In everything we do, the most disadvantaged children and the countries in greatest need have priority.

– adapted from the UNICEF Mission Statement
KEY POINTS

Millions of children and their families have benefited from the advances in the global AIDS response. Yet the evidence indicates that millions more continue to be left out because of economic, geographic and gender inequalities, as well as social exclusion. Key actions to decrease inequities while improving efficiency and effectiveness in programming for an ‘AIDS-free generation’ include:

- **Reach key affected populations with HIV testing and counselling—a first step to eliminating the vertical transmission of HIV and improving access to HIV prevention, treatment and care services.**
  - In 2010, only 35 per cent of pregnant women and 28 per cent of infants born to HIV-positive mothers in low- and middle-income countries had been tested for HIV.
  - Only 8 per cent of young women (aged 15-24) in developing countries who received an HIV test knew their results.
  - Despite rapid disease progression in infants and children, only 23 per cent of the 2.02 million children in need of antiretroviral therapy received it in 2010, compared with 51 per cent of adults.
  - In 2009, an estimated 5 million young people (aged 15-24) and 2 million adolescents (aged 10-19) were living with HIV.

- **Expand adolescent and young people’s access to high-impact, context specific HIV prevention interventions.**
  - High impact interventions include: AIDS treatment, including ‘treatment as prevention’; HIV testing as a gateway to treatment and prevention; comprehensive condom programming; male medical circumcision in generalized epidemics; and harm reduction services for young people who use drugs.
  - Young people accounted for 41 per cent of all new HIV infections among 15-49 year olds in 2009.
  - There is neither disaggregated treatment data for 15-24 year olds, nor sufficient HIV testing data on young men in developing countries. We must improve monitoring, especially at decentralised levels.

- **Mitigate the impact of HIV and AIDS on children and families, and end HIV-related stigma and discrimination.**
  - Between 2005 and 2009, across a global sampling of countries, only 11 per cent of households caring for orphans and vulnerable children received external support.
  - While poverty is not a determinant of HIV infection, HIV impacts the resilience of households to withstand system shocks (e.g. food, fuel and financial crises) and impacts HIV morbidity and mortality outcomes and potentially the vulnerability of children to HIV infection.
  - Nearly one-third of countries do not have laws to protect people living with HIV in health, education and employment services — including children and their family members.

- **Adopt innovative approaches that promote equity and accelerate progress towards an ‘AIDS-free generation’**
  - Optimize partnerships to accelerate implementation of innovations, focusing on high-impact, evidence-based prevention and treatment interventions, and improving the resilience of households affected by AIDS.
  - Use innovations to direct resources to key affected populations, including the most marginalized and under-served.
  - Apply ‘what we know works’ by learning from operational and implementation research conducted by local level programmers and researchers.
The purpose of this brief is to provide a summary of the evidence at a global level of ‘who is missing out’ on programming to achieve an AIDS-free generation, and ‘which evidence-based interventions may be implemented with partners to improve both HIV and equity outcomes’. However, this is a global snapshot, and no one specific context will match the situation presented in this brief. An equitable children and AIDS response must be based on local data and experience to determine the most appropriate interventions.

Please note that the references have been removed to limit the number of pages. The full referenced document can be accessed at: http://www.unicef.org/aids/index_documents.html
Over the past decade, there have been important advances in the global fight against HIV and AIDS and in achieving the Millennium Development Goals (MDGs). The global AIDS response has become more equitable by placing children at the center of treatment, prevention, care and support policies and programs.

Since 2001, the number of new global HIV infections has fallen by 15 per cent, and since 2003, the number of people receiving treatment has increased 17-fold. Expanded access to treatment has contributed to an 18 per cent decline in deaths among people living with HIV between 2005 and 2010, an important outcome for children and families affected by the epidemic. Over the past five years, there have also been notable gains in the coverage and uptake of prevention of mother-to-child transmission (PMTCT) services, with a steady concomitant decline in the number of children who have contracted HIV through pregnancy, birth and breastfeeding. In 2010, 48 per cent of pregnant women with HIV in low and middle income countries received the most effective antiretroviral regimens (excluding single dose nevirapine) for PMTCT, as compared with 14 per cent (including single dose nevirapine) in 2005; and an estimated 390,000 children contracted HIV during the perinatal and breastfeeding period in 2010, down from a peak of 560,000 in 2002 and 2003. The decrease in HIV infection in children mirrors an increase in children on treatment, partially due to intensified HIV case finding. In 2005, only 71,500 children under the age of 15 received antiretroviral treatment, and by 2010, approximately 456,000 children (23 per cent of children in need) were receiving treatment. The number of young people living with HIV has remained relatively steady, with 5.2 million young people living with HIV in 2005, as compared with an estimated 5 million in 2010. Although the target set in 2001 of a 25 per cent global reduction in HIV prevalence among young people by 2010 was not
achieved, in 15 of the most severely affected countries, HIV prevalence has fallen by more than 25 per cent among young people.

Despite these gains, emerging evidence indicates that across the world’s developing countries, there are considerable and enduring disparities in children’s survival, development, and protection. National burdens of disease, undernutrition, ill health, illiteracy and many abuses are often concentrated in the most impoverished child populations (poorest economic quintile). Economically and socially excluded populations, including the disabled, ethnic minorities and refugees often have much lower coverage of services and interventions.

For example, an analysis of 26 developing countries found that in 18 countries experiencing a decline in under-five mortality of 10 per cent or more between 1990 and 2008, inequality in under-five mortality between the poorest 20 per cent and the richest 20 per cent of households either increased or stayed the same. In 10 of these 18 countries, inequality in under-five mortality increased by 10 per cent or more (see Figure 1).

Similarly, although children have benefited from advances in the global AIDS response, there are also millions of women, children, and young people who have been left behind due to inequities related to economic status, geographic location, gender, and social exclusion. For an ‘AIDS-free generation’ to be realized, a more targeted and strategic investment approach to the global HIV epidemic – one which prioritizes equity – is urgently needed. Across epidemic settings, this requires reaching key affected populations, including those least likely to access services, with high-impact, evidence-based prevention and treatment interventions for a more efficient and effective response.

Figure 1: In many countries, a reduction of under-five mortality has been accompanied by increasing inequality

Source: UNICEF. Progress for Children: Achieving the MDGs with Equity, Sep 2010.
Note: Data from Demographic and Health Surveys (DHS), various years
Eliminating New HIV Infections in Children and Keeping Families Healthy

In low and middle income countries, only one third of rural women receive four or more antenatal care visits, the entry point for PMTCT, compared with two-thirds of urban women.

In all regions, women from the richest 20 per cent of households are more likely than those from the poorest 20 per cent of households to deliver with the assistance of skilled health personnel.

For many rural and poor women, transportation remains an enduring barrier to accessing antenatal and delivery care, including PMTCT services.

In 2010, 18 per cent of HIV-positive pregnant women still received the least efficacious ARV regimen - single-dose nevirapine - to prevent vertical transmission.

Globally, only 23 per cent of children vs. 51 per cent of adults have access to treatment.

KEY DIMENSIONS OF INEQUITY

Barriers to Access, Coverage and Quality
Despite efforts to scale up pilot projects to national programs, comprehensive PMTCT services continue to be out of reach for many HIV-positive women. PMTCT services, particularly in rural areas and at the primary health care level, are often unavailable due to inadequate decentralization, limited financial resources, weak infrastructure, severe human resource constraints, and lack of provider capacity. Where services do exist, numerous barriers to accessing these services have been documented, such as lack of transportation or long travel times to district hospitals; financial barriers such as user fees for antenatal and delivery care services; cost of transportation; gender norms and HIV-related discrimination; and exposure to conflict.

Geography and Wealth
Globally, 22 countries account for an estimated 88 per cent of the 1.5 million pregnant women with HIV (see Box 1). The same countries are also home to approximately 90 per cent of children under 15 years of age in need of antiretroviral therapy.

Examination of antenatal care (ANC) coverage, skilled delivery support and the integration of PMTCT services within ANC show disparities in access by residence and household economic status in many high burden countries. Although globally 79 per cent of pregnant women have at least one antenatal care visit, a smaller proportion have at least four visits, as recommended by the World Health Organization (WHO). In low and middle income countries, only one third of rural women receive four or more antenatal care visits, compared with two-thirds of urban women.
**Skilled health attendant at birth:** Less than half of all births in South Asia and sub-Saharan Africa are attended by skilled health personnel. Poor and rural mothers are less likely to deliver with the assistance of a skilled health attendant. In all regions, women from the richest 20 per cent of households are more likely than those from the poorest 20 per cent of households to deliver with the assistance of skilled health personnel.

**HIV testing and counseling:** In 2010, only 35 per cent of pregnant women in low and middle income countries had been tested for HIV, and only 28 per cent of children born to HIV-positive mothers received an HIV test within the first two months of life. Although there has been significant scale up of PMTCT services across low- and middle-income countries since 2004, AIDS remains a leading cause of death among women of reproductive age globally and one of the main causes of maternal and under-five mortality in countries with high HIV prevalence. Undiagnosed HIV, as well as late diagnosis, are major contributing factors to AIDS-related morbidity, mortality and the continued incidence of HIV.

**Access to efficacious regimens for pregnant women with HIV:** In 2010, across 101 countries, 18 per cent of HIV-positive pregnant women received single-dose nevirapine (no longer recommended by the WHO), 57 per cent received the most effective regimens, and 23 per cent received antiretroviral therapy for their own health.

**Gender**

**Access of pregnant women with HIV to treatment for their own health** is much lower than global treatment access for other adults, despite the fact that a much higher proportion of pregnant women know their status globally than other adults in the general population. ARV therapy for the mothers’ own health promotes both maternal and child survival and reduces the likelihood of maternal orphanhood.

**Women’s uptake of services is affected by gendered inequalities and cultural norms** related to pregnancy, childbirth, and breastfeeding, as well as fears of community and partner rejection associated with an HIV positive diagnosis.

**Age**

**Globally, children have lower access to treatment than adults (23 per cent vs. 51 per cent).** Paediatric treatment access is higher than adult access in most regions of the world, but much worse in sub-Saharan Africa, resulting in the large gap in global access.

**Populations affected by Humanitarian Emergencies**

Preliminary estimates indicate that nearly half (48 per cent) of the HIV-positive pregnant women in 25 high burden mother-to-child transmission countries in 2009 were living in countries affected by humanitarian crises.

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**Box 1: 22 Priority countries for PMTCT**

22 countries account for nearly 90 per cent of the world’s pregnant women living with HIV


- Angola
- Botswana
- Burundi
- Cameroon
- Chad
- Cote d’Ivoire
- Democratic Republic of Congo
- Ethiopia
- Ghana
- India
- Kenya
- Lesotho
- Malawi
- Mozambique
- Namibia
- Nigeria
- South Africa
- Swaziland
- Uganda
- United Republic of Tanzania
- Zambia
- Zimbabwe
situations (conflict, post-conflict, cyclical crisis, etc.). Access and coverage of services for women in these settings remains a challenge.

**ACTIONS TO IMPROVE HIV AND EQUITY OUTCOMES**

*Focus on countries with the highest burden while ensuring PMTCT is part of national AIDS strategies in lower burden countries.* Achieving the elimination of new HIV infections in children with equity entails focusing on the 22 countries with 88 per cent of the world’s pregnant women living with HIV (see Box 1), while simultaneously providing support to countries with low prevalence and concentrated epidemics to reach women and children less likely to access PMTCT services due to geography, wealth and stigma and discrimination.

Expand access to HIV testing and counseling both within and outside of ANC services and diagnose pregnant women, infants, and children exposed to HIV as early as possible.

Early testing and diagnosis of HIV infection is integral to improving access to prevention services and treatment outcomes. Various studies indicate that provider-initiated testing and counselling in health facilities can result in significant improvements in testing uptake. In high prevalence settings, universal HIV testing of infants through routine MNCH services, such as immunisation visits, has been shown to be acceptable and feasible. Across epidemic settings, routinely offering testing at points of care where the concentration of infected children is likely to be higher (e.g. paediatric inpatient wards) can also help identify HIV-positive children.

Outside of health facilities, community-based strategies such as mobile testing services and home-based HIV testing and counseling have the potential to enhance utilization of HIV testing and counseling among hard-to-reach, rural and marginalized communities.

*Integrate PMTCT and antiretroviral treatment for eligible HIV-positive mothers within the Maternal, Neonatal and Child Health (MNCH) platform, especially within lower level clinics.* The effectiveness of PMTCT and paediatric AIDS programmes depends upon the uptake of a continuum of interventions: early and repeat ANC visits, as well as good quality ANC and postnatal services. The loss to follow-up of mothers and HIV-exposed infants has been documented as a significant obstacle to the effective prevention of MTCT. To address geographic barriers to access, services should be available at sites closest to home within lower level clinics, where women and children routinely receive care.

*Improve the quality of service delivery by addressing human resources for health.* Sub-Saharan Africa has two-thirds of the world’s HIV cases and only 3 per cent of the world’s health workforce. Task shifting (for example, the delegation of tasks from physicians to nurses or from clinic-based health professionals to community health workers) can increase the efficiency of health services while maintaining quality of care.

*Address financial barriers that constrain women from accessing PMTCT and MNCH services.* Removing or reducing user fees or creating incentives to use MNCH services and deliver in a health facility (e.g. through cash transfers and maternity vouchers) can enhance access for the most marginalised communities.

*Promote community-based programming and male involvement to increase demand and utilization.* The fear of social rejection and of a partner’s negative reaction are often cited as demand-side barriers to the uptake of HIV testing and counseling among pregnant women. With the consent of women, promoting male involvement is an important strategy for improving the uptake of HIV testing, prevention, treatment, and care among pregnant women and their partners. Engaging communities, women living with HIV, and their male partners is critical for creating demand, addressing stigma and discrimination, and strengthening adherence to comprehensive PMTCT and paediatric HIV services, care, and support.

*Ensure access to a comprehensive package of efficacious interventions, including the most effective ARV drug regimens for women and children.* If the elimination of new HIV infections in children is to be realized, high burden countries need to achieve much higher rates of service coverage of a comprehensive package of efficacious interventions for the prevention of vertical transmission and the establishment of ART eligibility interventions for mothers.

*Provide high quality treatment for all infants, children, and adolescents living with HIV, and address the current global inequity in treatment access relative to adults.* Almost 3.4 million children are already living with HIV. It remains an urgent imperative to reach all of these children with life-saving treatment. New drugs and lab technologies that will enable simplified treatment to be provided are critical to decentralizing treatment to mother-child health clinics in remote and underserved areas.
Preventing HIV Infections Among Adolescents and Young People

Globally, there are 1.3 million adolescent girls (10-19 years) living with HIV as compared with 780,000 adolescent boys (10-19 years).

In developing countries, only 31 per cent of young men and 19 per cent of young women (15-24 years) have comprehensive and correct knowledge of HIV and AIDS.

In sub-Saharan Africa, condom use is lower among young people living in poorer households and in rural areas.

One in every five adolescent girls reports their first sexual experience as forced or coerced in Southern Africa.

Globally, many adolescents living with HIV do not know their status and are not receiving treatment.

The most promising scientific breakthroughs have not been tested among adolescent populations.

Most-at-risk adolescents face stigma, discrimination and punitive laws that impede access to evidence-based HIV prevention services.

KEY DIMENSIONS OF INEQUITY

Barriers to Access, Coverage and Quality
What causes the transmission of HIV among young people is no mystery: unprotected sex with an HIV-positive person or contact with infected blood or other fluids through the sharing of non-sterile injecting equipment. Reducing HIV incidence through these modes of HIV transmission requires not a single intervention, but a continuum of high impact HIV prevention interventions to decrease risk among young people, particularly young key affected populations (e.g. sex workers, people who use drugs, and men who have sex with men). High impact interventions include HIV testing and counseling as a gateway to prevention, treatment and care; medical male circumcision in generalised epidemics; comprehensive condom programming; harm reduction for young people who use drugs; and antiretroviral treatment, including treatment as prevention. To promote a continuum of HIV prevention, there is also a need to address underlying barriers to the scale-up of evidence-based interventions: lack of opportunity and rights for young people, gender inequality, poverty, stigma and discrimination, and other context-specific challenges.

Gender
More than 60 per cent of all young people living with HIV are female. In sub-Saharan Africa, young women are up to 8 times more likely to be infected with HIV than boys, comprising more than 70 per cent of all young people living with HIV. Globally, there are 1.3 million adolescent girls (10-19 years) living with HIV as compared with 780,000 adolescent boys (10-19 years). Early sexual debut, often with older partners, and low condom use, particularly among adolescent girls, combined with their biological vulnerability increase their risk of infection. While globally just over 1 in 10 adolescent girls are sexually
active before the age of 15, in Latin America and the Caribbean 22 per cent of adolescent girls have sex before age 15.

Across all regions, accurate knowledge about HIV and AIDS is low. In developing countries, only 31 per cent of young men and 19 per cent of young women (15-24 years) have comprehensive and correct knowledge of HIV and AIDS. Knowledge levels remain low in most high-burden countries in sub-Saharan Africa, with disparities reported by wealth quintile, residence, and gender. In sub-Saharan Africa, accurate knowledge of HIV and AIDS among young people is lowest among the poorest households and in rural areas, and young women are less likely to have accurate knowledge about HIV and AIDS than young men.

Condom use remains low in most high HIV burden countries, and gender disparities in condom use exist across all regions. In sub-Saharan Africa, only 48 per cent of young men (aged 15-24) and 35 per cent of young women (aged 15-24) that reported having sex with multiple partners during the previous 12 months indicated they had used condoms at their last intercourse. In sub-Saharan Africa, condom use is lower among young people living in poorer households and in rural areas. It is likely that low condom usage is related, in part, to low availability. In 2008, only four condoms were available for every adult male of reproductive age in sub-Saharan Africa and even less for female condoms.

Violence indirectly or directly exposes women and girls to HIV infection. Data from Southern Africa indicates that one in every five adolescent girls aged 12–17 years said they had been forced or coerced to have sex. Violence is experienced disproportionately more by young women than young men, predisposes them to risks for HIV infection both biologically and socially, and is an egregious violation of human rights.

Age

Young people accounted for 41 per cent of all new HIV infections among those aged 15-49 in 2009, and almost 2500 young people are infected with HIV each day. However, implementation of evidence-based interventions among young people remains a significant challenge, often due to social norms associated with discussing high risk behaviors, including sex and drug use, at home, in school settings and within the community.

Fewer adolescents (aged 15-19) know their HIV status than adults. Although there are over 5 million young
people living with HIV globally, many do not know they are infected. The age at which adolescents and young people can be tested without parental consent varies considerably among countries. In the most-affected regions, few countries allow minors to access HIV prevention services without parental consent. According to survey data collected between 2005 and 2010, among young people in sub-Saharan Africa, only 10 per cent of young men and 15 per cent of young women (aged 15-24) know their HIV status, implying a ‘hidden epidemic’ among young people.

Globally there are 2 million adolescents aged 10-19 and 5 million young people aged 15-24 living with HIV. Adolescents living with HIV often face challenges as they transition from paediatric to adult care, address issues of disclosure, and become sexually active.

Adolescents are rarely included in biomedical HIV prevention clinical trials. Despite their heightened vulnerability to HIV infection and unique psychological and physiological characteristics, adolescents less than eighteen years of age are rarely included in biomedical HIV prevention research. For example, clinical trials associated with two recent breakthroughs in HIV prevention research, tenofovir gel, an antiretroviral microbicide which can prevent HIV infection in women, and the early initiation of ART as protective against HIV infection in discordant couples—only included participants 18 years and older. Although ethical and legal considerations must be addressed and adolescents’ rights protected, given that adolescents are likely to be recipients of future biomedical interventions, adolescent participation is critical for verifying the safety, efficacy, and acceptability of new interventions for their age group.

Stigma and Discrimination

Most-at-risk adolescents (MARA) constitute a considerable proportion of key affected populations, but the response is limited. Young intravenous drug users, young men who have sex with men and adolescents that sell sex have higher HIV infection rates. Although they require attention in all epidemic settings, most-at-risk populations constitute a large percentage of people living with HIV in concentrated epidemic settings: 76 per cent in Eastern Europe and Central Asia, 35 per cent in South and Southeast Asia (excluding India), and 49 per cent in Latin America. Punitive laws and legislation as well as stigma and discrimination within health facilities, communities, and schools often drive MARA underground, restricting their access to interventions and services. A review of drug use laws in 59 countries found that 32 (54 per cent) impose the death penalty for drug offenses, 79 countries and territories criminalize same-sex sexual relations between consenting adults and more than 100 countries criminalize aspects of sex work.

**ACTIONS TO IMPROVE HIV AND EQUITY OUTCOMES**

Expand adolescent and young people’s access to biomedical interventions that reduce the transmission of HIV. As part of a combination prevention approach over the life cycle of an adolescent, comprehensive condom programming for young people and adolescents who are sexually active is required on a significantly larger scale, particularly in high HIV burden countries. Moreover, the evidence clearly indicates that condom promotion among young people does not lead to increased sexual or high-risk behavior.

In combination with other prevention approaches, male medical circumcision has proven results in reducing the risk of acquiring HIV. In contexts where heterosexual activity is the primary mode of HIV transmission, male circumcision reduces by 60 per cent a man’s risk of contracting HIV.

Besides unprotected sex, the use of unsafe needles and needle sharing is a primary mode of HIV transmission in young people. There is good evidence of the benefits of needle and syringe programs and opioid substitution therapy in reducing HIV infection. Minimum age requirements to access treatment and other services as well as the political support to promote needle exchange among youth are often inadequate.

Increasingly the benefits of treatment as prevention are being recognized. Treatment has been shown to greatly reduce the risk of HIV transmission from 50–95 per cent in sero-discordant couples, and its applicability to prevention among young people needs to be explored.

Behavior change communication, though combinations of mass media, peer education and interpersonal communication, especially with parents, is important in implementing these high-impact interventions. Evidence indicates that programs promoting sexual abstinence are effective when abstinence is presented along with condoms and safer-sex strategies as other options.
Increase the number of adolescents and young people who know their HIV status and, if eligible, are accessing treatment. Too many young people do not know their HIV status. Yet HIV testing and counseling is the gateway to prevention, treatment, and care, and has been associated with risk reduction. As a first step, legal and policy barriers that discourage or deny access to testing and treatment to adolescents and young people should be reviewed and addressed in countries where they exist.

A variety of approaches to the delivery of HIV testing services have demonstrated positive effects on utilization. These including same day rapid testing, the provision of testing services in locations convenient to young people (e.g. workplaces, community settings, mobile clinics), home-based testing, and provider-initiated testing in medical facilities. Home-based HIV testing and counseling has been shown to reduce existing inequalities in HIV testing, increasing uptake in rural areas, among young people, among groups with low educational attainment, and among the poorest populations. For undiagnosed adolescents living with HIV, provider-initiated testing and counseling for adolescents in chronic care facilities can help improve the diagnosis of HIV infection.

There should also be investment in antiretroviral therapy for those young people who know their status and are living with HIV.

Provide adolescents and young people with age-appropriate, comprehensive sexuality education in school and out of school. Although few sexuality education programs have documented an impact on biological markers such as HIV status or STIs, successful programs have been shown to increase knowledge as well as contribute to later sexual debut and more responsible sexual behavior. Effective programs have key common characteristics which include, for example, a standardized curriculum; participative teaching methods; an emphasis on risk and protective factors and behaviors; attention to personal values and attitudes and peer, family and community norms regarding sexuality as well as; sexual negotiation and self efficacy skill building. In school settings, the delivery of sexuality education by trained, capable, and motivated teachers can maximize impact. While comprehensive sexuality programs in schools can reach large numbers of young people, many vulnerable adolescents and young people are out of school. Effective programs should be expanded to ensure that young people who are out of school also have access to comprehensive sexuality education.

Optimize laws and policies to improve adolescent and young people’s access to sexual and reproductive health and harm reduction HIV prevention services. Due to age restrictions limiting access to medical services and treatment, most young people have limited or no access to sexual and reproductive health programs, including HIV-related health services (e.g. HIV prevention education, condoms, HIV testing and counseling) and harm reduction services, such as needle and syringe exchange programmes and opioid substitution therapy. Few countries allow minors to access contraceptives, HIV testing, and/or harm reduction services, without parental consent. Lowering the age at which adolescents can consent to HIV testing and treatment, as well as access harm reduction services without the permission of an adult can help improve HIV prevention outcomes.

Keep girls in school and address gendered inequalities that make young women particularly vulnerable to HIV infection. Factors that contribute to adolescent and young women’s increased risk of infection in sub-Saharan Africa include increased biological vulnerability coupled with a lack of access to information, services, and commodities and unequal, often exploitative gendered dynamics (e.g. age disparate, transactional sex and early marriage). By empowering girls with knowledge, skills, and resources to protect themselves from HIV, the structural inequalities that heighten the vulnerability of girls and young women can be addressed.

Although there is no single prevention strategy that is effective in all epidemic settings, evidence shows that school participation reduces early sexual debut and risky behaviour, which impacts on HIV transmission. Yet, girls are an increased risk of dropping out as they approach adolescence, which is also when the risk of HIV infection increases. When used as part of a combination prevention approach that includes behavioral, biomedical, and structural components, keeping girls in school is an important strategy for HIV prevention, particularly in high burden countries.
Protection, Care and Support for Children Affected by HIV and AIDS

The poorest households are often least resilient to the impacts of HIV, yet carry the greatest economic burden of care.

In 25 countries where household surveys were conducted between 2005 and 2009, only 11 per cent of households caring for OVC received any form of external care or support.

Women and girls account for at least two thirds of all caregivers for people living with HIV in Africa.

KEY DIMENSIONS OF INEQUITY

Barriers to Access, Coverage and Quality

Although you do not need to be poor to be vulnerable to HIV infection, HIV and AIDS can push people into poverty and marginalize those affected or associated with the virus. The impact of HIV is felt most strongly at the individual and household levels, and HIV pushes poor families further into poverty. Poverty is also a social determinant of access, coverage and quality of prevention, treatment and care, indicating the need for mitigating the impact of the epidemic on children and families to ensure an equitable AIDS response, and supporting the attainment of development goals with equity.

Geography and Wealth

Sub-Saharan Africa has the largest burden of disease and demand for AIDS care and support. It is estimated that 22.9 million (68 per cent) of people living with HIV globally live in sub-Saharan Africa. Of the 16.6 million children who have lost one or both parents to AIDS, 14.9 million reside in sub-Saharan Africa.

Household wealth is often a stronger predictor of child vulnerability than orphanhood or AIDS-affectedness. Orphanhood alone as a proxy for AIDS-affectedness is not a consistently useful predictor of child vulnerability within the context of HIV and AIDS. The evidence indicates that household economic status is often a better predictor of child outcomes. More multi-dimensional, context-specific understandings and measures of vulnerability that take into account the multiple factors (e.g. age, gender, residence, household economic status, etc) and stressors that shape child vulnerability are needed.
Poverty intensifies the impact of HIV and AIDS on children’s lives and the poorest households are often least resilient to the impacts of HIV. Although the impact of HIV on children and families varies according to epidemic and context, HIV and AIDS often heighten children’s vulnerability and have negative impacts on household economic capacity, food security, health-care access, as well as abuse, exploitation, and neglect. Numerous studies have documented how poverty intensifies the impact of HIV and AIDS on children’s lives, the poorest households are often least resilient to the impacts of HIV, and HIV in itself is impoverishing.

Families face the largest burden of care for ill family members and children affected by HIV and AIDS, with little external support. Millions of dollars have been invested in programs for orphans and vulnerable children (OVC). Yet, a disproportionate share of the burden of care of vulnerable children continues to be shouldered by affected families and communities. In communities affected by HIV and AIDS, families bear 90 per cent of the costs of responding to the impact of the epidemic. In 25 countries where household surveys were conducted between 2005 and 2009, only 11 per cent of households caring for OVC received any form of external care or support. In addition, AIDS care and support requires chronic disease and palliative care interventions, which are often unavailable at health care facilities in the poorest locations.

Economic pressures are often barriers to school access for children affected by AIDS. Although many countries in sub-Saharan Africa have made progress towards parity in school attendance for orphans and non-orphans 10-14 years, parity has still not been achieved. Many studies indicate that children affected by AIDS, especially older adolescents, may be absent more frequently or drop out of school due to increased economic pressures and caregiving responsibilities. Globally there are 71 million adolescents of lower secondary school age out of school. In the least developed countries, only 30 per cent of boys and 28 per cent of girls attended secondary school from 2005-2009, and in many countries, gender disparities in school attendance persist. Globally, 54 per cent of out-of-school adolescents in 2007 were girls. Disability may also compound inequities in access, as children with disabilities account for one third of the 72 million children of primary school age out of school in the world.

Stigma and Discrimination
HIV-related stigma and discrimination can be barriers to schooling, health and other essential services. Various studies have described how children affected by HIV have been excluded from schools, families, communities, and services due to stigma and discrimination. Yet, nearly 30 per cent of countries do not have laws to protect access to health, education and employment services for people living with HIV— including children and their family members.

Children of parents who are socially excluded suffer on many fronts. In concentrated epidemic settings, where HIV clusters in key population groups such as sex workers, intravenous drug users, and men who have sex with men, issues of stigma, discrimination and social exclusion and their associated impacts on children are paramount. Many of the adults who fall into these categories are also parents. Although additional evidence is needed, it is likely that children

Box 2: An Integrated Community Child Protection System Keeps Families Together in South Africa

In South Africa, the Isibindi programme is a good example of how investment in community child protection systems can help vulnerable children and their parents gain access to child support grants as well as to ART. The Isibindi model of care mobilises trained child and youth-care workers from the local community to respond comprehensively to the needs of vulnerable children and their families, many of them affected by AIDS. Through regular informal home visits, the care workers ensure that children remain in their communities and live with their families.
Across epidemic contexts, reducing the cost of schooling for the families affected by HIV and AIDS can contribute to a more equitable HIV response and accelerate progress towards the MDGs by mitigating the impacts of poverty and social exclusion on children and families. An established mechanism used by industrialized countries is vital for realizing equitable outcomes for children. An strong and functioning social welfare system is especially needed. Across epidemic contexts, mitigating the social and economic impacts of the epidemic on children’s lives is essential for achieving more equitable outcomes for children. Yet specifically targeting orphans or children affected by AIDS can magnify HIV-related stigma and discrimination and also inadvertently exclude other vulnerable children and promote inequities. For targeting, a combination of variables (age, gender, household wealth, orphan status, residence status, and household education level) should be used to identify and reach vulnerable children, including children affected by HIV and AIDS.

Gender
The burden of caring for ill family members due to HIV and AIDS often falls disproportionately on women and girls. This can have negative impacts on girls’ school enrollment and participation. In countries hardest hit by HIV, most of the care for people living with HIV takes place in the home, and women and girls account for two thirds to ninety per cent of all caregivers for people living with HIV in Africa, with similar trends across the developing world.

Actions to Improve HIV and Equity Outcomes

Utilize multi-dimensional targeting criteria to identify and reach vulnerable children, including children affected by HIV and AIDS. Across epidemic contexts, mitigating the social and economic impacts of the epidemic on children’s lives is essential for achieving more equitable outcomes for children. Yet specifically targeting orphans or children affected by AIDS can magnify HIV-related stigma and discrimination and also inadvertently exclude other vulnerable children and promote inequities. For targeting, a combination of variables (age, gender, household wealth, orphan status, residence status, and household education level) should be used to identify and reach vulnerable children, including children affected by HIV and AIDS.

Social protection and social transfers can contribute to more equitable health outcomes for vulnerable children and families by addressing the economic and gender inequalities that drive the epidemic (e.g. keeping girls in school through social transfers) as well as financial barriers (e.g. transportation vouchers) that inhibit access to prevention and treatment. Social transfers have demonstrated positive impacts on the nutrition of people receiving HIV treatment and also have the potential to improve HIV treatment uptake and outcomes.

Strengthen national social protection and social welfare systems for the care, protection, and support of all vulnerable children, including children affected by HIV and AIDS. A strong and functioning social welfare system is vital for realizing equitable outcomes for children. An established mechanism used by industrialized countries to protect their most vulnerable citizens, social protection can contribute to a more equitable HIV response and accelerate progress towards the MDGs by mitigating the impact of poverty and social exclusion on children and families affected by HIV and AIDS.

As a complement to strengthening national child-protection systems, strengthen community systems to improve vulnerable children’s access to health and social services. Families and communities have been at the frontline in addressing and mitigating the impacts of the HIV epidemic on children’s lives, yet they have received little external support. Community systems strengthening, including the compensation of caregivers for care work that is often unpaid and unrecognized is vital to promoting equitable outcomes for vulnerable children, families, and communities affected by HIV and AIDS. Across various country contexts, it has been demonstrated that child focused community groups can improve vulnerable children’s protection outcomes and well being. Communities can be particularly helpful in developing local criteria of vulnerability as well as identifying and providing referrals to services for vulnerable children.

Promote family and community centered approaches to HIV care, treatment and support – one that engages men and boys. HIV is often a family disease, especially in high burden countries. It affects the entire family and often clusters in families. Family and community centered approaches, including men and boys, provide an entry point for preventing pediatric infections and have the potential to enhance health outcomes for mothers and children, as well as other family members. Global initiatives continue to promote communities as key to the provision of HIV services (e.g. Treatment 2.0), however greater community engagement in determining how best to implement treatment care and support is urgently needed.

Increase school attendance for all children, especially adolescent girls. Reducing the cost of schooling for the poorest families through free and universal education, education subsidies, predictable cash transfers and other social protection programs can all contribute to a more equitable school access, and contribute to reducing parity between orphans and non-orphans in school attendance. School attendance can also help reduce early sexual debut and risky behavior which impacts on HIV.

Design context-specific strategies to overcome HIV-related stigma and discrimination. Laws and legislation, as well as enforcement and redress mechanisms, are important tools for combating stigma and discrimination, especially in institutional settings. Equally important is working with communities and involving people living with HIV to change social norms and raise awareness of the harmful effects of stigma. Specific strategies to address stigma and discrimination against populations at highest risk and their families are especially needed.
MOVING FORWARD

• Equity is at the center of the AIDS response.

• We need decisive action to ensure the MDGs are achieved with equity and the most vulnerable and marginalized children, adolescents and families benefit from the remarkable advances in HIV prevention, treatment, care, and support.

• We have a broad understanding of the key dimensions of HIV and inequity, but there is still a great deal we do not know about women and children. More than ever, information is needed about the many diverse communities at sub-national levels – in cities, peri-urban areas and rural locations. A better understanding of country-specific responses and policy bottlenecks to coverage and access to quality services is vital, particularly for marginalized women and children.

• The next step will be to work with communities, governments, the private sector, academics and other partners to analyze data at various levels and to plan context-specific responses. Knowing who is underserved will help us to invest our resources more efficiently and effectively.

• Success depends upon partnerships and innovation that apply ‘what we know works’ to all.