and Southern Africa. In 2016, only 49 per cent of pregnant women living with HIV in West and Central Africa received effective PMTCT ART and 21 per cent of children with HIV received ART. The majority of pregnant women and children missed by HIV services were in Nigeria. To close the gap, UNICEF piloted the integration of maternal HIV testing in HIV high-priority states during the Government-led Maternal, Newborn and Child Health Week campaigns that cover the entire country. The pilot programme was well-received by the women involved and their communities, and the Government is now planning to roll out the integration initiative in other HIV high-priority states. Nigeria has also been exploring the introduction of HIV testing in paediatric inpatient wards and other child health platforms to find children in need of ART.

17. Data on HIV interventions in adolescents remain limited. In 2015, the All In initiative to end the adolescent AIDS epidemic was launched to focus attention on adolescents in the fast-track efforts to end the AIDS epidemic by 2030 and provide three targets for the year 2020 specifically related to adolescents. As part of the initiative, UNICEF and UNAIDS have continued to coordinate national reviews of the adolescent epidemic and data from different sectors with Governments and such key partners as PEPFAR, the Global Fund, the United Nations Population Fund (UNFPA), WHO and the Y+ Programme, established by the Global Network of People Living with HIV as a focal point for young people living with HIV. To date, 25 countries have conducted data reviews and analysed their national response efforts in order to understand the impact of HIV on adolescents. The data has increased both national and global attention to this age group. For example, in Botswana, Mozambique, Namibia, Nigeria, Rwanda, Uganda and Zimbabwe, the bottleneck analysis is being used to inform the planning of responses and funding priorities. In Botswana, Mozambique, Namibia and Rwanda, UNICEF and partners are supporting priority districts to develop and implement corrective action plans. Kenya, Malawi and Zambia have adapted the All In process to support existing strategies that focus on HIV and adolescents, including using dashboards to track and monitor progress in the scale-up of adolescent treatment.

18. Globally, progress in preventing new HIV infections has been slow among adolescents, specifically adolescent girls, and young women. The number of new HIV infections among adolescents aged 15 to 19 years in 2016 was only 14 per cent lower than in 2010 and 17 per cent lower than in 2005, compared with 47 per cent and 63 per cent declines, respectively, during the same time periods in new HIV infections among children under the age of 5 years. Thirty-six per cent (610,000) of the 1.7 million new infections reported among adults over the age of 15 years occurred in the age group 15 to 24 years (260,000 among those aged 15
to 19 years and 350,000 among those aged 20 to 24 years). Adolescent girls and young women accounted for 360,000 of the new infections in adults, while 67 per cent of new infections among adolescents aged 15 to 19 years were among girls.

19. Between 2010 and 2016, trends in new HIV infections among adolescents aged 15 to 19 years ranged from a 27 per cent increase in Eastern Europe and Central Asia, driven by an intravenous drug use epidemic in a highly stigmatized and marginalized population, to a 21 per cent decline in Eastern and Southern Africa.

20. UNICEF results from the All In initiative show that current HIV-prevention efforts in most countries are fragmented, poorly coordinated and not implemented at scale. They range from pilots to small-scale projects on specific interventions, without the effective targeting of high-risk populations or high-prevalence geographical areas. Furthermore, intervention packages and the intensity of effort for HIV prevention among adolescents and young women vary, and many interventions are implemented outside of national systems, with limited sustainability.

21. In response to the prevention gap, the Global HIV Prevention Coalition was launched in October 2017 to fast-track and catalyse prevention towards the All In target of at least a 75-per-cent reduction in HIV infection by 2020, including among adolescent girls and young women. The All In initiative, operating in 25 priority countries, is well aligned with the Global Prevention Coalition and has helped to galvanize the necessary partnerships at the regional and country levels for comprehensive multisectoral programme support. The All In assessment tool includes indicators from multiple sectors to enable the analysis of the full range of vulnerabilities faced by adolescents. In many countries that conducted the assessments, the relevant sectors were meeting for the first time to jointly review the data.

22. The PEPFAR DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored and Safe) partnership to reduce HIV infections among adolescent girls and young women has made investments in 15 countries to address the multiple vulnerabilities of girls, including in social protection schemes aimed at keeping them in secondary school, reducing gender-based violence and providing a combination of prevention interventions, including pre-exposure prophylaxis (PrEP) to reduce their risk of HIV acquisition. The Three Frees Framework applies a life-cycle approach to (a) close the gaps in PMTCT efforts (Start Free); (b) reduce new infections in adolescents and young women (Stay Free); and (c) close paediatric HIV-treatment gaps (AIDS Free). UNICEF has partnered with PEPFAR to lead the Stay Free collaboration, building upon the DREAMS and All In initiatives, with the goal of reducing new infections in this population to fewer than 100,000 by 2020.

23. UNICEF is working through various platforms in support of the Stay Free goal including: (a) using PMTCT as an entry point to adequately address the HIV prevention and treatment needs of pregnant adolescents from both the provider and the client perspectives; (b) improving the transitioning of children in treatment to adult care; and (c) working with community networks to target adolescent girls, young women and out-of-school adolescents to create awareness and locate those who are most at-risk and vulnerable in order to link them to prevention services.

**Issue 2: Intensification of collaboration with communities to end AIDS by 2030**

24. There is a substantial body of literature on the positive impact of Government-supported, community-led peer interventions to address the HIV epidemic, but few country programmes have implemented such interventions at the national scale. As the Optimizing HIV Treatment Access initiative, funded by Sweden and the Norwegian Agency for International Development, draws to a close, UNICEF and national partners in the four implementing countries — Côte d’Ivoire, the Democratic Republic of the Congo, Malawi and Uganda — are documenting some of the key promising practices around community
engagement in order to create demand for HIV treatment and retaining pregnant and breastfeeding women living with HIV in care.

25. In low and concentrated HIV epidemic settings, UNICEF is also intensifying its work with community networks of people living with HIV (PLHIV) to improve and leverage their access to services. For example, in Bangladesh, UNICEF has been supporting the Government to initiate comprehensive PMTCT and ART services in four leading tertiary hospitals located in Dhaka, Sylhet, Chittagong and Khulna to improve access. To foster a continuum of care between community actors and the clinicians, UNICEF is also supporting networks of PLHIV community peer educators to provide mentorship and support. For adolescents, UNICEF is working through community service organizations to increase the participation of adolescent populations at increased risk of HIV infection.

26. Across regions, UNICEF is supporting various community initiatives to improve paediatric and adolescent HIV treatment uptake and retention. These include peer support, such as the Community Adolescent Treatment Supporters in Zimbabwe and teen clubs in Nigeria and Swaziland, as well as social media and mobile-based applications in several countries to provide information about HIV and service sites and to answer the questions of adolescents and young adults on various health and social issues.

27. As part of the broader aim of Goal Area 1 of the UNICEF Strategic Plan, 2018–2021 (Every child survives and thrives), UNICEF is working with ministries of health, specifically community-based health teams and community actors, to strengthen health and community systems in order to create child-friendly communities in West and Central Africa, using specific child indicators, including HIV, as proxies for success. As part of this initiative in Cameroon, the Central African Republic, the Democratic Republic of the Congo, Nigeria and Togo, a family-centred HIV testing model is being deployed to reach undiagnosed children and to extend support to families affected by HIV.

**Issue 3: Mitigation of the budgetary shortfall for the 2016–2021 Unified Budget, Results and Accountability Framework and joint resource mobilization for a fully funded framework**

28. The 2016–2021 UBRAF supports UNAIDS and joint work by the 11 co-sponsors in more than 100 countries with a biennial budget of $484 million for the period 2016–2017, which the PCB approved at its thirty-eighth meeting, in December 2015.

29. However, despite considerable effort over the past two years, the UNAIDS secretariat and co-sponsors have not been able to mobilize the full UBRAF budget, resulting in a 50-per-cent reduction in funding to each of the co-sponsors in 2016 and 2017. To mitigate the funding shortfall, UNICEF re-allocated some of its core funding to stabilize essential staff posts, reduced staffing levels and redefined its programme of support by applying a more differentiated approach that takes into account both the HIV-epidemic context and the strength of the country response. UNICEF is also working to further integrate and mainstream the HIV response across other sectoral responses and mandates, while ensuring accountability to results.

30. Given the financial challenges, the PCB, at its thirty-ninth meeting, in December 2016, approved a review of the operating model of UNAIDS to ensure that it was fit for purpose in the era of the Sustainable Development Goals. The Global Review Panel acknowledged that the programme remained an indispensable actor in the AIDS arena. The panel also endorsed the UNAIDS agenda to fast-track global action to end AIDS by 2020 and validated the joint programme as a unique model for the effective leveraging of the competencies of each co-sponsor agency and other key partners to achieve results.

31. The budget for the period 2018–2019 and the revised resource allocation model were approved by the PCB at its fortieth meeting, with $140 million allocated annually to UNAIDS
for headquarters and country programmes; $2 million allocated annually to each of the co-
sponsors (or $22 million in total for 11 co-sponsors) and $22 million allocated as country-
level resource envelopes to leverage joint action by co-sponsors in the 33 fast-track countries
and in support of populations at greatest need in non-fast-track countries. UNICEF and the
other co-sponsors engaged in discussions with UNAIDS on developing appropriate guidance
for the country envelopes and the development of a joint resource mobilization plan for a
fully funded UBRAF.

32. The current central UBRAF allocation to UNICEF is 84 per cent lower than in the
2014–2015 UBRAF biennium and 67 per cent lower than in the 2016–2017 biennium. With
the continued reductions in UBRAF funding, UNICEF regional offices have reduced staffing
levels for HIV work and have integrated some of the functions into other sectors, such as
child protection, health and education. UNICEF headquarters has cut its staff for HIV work
by half. To maintain critical functions, the organization has transferred some of the funds
intended for staff salaries to the UNICEF core budget. UNICEF has also embarked on a
fundraising drive (in line with the joint resource mobilization plan) based on a fundraising
strategy developed in 2016 and the outcome of a partnership forum convened in New York
in May 2017. The fundraising drive is intended to raise sufficient catalytic funding for priority
countries to support key work to end AIDS in children.

33. Regional offices are engaging with other United Nations agencies in joint
programming. For example, in 2017, the UNICEF regional office in Eastern and Southern
Africa, along with UNFPA, UNAIDS and WHO, mobilized funds from Sweden to implement
a four-year project (2018–2021) to scale up services for integrated sexual and reproductive
health; HIV; and gender-based violence in Lesotho, Malawi, Uganda, Zambia and
Zimbabwe. The focus of UNICEF in this project will be PMTCT and adolescent HIV. The
joint project will have a regional component focused on leveraging lessons learned and
progress made to benefit other high-burden countries in Eastern and Southern Africa.

34. UNICEF supported the UNAIDS secretariat together with other co-sponsors to draft
the narrative for the Performance Monitoring Report to ensure that technical assistance as
well as core and non-core contributions of the regional and country offices were well
captured.
Annex

Additional information on UNICEF HIV programming in the period 2016–2017 across the two decades of childhood

Status of the epidemic in children and adolescents

1. For the UNICEF HIV programme of support, ending AIDS in children means significantly reducing new infections in children, adolescents and young women as well as HIV-related mortality in children, adolescents and their mothers, as set out in the fast-track UNAIDS Strategy 2016–2021 and the 2016 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).

Reduction in new infections in children and adolescents

2. Considerable progress has been made in reducing new HIV infections in children globally, from 429,000 in 2005 to 160,000 in 2016 (a decline of 62 per cent). This has come about as a result of countries aggressively scaling up the provision of effective antiretroviral (ARV) medicines to pregnant women living with HIV (figure 1), which stops them from transmitting the infection to their children. The quality of programming has also improved as all countries transition their prevention of mother-to-child transmission of HIV (PMTCT) guidance to the World Health Organization “treat all” recommendations for pregnant women living with HIV, both for PMTCT and to improve the health of mothers.

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 (0–14 years), global, 2000–2016

3. Much of the decline in new infections among children occurred between 2010 and 2016 (47 per cent) owing to the commitment of most high-HIV-burden countries to the Global Plan Towards the Elimination of New HIV Infections among Children by 2015 and Keeping Their Mothers Alive: 2011-2015 and the coordinated country support provided by UNICEF and partners in response.

4. Despite this progress, the updated gap analysis on paediatric prevention, treatment, care and support showed that the epidemic in children is far from over. National commitments vary and there are stark regional differences in the rate of reduction of new infections in children (figure 2), ranging from 56 per cent in Eastern and Southern Africa to 3 per cent in the Middle East and North Africa. UNICEF will continue to support country efforts to address country disparities.

Figure 2
**Percentage reduction in the estimated number of new HIV infections among children (0–14 years), by region, 2010–2016**

![Diagram showing percentage reduction in HIV infections among children by region]


5. Compared with the steep decline in new HIV infections among children, there has been much slower progress globally for adolescents and adults. Acknowledging this gap at its thirty-ninth meeting in December 2016, the Joint United Nations Programme on HIV/AIDS (UNAIDS) Programme Coordinating Board called for the establishment of a global HIV prevention coalition to fast-track the reduction of new infections by 75 per cent by 2020 compared with 2010 levels.

6. The Global Prevention 2020 Coalition, launched in October 2017, is applying the lessons learned from the Global Plan to galvanize the necessary high-level commitment and technical support.

7. In 2016, there were 1.7 million new HIV infections among adults aged 15 years and older, a decline of only 10 per cent since 2010 (figure 3), and 260,000 among adolescents aged 15 to 19 years, 14 per cent less than in 2010 (figure 4). Most of the new infections (67 per cent) in the adolescent population were in girls.

8. In all regions, men who have sex with men, transgender people, people who sell sex and people who inject drugs are disproportionately at higher risk for HIV infection. Forty-five per cent of new HIV infections in 2016 globally were in these key populations and their
partners. Reaching these vulnerable and socially excluded populations are key to halting the spread of the HIV epidemic.

Figure 3
New HIV infections among adults (15 years and older), global, 2010–2016 and 2020 target trajectory


Figure 4
Estimated number of new HIV infections among children (0–14 years), adolescents (15–19 years) and young people (20–24 years), global, 2000–2016

Source: UNAIDS 2017 estimates.
Access to antiretroviral treatment and HIV-related mortality

9. Although treatment access has been increasing among children with HIV (figure 5), in 2016, only 43 per cent of children (0–14 years) received antiretroviral treatment (ART) compared with 54 per cent of adults aged 15 years and older (figure 6). Without treatment, 30 per cent of children with HIV will die by the age of 1 year, 50 per cent by the age of 2 years and 80 per cent by the age of 5 years. Figure 5 also shows the declining trend in HIV-related mortality compared with new infections. In 2016, 120,000 children died of HIV-related causes.

Figure 5
Trends in coverage of antiretroviral treatment, number of new infections and number of AIDS-related deaths among children (0–14 years), global, 2010–2016

Figure 6
Percentage of adults (15 years and older) and children (0–14 years) living with HIV receiving antiretroviral therapy, global, 2000-2016


10. Data from 41 countries that reported age-disaggregated data in 2016 show that coverage of ART is lower for adolescents aged 10 to 19 years (36 per cent) (figure 7) than for children and adults (figure 6) and HIV continues to be a leading cause of death among adolescents aged 10 to 14 years globally and the leading cause of death in adolescents in sub-Saharan Africa.  

1, 2 Two thirds of all AIDS-related deaths among adolescents in 2016 occurred in nine countries in sub-Saharan Africa. 3

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2 World Health Organization, “Health for the world’s adolescents: a second chance in the second decade”, May 2014.

3 Ethiopia, Kenya, Malawi, Mozambique, Nigeria, South Africa, United Republic of Tanzania, Uganda and Zambia. Source: UNAIDS estimates.
Figure 7
Percentage of adolescents (10–19 years) living with HIV receiving antiretroviral therapy, 41 countries reporting, by UNICEF region, 2016

Median = 36%


New opportunities

11. Since 2015, global efforts have shifted to supporting data-driven differentiated responses in countries in order to super-fast-track ending AIDS in children by 2020. UNICEF is maximizing interventions within the agreed United Nations Three Frees Framework and targets to close the gaps in the HIV response in countries and specific geographical areas and population groups. The three pillars of the framework are:

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

(b) Prevent new HIV infections in adolescent girls and young women (Stay Free);

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

The results framework in the UNICEF Strategic Plan, 2018-2021 is aligned with the Three Frees targets.

12. Building upon the evidence of the social protection impact on HIV vulnerability of (a) cash transfers and (b) keeping girls in school and the growing community responses to address early marriage and gender-based violence, UNICEF is expanding opportunities for integrated programming that addresses multiple vulnerabilities and empowers vulnerable populations, including adolescent girls and young women.
Programmatic results and remaining challenges

13. The scale-up of PMTCT service coverage globally is one of the greatest public health achievements of the past decade. In 2016, 76 per cent of pregnant women received effective PMTCT ART. Most of this progress was in Eastern and Southern Africa (88 per cent), followed by Latin America and Caribbean (75 per cent) and East Asia and the Pacific (54 per cent). Figure 8 shows the progress in high-burden countries. In 2016, over 90 per cent of pregnant women living with HIV were receiving effective PMTCT ART in Botswana, Namibia, South Africa, Swaziland, Uganda and Zimbabwe and between 80 per cent and 90 per cent in Kenya, Malawi, Rwanda, United Republic of Tanzania and Zambia. Of concern are Angola, Indonesia and Nigeria, where coverage ranged from 14 per cent to 44 per cent.

Figure 8
Percentage of pregnant women living with HIV receiving the most effective antiretroviral treatment for the prevention of mother-to-child transmission of HIV, 23 countries with over 10,000 pregnant women living with HIV, 2016


14. UNICEF has continued to provide technical assistance to country programmes on new ways to reach more pregnant women living with HIV and to enhance their retention in care. Supported by Norway and Sweden, UNICEF has continued to assist community peer counsellors and support groups of women living with HIV to strengthen community facility linkages in order to improve access to PMTCT services and retention in care in Côte d’Ivoire, the Democratic Republic of the Congo, Malawi and Uganda. The results indicate increased service uptake and retention in care. Uganda is using village health committees to sustain the response. Those results are being documented to foster the wider dissemination and adoption of the approach.

15. The lessons learned in the four countries will be shared at a regional conference convened by the International Community of Women Living with HIV, in Cameroon, in November 2017; at the International Conference on AIDS and Sexually Transmitted Diseases, in Côte d’Ivoire, to be held in in December 2017; and at the Paediatric-Adolescent Treatment Africa Continental Summit, to be held in October 2017.

16. In some countries with low coverage of treatment and poor retention in care, challenges include a reluctance by national Governments to decentralize service delivery and allow trained lower-level cadres to deliver services through task shifting; a poor supply chain; poor
data systems for monitoring performance; and inadequate support to women. In Nigeria, following a successful UNICEF pilot programme to integrate the HIV testing of pregnant women during Child Health Week campaigns, the Government recently adopted the approach in several local government administrative areas, with the aim of increasing the number of pregnant women tested for HIV. In Ukraine, with emergency funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria, UNICEF has provided procurement services to maintain the sustained delivery of ART to people living with HIV, including pregnant women and children in restricted areas. In South Africa, UNICEF is supporting the national Government to introduce the digital platform RapidPro, which will deliver real-time information to mothers to connect them to maternal and child health and HIV services, and district data dashboards to monitor performance for the better allocation of resources to meet remaining gaps. In Guatemala, UNICEF is collaborating with the Pan American Health Organization and the Government to introduce community testing by local midwives for HIV, syphilis and hepatitis B among pregnant women in indigenous and rural populations.

17. In 2016, 2,100,000 children were living with HIV globally, and only 43 per cent of them had access to ART compared with 54 per cent of adults (figure 6). A key factor for the slower progress among children is poor access to the HIV testing of infants and inadequate systems for sample transportation and results return, as infant testing requires sophisticated laboratories with skilled staff. UNICEF and partners continue to introduce innovations aimed at improving these systems, including the introduction of drones in Malawi for sample transportation and text-messaging platforms for the timely transmission of results to facilities.

18. Since 2012, funding from UNITAID, UNICEF and the Clinton Health Access Initiative has been supporting the introduction of point-of-care HIV diagnostics, including infant diagnosis in seven countries (Ethiopia, Kenya, Malawi, Mozambique, the United Republic of Tanzania, Uganda and Zimbabwe). Results from these countries demonstrate the feasibility of integrating point-of-care diagnostics to achieve a same-day turnaround time for test results in order to increase the initiation of treatment in infants. With additional funding from UNITAID, the project is being rolled out to three additional countries in West and Central Africa (Cameroon, the Democratic Republic of the Congo and Senegal). It is likely to be a game-changer in improving access to both ART for children and infant testing in child health and community systems.

19. With the success of PMTCT services and the diminishing numbers of new infections in children, HIV service providers for children must adapt their testing approaches to include the integration of HIV testing through entry points with a high potential to identify infected children. In Cameroon, Chad, the Democratic Republic of the Congo, Gabon, Ghana, Liberia and Nigeria, UNICEF is introducing a family-centred approach to identifying undiagnosed children through an index parent or another child in the family living with HIV. The challenge is to make sure that mechanisms are in place to effectively link to ART the children identified through the expanded entry points, when such treatment may be available at only a few sites. In Eastern Europe and Central Asia, the integration agenda includes, in addition to HIV services, managing the impact of drug addiction on broader child health.

20. 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 organizations (CSOs), 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 (a) a 65-per-cent reduction in AIDS-related mortality; (b) a 75-per-cent reduction in new infections among adolescents; and (c) the elimination of stigma and discrimination.

21. Current efforts are far from adequate. For example, the analysis of ART data disaggregated by age from 41 countries in 2016 shows that, with a median of 36 per cent of adolescents aged 10 to 19 years receiving ART, access to treatment for that age group is lower than for adults (54 per cent) and for children aged 0 to 14 years (43 per cent) (see
figures 6 and 7). UNICEF is working to support countries to improve the availability of data disaggregated by age and strategies for safely transitioning children in treatment from pediatric to adult care.

22. UNICEF has been providing All In technical assistance to multiple countries across all regions to mobilize national partners to review the available data in order to identify data gaps and key implementation bottlenecks for high-impact HIV interventions for adolescents. These multisectoral analyses have now been supported in over 25 countries, which are using the data to sharpen their action plans through multisectoral efforts.

23. All In reviews show that the delivery of HIV ART to adolescents remains challenging, from locating those who are infected to the take-up of services to retention in care. Most services are provided either in child or adult service centres and are not tailored to the needs of adolescents. Some of the factors related to the poor access of adolescents to ART include inadequate health-care provider skills; restrictive age-of-consent laws for HIV testing; fear among adolescents due to high levels of stigma and discrimination surrounding HIV, including in health-care settings and schools; inadequate support to adolescents regarding treatment; and the limited sharing of information.

24. Almost 70 per cent of new infections in adolescents aged 15 to 19 years are in 10 countries (figure 9). UNICEF regional and country offices are prioritizing these countries for intensified UNICEF support, building upon the All In partner coalition.

Figure 9  
Proportion of new HIV infections among adolescents (15–19 years), global, 2016


25. UNICEF also recognizes that girls and young women continue to be disproportionately affected. PEPFAR and UNICEF are co-leading the Global UNAIDS Stay Free working group to accelerate prevention efforts. UNICEF has embarked upon a project to map key
investments targeting this group to inform advocacy for increased attention and the better allocation of resources, in addition to investments by PEPFAR and the Global Fund. The Global Fund has also increased its investments in 13 countries and UNICEF has partnered with the Global Fund to provide technical support to 7 of those.

26. In countries with low and concentrated HIV epidemics, in which the epidemic is driven by marginalized, stigmatized and excluded populations, UNICEF, along with other United Nations entities, including UNAIDS, the United Nations Development Programme, UNFPA, the United Nations Office on Drugs and Crime and UN-Women, as well as CSOs are working together to generate the necessary data and evidence to create a conducive policy environment for prevention and to address a range of factors that increase vulnerability and hinder access to services.