



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

2014 ANNUAL RESULTS REPORT HIV AND AIDS

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***UNICEF's Strategic Plan 2014–2017** is designed to fulfil the organization's universal mandate of promoting the rights of every child and every woman, as put forth in the Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination Against Women, in the current international context. At the core of the Strategic Plan, **UNICEF's** equity strategy – emphasizing the most disadvantaged and excluded children and families – translates **UNICEF's** commitment to children's rights into action. The first year of the Strategic Plan coincides with intensifying discussion in the international community on what the post-2015 development agenda will be. What follows is a report on what **UNICEF** set out to do in its Strategic Plan for 2014–2017 to advance the equity agenda through the organization's work on HIV and AIDS; what was achieved in 2014, in partnership with many diverse organizations and movements; and the impact of these accomplishments on the lives of children and families. This report is one of eight on the results of **UNICEF's** efforts this past year, working in partnerships at the global, regional and country levels (one on each of the seven outcome areas of the Strategic Plan and one on humanitarian action). A results report on the **UNICEF** Gender Action Plan has also been prepared as an official **UNICEF** Executive Board document. The organization's work has increasingly produced results across the development-humanitarian continuum, and in 2014, **UNICEF** contributed to an unprecedented level of humanitarian assistance and emergency response. The report lays out what was learned through reflection and analyses, and what is planned for next year. It is an annex and is considered to be integral to the Executive Director's Annual Report 2014, **UNICEF's** official accountability document for the past year.*

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Teenage girls gather in Beira City, Mozambique. Girls are disproportionately affected by HIV. In 2013, two thirds of the 250,000 new HIV infections were among girls aged 15–19.

CONTENTS

Executive Summary	2
Strategic Context	4
Planning and Results	18
Programme area 1: First decade – Children under age 5, pregnant women and mothers	18
Programme area 2: Second decade – Adolescents	30
Programme area 3: Across both decades – Protection, care and support	39
Revenue	46
Financial Implementation	52
Future Workplan	59
Expression of Thanks	61
Abbreviations and Acronyms	62
Endnotes	63
Annex	65

FIGURES AND TABLES

Figure 1 Percentage decline in new HIV infections among children in 21 Global Plan priority countries, 2009–2013 **7**

Figure 2 New infections among children rapidly declining as PMTCT coverage increases **7**

Figure 3 Final mother-to-child HIV transmission rates after breastfeeding in 21 Global Plan priority countries, 2013 **8**

Figure 4 Percentage of adults (aged 15+) and children (aged 0–14) living with HIV who were receiving antiretroviral therapy in 21 Global Plan priority countries, 2013 **11**

Figure 5 Estimated number of children (aged 0–17) who have lost one or both parents to an AIDS-related cause, by UNICEF region, 1990–2013 **12**

Figure 6 Estimated number of new HIV infections among adolescents (aged 15–19), globally and by three regions with the largest number of new adolescent infections, 2000–2013 **13**

Figure 7 Estimated number of AIDS-related deaths among children (aged 0–9), adolescents (aged 10–19) and young people (aged 20–29), 2001–2013 **13**

Figure 8 Number of adolescents living with HIV by mode of infection in the 25 countries that contribute to the majority of AIDS-related deaths among this age group, 2013 **14**

Figure 9 Adolescents living with HIV in 2013 **15**

Figure 10 Prevalence of intimate partner violence in the past 12 months among adolescent girls aged 15–19 **16**

Figure 11 Estimated number of new HIV infections in children (aged 0–14): Global trends, % decline and global projections, 2001–2015 **18**

Figure 12 Other resource contributions 2006–2014: Thematic vs. non-thematic **46**

Figure 13 Other resources by funding modality and partner group, HIV and AIDS, 2014: US\$69 million **48**

Figure 14 HIV and AIDS other resources funding trends, 2003–2014 **49**

Figure 15 Thematic contributions to Strategic Plan outcome and cross-cutting areas, 2014: US\$341 million **51**

Figure 16 UNICEF expenditure by outcome area, 2014 **53**

Figure 17 Expenditure for HIV and AIDS, by funding source, 2014 **54**

Figure 18 Expenditure for HIV and AIDS, by region, 2014 **55**

Figure 19 Expenditure by region for HIV and AIDS **56**

Figure 20 Expenditure by programme areas for HIV and AIDS, 2014 **58**

Figure 21 Key strategies for better results **60**

Table 1 Thematic contributions by resource partner to HIV and AIDS, 2014 **50**

Table 2 Total UNICEF expenses by Strategic Plan outcome area and funding source, 2014 **52**

Table 3 Expenditure by funding source for HIV and AIDS, 2014 **53**

Table 4 Expenditure by region and funding source for HIV and AIDS, 2014 **55**

Table 5 ORR expenditure by thematic and non-thematic for HIV and AIDS, 2014 **56**

Table 6 Top 10 country office expenditure for HIV and AIDS **57**

Table 7 Top 10 country offices, by total expenditure, emergency and non-emergency funds for HIV and AIDS, 2014 **57**

Table 8 Expenditure by programme areas for HIV and AIDS, 2014 **58**

EXECUTIVE SUMMARY

An AIDS-free generation is within reach: a generation in which children are born free of HIV and remain so into adulthood, and children living with HIV have access to the care and treatment they need to survive and thrive. Ending AIDS among children is vital to ending the AIDS epidemic as a public health threat by 2030 – the overarching goal of the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the draft post-2015 sustainable development target.

Globally, more than 1 million new paediatric HIV infections have been averted by prevention of mother-to-child transmission (PMTCT) programmes since 2005. Between 2009 and 2013, new HIV infections among children were reduced by 40 per cent, surpassing the percentage of reduction achieved during the entire previous decade. The extraordinary progress for children in their first decade of life was achieved through a technical partnership between governments and the 36 organizations in the Inter-Agency Task Team (IATT), co-convened under the leadership of UNICEF and the World Health Organization (WHO). The IATT provided the know-how for the Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive, which places the primary focus on the 22 Global Plan countries that account for 90 per cent of new paediatric HIV infections.

Despite the ongoing progress, disparities and inequities persist for children under age 5, pregnant women, mothers and adolescents. Antiretroviral therapy (ART) coverage at the end of 2013 was 37 per cent for adults but only 23 per cent for children. AIDS is now the leading cause of death among adolescents in Africa and the second most common cause of death among adolescents globally.¹ In 2013, 120,000 [100,000–130,000]² adolescents died of AIDS-related illnesses. AIDS remains the leading cause of death among women of reproductive age (15–49) globally, and while substantial progress has been made to reduce mother-to-child transmission of HIV, data available from the most recent year (2013) indicate progress may be stalling in some countries.

In its work to redress maternal and child HIV-related inequities, UNICEF is promoting the Double Dividend approach developed in cooperation with WHO and the Elizabeth Glaser Pediatric AIDS Foundation. Moving beyond a focus on just one disease, the Double Dividend framework for action focuses on data-driven integration of HIV testing and nutrition, immunization and child health services to place the overall health

needs of children first. The Governments of Zimbabwe and Swaziland led, with support from UNICEF, the operationalization of integrated HIV and maternal, newborn and child health (MNCH) services during 2014. UNICEF application of the Monitoring Results for Equity System (MoRES) in 19 countries in West and Central Africa has strengthened the integrations of HIV and MNCH in the scale-up of ART for pregnant women, their infants and mothers living with HIV. A newly established memorandum of understanding between UNICEF and the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) has leveraged more than US\$430 million in the New Funding Model with the aim of improving the alignment of MNCH, malaria and HIV services.

In low and concentrated HIV epidemic settings, stigma and discrimination are still pervasive, especially towards key affected populations. In Eastern and Southern Africa, UNICEF has been instrumental in supporting governments to adopt HIV-sensitive social protection policies to alleviate poverty and the impact of HIV on households, in Ethiopia, Lesotho, South Sudan and Zambia. Countries such as China and Nepal – with UNICEF regional office support in eastern and southern Asia – are creating social protection programmes that allow for children affected by AIDS to receive support through their household rather than being ‘targeted’ for interventions and potentially exposed to discrimination.

AIDS mortality and new HIV infection trends among adolescents are of significant concern. Nearly two thirds of new HIV infections globally among adolescents (aged 15–19) are in girls. In 2013 alone, HIV claimed the lives of 120,000 adolescents aged 10–19, or more than 300 every day. The key populations that are at risk of becoming infected with HIV include gay and bisexual boys, transgender adolescents, adolescents who sell sex – including children (aged 10–17) who are sexually exploited through selling of sex³ – and those who inject drugs. Many are never diagnosed because they fear legal and social repercussions if they seek information, enter prevention programmes or get tested.

UNICEF country office annual reporting in 2014 indicates 64 of 117 country offices reported strategies to address HIV among key affected adolescent populations, and many of those strategies only address HIV treatment. UNICEF efforts in collaboration with the Governments of Brazil, Indonesia and Ukraine have



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Prevention of mother to child transmission works. Baby Lundiwe's mother, Sipiwe, was already on life-long antiretroviral treatment when she became pregnant with Lundiwe. Lundiwe is happy, healthy baby, always smiling, very curious, and free of HIV.

focused on expanding access to HIV testing and driving equitable responses to reach key affected adolescent populations.

The Executive Directors of UNICEF and UNAIDS joined forces in June 2014 to take action to end adolescent AIDS. A high-level event led by the Governments of Brazil and Kenya was held during the United Nations General Assembly, and a leadership group was formed with the United States President's Emergency Plan for AIDS Relief (PEPFAR), United Nations Population Fund (UNFPA), WHO, the Global Fund, youth networks and MTV to work with countries to define strategies for mobilizing all sectors of the development responses. This initiative established a new platform – ALL IN to #EndAdolescentAIDS– and set targets of a 65 per cent reduction in AIDS-related deaths and a 75 per cent reduction in new HIV infections among adolescents by 2020, with a programme focus on 25 lead countries, representing all regions of the world.

UNICEF and the World Bank supported the Call to Action for Children Affected by AIDS at the Global Partners Forum held during the 2014 International AIDS Conference, which focused on scaling up social protection interventions for vulnerable children and

their families to improve HIV outcomes. A UNICEF and Government of South Africa effort to implement long-term HIV-sensitive social protection exemplifies the commitment to the Call to Action. It demonstrated that 'household child support grants' received before age 5 were associated with significant reductions in adolescent HIV-associated 'risky' behaviours (sexual intercourse, alcohol/drug use and criminal activity) and increases in protective behaviour (reducing the number of sexual partners and preventing early pregnancy) 15 years later.⁴

HIV infection and HIV-related mortality trends clearly reveal inequities in adult vs. child HIV response and demand UNICEF's attention. A modelling by UNICEF and the Futures Group, built on the UNAIDS Investment Framework modelling of 2011, suggests that 75 per cent of resources for adolescent programming be invested in interventions within the education, child protection, social protection, justice and non-medical health sectors and aligned with the scale-up of high-impact interventions, including PMTCT, HIV treatment and pre-exposure prophylaxis, voluntary male medical circumcision (VMMC), condom use, harm reduction and targeted behaviour change.⁵ According to one analysis, however, national HIV programmes in

2012 spent less than 2 per cent of their total resources on these areas for adolescents.⁶ UNICEF is making substantial efforts to address structural drivers of the epidemic, such as addressing gender-based violence in South Sudan; scaling up youth-friendly services in Zimbabwe; and integrating services for drug addiction and maternal health in Ukraine.

Challenges to achieving an AIDS-Free Generation are integrally linked to obtaining all the goals of the UNICEF Strategic Plan 2014–2017. System strengthening and integration (health, nutrition and social protection) must focus on delivering results for mothers and children, rather than on impacting one disease. UNICEF must promote better collection and analysis of data not only at national, but also at decentralized levels, and through the use of that data UNICEF must serve the most marginalized within society, who are so often left out of our national and global responses, especially people living in poverty and girls. HIV-specific challenges must address the isolation of marginalized populations at risk for HIV infection, of whom many are undiagnosed and do not access services for fear of stigma and discrimination; and some cannot afford an HIV test or treatment. For the youngest, appropriate and affordable paediatric drug formulation options are significantly lacking.

The year 2014 was particularly crucial for the HIV sector as development partners and governments worked to accelerate progress towards the MDGs, and UNICEF began the first year of transition to its Strategic Plan 2014–2017. MDG 6 (Combat HIV, malaria and other diseases) is one of the MDG success stories. However, our collective efforts have not always been equitable, as elucidated by increasing death rates for adolescents and lower levels of ART access for children compared with adults. Ending AIDS among children is vital to ending the AIDS epidemic as a public health threat by 2030. UNICEF and the Joint United Nations Programme on HIV/AIDS (UNAIDS) are advocating for inclusion of this target in the Sustainable Development Goals.

“ELIMINATING new HIV infections among children is an ambitious but achievable goal. With the support of the Every Woman Every Child movement, an AIDS-free generation can be ours. There is no better investment than the health of women and children.”

Ban Ki-moon

Secretary-General of the United Nations

In the coming year, UNICEF’s HIV and AIDS programme will focus on data-driven planning at decentralized levels – specifically, by examining subnational disparities to uncover the highest burden areas and hidden inequities, and implementing the best HIV and MNCH health system interventions to improve the efficiency and quality of service delivery, especially through community-based organizations. For PMTCT, these efforts will focus on eight countries where 70 per cent of all mother-to-child transmission of HIV currently occurs. In the second decade of life, intensified efforts will examine epidemiological and structural drivers of the epidemic in 25 roll-out countries, and inform the scale-up of HIV testing and follow-up services, cash transfers and eHealth multi-media innovations to decrease HIV risk-taking behaviours, HIV infections and AIDS-related deaths among adolescents.

To address persistent inequities in the children and AIDS response, UNICEF continues to advocate for investments through the organization. Over the past six years, expenditures for this sector have oscillated between a high of US\$187 million (2009) and a low of US\$102.5 million (2012). Among the Strategic Plan 2014–2017 outcome areas, HIV and AIDS had the lowest expenditure. Thematic contributions were 17 per cent of total other resources for HIV and AIDS. Eighty-six per cent of thematic contributions came from eight National Committees for UNICEF.

STRATEGIC CONTEXT

Strategic investments in the AIDS response continue to generate concrete results, fuelling optimism about ending the epidemic by 2030. By the end of 2013, from the latest data available, 35 million [33.2 million–37.2 million] people were living with HIV worldwide. New HIV infections in 2013 were

estimated at 2.1 million [1.9 million–2.4 million] – 38 per cent lower than in 2001. Between the peak rate in 2005 and the most recent figures of 2013, the number of AIDS-related deaths has been reduced by 35 per cent, to 1.5 million [1.4 million–1.7 million].

UNICEF STRATEGIC PLAN OUTCOME FOR THE 2014–2017 PERIOD

IMPROVED AND EQUITABLE USE OF PROVEN HIV PREVENTION AND TREATMENT INTERVENTIONS BY CHILDREN, PREGNANT WOMEN AND ADOLESCENTS

Impact indicator	Base line* (2012)	Latest year (2013)	Target
Number of new HIV infections among children under 15 years (2012 United Nations General Assembly Political Declaration on HIV and AIDS)	270,000 children	240,000 [210,000–280,000]	40,000 (2015)
2b. Percentage of children under 15 years with access to HIV prevention and treatment	19%	23%	90% (2015)
Outcome indicator	Base line* (2012)	Latest year (2013)	Target
P2.1 Countries with at least 80% coverage of antiretroviral treatment (ART) among eligible children aged 0-14 years and eligible adolescent girls and boys aged 10-19 years	0-14: 3 10-19: No Data	0-14: 3 10-19: No Data	38 UNAIDS Priority countries
P2.2 Countries providing at least 80% coverage of triple drug regimens for all pregnant women living with HIV	4	18 of the 22 Global Plan Countries	All (22) of the Global Plan Countries
P2.3 Countries where at least 50% of the overall HIV and AIDS budget is funded through domestic resources	61	61 (2012) no new data from UNAIDS.	144
P2.4 Countries with at least a 60% coverage in condom use at last sexual encounter among adolescents aged 15-19 years reporting multiple partners in last year	Males: 10 out of 14 Females: 1 of 13	Males: 9 out of 20 Females: 1 of 17 (2013)	38 UNAIDS priority countries
P2.5 Number and percentage of people in humanitarian situations who have access to HIV prevention and treatment	N/A	35% (41) of UNICEF CO reported at least 22,000 known pregnant women living with HIV impacted by emergency. No coverage data.	80% target population

* Note: Baseline values, derived from HIV estimates modelled on an annual basis, are updated each year in accordance with the new estimation assumptions using the latest demographic, epidemiological and programme coverage data. The new estimates are recalculated for all years from 1970 to the present. Assessment of trends, therefore, has to be done using recalculated HIV estimates and not those previously published.

For children under age 5, pregnant women, mothers and adolescents, however, inequities persist. ART coverage at the end of 2013, for example, was 37 per cent for adults but only 23 per cent for children. AIDS is now the leading cause of death among adolescents in Africa and the second most common cause of death among adolescents globally.⁷ In 2013, 120,000 [100,000–130,000] adolescents died of AIDS-related illnesses. AIDS remains the leading cause of death among women of reproductive age (15–49) globally, and while substantial progress has been made to reduce mother-to-child transmission of HIV, data available from the most recent year (2013) indicate progress may be stalling in some countries.

Resources mobilized for AIDS programmes in 2013 included US\$19.1 billion in funding from external sources (bilateral, multilateral and private sector) and domestic resources in low- and middle-income countries, of which US\$8.1 billion was donor government commitments.⁸ Countries have increased their own investments in AIDS programmes, as international assistance has flattened during recent years. But there is still a need to focus investments on the most efficient, effective and human rights-based interventions, and international investments often assist in driving this effort.⁹

In the context of strategic partnerships, UNICEF collaborates with UNAIDS and other organizations, such as WHO, UNFPA and the World Bank. UNICEF plays a critical role in the design, implementation and evaluation of the global programme. The organization is also directly responsible for three goals in the joint programme, co-convenes three inter-agency task teams to coordinate all 11 co-sponsors and is a partner on: Social Protection Care and Support (UNICEF and the World Bank); Young People and HIV (UNICEF and UNFPA); and the Prevention and Treatment of HIV Infection in Pregnant Women, Mothers and Children (UNICEF and WHO). The UNAIDS accountability and budget matrix (known as the UBRAF) was developed to improve the accountability of the joint programme and strengthen monitoring for results. The UBRAF provides outcomes, outputs and deliverables for the UNAIDS family, as well as a set of indicators to monitor progress. UNICEF's accountabilities under the UBRAF and the UNAIDS Division of Labour are aligned with the priorities of the UNICEF HIV programme – and assist us in evaluating and monitoring our programme in relation to the other 11 co-sponsors of UNAIDS.

FIRST DECADE: CHILDREN UNDER 5, PREGNANT WOMEN AND MOTHERS¹⁰

The Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive was launched in July 2011 at the United Nations General Assembly High Level Meeting on AIDS. The Global Plan prioritizes 22 countries with the highest number of pregnant women living with HIV in need of services, specifically Angola, Botswana, Burundi, Cameroon, Chad, Côte d'Ivoire, the Democratic Republic of the Congo, Ethiopia, Ghana, India, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, South Africa, Swaziland, Uganda, the United Republic of Tanzania, Zambia and Zimbabwe.

FEWER CHILDREN ARE ACQUIRING HIV, BUT DECLINES VARY WIDELY ACROSS COUNTRIES

Since 2009, there has been a 43 per cent reduction of new HIV infections among children in the Global Plan priority countries, from 350,000 [310,000–380,000] in 2009 to 199,000 [170,000–230,000] in 2013. This is the first time since the early 1990s that the number of new infections among children in these countries has dropped to under 200,000. Declines in new HIV infections were recorded in all priority countries between 2009 and 2013, although at varying rates (*see Figure 1*). Malawi had the largest decline, at 67 per cent, even though it started from a higher transmission rate than many other countries. New HIV infections among children were reduced by 50 per cent or more in seven other countries: Botswana, Ethiopia, Ghana, Mozambique, Namibia, South Africa and Zimbabwe.

However, between 2012 and 2013 the pace of progress in reducing new HIV infections among children across the Global Plan countries slowed, with the exception of India. Twenty-one countries recorded an 11 per cent reduction between 2012 and 2013, compared with a 19 per cent reduction from 2011–2012 (see Figure 1). Although the decline in Nigeria was 19 per cent since 2009, the country continues to carry the highest burden of new HIV infections among children: Among all priority countries in 2013, nearly one quarter of new HIV infections among children (aged 0–14), nearly 51,000 [44,000–60,000] cases, occurred in Nigeria.

FIGURE 1

**PERCENTAGE DECLINE IN NEW HIV INFECTIONS AMONG CHILDREN
IN 21 GLOBAL PLAN PRIORITY COUNTRIES, 2009–2013**

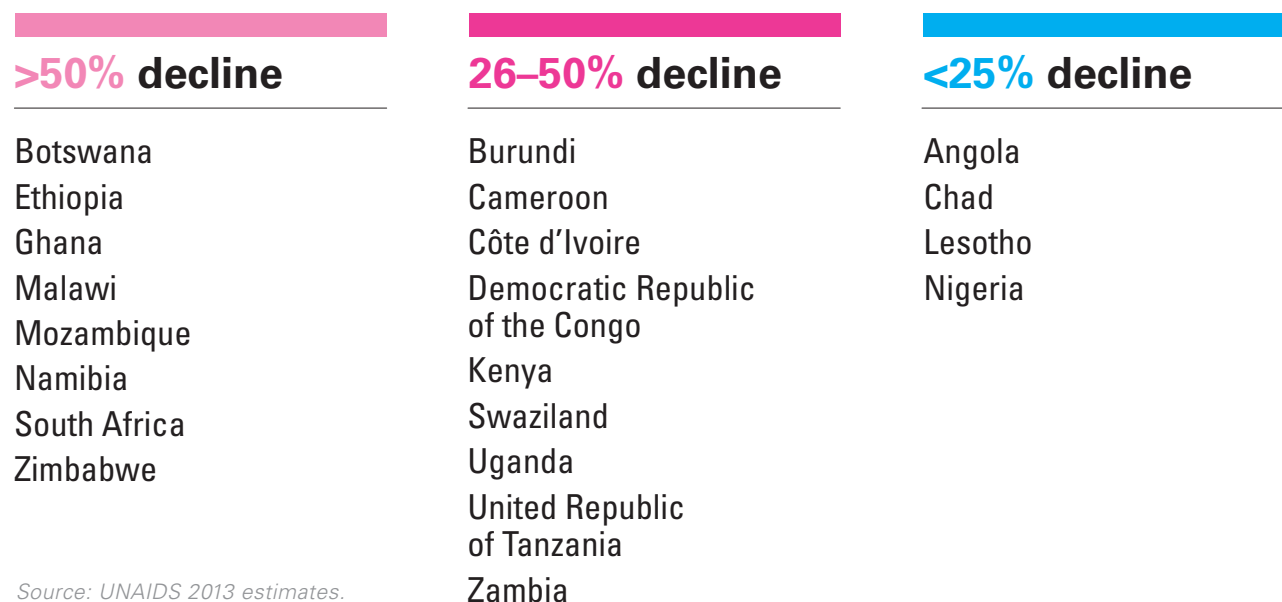
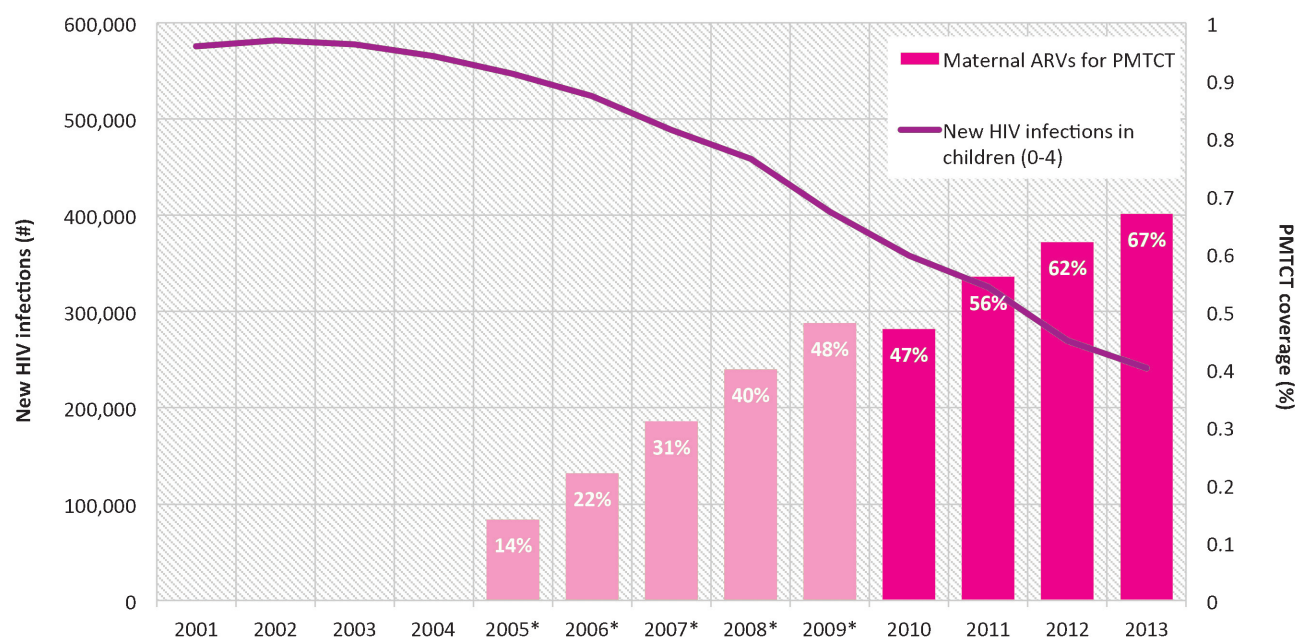


FIGURE 2

NEW INFECTIONS AMONG CHILDREN RAPIDLY DECLINING AS PMTCT COVERAGE INCREASES



Estimated number of new HIV infections among children (aged 0–14) and coverage of antiretroviral medicines for PMTCT in all low- and middle-income countries 2001–2013.

*Note source: Data from 2005 through 2009 include single-dose nevirapine, a regimen no longer recommended by WHO. Therefore, values from 2005–2009 are not comparable to those from 2010–2013.

Source: UNAIDS, UNICEF and WHO, 2005–2013, global AIDS response progress reporting, and UNAIDS, 2013 HIV and AIDS estimates, July 1014.

PREGNANT WOMEN LIVING WITH HIV ARE GETTING SERVICES, BUT PROGRESS IS STALLING AND IN SOME CASES REVERSING

For the first time, all the Global Plan priority countries have guidelines officially endorsing the more efficacious antiretroviral medicines (Option B or B+) and the phasing out of Option A, which is no longer recommended by WHO.

The proportion of pregnant women living with HIV, in the 21 African Global Plan priority countries, who received antiretroviral medicines for PMTCT has doubled over the past five years, from 33 per cent [31–35 per cent] to 68 per cent [64–74 per cent] and the regimens being received are now more efficacious (*see Figure 2*). In Botswana, Namibia, South Africa and Swaziland, 90 per cent or more of pregnant women living with HIV were receiving antiretroviral medicines in 2013. Nonetheless, there is concern about stagnation: Between 2012 and 2013, the percentage of women receiving antiretroviral medicines rose only marginally, from 64 per cent to 68 per cent. In the same period, only

37,000 additional pregnant women living with HIV were reached with antiretroviral prophylaxis or treatment, compared to nearly 97,000 between 2011 and 2012.

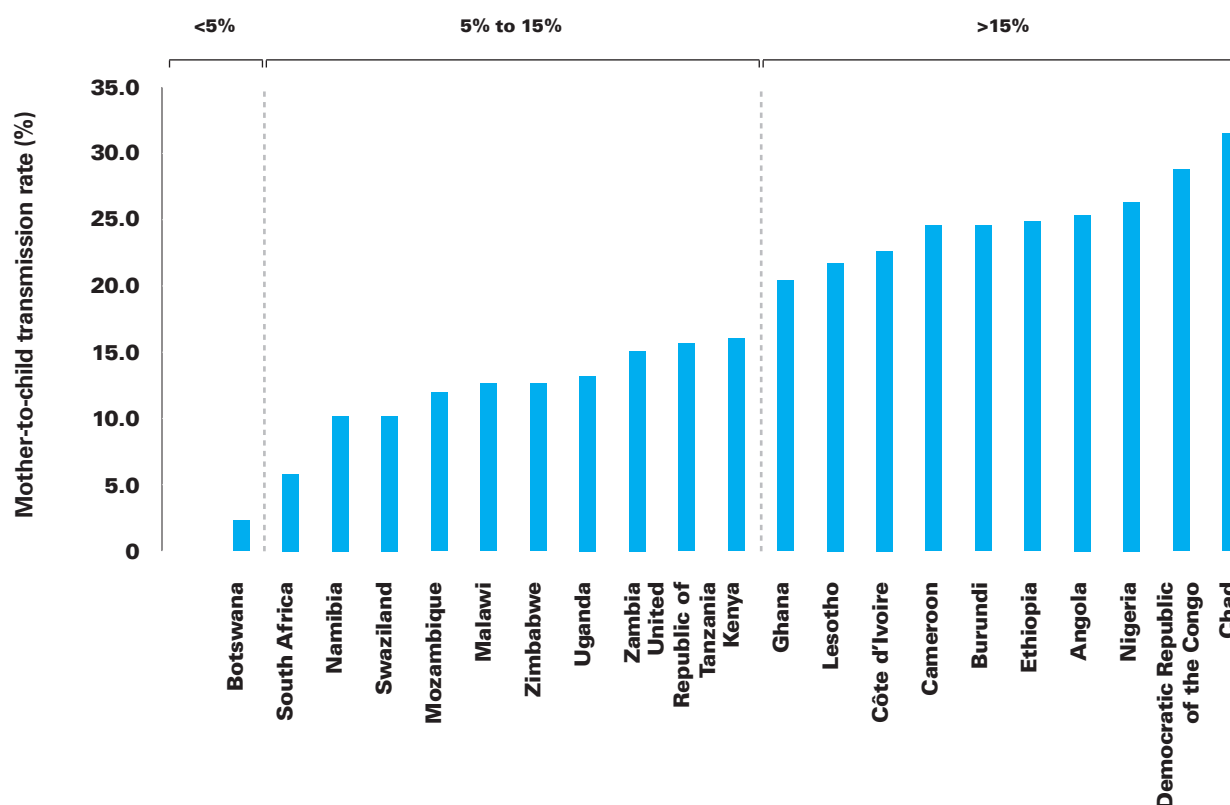
In some countries, there has been a stalling or even a decrease in coverage. Stalling was documented in Botswana, South Africa, Uganda, the United Republic of Tanzania and Zimbabwe, while declines of at least 10 per cent were documented in Chad, Ghana, Lesotho and Zambia. The reasons for these observed changes differ. Countries such as Botswana and South Africa, for example, already have high coverage and may be reaching a saturation point. Other countries may be experiencing programming fluctuation due to health worker capacities, while others have made improvements to monitoring systems that allow for more accurate estimates.

RISK OF HIV TRANSMISSION IS NOW CONCENTRATED DURING THE BREASTFEEDING PERIOD

Encouragingly, between 2009 and 2013 there was a sharp increase in the percentage of women reportedly

FIGURE 3

FINAL MOTHER-TO-CHILD HIV TRANSMISSION RATES AFTER BREASTFEEDING IN 21 GLOBAL PLAN PRIORITY COUNTRIES, 2013



Source: UNAIDS 2013 estimates.

receiving antiretroviral medicines (prophylaxis or life-long therapy) during breastfeeding, from 20 per cent to 61 per cent (indicated by the *WHO Consolidated Guidelines on the Use of Antiretroviral Drugs for Treating*).¹¹

In 2009, prior to the launch of the Global Plan, the overall transmission rate, including the breastfeeding period, was 26 per cent in the 21 Global Plan countries. Since the roll-out of the Global Plan, the rate has dropped to 16 per cent. While this progress is encouraging, it remains short of the Global Plan's 5 per cent goal (see Figure 3). With a modelled transmission rate of 2 per cent in 2013, Botswana appears to have accomplished the goal of virtual elimination of mother-to-child transmission, and South Africa is not far behind at 6 per cent. The remaining priority countries have transmission rates of over 10 per cent, with 10 of them having transmission rates that are higher than 20 per cent. Considerable efforts – including high coverage for HIV testing and counselling, high coverage with effective PMTCT regimens and support for adherence – are needed to achieve the Global Plan goals. This is particularly important during breastfeeding.

Analysis of 2013 data shows that the mother-to-child transmission rate is 7 per cent during the first six weeks of an infant's life, but this rises to 16 per cent after breastfeeding ends. Because the scale-up of PMTCT and more effective regimens have reduced the risk of HIV transmission during pregnancy and delivery, the risk of HIV transmission is now concentrated during the breastfeeding period.

MARGINAL PROGRESS IN PREVENTING NEW HIV INFECTION AMONG WOMEN OF REPRODUCTIVE AGE In order to eliminate mother-to-child transmission among children and also keep women healthy, it is important to reduce new HIV infections among women of reproductive age, especially among adolescents and young women. Therefore, the Global Plan aspired to reduce this number by 50 per cent between 2009 and 2015 in the priority countries. The data show, however, that only marginal progress has been made. In 2009, 740,000 [680,000–800,000] women became infected with HIV, compared to 620,000 [560,000–680,000] in 2013, a reduction of only 17 per cent. These numbers are added to the existing pool of women who were infected earlier and need services to prevent mother-to-child transmission when they become pregnant. Consequently, the total number of women requiring these services remains high in the priority countries, at 1.3 million [1.2 million–1.4 million].

In addition, access to ART means that more women living with HIV are healthy and able to have

“Children and young people should be the first to benefit from the progress we have made in ending the epidemic, not the last.”

Anthony Lake

UNICEF Executive Director

children. For the fulfilment of women's rights, continued investment in PMTCT services and access to antiretroviral medicines are required, due to the slow decline in new HIV infections among women and the growing number of women living with HIV who are alive and healthy because of treatment.

UNMET FAMILY PLANNING NEEDS AMONG WOMEN In the priority countries, the Global Plan aims to eliminate all unmet needs for family planning among all women, including women living with HIV, thereby ensuring that all women who desire contraception can have access to it. However, according to most recent population-based surveys, more than half of the priority countries are failing to meet the needs for family planning among at least 25 per cent of all married women. This is the case in Burundi, Côte d'Ivoire, the Democratic Republic of the Congo, Ethiopia, Ghana, Kenya, Malawi, Mozambique, the United Republic of Tanzania, Uganda and Zambia. Unmet need among girls aged 15–19 (married or in union) is higher than for women and girls aged 15–49 (married or in union) in more than half of the 69 Family Planning 2020 focus countries. The level of disparity between adolescents' needs and overall unmet needs is highest in the Caribbean and Latin America, and lowest in Eastern and Central Asia.¹² Barriers to access range from the supply side, including procurement, supply chain, cost and trained personnel, to demand, such as legal, social, economic barriers for girls and women.

INFANT HIV DIAGNOSIS WHO recommends that children exposed to HIV be tested within four to six weeks of birth, so that those who are already infected can immediately begin treatment. Infant diagnosis rates (both early diagnosis and final diagnosis after 18 months) and HIV testing during and after the breastfeeding period remain poor in many countries. This creates a bottleneck to scaling up treatment for children, especially those younger than 18 months of age. Currently, the virological test is performed on dried blood spot (DBS) speci-

mens collected at local sites and then transported and tested in large centralized laboratories. This has sometimes led to long waiting periods before the results are returned to the caregiver, increasing the rates of loss to follow-up and failure to start treatment even among those infants diagnosed as infected.

Despite significant investment in the 21 African Global Plan priority countries, only 39 per cent of children exposed to HIV received HIV virological testing within the first two months of life, and only six of the priority countries were providing early infant diagnosis to more than 50 per cent of children exposed to HIV in 2013: Swaziland (89 per cent), South Africa (78 per cent), Botswana (58 per cent), Namibia (56 per cent), Zambia (55 per cent) and Zimbabwe (50 per cent). Success in these countries is often associated with a mix of factors, including stronger health systems, access to financial resources and strong, organized communities of people living with HIV. In the remaining priority countries, the number of infants receiving virological testing was less than 50 per cent, and was unchanged or decreased slightly from previous years. In nine priority countries, the number of children exposed to HIV receiving virological testing was less than 25 per cent.

PAEDIATRIC HIV TREATMENT Because infants and young children who acquire HIV have an exceptionally high risk of morbidity and mortality, UNAIDS, WHO and UNICEF are encouraging countries to fast-track diagnosis and treatment in children. Without treatment, up to 50 per cent of children who have HIV die before their second birthday. WHO now recommends that ART be initiated in all children living with HIV under 5 years of age and for older children living with HIV, with Cluster Designation 4 cell count <500 cells/mm³.¹⁴

Since 2009, the number of children receiving ART has increased in all countries. Botswana has achieved universal access (defined as 80 per cent coverage), with 84 per cent of children living with HIV receiving treatment. Three priority countries – Namibia, South Africa and Swaziland – are providing treatment to nearly half the children living with HIV. But most priority countries have a long way to go. Cameroon, Chad, Côte d'Ivoire, the Democratic Republic of the Congo and Ethiopia provide treatment to less than 10 per cent of their children living with HIV. Only 22 per cent of children living with HIV are receiving HIV treatment in the 21 high-burden countries. Although this represents an increase from the 8 per

cent baseline in 2009, it is much lower than the 34 per cent of pregnant women living with HIV who are currently on treatment in the 22 priority countries or 39 per cent among all adults living with HIV in the 21 high-burden countries (*see Figure 4*).

Although the number of newly infected children requiring HIV treatment will decline as new HIV infections are prevented, there is an urgent need to identify the children currently living with HIV and link them to care and treatment services so that their morbidity and mortality is reduced over time.¹³

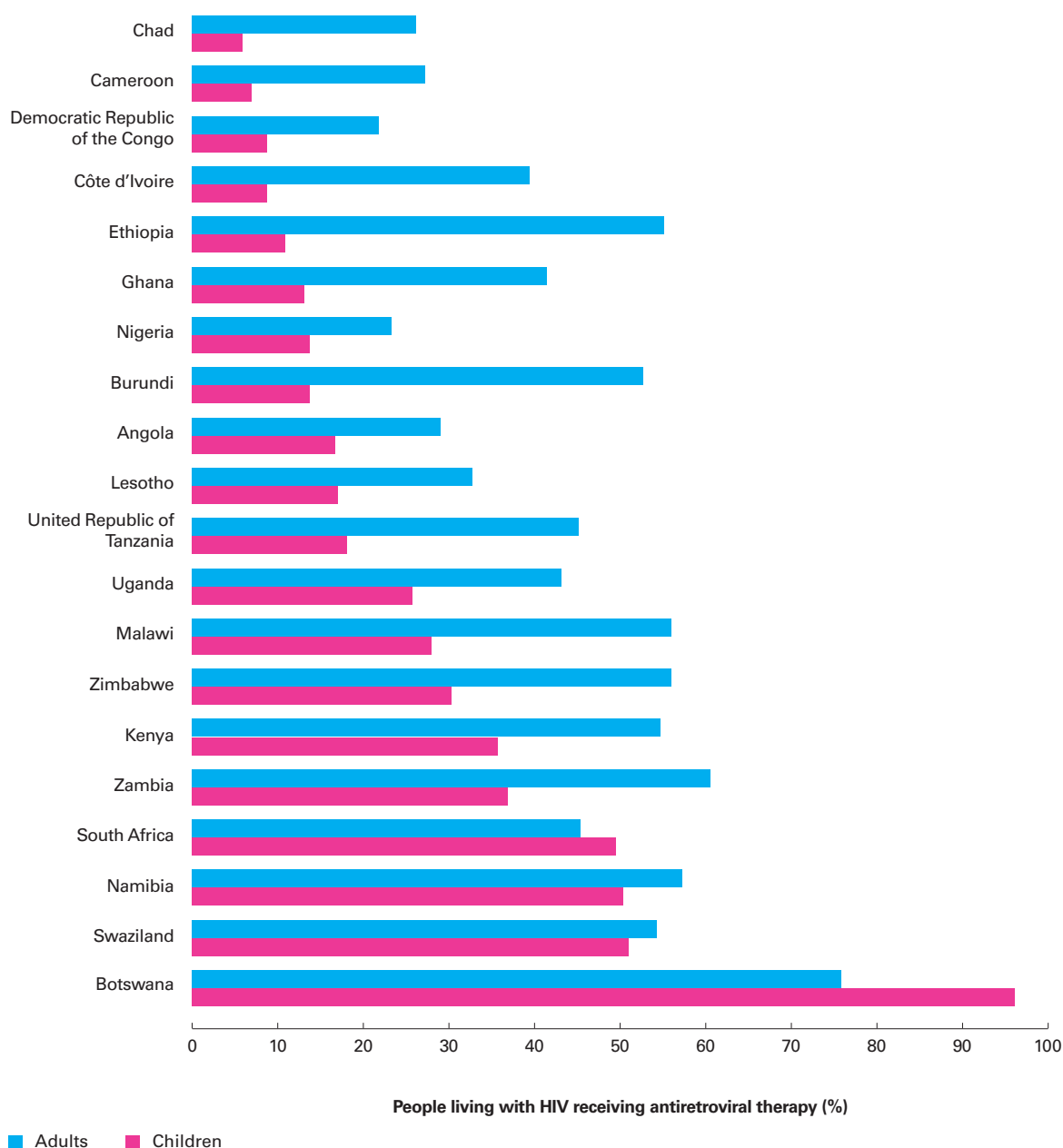
CO-TRIMOXAZOLE PREVENTIVE THERAPY Although the 2013 *WHO Consolidated Guidelines* recommend co-trimoxazole preventive therapy among children for prevention of pneumocystis pneumonia, toxoplasmosis and bacterial infection, the data suggest low utilization of this highly efficacious therapy. Only five priority countries provided co-trimoxazole preventive therapy to at least 50 per cent of such infants: Swaziland (90 per cent), Botswana (80 per cent), South Africa (78 per cent), Mozambique (68 per cent) and Zimbabwe (55 per cent). There is a great need for countries to reprioritize co-trimoxazole prophylaxis as part of the paediatric HIV treatment package, as recommended by WHO since 2006. This will require a set of interrelated interventions, including strengthening links between HIV testing and treatment, as well as follow-up for infants and children exposed to HIV.

HIV-SENSITIVE SOCIAL PROTECTION IN THE FIRST-DECADE RESPONSE¹⁵ While the clinical interventions required to achieve Global Plan goals are well articulated, social and economic barriers continue to hinder access, uptake and retention in services. Elimination will not be achieved without effective community engagement and improved links between communities and health facilities.¹⁶ Social protection can help reduce access barriers, empower women to adopt health-seeking behaviours,¹⁷ and reduce financial and social barriers to service uptake.¹⁸

Most countries have a system of formal and informal social protection, although the philosophy, coverage, eligibility criteria and content vary. For example, nearly 90 per cent of older adults in high-income countries receive some social or private pension benefits, whereas only 20 per cent of the elderly can rely on such income in low-income countries. Low coverage and limited scope of social protection in low- and middle-income countries is typically explained in terms of the state's limited ability to generate revenue through taxes,

FIGURE 4

PERCENTAGE OF ADULTS (AGED 15+) AND CHILDREN (AGED 0–14) LIVING WITH HIV WHO WERE RECEIVING ANTIRETROVIRAL THERAPY IN 2013, IN 21 GLOBAL PLAN PRIORITY COUNTRIES

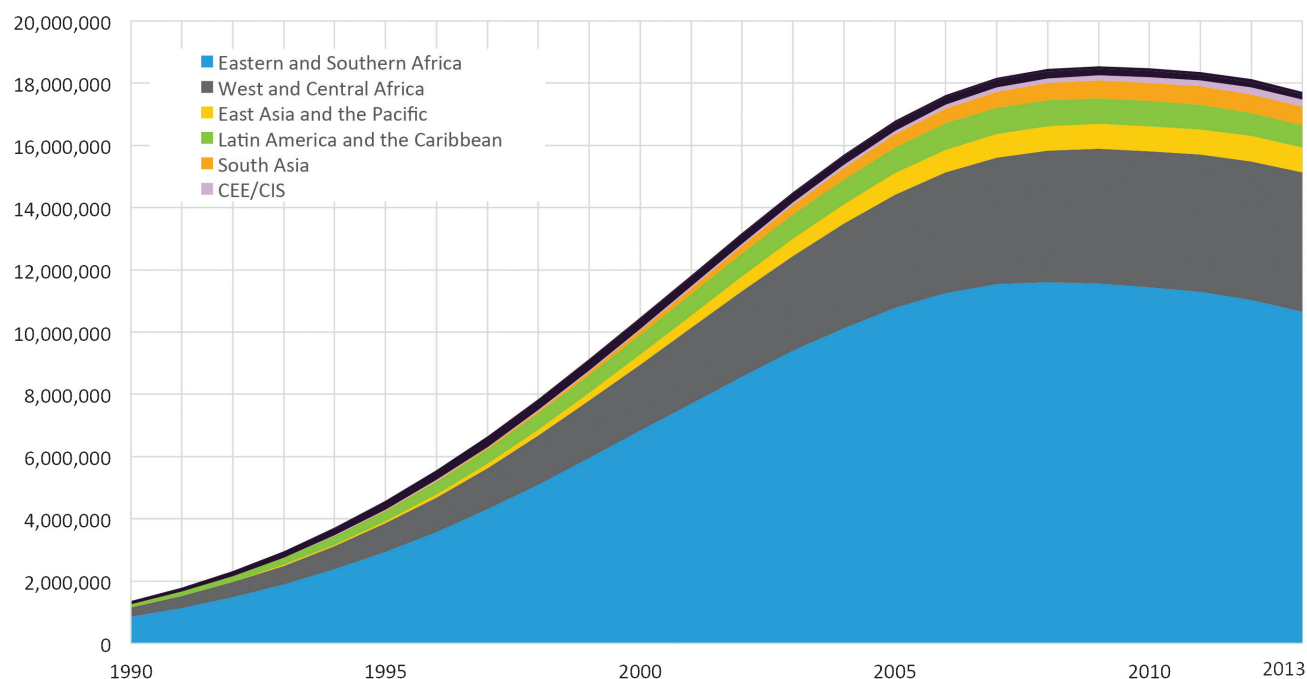


Source: UNAIDS/UNICEF/WHO 2013 Estimates.

tariffs or other sources to finance public services.¹⁹ A recent study of community perceptions regarding social protection found that in Malawi, participants viewed social transfers as 'a gift' for which they should be grateful and uncomplaining, whereas in the State of Palestine, people viewed social transfers as a right to be demanded.²⁰ In 2006, the Tear Fund estimated that faith-based organizations

in Africa contributed US\$5 billion worth of labour to HIV programmes,²¹ indicating the important role that communities are playing in responding to the epidemic.²²

Paediatric AIDS interventions must also look beyond HIV disease impacts to ensure the long-term survival of the child. HIV-exposed and infected children face

FIGURE 5**ESTIMATED NUMBER OF CHILDREN (AGED 0–17) WHO HAVE LOST ONE OR BOTH PARENTS TO AN AIDS-RELATED CAUSE, BY UNICEF REGION, 1990–2013**

Source: UNICEF analysis of UNAIDS 2013 HIV and AIDS estimates, July 2014.

a range of significant risks to child development, including higher rates of developmental delays, resulting from stresses on physical and mental health, compromised parenting, economic strains and stigma.²³ The early years present opportunities for protection and risk mitigation.²⁴ In concentrated epidemics, children of mothers living with HIV face higher risks of abandonment and institutionalization,²⁵ and social protection has been shown to play a positive role in improving childhood well-being and quality of care.²⁶ For example, when orphans are placed in an extended family situation, social protection improves caregiver ability to provide for children's basic needs. The number of children who have lost parents to AIDS has not declined, and in settings such as sub-Saharan Africa, where most of the 18 million orphaned children reside, such support is critical²⁷ (see Figure 5).

SECOND DECADE: ADOLESCENTS²⁸

AIDS among adolescents is not under control, and new HIV infections among adolescents are not decreasing as quickly as they should. In 2013,

one adolescent aged 15–19 was newly infected with HIV every two minutes. Progress is also uneven across different regions. For example, the number of new HIV infections has remained relatively stable in Asia and the Pacific since 2005, while it has decreased in Eastern and Southern Africa although it remains unacceptably high (see Figure 6).

AIDS is now the leading cause of death among adolescents in Africa and the second most common cause of death among adolescents globally.²⁹ In 2013, 120,000 [100,000–130,000] adolescents died of AIDS-related illnesses. According to UNICEF, UNAIDS and WHO estimates, adolescents are the only age group in which deaths due to AIDS are not decreasing – while all other age groups combined experienced a decline of 38 per cent in AIDS-related deaths between 2005 and 2013 (see Figure 7).

AIDS-related deaths among adolescents today mostly reflect HIV infections in children from at least a decade ago. Many children slipped out of care and treatment programmes, were lost to follow-up or were never

FIGURE 6

ESTIMATED NUMBER OF NEW HIV INFECTIONS AMONG ADOLESCENTS (AGED 15–19) OVER THE PERIOD 2000–2013: GLOBAL AND THREE REGIONS WITH THE LARGEST NUMBER OF NEW ADOLESCENT INFECTIONS

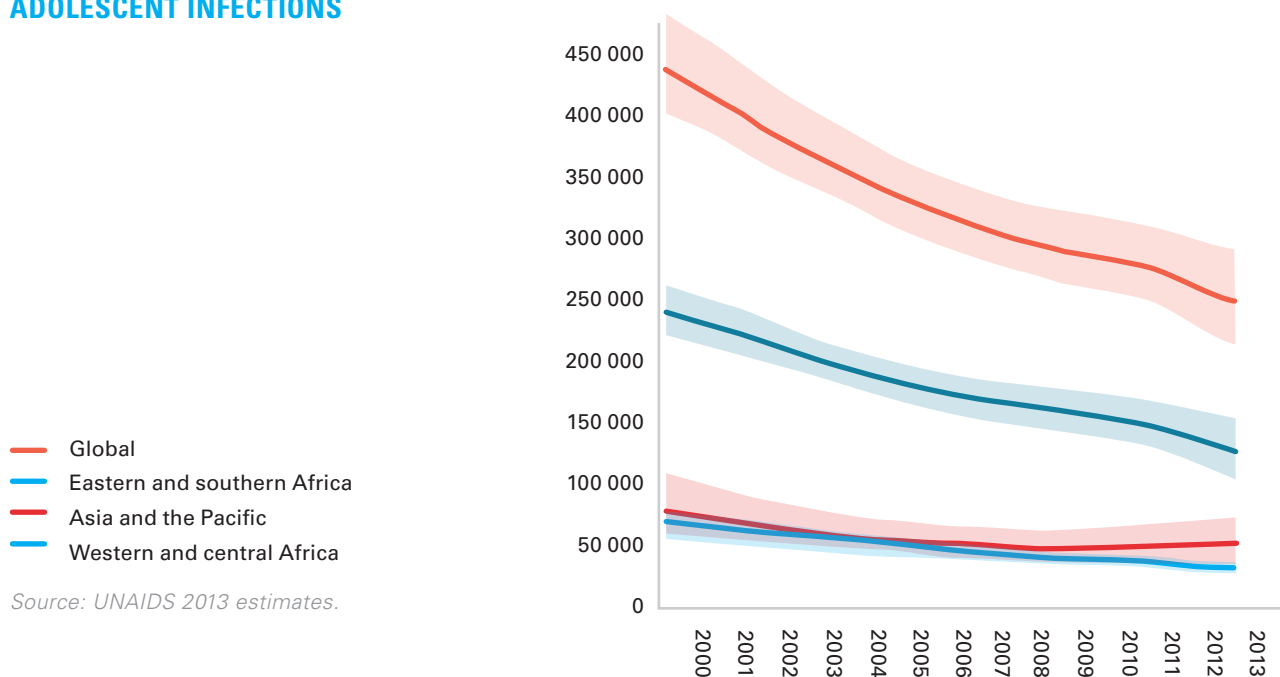


FIGURE 7

ESTIMATED NUMBER OF AIDS-RELATED DEATHS AMONG CHILDREN (AGED 0–9), ADOLESCENTS (AGED 10–19) AND YOUNG PEOPLE (AGED 20–29) OVER THE PERIOD 2001–2013

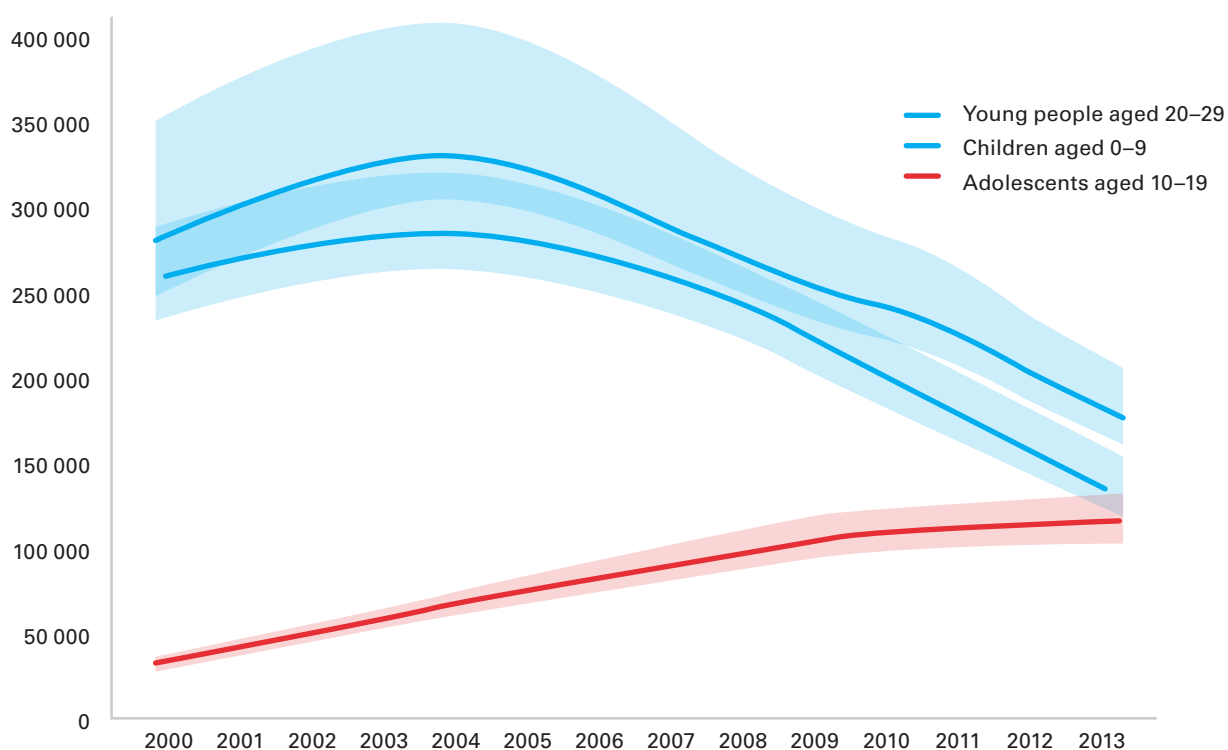
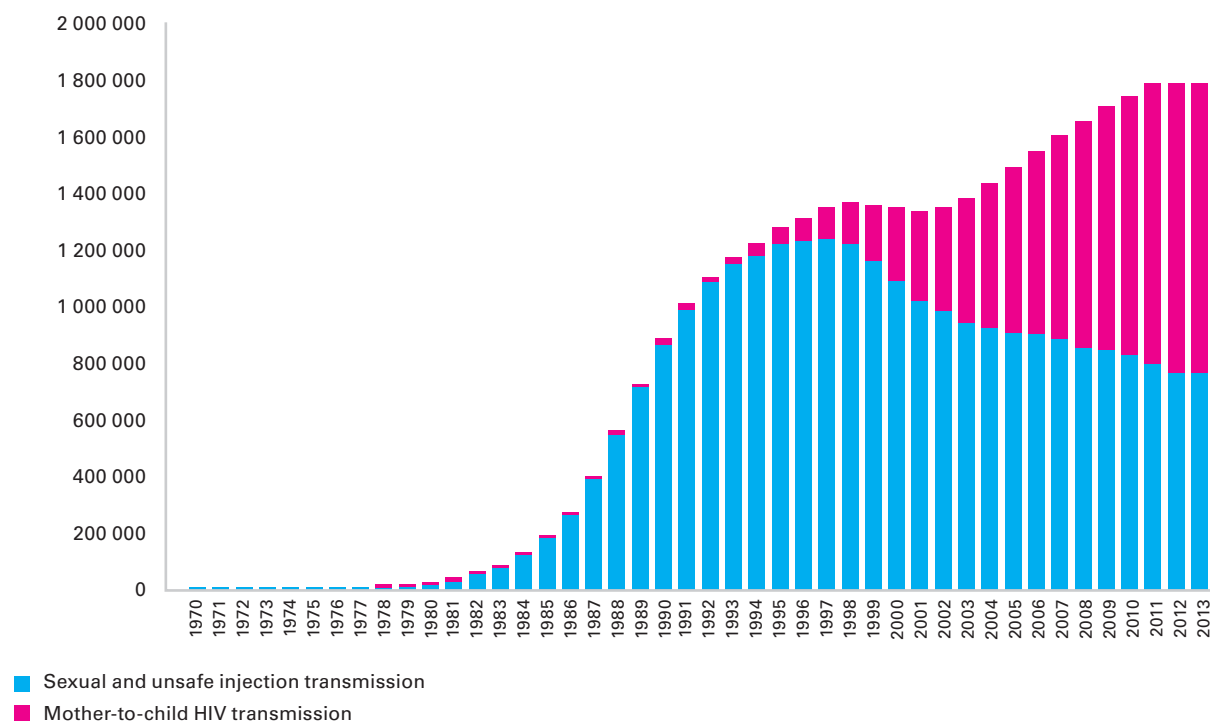


FIGURE 8

NUMBER OF ADOLESCENTS LIVING WITH HIV BY MODE OF INFECTION IN THE 25 COUNTRIES WHICH CONTRIBUTE TO THE MAJORITY OF AIDS-RELATED DEATHS AMONG THIS AGE GROUP



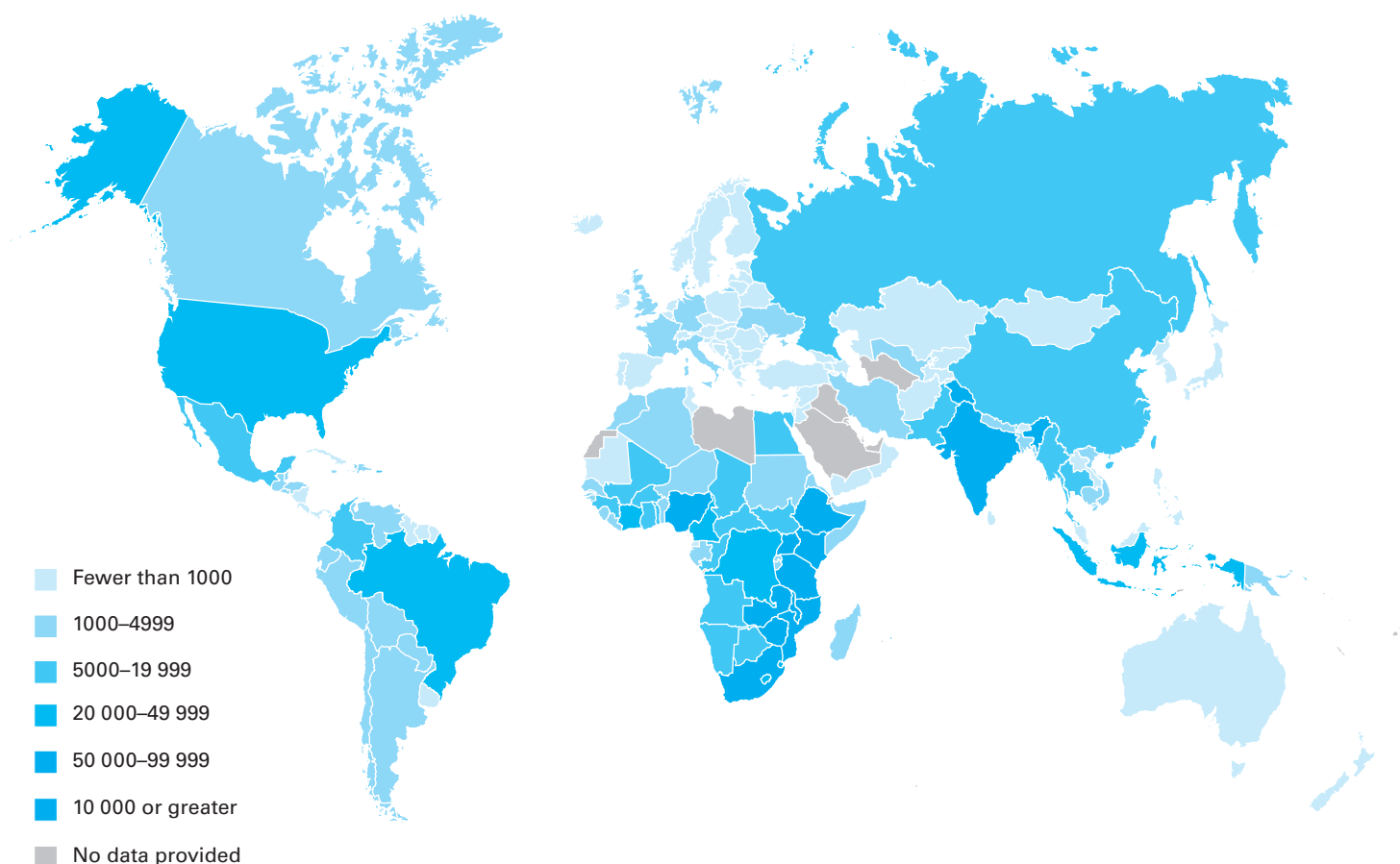
Source: UNAIDS 2013 estimates

diagnosed.³⁰ The majority of the 2.1 million [1.9 million–2.3 million] adolescents living with HIV in 2013 were infected via vertical (mother-to-child) transmission, and many do not know their status because they were lost to follow-up services immediately after birth or later in life (see Figure 8). Although their AIDS-related deaths are preventable, they enter early adolescence with limited opportunities for early detection or referral to treatment programmes. Of the total number of adolescents living with HIV globally in 2013, 83 per cent resided in sub-Saharan Africa (see Figure 9).

ADOLESCENT GIRLS DISPROPORTIONATELY AFFECTED BY HIV: The majority of HIV infections are in Africa and India (see Figure 10), and girls remain disproportionately affected in these countries. In 2013, two thirds of the 250,000 [210,000–290,000] new HIV infections among adolescents aged 15–19 were among girls. In some sub-Saharan African countries – including Cameroon, Côte d’Ivoire, Guinea and Swaziland – girls aged 15–19 are five times more likely to be infected than boys.³¹

Gender inequality, child marriage, age-disparate sexual relationships and intimate partner violence are three factors that put girls at increased risk of acquiring HIV. According to the latest available data from household surveys (2006–2014) in selected countries where adolescent girls (aged 15–19) are at increased risk of HIV, condom use at last higher-risk sex ranges from as low as 12.1 per cent in the Democratic Republic of the Congo to a high of 61.4 per cent in Cameroon. In the following countries, less than 45 per cent of adolescent girls used a condom at last higher-risk sex: Uganda (26 per cent), Côte d’Ivoire (32 per cent), Lesotho (37 per cent), Nigeria and the United Republic of Tanzania (38 per cent), Haiti and Malawi (42 per cent), and Mozambique (43 per cent).

In many settings, adolescent girls’ right to privacy and bodily autonomy is not respected, and many report that their first sexual experience was forced. In Nepal, for example, 47 per cent of women aged 15–49 who had sex before age 15 report that their first sexual experience took place against their will.

FIGURE 9**ADOLESCENTS LIVING WITH HIV IN 2013**

Source: UNAIDS 2013 estimates

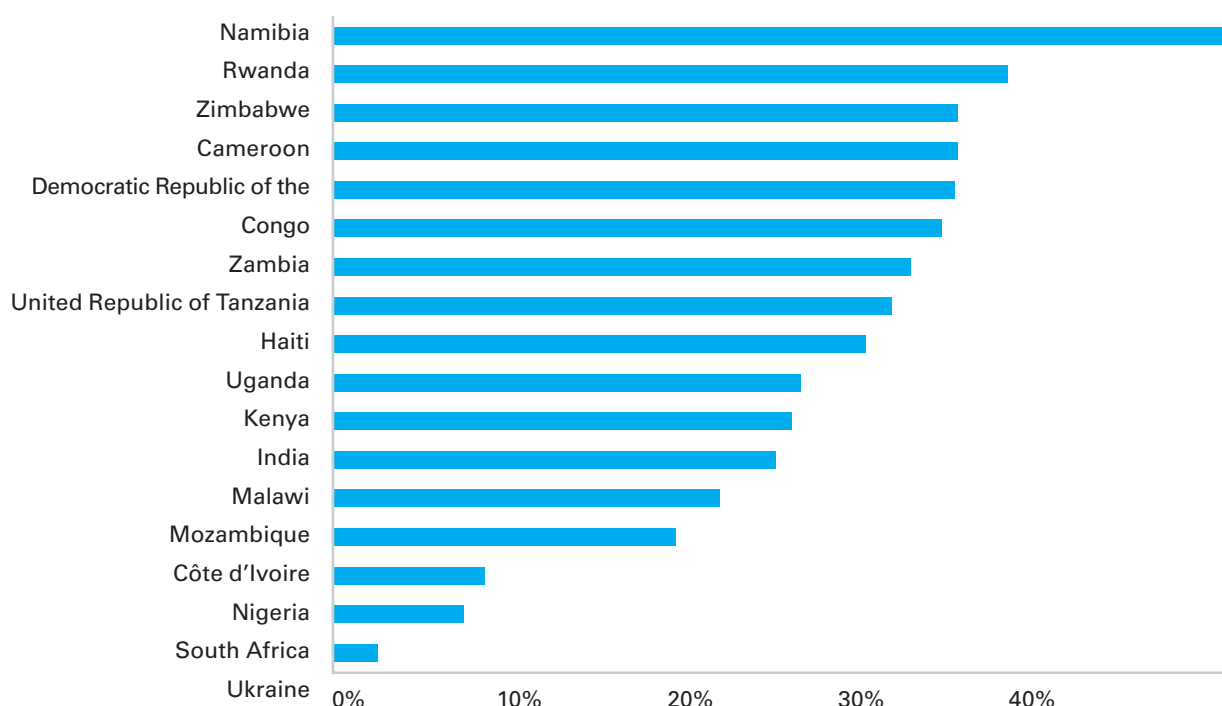
Age-disparate relationships also contribute to relatively high rates of HIV among adolescent girls. In South Africa, one in every three sexually active adolescent girls is involved in a sexual relationship with a sexual partner who is more than five years older.

Experience of intimate partner violence is alarmingly high among adolescent girls in many of the high-prevalence countries. In 9 of the 16 high-prevalence countries where data are available, more than one in three adolescent girls had experienced intimate partner violence within the past 12 months of the time of the survey. In six of the countries – Cameroon, Haiti, India, Malawi, Namibia and Zimbabwe – prevalence of intimate partner violence was higher among adolescents (aged 15–19) than among women aged 20–49 (see Figure 10).

“AIDS is the leading cause of death among adolescents in Africa. Globally, two thirds of all new infections among adolescents were among adolescent girls. This is a moral injustice. I am calling on young people to lead the ALL IN movement, alongside the United Nations, public and private partners, and countries themselves, to end the adolescent AIDS epidemic.”

Michel Sidibé

Executive Director, UNAIDS

FIGURE 10**PREVALENCE OF INTIMATE PARTNER VIOLENCE IN THE PAST 12 MONTHS AMONG ADOLESCENT GIRLS AGED 15–19**

Source: Most recent population-based survey per country, 2007–2014.

ADOLESCENT KEY POPULATIONS ARE BEING LEFT BEHIND³²

Worldwide, adolescents in key population groups – including gay and bisexual boys, transgender adolescents, adolescents who sell sex – including children (aged 10–17) who are sexually exploited through selling of sex³³ – and those who inject drugs – are at a higher risk of HIV infection. These marginalized groups face discrimination and human rights violations, and they are often excluded from services.

Many injecting drug users begin use at a young age. In a multi-country study of injecting drug users aged 15–24, up to 30 per cent reported that their first injection took place before they were 15 years old.³⁴ In a study conducted in Viet Nam, 48 per cent of injecting drug users were less than 25 years old, 24 per cent of them had started injecting within the previous 12 months, and of this group, 28 per cent were infected with HIV.³⁵

Many HIV infections are linked to transactional sex or sexual exploitation and occur among sex workers

and their clients or sexually exploited children and their abusers. Children and youth may be particularly vulnerable to HIV infection. In a study conducted in St. Petersburg, Russian Federation, 33 per cent of the children and adolescents under 18 years old who had been subjected to sexual exploitation though selling sex were found to be HIV-positive. In Guyana, 27 per cent of young sex workers were found to be HIV-positive.³⁶ In Asia, condom use among transgender youth, males who have sex with males (MSM) and sex workers is low or inconsistent and was associated with younger ages and lower levels of education.³⁷

Although data on adolescent MSM are very challenging to obtain, there is research among young people that indicates the magnitude of the effects of HIV on this vulnerable population. HIV prevalence among the under-25 age group of MSM was found to be 13 per cent in Paraguay, 12 per cent in Mexico, 10.5 per cent in Peru, 9.5 per cent in Colombia, 9 per cent in Argentina, and more than 5 per cent in several other countries in Central and South America.³⁸

HIV-SENSITIVE SOCIAL PROTECTION IN THE SECOND-DECADE RESPONSE³⁹

Failure to protect adolescents is one factor that places them at higher risk of acquiring HIV. With the assistance of social and child protection programmes – including economic empowerment – parents, caregivers and communities can help reduce economic and social exclusion of girls and other key adolescent populations, thus reducing the impetus for higher-risk behaviour.⁴⁰ Economic support can strengthen a family's capacities to care for adolescents, which in turn has a positive effect on adolescents' attitudes towards risk-taking behaviour.

Young people (aged 15–24) make up 40 per cent of the world's unemployed population. The lack of predictable income increases social exclusion and can fuel the spread of HIV.⁴¹ Cash transfers, income-generation schemes, vocational training and other economic-strengthening initiatives for adolescents need to be part of the protection, care and support response. Such programmes can empower adolescents to access key services, change behaviour and help eliminate harmful social norms, attitudes and practices, such as child marriage.

Recent reviews indicate that cash transfers can be a powerful tool for achieving HIV-mitigation outcomes; in combination with other HIV and social protection activities, cash transfers can make an even greater contribution to HIV prevention, treatment, care and support outcomes. A review of studies in sub-Saharan Africa (Kenya, Malawi, South Africa, Uganda, the United Republic of Tanzania, Zambia and Zimbabwe) and North America (Mexico and the United States) found that, among the 10 cash transfer programmes that measured sexual behaviour, nine had a positive HIV-prevention effect.⁴²

In South Africa, a national study of an existing publicly funded cash transfer programme found that among more than 3,000 families receiving regular child support grants or foster child grants, adolescent girls showed a 53 per cent reduction in incidence of transactional sex and a 71 per cent reduction in age-disparate sex.⁴³ Another study in South Africa showed that adolescents in families receiving a child support grant were 16 per cent less likely to have had sex. Girls who received a grant earlier in their childhood had fewer pregnancies than those who received a grant later in childhood.⁴⁴

An evaluation of Kenya's largest national social protection programme – Cash Transfers for Orphans and Vulnerable Children, which aims to alleviate poverty in nearly 150,000 households – found that young

people residing in households supported by the programme were 31 per cent less likely to have become sexually active, and were thus at significantly reduced risk of HIV infection.⁴⁵ In Zomba District, Malawi, a randomized controlled trial with more than 1,200 never-married, in-school and out-of-school women aged 13–22 explored the effects of making cash transfers to schoolgirls and their parents, conditional on the girls' school attendance, and independent of HIV or reproductive health education. For girls who stayed in school, those receiving any cash transfer showed a 64 per cent odds reduction in HIV-prevalence and a 76 per cent odds reduction in the prevalence of herpes simplex virus type 2.⁴⁶ This study adds important evidence to another analysis from Malawi on the importance of education as a structural intervention to reduce HIV infection.⁴⁷

Cash transfers do not stand alone in social protection strategies. A study in South Africa tested impacts of augmenting financial support with social support from parents or teachers ($n = 3,401$) and found that 'cash plus care' increased HIV-prevention benefits over cash alone. Results showed reductions in incidence of multiple and concurrent partners and other HIV-risk behaviours by 50 per cent for boys and by 55 per cent for girls. This type of study is unpacking the psychosocial pathways through which social and economic drivers, such as poverty, lead to increased HIV risk⁴⁸ through such factors as dropping out of school, child abuse, behavioural conduct problems, drug and/or alcohol use and psychological distress, and how cash transfers and care can interrupt these pathways.⁴⁹

The UNAIDS Investment Framework modelling of 2011 suggested that globally US\$22 billion–US\$24 billion would be required to bring HIV programmes to scale by 2015. Of that total, the model proposed investing 40 per cent in 'enablers and synergies' (15 per cent and 25 per cent, respectively) and 60 per cent in basic programmes. A modelling by UNICEF and the Futures Group published in 2014 suggests that 75 per cent of resources for adolescent programming should be invested in critical enablers and development synergies in the education, child protection, social protection, justice and health sectors – and align with the scale-up of high-impact interventions, including PMTCT, HIV treatment such as pre-exposure prophylaxis, VMMC, condom use, harm reduction and targeted behaviour change.⁵⁰ However, it is clear that investments in these enablers and synergies have not been sufficient; according to one analysis, national HIV programmes in 2012 spent less than 2 per cent of their total resources on these areas.⁵¹

PLANNING AND RESULTS OUTLINED BY PROGRAMME AREA

UNICEF's accountability for the HIV response covers the first two decades of a child's life, as stated in the Strategic Plan 2014–2017. This is reflected in the following programme areas: **(1) first decade – children under age 5, pregnant women and mothers; (2) second decade – adolescents; and (3) across both dec-**

ades – protection, care and support. Accordingly, the organization has committed itself to reporting on the successes and challenges in achieving an AIDS-Free Generation by responding to the needs of children under age 5, pregnant women, mothers and adolescents.

PROGRAMME AREA 1 – FIRST DECADE

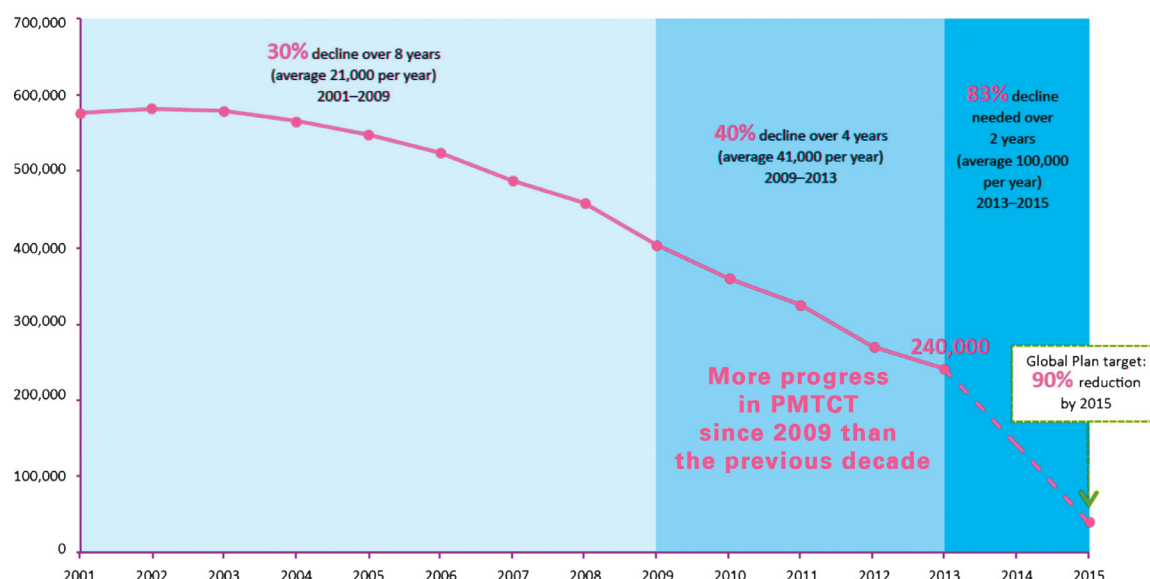
CHILDREN UNDER AGE 5, PREGNANT WOMEN AND MOTHERS

The Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive has guided UNICEF's strategic partnerships to address its core: to serve pregnant women, their children and mothers living with or affected by HIV and AIDS. As in previous years, UNICEF played a leading role during 2014 in convening technical experts to improve the technical capacities of national stakeholders and to optimize HIV service delivery for pregnant women, infants and mothers.

At the end of 2014, the IATT on the Prevention and Treatment of HIV Infection in Pregnant Women, Mothers and their Children commemorated 16 years of successful partnership. Convened by UNICEF and WHO, the IATT consists of 36 member organizations supported by six secretariat members, eight thematic working groups, two regional teams and 44 country focal points (one UNICEF and one WHO focal point in each of the 22 Global Plan priority countries). Under UNICEF's leadership, the IATT focuses on three mandates: **(1) provision of technical support; (2) produc-**

FIGURE 11

ESTIMATED NUMBER OF NEW HIV INFECTIONS IN CHILDREN (AGED 0–14): GLOBAL TRENDS, % DECLINE AND GLOBAL PROJECTIONS, 2001–2015



Source: UNICEF analysis of UNAIDS 2013 HIV and AIDS estimates, July 2014.

tion of guidance and tools; and (3) monitoring and evaluation.

The commitment of this partnership to support countries towards elimination of mother-to-child transmission (eMTCT) of HIV and keeping mothers alive is evidenced by marked progress, particularly between 2009, the baseline year for the eMTCT Global Plan, and 2013. This was done through a systematic approach of providing technical support for health systems strengthening, including the mobilization of community-based responses; integration of MNCH, nutrition and HIV services; and more thorough analyses of decentralized data to better understand why women and their infants are at a loss to follow-up in antenatal care and HIV services. During this period, 21 of the 22 Global Plan priority countries had a 43 per cent reduction in new paediatric infections, a twofold increase in maternal antiretroviral (ARV) coverage, and a threefold increase in treatment coverage among children under 15 years old living with HIV (*see Figure 11*).

The IATT has also produced a number of publications during 2014 to support country implementation, including an updated IATT Option B/B+ toolkit that provides a module titled 'Moving towards Expanded HIV Services for Children: Readiness assessment checklist and discussion guide'. It also published the 'HIV Rapid Test Quality Assurance Checklist', 'Tuberculosis/HIV Checklist', 'Updated Pediatric ARV Formulary List' and 'Integrated Service Delivery Model Case Studies'.⁵²

INTEGRATION OF HIV, MNCH AND SOCIAL PROTECTION SERVICE DELIVERY PLATFORMS

During 2014, UNICEF strengthened a number of partnerships that are vital for achieving an AIDS-free generation by promoting the integration of reproductive, maternal, newborn, child and adolescent health and development. Under the Secretary-General's Partnership for Maternal and Child Health, UNICEF continues to provide leadership for the Global Plan and the Double Dividend, which place the comprehensive health of women and children at the centre by promoting a fundamental principle of integrating and linking services to promote 'value for money' while responding to the urgent needs of women and children who do not have the financial resources and time to seek care through multiple health-care service delivery points.

HIV and maternal health – Addressing the leading killer of women 15–49 years old: HIV remains the leading cause of death of women of reproductive age globally. UNICEF HIV and health staff have placed considerable effort into policy advocacy to promote optimal treatment regimens for pregnant women and mothers to save their lives and the lives of their children. In 2014, the collective energy of the IATT partnership under the leadership of UNICEF and WHO achieved a huge milestone of having all 22 Global Plan countries officially endorsing Option B/B+, with 16 of the 22 having adopted Option B+.

The UNICEF West and Central Africa Regional Office (WCARO) takes a leading role in mobilizing partners to drive policy change. In 2014, UNICEF provided technical support to understanding the potential impacts of more efficacious HIV drug regimens in Chad, Burkina Faso, Gabon, Mali and the Niger, which all adopted Option B+ for PMTCT. Individual experts met with national PMTCT coordinating bodies and key stakeholders to drive this agenda forward. This initiative led to 15 countries in West and Central Africa implementing the Option B+ policy,⁵³ including three priority countries: Cameroon, Chad and the Democratic Republic of the Congo.

In Eastern and Southern Africa, Option B+ is being rolled out by many countries. In Zimbabwe and the United Republic of Tanzania, UNICEF provides technical assistance to conduct implementation reviews and generate early lessons learned, which will inform national scale-up within these countries and across the region, and to inform the implementation of Global Fund grants.

Substantial efforts have also been made to implement national policies that promote the integration of HIV and maternal health-care services.

In Indonesia, UNICEF's policy and service delivery interventions, which focused on training health-care workers on various methods of retaining pregnant women and mother-baby pairs in PMTCT services, resulted in a considerable increase in the number of pregnant women who access prevention of parent-to-child transmission (PPTCT) services. Within the first eight months of 2014, a total of 24,805 pregnant women were tested for HIV, or 33 per cent of all pregnant women presenting for an antenatal check-up in the three focus districts of West Jakarta, Surabaya and Sorong. The results in such a short time frame indicate a very positive development in comparison with the 2012 baseline

of 5 per cent of pregnant women tested for HIV. Treatment coverage for pregnant women by August 2014 increased from 66 per cent to 90 per cent in less than one year of implementation.

As a result of UNICEF Indonesia's successful demonstration, local budgets amounting to US\$400,000 were allocated to the PPTCT response at the local level in 2014. Also, following intensive advocacy with the Governor of Surabaya District, local budget funds amounting to US\$250,000 were made available by both provincial and district governments to expand PPTCT services in Surabaya. In Jakarta, a Governor decree was released in July 2014 to pay health services not covered under the universal health-care scheme, including HIV and syphilis testing for pregnant women residing in Jakarta.

In Fiji, UNICEF provided financial and technical support to decentralize confirmatory testing for HIV at divisional and sub-divisional hospitals as well as introduce point of care testing at remote and rural antenatal care clinics. This resulted in more than 80 per cent of pregnant women being tested for HIV and receiving their results, a significant increase in retention rates before 2014.

In Viet Nam, UNICEF supported capacity assessment of maternal and child health (MCH) staff in six provinces on implementing the PMTCT programme to inform interventions for PMTCT in the MCH system. The assessment identified critical barriers, such as poor knowledge of PMTCT among MNCH staff, and poor coordination between HIV and MCH systems in implementing PMTCT programmes. Key findings led to a commitment by the MCH department to develop a National Operation Guideline for implementing PMTCT in the MCH system.

In India, UNICEF supported a four-state assessment of HIV testing among pregnant women and the implementation of multi-drug PMTCT regimens. Lessons learned from that assessment were used for the re-formulation of the national PMTCT strategy. Continued advocacy in India resulted in the Ministry of Health and Family Welfare accepting universal screening of pregnant women for HIV as a policy for moving towards elimination of MTCT, with domestic allocation of US\$7 million annually for HIV testing of pregnant mothers.

In Belarus, in order to ensure the highest coverage, UNICEF supported the Ministry of Health to develop on-the-job training for antenatal care clinic staff on PMTCT. The team of trainers rolled out in-

stitutionalized on-the-job trainings on HIV testing and counselling (HTC), contributing to improved PMTCT and HIV knowledge and skills of 1,857 obstetricians, midwives and nurses.

UNICEF Cambodia supported the Ministry of Health to implement the 'finger-prick' testing method for rapid test results for pregnant women. Fifty-eight per cent of pregnant women attending antenatal care and delivery services at health centres were tested for HIV and received results in the first nine months of 2014, while there had been only minimal HIV testing in antenatal care in 2013. In Solomon Islands, 20 facilities used point-of-care testing to provide services for pregnant women and young people with test results delivered instantly, and the sites reported that 100 per cent of pregnant women tested for HIV received their results.

PAEDIATRIC AIDS TREATMENT AND CARE: A CHILD SURVIVAL AGENDA

The UNICEF Eastern and Southern Africa Regional Office (ESARO) conducted a four-country study (Malawi, Tanzania, Uganda and Zimbabwe) to catalogue the 'Landscape and Missed Opportunities for Integrated Reproductive Maternal Neonatal Child Health'. The study reviewed bottlenecks and barriers to integrated service delivery, and modelled lost impact (additional lives that could be saved; additional new paediatric HIV infections that could be averted), if MNCH platforms were able to attain and sustain high coverage. The study makes the case that an effective implementation of such a model would require better coordination across services, clear protocols for integrated case management, and greater efforts to monitor progress against the total package – at primary, subnational and national levels. The study findings will be used to further motivate purposeful and sustained investments to ensure delivery of an integrated package across the continuum of care, and to advance the integration knowledge base.

This survey and additional data from Africa provided the basis for the development of the Double Dividend framework, which was discussed at a meeting of country teams, including Swaziland and Zimbabwe, to define next steps for operationalization of the framework at country level.

The Double Dividend strategy reinforces what many countries have been pursuing. UNICEF Malawi supported the finalization of newborn

standard of care protocols, taking into account the needs of infants born to HIV positive mothers. WHO and UNICEF Malawi and Zambia provided technical support training of MNCH and HIV workers on Caring for Newborns at Home, adapted for high HIV and TB settings. In India, to further strengthen convergence of PPTCT programmes with health services, UNICEF supported orientation of HIV programme managers and service providers to the reproductive, maternal, newborn, child and adolescent health (RMNCAH) strategy/ Call to Action for Child Survival, so that HIV programmes do not operate in isolation of broader MNCH programmes.

In 2014, UNICEF WCARO and partners were vigilant in addressing the disparities between paediatric and adult HIV care and treatment. Support from UNICEF WCARO and the Joint United Nations Regional Team on AIDS (JURTA) partners in 13 countries in the region resulted in the adoption of the 2013 WHO guidelines for paediatric HIV care and treatment. To further strengthen evidence-based programming, UNICEF provided technical and financial support to conduct assessments of national paediatric HIV programmes in 11 countries. Findings from these assessments will guide development of country-specific acceleration plans. In 2014, three countries – Chad, Liberia and Togo – completed the paediatric HIV assessment, informing national paediatric AIDS acceleration plans as part of broader child survival initiatives.

Examining barriers to identifying paediatric AIDS cases in West and Central Africa has led to screening in multiple settings. Effective case-finding was modelled in Chad by institutionalizing HIV testing in services for the management of severe acute malnutrition. The Government of Malawi, supported by the Canadian Department of Foreign Affairs, Trade and Development (DFATD) and UNICEF, took steps to integrate HIV and child malnutrition services. Preliminary results indicate that the involvement of male motivators, who conducted door-to-door visits, averted 328–1,069 new HIV infections/cases of malnutrition in the project area.⁵⁴ DFATD also supported HIV and nutrition integration programmes in Mozambique and Zimbabwe.

Responding to the needs of children often requires working with pregnant women from marginalized populations. In Cambodia, UNICEF supported integration of paediatric AIDS care services in Chhouk Sar clinic, which serves HIV infected children of entertainment workers. As a 'one-stop' ART service for mothers and children in the same location in

Phnom Penh, the clinic helped reduce transportation costs and saved time for clients.

PARTNERING WITH THE GLOBAL FUND FOR IMPROVED MNCH OUTCOMES

In April 2014, UNICEF and the Global Fund signed a memorandum of understanding to better coordinate efforts aimed at reducing the burden of HIV, tuberculosis and malaria and improving the health of mothers, newborns and children. Current efforts are focused on developing strong, technically sound concept notes, to ensure maximum value for money and optimal implementation of integrated delivery, as countries transition into the grant implementation phase.

There are currently 25 Phase I countries for both HIV and malaria where UNICEF and the Global Fund are working together to operationalize the memorandum of understanding. Nineteen countries have submitted concept notes where RMNCH has been integrated. Of the 22 countries prioritized for integration of child health into malaria/health system strengthening concept notes, 14 have submitted concept notes, including the Democratic Republic of the Congo, Nigeria, Uganda and Zambia; these are currently in grant-making, and implementation starts in early 2015. Of the 11 countries targeted for integration of MNCH into HIV and HIV/TB concept notes, 5 have submitted integrated concept notes as of fourth quarter 2014; and 65 per cent of the planned country support for countries submitting concept notes has been implemented for the 25 Phase I countries, with higher rates of implementation for malaria/integrated community case management. Of the five countries that have integrated MNCH into their concept notes, resources can now be leveraged for the three diseases to strengthen broader MNCH systems and improve a broader range of outcomes pertaining to Millennium Development Goals 4 and 5, in addition to Millennium Development Goal 6. Negotiation of the use of funds for integrated training for HIV, malaria and MNCH trainings will be done during 2015. UNICEF will cover any non-Global Fund finance commodities, per a memorandum of understanding. To date, UNICEF and national Global Fund Country Coordinating Mechanisms members have leveraged more than US\$430 million in the New Funding Model with the aim of improving the alignment of MNCH, malaria and HIV services.

REACHING PREGNANT WOMEN AND GIRLS WITH INTEGRATED PMTCT AND ADDICTION CARE SERVICES IN UKRAINE

Despite the success of PMTCT programmes and the substantial reduction in the number of new HIV infections among children in Ukraine, poor access and late entry into antenatal care services remain a problem for pregnant women who use drugs. This represents a challenge not only to their own health but also to the rights of their children to be born HIV free.

National data from 2011 indicated that injecting drug use was the key route of HIV infection among 19.1 per cent of HIV-positive reproductive-age women. Approximately 3.5 per cent of all pregnant HIV+ women reported active drug use during the latest pregnancy – though this is most likely a substantial underestimate due to the high stigma of admitting drug use, especially during pregnancy. Only 7.3 per cent (29 of 395) of HIV+ pregnant women who used drugs received opioid substitution maintenance therapy and the majority of them continued using street drugs during pregnancy.

Women who use drugs are 3.5 times more likely to be diagnosed with HIV in labour than other women (Thorne 2012). Moreover, relatively few HIV+ pregnant women who injected drugs received ARV prophylaxis (65 per cent compared with 94.5 per cent overall).

UNICEF used this data to advocate for the following interventions for prevention of MTCT among pregnant women who use drugs. UNICEF advocacy led to the adoption of clinical protocols and guidelines related to the treatment, care and support of preg-

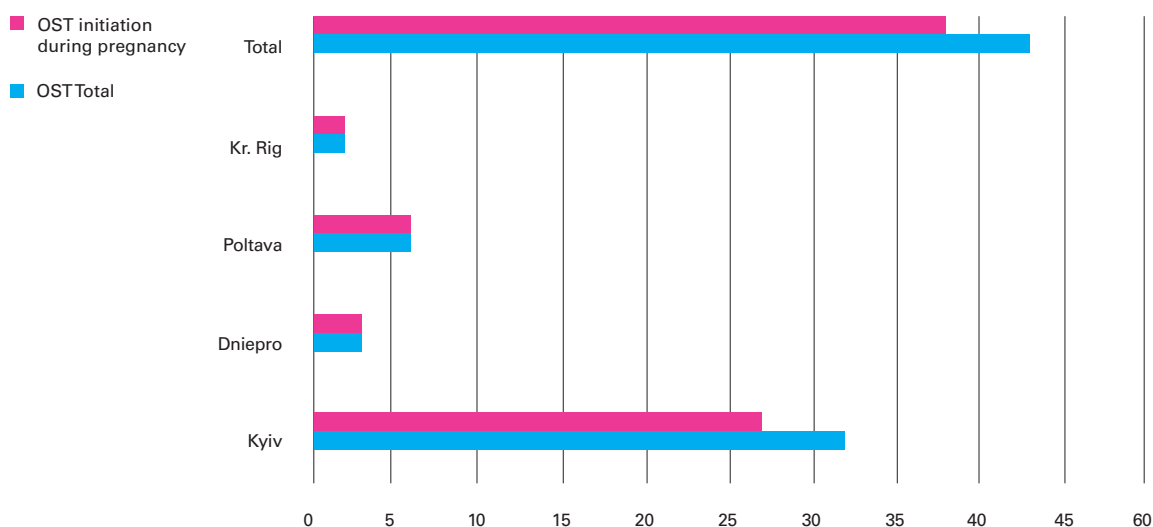
nant women living with HIV who use illicit drugs.

- Integration of services for drug using pregnant women into MCH services with the objective to improve pregnancy outcomes, prevent HIV infection among infants and improve health and wellbeing of mothers;
- Setting up functional linkages between MCH, HIV services and addiction services to prevent MTCT among pregnant women who use drugs and contribute towards elimination of MTCT in the country;
- Strengthening cooperation between government and civil society organizations, particularly those that have been working on prevention and support to drug using populations in order to help build trust and demand for services.

No case of HIV transmission from mother-to-child was diagnosed during the project. Among 79 children born to HIV positive women who used drugs during pregnancy, all received early infant diagnosis with DNA PCR test at one month. All women chose to formula feed their children.

In addition, health-care workers gained skills and knowledge on the management of drug dependent pregnant women and their infants, strengthening treatment, care and support services. This led to significant improvement of uptake of opioid substitution treatment (OST) among drug using pregnant women as well as to significant improvements in attitudes towards them.

Improved uptake of OST by pregnant women who use drugs





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REACHING WOMEN WITH DISABILITIES FOR MTCT ELIMINATION

According to WHO and the World Bank, over 1 billion people, about 15 per cent of the world's population and 16 per cent of the world's women, have some form of disability. They have less access to health care and health promotion services. Women with disabilities are recognized as particularly disadvantaged, experiencing a double burden of exclusion due to their gender and disability, and they are often vulnerable to abuse (WHO, World Bank, 2011). UNICEF's report *Women with Disabilities: An essential group for MTCT elimination* explores the situation of women with disabilities of reproductive age in two Africa countries and the relevance of this group for the elimination of mother-to child transmission (MTCT) of HIV. The report includes outcomes of structured conversations and interviews with key informants, group discussions and focus groups with women with disabilities that were carried out in Pretoria, South Africa (14–18 May 2012). It also includes inputs from a subsequent group discussion held in Maputo, Mozambique, with women with disabilities, in which personal stories on access to services for the prevention of MTCT were collected (see www.unicef.org/aids/files/Women-SA_8.5x11_final_web_r1.pdf).

The explorative visit confirmed most of the existing presumptions in relation to the need to further include women with disabilities in PMTCT programmes. The most relevant conclusions in terms of the bottlenecks and recommendations for future action include:

- Women with disabilities are an essential group for achieving the eradication of mother-to-child transmission.
- Expand effective linkages with DPOs to close the implementation gap.
- Make MCH programmes more inclusive by investing in outreach and family-based approaches.
- Map capacities to increase the use of community resources and involve persons with disabilities as health agents.
- Include women with disabilities in campaigns to reduce stigma and introduce zero tolerance to discrimination in health services.

In West and Central Africa, UNICEF WCARO assisted countries in country coordinating mechanisms applications for approximately US\$800 million in funds for 2013–2014, to be used during 2015–2017 for HIV. The office also advocated for a systematic review of the evidence – often highlighting the inequities in adult vs. child access to prevention and treatment. A pool of 45 trained consultants was established at the regional level by JURTA to support countries in developing concept notes for the Global Fund's new funding model. To leverage this opportunity for the eMTCT and paediatric HIV acceleration, UNICEF supported additional training for eight consultants to strengthen integration between eMTCT, paediatric HIV treatment and SHR/MNCH/Nutrition in applications countries submit to the Global Fund (Chad, the Democratic Republic of the Congo, the Gambia, Guinea, Nigeria and Senegal).

UNICEF ESARO also provided multi-country support for the Global Fund New Funding Model concept note development. This was facilitated at a regional meeting held in Johannesburg in July 2014 in collaboration with the Global Fund, WHO and UNFPA and 10 country teams. Of the 22 Global Plan countries, 12 had submitted concept notes by December 2014, of which intensified support was provided to Burundi, the United Republic of Tanzania, Uganda, and Zambia.

The UNICEF East Asia and the Pacific Regional Office (EAPRO) has been actively engaged in implementing the PMTCT and MNCH components of Global Fund grants. In Indonesia, UNICEF was instrumental in advocating for a reprogramming of the Global Fund and central government funds for the procurement of syphilis reagents (US\$13,483 and US\$600,000, respectively). This represents an increase of 44 per cent of resources allocated to PPTCT at the national level. The initial PPTCT budget from the Global Fund is US\$600,000 for 2013–2015, mainly for health staff training in 12 provinces.

In Myanmar, UNICEF, in partnership with the Department of Health, the Global Fund, UNFPA and others, scaled up PPTCT services to 84.5 per cent of the country, including 279 townships out of the total 330 townships and 38 hospitals, and committed to eliminate HIV among newborns. UNICEF and the Global Fund increasingly supported point-of-care testing in communities, and the HIV testing rate rose to about 430,000 pregnant women who received HIV testing during antenatal care in 2014, compared to 365,533 women in 2013.

HEALTH SYSTEM STRENGTHENING AND DECENTRALIZED SERVICE DELIVERY

Human resources, community systems strengthening and task shifting: Through the Optimizing HIV Treatment Access (OHTA) initiative, UNICEF is providing catalytic support to initiate pregnant women on HIV treatment, improve retention and reduce new HIV infections among children in Côte d'Ivoire, the Democratic Republic of the Congo, Malawi and Uganda. The OHTA initiative, supported by the governments of Sweden and Norway, through Ministries of Health and NGO partners, is employing various community-based strategies to improve programme performance in these areas. A literature review and compendium report was commissioned by UNICEF through the OHTA Initiative to help strengthen community-facility linkages in support of lifelong ART for pregnant and breastfeeding women living with HIV. The review offers an update of the literature and programmatic experience on community engagement for PMTCT, as well as a conceptual framework outlining eleven promising practices associated with increased service uptake, adherence or retention along the continuum of care.

In Malawi, scale-up of B+ has been significantly boosted by shifting HIV testing and counselling responsibilities to Health Surveillance Assistants and ART initiation to Nurses. UNICEF and implementing partners also provided support for active defaulter tracing, sample transportation, training and mentorship of health workers for strengthened eMTCT activities at facility level. Implementing partner Mothers to Mothers, in collaboration with UNICEF, used mentor mothers (a cadre of lay counsellors and former PMTCT clients) to support community interventions, including peer-based support and education, which have been instrumental in increasing demand for, uptake of and adherence to PMTCT/RMNCH services.

In the Democratic Republic of the Congo, HIV and MNCH sensitization sessions were organized in the community by peer educators, church community mobilizers, and community extension health workers to ensure pregnant women and their male partners knew about and utilize services. As part of the psychosocial support to people living with HIV, support groups were established in each health zone to boost the retention of newly detected cases in antenatal care services, and home visits were conducted if women missed their appointments. Approximately 75 per cent of HIV-positive women (463 out of

UNICEF Cambodia, in collaboration with UNAIDS and the Flagship Programme (KHANA, PSI, FHI 360) supported the National Centre for HIV/AIDS, Dermatology and STD Control (NCHADS) to conduct baseline assessment on Cambodia 3.0, the Elimination of Vertical Transmission by 2020 in seven Operational Districts. Active case management mechanisms were established to monitor and minimize loss to follow-up and ensure HIV incident cases access treatment in a timely manner. As a result of this intensified monitoring at district level, an HIV outbreak was identified in ROKAR commune. Additionally, early infant diagnosis (EID) was identified as a barrier to scale-up of eMTCT, and with the support of UNICEF in 2014, 68 per cent of HIV exposed infants who received EID by the end of October 2014, and national paediatric treatment and social protection reached over 3,000 children from 30 provinces/municipalities with free paediatric AIDS treatment and social economic support.

618) enrolled in the project between October 2013 and February 2014 have been retained six months after initiation of treatment, as compared with very low retention rates.

UNICEF WCARO and JURTA members conducted advocacy and technical assistance missions to Chad and Côte d'Ivoire to promote the adoption of the task shifting policy for ARV treatment, as part of a broader process to create an enabling environment for adoption and roll-out of Option B+. As a result, Chad and Côte d'Ivoire adopted the task shifting policy, bringing to 10 the number of countries in West and Central Africa implementing such policy.⁵⁵ In 2014, UNICEF Côte d'Ivoire took the lead in organizing meetings with the Ministry of Health, PEPFAR and other partners to adopt a road map for effective Option B+ rollout. As a result, the national task shifting policy allowing HIV treatment to be administered by nurses and midwives was approved in October 2014.

Health Management and Information Systems (HMIS) and monitoring: The integration of HIV and MNCH services requires aligned HMIS systems – and respective indicators for monitoring. UNICEF and WHO provision of joint technical support in Nepal resulted in the incorporation of PMTCT indicators into the HMIS, and the UN Joint Team provided support to full integration of PMTCT programmes with the Maternal and Child Health Program-Family

Health Division (FHD), Department of Health Services (DoHS). In Cambodia, UNICEF and WHO regional offices have provided technical support to the National Centre for HIV/AIDS, Dermatology and STD Control on the use of Internet communication technology to link the vertical HIV and AIDS database to the HMIS that will benefit health-care providers by allowing access to programme monitoring and planning data and reduce paper based recording and registration. This initiative will be the main tool to support the eMTCT validation process. In Myanmar, UNICEF supported a web-based patient management system that would assist service providers to improve quality of care and simultaneously provide data on quality of care for children and adolescents living with HIV; and in Thailand, UNICEF technically supported the development and launch of the AIDS Zero Portal in June 2014, providing up-to-date data for policy and programming use at all levels.

India was supported by UNICEF to scale up an integrated electronic medical records system that links maternal HIV medical records to the broader health information system – called the Mother-Child Tracking System (MCTS). This model, which was piloted in Karnataka in 2013, has been scaled up across all 30 districts in 2014. Of 3,659 registered mothers living with HIV, 3,105 are tracked through MCTS, while none was tracked in the first quarter of 2013.

Decentralized evidence generation and programme planning to optimize HIV and RMNCH service delivery: UNICEF, WHO and UNAIDS have collaborated to provide intensified support to generate evidence and inform policy dialogue and advocacy – and remove bottlenecks to uptake PMTCT interventions. The Monitoring Results for Equity System (MoRES) is a central implementation strategy in decentralized services delivery. WCARO staff supported the utilization of the MoRES data-driven approach in 19 countries to inform their national eMTCT plans. This approach was applied also at decentralized level. In 2014, 15 districts in Guinea and 7 districts in Senegal developed an evidence-based plan for eMTCT based on the results of a bottleneck analysis. This approach informed the integration of PMTCT within reproductive, maternal, newborn and child health services and contributed to the acceleration of PMTCT uptake in West and Central Africa during 2014.

After the implementation of 'data-driven planning' in Chad, by which local health-care managers reviewed data on loss to follow-up during the antenatal period in 10 high-HIV-burden districts, the num-



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The earlier an infant is diagnosed the better. Ensuring mothers follow up on treatment if the baby tests positive for HIV is the critical next step.

ber of HIV-positive pregnant women who received ARV services more than doubled in one year – from 1,105 in 2013 to 2,781 in 2014. In Nigeria, data-informed plans in Anambra and Kaduna States led to even greater increases in the number of HIV-positive pregnant women who received ARV, rising from 1,984 in 2013 to 5,192 in 2014.

In Eastern and Southern Africa, UNICEF coordinated United Nations inter-agency support (either by in-country visits or online) to all Global Plan priority countries in the region to align national eMTCT plans with the WHO 2013 guidelines, and to identify bottlenecks to implementing national eMTCT plans. UNICEF and partners assisted countries in conducting subnational analysis of programme performance in Kenya, Lesotho, Malawi, Uganda and the United Republic of Tanzania. These MoRES analyses resulted in more focused programming and in improved eMTCT outcomes.

In Central Asia, a UNICEF-led analysis of the barriers to scaling up paediatric AIDS treatment revealed quickly that infants exposed to HIV were not being tested in an appropriate and timely manner.



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DBS specimens pose less of a biohazard risk to handlers and are relatively easy to transport and store.

Following the joint planning workshop on the implementation of EID using dried blood spot (DBS) sampling in November 2013, national teams from Kazakhstan, Kyrgyzstan, Uzbekistan and Tajikistan engaged in the development and adaptation of clinical guidelines and other normative documents required for the implementation and the national

scale-up of EID using DBS. Activities implemented in 2014 built on the analysis in fourth-quarter 2013 in support of the national scale-up of EID: (1) An in-depth eight-day training course for laboratory specialists took place in April 2014 in Moscow; (2) The Uzbekistan Institute for Virology finalized its methodology for DBS testing and management and shared it with the National AIDS Centre for the scale up of EID; and (3) In Kyrgyzstan, 60 nurses were trained on the use of DBS for blood drawing and transportation.

INNOVATIONS TO ADDRESS BARRIERS TO SCALE-UP

In Viet Nam, UNICEF supported the Administration for AIDS Control to develop two documentaries that promoted the role of men in PMTCT programmes and eliminating discrimination against women and children who are HIV infected and affected by HIV. Broadcasting of the documentaries in the national television programmes contributed to increasing greater understanding about HIV, especially addressing stigma and discrimination of people living with HIV, particularly women and children. Two CD-ROM sets on infant feeding for children living with HIV and on women and children who are infected with or affected by HIV and AIDS were developed and broadcast on the Voice of Vietnam radio system across the country. Training of trainer courses built greater capacity among health staff in 63 provinces to effectively communicate messages on HIV prevention and PMTCT to people and pregnant women in their local health facility and community.

WHO and UNICEF in East Asia and the Pacific supported efforts using Internet communication technology to strengthen linkages between MNCH and HIV programmes by focusing on the PPTCT cascade and addressing loss to follow up, and UNICEF EAPRO assessed the adoption of mHealth in Fiji and Solomon Islands, including OpenSRP for data collection and reporting on HIV, STI and MCH. Similarly, India has successfully piloted the use of SMS to address loss to follow up in PPTCT and early infant diagnosis. Nepal received support to conduct an assessment on the situation of services for early infant diagnosis and paediatric treatment, as a preliminary for strengthening services for paediatrics.

A paediatric telemedicine initiative in India, technically supported by UNICEF and funded by the M·A·C AIDS Fund, has been adopted by the government as one of the strategies to reach the un-

reached populations in rural India. This application of video-linked technology is a tool for providing paediatric HIV service in areas where there is no opportunity for HIV-specialized care. In 2014, the initiative, in partnership with the Network of Positive people, added a component of 'demand side' intervention to improve access to ART. Based on the comprehensive model above in two states of Maharashtra and Karnataka, the initiative is poised for a wider scale-up in the country, with five more states initiating feasibility assessments in late 2014 and early 2015 on strengthening referral mechanisms.

SOUTH-TO-SOUTH AND TRIANGULAR LEARNING

In 2014, regional eMTCT discussions were held in East Asia and the Pacific, Eastern and Southern Africa, South Asia, and West and Central Africa to refine national eMTCT strategies. UNICEF ESARO conducted a forum to review the status of country-level MTCT operational plans across all Global Plan targets, and to identify strategies for improving programme effectiveness. Bottlenecks were identified across all four prongs of eMTCT, and country plans were re-prioritized to address them. Linked to the meeting South-to-South exchange visits were organized to South Africa PMTCT programme sites (including participants from Ethiopia, Angola, Lesotho, Swaziland, Uganda and the United Republic of Tanzania). Given the progress being made in the region, the concept of validation of mother-to-child HIV and syphilis elimination efforts was also discussed and front-runner countries identified to begin preparatory work towards validation of elimination.

UNICEF WCARO initiated a collaboration with Réseau EVA (Enfant Vivant avec Le VIH), a regional capacity-building network, to enhance the expertise of 54 paediatric HIV clinicians from French-speaking countries. This pool of 54 experts will support the roll-out of the 2013 WHO paediatric ARV guidelines through decentralized training and mentorship for effective task-shifting of paediatric HIV case management at the country level.

UNICEF's CEE/CIS regional office has been collaborating with a team of top HIV paediatric care experts and developing training seminars that have resulted in significant strengthening of the knowledge, skills and capacity of paediatric and adolescent HIV care providers in the region. UNICEF, in

MOMCONNECT IN SOUTH AFRICA – LINKING MATERNAL, CHILD HEALTH AND HIV SERVICES



In 2014, UNICEF continued to support the Government of South Africa to implement the MomConnect pilot project, which seeks to close the gaps in the PMTCT and maternal and child health continuum of care by using mobile technology linked with patient electronic medical records in two districts (39 health facilities) of KwaZulu-Natal province. Text alert messages are sent to women who enrol, providing information and reminders for clinic visits. Building capacity and strengthening service delivery has been an important component of MomConnect since its inception. Nursing staff and information officers in all 39 clinics in the UNICEF supported pilot project were trained and mentored to register and track mothers and children using the electronic medical record system installed in all the clinics. In 2014, 45 data collectors, 75 nurses, 27 managers and 16 support staff from the two districts were trained to capture data in electronic maternal case records.

Since April 2013, a cohort of 5,044 women is being followed from pregnancy to 18 months after delivery across 39 health facilities of uMgungundlovu and eThekweni Districts in Kwa-

Zulu-Natal. Of the 5,044 women who enrolled in MomConnect, 1,977 are HIV-positive, and a total of 694 infants were tested for HIV. Of the infants tested, 18 tested positive for HIV, 15 of whom are in treatment, and the remaining 3 are currently lost to follow-up. Several efforts for tracing these lost infants are ongoing, but preliminary information suggests that they may have moved out of the catchment area of the particular health facility, possibly to a different province.

The M•A•C AIDS Fund supported MomConnect pilot project has also had a significant impact on national health policy and programming in South Africa. A national mobile health project launched in August 2014 by the South Africa National Department of Health was informed by lessons learned from the MomConnect pilot project and uses the name MomConnect, based on the work in KwaZulu-Natal. The national MomConnect project is expected to reach all 1.2 million pregnant women in the country each year with informational text messages on pregnancy, labour and delivery and the post-natal period.

As of December 2014, 160,000 pregnant women were registered on the national MomConnect programme, one of the largest initiatives of its kind in the world

Watch the video on the MomConnect project on YouTube:

www.youtube.com/watch?v=pi0DITVXdYcs

collaboration with the Pediatric European Network for Treatment of AIDS has run capacity building seminars that have resulted in improved skills of care providers from eleven countries. Two regional seminars on improving paediatric care, treatment and support for children and families affected by HIV in CEE/CIS (in St. Petersburg and Tbilisi) took place in 2014. In addition, a network of paediatric HIV care providers from the region is operational and includes more than 300 active participants.

The IATT on eMTCT, Community of Practice, has provided a platform throughout 2014 for delivery of breakthrough scientific updates, presentation of best practices around the globe and sharing of tools, documents and publications as a means for strengthening a knowledge base and building

skills. The Community of Practice has more than 2,000 members from 88 countries and the website has registered more than 27,000 users. In the last quarter of 2014, the number of website users grew by 10 per cent.

A survey completed by IATT Community of Practice users provided positive feedback on its value and the difference it is making. The feedback received suggests that knowledge shared is being fed back into the work of programme managers, technical working groups and implementing organizations, as well as to frontline health care workers to improve their skills. For example, Cameroon developed a method to model mother-to-child transmission using statistics tools based on information gathered from the webinars.

CERTIFICATION AND VALIDATION OF THE ELIMINATION OF MOTHER-TO-CHILD TRANSMISSION OF HIV

UNICEF Latin America and the Caribbean Regional Office (LACR) and the Pan American Health Organization have supported countries to make progress in validating and certifying Global Plan elimination targets. UNICEF LACR and the Pan American Health Organization developed a field guide, including questionnaires for use during the pre-validation and the validation processes. With UNICEF support, Cuba, El Salvador and Saint Lucia were pre-assessed. Only Cuba passed the test and has been forwarded to the Regional Validation Committee for review of progress. UNICEF LACR is a member of the Regional Validation Committee and is involved at every stage of the process.

Asia-Pacific is moving forward towards the elimination of parent-to-child transmission (EPTCT) of HIV and syphilis. UNICEF EAPRO and the UNICEF Regional Office for South Asia (ROSA) and the WHO regional offices jointly organized an Asia-Pacific regional core group meeting for the validation of EPTCT of HIV and syphilis on 10 November 2014 in Bangkok. The meeting was convened to establish a regional mechanism for validation and to discuss next steps to support regional and country activities in Asia-Pacific. Lessons learned from the pilot validation exercises in Latin America and the Caribbean contributed to the discussion on the proposed regional mechanism for validation, including the terms of reference for the Regional Validation Committee and the selection criteria of its members.

UNICEF EAPRO participated in the consultation organized by the Thailand Department of Health, Ministry of Public Health and the United States Centers for Disease Control and Prevention contributed to building a better understanding on the national, regional and global validation process. The consultation resulted in the assessment of the validation tools and a series of actionable next steps in 2015, to examine Thailand's readiness to achieve the eMTCT goal.

CONSTRAINTS AND CHALLENGES

- Integration with broader MNCH and social protection services for improved survival and development must address weak coordination among HIV and MNCH personnel.

- How to' evidence is lacking to inform national, district and local level decision makers on the best mechanisms to integrate HIV, MNCH and social protection services with measurable impact on HIV and MNCH outcomes.
- Health system strengthening (procurement and supply chain management, HMIS, human resources and health financing) efforts are insufficient to address maternal and infant HIV diagnosis; ART retention and adherence; co-trimoxazole uptake; and support for the mother living with HIV through the breastfeeding period.
- Task shifting of HIV-related services, including ART, to nurses and community health care workers, has not been sufficiently scaled up.
- Humanitarian crises affect the continuity of ART and PMTCT care, impacting essential HIV services for pregnant women and children.
- Paediatric treatment innovations are needed to address the lack of options for age-appropriate antiretroviral regimes and of affordable formulations for infants.
- Low prevalence settings.
 - Stigma and discrimination remain major barriers to uptake of services, even if they are available – discrimination by communities, families and health care providers.
 - Pregnant women living with HIV have to be identified earlier in point-of-care settings when universal HIV testing is not being offered to pregnant women.
- Equity: Reaching marginalized women – sex workers, drug users, migrants, pregnant girls and others who face multiple layers of discrimination and/or require multiple health and social protection interventions, i.e., economic support; medical care; harm reduction services.
- Primary prevention among women of reproductive age (15–49) and family planning for women and girls living with HIV remain weak in most countries. Primary prevention and family planning are necessary programme interventions to achieve the goals of the Global Plan.
- Financial resources to increase coverage of PMTCT and paediatric HIV care and treatment services at decentralized levels are limited, including funding envelopes from the Global Fund to scale up services and domestic investments.

PROGRAMME AREA 2 – SECOND DECADE

ADOLESCENTS

The Executive Directors of UNICEF and UNAIDS joined forces in June 2014 in a new initiative to end adolescent AIDS – ALL IN to #EndAdolescentAIDS. A high level event with the leadership of the governments of Brazil and Kenya was held at the UN General Assembly in September 2014, engaging lead countries in preparation for the formal launch of ALL IN in 2015. A leadership group was formed with PEPFAR, UNFPA, WHO, Global Fund, youth networks and MTV to work with countries to define strategies for mobilizing all sectors of the development response to urgently act to end adolescent AIDS.

ALL IN to #EndAdolescentAIDS is a platform for action and collaboration to inspire a social movement and to drive better results with and for adolescents through critical changes in programmes and policy. It aims to unite actors across relevant sectors in order to accelerate reductions in AIDS-related deaths and new HIV infections among adolescents by 2020 as part of the global push to end the AIDS epidemic for all by 2030.

ENGAGE, MOBILIZE AND SUPPORT ADOLESCENTS AS LEADERS AND AGENTS OF SOCIAL CHANGE

Adolescents' engagement in planning processes is vital for improving the efficiency and effectiveness of programmes aimed at decreasing their risk of acquiring HIV and dying from AIDS. In India, a national consultation with senior political and administrative leaders, led by UNICEF, was conducted in January 2014 with adolescents living with HIV (ALHIV) and those affected by HIV. The consultation created a platform for ALHIV and adolescents affected by HIV to highlight their needs and concerns, and it enabled them to develop the first list of recommendations for the relevant ministries.

UNICEF LACR has supported a number of adolescent engagement activities that have informed HIV programming in the region. In Argentina, through the Initiative 10x10, 530 adolescents in 12 provinces participated in training on the fulfilment of their sexual and reproductive rights from a gender and human rights perspective, including adolescents and young people living with HIV from Red Argentina de Jóvenes y Adolescentes Positivos (RAJAP). Ecuador had its first national meeting of adolescents and young people liv-

ing with HIV to contribute to national HIV programme planning processes. Guatemala increased the capacity of youth-led community-based organizations in 60 municipalities to recruit and train adolescents as HIV prevention and sexual reproductive health education peer educators, while also promoting the engagement of adolescents with the Global Fund Country Coordinating Mechanism on the development of an HIV grant.

Not all adolescents are at equal risk for acquiring HIV infection. UNICEF has worked with governments and local civil society to make sure that adolescents most at risk for HIV infection are actively engaged in HIV programming. Depending on the country context, different kinds of behaviours among adolescents and degrees of social marginalization increase their risk of HIV infection. In predominately heterosexual epidemics in sub-Saharan Africa, adolescent girls are more vulnerable due to gender inequality, age-disparate sexual relationships and intimate partner violence. Throughout the world, gay and bisexual boys, transgender adolescents, adolescents who sell sex – including children (aged 10–17) who are sexually exploited through selling of sex – and those who inject drugs are at higher risk for acquiring HIV infection. In partnership with the United Nations Educational, Scientific and Cultural Organization (UNESCO), UNICEF provided technical and financial support to Youth LEAD's regional office to revise a



Elijah Zachary Simel, 11 years old, shares his story as a child living with HIV. More than a million people in Kenya are living with HIV. For children such as Elijah, access to antiretroviral treatment is vital. However, according to the latest data from the Government of Kenya, only 43 per cent of Kenyan children between 0–14 years old in need of ART are receiving it. Watch the 'real-life story' at www.youtube.com/watch?v=9-0d7W1pwm4.

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curriculum on leadership among key affected youth populations, which was launched at the 2014 International AIDS Conference in Melbourne. The curriculum was rolled out in national trainings (supported by United Nations partners) in Cambodia, China and Thailand by the end of 2014, reaching more than 100 key affected youth leaders. UNICEF China and United Nations partners rolled out their adapted New-Gen curriculum among 21 youth leaders from five key affected population organizations across China. Each organization drafted plans on rolling out the project at the community level and on recruitment of key affected adolescent populations into the project. In Thailand, 25 youth leaders from organizations of men who have sex with men, sex workers, drug users and adolescents living with HIV actively participated in a forum with key partner organizations, including government and international agencies. The specific health needs they identified for their peers are included in their respective organizational workplans for 2015.

United Nations agencies were able to jointly support a strong team of youth negotiators and lobbyists at the World Conference on Youth in 2014, where issues of young key populations, including adolescents living with HIV, were highlighted and included in the Colombo Declaration on Youth. UNICEF supported youth leaders in Thailand to participate in the first national seminar on teenage pregnancy organized by UNFPA, the Government of Thailand, the National Institute of Children and Family Development and the Path2Health Foundation. Participating youth leaders requested youth friendly services, comprehensive sexual education, youth participation and reduction of stigma against vulnerable youth populations, including those affected by HIV. UNICEF Thailand is supporting adolescents to follow up on the recommendations in 2015.

In Kenya, given the relatively limited national and county capacity to establish programmes with and for adolescents, including young key populations and adolescents living with HIV, the office strengthened and developed several new partnerships to lay the foundation for this output. UNICEF partnered with the National Empowerment Network of People living with HIV to empower adolescents living with HIV to participate in the national response to issues that affect them and to bring the views of adolescent boys and girls living with HIV to the forefront. The partnership focuses on three priority counties: Kisumu, Mombasa and Nairobi. Provided additional resources can be mobilized, the partnership is expected to be expanded to the six counties prioritized under the HIV outcome.

EVIDENCE GENERATION, POLICY DIALOGUE AND SERVICE DELIVERY

Data-informed programming is the foundation of an effective public health response – Know Your Epidemic – Know Your Response. UNICEF EAPRO has supported many regional and country-level initiatives to support data collection. In 2014, the office led a respondent driven sampling (RDS) skills building workshop at the International AIDS Conference and strengthened capacities of over 100 HIV programme staff to use RDS methodologies to collect and utilize data from adolescent key affected populations. Support from UNICEF on RDS has led to increased availability of strategic information on these populations.

These efforts help to address the challenge reported in 2014 UNICEF country office annual reports, which indicated that only 55 per cent of countries have strategies to address HIV among key affected adolescent populations and that many of those strategies only address HIV treatment.

In Myanmar, the UNICEF study ‘Situation and Barriers to Access to HIV services (Prevention, Care and Treatment) by Young Key Populations’ was completed in 2014, utilizing RDS methodologies. The study contributed to national planning processes on comprehensive, evidence-based HIV/AIDS strategies, comprehensive sexuality education and adolescent/youth-friendly health services. In China, a UNICEF-supported needs assessment identified transgender adolescents’ healthcare needs in Tianjin, Tongren, and strengthened the capacity of volunteers for advocacy and better use of RDS data. The assessment also identified key challenges and recommendations for follow-up action with the Chinese Center for Disease Control local administrators.

UNICEF ROSA supported five countries – Afghanistan, Bangladesh, India, Nepal and Pakistan – to varying degrees in national reviews of existing data on adolescent key population’s access to HIV-related services, including prevention, testing, treatment and care. These countries were supported to collect data from selected health facilities, as well as to collect qualitative data from key populations on barriers to accessing services. The compiled data will be used for advocacy and to support implementation of ALL IN #EndAdolescentAIDS. The finding of the reviews highlighted gaps and promoted national initiatives. In Pakistan UNICEF is supporting the government to implement home-based testing for

spouses of men who inject drugs in three districts, with special attention to adolescent wives; and Nepal has developed operational research protocols to improve efforts to reach females who inject drugs and their partners.

UNICEF Thailand, in close collaboration with the Ministry of Public Health, UNFPA and UNESCO, supported a situational analysis of young people at high risk of HIV exposure in Thailand. The study was completed in 2014 and contributed to national programme planning of HIV prevention and care among young people who were sex workers, men who have sex with men and migrant populations; the development of a new country proposal for submission to the Global Fund under the new funding model; and a brief video and newspaper articles.

In the Pacific Island countries, UNICEF with UNAIDS supported 10 countries – Cook Islands, Fiji, Kiribati, the Marshall Islands, Micronesia, Nauru, Samoa, Solomon Islands, Tonga and Vanuatu – to update HIV epidemiological data and fulfil requirements of the Global AIDS Periodic Reporting, including age and sex-disaggregated data for adolescents. As a result, all 10 countries were able to use the data from these reports to improve planning and implementation of their national HIV response for adolescents.

A number of UNICEF offices in Eastern and Southern Africa supported governments to analyse population-based data on adolescents (Kenya, Swaziland, the United Republic of Tanzania and Zambia) and country offices were encouraged to engage with the DHIS 2 initiatives in their countries to strengthen the collection and analysis of routine disaggregated HIV and sexual reproductive health (SRH) data on adolescents. For example, in Zimbabwe, advocacy with Ministry of Health and Child Care led to incorporation of adolescent HTC data in DHIS in 2014. Based on this data, by September 2014, 16 per cent of all HTC clients were found to be adolescents aged 10–19. Overall, young people aged 10–24 accounted for 42 per cent of all clients. In addition, the use of DHIS data was able to demonstrate that adolescents aged 10–19 accounted for 33 per cent of all clients in a HTC community campaign in two provinces that was supported by UNICEF (in total 64 per cent were young people). As a result in one of the provinces, the HTC campaign in Mashonaland West province tested 174,283 people in 10 days compared with 93,071 tested from January to June 2014 through health facilities

In 2014, UNICEF WCARO, with support from headquarters, used the MoRES methodology to design

a bottleneck analysis tool for adolescents' access and utilization of HIV-related services. The tool was rolled out in the majority of countries in West and Central Africa. In Côte d'Ivoire, Chad, Gabon and Mauritania, UNICEF worked with key stakeholders, including government sectors and civil society, to implement the bottleneck analysis. In Côte d'Ivoire this led to two important achievements: (1) a UNICEF-supported nationwide study on adolescent and youth vulnerability to HIV that was validated and owned by Government and key partners; and (2) linking findings from HIV to an assessment of early pregnancy among school girls, which informed and led to a national strategic framework on adolescent health with the Ministries of Health, Education and Youth. In Mauritania, data are informing the national HIV coordination body to integrate an adolescent needs component in the Test & Treat process, launched in 2014 as part of the six-country pilot supported by UNAIDS. In Chad and Gabon, UNICEF technical support has identified loss to follow-up of youth from traditional medical facilities, to establish experimental platforms for the delivery of HIV-SRH integrated services via school-based health clubs in Gabon and district centres for reading and communication in Chad.

HIV testing and follow-up services – with a focus on reaching adolescents most at risk for HIV infection: UNICEF's regional office for CEE/CIS addressed the challenge of getting more vulnerable adolescents and young people in the region to know their HIV status. In 2014, UNICEF worked with partners in five countries of the CEE/CIS region (Azerbaijan, Belarus, Georgia, the Republic of Moldova and Ukraine) to strengthen capacity of civil society and governments to promote quality HIV testing and counselling (HTC). Analysis of the views of more than 3,300 adolescents and youth were surveyed in relation to HTC in five countries. The capacity of over 3,800 community service organizations and government service providers was built to provide confidential, non-judgemental HTC services to adolescents, with emphasis on most-at-risk adolescents. HTC services provided by NGOs and government were promoted among over 65,000 adolescents and youth through outreach. More than 20,300 (34 per cent) adolescents and youth were tested and counselled and now know their HIV status; and 100 per cent of those who received HIV-positive tests were referred to appropriate HIV medical services.

In Belarus, UNICEF concentrated its efforts on raising awareness among young people on HIV testing and counselling. The 5 Steps education campaign



Valentine, who is 17 and lives in Kenya, shares the challenges of staying healthy when confronted by discrimination by her school peers.

View the 'real life story' at:

www.youtube.com/watch?v=okBN7qgYTwa - t=70

reached more than 300,000 young people through traditional and social media. The 5 Steps website (www.5shagov.by) provides information on how to get a 'quick' HIV-test and promotes HIV testing as a simple and routine part of living. In Georgia, UNICEF and partner Bemoni Public Union, with funding from the European Union and UNICEF, built the capacity nurses and physicians to provide HTC to most-at-risk adolescents and other vulnerable adolescents throughout Georgia. In all, 17 experts, 55 peer outreach workers and 140 peer educators were trained by the Georgian Youth Development and Education Association, a Tbilisi-based non-governmental organization. Approximately 4,500 adolescents and young people, including those who are most at risk, were tested for HIV, where there was previously very little testing among this population.

In Bangladesh, UNICEF supported efforts towards developing a community-based approach for delivering HIV- and AIDS-related interventions to adolescents, young MSM and Hijras/transgender people. These efforts were based on data that informed the development of a national HIV strategy and hence an operational plan for reaching transgendered populations with HTC and follow-up services through peer-outreach. The national target is to reach 60 per cent of those who need these services based on the data collected.

In Brazil, a project funded by the M·A·C AIDS Fund and led by UNICEF, Figue Sabendo Jovem (FSJ), based in the municipality of Fortaleza, has provided HIV and STD testing services to 950 high-risk adolescents and young people. They are using a mobile unit with youth outreach workers to recruit adolescents to get tested. Of the estimated 3,500 HIV tests that were performed in Fortaleza from January to

November 2014 among 13–29 year olds⁵⁶ through municipal HIV testing and counselling services, approximately 27 per cent were conducted by Figue Sabendo Jovem. Of the 950 people tested directly by the mobile unit, 394 were adolescents aged 13–19 years (209 male and 185 female), 51 were adolescent MSM (13–19 years), and 131 were adolescent boys and girls (13–19 years) in conflict with the law. Of the 950 people tested, 2.2 per cent tested positive for HIV infection (1 female and 20 male). However among men who have sex with men, the per cent that tested positive was far higher (7.4 per cent). Among adolescents (aged 13–19) tested through FSJ, 70 per cent were tested for the first time, contributed to the project goal of scaling up HIV testing among adolescents. The Municipal Health Secretariat of Fortaleza has been a key partner in developing the project from its inception, and the municipality has since adopted the strategies formulated through FSJ as public policy, ensuring its sustainability over time. In addition, based on the successful experience of FSJ in Fortaleza, and considering the seriousness of the HIV situation in the state of Rio Grande do Sul, and in particular in the city of Porto Alegre (the only Brazilian city where the epidemic is no longer considered concentrated but generalized), UNICEF Brazil is now working closely with local government leadership in Porto Alegre to expand the project to this municipality.

UNICEF Tanzania and ESARO supported the implementation of high impact HIV interventions for adolescents and young people, including those living with HIV and key populations, through partnerships with Restless Development, Support Makeete Self-Support (SUMASEAU), Pastoral Activities and Services for people with AIDS Dar es Salaam Archdiocese (PASADA, a faith-based organization), Baylor College of Medicine Children's Foundation Tanzania and AMREF, resulting in over 30,000 adolescents and youth accessing HTC/SRH services, and 1,812 adolescent boys accessing VMMC. The Shuga radio program, a youth participatory mass media campaign delivered through a soap opera format, was implemented in Mainland with approximately 3.5 million young people reached with key messages on HTC and condom use.

In Cameroon and Nigeria, UNICEF supported efforts in 2013 to generate evidence on adolescents and HIV, based on vulnerability studies and situation analysis. These data were used in 2014 to justify an increase in HIV testing and counselling, by increasing demand for provider-initiated counselling and testing, and innovative, creative community-based

interventions. In two high-HIV-burden states (Benue and Kaduna), data collected in 2014 informed the development of a plan to reach 70,000 adolescents and youth with HIV testing and follow-up services by 2016, an 80 per cent increase in HCT. UNICEF also supported efforts to routinely collect age-disaggregated data specifically on adolescents accessing HIV services. A pilot in 10 high-volume HIV testing sites was undertaken in Lagos State in 2014 and informed scale-up for 2015.

VOLUNTARY MALE MEDICAL CIRCUMCISION (VMMC)

UNICEF ESARO participated in a global consultation led by UNICEF Headquarters on VMMC modelling, which promoted a revised focus on older adolescents, and a consultation on early infant male circumcision. The regional office is also a member of the global adolescents and VMMC Technical Advisory Group, which is undertaking assessments of adolescent utilization of VMMC in South Africa, United Republic of Tanzania, Zimbabwe and Zambia. UNICEF Tanzania supported the non-profit health organization Jhpiego in assessing effective youth-led demand creation approaches, and supported Restless Development, SUMASESU, PASADA, Baylor College of Medicine Children's Foundation-Tanzania and AMREF, to provide VMMC and other prevention services to 1,812 adolescent boys. UNICEF Zambia supported efforts to assess attitudes to VMMC among adolescents and promote acceptability of VMMC. UNICEF Zimbabwe supported their 'Young People We Care' partners to undertake a mix of demand creation approaches for both HTC and VMMC. In addition, UNICEF Malawi supported a government-led early infant male circumcision task force.

ADOLESCENT HIV TREATMENT

In the CEE/CIS region, a programme to strengthen services for adolescents who are living with HIV has been developed by UNICEF – in partnership with the Children's HIV Association, the Eastern Europe and Central Asia Union of PLHA (people living with HIV/AIDS) Organisations and the Ukrainian Foundation for Public Health – and is being implemented in the Russian Federation, Ukraine and Uzbekistan.. Existing medical, social, psychological and other support services for ALHIV in Kyiv, Donetsk and Mykolaiv (Ukraine) were assessed and documented, and the

needs of adolescents were identified. From this data, five project service sites are delivering a model of comprehensive health and social services for ALHIV in Ukraine, providing HTC services to more than 2,000 adolescents, the vast majority of whom practice high-risk behaviours. Russian-speaking ALHIV have developed a networking platform for HIV-positive adolescents (www.teenergizer.org) that is run by adolescents and provides information and up-to-date news about HIV and AIDS, including through an interactive chat room and through counselling.

In Thailand, UNICEF provided technical and financial support to conduct operational research on improving low ARV adherence and positive prevention among adolescents living with HIV. The results were used to improve ARV treatment and reproductive health services.

In Eastern and Southern Africa, four countries were supported to develop innovative responses to increase provider-initiated counselling and testing for all adolescents, especially those aged 10–14, and to integrate care and treatment of ALHIV within the national ART programme services. UNICEF Tanzania facilitated two new partnerships to support ALHIV, with Baylor Tanzania in Mbeya, Iringa and Njombe, and PASADA in Dar es Salaam. Baylor reached 456 ALHIV with life skills and support for comprehensive adolescent HIV care. A random sampling of charts undertaken in fourth-quarter 2014 indicated a loss-to follow-up rate of 1.3 per cent among teen club members (n = 56) compared with 12.9 per cent of non-teen club members (n=318). Teen club programmes are being scaled up.

UNICEF Namibia has provided technical support to the government to roll out national ALHIV guidelines to districts, and also provided technical assistance to develop the National Strategy and Action Plan for HIV Testing and Counselling 2014/2015–2016/2017, and the development of the Combination Prevention Strategy for HIV 2015–2017, which promotes integration and synergies for effective prevention outcomes for adolescents.

In Zimbabwe, UNICEF, UNFPA and others have supported the roll-out of adolescent-friendly health services in an effort to increase access for adolescents who are living with HIV. In 2014 UNICEF's contributions included: training of 425 health workers in management of ALHIV in 10 districts; training and support to 120 Community Adolescent Treatment Supporters, who provided follow-up and support to 4,513 peers (54 per cent female) in 9 districts; train-



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Fique Sabendo Jovem youth peer educators provide HIV/STD prevention education outside the mobile health unit.

INNOVATIVE HIV TESTING AMONG KEY AFFECTED ADOLESCENT POPULATIONS IN BRAZIL

Since 2013, UNICEF Brazil, in partnership with the M•A•C AIDS Fund, has been implementing the Fique Sabendo Jovem (FSJ, or Youth Aware) project in the city of Fortaleza in northeastern Brazil. This project seeks to make a difference in the lives of young people at risk of or living with HIV and AIDS by:

- Increasing the efficacy of health promotion activities for young at-risk populations in an effort to reduce the incidence of sexually transmitted infections (STIs), including HIV and AIDS;
- Increasing access to voluntary testing of HIV, syphilis, and hepatitis B and C;
- Improving retention in care and treatment for adolescents and young people with sexually transmitted diseases (STDs) and HIV and AIDS, including men who have sex with men (MSM), young people in conflict with the law and those who have been sexually exploited, as well as for the general adolescent and youth population.

The table below shows the number of people tested (all ages) through Youth Aware, HIV status results and percentage of HIV infection, by population, in Fortaleza, 2014. Before this project,

there were no data on adolescents or specific programmes aimed at improving the retention in services. As part of the FSJ project, all adolescents and young people identified as HIV-positive are immediately referred for treatment and care (given an appointment upon a positive diagnosis) and followed up to promote treatment initiation and retention (Brazil has a 'test and treat' policy). FSJ has also initiated retention groups at a specialized health centre in Fortaleza to support and retain HIV-positive adolescents in treatment.

Population tested for HIV (all ages)	Number tested	HIV-positive result	% testing positive
MSM	189	14	7.4%
General at risk population	761	7	0.9%
Total	950	21	2.2%

Source: Project Youth Aware Reports - Fortaleza Technical Division of STD, AIDS and Viral Hepatitis, 2014.

ing of 148 health workers in 10 districts on child and adolescent counselling; training of 540 caregivers for ALHIV; establishment and strengthening of 38 support groups for ALHIV; support to 550 young HIV-positive mothers; finalization of the Adolescent Sexual and Reproductive Health (ASRH) Strategy Plan for 2014–2015 and the ASRH Advocacy Package, and development of a draft national monitoring and evaluation framework to guide implementation of ASRH programmes. However, adolescents who are living with HIV still face challenges in accessing services and stigma from peers, especially in schools, and this has led to default from ART.

Together with UNAIDS, UNICEF ESARO participated in the meeting in Cape Town, South Africa, that led to the establishment of the Adolescents HIV Treatment Coalition. The coalition has been advocating for increased access to second- and third-line treatment and special programmatic efforts to support adherence and retention in care, especially for young adolescents. As part of the HIV Prevention Working Group of the Regional AIDS Team in East and Southern Africa, technical assistance was undertaken with the Southern African Development Community, UNAIDS and the United States Agency for International Development (USAID) to support the development of the regional HIV prevention capacity-building module, the review of national strategic frameworks and Global Fund concept notes.

INNOVATION AND ADVOCACY TO ADDRESS BARRIERS TO SCALE-UP

In China, UNICEF supported enhancements to the adolescent ICT platform to disseminate knowledge on HIV and SRH, and to strengthen adolescent networks. Counselling was provided to more than 3,000 adolescents on HIV, STI and pregnancies via the hotlines, WeChat account, QQ chat group and the UNICEF-supported Blue-Red Ribbon health centres in designated UNICEF-Government of China project districts. In 2014, more than 85,000 young people participated in HIV and sexual and reproductive health learning via community outreach, ICT portals in universities and vocational schools, and interactive HIV education sessions. Service referrals via WeChat, QQ and Weibo had helped adolescents and young people access early diagnoses of HIV, STI and Hepatitis B. An online group application supporting instant message exchange enabled 74 child welfare directors with cellular Internet access and 27 programme managers and experts to exchange information on a daily basis and

support one another on how to provide services to children in households with parents living with HIV.

In Nepal, a joint UNFPA, USAID, GIZ initiative for mobile health (mHealth) was launched in September 2014 with the aim to improve knowledge and information among adolescent on SRH issues, including HIV, and to improve access to ASRH. Within 40 days of the launch, 246,643 adolescents and youth participated in the m4ASRH programme and more than 50 per cent of them actively participated in the ASRH quiz.

UNICEF is funding and co-managing the U-report system in Zambia, which has completed its second year of implementation. The Government, through the National AIDS Council, has been able to reach, in real time and continuously, more than 74,000 adolescents and youths (from 30,000 in December 2013) with health- and HIV-related information in the two provinces with the highest HIV prevalence. This SMS platform was also used to conduct bottleneck analysis of the determinants of teenage pregnancy. The data have informed a national dialog on the issue. UNICEF Kenya supported the assessment of a digital platform operated by LVCT Health, a non-governmental organization that provides mobile and web-based information and counselling on HIV and sexual and reproductive health to adolescents nationwide. The findings and recommendations from the assessment have been used to develop the basis for a new partnership with LVCT Health and Safaricom to scale up access to correct and age-appropriate HIV and SRH information and real-time data on adolescents.

In West and Central Africa, advocacy efforts were intensified in 2014 with key regional institutions, such as the Economic Community of West African States, the West African Health Organization (WAHO) and USAID, to increase attention to young key populations, especially male adolescents who have sex with men and adolescents exploited through selling sex. This was introduced in the WAHO regional strategic plan 2012–2016 during its mid-term review and was retained in the regional programmatic recommendations issued by the regional consultation on key populations organized in Accra in May 2014 by USAID. UNICEF co-led the development and publication of a special Journal of Acquired Immune Deficiency Syndromes supplement comprised of 11 peer-reviewed articles on adolescents and HIV, launched in July 2014. Additional platforms used for dissemination include multiple events at the July 2014 International AIDS Society conference; the 2014 Pediatric AIDS Conference; the International HIV Research Conference in Kigali

in December 2014; the regional adolescent reproductive health rights and HIV symposium in Lusaka in December 2014; and at webinars. During 2014, the UNICEF Headquarters HIV section developed an internal document on programming for adolescent key populations and technical briefs on young key populations (through the interagency working group on key populations). These will strengthen UNICEF programming, including the operationalization of the organization's sexual orientation and gender identity policy position.

INTEGRATION OF HIV, SOCIAL PROTECTION AND EDUCATION DEVELOPMENT SECTORS

In 2014, UNICEF EAPRO's HIV and Child Protection sections organized a dialogue between child protection and HIV technical experts in East Asia and the Pacific to address HIV vulnerabilities among sexually exploited children. The meeting convened experts in HIV, child protection, social protection and social welfare from UNICEF, academia and civil society to promote cross-sectoral dialogue in the East Asia and Pacific region, with the objective of ensuring that the HIV and Child Protection efforts of UNICEF and partners are firmly rooted in child rights principles and in international human rights law. Critical next steps and recommendations included EAPRO's undertaking a legal review on violence against children in ASEAN member states; preparation of guidance for strengthening integration and collaboration between HIV and Child Protection in UNICEF; and the preparation of a United Nations-wide policy brief on sexually exploited children to facilitate consistent leadership, advocacy and guidance at all levels on the issue of sexual exploitation of children.

In Indonesia, UNICEF, in partnership with the provincial government of Papua and West Papua provinces, focused on establishing a conducive policy environment framework for mainstreaming HIV and AIDS into the education sector. A knowledge, attitudes and practices survey conducted by UNICEF in 2010 revealed that young people in and out of school have limited comprehensive knowledge of HIV and AIDS, and studies indicated that unprotected heterosexual sex remain the main driver of the epidemic. In Tanah Papua province, UNICEF supported the development of institutional frameworks for mainstreaming HIV and AIDS that were integrated into the education sector through provincial regulations and policies. The frameworks enabled UNICEF to support gov-

ernment and civil society partners' capacity building interventions, designed for the education of managers/teachers and development of life-skills teaching/learning materials for all education levels and out-of-schools settings (benefiting over 50,000 children/adolescents). Considering the high numbers of adolescents not in school, interactive and participatory learning materials were developed in 2014 in partnership with civil society partners, and a cohort of young people was trained to accelerate delivery of the programme in out-of-schools settings.

In Myanmar, UNICEF supported the life skills curriculum coverage and provided orientation training to 209 district and township level education officers from Upper Myanmar, in order to successfully manage 23 zonal trainings for 9,322 secondary teachers from 153 townships. In the Philippines, as part of a high-level policy dialogue – Ako Para Sa Bata (cultural beliefs and practices affecting child protection) – HIV and adolescent health case studies were explored from child protection perspectives and provided valuable reflection on the role of social workers and the child protection sector in the provision of essential commodities and services for minors.

In Nepal, a review of teachers' training, training materials and comprehensive sexuality education in the formal school curricula (Grades 1–10) identified gaps and recommended further integration of comprehensive sexuality education into the curricula, as well as strengthening of in-service training of teachers on the subject.

Three countries in Eastern and Southern Africa implemented activities from the health sector work plan drafted at the East and Southern Africa Ministerial Commitment, supporting comprehensive sexuality education and sexual and reproductive health services for adolescents and young people (www.unesco.org/new/en/hiv-and-aids/our-priorities-in-hiv/sexuality-education/east-and-southern-africa-commitment/). UNICEF Swaziland supported the piloting of comprehensive sexuality education modules under ESA; and UNICEF Lesotho supported the coordination of the Eastern and Southern Africa working group around the revision of secondary curricula.

CONSTRAINTS AND CHALLENGES

- Data on adolescents and HIV is limited in many settings, and when available, does not often inform national HIV strategies.

- Adolescents most at risk for HIV, including gay and bisexual boys, adolescents who inject drugs, adolescents who sell sex – including children (aged 10–17) who are sexually exploited through selling of sex – and transgender adolescents remain largely invisible in national strategies.
- Age- and gender-disaggregated treatment data are collected at the service delivery level, but often not shared with district programme managers and national-level policy directors for planning purposes. HIV testing and counselling for adolescents and linkages to prevention, treatment, care and support remain unacceptably low.
- Legal barriers (age of consent) limit access to HIV and medical services, and in some countries only married persons can access sexual and reproductive health services.
- Stigma and discrimination of adolescents most at risk for infection by family, friends and health care providers and punitive laws compound the barriers to access HIV testing and to follow-up services.
- Knowledge of HIV and perceptions of risk are limited – many adolescents still do not have the correct knowledge on HIV transmission, nor do they perceive themselves at risk when they practice high-risk behaviours.

PREVENTING DISCRIMINATION: WELFARE SYSTEM IN CHINA PROVIDES SUPPORT FOR CHILDREN AFFECTED BY AIDS AS PART OF A COMPREHENSIVE PROGRAMME FOR VULNERABLE CHILDREN

UNICEF China's support to village child welfare directors and China National Committee on Care for Children focal points allowed for provision and coordination of social protection and welfare services for vulnerable children, including children affected by AIDS. This resulted in over 2,000 children registered into the 'hukou' system and the medical insurance system. Over 3,000 children received grants for formal and vocational education, and over 1,000 children from poor families received 'dibao' cash assistance, including children affected by AIDS. To avoid discrimination, children affected by AIDS were not labelled as such.



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In a small village located six hours away from the nearest city, Arij lives with his illiterate grandfather and elder siblings after losing his mother to AIDS. Hailairize, a barefoot social worker, became close with Arij's family. She has been supporting the children by responding to their health and education needs. In early 2014, Arij had pneumonia and his grandfather went to see the traditional healer. Hailairize learned about Arij's worsening situation and persuaded the grandfather to seek hospital treatment. She arranged transportation and accompanied Arij to the hospital. According to the doctor, she saved Arij's life. To support Arij and his family in applying for social protection subsidies, Hailairize reported the predicament of Arij's family to the village committee. All four siblings are now covered by the cash assistance system for especially vulnerable children under Jinyang County. Currently, the four siblings receive a maintenance grant of 920 Yuan per month.

- Experience of health care professionals to treat, retain and follow-up with adolescents living with HIV and AIDS is limited.
- Addressing structural drivers of adolescent HIV infection requires the collaboration of many sectors (health, education, protection, gender, labour), but the political will remains weak and evidence of successful synergies is sparse. Addressing gender inequities: Girls in generalized epidemics are inadequately supported to prevent HIV infection. There are no effective gender-based violence interventions, and economic empowerment and other evidence-informed interventions are lacking. Boys in concentrated epidemics who are having sex with other males face significant legal and political barriers to accessing HIV services.
- Adolescent HIV programmes are not often donor or national government priorities – as adolescents are relatively healthy – and focus on key affected adolescent populations, often compounding punitive laws towards LGBTI and drug users as well as age of consent laws, which restrict adolescents' right to health.
- Promoting the meaningful participation of adolescents in HIV and other development programmes is labor- and resource-intensive, yet is needed to bring high-impact, evidence-informed interventions to scale.

PROGRAMME AREA 3 – ACROSS BOTH DECADES

PROTECTION, CARE AND SUPPORT

As for all HIV programming, 'knowing your HIV epidemic and response', 'knowing your social context and drivers', and 'knowing your affected populations' is crucial to leveraging HIV-sensitive, specific and relevant protection, care and support. UNICEF and the World Bank supported a Call to Action for Children Affected by AIDS at the Global Partners Forum held at the International AIDS Conference in 2014, focused on scaling up protection interventions for vulnerable children and their families to enhance HIV outcomes.

EVIDENCE GENERATION, POLICY DIALOGUE AND SOUTH TO SOUTH LEARNING

A UNICEF and Government of South Africa effort to implement HIV-sensitive protection, care and support exemplifies the commitment to the Call to Action, and demonstrates that 'household child support grants' received before age five were associated with significant reductions in adolescent HIV-associated risky behaviour and increases in protective behaviour⁵⁷ 15 years later.⁵⁸ In 2014, UNICEF assisted four countries in South Asia – Bangladesh, India, Nepal and Pakistan – to conduct an assessment of HIV-sensitive social protection initiatives that examined adolescent key populations' access to social services. The findings, published in HIV Sensitive Social Protection Measures in South Asia: A Mapping in Bangladesh, India, Nepal

and Pakistan, by the UNICEF Regional Office for South Asia, revealed, among a number of issues, that while services were often present, adolescent key populations were largely underserved due to challenges with stigma from health care professionals, family and peers. Mechanisms for alleviating stigma, appropriate for cultural contexts, are needed.

In Thailand, a study on alternative care of children with a special focus on children infected with and affected by HIV and AIDS for evidence-based policy dialogue and to promote equitable services was conducted with UNICEF's support. The findings from this study contributed to increased equitable access to essential child-focused services, life-saving interventions, and informed legislation to address stigma and discrimination of people living with HIV.

UNICEF ESARO supported the generation of evidence on practical operational experience on the linkages between child protection systems and HIV and AIDS services. In Nigeria, Zambia and Zimbabwe, cases for analysis, UNICEF has supported countries to highlight the importance of programmes supporting development of parenting skills, peer support, inter-generational dialogue and streamlined service delivery for both HIV and child protection services. These experiences have informed a UNICEF-supported training and work planning workshop for the Southern African Development Community to implement the 'Minimum Package of Services (MPS) for OVC & Youth' and its companion guidelines.

UNICEF ESARO has also contributed to bringing the regional perspective, through South-to-South experience sharing, to shape global processes – including the IATT on Social Protection, Care and Support Group, Global Structural Drivers meeting and UNAIDS Programme Coordinating Board discussions. As of 2014, almost all priority countries in Eastern and Southern Africa have an approved Social Protection Policy or Strategy, or are in the process of developing one. More than 40 African Union member states participated in the African Union Consultation on Children and Social Protection Systems – led by the African Union, the Government of South Africa and UNICEF. Key results include social protection commitments in the 4th Session of the African Union Ministers of Social Development Meeting, focusing on human rights-based social protection, expansion, systems building and national financing of social protection systems.

UNICEF ESARO has supported countries to strengthen the links between child protection and HIV, recognizing the role that care and support can play in enhancing the quality of life of children affected by AIDS. In 2014, technical support and evidence-based advocacy resulted in the adoption of social protection strategies and policies in such countries as Ethiopia, Lesotho, South Sudan and Zambia that recognize the needs of children and families affected by HIV and AIDS and the role social protection plays in their well-being.

As examples, in Lesotho, the National Social Protection Strategy was adopted, re-affirming the Government's support to a comprehensive approach to inclusive and HIV-sensitive social protection. In Zambia, the policy was developed under five key pillars, including social assistance, social insurance, livelihood promotion (HIV-related), protection and disability. In both cases, current efforts are in place to operationalize the systems approach reflected in these policies, to ensure existing programmes are coherent, coordinated and with the effective mechanisms to link beneficiaries with other key social services. In Ethiopia, the Social Protection Policy Framework emphasizes the need for building human capital, as well as addressing the root causes of poverty and reducing inequalities. A key element of the Policy Framework is the inclusion of child welfare services for HIV-affected and infected people, psychosocial support, alternative care, grants for the elderly, disability grants and other social services.

UNICEF has fostered the development of a strate-

gic partnership with the African Union Commission of Social Affairs on children and social protection systems. This partnership was catalysed by an African Union Expert Consultation on Children and Social Protection Systems (Cape Town, April 2014), in collaboration with the Government of South Africa and UNICEF. The Expert Consultation gathered government delegates from 40 countries across the continent, discussing the state of the evidence around social protection, implications around design and implementation of programmes, as well as looking ahead in terms of opportunities and challenges around scale-up, expansion and financing. The recommendations out of the Cape Town meeting (around political will, financing and expansion of coverage) were included in the Ministerial Declaration of the Fourth Session of the African Union Meeting of Ministers of Social Development-CAMSD4 (Addis Ababa, May 2014). At the CAMSD4, Social Development Ministers committed to develop a human rights-based approach to social protection and children; expand the coverage of current programmes; and allocate national resources to inclusive and child-sensitive social protection systems.

Several countries in Eastern and Southern Africa continue to have policies that aim to reach orphans and vulnerable children and programmes for these children running in parallel to child protection and other sectorial interventions. In 2014, UNICEF ESARO commenced a series of initiatives to make sure that multiple interventions were not attempting to serve the same group of children and families. UNICEF initiated a study to identify promising practices in linking child protection systems and services with HIV and AIDS services, selecting Nigeria, Zambia and Zimbabwe as cases for analysis. Preliminary findings indicate that adolescents are particularly exposed to and impacted by both HIV and child protection risks, and that the effects of stigma and discrimination – largely stemming from HIV status, sexual orientation, gender-based violence and/or sexual abuse – remain a grave concern for children and caregivers.

In addition to providing technical support to Zambia and Zimbabwe to translate the findings of the study to programmes, UNICEF Namibia supported the Ministry of Gender and Child Welfare to strengthen statutory care and protection functions for the protection of vulnerable children, including orphans and other children in need of alternative care. In 2014, ESARO initiated a partnership with Stellenbosch University to participate in a longitudinal 'Child Community Care Study: Children Af-



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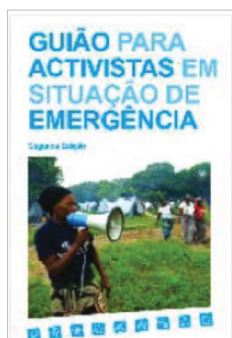
Jaquina Mariana Chigalo, living with HIV, and her son, Clayton Elias Chigalo, free of HIV, benefit from the integration of maternal and child health in one clinic in Mozambique.

ected by HIV/AIDS’ served by community-based programmes taking place in Malawi, South Africa and Zambia. The study aims to learn more about the impact of a wide range of community-based interventions for children’s well-being, and how/if these ‘informal’ services are linked to formal services delivered with government support. In the long-run the study will contribute to the emerging evidence base on the impact of ‘cash plus care’ packages of services on increasing resilience and improving overall wellbeing outcomes of children and families. It will also contribute to a better understanding of how case management is carried out at the community level.

UNICEF has made noteworthy progress towards its goal of increasing access to quality early childhood development programmes for children affected by HIV and AIDS in Kenya, the United Republic of Tanzania and Zambia – particularly through the three-year UNICEF project funded by the Conrad N.

Hilton Foundation and evaluated in 2014. In Tanzania, UNICEF led training for 84 civil society organizations on integrated early childhood development concepts, and 21 mother mentors and 58 members of mother support groups received PMTCT training. In addition, 3,870 women have been enrolled into the Mother-to-Mother programme and followed through a continuum of PMTCT care. Through this programme, 51,791 children were assessed for malnutrition, and 517 children diagnosed with severe malnutrition were referred to higher facilities for therapeutic intervention. In addition, 151 HIV-exposed children who had been lost to follow-up were traced by mother support group members, and 139 of them were returned to take part in health services.

UNICEF WCARO has been working to increase access to protection, care and support for vulnerable families affected by HIV through implementation of the family-centred approach, which aims to achieve



During the floods emergency in Mozambique, UNICEF distributed a leaflet to community activists with information about HIV, violence and malaria prevention, hygiene and sanitation promotion. The cover photo features an activist in Chiaquelane camp inviting the community to participate in an awareness session on hygiene promotion.

higher treatment adherence and health retention of pregnant women and children living with HIV; identification of HIV-positive adults, adolescents and children who will quickly be provided with the necessary health care and support; and increased attention to children made vulnerable to HIV so they can grow in secure and supportive environments.

Cameroon, Côte d'Ivoire and Senegal have integrated a family-centred approach in their national HIV programming strategies. In Côte d'Ivoire, the process was initiated in January 2013 through a workshop supported by the UNICEF regional office in collaboration with Save the Children, Alliance Côte d'Ivoire, PNOEV (the National Program for Orphans and Vulnerable Children) and PEPFAR. The workshop involved various ministries and members of civil society and led to an agreement by all stakeholders that the implementation of the family-centred approach in Côte d'Ivoire should become a priority in the national HIV programming for improved continuum of care. UNICEF WCARO supported Cameroon by organizing a national consultation of key ministries working around HIV to revitalize the dialogue on implementation of the approach in November 2014. This consultation led to the creation of a national coordination platform for implementing the family-centred approach; the platform includes organizations working with female sex workers and will be led by the Ministry of Women's Affairs and Family, coordinated by National Agency for the Control of AIDS (NACA). In Senegal, a meeting facilitated by UNICEF with the NACA and various relevant ministries, resulted in a decision that a national committee on the family-centred approach would be set up under the leadership of NACA and coordinate the work of the Ministries of Health and Social Welfare.

CASH TRANSFERS

In Nepal, UNICEF provided technical support to the Ministry of Health and Population to extend the cash transfer programme to support 1,500 children of HIV-infected/affected (CABA) families in the existing HIV intervention programme areas. Efforts are continuing to include CABA in the broader national social protection programmes, which will ensure that these children are able to pay for out-of-pocket expenses for health care and education.

To assist countries in impact evaluations of national social protection programmes in Eastern and Southern Africa, UNICEF provided evidence on the impact of social cash transfer programmes and promoted learning on the design and implementation evaluations and research. With the UNICEF-provided data, the Governments of Kenya, Lesotho, the United Republic of Tanzania and Zambia committed a significant expansion of coverage of their social protection programmes. For instance in Lesotho, UNICEF, in partnership with the European Union, provided technical support to the Ministry of Social Development to increase the number of vulnerable households receiving cash assistance from 19,813 in 2013 to 25,600 in 2014.

The results of the research and programme implementation have been widely disseminated as well as discussed in such forums as the World Bank/UNAIDS Structural Drivers Meeting in Johannesburg, the IATT on Social Protection Care and Support meetings, and the Regional IATT on Children and AIDS. In addition, in partnership with UNAIDS, USAID, University of Oxford, Transfer Project and Economic Policy Research Institute, UNICEF developed a policy brief on social protection and HIV prevention, highlighting the results of these evaluations, and discussing key policy implications of the findings.

In addition, as part of its South-to-South exchange and strategy to strengthen implementation capacity at the country level, ESARO supports the Community of Practice on Cash Transfers in Africa, in partnership with the World Bank in Africa, which held its third face-to-face meeting in Livingstone, Zambia, gathering government delegates from more than 11 countries in Eastern and Southern Africa. Key topics of discussion and exchange included expansion and scale-up and linking cash transfers with other key services across sectors.

SYSTEM STRENGTHENING AND DECENTRALIZED SERVICE DELIVERY

UNICEF technical assistance, evidence generation, policy guidance and advocacy have contributed to a rising trend in the region from small-scale, fragmented donor-financed programmes, to a nationally owned integrated social protection system. UNICEF has been providing technical assistance in the operationalization of such systems. Kenya, Lesotho, Malawi and Rwanda, with technical support from UNICEF, are strengthening their national management and information systems (MIS) to make sure that they effectively link existing social assistance programmes at the country level. In Kenya, UNICEF is using a coherent targeting and registry approach to support integration of the country's five social assistance programmes.

In the United Republic of Tanzania, UNICEF has assisted the Government with maximizing links between the Child Protection MIS and the Tanzania Output Monitoring System for HIV/AIDS (TOMSHA under TACAIDS), the Tanzania Social Action Fund (TASAF) monitoring and evaluation system and the database on most vulnerable children (under DSW). Moreover, UNICEF helped launch and implementation of the 2nd National Costed Plan of Action for Most Vulnerable Children (2013–2017), to ensure that the most vulnerable children have access to basic social services. Through sustained advocacy, relevant ministries – including PMO-RALG and the Ministry of Finance – are taking forward specific commitments to increase funding for the most vulnerable children to implement NCPA-II across all relevant sectors.

In Lesotho, UNICEF, in partnership with the European Union, supported the Ministry of Social Development to increase the number of households captured in the National Information System for Social Assistance (NISSA) database from 84,000 in 2013, to 103,271 in 2014. These additional households were used to target an additional 5,000 households enrolled this year during CGP expansion. Furthermore, UNICEF in partnership with the European Union supported the NISSA and targeting review with the aim of developing a single registry for targeting, coordination and integration of programmes.

HIV IN EMERGENCIES

Forty-one of 117 UNICEF country offices reported through their annual report SMQs a humanitari-

an response within their offices, impacting nearly 20,000 pregnant women known to be living with HIV in locales with UNICEF-supported programmes.

In 2014, UNICEF child protection, HIV and health sections piloted an innovative community-based social norm programme in Somalia and South Sudan – Communities Care: Transforming Lives and Preventing Violence – to support all women and girls. Baseline data in control and intervention sites were collected using a social norms measurement tool developed by Johns Hopkins University in conjunction with UNICEF. The programme follows a two-pronged approach to prevent and respond to sexual violence: (1) community conversations amongst the population and (2) community health workers trained to provide care to survivors of sexual assault.

Lessons learned from the 2013 floods in Mozambique revealed how HIV programming was impacted, and UNICEF analysed the experience, took stock of the HIV response, and identified lessons learned based on the Core Commitments for Children. The case study seeks to highlight areas where adjustments to programming can be made to improve future HIV response for children, pregnant women and adolescents in other emergency situations. The information included in the case study was drawn from reports drafted by UNICEF and partner organizations, and first-hand accounts from UNICEF staff. It also includes ways to better take risk into account in programming. One of the major lessons learned was a need for clearer roles and responsibilities. Because HIV was not included in contingency planning, there was initially a great deal of confusion between partner organizations about their roles and responsibilities. The National AIDS Commission (NAC) was slow to react to the emergency, and some partners were unable to provide support during the emergency because it was not in their workplan.

The HIV section also responded to the Ebola epidemic and other crises by contributing to a technical note on HIV in Ebola, developed and circulated by the Inter-Agency Task Team on Emergencies. UNICEF headquarters also supported efforts by deploying three HIV staff to Sierra Leone and Guinea to work on the crises. UNICEF also worked on the integration of newborn HIV interventions in the Central African Republic briefs, guiding PMTCT and paediatric interventions in that context.

Conflict in the Central African Republic has had severe consequences, both within the country and



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The involvement of fathers can improve the health of babies and mothers, and help to reduce mother to child transmission of HIV. Friday Mkuzi (25 years) was part of a male champion programme in Malawi and rejoices in the health of his daughter Emily and mother Mary Mkuzi (18 years).

in neighbouring countries. Prior to the conflict, the Central African Republic had one of the highest HIV prevalence rates in the region – with areas such as Obo, where the Ugandan LRA settled down, as high as 11.9 per cent. The conflict has displaced nearly 1 million people, both internally and cross border and disrupted treatment for men, women and children, including adolescents (30,000 out of 150,000), which puts them at risk of drug resistance and illness. The number of patients on ART dropped from 15,591 in November 2013 to 7,747 during the acute crisis in December 2013, but through UNICEF's and partners' interventions, such as active case finding of patients needing ARVs in the urban IDP camps in Bangui, increased again to 10,273 in January 2014 and to 14,780 in February 2014. In response to the crisis, UNICEF provided technical support to the government and to dynamic community-based organizations, including the reactivation of 81 PMTCT sites (against the initial 106 health sites), testing of 35,000 pregnant women for HIV, as well as HIV counselling and testing for 510,000 adolescents in Bangui and Bossangoa. Medical and nutritional support was also provided in all the active PMTCT centres.

In Côte d'Ivoire, out of 102,723 pregnant women attending antenatal care in the UNICEF intervention zone, 65,704 received counselling and 2,091 testing positive for HIV were referred and received ART and prophylaxis for their children. Some 404,140 adolescents and young people received information and life skills on HIV and AIDS, STIs, reproductive health and gender-based violence; 52,586 youth tested for HIV and STIs, and those testing positive (251 for HIV and 3,410 for STIs) received appropriate care and treatment.⁵⁹

In South Sudan, UNICEF continued mentoring staff at 42 maternal and newborn health and PMTCT sites across the country. The organization supported 19 mother-to-mother support groups with training, outreach and community engagement to lower the transmission of HIV and support those living with the virus. As a result, 5,772 pregnant women attending antenatal care, 92 per cent of those the initiative intended to reach, received counselling and testing.

UNICEF also initiated a demonstration intervention to integrate HIV care in malnutrition units in Chad,

which will further be scaled up in 2015. As a result, 1,440 children with severe acute malnutrition (SAM) were tested for HIV, out of which 170 were found to be HIV-positive (11.8 per cent). Out of 37 children under 5 with SAM with complications, who were tested for HIV, 11 were found HIV-positive (29.7 per cent). These results highlight the need for further interventions of this kind, the importance to maintain close integration between HIV and nutrition activities and to ensure that relevant drugs and tests are available on sites.

UNICEF Supply Division and Programme Division have also been working together to promote treatment continuity and respond to gender based violence in emergency contexts. UNICEF has worked with partners to develop a package of commodities for sexual assault defined for the UNICEF supply division website. This will facilitate the ordering of supplies for country offices and will simplify paediatric formulations of drugs for post-exposure prophylaxis. UNICEF participated in discussions with the Global Fund (led by the Office of the United Nations High Commissioner for Refugees and the World Food Programme) on reprogramming for the Central African Republic, and the Emergency Fund for which UNICEF is now prequalified.

CONSTRAINTS AND CHALLENGES

- Generating political will: A major challenge is to find sufficient evidence/case studies, generate political buy-in and identify strategic entry points for operationalization.
 - Evidence should be integrated – bringing economic, epidemiologic and social research together to inform social protection and universal health care system building.
- Most countries in highly affected regions retain separate financing for HIV prevention, care and treatment with heavy reliance on international funding. There are often few linkages with national health schemes and other social protection programmes. Even when treatment is covered under state schemes, access barriers for PLHIV and other key populations are pervasive.
 - The challenge of countries rapidly transitioning from Global Fund to domestic funding for HIV, and the resultant need to integrate financing, adapt health insurance schemes, and integrate programme planning and implementation, has to be addressed.
- Very few universal health schemes have any aspect of preventative services so there are few channels for integrating sexual and reproductive health services into national schemes. This concept needs to be promoted and backed by evidence of cost effectiveness.
- Key populations are reluctant to enter mainstream (universal health care) services. More work needs to be done to develop working partnerships between civil society organizations delivering prevention, treatment and care to key populations and supporting entry into mainstream services.
 - Small sizes of populations affected by HIV, which are hidden among huge population sizes, pose a challenge to reaching these groups.
- Capacity of the child protection sector to monitor the impact of its interventions and develop evidence-based programmes is limited when compared to other sectors.

HIV in emergency settings should receive more priority, especially as many of the Global Plan 21 priority countries and the ALL IN to #EndAdolescentAIDS25 roll-out countries have experienced or are experiencing humanitarian crises, including chronic conflict.

REVENUE

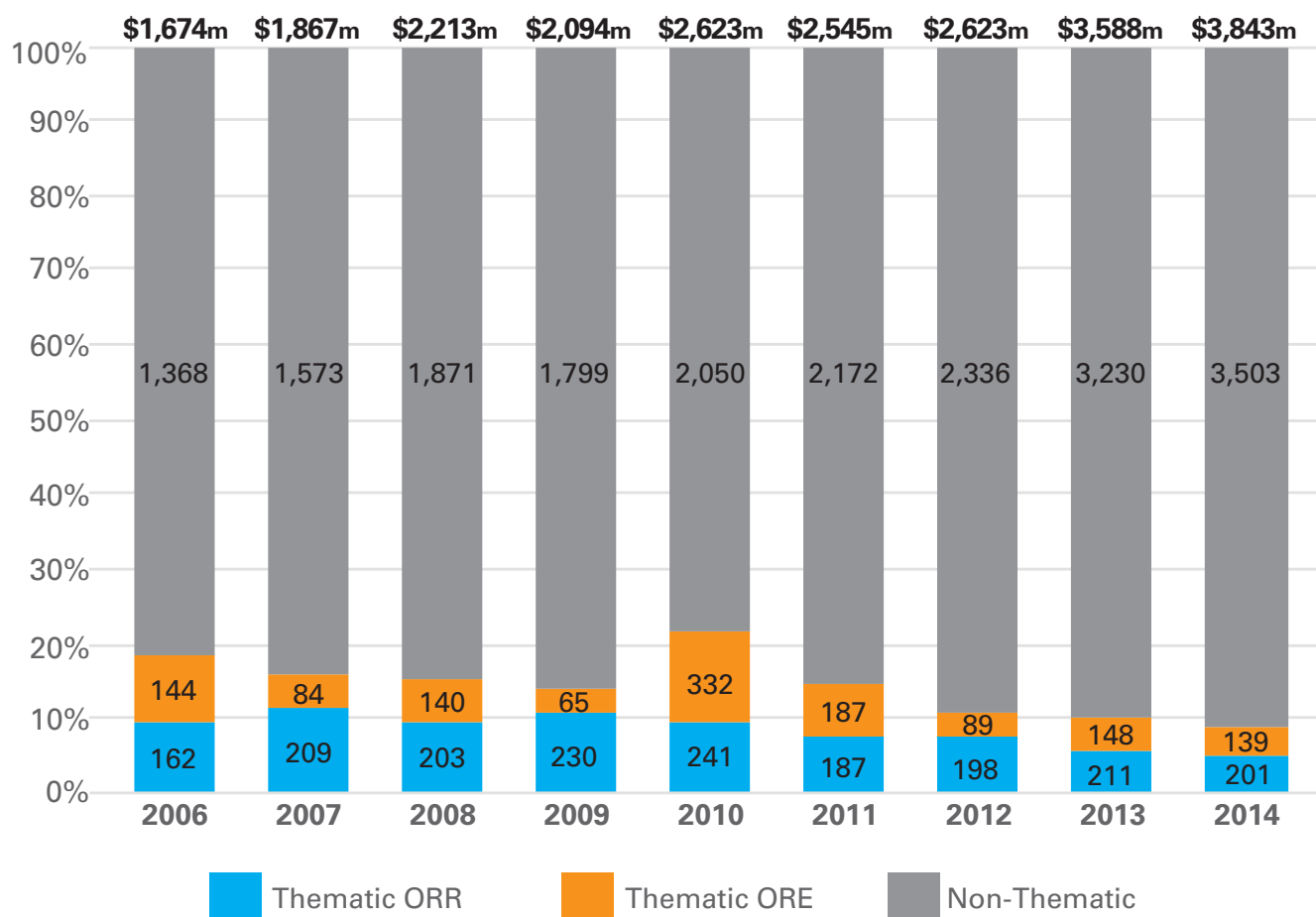
UNICEF is entirely dependent on voluntary contributions. Regular resources are unearmarked, unrestricted funds. The overwhelming majority of these funds are allocated to country programmes on the basis of under-5 mortality rates; gross national income per capita; and child population, which ensures that most resources are spent in the least developed countries. In turn, each country programme invests its share of regular resources in response to the specific context and development priorities of the country concerned. UNICEF revenue also comes from earmarked or other resources, which include, among others, pooled funding modalities such as thematic funding for UNICEF Strategic Plan outcome and cross-cutting areas. Other resources are restricted to a particular programme, geographic area or strategic priority, or to fund emergency response.

Despite a 5 per cent increase in 2014 to US\$1,326 million, regular resource contributions have continued to decline as a share of overall revenue since the turn of the new millennium, from 50 per cent to just over 25 per cent. As we look to the post-2015 agenda, being 'Fit for Purpose' to deliver on the draft SDGs and aligned UNICEF Strategic Plan, flexible and predictable other resources are needed to complement a sound level of regular resources. It is only with more flexible resources that UNICEF can:

- **Maintain** its independence, neutrality and role as a trusted partner, with adequate and highly skilled capacity at country level, for country-driven, innovative and efficient programming;
- **Achieve** key results for all country programmes of cooperation; and

FIGURE 12

OTHER RESOURCE CONTRIBUTIONS 2006–2014: THEMATIC VS. NON-THEMATIC



THE VALUE OF THEMATIC FUNDING (OR+)

While regular resources remain the most flexible contributions for UNICEF, thematic other resources (OR+) are the second-most efficient and effective contributions to the organization and act as complementary funding. Thematic funding is allocated internally on a needs basis, and allows for longer-term planning and sustainability of programmes. A funding pool has been established for each of the Strategic Plan 2014–2017 outcome areas, as well as for humanitarian action and gender. Resource partners can contribute thematic funding at the global, regional or country levels.

Contributions from all resource partners to the same outcome area and humanitarian action are combined into one pooled-fund account with the same duration, which simplifies financial management and reporting for UNICEF. A single annual consolidated narrative and financial report is provided at global, regional and country levels that is the same for all resource partners. Due to reduced administrative costs, thematic contributions are subject to a lower cost recovery rate, to the benefit of UNICEF and resource partners alike. For more information on thematic funding, and how it works, please visit www.unicef.org/publicpartnerships/66662_66851.html.

PARTNER TESTIMONIAL

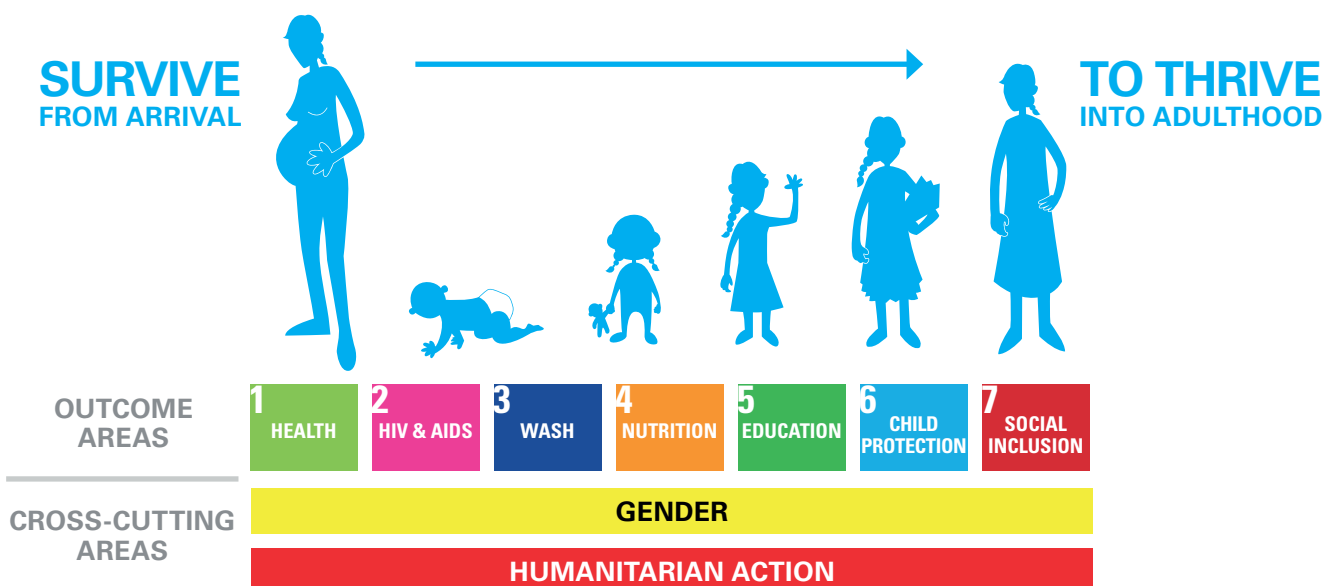
*"Helping children in need is the most important investment that we can make to achieve development, human rights, peace and stability. **UNICEF** is a key partner in this respect. [...]"*

*The flexibility of **UNICEF's** thematic funding allows us to reach the most vulnerable children, improve the effectiveness of our response and achieve better results. It also enables us to promote innovation and sustainability, improve coordination and long-term planning, and reduce transaction costs.*

*In accordance with its mandate, **UNICEF** works to promote the protection of children's rights and the fulfilment of their basic needs, and to increase children's opportunities so that they can reach their full potential. In today's world, **UNICEF's** work to fulfil this mandate is more important than ever."*

Børge Brende
Minister of Foreign Affairs,
Government of Norway

UNICEF Strategic Plan 2014-17 Thematic Windows:



- **Respond** quickly and flexibly to changing circumstances, including sudden-onset emergencies, allowing the channelling of resources to programme areas where they are most needed.

Additional and complementary earmarked funds can then be used to bring solutions to scale in different contexts.

Of the US\$5,169 million of UNICEF's revenue in 2014, US\$3,843 million were other resources. Of these, US\$341 million constituted thematic contributions, marking a 5 per cent decrease from the US\$359 million received in 2013. This reflects a continuing decline in themat-

ic funding as a percentage of other resources, from an all-time high of 21 per cent in 2010 to an all-time low of just under 9 per cent in 2014 (see Figure 12).

Of the US\$69 million other resources to HIV and AIDS, 83 per cent were highly earmarked funds (see Figure 13).⁶⁰ The remainder were thematic contributions. Of the US\$12 million in thematic contributions, 71 per cent were given most flexibly at the global level. Less flexible funding continues to be a challenge for UNICEF, as resources and efforts shift to preparing project proposals and reporting for tighter earmarked contributions.

FIGURE 13

OTHER RESOURCES BY FUNDING MODALITY AND PARTNER GROUP, HIV AND AIDS, 2014: US\$69 MILLION

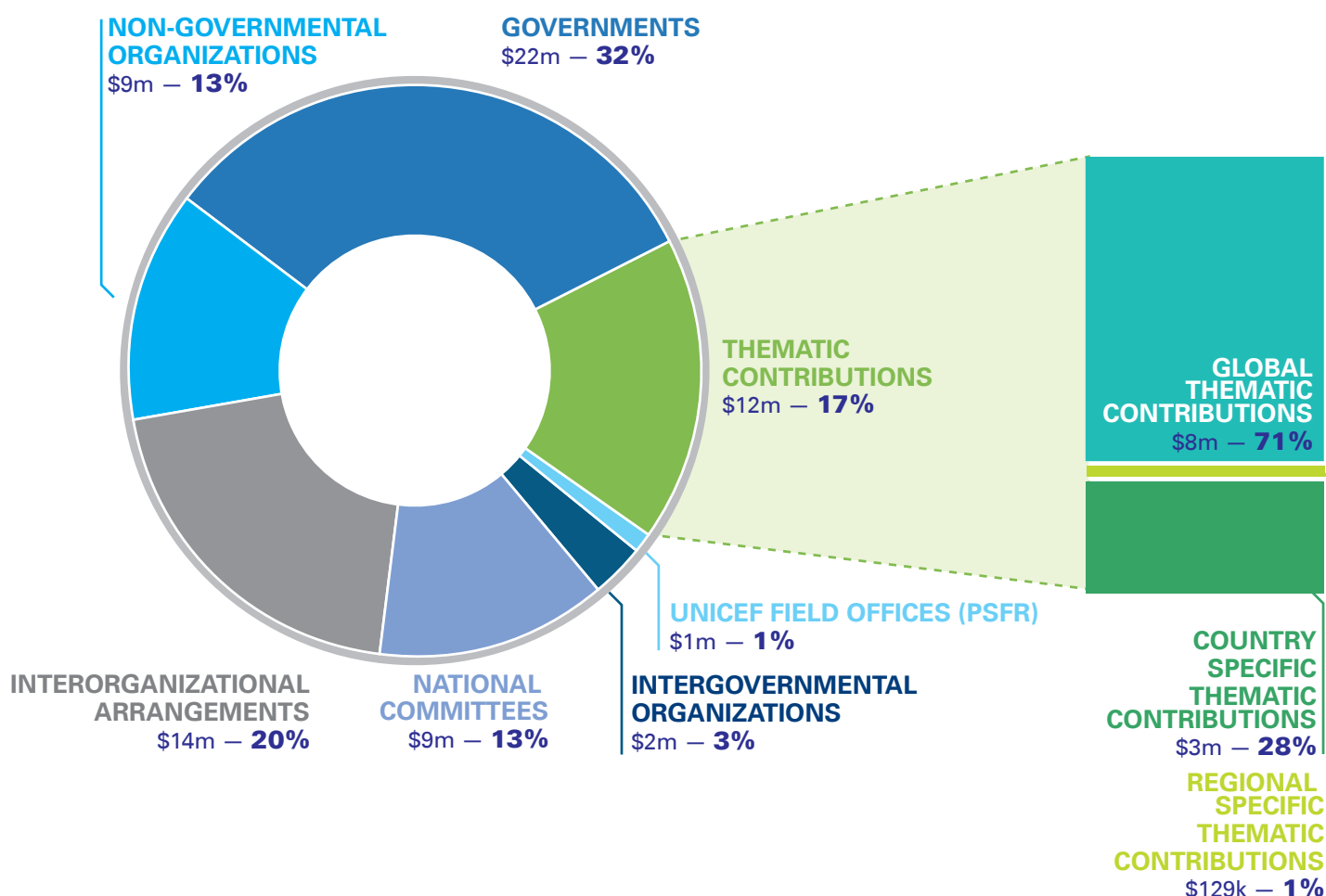
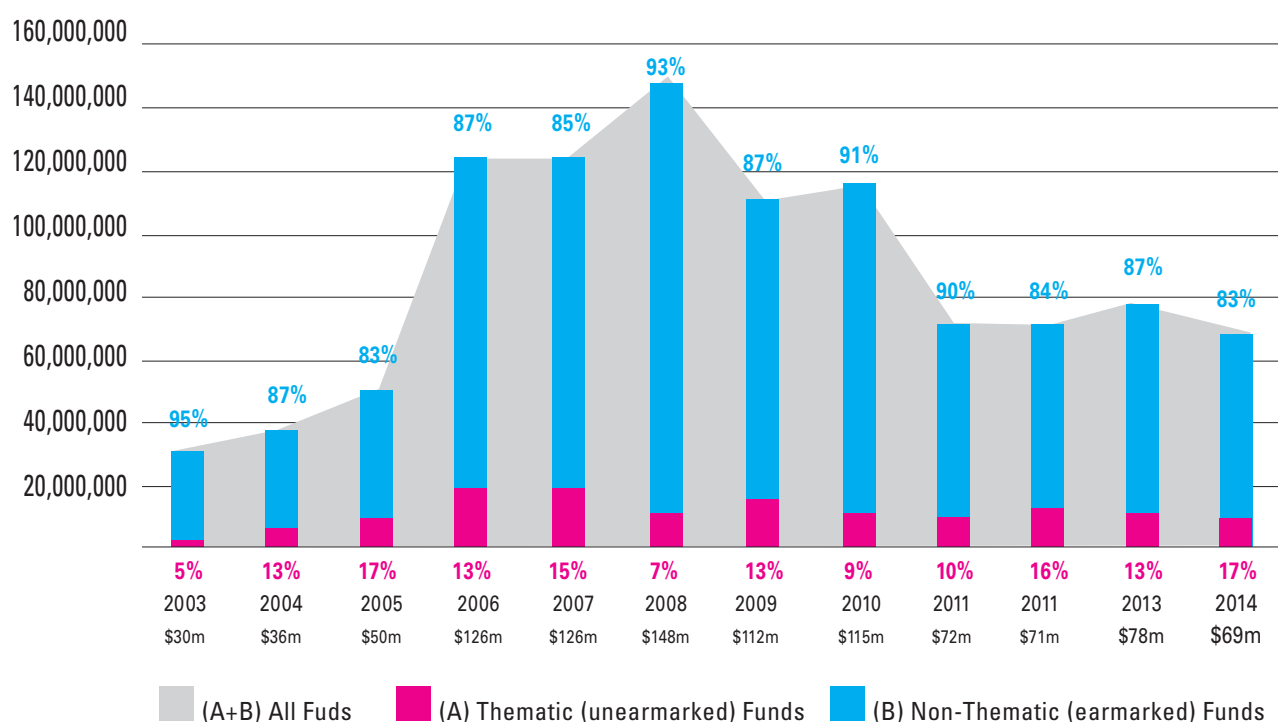


FIGURE 14

HIV AND AIDS OTHER RESOURCES FUNDING TRENDS, 2003–2014



**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.*

**Change in accounting policy to IPSAS on 1 January 2012 does not allow comparisons between 2012 figures and prior years.*

Overall support to the sector has declined since 2008, although thematic contributions increased by 13 per cent in 2014 (*see Figure 14*). While this slight upward trend in thematic funding is promising, to meet the accountabilities set out in the Strategic Plan 2014–2017, UNICEF will require approximately US\$185 million per year for HIV programming across the two decades from birth through age 19. This is based on a 2013 HIV costing exercise that informed the development of the Strategic Plan. In 2013, National Committees aimed to have annual resources for HIV increased to US\$45 million yearly by 2017. As previously mentioned in this report, UNICEF mandate's on HIV programming across the two decades from childhood into adulthood is clear.

To fulfil the international expectations of its obligations under the mandate, UNICEF needs funding levels to return to the feasible threshold of 2009. Restoration of funding for HIV will maximize the benefits of investments already made and ensure that the significant progress in eMTCT is sustained, and it will strengthen UNICEF's advocacy and programmatic push on paediatric treatment and HIV prevention, and treatment and care of adolescents 10–19 years old.

Eighty-six per cent of thematic contributions received for the sector in 2014 came from eight National Committees for UNICEF, and were utilized at the global and country levels: the Plurinational

State of Bolivia, Cameroon, Malawi, Myanmar, Namibia, South Sudan, Swaziland, Uganda and the United Republic of Tanzania. Governments provided 14 per cent of all thematic contributions to HIV and AIDS in 2014. Liechtenstein was the only contributor of thematic funding at the regional level, to CEE/CIS, while the Governments of Sweden and Belgium contributed thematically at the country level to Zimbabwe and Malawi, respectively. The Korean and Dutch Committees

for UNICEF continued to be the largest contributors of thematic funding for HIV and AIDS in 2014 (*see Table 1*).

UNICEF is seeking to broaden and diversify its funding base (including thematic contributions), and has gained two new National Committee partners to HIV and AIDS thematic funding since 2013, raising to 14 the overall number of contributors of thematic funding to the sector.

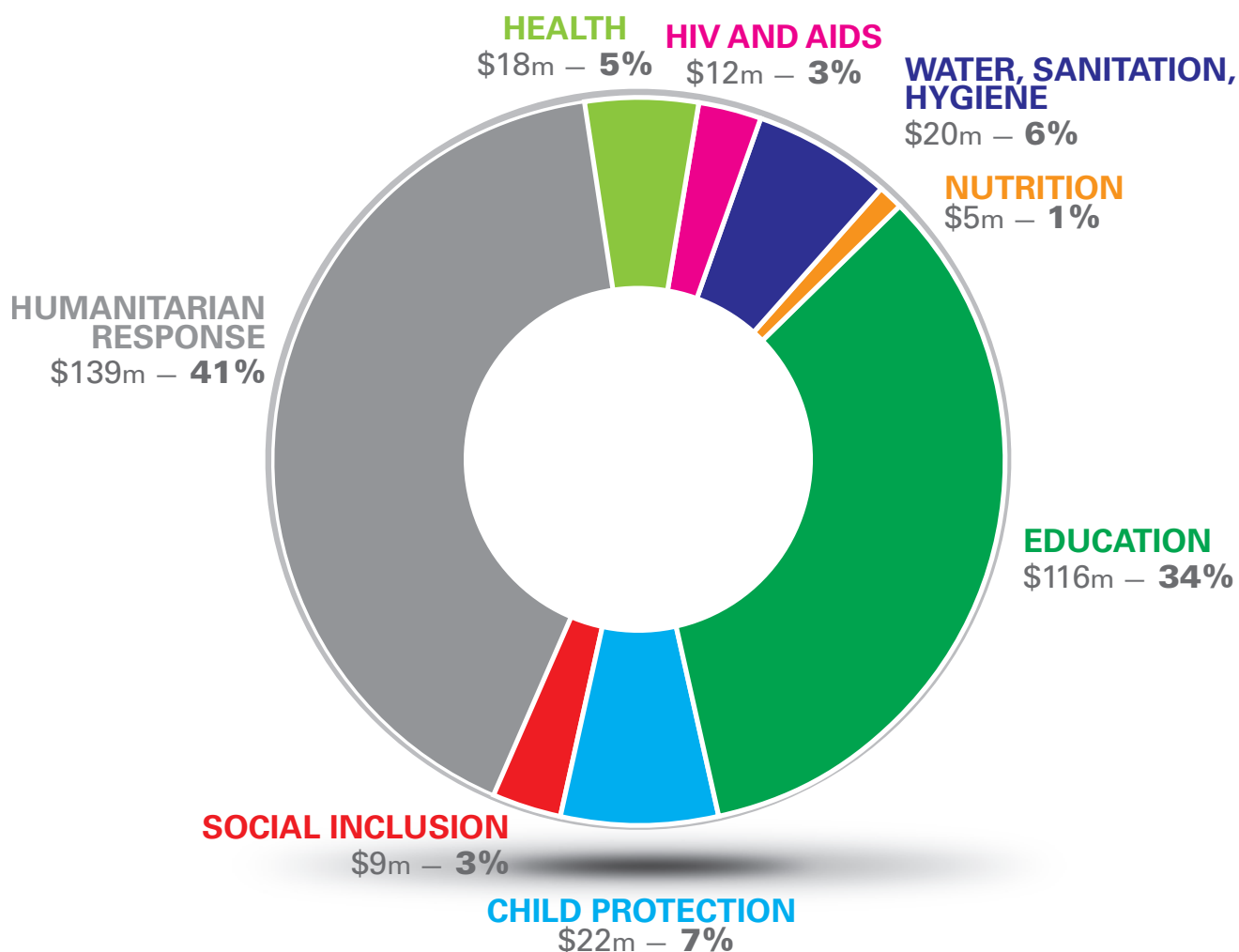
TABLE 1

THEMATIC CONTRIBUTIONS BY RESOURCE PARTNER TO HIV AND AIDS, 2014

Resource partner type	Resource partner	Amount (in US\$)	Percentage
Governments (14%)	Sweden	14 1,114,404	9.56%
	Flanders International Cooperation (Belgium)	343,879	2.95%
	Liechtenstein	128,999	1.11%
National Committees (86%)	Korean Committee for UNICEF	6,437,951	55.22%
	Dutch Committee for UNICEF	1,923,093	16.50%
	Hong Kong Committee for UNICEF	509,969	4.37%
	Finnish Committee for UNICEF	469,388	4.03%
	United States Fund for UNICEF	372,482	3.20%
	Danish Committee for UNICEF	164,957	1.41%
	Andorran Committee for UNICEF	92,937	0.80%
	Norwegian Committee for UNICEF	60,116	0.52%
	Japan Committee for UNICEF	34,971	0.30%
	Canadian UNICEF Committee	4,516	0.04%
	Australian Committee for UNICEF Limited	611	0.01%
Grand total		11,658,271	100.00%

FIGURE 15

**THEMATIC CONTRIBUTIONS TO STRATEGIC PLAN OUTCOME AND CROSS-CUTTING AREAS,
2014: US\$341 MILLION**



The decline in thematic funding pools overall, including having received no gender equality thematic contributions (*see Figure 15*), needs to be addressed to fulfil the shared commitment made by UNICEF partners to provide more flexible and pooled funding. In the Quadrennial Comprehensive Policy Review resolution, Member States called for enhanced cost-effectiveness, highlighting pooled funding modalities as a means of achieving this objective. Subsequently, the dialogue on financing

the Strategic Plan structured by the UNICEF Executive Board called for partners to enhance the flexibility and predictability of resources aligned to the organization's strategic mandate. Board Members further chose to highlight the importance of thematic funds as an important complement to regular resources for both development and humanitarian programming and the links between the two, in line with UNICEF's universal mandate and in support of country-specific priorities.

FINANCIAL IMPLEMENTATION

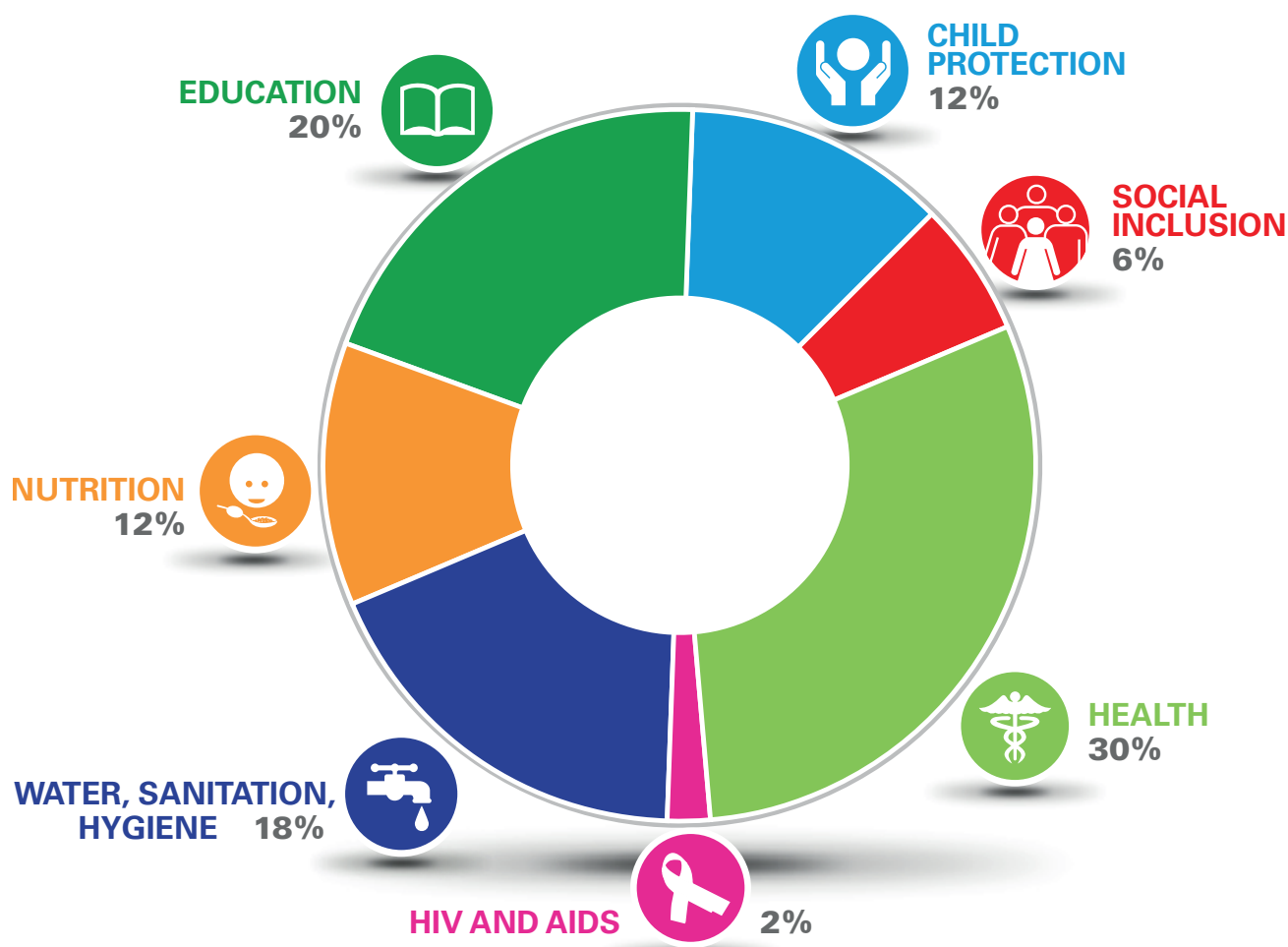
In 2014 UNICEF expenditure on HIV and AIDS amounted to US\$107 million or 3 per cent of the total UNICEF expenditure of US\$4.1 billion (*see Table 2 and Figure 16*). From a peak of US\$187 million in 2008, expenditures on HIV declined to US\$151 million in 2011. Since then, expenditure has plateaued. In 2014, total HIV expenditure was US\$107 million.

Expenses are higher than the income received, as while income reflects only earmarked donor contributions, to the specific outcome area in 2014, the expenses are against total allotments including regular resources and other resources (balances carried over from prior years) which are contributing to the same programme outcome area.

TABLE 2

TOTAL UNICEF EXPENDITURE BY STRATEGIC PLAN OUTCOME AREA AND FUNDING SOURCE, 2014

Outcome area	Other resources – (emergency)	Other resources – regular	Regular resources	Grand total	Expenditures (%)
Health	250,129,359	729,517,594	249,330,250	1,228,977,204	30%
HIV and AIDS	4,030,935	65,633,899	37,451,004	107,115,838	3%
WASH	349,811,171	276,212,322	101,344,461	727,367,953	18%
Nutrition	245,138,305	173,477,324	65,561,501	484,177,129	12%
Education	182,614,274	508,003,766	135,605,237	826,223,276	20%
Child Protection	150,462,660	218,019,161	145,870,856	514,352,677	12%
Social Inclusion	21,112,189	96,414,231	125,071,950	242,598,370	6%
Grand total	1,203,298,893	2,067,278,296	860,235,259	4,130,812,447	100%

FIGURE 16**UNICEF EXPENDITURE BY OUTCOME AREA, 2014****TABLE 3****EXPENDITURE BY FUNDING SOURCE FOR HIV AND AIDS, 2014**

Fund Category	Expenditure	Expenditure (%)
Other Resources - Emergency	4,030,935	4%
Other Resources - Regular	65,633,899	61%
Regular Resources	37,451,004	35%
Grand Total	107,115,838	100%

A comparison between 2013 and 2014 HIV and AIDS expenditures indicates an increase in expenditure of regular resources (RR) – up from US\$30.9 million to US\$37.4 million, which represents 4 per cent of total RR expenditure. During the same period, expenditures in other resources – regular (ORR) as well emergencies (ORE) decreased from US\$71.2 million to US\$65.6 million and from US\$9.7 million to US\$4 million ([see Figure 17](#)).

Sub-Saharan Africa remains the epicentre of the HIV epidemic, and the Eastern and Southern African region had the highest expenditures on HIV, US\$41 million, followed by West and Central African region, US\$29.9

million ([see Figure 18](#)). Among the regions with concentrated epidemics, South Asia spent US\$9.2 million, followed by Latin America and the Caribbean, US\$4.5 million. The Middle East and North African region has the lowest expenditure on HIV, US\$3.4 million. This expenditure trend is largely the same as in 2013.

In South Asia and West and Central Africa, RR accounts for 57 per cent and 53 per cent, respectively, of the total regional expenditure on HIV. ORR is the most important expenditure source in the CEE/CIS, HQ, Middle East and North Africa, and Eastern and Southern Africa, with 86 per cent, 75 per cent, 73 per cent and 71 per cent of the total regional/HQ expenditure ([see Table 4 and Figure 19](#)).

FIGURE 17

EXPENDITURE FOR HIV AND AIDS, BY FUNDING SOURCE, 2014

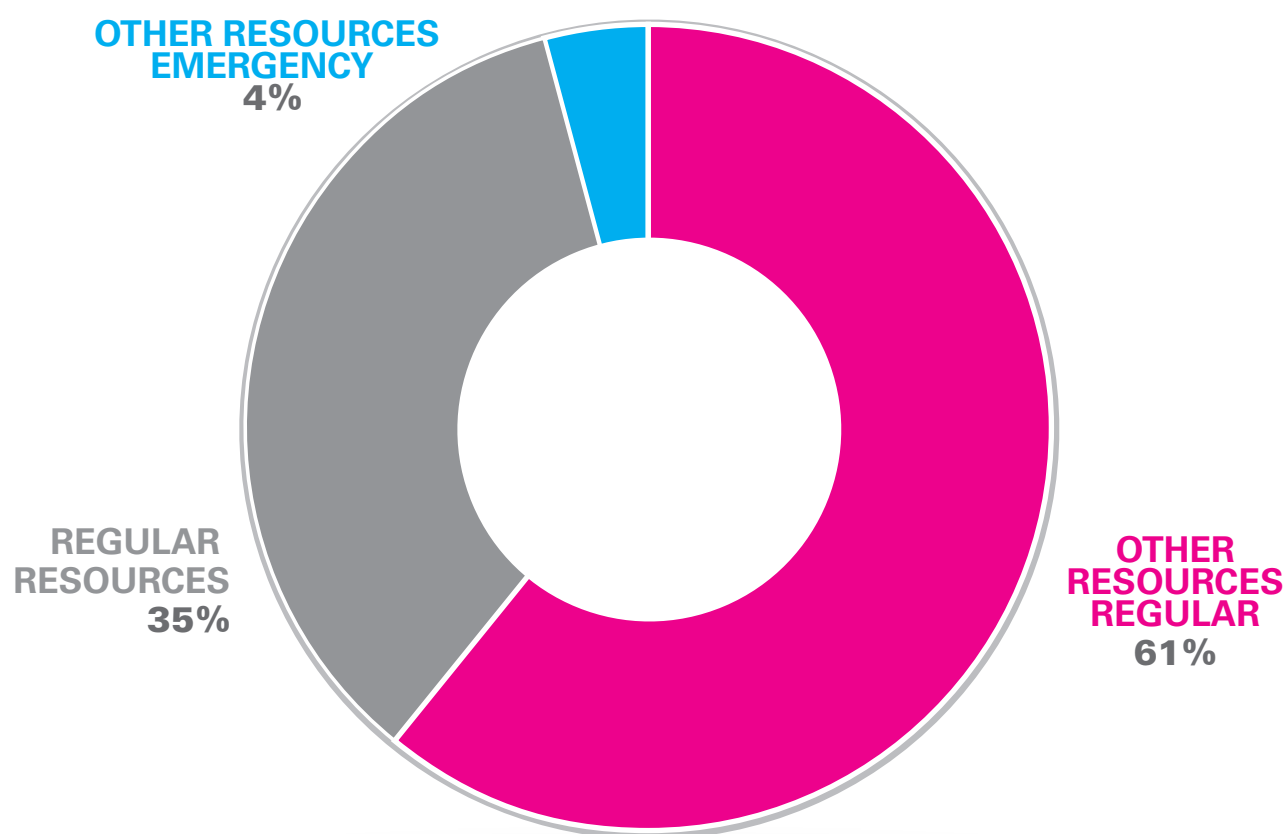
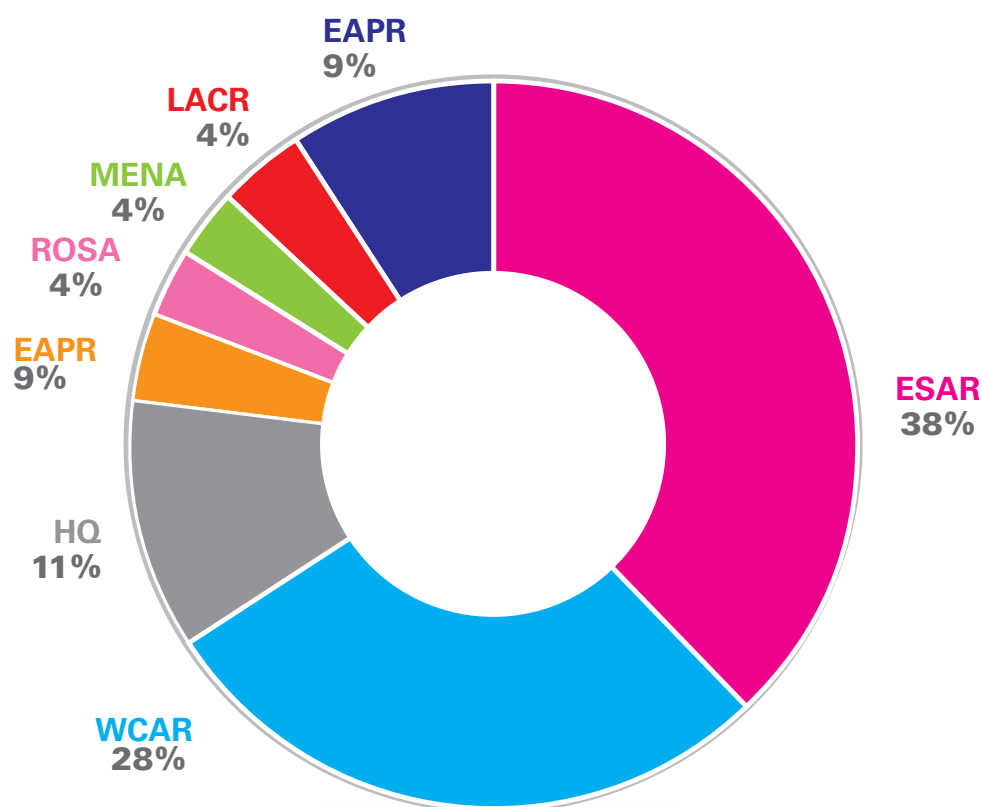
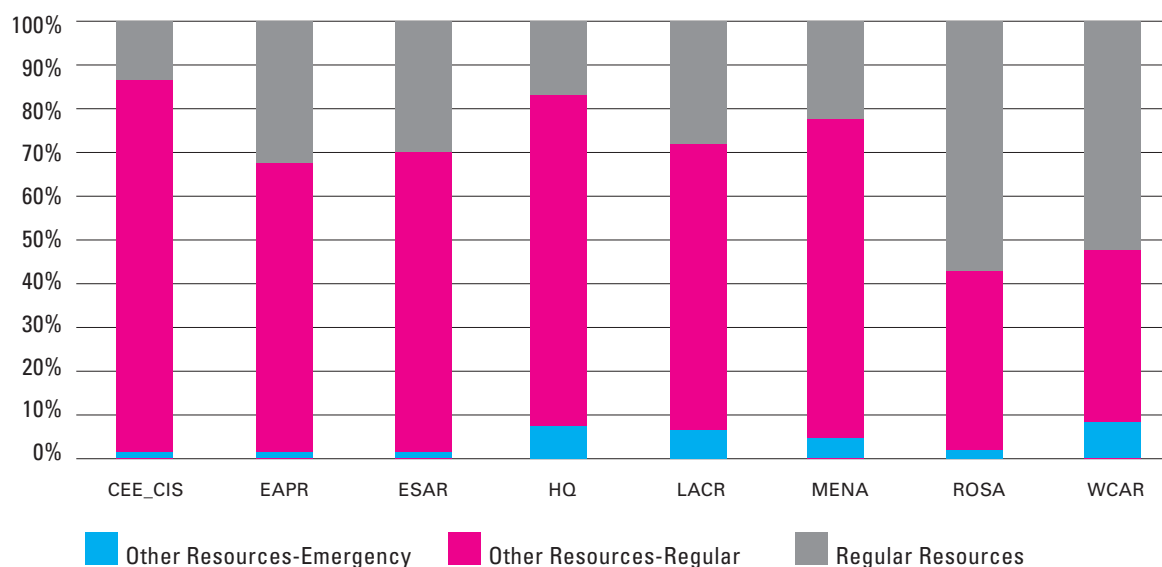


FIGURE 18**EXPENDITURE FOR HIV AND AIDS, BY REGION, 2014****TABLE 4****EXPENDITURE BY REGION AND FUNDING SOURCE FOR HIV AND AIDS, 2014**

Region	Other resources - emergency	Other resources - regular	Regular resources	Grand total
CEE_CIS	32,413	3,396,240	542,464	3,971,117
EAPR	22,806	6,225,100	3,044,953	9,292,860
ESAR	151,995	28,909,171	11,939,154	41,000,320
HQ	840,598	8,530,143	1,958,719	11,329,459
LACR	319,812	2,889,423	1,307,565	4,516,800
MENA	160,560	2,545,532	791,995	3,498,087
ROSA	75,068	1,470,245	2,046,049	3,591,363
WCAR	2,427,683	11,668,044	15,820,105	29,915,832
Grand Total	4,030,935	65,633,899	37,451,004	107,115,838

FIGURE 19**EXPENDITURE BY REGION FOR HIV AND AIDS, 2014**

Of the grand total ORR spent, thematic and non-thematic expenditure accounted for 16 per cent and 84 per cent, respectively (*see Table 5*). Focusing on the grand total of thematic expenditures, the highest thematic expenditures among the regions were in Eastern and Southern Africa and West and Central

Africa. The breakdown of the total ORR expenditures per region reveals that the highest thematic expense was in Latin America and the Caribbean and the Middle East and North Africa, at 28 per cent and 22 per cent, respectively.

TABLE 5**ORR EXPENDITURE BY THEMATIC AND NON-THEMATIC FOR HIV AND AIDS, 2014**

Region	Thematic	Non-thematic	Total ORR
CEE_CIS	468,605	2,927,635	3,396,240
EAPR	1,149,521	5,075,580	6,225,100
ESAR	4,486,102	24,423,069	28,909,171
HQ	1,505,263	7,024,880	8,530,143
LACR	805,002	2,084,420	2,889,423
MENA	567,909	1,977,623	2,545,532
ROSA	187,553	1,282,692	1,470,245
WCAR	1,285,050	10,382,994	11,668,044
Grand Total	10,455,005	55,178,894	65,633,899

The countries with the highest HIV expenditures in 2014 are Malawi (US\$8 million), Nigeria (US\$6 million) and Somalia (US\$6 million), followed by

Uganda (US\$5 million), the United Republic of Tanzania (US\$4 million) and Chad (US\$4 million) (*see Table 6 and table 7*).

TABLE 6

TOP 10 COUNTRY OFFICES BY TOTAL EXPENDITURE FOR HIV AND AIDS, 2014

Country Office	Expense US\$ million	Country Office	Expense US\$ million
Malawi - 2690	8	Chad - 0810	4
Nigeria - 3210	6	Republic of Cameroon - 0690	3
Somalia - 3920	6	Cote D'Ivoire - 2250	3
Uganda - 4380	5	WCARO, Senegal - 381R	3
United Rep. of Tanzania - 4550	4	Zambia - 4980	3

TABLE 7

TOP 10 COUNTRY OFFICES, BY TOTAL EXPENDITURE, EMERGENCY AND NON-EMERGENCY FUNDS FOR HIV AND AIDS, 2014

Non-Emergency Funds		Emergency Funds	
Country Office	Expense US\$ million	Country Office	Expense US\$ million
Malawi - 2690	8	Central African Republic - 0750	0.7
Somalia - 3920	6	WCARO, Senegal - 381R	0.7
Nigeria - 3210	6	Cote D'Ivoire - 2250	5.0
United Rep. of Tanzania - 4550	4	Haiti - 1830	3.0
Uganda - 4380	4	Uganda - 4380	0.3
Chad - 0810	4	Mauritania - 2820	2.0
Republic of Cameroon - 0690	3	MENA, Jordan - 234R	0.1
Zambia - 4980	3	Kenya - 2400	0.1
Cote D'Ivoire - 2250	3	Chad - 0810	1.0
Kenya - 2400	3	Malawi - 2690	0.1

Emergency funds = ORE

Non-emergency = ORR and RR (including EPF)

In regard to the breakdown of expenditures against programme areas in 2014, expenditures for the 'first decade' programme area amounted to 39 per cent of total expenditures, expenses for adolescents ('second decade') and 'protection, care and support' to-

talled 17 and 4 per cent, respectively. Forty per cent (general) of total expenditures included technical assistance across programme areas, procurement supply, management, planning and monitoring and evaluation (*see Figure 20 and Table 8*).

FIGURE 20

EXPENDITURE BY PROGRAMME AREAS FOR HIV AND AIDS, 2014

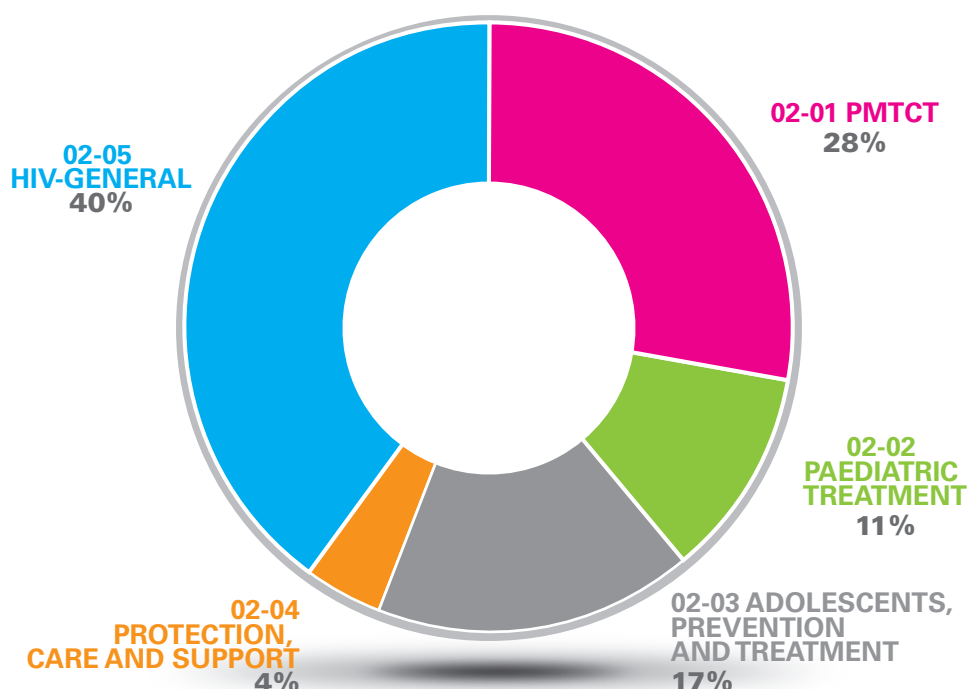


TABLE 8

EXPENDITURE BY PROGRAMME AREAS FOR HIV AND AIDS, 2014

Programme area	Other resources - emergency	Other resources - regular	Regular resources	Grand total	% to Total
02-01 PMTCT and infant male circumcision	1,120,868	16,722,861	12,606,858	30,450,588	28%
02-02 Care and Treatment of Children affected by HIV and AIDS	231,638	7,412,363	3,883,723	11,527,724	11%
02-03 Adolescents and HIV/AIDS	94,147	10,907,153	7,397,496	18,398,796	17%
02-04 Protect, care and support children & families affected by	200,759	2,845,279	1,080,631	4,126,669	4%
02-05 HIV - General	2,383,524	27,746,242	12,482,296	42,612,062	40%
Grand total	4,030,935	65,633,899	37,451,004	107,115,838	100%

FUTURE WORKPLAN

The right to access life-saving HIV prevention, treatment and care cannot be abrogated by age, poverty, gender inequality or social status. UNICEF and its partners' responses must ensure all children are born free of HIV and remain HIV-free for the first two decades of life, from birth through adolescence. This means that all children living with HIV have access to the treatment, care and support they need to remain alive and healthy. This is UNICEF's vision of an AIDS-free generation.

This shift towards an integrated programming approach across two decades of life is reflected in the Strategic Plan 2014–2017 and detailed in 'Vision and Direction for Action, 2014–2017: Achieving an AIDS-free generation'⁶¹ UNICEF's HIV programme is adopting a more integrated approach to programming, organized around the first and second decades of life and grounded in the principles of equity, gender equality and human rights.

Looking at the first decade, UNICEF recognizes gains, but also acknowledges achieving the 2015 Global Plan target of reducing the annual number of new HIV infections among children by 90 per cent will require accelerated efforts and an understanding of where to concentrate those efforts. Analyses of data to date suggest that to bring the number of new paediatric infections down to 40,000 by 2015 will require an average of 100,000 fewer cases per year, an 85 per cent reduction, in both 2014 and 2015. While some countries, such as Botswana and South Africa, are on their way to reaching their Global Plan targets, many are lagging significantly. More than 70 per cent of the global paediatric HIV burden is concentrated in eight high-burden countries: Cameroon, Kenya, Mozambique, Nigeria, South Africa, Uganda, the United Republic of Tanzania and Zambia. UNICEF will intensify support to these countries by specifically examining subnational disparities to uncover the highest burden areas and hidden inequities, and scale up efficient, high-quality HIV and MNCH health system interventions. For PMTCT, efforts will also focus on opportunities to integrate HIV treatment and care with broader maternal and child health interventions – seeking Double Dividends for mother and child. For women who test positive, UNICEF will strengthen community-led responses to retain women and their children in care. Headquarters and regional offices will support efforts for South-to-South learning to support countries to tailor policy and programming

to their specific needs and contexts – and document successes and challenges.

UNICEF's work on the second decade is accelerating. With the launch of ALL IN to #EndAdolescentAIDS in early 2015 there is now a platform for action and collaboration to inspire a social movement to drive better results for adolescents. The platform aims to unite actors across sectors to accelerate reductions in AIDS-related deaths and new HIV infections among adolescents by 2020, towards ending the AIDS epidemic for all by 2030. It is convened by a leadership group that includes UNAIDS, UNICEF, UNFPA, WHO and PEPFAR, as well as the Global Fund, the MTV Staying Alive Foundation and the adolescent and youth movement represented by the HIV Young Leaders Fund on behalf of the PACT and Y+. In the coming year, UNICEF will focus on providing leadership to mobilize partnerships to drive results in HIV among adolescents in 25 countries that account for the majority of AIDS-related deaths among adolescents. Efforts will focus on 1) engaging adolescents as agents of social change; 2) improving data use to strengthen adolescent components of national HIV programmes; 3) scaling up innovative programme approaches and technologies; and 4) advocating for increased donor and government attention to address inequities in the AIDS response that negatively affect adolescents.

As part of wider efforts to strengthen national social protection systems, UNICEF will work with national governments and development partners to expand HIV-sensitive social protection, economic support and family-based care to strengthen the resilience of children and families and promote sustained access to HIV prevention, treatment and care. Applying UNICEF's new vision for its HIV/AIDS programming to fragile and humanitarian situations will be especially important for ensuring that at-risk and emergency-affected populations are not excluded from programming in times of greatest need.

To advance UNICEF's HIV programme in the new Strategic Plan, UNICEF will utilize both the Monitoring Results for Equity System (MoRES) framework for supporting countries with data-driven planning and monitoring and the tools of the UNAIDS Investment Approach. The HIV programme will continue to lead on gathering evidence for integration and promoting 'double dividends' for mothers and their

infants, not only preventing illness and death from HIV, but promoting access to essential health and social protection services that prolong their lives – and improve well-being.

At the country level, all UNICEF offices are accountable for knowing their national and subnational HIV epidemics and shaping their response for women and children, including adolescents, accordingly. This includes ensuring that HIV programming for both decades of childhood is well integrated into national health, education and protection strategies, UNICEF's country programme documents as well as other Unit-

ed Nations and key partners' strategic planning documents. Regional offices and Headquarters will support this process by providing the technical support, guidance, advocacy, resource mobilization and partnership building necessary to leverage action.

UNICEF's new HIV and AIDS vision and direction for action will be realized through application of the UNICEF Strategic Plan 2014–2017. This includes applying the normative principles of gender equality and human rights as core elements of equity, and driving forward six key implementation strategies (*see Figure 21*).

FIGURE 21

KEY STRATEGIES FOR BETTER RESULTS



STRATEGY 1: MONITORING RESULTS FOR EQUITY

Monitor results for equity with a focus on assessing and responding to disparities in access, coverage and quality of high impact HIV interventions especially for socially excluded populations.



STRATEGY 2: INTEGRATION AND SERVICE DELIVERY AT decentralised LEVELS

Build capacities at the national and subnational levels to integrate HIV and other health, education, and child and social protection services, and implement decentralised management and service delivery.



STRATEGY 3: INNOVATION FOR SIMPLIFIED AND OPTIMIZED SERVICE DELIVERY

Accelerate results through technological and programmatic innovations that simplify approaches to increase coverage, access, and quality of high impact treatment and prevention interventions.



STRATEGY 4: STRATEGIC PARTNERSHIPS AND COMMUNITY ENGAGEMENT

Build effective partnerships to leverage resources and action and strive for participation of communities in programmatic design, service delivery, demand creation, and monitoring and evaluation.



STRATEGY 5: EVIDENCE UTILIZATION AND PROMOTION OF SOUTH-TO-SOUTH COOPERATION

Support the generation, dissemination and utilization of knowledge by staff and partners, positioning UNICEF and Southern partners as knowledge leaders on children and AIDS.



STRATEGY 6: POLICY DIALOGUE, ADVOCACY AND COMMUNICATION

Enhance programming and policy results for children through strategic communication and effective advocacy efforts.

Application and implementation of these six strategies and the UNAIDS Investment Approach will vary by region and country, epidemic typology, national plans and priorities, national situational analyses, UNICEF's comparative advantage vis-a-vis its partners, and the availability of financial and human resources.

EXPRESSION OF THANKS

UNICEF expresses its deep appreciation to all resource partners who contributed to our work on HIV and AIDS throughout the 2014 funding window. It is because of thematic funding that UNICEF has been able to provide technical, operational and programming support to countries in all regions for both upstream and decentralized work that helps to deliver quality services to marginalized children and communities. Thematic funding provides greater flexibility, longer-term planning and

sustainability of programmes. It reflects the trust 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. Special thanks are given to the Government of the Sweden and the UNICEF National Committees for providing consistent and generous support, especially the Korean Committee for UNICEF, the Dutch Committee for UNICEF and the Hong Kong Committee for UNICEF.

ABBREVIATIONS AND ACRONYMS

AIDS	acquired immune deficiency syndrome	PASADA	Pastoral Activities and Services for people with AIDS Dar es Salaam Archdiocese
ALHIV	adolescents living with HIV	PEPFAR	United States President's Emergency Plan for AIDS Relief
ART	antiretroviral therapy	PMTCT	prevention of mother-to-child transmission (of HIV)
ARV	antiretroviral	PPTCT	prevention of parent-to-child transmission (of HIV)
CABA	children affected by AIDS	RDS	respondent driven sampling
CEE/CIS	Central and Eastern Europe and the Commonwealth of Independent States	RMNCAH	reproductive, maternal, newborn, child and adolescent health
CSE	comprehensive sexuality education	ROSA	Regional Office for South Asia (UNICEF)
DBS	dried blood spot	STD	sexually transmitted disease
EID	early infant diagnosis	STI	sexually transmitted infection
eMTCT	elimination of mother-to-child transmission (of HIV)	SUMASEAU	Support Makete Self-Support
ESARO	Eastern and Southern Africa Regional Office (UNICEF)	UNAIDS	Joint United Nations Programme on HIV/AIDS
FSJ	Fique Sabendo Jovem	UNESCO	United Nations Educational, Scientific and Cultural Organization
GDP	gross domestic product	UNFPA	United Nations Population Fund
HIV	human immunodeficiency virus	UNITAID	International Drug Purchase Facility
IATT	Inter-Agency Task Team (United Nations)	USAID	United States Agency for International Development
JURTA	Joint United Nations Regional Team on AIDS	VMMC	voluntary male medical circumcision
LACR	Latin America and the Caribbean Regional Office (UNICEF)	WCARO	West and Central Africa Regional Office (UNICEF)
MCH	maternal and child health	WHO	World Health Organization
MIS	management and information systems		
MNCH	maternal, newborn and child health		
MoRES	Monitoring Results for Equity System		
NGO	non-governmental organization		

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Impact and Outcome Indicators

Indicators	Baseline	2017 Target	2014 update or data from most recent year
2a. Number of new HIV infections among children under 15 years (2012 United Nations General Assembly Political Declaration on HIV/AIDS)	270,000 ^{††} children (2012)	40,000 (2015)	240,000 (2013)
2b. Percentage of children under 15 years living with HIV receiving antiretroviral therapy ‡	19% (2012)	90% by 2015	23% (2013)
P2.1 Countries with at least 80% coverage of antiretroviral treatment (ART) among all children aged 0–14 years and adolescent girls and boys aged 10–19 years living with HIV ‡	0–14 years old: 4 (2012) 10–19 years old: data not available (2012)	38 UNAIDS priority countries	0–14 years old: 3 out of 38 UNAIDS priority countries (2013) 10–19 years old: data not available (2013)
P2.2 Countries providing at least 80% coverage lifelong ART for all pregnant women living with HIV ‡	0 (2012)	22 Global Plan for EMTCT priority countries	0 out of 22 Global Plan for EMTCT priority countries (2013)
P2.3 Countries where at least 50% of the overall HIV and AIDS budget is funded through domestic resources	61 (2012)	144 ¹	18 out of 44 countries with data (2013)
P2.4 Countries with at least a 60% coverage in condom use at last sexual encounter among adolescents aged 15–19 years reporting multiple partners in last year	Males: 10 out of 14 Females: 1 of 13	38 UNAIDS priority countries	Male: 9 out of 20 UNAIDS priority countries with data (2006–2013) Female: 1 out of 17 UNAIDS priority countries with data (2006–2013)

¹ The target is 100 out of the 144 low- and middle-income countries (according to the World Bank income classification as of July 2012).

Output Indicators

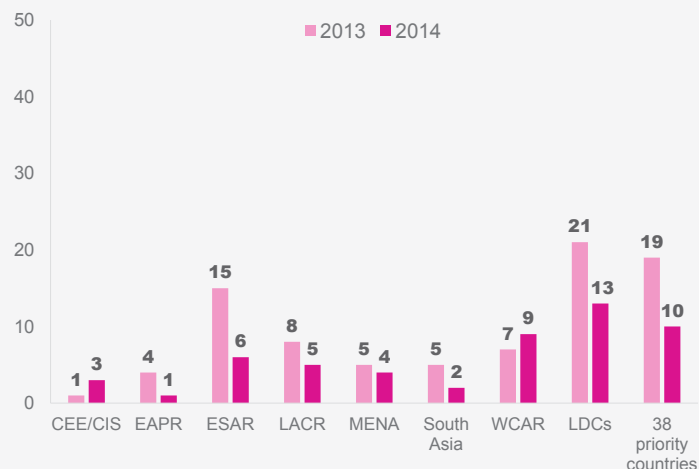
P2.a.1

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

Baseline 19 2014 update 10

2017 Target 38

Source: UNICEF country offices, 2014.



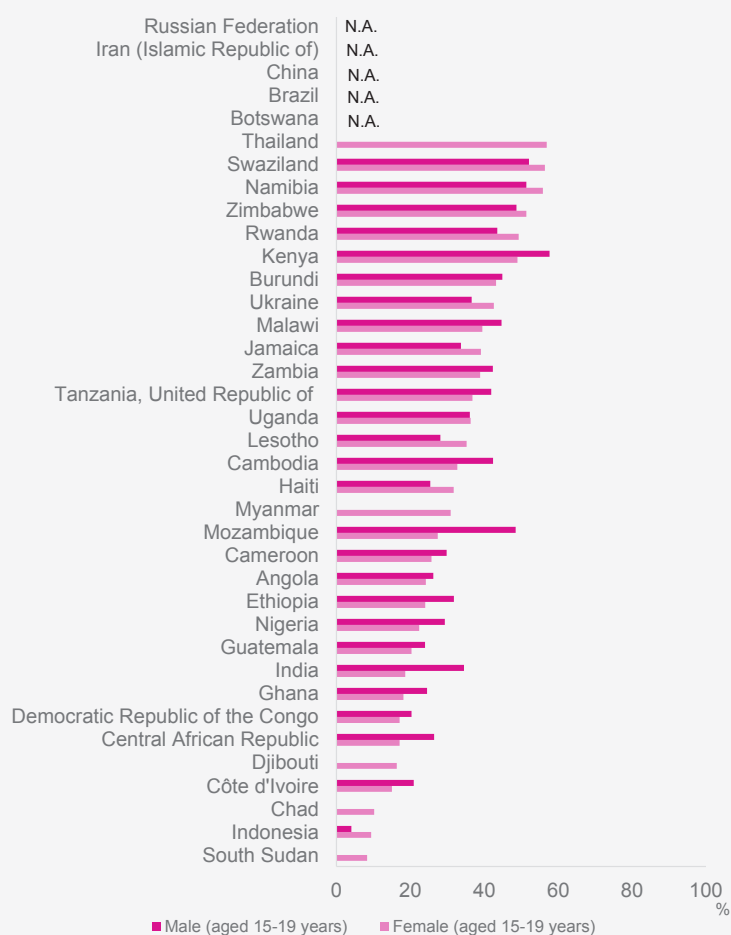
P2.a.2

Countries with at least 80% of adolescents aged 10–19 years have comprehensive knowledge about HIV and AIDS ‡

Reported as percentage of adolescents (aged 15–19 years) who have comprehensive knowledge about HIV and AIDS, 38 UNAIDS priority countries (2005–2014) »»

Baseline 0

2017 Target 38



P2.b.1

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

Baseline 0

2017 Target 16

Source: UNICEF global databases, 2015.

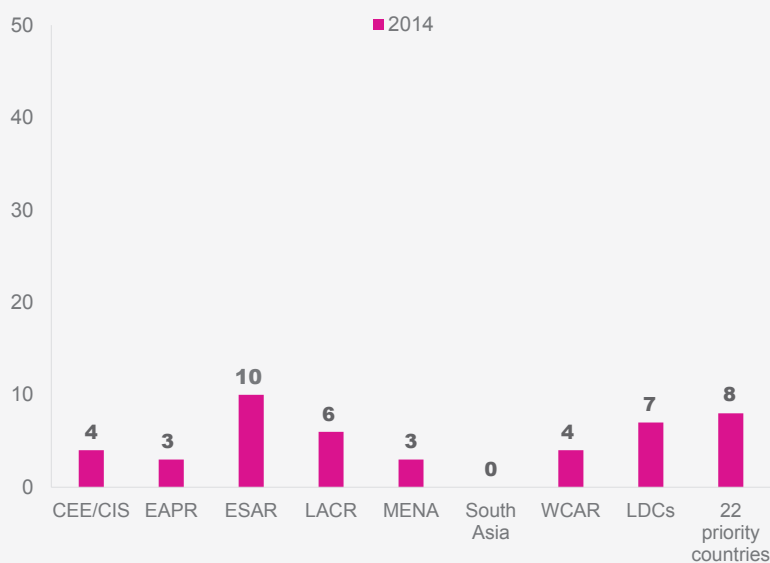
16 priority countries	Year	Males (aged 15–19 years)	Males (aged 20–24 years)	Males (aged 15–24 years)
Ethiopia	2011	87.6	91.1	89.1
Kenya	2008–2009	75.5	89.4	81.7
Tanzania, United Republic of	2011–2012	66.2	75.5	70.2
Mozambique	2011	36.2	44.0	39.5
South Africa	2012	33.3	46.9	39.7
Lesotho	2009	26.8	62.2	42.1
Uganda	2011	23.4	30.7	26.3
Zambia	2013–2014	22.7	27.6	24.7
Malawi	2010	21.7	22.2	21.9
Namibia	2013	21.0	22.8	21.8
Zimbabwe	2014	15.3	9.4	13.1
Rwanda	2010	10.0	16.1	12.7
Botswana	2008	5.7	10.4	8.0
Central African Republic	–	–	–	–
South Sudan	–	–	–	–
Swaziland	2010	–	–	18.2

P2.b.2

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

Baseline † 9 **2014 update** 8
(out of 22 Global Plan priority countries)

2017 Target 22

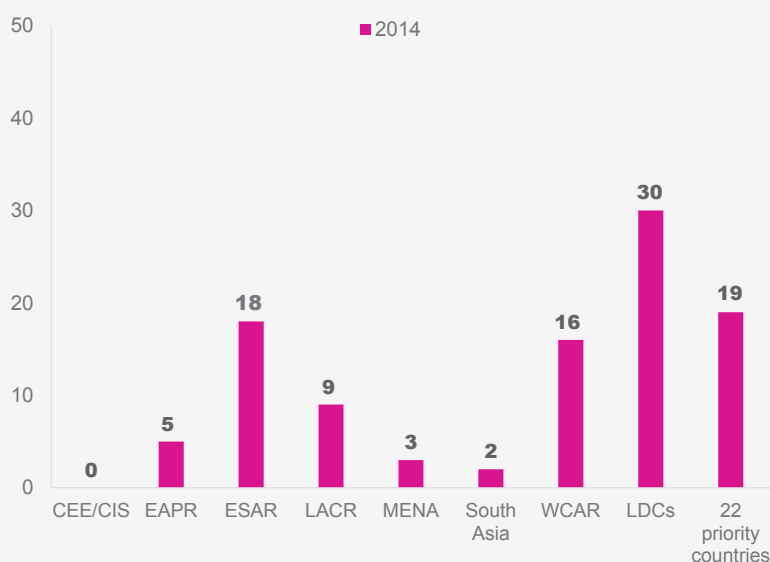


P2.b.3

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

Baseline † 10 **2014 update** 19 (out of 22 Global Plan priority countries)

2017 Target 22



Source: UNICEF country offices, 2014.

SPPL

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

2014 20

Note: Among 38 UNAIDS priority countries, only UNICEF programme countries are shown.

38 UNAIDS priority countries*

At least 50% of facilities in UNICEF targeted areas offering provider-initiated testing and counselling		Less than 50% of facilities in UNICEF targeted areas offering provider-initiated testing and counselling	Data not available or not applicable
CEE/CIS Ukraine	LACR Guatemala Haiti Jamaica	EAPR Indonesia	EAPR China Myanmar Thailand
EAPR Cambodia	WCAR Central African Republic Cote d'Ivoire Democratic Republic of Congo Ghana	ESAR Angola South Sudan Zambia	LACR Brazil
ESAR Botswana Burundi Ethiopia Kenya Lesotho Malawi Rwanda South Africa Swaziland Uganda Zimbabwe		MENA Djibouti Iran (Islamic Republic of)	South Asia India
		WCAR Cameroon Chad	ESAR Mozambique Namibia Tanzania, United Republic of Nigeria

SPPL

Countries that have adopted the 2013 WHO HIV treatment guidelines for children and adolescents

2014 30

Note: Among 38 UNAIDS priority countries, only UNICEF programme countries are shown.

38 UNAIDS priority countries*

2013 WHO HIV treatment guidelines for children and adolescents has adopted		2013 WHO HIV treatment guidelines for children and adolescents has NOT adopted	
CEE/CIS Ukraine	South Africa South Sudan Swaziland	South Asia India	EAPR China Indonesia
EAPR Cambodia Myanmar Thailand	Tanzania, United Republic of Uganda Zambia Zimbabwe	WCAR Cameroon Central African Republic Chad Democratic Republic of Congo Ghana Nigeria	ESAR Angola
ESAR Botswana Burundi Ethiopia Kenya Lesotho Malawi Mozambique Namibia Rwanda	LACR Guatemala Haiti		LACR Brazil Jamaica
	MENA Iran (Islamic Republic of)		MENA Djibouti
			WCAR Cote d'Ivoire

SPPL

Number of countries where 80% of health facilities are providing paediatric ART

2014 9

Note: Among 38 UNAIDS priority countries, only UNICEF programme countries are shown.

Source: UNICEF country offices, 2014.

38 UNAIDS priority countries*

At least 80% of health facilities providing paediatric ART	Less than 80% of health facilities providing paediatric ART		Data not available or not applicable
CEE/CIS Ukraine	EAPR Cambodia Indonesia Myanmar Thailand	LACR Brazil Guatemala Haiti Jamaica	EAPR China
ESAR Botswana Kenya Malawi Rwanda South Africa Swaziland Zimbabwe	ESAR Angola Burundi Lesotho Mozambique Namibia Tanzania, United Republic of Uganda Zambia	MENA Djibouti Iran (Islamic Republic of)	ESAR Ethiopia Nigeria South Sudan
WCAR Democratic Republic of Congo		South Asia India	
		WCAR Cameroon Central African Republic Chad Cote d'Ivoire Ghana	

P2.c.1

Countries reporting age- and sex-disaggregated data on HIV testing and counselling among adolescents 10–19 years and by sex ‡

Baseline
Females 23
Males 18

2014 update
Females 26
Males 24

2017 Target 38

Note: Among 38 UNAIDS priority countries, 26 countries with data for this period are shown.

Source: UNICEF global databases, 2015.

38 UNAIDS priority countries*

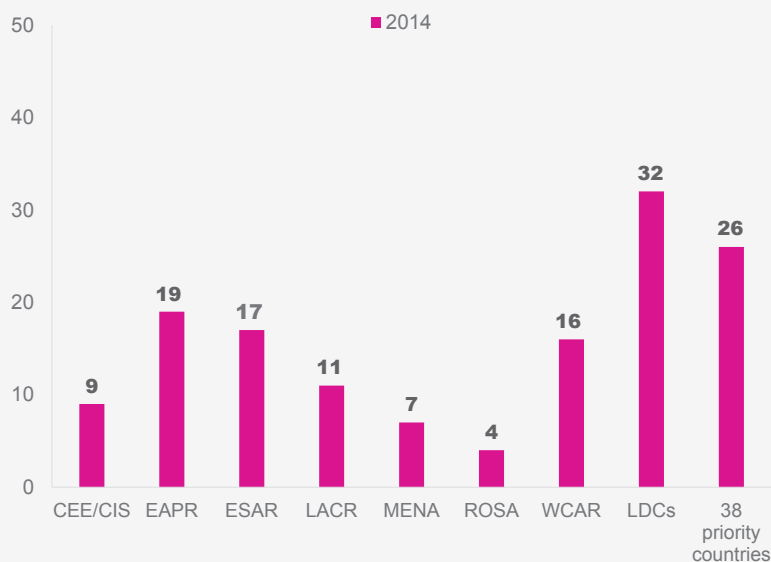
Data for both male and female available (2006–2014)		Data for either male or female available (2006–2014)	Sex-disaggregated data not available in this period
CEE/CIS Ukraine	LACR Haiti Jamaica	EAPR Thailand (female)	CEE/CIS Russian Federation
EAPR Cambodia	South Asia India	WCAR Chad (female)	EAPR China Indonesia Myanmar
ESAR Burundi Ethiopia Kenya Lesotho Malawi Mozambique Namibia Rwanda Swaziland Tanzania, United Republic of Uganda Zambia Zimbabwe	WCAR Cameroon Central African Republic Côte d'Ivoire Democratic Republic of the Congo Ghana Nigeria		ESAR Angola Botswana South Africa South Sudan
			LACR Brazil Guatemala
			MENA Djibouti Iran (Islamic Republic of)

P2.c.2

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

Baseline † / 2014 update 26

2017 Target 38



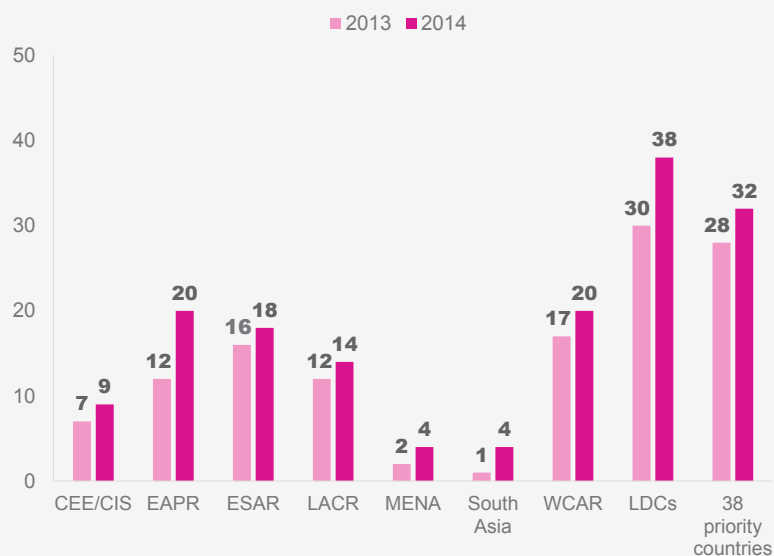
Source: UNICEF country offices, 2014.

P2.c.3

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

Baseline † 28 2014 update 32

2017 Target 38

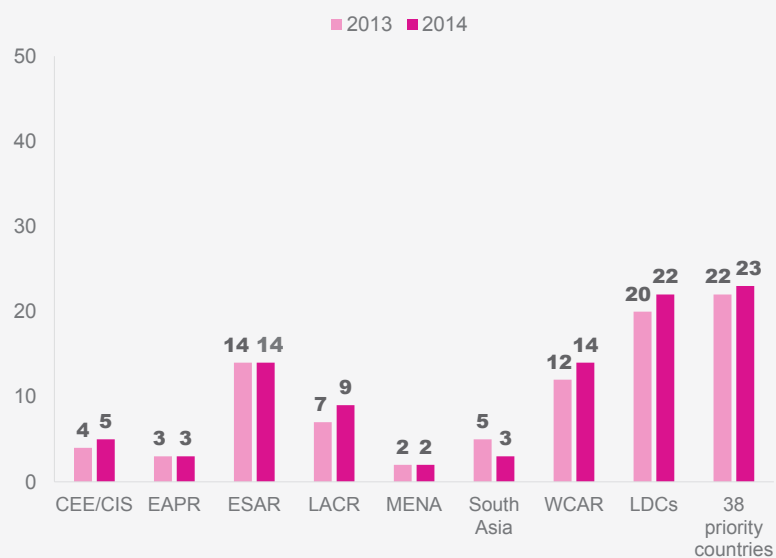


P2.c.4

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

Baseline † 22 2014 update 23

2017 Target 38

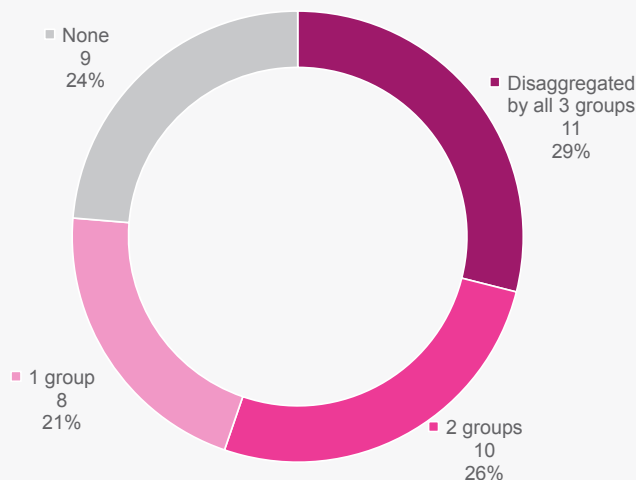
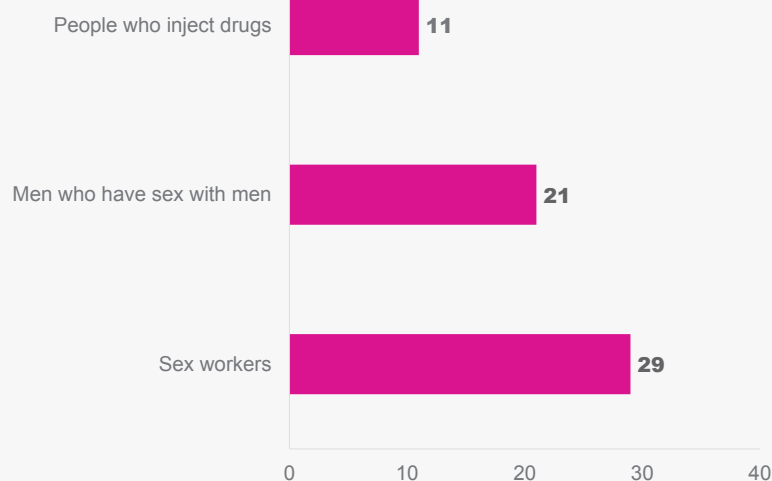


Source: UNICEF country offices, 2014.

SPPL

Countries reporting disaggregated data on HIV testing and counseling among adolescent key populations (boys who have sex with other males, those who inject drugs, and those sexually exploited)

2014 11



Note: Data on 38 UNAIDS priority countries are shown.

Source: UNICEF global databases, 2015.

SPPL

Countries in which at least 50% of antenatal care facilities in targeted areas have community accountability mechanisms involving women and men living with HIV

2014 6

38 UNAIDS priority countries*			
At least 50% of antenatal care facilities in UNICEF-targeted areas have community accountability mechanisms involving women and men living with HIV	Less than 50% of antenatal care facilities in UNICEF-targeted areas have community accountability mechanisms involving women and men living with HIV	Data not available or not applicable	
ESAR Burundi Namibia South Africa Zambia Zimbabwe WCAR Chad	CEE/CIS Ukraine EAPR Myanmar ESAR Angola Lesotho South Sudan Tanzania, United Republic of Uganda LACR Haiti Jamaica MENA Iran (Islamic Republic of) WCAR Cameroon Central African Republic Cote d'Ivoire Ghana	EAPR Cambodia China Indonesia Thailand ESAR Botswana Ethiopia Kenya Malawi Mozambique Rwanda Swaziland LACR Brazil Guatemala MENA Djibouti South Asia India WCAR Democratic Republic of Congo Nigeria	

Note: Among 38 UNAIDS priority countries, only UNICEF programme countries are shown.

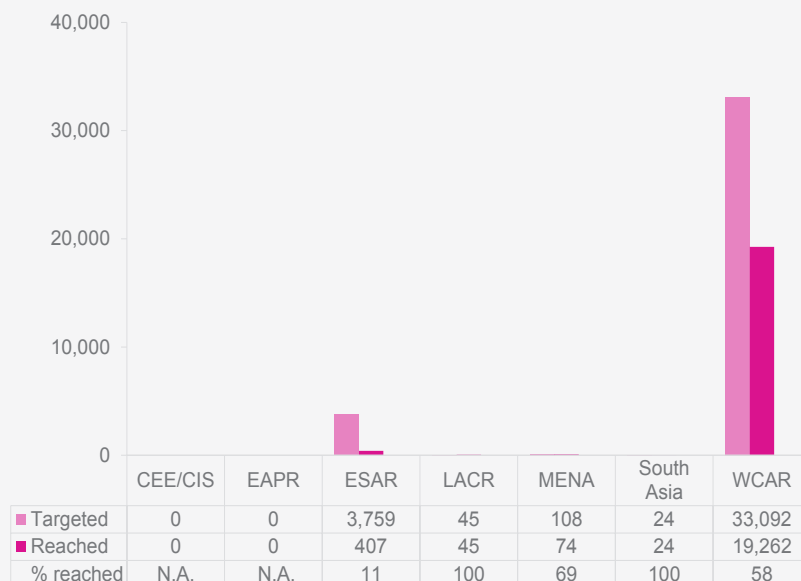
Source: UNICEF country offices, 2014.

P2.d.1

Number and percentage of 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

Baseline NA **2014 update**
19,812 for continuing

2017 Target 80% (53.5%)

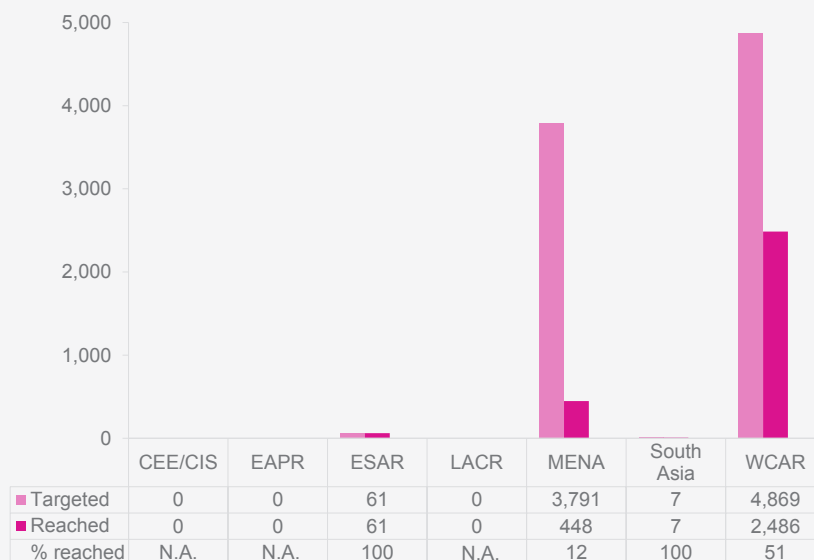


P2.d.2

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

Baseline NA **2014 update**
3,002 for continuing

2017 Target 80% (34.4%)



Source: UNICEF country offices, 2014.

P2.e.1

Countries with national household survey based data on HIV disaggregated by age and sex collected within the preceding 5 years

Baseline 18 **2014 update** 16

2017 Target 38

38 UNAIDS priority countries*	
Age- and sex-disaggregated data on HIV prevalence available from national household survey (2010–2014)	Age- and sex-disaggregated data on HIV prevalence not available from national household survey (2010–2014)
ESAR Burundi Ethiopia Kenya Malawi Namibia Rwanda South Africa Tanzania, United Republic of Uganda Zambia Zimbabwe LACR Haiti WCAR Cameroon Central African Republic Cote d'Ivoire Democratic Republic of Congo	CEE/CIS Russian Federation Ukraine EAPR Cambodia China Indonesia Myanmar Thailand ESAR Angola Botswana Lesotho Mozambique South Sudan Swaziland LACR Brazil Guatemala Jamaica MENA Djibouti Iran (Islamic Republic of) South Asia India WCAR Chad Ghana Nigeria

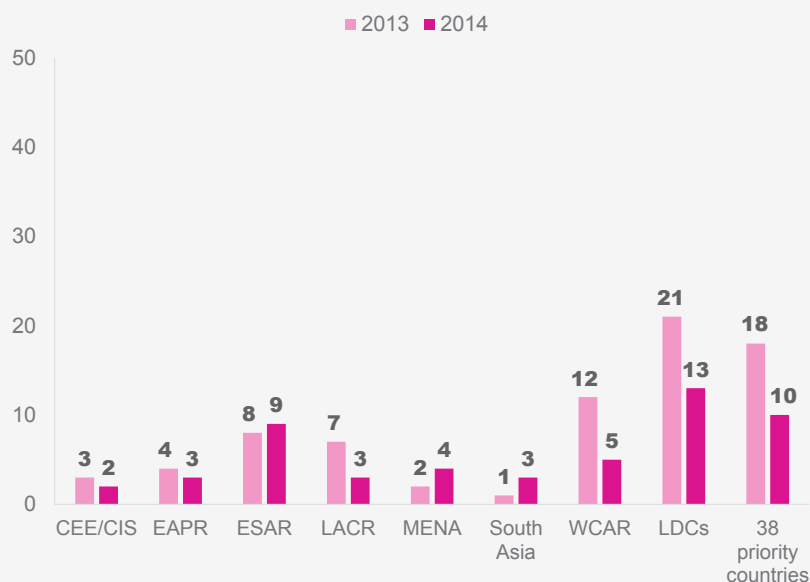
Source: UNICEF global databases, 2015.

P2.e.2

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

Baseline † 18 **2014 update** 10

2017 Target 38



Source: UNICEF country offices, 2014.

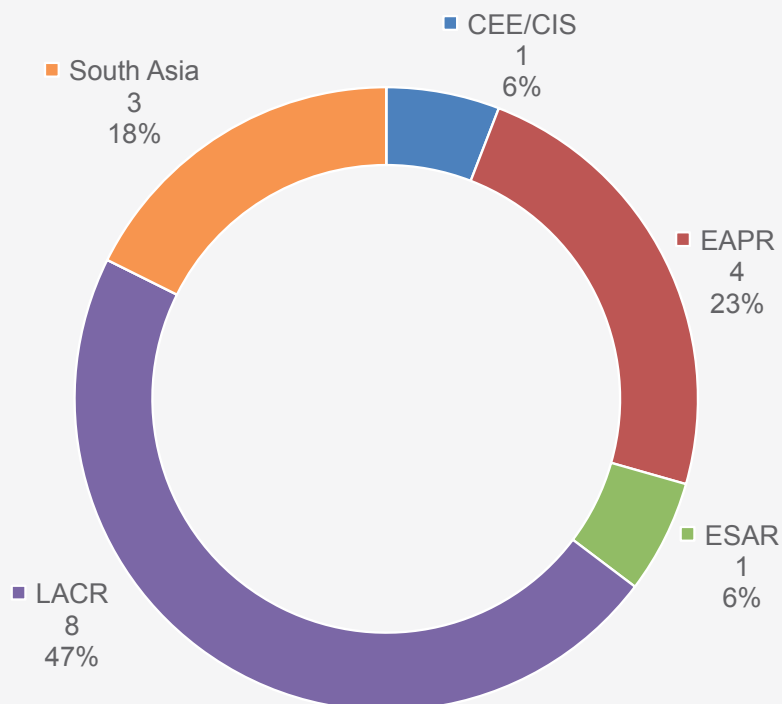
P2.f.1

Number of peer reviewed journal or research publications by UNICEF on HIV and AIDS

Baseline † / 2014 update 17

2017 Target 20

Note: Data reflect number of papers that UNICEF country offices have authored or co-authored in peer-reviewed journal in 2014.



P2.f.2

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

Baseline 6 2014 update 6

2017 Target 6

Global Initiatives

- ALL IN Ending the AIDS epidemic in adolescents
- Double Dividend – action to improve survival of HIV exposed children in the era of EMTCT and renewed child survival campaigns
- Global Partners' Forum on children affected by AIDS
- Global Plan Towards the Elimination of New HIV Infections Among Children by 2015 and Keeping Their Mothers Alive
- IATT Young people
- Social Protection, Care and Support Working Group

Source: UNICEF country offices, 2014.



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