United Nations Children’s Fund
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Oral report background note

UNICEF follow-up to the recommendations and decisions of the forty-first and forty-second Joint United Nations Programme on HIV/AIDS Programme Coordinating Board meetings

I. Introduction

1. The present report presents an update of progress made on and UNICEF responses to the discussions and decisions of the forty-first and forty-second 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 12 to 14 December 2017 and from 26 to 28 June 2018.

2. The report highlights three PCB issues relevant to the work of UNICEF:

   (a) HIV prevention 2020: a global partnership for delivery;

   (b) Elimination of the stigma surrounding HIV and discrimination towards people living with HIV and members of other populations highly vulnerable to HIV (“key populations”) in the context of the UNAIDS fast-track initiative and its associated targets, including zero discrimination in health-care settings;

   (c) Implementation of the UNAIDS Joint Programme Action Plan.

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

* E/ICEF/2019/1.
II. Issue 1: HIV prevention 2020 – a global partnership for delivery

4. Under the UNAIDS Division of Labour, UNICEF is co-convener, together with the United Nations Educational, Scientific and Cultural Organization (UNESCO) and the United Nations Population Fund (UNFPA), of activities relating to HIV prevention among young people. In line with that mandate, the focus of UNICEF support to HIV prevention has been to advance targeted and tailored behavioural, structural and biomedical interventions, especially for adolescent and young key populations (AYKP) and adolescent girls and young women (AGYW), as set out within the UNAIDS HIV Prevention 2020 Road Map.

5. In much of the world, including many countries with a high HIV burden and heightened risks for acquiring HIV among young people, the scope and impact of prevention programming for adolescents continues to be constrained by siloed funding, vertical programmes poorly integrated into the key youth-serving platforms and inadequate collaboration across key partners and sectors, all of which lead to patchy and weak implementation. As a result, there has been limited success in taking consistent and evidence-based programmes to scale.

6. Working in close collaboration with UNFPA, the United Nations Development Programme (UNDP), UNESCO and UNAIDS, UNICEF is leading work to identify and deploy key strategic actions to overcome the unique challenges and barriers that pertain to youth. A successful effort will include the creative leveraging of new media, digital programming and total market approaches to reach vulnerable, underserved, and hidden youth.

7. The momentum to accelerate action for adolescent and youth prevention is growing, with notable investments – by the United States President’s Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), specifically – for AGYW in the highest-burden settings. The UNICEF response supports those efforts, but goes beyond to focus on advocacy, analysis and technical assistance to strengthen and bring to scale the prevention response for key segments of the adolescent and youth demographic in danger of being left behind. These include adolescent key populations, AGYW who are pregnant or young mothers and AGYW in targeted low-burden settings who nevertheless have a high risk of acquiring HIV.

8. Through its joint collaborative response centres, UNICEF has identified programmatic and operational tools and guidance that can be adapted by national programmes and implementing partners to take to scale validated best practices of combination prevention interventions that address multiple vulnerabilities of AGYW and AYKP. (Combination prevention refers to layering biomedical, behavioural and structural interventions, such as improving access to antiretroviral medicines as pre-exposure prophylaxis; addressing social norms and gender-based violence; and empowering and keeping girls safe by keeping them in school.) These tools and guidance target national authorities and their subnational counterparts as the primary audience, and are aimed at providing a spectrum of instruments across the entire programming cycle. They are intended to enhance planning, design, analysis, implementation, oversight and resourcing of contextually appropriate, cutting-edge prevention programmes that make the most sense for the lives and realities of young people. Some key efforts are summarized below.

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1 “New media” refers here to computer-related media.
A. In 2018, UNICEF worked to develop enhanced protocols and analytics to improve size estimations and target-setting for key adolescent populations and ensure the incorporation of these analyses into national plans

9. HIV national strategic plans are essential for formulating a country’s national response to HIV/AIDS and directing funding and human and other resources. However, in most cases, little or no information on AYKP aged 15 to 24 years is available on which to base the plans. Yet, this is the group at the greatest risk of HIV infection in all contexts. (For the purposes of the present report, key populations include adolescent boys and young men who have sex with men, transgender adolescents, adolescents exploited through sex work and adolescents who inject drugs.)

10. UNICEF has supported the extraction of available population size and HIV-related data for this AYKP population, disaggregated into two age bands, 15 to 19 years and 20 to 24 years. This work has resulted in the collection of data on age at initiation of risk behaviours and HIV prevalence and other key HIV-related indicators. In addition, population size estimations have been collated for 25 countries prioritized by the UNICEF All In initiative to end the adolescent AIDS epidemic in Africa (Botswana, Cameroon, Côte d'Ivoire, the Democratic Republic of the Congo, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Swaziland, Uganda, the United Republic of Tanzania, Zambia and Zimbabwe); Latin America and Caribbean (Brazil and Haiti); Asia (India, Indonesia and Thailand); the Middle East (the Islamic Republic of Iran); and Eastern Europe (Ukraine). These 25 countries collectively account for an estimated 86 per cent of all new HIV infections in adolescents. These analyses were extended to eight additional countries (Angola, China, Djibouti, the Dominican Republic, Ghana, Myanmar, the Philippines and Viet Nam) to sharpen and refine the adolescent components of their national strategic plans for HIV.

11. In Pakistan, where the HIV epidemic among adolescents and young adults is concentrated among key populations, UNICEF supported the Ministry of Health to conduct secondary analyses of data from the most recent integrated HIV biobehavioural survey to generate estimates for the 15-to-24-year age group. The findings, conclusions and recommendations were disseminated among decision makers from Government along with those in academia, the Joint United Nations Team on AIDS, civil society organizations and key population networks. This critical data-improvement effort has provided an evidence base for advocacy and expanded opportunities to refine adolescent-focused prevention and treatment programming in Pakistan.

B. UNICEF has provided technical support to enhance the impact, alignment and sustainability of key investments in high-impact HIV prevention interventions for adolescent girls and young women and their sexual partners

12. UNICEF, together with WHO, is providing technical assistance and support for the implementation of the Global Fund’s catalytic investment, a 13-country targeted financing initiative intended to catalyse and institutionalize HIV prevention efforts among AGYW.

13. In Eastern and Southern Africa, UNICEF supports national authorities, subnational authorities and communities in Botswana, Cameroon, the Democratic
Republic of the Congo, Eswatini, Lesotho, Namibia, the United Republic of Tanzania and Zimbabwe. The focus of this work is to refine girl-centred HIV prevention programmes that combine biomedical and support interventions and commodities in response to the multiple dimensions of risk and vulnerability experienced by girls and young women aged 10 to 24 years and prevent HIV. The main objectives are to support ambitious prevention targets and packages; strengthen national coordination structures to ensure harmonized implementation across global and local stakeholders; fill capacity-building gaps; and develop strategic and behavioural change communication strategies that leverage the power of new media.

14. In Nigeria, UNICEF is collaborating with other UNAIDS co-sponsors (UNFPA and UNESCO) to provide technical support to the National Agency for the Control of AIDS, the Federal Ministry of Health and civil society groups for the design and roll-out of a national prevention multimedia campaign focused on adolescents and youth (15 to 24 years). The campaign is aimed at increasing comprehensive knowledge, demand, awareness and referrals for HIV testing, condom promotion and gender-based violence (GBV) services in four priority states.

C. UNICEF has been working since 2014 to expand and scale up HIV-sensitive social protection services for adolescents at risk of HIV within national social protection programmes, providing technical assistance to link at-risk adolescents in eligible households to social and health services

15. Specific approaches include promoting comprehensive information on health and HIV, supporting HIV and broader sexual and reproductive health (SRH) education and referrals, collaborating on efforts to provide educational assistance and financial literacy, identifying pathways to jobs and supporting improvements in and access to other protective social assets. Across these approaches, adolescent- and gender-sensitive case management has been a central coordinating principle. This work has entailed linking across various sectors, including health, social welfare, justice, child protection and social development to achieve layered interventions. Countries supported under this programme of work have included Kenya, Lesotho, Malawi, the United Republic of Tanzania, Zambia and Zimbabwe.

16. In the United Republic of Tanzania, UNICEF is providing technical support to the Tanzania Social Action Fund, the Tanzania Commission for AIDS and other partners to develop, implement and evaluate a specialized social protection and economic empowerment intervention as part of the national Productive Social Safety Net programme. The intervention is intended to reach more than 10,000 of the most vulnerable households in the country. UNICEF support also prioritizes improved access to HIV prevention and SRH, safe spaces and education services. As of this writing, the evaluation was still in progress, but the intervention has already leveraged an additional $16 million from the Global Fund to expand social protection programming nationally.

17. In Zimbabwe, UNICEF, in collaboration with the PEPFAR Zimbabwe DREAMS partnership, has worked closely with the Ministry of Public Service, Labour and Social Welfare in several areas of importance to HIV prevention and social protection among AGYW. Efforts within this partnership have focused on supporting enhanced case management for AGYW HIV prevention; strengthening community referral pathways and case coordination across education, health, justice, protection and welfare; improving targeting to enhance AGYW coverage of social protection mechanisms; and expanding opportunities for access to justice for survivors of GBV.
and violence against children. UNICEF, working with PEPFAR, has reached more than 20,000 AGYW through the integrated national case management system and the Harmonized Social Cash Transfer programme in six districts with a high HIV burden in Zimbabwe (i.e., Chipinge, Mutare, Makoni, Mazowe, Gweru and Bulawayo).

D. UNICEF has provided cutting-edge programmatic interventions to improve prevention services for adolescents and young key populations

18. In China, as part of the All In initiative, UNICEF is supporting the Chinese Association of Sexually Transmitted Disease/AIDS Prevention and Control, the Guangzhou Centre for Disease Control and Prevention and Super Young, a community-based network for adolescents, to pilot a novel “online to offline” model to close the “last mile” in providing adolescent and youth HIV and sexual health services for men who have sex with men. The model’s components include mobilization activities, peer-based approaches, venue-based HIV testing and self-testing, service referrals and interventions to ensure an enabling environment. The model has been included in the Adolescent-Friendly HIV Service Manual, which was jointly developed by UNICEF and government partners for training community-based organizations and local health providers, most recently at the 2018 National AIDS Conference. Since its development, the model has been scaled up within Guangdong Province and is currently being rolled out in other provinces, including Sichuan, the province with the highest number of reported HIV cases.

E. UNICEF has engaged in pioneering work to link HIV and sexual and reproductive health programmes to improve HIV prevention and treatment outcomes for adolescent girls and young women

19. UNICEF leads the adolescent component of a Swedish-funded joint United Nations programme (a new collaboration involving UNFPA, UNAIDS, UNICEF and the World Health Organization (WHO) to reduce unintended pregnancies, sexually transmitted infections (STIs), new HIV infections, maternal mortality, sexual violence and GBV across Eastern and Southern Africa. The work commenced in the third quarter of 2018, and although it is too soon to demonstrate a concrete impact, it has already driven innovative ways of working across the four United Nations agencies in support of a single multi-country programme. UNICEF support within this programme focuses on the Governments of Lesotho, Malawi, Uganda, Zambia and Zimbabwe to scale up and deliver quality HIV/SRH services for AGYW living with HIV and underserved and at-risk adolescents. UNICEF engagement in the programmes includes work aimed at improving the suboptimal uptake of treatment and prevention services, including by addressing barriers and access to information and post-GBV services.

III. Issue 2: Elimination of the stigma around and discrimination towards people living with HIV and key populations in the context of fast-tracking the HIV response and zero discrimination in health-care settings

20. UNICEF supports efforts to reduce HIV-related stigma and discrimination in health-care settings as a part of its mandate to improve equitable access to and the utilization of basic services by mothers, children and adolescents. UNICEF leverages opportunities to work at various levels, from national to local communities, to offer
and implement multiple interventions that target both policy makers and front-line workers. The main priorities of these interventions include improving the knowledge, attitudes and practices of providers at all levels of service delivery; driving change through the leadership of people living with HIV by using technology-supported communication platforms to amplify their voices; creating demand for discrimination-free services; and supporting change towards enabling policies and legal environments and their institutionalization. Some key efforts are summarized below:

A. **UNICEF has fostered community engagement in service delivery, with the primary goal of enhancing the quality of care and promoting engagement in care**

21. In 2017, UNICEF concluded the Optimizing HIV Treatment Access (OHTA) for Pregnant and Breastfeeding Women initiative, a multiyear project to identify strategies to increase the uptake of services and retention in care for pregnant women living with HIV in four countries in sub-Saharan Africa (Côte d’Ivoire, the Democratic Republic of the Congo, Malawi and Zimbabwe). A key focus within this work was to strengthen community-facility linkages by deploying women with HIV, who had been through prevention of mother-to-child transmission (PMTCT) programmes, to serve as mentors to newly diagnosed mothers. As a result, women with HIV became embedded in the workforce as valued colleagues and professionals, and anecdotal evidence suggests that this contributed to reducing HIV-related stigma in the facilities in which the mentor mothers worked as well as self-stigma among new clients. In addition, by presenting themselves as role models to clients, mentor mothers encouraged other women to themselves become agents of change.

22. In China, UNICEF has worked in the coastal city of Nanjing to support a scalable and sustainable model of adolescent engagement to promote stigma-free access to services. Nanjing has seen a huge surge in new HIV infections, including among adolescents and young people, especially students. Over 800 new infections in Nanjing were reported in 2015, the majority of them (over 90 per cent) among men who have sex with men; this number has increased more than ten-fold in the past 10 years. Under the All In platform, UNICEF supported several youth-led innovations to promote greater access among AYKP to high-quality HIV/SRH services. One of these – a mobile app titled “Secret Client” – targets AYKP and is aimed at destigmatizing HIV testing, promoting greater service uptake among youth, and addressing barriers for youth to using existing HIV services. Surveys are administered through the app to record the “youth-friendliness” of testing services.

B. **UNICEF has worked to integrate sensitization on stigma reduction for health-care providers through broader capacity development initiatives for reproductive, maternal, newborn, child and adolescent health services, including antenatal and obstetric care and child and adolescent health clinics**

23. In Pakistan, UNICEF is supporting the Government in efforts to reduce discrimination in health-care settings through capacity-building and sensitization for health care providers. Stigma reduction is incorporated into guidelines on HIV treatment, PMTCT and paediatric care and all trainings provided to health workers in reproductive, maternal, newborn, child and adolescent health (RMNCAH) settings. A separate session on stigma and discrimination and their implications for the HIV response is part of the training package.
C. The unique U-Report platform of UNICEF has helped to document stigma in communities and empower women, children and adolescents living with HIV, including young key populations, by amplifying their voices to the global stage

24. On World AIDS Day 2017, the PACT and Youth Voices Count (YVC), two networks serving young people, reached out to them to better understand what they knew and thought about HIV and SRH services in their communities. The PACT and YVC partnered with UNICEF to launch a U-Report poll, and as a follow-up, YVC conducted an in-depth online survey. The survey reached 270,000 adolescents and young people between the ages of 10 and 24 years in 21 countries, with all respondents asked to comment on the availability, accessibility, acceptability and quality of youth-friendly HIV and SRH services, including if they were offered stigma-free. The findings highlighted pervasive stigma in health facilities and throughout communities in general. The results of the poll are being used by youth groups at various levels for advocacy and action.

D. UNICEF has leveraged global partnerships to support countries to deliver stigma-free HIV programmes at scale for adolescents and young people

25. The All In initiative includes zero stigma and discrimination as a key priority in the context of improving HIV responses among AYKP and AGYW at risk of HIV and adolescents living with HIV. In country, within the collaborative framework, All In partners have undertaken a range of prevention and treatment activities informed by adolescents themselves to overcome stigma and discrimination to improve adolescent access to services.

26. In line with the current UNAIDS division of labour, UNICEF together with UNFPA, UNDP, UNESCO and other UNAIDS co-sponsors, and in partnership with networks of key populations and other stakeholders, is developing a four-part toolkit to support the implementation of prevention and treatment programmes for adolescents, including AGYW, members of key populations and pregnant adolescents. All the modules of this toolkit contain tools that specifically promote stigma-free youth-friendly services and the engagement of adolescents and youth to monitor the quality of care.

E. UNICEF engages in advocacy to promote an enabling policy and legal environment, reduce stigma and improve access, with a focus on age-of-consent laws and policies relating to adolescent reproductive and sexual health services

27. UNICEF and UNDP supported a systematic review of age of consent laws and policies in the period 2016–2017 as part of the All In initiative. That review recommended that at a minimum, countries should (a) specifically provide for age-of-consent laws that are non-contradictory and reflect the evolving capacity, age and maturity of the adolescent; (b) ensure that the age of consent applies to all adolescents, irrespective of sex, gender, sexual orientation or gender identity; and (c) consider providing for an adolescent who has not reached the age set by law to give consent on the basis of an assessment of factors, such as the evolving capacity, age and maturity of the adolescent, the risk of HIV infection and the independence from or absence of parental or alternative care.
28. Building upon this body of work, UNICEF is advancing a United Nations-wide collective effort to develop a unified position and standard public and policy advocacy messages to mount a multi-country advocacy initiative to address age of consent inconsistencies and barriers. This work has also extended to country-level efforts. In the Philippines, UNICEF has worked to integrate adolescent and reproductive health services with HIV prevention. In close partnership with government agencies and other development partners, UNICEF is supporting the development of a national policy on proxy consent and case management for minors living with HIV. This builds upon learning from the Proxy Consent Pilot Project, a six-city initiative to sensitize providers on the concept of proxy consent for minors by using practical trainings and implementation tools.

IV. Issue 3: Implementation of the UNAIDS Joint Programme Action Plan

29. The UNAIDS 2018–2019 budget and revised resource allocation model, approved at the fortieth PCB meeting, included significant reductions to central co-sponsor allocations and the introduction of country resource envelopes. Under the new allocation model, out of the $184 million raised for the 2018 Unified Budget, Results and Accountability Framework, $140 million was allocated to the UNAIDS secretariat, $2 million to each of the 11 co-sponsors and $22 million to the country-level resource envelopes for 33 fast-track countries and in support of populations most vulnerable to HIV in 28 non-fast-track countries.

30. To generate additional resources above those allocations, co-sponsors are working with UNAIDS on additional joint resource mobilization activities. One such initiative is the Joint Programme investment book of joint proposals to address critical programming gaps that are currently underfunded. UNICEF, to close the paediatric and adolescent treatment gap, has included a proposal developed with WHO on strengthening systems and services to inform ongoing discussions with national Governments, the Global Fund, donors, including foundations, high-net-worth individuals and the corporate and public sectors.

31. A fundraising strategy is in place focused on bringing innovations to scale and programme approaches that address critical gaps at the country level.

32. The country envelope is a new UNAIDS Joint Programme Action Plan funding mechanism. Of the total country envelope funding of $22 million allocated from the annual budget of the Joint Programme, UNICEF country offices leveraged and received $4,924,100 in 2018, an amount equal to 22.4 per cent of the total annual country envelope budget. Decision-making around resource allocation for the country envelope is decentralized to the country level on the basis of parameters established by the UNAIDS secretariat, with guidance from regions and countries.

33. However, despite this reality at the country level, a PCB mission to South Africa in October 2018 raised concerns about how resources are being allocated. In some cases, the different United Nations agencies are advocating for their own allocations, and funds are simply divided up across agencies and not by priority area. The opinion of the PCB was that, so far, the country envelope process has raised more concerns than achieved strategic outcomes.

34. The UNAIDS Division of Labour has been updated. UNICEF now co-convenes two strategic result areas (SRAs): SRA 2 (the elimination of mother-to-child transmission of HIV (EMTCT) and keeping mothers, children and adolescents alive), with WHO, and SRA 3 (HIV prevention among young people), with UNESCO and
UNICEF/UNFPA. The three agencies charged with the co-leadership of SRA 3 will work together on advancing knowledge management, joint advocacy and communications, data management and coordinated country technical support.

V. Activities in support of the two strategic result areas for which UNICEF is accountable: (a) the elimination of mother-to-child transmission of HIV and keeping mothers, children and adolescents alive and (b) HIV prevention among young people

A. Paediatric treatment and early infant diagnosis in West and Central Africa

35. Early infant diagnosis (EID) and paediatric treatment coverage in West and Central Africa are among the lowest globally, at 21 per cent for EID and 26 per cent for paediatric treatment coverage. Following the launch, in 2016, of the West and Central Africa Catch-up Plan, organized by UNAIDS, 18 countries embarked on intensified programming aimed at tripling the number of people on antiretroviral therapy (ART) by December 2018. A UNICEF review of these catch-up plans highlighted the absence of equally ambitious paediatric treatment goals. To address this gap, high-impact approaches for identifying children living with HIV, such as family HIV testing, are being introduced in Chad, Equatorial Guinea, Ghana and Mali, following joint United Nations country missions.

36. The integration of point-of-care (POC) machines in underserved facilities is one of the most promising solutions for improving access to paediatric treatment through the expansion of rapid early infant diagnosis (EID) testing services. POC EID allows for same-day test results to be returned to the caregiver and for infants found infected with HIV to be started promptly on ART. UNICEF and implementing partners (African Society for Laboratory Medicine, Clinton Health Access Initiative and Elizabeth Glaser Pediatric AIDS Foundation) have been working to introduce and scale up POC EID across 15 early adopter countries. In addition, Unitaid has committed over $150 million since 2015. Early pilots and implementation research have been shown to dramatically reduce turnaround times for test results to a median of zero days and significantly improve ART initiation rates. In Mozambique, for example, POC EID increased the proportion of infants initiating ART within two months by seven-fold. UNICEF is investing catalytic funding from its Innovations-for-scale budget 2018–2019 to leverage additional partners and co-financing for the introduction and expansion of POC EID of HIV in West and Central Africa.

B. Achieving the “last mile” for the elimination of mother-to-child transmission

37. Significant progress continues to be made in PMTCT globally, with Malaysia most recently receiving validation for EMTCT of HIV and syphilis. However, despite this progress, achieving EMTCT remains elusive in many high-burden countries. The aggregate coverage gap of 20 per cent masks large regional disparities and programming issues between and within countries. This calls for programming adapted to a country’s HIV epidemic and response. To address this issue, UNICEF is leading a process with key partners to support countries to adopt differentiated approaches to programming based on the latest scientific research and programmatic evidence to close gaps to reach the finish line. A programming guide is in development, with completion expected in 2019. One such
initiative, in South Africa, mobilizes adolescents living with HIV, who have gone through the PMTCT programmes, to become mentors for their newly identified peers to improve their access and retention in antenatal care and PMTCT services.

C. **Population size estimations and HIV key indicator data among adolescent and young key populations**

38. HIV national strategic plans are essential for planning a country’s national response to HIV/AIDS and directing funding, resources and human capacity. However, these plans often exclude important information about adolescent (15 to 19 years) and young (20 to 24 years) key populations (AYKP) at higher risk of HIV infection. UNICEF supported the data extraction of available population size and HIV-related data for AYKP to identify gaps and to build knowledge and guide programme action.

D. **Analysis of epidemic projections**

39. UNICEF recently completed HIV epidemic projections through 2030 for children and adolescents. As the world’s population increases, and at the current pace of prevention, about 2 million more adolescents could become infected with HIV between 2018 and 2030. HIV incidence among adolescents compared with that of children has been decreasing more slowly or is even showing signs of increasing in some regions. New HIV infections among adolescents are also projected to decline at a far slower rate, by 23 per cent, compared with 45 percent among children, between 2018 and 2030. UNICEF announced the initial projections and findings of the analysis at the International AIDS Conference in Amsterdam in July 2018, and the complete analysis on World AIDS Day 2018, on 1 December 2018. The analysis bolsters the arguments of UNICEF and provides an evidence basis for its continuing advocacy about the urgent need for increased effort and investment in preventing HIV among adolescents.
Annex

State of the HIV epidemic in children and the UNICEF response in the period 2017–2018 across the two decades of childhood

I. Status of the epidemic in children and adolescents

1. The work of ending AIDS in children and adolescents remains the main focus of the UNICEF HIV programme and is aligned to the objectives of the Strategic Plan, 2018–2021, specifically to Goal Area 1: every child survives and thrives. The approach is centred around three programmatic interventions: (a) to ensure that children are protected from acquiring HIV through the effective prevention of mother-to-child transmission (PMTCT); (b) to ensure that children and adolescents living with HIV receive the treatment, care and support they need to remain HIV-free; and (c) to prevent new HIV infections in adolescents and young women, including among key populations. The fast-track UNAIDS Strategy 2016–2021, which was endorsed by the General Assembly during its 2016 High-Level Meeting on Ending AIDS, lays out the goals and targets for each of these three focus areas.

II. Reduction in new infections in children and adolescents

2. Despite the progress made in reducing the rates of mother-to-child transmission of HIV, updated modelling estimates by the Joint United Nations Programme on HIV/AIDS suggest that, in 2017, there were 180,000 new infections in children (0–14 years). Moreover, 89 per cent of those infections occurred in sub-Saharan Africa (see figure I).
Figure I
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), 2000–2017


3. Nearly all low- and middle-income countries have now adopted lifelong antiretroviral treatment (ART) for all pregnant and breastfeeding women. By 2017, owing to the scale-up of implementation over time, ART coverage had reached 80 per cent of this population. But ART coverage and its impact on preventing transmission to children is beginning to flatline. Results vary by country, but current global efforts are not on track to reach the targets of 95 per cent coverage of ART in pregnant women with HIV and less than 20,000 new infections in children by 2020.

4. In addition, not all regions are making the same progress (see figure II). In West and Central Africa, for example, ART coverage for pregnant women is below 50 per cent. UNICEF has targeted these and other priority regions for focused attention on strategies to increase HIV testing and ART coverage among pregnant and breastfeeding women.
Figure II

Percentage of pregnant women living with HIV receiving the most effective antiretroviral treatment for the prevention of mother-to-child transmission of HIV, by region and in the Start Free countries\(^a\), 2017

![Figure II](image-url)

Source: Global AIDS Monitoring 2018 and UNAIDS 2018 estimates.

\(^a\) Start Free is the first of three “frees” in the super-fast-track framework led by UNAIDS and the United States President’s Emergency Plan for AIDS Relief for ending AIDS among children, adolescents and young women by 2020. The framework includes targets for eliminating mother-to-child transmission of HIV (Start Free), reducing the number of new HIV infections (Stay Free) and providing antiretroviral treatment (ART) for children and adolescents (AIDS Free). Start Free priority countries are Angola, Botswana, Burundi, Cameroon, Chad, Côte d’Ivoire, the Democratic Republic of the Congo, Eswatini, Ethiopia, Ghana, India, Indonesia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, South Africa, Uganda, the United Republic of Tanzania, Zambia and Zimbabwe.

5. These regional differences in ART coverage translate into stark variations in the reduction of new infections. Globally, there was a 35 per cent decrease in new infections in children from 2010 to 2017, but in some parts of the world (e.g., the Middle East and North Africa), the number of new infections may be on the rise, although this estimate is based on small numbers and limited datasets (see figure III). A primary reason for this is poor coverage of testing in antenatal settings, while another is unchecked new infections among women of childbearing age.
6. While less than optimal, the decline in new HIV infections in children is still far greater than that seen in adults and adolescents. This so-called prevention gap has received global attention, in part spurred by the establishment of the Global HIV Prevention Coalition, launched by UNAIDS and the United Nations Population Fund (UNFPA) in October 2017. Within this coalition, UNICEF and PEPFAR are the lead technical partners for advancing prevention among adolescent girls and young women and are working with UNFPA and the United Nations Educational, Scientific and Cultural Organization for broader youth prevention, including among often marginalized key populations.

7. The Global HIV Prevention Coalition has adopted the UNAIDS super-fast-track targets outlined in the Three-Frees framework (in particular the targets for Stay Free). One of those targets calls for a more than 75 per cent reduction in new infections among adolescent girls and young women by 2020, which would correspond to 100,000 per year from a baseline of 440,000 per year in 2010. In 2017, there were 340,000 new HIV infections among adolescent girls and young women, a decline of only 22 per cent since 2010. The pace of prevention must increase significantly if that super-fast-track goal is to be met (see figure IV).

8. UNICEF believes in the fundamental right of all adolescents and young people to have access to HIV prevention services. In all regions of the world, key populations are at higher risk for HIV infection, and this is especially true for adolescent key populations. Data cited by UNAIDS suggest that, globally, 47 per cent of new HIV infections in 2017 occurred in adolescent key populations and their partners.\(^1\) Reaching these vulnerable and socially excluded adolescents is key to halting the spread of the HIV epidemic.

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III. HIV-related mortality and access to antiretroviral treatment

9. Treatment access for children (0–14 years) continues to make small incremental progress. In 2017, just over half (52 per cent) of all children in this age group living with HIV were accessing ART. By contrast, 59 per cent of adults with HIV were on treatment. In proportion to the numbers on treatment, this gap between adults and children is the widest it has been since 2010 (see figure V).
Figure V
Antiretroviral treatment coverage (percentage) of children (0–14 years) and adults aged 15 years and older, 2010–2017

Source: Global AIDS Monitoring 2018 and UNAIDS 2018 estimates.

10. For children, the consequences of such poor access to treatment are dire. HIV is an aggressive infection in children, especially when they are infected in late gestation and during labour and delivery. Without treatment, 30 per cent will die by the age of 1 year, 50 per cent by 2 years and 80 per cent by 5 years.

11. Fortunately, treatment greatly reduces mortality risk and there has been a steady decline in HIV-associated mortality in the era of ART roll-out (see figure VI).
Figure VI
Trends in coverage of antiretroviral treatment, number of new infections and number of AIDS-related deaths among children (0–14 years), global, 2000–2017

Source: Global AIDS Monitoring 2018 and UNAIDS 2018 estimates.

12. Information on adolescent ART access is scarce, but among countries that report on age-disaggregated adolescent data, the median coverage for ART is significantly lower than in adults. The situation is especially grave for adolescents aged 15–19 years. Adolescent boys, in particular, have very poor access to ART (see figure VII). As that figure also shows, estimates and trends in treatment coverage are somewhat better for adolescents aged 10–14 years, the majority of whom are vertically infected children who are identified and treated earlier in life. Overall, though, HIV continues to be a leading cause of death in adolescents in sub-Saharan Africa and these data highlight the need to increase access to testing and treatment services in this population.
Figure VII
Percentage of adolescents (10–19 years) living with HIV who are receiving antiretroviral treatment, 40 countries reporting, 2017


13. Under the All-In initiative, UNICEF has been providing technical assistance to countries across all regions to mobilize national partners to review their adolescent data to identify gaps in the response. These efforts have shown that new HIV infections among adolescents are an issue for all regions, and that sub-Saharan Africa accounts for almost 75 per cent of them (see figure VIII).
**Figure VIII**

Proportion of new HIV infections among adolescents (15–19 years), by UNICEF region

![Figure VIII](image)

Source: UNAIDS 2018 estimates.

**IV. UNICEF response to addressing ongoing challenges**

**A. Prevention of mother-to-child transmission of HIV**

14. The mismatch between the rapid rise in ART coverage for pregnant women with HIV and the relatively modest fall in the population-level mother-to-child transmission rate points to critical failings in the HIV response for pregnant and breastfeeding women, including high rates of loss to follow-up and undiagnosed incident infection. These gaps in comprehensive PMTCT services continue to drive new infections in children. Addressing these challenges will require new approaches and tools and highlights the need to think differently about what can and should be done to eliminate mother-to-child HIV transmission.

15. UNICEF is promoting a differentiated approach to PMTCT programming – one that takes a closer look at what is driving ongoing transmissions in specific national programmes and subnational regions. Together with the World Health Organization (WHO) and other key global partners, UNICEF is leading the work to systematize this differentiated approach by characterizing the epidemic in terms of coverage, geographical reach and quality of care, and modifying the programme response to fill specific gaps and address emerging needs. What is clear is that the high coverage of
ART services is necessary, but not sufficient; retention in care is also necessary. Those who start on treatment must stay on treatment, but too many drop out or are lost to follow-up, increasing their risk of transmitting HIV to their partners or babies. Unless more countries address the poor rates of retention in care and the acquisition of HIV during pregnancy and breastfeeding, insufficient progress will be made towards reaching global targets or indeed the goals of the UNICEF Strategic Plan.

16. Targeting the remaining countries and regions of the world in which there is low coverage as well as missed opportunities to identify pregnant women with HIV is an urgent priority. In West and Central Africa, for example, although HIV prevalence is relatively low, there are large gaps in coverage and public health systems, and services are weak. UNICEF supports Governments in utilizing a health-systems strengthening approach to create sustainable change in access to ART for pregnant women by integrating HIV services, including testing, prevention and treatment for women living with HIV, into routine antenatal care programming.

17. The UNICEF five-year Optimizing HIV Treatment Access for Pregnant Women (OHTA) initiative, which was supported by the Governments of Norway and Sweden, demonstrated that community engagement is critical to increase access to services. Linking PMTCT clients to trained mentor mothers who live in the same community has a significant impact on the likelihood of women presenting for and being retained in care. Building upon this learning, UNICEF will work in collaboration with key implementers (e.g., mothers2mothers), advocacy organizations (e.g., Organization of African First Ladies against HIV/AIDS) and national Governments to scale up community interventions, with a focus on expanding the number of paid and supervised peer supporters for women living with HIV.

B. Paediatric antiretroviral treatment

18. Treatment access for children has stagnated. Although increases in coverage continue, the increments are small. Only about half (52 per cent) of all children with HIV have access to treatment, and the situation is worse for adolescents. In part, this global stagnation reflects the fact that coverage varies widely in different regions of the world. West and Central Africa is especially poor in terms of paediatric access, with only 26 per cent of children living with HIV on ART. One of the key factors that contributes to this poor performance is the lack of access to diagnostic tools and services.

19. There is an urgent need to improve the testing capacity in the region. UNICEF is working together with WHO and UNAIDS to improve ART coverage by promoting the use of optimal antiretroviral formulations in all regions and by working to improve access to HIV testing for children, including through the rapid roll-out of point-of-care (POC) infant diagnosis. A major focus of this effort is West and Central Africa, where UNICEF is providing targeted technical support to Ministries of Health and partners in nine countries in the region to adopt innovative strategies to identify children living with HIV, including by using family-based testing approaches.

20. With the successful roll-out of high-impact PMTCT interventions, such as universal ART for all pregnant and breastfeeding women, the number of known HIV-exposed infants who acquire HIV has fallen significantly. Testing to identify children with HIV now needs to expand beyond PMTCT programmes to additional high-yield entry points. In several countries, including Cameroon, Chad, the Democratic Republic of the Congo, Gabon, Ghana, Liberia and Nigeria, UNICEF is introducing a family-centred testing approach that targets adults and children who are already enrolled in treatment programmes and offers testing to their family members,
especially children and adolescents whose status is unknown. Pilot studies have shown this approach to be a high-yield strategy, especially in West and Central Africa, where PMTCT services historically have been weak and where untested children of women with HIV are more likely to be infected. In the next year, these pilots will be taken to scale in West and Central Africa, with the goal of doubling the number of children on treatment in that region over the next two years.

21. Access to POC tools for early infant diagnosis (EID) should be increased. With the support of UNITAID and in partnership with the Clinton Health Access Initiative, UNICEF has been scaling up POC EID across both regions in sub-Saharan Africa. Now, with seed funding from the UNICEF Innovations-for-scale initiative, the work in West and Central Africa will be expanded to 10 additional countries in the region, using an integrated tuberculosis and HIV testing approach.

C. Adolescent prevention

22. In sub-Saharan Africa, adolescent girls and young women (AGYW) account for a large proportion of new HIV infections. In other parts of the world, adolescent key populations have a high risk of acquiring HIV, are typically underserved by health services and have poor access to prevention information. Even though there are established evidence-based strategies to stem these new infections, progress remains slow. UNICEF predicts that, as the population of young people increases, it will outstrip the slow decline in incidence and result in new increases in the annual number of new infections among adolescents.

23. At the country level, UNICEF is implementing a range of different programmes with similar aims. They include HIV-sensitive social protection and digital platforms for engaging young men who have sex with men to ensure that they receive access to HIV testing services and HIV prevention information.

24. UNICEF is developing a package of global guidance and tools to facilitate the scale-up of adolescent- and youth-centred HIV prevention programming. These tools will address all populations, including AGYW and youth key populations, and tackle the spectrum of programming needs, from size estimation and planning to implementation and monitoring.