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Oral report background note

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

Summary

This report presents a global overview of the HIV epidemic among children and adolescents, and of the current key challenges and opportunities for progress. It highlights the work of UNICEF to achieve high coverage of quality HIV prevention, treatment and care services, most recently against the backdrop of the coronavirus disease 2019 (COVID-19) pandemic, which has disrupted HIV programming and underscored the vulnerability of children and families living with or at risk of HIV. The report also offers a response to the decisions of the forty-fifth and forty-sixth Joint United Nations Programme on HIV/AIDS (UNAIDS) Programme Coordinating Board meetings. The report shows that the HIV response for children stands at an important juncture. Successes were in the past, not in the present. At the global level, despite the gains made at the start of the last decade, not one of the super-fast-track targets for children and adolescents that was set for 2018 and 2020 has been met. Several promising accomplishments, however, show that real gains, and lasting success, are possible with will, resources and innovative approaches.

* E/ICEF/2021/1.

I. Overview

1. The COVID-19 pandemic has been a startling reminder that mothers, children and adolescents living with and at risk of HIV remain extremely vulnerable. Preliminary survey data show that the pandemic has caused significant disruption of services and increased the risk of HIV transmission. Children have been deeply affected: paediatric ART and viral load testing showed great declines (50–70 per cent in reporting countries), and new treatment initiations for children aged 0–14 years fell by 25–50 per cent. Health facility deliveries and maternal HIV testing and ART initiation have also decreased substantially in a number of countries. Supplies of key commodities have been disrupted and prevention services for adolescents have been put on hold as economies falter and governments and other stakeholders divert resources to pandemic response. People living with HIV have not come for follow-up, and, at the same time, within homes and communities violence is on the rise, exposing a whole new generation to HIV.[1]

2. To respond to the disruptions to HIV prevention and care caused by the pandemic, UNICEF has made use of digital technologies to reach people where they are (tele-case management, tele-counselling/psychosocial support, health education and social messaging using U-report and tele-peer support); worked with governments to modify guidelines (e.g., to make use of multi-month drug dispensing); and encouraged and supported home-based services (e.g., early infant diagnosis and viral load testing) for families and adapted self-testing coupled with tele-counselling.

3. The effects of the global pandemic on the global AIDS response only exacerbate the poor progress in the AIDS response of recent years. Progress in HIV prevention and treatment for children and adolescents began to stall in 2015 – long before the pandemic took hold. There are fewer new infections per week (globally) among adolescents and young people, but only 18 per cent fewer than in 2015. Gains in the coverage of antiretroviral treatment (ART) for prevention of mother-to-child transmission were only 3 percentage points (from 82 to 85 per cent) from 2015 to the end of 2019. Over the same time frame, the percentage of children living with HIV who were on treatment increased by only 12 percentage points (from 41 to 53 per cent). There continue to be 110,000 deaths among children and adolescents aged 0–19 years annually. Overall, this pace of progress fell far below what was needed to achieve the 2018 and 2020 global targets to fast track progress towards ending AIDS in children.

4. UNICEF believes that there are three main reasons why global progress in the response to HIV/AIDS has stalled. First, diminishing political will across the board – from funders to government stakeholders to implementing partners – has translated into fewer resources to address critical gaps in local HIV responses. Secondly, the context of programming has changed dramatically over the past decade, but approaches to programming have not: in countries where progress has stalled, there is still overreliance on centralized services, along with siloed programmes that remain poorly integrated with other health services. And, lastly, there is the “new normal” of the COVID-19 pandemic, described above.

[1] United Nations Children’s Fund and International Rescue Committee, COVID-19 – GBV risks to adolescent girls and interventions to protect and empower them, guidance note, UNICEF, 2020 (available at: www.unicef.org/documents/covid-19-gbv-risks-adolescent-girls-and-interventions-protect-and-empower-them); Cousins, Sophie, “COVID-19 has ‘devastating’ effect on women and girls”, *The Lancet*, vol. 396, no. 10247, 1 August 2020 (available at: www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)31679-2/fulltext).

5. Embedded in the current strategic plan for the UNICEF HIV programme, and in UNICEF response to HIV globally, are solutions to these impediments to progress, and in efforts in key countries there is evidence that these solutions can work. A differentiated approach to services for women, children and adolescents living with and at risk of HIV allocates shrinking resources more efficiently to target need. Decentralization of HIV service to the primary health-care level – for example, by integrating HIV treatment and prevention into Integrated Management of Childhood Illness training materials – increases access and promotes sustainability by making HIV prevention and treatment part of the routine management of all children. UNICEF has successfully integrated HIV responses into other sectors. A few examples include health (integrated testing and treatment within antenatal care services) and education (keeping girls in school to prevent HIV). UNICEF is also uniquely positioned to help create standards for care and treatment that can be embraced by countries and sustained by donors (such as the pioneering work on roll-out of universal antiretroviral treatment for all pregnant women living with HIV, Option B+); it is also well-placed to help children and young people become agents of change (for example, in Belarus, where a strong group of adolescent advocates was able to overturn harmful, stigmatizing legal requirements for HIV reporting in educational institutions).

6. The challenges and stalled progress are made more compelling by the knowledge that there are strong achievements and even startling milestones that countries have reached over the last year. Eswatini has accomplished the goal – even in the midst of the pandemic – of the "three 90s": 90 per cent of people living with HIV knowing their status, 90 per cent of those who are positive receiving treatment, and 90 percent of those on treatment experiencing viral suppression. Botswana submitted a request to WHO seeking validation for being on the Path to Elimination of new HIV infections in children and, in Lesotho, the UNICEF-supported Young Mothers Programme mobilized peer mentors in the community to provide social protection packs containing food and cash support, COVID-19 prevention information, HIV prevention counselling and HIV care services to hundreds of pregnant and breastfeeding adolescents. These examples show what is possible with will and resources and provide a model for other countries hoping to do the same.

7. The mandate of UNICEF to work on behalf of children and adolescents has never been more important than today. In fact, it forms a critical component of the next UNAIDS global strategy for HIV/AIDS, which will cover 2021–2025. Within this revised strategy, UNICEF will continue to support efforts to improve testing and treatment of HIV in children and adolescents, eliminate mother-to-child transmission (EMTCT) of HIV, and prevent HIV among adolescents and young people through strengthened primary health care and other systems.

II. UNICEF commitments within the Joint United Nations Programme on HIV/AIDS

8. The 2018 revised Division of Labour of UNAIDS is centred on 10 key commitments of the fast-track agenda.[2] Collectively, these commitments are closely associated with overall efforts to achieve 10 of the 17 Sustainable Development Goals that underpin the 2030 Agenda for Sustainable Development.

9. The mandate of UNICEF within the HIV response is enshrined in the Convention on the Rights of the Child. This mandate is to advance and fulfil the rights of mothers, children and adolescents to access HIV prevention education, treatment

[2] Joint United Nations Programme on HIV/AIDS, UNAIDS Joint Programme Division of Labour Guidance Note 2018.

and care in an integrated manner, through advocacy, partnerships and programmatic excellence.

10. Under the UNAIDS Division of Labour, UNICEF focuses on catalytic prevention and treatment actions for children and adolescents in two strategic results areas of the Unified Budget Results and Accountability Framework: (1) EMTCT and keeping mothers, children and adolescents alive and well and (2) HIV prevention among young people.

11. As a child rights organization with strong and respected programmes in health, nutrition, water, education, child protection and social protection, UNICEF is uniquely positioned to support children and adolescents living with HIV. The organization leverages its broad and deep field presence, the trust that it enjoys with Member States and other partners, its reputation for programmatic excellence and its ability to programme in multiple sectors and incorporate cross-sectoral elements, including human rights, community engagement and gender sensitivity.

12. UNICEF has actively participated in developing the next UNAIDS strategy to shape the future of UNAIDS priorities for children and adolescents. For example, UNICEF organized a virtual focus group discussion on 29 September 2020 on how to enhance health and community systems to respond to the needs of children, adolescents and pregnant women to improve HIV results. As a result of UNICEF advocacy, health and community systems strengthening for HIV as well as HIV-sensitive social protection will now be incorporated as strategic results areas in the next UNAIDS strategy. In addition, several UNICEF programme specialists have been participating in UNAIDS strategy development teams to define future actions for children and adolescents.

III. Context for the work of UNICEF: Current state of the HIV epidemic and response for children and adolescents

A. The global situation: Slow progress made worse by the COVID-19 pandemic

13. Over the past decade, many countries around the world have achieved considerable successes in curbing the HIV epidemic among children and adolescents. However, much of this progress occurred between 2010 and 2015. Since then, decreased funding of the global AIDS response (especially since 2017) and the shift to prioritize “epidemic control” (ending HIV transmission among adults and key populations) has effectively flatlined the response for children and adolescents. The COVID-19 pandemic has exacerbated this situation (see Overview, paragraphs 1 and 2).

14. Although the consequences of the pandemic-related disruptions on the 2020 HIV indicators for women, children and adolescents will not be understood until mid-2021, it is clear that UNICEF will fall far short of the global “super fast-track” 2020 targets set by UNAIDS.[3] Table 1 shows the current state of progress against these indicators. Data on adolescent treatment coverage are not shown.

[3] Start Free, Stay Free, AIDS Free, A super-fast-track framework for ending AIDS among children, adolescents and young women by 2020. See: https://free.unaids.org.

Table 1
Global data compared with the "three frees" super-fast-track targets for women, children and adolescents – 2015 and 2019, and 2020 target

PMTCT (Start Free)	*2015 baseline*	*2019 actual*	*End 2020 target*
Eliminate new HIV infections among children (aged 0–14) by reducing the number of children newly infected annually to less than 20,000 by 2020			
Global	190 000	150 000	40,000
Focus countries	140 000	110 000	
Reach and sustain 95% of pregnant women living with HIV with lifelong HIV treatment by 2018			
Global	82%	85%	95%
Focus countries	86%	88%	
Prevention in adolescent girls and young women (Stay Free)	*2015 baseline*	*2019 actual*	*End 2020 target*
Reduce the number of new HIV infections among adolescents and young women (aged 15–24) to less than 100,000 by 2020			
Global	350 000	280 000	100 000
Focus countries	280 000	220 000	
Children and adolescents on treatment (AIDS Free)	*2015 baseline*	*2019 actual*	*End 2020 target*
Provide 1.4 million children (aged 0–14) with HIV treatment by 2020			
Global	860 000	950 000	1.4 million
Focus countries	708 000	773 000	
Provide 1 million adolescents (aged 15–19) with HIV treatment by 2020			
Global	not available	not available	1 million
Focus countries	not available	not available	

Source: UNAIDS, *Progress Towards the Start Free, Stay Free AIDS Free targets: 2020 Report*, p. 7.

B. Regional variations: Increased prioritization in lower-prevalence settings could lead to improved results

15. There are differences in the pace of progress by region and country. The level of service coverage seems to correlate with HIV prevalence: high-prevalence countries tend to have high levels of coverage, whereas low-prevalence countries, perhaps as a result of less prioritization of HIV, have poor service coverage, and the unmet need in these countries is high. This distinction is exemplified by the contrast between the Eastern and Southern Africa and West and Central Africa regions. Coverage of services for prevention of mother-to-child transmission (PMTCT) and paediatric treatment is markedly lower in the latter countries than in the former (52 per cent compared with 95 per cent and 32 per cent compared with 58 per cent, respectively). Outside of Africa, in four of the UNICEF regions with low and concentrated epidemics (East Asia and the Pacific, Europe and Central Asia, Middle East and North Africa, and South Asia), PMTCT antiretroviral coverage was less than 60 per cent in 2019. Furthermore, none of the regions has achieved 95 per cent treatment coverage in children and only two of the regions (Middle East and North Africa and South Asia) have achieved greater than 70 percent coverage. Progress

towards preventing HIV in adolescents and young people is significantly worse (table 2).

16. Slow progress in preventing HIV among adolescents is especially troubling. West and Central Africa has one of the fastest growing adolescent populations in the world; if the current trajectory is maintained over the next decade, the number of new HIV infections in adolescents will not decline fast enough to end AIDS as a health threat, even by the year 2050. Overall, the burden of unmet need is shifting from Eastern and Southern Africa to lower-prevalence regions of the world, especially West and Central Africa. In one recent analysis, when countries were divided into lower-prevalence and higher-prevalence groups (with a prevalence of 4.5 per cent prevalence as the cut-off) 63 per cent of deaths were in lower-prevalence countries. There were 200,000 more new infections per year in lower-prevalence countries that in higher-prevalence countries.[4]

17. In West and Central Africa, UNICEF seeks to close the gaps in coverage by increasing access to testing and treatment for women accessing ANC; using innovative point-of-care testing to identify HIV-infected infants and children; and providing novel adolescent prevention methods including HIV self-testing and pre-exposure antiretroviral (ARV) prophylaxis, along with use of social media platforms to deliver information about HIV risk and prevention to adolescents and offer access to innovative HIV self-tests and pre-exposure antiretroviral prophylaxis.

Table 2
HIV intervention coverage by region, 2019

	HIV incidence per 1,000 adolescents (Aged 10–19)	Mother-to-child HIV transmission rate (%)	PMTCT coverage (ART) (%)	Early infant diagnosis coverage (%)	ART coverage among children 0–14 (%)	HIV-tested in the last 12 months and received the result (%)		Condom use among those with multiple partners (%)		Comprehensive knowledge of HIV (%)	
						Girls[a]	Boys[a]	Girls[a]	Boys[a]	Girls[a]	Boys[a]
Eastern and Southern Africa	1.90 [0.51–3.81]	8.05 [6.52–0.49]	95 [71–>95]	68 [57–91]	58 [40–66]	21.9	15.8	30.2	53.6	33	37.6
West and Central Africa	0.46 [0.11–1.04]	19.91 [15.62–23.95]	52 [32–89]	33 [25–47]	32 [22–45]	7.1	4.5	32.6	48.6	22.2	23.6

[a]Aged 15–19 years
Source: Global AIDS Monitoring 2020, UNAIDS 2020 estimates and UNICEF global databases of nationally representative population-based surveys 2012–2018.

C. Keeping the world's attention on the epidemic at a time of financing challenges and competing development priorities

18. Donor funding for HIV/AIDS is declining. Notwithstanding the record $14 billion raised to replenish the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) in 2019, countries are being asked to do more with less and to increasingly leverage domestic resources to support their programmes. But the capacity of many low- and middle-income countries to do this is severely limited, especially given the COVID-19 pandemic and the ensuing global economic downturn. This is a pivotal moment for the AIDS response. The HIV epidemic will not be overcome without sustained efforts to mobilize funding at all levels.

[4] Kempton, Joe et al., "Most new HIV infections, vertical transmissions and AIDS-related deaths occur in lower-prevalence countries", *Journal of Virus Eradication,* vol. 5, no. 2, 2019, pp. 92–101.

19. The knowhow and advocacy of UNICEF will be key to securing sufficient external funding to enable countries to deliver services that promote equitable and comprehensive care for women, children and adolescents. Part of the challenge is the pervasive belief that "AIDS is over". UNICEF must advocate to show that for women, children and adolescents this is far from the case.

20. At the same time, it is critical to continue to identify opportunities for integration of HIV into health and community systems and ensure that health systems strengthening efforts, especially those supported by the Global Fund, encompass HIV-specific responses.

D. Glimmers of hope

21. Despite the many challenges, there are notable successes in some countries. Eswatini recently announced that it had reached the elusive goal of the "three 90s", even in the midst of the COVID-19 pandemic. This refers to the UNAIDS target of 90 per cent of all people living with HIV knowing their status, 90 per cent of known HIV-positive clients on antiretroviral therapy (ART) and 90 per cent of those on treatment (including pregnant and breastfeeding women and children) being virologically suppressed. And Botswana has submitted a request to WHO seeking validation for being on the Path to HIV Elimination. Replicating such examples could have significant and long-lasting impact on the course of the HIV epidemic.

IV. The UNICEF approach: Advocacy and partnership to promote differentiated, integrated, multisectoral programming

22. The UNICEF HIV/AIDS programme of work is guided by the UNICEF Strategic Plan, 2018–2021 and specifically by five programming approaches that are implemented in the three areas of focus – PMTCT, paediatric and adolescent treatment and adolescent HIV prevention. The five programming approaches are:

(a) *Differentiate*: Data-informed, evidence-based, prioritized and differentiated responses for country and programme prioritization;

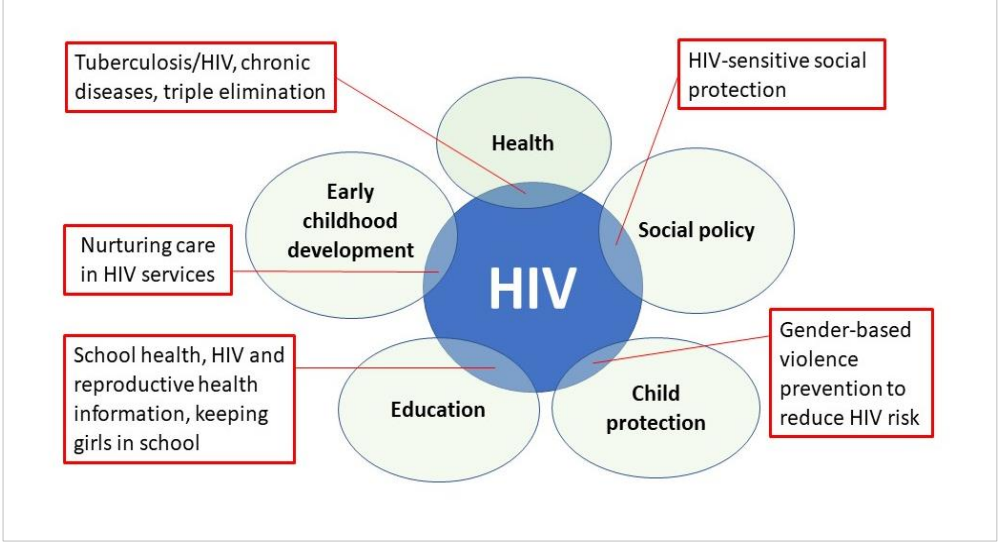
(b) *Integrate*: Effective integration with health and other sectors with joint results and clearly defined accountability (see figure I);

(c) *Partner*: Intensified partnerships to leverage resources for joint action;

(d) *Innovate*: Innovation using novel diagnostic, treatment, prevention and information technologies, combined with knowledge leadership to enhance programme responses;

(e) *Advocate*: Advocacy for renewed focus on children, adolescents and women and for best practices.

Figure I
Examples within UNICEF of HIV integration with other sectors



23. Differentiated programming is a central pillar of the UNICEF response. Such programming delivers tailored, evidence-based interventions that are informed by local context and granular data – so, not one size fits all – to understand and address specific gaps and challenges. This targets interventions to the greatest need and optimizes resource use. Specific examples of using differentiated programming with populations of women, children and adolescents are highlighted below and summarized in table 3.

A. Prevention of mother-to-child transmission of HIV and elimination of vertical transmission

24. The substantial progress made towards eliminating mother-to-child transmission (EMTCT) is one of the most successful aspects of the global HIV response. Since 1995, an estimated 2 million new HIV infections in children have been averted by providing antiretroviral medicines to pregnant and breastfeeding women living with HIV. Just over half of these infections (1.1 million) were averted between 2010 and 2015.

25. In that timeframe, coverage of effective ARV treatments to prevent vertical transmission of HIV almost doubled from 44 per cent in 2010 to 82 per cent in 2015. Since then however, progress has stalled, with coverage increasing by only 1 to 2 percentage points each year.

26. To address this stalled progress, UNICEF works with national governments and partners to promote:

(a) Differentiated programming that uses data to select and implement targeted interventions for HIV testing, prevention, treatment and adherence among both HIV-negative women and those living with HIV;

(b) Integrating elimination of mother-to-child transmission of syphilis and hepatitis B by building on the pioneering efforts of UNICEF to roll out Option B+ (universal lifelong antiretroviral treatment for pregnant women with HIV) and implementing testing and treatment for all three diseases within the ANC platform;

(c) Greater focus on pregnant adolescents living with HIV to improve outcomes for them and their children.

27. Through technical support from UNICEF, these approaches have been incorporated into Global Fund proposals to improve programme quality and efficiency.

28. UNICEF is also working closely with UNAIDS, the World Health Organization (WHO) and other partners to develop a guidance document for achieving EMTCT in low-prevalence settings.

B. Paediatric and adolescent HIV treatment

29. The epidemiology of HIV among children and adolescents living with HIV is changing: with the success of PMTCT, the majority of children living with HIV are older (aged 5–13 years). This trend is expected to continue as children and adolescents currently living with HIV grow into adulthood. Case identification strategies must go beyond a focus on the period of infancy and span entry points throughout the life cycle. They must also move beyond the health sector to the education and social sectors. Children and adolescents living with HIV who are initiated on treatment have poorer viral suppression than adults. Meeting this challenge will require an expanded focus on quality improvement and systems strengthening.

30. The COVID-19 pandemic has exacerbated the cycle of children's poorer access to treatment and poorer outcomes while on treatment. With reversals in progress for children and adolescents living with HIV caused by the pandemic, it is timely that last year UNICEF and partners designed and developed a consensus-based service delivery framework that draws on field-based and published evidence of what works. UNICEF is now working with partners to roll out this framework, primarily in high-prevalence settings.

31. The framework focuses on service delivery as one of three pillars of an effective HIV response, together with diagnostics and drug treatment. It recognizes that drugs and commodities cannot produce needed results without optimal service delivery. The framework offers a process for in-country health authorities and partners to systematically walk through the epidemiological context at national and subnational levels. They can identify programmatic gaps and barriers and select from a menu of targeted solutions – including innovative and technology-based solutions that are evidence-based and built on collective learning over time on what works. This mix includes a subset of solutions appropriate to the context of maintaining essential services while mitigating the spread of COVID-19, such as self-testing, case management by mobile phone, social network testing and telemedicine.

32. In addition to differentiated testing and treatment, UNICEF has also identified ways to decentralize HIV services for children by integrating paediatric treatment into primary health care. Treatment regimens have been optimized through use of dispersible fixed-dose tablets for children that contain all the drugs needed in one pill. Simpler treatment protocols now enable lower cadre front-line workers to start and maintain children on HIV treatment.

33. On the diagnostic front, groundbreaking work by UNICEF in West and Central Africa to strengthen laboratory systems by introducing point-of-care (POC) tests for diagnosis of HIV in HIV-exposed infants has become a fulcrum for integrated testing for HIV, tuberculosis, COVID-19 and Ebola. These POC tests are a game-changing technology for the region because they enable complex molecular testing for many diseases in clinics and wards, without any need for specialized training or laboratory infrastructure.

34. In 2020, UNICEF and partners worked with partners and governments to close the gap in treatment access by:

(a) Making adaptations to service delivery to mitigate disruptions due to the COVID-19 pandemic. These adaptations include:

(i) A range of digital technology solutions including tele-case management, tele-counselling/psychosocial support, health education and social messaging using U-report and tele-peer support;

(ii) Amplifying use of local media (radio) to provide tailored messaging on COVID-19;

(iii) Multi-month drug dispensing (MMD), including at community drop-off points, to mitigate HIV treatment disruptions;

(iv) Encouraging home-based services for families, i.e., testing of children of adults who are living with HIV, early infant diagnosis and viral load testing;

(v) Adapted self-testing (with tele-counselling);

(vi) Reinforced health systems support to ministries of health for rapid modification of guidelines (for MMD); ARV stock assessment, forecasting and procurement; personal protective equipment procurement and training in infection prevention and control; COVID-19 diagnosis at the point of care and enhanced monitoring.

(b) Improving HIV responses for children by scaling up catalytic, innovative approaches, e.g., the roll-out of POC infant diagnosis in decentralized or primary care facilities with poor access to laboratory-based diagnostic testing and use of HIV self-tests for adolescents who may be at risk for HIV.

(c) Strengthening linkages between health systems and community systems and engaging young people and mothers in HIV responses. For example, UNICEF is working with the Global Network of People Living with HIV to create demand for use of HIV testing services for infants and children in West and Central Africa.

C. Adolescent prevention

35. As the 2020 year-end review approaches, a slight acceleration in the reduction in annual new HIV infections is noted among adolescents (aged 15–19 years) and young women (aged 20–24 years). However, the rate of change remains insufficient to reach the 2020 targets. For adolescent prevention, programme integration is critical since the most effective way of protecting adolescents from HIV is through multisectoral combination prevention. To support adolescent HIV prevention at the regional and country levels, UNICEF:

(a) Utilizes analysis and modelled data to generate customized geographical and risk profiles to improve the ability to differentiate the programme response, target vulnerable populations and enhance person-centred programme design;

(b) Provides technical support to the Global Fund grant-making process; and makes technical assistance available to countries receiving Global Fund grants to advance delivery of combination prevention packages for adolescent girls and young women (aged 15–24 years), including in Botswana, Cameroon, the Democratic Republic of the Congo, Eswatini, Lesotho and Zimbabwe;

(c) Is building a regional collaborative to make available to national authorities and implementers analytical tools to strengthen strategic prioritization, targeting and

costing within the prevention agenda for adolescent girls and young women; this focuses on the needs of lower-prevalence countries with a substantial burden, including five high-burden countries (Cameroon, Côte D'Ivoire, the Democratic Republic of the Congo, Ghana and Nigeria) and five moderate-incidence countries (Central African Republic, Equatorial Guinea, Gabon, Guinea-Bissau and Congo) in West and Central Africa;

(d) Invests in, partners with and collaborates with girl- and young women-led networks, coalitions and movements, particularly in high-burden regions and highly affected contexts, as part of the UNICEF commitment to investing in the next generation of feminist leadership within the HIV response;

(e) Under the coordination of the UNAIDS Secretariat, and in collaboration with other UN agencies – UN-Women, United Nations Population Fund (UNFPA) and the United Nations Scientific, Educational and Cultural Organization (UNESCO) – UNICEF is co-leading the design of a new strategic advocacy and influence platform to advance girls' and young women's empowerment and education for HIV prevention in sub-Saharan Africa;

(f) Builds and enhances prevention systems in countries to optimize outcomes for the most vulnerable adolescents, with attention to engendering home-grown, domestically led responses that are fully integrated into national systems;

(g) Improves stewardship of multi-layered and multisectoral programming by bringing together and aligning actions across health, social protection and education; and reinforces strategic coordination structures to ensure that these sectors use evidence to improve results for adolescents and young people;

(h) Enhances existing prevention programmes by incorporating digital platforms and tools to improve geographical and risk profiling through geo-localization/geo-mapping and digital service delivery modalities;

(i) Promotes innovations that expand access to services and reduce HIV risk, such as self-testing and PrEP.

Table 3
Examples from ongoing and planned activities that showcase the UNICEF Strategic Plan in action across the three HIV/AIDS thematic areas of focus

	Action				
Thematic Area	*Integrate*	*Differentiate*	*Innovate*	*Partner*	*Advocate*
Prevention of mother-to-child transmission (PMTCT) of HIV	With health: Link HIV, syphilis and hepatitis B testing and treatment in pregnancy to move towards "triple elimination"	Implement "Last mile" framework to link data on PMTCT to targeted interventions Guidance on best practices for pregnant adolescents Guidance on achieving elimination of mother-to-child transmission (EMTCT) in low-HIV-prevalence settings	Using ARV drugs for pre-exposure prophylaxis (PrEP) in HIV-negative pregnant and breastfeeding women Using HIV-self-test for partners of pregnant and breastfeeding women to prevent new HIV infections in women Using viral load testing in pregnant	Global Validation Advisory Committee for EMTCT Start Free Partnership	Advocate for investment beyond treatment, while designing EMTCT "last mile" strategies

	Action				
Thematic Area	*Integrate*	*Differentiate*	*Innovate*	*Partner*	*Advocate*
			women to enhance PMTCT outcomes		
Paediatric and adolescent treatment	With health: Use HIV programme learning to develop approaches for chronic disease management in children	Roll-out of the paediatric service delivery framework to identify gaps and implement best practice solutions Differentiated service delivery models to improve outcomes for adolescents living with HIV	Expand roll-out of multiplex testing at point of care for HIV, COVID-19, cervical cancer and hepatitis B Social media engagement to promote adolescent retention in care	AIDS Free Partnership Child Survival Working Group Global Network of People Living with HIV (GNP+)	National and subnational advocacy for change in policies and practices Advocacy to ensure that paediatric and adolescent populations are prioritized under universal health coverage
Adolescent prevention	Multisectoral integration with gender and adolescent health to scale up multilevel, multilayered combination prevention Integrate primary prevention into care for adolescents living with HIV	Geo-localized and data-driven prioritization to improve targeting of adolescent and young at-risk/key populations	HIV self-testing, oral PrEP for adolescents Digital data and digital service delivery to identify and link at-risk adolescents to services	Stay Free Partnership Global HIV Prevention Coalition Education plus initiative for girls and young women	Advocacy for integration of HIV with Education and Gender for integrated sexual and reproductive health and rights Advocacy for adolescent-friendly policies to access prevention commodities and services

V. UNICEF work on Programme Coordinating Board priority issues

36. At the forty-fifth and forty-sixth Programme Coordinating Board (PCB) meetings, UNAIDS identified several issues for its co-sponsors to focus while determining their HIV strategies, programming and activities.[5] The following four issues are relevant to the work of UNICEF: annual progress on HIV prevention; strengthening and integrating comprehensive HIV responses into sustainable health systems for universal health coverage; actions to reduce stigma and discrimination in all its forms; and support to the UNAIDS Strategy revision process.

A. Annual progress towards HIV prevention

37. Responding to the UNAIDS PCB (45th session) request that co-sponsors accelerate scaled-up prevention response at the country level, UNICEF has played a catalytic role in two key areas of work: PMTCT and HIV prevention among adolescents and young people through enhanced advocacy, partnerships and technical and financial support.

[5] See: Details of the 45th PCB decision points and the 46th PCB decision points. Available at: www.unaids.org/sites/default/files/media_asset/12122019_UNAIDS_PCB45_Decisions_EN.pdf and http://www.unaids.org/en/resources/documents/2020/PCB46_Decisions respectively. In previous years, this information was included in Annex 1 of this Oral Report.

38. Preventing new infections is central to the HIV response for children, young people and pregnant mothers. In cooperation with key partners at all levels, UNICEF has driven the prevention agenda using multisectoral approaches that address biomedical, behavioural and structural issues; provide technical, programmatic, and financial assistance; and promote gender-transformative solutions.

39. UNICEF has leveraged its unique global technical expertise in HIV prevention, especially among adolescent girls and young women, and has played a catalytic role in bringing their voices and needs to the fore. Global partnerships that promote this include the Education Plus Initiative, the UNAIDS Three Frees Initiative to fast-track ending AIDS in children, adolescents and pregnant women, the Global HIV Prevention Coalition and the Coalition for Children Affected by AIDS.

40. The UNICEF Executive Director joined four other female executive leaders representing UNAIDS, UNESCO, UNFPA, and UN-Women to advance the Education Plus Initiative. This initiative supports young women to complete quality secondary education; facilitates universal access to comprehensive sexuality education; provides access to sexual and reproductive health services and education; works to ensure freedom from sexual and gender-based violence; and facilitates school-to-work transitions, economic security and broader empowerment.

41. Current strategies for combination prevention (which includes biomedical, behavioural and structural interventions) are hindered by national age-of-consent policies, punitive laws and HIV-related stigma – all of which discourage adolescents from seeking services. HIV prevention interventions such as PrEP and HIV self-testing will only be effective when adolescents are explicitly considered in market-shaping strategies and when the tools are paired with population-specific support services. The following examples include a range of interventions, including peer-to-peer support to enhance youth-led prevention efforts, establishment of testing and prevention services, and increasing access to integrated sexual and reproductive health services, and they all occurred with support from UNICEF:

(a) **Lesotho**: The Government of Lesotho developed the Minimum Standards and Implementation Guide for adolescent health-friendly services; these materials reflected young people's voices brought out by the Let Youth Lead Programme. The correct knowledge of sexual and reproductive health and rights (SRHR) and service quality among health workers has increased from 35 per cent to 75 per cent.

(b) **Jamaica**: The Ministry of Health and Wellness began to recognize the importance of non-traditional access points for adolescents outside of health-care facilities, so it established the Teen Hub, which served the needs of more than 6,500 adolescents (aged 10–19 years) between January and October 2019 and provided HIV testing and counselling for 496 adolescents (262 girls) aged 16–19 years. The Teen Hub provided pregnancy testing and counselling on effective family planning methods in addition to HIV counselling and testing. The successful model is being expanded to five additional locations.

(c) **Thailand**: The Ministry of Health developed an adolescent PrEP strategy and operational guidelines for the national HIV programme.

(d) **Botswana**: The Ministry of Health developed a national prevention framework for adolescent girls and young women that includes PrEP.

(e) **Côte d'Ivoire**: In 2019, based on programme learning from East Asia and the Pacific, UNICEF developed a strategy for digital programming to accelerate prevention efforts by reaching at-risk adolescents with self-testing and pre-exposure prophylaxis (PrEP), especially focusing on subnational geographical areas (small area estimates) and broader vulnerabilities of adolescents and young people.

(f) **Guatemala**: A national campaign launched in October 2019 taps into digital media and social networks commonly used by adolescents and young people to provide information on ways HIV can be transmitted; how to prevent HIV infection; and the importance of attending health services, particularly those designated as “teen-friendly spaces”.

(g) **Madagascar**: UNICEF helped formulate the National Policy for Adolescent Health and supported the design of 44 integrated youth-friendly health centres. More than 38,000 teenagers received health check-ups at these centres, while HIV testing was provided for nearly 6,000 adolescents and pregnant young women (aged 15–19 years).

(h) **Namibia**: UNICEF provided life-skills-based HIV and sexuality education for more than 4,000 girls in 11 of the 14 regions of Namibia in partnership with UNAIDS, the United States Centers for Disease Control and the governments of Germany, Sweden and Switzerland.

(i) **Central African Republic**: Thirty-two health-care facilities introduced child- and adolescent-friendly services that trained 56 adolescent peer educators.

(j) **Lesotho, Malawi, South Africa and Zimbabwe**: UNICEF invested in adolescent peer networks in these countries to provide HIV prevention information to retain teen mothers on HIV care.

B. Strengthening and integrating comprehensive HIV responses into sustainable health systems for universal health coverage

42. Integration is a key pillar of the UNICEF HIV Strategic Plan and central to the long-term sustainability of HIV services. This is especially true in the context of rapidly shifting health needs and priorities.

43. In the push for universal health coverage, UNICEF has further strengthened and integrated HIV prevention, care and treatment into broader services for children, adolescents and pregnant women, especially the most marginalized. It built capacity and improved diagnosis and care for chronic conditions, including not only HIV and tuberculosis but also noncommunicable diseases. Being uniquely positioned to promote multisectoral integration, for example with social services, education and nutrition sectors, UNICEF has worked to improve access to sustainable health systems for children, adolescents, and pregnant women living with HIV, thereby advancing progress towards universal health coverage.

44. There is growing determination to expand access to integrated HIV testing and ART services in infants and children, and within broader maternal, neonatal and child health services. UNICEF and WHO are working with other implementing partners to improve access to effective integrated service delivery models that can improve results among infants and children. These include adult ART clinics, in-service wards and outpatient services for sick children, immunization clinics, nutrition services and community care points.

45. Within UNICEF’s work, HIV programme implementation uses a continuum of care approach that recognizes that all elements of HIV service delivery – from testing to referral to treatment to lifelong retention in care – are necessary to achieve sustained benefits for women, children and adolescents. Within programme countries, UNICEF programming to better integrate HIV reflects this continuum of care approach as shown below:

1. Advocacy

– **Renewing commitment in West and Central Africa**: In 2019, public health leaders, ministries of health and representatives from partnering agencies from 18 countries in West and Central Africa, supported by UNICEF, WHO and UNAIDS, signed a commitment to achieve rapid progress in reducing new HIV infections and deaths among children and adolescents by strengthening and integrating comprehensive HIV response into national health systems.

2. Integrated testing

– **Guinea-Bissau**: UNICEF promoted the integration of HIV testing into severe acute malnutrition (SAM) treatment and care at nutritional rehabilitation centres (NRCs). By the end of 2019, all 69 NRCs in the country offered routine HIV testing to nearly 700 children under age 5, of whom 23.6 per cent were found to be HIV-positive. To build institutional capacity to sustain this approach, UNICEF supported training of health workers within NRCs and ART sites on SAM treatment and ART protocols.

3. Integrated treatment

– **Guatemala and Viet Nam**: UNICEF supported both Guatemala and Viet Nam to develop plans and standard operating procedures to achieve "triple elimination" of HIV, syphilis and hepatitis B, mainstreaming it into the national maternal, newborn and child health programme.

4. Integrated community support for retention in care

– **Zimbabwe**: With the support of UNICEF, the National AIDS Council of Zimbabwe trained 264 community health workers (75 per cent of them female) who oriented 1,838 people (59 per cent female) from their communities (including 250 people with disabilities who were referred to the programme by the National Council for Disabled Persons of Zimbabwe) in Chipinge and Chimanimani districts. Individuals received training on HIV management and treatment, cholera and other diarrhoeal disease prevention, risk factors, hygiene and control measures. Young people were divided into groups and given age-appropriate content through use of song, drama and poetry.

– **Eswatini**: UNICEF supported the Ministry of Health to strengthen community follow-up systems for mothers and their infants by training 300 mentor mothers to improve retention in care for women living with HIV. UNICEF also developed a newborn care training package that integrates HIV and PMTCT care into general aspects of newborn care. Using this modified curriculum, UNICEF trained 27 health workers from 11 health-care facilities that offer maternity services.

C. Progress of actions to reduce stigma and discrimination in all its forms

46. UNICEF recognizes that persistent HIV-related stigma is a huge obstacle to more effective HIV responses. While adolescent girls, women and key populations often directly experience stigma, HIV-related stigma affects all people in all epidemic contexts. Along with partners, UNICEF is reducing stigma by directly addressing the social, cultural and legal contexts that perpetuate HIV-related stigma.

– **Belarus**: Legal requirements to report HIV status to kindergartens, schools, colleges, universities and other educational facilities threatened confidentially and exposed students to bullying and discrimination. UNICEF-supported interventions, including programmes on adolescent leadership training and on increasing knowledge of SRHR and ART adherence, helped to create a dedicated, well-informed group of

adolescent advocates. Their advocacy efforts contributed to the successful removal of these reporting requirements in July 2019.

47. Stigma is a core barrier to successful HIV testing, care and treatment of children and adolescents. Fear of disclosure, one consequence of HIV-related stigma, is common among all people living with HIV. Yet it can be particularly complicated and terrifying for adolescents because they are uniquely vulnerable in so many other ways. Even though the situation has improved in many countries where ART has become widely available and death rates have plunged, stigma is a persistent challenge to more successful efforts for effective prevention and treatment services among adolescents.

– **Kenya**: UNICEF is supporting an innovative application of digital solutions to break through stigma and improve multiple outcomes, including adherence to medications among adolescents. During the implementation phase in 2019, the project reached more than 70,000 adolescent boys and girls aged 10–19 years with information on HIV, SRHR and gender-based violence through the one2one web- and mobile-based platforms.

– **United Republic of Tanzania**: A UNICEF-supported a cross-sectional study on adolescents living with HIV helped to pave the way for easier access of adolescents to HIV testing, and greater uptake of treatment for those diagnosed as positive – which, ideally, will help to destigmatize HIV. The study informed advocacy that in turn contributed to parliamentary approval of an amendment of the HIV Act, which took effect in November 2019. The amendment allows adolescents to be tested for HIV without parental consent.

D. Support to development of the revised UNAIDS strategy

48. UNICEF has been actively involved in the UNAIDS Strategy Beyond 2021 development process since it started in early 2020. This engagement is critical, because the UNAIDS strategy defines the global AIDS response and creates a platform for advocacy and partnership-building.

49. UNICEF has contributed either directly or indirectly to the following reviews and consultations that have been successfully concluded prior to November 2020. All are relevant to the UNICEF mandate and include:

(a) July 2020: Evidence review of the implementation of the UNAIDS Strategy 2016–2021: On the Fast-Track to end AIDS;

(b) May–August 2020: Global online survey in 16 languages with more than 8,300 respondents from 120 countries;

(c) June 2020: 65 in-depth stakeholder interviews;

(d) June–October 2020: Focus group discussions led by UNAIDS, partners and stakeholders.

50. In September 2020, UNICEF organized a virtual focus group discussion on how to enhance health and community systems to respond to the needs of children, adolescents and pregnant women. The goal was to support UNAIDS strategy development in this critical programme area. The UNAIDS Secretariat and co-sponsors consider health systems strengthening to be one of the new UNAIDS Joint Programme Result Areas in the revised strategic plan. During the discussion, participants identified private sector engagement and community systems strengthening as two key areas for intervention.

Annex

State of the HIV epidemic

A. Impact of the COVID-19 pandemic on HIV services

1. The COVID-19 pandemic has caused significant disruption of HIV services for women, children and adolescents and impacted many aspects of HIV programming. Many countries, including those highly impacted by HIV, instituted partial or full lockdowns and social distancing measures in the second quarter of 2020, coinciding with decreased demand for services, less PPE availability, supply chain disruption and redeployment of health-care workers. In many of these countries, restrictions on movement are still in place and continue to hamper access to and uptake of and HIV services.

2. According to the UNAIDS HIV Service Disruption data (September 2020) coming from 13 out of 86 reporting countries, and with at least 50 per cent of facilities reporting coverage,

(a) Testing and treatment initiation services were disrupted among children and pregnant women living with HIV in April and May.

(b) Paediatric ART coverage and viral load testing in children showed the greatest declines, at 50–70 per cent (median 35–45 per cent). New treatment initiations in children were down by 25–50 percent (median 25–45 per cent).

(c) Infant HIV testing services were also affected, but relatively less so, with a median decline of 10 per cent.

(d) Health facility deliveries and maternal treatment reduced by 20–60 per cent (median 15–25 per cent), whereas maternal HIV testing and ART initiations decreased by 25–50 per cent (median 15–20 per cent).

3. In many countries, uptake of HIV services rebounded in June due to easing of lockdown measures and strategic efforts to prioritize the health needs of pregnant women and children. However, coverage levels are still far from numbers expected prior to the COVID-19 pandemic.

B. Focus of the UNICEF response

4. The main focus of the UNICEF HIV programme remains ending AIDS in children and adolescents. This is aligned to the objectives of the UNICEF Strategic Plan, 2018–2021, specifically to Goal Area 1: Every child survives and thrives. The focus is on three programmatic areas:

(a) To ensure that children are protected from acquiring HIV through the effective prevention of mother-to-child transmission (PMTCT) of HIV;

(b) To ensure that children and adolescents living with HIV receive the treatment, care and support they need to remain HIV-free;

(c) To prevent new HIV infections in adolescents and young women, including among key populations.

C. Reduction in new infections in children and adolescents

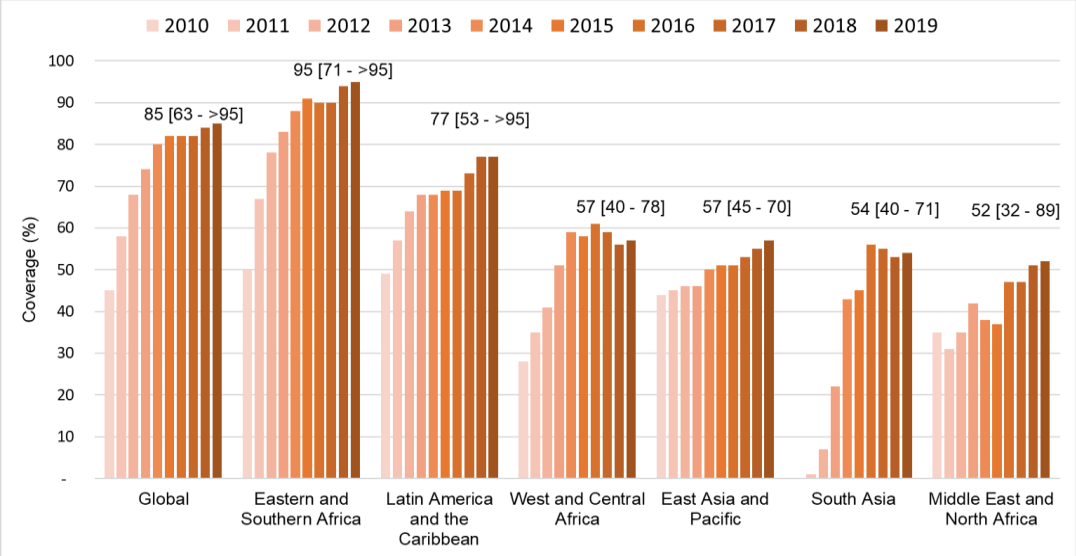
5. The Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates that in 2019 there were 150,000 new infections in children aged 0–14 years. Moreover, 88 per cent of those infections occurred in sub-Saharan Africa.

6. Nearly all low- and middle-income countries have now adopted lifelong antiretroviral treatment (ART) for all pregnant and breastfeeding women. By 2019, ART coverage had reached 85 per cent of this population; however, coverage has remained static over the past five years.

7. Not all regions are making the same progress (see figure I). In West and Central Africa, for example, ART coverage among pregnant women is below 60 per cent.

Figure I

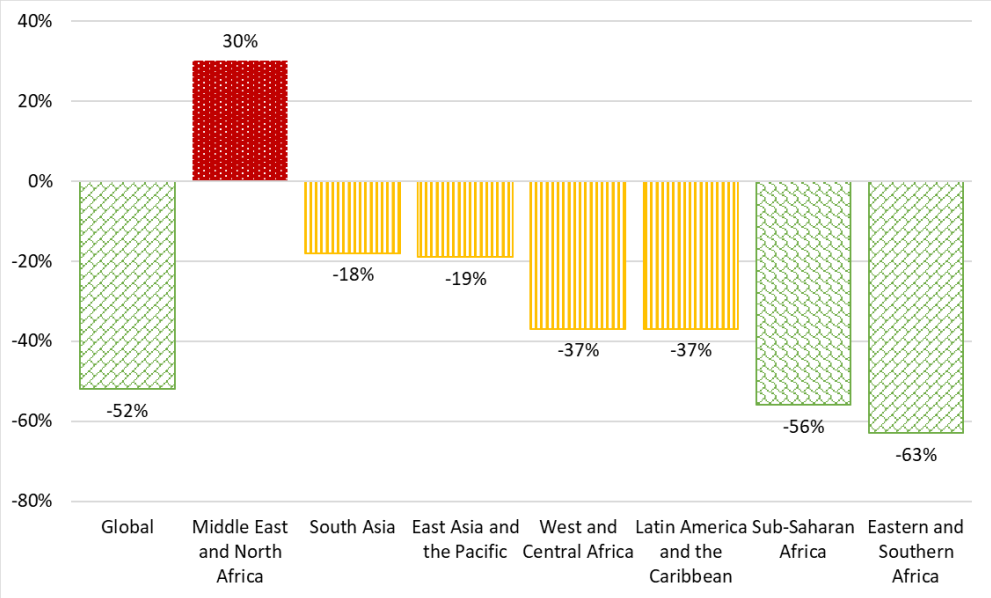
Percentage of pregnant women living with HIV receiving effective antiretrovirals for prevention of mother-to-child transmission, by region, 2010–2019



Source: Global AIDS Monitoring and UNAIDS 2020 estimates.
Note: Data are not available for Eastern Europe and Central Asia, North America and Western Europe; data exclude single-dose nevirapine.

8. Regional differences in ART coverage translate into stark variations in reduction of new paediatric infections. Globally, new paediatric HIV infections decreased by 52 per cent from 2010 to 2019, but in the Middle East and North Africa, new infections may be on the rise, although this estimate is based on small numbers and limited data sets. The Eastern and Southern Africa region recorded the largest decline, at 63 per cent (see figure II).

Figure II
Percentage change in the estimated number of new HIV infections among children (0–14 years), by region, 2010–2019

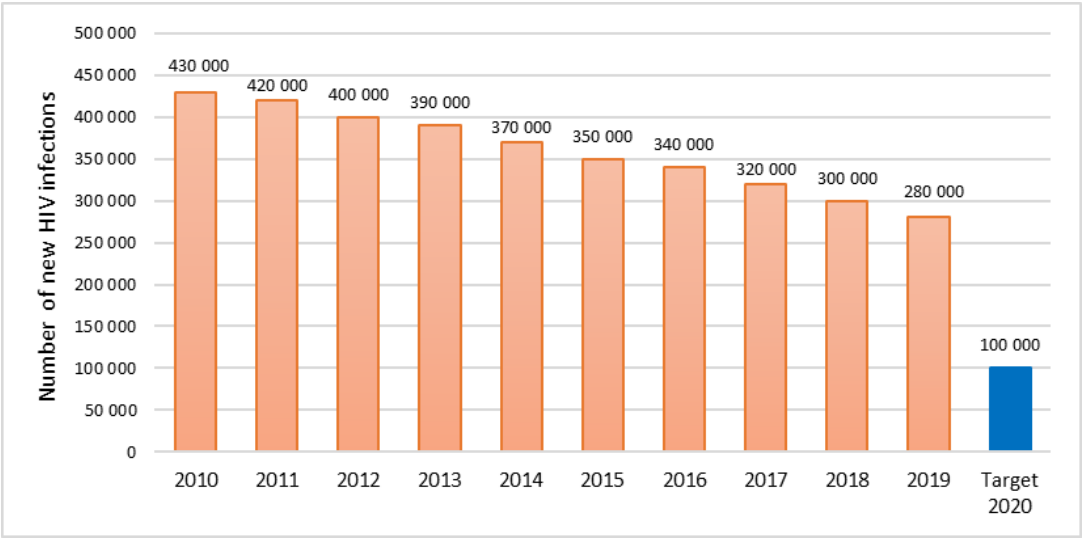


Source: UNAIDS 2020 estimates.

9. While less than optimal, the decline in the number of new HIV infections in children is still far greater than the decline in adults and adolescents.

10. In 2019, there were 280,000 new HIV infections among adolescent girls and young women; the pace of decline must significantly increase to be able to meet the 2020 UNAIDS fast-track target of 75 per cent reduction, corresponding to 100,000 per year from a baseline of 430,000. The target is highly unlikely to be met (see figure III).

Figure III
Estimated number of new HIV infections among adolescent girls and young women (15−24 years), 2010−2019 trends and 2020 target

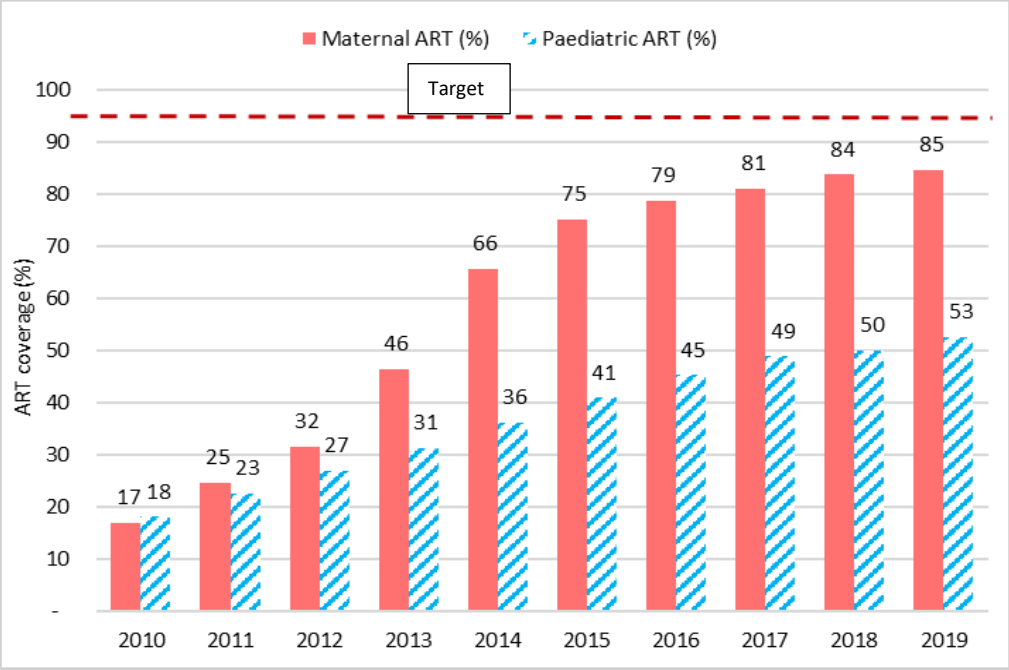


Source: UNAIDS 2020 estimates.

D. HIV-related mortality and access to antiretroviral treatment

11. Incremental progress continues in treatment access for children (0−14 years). In 2019, just over half (53 per cent) of all children living with HIV in this age group were accessing ART. By contrast, 85 per cent of pregnant and breastfeeding women with HIV were accessing treatment (see figure IV). The target for both groups is 95 per cent.

Figure IV
Paediatric antiretroviral treatment coverage (0–14 years) and maternal antiretroviral treatment (ART) coverage (prevention of mother-to-child transmission of HIV), 2010–2019



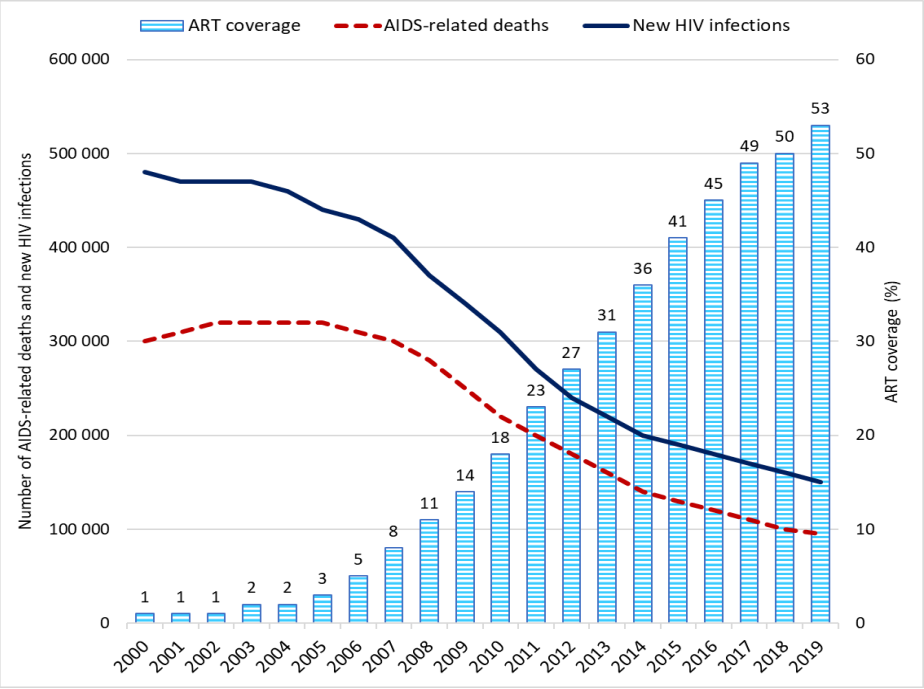
Source: Global AIDS Monitoring 2020 and UNAIDS 2020 estimates.

12. HIV is an aggressive infection in children who contract it during pregnancy and childbirth. Without treatment, 30 per cent will die by the age of 1 year, 50 per cent by age 2 and 80 per cent by age 5.

13. Fortunately, treatment greatly reduces mortality risk and there has been a steady decline in HIV-associated mortality (see figure V).

Figure V

Trends in coverage of antiretroviral treatment, number of new infections and number of AIDS-related deaths among children (0–14 years), global, 2000–2019

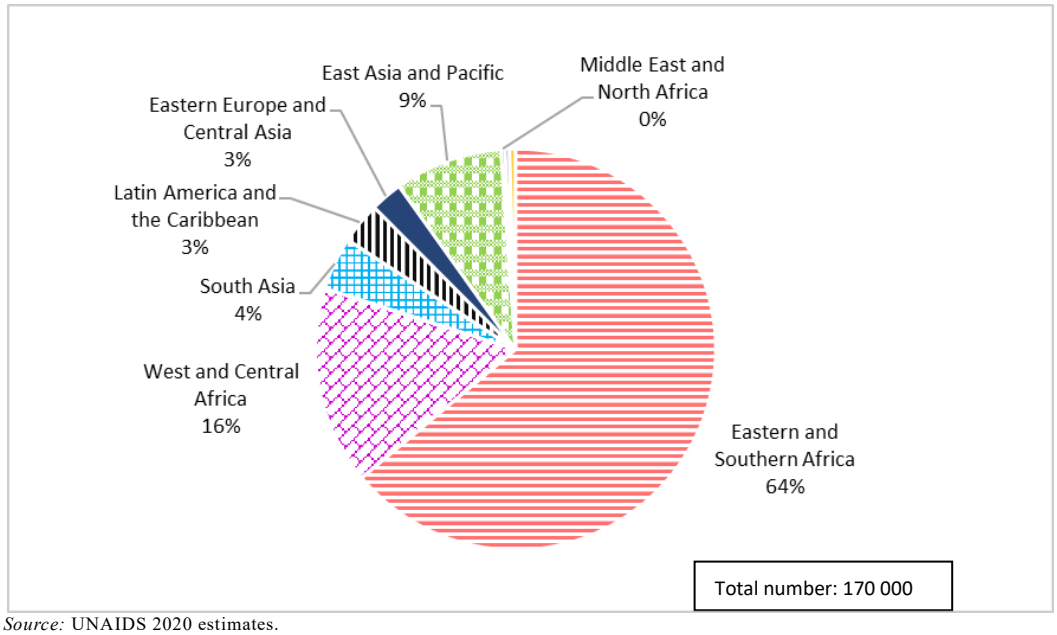


Source: Global AIDS Monitoring 2020 and UNAIDS 2020 estimates.

14. While new HIV infections among adolescents are an issue for all regions, sub-Saharan Africa accounts for 83 per cent of them (see figure VI).

Figure VI

Proportion of new HIV infections among adolescents (15–19 years), by UNICEF region, 2019



Source: UNAIDS 2020 estimates.
Note: Due to rounding, the percentages do not add up to 100 per cent.