



Addressing the Global HIV Epidemic Among Pregnant Women, Mothers, Children and Adolescents

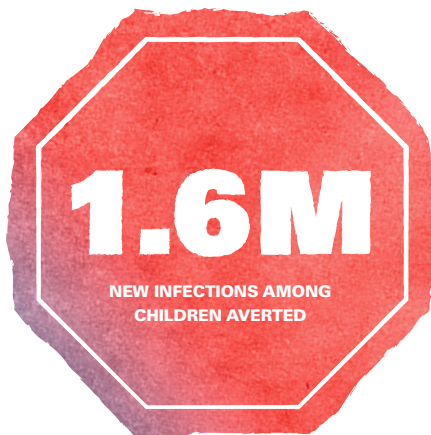
UNICEF's Global HIV Response 2018 – 2021

SECTION		PAGE
1	Background	1
2	HIV/AIDS and Children, Adolescents & Mothers: Data and Disparities	2
3	Funding Trends	7
4	Towards 2030: UNICEF's Global HIV Response for 2018–2021	9
5	Aligning UNICEF's HIV Response with Global Development Agendas	14
6	Next Steps	16

Background

UNICEF has long been at the heart of global efforts to put the HIV epidemic into an irreversible and rapid retreat. Under the Strategic Plan for 2018–2021, UNICEF will continue to align its HIV-related commitments to global goals and targets detailed in the 2030 Agenda for Sustainable Development; the Political Declaration agreed to at the June 2016 United Nations High Level Meeting on Ending AIDS; the Fast Track Strategy to End AIDS developed and championed by the Joint United Nations Programme on HIV/AIDS (UNAIDS); the United Nations Global Strategy for Women's, Children's and Adolescents' Health 2016–2030; the 'Start Free, Stay Free, AIDS Free' Framework for Ending AIDS in Children, Adolescent Girls; and the All In Framework to end AIDS in Adolescents and Young Women by 2020 that emerged following the success of the Global Plan Towards the Elimination of New Infections Among Children by 2015 and Keeping their Mothers Alive (Global Plan).

UNICEF's efforts will be grounded in core principles that include human rights, building resilient health and community systems, and ensuring lifesaving services in humanitarian settings. Yet the changing global development landscape requires UNICEF to constantly learn and adapt. In the run up to 2018, the agency plans to scale up current HIV initiatives centred on prevention of mother-to-child transmission (PMTCT), paediatrics and adolescents, while also shifting focus to reach the 'last mile' and bring the most marginalized children, adolescents and communities into the fold. UNICEF will strengthen its work with local and national governments in responding to HIV and related health, development and human rights challenges that affect the lives of children. People-centred systems that serve everyone are needed, which is why UNICEF will engage with, and design programmes for, the most vulnerable and socially excluded at the core of its mandate: children and adolescents within marginalized populations such as people who inject drugs, boys who have sex with boys, transgender boys and girls, sex workers, migrants and children with disabilities.



▲ *That's 1.6 million new infections among children averted*



2 | HIV/AIDS and Children, Adolescents & Mothers: Data and Disparities

▲ REMARKABLE SUCCESS

Through the guidance and leadership of UNICEF and partners, the scale-up of prevention of mother-to-child transmission of HIV services, particularly in the past five years, has been shown to be one of the greatest public health achievements of recent times.

Services are increasingly integrated, new ways of delivering those services have been introduced, and antiretroviral (ARV) regimens to prevent children from acquiring HIV and support maternal health have improved. In 2016, Armenia, Belarus and Thailand joined Cuba to receive the WHO certification for elimination of mother-to-child transmission of HIV (EMTCT). Several other countries are similarly on track to achieve this goal within a few years.

Achievements such as these help to explain why 1.6 million new infections among children (0–14) have been averted since 2000.

Among the 21 countries in sub-Saharan Africa that were part of the Global Plan, there was a 60 per cent decline in new HIV infections among children (from 270,000 to 110,000 cases between 2009 and 2015). The Global Plan demonstrated that with political commitment and resources, remarkable progress in addressing HIV among women and children worldwide can be achieved. In 2015, of the estimated 1.4 million pregnant women living with HIV, more than 1 million received the most effective regimens of antiretroviral medications (ARVs) for PMTCT, with an estimated 79 per cent coverage in sub-Saharan Africa.



▲ *In 2015, 7 out of 10 pregnant women received antiretrovirals for the prevention of mother to child transmission of HIV.*



Tecla, 6 months, is weighed at a routine health care visit. Her mother is living with HIV, but was able to prevent transmission of the virus to her daughter.

▲ PERSISTENT GAPS AND CHALLENGES

While the success of PMTCT is indisputable, progress remains uneven. Notable gaps continue to exist, with an estimated 150,000 children around the world below the age of 15 newly infected with HIV in 2015, and nearly 85 per cent of them live in sub-Saharan Africa. The majority of these infections occurred during the breastfeeding period. The shift in the timing of HIV transmission from mother to child has created a new urgency for focusing on adherence to medicines and retaining mothers and infants in care to the end of the breastfeeding period and beyond.

Rapid scale-up of initiation on antiretroviral therapy (ART) continues around the world as countries implement revised World Health Organization (WHO) HIV treatment guidelines to 'treat all'. More than 18 million people are now on ART; about half of the estimated global population of people living with HIV. Advancements in bridging the treatment gap for children have been equally impressive. Expanded treatment access to ART is the primary reason AIDS-related deaths among children were reduced by 53 per cent between 2009 and 2015.

Concurrently, treatment gains for children have not kept up with prevention. Half of the 1.8 million children (aged 0–14) living with HIV around the world in 2015 did not receive ART, and when they did gain access it often came far later than necessary. The average age of treatment initiation for HIV-positive children was three and a half in sub-Saharan Africa. Without timely treatment one third of children with HIV die by the age of one and half before their second birthday.



©UNICEF/Mozambique/Schermbrucker/2014

Here, Clayton, 8 months old, and born to a mother living with HIV, has his upper arm circumference measured to screen for malnutrition.

- ▲ *Testing children affected by HIV early is paramount. Screening at well child services is a good way to identify children living with HIV as well as to provide comprehensive and efficient care and infant feeding counselling support and adherence support to mothers on HIV medication*

▲ ADOLESCENTS

The situation is even more complicated and distressing in the second decade of life. Between 2000 and 2015, annual AIDS-related deaths declined for all age groups except adolescents aged 10-19. Mortality more than doubled from 18,000 to 41,000 cases. In fact, AIDS is the leading cause of death among adolescents between the ages of 10 and 19 in sub-Saharan Africa. Of the 1.8 million adolescents living with HIV in 2015, 60 per cent (1.1 million) reside in eastern and southern Africa alone.

Progress in preventing new infections among adolescents has also been unacceptably slow. Globally, the number of annual new HIV infections among adolescents aged 15–19 is just 8 per cent lower than in 2009, a period in which the comparable decline among adults was more than three times higher. Globally, 1.8 million adolescents aged 10–19 were living with HIV in 2015, a 28 per cent increase from 2005. Furthermore, demographic realities make it difficult to slow new infections among adolescents, or to keep them from rising. High population growth in many lower- and middle-income countries (LMICs) has created a 'youth bulge' that poses significant challenges to health, social, economic and environmental systems. Projections show that should current efforts be maintained, HIV incidence among adolescents would not decrease – even if the rate of new HIV infections among adolescents stalls at 250,000 cases between now and 2021, the number of new infections will still rise to 300,000 by 2030.

Poor global HIV prevention and treatment results among adolescents are particularly calamitous for girls and members of key populations. Adolescent girls account for about 65 per cent of all new HIV infections in the 15–19 age group worldwide, a level little changed from the 67 per cent estimate in 2000. Additionally, 1,100 young women aged 15–24 around the world are infected with HIV every day.

HIV tends to disproportionately affect the most vulnerable and socially excluded, regardless of country or region. In 88 of 159 countries, more than half of all new infections in 2015 were among key populations:

males who have sex with other males, individuals engaged in sex work, and people who use drugs. Adolescents, girls and members of vulnerable populations tend to be most at risk of contracting HIV and are least likely to have access to treatment and other services. This disproportionate impact among key populations is underscored by estimates indicating that nearly 32 per cent of all new infections among all adolescents in that age group occurred outside sub-Saharan Africa (SSA).



Anouk is a pregnant teenager living with HIV in Côte d'Ivoire. Stories like hers point to the need for improving knowledge about sexual reproductive health and preventing new infections in both adolescents and babies.

▲ CHILDREN ORPHANED AND AFFECTED BY AIDS

In few areas are the devastating long-term social and economic consequences of HIV as evident as in regards to children orphaned by AIDS. Since 2002, at least 10 million children under the age of 18 have lost one or both parents to AIDS. This number peaked in 2009, when an estimated 15 million children had lost one or both parents to AIDS. Although this number has gradually fallen, in 2015 there were still more than 13 million children who had lost one or both parents to AIDS.

Remarkable gains, however, have been achieved in mitigating the economic and social impact of HIV and AIDS on children and families over the past decade. Evaluations of national social protection programmes have established that social protection (in particular, cash transfers) contributes to a broad range of impacts across multiple sectors, improving access to health, education, and nutrition, strengthening social networks, increasing access to HIV and AIDS treatment and prevention and reducing adolescent vulnerability and risk taking. Investing in social protection, care and support systems can improve the access, reach and utilization of proven high-impact bio-medical interventions to achieve reductions in HIV related morbidity and mortality. These investments can enhance the quality of life for children and adolescents who are infected and affected and mitigate the impacts of HIV that drive new HIV infections.



▲ 13 million+ children worldwide have lost one or both parents to AIDS.

3 | Funding Trends



Funding Trends

Reversing the HIV epidemic and ending AIDS by 2030 requires coordinated, comprehensive partnerships involving all relevant actors—including governments, civil society, people living with and affected by HIV, and the private sector. More funds are also required. The scope, pace and sustainability of treatment and prevention scale-up are today threatened by financing challenges.

Currently, around 85 per cent of the estimated US\$22 billion spent each year on HIV responses in lower- and middle-income countries (LMICs) comes from three sources: domestic resources, the US President's Emergency Plan for AIDS Relief (PEPFAR), and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund). In recent years, however, the total amount of external financing for HIV responses—including that provided by the Global Fund, PEPFAR and other bilateral donors, and all other non-domestic sources—has plateaued, and most signs indicate that such funding is more likely to decline or remain stagnant rather than increase again in the short term at least. 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 other related services. Many LMICs, however, have limited financial capacity to increase domestic resources.

- ▲ *Currently, around 85 per cent of the estimated US\$22 billion spent each year on HIV responses in lower- and middle-income countries (LMICs) comes from three sources: domestic resources, the US President's Emergency Plan for AIDS Relief (PEPFAR), and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund).*

UNICEF cannot fund HIV responses alone. But as a technical agency with experience in leveraging results, it has unique and important roles to play in this uncertain time of heightened expectations and limited resources. UNICEF engagement in HIV responses at national and global levels over the next few years will be crucial in helping countries navigate difficult paths and deliver comprehensive, quality, efficient, rights-based HIV services to growing numbers of individuals who want and need them.



A photograph of a woman from behind, carrying a young child on her back. She is wearing a vibrant green sleeveless top with a black and blue pattern and a purple wrap with orange and yellow accents. The child is looking towards the camera. They are standing on a dirt path in a rural, green landscape.

4 | Towards 2030: UNICEF's Global HIV Response for 2018-2021

The UNICEF 2018–2021 Strategic Plan will build on core commitments to “realize the rights of every child, especially the most disadvantaged.” The agency will use its comparative advantage to launch, support and expand innovative, equitable and inclusive HIV programmes, approaches and activities.

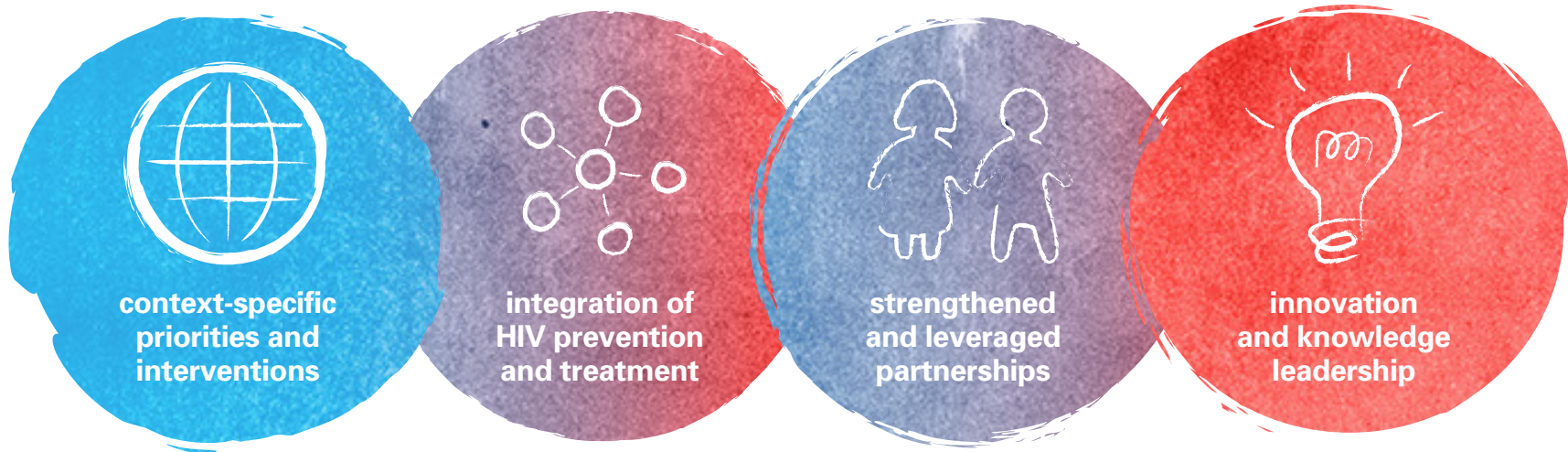
©UNICEF/Malawi/Schermbrucker/2017

▲ HIV PROGRAMME OBJECTIVES AND TARGETS

UNICEF objectives and targets will be adapted to each region and country, and will address existing opportunities to complete unfinished business for mothers, children and adolescents. While objective and targets will vary in size and scope, depending on the country context, they will align with and contribute to the new Start Free, Stay Free, AIDS Free initiative along with the UNAIDS Fast-Track Strategy.

To generate progress that is sustainable, UNICEF will design interventions based on three core objectives: EMTCT, testing, treatment and retention for children and adolescents, and scaling up targeted HIV prevention for adolescents.

UNICEF will focus on the following four specific areas to generate the greatest impact for children, adolescents and mothers living with and at risk for HIV:



▲ CONTEXT-SPECIFIC PRIORITIES AND INTERVENTIONS

Because the HIV epidemic affects mothers, children and adolescents differently from region to region and country to country, programmes need to be tailored to specific needs and opportunities as well as countries' prioritized for support. Understanding the situation of child and adolescent populations is crucial if they are to be reached at the right times, in the right places, and with the right combination of approaches that meets their needs. This concept is often referred to as 'differentiated service delivery'.

UNICEF's context-specific interventions are rooted in a four-pronged approach of identifying HIV epidemiology gaps and inequities; measuring the strength of government and community systems to provide a balanced response; advocating for increased stakeholder investment; and relying on UNICEF's comparative advantage to guide and support innovative practices, programmes and advocacy, and facilitate learning.

UNICEF regularly applies modified versions of this four-pronged approach at national, sub-national and community levels. Working in this way helps partners and stakeholders to better track HIV resources, epidemiology and responses and to design projects that close current gaps or address national inequalities that affect the HIV response. It also shows where support to governments and local partners can be increased in scaling up programmes that work, or in implementing newer systems that are efficient, effective and equitable.



▲ INTEGRATION OF HIV PREVENTION AND TREATMENT

UNICEF has played a leading role in integrating HIV in programmes across both decades of childhood, including those focusing on PMTCT, nutrition, maternal, newborn and child health (MNCH), early childhood development, vaccinations, and the roll out of the Global Plan Towards the Elimination of New HIV Infections among Children by 2015 and Keeping their Mothers Alive. This is done based on the realization that improved and equitable use of prevention and treatment interventions can only occur when HIV/AIDS is taken 'out of isolation' and integrated into a range of maternal, newborn, child and adolescent programmes, platforms, policies and campaigns.

Integration bolsters health outcomes and efficiency gains, and the Double Dividend framework (which UNICEF developed with partners) promotes a programming approach that aims to improve paediatric HIV care and child survival in populations where children are at high risk of being infected with HIV. Efforts to integrate paediatric HIV testing and treatment with other child health services (e.g., routine vaccinations) are showing promise as they can help identify cases of HIV among children missed by PMTCT programmes and facilitate treatment initiation.

Furthermore, protection and education responses are necessary to address the underlying social, economic and political barriers that impede better HIV outcomes. Early evidence shows that HIV-integrated services—delivered through decentralized management and service delivery systems, and health, education, justice and protection sectors—can contribute to the efficient and effective implementation of HIV interventions and lead to broader development outcomes. For example, integrated HIV, maternal and drug-dependency services have demonstrated positive outcomes for HIV and opiate addiction.



In response to the potential, UNICEF is investing in new, integrated opportunities. It is tracking non-HIV resource contributions to the HIV/AIDS programme – as well as HIV resource contributions to other projects, agendas and sectors – to determine where results can be best achieved and maximized, which interventions to scale up, and how and with whom to scale them up. The evidence UNICEF gathers is shared with its partners so they can strengthen family and community systems, whether or not they provide direct HIV services, and thus help to ensure that children and adolescents get into and remain in care.

The integration approaches UNICEF is undertaking, and plans to undertake, also have beneficial impacts on countries' efforts to meet the Sustainable Development Goals (SDGs). The reverse is also true: positive steps taken toward meeting many of the targets and indicators within the 17 SDGs will help improve HIV responses. This relationship lies at the foundation of UNICEF's strategic leadership and guidance.

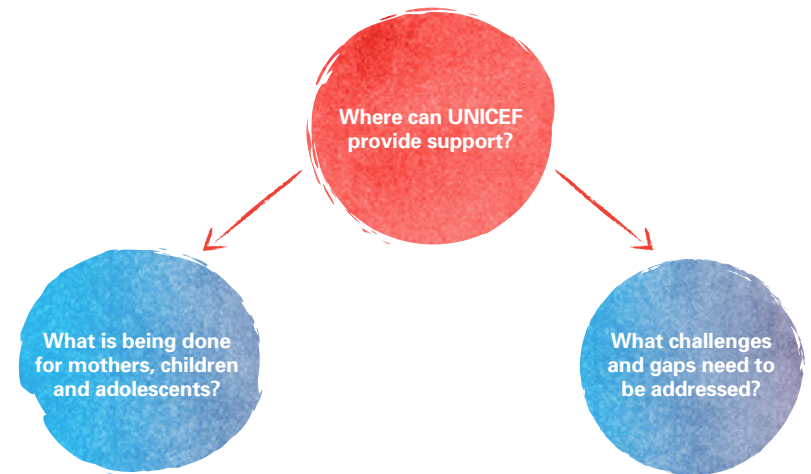
▲ STRENGTHENED AND LEVERAGED PARTNERSHIPS

Partnerships are necessary for progress to be made across priority areas. UNICEF's primary donors and implementing partners comprise people living with and affected by HIV; governments at various levels; non-government implementing partners from other sectors, including civil society (in which communities and faith-based organizations, among others, are grouped); the private sector; and academia.

Donors and implementers of contemporary AIDS responses are responsible for nearly US\$22 billion annually—funds that support activities implemented by a variety of actors. Taking into consideration regional and/or country context, UNICEF will assess partner engagement to determine what is being done for mothers, children and adolescents and AIDS; what is being done but requires additional support, strengthening or redirection; and what is not being done.

By answering these questions through data and programme reviews, UNICEF can strengthen and redirect its efforts, including by assisting its partners and other stakeholders in effectively advocating for financial resources and identifying and using technical innovations. Also important will be UNICEF's support in reforming and strengthening social protection components of HIV services and programmes; maternal, child and adolescent health programmes; and relevant social, legal and economic policies and/or research competencies. These are all part of an overall effort to slow HIV transmission, improve access to care and treatment, and eventually bring an end to AIDS among children and adolescents.

Global, regional, national and community-level collaborations form the backbone of HIV responses. Partnerships bring communities together and make them more robust, while also providing the next generation with more, and higher-quality, data and evidence. Working together gives strength to programming for children, adolescents and their families. Furthermore, people living with and affected by HIV are crucial to the response in every context. UNICEF collaborates with community-based groups such as mothers2mothers and the Global Network of People Living with HIV (GNP+) to drive effective PMTCT and HIV responses, and it works directly with adolescents to design and implement adolescent-targeted services. Such engagement will remain central to the agency's work.



◀ INNOVATION AND KNOWLEDGE LEADERSHIP

As a leader in learning, data sharing and programming, UNICEF has guided the discourse on HIV prevention, treatment, care and support for children and adolescents living with HIV. However, data on HIV among adolescents and children has never been easy to gather or present with much confidence and/or precision because of social, political and economic determinants. Thankfully the situation is changing due to a larger volume of global data that is also disaggregated more extensively.

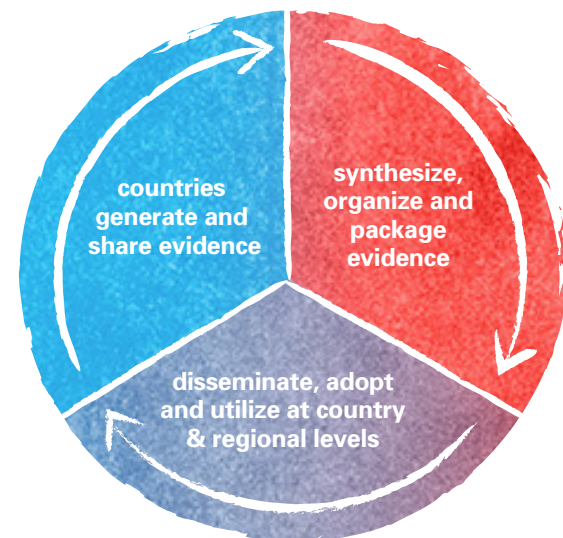
UNICEF plans to carry this momentum forward and increase the evidence base to motivate partners and decision makers on how best to address the needs of the most vulnerable and marginalized. The first step involves advocating for more comprehensive and granular data so that governments understand the benefit of expanding the scope and quality of their statistics by identifying groups most at risk. The second step is to strengthen data systems at regional, national and local levels so that stakeholders can more effectively map the trajectory of the HIV epidemic in specific locations, zero in on gaps in the response, and address social determinants of HIV across both decades of childhood.

A third, and critical, aspect of UNICEF's data- and knowledge-focused work will be to engage young people in design, planning, service delivery, demand creation, and monitoring and evaluation in order to achieve better results. Given the large number of adolescents coming of age between now and 2030—and their heightened risk of HIV—they must take part in all stages of programming (e.g., through focus groups and applications like U-Report) to ensure the preparation and implementation of holistic, inclusive, acceptable and sustainable initiatives.

In strengthening knowledge leadership and creating a Learning Collaborative, UNICEF will be positioned as a global leader in the application of science, knowledge management and innovation.

This will include, as an example, ongoing engagement in generating evidence on pre-exposure prophylaxis (PrEP), biomedical innovation for HIV prevention among adolescents, or the use of 'Cash Plus' to alter HIV outcomes for girls and in broader health outcomes, such as teenage pregnancy and educational attendance. UNICEF's work on U-Report and Rapid Pro also offers the potential to track interventions and promote adolescent participation to improve services.

Additional coalitions, similar in nature, need to be built to review what partners are doing and to facilitate learning and adoption of the best performing approaches. These coalitions will also help partners identify gaps and the stakeholders that require support in synthesizing and analysing their information. Although turning data into strategic information is a process, it is a critical step for convincing government and non-government partners to sustain and/or accelerate the gains they have made.



A photograph of a woman in a patterned skirt holding a young child in front of a mud-brick building. The sky is filled with white clouds. In the foreground, another person is crouching near a well. The scene is set in a rural, open area.

5 | Aligning UNICEF's Global HIV Response With Global Agendas









Aligning UNICEF's HIV Response with Global Agendas

Current trends and existing gaps require UNICEF to pivot so it can maximize its expertise and impact. Such adaptation includes aligning strategic programme aims with global agendas such as the SDGs and the Fast-Track '90-90-90' targets.

For example, by aligning parts of UNICEF's 2018–2021 Strategic Plan with the SDGs, the agency has enhanced its ability to fast track the HIV response for pregnant women, mothers, children and adolescents by 2020. Such alignment will also strengthen efforts to build resilient government and community systems that can address current equity gaps and gender- and HIV-related vulnerabilities. It also offers UNICEF more opportunities to help infuse HIV approaches into sectors other than health and education.

Realizing the rights of every child means providing mothers, children and adolescents in all contexts with access to services and support. This includes socially excluded and marginalized populations. By anchoring its HIV strategy in the SDGs and similar frameworks, UNICEF can more effectively apply people-centred approaches from the global HIV movement to broader development challenges of social inclusion, equity and rights.

UNICEF HIV PROGRAMME CONTRIBUTIONS TO THE SDGS

<p>GOAL 1: Fast track the HIV response by 2020 for pregnant women, mothers, children and adolescents</p>		<p>GOAL 2: Build resilient government and community systems to decrease HIV service inequities among pregnant women, mothers, children and adolescents and reduce gender, age and socio-economic HIV-related vulnerabilities.</p>			
PRIMARY		PRIMARY			
	Good health		Gender equality	Reduced inequalities	Peace & justice
SECONDARY		SECONDARY			
	Zero hunger		No poverty	Quality education	Partnerships for the goals

A young boy with short brown hair and a serious expression is sitting on a concrete ledge. He is wearing a white and dark blue sleeveless shirt and light green shorts. He is barefoot and has his legs crossed, with his arms resting on his knees. The background is a wall covered in graffiti. The upper part of the wall is pinkish-red with blue and green graffiti. The lower part is grey with large, bold graffiti in black, red, and white. The overall scene suggests an urban environment.

6 | Next Steps

Next Steps

The current state of the AIDS response calls for innovation in implementation and dissemination of knowledge for programme optimization. A centerpiece of the approach is to use what is known as a foundation to help focus new action that is result focused. The work must extend across development sectors, and must also engage with non-traditional actors who meet children, adolescents and their families where they are, throughout their lives.

UNICEF will continue to fulfil its organizational mandate in the next strategic plan by monitoring and reporting on the coverage, quality, equity and impact of recommended HIV interventions for mothers, children and adolescents. The organization will use its expertise, evidence and relationships to identify high-value opportunities to strengthen the response for children, and focus on the core thematic areas of PMTCT, paediatric treatment and adolescent programming in new, more selective and efficient ways.

As 2020 draws near, UNICEF will continue to be the world leader in HIV prevention in children and adolescents in all regions. The agency will implement four programmatic shifts by 2020 and apply them when delivering selective, strategic HIV results with, and for, mothers, children and adolescents. Funding and technical expertise for HIV-specific and HIV-relevant results—once part of dedicated HIV programs—will be mainstreamed into other national and international development sectors. Ending AIDS requires this integration and recognition that we address the social and economic factors that continue to fuel the AIDS epidemic. Poverty, food insecurity, drug and alcohol use, social marginalization, exclusion, stigma, inequity, gender inequality, violence and sexual exploitation all increase risk and decrease resilience in vulnerable populations.

Ending AIDS in children and adolescents is within sight. With strong political commitment and adequate resources, we can continue to achieve dramatic change. By elevating those at greatest risk – women, children and adolescents – to the forefront of the AIDS response, we can achieve our historic goal.

