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HEALTH
HIV AND AIDS
WATER, SANITATION AND HYGIENE
NUTRITION
EDUCATION
CHILD PROTECTION
SOCIAL INCLUSION
GENDER EQUALITY
HUMANITARIAN ACTION

Annual Results Report 2017

HIV AND AIDS

UNICEF's Strategic Plan 2014–2017 guides the organization's work in support of the realization of the rights of every child. At the core of the Strategic Plan, UNICEF's equity strategy – which emphasizes reaching the most disadvantaged and excluded children, caregivers and families – translates this commitment to children's rights into action.

The following report summarizes how UNICEF and its partners contributed to the global HIV and AIDS response in 2017 and reviews the impact of these accomplishments on children and the communities where they live. This is one of nine reports on the results of efforts during the past year, encompassing gender equality and humanitarian action as well as each of the seven Strategic Plan outcome areas – health, HIV and AIDS, WASH, nutrition, education, child protection and social inclusion. It complements the 2017 Executive Director Annual Report (EDAR), UNICEF's official accountability document for the past year.

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Estere Chimkango (24 years old) and one of her 9-month-old twins, Talandira, outside their home in Billy Village Ngabu, Chikwawa, Malawi. Estere benefits from the services that Mothers2Mothers (with support from UNICEF) offer at the nearest health facility.

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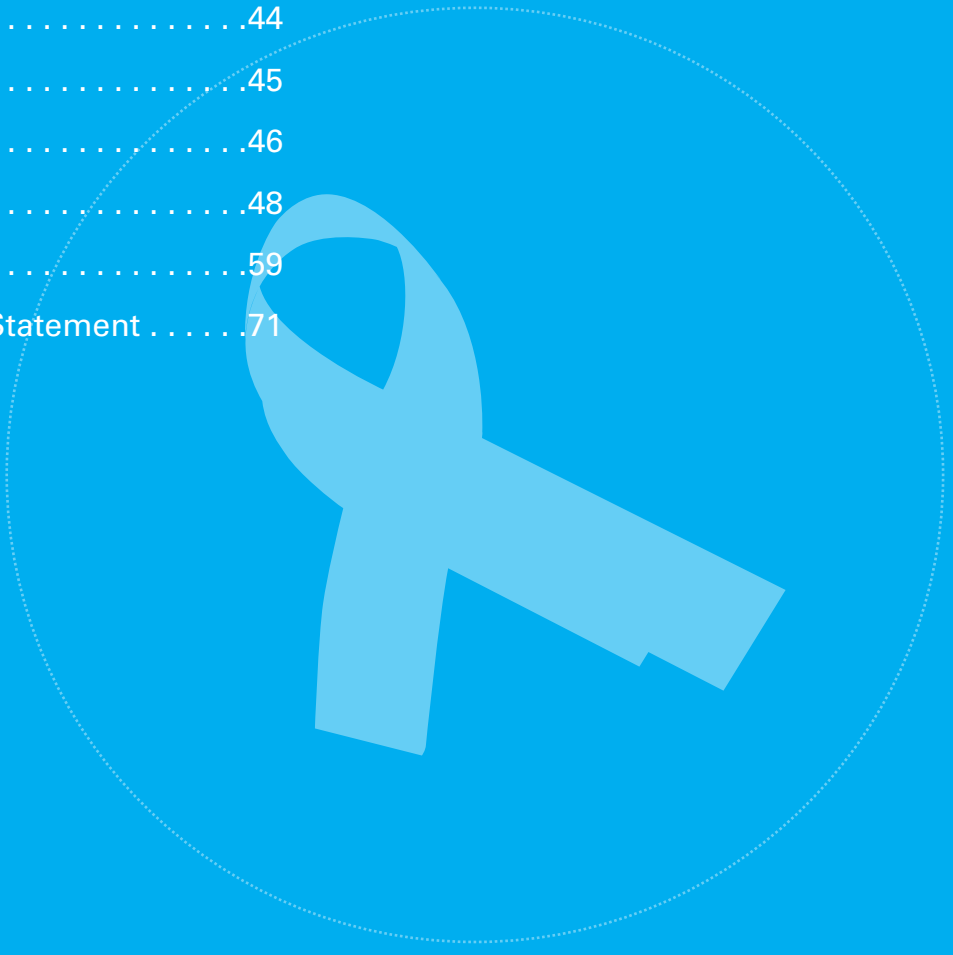

EXECUTIVE SUMMARY

Throughout 2017, UNICEF continued to play a central role in global, regional and national efforts to strengthen, expand and sustain HIV responses among children and adolescents worldwide. Based on the priorities outlined in the UNICEF Strategic Plan, 2014–2017, the organization focused its technical support, expertise and experience for children in both the first and second decades of life.

UNICEF'S WORK AND KEY RESULTS IN 2017

Varying degrees of progress have been made during the strategic plan period in both reducing the annual number of new HIV infections and increasing access to antiretroviral therapy (ART), with considerable improvements among children contrasting with much smaller improvements among adolescents. Globally, new infections among those children declined by 47 per cent, to 160,000, in 2016, and of the 2.1 million children living with HIV, 43 per cent were on ART that year. Despite this progress, however, these results fall short of the strategic plan's 2017 targets for new infections (93,000) and ART access (50 per cent) for this age group.

Progress on elimination of new HIV infections in children under 15 years of age has been variable among regions and countries. By the end of 2017, ten countries and territories had received World Health Organization (WHO) certification for elimination of mother-to-child transmission (EMTCT) of HIV. At least 10 of the 21 high-burden countries in sub-Saharan Africa prioritized for EMTCT met or exceeded the 2017 strategic plan target of 80 per cent ART access among all pregnant women living with HIV as well as the associated target of at least nine countries meeting this milestone of 80 per cent access. Yet to attain EMTCT, even the countries that have achieved the ART access target will need to focus efforts to further prevent new HIV infections in children by improving mothers' adherence to ART and retention in care, including during the breastfeeding period; by reaching and bringing into care pregnant women not accessing antenatal and HIV services; and by institutionalizing HIV retesting of previously negative women and testing of spouses to prevent new HIV infections among mothers during pregnancy and the breastfeeding period.

UNICEF, through its learning collaborative, continues to learn from programmes and share what works in what circumstances with policymakers and implementing partners, in order to improve programme quality and effectiveness. Reaching the 'last mile' of eliminating new infections in children will be challenging but is a priority for the next UNICEF Strategic Plan, 2018–2022. The recent (and ongoing) rapid scale-up of access to ART and emerging new technologies such as HIV self-testing platforms and HIV prevention tools such as pre-exposure prophylaxis (PrEP) have put this global health goal within reach. With this goal in mind, in 2017 UNICEF placed considerable attention on working with partners to highlight regional gaps and disparities in progress that are often obscured by the global figures, and direct resources and support to close these gaps.

For example, West and Central Africa is a region that is lagging behind. In 2016, only 49 per cent of pregnant women living with HIV there had access to effective ART regimens for prevention of mother-to-child transmission (PMTCT), compared with 88 per cent in Eastern and Southern Africa. Critical bottlenecks include weak health-care delivery systems, user fees and delays in the adoption of policies to decentralize services to lower levels of care. UNICEF advocacy efforts helped to galvanize support for children and their mothers in the West and Central Africa Catch-up Plan, endorsed at an African Union Summit in July 2017. The Catch-up Plan includes ART targets for different population groups, including children, pregnant women and mothers.

UNICEF's strategic plan target for 2017 was to provide ART to at least 80 per cent of children (0–14 years old) or adolescents (10–19 years old) living with HIV in nine of the priority countries identified by the Joint United Nations Programme on HIV/AIDS (UNAIDS). With 54 per cent of the world's adults living with HIV receiving ART in 2016, progress in increasing the global ART coverage share among children living with HIV from 31 per cent in 2012 to 43 per cent in 2016 still fell short of the current access in the adult population. Moreover, the 2017 target of nine priority countries achieving 80 per cent ART coverage in children was also not reached, with only 3 of the 38 priority countries achieving the target among children (0–14 years old) and 2 of 10 among adolescents (10–19 years old).

Faster improvement is critical. Untreated HIV infection in children follows a very aggressive course, with 30 and 50 per cent of children dying before their first and second birthdays, respectively. A key bottleneck to advancing initiation of HIV treatment in children more quickly is poor access to early infant diagnosis (EID) for HIV, a process that requires sophisticated technology and expertise, which in many countries only exists in centralized national or regional laboratories. Worldwide, only 43 per cent of infants born to mothers living with HIV received an HIV test at the recommended 4–6 weeks of age. In 2017, UNICEF continued to support countries to improve and expand their testing capacities at multiple service delivery points,

including actions to improve sample transportation and transmission of test results, and to introduce new point-of-care (POC) testing technologies that can be deployed at primary care facilities with no specialized laboratory. Also, in many countries capacity to deliver HIV treatment to children under the age of 15 remains limited to a few health-care facilities and has not been fully decentralized to all facilities providing treatment to mothers or otherwise integrated with services for adults. Integration of HIV treatment services, simplification of treatment approaches and strengthening of referral linkages will remain key priorities for UNICEF's work.

Progress for adolescents has generally been more modest than for children (0–14 years old). Only about one third (36 per cent) of adolescents aged 15–19 years living with HIV had access to ART in 2016 for reasons including prohibitive policies for adolescents to access HIV testing and poor organization of adult treatment services to provide effective differentiated care to adolescents. Unlike for PMTCT services, adolescent prevention efforts have struggled to make headway. As a result, the rate of new HIV infections among that age group has barely declined since 2010.

UNICEF output indicators included a target for the number of countries with comprehensive behaviour communication strategies and those with at least 80 per cent of adolescents having comprehensive knowledge about HIV and AIDS. Over the UNICEF Strategic Plan, 2014–2017, the performance of these two indicators against the targets was not as expected at the time the targets were established (in 2012). The two indicators imply that country investments in behaviour change communication strategies are targeted towards the general population. However, with an increasing understanding of vulnerability and risk, countries are shifting their focus towards more targeted and integrated approaches to the delivery of adolescent HIV services that focus on the right populations and geographies, and UNICEF is promoting such approaches to increase efficiency and effectiveness.

UNICEF and UNAIDS launched the 'All In to End Adolescent AIDS' ('All In') initiative in 2015. Through its leadership in 'All In', UNICEF led reviews in 25 countries across all regions. The findings reveal fragmented implementation of key interventions and major data gaps in reports and administrative instruments that need to be strengthened. The support being galvanized through the Global HIV Prevention Coalition, established in 2017, includes UNICEF's enhanced focus and leadership on preventing HIV among adolescent girls and young women as well as adolescents from key marginalized vulnerable populations, including in areas such as target-setting and data-informed awareness-raising. New and innovative technologies and interventions offer renewed hope that, with increased attention and support, a wide range of options can promote substantial improvements in every context, boosting countries' efforts to meet their targets.

Adolescent girls and young women are bearing the brunt of the AIDS epidemic. Their heightened vulnerability to HIV is evident globally and in every region, and their vulnerability increases with age, underscoring the sex-power dynamics that are not in their favour. New data generated in South Africa confirmed that many adolescent girls acquiring new HIV infections engage in relationships with older men in the highest HIV risk age-group bracket. Many of these men also have poor access to ART services. The risk factors underlying such relationships – including poverty and gender and social norms – explain why empowerment across all aspects of their lives is necessary to reduce HIV vulnerability among adolescent girls and young women.

Limited knowledge and data exist on adolescent key populations, including the size of such populations, what their main risks are in specific contexts, what their priority needs are, and what kinds of services they might find most acceptable in the face of massive stigma, discrimination and legal, social and cultural barriers. Such barriers undeniably limit their ability and inclination to access HIV treatment and prevention services, making them disproportionately vulnerable when compared with the adolescent population overall. No country can have an effective, sustained HIV response that clearly moves towards 'ending AIDS' without a focus on both treatment for all population groups and comprehensive prevention efforts, and without aggressively tackling the behavioural and structural barriers that make it so difficult to safeguard the health and overall well-being of adolescent girls and young women and all adolescent key populations.

In 2016, some 16.5 million children (under 18 years of age) had already lost one or both parents to AIDS, and the sad truth is that these children are still often shunned and face significant economic and social obstacles. They require protection, care and support. UNICEF in 2017 continued to support HIV-sensitive social protection programmes, including cash transfers in Lesotho and the United Republic of Tanzania, to lower HIV risk and vulnerability among adolescents (especially girls).

UNICEF in 2017 broadened and deepened its efforts to respond to these complex challenges in multifaceted ways. It is clear that there is no 'one size fits all' solution; there needs to be a diversity of approaches based on key characteristics of the local epidemic and on countries' capacities and resources. Knowledge and experience of what works are also critical to how and where services are delivered; for example, peer-led support provided by communities can often be more acceptable and friendly for young people than formal programmes.

By embracing and initiating cross-cutting approaches, UNICEF has been delivering on the integration that is envisaged by the Sustainable Development Goals (SDGs). Although HIV is not a top-line target, the progress that is made towards several of the SDGs – for example,

ending poverty (SDG 1), ensuring healthy lives and quality education for all (SDGs 3 and 4), and achieving gender equality and empowerment (SDG 5) – will directly affect children, pregnant women and adolescents living with or highly vulnerable to HIV.

LOOKING AHEAD

Donor funding for HIV programming overall has not increased notably for several years, and the SDGs have further narrowed the space for substantial external HIV-specific funding in most countries, even as they are seeking to scale up their responses. In the current financial environment, stakeholders are prioritizing efficiency and evidence-based interventions. UNICEF has also been moving in this direction through its advocacy for greater political commitment among governments and donors, and by building the necessary partnerships to collectively define what needs to be done.

UNICEF's expertise and leadership in data-driven decision-making, integration and innovation are vital components of its future HIV priorities. Many of the steps taken by UNICEF and partners in 2017 have laid a clear path that should ensure continuity even as efforts and approaches become more targeted.

The new UNICEF Strategic Plan, 2018–2021, calls for speed and efficiency to further hasten progress towards EMTCT aligned to the new global targets for children and adolescents. These include milestones for two outcome indicators: (1) reaching 81 per cent of girls and boys living with HIV with ART (in two age groups: 0–14 years and 10–19 years); and (2) reaching 1.19 million pregnant women living with HIV with antiretroviral (ARV) medicine to reduce the risk of mother-to-child transmission of HIV through UNICEF-supported programmes. Progress is progress, no matter how uneven; but still, millions of children and adolescents remain affected by HIV, are at risk of infection or are living with the virus. Looking forward, the pace of progress to attain the targets – and to reach every child – must accelerate, as a matter of urgency.

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Doumbia Dgnebou, 35, is seven months pregnant with her fourth child. She came to Odienné health centre, in Côte d'Ivoire, for a prenatal check-up. She is living with HIV. "When I was pregnant with my third child, I did an HIV test. The result was positive. I cried and I was afraid," she says. "They – the nurse – told me to take the medication they prescribed and I did. … Luckily, my son was seronegative. I am not afraid anymore. Our previous son was born healthy because I took the right medication."

STRATEGIC CONTEXT

Overview of global trends

Through the efforts of UNICEF and partners, children and adolescents worldwide have continued to benefit from expanded access to HIV treatment and prevention services and support. Yet the gains have been uneven – and countries scaling up their responses face many challenges.

Significant progress is evident in many crucial areas. The roll-out and prioritization of prevention of mother-to-child transmission (PMTCT) of HIV services have been largely responsible for averting an estimated 2 million new infections in children since 2000 – 1.6 million of them since 2010.[1] By 2016, about three quarters of all pregnant women living with HIV had access to effective antiretroviral medicines (ARVs) for PMTCT, thereby helping to safeguard the health of their infants – up from 47 per cent in 2010. By the end of 2017, ten countries and territories had received World Health Organization (WHO) certification for the elimination of mother-to-child transmission (EMTCT) of HIV, signalling the potential for eliminating such transmission everywhere.

These gains are variable, however, with only the Eastern and Southern African region and 12 high-burden countries in sub-Saharan Africa meeting the 2017 milestone in the UNICEF Strategic Plan, 2014–2017, of 80 per cent of pregnant women living HIV receiving effective ARVs for PMTCT. Much more must be done to expand PMTCT services. Children continue to acquire HIV, and their access to antiretroviral therapy (ART) is lower than that of their mothers and lower than the strategic plan target of 80 per cent. Identification of these children remains challenging as infant HIV testing requires sophisticated laboratories and technical expertise not available in primary health care facilities in decentralized systems. In 2016, fewer than half of all infants born to mothers with HIV were tested for HIV infection by 2 months of age (43 per cent), as recommended by WHO. As a result, just 43 per cent of the 2.1 million children living with HIV across the globe were on ART, an achievement below the strategic plan's 2017 target of 50 per cent. In light of the low coverage rates, it can be no surprise that at least 120,000 children died of AIDS-related causes in 2016.

Some of the same challenges, though with different emphases and scale, are contributing to the unfolding tragedy among adolescents, the age group that is the focus of UNICEF's 'second decade' of life HIV response. Between 2010 and 2016, the rate of new HIV infections among adolescents aged 15–19 years declined by only 14 per cent, in sharp contrast to the rate of new infections in children aged 0–14 years, which decreased by 47 per cent over the same period. In addition, as treatment access improves for young children living with HIV, they are living longer and surviving into adolescence. As a result, in 2016 an estimated 2.1 million adolescents aged 10–19 years were living with HIV worldwide – 30 per cent more than in 2005 and 15 per cent more than in 2010. Only 36 per cent of these adolescents accessed treatment in 2016.

The heightened vulnerability of adolescent girls and young women in many of the world's highest-burden countries and regions accounts for why they bear the majority of the burden of new infections among adolescents and youth (aged 10–24 years) globally every year. As is the case for their adult counterparts, adolescent key populations are also at much greater risk than members of their age group in general. Outside sub-Saharan Africa, the majority of new HIV infections among adolescents are in key populations and their partners (adolescent boys who have sex with men; transgender individuals; adolescent girls and young women involved in sex work; and adolescents and young people who inject drugs). Over the course of the UNICEF Strategic Plan, 2014–2017, there has been minimal progress in reducing new infections in adolescents due to fragmentation in programme designs, gaps in data to inform effective programmes and insufficient investments in overall prevention.

UNICEF and partners have sought to sound the alarm about HIV in children and accelerate action for prevention and treatment. In 2016, the Joint United Nations Programme on HIV/AIDS (UNAIDS) established a series of 'super-fast-track' targets to be reached by 2018 and 2020 to advance progress towards ending AIDS among children, adolescents and young women by 2020. UNICEF has built on lessons learned from PMTCT efforts and the findings from the country assessments from the All In to End Adolescent AIDS initiative ('All In') launched with UNAIDS in 2015. Super-fast-track targets are driving resource allocations by partners and governments, as well as technical assistance. They have also led to innovations such as: self-testing among adolescents; point-of-care (POC) diagnostic technologies for infant testing; and pre-exposure prophylaxis (PrEP) to prevent HIV infection among not only adolescents but also pregnant or lactating women and their partners.

Disparity in regions: changes in programme impact between 2015 and 2016

Trends and changes across different regions – each of which is facing a different HIV epidemic in terms of scale, impact and options – underscore the context-specific

nature of opportunities and challenges in the next year and beyond.

The overall relative success of PMTCT service scale-up is evidenced by the fact that from 2015 to 2016, the share of pregnant women living with HIV who received effective ARVs for PMTCT increased in the six regions comprising most of the developing world.[2] Improvements in percentage terms tended to be smaller in countries where coverage is already high *(see Figure 3, p. 11)*. In Eastern and Southern Africa, home to the highest-burden countries in terms of the overall HIV epidemic, an estimated 88 per cent of pregnant women living with HIV received ART in 2016, up about 2 percentage points from 2015. At the other end of the spectrum, maternal ART coverage stood at just 41 per cent in West and Central Africa, 38 per cent in South Asia and 37 per cent in the Middle East and North Africa. Although these three regions had improved substantially compared with the previous year, current coverage remains well below the strategic plan coverage target of 80 per cent and much more needs to be done.[3]

Regional trends in paediatric ART coverage vary as well. Although in all regions coverage is significantly lower among children than among adults and pregnant women, the strategic plan's 2017 target of 50 per cent of children (0–14 years) living with HIV was met in four regions: East Asia and the Pacific, Middle East and North Africa, Latin America and the Caribbean, and Eastern and Southern Africa. It is important to note that ART coverage rates for the two regions with the most children living with HIV – Eastern and Southern Africa, and West and Central Africa – stand at just 51 per cent and 21 per cent, respectively, though both saw increases from 2015 to 2016 *(see Figure 5, p. 15)*.

The slow pace of progress in some regions since 2014 is a matter of concern. In Latin America and the Caribbean, 53 per cent of children aged 0–14 years living with HIV were on ART in 2016 – about the same proportion as in the previous two years. The situation is similar in South Asia, where the 33 per cent coverage level in 2016 has barely changed since 2013.

HIV and the Sustainable Development Goals

HIV prevention and treatment is not as visible in the Sustainable Development Goals (SDGs) as it was in the Millennium Development Goals (MDGs), which were far fewer in number and narrower in focus. The new era of the 2030 Agenda for Sustainable Development strives to integrate HIV into the broader SDG for health (good health and well-being) and other SDGs (no poverty; quality education; gender equality; reduced inequalities; peace, justice and strong institutions). Thus, the HIV response is a priority in several SDGs.[4]

Many of the issues and indicators targeted by the SDGs have long been at the core of principles and strategies underlying UNICEF's HIV programme. UNICEF has shared the lessons learned from its work on HIV in all programming contexts, including lessons learned in working with civil society and community systems. Many of these lessons contribute to the broader development agenda beyond HIV and should provide the basis for building integrated health and development programming that links various SDGs. These include: the importance of creating a supportive, care-seeking environment with policies that protect the rights of people living with HIV and increase access to testing and treatment; the importance of national and decentralized accountability mechanisms to monitor the quality of services; and the need to engage and empower clients to advocate for their rights and to make informed choices about their health.

UNICEF is seeking to leverage opportunities across the 2030 Agenda that can help to boost countries' efforts to prevent HIV in adolescents and young women; initiate and retain infants and adolescents in treatment and care; and 'finish the job' of PMTCT by identifying differentiated responses that are needed at the country level to eliminate such transmission altogether. It is already evident, for example, that improvements in keeping girls in school (associated with the first target for the SDG on quality education) have a direct effect in terms of reducing girls' vulnerability to HIV, not least by reducing child marriage and by offering them more access to information and services aimed at increasing HIV awareness and prevention.

Value for money

The excitement and energy accompanying the launch of the 2030 Agenda must be tempered by some sobering realities. One is financial. The integrated nature of the SDGs could mean that investments in one development area will have a beneficial impact in others, but approaches adopted and specific results achieved from a combination of official development assistance (ODA), domestic resourcing and other funding sources (e.g., innovative financing mechanisms) have yet to be documented.

Those involved in the HIV response have already been aware of this problem for a few years. External funding (e.g., from donors) for HIV programming overall has not increased notably for several years. The SDGs, with their nudge towards a wider range of development financing, along with increased advocacy and attention to other development priorities such as climate change, have further narrowed the space for substantial external HIV-specific funding in most countries, even as they are seeking to scale up their responses.

In the current environment, stakeholders are prioritizing efficiency and evidence-based interventions. UNICEF has also been moving in this direction through its advocacy

for greater political commitment among governments and donors, and by building the necessary partnerships to collectively define what needs to be done. One notable high-profile example is 'All In', which is based on an integrated approach that seeks to enhance current programming efforts targeting adolescents. 'All In' aims to facilitate a move towards a more evidence-based and coordinated response in the priority countries that account for most of the disease burden.

Addressing the challenges

The organization will support efforts to address some of the most pronounced and complex challenges in its HIV programming in the UNICEF Strategic Plan, 2018–2021 period. HIV and AIDS priorities for children are: to finish the 'unfinished business' of PMTCT; to prevent HIV in adolescents; and to close the treatment gap for children and adolescents. For example, further reducing mother-to-child transmission (MTCT) will require women living with HIV to adhere well to their ARV regimens (at least until they stop breastfeeding their infants). Exclusive and continued breastfeeding and lifelong ART will improve both the mother's health and quality of life and the infant's growth and development, while ensuring reduced HIV transmission.

UNICEF has been supporting various models for strengthening the linkages between communities and health facilities so as to improve the quality of services promoting women's adherence to ART in the postnatal period. It is also working to improve testing, treatment initiation and adherence among adolescents living with HIV or AIDS. Expanded and enhanced improvements are critical for this population because AIDS-related mortality remains a major challenge. Globally, the annual number of AIDS-related deaths among adolescents (aged 10–19 years) decreased by just 5 per cent between 2010 and 2016. Among the older members of this broad group, those aged 15–19 years, mortality due to AIDS *increased* by 9 per cent over the same period. Wide variations can be found across regions, but such global trends point to the need for countries to scale up treatment and prevention services for adolescents, with the assistance of UNICEF and its partners. Action is urgently needed: AIDS is the leading cause of death among adolescents in Africa and the second most common cause of death among adolescents globally.[5]

Rose and her daughter Azel, beneficiaries of Mothers2Mothers services at the Bvumbe Health Centre, Thyolo, Blantyre, Malawi.

RESULTS BY PROGRAMME AREA

To achieve an AIDS-free generation, UNICEF has been implementing six key strategies, as outlined in its vision paper, *UNICEF'S HIV/AIDS Programme Vision and Direction for Action, 2014–2017*.

The specific results from the UNICEF Strategic Plan, 2014–2017, that the organization sought to achieve through its HIV and AIDS interventions are captured in the box below.

Programme outcome areas

UNICEF's HIV programme – working alongside health, nutrition, early childhood development, gender, child protection, social inclusion and adolescent development – focuses on the first two decades of life. The first decade (ages 0–9 years) responds to the prevention and treatment of HIV in infants and young children with a focus on

HIV AND AIDS RESULTS FRAMEWORK

(from 'Final results framework of the UNICEF Strategic Plan, 2014–2017', 4 April 2014)

IMPACT INDICATORS

(2a) Number of new HIV infections among children under 15 years (based on United Nations General Assembly Political Declaration on HIV/AIDS, 2012)

(2b) Percentage of children under 15 years with access to HIV treatment (based on Global Plan for 22 EMTCT priority countries)

OUTCOME INDICATORS

(P2) Improved and equitable use of proven HIV prevention and treatment interventions by children, pregnant women and adolescents

OUTPUT INDICATORS

(a) Enhanced support for children and caregivers for healthy behaviours related to HIV and AIDS and use of relevant services, consistent with the UNAIDS Unified Budget, Results and Accountability Framework

(b) Increased national capacity to provide access to essential service-delivery systems for scaling up HIV interventions

(c) Strengthened political commitment, accountability and national capacity to legislate, plan and budget for scaling up HIV and AIDS prevention and treatment interventions

(d) Increased country capacity and delivery of services to ensure that vulnerability to HIV infection is not increased and HIV-related care, support and treatment needs are met in humanitarian situations

(e) Increased capacity of governments and partners, as duty bearers, to identify and respond to key human rights and gender equality dimensions of HIV and AIDS

(f) Enhanced global and regional capacity to accelerate progress in HIV and AIDS.

pregnant women, mothers and their children, while the second decade (ages 10–19 years) focuses on preventing and treating adolescent HIV infection. Across both decades and as part of a continuum of care, UNICEF promotes equitable social protection interventions, including efforts to address acute and chronic emergencies and their impacts on children, adolescents and young women living with or affected by HIV and AIDS.

The following three sections detail the results achieved in 2017 through the key implementation strategies in each of the programme areas. Results summaries under each decade and then across both decades highlight progress towards the targets set in the UNICEF Strategic Plan, 2014–2017. The selection of country and region examples[6] illustrates UNICEF's achievements across both decades and celebrates noteworthy results in its target countries, which include: the 38 high-burden countries determined by UNAIDS; the countries prioritized through the 'Start Free, Stay Free, AIDS Free' (the 'Three Frees') framework, which was adopted at the June 2016 United Nations High-Level Meeting on Ending AIDS;[7] and countries affected by emergencies.

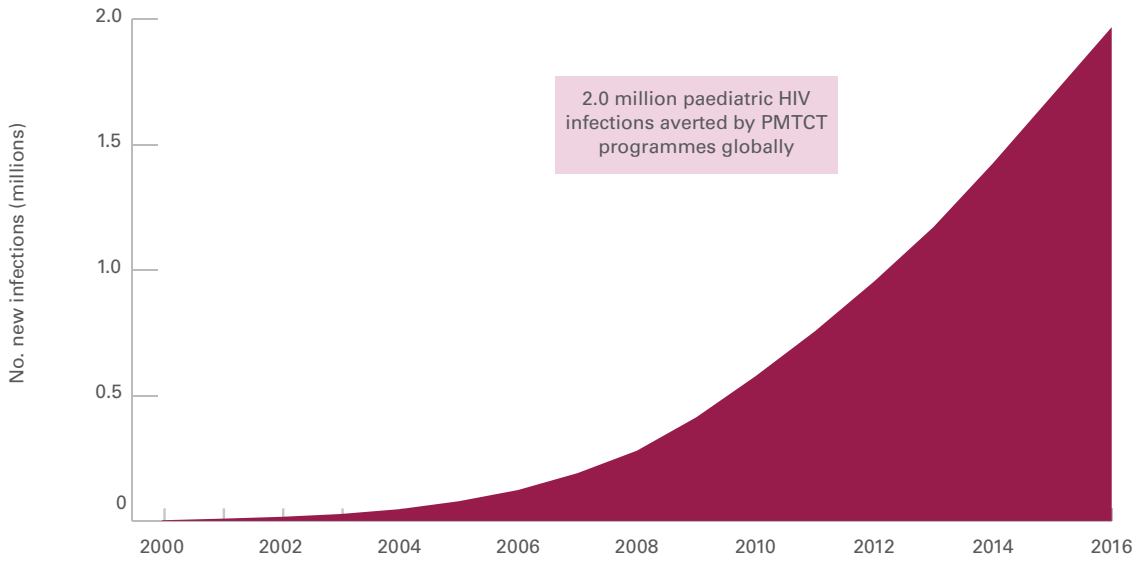
PROGRAMME AREA 1: FIRST DECADE – CHILDREN, PREGNANT WOMEN AND MOTHERS

Prevention of mother-to-child transmission of HIV

The impressive global effort to reduce mother-to-child transmission (MTCT) of HIV is one of the signature health and development successes of recent years. The prominent impact by 2015 of the Global Plan Towards the Elimination of New HIV Infections Among Children and Keeping Their Mothers Alive (the Global Plan) deserves special recognition, as much of the progress occurred after this was put in place in 2010.

The annual number of new infections among children in 2016, the latest year for which data were available as this report was being compiled, was 160,000. Although below the strategic plan benchmark for 2017 (93,000 new infections), this number is nearly half the size of the comparable 2010 figure (300,000 new infections). Cumulatively, an estimated 2 million infections in children have been averted since 2000, of which 1.6 million have been since 2010 *(see Figure 1)*.[8]

FIGURE 1: Estimated number of new HIV infections averted by PMTCT programmes globally (cumulative), 2000–2016



Source: UNICEF analysis of UNAIDS 2017 estimates.

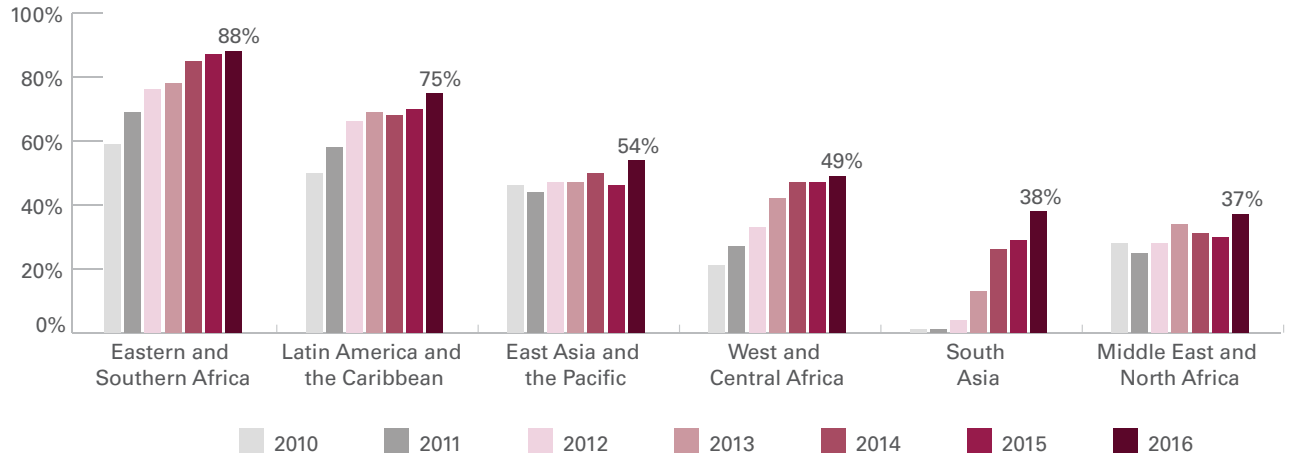
A 32-year-old seropositive mother of four is visiting Daola hospital, in the west of Côte d'Ivoire, to get her six-week-old baby tested for HIV. The young woman found out she was HIV positive right after her child was born.

Globally, of the estimated 1.4 million pregnant women living with HIV in 2016, about 1.1 million had access to effective ARVs for PMTCT. Yet progress across the world has been uneven, and expanding PMTCT services remains a challenge in some countries and regions. Many countries in the West and Central Africa region, including Chad, the Democratic Republic of the Congo and Nigeria, are lagging behind. Across that region, only about half (49 per cent) of pregnant women living with HIV had access to ARVs for PMTCT in 2016, a level much lower than the strategic plan target of 80 per cent. The comparable figure for Eastern and Southern Africa, home to many of the world's highest HIV-prevalence countries, was 88 per cent *(see Figure 2)*. Key challenges that are making it difficult to achieve more substantial progress include weak health systems, slow adoption of policies to allow decentralization of services and task-shifting, and continued application of user fees for mothers to access antenatal care (ANC) and other services.

Six countries and territories – Anguilla, Antigua and Barbuda, Bermuda, Cayman Islands, Montserrat, and Saint Kitts and Nevis – were validated by WHO in 2017 as having eliminated MTCT of HIV, joining four others that were validated in 2015 and 2016.[9] Even high-burden countries are nearing the finish line: in sub-Saharan Africa, 12 countries have met the strategic plan's 2017 target of maternal ART coverage of 80 per cent or more *(see Figure 3)*.

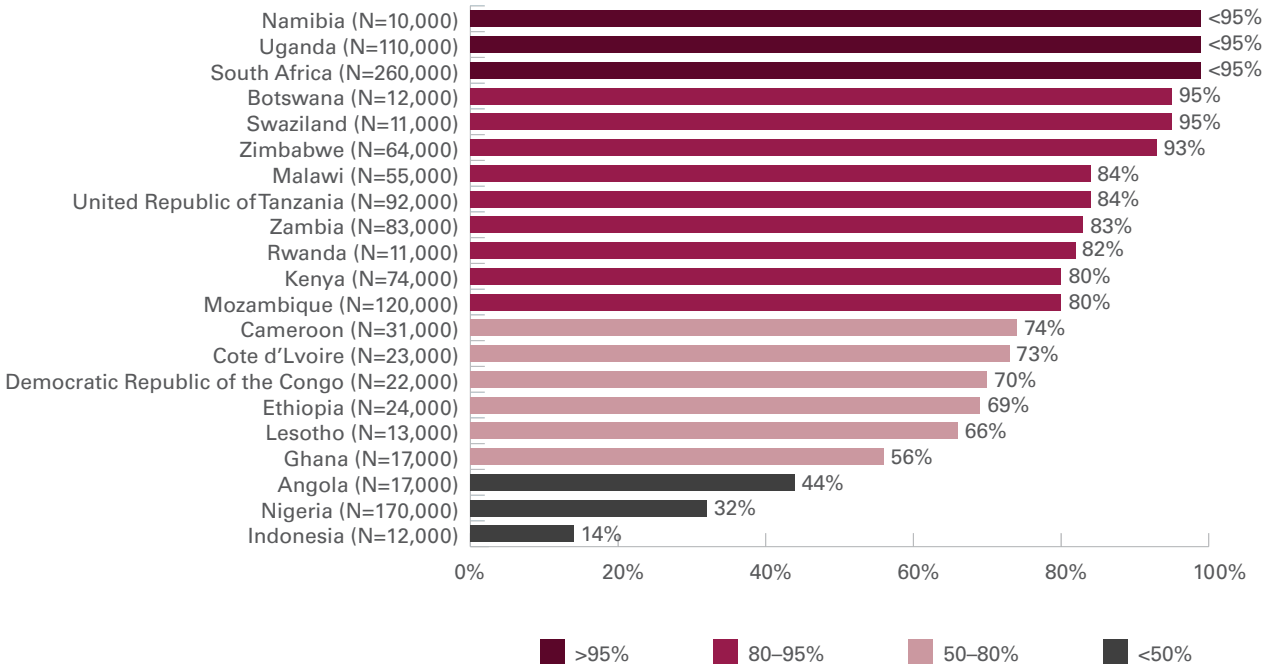
This global multi-stakeholder effort is valuable not only for its impact, but also for the lessons learned from the coordinated, collaborative process it has involved. Maintaining this coordinated support will be necessary if progress is to continue and to accelerate. The 'last mile' is always the hardest in any such journey, as it will entail finding and supporting women and children to be retained in care in highly challenging environments, including conflict settings, humanitarian crises and where health systems are weak or do not reach all areas.

FIGURE 2: Percentage of pregnant women living with HIV receiving effective ARVs for PMTCT, by UNICEF region, 2010–2016



Source: UNAIDS/UNICEF/WHO Global AIDS Response Progress Reporting 2017 and UNAIDS 2017 estimates.

FIGURE 3: Percentage of pregnant women living with HIV receiving effective ARVs for PMTCT, in countries with at least 10,000 pregnant women living with HIV, 2016



Source: UNAIDS 2017 estimates. Note: Selected countries include all countries for which data were available and in which an estimated minimum of 10,000 pregnant women were living with HIV in 2016; excludes single-dose nevirapine.

In response, the UNICEF Strategic Plan, 2018–2021 calls for a two-pronged approach focusing on: (1) countries with the highest ART coverage among pregnant women living with HIV and within reach of the 'path to elimination'; and (2) countries that are severely lagging behind, and thus require what might be termed 'accelerated-plus' efforts to come close to meeting the 2020 'super-fast-track' goal on PMTCT. In terms of the high-performing countries, UNICEF is supporting several in sub-Saharan Africa, including Botswana, Namibia and Uganda, that plan to seek official recognition from WHO as being on the 'path to elimination' in 2018.

The organization's work in South Africa shows the value of data-driven programming. Action is based on data, and 'action dashboards' generated at the district level are used for planning and performance assessments. A decentralized national EMTCT framework helps to coordinate, align and compare PMTCT services at all levels of the health system.

In Myanmar in 2017, a significant achievement was the incorporation into PMTCT reports of data on syphilis testing for all pregnant women at ANC facilities. All the main indicators of the PMTCT programme have been incorporated into DHIS2, the country's national health information system. This consolidation of comprehensive data is helping to move Myanmar closer to EMTCT of both HIV and syphilis in the next decade or so.[10]

Many of the pregnant women living with HIV now with access to effective ARVs for PMTCT have benefited from UNICEF's leadership in supporting countries to scale up their implementation of Option B+, a protocol under which pregnant women are tested for HIV and all those who are positive receive ART as soon as possible and for life. Option B+ was a model for the universal 'treat all' approach that is now at the core of WHO HIV treatment guidelines.[11]

One of UNICEF's most important contributions to Option B+ implementation was its championing of effective models for strengthening community-facility linkages, including support from peers and community health cadres to improve uptake of services, adherence to medicines and retention in care. Efforts in four high-priority countries in sub-Saharan Africa were supported through the Optimizing HIV Treatment Access (OHTA) initiative, a five-year catalytic project through 2017 targeting pregnant and breastfeeding women that was funded by the Swedish International Development Cooperation Agency (Sida) and the Norwegian Agency for Development Cooperation (Norad) *(see Case Study 1)*. Lessons learned have been shared with the wider community of women living with HIV and with policymakers at various forums, including the International Conference on AIDS and Sexually Transmitted Infections in Africa (ICASA) in December 2017.

CASE STUDY 1: OHTA INITIATIVE: COMMUNITY CADRES WORKING TO TRANSFORM THE LIVES OF HIV-POSITIVE PREGNANT AND BREAST-FEEDING WOMEN IN SUB-SAHARAN AFRICA

The Optimizing HIV Treatment Access for Pregnant and Breastfeeding Women (OHTA) initiative, which ran from 2012 to 2017, was funded by the Swedish International Development Cooperation Agency (Sida) and the Norwegian Agency for Development Cooperation (Norad). It aimed primarily to accelerate access to Option B+ – the provision of lifelong ART for pregnant and breastfeeding women living with HIV – in Côte d'Ivoire, the Democratic Republic of the Congo, Malawi and Uganda.

OHTA focused on strengthening the capacity of primary health-care systems to deliver Option B+; creating demand for PMTCT services; increasing pregnant women's uptake and timely utilization of these services; and retaining these women in the health-care system. In 2016, funding for the initiative was extended by a year to document and leverage the promising practices that were demonstrated in the four countries.

One persistent challenge in many places has been keeping mothers living with HIV connected with health systems and facilities. To address this, OHTA implemented context-specific strategies across the four countries to strengthen community engagement in selected districts. In all four countries, the project trained peers, lay counsellors and community health workers (CHWs) to provide counselling, psychosocial support and follow-up for pregnant women and mother-infant pairs, with the goal of improving retention. Building on existing health systems and community structures, the countries selected different methods for implementation. In Côte d'Ivoire, CHWs were deployed to improve community client tracing; mentor mothers were trained in the Democratic Republic of the Congo, Malawi and Uganda; and in Malawi, health surveillance assistants (HSAs) and expert clients were trained.

The CHWs, mentor mothers and HSAs contacted women who missed their regularly scheduled appointments through phone, Short Message Service (SMS) and/or home visits. They also provided individualized health education about the importance of regular diagnostic monitoring (e.g., viral load testing), treatment adherence, ANC, good nutrition and exclusive breastfeeding. Counselling was tailored to the specific barriers experienced by individual clients. This effort also revealed the unique barriers faced by adolescent and young pregnant women and breastfeeding mothers living with HIV, and their need for tailored support, which is currently being addressed through other initiatives.

Over the five-year project, OHTA contributed to reaching more than 180,000 pregnant and breastfeeding women living with HIV and initiating them on treatment, with more than 46,000 of them added in 2017.[12] One key finding was that training and engagement of community cadres helped to reduce the number of mother-infant pairs who dropped out of attending clinics. For example, in Malawi more than 40 per cent of mother-infant pairs who were traced in 2016 returned to a health-care facility following an HSA intervention. On-site mentoring and supervision of CHWs under the project served not only to strengthen community-facility linkages but also to improve the quality and accuracy of health information provided to community members. The enlistment of CHWs and volunteers helped to increase knowledge of the importance of ANC and PMTCT, and to both improve demand for and expand the provision of these services.

Many countries are close to achieving elimination of mother-to-child transmission (EMTCT) of HIV. Reaching the 'finish line' will require full engagement of the community – and especially of women living with HIV – with services for PMTCT and HIV treatment. The results of the OHTA project show that investment in community cadres can make a difference in the coverage, quality and continuity of care provided to women living with HIV and their infants.

Following the success of the OHTA project, Sida selected UNICEF to lead a new initiative to scale up integrated services for sexual and reproductive health, HIV and gender-based violence. This regional programme will be implemented in partnership with the United Nations Population Fund (UNFPA), UNAIDS and WHO, and will focus on five countries in Eastern and Southern Africa (Lesotho, Malawi, Uganda, Zambia and Zimbabwe), where joint efforts will seek to improve policies, service delivery and utilization.

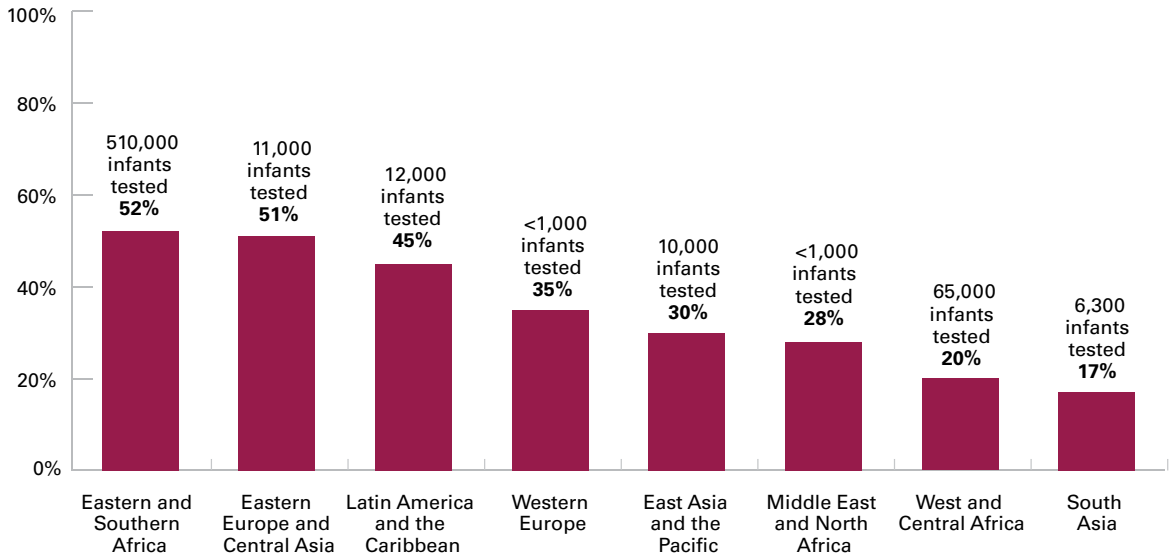
Some gaps in PMTCT progress have proven more difficult to narrow. Early infant diagnosis (EID) remains a difficult intervention to get right for logistical and timing reasons. PMTCT protocols call for infants born to mothers with HIV to be screened for HIV within their first two months of life, because delays in treatment can be deadly – left untreated, half of children with HIV will die before the age of 2 years. Worldwide, however, only 43 per cent of infants born to mothers living with HIV currently receive the test in a timely manner *(see Figure 4 for percentages per region)*.

Moreover, far too often infants exposed to HIV who test negative at initial screening are acquiring HIV during the breastfeeding period. This typically occurs when lactating women with HIV do not adhere to their ARVs or drop out of care. Much more difficult to track and respond to are women who have been newly infected during the breastfeeding period and remain unaware of their HIV status and thus are not on treatment. In such cases, follow-up testing for these women and their infants after birth often does not take place. The 2016 joint WHO–UNICEF guidance on HIV and infant feeding aims to address these obstacles by promoting both optimal breastfeeding practices and ART adherence.[13]

In Namibia, enhanced training offered to 165 health workers contributed to 95 per cent of primary health-care facilities offering Option B+, which in turn allowed over 95 per cent of HIV-positive pregnant women to receive ART.[14] With targeted support to community cadres to assist pregnant women living with HIV to access treatment and to be

Maria (mentor mother) and her two children, Joyous (aged 6 years) and Eliza (aged 2½ years), at their home Gunde village, Thyolo, Malawi. "When I got the results that my babies were born HIV-negative, I immediately called all my relatives sharing with them the truth that although I was HIV-positive my children were born negative. This was cause for much celebration."

FIGURE 4: Percentage of infants born to women living with HIV receiving a virological test for HIV within two months of birth (early infant diagnosis), by UNICEF region, 2016



Source: UNAIDS/UNICEF/WHO Global AIDS Response Reporting 2017 and UNAIDS 2017 estimates. Note: Data not available for North America. In Western Europe, 13 of 28 countries reported early infant diagnosis.

retained in care. Uganda experienced similar results, with effective ARV coverage among pregnant women increasing from below 50 per cent in 2011 to over 95 per cent in 2016.[15] This high level of coverage is directly responsible for the annual number of HIV infections among newborns falling from 25,000 in 2010 to about 3,400 in 2016.[16] Further improvements were expected in 2017.

As indicated by a growing number of studies and surveys, including UNICEF-supported data reviews in Rwanda and Zimbabwe, pregnant adolescent girls and young women do not fare as well as older women in terms of ART uptake and retention in HIV care and services, resulting in higher rates of HIV transmission to their babies. UNICEF has begun prioritizing and focusing on this vital subset of mothers. In Lesotho, Malawi and Zimbabwe, for example, UNICEF – in partnership with the national ministries of health and various non-governmental organizations (NGOs) – is supporting the building of health workers' capacity as part of an effort to strengthen the delivery of adolescent-friendly health services.

Because they are generally harder to identify and reach, effectively supporting pregnant adolescents living with HIV typically requires a more personalized, local approach. This challenge therefore reinforces the validity of decentralizing PMTCT service provision in most countries. UNICEF is working to bring PMTCT services closer to women. In Guatemala, for example, HIV screening services were brought to communities through the roll-out of rapid HIV tests at local health-care facilities in rural indigenous areas in three provinces. A total of 2,174 pregnant women were screened in these areas in 2017 and those found to be positive were successfully referred for ART.

Another component of this work is promoting peer support to increase the uptake of PMTCT by pregnant adolescents living with HIV. In South Sudan, community health peer networks were strengthened in an effort to increase the uptake of maternal health and HIV services and to promote women's and girls' health in one of world's most challenging operating environments. In Nepal, similar support has included training and orienting a total of 1,468 health workers and 1,359 community health volunteers on community-based PMTCT.

Such efforts will be continued while consistently focusing on some of the more tenacious problems, settings and regions where progress is severely lagging. One of those is West and Central Africa. UNICEF signalled this emphasis in a report prepared together with UNAIDS, *Step Up the Pace: Towards an AIDS-free generation in West and Central Africa*, which highlighted the gaps in the response and the key barriers.[17] The report was launched in Abidjan, Côte d'Ivoire, at the ICASA conference in December 2017.

In West and Central Africa, UNICEF will step up advocacy for policy changes that will put lifelong HIV treatment within reach of all pregnant women living with HIV and eliminate MTCT, as well as advocacy for the adoption of innovative approaches to reach women not accessing health care, such as integration of HIV testing in child health weeks and use of SMS (text messages) to remind women about clinic appointments. Strengthening health systems and communities at all levels (national and subnational) is a top-line priority that should be informed by better and more timely programme data and information.

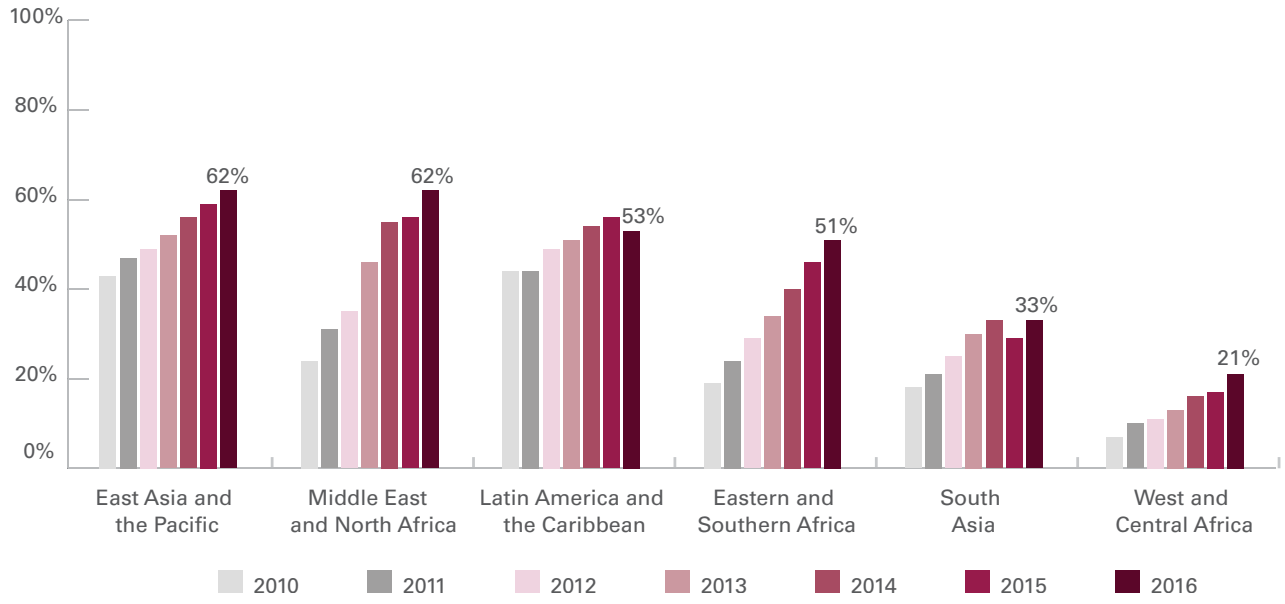
Paediatric HIV diagnostics and treatment

Low paediatric ART coverage and retention in care has been one of the most intractable challenges for HIV programmes. Global coverage of ART among the estimated 2.1 million children aged 0–14 years living with HIV is just 43 per cent, which is lower than coverage among pregnant women living with HIV, adults living with HIV, and the strategic plan's 2017 coverage target of 80 per cent. This and other substantial gaps exist in most regions, with ART coverage among children being the lowest in West and Central Africa, where only around a fifth (21 per cent) of children living with HIV have access to the life-saving medicines *(see Figure 5)*. The one exception is the Middle East and North Africa, a region in which countries have relatively low HIV prevalence. ART coverage among children in that region is higher, at 62 per cent, than the 32 per cent share among people aged 15 years and above.

The good news is that these results still represent progress during the last strategic plan period, even though the main overall target was missed. Since 2010, for example, paediatric ART coverage rates have more than doubled in Eastern and Southern Africa, West and Central Africa, and the Middle East and North Africa. Between 2010 and 2016, the number of children on ART in West and Central Africa increased by more than 200 per cent.

UNICEF and its many partners have contributed to these promising trends. However, there is still much work to do to better address the multiple factors responsible for outcomes among children that tend to lag behind those of other age groups. One of these factors is that most infants exposed to HIV lack access to efficient and effective HIV diagnosis. This challenge persists in large part because infant-testing services have mostly remained centralized at laboratories with sophisticated testing equipment and technical expertise. Testing is thus subject to delays due to barriers such as inefficient sample transportation and poor systems for timely transmission of results to facilities providing treatment. If children are not diagnosed in infancy, their likelihood of being diagnosed at other health-care service-delivery points, and of being linked to treatment, is low. Delaying treatment for HIV-positive children negatively impacts their growth and development, including their cognitive functions, as well as their response to treatment when it is initiated.

FIGURE 5: Percentage of children aged 0–14 years living with HIV receiving ART, by UNICEF region, 2010–2016



Source: UNAIDS 2017 estimates. Note: Data not available for Eastern Europe and Central Asia, North America, and Western Europe.

A nurse performs an HIV test for a mother and child at Kaboko Clinic, Kasenga, Haut-Katanga Province, Democratic Republic of the Congo.

Innovations in technology, systems and service-delivery approaches

UNICEF, in partnership with the Clinton Health Access Initiative (CHAI), the African Society for Laboratory Medicine (ASLM) and Unitaid, is supporting the introduction and scale-up of point-of-care (POC) technologies to improve access to early infant diagnosis (EID) in 10 countries. Findings to date show that both turnaround times for providing test results and the timely initiation of treatment have been greatly improved, with results usually returned to patients on the same day as the testing *(see Case Study 2)*.

UNICEF has provided technical and other support for the introduction and scale-up of new POC technologies by developing a set of implementation tools that could transform access to HIV testing in infants and viral load monitoring of treatment outcomes in all populations, including children. In Kenya, UNICEF support for the development of a POC implementation plan contributed to improvements in laboratories' ability to process and return HIV test results in a timely manner to support timely initiation of treatment. The average turnaround time for test results declined from more than 20 days to fewer than 7.

In Myanmar in 2017, a focus on technology and innovation has resulted in a partnership with CHAI to support a laboratory information management system (LIMS)

CASE STUDY 2: ONGOING INITIATIVE SHOWS GREAT PROMISE FOR POINT-OF-CARE DIAGNOSTICS FOR PAEDIATRIC HIV CASES

UNICEF has partnered with the Clinton Health Access Initiative (CHAI) and the African Society for Laboratory Medicine (ASLM) on a Unitaid-funded multi-country initiative aimed at more timely and effective diagnosis of HIV among infants. Worldwide, in 2016 just 43 per cent of all HIV-exposed babies were tested for HIV within the first two months of life, as is globally recommended. A significant share of early infant diagnosis (EID) test results never make it back to the client and others are only returned after lengthy delays, which can lead to morbidity or mortality among HIV-positive infants who are not identified soon enough to start life-saving treatment.

The initiative seeks to improve such poor results by introducing and supporting the scale-up of point-of-care (POC) EID tests. With POC technology, EID tests can be performed in the clinic itself and within hours of the sample being collected, thereby allowing clients to get their results on the same day or even during the same clinic visit. Treatment can then be initiated immediately or soon after a positive diagnosis. Timely initiation of ART is important for all individuals with HIV, but it is especially critical for HIV-positive infants, among whom mortality peaks in the first two to three months of life. Although suitable for a variety of health-care settings, one of the key benefits of POC testing platforms is that they are easy to operate and can be used at primary health-care facilities by non-laboratory personnel. POC EID technologies are potentially a game changer in global efforts to reduce paediatric AIDS deaths.

The 10 countries involved in the initiative are Cameroon, the Democratic Republic of the Congo, Ethiopia, Kenya, Malawi, Mozambique, Senegal, Uganda, the United Republic of Tanzania and Zimbabwe. Implementation is ongoing and will continue through 2020. Key challenges include: unclear regulatory pathways that create delays in product registration at the country level; unsatisfactory service and maintenance agreements for POC devices; and inadequate support for quality control and data management for decentralized POC testing. The partners are working with national governments and manufacturers to proactively address each of these challenges in project countries, which will ultimately ensure a consistent supply of test cartridges and improved pricing.

One of the main contributions of the project to date has been to generate direct evidence of the impact of POC EID testing. Results from implementation of pilot projects in Malawi and Mozambique, conducted between September 2015 and June 2016, provide strong evidence of the benefits of POC EID tests in terms of reducing turnaround times for results and accelerating treatment initiation rates. In particular, Mozambique went from having a median turnaround time for return of EID results of 122 days with conventional laboratory-based testing to having 98.2 per cent of clients receive their results the same day.

POC EID testing has the potential to expand access to infant diagnosis beyond PMTCT programmes through deployment at other entry-points where HIV-infected and -exposed infants seek care, such as inpatient wards, sick child clinics and malnutrition units. To this end, the project is currently implementing a pilot study in Uganda to assess the feasibility and acceptability of EID testing via alternative entry-points such as these; the results will be available in mid-2018.

CASE STUDY 3: DEMOCRATIC REPUBLIC OF THE CONGO AND ZIMBABWE: FAMILY-CENTRED APPROACHES TO IDENTIFYING CHILDREN WITH HIV

It is critical that children living with HIV are tested and started on appropriate treatment as early as possible. Yet most children and younger adolescents largely depend on their caregivers and support networks to access health care, including HIV testing services. Identifying a family member living with HIV can be an effective strategy for finding undiagnosed cases of HIV among children and adolescents in their families, and identifying those who may be at risk for HIV infection.

A family-centred approach means that for every client recently identified as HIV-positive (or already in care and treatment), an inquiry is made about the status of family members so they can be provided with family counselling and testing, support with HIV disclosure within the family setting, and family case management at the health-facility level. When one or more family members do not know their status, they are invited for testing and linked to prevention or treatment services. However, specific approaches can vary as deemed relevant for the local context, as can be seen in initiatives in the Democratic Republic of the Congo and Zimbabwe.

Working with the ministries of health in those two countries, UNICEF coordinated operational research with a range of interventions aimed at rolling out effective family-centred approaches. Its support included training, supervision and mentoring for facility staff and community health workers, as well as the introduction of new tools and adaptation of the registers to collect additional information.

In Zimbabwe, the core part of the approach was to simply ask the HIV-positive client to bring family members back for testing or to take them to any testing point of their choice and return with the results. This was complemented by weekend visits for school-going children and peer support to extend HIV testing and treatment to older adolescents.

In the Democratic Republic of the Congo, a more active approach was used with HIV-positive adults and children over a period of six months, with two options offered: home-based testing or return to the facility for testing. Transport money was provided for family members who needed this support to return to the facility. In parallel with this intervention, a retrospective analysis of the records of 1,057 patients admitted to four hospitals between 2008 and 2015 was undertaken to see the extent to which family testing was taking place in the country and to identify ways to strengthen the family-centred approach.

As of March 2017, the positive impact on the health of many children had been substantial, especially in the Democratic Republic of the Congo, where family testing was implemented in four urban and semi-urban health facilities (in Kinshasa, North-Kivu and North Katanga). A large number of children living with HIV were identified, with an average yield of 1.5 children for every adult living with HIV (index case). A total of 631 children were identified through inquiries among 309 adult clients living with HIV on ART. Of those children, 375 were screened (59 per cent) and 161 were identified as HIV-positive (43 per cent of those screened). Of the 161 positive cases, 159 (99 per cent) started treatment.

In the Bindura and Makoni Districts of Zimbabwe, 520 children were identified in eight rural health facilities from among 602 adults living with HIV. Of those children, 277 were screened (53 per cent) and 9 were found to be HIV-positive (3 per cent of those screened). All nine children who tested positive were put on treatment.

One of the most important elements that contributed to successful linkage to treatment was greater engagement of other community workers involved in social services – e.g., those working with programmes providing cash transfers and supplementary food – to assist with linkages for those in need. A well-resourced patient follow-up system, using community workers and complemented by health provider-led home visits, supported implementation of the family-centred approach.

Women living with HIV and their babies in the Democratic Republic of the Congo. Innovative point-of-care diagnostic technologies can reduce the time it takes to return to the mother the results of her child's HIV test. Early infant diagnosis with immediate start of treatment can save the lives of children who acquired HIV at birth.

to enhance data sharing between the National Health Laboratory system and the National AIDS Programme. The innovation features the introduction of an SMS printer at each high-volume site (thus reducing the time required to deliver reports to service providers), and the involvement of 'expert clients' to encourage other clients to have their babies tested. As a result, the testing of HIV-exposed infants using polymerase chain reaction (PCR) technology increased from 39 per cent in 2015 to 50 per cent among all live births of HIV-exposed infants in October 2017.

In India, UNICEF in 2017 sustained support for the use of telemedicine (the use of telecommunications technology to provide health services remotely) to improve linkages between peripheral ART centres and Paediatric Centres of Excellence (PCOEs). This effort offers major opportunities to support quality paediatric HIV care. Early evidence of beneficial results in four 'proof of concept' Indian states has prompted partners to expand the telemedicine intervention with PCOEs to seven additional states.

Innovations are also having beneficial impacts when it comes to interventions and service delivery. In 2017, UNICEF supported several strategic interventions aimed at improving HIV case-finding approaches, such as family-centred approaches that are based on reaching out to and encouraging undiagnosed family members of people living with HIV to be tested themselves. This approach has shown promise in identifying children and adolescents living with HIV, many of whom have at least one HIV-positive parent *(see Case Study 3)*.

Other types of innovative solutions, driven by the need for efficiency and better use of data, are being implemented in some countries. In South Africa, for example, UNICEF supported a project that regularly sends out customized laboratory test results of infants to PMTCT focal persons in three districts. As a result of this innovation, HIV-positive infants across the country now receive ART earlier on average.

Integration and coordination

To sustain continued access to paediatric ART, UNICEF and other partners are working to effectively integrate the service into broader child health and care services, similar to what has been achieved for pregnant women. UNICEF has been leading and supporting efforts to make health systems deliver better for children, by integrating HIV testing into health interventions and services that primarily reach children. Such platforms include immunization services and facility- and home-based treatment services for malnutrition, fever and diarrhoeal conditions. Adaptations and shifts of this sort require national commitment to make the necessary policy changes and to make resources available for better and more consistent access to diagnostic tests. Also needed are training and support for lower-level health-care workers (especially at the community level) so they have the ability and confidence to administer tests and evaluate results, and then link clients and their families to HIV care and treatment. Such shifts and changes have been slow in some of the 22 priority countries, as exemplified in the strategic plan results indicating that only 13 of them had achieved the target of having 80 per cent of health-care facilities providing paediatric ART by 2017.

In 2017, UNICEF helped to initiate, expand and sustain cross-sectoral initiatives between HIV and nutrition, health, child protection, education, and social policy and research. Four districts in Malawi with high HIV prevalence and insufficient food in households received support to ensure that all children presenting to community management for acute malnutrition (CMAM) were screened and referred for HIV testing. In Nigeria, the implementation of an HIV and tuberculosis integrated community case management (iCCM) approach was based on the correct assumption that trained community health volunteers could identify children at risk of HIV and exposed to tuberculosis and refer them to health-care facilities.

In the era of the 2030 Agenda, integration is a core priority, not just an ancillary strategy, for countries' HIV responses. UNICEF has long sought to encourage and promote integration of HIV services with other health and development priorities, as evidenced by its efforts to link HIV testing opportunities for children and adolescents with routine immunization and family planning services, among others. Yet, even as UNICEF has embraced integration, it recognizes that the diverse nature of the HIV epidemic calls for more targeted interventions based on data and current evidence, to assure complementarity and synergy for impact. And no matter how effective or efficient they are, practical interventions can only have limited impact in the absence of sufficient backing from and engagement of health officials, from the national level to the community level *(see Box 'Advocacy for paediatric HIV testing and treatment in West and Central Africa')*.

ADVOCACY FOR PAEDIATRIC HIV TESTING AND TREATMENT IN WEST AND CENTRAL AFRICA

UNICEF has worked closely in recent years with governments and other stakeholders to bolster political will and commitment in areas with the most serious gaps in paediatric testing and treatment. At the ICASA conference in Côte d'Ivoire in December 2017, the UNICEF delegation, which included staff and 53 partners from governments and civil society organizations, sought to leverage joint efforts and push for greater commitment from governments and partners to reaching and supporting all children living with HIV in West and Central Africa. This work built on an earlier high-profile development that signalled increased momentum for improvement. In July 2017, during the twenty-ninth African Union Summit, leaders endorsed a West and Central Africa Catch-up Plan to rapidly accelerate access to HIV treatment and close the gap between that region and others. One notable goal of the Catch-up Plan is to increase the number of people on ART in the region from 1.8 million in 2015 to 2.9 million by 2018, with at least 120,000 of the 1.1 million newly initiated being children.[18] This would result in a total of 228,000 children being on ART by 2018 in West and Central Africa, close to double the number at the end of 2016. With the support of WHO, UNAIDS and UNICEF, 12 countries (Benin, Burkina Faso, Cameroon, the Central African Republic, Côte d'Ivoire, the Democratic Republic of the Congo, Guinea, Liberia, Mali, Nigeria, Senegal and Sierra Leone) have adapted this regional initiative to their national contexts and developed country catch-up plans.

These political and advocacy initiatives have been accompanied by targeted donor support, including from the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and the US President's Emergency Plan for AIDS Relief (PEPFAR). Engagement by donors and technical agencies is extending beyond financial support to include changes in systems and procedures to boost efficiency. In Cameroon, the Democratic Republic of the Congo and Nigeria, civil society groups (including from the influential faith-based communities in these countries) have committed to intensifying their support for paediatric ART scale-up.

At ICASA, UNICEF, together with UNAIDS, convened a meeting of country representatives and partners to reflect on the shortfalls within West and Central Africa country catch-up plans and to agree on ways to sharpen acceleration strategies and interventions that will increase access to paediatric ART. The urgent need to close the gaps in paediatric HIV testing and treatment was the focus of the meeting. In West and Central Africa, there has not been enough progress in increasing access to ART for children (aged 0–14 years), and the treatment gap between ART for children and ART for adults is increasing. In 2016, ART coverage was 35 per cent in adults and 49 per cent in pregnant women, while in children it was 21 per cent. Nearly four out of five children aged 0–14 years who are living with HIV are not accessing life-saving ART, most of them because they have not been diagnosed – even though their parents may be receiving treatment.[19]

The meeting at ICASA had three high-level strategic objectives:

1. Call greater attention to the gap in paediatric HIV testing, including early infant diagnosis (EID), and paediatric treatment within the West and Central African country catch-up plans;
2. Define the priority actions for children in country catch-up plans in 2018;
3. Galvanize partnerships in support of country catch-up plans.

Participants identified three 'game changers' that, if adopted into catch-up plans, would accelerate the pace of paediatric HIV programme scale-up: enhanced infant HIV diagnosis; expanded entry-points for testing children outside PMTCT programmes; and task-shifting for paediatric HIV care and treatment.

The policy and advocacy agenda that was adopted included the following actions: redefining of paediatric HIV targets in line with the AIDS Free super-fast-track targets by 2018 and 2020; the engagement of high-level political and community leadership for paediatric treatment catch-up (e.g., ministers of health, first ladies, religious leaders); and advocacy for the adoption or extension of ART task-shifting policy to paediatric treatment, for policy to boost EID and family testing, and for leveraging resources, both external and domestic.

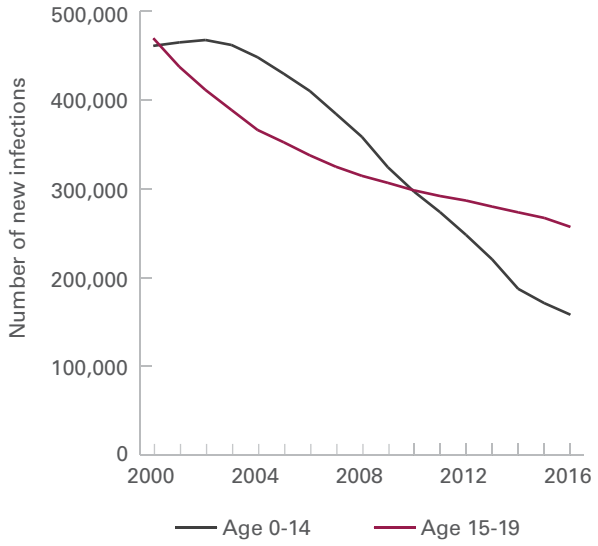
PROGRAMME AREA 2: SECOND DECADE – ADOLESCENTS

The expansion of ART access is an essential strategy for reducing HIV transmission rates, and is at the heart of such bold targets as the UNAIDS 90–90–90 targets that have galvanized countries and their development partners.[20] Yet, improving primary prevention of HIV is also essential. Accumulating evidence suggests that expanding treatment alone will not be sufficient to bring the epidemic under control and is anyway unlikely to be a sustainable option in all contexts. Simply put, it will not be possible to reduce new HIV infections without stepping up comprehensive prevention efforts.

In many countries, however, primary prevention remains a relative afterthought in terms of financial and other resources across overall HIV programming, or is squeezed out by the large financial burden imposed by treatment. Such decisions have a negative impact on adolescents and young people, because of their disproportionate and ever-increasing risk and vulnerability to HIV – a matter of immediate concern. To galvanize the necessary support, UNICEF and UNAIDS in 2015 launched the 'All In to End Adolescent AIDS' ('All In') initiative and since then have conducted epidemic and programme reviews in 25 countries across all regions. Results from these reviews show that current adolescent HIV prevention and treatment efforts in most countries are fragmented, poorly coordinated and not implemented at scale. Within key populations (men who have sex with men, transgender people, injecting drug users and sex workers), adolescents of both sexes (aged 10–19 years) and young women (up to age 24 years) are faring the worst. These data are helping to inform HIV investments targeting this population from major donors such as PEPFAR and the Global Fund.

An estimated 260,000 adolescents aged 15–19 years were newly infected with HIV worldwide in 2016. The burden is particularly stark in sub-Saharan Africa, which accounts for 73 per cent of the global total of new infections in this age group *(see Table 1)*. Adolescent girls account for more than 7 in 10 new HIV infections in the 15–19 years age group in sub-Saharan Africa. Globally, new HIV infections among adolescents aged 15–19 years are not decreasing as quickly those as among children aged 0–14 years *(see Figure 6)*.

FIGURE 6: Globally, new HIV infections among adolescents aged 15–19 years not decreasing as quickly as among children aged 0–14 years



Source: UNAIDS 2017 estimates.

TABLE 1: Global summary of HIV epidemic among adolescents aged 10–19 years, 2016

	GLOBAL			SUB-SAHARAN AFRICA (% of global)
	Total	**Female**	**Male**	
Estimated number of adolescents aged 10–19 years living with HIV	2,100,000	1,200,000	900,000	84%
Estimated number of adolescents aged 15–19 years newly infected with HIV	260,000	170,000	86,000	73%
Estimated number of adolescents aged 10–19 years dying of AIDS-related causes	55,000	26,000	29,000	91%

Source: UNAIDS 2017 estimates.

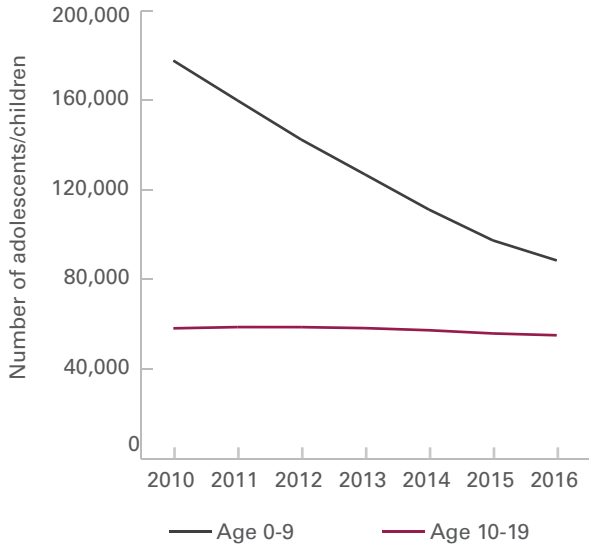
Dawwing Ouma, who acquired HIV at birth, is a Sauti Skika coordinator for Kisumu County, Kenya. Sauti Skika is an initiative supported by UNICEF, with a goal to ensure that young people and adolescents living with HIV are heard at all levels of the HIV response.

Low rates of treatment uptake are one reason that an estimated 55,000 adolescents (aged 10–19 years) died of AIDS in 2016 *(see Figure 7)*. According to WHO, AIDS is the second most common cause of death among adolescents globally (the most common is road injuries). The majority of these adolescents acquired HIV through mother-to-child transmission. Regardless of the way in which HIV was contracted, key challenges to programme effectiveness include identifying these adolescents; linking them to treatment services, including transitioning them from paediatric to adult treatment services; and retaining them in care and getting them to adhere to their medications.

Prevention and other services targeting adolescents and young people

In 2017, UNICEF actively engaged in the development of the HIV Prevention 2020 Road Map, which provides the basis for a country-led movement to scale up HIV prevention programmes with efforts supported by a global coalition of United Nations Member States, donors, civil society organizations and implementers led by UNAIDS and the United Nations Population Fund (UNFPA).[21] The Global Prevention Coalition aims to fast-track and catalyse prevention so as to reduce new HIV infections by 75 per cent by 2020, to 500,000 new infections overall (and to 100,000 in adolescent girls and young women). The

FIGURE 7: Estimated number of AIDS-related deaths, by 10-year age groups, 2010–2016



Source: UNAIDS 2017 estimates.

'All In' initiative, mentioned earlier in this report, is well aligned with global HIV prevention targets and has helped to galvanize partnerships at the regional and country levels for support to adolescent prevention and treatment programmes.

The 2020 Road Map proposes a 10-point action plan with immediate, concrete steps that countries should take to accelerate progress in reducing new HIV infections. One notable focus is on identifying the major gaps where opportunities exist for maximum impact, which in most countries includes among young people and members of key populations. The idea is that differentiated approaches to prevention programming will target resources to identify 'hot spots' for specific populations in geographic areas where transmission is high. UNICEF's emphasis on analysing decentralized data and generating evidence for decision-making is well aligned.

As part of the Global Prevention Coalition, UNICEF has provided strategic and constructive contributions at the global level, and brought to the discussion its life cycle approach to addressing the major gaps that have been identified to end AIDS in children – including putting a focus on HIV prevention among vulnerable adolescent girls and young women and their partners. The latter reflects the need to make sure that men and adolescent boys have equitable access to treatment as part of the prevention agenda.

UNICEF is ramping up more targeted evidence-informed adolescent HIV work at the country level to improve effectiveness and impact, including increasing access to testing and counselling services and promoting pre-exposure prophylaxis (PrEP), peer-to-peer support, cash transfers and education, with a focus on the most marginalized, especially adolescents from key populations. As such, during the course of the UNICEF Strategic Plan, 2014–2017, fewer investments were directed towards more generalized knowledge and awareness raising and blanket strategy reviews.

For example, with partners in Nigeria's Benue State, including the Benue State Agency for the Control of AIDS, a pilot initiative from 2014 to 2016 provided comprehensive HIV service delivery for adolescents and young people using HIV testing and counselling as an entry-point. Nearly 40,000 adolescents and young people were tested and given their HIV results.[22] More than 96 per cent tested negative but now have some engagement with facilities that can offer them prevention services. Those who tested positive were referred to HIV care and treatment services.

A boy at the HAPPY Kids and Adolescents NGO in Kenema, Sierra Leone. HAPPY Kids and Adolescents is supported by UNICEF to provide services to children living with HIV and AIDS, orphans of people who have died of the disease or those who are at risk of becoming infected.

Elsewhere in West and Central Africa, in Cameroon, UNICEF has worked in close collaboration with the Ministry of Youth Affairs and Civic Education to provide HIV prevention services throughout a network of 19 social and recreational centres run by the ministry that welcome both in-school and out-of-school adolescents. Since 2016, these centres have been offering HIV testing and counselling to adolescents aged 15–19 years and strengthening referral mechanisms to link those who test positive for HIV with treatment services. To date, at the time of writing, HIV testing and counselling has been provided to about 200,000 adolescents in priority districts.

Most projects have been designed to apply to specific contexts. China has expressed interest in rolling out self-testing. A pilot project in China's Guangdong Province, known as Online to Offline (O2O), provided an evidence-based model of adolescent-friendly HIV services and was adopted in 2017 as a national pilot under the China Comprehensive AIDS Response Programme for adolescent self-testing. In Ethiopia, meanwhile, UNICEF supported work in 120 target *woredas* (districts) of six regions to reach more than 61,000 adolescent girls with HIV testing and counselling, training on life skills, and peer education.

Using strategies and messages that young people might respond to and find attractive is often just as important as the actual services provided. In Ukraine, UNICEF helped develop a partnership with top Ukrainian celebrity Monatik to promote HIV testing among young people. It is estimated that some 500,000 people have been successfully reached with key messages on HIV testing through this partnership.

Combination prevention for greater impact

By grounding its work in the principles of differentiation and integration, UNICEF has positioned itself as a strong promoter of combination prevention, which refers to the use of a combination of biomedical, behavioural and structural interventions to be tter meet the needs of all vulnerable populations as well as the overall population (in both generalized and concentrated epidemic contexts).

In conjunction with partners, UNICEF has focused its prevention work on the five prevention pillars of the HIV Prevention 2020 Road Map to "chart the way forward to achieving global HIV prevention goals by 2020".[23] Countries have been encouraged to centre efforts to strengthen their national HIV primary prevention responses on these pillars: (1) combination prevention for adolescent girls, young women and their male partners in high-prevalence locations, mainly in Africa; (2) combination prevention programmes for all key populations; (3) strengthened national condom and related behavioural change programmes; (4) voluntary medical male circumcision (VMMC); and (5) provision of PrEP to population groups at substantive risk and experiencing high levels of HIV incidence.

Awareness raising, exchange of knowledge and capacity-building among partners are often initial steps in countries. For example, UNICEF co-hosted a capacity-development workshop for government health policymakers, community outreach workers, adolescents/young key populations and health service staff from China, Indonesia and the Philippines. The workshop contributed to improving knowledge and understanding on innovative technologies and novel service-delivery approaches, including PrEP, HIV self-testing and community-based testing to reach at-risk adolescents.

In Botswana, programme teams in four districts (Selebi Phikwe, Boteti, Good Hope and Ghanzi) conducted an analysis of the bottlenecks and barriers to delivering HIV interventions for adolescents. The exercise helped to build the skills of district teams to collect, analyse and utilize data to design programmes. Bottlenecks identified included: a lack of information and knowledge among adolescents on how and where to access services; limited access to, and use of, key HIV services (testing, condoms, treatment); stock-outs of test kits and other essential commodities; limited availability of trained health-care workers for the provision of adolescent-friendly health services; difficulties in identifying adolescents and young people living with HIV; poor treatment retention and adherence; and low utilization of safe medical circumcision due to individual and community attitudes and beliefs.

UNICEF also used the bottleneck analysis methodology in Zambia, although in a much more targeted fashion: to identify ways to promote and distribute condoms. This work was deemed a priority in response to high rates of unprotected sex among adolescents and young people, which is often associated with early sexual debut and teenage pregnancy. UNICEF's analysis of the 'condom use cascade' has been accompanied by support for condom campaigns through radio, U-Report and other platforms. Other components of the initiative include peer education and improving condom supplies to meet needs and demands.

The support for U-Report in Zambia was replicated in several other countries in 2017 as UNICEF continued to build and expand it. U-Report is a global social messaging tool that encourages adolescents and young people to speak out on issues that affect them. Available free of charge, it also allows its users to anonymously text questions about HIV and AIDS. In Mozambique, UNICEF and three government ministries (Health, Education, and Youth and Sport), UNFPA and the youth association Coalizão (Coalition) have adapted the U-Report platform to create a comprehensive national HIV communication programme centred on peer-to-peer education. The initiative (SMS Biz) supports a counselling hub with 24 trained peer counsellors. The counsellors use specialized communication tools and reference guides to respond to adolescents' questions about sexual and reproductive health, HIV and gender-based violence.

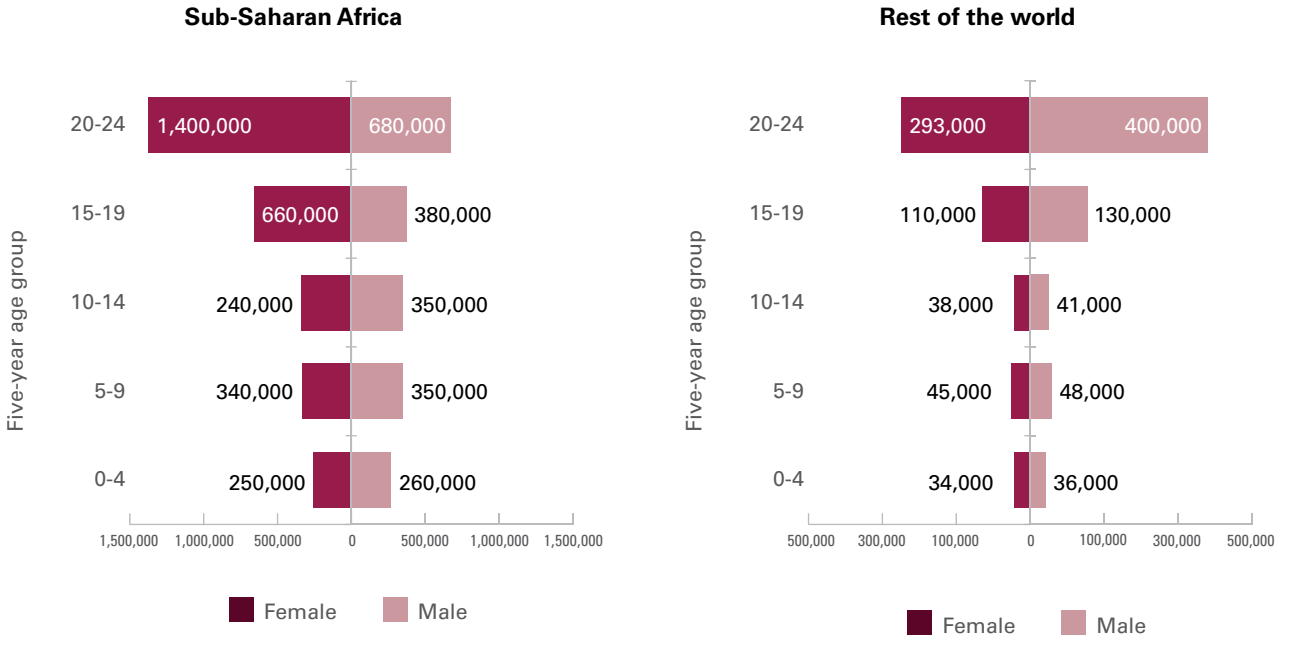
Happiness Mbewe (18 years old) and her baby Davis Christopher (aged 1 year 2 months), in Fuka Fuka, Blantyre, Malawi. Happiness benefits from the services that Mothers2Mothers (with support from UNICEF) offer at the nearest health facility.

Adolescent girls and young women

The persistently high vulnerability of adolescent girls and young women to HIV is a dominant road block on the path to epidemic control. The pronounced gender dimension of many countries' and regions' epidemics, which can be seen in the gaps between adolescent girls and adolescent boys *(see Figure 8)* and between adolescent girls and adult women, call for concerted action and UNICEF accountability. To catalyse the achievement of results, action is framed under 'Stay Free' of the Three Frees Framework for ending AIDS in children, with UNICEF and PEPFAR as co-conveners and a focus on 18 countries. UNICEF's leadership role in this area has been embraced by the Global HIV Prevention Coalition and the new UNAIDS Division of Labour.

Numerous biological factors increase women's risk of HIV, wherever they live. But adolescent girls and young women tend to face a multitude of additional vulnerabilities to HIV, in differing contexts. Among them are: social and cultural traditions such as early marriage; devalued or deprioritized education for girls; patriarchal legal systems and social expectations; and lack of opportunities for income generation. Low social status, household poverty, food insecurity and poor-quality education all limit opportunities for adolescent girls and young women and expose them to gender-based inequalities, exclusion, discrimination and violence, which ultimately put them at increased risk of acquiring HIV.

FIGURE 8: Estimated number of children, adolescents and youth living with HIV, global, 2016



Source: UNAIDS 2017 estimates.

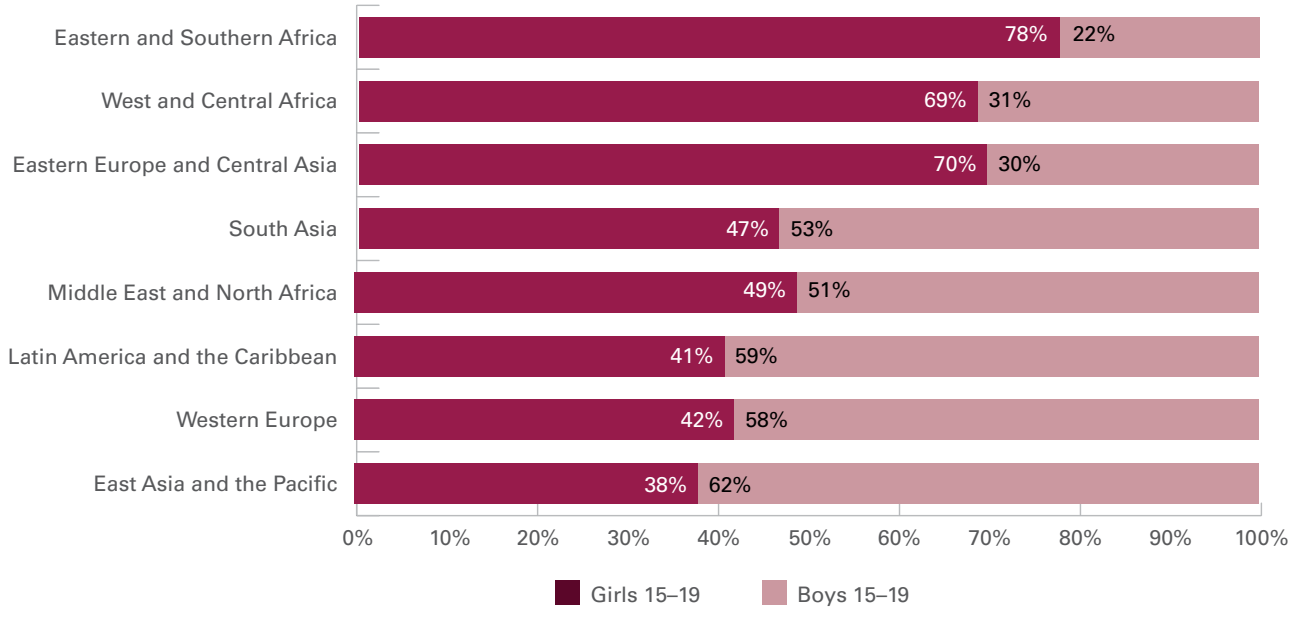
Their vulnerability increases with age, thereby underscoring the sex-power dynamics that are not in their favour. In West and Central Africa, for example, girls aged 0–14 years accounted for about half (49 per cent) of all new infections in 2016 among all children in that age group, among whom by far the most common mode of transmission was from mother to child.[24] However, adolescent girls accounted for more than two thirds (69 per cent) of estimated new infections that year among all adolescents aged 15–19 years, a group in which nearly all new infections are sexually transmitted.[25] Similar patterns are seen in other regions, including Eastern and Southern Africa, Europe and Central Asia, and Latin America and the Caribbean *(see Figure 9)*. In the latter two regions, the vulnerability of adolescent girls to HIV has been obscured by epidemics squarely centred around key populations: adolescent girls account for an alarming 70 per cent among of new infections in adolescents aged 15–19 years in Eastern Europe and Central Asia and 41 per cent in Latin America and the Caribbean.

This increased risk is not necessarily associated with girls having earlier sex or more sexual partners than boys. Instead, a key factor is with whom many of them are having sex. Evidence from high-prevalence settings indicates that many adolescent girls are engaging in relationships with older men, who might have acquired HIV previously, and may not be aware of their HIV status or their viral load.[26] Other studies have shown that condom use remains low among sexually active adolescent girls (aged 15–19 years) with multiple partners compared with adolescent boys in the same age group in most countries throughout sub-Saharan Africa.

The combination of these two trends signals high vulnerability. This form of age-disparate sex typically has an economic basis that relates to power. Older men may be able and willing to give younger girls money, food, mobile phones, clothing or other 'gifts' in exchange for sex; they may offer educational opportunities or access to powerful social networks; and too often girls are unable to negotiate condom use with these partners. These realities are echoed in the HIV epidemics in Latin America and the Caribbean, where girls' HIV risk is driven by gender-based violence, and in Eastern Europe and Central Asia where the female sexual partners of people who inject drugs are at particular risk, as are girls trafficked or exploited for sexual purposes. In all contexts, the power dynamics are a malign force which must be addressed if adolescent girls and young women are to regain control of their destinies.

Such underlying factors explain why empowerment across all aspects of their lives is necessary to reduce HIV vulnerability among adolescent girls and young women. UNICEF supports the development and implementation of holistic programmes that address such broad needs. In South Africa, 'She Conquers' is a three-year campaign (2016–2019), led by the government, focusing on adolescent girls and young women aged 15–24 years.

FIGURE 9: Estimated distribution of new HIV infections among adolescents aged 15–19 years, by sex, UNICEF region, 2016



Source: UNAIDS/UNICEF/WHO Global AIDS Response Progress Reporting and UNAIDS 2017 estimates. Note: Data not available for North America.

It aims to prevent new HIV infections, reduce teenage pregnancy, keep girls in school, address gender-based violence, create economic opportunities and empower adolescent girls and young women.

Namibia made progress in mainstreaming gender in HIV through providing technical support to the Adolescent Girls and Young Women technical working group. The technical working group has since developed a core package of support for adolescent girls and young women as part of the HIV combination prevention strategy to curb new infections. National guidelines for integrated services to address gender-based violence and violence against children were developed and disseminated. In Brazil, adolescent networks with girls in leadership roles, particularly the National LGBT [lesbian, gay, bisexual and transgender] Adolescent Network and the National Network of Adolescents and Youth Living with HIV/AIDS, addressed the LGBT and girls' empowerment agenda. In Indonesia, the LOLIPOP (Linkages for Quality Care for Young Key Populations) model addresses the needs of girls and young women who self-identify as key populations *(see Case Study 4)*.

UNICEF has also worked to strengthen and implement priority adolescent-oriented initiatives funded by large donors. Examples of its close collaboration with the Global Fund include providing technical support to design and implement targeted initiatives at the country level, funded though the Global Fund Catalytic Initiative on Adolescent Girls and Young Women or through the Global Fund's regular grant-based funding mechanism. In Kenya, the previous Country Operational Plan of the US President's Emergency Plan for AIDS Relief (PEPFAR) only narrowly covered adolescents through the DREAMS initiative[27], which focused solely on HIV prevention for adolescent girls and young women. Through advocacy, UNICEF helped to ensure that the country's new Country Operational Plan has allocated specific funds aimed at broader adolescent programming that includes boys and goes beyond prevention to include care, treatment and psychosocial support.

The Global Fund's signature investments in adolescent girls and young women will unlock over US$100 million in new and existing funding to intensify effective prevention programming within new grants. UNICEF is partnering with the Global Fund to make sure its catalytic investment for adolescent girls and young women is efficiently allocated and effectively used, including through high-quality technical assistance to governments and principal recipients of grants. The contributions from the Global Fund and other partners could ultimately change the future trajectory of the HIV epidemic in sub-Saharan Africa. However, with the exception of a handful of countries, current financing levels for HIV prevention – across all investment partners – remains well under the target of 25 per cent of all AIDS spending, as agreed upon by the signatories to the 2016 Political Declaration on HIV and AIDS.[28]

Key populations

The term 'key populations' refers to groups of people who are disproportionately at risk for contracting HIV and disproportionately likely to be living with it. Vulnerability to HIV differs by country and context, but certain groups of people are highly vulnerable and affected almost everywhere due to combinations of factors including epidemiology, sexual and other behavioural practices, and social, economic, legal and political exclusion or discrimination. These include men who have sex with men (MSM), transgender people, people who inject drugs, and sex workers.

Within key populations, adolescents are in a sense 'doubly vulnerable', which can mean that interventions targeted at adolescents in general do not fully meet their needs, and neither do interventions targeted at their key population overall.

A series of high-impact HIV prevention interventions can have immediate, far-reaching results in halting transmission among key populations of all ages, including access to PrEP, post-exposure prophylaxis (PEP), needle and syringe exchange options, and condoms and lubricants. To have the greatest possible effect, these commodities should be made available in a non-judgemental manner. Community-based organizations and peer-provided interventions are often more likely to be accepted and trusted than government-provided services, especially in places with legal and social environments that marginalize key populations.

In 2017, UNICEF worked with UNFPA to support initiatives that provided safe spaces for vulnerable adolescents and youth from key populations to voice their concerns and engage in programming. In many countries, comprehensive behaviour change communication strategies for adolescents and youth (including those from key populations) have been developed, updated and implemented. UNICEF engagement in interventions aimed primarily or partly at reaching key populations has consistently been based on assessing the political and economic space in the local context and seeking to ensure that safety, quality and sustainability can be assured.

One example of this targeted support can be seen in Indonesia, where UNICEF has supported the innovative LOLIPOP initiative targeting young key populations (see *Case Study 4)*.

Other UNICEF engagement in PrEP expansion has taken place more widely in the East Asia and the Pacific region, where the organization has collaborated with UNAIDS to support 'Youth Voices Count' in the completion of 'We Want PrEP', a study on preparedness for PrEP use among adolescent MSM and transgender people in Indonesia, the Philippines, Thailand and Viet Nam. The study revealed that 83 per cent of adolescents who participated in the online survey were willing to use PrEP. Recommendations based on the study findings will be used in advocating

CASE STUDY 4: INDONESIA: REACHING YOUNG KEY POPULATIONS AT RISK OF AND LIVING WITH HIV: EARLY LESSONS LEARNED FROM THE LOLIPOP PROJECT

From 2011 to 2015, reported new HIV infections in Indonesia increased annually by 13.1 per cent among older adolescents (aged 15–19 years) and by 11.8 per cent among young adults (aged 20–24 years). The risk of infection is particularly high among members of these young key populations (YKPs), yet most individuals in these population groups have never been tested for HIV, and clinical care and engagement among them is difficult due to stigma and social conservatism.

In 2015, the national Ministry of Health initiated a demonstration project called LOLIPOP (Linkages for Quality Care for Young Key Populations) that is now active in four cities – Bandung, Denpasar, Jakarta and Surabaya – with the aim of closing HIV prevention and treatment gaps in YKPs. Specific objectives include increasing awareness of and access to services (e.g., for testing and adherence support); strengthening health-care provider capacity to deliver services; and utilizing strategic information to foster adaptive learning and continuous programme improvement. The project was funded through a MAC AIDS Foundation grant.

Early results have been promising, although uneven. In Bandung, the country's third-largest city, analysis of an age-disaggregated national HIV testing and treatment dataset showed a 43 per cent increase in access to HIV testing among adolescents and young people from key populations (aged 15–24 years) between 2015 and 2017. Linkage to treatment did not show the same improvement, however. One barrier cited is age of consent policies that require parental consent for those younger than 18 years of age to get an HIV test and to access treatment. Another is directly associated with fear of disclosure: even individuals who are old enough to initiate treatment on their own do not always do so because of the possible consequences of family members or others finding out they are taking HIV medications.

Nevertheless, the notable success in increasing testing and awareness seems likely to translate into substantial improvements in treatment access over time, especially among those in key populations aged 18 years and older. Several factors have contributed to the project's initial positive outcomes. For one, social media has been an important vehicle for generating demand for services, with current and potential clients also using LOLIPOP social media platforms to interact. The project has directly contributed to improved quality of care and reduced stigmatization by increasing awareness among health workers of the specific needs and vulnerabilities of YKPs. The Bandung AIDS Commission and the Bandung Health Office are jointly developing the city's HIV strategy, which is inclusive and supportive of YKPs.

Drawing on these early lessons, one priority as the project scales up further in Bandung and other Indonesian cities will be to integrate critical interventions into the project's services, such as offering pre-exposure prophylaxis (PrEP) as a prevention method. The social media strategy will be enhanced and expanded through capacity-building of networks of YKPs to include real-time monitoring of utilization of services and health outcomes among YKPs; online counselling; and peer-led communications and support. Broader social and political engagement to address policy barriers (e.g., age of consent restrictions) remain critical to enable further scale-up. One notable observation is that the involvement of YKPs as 'champions' in LOLIPOP has greatly contributed to the successful branding and attitude changes among service providers, by demonstrating the leadership skills of YKPs themselves.

for participation of adolescents at substantial risk of HIV infection in national PrEP demonstrations and roll-outs.

In the Islamic Republic of Iran, a programme in partnership with the Ministry of Health and Medical Education has intensified action towards HIV prevention among the most at-risk adolescent populations. A series of adolescent well-being clubs have been piloted in five provinces; each provides sexual and reproductive health and HIV-testing services along with substance-abuse prevention and life-skills education.

In Latin America, UNICEF contributed to shaping strategies to better address the preventive-health needs of adolescents from key populations through its work on the Regional Task Force on PrEP, convened by the Pan American Health Organization (PAHO, WHO Regional Office for the Americas). In Brazil, the Youth Aware project provided a range of adolescent-friendly services and support for adolescents within key population groups in six cities, resulting in increased rates of HIV testing, ART initiation and viral load suppression in these groups *(see Case Study 5)*.

CASE STUDY 5: BRAZIL: A TALE FROM SIX CITIES – INCREASING HIV TESTING AMONG ADOLESCENTS AND YOUTH FROM KEY POPULATIONS

Young people are bearing the brunt of the HIV epidemic in Brazil. Over the past decade, the rate of new HIV infections among young people (aged 15–24 years) has significantly increased. Although the AIDS-related mortality rate decreased by 5 per cent in the general population between 2004 and 2014, over the same time period AIDS-related deaths increased by 43 per cent among adolescents aged 15–19 years.

Within this context, UNICEF supported the implementation of the *Viva Melhor Sabendo Jovem* (Youth Aware) project in collaboration with the MAC AIDS Fund, and in partnership with local, state and national public institutions, NGOs and community networks. This prevention- and awareness-oriented project uses mobile health units to bring essential services – including HIV testing and counselling, and testing for syphilis and hepatitis B and C – to adolescents and young people, especially those most vulnerable to HIV infection, such as men who have sex with men (MSM), sexually exploited adolescents, and adolescents in conflict with the law. For young people living with HIV, the mobile units also promote engagement with the health system and retention in care.

The project uses a range of strategies to improve the acceptability of and interest in its services among target populations, including through a public awareness campaign involving bloggers, rappers and hip-hop musicians. This was particularly effective in reaching out to young males, who represented 60 per cent of the total audience reached over the project's first three years. Of those male clients, 40 per cent self-identified as MSM. Behaviour change communication strategies included peer mobilization and direct dialogue among peers, which helped raise awareness of the ways in which HIV is prevented and the importance of testing for HIV and sexually transmitted infections (STIs).

The project began in 2013 in six cities across Brazil: Belém, Fortaleza, Manaus, Porto Alegre, Recife and São Paulo. To varying extents in each of those cities, the project has increased HIV testing and ART initiation rates among adolescents and increased the number of adolescents living with HIV who have reached and sustained undetectable viral loads. The provision of adolescent-friendly health services and the establishment of ART retention support groups in Fortaleza, for example, contributed to 85 per cent of adolescents and young people in treatment having undetectable viral loads after six months. In São Paulo, the total number of tests performed increased by 47 per cent in 2016 compared with 2015. The strategy of 'linkers' (peers who accompany the youths who have tested positive to health services for ART initiation) helped lead to an exceptionally good result of 97 per cent of treatment initiation of all those diagnosed with HIV within five months of being linked. Those who tested negative for HIV were counselled to repeat the testing and provided with critical information about preventing HIV and STIs and the availability of HIV-related services in the region.

Youth Aware's multisectoral strategy was built on existing health structures at municipal, state and national levels, and relied on the active participation of the local community. UNICEF played a key role in the overall project design, convened private and public institutions, provided technical assistance in the development of guidelines and communication materials, and supported monitoring and evaluation.

UNICEF has supported and will continue to support local governments to expand Youth Aware to other cities, based on a composite index for each city (calculated using the AIDS detection rate, AIDS-related mortality rate, and average baseline CD4 counts). In 2017, Youth Aware was implemented in Rio de Janeiro and São Luis, and will be expanded to Salvador in 2018. Also in 2018, there are plans to re-launch the project in São Paulo, in a different location (the original project there was conducted for just one year, ending in 2016).

Adolescents living with HIV

Adolescents living with and at risk from HIV often do not respond to programmes and interventions that seek to serve the general population in any community or city. The daunting and seemingly impossible task of staying on ART for life has varying effects on those who have initiated treatment. The overall poor retention in care of adolescents living with HIV suggests that context-specific, targeted approaches are needed to support them to remain on treatment and in regular contact with health and support systems. Approaches in Zimbabwe, for example, included collecting age-disaggregated data to identify poor-performing districts ('hot spots') and improving the quality of care by mentoring nurses to build their confidence and aptitude in adolescent and paediatric ART care.

Such proactive interventions are needed in light of survey data showing lower rates of viral load suppression among young people on ART compared with older people on ART. The extent of the gap is evident in comprehensive data released by PEPFAR in mid-2017 from the Population-based HIV Impact Assessments (PHIA), a complex and detailed undertaking that consists of nationally representative household HIV surveys in 14 countries.[29] According to pooled PHIA data from Malawi, Swaziland, Zambia and Zimbabwe, the prevalence of viral load suppression in people diagnosed with HIV is distinctly lower among people aged 15–24 years in all countries compared with people in older age groups.[30] The finding is significant because it reveals key gaps in HIV prevention and treatment programmes for adolescents and young people that require urgent attention and action.

Evidence and observations indicate that adherence, retention in care and overall engagement with health services among adolescents improve when peer-based support is offered. Peer support may range from being available to meet an individual at a clinic or other facility immediately after HIV diagnosis to long-term adherence support. Other types of support are aimed more at collectively helping each other to remain HIV-negative.

UNICEF has supported the creation, growth, maintenance and assessment of a range of peer-support interventions. In Malawi, UNICEF supported a series of teen clubs for adolescents living with HIV, with enrolment increasing from 393 (in 2016) to 887 (in 2017). A 2017 assessment showed that adolescents living with HIV who were enrolled in teen clubs had improved HIV and sexual and reproductive health knowledge, skills and service uptake. Twelve per cent of assessed members reported using modern contraceptives, up from zero at baseline, and 88 per cent demonstrated knowledge about good nutrition (58 per cent at baseline). Sessions with parents on disclosure and adherence complemented the teen clubs. In Namibia, teen clubs offered support for adolescents living with HIV in maintaining their treatment *(see Case Study 6)*.

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A 16-year-old boy who came to check out the HIV/AIDS awareness-raising and health tips display booth set up by the National AIDS Program (Mandalay Region, Myanmar) with the support of UNICEF and partners at the famous Taung Pyone Festival in 2016. "We are able to gain so much of knowledge on health-related issues, especially on HIV/AIDS health tips by coming to this display booth," he said.

CASE STUDY 6: NAMIBIA: IMPROVING TREATMENT, CARE AND SUPPORT FOR ADOLESCENTS LIVING WITH HIV

Since 2010, UNICEF has received funds through a partnership with the US Centers for Disease Control and Prevention (CDC) to scale up PMTCT services; improve access to and the quality of HIV prevention, care and treatment services for children and adolescents; and assess violence against children. Under the current agreement, several UNICEF country offices, including Cameroon, Côte d'Ivoire, Mozambique, Namibia, South Africa, Uganda and the United Republic of Tanzania, have implemented projects tailored to the country context.

With these funds, UNICEF Namibia supported the government in designing and implementing effective interventions to improve psychosocial well-being and adherence to HIV treatment among adolescents living with HIV. One central obstacle is that most of them (62 per cent of young women and 51 per cent of young men) lack comprehensive knowledge about sexual and reproductive health, and nearly one third of young people (15–24 years of age) do not know their HIV status. This is compounded by the limited availability of adolescent-friendly services.

To address the challenges of keeping adolescents living with HIV on treatment and regularly connected with health services, the government established teen clubs in the Ohangwena and Oshana regions of Namibia, where HIV prevalence among adolescents is relatively high. The teen clubs provide a safe and nurturing environment for adolescents living with HIV, with the goal of improving ART adherence, building supportive relationships, increasing adolescents' self-esteem and reinforcing healthy habits. Coupled with this, the project also aims to build the capacity of health-care providers and caregivers to provide adolescent-friendly care and support. Informed by the 'All In' initiative country assessments conducted in 2015 and 2016, the project also contributes to the implementation of the regional action plans on improving prevention and treatment outcomes for adolescents living with HIV.

Since 2015, the project has established 16 teen clubs and reached 1,140 individuals with treatment adherence support, psychosocial support and HIV prevention education in Namibia. In addition, 144 health workers and 115 caregivers acquired new knowledge and skills for providing adolescent-friendly services with an emphasis on facilitating adolescent HIV disclosure, including to parents. UNICEF also provides technical assistance to the Namibian Ministry of Health and Social Services for the revision of the National Guidelines on Adolescents Living with HIV (2012) and the development of operational guidance and tools to establish and maintain teen clubs.

UNICEF Goodwill Ambassador Priyanka Chopra (right) listens during a meeting with adolescents living with HIV, at the AFRICAID support centre in Zimbabwe, during a field visit in May 2017. AFRICAID provides specialized services in support of the government's National Action Plan for Orphans and Vulnerable Children.

A similar approach was used in the United Republic of Tanzania, where teen clubs supported by UNICEF and partners have been introduced to support adolescents living with HIV. At 80 facilities where the clubs were introduced, about 72 per cent of targeted eligible individuals (more than 4,350 adolescents) attended the clubs a least once. Clear signs of success can be seen in Swaziland, where UNICEF supported the strengthening of psychosocial support for ART adherence through the use of the organization's RapidPro SMS platform among members of teen clubs. A total of 425 adolescents living with HIV were reached, with results showing 73 per cent retention in ART in supported areas – a clear improvement on the 55 per cent national average.

Most teen clubs rely to a significant extent on reaching adolescents where they are, using the types of messages that resonate best with them. Flexible and innovative prevention interventions aimed at adolescents and young people follow the same principle. Social media and associated technologies are the most prominent entry-points for contemporary young people in most contexts because they are integrated so thoroughly into their lives.

STRENGTHENING DATA SYSTEMS FOR BETTER PROGRAMMING FOR ADOLESCENTS

The urgency to 'get it right' with HIV responses for adolescents and young people makes it more essential than ever to ensure that strategies, approaches and interventions have a more than reasonable chance of showing successful, transformative results. Reliable and up-to-date data are needed to guide and underpin all such efforts.

The 'All In' initiative prioritizes the collection, analysis and proactive use of data to design activities and programmes. To date, UNICEF has led more than 20 'All In' countries in conducting data reviews to understand the impact of HIV on adolescents and to improve country response efforts. Countries received targeted support at national and subnational levels using the 'All In' assessment tool to guide the systematic data gathering. UNICEF support continues with analysis on priority interventions, including those focused on adolescents and HIV prevention, care and treatment, as well as analysis of other cross-sectoral areas such as adolescent pregnancy and child birth, violence, early marriage and social protection.

The influence of data on 'All In' guidance and its impact is evident at both regional and country levels. In West and Central Africa, the 'All In' agenda has been catalytic in supporting countries to better define adolescent-specific indicators in their national HIV/AIDS strategic plans, and they have subsequently prioritized allocation for adolescent girls and young women within their Global Fund concept notes (for the 2016–2019 funding cycle). The agenda has also fostered age-disaggregated data collection and analysis, and the introduction of new technologies and tools for HIV prevention, including PrEP and HIV self-testing. Similar results occurred in Namibia, where 'All In' assessment findings informed the formulation of the new National Strategic Plan and the Global Fund proposal.

The quality of data is, of course, as important as the quantity. At a minimum, age-disaggregated data are needed to design appropriate, targeted interventions for adolescents based on risk factors and gaps. Gender-disaggregated and location-disaggregated data are nearly as useful. The likelihood of reaching the individuals and populations most in need, in hot spots or other priority target areas, increases with the amount and scope of data available.

UNICEF has been supporting increased availability of age-disaggregated data on adolescents and HIV in many countries. Results have been impressive and highly instructive in many places. In Uganda, results from a national health facility assessment led to the revision of the health management information system to provide age-appropriate data on adolescents. From July 2016, Uganda started to routinely collect age- and sex-disaggregated data on adolescents, with the first annual report made available in 2017. This shift helped to improve coverage for adolescent HIV testing services from 9 per cent in 2016 to 32 per cent (100,603 individuals) in 2017.

In China, few data exist to help policymakers and health-care providers understand the situation of adolescent key populations. UNICEF worked with the government to identify ways to collect and strengthen strategic information on such populations, particularly young MSM. They agreed to use a respondent-driven sampling (RDS) methodology, designed with support from the US Centers for Disease Control and Prevention (CDC). UNICEF and the CDC organized a capacity-building workshop in April 2017, and a targeted survey among adolescent MSM (15–19 years of age) using RDS methodology has been initiated in Beijing, Guangzhou and Tianjin. The data are being collected using WeChat platforms. These findings, once available, will strengthen the government's efforts on programming for adolescent and young MSM in China.

PROGRAMME AREA 3: ACROSS BOTH DECADES – PROTECTION, CARE AND SUPPORT

To an extent not associated with most other infectious diseases or health problems, HIV disproportionately impacts some of the most vulnerable and marginalized members of societies, including adolescent girls and key populations; its human rights dimension is shared by few otherwise comparable health risks and conditions. HIV/AIDS is a scary and confusing disease to most people. It cannot be seen or cured. People usually get HIV from behaviour and activities that many others disapprove of, or are uncomfortable discussing. It is impossible to know who is living with the virus or whether it is being effectively suppressed by treatment.

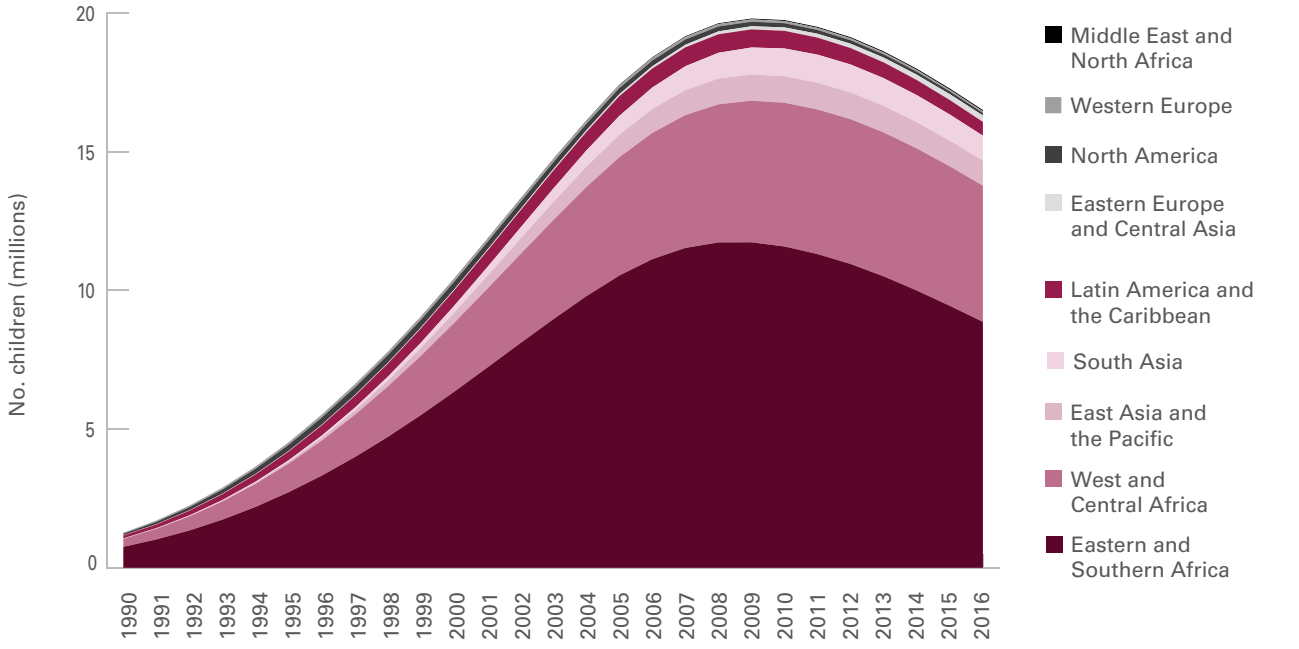
Such considerations are important for children and adolescents around the world, and especially in higher-burden countries where HIV risks are heightened and constant. ART scale-up has improved the situation somewhat by showing that HIV is a manageable condition. But in 2016, some 16.5 million children (under the age of 18 years) had already lost one or both parents to AIDS *(see Figure 10)*, and the sad truth is that these children are still often shunned and face significant economic and social obstacles to their health and well-being. For them and the millions of people living with HIV, although HIV infection is no longer necessarily a death sentence, it can be a constant challenge that prevents people from reaching their fullest potential in life. UNICEF has responded by strengthening and scaling up social welfare services and other approaches to child protection for all vulnerable children, including those affected by HIV and AIDS.

For these and other reasons, better efforts must be made to protect, care for and support children and adolescents who are vulnerable to or living with HIV. To substantially reduce their vulnerability, these efforts should include interventions and programmes that address the underlying drivers of the epidemic in different contexts. Collectively, many are categorized as social protection programmes.

Social protection programmes that are HIV-sensitive

UNICEF is a leading proponent of HIV-sensitive social protection programmes for children and adolescents. Direct provision of cash to individual beneficiaries is one method it has prioritized in recent years. Most interventions of this type share a guiding philosophy: that providing targeted populations with small amounts of cash on a regular basis can be a powerful HIV prevention tool. The assumption is that even these small amounts will help to keep children and adolescents – especially girls – in school by easing the pressure they feel to scramble for funds to pay for school uniforms, work for basic sustenance, get married, or have sex in exchange for gifts or money. Most programmes also

FIGURE 10: Estimated number of children (aged 0–17 years) who have lost one or both parents to an AIDS-related cause, by UNICEF region, 1990–2016



Source: UNAIDS 2017 estimates.

include an education and awareness component, which further reduces HIV vulnerability.

Promising evidence exists, including from countries in Eastern and Southern Africa, that cash transfers can have a salutary impact on sexual behaviour and risk-taking, and can increase access to prevention and treatment services. Based on such early findings, UNICEF is supporting governments in that region to strengthen linkages between social protection programmes and HIV prevention, treatment and care initiatives. That includes integrating HIV-sensitive interventions (e.g., community-based peer support approaches and case management and referral systems) within existing cash transfer programming in Malawi, Mozambique, Zambia and Zimbabwe.

Farther north in the region, Kenya and the United Republic of Tanzania have introduced HIV-sensitive cash transfer schemes with the support of UNICEF. In the United Republic of Tanzania, the 'cash plus' programme builds on the national government cash transfer programme with additional components for livelihoods and economic empowerment; education on sexual and reproductive health, HIV, gender and violence prevention; and linkages to relevant services for those who need them. A randomized controlled trial will assess the impact of the 'plus' component. A 'cash plus' pilot project in Kisumu County, Kenya, has objectives including promoting school attendance and reducing bottlenecks to access to HIV health services among adolescents. The pilot started with HIV counselling in the second half of 2017 and will continue in 2018.

UNICEF has also been directly involved in developing, supporting and funding social protection interventions that do not involve cash transfers. In Jamaica, an evaluation[31] was recently completed of a three-year HIV-sensitive social programme implemented in collaboration with the country's Ministry of Health and a Jamaican NGO, Eve for Life (EFL). Known as 'I Am Alive' (IAA), the project centred on three high-prevalence parishes (districts) and addressed the specific needs of adolescent mothers living with HIV. The IAA project, designed and overseen by EFL, aimed to increase adolescent girls' knowledge on HIV and pregnancy prevention; to improve PMTCT service delivery; to improve ART adherence and follow-up among adolescent mothers through peer mentorship; and to support positive prevention and adherence through income-generating activities.

The programme involved a support team comprising older women living with HIV who trained to be 'life coaches' and young programme 'graduates' who trained to function as 'mentor moms'. Those individuals provided counselling and follow-up care to participants. Survey responses and focus group discussions indicated that the programme was effective in building knowledge on sexual and reproductive health issues and HIV transmission among

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Kady Diarra, is a 32-year-old old community health mobilizer, who visits people in communities to raise awareness about HIV. She visited Odienné, in north-west Côte d'Ivoire, to give advice and information about HIV and contraception.

Adolescent boys and girls participate in a life skills event in Djibouti. UNICEF is supporting the programme with the aim of empowering adolescents and young people to think critically, boost their self-esteem and make healthy choices.

the programme's primary target population, in addition to helping participants build their sense of self-worth and accept their HIV status. Health-care providers trained by EFL also reported improvements in their knowledge about providing care for adolescents as well as their attitudes towards adolescent clients.

Based on the evaluation findings, the Government of Jamaica has adapted aspects of the IAA project to support adolescents and young people living with HIV. For example, the Ministry of Health has employed a cadre of peer navigators and mentor moms as key members of its care and support teams.

The evaluation noted the absence of a clear economic empowerment component to the project, and recommended the strengthening and expansion of opportunities not just for women's economic empowerment but also to enhance the potential for programme sustainability.

Working jointly with education

As noted previously, most HIV-sensitive social protection programmes targeting adolescents and children aim explicitly to support them to stay in school. Of particular benefit from an HIV perspective is evidence indicating that in countries with high HIV burdens, girls who attend secondary school are more likely to abstain from sex, thus are at lower risk of HIV infection, while young people with higher levels of education are more likely to use condoms and less likely to engage in casual sex than their peers with less education.[32]

The correlation may be due in part to the fact that those who stay longer in school are more likely to receive quality, comprehensive sexuality education (CSE) at one time or another. CSE is a pivotal strategy and health-improving entry point that has to be scaled up. Whether provided in schools or elsewhere, CSE is key to reducing new infections, especially among girls. UNICEF partnered with the United Nations Educational, Scientific and Cultural Organization (UNESCO), UNAIDS and other United Nations agencies to revise the international technical guidance on CSE, which was issued in January 2018. This was intended to help any appropriate authority to develop and implement CSE programmes and materials, whether they are to be used within or outside of schools. Based on international best practice, it aims to support a curriculum and a structured learning environment that will provide CSE to children before the point at which they become sexually active.

UNICEF has also helped to develop and implement innovative ways of reaching adolescents with quality sexuality education outside the classroom. In Kenya, some 17,000 adolescents received information through life-skills education in Turkana County, with another 12,000 adolescents from various other counties reached through information and counselling services as part of the one-to-one Integrated Digital Platform, a peer-led and

evidence-based programme offering quality services and literacy through mobile and web-based platforms and mainstream media. This intervention is one of several efforts aimed at attaining a national fast-track target of 80 per cent comprehensive knowledge about HIV and AIDS for adolescent boys and girls aged 15–19 years by 2018.[33] Progress will be assessed in Kenya's next Demographic and Health Survey.

In India, the National AIDS Control Organization (NACO) conducted an assessment of the Adolescent Education Programme (AEP) in 2017. Two key objectives of the AEP are to provide young people with accurate, age-appropriate and culturally relevant information about HIV in the context of life skills to students in grades 9–11, and to promote healthy attitudes and develop skills that enable young people to respond effectively to real-life situations. The assessment, conducted in six states, showed that the level of knowledge had increased slightly but that gaps remained in terms of programme implementation. These include issues of political sensitivities to the curriculum and poor linkage to service delivery.

Gender

Women and girls are at greater risk of HIV in most of the world's high-burden countries, which are home to the majority of people living with HIV. It is worth repeating that girls accounted for 69 per cent of new infections in 2016 among those aged 15–19 years in West and Central Africa.[34] The proportion was even higher in Eastern and Southern Africa (78 per cent), and in the region with the world's fastest-growing HIV epidemics, Eastern Europe and Central Asia (70 per cent).

Biological characteristics contribute to women's and girls' vulnerability to HIV, and gender inequality is an overarching factor. In most contexts, women's socio-economic status is lower than men's, with that discrepancy enshrined in law in some places. Gender norms, expectations and pressure further disadvantage adolescent girls and young women by limiting their ability to negotiate safer sex or to resist or report instances of abuse, harassment or violence. A recent study by WHO found that women living with HIV often experience higher levels of intimate partner violence than other women.[35]

Gender-based violence is a serious problem that continues to obstruct and complicate otherwise successful efforts to reduce HIV risk and impact among female children and adolescents. It is both a cause and a symptom of HIV: adolescent girls and young women are more vulnerable to contracting HIV when they experience violence, and they are often more vulnerable to violence and abuse when they are living with HIV. Many adolescent girls who are victims of violence and abuse do not have the support they need, including legal and social services, or services for the prevention of HIV and other sexually transmitted infections.

Addressing all obstacles and challenges associated with HIV among women and girls requires strong, consistent attention to the epidemic's human rights and gender-equality dimensions. Some countries have taken this imperative more seriously than others by, for example, disaggregating household survey-based data on HIV by sex and age and undertaking gender reviews of the HIV policies and strategies of their current national development plans. Far too many, however, have not committed the attention or resources for such tasks or strengthened the necessary skills to undertake them properly. For these reasons, UNICEF has fallen short in the two output indicators in the last strategic plan that refer to these gender issues. The 2017 target was for 38 countries to have sex-disaggregated survey data collected within the preceding five years, but only 16 countries have achieved this. In terms of gender reviews, the 2017 result of 12 countries undertaking them with UNICEF support was far below the strategic plan's target of 38.

Although such gaps show the need for accelerated action on gender equality, UNICEF remains strongly engaged in addressing gender-specific risks and vulnerabilities, including by continuing to expand efforts to address gender-based violence as an underlying factor in HIV risk. In Botswana in 2017, it worked with leaders of the women's wings of local political parties to raise awareness among politicians around sexual abuse. As a result, the ruling party passed a resolution at its annual party congress to prioritize gender-based violence and sexual abuse. Through UNICEF's and UNFPA's joint collaboration with government partners in Ethiopia, 7,716 teachers, community leaders and parents received training aimed at raising their awareness and building skills related to the prevention of violence and HIV.

In addition, UNICEF and UNFPA teamed up in Myanmar to develop two joint programmes to address gender-based violence and violence against children. Work was done to increase the capacities of social welfare agencies to respond to survivors of violence; gender-sensitivity training was conducted in Kachin State with 17 NGOs; and development partners working in the state's capital city, Myitkyina, were assisted in mainstreaming gender more effectively.

The United Republic of Tanzania offers examples of wide-ranging and context-specific approaches. UNICEF has supported the government in rolling out a package combating violence against children to primary schools and communities in selected districts. This package included the development of a weekly radio programme and placement of content on social media platforms. Some 48 weekly radio programmes were produced and broadcast through 22 local radio stations. Through outreach activities, visits and engaging people in more than 25 districts, a total of 131 community listening clubs have been established, which convene every week to listen to the radio programme, discuss the topic and reflect on local practices.

Humanitarian action

Meeting the HIV prevention and treatment needs of mothers, children and adolescents is difficult in even the

most stable and well-resourced contexts. The challenges are magnified for those who live in fragile, conflict-affected and/or humanitarian settings. In some such places, health systems and other public services barely function, if they exist at all. Access to medicines, diagnostic tools (including HIV test kits) and other commodities may be intermittent at best, as supply chains can be disrupted during crises. Information and support services may not be available. Adolescents frequently face threats and risks such as rape and conscription into militias or other armed forces, and members of key populations are likely to be even more marginalized, ignored or harassed than they are in stable countries.

In 2017, UNICEF prioritized addressing HIV in humanitarian settings as part of its Core Commitments for Children. Broadly speaking, UNICEF's work on HIV in emergency settings is centred around three core commitments: providing access to information regarding prevention and care; providing women, children and adolescents with access to services; and sustaining these services – in particular HIV treatment – for the duration of the emergency and beyond.

UNICEF supported more than 46,000 pregnant women in emergency settings who were living with HIV to continue ART – reaching 81 per cent of the target group. This represents a significant increase from 62 per cent in 2016, and exceeds the goal of 80 per cent set for the end of the UNICEF Strategic Plan, 2014–2017. In addition, more than 40,000 children were supported to continue ART, compared with 23,000 in 2016. Throughout the year, the HIV programme continued to strengthen the integration of HIV activities into emergency responses; it also documented approaches and lessons learned on risk-informed programming for HIV in emergencies.

Accurate information about modes of HIV transmission and the availability of prevention, testing and treatment services is a critical aspect of the HIV response in emergencies. In the Central African Republic, for example, UNICEF worked with local NGOs and the Ministry of Health to conduct HIV awareness and testing campaigns in camps for internally displaced persons, reaching more than 50,000 people, including more than 2,500 who agreed to an HIV test. In Zimbabwe, where populations were affected by multiple natural hazards in 2017, UNICEF supported the development of integrated HIV, nutrition, child protection, and water, sanitation and hygiene (WASH) guidance. A total of 64 community leaders (14 women and 50 men) and 133 volunteer health workers (102 women and 31 men) were offered training on this guidance, and more than 20,000 people were reached through HIV awareness sessions facilitated by these trainees. In the United Republic of Tanzania, health information teams reached some 220,000 refugees with information on health education, prevention and living with HIV/AIDS, as well as the importance of maternal and child care, and early health-seeking behaviour.

UNICEF worked across countries with a high HIV burden to ensure that programmes continued to reach and serve people living with and at risk from HIV during periods of crisis. In Chad, UNICEF supported nearly 21,000 pregnant and breastfeeding women in emergency-affected areas to access HIV testing and PMTCT services. Within internally displaced persons camps and their host communities, 98 per cent of pregnant women with HIV received ART in 2017, compared with the national average of 68 per cent.

In Ukraine, in the non-government controlled regions of Donetsk and Lugansk, UNICEF enabled the expansion of HIV prevention programmes through support to local health departments in conflict-affected areas; this included establishing two new youth-friendly clinics that will serve 300 young people every month. These efforts helped to avert a risk of disruption of treatment for people living with HIV in the non-government-controlled areas, which have some of the highest HIV infection rates in all of Europe. UNICEF supplied both diagnostic and treatment commodities: HIV testing kits that enabled 25,000 pregnant women to learn their status; and ARVs for over 12,000 people living with HIV.

In response to the effects of the 2016 El Niño drought in Southern Africa, UNICEF mounted a multi-country, multisectoral response throughout 2017 that catalysed HIV, WASH, nutrition, health and social protection programming to enhance nutrition outcomes for children. In Malawi and Zimbabwe, the integration of HIV testing into nutrition centres resulted in all children with severe acute malnutrition being tested for HIV. And in Uganda, UNICEF worked in collaboration with the government, civil society groups and other United Nations agencies to deliver critical life-saving services for HIV, WASH, nutrition, health, child protection and education to approximately 1 million refugees, 650,000 of whom were children.

Humanitarian crises, particularly conflicts, can persist for years. Ensuring that HIV services are sustained is therefore an important part of the emergency response. In the Philippines, UNICEF continued to prioritize the continuation of HIV treatment in response to the observed increase in HIV cases among young people. Based on lessons learned, UNICEF developed a regional guidance document on integrated HIV and sexual and reproductive health service delivery for adolescents in emergency settings. At the local level, in communities, UNICEF facilitated dialogue with religious and tribal leaders to build support for the national adolescent health policy. Sixty such leaders were provided with information to improve their participation in health services and were offered support in promoting HIV and sexual and reproductive health services for adolescents. In Zimbabwe, UNICEF supported the continuation of service delivery for children, adolescents and pregnant women with HIV in 20 crisis-affected districts. By the end of November 2017, nearly 64,000 children, adolescents, and pregnant and breastfeeding women had continued ART in these districts.

MITIGATING HIV RISKS DURING A REFUGEE INFLUX IN KENYA

In 2017, Kenya faced a dramatic influx of refugees from Somalia and South Sudan. In response, UNICEF mounted a data-driven, multisectoral effort that included action on HIV.

An assessment in Turkana County revealed that adolescent girls were twice as likely to acquire HIV infection than their male counterparts. The possible drivers of HIV in these young women included: decreased access to and use of condoms; low levels of knowledge on HIV; high rates of sexually transmitted infection and teenage pregnancy; and age-disparate transactional sex with older men. Other contributors identified included sexual and gender-based violence, alcohol and drug use, food insecurity and multiple sexual partners.

UNICEF extrapolated these data and established targeted and rights-based interventions aimed at improving the health and well-being of children, adolescents, and pregnant or breastfeeding women living with HIV. Nearly 234,000 adolescents in Kakuma refugee camp and surrounding communities received HIV testing (exceeding the target) and those found to be HIV-positive were quickly linked with treatment and care, including psychosocial support. In addition, UNICEF and the Kenyan Ministry of Health and Ministry of Education reached nearly 25,000 adolescents in refugee camps and host communities with life-skills education. The Ministry of Health also received technical support for developing risk-informed contingency plans to avert stock-outs of essential commodities, such as life-saving HIV treatment.

Based on these achievements, UNICEF will continue to advocate for and support the use of data that are disaggregated by age and gender, and related evidence, so as to ensure the resilience of programmes and to inform action in future crises.

A fisherman draws in his fishing line as he walks the shore of Lake Turkana near Loiyangalani, Kenya. This region experienced an influx of refugees from Somalia and Sudan in 2017. UNICEF mounted risk-informed response across sectors, including HIV programming for treatment and prevention.

CROSS-CUTTING ISSUES

The 2030 Agenda for Sustainable Development offers a framework through which all development programming and services recognize and directly address entrenched social norms, social exclusion and legal barriers that undermine health and development outcomes. Tireless advocacy and evidence-gathering have made it clear over the years that the most effective, equitable and sustainable HIV-related interventions are those in which the human rights of HIV-affected communities are ingrained priorities within the programme design, monitoring and impact assessment. Similar permeation of human rights priorities is anticipated across a far wider development agenda because the urgency and need to deliberately target those who have been 'left behind' is also a core overarching obligation in the 2030 Agenda.

Adolescent girls take a selfie at the Union Development & Culture Community Centre in Djibouti where they are part of a youth empowerment programme supported by UNICEF.

Examples of how UNICEF offices around the world are working through integrated platforms to reach more women, children and adolescents have been included throughout this report. Some additional areas where UNICEF is working on cross-cutting issues – including disabilities, Communication for Development (C4D) and human rights – are included below.

HIV and children and adolescents with disabilities

Children and adolescents with physical disabilities and/or cognitive and intellectual disabilities may experience heightened HIV risk. Often, they have been deliberately excluded or ignored in programme design and service delivery, including in some basic ways such as failure to make facilities accessible for those with mobility challenges, or by not providing adequate transportation alternatives to sites for them and their families. As these access-related challenges suggest, these children and adolescents have diverse needs that require tailored responses if they are not to continue being left behind.

UNICEF is helping to pioneer tailored responses in a range of settings. In Namibia, it is supporting an initiative offering opportunities for adolescents living with HIV who are also living with one or more disabilities (e.g., hearing or visual impairment) to participate in various sporting activities. More than 20 individuals from these populations participated in the Ohangwena regional tournament, where they interacted with adolescents from more than 30 schools during games and sports, as a healthy lifestyle strategy that also promotes discipline, team spirit and organization skills.

Communication for Development, sport for development, social media

Communication for Development (C4D) is the bedrock of HIV prevention, counselling and ART adherence. UNICEF's C4D activities aim to help children survive and thrive through addressing behavioural and sociocultural challenges in both development and humanitarian contexts using a mix of communication tools and approaches. The goals it works towards include: greater demand for and utilization of services; the adoption of key parenting, family and community practices; and the abandonment of harmful social norms. It also supports the empowerment and engagement of communities and young people, particularly the most marginalized, which involves ensuring that they participate in the design and ownership of interventions and that duty bearers are held accountable for the delivery of quality services.

Throughout much of the world, HIV and AIDS remain highly stigmatized. Sex-related social norms have created barriers to the dissemination of information about the prevention and treatment of the disease. UNICEF works with caregivers, especially mothers, to communicate its prevention activities in support of young children, and targets adolescents directly in its efforts to reframe the HIV/AIDS conversation and prevent the spread of the disease. Across all age groups, UNICEF promotes equitable social protection interventions, including efforts to address the impacts of acute and chronic emergencies on people living with or affected by HIV and AIDS.

C4D is an integral strategy to promote positive social and behavioural change within the 'All In' initiative in 25 priority countries. Activities range from radio soap operas with story lines about young people and HIV and AIDS to online portals offering information and anonymous counselling. UNICEF has strengthened its global C4D capacity by placing C4D advisers in all regional offices and by increasing its focus on building C4D capacity of national governments and other local partners.

In South Africa, UNICEF has sought to boost rates of exclusive breastfeeding – the most nutritious and health-enhancing source of food for infants – in an environment characterized by fears of mother-to-child transmission of HIV. Many mothers are unaware of the unassailable value of exclusive breastfeeding or the fact that ARVs prevent HIV transmission from a breastfeeding mother by suppressing her viral load.

UNICEF and South Africa's National Department of Health (NDOH) designed and launched a national breastfeeding communication and behavioural change campaign. The campaign was rolled out in the form of posters and billboards displayed in public spaces (including taxi ranks and health facilities), advertisements in magazines, and public service announcements on television. Videos were developed in support of MomConnect, a mobile health (mHealth) initiative that links pregnant women and mothers to health-care information through mobile phone technology. These videos were promoted on the social media platforms of the partners, and a social media plan was developed for implementation by the NDOH.

UNICEF's HIV work in Kenya has a strategic focus on the second decade of life. In 2017, in partnership with musician and activist King Kaka and his campaign *Kula Life na Adabu* ('Live Life Responsibly'), UNICEF increased awareness of HIV among 1 million adolescents through social media platforms. A social media campaign in Lesotho, meanwhile, centred on children telling their stories about the fight against HIV and how it has affected them. Some 15,000 people were reached through this campaign, which generated continuing dialogue about the universal 'test all' approach, stigma, prevention of new infections among adolescents, voluntary medical male circumcision (VMMC) and LGBTI (lesbian, gay, bisexual, trans and intersex) rights. The campaign continued through World Children's Day (20 November).

Sport is an entry-point that UNICEF has sought to exploit in various contexts, recognizing its contribution to healthy growth and development in children and adolescents. Sport can build self-esteem and life skills; mobilize communities; foster peace and tolerance; and teach important life lessons about respect, cooperation and leadership.

The 'Galz and Goals' programme in Namibia empowered 4,000 adolescent girls from 12 regions in 2017 (an increase from 3,200 from 10 regions in 2016), addressing adolescent pregnancies and HIV. Separately, more than 20,000 adolescents in Namibia acquired knowledge and skills, including prevention of HIV, pregnancy, alcohol and drug abuse, and the importance of treatment adherence, through in-school life-skills education, comprehensive sexuality education (CSE), sport for development (S4D) programming and teen clubs.

Mobile technology has also been an important component of the C4D strategy for HIV/AIDS in Mozambique. For over 18 months the U-Report platform has been used to provide counselling services and to conduct polls on sexual and reproductive health and HIV prevention for adolescents and young people.

One critical component of successful efforts to reach adolescents, children and their mothers with the information and services they need is to make it available in ways and places that are most convenient and acceptable to them. A potentially useful strategy is to learn from young people who their 'influencers' are, such as celebrities from the worlds of sport or entertainment, and to use that knowledge strategically for optimal impact.

From the service-delivery standpoint, online solutions such as social media platforms and telemedicine underscore the extent to which technology has advanced in unprecedented ways over the past decade. These innovations are increasingly driving and supporting community-level changes as well as local, national and global economies, and international development efforts. Technology can support the C4D emphasis on communication models that aim to facilitate participation, inclusion and empowerment.

Respecting the human rights of children and adolescents in the context of HIV and AIDS

A human rights-based approach is at the centre of UNICEF's vision to create a protective environment where children and adolescents are free from violence, exploitation and unnecessary separation from family. UNICEF plays an active role in providing targeted advocacy, policy advice and technical assistance to improve constitutional and legal frameworks. Over the span of the UNICEF Strategic Plan, 2014–2017, the organization particularly supported countries in implementing the necessary reforms to reflect their international human

rights commitments as signatories to the Convention on the Rights of the Child (CRC), the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the Convention on the Rights of Persons with Disabilities (CRPD), and to respond to the recommendations issued by their respective committees.

Having relevant legal and policy frameworks is an important step towards leaving no one behind, but effective implementation sometimes remains a challenge. UNICEF continues to provide technical assistance to address these implementation gaps. It also aims to strengthen accountability systems, which contribute to giving a voice to children and adolescents, and which also improve their access to remedies in case of violation of their rights. For example, continuous support is provided to independent national human rights institutions not only to strengthen their monitoring mandate but also to ensure that complaint mechanisms are child friendly.

Whether in an emergency situation or in a development setting, a rights-based approach will ensure that the goal of leaving no one behind will be achieved, and that children everywhere will have their fundamental rights protected.

A growing body of evidence demonstrates how children and adolescents living with or affected by HIV are especially vulnerable to human rights challenges such as violence, abuse, neglect and exploitation. Policymakers and other key actors involved in child protection and HIV aim to strengthen existing child protection systems, policies and laws so that they include HIV-sensitive and adolescent-sensitive responses. Other important considerations in increasing adolescents' access to information and services include promoting policies that allow adolescents to have access to a broad range of health services, including sexual and reproductive health, and conducting implementation research on the delivery of services for adolescents.

In this area of work, UNICEF supported a legal review of consent laws and policies in 22 countries and a review of ethical, social and cultural barriers in 11 countries, in collaboration with the Southern African AIDS Trust (SAT) and law firms in the Thomson Reuters network. This exercise helped to increase understanding of the legal, policy and cultural barriers that prevent adolescents from accessing services for sexual and reproductive health and HIV. For example, several countries reviewed require the adolescent to obtain parental consent for HIV testing, or will report the result of an adolescent's HIV test to the parent. Specifically, the focus of the review was on legislation and practice in relation to sexual activity, contraception, HIV testing, ART, PrEP, PEP, abortion, ANC, human papillomavirus (HPV) vaccination, and cervical cancer screening and treatment. The evidence from these country reviews is intended to inform national advocacy efforts aimed at bringing about changes in laws and policies. The reports were launched in early 2018.[36]

UNICEF is also responding to increasingly urgent needs in the Philippines. The country has the fastest-growing HIV epidemic in Asia, with the annual number of new infections surging over the past six years.[37] Young people are disproportionately affected, as 68 per cent of newly reported HIV cases occur among young persons aged 15–24 years.[38] Reaching them with the information and services they need is hindered by restrictive legal provisions requiring those younger than 18 years to obtain written consent from their parents if they are to access reproductive health services and to be tested for HIV.

UNICEF is supporting a partnership model with local government units for the provision of care to those under 18 years of age in the Philippines through a memorandum of understanding with non-government service providers. As a result, two high-burden cities have amended their HIV ordinances by lowering the age of consent for HIV testing from 18 to 15 years old. Most service providers are more comfortable and willing to provide services through the partnership model. Most importantly, more than a thousand younger adolescents have accessed HIV counselling and testing, with those screening positive for HIV being linked to services.

UNICEF in Myanmar has sought to ensure equitable scale-up of HIV testing, prevention and treatment services – another indicator of how and whether human rights are prioritized. As in the Philippines, one effort has been to change age of consent laws that restrict many adolescents from obtaining HIV, sexual health and other services without their parents' permission. As a result of joint advocacy with partners in Myanmar, a draft law was prepared which states that people aged 16 years or older should be able to decide for themselves if they wish to access HIV services. The draft law is being submitted to parliament.

FUTURE WORKPLAN: UNICEF STRATEGIC PLAN, 2018–2021

Existing achievements and lessons learned during 2014–2017

As the results in this report indicate, UNICEF's work on HIV has highlighted the critical gaps that remain and the impact of different programme approaches and innovations. Much of UNICEF's technical support and guidance has helped to push through the required shifts in HIV programming approaches and priorities, with an emphasis on data-driven decision-making; fostering of integration across other health and development sectors; and including effective engagement of civil society, communities of people living with HIV, and key and vulnerable populations in all aspects of HIV treatment and prevention services.

At the same time, UNICEF has been a consistent, strong advocate for the health and rights of children, pregnant women and mothers, and adolescents affected by HIV and AIDS in all contexts. In 2017, its work through the 'All In' platform continued to galvanize attention and resources to one of the most challenging and devastating gaps in global HIV responses: the continued failure to halt new infections among adolescents and young people, particularly girls and women, and to improve their access to treatment.

UNICEF has not let its work on the most difficult and challenging problems detract from its attention to areas where more notable progress has been achieved. For example, it has sought to push governments and development and civil society partners to maintain the momentum towards worldwide EMTCT and reaching more children and adolescents with HIV testing and ART. Continued progress, especially through the difficult 'last mile' of reaching the most vulnerable and those living in the most disadvantageous environments, will not only be valuable for its direct impacts but will also yield vital ancillary and long-lasting benefits through having created strong, proven systems and processes that can be adapted for other components of HIV and health programming.

Some of the learning and adaptations from effective PMTCT scale-up have broader implications for achieving results in HIV treatment in children and adolescents and HIV prevention in adolescents, including adolescent girls and young women. UNICEF will continue driving its responses to ensure that the effects of HIV are mitigated among all children, adolescents and their families. Its pioneering support for social protection schemes and

Children play at sunset in Kisenga, Haut-Katanga Province, Democratic Republic of Congo. In this region, UNICEF focused on PMTCT through the OHTA initiative in which community facility linkages were strengthened, partners were encouraged to take part in antenatal care, and facilities were supported to provide women and children with the care they need.

policies represents one approach. Another is its recognition of the value of differentiated service approaches in boosting efficiency and effectiveness, which will only become more important as countries are expected to do more with less. Targeting resources to where and among whom the epidemic is most severe, or most likely to be threatening over time, is a strategy that UNICEF and many of its partners will continue to ramp up. As this happens, the challenges and needs of young key populations and adolescent girls and young women will almost certainly remain at the forefront of UNICEF's attention.

HIV and AIDS in the new UNICEF Strategic Plan, 2018–2021

UNICEF's HIV programme will build on and expand such work over the period of the new UNICEF Strategic Plan, 2018–2021. The programme's focus on integration in recent years is well suited to the needs and expectations of the new strategy, which was designed to feed into and be influenced by the 2030 Agenda. HIV and AIDS programme priorities in the new strategic plan period are: (1) finishing the unfinished business of PMTCT, (2) preventing HIV in adolescents, and (3) closing the treatment gap for children and adolescents.

These highlights underscore that the new strategy will confirm to and build on UNICEF's core mandate and commitments to realizing the rights of every child, especially the most disadvantaged, and the organization's comparative advantage in its work on the HIV response. However, UNICEF will work in new ways that focus its HIV resources and talents more selectively and collaboratively so as to define and deliver HIV results.

UNICEF has identified four operational shifts in the new strategy period that are intended to maximize its successful work to date while also ensuring it retains the flexibility and scope to engage in new ways. All of the following are intended to enable UNICEF to achieve the greatest impact for children and adolescents from available resources:

1. A differentiated response for country and programme prioritization;
2. Effective integration with joint results and clearly defined accountability;
3. Intensified partner leveraging for resources and action;
4. Strengthened knowledge leadership to enhance programme responses through a learning collaborative.

A differentiated response for country and programme prioritization

The HIV epidemic and the response to it for children and adolescents varies across and within countries. Working with partners, the UNICEF programme will actively identify these variations and differentiate its support and interventions according to the specific needs and opportunities in each region, country or subnational setting. The factors and criteria for differentiation include the following:

- Key characteristics of the current burden of HIV, including its geographical distribution, HIV incidence, modes of transmission, and population mixing patterns;
- A country's capacity to respond to the needs of mothers, children and adolescents, and the strength of the systems used to do this;
- The capacities and investments of partners in the HIV response, including government, community and civil society, the private sector and development partners (UNICEF will focus on unmet need);
- A focus on adolescents, especially adolescent girls and adolescent members of key populations;
- UNICEF's comparative advantage.

UNICEF's highest-value contributions for mothers, children and adolescents depend on the convergence of four criteria in each country and region: advocacy and convening; technical support for the implementation of services; research and securing the best available data on children and HIV; and providing guidance and support on how data are best used. In all settings, UNICEF will seize every opportunity to drive a 'proof of concept' of innovations and to disseminate and facilitate learning.

Effective integration with joint results and clearly defined accountability

The logic of integration is undeniable, and the 2030 Agenda for Sustainable Development has placed this front and centre for HIV and other development programming. Gauging the impact and value of integrated responses can be difficult, however, and it is not always clear where and how to proceed if funding dries up for specialized services (e.g., for adolescents living with HIV). Greater accountability is needed across country programmes – for example, to determine the costs and benefits of programmes in other sectors that have an impact on HIV responses.

The new strategic plan calls for integration with accountability in three ways: (1) tracking of non-HIV resource contributions to the HIV programme, such as those from UNICEF's health, education, protection, gender, adolescent, early childhood development and social policy sections; (2) tracking of HIV resource contributions to other programme outcomes; and (3) bolstering systems for accountability, so that multiple sectors have both resources and reporting accountability for agreed joint HIV results. Emphasis will be placed on joint programming for adolescent girls and young women, with particular attention to generating prevention results through investments in secondary education, social protection, sexual and reproductive health and rights, and violence prevention and response systems.

In the UNICEF Strategic Plan, 2018–2021, HIV is part of Goal Area 1, with the following outcome: "Girls and boys, especially those that are marginalized and those living in humanitarian conditions, have access to high-impact health, nutrition, HIV and ECD interventions from pregnancy to adolescence, enabling them to survive and thrive."

Intensified advocacy and partner leveraging for resources and action

The nearly US$22 billion spent annually on HIV responses flows from and is used by a wide range and variety of actors. UNICEF's efforts to address unmet need will require greater understanding of partners' work and its impact. To this end, UNICEF will need to assess partners' engagement in each region or country to determine: (1) what is being done for mothers, children and adolescents and HIV; (2) what is being done, but could use UNICEF support to strengthen or redirect efforts; and (3) what is not being done. Where there are gaps, UNICEF will use its leadership and convening power to advocate for such gaps to be closed.

A key part of such assessments will be to focus on the need for and availability of non-biomedical interventions. By far the largest share of HIV resources in contexts worldwide is used to cover ART provision, which is at the heart of the UNAIDS 'fast-track' targets that countries are seeking to meet. Quality, effective and sustainable HIV treatment requires more than just pills, however. Critical supportive interventions such as adherence support, which is often provided by community and other civil society groups, also require increased and sustained resources. Similarly, more effective HIV prevention efforts, including among adolescent girls and young women, depend on social and behavioural change interventions.

UNICEF already champions and supports such work, and it will advocate with partners to increase their investments in such areas. UNICEF advocacy takes place in both the public and political spheres; it is based on evidence and UNICEF's experience 'on the ground'. UNICEF's policy advocacy is an integral part of its HIV and AIDS programme.

Strengthened knowledge leadership to enhance programme responses through a learning collaborative

UNICEF will seek to further magnify its data- and efficiency-centred approach to HIV programming by spreading information that can help governments and other partners make more strategic decisions. To help achieve that objective, a global learning collaborative led by global and regional colleagues will support countries to generate, synthesize and share evidence. The specific focus will be on actively locating and then linking and retaining pregnant and lactating women, children and adolescents (aged 10–19 years) to HIV-specific and HIV-relevant services. Another aim will be to transform the narrative around monitoring and evaluation from perfunctory reporting to a source of empowerment and a foundation of accountability. The learning collaborative will synthesize, organize and package available and emerging evidence, learning and results across different actors and settings – and share these within and among other countries and regions. It will support knowledge dissemination efforts by communities, service providers and policymakers at country and regional levels so as to inform the scale-up of effective interventions and to create demand for them.

EXPRESSION OF THANKS

UNICEF expresses its appreciation to all resource partners that contributed to its work on HIV and AIDS throughout 2017. Thematic funding has allowed UNICEF to provide technical, operational and programming support to countries in all regions for both upstream and decentralized work, and to deliver quality services to marginalized children, adolescents, women and communities. Thematic funding provides greater flexibility and supports longer-term planning and the sustainability of programmes. It reflects the trust that resource partners have in the ability of UNICEF to deliver quality support under all circumstances and has made possible the results described in this report.

UNICEF will continue to explore new ways of enhancing visibility for partners that provide global-level thematic funding, and looks forward to brainstorming with the partners themselves about how to develop new approaches that are "fit for purpose".

UNICEF would like to express its gratitude, especially to those partners who provided support through the Korean Committee for UNICEF, the largest contributor to the HIV and AIDS programme; and to the Global Fund, UNAIDS, the United States of America and the Netherlands, for their generous contributions to the organization's flagship programmes and innovations.

Fred Zake and his wife, Abasa Navassa Prossie live in Kabale, western Uganda, with their two daughters, Beyonce and Alinda Avis. After Abasa fell pregnant with Beyonce, Fred accompanied her to the health centre where she received antenatal care. During the visit, Fred was tested positive for HIV. Abasa was not infected and the couple received support and guidance on how to prevent infection. Fred was given advice on how he could support his wife – from making sure she was getting the right nutrients during pregnancy, to the importance of keeping up to date with immunizations.

ABBREVIATIONS AND ACRONYMS

2030 Agenda	2030 Agenda for Sustainable Development
AIDS	acquired immunodeficiency syndrome
All In	All In to End Adolescent AIDS initiative
ANC	antenatal care
ART	antiretroviral therapy
ARV	antiretroviral
C4D	Communication for Development
CDC	United States Centers for Disease Control and Prevention
CHAI	Clinton Health Access Initiative
CSE	comprehensive sexuality education
EID	early infant diagnosis
EMTCT	elimination of mother-to-child transmission
HIV	human immunodeficiency virus
ICASA	International Conference on AIDS and Sexually Transmitted Infections in Africa
MDG	Millennium Development Goal
MSM	men who have sex with men
MTCT	mother-to-child transmission
NGO	non-governmental organization
PEP	post-exposure prophylaxis
PEPFAR	The United States President's Emergency Plan for AIDS Relief
PHIA	Population-based HIV Impact Assessments
PMTCT	prevention of mother-to-child transmission
POC	point of care
PrEP	pre-exposure prophylaxis
SDG	Sustainable Development Goal
SMS	Short Message Service (text message)
STI	sexually transmitted infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
WASH	water, sanitation and hygiene
WHO	World Health Organization

Note on data: Country examples, including country data, were provided for this report by UNICEF country offices in their annual reporting for 2017, except where otherwise specified. Data cited throughout the report are from UNAIDS 2017 estimates, unless otherwise specified. The UNAIDS estimates are based on data collected and analysed at the end of 2016. The complete data are available on UNICEF's data site: <https://data.unicef.org/topic/hivaids/global-regional-trends/>.

ENDNOTES

1. Joint United Nations Programme on HIV/AIDS, , UNAIDS, Geneva, 2016, <www.unaids.org/en/resources/documents/2016/prevention-gap>, accessed 30 March 2018.

2. The six regions are Eastern and Southern Africa, West and Central Africa, East Asia and the Pacific, South Asia, Latin America and the Caribbean, and the Middle East and North Africa.

3. Data cited throughout the report are from UNAIDS 2017 estimates, unless otherwise specified. The UNAIDS estimates are based on data collected and analysed at the end of 2016. The complete data are available on UNICEF's data site: <https://data.unicef.org/topic/hivaids/global-regional-trends/>.

4. Improved HIV responses are particularly relevant for and linked with the following SDGs, all of which are of high priority for UNICEF: SDG 1 (End poverty in all its forms everywhere); SDG 3 (Ensure healthy lives and promote well-being for all at all ages); SDG 4 (Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all); SDG 5 (Achieve gender equality and empower all women and girls); SDG 10 (Reduce inequality within and among countries); and SDG 16 (Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels.

5. World Health Organization, Global Health Observatory data repository, WHO, Geneva, 2012; and World Health Organization, *Health for the World's Adolescents: A second chance in the second decade*, WHO, Geneva, 2014, <www.who.int/maternal_child_adolescent/documents/second-decade>, accessed 30 March 2018.

6. Country examples, including country data, were provided for this report by UNICEF country offices in their annual reporting for 2017, except where otherwise specified. Data cited throughout the report are from UNAIDS 2017 estimates, unless otherwise specified. The UNAIDS estimates are based on data collected and analysed at the end of 2016. The complete data are available on UNICEF's data site: <https://data.unicef.org/topic/hivaids/global-regional-trends/>.

7. Joint United Nations Programme on HIV/AIDS, *Start Free, Stay Free, AIDS Free: A super-fast-track framework for ending AIDS among children, adolescents and young women by 2020, UNAIDS*, Geneva, 2016, <www.unaids.org/en/resources/documents/2016/20160926_startfree_vision>, accessed 30 March 2018. The 'Three Frees' framework is centred around three pillars: (1) eliminate mother-to-child transmission of HIV (Start Free); (2) reduce the rate of new HIV infections among adolescents and young women (Stay Free); and (3) increase HIV treatment for both children and adolescents (AIDS Free). The framework guides the 'super-fast-track' targets set by UNAIDS (and supported by UNICEF) for the years 2018 and 2020, with the goal of ending AIDS among children, adolescents and young women by 2030.

8. *Prevention Gap Report*, 2016.

9. World Health Organization, 'WHO Validation for the Elimination of Mother-to-Child Transmission of HIV and/or Syphilis', WHO, Geneva, 2018, <www.who.int/reproductivehealth/congenital-syphilis/WHO-validation-EMTCT/en/>, accessed 28 April 2018.

10. Country examples, including country data, were provided for this report by UNICEF country offices in their annual reporting for 2017, except where otherwise specified.

11. World Health Organization, *Guideline on When to Start Antiretroviral Therapy and on Pre-Exposure Prophylaxis for HIV*, WHO, Geneva, 2015, <www.who.int/hiv/pub/guidelines/earlyrelease-arv/en/>, accessed 30 March 2018.

12. Optimizing HIV Treatment Access, 'Final Programme Summary' (working draft), OHTA, 2018.

13. World Health Organization and United Nations Children's Fund, *Guideline: Updates on HIV and Infant Feeding: The duration of breastfeeding, and support from health services to improve feeding practices among mothers living with HIV*, WHO, Geneva, 2016, <http://apps.who.int/iris/bitstream/handle/10665/246260/9789241549707-eng.pdf>, accessed 28 April 2018.

14. Joint United Nations Programme on HIV/AIDS, *On the Fast-Track to an AIDS-Free Generation*, UNAIDS, Geneva, 2016, <www.unaids.org/en/resources/documents/2016/GlobalPlan2016>, accessed 30 March 2018.

15. Ibid.

16. Ibid.

17. United Nations Children's Fund and the Joint United Nations Programme on HIV/AIDS, *Step Up the Pace: Towards an AIDS-free generation in West and Central Africa*, UNICEF, New York, 2017, <www.unicef.org/publications/files/Step_Up_the_Pace_West_and_Central_Africa.pdf>, accessed 30 March 2018.

18. UNAIDS, Médecins Sans Frontières (MSF) and the African Union, *The Western and Central Africa Catch-up Plan: Putting HIV treatment on the fast-track by 2018*, UNAIDS, Geneva, 2017, <www.unaids.org/sites/default/files/media_asset/WCA-catch-up-plan_en.pdf>, accessed 30 March 2018.

19. UNICEF and UNAIDS, *Catalysing Paediatric HIV Early Diagnosis and Treatment within West and Central Africa Country Catch-up Plans: Report of the meeting at ICASA 2017 and Agenda for Action*, UNICEF and UNAIDS, Dakar, 2018.

20. The 90-90-90 targets are at the heart of the UNAIDS Fast-Track agenda. The three main overarching targets are that the following will be achieved by 2020: 90 per cent of all people living with HIV will know their HIV status; 90 per cent of all people with diagnosed HIV infection will receive sustained ART; and 90 per cent of all people receiving ART will have viral suppression. Further information is available at the website: <www.unaids.org/en/resources/909090>.

21. Joint United Nations Programme on *HIV/AIDS, HIV Prevention 2020 Road Map: Accelerating HIV prevention to reduce new infections by 75%*, UNAIDS, Geneva, 2017, <www.unaids.org/en/resources/documents/2017/hiv-prevention-2020-road-map>, accessed 30 March 2018.

22. *Step Up the Pace*.

23. *HIV Prevention 2020 Road Map*.

24. *Step Up the Pace*.

25. Ibid.

26. CD4 cells are white blood cells that fight infection. In a person infected with HIV, the virus attacks and kills off these cells, and as HIV progresses, the number of CD4 cells declines. When the CD4 count drops below 200, a person is diagnosed with AIDS.

27. DREAMS is an ambitious partnership to reduce HIV infections among adolescent girls and young women in 10 sub-Saharan African countries. The goal of DREAMS is to help girls develop into Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe women. <www.pepfar.gov/partnerships/ppp/dreams/>, accessed 2 May 2018.

28. United Nations General Assembly, Political Declaration on HIV and AIDS: On the fast-track to accelerate the fight against HIV and to end the AIDS epidemic by 2030, Resolution adopted by the General Assembly on 8 June 2016 (A/RES/70/266), paragraph 62 (g), United Nations, New York, 2016.

29. The PHIA project is funded by the US President's Emergency Plan for AIDS Relief (PEPFAR), with technical support from the US Centers for Disease Control and Prevention (CDC) and implemented by ICAP at Columbia University in New York City. Survey outcomes include national HIV incidence among adults, subnational prevalence of viral load suppression, and HIV prevalence among adults and children.

30. Detailed information and results for all countries are available at <http://phia.icap.columbia.edu/>.

31. Russell-Brown, Pauline, *Evaluating the 'I Am Alive' Programme for Adolescent Girls Living with HIV: Final Report*, PEY & Associates, undated, <www.unicef.org/evaldatabase/files/Final_Evaluation_Report_I_Am_Alive.pdf>, accessed 28 April 2018.

32. For example: United Nations Children's Fund, *Girls, HIV/AIDS and Education*, UNICEF, New York, 2004, <www.unicef.org/publications/files/Girls_HIV_AIDS_and_Education_(English)_rev.pdf>, accessed 30 March 2018.

33. National AIDS Control Council, *Kenya's Fast-Track Plan to End HIV and AIDS Among Adolescents and Young People*, NACC, Nairobi, 2015, <www.ilo.org/aids/legislation/WCMS_532691/lang--en/index.htm>, accessed 30 March 2018.

34. *Step Up the Pace*.

35. WHO. Multi-country study on women's health and domestic violence against women: initial results on prevalence, health outcomes and women's responses. Geneva: WHO, 2015.

36. SRHR Africa Trust, TrustLaw and Arnold & Porter Kaye Scholer LLP, *Age of Consent: Global legal review*, SAT, 2017, <www.satregional.org/wp-content/uploads/2018/02/Age-of-consent-Global-Legal-Review-Report-Draft-21.pdf>, accessed 28 April 2018.

37. UNAIDS, Ending AIDS: Progress towards the 90–90–90 targets. Global AIDS Update 2017, UNAIDS, Geneva, 2017, <www.unaids.org/sites/default/files/media_asset/Global_AIDS_update_2017_en.pdf>, accessed 22 May 2018.

38. Ibid.

ANNEX 1: DATA COMPANION

Visualizing achievements

Each achievement is expressed as a percentage and visualized through colour coding:

Green

Output level
Average achievement of indicators for the output is at or above 100%

Amber

Output level
Average achievement of indicators for the output is between 60% and 99%

Red

Output level
Average achievement of indicators for the output is less than 60%

Impact Indicator	Baseline*	2017 Target	2017 Update**
2a. Number of new HIV infections among children under 15 years (2011 Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS (General Assembly resolution 65/277, annex)	230,000 (2012)	93,000	160,000 (2016)
2b. Percentage of children under 15 years living with HIV receiving antiretroviral therapy	31% (2012)	50%	43% (2016)

Outcome Indicator	Baseline*	2017 Target	2017 Update**
P2.1 Countries with at least 80% coverage of ART among all children aged 0–14 years and adolescent girls and boys aged 10–19 years living with HIV	0–14 years old: 0 (2012) 10–19 years old: data not available (2012)	9 UNAIDS priority countries	0–14 years old: 3 out of 36 UNAIDS priority countries with available data (2016) 10–19 years old: 2 out of the 10 UNAIDS priority countries with available data (2016)
P2.2 Countries providing at least 80% coverage of lifelong ART for all pregnant women living with HIV	0 (2012)	9 Global Plan for EMTCT priority countries	11 out of 22 Global Plan EMTCT priority countries (2016)
P2.3 Countries in which at least 50% of overall HIV and AIDS spending is funded through domestic resources	32%	40%	40% (32 of the 80) low-and-middle-income countries that reported their latest HIV expenditures in the last 5 years had a domestic share of at least 50% (2012–2016)
P2.4 Countries with at least 60% coverage in condom use at last sexual encounter among adolescents aged 15–19 years reporting multiple partners in past year, disaggregated by sex	Males: 10 out of 14 Females: 1 out of 13	38 UNAIDS priority countries	Males: 10 out of 23 UNAIDS priority countries with data (2010–2017) Females: 1 out of 22 UNAIDS priority countries with data including India (2010–2017)

Output a

Enhanced support for children and caregivers for healthy behaviours relating to HIV and AIDS and to the use of relevant services, consistent with UNAIDS Unified Budget, Results and Accountability Framework

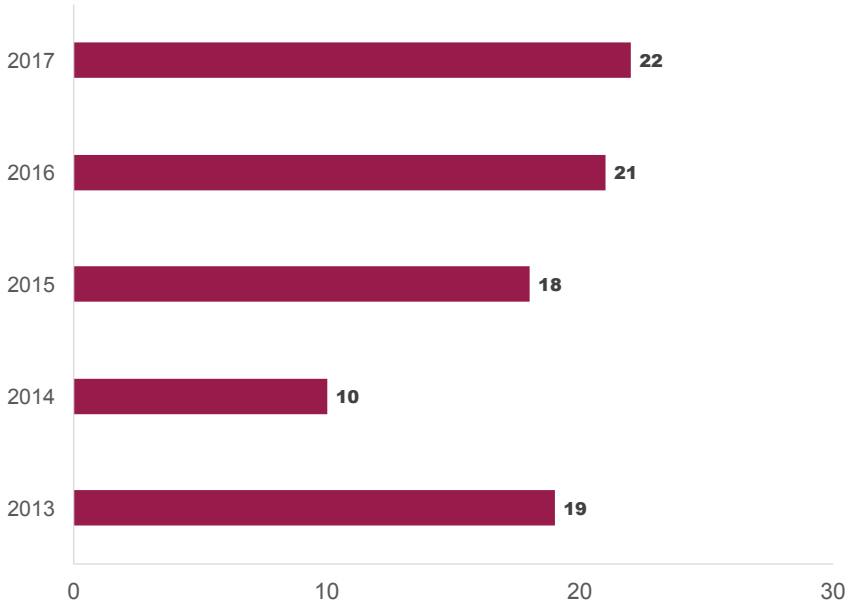
Average output achievement

8%

P2.a.1

Countries that have comprehensive behaviour-change communication strategies for adolescents and youth, including those from key populations

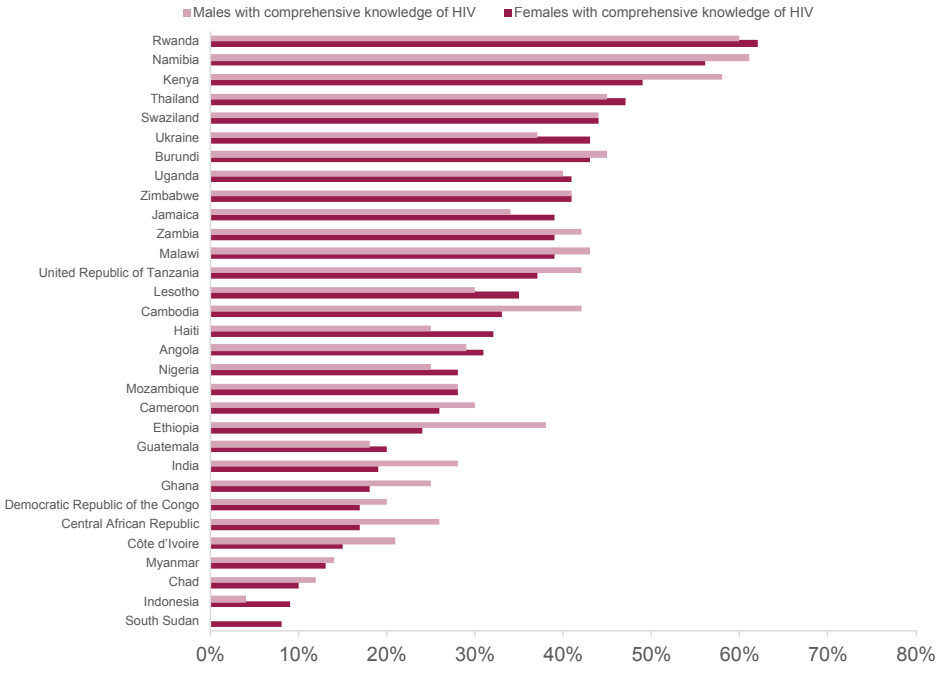
2013 Baseline	19
2014 Result	10
2015 Result	18
2016 Result	21
2017 Result	22
2017 Target	38



P2.a.2

Countries in which at least 80% of adolescents aged 15–19 years have comprehensive knowledge about HIV and AIDS

2013 Baseline	0
2014 Result	0
2015 Result	0
2016 Result	0
2017 Result	0
2017 Target	6



Output b

Increased national capacity to provide access to essential service delivery systems for scaling up HIV interventions

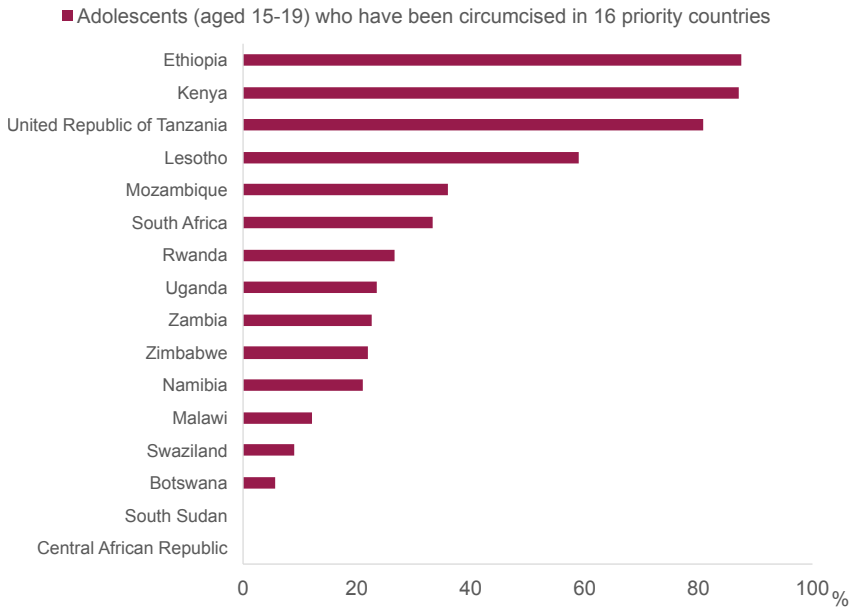
Average output achievement

68%

P2.b.1

Countries with at least 80% of eligible adolescents 10–19 years receiving voluntary male medical circumcision

2013 Baseline	0
2014 Result	0
2015 Result	0
2016 Result	0
2017 Result	—
2017 Target	16

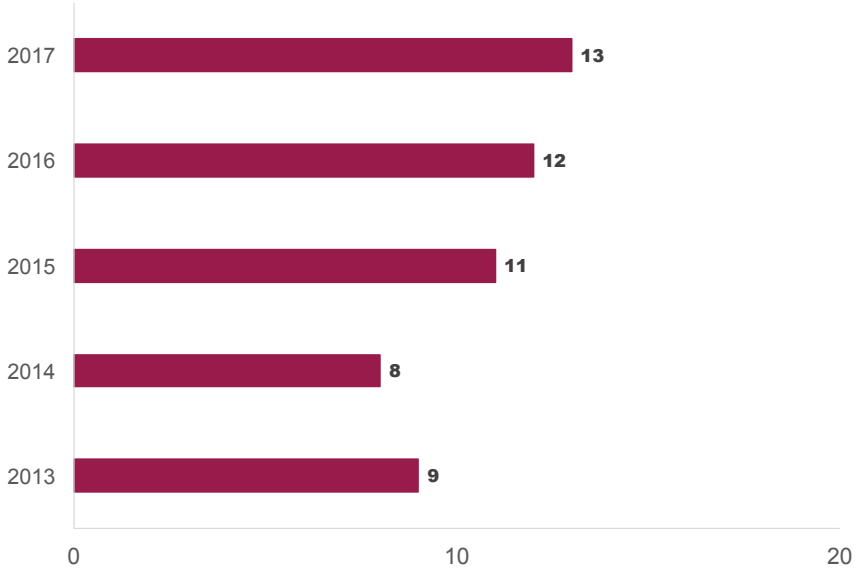


Note: This indicator is not considered in the summary analysis as no countries have provided age-disaggregated data for coverage of voluntary medical male circumcision (VMMC) among adolescents in 2017. The push to roll out VMMC has been focused on sexually active adult men, with adolescent and infant circumcision seen as a second phase intervention to maintain levels of circumcision in the population. Data from population-based surveys on the uptake of VMMC are limited. The graph shows 2016 data for all circumcisions, including VMMC and traditional circumcisions.

P2.b.2

Countries with at least 80% of antenatal care settings/facilities in targeted areas offering ART

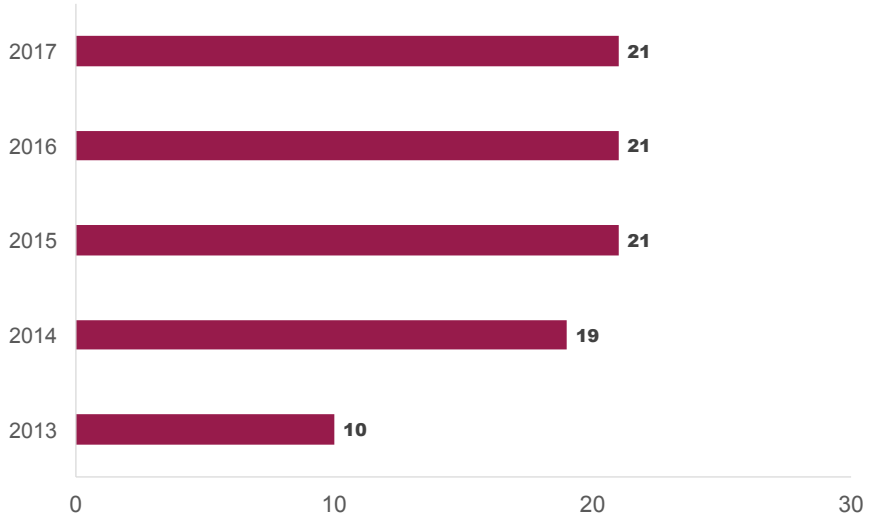
2013 Baseline	9
2014 Result	8
2015 Result	11
2016 Result	12
2017 Result	13
2017 Target	22



P2.b.3

Countries implementing task-shifting or task-sharing for non-physician health-care providers to provide ART

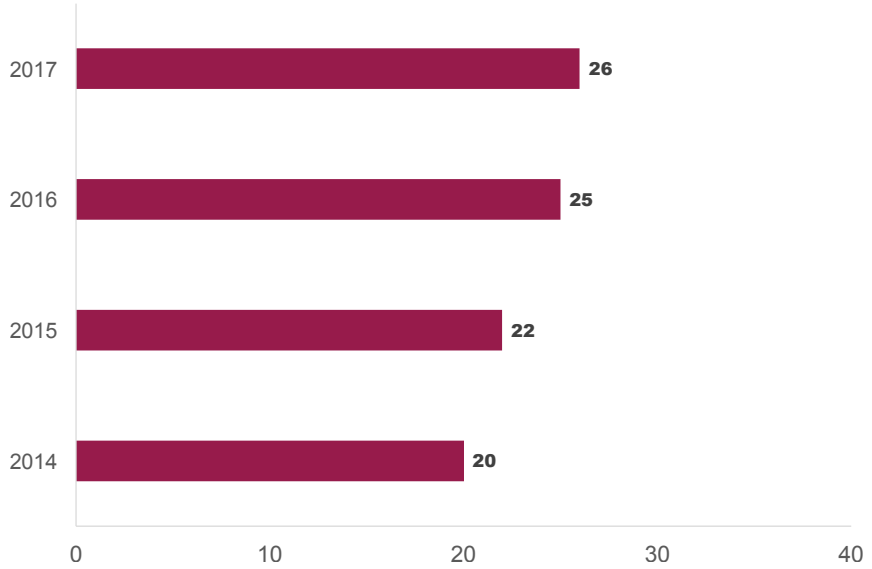
2013 Baseline	10
2014 Result	19
2015 Result	21
2016 Result	21
2017 Result	21
2017 Target	22



P2.b.4

Countries in which at least 50% of facilities in targeted areas offer provider-initiated testing and counselling to children aged 0–19 years

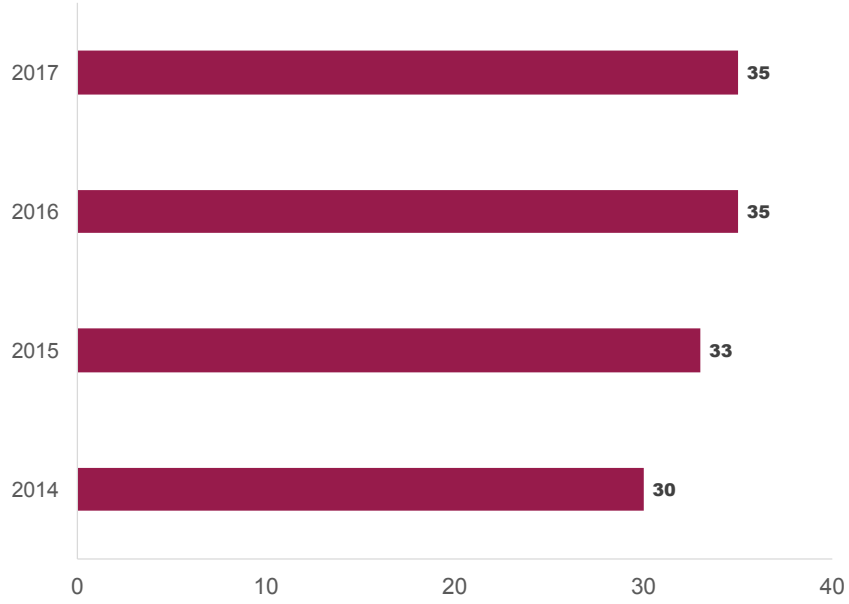
2014 Baseline	20
2015 Result	22
2016 Result	25
2017 Result	26
2017 Target	38



P2.b.5

Countries that have adopted the 2013 World Health Organization HIV treatment guidelines for children and adolescents

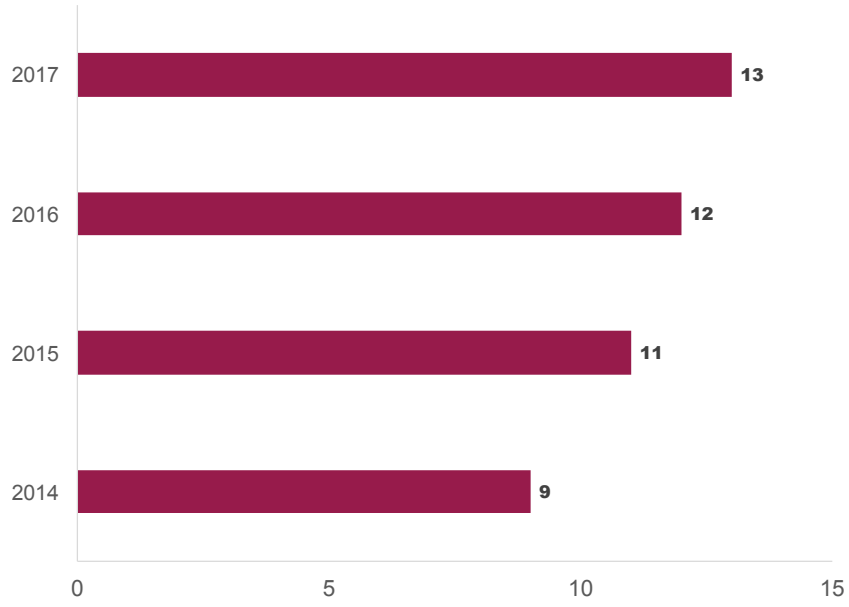
2014 Baseline	30
2015 Result	33
2016 Result	35
2017 Result	35
2017 Target	38



P2.b.6

Countries in which 80% of health facilities are providing paediatric ART

2014 Baseline	9
2015 Result	11
2016 Result	12
2017 Result	13
2017 Target	22



Output c

Strengthened political commitment, accountability and national capacity to legislate, plan and budget to scale up HIV and AIDS prevention and treatment interventions

Average output achievement

62%

P2.c.1

Countries reporting age- and sex-disaggregated data on HIV testing and counselling among adolescents 15–19 years

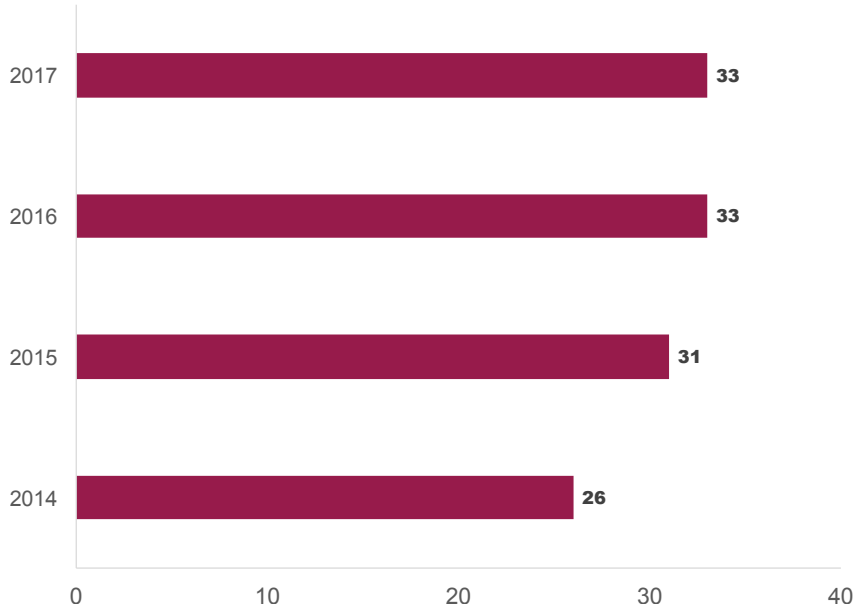
2013 Baseline	18
2014 Result	24
2015 Result	23
2016 Result	23
2017 Result	31
2017 Target	38

Disaggregated data available		Disaggregated data not available
• Angola	• Kenya	• Botswana
• Burundi	• Lesotho	• Brazil
• Cambodia	• Malawi	• China
• Cameroon	• Mozambique	• Djibouti
• Central African Republic	• Myanmar	• Indonesia
• Chad	• Namibia	• Iran
• Côte d'Ivoire	• Nigeria	• Russian Federation
• Democratic Republic of the Congo	• Rwanda	
• Ethiopia	• South Africa	
• Ghana	• South Sudan	
• Guatemala	• Swaziland	
• Haiti	• Thailand	
• India	• Uganda	
• Jamaica	• Ukraine	
	• United Republic of Tanzania	
	• Zambia	
	• Zimbabwe	

P2.c.2

Countries with national HIV/AIDS strategies that include proven high-impact evidence-based interventions to address HIV among adolescents

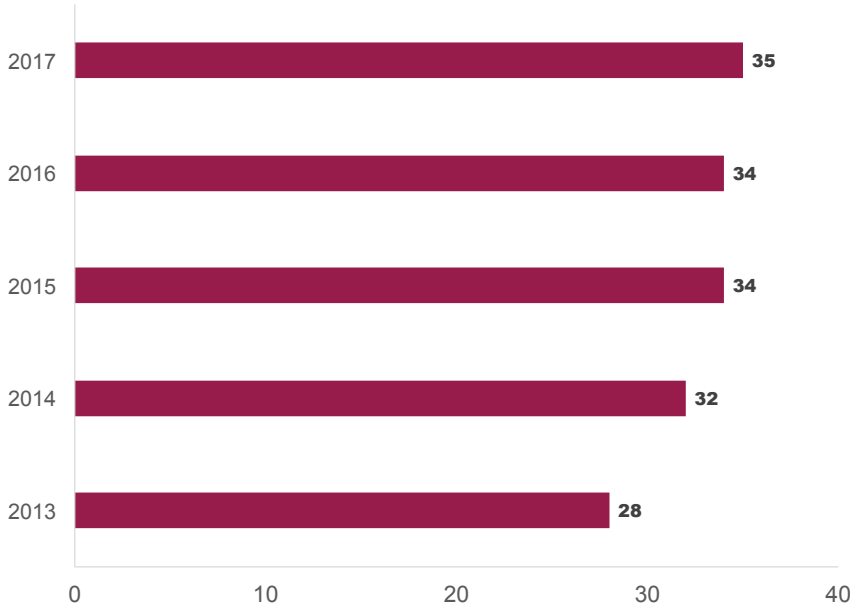
2014 Baseline	26
2015 Result	31
2016 Result	33
2017 Result	33
2017 Target	38



P2.c.3

Countries with national policies to implement sexuality or life skills-based HIV education in upper primary schools

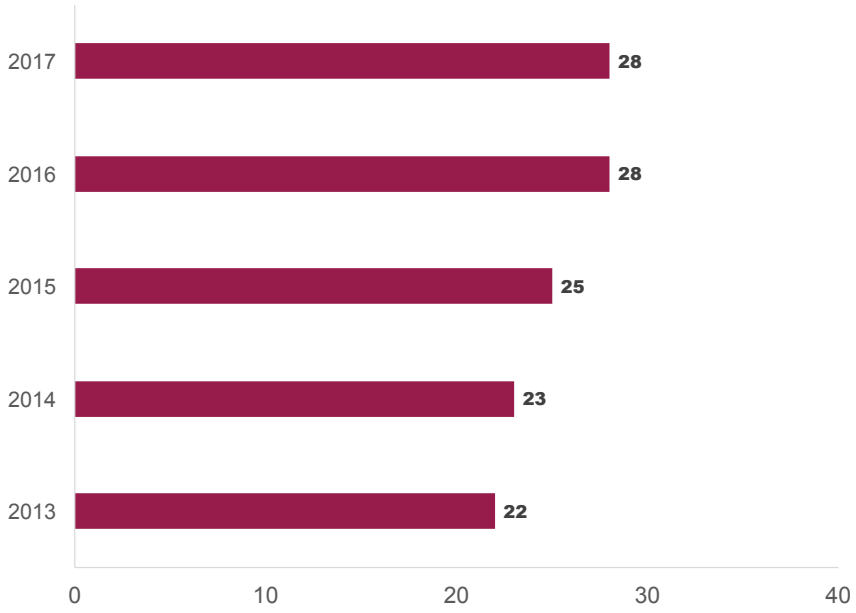
2013 Baseline	28
2014 Result	32
2015 Result	34
2016 Result	34
2017 Result	35
2017 Target	38



P2.c.4

Countries with either a national child protection strategy or a national social protection strategy that includes elements focused on HIV

2013 Baseline	22
2014 Result	23
2015 Result	25
2016 Result	28
2017 Result	28
2017 Target	38



Output d

Increased country capacity and delivery of services to ensure that vulnerability to HIV infection is not increased and HIV-related care, support and treatment needs are met in humanitarian situations

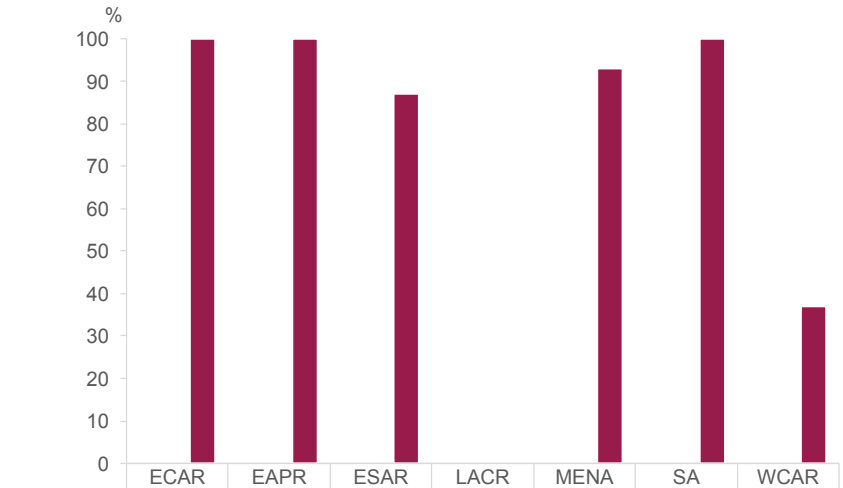
Average output achievement

85%

P2.d.1

HIV-positive pregnant women (out of those targeted by UNICEF) in humanitarian situations who receive treatment (either initiated or continuing) to prevent mother-to-child-transmission of HIV

2014 Baseline	54%
2015 Result	59%
2016 Result	62%
2017 Result	81%
2017 Target	80%

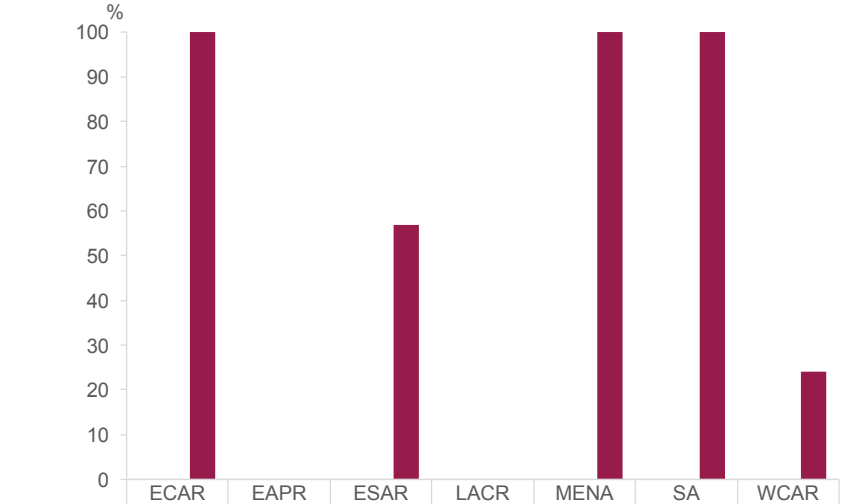


	ECAR	EAPR	ESAR	LACR	MENA	SA	WCAR
Targeted	87	8	49,961	0	16	23	7,110
Reached	87	8	43,529	0	15	23	2,656
% reached	100	100	87	—	93	100	37

P2.d.2

HIV-positive children (out of those targeted by UNICEF) in humanitarian situations who receive ART

2014 Baseline	34%
2015 Result	20%
2016 Result	25%
2017 Result	55%
2017 Target	80%



	ECAR	EAPR	ESAR	LACR	MENA	SA	WCAR
Targeted	212	0	67,795	0	6	77	4,812
Reached	212	0	38,769	0	6	77	1,171
% reached	100	—	57	—	100	100	24

Output e

Increased capacity of Governments and partners, as duty-bearers, to identify and respond to key human-rights and gender-equality dimensions of HIV and AIDS

Average output achievement

21%

P2.e.1

Countries with national household survey-based data on HIV disaggregated by age and sex collected within the preceding five years

2013 Baseline	18
2015 Result	17
2016 Result	17
2017 Result	16
2017 Target	38

Data available

ESAR
- Angola
- Ethiopia
- Lesotho
- Malawi
- Mozambique
- Namibia
- Rwanda
- Swaziland
- Uganda
- United Republic of Tanzania
- Zambia
- Zimbabwe

SA
- India

WCAR
- Chad
- Democratic Republic of the Congo
- Ghana

Data not available

ECAR
- Ukraine

EAPR
- Cambodia
- China
- Indonesia
- Myanmar
- Thailand

ESAR
- Botswana
- Burundi
- Kenya
- South Africa
- South Sudan

LAC
- Brazil
- Guatemala
- Haiti
- Jamaica

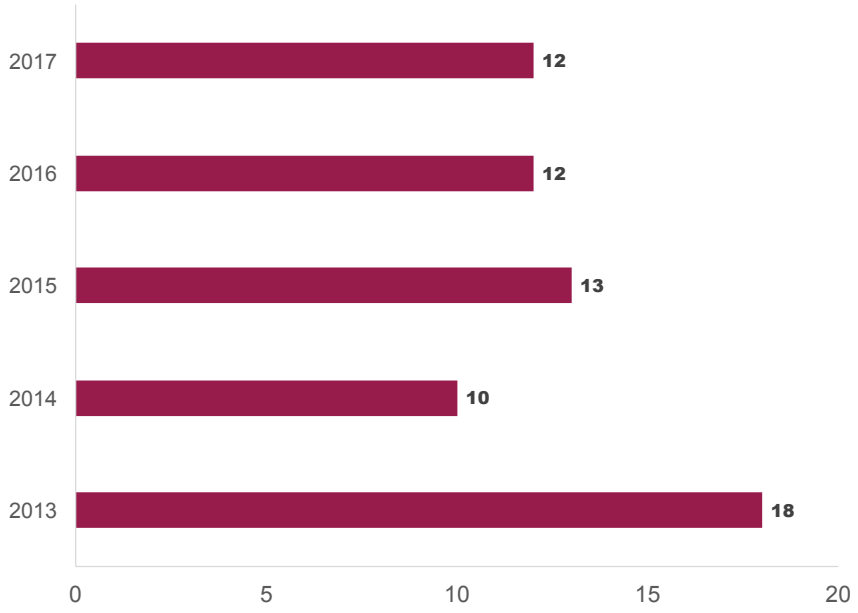
MENA
- Djibouti
- Iran

WCAR
- Cameroon
- Central African Republic
- Côte d'Ivoire
- Nigeria

P2.e.2

Countries that have undertaken a gender review of the HIV policy/strategy of the current national development plan with UNICEF support

2013 Baseline	18
2014 Result	10
2015 Result	13
2016 Result	12
2017 Result	12
2017 Target	38



Output f

Enhanced global and regional capacity to accelerate progress in HIV and AIDS

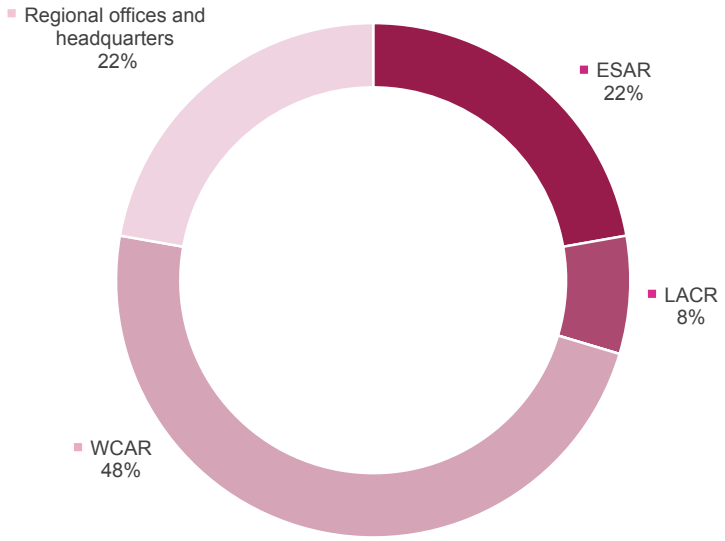
Average output achievement

143%

P2.f.1

Peer-reviewed journal or research publications by UNICEF on HIV and AIDS

2014 Baseline	17
2015 Result	22
2016 Result	19
2017 Result	27
2017 Target	20



P2.f.2

Key global and regional HIV/AIDS initiatives in which UNICEF is a co-chair or provides coordination support

2013 Baseline	6
2014 Result	6
2015 Result	8
2016 Result	7
2017 Result	12
2017 Target	6

Global partnerships and initiatives

- Adolescent HIV Prevention and Treatment Implementation Science Alliance (Office of the Global AIDS Coordinator/National Institutes of Health in the United States)
- ALL IN to #EndAdolescentAIDS initiative
- Global HIV Prevention Coalition (Adolescent Girls and Young Women Pillar)
- Inter-Agency Task Team for Social Protection and HIV
- Joint United Nations Programme on HIV/AIDS (UNAIDS)
- Start Free, Stay Free, AIDS Free – A super-fast-track framework for ending AIDS among children, adolescents and young women by 2020.

Regional partnerships and initiatives

- Asia eHealth Information Network
- Asia-Pacific Inter-Agency Task Team on Young Key Populations
- Asia-Pacific Prevention of Parent-to-Child Transmission of HIV Task Force
- Joint United Nations Regional Programme on sexual reproductive health rights (SRHR), HIV and sexual and gender-based violence integration
- Regional Inter-Agency Task Team on Children and AIDS (ESAR)
- Regional Support Team for East and Southern Africa

ANNEX 2: FINANCIAL REPORT*

Total revenue to UNICEF increased in 2017, especially in earmarked funds to specific programmes ('other resources'), which grew by 33 per cent over 2016, reaching an all-time high of US$5,153 million. This was largely due to the cooperation agreement signed with the World Bank Group for Yemen, and the revision of UNICEF's accounting policy, which recognizes revenue at the date that an agreement is signed. Although 'regular resources' also increased in 2017, by 8 per cent from US$1,317 million in 2016 to US$1,424 million in 2017, they decreased as a proportion of total revenue to UNICEF to 22 per cent (from 25 per cent in 2016). Henceforth, revenue refers to the total amount committed in the year the agreement was signed plus any adjustments, while contributions refer to disbursements received in a particular year, inclusive of adjustments.

Other resources contributions rose 19 per cent over 2016, while contributions to the nine thematic funding pools grew more conservatively, by 16 per cent, from US$312 million to US$363 million. Thematic funding has declined as a percentage of all other resources to just 8 per cent, from a high of 21 per cent in 2010. Thematic funding remains a critical source of revenue for UNICEF programme delivery.

In 2017, partners contributed US$44 million in other resources for HIV and AIDS, a 5 per cent decrease from the previous year and a 38 per cent decrease compared with 2013. The top five resource partners to UNICEF's HIV and AIDS programme, accounting for 60 per cent of contributions, were the Korean Committee for UNICEF,

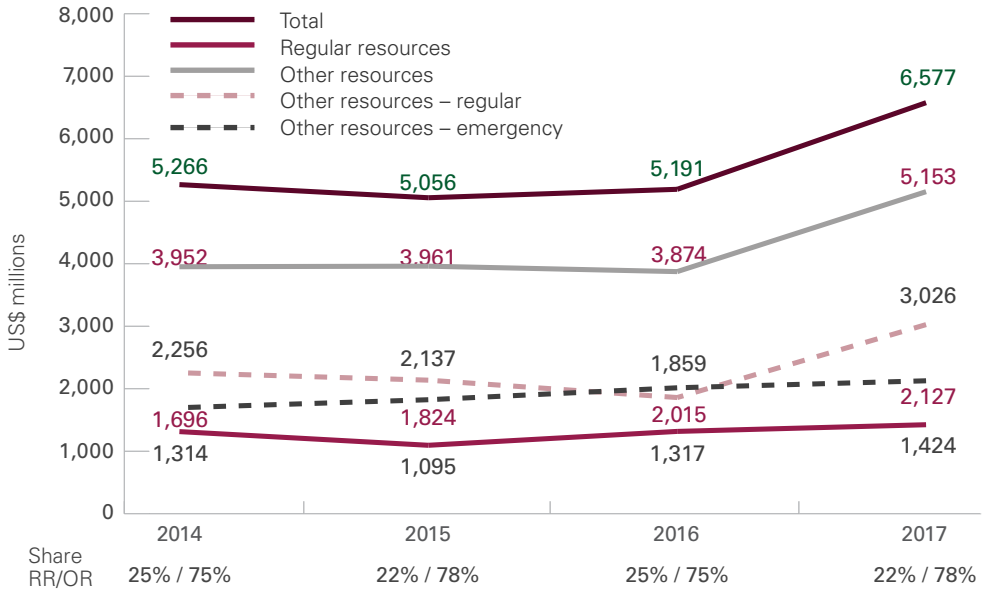
Regular resources (RR): Un-earmarked funds that are foundational to deliver results across the strategic plan.

Other resources (OR): Earmarked funds for programmes; supplementary to RR and made for a specific purpose, such as an emergency response or a specific programme in a country/region.

Other resources – regular (ORR): Funds for specific, non-emergency programme purposes and strategic priorities.

Other resources – emergency (ORE): Earmarked funds for specific humanitarian action and post-crisis recovery activities.

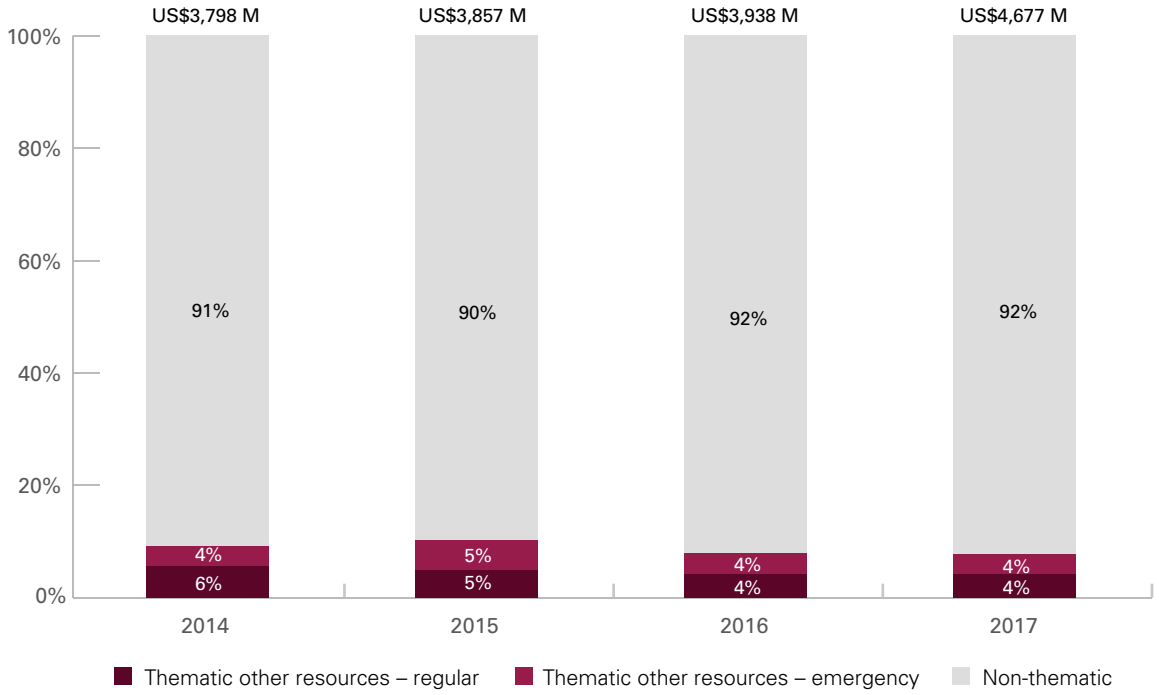
FIGURE A1: Revenue by funding type, 2014–2017*



*All funding data as of 1 April 2018 pending audit and certification.

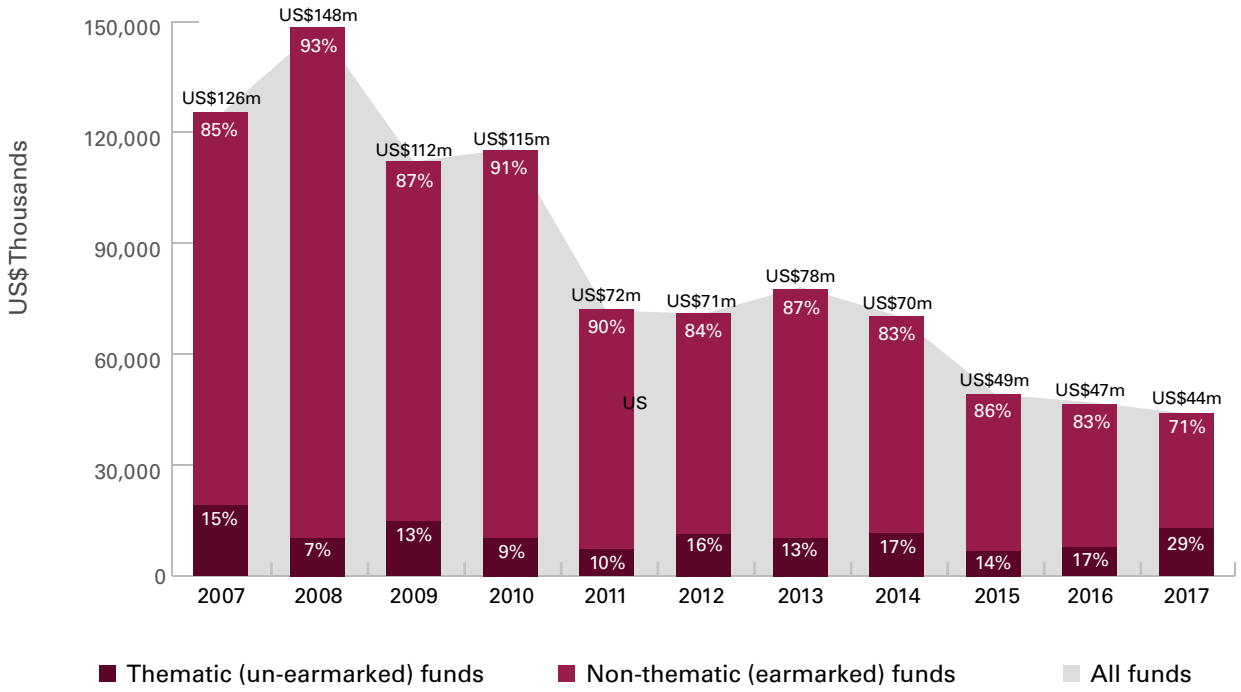
*Due to a change in UNICEF's revenue recognition policy, revenue from 2014 onwards has been restated here, and cannot be directly compared to previous years.

FIGURE A2: All other resources contributions 2010–2017, as share of total funding, US$*



*Due to a change in UNICEF's revenue recognition policy, revenue from 2014 onwards has been restated here, and cannot be directly compared to previous years.

FIGURE A3: HIV and AIDS other resources contributions 2007–2017*



*Regular resources are not included since they are not linked to any one outcome or cross-cutting area at the time of contribution by a partner.

the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund; mainly for emergency settings), the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United States of America, and the Netherlands. The largest contribution was made by the Korean Committee for UNICEF as global thematic funding, followed by the Global Fund's contribution for preventing new HIV infections and reducing HIV-related mortality and morbidity in Somalia; UNAIDS contributions to UNICEF; and the Dutch Government's support to expanding and scaling up HIV-sensitive social protection work in multiple UNICEF country offices in Eastern and Southern Africa.

HIV financing remains challenging and unstable, with further reductions in UNAIDS contributions to UNICEF from 2018 onwards. Funding sources for the global HIV response now come mainly from domestic resources, the US President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund. However, such funding is more likely to decline or remain stagnant rather than increase, at least in the short term. Domestic resources already account for more than 50 per cent of overall HIV response financing, and most countries are being urged by UNAIDS, other multilateral partners, and global and local advocates to allocate more budget support to HIV treatment and prevention. However, it is very challenging for low- and middle-income countries to further increase or sustain the HIV budgets because of other competing priorities in the public health sector.

With regard to UNAIDS funding, the 2016–2021 Unified Budget, Results and Accountability Framework (UBRAF) financially supports UNAIDS and joint work by the 11 co-sponsors in more than 100 countries with a biennial budget of US$484 million for the period 2016–2017, which was approved in late 2015. However, despite considerable effort over the past two years, the UNAIDS secretariat and co-sponsors have not been able to mobilize the full UBRAF budget, resulting in a 50 per cent reduction in funding to UNICEF in 2016 and 2017 and 84 per cent from 2018 onwards.

To mitigate the funding shortfall, UNICEF re-allocated some of its core funding to stabilize essential staff posts, reduced staffing levels, and redefined its programme of support by applying a more differentiated approach that takes into account both the HIV-epidemic context and the strength of the country response. UNICEF is also working to further integrate and mainstream the HIV response across other sectoral responses and mandates, while ensuring accountability in achieving its programme results.

UNICEF has also embarked on a fundraising drive, both for dedicated UNICEF funding and joint UN actions, based on a strategy developed in line with partners in 2016–2017. Regional offices are also engaging with other United Nations agencies in joint programming. For example, in 2017, the UNICEF Eastern and Southern Africa Regional Office, along with UNFPA, UNAIDS and WHO, mobilized funds from Sweden to implement a four-year project (2018–2021) to scale up services for integrated sexual and reproductive health, HIV and gender-based violence in Lesotho, Malawi, Uganda, Zambia and Zimbabwe. The UNICEF focus in this project will be on PMTCT and adolescent HIV.

Thematic resources act as an ideal complement to regular resources. They are allocated on a needs basis, and allow for long-term planning and sustainability of programmes. With a funding pool for each of the strategic plan outcome areas as well as humanitarian action and gender equality, resource partners can contribute thematic funding at the global, regional or country level. Overall, these are the second-most efficient and effective contributions, and

TABLE A1: Top 20 resources partners to HIV and AIDS by total contributions, 2017

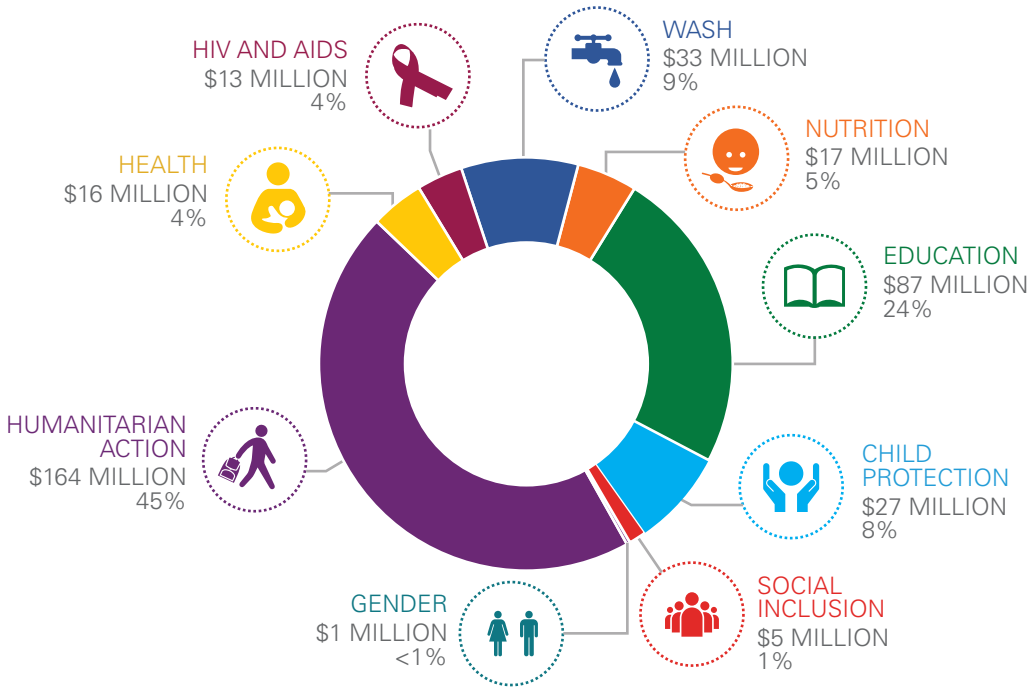
Rank	Resource partners	Total (US$)
1	Korean Committee for UNICEF	9,672,050
2	Global Fund	7,759,639
3	UNAIDS	6,115,374
4	United States*	2,777,332
5	Netherlands	2,322,880
6	Norway	1,666,911
7	Hong Kong Committee for UNICEF	1,168,304
8	French Committee for UNICEF	1,099,821
9	Alliance Côte d'Ivoire	1,075,082
10	Sweden	886,485
11	Unitaid	776,617
12	Indonesia	687,379
13	Canada	376,231
14	Swedish Committee for UNICEF	313,341
15	United Kingdom Committee for UNICEF	284,383
16	Dutch Committee for UNICEF	279,143
17	Finnish Committee for UNICEF	277,481
18	German Committee for UNICEF	252,521
19	U.S. Fund for UNICEF	222,064
20	Danish Committee for UNICEF	189,716

**Includes cross-sectoral grant SC150577 (Gender and HIV and AIDS).*

TABLE A2: Top 10 contributions to HIV and AIDS, 2017

Rank	Resource partner	Grant description	Total (US$)
1	Korean Committee for UNICEF	HIV/AIDS, global thematic funding	9,272,050
2	Global Fund	Reducing new HIV infections and HIV-related mortality and morbidity, Somalia	7,759,639
3	UNAIDS	Regional offices/UBRAF 2016–2017	4,206,338
4	Netherlands	Expansion and scale-up of HIV-sensitive social protection, Eastern and Southern Africa region	2,322,880
5	UNAIDS	Unified Budget, Results and Accountability Framework (UBRAF) 2016–2017	1,793,662
6	Norway	UNFPA–UNICEF Joint Programme on Rights-Based Approach for Youth Phase II, Ethiopia	1,666,911
7	Alliance Côte d'Ivoire	Norway–UNFPA–UNICEF Joint Programme on Rights-Based Approach for Youth Phase II, Ethiopia	1,075,082
8	French Committee for UNICEF	Access to HIV paediatric treatments for young people, West and Central Africa region	941,176
9	Sweden	HIV/AIDS, global thematic funding	886,485
10	Unitaid	Accelerate Access to Innovative Point of Care HIV Diagnostic (Phase II)	776,617

FIGURE A4: Thematic contributions by outcome area and humanitarian action (US$), 2017: US$363 million



have been invaluable for maintaining critical HIV and AIDS programmes.

Overall contributions to the thematic funding pools increased from US$312 million in 2016 to US$363 million in 2017. The largest public sector contributors to the thematic funding pools in 2017 were Norway, Sweden, the Netherlands and Denmark, while the largest private sector contributions were facilitated by the German Committee and the U.S. Fund for UNICEF. A complete financial statement of thematic funding contributions and expenditures is been annexed to this report. For more information on thematic funding and how it works, please visit <www.unicef.org/publicpartnerships/66662_66851.html>.

Thematic funding contributions for HIV and AIDS reached US$13 million in 2017, a 65 per cent increase over the US$8 million received in 2016. This was largely thanks to the Korean Committee for UNICEF, which alone provided 75 per cent of all contributions to the pool as global thematic funding, and increased its contribution by more than US$5 million over the previous year. The committee has remained the top thematic funding contributor to UNICEF's HIV and AIDS programme throughout the 2014–2017 strategic plan period. In total, 89 per cent of all thematic funding came through UNICEF National Committees. The Hong Kong, China, Dutch and Finnish committees also provided flexible contributions at the global level.

UNICEF is seeking to broaden and diversify its funding base (including thematic contributions). The number of partners and UNICEF National Committees contributing thematic funding to HIV and AIDS increased from 12 in 2016 to 14 in 2017, thanks to the global-level contribution from the Government of Canada and the country-level contributions from the Canadian National Committee for UNICEF to the HIV and AIDS programme in Ethiopia.

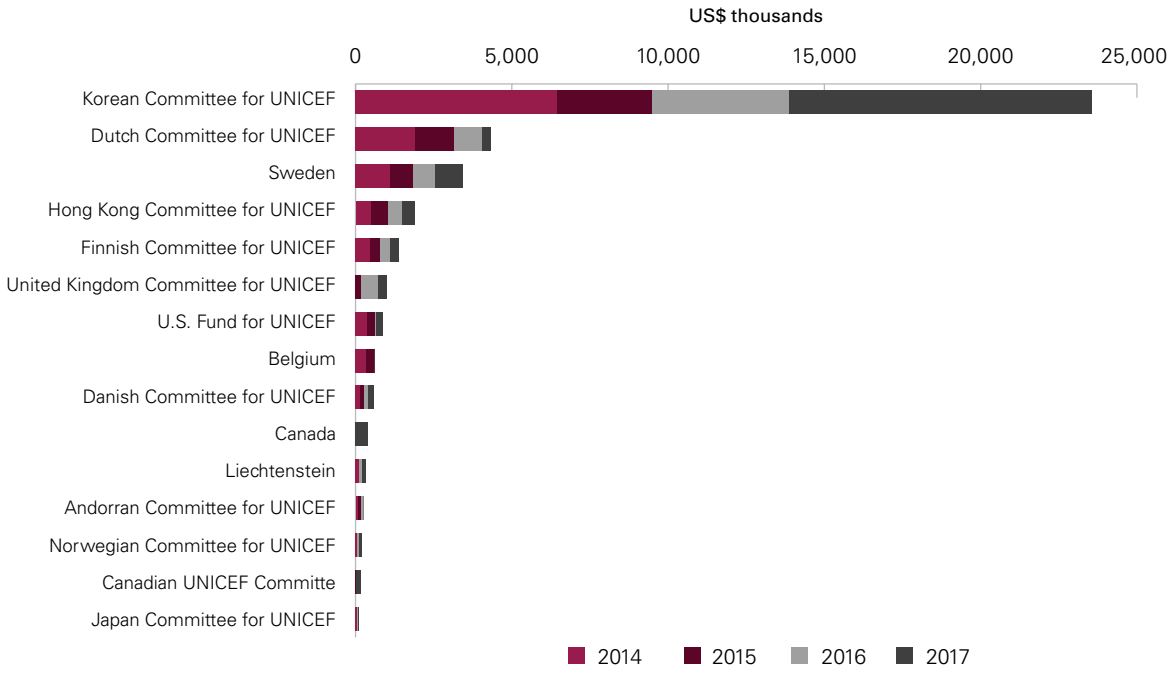
Thematic contributions were also received from the governments of Sweden and Liechtenstein for programmes in Bolivia and the Europe and Central Asia region, respectively. Both governments have ranked among the top

TABLE A3: Thematic funding contributions by resource partner to HIV and AIDS, 2017

Resource Partner Type	Resource Partner	Total (US$)	Percentage of total
Governments 10.7%	Sweden	886,485	**6.84%**
	Canada	401,569	**3.10%**
	Liechtenstein	97,561	**0.75%**
National Committees 89.3%	Korean Committee for UNICEF	9,672,050	74.67%
	Hong Kong Committee for UNICEF	389,682	3.01%
	Dutch Committee for UNICEF	279,143	2.16%
	Finnish Committee for UNICEF	277,481	2.14%
	United Kingdom Committee for UNICEF	268,457	2.07%
	U.S. Fund for UNICEF	202,809	1.57%
	Danish Committee for UNICEF	189,716	1.46%
	Canadian Committee for UNICEF	143,800	1.11%
	Norwegian Committee for UNICEF	80,308	0.62%
	French Committee for UNICEF	52,600	0.41%
	Japan Committee for UNICEF	11,381	0.09%
Grand Total		**12,953,043**	**100.00%**

Grant numbers are provided for IATI compliance: SC1499020058, SC1499020063, SC1499020060, SC1499020046, SC1499020037, SC1499020033, SC1499020057, SC1499020049, SC1499020065, SC1499020064, SC1499020042, SC1499020050, SC1499020062, SC1499020045, SC1499020056, SC1499020061, SC1499020043, SC1499020058.

FIGURE A5: Top 15 resource partners by level of thematic funding provided for HIV and AIDS, 2014–2017



15 thematic donors to UNICEF's HIV and AIDS programme throughout the 2014–2017 period.

Global thematic funds remain the most flexible source of funding to UNICEF after regular resources. The allocation and expenditure of all thematic funding contributions can be monitored on UNICEF's transparency portal <open.unicef.org>, and the results achieved with these funds against Executive Board approved targets and indicators at the country, regional and global levels are consolidated and reported on across the suite of Annual Results Reports. Specific reporting for country and regional thematic funding contributions is provided separately for partners giving at those levels. The main criteria of global thematic funding allocation are HIV prevalence among those 15–24 years old and adults, new infections among children 0–14 years old and those 15–24 years old, persons living among HIV who are 0–24 years old, and number of UNAIDS fast-track countries in the region.

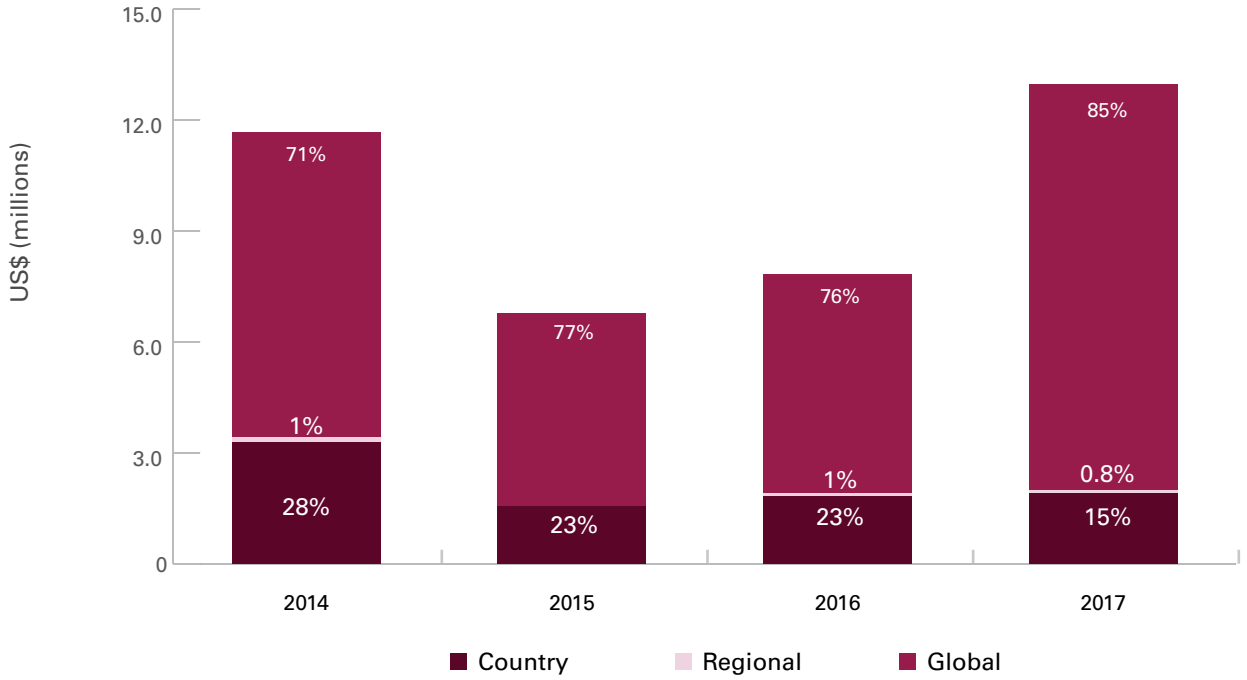
In addition, the following criteria are considered:

- Is the country among the UNAIDS fast-track countries?
- Has the country office provided core funding and human resources for HIV?
- Will the thematic allocation leverage results expected from programming of other donor contributions?
- What has been the office's record on thematic expenditures and donor reporting?
- Is this an emerging issue in HIV for which funding is not readily available?

In line with the internal UNICEF guidance, 78 per cent of global thematic funds went to the country offices, 12 per cent to the regional offices and 10 per cent to headquarters, where the regional and global portions of the global thematic funds were mainly used to provide technical support and bridge the funding gap for staff salaries.

The majority of the funding was allocated at the country level to prioritize the Global Vision and Strategic Direction document ('intensive programming countries'). The regional shares for country office allocation will be in support of country efforts to end AIDS in children through enhanced efforts to eliminate new HIV infections in children where there are critical gaps, provide treatment and care to children and adolescents, and follow up on the All In to End Adolescent AIDS ('All In') assessments with priority multisectoral actions to prevent HIV in adolescents.

FIGURE A6: HIV and AIDS thematic funding contributions at country, regional and global levels, 2014–2017



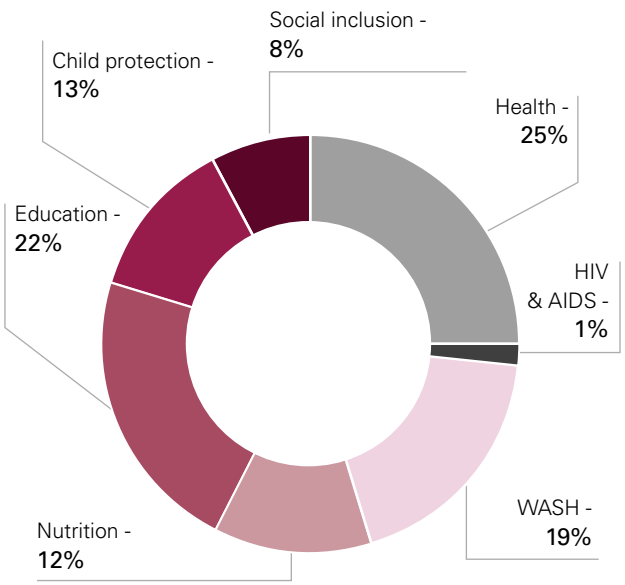
TRANSPARENCY: follow the flow of funds from contribution to programming by visiting <http://open.unicef.org>

Expenditure

Expenses are higher than the contributions received because expenses comprise total allotments from regular resources and other resources (including balances carried over from previous years) to the outcome areas, while contributions reflect only those earmarked from 2017 to the same.

In terms of spending on various technical aspects of UNICEF's HIV and AIDS programming, most of the funds were spent on the three top priority areas: PMTCT, prevention among adolescents, as well as paediatric and adolescent care and treatment *(see Table A4)*. Despite impressive gains in the HIV response, as outlined in this report, progress remains uneven as does funding. UNICEF must help countries sustain their gains and expand their response. Losing momentum now risks the reversal of hard-won results. In the SDG era, global attention to HIV is diminishing – along with traditional donor funds, including those for UNAIDS. Tapping into available funding requires innovative and creative approaches. Planning and strategies should be guided by new technologies, treatments and approaches that promise improved outcomes for children and for the response more broadly. UNICEF will work closely with its partners to meet these funding needs and fulfil the shared commitments and results in the UNICEF Strategic Plan, 2018–2021.

FIGURE A7: Expenses for HIV and AIDS by outcome area, 2017 (US$)



EXPENSES VS. EXPENDITURE

'Expenses' are recorded according to IPSAS (International Public Sector Accounting Standards) and are accrual based. These are used for official financial reporting. 'Expenditures' are recorded on a modified cash basis. They are used for budget reporting since they are aligned with cash disbursements and goods receipts (the way budgets are consumed).

FIGURE A8: Trend of expenses for HIV/AIDS by fund type, 2014–2017

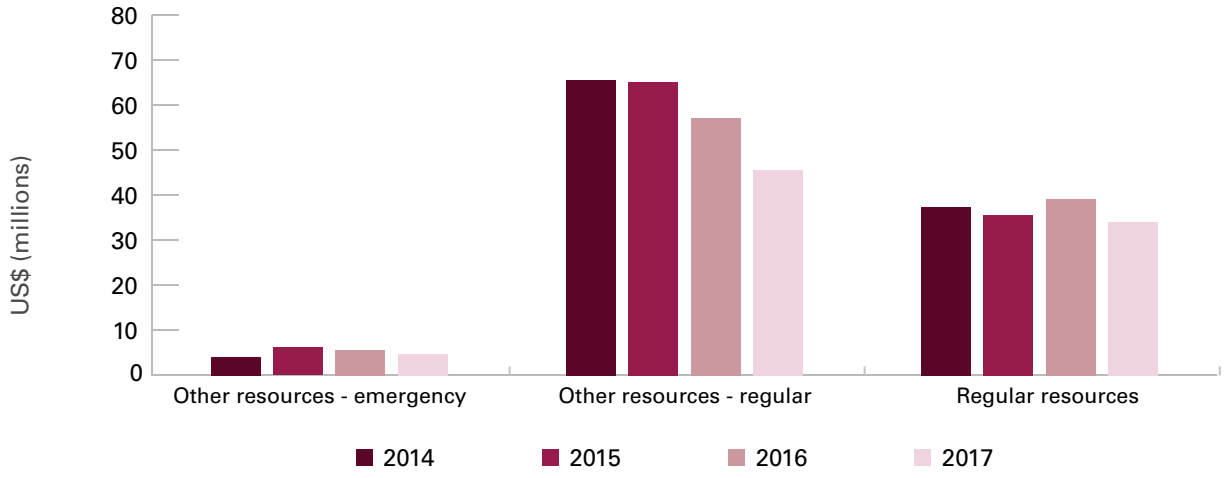
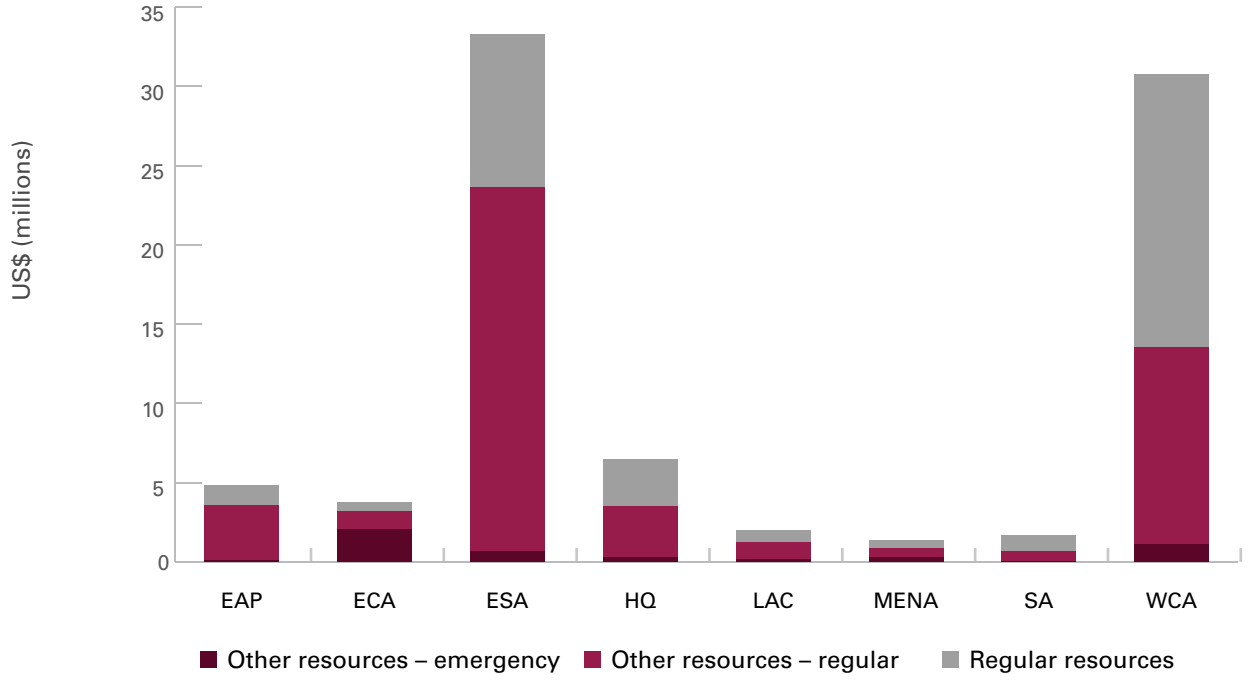


FIGURE A9: Expenses for HIV/AIDS by fund type, per region, 2017 (US$)



Notes: EAP, East Asia and the Pacific; ECA, Europe and Central Asia; ESA, Eastern and Southern Africa; HQ, headquarters; LAC, Latin America and the Caribbean; MENA, Middle East and North Africa; SA, South Asia; WCA, West and Central Africa.

FIGURE A10: Expenses for HIV/AIDS by country, 2017

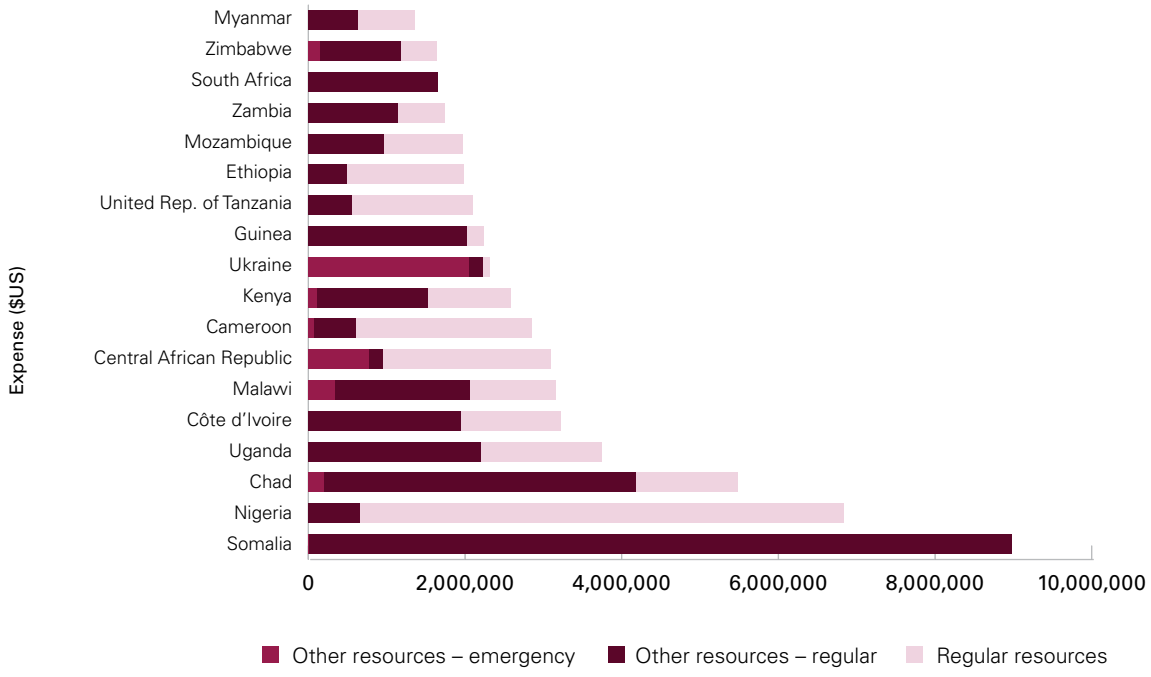


TABLE A4: Expenses for HIV and AIDS by programme area and fund type, 2014–2017 (US$)

Programme area	Other resources – emergency	Other resources – regular	Regular resources	GRAND TOTAL
PMTCT and infant male circumcision	3,757,955.13	70,899,951.52	48,064,109.22	122,722,015.87
2014	1,120,868	16,722,861	12,606,858	30,450,588
2015	1,769,259	22,860,002	12,396,364	37,025,625
2016	709,074	20,471,555	12,386,217	33,566,846
2017	158,754	10,845,534	10,674,670	21,678,958
Care and treatment of children affected by HIV and AIDS	1,209,106.27	20,907,804.89	12,313,939.22	34,430,850.39
2014	231,638	7,412,363	3,883,723	11,527,724
2015	214,356	6,494,856	3,194,837	9,904,049
2016	271,907	3,699,098	3,169,817	7,140,822
2017	491,205	3,301,488	2,065,562	5,858,255
Adolescents and HIV/AIDS	1,619,421.00	29,029,641.59	29,620,871.70	60,269,934.29
2014	94,147	10,907,153	7,397,496	18,398,796
2015	145,501	6,735,674	7,047,657	13,928,832
2016	691,419	5,886,724	8,541,654	15,119,797
2017	688,354	5,500,091	6,634,065	12,822,510
Protect, care and support children and families affected by HIV and AIDS	231,425.32	6,293,404.55	2,992,627.10	9,517,456.97
2014	200,759	2,845,279	1,080,631	4,126,669
2015	11,422	1,968,889	640,138	2,620,450
2016	4,428	956,126	638,529	1,599,083
2017	14,817	523,109	633,329	1,171,255
HIV, General	13,742,151.44	106,337,105.80	53,212,829.16	173,292,086.40
2014	2,383,524	27,746,242	12,482,296	42,612,062
2015	4,075,237	27,149,880	12,404,402	43,629,519
2016	3,966,342	26,087,480	14,346,131	44,399,953
2017	3,317,049	25,353,504	13,980,000	42,650,552
Grand Total	**20,560,059.17**	**233,467,908.35**	**146,204,376.40**	**400,232,343.92**

TABLE A5: Expenses for HIV/AIDS by cost category, 2014–2017 (US$)

Cost Category	Other resources – emergency	Other resources – regular	Regular resources	GRAND TOTAL
Contractual services	981,035.67	13,902,645.38	11,545,267.50	26,428,948.55
2014	250,433	4,925,393	2,086,450	7,262,276
2015	(162,949)	3,996,201	2,186,123	6,019,375
2016	646,367	2,610,661	4,269,277	7,526,306
2017	247,184	2,370,390	3,003,417	5,620,992
Equipment, vehicles and furniture	186,500.63	466,049.51	1,420,330.21	2,072,880.36
2014	28,138	64,303	261,635	354,075
2015	86,741	54,820	399,659	541,220
2016	48,581	287,569	386,149	722,299
2017	23,041	59,358	372,888	455,287
General operating + other direct costs	992,597.98	10,418,067.44	17,114,817.03	28,525,482.46
2014	241,779	3,794,503	4,564,281	8,600,563
2015	431,374	3,158,242	4,012,438	7,602,054
2016	195,120	1,982,511	4,629,315	6,806,946
2017	124,324	1,482,811	3,908,783	5,515,919
Incremental indirect costs	1,567,153.78	14,447,873.71	0.00	16,015,027.49
2014	309,300	3,937,728		4,247,028
2015	484,444	3,929,677	–	4,414,121
2016	392,988	3,815,632	–	4,208,621
2017	380,422	2,764,836	–	3,145,258
Staff and other personnel costs	5,358,355.19	46,484,432.60	51,103,780.32	102,946,568.11
2014	1,328,039	12,776,234	13,391,705	27,495,977
2015	2,279,762	12,879,012	12,079,791	27,238,565
2016	1,183,392	11,547,422	13,333,466	26,064,280
2017	567,163	9,281,764	12,298,819	22,147,746
Supplies and commodities	5,409,641.29	30,772,062.14	9,043,118.74	45,224,822.17
2014	610,255	7,350,212	2,098,130	10,058,596
2015	1,140,826	11,538,106	2,499,135	15,178,066
2016	1,738,573	6,576,744	2,013,678	10,328,995
2017	1,919,987	5,307,001	2,432,176	9,659,164

Transfers and grants to counterparts	5,159,725.61	107,276,589.01	47,752,235.36	160,188,549.98
2014	983,356	29,547,039	12,693,403	43,223,797
2015	1,650,020	26,721,763	12,434,661	40,806,445
2016	1,255,387	28,537,751	12,446,634	42,239,773
2017	1,270,962	22,470,036	10,177,537	33,918,535
Travel	905,049.02	9,700,188.56	8,224,827.04	18,830,064.61
2014	279,636	3,238,488	2,355,402	5,873,525
2015	305,556	2,931,480	2,071,592	5,308,628
2016	182,761	1,742,692	2,003,829	3,929,282
2017	137,096	1,787,529	1,794,004	3,718,629
Grand Total	**20,560,059.17**	**233,467,908.35**	**146,204,376.21**	**400,232,343.73**

*Due to rounding, the totals may differ slightly from the sum of the columns.

2017 THEMATIC FUNDS FINANCIAL STATEMENT

STATEMENT OF ACCOUNT AS OF 31 DECEMBER 2017 IN US DOLLARS

CONTRIBUTIONS:

Donor	Prior Year(s)	2017	Cumulative
Andorran National Comm. for UNICEF	257,115.91	0.00	257,115.91
Australian Committee for UNICEF	614,475.05	0.00	614,475.05
Austrian Committee for UNICEF	332,438.82	0.00	332,438.82
Belgian Committee for UNICEF	4,945.05	0.00	4,945.05
Canadian UNICEF Committee	1,101,527.28	143,800.44	1,245,327.72
Czech Committee for UNICEF	400,583.80	0.00	400,583.80
Danish Committee for UNICEF	3,042,072.46	189,715.52	3,231,787.98
Elizabeth Glaser Pediatric	25,000.00	0.00	25,000.00
Finnish Committee for UNICEF	5,133,025.47	277,481.32	5,410,506.79
French Committee for UNICEF	1,200,858.35	52,600.00	1,253,458.35
Government of Belgium	1,278,304.85	0.00	1,278,304.85
Government of Canada	76,671.78	401,568.51	478,240.29
Government of Liechtenstein	1,005,882.63	97,560.98	1,103,443.61
Government of Netherlands	22,688,573.18	0.00	22,688,573.18
Government of New Zealand	140,846.00	0.00	140,846.00
Government of Norway	3,044,200.00	0.00	3,044,200.00
Government of Sweden	10,133,125.65	886,485.43	11,019,611.08
Hellenic National Committee	904,395.23	0.00	904,395.23
Hong Kong Committee for UNICEF	2,498,136.75	389,682.25	2,887,819.00
Hungarian National Comm for UNICEF	51,048.15	0.00	51,048.15
Israel Fund for UNICEF	5,000.00	0.00	5,000.00
Italian National Committee	5,568,861.73	0.00	5,568,861.73
Japan Committee for UNICEF	2,912,815.50	11,380.62	2,924,196.12
Korean Committee for UNICEF	33,371,861.13	9,672,050.00	43,043,911.13
Netherlands Committee for UNICEF	11,183,807.17	279,143.30	11,462,950.47
New Zealand Committee for UNICEF	162,163.66	0.00	162,163.66

Norwegian Committee for UNICEF	1,190,879.05	80,307.84	1,271,186.89
Polish Committee for UNICEF	7,792.65	0.00	7,792.65
Portuguese Committee for UNICEF	482,400.99	0.00	482,400.99
Spanish Committee for UNICEF	3,753,480.92	0.00	3,753,480.92
Swiss Committee for UNICEF	453,343.88	0.00	453,343.88
Tetsuko Kuroyanagi	199,840.00	0.00	199,840.00
UN Agencies Staff	5,000.00	0.00	5,000.00
Unaids	2,804,664.89	0.00	2,804,664.89
UNICEF Ireland	2,407,631.47	0.00	2,407,631.47
UNICEF Slovenia	603,848.04	0.00	603,848.04
UNICEF-United Arab Emirates	408.72	0.00	408.72
United Kingdom Committee for UNICEF	10,815,536.10	268,456.92	11,083,993.02
United States Fund for UNICEF	11,381,739.17	202,809.41	11,584,548.58
Total	**141,244,301.48**	**12,953,042.54**	**154,197,344.02**

EXPENDITURES

Donor	Prior Year(s)	2017	Cumulative
Afghanistan	52,500.00	0.00	52,500.00
Albania	105,071.75	0.00	105,071.75
Angola	628,938.38	0.00	628,938.38
Azerbaijan	168,739.22	0.00	168,739.22
Bangladesh	550,225.52	112,778.47	663,003.99
Barbados	616,556.30	0.00	616,556.30
Belarus	68,250.00	65,524.32	133,774.32
Benin	1,044,473.66	90,661.29	1,135,134.95
Bhutan	10,517.38	43,950.93	54,468.31
Bolivia	1,476,114.61	44,859.32	1,520,973.93
Botswana	1,161,724.84	90,357.05	1,252,081.89
Brazil	1,726,744.56	125,084.53	1,851,829.09
Burkina Faso	1,043,406.49	0.00	1,043,406.49
Burundi	661,727.73	(0.00)	661,727.73
Cambodia	1,920,167.53	(1.84)	1,920,165.69

Central African Republic	2,149,349.21	10,662.54	2,160,011.75
Chad	952,084.83	58,626.24	1,010,711.07
China	2,437,158.90	175,670.13	2,612,829.03
Colombia	292,749.26	0.00	292,749.26
Congo	822,363.56	52,594.49	874,958.05
Cote D'ivoire	2,263,239.85	(62.14)	2,263,177.71
Data, Research And Policy	254,838.40	0.00	254,838.40
Democratic Republic Of Congo	1,444,114.94	148,788.98	1,592,903.92
Division Of Communication	1,005,079.24	(0.00)	1,005,079.24
Division Of Human Resources	53,611.57	0.00	53,611.57
Djibouti	839,516.13	112,018.52	951,534.65
Dominican Republic	825,783.17	140,532.05	966,315.22
Eapro, Thailand	569,239.41	220,080.42	789,319.83
Ecaro, Switzerland	3,181,994.05	175,010.01	3,357,004.06
Ecuador	157,706.69	0.00	157,706.69
Egypt	567,277.93	70.13	567,348.06
El Salvador	114,165.61	17,070.84	131,236.45
Equatorial Guinea	214,804.07	113,131.13	327,935.20
Esaro, Kenya	3,976,441.91	116,334.15	4,092,776.06
Ethiopia	7,364,749.38	0.00	7,364,749.38
Evaluation Office	220,046.55	0.00	220,046.55
Fiji (Pacific Islands)	1,788,095.36	71,725.01	1,859,820.37
Gabon	377,419.94	62,860.25	440,280.19
Gambia	52,469.84	0.00	52,469.84
Georgia	105,033.36	(33.91)	104,999.45
Ghana	537,885.91	134,681.56	672,567.47
Guatemala	798,752.71	127,141.96	925,894.67
Guinea	105,068.80	0.00	105,068.80
Guinea Bissau	1,078,680.62	150,667.01	1,229,347.63
Guyana	463,085.39	25,878.21	488,963.60

Haiti	1,537,564.84	54,018.65	1,591,583.49
Honduras	105,156.60	0.00	105,156.60
India	1,940,042.38	210,902.60	2,150,944.98
Indonesia	1,347,988.65	126,200.97	1,474,189.62
Iran	447,699.19	52,544.54	500,243.73
Jamaica	725,192.21	58,199.48	783,391.69
Kazakhstan	570,974.47	51,734.74	622,709.21
Kenya	2,030,293.17	436,815.10	2,467,108.27
Kosovo	104,769.49	0.00	104,769.49
Lacro, Panama	1,170,440.93	80,519.03	1,250,959.96
Lao People's Dem Rep.	210,279.68	(0.00)	210,279.68
Lesotho	1,041,112.11	139,516.95	1,180,629.06
Liberia	257,250.00	0.00	257,250.00
Madagascar	470,247.28	0.00	470,247.28
Malawi	5,782,722.11	281,256.46	6,063,978.57
Malaysia	104,496.21	0.00	104,496.21
Maldives	77,906.98	15,722.97	93,629.95
Mali	366,369.51	0.00	366,369.51
Mauritania	262,842.72	0.00	262,842.72
Mena, Jordan	519,807.84	182,312.23	702,120.07
Moldova	130,203.64	0.00	130,203.64
Mongolia	201,247.93	0.00	201,247.93
Morocco	210,224.19	0.00	210,224.19
Myanmar	1,445,434.51	722,708.94	2,168,143.45
Namibia	1,162,693.08	128,642.82	1,291,335.90
Nepal	1,708,523.31	98,418.10	1,806,941.41
Nicaragua	304,937.96	70,672.82	375,610.78
Niger	661,838.73	0.00	661,838.73
Nigeria	1,405,364.94	(6.01)	1,405,358.93
Pakistan	1,013,912.09	132,096.70	1,146,008.79

Palestine, State Of	21,000.00	0.00	21,000.00
Panama	151,895.35	0.00	151,895.35
Papua New Guinea	1,324,498.13	160.06	1,324,658.19
Paraguay	105,145.83	0.00	105,145.83
Peru	178,687.89	0.00	178,687.89
Philippines	352,060.12	28,471.40	380,531.52
Programme Division	10,933,692.02	391,455.48	11,325,147.50
Public Partnerships Division	127,979.20	4,433.73	132,412.93
Rep Of Uzbekistan	399,580.74	41,001.22	440,581.96
Republic Of Cameroon	1,980,991.99	124,844.16	2,105,836.15
Republic Of Kyrgyzstan	323,704.44	31,040.10	354,744.54
Republic Of Mozambique	6,305,673.62	0.11	6,305,673.73
Rosa, Nepal	701,087.42	33,563.23	734,650.65
Rwanda	543,330.89	183,158.18	726,489.07
Sao Tome & Principe	216,752.75	0.00	216,752.75
Saudi Arabia	92,030.80	(0.01)	92,030.79
Senegal	98,181.92	(0.00)	98,181.92
Serbia	105,000.00	0.00	105,000.00
Sierra Leone	579,503.27	10,438.44	589,941.71
South Africa	2,682,699.76	236,733.47	2,919,433.23
South Sudan	1,538,484.62	8,488.93	1,546,973.55
Sri Lanka	364,038.84	8,892.87	372,931.71
Sudan	1,241,253.44	0.00	1,241,253.44
Swaziland	3,625,328.04	566,393.63	4,191,721.67
Syria	206,791.40	0.00	206,791.40
Tajikistan	265,409.87	170,456.89	435,866.76
Thailand	157,634.99	0.00	157,634.99
Timor-Leste	509,245.42	0.00	509,245.42
Togo	537,378.18	79,428.13	616,806.31
Tunisia	58,479.99	77,382.84	135,862.83

Uganda	990,132.74	115,140.38	1,105,273.12
Ukraine	1,419,100.75	378,734.36	1,797,835.11
UNICEF Supply Division (CPH)	151,680.18	0.00	151,680.18
United Rep. of Tanzania	2,324,666.92	198,531.13	2,523,198.05
Vietnam	875,182.94	34,485.94	909,668.88
Wcaro, Senegal	1,398,061.59	120,842.32	1,518,903.91
Yemen	63,077.08	0.00	63,077.08
Zambia	872,443.32	306,708.16	1,179,151.48
Zimbabwe	3,290,002.48	755,949.10	4,045,951.58
TOTAL	**120,677,390.24**	**9,235,673.04**	**129,913,063.28**

SUMMARY

Donor	Cumulative Contributions	Cumulative Expenditures	Thematic Funds Available
Total	**154,197,344.02**	**129,913,063.28**	**242,84,280.74**

United Nations Children's Fund

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