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

Annual Results Report 2015

HIV AND AIDS

UNICEF's Strategic Plan 2014–2017 guides the organization's work in support of the realization of the rights of every child, especially the most disadvantaged. At the core of the Strategic Plan, UNICEF's equity strategy – emphasizing the most disadvantaged and excluded children, caregivers and families – translates UNICEF's commitment to children's rights into action. What follows is a report summarizing how UNICEF and its partners contributed to HIV and AIDS in 2015 and the impact of these accomplishments on the lives of children, caregivers and families.

This report is one of nine on the results of UNICEF's efforts this past year, one on each of the seven outcome areas of the Strategic Plan, one on gender and one on humanitarian action. It is an annex to the 'Report on the midterm review of the Strategic Plan, 2014–2017 and annual report of the Executive Director, 2015', UNICEF's official accountability document for the past year. An additional results report on the UNICEF Gender Action Plan 2014–2017 has also been prepared as an official UNICEF Executive Board document.

Martha Jere was born with HIV in 1996 in Malawi. At the time, an HIV diagnosis was practically a death sentence, especially for children in low-income countries. Now 19 years old and a mother herself, Martha has defied the odds, and her son is part of Malawi's AIDS-free generation.

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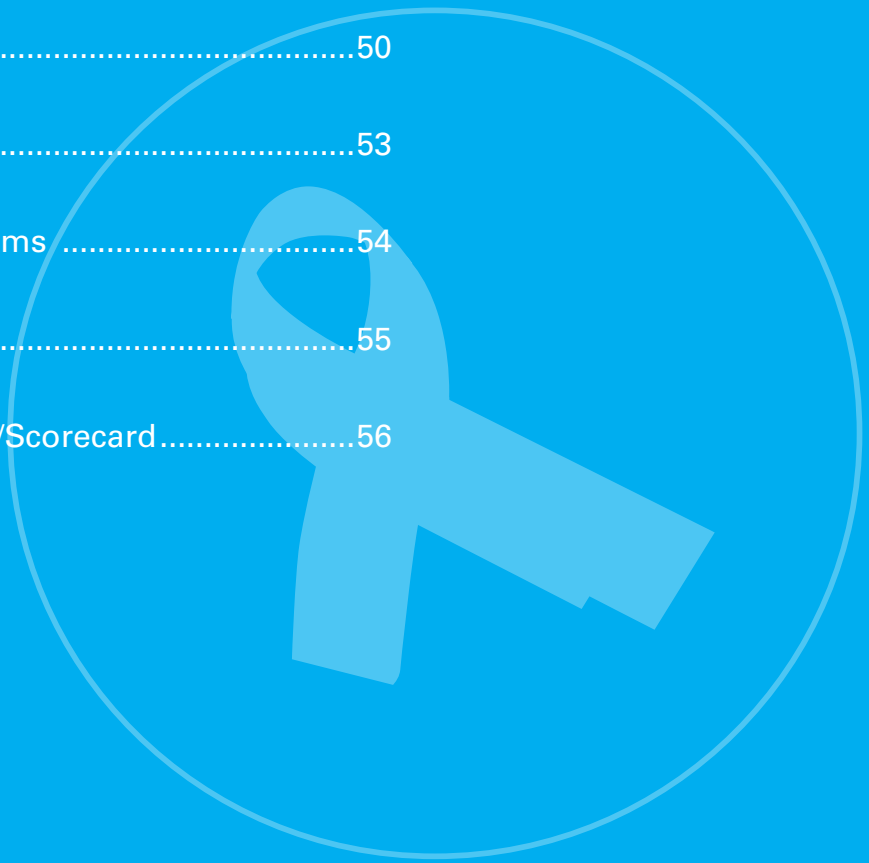


EXECUTIVE SUMMARY

UNICEF's HIV response for children must ensure that neither age, poverty, gender inequality, nor social exclusion determine access to life-saving HIV prevention, treatment and care. UNICEF and our 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. It means that all children living with HIV have access to the treatment, care and support they need to remain alive and healthy – and are afforded the opportunities of an AIDS-free generation.

Towards this end, 2015 marks the end of an era that saw quantum shifts in the global children and AIDS response. At the onset of the Millennium Development Goal period in 2000, an HIV diagnosis was equivalent to a death sentence for most children and their families in low-income countries. A child born to a mother with HIV in 2000 had a 45 per cent chance of acquiring the infection and a 50 per cent chance of dying before age two. Today a child, in the same context, has a 95 per cent chance of staying HIV negative.

A mother living with HIV in 2000 would most likely have been lost to follow-up services due to complicated HIV testing procedures and drug regimens resulting in illness and death. Today that same mother may access a rapid point-of-care HIV test and simplified antiretroviral therapy (ART) of 'one pill a day' for the rest of her life, which will provide her with a life expectancy nearly the same as her peers who are free of HIV.

With each passing year, new science and experience on the ground further inform our approach, making ending AIDS by 2030 a real possibility as we enter the era of the Sustainable Development Goals. Yet many individuals cannot currently access the treatment and other HIV-related services they need. Of the 36.9 million people living with HIV globally, 60 per cent remain without access to HIV treatment, and children are disproportionally underserved: only 31 per cent of the 2.6 million children living with HIV are on treatment, as compared to 42 per cent of adults. In 2015, UNICEF worked with a wide array of partners to bring new science and innovations to scale so the most vulnerable women and children benefit from the latest scientific advances.

Helping to shape work around children and AIDS for years to come, UNICEF in 2015 advocated for the inclusion of women, children and adolescents affected by HIV and AIDS in the strategic planning processes of the UNAIDS Secretariat and its 11 United Nations co-sponsoring agencies. Women (particularly pregnant women), mothers, girls, children and adolescents are now solidly reflected in the new UNAIDS 2016–2021 Strategy. This Strategy provides the political framework for UNICEF and its partners to pursue the vision of an AIDS-free generation.

In 2015, UNICEF engaged in the children and AIDS response in all UNICEF regions, propelled by more than 150 staff working on HIV and AIDS, who are positioned in the HIV and AIDS, health and child protection sectors.

UNICEF's work and results in 2015

UNICEF's HIV and AIDS accountabilities under the UNICEF Strategic Plan 2014–2017 and the UNAIDS Strategy are guided by a theory of change driven by six output areas designed to accelerate progress across the first and second decades of life.

UNICEF's successes and challenges across the six output areas in 2015 are reflected in the most recent internal monitoring data in select countries.[1] These data reveal that UNICEF achieved an average of 81 per cent success for all outputs in 2015. There was exceptional achievement in the area of strengthening communities and health care providers to deliver HIV and AIDS services to pregnant women and children, including in emergency contexts, and in documenting that knowledge for global consumption and use. However, some challenges in advocating for adolescent behaviour change policies and gender-sensitive HIV strategy development were noted in some contexts.

In the programme area covering the **first decade of childhood**, successes in preventing mother-to-child transmission and keeping HIV-positive mothers alive were achieved by on-the-ground work by UNICEF, government partners and civil society to strengthen community system responses to the epidemic, impacting broader maternal, newborn and child health outcomes. Eleven out of 12 targeted countries in 2015, up from 8 in 2014, reported 80 per cent of antenatal care settings and facilities in targeted areas offering antiretroviral therapy (ART). Additionally, 21 countries implemented task-shifting for non-physician health care providers to provide ART, exceeding UNICEF's 20-country target for 2015; and 33 countries had adopted the 2013 World Health Organization HIV treatment guidelines for children and adolescents, meeting 100 per cent of UNICEF's target.

A flagship programme funded by the Swedish government supported four countries (Côte d'Ivoire, the Democratic Republic of the Congo, Malawi and Uganda) in 2014–2015 to boost uptake of and retention on life-long HIV treatment (called Option B+ for prevention of mother-to-child transmission) by strengthening community-facility linkages. This work has informed efforts in African

Two boys going about their daily lives in Malawi.

countries that face similar challenges to delivering quality, lifelong services via health systems that are often weak. As an example, in Malawi, the revitalization of the community health worker role as a way to link communities and health facilities improved treatment uptake and retention in care: six-month retention rates increased from 72 per cent to 79 per cent between 2013 and 2015, and 12-month retention rates increased from 66 per cent to 74 per cent.

In the programme area covering **the second decade of childhood**, UNICEF recognizes that much needs to be done to address increasing death rates due to HIV among 10–19-year-olds. HIV is the leading killer of adolescents in sub-Saharan Africa, and girls throughout the region remain especially vulnerable to HIV infection. Young boys and girls who engage in high-risk behaviours in all regions of the world (key populations) remain especially vulnerable. Responding to these disparities, UNICEF and UNAIDS launched in 2015 the initiative All In to #EndAdolescentAIDS in Nairobi with the president of Kenya. This initiative aims to reduce new HIV infections among adolescents by 75 per cent, reduce adolescent AIDS deaths by 65 per cent and eliminate stigma and discrimination by 2020.

The All In initiative is powered by in-country work to scale up efficient, effective and equitable HIV and health programmes for adolescents. UNICEF's 2015 data show that progress has been lagging behind on the generation of age- and sex-disaggregated data, and more remains to be done to excel in this output area. Seventeen out of 23 countries targeted in 2015 reported having national household survey data on HIV disaggregated by age and sex. However, by 2015, only 13 out of 20 target countries had undertaken a gender review of their HIV policy or strategy with UNICEF support.

To address this challenge, UNICEF has supported a number of national partners to apply a Monitoring Results for Equity System (MoRES) approach, which incorporates a gender analysis. To date, 19 countries[2] have initiated data collection and analysis, bringing together multiple stakeholders. For the first time in many countries, there is an understanding of the specific needs of adolescents affected by and living with AIDS. Such data collection efforts are also being used in countries like Jamaica and Swaziland to leverage resources from the Global Fund to Fight Aids, Tuberculosis and Malaria (GFATM) and other partners.

Across both decades of a child's life, the third programme area, UNICEF has led the way in strengthening systems to respond to the needs of vulnerable children affected by HIV. UNICEF raised 5 million euros from the Government of the Netherlands for the Eastern and Southern Africa Regional Office in 2015 to support national social protection programmes in Malawi, Mozambique, Zambia and Zimbabwe. These programmes benefit vulnerable children, including children affected by HIV and AIDS. Twenty-five of 28 UNICEF focus countries had either a national child protection strategy or a national social protection strategy in place with elements sensitive to HIV and AIDS needs, with accelerated efforts during 2015 in West and Central Africa.

UNICEF's HIV and AIDS programme intensified efforts to strengthen risk-informed programming in 2015. During the Ebola emergency, UNICEF secured continuity of access to antiretroviral medicines for children and their families and essential HIV prevention interventions, including PMTCT. Overall, UNICEF's emergency programming reached 59 per cent (out of a targeted 60 per cent) of HIV-positive pregnant women in humanitarian situations with treatment to prevent mother-to-child-transmission of HIV in 2015. These interventions were also essential to preventing new infections. Demonstrating UNICEF's leadership in responding to HIV in humanitarian crises, GFATM provided an emergency grant of US$3.7 million to UNICEF to secure a one-year supply of ART for 8,000 children and their families, and 30,000 HIV tests for pregnant women in non-government-controlled areas in Eastern Ukraine in 2015.

Meanwhile, in 2015 UNICEF published 22 articles in peer-reviewed journals and research publications on first- and second-decade HIV programming for children, surpassing the 2015 target of 18. This demonstrates UNICEF's knowledge leadership on children and AIDS.

UNICEF is grateful to all its resource partners for their continued support to HIV and AIDS. From a peak of US$187 million in 2008, UNICEF's expenditures on HIV and AIDS steadily declined to approximately US$107 million in 2015, a 43 per cent drop.

Looking ahead

UNICEF's spending on children and AIDS work reflects a global AIDS response at a crossroads. The epidemiology of the epidemic is swiftly changing – as is the financing of the response. While increasing domestic expenditures on HIV programming are a positive trend, in some settings these funds are directed towards political rather than evidence-informed priorities. The Sustainable Development Goals are influencing GFATM's three-disease focus to include the strengthening of health and community systems; and a 50 per cent budget reduction at UNAIDS – precipitated by competing global development priorities – has impacted UNAIDS' ability to coordinate and meet financial commitments to its co-sponsors.

HIV remains now and in the near future a priority for UNICEF. We will work with our partners to ensure women and children are not left behind on the Fast-Track to end the AIDS epidemic by 2030, which is part of the Secretary General's Global Health Strategy for Women, Children and Adolescents; and that they are not left by the wayside in pursuit of the Sustainable Development Goals.[3] We aim to do this by focusing on vulnerable women and children, in line with UNICEF's Strategy for Health (2016–2030), and by building the HIV-specific capacity of health, education and protection systems to respond to the growing population of people on HIV treatment, now at 15.6 million, and the 2 million new HIV infections a year – a majority of whom are women and children.

STRATEGIC CONTEXT

The world has exceeded the AIDS target of Millennium Development Goal (MDG) 6, halting and reversing the spread of HIV, and more and more countries are getting on the Fast-Track to end the AIDS epidemic by 2030 as part of the Sustainable Development Goals (SDGs).[4] At the turn of the century, and the beginning of the Millennium Development Goals, an HIV diagnosis was equivalent to a death sentence for most children and their families in low-income countries. Now, an early diagnosis paired with treatment and care can ensure long healthy lives, regardless of location, and can help prevent transmission of HIV to others.[5]

"Today we shine a light on what can only be described as a "blind spot" in the global fight against HIV/AIDS: adolescents. Because while deaths due to AIDS have decreased by 40 per cent for most age groups since 2005, for adolescents, they have actually increased. This is wrong. Worse, these infections narrowly—unjustly, unacceptably—affect the most vulnerable groups. These include girls, who comprise two-thirds of all HIV-infected adolescents."

—Anthony Lake, UNICEF Executive Director, remarks at 'All In!' AIDS event held in New York

New HIV infections have fallen by 35 per cent since 2000, including a 58 per cent drop among children 0–14 years, and AIDS-related deaths have declined by 42 per cent since the peak in 2004, with AIDS-related deaths among children decreasing from 260,000 in 2000 to 150,000 in 2014. The global response to HIV has prevented 30 million new HIV infections and nearly 8 million (7.8 million) AIDS-related deaths since 2000, when the MDGs were set. Ensuring access to antiretroviral therapy for 15.8 million people is an achievement deemed impossible 15 years ago. In 2000, fewer than 1 per cent of people living with HIV in low- and middle-income countries had access to treatment. In 2014, the global coverage of people receiving antiretroviral therapy was 40 per cent. But HIV still continues to shine a harsh light on the inequalities of the world. AIDS is still unfinished business.

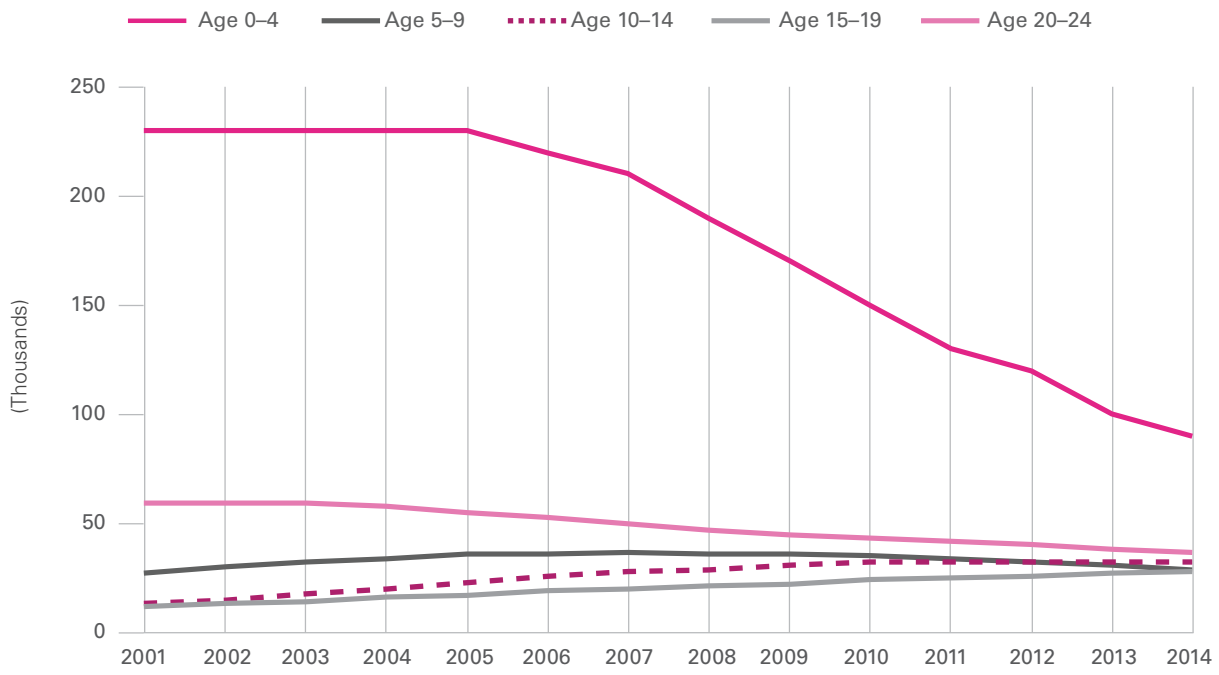
Significant gaps and shortcomings of response must be rectified. Of the 36.9 million people living with HIV globally, 17.1 million are unaware they have the virus. Roughly 22 million do not have access to HIV treatment. The most effective antiretroviral treatment now reaches 73 per cent of pregnant women living with HIV in low- and middle-income countries and has prevented 1.3 million new infections among children since 2000. Only 1 in 3 of the 2.6 million children living with HIV are on treatment and 25 children are still infected with HIV every hour.

The majority of adolescents lack access to proven prevention interventions. This is especially acute for girls, who represent two thirds of all adolescents living with

Only 1 in 3 children have access to life-saving treatment.

FIGURE 1

Estimated number of AIDS-related deaths, by 5-year age group, 2001–2014



Source: UNICEF analysis of UNAIDS 2014 HIV and AIDS estimates, July 2015.

HIV, and all those at risk of new infection including gay and bisexual adolescent boys, transgender adolescents, and those who inject drugs or are sexually exploited.

"The countdown to 2020 has begun. We need to work in new ways. The 2030 Agenda for Sustainable Development commits the global community to leaving no one behind and to open space to scale up what we know works for AIDS. The world came together in the new millennium and dared to commit to halting and reversing the AIDS epidemic; together, we achieved that. Now is the time to come together again and finish what we started. Let us seize this opportunity and join the Fast-Track towards ending AIDS as a public health threat by 2030."

–Michel Sidibé, UNAIDS Executive Director

After the success of the MDGs, the next phase of the AIDS response must account for new realities, opportunities and evidence, including a rapidly shifting context and the new SDG agenda. With the SDGs, the world has committed to end the AIDS epidemic by 2030. This ambitious yet wholly attainable objective is an unparalleled opportunity to eradicate a disease that has ravaged the lives of millions of children and families. This is an exciting time in the AIDS response. The world is building momentum towards a sustainable, equitable and healthy future for all. Over the next five years the AIDS response requires increased investments to address the remaining gaps for children and adolescents, as well as innovative delivery mechanisms and partnerships to ensure that no one is left behind, especially vulnerable adolescents, young people and key populations.

First decade: Children under 5, pregnant women and mothers

In 2014, there were an estimated 1.5 million pregnant women living with HIV globally.[6] Without intervention, nearly half of these women would transmit HIV to their children during pregnancy, childbirth and through breastfeeding. Major initiatives, such as the *Global Plan to Eliminate New HIV Infections among children by 2015 and Keeping Mothers Alive* (Global Plan)[7] have had significant impact on coverage of services to prevent mother-to-child transmission (PMTCT) and access to maternal antiretrovirals (ARVs). By the end of 2014, lifelong antiretroviral treatment (Option B+) reached

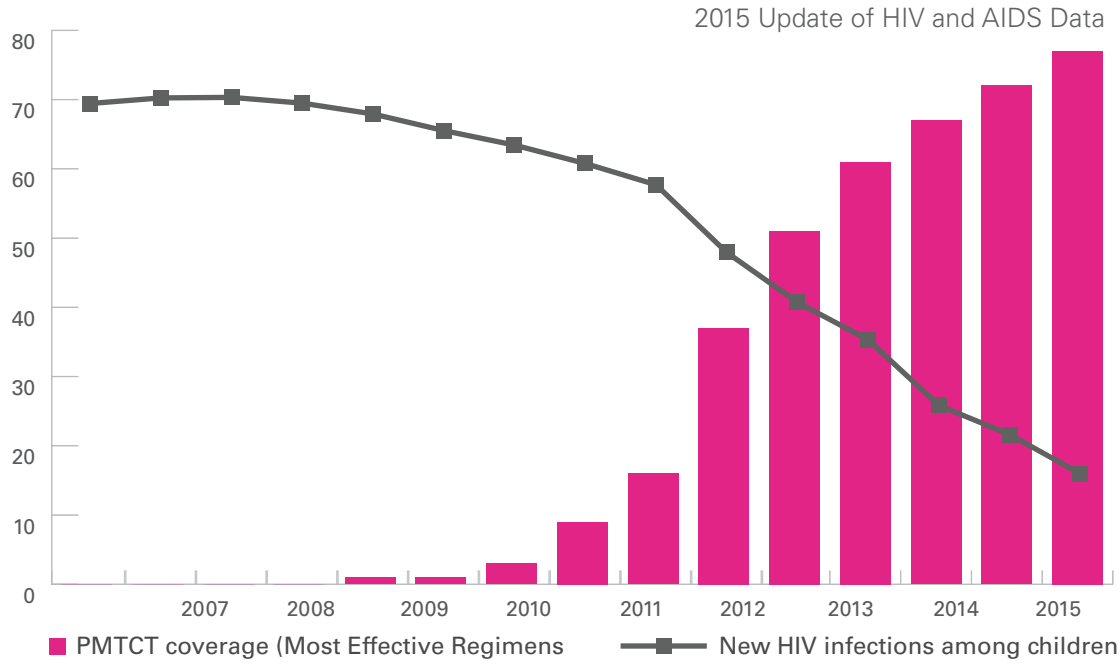
66 per cent of pregnant women in the 21 Global Plan[8] priority countries in sub-Saharan Africa, which accounted for nearly 90 per cent of the global HIV burden.[9] As a result, there were less than 200,000 new paediatric HIV cases in 2014, down from a peak of over 550,000 in 2000. South Africa has made the greatest progress, reducing new HIV infections among children (aged 0–14) from 38,000 in 2009 to 9,200 in 2014.

While there has been considerable progress in scale-up of PMTCT services, at the end of 2014 there were an estimated 2.2 million children under age 14 living with HIV in the 21 Global Plan countries in sub-Saharan Africa (there were 2.6 million globally). Only 31 per cent received antiretroviral therapy (ART) compared to 66 per cent of pregnant women living with HIV.[10] Half of all children living with HIV are in six countries: Nigeria, South Africa, Mozambique, Kenya, Uganda and Zimbabwe. Nigeria accounts for one third of all new HIV infections among children in the priority countries, which is roughly equivalent to the combined total in the five countries with next-highest HIV burden.

In the absence of antiretroviral treatment and care, most HIV-infected children die before their fifth birthday, with 50 per cent of these deaths occurring by 24 months of age.[11,12] Delayed diagnosis of HIV in infants and children has posed significant barriers to increasing timely coverage of treatment before peaking of mortality. WHO recommends that children exposed to HIV be tested within four to six weeks of birth, followed by immediate ART, for the greatest chance of reducing mortality. Yet infant diagnosis rates and early infant diagnosis (EID) during and after the recommended breastfeeding period remain poor in many countries, with most children being diagnosed after the age of three years. In 2014, fewer than half of children exposed to maternal HIV infection were tested for HIV before they reached their first birthday. Data on testing rates at the end of the breastfeeding period are limited, which underscores the need to improve long-term follow-up of mother-infant pairs. Data systems are in the midst of dramatic shifts from cross-sectional to longitudinal tracking systems.

Additionally, while mother-to-child transmission of HIV at six weeks of age has been reduced from 19 per cent in 2000 to 6 per cent in 2014, late transmission from breastfeeding remains at 15 per cent in 2014 (from 38 per cent in 2000). Reduced adherence and retention during the breastfeeding period resulted in twice as many new paediatric HIV infections as during pregnancy, labour and delivery. This finding indicates an urgent need for more concerted and systematic efforts to understand and address barriers, specifically reviewing equity dimensions

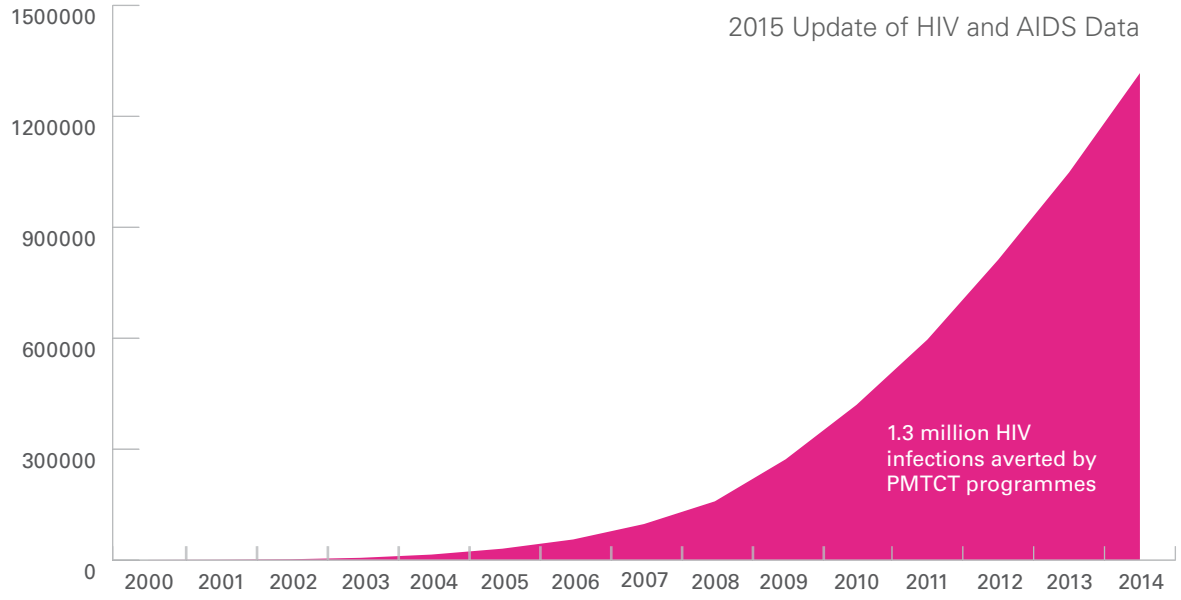
FIGURE 2
Trends in percentage of pregnant women living with HIV receiving most effective antiretroviral medicines for PMTCT and new HIV infections among children 0–14, 21 sub-Saharan African Global Plan countries, 2000–2014



Source: UNICEF analysis of UNAIDS 2014 HIV and AIDS estimates, July 2015.

FIGURE 3

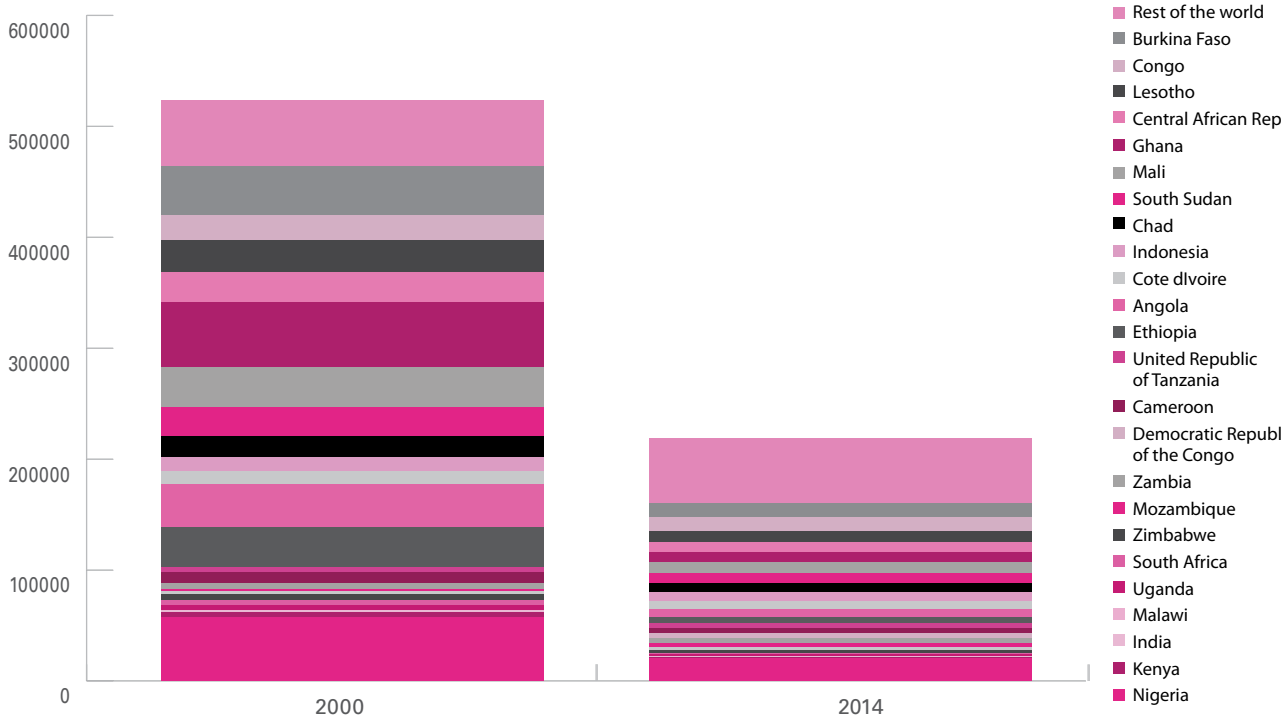
Estimated number of new HIV infections averted by PMTCT programmes (cumulative) in all low- and middle-income countries, 2000-2014



Source: UNICEF analysis of UNAIDS 2014 HIV and AIDS estimates, July 2015.

FIGURE 4

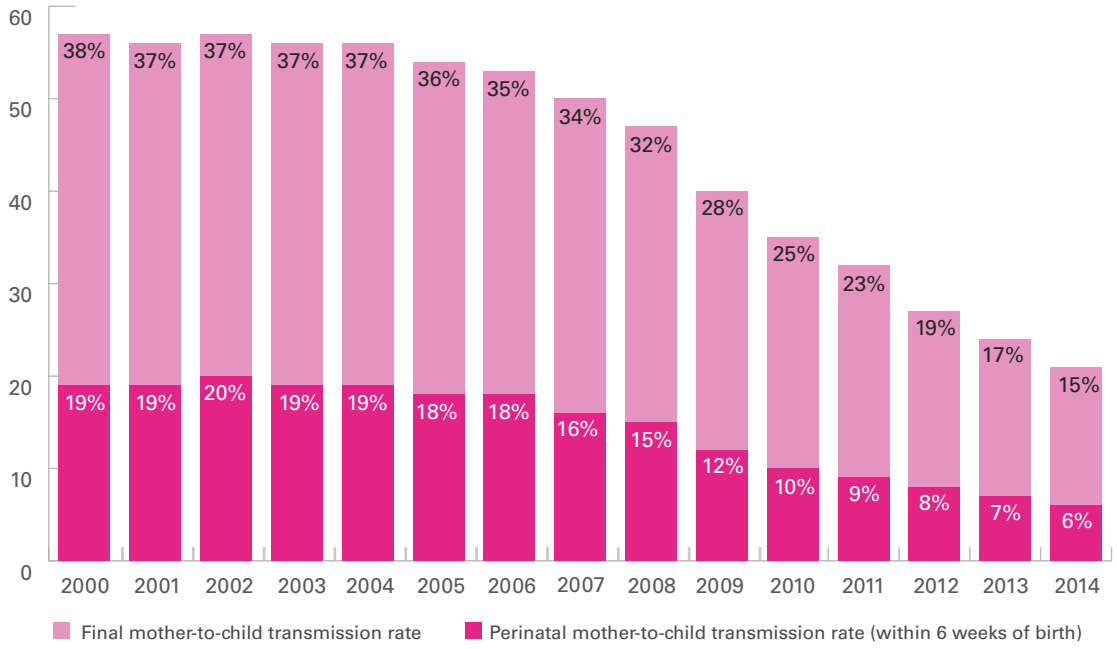
Estimated number and percentage of new HIV infections among children (aged 0–14), high burden countries, 2000 vs. 2014



Source: UNAIDS 2014 HIV and AIDS estimates, July 2015.

FIGURE 5

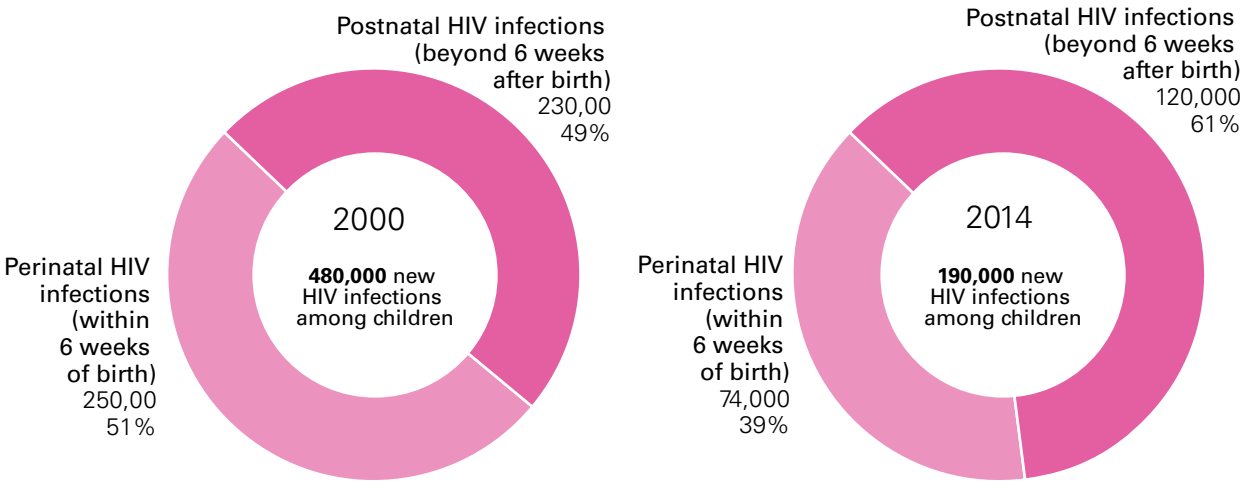
Estimated percentage of infants born to pregnant women living with HIV who become vertically infected with HIV (mother-to-child transmission rate), sub-Saharan Africa, 2000-201



Source: UNICEF analysis of UNAIDS 2014 HIV and AIDS estimates, July 2015.

FIGURE 6

Estimated number of new HIV infections among children (aged 0-14), sub-Saharan Africa, 2000 vs. 2014



Source: UNICEF analysis of UNAIDS 2014 HIV and AIDS estimates, July 2015.

(e.g., gender and age), the participation of women in follow-up services and good adherence to HIV treatment and optimal infant-feeding practices.

UNICEF's focus to date has been on its role as co-convener, with WHO, of the Interagency Task Team on the Prevention and Treatment of HIV Infection in Pregnant Women, Mothers and Children (IATT), the technical support to the Global Plan. While the work is not done, there is a clear road map to reach the Fast-Track targets for ending AIDS as a public health epidemic for children.

Second decade: Adolescents

AIDS is the leading cause of death among adolescents in Africa and the second highest cause of death among adolescents globally. Alarmingly, adolescents are the only age group where deaths due to AIDS are not decreasing. In fact, the estimated number of AIDS-related deaths among adolescents (aged 10–19) has tripled since 2000, which is largely due to the increased number of adolescents living with HIV who were vertically infected as infants. During the period 2005–2014, AIDS-related deaths among adolescents aged 10–19 increased by nearly 50 per cent (from 41,000 in 2005 to 60,000 in 2014), while all other age groups saw decreases during the same period. In 2014, there were an estimated two million adolescents living with HIV. In the same year, more than 60 per cent of the 220,000 new infections among 15–19-year-olds were among adolescent girls. About half of adolescents (aged 15–19) living with HIV are in just six countries: South Africa, Nigeria, Kenya, India, Mozambique and the United Republic of Tanzania.[13] The top 20 high-burden countries are shown below.

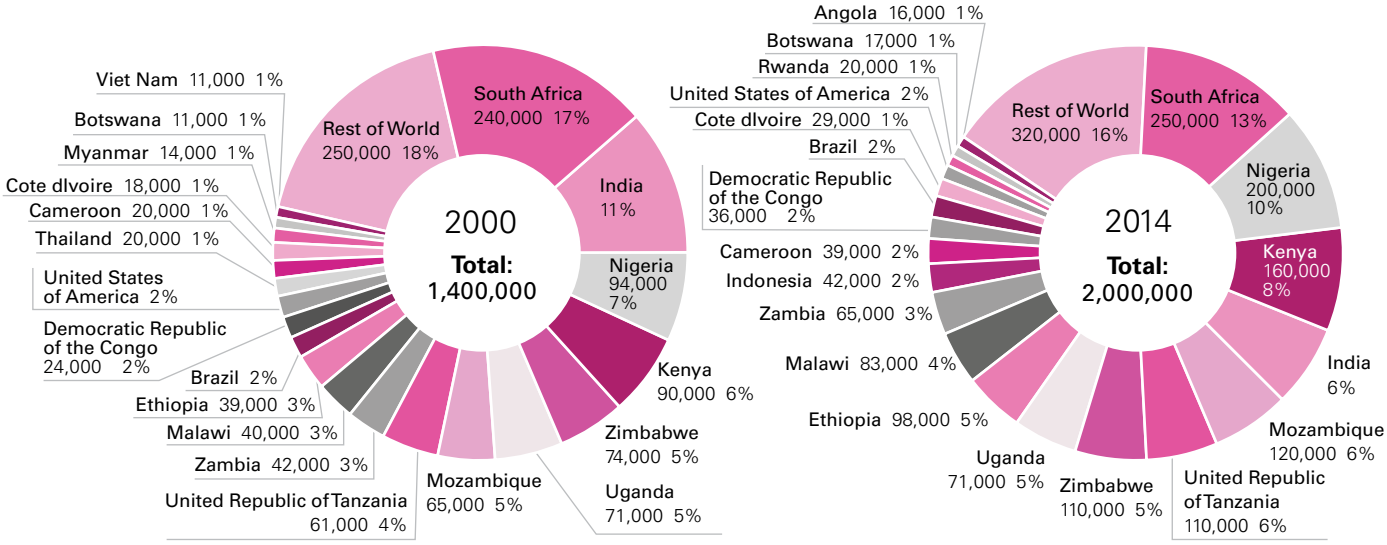
In 2000, India and Brazil entered the list of the top 10 countries with the highest numbers of new HIV infections among adolescents. By 2014, in addition to India and Brazil, Indonesia and the United States had also joined this list due to high numbers of new HIV infections among key populations.

Globally, 81 per cent of all adolescents living with HIV in 2014 were infected via vertical (mother-to-child) transmission, many of these cases occurring during peak years of the early 2000s. At the same time, new HIV infections in adolescents (15–19) are not declining as rapidly as for other age groups (*see Figure 22*), especially among adolescent girls in sub-Saharan Africa and adolescents who inject drugs, gay and bisexual adolescent boys, transgender adolescents and adolescents who are sexually exploited.[14]

Levels of HIV knowledge have barely increased among adolescent populations over the past 15 years, particularly in sub-Saharan Africa where 70 per cent of boys and girls (aged 15–19) lack comprehensive HIV knowledge. In sub-Saharan Africa, 70 per cent of girls (aged 15–19) with multiple sexual partners in 2014 did not use a condom during their last sexual encounter, and 7 out of every 10 new infections among 15–19-year-olds are among girls. Gender and other social and economic inequalities play a marked role in the increasing vulnerability of adolescent girls and their disproportionate levels of HIV infection.

FIGURE 7

Estimated number and percentage of adolescents (aged 10-19) living with HIV, top 20 high-burden countries, 2000 vs. 2014



Source: UNAIDS 2014 HIV and AIDS estimates, July 2015.

FIGURE 8
Trends in new HIV infections among adolescents 15–19

Source: UNAIDS 2014 HIV and AIDS estimates, July 2015.

Data gaps prove a challenge in tracking the coverage of HIV interventions among adolescents. Considering the low coverage of HIV testing and treatment among adults living with HIV, and legal, social and financial constraints faced by adolescents, HIV service uptake among adolescents is expected to be much lower. Evidence from limited studies also indicates that PMTCT outcome in pregnant adolescent girls and mothers is worse than for adult women, especially with reference to retention in care and loss to follow. Beyond the importance of increased HIV testing and counselling (HTC) and an expanded access to effective antiretroviral therapy for adolescents, accelerated improvements in adolescent responsive policies and health services are urgently needed. Brokering innovative partnerships with the education, social protection and private sectors will improve equity and outreach and ensure swift identification of adolescents living with HIV and successful oversight of comprehensive care and transition needs. In addition, targeted prevention interventions are critical for adolescent girls and adolescent key populations.

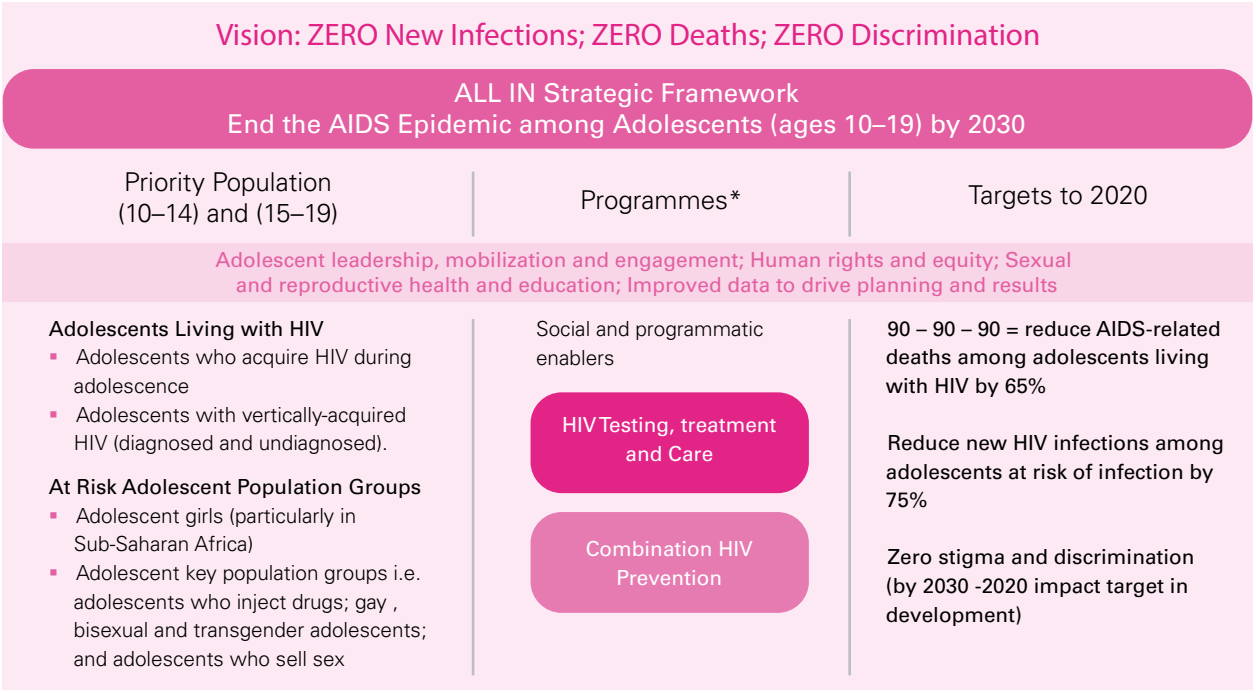
The persistent patterns that characterize the epidemic in adolescents – slow progress in reduction of new HIV infections, rising AIDS-related mortality in adolescents, predominance of new infections in adolescent girls, vulnerability of adolescent key populations – underscore that this phase of the global epidemic response is very much about reaching the hard-to-reach and tackling the deeply rooted social issues, including exclusion and gender inequality, most resistant to change. Appropriate and effective targeting, integration and innovation will be key to achieving equity and efficiency in the response.

The All In to #EndAdolescentAIDS initiative has engaged multiple countries in a data-driven planning exercise to sharpen adolescent focus in the national HIV response. Data from five countries (Botswana, Cameroon, Jamaica, Swaziland and Zimbabwe) reveal a pattern of increasing HIV prevalence from younger adolescents (aged 10–14) to older adolescents (aged 15–19), and becoming more pronounced in young people (aged 20–24). Gender disparities in HIV prevalence emerge with increasing age in girls in four countries and in boys in one country.[15] Addressing these priorities is as much a concern for HIV programmes as it is for broader adolescent health and development programmes.

Growing momentum to accelerate progress for adolescents has led to their prominence in multiple global initiatives, such as the UNAIDS Fast-Track initiative to end the HIV/AIDS epidemic by 2030; All In to #EndAdolescentAIDS; Every Woman Every Child and Every Adolescent (United Nations Secretary-General's Health Strategy 2.0); The (United States) President's Emergency Plan for AIDS Relief (PEPFAR) 3.0 Right Things, Right Places, Right Now; the DREAMS Initiative; and the GFATM Women and Adolescent Girls' Initiative. With increased global political commitment, leadership engagement and commitment of resources, the opportunity to address adolescent health and its underlying vulnerabilities will greatly influence HIV-specific outcomes for adolescents. Strategic partnerships with governments, resource partners, civil society and the private sector will be key in achieving successful HIV prevention, treatment and care in adolescents.

Strengthening national health systems and programmes is the most critical opportunity for a sustained response. Domestic resources accounted for 60 per cent of the

FIGURE 9
All In strategic framework



*PACKAGE appropriate mix of proven programmes for each defined adolescent population group based on epidemiological context

estimated US$20 billion spent to fight HIV and AIDS in 2014. Private sector contributions such as mobile-driven communication, outreach and social engagement represent inspired and innovative approaches to addressing traditional bottlenecks in programme delivery and social change. Adolescents themselves are an underutilized resource for change but are increasingly lending their voices to efforts by civil society, governments and the private sector to improve the design and delivery of programmes that affect their lives.

Across both decades: Protection, care and support

Achieving an AIDS-free generation will require direct programme interventions aimed at the 90-90-90 goals, and addressing the social and economic factors that continue to fuel and impact the epidemic. Drivers of the epidemic – such as poverty, food insecurity, drug and alcohol abuse, social marginalization, exclusion, stigma, inequity, gender inequality, violence and sexual exploitation – increase risk, decrease resilience and compound the impact of the epidemic. The protection, care and support of all vulnerable children must underpin multi-sector efforts to scale up high-impact interventions through the first two decades of life.

Over the past decade, evidence on the impact of social protection programmes on HIV outcomes, as well as on childhood and adolescent well-being, has expanded considerably.[16] Evaluations of national social protection programmes have established that social protection, in particular cash transfers, contributes to a broad range of impacts across multiple sectors, among them improving access to health, education, and nutrition, strengthening social networks, and impacting HIV and AIDS by increasing access to treatment and prevention, and reducing adolescent vulnerability and risk taking.[17] In addition, we know much more about which approaches best protect, care and support children and families affected by AIDS and about the pathways between multiple childhood deprivations and subsequent HIV outcomes. Social protection programmes are increasingly HIV-sensitive, and their rapid scale-up is reaching a growing number of vulnerable households affected by HIV.

Investing in social protection, care and support systems will bolster the access, reach and utilization of proven high impact bio-medical interventions to achieve reductions in HIV-related morbidity and mortality and prevent new infections. Enhancing the quality of life for infected children and adolescents can also mitigate the realities of HIV that drive new transmissions. Cash transfers, rapidly expanded from 25 programmes found in 9 countries

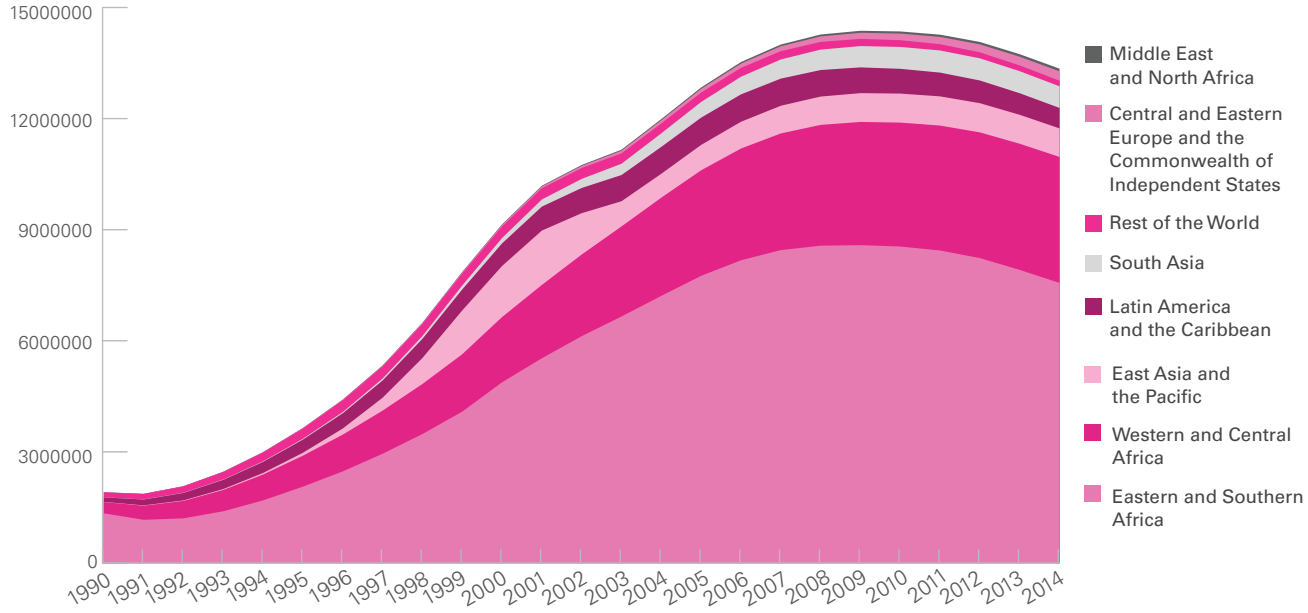
in 2000 to 245 programmes in 41 countries in 2012, have proven especially compelling, with total transfers estimated at US$10 billion. But there is much to be done. Strengthened and far-reaching interventions are crucial, including the provision of predictable transfers (cash, food or other resources), and those that increase access to basic health and social services for the most vulnerable. Economic and psychosocial support is particularly important for the estimated 13.3 million children who have lost one or both parents to AIDS globally as of 2014.

The sustainable development agenda provides an unprecedented opportunity to expand rights-based HIV responses and to strengthen links with broader human rights, social justice and rule-of-law movements to promote inclusive societies for sustainable development. In the post-2015 SDGs era of integration, efficiency and country ownership, HIV responses that are multi-sectoral with cross sector health and development outcomes will be increasingly critical.

The new UNAIDS 2016–2021 Strategy establishes what the SDGs mean in concrete terms for the AIDS response and sets ambitious programmatic and resource targets to be met by 2020, which will set a course to ending the AIDS epidemic as a public health threat by 2030. For example, achieving Target 10 of the Strategy aims to ensure that 75 per cent of people living with and affected by HIV receive HIV-sensitive social protection that prevents marginalization within the community. Addressing the social and economic drivers of HIV epidemics is an essential aspect of the HIV response and achieving Agenda 2030, including the target of ending AIDS by 2030.

FIGURE 10

Estimated number of children (aged 0–17) who have lost one or both parents to an AIDS-related cause, by UNICEF region, 1990–2014



Source: UNAIDS 2014 HIV and AIDS estimates, July 2015

RESULTS BY PROGRAMME AREA

UNICEF's HIV programme, working alongside health, nutrition, early childhood development, communication for development (C4D), gender, rights and adolescent development focuses on the first two decades of life – the first decade responds to the needs of pregnant women, mothers and their children. The second decade focuses on adolescents. Across both decades of life UNICEF promotes equitable child protection interventions, including efforts to address acute and chronic emergencies and their impacts on people living with or affected by HIV and AIDS.

UNICEF's Theory of Change aims to achieve the Strategic Plan outcome of improved and equitable use of proven HIV prevention and treatment interventions by pregnant women, mothers and their children and adolescents. Through six key implementation strategies, based on UNICEF's vision for realizing the Strategic Plan outcome and outputs (letters a-f in the annex) on HIV and AIDS, UNICEF utilizes a range of strategic interventions targeted towards this outcome. These are outlined in UNICEF's vision paper *UNICEF'S HIV/AIDS Programme Vision and Direction for Action, 2014–2017*, which defines define UNICEF's 2014–2017 vision and direction for headquarters, regional and country offices to support national programmes to achieve an AIDS-free generation, in line with the Strategic Plan and Theory of Change (*see schematic below*).

The specific Strategic Plan outputs UNICEF is aiming to achieve through its HIV and AIDS interventions are as follows:

- Output 1: Enhanced support for children and caregivers for healthy behaviours related to HIV and AIDS and to use of relevant services, consistent with the UNAIDS Unified Budget, Results and Accountability Framework;
- Output 2: Increased national capacity to provide access to essential service delivery systems for scaling up HIV interventions;
- Output 3: Strengthened political commitment, accountability and national capacity to legislate, plan and budget to scale up HIV and AIDS prevention and treatment interventions;
- Output 4: Increased country capacity and delivery of services to ensure that vulnerability to HIV infection is not increased and HIV-related care, support and treatment needs are met in humanitarian situations;
- Output 5: Increased capacity of governments and partners, as duty-bearers, to identify and respond to key human rights and gender equality dimensions of HIV and AIDS; and
- Output 6: Enhanced global and regional capacity to accelerate progress in HIV and AIDS.

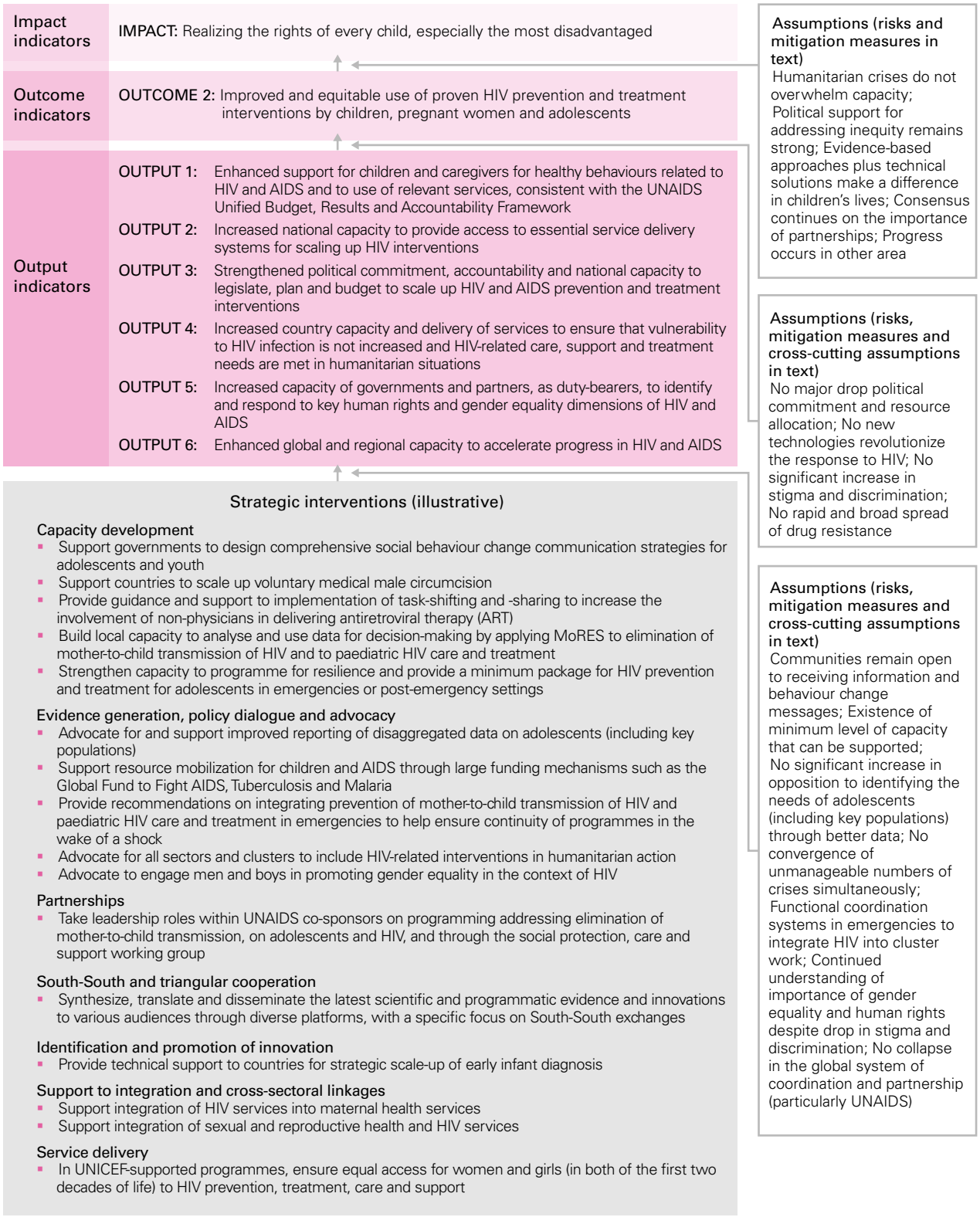
The following section details the results achieved in 2015 through the key implementation strategies in each of the programme areas. Results summaries under each decade highlight progress towards the targets set in the Strategic Plan. A detailed results assessment table with progress against the indicators can be found in the Annex. The selection of country examples is illustrative of UNICEF's achievements across both decades and celebrates noteworthy results in UNICEF's target countries, which include the 38 high-burden countries determined by UNAIDS, the 22 Global Plan countries and countries affected by emergencies.

PROGRAMME AREA 1: FIRST DECADE – CHILDREN UNDER AGE 5, PREGNANT WOMEN AND MOTHERS

Paediatric HIV and AIDS treatment and the elimination of mother-to-child transmission of HIV (EMTCT) continued to be important priorities for UNICEF during 2015, particularly in the 21 Global Plan countries in sub-Saharan Africa. Through the IATT partnership, UNICEF headquarters, regional and country offices supported 20 of the 21 Global Plan countries in sub-Saharan Africa to adopt, adapt and implement ART treatment for all pregnant women living with HIV. While the EMTCT successes are attributable to wider access to ART for all pregnant women, the system by which the ARTs are provided was enabled by UNICEF's efforts on decentralization and integration of HIV with antenatal health care services.

The most recent UNICEF internal monitoring data reflect significant progress at the national level towards achieving UNICEF's Strategic Plan outputs related to integration of HIV, maternal and community-based delivery. Under UNICEF's Strategic Plan output for increased national capacity to provide access to essential service delivery systems for scaling up HIV interventions, 11 out of

FIGURE 11
UNICEF Strategic Plan 2014–2017 schematic for outcome 2: HIV and AIDS



12 targeted countries in 2015, up from eight in 2014, reported 80 per cent of antenatal care settings and facilities in targeted areas offering antiretroviral treatment (ART). Additionally, 21 countries have implemented task-shifting for non-physician health care providers to provide ART, exceeding UNICEF's 20-country target for 2015. Thirty-three countries had adopted the 2013 WHO HIV treatment guidelines for children and adolescents by 2015, meeting UNICEF's target 100 per cent.

South Africa has made the greatest progress in reducing new HIV infections among children (aged 0–14) through PMTCT by 76 per cent, followed by the United Republic of Tanzania (72 per cent), Uganda and Mozambique (69 per cent each), Ethiopia (65 per cent), Namibia (64 per cent) and Swaziland (63 per cent). Half of the countries achieved a reduction of 50 per cent or more. In fact, several countries – including Botswana, Burundi, Namibia and Swaziland – had fewer than 1,000 new infections in 2014, almost approaching the WHO criteria for the elimination of mother-to-child transmission as a public health problem. A number of countries, however, have not made as much progress: Angola, Cameroon, Chad, Côte d'Ivoire, the Democratic Republic of the Congo, Kenya and Nigeria reduced new HIV infections among children by less than 30 per cent, well below the 48 per cent average across the 22 priority countries.

Overall, UNICEF's contribution to the global push on scaling up testing and treatment services for mothers has achieved significant results and impact in reducing the rate of new infection among newborn children. However, progress in reducing mortality, addressing the underlying vulnerability of exposure to HIV infection and scaling up prevention services, especially for adolescents, has been slow partly due to vertical programming, insufficient evidence, disaggregated data and lack of a compelling and necessary global focus. These continued challenges impacted the mid-term scorecard for the Strategic Plan.

Country examples throughout the results section demonstrate how UNICEF has employed the six strategies to overcome barriers to scale-up of national EMTCT and maternal, newborn and child health (MNCH) policies across the first decade of life and highlight the work that remains to be done.

Monitoring results for equity

One of the most significant challenges in the first decade of life is to narrow the persistent inequities which impact pregnant women. Many pregnant women live far from district capitals and therefore lack access and the ability to consistently participate in both HIV and MNCH services. With earmarked funding from the Swedish International Development Cooperation Agency and the Norwegian Agency for Development Cooperation, UNICEF is strengthening the linkages between community social service delivery mechanisms and facility-based treatment services to scale up lifelong ART and PMTCT

Saving lives by linking communities with facilities: A health worker in Malawi uses a bicycle to visit patients at home who have failed to attend clinic visits.

Nigeria case study

Despite concentrated efforts by UNICEF and implementing partners, Nigeria's contribution to the global HIV burden of new HIV infection in children continues to rise (from 11 per cent in 2000 to 27 per cent in 2014). PMTCT and paediatric HIV ART coverage remains significantly low (29 per cent and 12 per cent respectively) and has had the lowest percentage reduction in new paediatric HIV infections of all the 22 Global Plan priority countries (15 per cent). Without significant progress in Nigeria, the goal of ending HIV as a public health epidemic by 2030 will not be achieved.

UNICEF, the IATT and UN partners have been providing technical support to the Government of Nigeria to develop state- and local-level evidence-based, data driven EMTCT strategies and plans. Since 2013, MoRES-based EMTCT bottleneck analysis has been undertaken, focusing particularly on 12 states that account for 70 per cent of the national HIV burden. Data show that challenges experienced with the PMTCT programme in Nigeria include low uptake of PMTCT services by pregnant women even when available, minimal male involvement, poor community engagement for PMTCT and inadequate early infant diagnosis (EID) facilities in the country. UNICEF recognizes the need for decentralized data as an imperative to driving success due to the large populations and diversity within the country. Towards that end, in 2015 UNICEF supported the training of all Local Action Committee HIV M&E Officers in four states (Anambra, Benué, Kaduna and Lagos), as well as selected health-care providers, providing them with DHIS-configured mobile phones for data capturing and increased ability to report real time data from remote and difficult-to-reach areas. After data capturing tools were provided to all health facilities in Kaduna State, the reporting rate from these facilities subsequently increased to 75 per cent.

programmes in Côte d'Ivoire, the Democratic Republic of the Congo, Mali and Uganda, through the Optimizing HIV Treatment Access for Pregnant and Breastfeeding Women (OHTA) Initiative. Key results for this initiative are highlighted as a case study on page 22.

UNICEF in all regions continues to promote better data monitoring through the development of national indicator tools and complimentary computer dashboards which can be used by supervisors at all levels to monitor implementation. The improved use of data to inform policy upstream and implementation downstream significantly bolsters our work. As an example, in Cambodia, UNICEF funded and provided technical support in the development and revision of national guidelines and standard operating procedures for paediatric and adult ART to the National Centre for HIV/AIDS, Dermatology and STDs in line with the 2015 WHO consolidated guidelines on the use of antiretroviral drugs (ARV). These efforts have contributed to the expansion of the PMTCT services, including HIV testing and return for test results among pregnant women in antenatal care and at delivery, which improved from 75.7 per cent in 2014 to 80 per cent in 2015. Bottlenecks in HIV testing coverage included a shortage of HIV test reagents, access for pregnant women who live in remote areas and capacity of health care providers.

UNICEF's HIV programme has also utilized strong capacities within the data and analytics team to improve HIV outcomes. For example, in Brazil, UNICEF worked with the Government to develop monitoring plans in five states based on the Monitoring Results for Equity System (MoRES), and DEVINFO system. In 2015, with support of UNICEF, the states of Amapá, Pará, Maranhão and Acre designed and implemented these plans to define the lines of care aiming at the prevention of HIV and syphilis through mother-to-child transmission. The main objectives of these plans are to increase rapid tests of HIV and syphilis, the initiation of antiretroviral and benzathine penicillin treatment and to strengthen the epidemiological surveillance for HIV and syphilis, thus allowing pregnant women in these states to immediately benefit from improved health services.

Globally, approximately 1.8 million HIV-positive children under age 15 are not receiving treatment. The IATT, led by UNICEF, supported 10 countries in West Africa to undertake paediatric HIV situational analyses for the development of five-year national strategies to identify and prevent HIV-exposed children from being lost to follow-up in MNCH services. Under the leadership of UNICEF, the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), the Clinton Health Access Initiative (CHAI) and others, the IATT paediatric working group developed operational guidance on the release of a new antiretroviral pellet formulation recommended for young infants. Data remains critical to eliminating new HIV infections in children. Using UNICEF's data and analytics team, the IATT M&E working group offered technical assistance in eight national PMTCT and paediatric assessments to help countries direct their five-year strategies, including ambitious two-year paediatric acceleration plans.

Integration and service delivery at decentralized levels

UNICEF leads the way in promoting integration of HIV response and MNCH and continues to advocate service delivery at decentralized levels.

As an example, UNICEF supported Bangladesh's National AIDS/STD Programme (NASP) in reducing bottlenecks to antenatal care and increasing uptake in comprehensive HIV packages, efforts that directly led to improved MNCH and HIV outcomes. Through this action, 20,000 pregnant women in antenatal care and delivery received an HIV test and their results in 2015, a sharp rise from 13,000 in 2014. HIV testing and counselling among women in antenatal care climbed to 88 per cent in 2015, up from 54 per cent in 2014; at labour or delivery, HIV testing and counselling (HTC) rose to 39 per cent in 2015 from 20 per cent in 2014.

In the Plurinational State of Bolivia, UNICEF supported the Ministry of Health's National AIDS Program, focusing on integrating HIV prevention programmes with maternal and child health services in Santa Cruz, Cochabamba and Potosi. Access to rapid HIV testing among pregnant women increased from 78 per cent in 2014 to 86 per cent in 2015, and in rural areas increased from 30 per cent in 2014 to 39 per cent in 2015. The number of health facilities offering these tests to pregnant women increased from 51 per cent in 2014 to 59 per cent in 2015.

In Mozambique, as part of the expansion of Option B+, UNICEF trained 228 maternal and child health nurses to provide ART treatment to pregnant women and an additional 77 technicians to collect PCR blood samples for early infant diagnosis in four provinces. As a result, more than 70 per cent of health facilities are implementing PMTCT Option B+. UNICEF supported the expansion of ARV treatment sites from 744 sites in 2014 to 853 sites in 2015, all of which are integrated into maternal child health services.

Paediatric HIV outcomes greatly benefit from integration with broader child health and nutrition services. In Swaziland, over 70 per cent of cases of severe malnutrition among children under five are HIV/TB co-infected. To address this issue, UNICEF supported the National Nutrition Council to strengthen growth monitoring and alleviate shortages of therapeutic feeding supplies by procuring and distributing anthropometric measuring equipment for 150 health facilities that provide HIV services, as well as a six-month supply of F100, F75 and ready-to-use therapeutic food (RUTF).

As part of UNICEF's efforts to promote integration, UNICEF is advocating that the mother-baby pair be supported to access comprehensive MNCH/nutrition/HIV services together. In Zimbabwe, UNICEF provided technical support at the national level to develop the mother-baby pair registry, a project of longitudinal tracking of HIV-positive mothers and their babies aimed at reducing loss to follow-up services. Sixty-two per cent of health facilities initiated paediatric ART in 2015, compared to 39 per cent in 2014. The proportion of children under age five identified as HIV-positive who received antiretroviral treatment was at 82 per cent. UNICEF's contribution towards these results included training of health workers on Option B+ and paediatric ART in ten districts, post training follow-up and supportive supervision, as well as training of community-based workers in later referral, tracking and tracing of HIV-infected mother baby pairs.

Maternal, newborn and child health services are not the only services a mother requires. In Ukraine, many of the women who are living with HIV are also addicted to opiates. UNICEF advocacy and technical assistance to the government of Ukraine led to a revised national PMTCT regulation, allowing for the integration of PMTCT interventions with opioid substitution treatment. The Ukrainian Center for Disease Control, with support from UNICEF, approved a one-year implementation plan to pilot dried blood spot (DBS) testing in order to expand early infant diagnostics of HIV and improve access to timely ART treatment among newborns. As a result, in 2015, over 1,100 children born to mothers living with HIV who were opioid users received early testing for HIV within 48 hours of delivery and timely life-saving ART.

Innovations for optimized and simplified service delivery

Innovations in the HIV sector are urgently needed to: 1) reach those most at risk for HIV infection and provide HIV testing and follow-up services; 2) retain people living with HIV in services and promote adherence to life-saving medication; and 3) prevent new HIV infections. Innovations in these areas directly impact Strategic Plan results on the provision of paediatric ART, task shifting to non-health care providers to provide ART and the number of ANC facilities that provide ART.

One of the major challenges of retaining children in care is the complexity of the drug regimens and the side effects of medications. In 2015, the IATT paediatric working group on EMTCT, working at the global level under UNICEF leadership, developed operational guidance, translating normative recommendations on the newly released paediatric pellet formulation for young children under the age of 3. New research and innovations are still needed to make ART palatable for children and easy to administer for mothers and caregivers. UNICEF acknowledges the pellets as a move in the right direction, but the market dynamics of new drugs pose many challenges to the development of new drugs given the low demand.

In Papua New Guinea, shortages of ARVs were negatively impacting all HIV outcomes. With the application of easy-to-use forecasting tools that could be utilized by national

Myanmar case study

UNICEF, in collaboration with WHO, provided financial and technical support in Myanmar to the National AIDS Programme for scaling up ART for adults and children and to decentralize ART provision. Through capacity building of states and regional ART training teams, paediatric HIV care and treatment services are now available at all state and regional ART centres and several district hospitals. The decentralization of ART improved accessibility of services for adults and children living with HIV; the integrated approach spearheaded by UNICEF – building ART on existing child health services and treatment programmes – underscored the needs of HIV-exposed and infected children. UNICEF actively initiated decentralization of HIV counselling and testing in antenatal care settings through capacity building of health professionals and service providers in all states and regions, including hard-to-reach areas. With technical support from the government, UNICEF, the United Nations Population Fund (UNFPA) and financial support from the government and GFATM, point-of-care testing for HIV was implemented in 85 per cent of townships (280 out of a total of 330) and the HIV testing rate among pregnant women receiving antenatal care rose significantly, from 65 per cent in 2014 to 84 per cent in 2015.

UNICEF also provides technical support to monitor the decentralized PMTCT, HCT (HIV counselling and testing) and ART services in all states and regions. In 2015, UNICEF undertook an assessment of the cascade of PMTCT services received by pregnant women living with HIV between 2012 and 2014. In Myanmar, PMTCT services are expanding year by year. As of February 2016, there were 301 PMTCT townships out of 330 (91 per cent), 82 ART centres and 137 decentralized ART sites. Lifelong ART initiation for pregnant women living with HIV can be received not only at ART centres, but also at decentralized ART sites. Moreover, ARV prophylaxis can be received in all PMTCT townships. Subsequently, the majority of pregnant women living with HIV are able to access care and treatment.

More children received an HIV test as a result of the decentralization of early infant diagnosis (EID) and training in all states and regions in 2015. UNICEF Myanmar spearheaded the establishment of an information management system in Myanmar's National Health Laboratory in partnership with the Clinton Health Access Initiative (CHAI). The number of HIV-exposed children receiving early infant diagnosis rose to 1,976 in 2015 from 724 in 2014. Ten per cent of HIV-exposed children who received EID tested positive in 2015 compared to 15 per cent in 2014. A mechanism for early referral of children to ART centres, as well as initiation of ART and other care will bolster their prospects of survival, and reduce infant and child mortality rates.

With a focus on improving quality of HIV care and data management for ART, UNICEF Myanmar, in partnership with the CHAI, is developing a web-based patient management system to be field-tested in four ART centres. Based on experience from the field-testing, the system (called Open MRS) will be re-customized and scaled up to all ART centres in Myanmar. This system will allow service providers at the point of care to use an algorithmic approach for HIV care including TB treatment. Service providers and their supervisors will be reminded to follow-up on visits using in-app tools and web-based report generation in order to reduce the numbers of patients who slip from care. The collection and analysis of real-time cohort data to track and improve programme performance will generate evidence for future planning and to monitor quality of care.

In addition to working with the government, UNICEF also supported capacity building and mobilization of communities and people living with HIV, to improve follow-up care through systematic referral linkage to EID, ART and other necessary follow-up for mothers, children and their families.

and local-level health managers, UNICEF was able to support the National Department of Health in procuring supplies for the HIV programme including HIV test kits, antiretroviral drugs and medicines for management of opportunistic infections. UNICEF's support has strengthened the procurement and supply chain management system, resulting in a regular supply of HIV supplies and reduced shortages. Because of sustained advocacy by UNICEF, the government has increased domestic funding towards the HIV programme, including funding for the procurement of HIV supplies.

Another barrier to retention in services is geography. Some families simply can't make the monthly or bimonthly trips to clinics. UNICEF, in collaboration with the M*A*C AIDS Fund, completed its pilot implementation of an innovative decentralized paediatric HIV service administered though video-linked interface (telemedicine) in Maharashtra state, India. Thirty-two out of 86 peripheral ART facilities were linked to the Paediatric Centre of Excellence in Sion hospital in Mumbai. Services offered via telemedicine included ART initiation, follow-up and adherence counselling. The

UNITAID partnership: Innovation for simplified and optimized service delivery

With funding from UNITAID, UNICEF – in close collaboration with the Clinton Health Access Initiative (CHAI) – is supporting seven countries (Ethiopia, Kenya, Malawi, Mozambique, Uganda, the United Republic of Tanzania and Zimbabwe) to evaluate and scale up new point of care (POC) technologies for CD4, EID and viral load HIV testing. The use of a new generation of POC diagnostics is speeding up clinical decision making by reducing test to result turnaround time to the same patient visit. This aligns with overall efforts to strengthen laboratory systems. An implementation pilot for POC EID is underway in Malawi and Mozambique. Extensive programmatic work is ongoing to prepare the seven focus countries for piloting and scale-up of POC EID and viral load testing.

https://youtu.be/EM5S8SzI2go?list=PLBmFtt9_ZeUkGX2_SVRADR9B4a7ugclFM

The POC project started in 2012 and is likely to be extended for an additional four years in 2016 (Phase 2b). UNICEF's Supply and Programme Divisions are working closely together to orchestrate both the supply and the demand sides of this innovative initiative in seven high-burden countries. Phase 2b will include three additional countries (Cameroon, the Democratic Republic of Congo and Senegal).

Improved service delivery and access in POC focus countries

Ethiopia[1]
- **Turnaround time**: Reduced from 21 to 0 days
- **Time to ART initiation**: Reduced from 28 to 14 days
- **Same-day test results:** Increased from 0% to 100%

Kenya[2]
- **Turnaround time**: Reduced from 24 to 0 days
- **Same-day test results**: Increased from 0% to 96%

Malawi[3]
- **Turnaround time**: Reduced from 20 to 0 days
- **Time to ART initiation: Reduced from 30 to 7 days**
- **Same-day test results**: Increased from 4% to 86%

Mozambique[4]
- **LTFU between diagnosis and ART**: Reduced from 64% to 32%
- **ART Initiation**: Increased by 85%

Tanzania[5]
- **Time to ART initiation**: Reduced from 19 to 14 days
- **Same-day test results**: Increased from 62% to 100%

Uganda[6]
- **Turnaround time**: Reduced from 35 to 0 days
- **Time to ART initiation**: Reduced from 56 to 14 days

Zimbabwe[7]
- **Turnaround time**: Reduced from 58 to 0 days
- **LTFU between diagnosis and ART**: Reduced from 27% to 4%

Source: [1]Ministry of Health (MOH) Ethiopia; [2]MOH Kenya; [3]MOH Malawi; [4]Jani et al (2011); [5]MOH Tanzania; [6]MOH Uganda; [7]MOH Zimbabwe.

preliminary findings on the pilot were presented during the mHealth summit at the end of 2015 in Washington. The results indicated that children and adolescents living with HIV receiving care through telemedicine were more likely to initiate ART early, to be alive and on treatment, and less likely to be lost to follow-up ($p<0.05$).

Strategic partnerships and community engagement

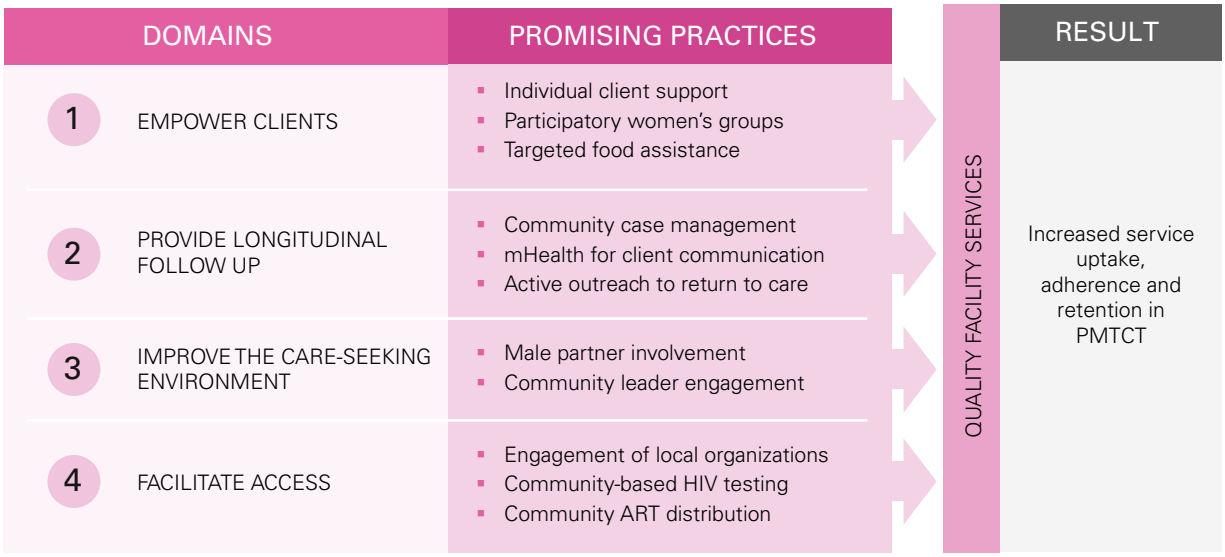
Communities of people living with HIV, including communities of mothers, and the closely knit social networks of rural communities all present opportunities for improved HIV and broader health outcomes, specifically Strategic Plan results focused on the uptake of HIV testing and treatment. UNICEF is using community-based models to drive HIV results as part of broader MNCH efforts.

In 2015, UNICEF focused on strengthening linkages between health facilities and the communities they serve. Recent programme data and assessments suggest high rates of disengagement from HIV care soon after ART initiation and after a newborn's first HIV test at 4–6 weeks of age. A recent study[18] commissioned by UNICEF in Côte d'Ivoire, the Democratic Republic of the Congo, Malawi and Uganda, and supported by the Governments of Norway and Sweden, identifies 11 promising practices in community-facility linkages, outlined in the figure below, that are associated with increased service uptake, adherence to drug regimens and retention in PMTCT, ART or MNCH care.

The study concludes that strong community-facility linkages can significantly improve PMTCT programme performance and recommends that country teams define and scale up a national package of community-facility linkages in support of PMTCT and MNCH more broadly.

Screening for infectious disease in early stages of pregnancy or before pregnancy is an innovative strategy to further decrease the mother-to-child transmission rates of HIV, hepatitis B, and syphilis and is being applied in China. In Yunnan Province, UNICEF supported the provincial government in developing a local community worker management mechanism to improve uptake of comprehensive ANC services, including PMTCT. Good practices on community mobilization, support for timely diagnosis and follow-up on PMTCT adherence were collected and integrated into the National PMTCT Scale-up Plan. Improved community care has increased the rate of early antenatal care visits, with HIV, hepatitis B and syphilis testing rising steadily from 35 per cent in 2012 to 65 per cent in 2015.

FIGURE 12
Community-facility linkages framework



Innovation to save lives

Optimizing HIV Treatment Access for Pregnant Women Initiative (OHTA): Côte d'Ivoire, the Democratic Republic of the Congo, Malawi and Uganda

The three-year OHTA project (2013–2015), funded by Sweden and the Norwegian Agency for Development Cooperation (NORAD), aims to accelerate HIV testing and immediate access to a simplified, one-pill-daily, lifelong treatment regimen (Option B+) for pregnant and breastfeeding women living with HIV.

The project uses catalytic investments to protect women's health and prevent HIV transmission to their babies and sexual partners in Côte d'Ivoire, the Democratic Republic of the Congo (Katanga Province), Malawi, and Uganda. Together, these four countries account for 22 per cent of the global gap in ARV coverage for PMTCT (prevention of mother-to-child transmission). The OHTA Initiative focuses on strengthening linkages between community social service delivery mechanisms and facility-based treatment services to scale up lifelong treatment programmes in these countries.

Solofina Mkanda, widow and mother of seven children, with her youngest, Alinafe (9 months old) in Nkhuloawe Village, Malawi. The little girl tested free of HIV thanks to services to prevent mother-to-child transmission (PMTCT). Health facilities use mobile phones to keep in touch with clients. But when they do not answer, it is best to follow up in person.

The 2015 midterm evaluation concluded that OHTA funding at facility and community levels decreased service delivery gaps, inspired community involvement and increased demand for services. In Malawi, for example, technical and material support was given to community-level health agents, community-facility referral mechanisms were formalized, campaigns undertaken to increase male involvement and supervisory facility reviews provided to both traditional and community leaders.

Findings from the evaluation concluded that OHTA revitalization of the community agent cadre proved a crucial link between communities and health facilities and improved ART uptake, service quality and retention in care, with six-month retention rates increasing from 72 per cent to 79 per cent. The 12-month retention rates rose from 66 per cent in 2013 to 74 per cent in 2015. District level M&E support provided by the OHTA grant to strengthen community-level planning and real-time monitoring diminished inequities in service delivery and fostered a culture of local ownership and understanding of data, leaving a health system strengthened beyond the PMTCT programme to the broader MNCH programme.

Global Fund to Fight AIDS, Tuberculosis and Malaria

UNICEF acts as the principal recipient of GFATM funding in Somalia and has used this opportunity to drive better integration of HIV services into primary health care. In Somalia, integration of PMTCT services launched in 2015 and has been operationalized at health facilities with functional ANC and delivery services. PMTCT services (HCT and referral to ART) are currently available in 46 health facilities. The Ministry of Health has an active role in supervision, co-facilitating the PMTCT training and directly implementing the programme in MCH services.

HIV testing of pregnant women is now routine, with higher numbers being captured during ANC visits. The revision of the PMTCT guidelines and PMTCT training of health staff in 2014, with the support of UNICEF, contributed significantly to the improved coverage and quality of PMTCT services. As a result, pregnant women living with HIV now consistently receive ART (Option B+) to reduce the risk of MTCT. ART coverage for pregnant women improved from 60 per cent in 2014 to 84 per cent in 2015. In 2015, UNICEF also supported the Ministry of Health to finalize the EID guidelines.

Using peer relations to promote quality care and improve adherence among people living with HIV (PLHIV), UNICEF, in collaboration with non-governmental organizations (NGOs) and the Government of Egypt, initiated an adherence programme through a 'health companion' system in four governorates. As a result, 1,936 PLHIV successfully received treatment in 2015, compared with 1,703 in 2014. This retention rate ranges between 70 and 79 per cent. PLHIV-tracking data reflected observable positive results in terms of reduction of the dropout rate and improvement of patients' regular uptake of their monthly treatment. Data analysis revealed that more than 72 per cent of beneficiaries remained adherent to ARVs after six months.

The growing numbers of people living with HIV across Eastern and Southern Africa are placing increased demands on health systems. People with HIV are also living longer, and this means that communities play increasingly important roles via task shifting – the delegation of clinical responsibilities to trained health care workers, often people who themselves are living with HIV.

In 2015, 92 per cent of pregnant women living with HIV in Uganda received life-long ART (Option B+). Option B+ has been rolled out to all 112 districts, covering 2,630 healthcare facilities across the country, including all national, regional referral and district hospitals, as well as health centres levels III and IV.

Evidence utilization and promotion of South-South cooperation

The UNICEF HIV programme seeks to promote South-South learning as a key strategy in addressing HIV. UNICEF helped counties marked by a high prevalence of HIV (Kisumu, Nairobi and Homa Bay) improve HIV interventions for children and adolescents. For the first time, all target counties were actively involved in developing work plans that aligned with national targets and cascaded down to facility level. At least 20 Ministry of Health national programme officers and 417 members from county and sub-county health management teams were taught strategies to mitigate gaps in paediatric and adolescent HIV programming. The result informed county work plans and 90-90-90 HIV targets received attention at facility level that improved response and accountability.

UNICEF also supported a South-South learning exposure visit for high-level officials of the Ghana Health Service (GHS) and Ghana AIDS Commission to the Republic of Zambia. The event focused on the process of integration of HIV care services into MNCH services. Three-year operational EMTCT plans were developed, including bottleneck analysis, for the Ashanti, Greater Accra and Western Regions, where HIV prevalence is higher than the national average of 2.5 per cent. These plans will help leverage resources for achieving the EMTCT target and also contribute to improving EID coverage and paediatric HIV care services.

Policy dialogue, advocacy and communication

In collaboration with WHO, the UNICEF HIV programme has been a strong advocate of the Global Plan, which defines global, regional and country targets for reducing HIV infections in children and AIDS-related maternal deaths in 22 priority countries. The promotion of PMTCT as a priority in national HIV strategies has been central to this, including treatment for all pregnant women living with HIV, early infant diagnosis of HIV and encouraging equity in national PMTCT plans.

UNICEF hosts the Secretariat of the Interagency Task Team (IATT) on the Prevention and Treatment of HIV Infection in Pregnant Women, Mothers and Children,

which comprises 32 member organizations, and co-chairs the IATT Executive Committee with the World Health Organization (WHO). UNICEF is also a core member of the Global Steering Group (GSG) of the Global Plan.

Through the IATT, UNICEF continued to provide technical support and programme guidance and tools for:

- Accelerating the roll-out of the WHO guidelines, which offer immediate and lifelong treatment to all pregnant women and mothers living with HIV (Option B+);
- Strengthening the tracking and testing of HIV-exposed infants and children for early identification of HIV;
- Increasing case finding of children who were not picked up through prevention of mother-to-child transmission (PMTCT) of HIV through 'Double Dividend' approaches to integrate paediatric HIV and child health platforms;
- Improving retention in care of mothers and infants until the end of the breastfeeding period; and
- Improving data systems to include retention, cohort and subnational programmatic data. In October 2015, the IATT, under UNICEF leadership, hosted a technical country consultation in Uganda with 15 countries to disseminate and discuss the IATT Option B+ monitoring and evaluation (M&E) framework and to build capacity in countries for M&E systems, with a focus on cohort and retention monitoring.

In 2015, UNICEF advocated Option B+ implementation in four countries (Côte d'Ivoire, the Democratic Republic of the Congo, Malawi and Uganda) with support from Sweden and Norway. As a result, countries shifted national policy and programme approaches to optimize the benefits of the new protocol. In the Democratic Republic of the Congo, an initial pilot of Option B+ in Katanga Province by UNICEF working with the Ministry of Health now informs practices across the country. UNICEF also supports five new focus districts in North Kivu Province. Through advocacy efforts by UNICEF, the Ministry of Health in Côte d'Ivoire has officially endorsed Option B+ and has shifted its policy in favour of task shifting, in which nurses and community health care workers are delegated some clinical responsibilities.

Advocating support for a government's national EMTCT scale-up requires persistence in the face of many competing priorities. This challenge has been overcome in places like Kenya, where UNICEF supported the partnership between the United Nations and the First Lady's Beyond Zero Campaign to eliminate new child HIV infections under the umbrella of preventable child and maternal deaths. Advocacy by UNICEF for HIV prevention resulted in five of six high-burden counties allocating domestic resources for HIV and AIDS in their county plans.

UNICEF provided coordination, planning and monitoring support to accelerate the roll out of Option B+ in Zambia during 2015. This involved streamlining the health facility assessment process and organizing the rapid training of providers on the new protocol. As a result, 95 per cent of MCH programmes country-wide are implementing Option B+, reaching 95 per cent in urban sites and 91 per cent in rural areas. Through continued advocacy in Côte d'Ivoire, UNICEF, in collaboration with WHO, UNAIDS, PEPFAR and GFATM, the Government adopted Option B+ for PMTCT, with the goals of testing and treating children up to 10 years of age and task shifting ART treatment prescription to nurses and midwives in 2015.

Validation and certification of the elimination of new HIV infections in children: Suriname, Thailand and Zimbabwe

Elimination of new HIV infections in children is the goal of the Global Plan, and UNICEF is both supporting countries as they strive to meet the requirements and advocating for their success.

Elimination of new HIV infections must be validated and certified by a WHO- and UNICEF- led process. UNICEF provided technical support to the government of Thailand to track the results of the EMTCT campaign launched in 2014 and consolidate the gains made from the implementation of early and lifelong ART for HIV-positive pregnant women (Option B+). The pre-validation report was prepared in November 2015, and Thailand aims to apply for validation of EMTCT in 2016. With these steady gains, Thailand remains on track with its national plan and the global goal to eliminate MTCT of HIV by 2030.

Suriname and Zimbabwe also initiated the EMTCT validation process. With the financial and technical support of UNICEF, a retreat was organized by the Suriname Ministry of Health in November 2015 with key stakeholders to discuss a roadmap to validate EMTCT in Suriname. UNICEF provided technical help analysing PMTCT data and assessing progress of implementation. The results informed prioritization of districts in Zimbabwe needed to achieve the validation of EMTCT planned for 2016–2017.

In South Africa, UNICEF provided technical and logistical support to all districts across the country through the provincial EMTCT stocktaking and planning workshops to translate the national EMTCT plan into concrete goals for local facilities in alignment with the global 90-90-90 and EMTCT validation targets and focused especially on districts with a high burden of new HIV infections in children. UNICEF developed the facility-level bottleneck analysis and monitoring tools that are being used for the 90-90-90 planning, implementation and monitoring processes.

In 2015, UNICEF supported Benin in the final year of its EMTCT plan as it reviewed how best to accelerate the implementation process. UNICEF financially and technically supported the National AIDS Control Programme to undertake an assessment of the 2012–2015 Plan and also to organize a validation workshop for the new EMTCT Plan for 2016–2020. And in Ghana, UNICEF provided technical assistance needed for a paediatric HIV services situation analysis. As a result of the findings, which showed gaps in coordination and service delivery of EID and paediatric HIV services, the Ministry of Health and other partners moved towards integration of PMTCT and paediatric HIV services into the Maternal, Neonatal and Child Health (MNCH) programme.

PROGRAMME AREA 2: SECOND DECADE – ADOLESCENTS

The year 2015 proved a milestone year for UNICEF's commitment to adolescent and HIV response. The latest available internal monitoring data from 2015 shows that UNICEF was on track to achieving its 2015 milestones towards the Strategic Plan targets set for 2017. Under the output for strengthened political commitment, accountability and national capacity to legislate, plan and budget to scale up HIV and AIDS prevention and treatment interventions, in 2015, 31 countries had national HIV/AIDS strategies in place that include proven, high-impact evidence-based interventions to address HIV among adolescents, exceeding UNICEF's target of 30 countries. As for countries with national policies to implement sexuality or life skills-based HIV education in upper primary schools, UNICEF aimed to reach 34 UNAIDS priority countries by 2015 and fully achieved this target.

Despite this great success, further acceleration towards UNICEF's targets is needed under the output for increased capacity of governments and partners, as duty-bearers, to identify and respond to key human rights and gender equality dimensions of HIV and AIDS, where 17 out of 23 countries targeted in 2015 reported having national household survey data on HIV disaggregated by age and sex, while 13 out of 20 target countries had undertaken a gender review of their HIV policy or strategy by 2015 with UNICEF support.

Planning for second decade success, UNICEF recognizes a number of critical barriers in accessing services for prevention, treatment and care. Many of these services remain out of reach or are inadequately designed to meet the needs of the most vulnerable adolescents. HIV knowledge among adolescents is low in many settings, and data on adolescent HIV are often disaggregated by sex or age. Where adolescent data are collected, data for younger adolescents (aged 10–14) are often unavailable in sentinel surveillance, monitoring systems, surveys and programme and research data. Challenges arise in obtaining ethical approval for the inclusion of adolescents in surveys that lack age-appropriate questions. For adolescent key populations (gay and bisexual adolescent boys, transgender adolescents, adolescents who are sexually exploited and sell sex and adolescents who inject drugs), this scarcity of data is compounded by discrimination and marginalization.

These factors make it difficult to measure progress in the adolescent HIV epidemic and HIV-related outcomes in a standard way and to design the most effective programmes to address HIV in adolescents. The immediate goal to strengthen data-driven planning through the All In to #EndAdolescentAIDS agenda is thus driving critical investments towards addressing this persistent gap.

Overall, UNICEF's contribution to the global push on scaling up prevention, testing and treatment services for adolescents has been strong. Country examples throughout the results section reveal the ways in which barriers to successful national adolescent policies and programmes across the second decade of life are surmounted and highlight the work that remains to be done.

Policy dialogue, advocacy and communication

In February 2015, UNICEF, UNAIDS and the President of Kenya launched All In to fast-track global and country efforts to end the AIDS epidemic among adolescents. This multi-stakeholder effort, which includes WHO, UNFPA, PEPFAR, Viacom MTV, GFATM and young people themselves, represented by Youth LEAD, brought the crisis of adolescents and AIDS to the attention of global policymakers and promoted the goal of a 65 per cent reduction in AIDS-related mortality and a 75 per cent reduction in new infections among adolescents by 2020.

The All In initiative aims to fast-track the AIDS response and requires UNICEF and the All In partners to instigate and follow through on policy discussions with governments. To this end, UNICEF galvanized a multitude of stakeholders for the global launch in Nairobi. The President of Kenya presided over the event, which resulted in increased strategic focus and commitments for resources and clear directives to ministries.

Participants included dignitaries from the GFATM, PEPFAR, WHO, MTV Staying Alive, GNP+, UNAIDS, UNFPA and UNICEF's Deputy Executive Director, Ministers of Health and Education, CSOs, government and adolescents. Young people, including those living with HIV, were actively involved in the launch and follow-up actions. This momentum led UNICEF, the National AIDS Control Council and partners to develop a national Fast Track Plan to end AIDS among Adolescents and Young People programme only seven months later, which again received the attention of the President.

In the lead up to the biennial International Conference on AIDS and STIs in Africa, held in Zimbabwe from 29 November to 4 December 2015, UNICEF, in partnership with UNAIDS, the United Nations Population Fund (UNFPA), the Y+ Young People Living with HIV Programme and PACT, the coalition of youth organizations, organized an All In consultation with adolescent and youth leaders to rally and engage stakeholders in the four workstreams (focus areas).

In an effort to use innovative social media to promote All In, a global portal (http://allintoendadolescentaids.org/) was designed to provide a platform to mobilize partners and raise attention for support and funding globally and nationally. Since then, UNICEF has supported the MTV Staying Alive Foundation to produce a fourth season of their media series Shuga, which focuses on adolescents and youth, combining traditional, mobile and social media.

Girls and adolescent key populations – including gay and bisexual adolescent boys, transgender adolescents, adolescents who inject drugs, and children aged 10–17 who are exploited through the selling of sex – face the highest risk of HIV infection. UNICEF plays a key role in supporting governments to collect evidence to address the needs of these especially vulnerable populations. In Bangladesh, UNICEF and UNAIDS co-led advocacy efforts that resulted in the Ministry of Health intervening to facilitate HIV services for at-risk adolescents in response to barriers posed by age of consent laws. An interim memo instructed service providers to allow HIV testing, condom promotion and needle syringe exchange for high-risk adolescents who live without their parents' support. This work was informed by the efforts of the Bangladesh Government, which, with UNICEF's support, initiated a new partnership with four community-based organizations that provided services to 450 adolescents. These interventions produced immediate results: 60 per cent of the targeted adolescents received HTC and subsequent referral to ART; 93 per cent received psychosocial counselling; 46 per cent received STI screening and an additional 52 per cent received TB screening. The experiences and success from this initiative drove policy change.

UNICEF's leadership in the Inter-Agency Task Team on young, key-affected populations led to the publication of the Asia-Pacific Adolescents and HIV report,[19] which drew enormous regional and global attention to adolescents and young key populations around the 2015 World AIDS Day. A comprehensive media package generated over 110 media stories to coincide with Worlds AIDS Day in 2015. The Guardian story on HIV and mobile technology got over 100,000 views and helped drive subsequent media coverage. Several radio and TV news interviews, including with ABC, BBC, Channel News Asia and Deutsche Welle, raised adolescents and HIV issues to unprecedented levels both regionally and globally.

UNICEF also championed the Government of India's efforts in convening the first national inter-ministerial consultation on 'Enhancing Policy and Programme Action around Adolescents Living with or Affected by HIV'. The conference brought together the Ministries of Health and Family Welfare, Women and Child Development, Human Resource Development, Social Welfare, Youth Affairs and Sports, Social Justice and Empowerment, the Parliamentarian's Forum on HIV/AIDS and the National Commission for the Protection of Child Rights, with the goal of accelerating effective action for adolescents.

Age of consent is one of the major barriers to guaranteeing adolescents' right to health. In Jamaica, advocacy by UNICEF has led to significant improvements in the policy environment and health sector to address HIV prevention, treatment and care for adolescents and young people. The Jamaican parliament appointed a committee to consider legislative changes to the age-of-consent law, so that health care providers are able to deliver medical services for adolescents under age 16 without fear of prosecution. These proposed changes, developed with UNICEF's financial and technical assistance, were endorsed by five government ministers and were widely shared through consultations with key interest groups. Jamaica's Ministry of Health has subsequently revised its standards for delivery of services among adolescents.

Monitoring results for equity

One of the most significant challenges in scaling up HIV and reproductive health interventions for adolescent populations is the lack of data for 10–19 year olds. The All In initiative has been critical in driving national efforts to collect age- and sex-disaggregated data.

Across the regions, countries are using the UNICEF-created Adolescent Assessment and Decision-Makers Tool, which is based on the Monitoring of Results Equity System (MoRES) approach to help pinpoint actions that will accelerate reductions in new HIV infections and AIDS-related deaths in adolescents. Between March and June 2015, as part of the All In agenda for adolescents, Botswana, Cameroon, Jamaica, Swaziland and Zimbabwe initiated country assessments to identify bottlenecks affecting effective delivery of key interventions for HIV prevention, treatment and care in priority adolescent

populations. Lessons from these assessments were synthesized into a global report to support governments and partners in other countries as they initiate the same approach.

To date, nine additional countries, including Côte d'Ivoire, the Democratic Republic of the Congo, Gabon, Haiti, Mozambique, Namibia, the Philippines, Rwanda and Ukraine have also initiated these adolescent assessments with UNICEF support, and a further six countries (China, Indonesia, Lesotho, Nigeria, Thailand, and the United Republic of Tanzania) are set to begin this work in the first six months of 2016.

In Zimbabwe, 100 per cent of all ART-providing sites offer HIV testing and ART to adolescents. As of September 2015, a total of 170,664 adolescents were tested for HIV, and 7,673 (4.5 per cent) tested HIV positive. Of the total 7,673 adolescents diagnosed as HIV-positive, 60 per cent were initiated on ART. This increased the numbers of HIV-positive adolescents accessing ART to 52 per cent for those aged 10–14 years and 63 per cent for those aged 15–19 years, as of September 2015. The main barrier to HIV testing reported by young people is fear of knowing the results. Results from the assessment have been used to develop an accelerated national plan to scale up HIV care and treatment for children and adolescents, as well as a National Health Care Strategy.

Under the leadership of Côte d'Ivoire's Ministry of Youth, the Government conducted a situation analysis of adolescent and HIV/AIDS, examining data from adolescent HIV programmes that were technically and financially supported by UNICEF. More than 60,000 adolescents were targeted with behaviour communications to influence them to obtain an HIV test. Among them 37,582 (62 per cent) were tested for HIV, and 1.5 per cent were diagnosed as HIV-positive. More girls (20,167) were tested than boys (17,415). The HIV prevalence is higher among adolescents between 15 and 19 years old, and more adolescent girls are infected (60 per cent vs. 40 per cent of boys). These figures are reversed among those 20–24 years old. At this age, the burden becomes higher among boys than girls (57 per cent vs. 43 per cent).

The annual data analysis of tested adolescents revealed that treatment retention is better among adolescent girls than among boys, with 67 per cent of HIV-positive adolescent girls receiving ARV. Nationally, adolescent

Rita is 24 years old and living with HIV in Malawi. She joined a mother's support group that has taught her a lot about protecting her child from HIV and staying healthy while on antiretroviral treatment.

girls have a higher prevalence rate of HIV (0.8 vs. 0.1 per cent). Peer-to-peer outreach was launched as a strategy to address this disparity in communities and schools. Out of the targeted 70 per cent of adolescents and youth in UNICEF-supported regions, 87 per cent gained accurate information and life skills regarding HIV/AIDS, STIs, sexual and reproductive health and gender-based violence (51 per cent of boys and 49 per cent of girls).

Integration and service delivery at decentralized levels

UNICEF recognizes that addressing HIV among adolescents requires a comprehensive plan involving education, reproductive health services and protection (such as for street children). Latin America and the Caribbean have historically led in integrating HIV education into school curricula, beginning with the International AIDS Conference in 2008, where Ministers of Health and Education came together to address HIV and its effect on broader health issues. In Honduras, UNICEF developed a communication strategy in partnership with the Ministries of Education and Health to address HIV and adolescent pregnancy through in- and out-of-school workshops, efforts that reached 425,000 adolescents and young people in 2015.

In Nicaragua, UNICEF collaborated with the U.S. Peace Corps to implement school-based life skills training on HIV, teenage pregnancy, youth violence and drug addictions. The programmes took place in Somoto, San Lucas and Bluefields, and served 350 adolescents (58 per cent girls), teaching habits that promote healthy behaviour, social inclusion and the prevention of risks most often affecting adolescents. A group of youth leaders was trained in HIV prevention and conducted peer counselling as part of a prevention campaign. With the support of technical advisers, a total of 442 teachers (349 women and 93 men) were trained in life skills and how to incorporate these lessons into the curriculum.

In 2015, UNICEF also contributed to the development of the Zimbabwe joint United Nations programme for young people, promoting collaboration between the Ministries of Education and Health in six districts. Through an HIV testing campaign in four provinces, 76 schoolteachers and 100 community leaders were oriented on testing of children and adolescents, and 84,809 people were tested. Data from the HTC campaign indicated that when schools and communities were engaged, more adolescents and children accessed HIV testing from outreach services than through routine health facilities: 46 per cent of those tested through outreach services were below 19 years of age, compared to 25 per cent of those who were tested through health facility-based HTC. Increasing outreach in communities significantly expanded the number of children and adolescents with access to preventive services.

Reproductive health services for adolescents offer a key entry point for HIV interventions, especially for girls. In 2015, Jamaica, with financial and technical support from UNICEF, conducted a study on knowledge, attitudes and behaviour among pregnant women living with HIV and post-partum mothers living with HIV aged 15–24 years in high-prevalence rural settings. The results revealed poor treatment literacy and critical gaps in awareness about HIV prevention and the risk of mother-to-child transmission. Almost one third of the adolescent girls and young women reported that their partner was not aware of their HIV status.

The results of the study are being used by the NGO Eve for Life to strengthen collaboration with the Ministry of Health in the most affected rural areas to ensure that antenatal services relate to the specific needs of HIV-infected adolescent girls and young women. Since the study, Eve for Life has provided approximately 1,400 adolescent girls and young women in 10 antenatal clinics in high-prevalence rural areas with access to HIV-prevention knowledge and skills through group and individual education sessions. In 2015, a total of 61 adolescent girls living with HIV received counselling and nutritional support along with skills-based education, including condom negotiation and treatment literacy. These girls, most of whom are also mothers, are now linked to one of three support groups. In order to improve their emotional support network and increase the likelihood of adhering to treatment, 75 per cent have received counselling to disclose their status to their families.

The launch of the All In to #EndAdolescentAIDS Initiative in 2015 provided Nigeria with much-needed momentum for an accelerated national HIV response to help the adolescents who bear the highest burden of HIV. Through an 18-month pilot programme under the leadership of the Government and with participation of adolescents and young people, NGOs and communities, UNICEF supported the efforts of two states (Benué and Kaduna) to strengthen their technical capacity to deliver equitable and comprehensive HIV services. As of November 2015, the pilot had reached 91,874 adolescents and young people with HTC in 15 months, against a planned target of 75,000 in 18 months. The goal of this pilot is to inform the scale-up of HIV prevention and sexual and reproductive health services for adolescents, as well as improving care for adolescents living with HIV.

In the Plurinational State of Bolivia, UNICEF supported a study of the prevalence of HIV, hepatitis B and syphilis among the Ayoreo indigenous population, applying tools used in Peru and validated in Bolivia. This research incorporated the participation of Ayoreo women. The results indicated that HIV prevalence in the Ayoreo indigenous population is 2.15 per cent, with a 6.7 per cent prevalence of syphilis and no cases of hepatitis. Ministry of Health representatives and Ayoreo community authorities used

the data to improve the delivery of comprehensive health services, including HIV and other reproductive health needs.

Sexual violence towards girls remains a significant global concern, an abuse of human rights with tremendous impacts on the emotional and physical well-being of girls. The Government of Togo, within the framework of actions to reduce the vulnerability of adolescents to HIV/AIDS, carried out a situation analysis focused on children aged 6 to 17 years living on the streets to analyse the various underlying social determinants. As a result of this survey, UNICEF developed life skills-based educational modules, including HIV prevention, with the Ministry of Primary and Secondary Education, to be used in primary schools from 2016 and later in junior high schools. A harmonized training package addressing gender-based violence, and including sexual abuse, was made available to all partners in the education sector for immediate use. Training on gender-based violence, especially violence against girls, was given to 1,044 teachers and principals and 358 members of Primary School Management Committees. UNICEF also provided support to NGOs for advocacy on the prevention of child marriage and sexual violence in the prefectures of Kozah and Dankpen, reaching 2,000 adolescents.

Social protection services are best equipped to meet the needs of adolescents who are sexually exploited or who inject drugs and remain at high risk for HIV. In Thailand, UNICEF supported the Chiang Mai-based NGO Volunteers for Children Development Foundation's project of HIV prevention and access to HIV-related services for adolescent key populations. The NGO's drop-in centre, which contains a child-friendly centre, functioned as an initial point of contact for children and adolescents in the immediate community. The project also reached out to parents and local leaders to generate awareness and improve attitudes regarding child rights, child protection and HIV/AIDS. In partnership with the NGO Path to Health, UNICEF Thailand developed an online platform that provides health information, including on HIV testing, counselling and referral services via chat and maintains full anonymity of platform users.

Innovations for optimized and simplified service delivery

The need for adolescents to be tested for HIV and to receive effective follow-up services and consistent access to treatment is clear. Yet persistent social and economic barriers remain, underscoring the need for bold and innovative actions that will fast-track the AIDS response.

As part of scaling up innovation, UNICEF led a global meeting on pre-exposure prophylaxis (PrEP) for adolescents, gathering researchers and technical specialists together to determine a set of key clinical, ethical and operational goals for the implementation of PrEP in sexually active older adolescents. The results will help steer the upcoming global implementation guidelines for PrEP, scheduled to be released in early 2016. In addition, UNICEF consulted with country offices in Brazil, South Africa and Thailand, and with partners in multiple countries, to design a five-year demonstration project to guide the introduction of PrEP as a key component of a comprehensive HIV-prevention programme for adolescents at particularly high risk of infection.

The M*A*C AIDS Fund has provided more than US$2.4 million to support innovations and enhance service delivery for adolescents in seven focus countries for one year ending in 2016: Brazil, China, India, Indonesia, South Africa, Thailand (East Asia and Pacific Region) and Ukraine. The funding has enabled innovative technologies and programmes to improve access to HIV testing, as well as to link adolescents living with HIV with follow-up treatment and support services.

Strategic partnerships and community engagement

UNICEF aims to foster strong relationships with adolescents, teaching them to advocate for social change alongside the organizations that serve them. At the global level, UNICEF leads efforts in four partnership platforms or workstreams to advance the All In agenda by engaging with networks of adolescents and young people. UNICEF developed and disseminated basic tools to guide data-driven planning which were conducted in 9 countries to date among all key stakeholders, including adolescent and youth groups – to facilitate their engagement. The results have yielded useful information in determining priorities for adolescent investments in multiple sector planning processes and also supporting resource mobilization and development of partner plans such as the GFATM. (*See Making the money work for young people: a participation tool for the Global Fund to Fight AIDS, Tuberculosis and Malaria for Country Coordinating Mechanism members and other Global Fund actors.)*

Strategic partnership with young people themselves, particularly adolescent populations most at risk for HIV infection, has proven effective in improving HIV outcomes. In Brazil, UNICEF, in partnership with the M*A*C AIDS Fund, continued to implement the Youth Aware project in Fortaleza, aimed at increasing testing and treatment for young key populations. From January to October 2015, 368 people between 15–24 years old were tested for HIV through a mobile unit. Out of those, 12 tested positive, which represents an increase of 3.3 per cent in the HIV prevalence, compared to the same period in 2014. All of the 12 attended their first medical appointment, and 70 per cent have initiated antiretroviral treatment. In Porto Alegre (where the project is also being implemented), from January to October 2015, 1,362 people between 15–29 years old were tested for

Technological innovations

Technology drives innovations in several UNICEF-sponsored HIV programmes. U-Report, for example, uses short message service (SMS) technology to bring communities in direct contact with their governments and UNICEF. U-Report is a real-time information tool made possible by RapidPro, an open-source software developed by UNICEF.

In Swaziland, the Government urged its citizens to join U-Report, with a goal of strengthening platforms for engaging communities, and especially adolescents and youth, on issues affecting them. As a result, 2,568 U-Reporters (65 per cent female and 74 per cent adolescents) subscribed to the platform in the space of three months. The U-Report platform is also linked to an ongoing radio programme supported by UNICEF, which allows young people to engage on issues such as HIV, drug and substance abuse, suicide, depression and peer pressure.

The platform has been adopted by the Ministry of Health as a quality assurance tool, enabling clients to provide feedback to service providers. UNICEF also supported efforts of the Swaziland Scout Association to mainstream adolescent sexuality, reproductive health and HIV/AIDS education in their national youth programme. Over 1,000 adolescents from across the country received life skill training using U-Report directed at preventing HIV infection and early pregnancies. The use of U-Report encouraged communal engagement and provided a place for adolescent voices to be heard.

UNICEF supports the national HIV response in Zambia with a focus on high-impact HIV interventions for adolescents, including through the U-Report platform. In 2015, UNICEF Zambia worked with the National AIDS Commission to promote HIV testing among adolescents through SMS and radio messages and via peer educators, youth counsellors and U-Reporters. As a result, more than 88,000 youth used U-Report to get free counselling services about HIV/AIDS.

U-Report, which is free, allows its users to anonymously text questions about HIV and AIDS. In doing so, it provides an alternative and critical information source to youth who might otherwise be uncomfortable seeking in-person advice. Results show that those enrolled in the programme increase their likelihood of going for HIV tests by 30 per cent, and participation confirms an eagerness for facts and access to information. Approximately 50 per cent of U-Report subscribers use the tool to seek confidential HIV and sexual and reproductive health (SRH) information through an SMS advice line. Polls on HIV issues elicit regular response from 20 per cent of the users. The National AIDS Commission used U-Report polling data as inputs in C4D interventions, and UNICEF assisted the NAC to design and implement a radio campaign that urged HIV testing and condom use. Preliminary data show high levels of HTC utilization, with one in four clients being adolescents aged 15–19.

Using technology to promote healthy behaviours among adolescents, because many of them enjoy and utilize mobile devices, UNICEF's country office in China created Health Walk, a mobile application to enable adolescent participation and access to services on an iOS platform. The app provides information on HIV and SRH services via a Geographic Information System. Through the UNICEF-supported Youth Ambassador Programme and various HIV participatory prevention activities, over 4,500 adolescents and young people sought adolescent-friendly counselling and other services where demand for these services was previously thought to be very low.

HIV through the mobile unit. Out of those, 21 tested positive. Among the 21 cases diagnosed, 86 per cent have attended their first medical appointment, and 78 per cent have initiated antiretroviral treatment.

To expand the use of PrEP as an innovation, UNICEF has established a global technical advisory group comprising leading researchers, implementers and national decision-makers.

To harness global response to the rising HIV infection among adolescents, WHO, with support from UNICEF and in collaboration with the Inter-Agency Working Group on Key Populations, issued four technical briefs on HIV and young key populations aged 10–24. The briefs outline programme approaches and considerations for effective HIV programming, with a focus on policy reform, integrated service delivery and improved accessibility, affordability, quality of service and human rights. UNICEF's role focused on the inclusion of considerations for children aged 10–17 years.

UNICEF's East Asia and the Pacific Regional Office, in partnership with United Nations agencies and youth-led and youth-serving civil society organizations continued to promote adolescents and young key populations in national AIDS responses through the Asia Pacific Inter-Agency Task Team (IATT) on Young Key Populations (YKP). With the IATT's technical support and guidance, Youth LEAD (Asia Pacific's YKP network) became the first-ever AP YKP youth network member of the NGO Delegation to the UNAIDS Programme Coordinating Board for 2015–2016.

In Jamaica, high-risk and hard-to-reach populations were targeted. As a result, more than 200 adolescent men who have sex with men (MSM) were provided with access to HIV prevention, counselling and services through a programme implemented by UNICEF's civil society partner Children First. Sexual health education and condom negotiation was taught to 225 adolescent and young MSM, and 37 per cent of these also received HIV testing and counselling.

As part of UNICEF's efforts to decrease stigma for adolescents both in and out of school and also to promote HIV testing and retention in treatment and care, UNICEF supported the launch of a national network of adolescents living with HIV, termed 'Sauti Skika' (Amplifying Voices), through the National Association of People living with HIV. Members of Sauti Skika have been actively involved in the development of new national government plans and programmes on adolescents and HIV.

Evidence utilization and promotion of South-South cooperation

UNICEF's East Asia and the Pacific Regional Office, as a member of the Regional Technical Working Group for the Pacific Islands Regional Multi-Country Coordinating Mechanism, also supported the submission of a concept note to GFATM, which resulted in approximately US$6.5 million of new funding for HIV and STI programming for the next 2.5 years. UNICEF provides technical support for the implementation of the GFATM grant through the Regional Technical Working Group, which includes the development of a single M&E system, research on young key populations and a telemedicine centre to support the management of HIV cases in Pacific Island countries.

In Argentina, UNICEF supported the Fundación Huésped in efforts to strengthen the response to HIV for adolescents, with an emphasis on reducing vertical

UNICEF and PEPFAR: All In to #EndAdolescentAIDS – with a focus on girls and women

PEPFAR DREAMS Initiative: Helping girls develop into Determined, Resilient, Empowered, AIDS-free, Mentored and Safe women[20]

The All In to #EndAdolescentAIDS platform led by UNICEF and UNAIDS seeks to mobilize partners to respond to increasing death rates attributable to HIV and faltering HIV prevention among adolescents. Girls and young women account for 71 per cent of new HIV infections among adolescents in sub-Saharan Africa. Many are marginalized and are too often devalued because of gender bias. Social isolation, economic disadvantage, discriminatory cultural norms, orphanhood, gender-based violence, and school drop-out all contribute to girls' disproportionate vulnerability to HIV.

DREAMS is an ambitious US$385 million partnership meant to reduce HIV infections among adolescent girls and young women in 10 sub-Saharan African countries. The 10 DREAMS countries (Kenya, Lesotho, Malawi, Mozambique, South Africa, Swaziland, the United Republic of Tanzania, Uganda, Zambia and Zimbabwe) account for nearly half of all new HIV infections that occurred among adolescent girls and young women globally in 2014.

DREAMS advocates multiple solutions for one problem. With support from PEPFAR, the Bill & Melinda Gates Foundation, Girl Effect, Johnson & Johnson, Gilead Sciences and ViiV Healthcare, DREAMS combines broad evidence-based approaches that encompass more than the health sector in order to tackle the structural drivers that directly and indirectly increase girls' HIV risk, including poverty, gender inequality, sexual violence and a lack of education.

Halima Mfaume is 16 years old, living with HIV and learning to become a hairdresser. She lives in Dar Esalaam in Tanzania with her grandmother. "My dream is to one day being a hairdresser... to have my own salon one day, designing people's hair. I also hope to be a mother," said Halima.

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transmission on the border with the Plurinational State of Bolivia, in the cities of Salvador Mazza and Tartagal (Salta) and Yacuiba (Tarija). Though the initiative is supported by the Ministries of Health in Argentina and Bolivia and UNICEF in both countries, there was strong ownership of the project by the local states. UNICEF also supported the Fundación para el Estudio de la Mujer (Foundation for the Study of Women) in conducting a participatory assessment on the situation of adolescent pregnancy in greater Buenos Aires. A subsequent awareness campaign for adolescent girls about unplanned pregnancy led FEIM and RedNac, supported by UNICEF, to use social media messages and also five YouTube videos and 60 news stories in print media, radio and TV, to supply reliable information to adolescents and youth. As part of the campaign, 10,000 HIV prevention kits and 110 awareness-raising posters were distributed. UNICEF also undertook a participatory analysis of determinants of adolescent health within society and officials of government agencies and adolescents themselves, to identify the main gaps in accessing sexual and reproductive services.

The All In technical working group also initiated the development of a National Programming Framework for Adolescents and HIV in Botswana. The Government of Botswana provided coordination and leadership support to a joint programme on adolescents and HIV between Botswana, Lesotho, Namibia, South Africa and Swaziland. UNICEF Botswana helped the programme define its priorities, including eliminating mother-to-child transmission, reducing new infections among adolescents and strengthening South-South cooperation among partners. The programme also focuses on increasing shared knowledge across the five UNICEF country offices and between the respective partners.

In Kenya, UNICEF assisted the PEPFAR and GFATM processes by providing data and technical support for the development of new programmes to prevent HIV among girls, young women and children as well as the development of the GFATM, Joint HIV and TB Concept Note, respectively. UNICEF and the Ministry of Health co-convened the first national Adolescent Health Symposium on HIV-related priorities for adolescents in Kenya to focus on the Sustainable Development Goals. Approximately 200 participants – including government officials, development partners, United Nations agencies, CSOs, academic and research organizations, the private sector and young people – reviewed trends and priorities and called for more specific gender-responsive adolescent health targets in national plans and investment cases. Adolescents and young people, including young mothers, were key partners in determining the programme and participating in the national event. Jointly with the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), Centers for Disease Control and Prevention (CDC) and USAID, the national symposium helped position adolescent health and HIV priorities on the agenda of Homa Bay County, which has the highest HIV prevalence in the country.

Raj Upendra Upadhya, 6 years old, with her parents in a Pediatrics Antiretroviral Therapy (ART) Centre in Maharashtra.

1. © UNICEF/UNI195634/Singh. India, 2015

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

In 2015, UNICEF worked to enhance HIV prevention, treatment, care and support outcomes for vulnerable families and individuals by improving social protection programmes and advancing research in social protection. Promoting the use of evidence-based, action-oriented recommendations that help identify and address the social and economic issues underlying HIV. Under UNICEF's Strategic Plan output for strengthened political commitment, accountability and national capacity to legislate, plan and budget to scale up HIV and AIDS prevention and treatment interventions, in 2015, 25 countries out of the 28 UNICEF targeted had either a national child protection strategy or a national social protection strategy in place, with elements focused on HIV.

Disease outbreaks, conflict, natural disasters, economic and political crises and other hazards can disrupt HIV services, preventing delivery of supplies, disrupting treatment retention and spiking new infections as protective societal norms break down. To achieve its vision of an AIDS-free generation for children, adolescents and pregnant women, UNICEF includes HIV in its Core Commitments to Children (CCCs) in Humanitarian Action to ensure access to HIV prevention and treatment for children, adolescents and pregnant women and mothers in risk-prone and emergency settings. Under the Strategic Plan output for increased country capacity and delivery of services to ensure that vulnerability to HIV infection is not increased and HIV-related care, support and treatment needs are met in humanitarian situations, UNICEF ensured 59 per cent of HIV-positive pregnant women in humanitarian situations received treatment to prevent mother-to-child-transmission of HIV in 2015, compared to 60 per cent targeted, reflecting a 98 per cent target achievement.

Evidence utilization and promotion of South-South cooperation

Collecting data in times of crisis is notoriously difficult, hindering a clear understanding of the burden of disease during emergencies. This has previously impeded policy decisions on HIV in emergency situations, but UNICEF is working with partners to improve efforts to collect this critical data. In 2015, UNICEF, in partnership with the United Nations High Commissioner for Refugees (UNHCR) and UNAIDS, using UNHCR and UNAIDS databases as well as modelling exercises, gathered updated and current data on the number of people living with HIV in emergency-affected countries. In 2014, the total number of people living with HIV who were affected by emergencies was 1.7 million, out of whom 174,293 were children, 80,956 were pregnant women and 192,761 were adolescents. These data were used to develop a background paper for the thematic segment of the 36th UNAIDS Programme Coordinating Board, outlining the need to include humanitarian settings in HIV programming, and were useful in advocating for emergencies and risk-informed programming in the new UNAIDS 2016–2021 Strategy.

For UNICEF, risk-informed programming helps to build more flexible, context-informed, disaster-prepared programmes that mitigate the impact of shocks and ensure that HIV prevention, treatment, protection, care and support services are not disrupted in the wake of a crisis. In 2015, UNICEF developed an HIV chapter on risk-informed programming highlighting examples from UNICEF country offices that have managed to sustain care and treatment in times of crisis. UNICEF, Save the Children and UNHCR finalized and disseminated a lessons learned document on PMTCT in humanitarian action that provides recommendations that focus on successful PMTCT health service delivery and specifically on continuation, or, where possible, initiation of lifelong ART during PMTCT.

In 2015, UNAIDS and the World Bank convened the Social and Structural Drivers of HIV Research Meeting to identify research gaps and sharpen efforts to strengthen the evidence base underlying HIV-sensitive social protection programming. UNICEF developed and published a compendium of best practices, which documents the impact of strong links between community social service delivery networks and facility-based services in the health sector.

For UNICEF to support its reporting responsibilities against standardized social protection indicators for the UNICEF Strategic Plan, the Sustainable Development Goals and the UNAIDS Global AIDS Response Progress Reporting, UNICEF is also piloting a social protection module in Kenya, Zimbabwe and Viet Nam for the multiple indicator cluster surveys (MICS). Inclusion of this module in future MICS, as well as other national household surveys, will provide countries with crucial data to report on key social protection indicators in the UNAIDS reporting system.

Monitoring results for equity

Keeping track of equity is an important strategy for correcting disparities in HIV interventions and social protection programmes for marginalized populations. In Rwanda, UNICEF supported the development of a consolidated monitoring system of data across social protection programmes. This database will serve as the foundational source of information for monitoring and addressing disparities in response, particularly for the most vulnerable women and children. UNICEF also supported a review of the child protection system to identify gaps in planning and budgeting at central and district levels.

Through the earmarked social protection grant funded by the Government of the Netherlands, UNICEF is providing technical and financial support to national social protection programmes in Malawi, Mozambique, Zambia and Zimbabwe, to ensure they reach HIV-affected populations and strengthen monitoring and evaluation frameworks. As a direct result, HIV-affected populations now have better access to social protection programme benefits that reduce their vulnerability and increase their capacity to use HIV prevention and treatment services.

Policy dialogue, advocacy and communication

UNICEF continues to advocate for improved HIV-sensitive social protection and consistent HIV response in emergencies. From 2014 to 2015, UNICEF worked in India to strengthen child protection systems and policies at the state level to ensure that children affected by AIDS had access to essential services. With UNICEF support, the state governments of Tamil Nadu, Karnataka and Maharashtra included children with HIV in their state child policies. In Bihar, the launch and roll-out of a foster care scheme for children affected by HIV has proved a significant achievement. Currently, more than 3,500 children are benefitting from this scheme.

In China, UNICEF supported grassroots-level interventions and advocacy for the development of national guidelines, plans and policies to strengthen family- and community-based care for women and children affected by HIV and AIDS. A communication campaign for children affected by AIDS was scaled up to 25 provinces, benefiting over 5,000 children. More than 70,000 children from 120 project villages received assistance from village Welfare Directors, who coordinated the provision of local social services in project sites. A plan to implement a government-funded child welfare project in 89 counties was launched, with the potential to benefit over 10 million children.

In the United Republic of Tanzania, UNICEF successfully advocated for adolescents to be prioritized in social protection efforts. As a result, the Tanzania Social Action Fund adopted an additional cash transfer programme, which is conditional on secondary school attendance. The Social Action Fund also revised its evaluation to measure the impact of cash transfers on sexual risk behaviours and well-being of adolescents in order to generate critical in-country evidence on impact.

UNICEF provided technical support to the Government of Uganda to revise the Draft National Social Protection Policy Framework in order to make its programme plan of interventions more child- and HIV-sensitive. A child poverty and vulnerability analysis was conducted, providing documentation of recommendations for strengthening social protection, care and support in Uganda. These were fully integrated into the Government- and World Bank-led social protection sector review report to guide future programming in the sector.

Driving the equity approach, UNICEF and its partners also reached out to the emergency-affected areas of Uganda to enhance HIV programming. UNICEF supported the roll-out of family planning services in all refugee settlements, and as a result, there were no shortages of contraceptive supplies. All refugee settlements received family planning counselling and maternal and child health services through health centres and outreach. The proportion of rape survivors who received post-exposure prophylaxis (PEP) was 96 per cent, which can be attributed to PEP availability and comprehensive training of health workers in clinical management of rape survivors. Refugees also had access to a fistula programme through collaboration with Ministry of Health and EngenderHealth, an indigenous NGO addressing fistula care.

In Viet Nam, UNICEF provided technical support to monitoring that studied HIV-sensitive child protection programmes. Visits were conducted in 13 out of 63

provinces and cities, specifically considering whether the education of children affected by HIV and AIDS has been improved through the establishment of the Inter-departmental Coordination Committee on HIV/AIDS Prevention in the Education Sector.

Integration of service delivery at decentralized levels

UNICEF's drive for integration of service delivery led to capacity building at national and sub-national levels in Nicaragua and Peru. In 2015, 93 per cent of health units in Nicaragua offered HIV counselling and testing in a decentralized manner, either in health care facilities or through home visits in communities. UNICEF and PAHO provided technical assistance to the Ministry of Health, through the Nicaraguan AIDS Commission, to implement the National HIV Strategic Plan 2015–2019. In Peru, the Ministry of Health, with support from UNICEF and UNAIDS, developed a plan for HIV care in Amazonian indigenous communities. UNICEF advocated for the validation of this protocol and with the Ministry of Health, consulted with representatives of the Awajún, Wampis, Achuar, Quechua, Chapra, Kandozi, and Shawi communities to achieve a better understanding and support for indigenous groups.

Through earmarked funding from the Conrad N. Hilton Foundation, UNICEF is providing technical and financial support to partners in Kenya, the United Republic of Tanzania and Zambia to help early childhood development (ECD) services provided through community-based protection, care and support services reach more children affected by AIDS. An approved follow-on agreement will expand support to Malawi and Mozambique in 2016. During 2015, the project supported decentralized design and supervised ECD programmes in Kenya; trained providers in the United Republic of Tanzania; and mobilized community health workers and social workers in eastern Zambia to improve the ability of community social service delivery networks to reach HIV-affected children with ECD programmes.

UNICEF provided an integrated emergency response to flooding in Malawi in 2015 to ensure continued access to HIV services. In the three most flood-affected districts of Chikwawa, Nsanje and Phalombe, there were an estimated 52,137 people living with HIV in need of ART, including 9,215 pregnant women and 842 children. By working closely with national and district officials, UNICEF was able to quickly identify and address gaps in service delivery. UNICEF supported HIV-related procurement and supply management in Malawi over the past decade, and in late 2014 handed over responsibility for the distribution of ARVs and HIV commodities to the Ministry of Health. As a result, at the onset of the emergency, all health facilities had adequate stock levels. NGO partners focused on providing people living in tented camps with HIV-related information and support, including HIV testing and counselling, condoms, family planning and screening and treatment for sexually transmitted infections. At the same time, UNICEF helped the flood-affected districts establish mobile clinics, which are typically used in Malawi only during health campaigns or emergency situations.

Following the outbreak of Ebola in Sierra Leone in May 2014, a rapid assessment of health facilities undertaken in October 2014 found a significant decline in the uptake of maternal and child health services, including a 23 per cent decline in the number of PMTCT visits, a 50 per cent decline in HIV testing and a 21 per cent increase in patients lost to follow-up. UNICEF worked with a local NGO, the HIV and AIDS Prevention Project for Youths, to mitigate the impact of AIDS on the lives of affected children and adolescents by ensuring access to quality care, treatment and support. Given the general reluctance of the population to seek care at health facilities due to the Ebola crisis, UNICEF, with the NGO, launched a Patient Tracing Project. By reaching out directly to patients, the effort allowed ongoing treatment and support for people living with HIV and helped prevent loss to follow-up. Patients were supplied with ART and provided with HIV services at the facilities of local NGOs when health facilities were closed.

UNICEF also undertook similar work in the Central African Republic and South Sudan in 2015, ensuring continuation of HIV services during emergencies. Additionally, in countries like Somalia and South Sudan, UNICEF worked to prevent gender-based violence in emergencies, which negatively impacts HIV incidence.

Innovation for simplified and optimized service delivery

Through the Emergency Fund of $30 million established by GFATM in 2014 to allow for continuity of services in situations of humanitarian crisis, UNICEF was able to continue its critical work on HIV in emergencies in Ukraine. Following a UNICEF assessment in Ukraine in March 2015, it became clear that shortages of life-saving ARVs and interruptions in treatment in the non-government-controlled areas posed a serious threat to the lives of children and families living with HIV, and a public health risk to the entire country. UNICEF worked with key partners and the health cluster in Ukraine to develop and submit an application for funding to the Emergency Fund of GFATM.

The Ukraine Ministry of Health and UNICEF signed a Memorandum of Understanding in October 2015 that sets out the framework processes, rights and obligations related to procurement services, and outlines areas of understanding between the parties. As part of the Memorandum of Understanding, the Ministry of Health provided US$10,971,807 to UNICEF's Supply Division in Copenhagen for the procurement of ARVs. UNICEF also

signed a US$3.7 million agreement with GFATM for the emergency provision of HIV supplies in non-government-controlled areas in eastern Ukraine. The agreement provided continuation of ARV treatment for one year for more than 8,000 adults and children living with HIV, and HIV testing for over 31,000 pregnant women and their children.

As part of the project, optimization of treatment regimens was introduced in the non-government-controlled areas; 90 per cent of patients were switched to a first-line ART regimen (one-tablet dose of EFV600mg+FTC200mg+TDF300mg). The new regimen simplifies the process of taking medicines, increasing patients' adherence to ART. This optimization also allowed cost savings in the procurement of ARVs.

To monitor the ART optimization, UNICEF provided technical assistance to health facilities and, in collaboration with an Experts Group under health sub-cluster on HIV and TB, analysed the results of the optimization of treatment regimens. Health centres were provided with monitoring forms developed by the Experts Group Forms to track the process of switching patients to the optimized ART regimen. Close cooperation between UNICEF and the Medicines Patent Pool, the All Ukrainian Network of People living with HIV and selected ARV manufacturers also resulted in major costs savings and accelerated procurement.

Strategic partnerships and community engagement

Through strategic partnerships and community engagement, UNICEF achieved significant results in the areas of HIV-sensitive social protection and HIV in emergencies. In Côte d'Ivoire, UNICEF worked with GFATM, WFP, NGOs and the Government to provide education, nutrition and protection support to 10,616 orphans and vulnerable children. 3,548 orphans and vulnerable childen benefited from vocational training, 3,232 received birth certificates, and 5,212 benefited from health support. At the national and policy level, UNICEF supported the development of the new 2016–2020 National Strategic Plan on orphans and vulnerable children.

In Lesotho, UNICEF made significant gains in building a child-, gender- and HIV-sensitive social protection system that would reach more vulnerable children. In partnership with the European Union, UNICEF supported the Ministry of Social Development to launch and disseminate the National Social Protection Strategy. In partnership with Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ), UNICEF Lesotho piloted a One Stop Shop initiative that integrates multiple public sector services and referrals at a single location. To date, a mapping exercise for health, HIV, education, social protection and child protection enabled the initiative to provide services to approximately 1,500 people.

UNICEF's HIV and AIDS and child protection programmes worked with the Mozambique Ministry of Health to strengthen multi-sector coordination and response to child protection issues in the country, with a strong emphasis on building a robust evidence base to enable more informed and strategic programming. Major achievements in 2015 included the development and endorsement of the National Strategy for the Prevention and Combating of Early Marriage (2015–2019). The first inter-religious forum on child marriage brought together 130 representatives from diverse faith groups and religious congregations from seven provinces and was attended by the First Lady and the Minister of Education and Human Development. The Matola Rio Declaration, signed by participants at the end of the conference, committed to strengthening collaboration between religious groups and civil society organizations at the national and provincial level to work together to prevent and eliminate child marriage.

UNICEF seeks to build partnerships that work to end discrimination and violence against girls. In Mozambique, the Ministry of Education, with support from UNICEF, trained 2,684 heads of schools, teachers and district advisers on gender-based violence prevention in schools. The Adolescent and Youth Development Programme reached 18,529 children, adolescents and youth. Of these, 11,999 received home visits aimed at identifying and addressing a broad range of risks and vulnerabilities, and 4,500 adolescents received life skills training to prevent HIV, violence and early pregnancies. In Swaziland, UNICEF supported civil society organizations led by Save the Children to facilitate a national campaign to end violence. Using radio and TV programmes, exhibitions and community dialogues, an estimated 50,000 people were taught to recognize and report various forms of abuse and violence. Raising awareness to end violence against children is a long-term goal of UNICEF and its partners. Globally, UNICEF is working to build a grassroots movement to raise awareness and support for national action, specifically focusing on children living in fragile and high-conflict environments,

In the context of the Ebola virus, in Guinea UNICEF collaborated with regional associations of people living with AIDS to train 15 community members (women's group leaders in the regional associations and community leaders) in skills transfer to help prevent HIV, STIs and Ebola. This programme benefited 9,690 women of reproductive age in five regions (Faranah, Kankan, Labé, Boké, Kindia). Awareness sessions on healthy behaviours were conducted in schools and listening centres through youth councils in the regions of Faranah and Nzérékoré for 1,779 elementary students, 44 teachers, and 6,237 young people of reproductive age, including 2,959 girls. In Sierra Leone, through a partnership with a local NGO, UNICEF facilitated access to quality education, medical and psychosocial services for over 250 children affected by HIV and AIDS in six districts.

FINANCIAL ANALYSIS

The year 2015 saw unprecedented political and public resolve – including the adoption of the Sustainable Development Goals (SDGs) – to address some of the greatest global challenges. Also known as Agenda 2030, the SDGs are of great importance to children and the work of UNICEF for the coming 15 years. They set multiple, ambitious, child-centred targets that demand significant and sustained investment for the long term. To be fit for purpose in this evolving context, UNICEF revised its Strategic Plan 2014–2017 resource requirements by outcome area from the US$14.8 billion originally planned to US$17 billion.

Of the two main types of resources, 'regular resources' are unearmarked, unrestricted funds that help UNICEF respond rapidly to emergencies, maintain programme continuity, identify and address the root causes of inequity, and deliver services in the most remote and fragile contexts. Because regular resources are not earmarked for a specific programme, they can also provide seed capital to develop innovative approaches to some of the world's most challenging issues and ensure a credible reach and specialized expertise on the ground.

Thanks to these foundational resources, UNICEF and partners can bring solutions to scale and contextually replicate them through additional and complementary earmarked funds or 'other resources', which include pooled funding modalities such as thematic funding for UNICEF Strategic Plan outcome and cross-cutting areas. These other resources are restricted to a particular programme, geographical area, strategic priority or emergency response. Flexible and predictable other resources should complement a sound level of regular resources for UNICEF to deliver its mandate.

TABLE 1
Strategic Plan integrated results and resources framework by outcome area, 2014–2017: Updated planned amounts (US$ millions)

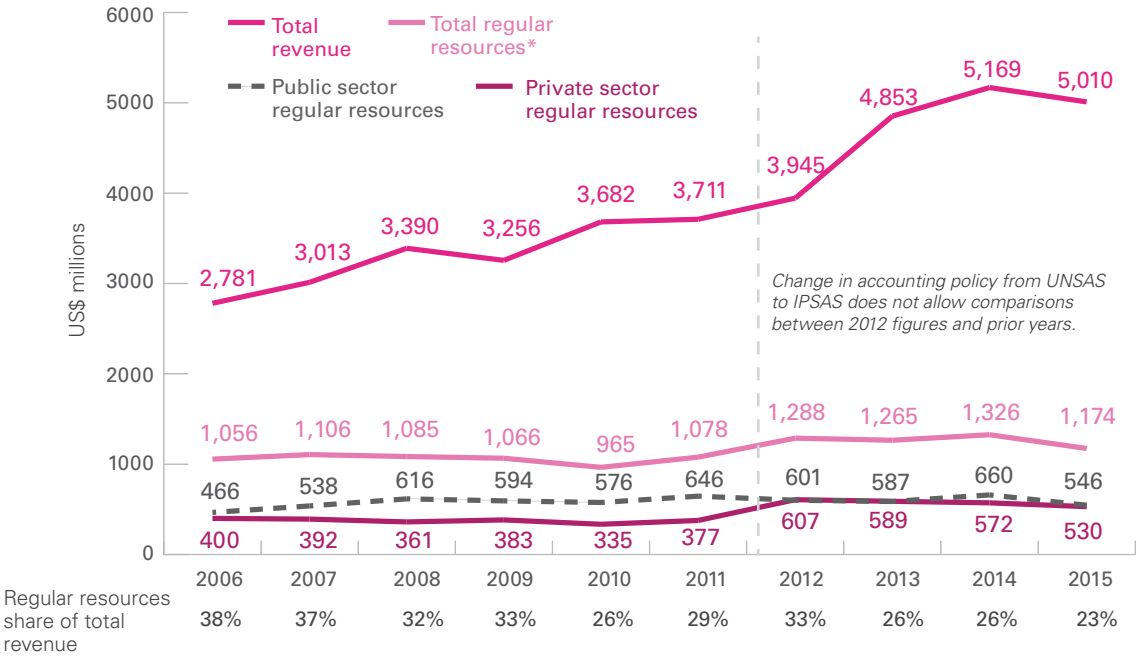
Outcome	Planned 2014–-2017		
	Regular resources	Other resources	Total resources
Health	1,023	3,760	4,783
HIV and AIDS	183	671	854
WASH	548	2,014	2,562
Nutrition	365	1,343	1,708
Education	730	2,686	3,416
Child protection	438	1,611	2,050
Social inclusion	365	1,343	1,708
Totals	**3,652**	**13,429**	**17,081**

* Data as of 1 April 2016

In 2015, funding to UNICEF was over $5 billion for the second year in a row, thanks to the organization's loyal and new resource partners. At the same time, slowing economic growth and currency fluctuations – particularly of major European currencies and the Japanese Yen vis-à-vis the US dollar – resulted in an overall decrease of 11 per cent of regular resources compared to 2014. Totalling US$1,174 million, this was the lowest level of regular resources in four years. At 23 per cent of overall revenue, this was the lowest level of regular resources in UNICEF's history, down from 50 per cent at the turn of the new millennium. Unearmarked contributions from public sector resource partners decreased by 17 per cent. As a result, UNICEF relied more heavily on softly earmarked funding streams for delivery of critical and otherwise underfunded programmes and activities.

FIGURE 13

Regular resource share by resource partner category, 2006–2015*



** Total regular resources includes other Revenue from interest, procurement services and other sources*

PARTNER TESTIMONIAL

"Children are a priority on Sweden's international agenda. Sweden has a long tradition of standing up for children's rights. UNICEF has been working for children for almost 70 years, and is a key partner to Sweden in development cooperation and humanitarian assistance.

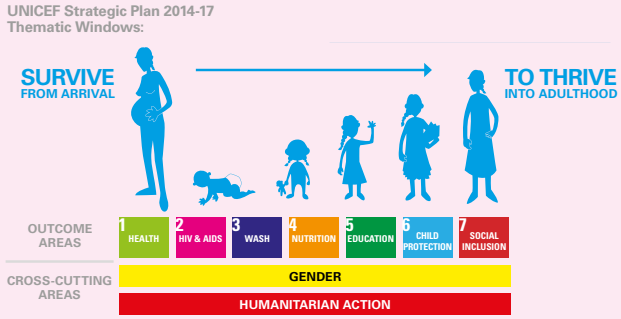
The most excluded and most vulnerable children are reached by UNICEF's thematic funding. As a form of un-earmarked programme support, Sida believes that this financing modality enhances effectiveness since it provides greater flexibility and the possibility to plan activities over the long term, while still being able to act quickly in the event of a crisis. Over the years, Sida's support to UNICEF has moved away from earmarked support towards fewer and larger contributions and increased thematic funding. This trend reflects Sida's confidence in UNICEF as an effective actor and a strong advocate for the implementation of children's rights.

Sida shares UNICEF's belief that all children have a right to survive, thrive and fulfill their potential - to the benefit of a better world. This means equal access to services and care that can make all the difference in children's lives. Children are the next generation who will help build the future. It is our mutual responsibility to give them the best possible conditions. Effectiveness should be the foundation of such an engagement."

– Ms. Charlotte Petri Gornitzka
Director-General, Sida (Swedish International Development Cooperation Agency)

The value of thematic funding (OR+)

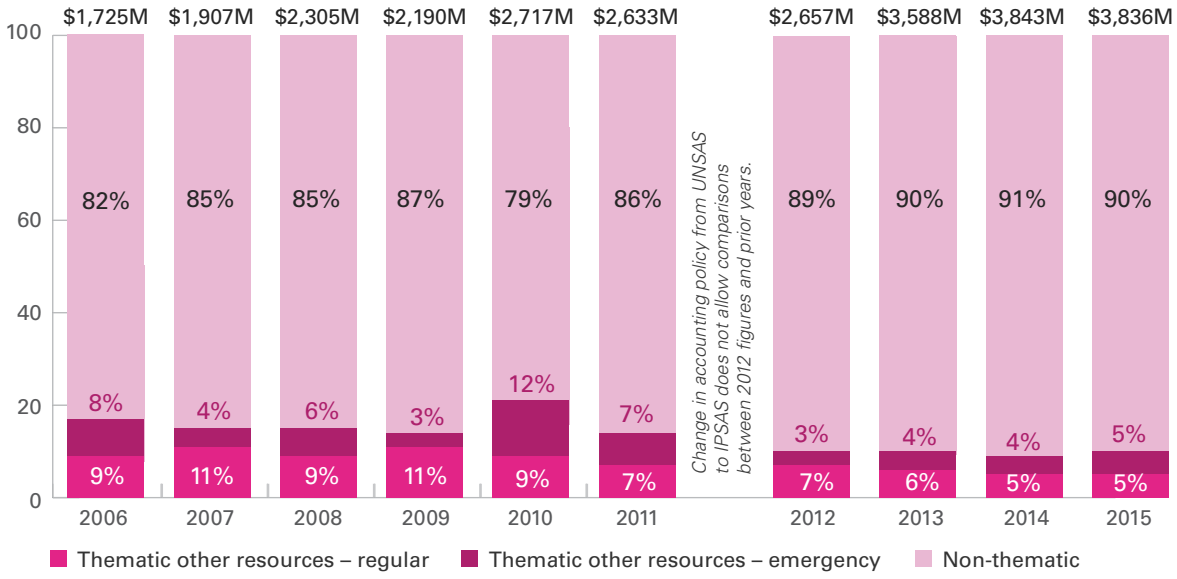
While regular resources remain the most flexible contributions for UNICEF, thematic other resources (OR+) are the second-most efficient and effective contributions to the organization and act as ideal complementary funding. Thematic funding is allocated on a needs basis, and allows for longer-term planning and sustainability of programmes. A funding pool has been established for each of the Strategic Plan 2014-17 outcome areas as well as for humanitarian action and gender. Resource partners can contribute thematic funding at the global, regional or country level.



Contributions from all resource partners to the same outcome area 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 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.

Of the US$5,010 million of UNICEF's revenue in 2015, US$3,836 million was earmarked. Of these other resources, US$390 million was softly earmarked as thematic, marking a 14 per cent increase from the US$341 million in 2014. UNICEF's Strategic Plan 2014–2017 called for partners to enhance funding aligned to the organization's strategic mandate. The flexibility and potential predictability of thematic funding makes these pools an important complement to regular resources for both development and humanitarian programming and the links between the two. This is in line with the universal mandate of UNICEF and in support of country-specific priorities.

FIGURE 14
Other resources, 2006–2015: Thematic vs. non-thematic (US$)



Supporting UNICEF's ability to deliver results for children

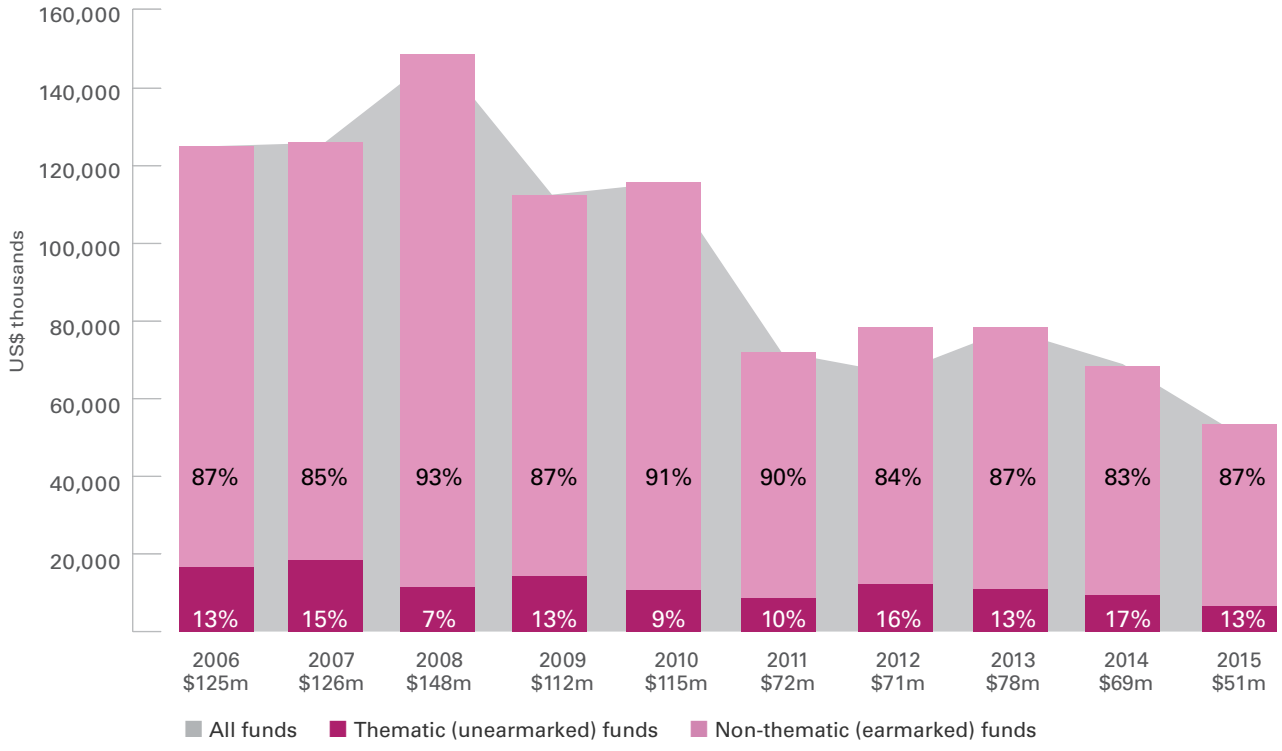
UNICEF's Cases for Support make the case for investing in children, while also spotlighting how the organization is able to deliver robust returns on such investments – for children and for society at large.

Investments in the most vulnerable children not only improve their lives and fulfil the obligation to realize their rights, they also yield benefits for everyone. Improving children's well-being – from providing essential health care and adequate nutrition and securing access to quality education, to protecting children from violence and exploitation – helps to break intergenerational cycles of deprivation that hamper economic development and erode social cohesion.

For each area, the Case describes the key results that UNICEF works to achieve and outlines the theory of change behind these results. This starts with an analysis of the situation of the world's children, focusing on the challenges facing the most deprived, and an overview of the evidence-based solutions that UNICEF promotes. The Cases also focus on lessons learned from our experience across the world and draw attention to current risks and the measures needed to mitigate them. Finally, they detail the resources needed to achieve results and highlight current gaps in funding.current risks and the measures needed to mitigate them. Finally, they detail the resources needed to achieve results and highlight current gaps in funding.

www.unicef.org/publicpartnerships/files/HIVandAIDSTheCaseForSupport.pdf

FIGURE 15
HIV and AIDS other resources funding trend, 2006–2015



** Regular resources are not included since they are not linked to any 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 for comparisons between 2012 figures and prior years.*

In 2015, UNICEF received US$51 million total in other resources for HIV and AIDS (*see Figure 15*), a 26 per cent drop from 2014, and the lowest level of funding to the outcome area in the last decade. UNICEF National Committees made up nearly half the top 20 resource partners in 2015, while the top government partners were the United States of America, Norway and Sweden.

In 2015, the top three resource partners for HIV and AIDS were UNAIDS, the United States and the Global Fund to Fight AIDS, Tuberculosis and Malaria (*see Table 2*). The UNAIDS resources provided flexibility to fund positions as well as programming activities. In 2015, UNICEF funded close to 40 positions at both global and regional levels with funding provided by UNAIDS. However, in November 2015, UNAIDS announced that its future contributions to UNICEF will drop by 50 per cent.

Notable contributions to HIV and AIDS programming included support from the Global Fund to Fight AIDS, Tuberculosis and Malaria in Somalia. UNAIDS provided funding for UNICEF's global work on HIV and AIDS, which represents 30 per cent of their total allocation to UNICEF for HIV; the balance (70 per cent) of the allocation is disbursed to the different regions.

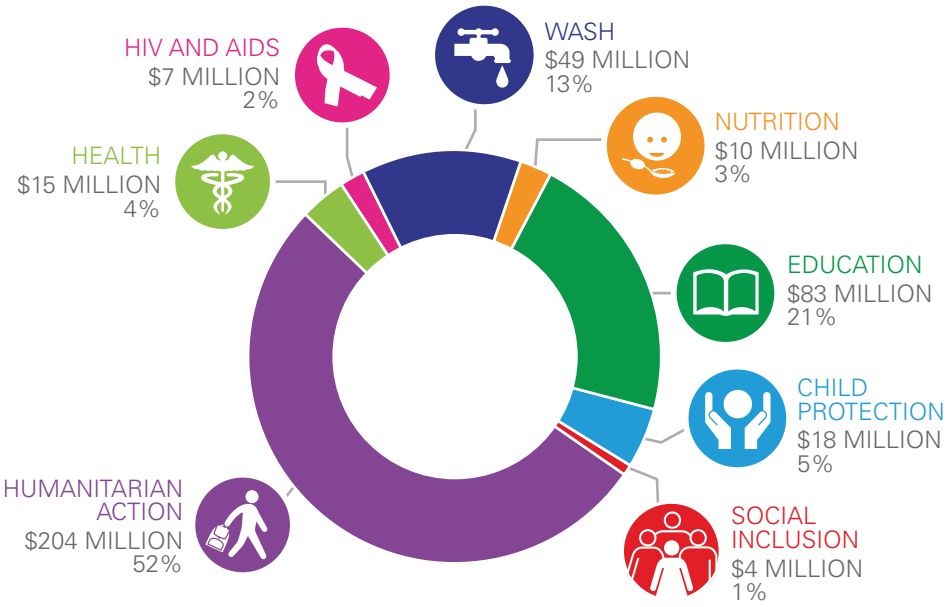
TABLE 2
Top 20 resource partners to HIV and AIDS, 2015*

Rank	Resource partners	Total (US$)
1	UNAIDS	12,230,892
2	United States	9,711,858
3	The Global Fund to Fight AIDS, Tuberculosis and Malaria	5,776,906
4	Korean Committee for UNICEF	3,037,472
5	Norway	1,994,507
6	Netherlands Committee for UNICEF	1,673,438
7	Hong Kong Committee for UNICEF	1,656,630
8	FOSAP	1,526,195
9	Swedish Committee for UNICEF	1,497,960
10	French Committee for UNICEF	1,444,243
11	UNITAID	1,144,766
12	Pooled Fund contributions (UNICEF)	814,604
13	UNICEF-China**	766,061
14	German Committee for UNICEF	730,017
15	Sweden	722,979
16	United Kingdom Committee for UNICEF	694,509
17	UNICEF-United Arab Emirates**	650,000
18	United States Fund for UNICEF	550,744
19	Alliance Cote d'Ivoire	548,280
20	Australian Committee for UNICEF	383,467

**Figures do not include financial adjustments.*
*** Private Sector Fund Raising by UNICEF country offices.*

FIGURE 16

Thematic revenue share by outcome area and humanitarian action, 2015: US$390 million

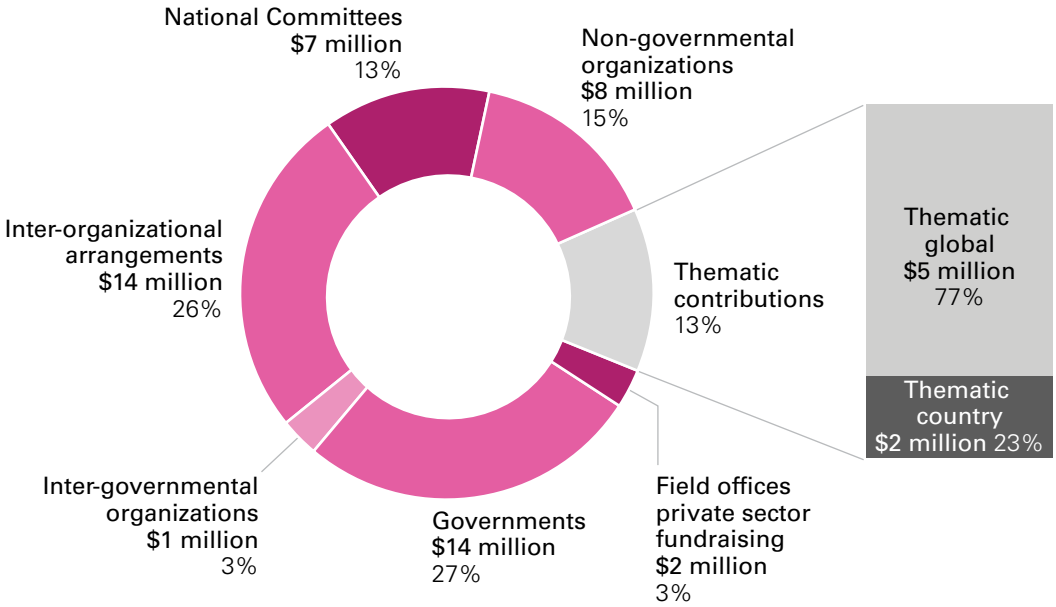


In 2015, UNICEF received US$7 million in thematic contributions for HIV and AIDS (*see Figure 16*), a 42 per cent drop compared to 2014, in part due to currency fluctuation and the strengthening of the US dollar. This significant drop is worrisome since thematic resources provide UNICEF with the flexibility to continue essential programming work for HIV.

Thematic contributions were 13 per cent of total 'other resources' for HIV and AIDS. Of thematic contributions to the sector, 77 per cent were given most flexibly as global thematic funding (*see Figure 17*). Ninety per cent of this global thematic funding was allocated to countries and regions.

FIGURE 17

Other resources by funding modality and partner group, HIV and AIDS, 2015: US$51 million*



Figures do not include US$1 million in adjustments.

The Governments of Flanders (Belgium) and Sweden contributed 15 per cent of all thematic funding in 2015, loosely earmarking their contribution to HIV and AIDS activities at the country level in Malawi and Zimbabwe.

Eighty-five per cent of thematic contributions received for HIV and AIDS came from UNICEF National Committees, and nearly half of that support was given at the global thematic level by the Korean Committee for UNICEF (*see Table 3*). Other notable global thematic contributions were received from National Committees in the Netherlands and Hong Kong.

UNICEF is seeking to broaden and diversify its funding base (including thematic contributions). The number of partners contributing thematic funding to HIV and AIDS increased from 14 in 2014 to 16 in 2015.

TABLE 3
Thematic revenue to HIV and AIDS by resource partner, 2015*

Resource partner type	Resource partner	Total (US$)	Percentage
Governments 15%	Sweden	722,979	10.66%
	Flanders International Cooperation (Belgium)	270,856	3.99%
National Committees 85%	Korean Committee for UNICEF	3,037,472	44.80%
	Netherlands Committee for UNICEF	1,223,438	18.04%
	Hong Kong Committee for UNICEF	518,652	7.65%
	Finnish Committee for UNICEF	310,458	4.58%
	United States Fund for UNICEF	249,256	3.68%
	United Kingdom Committee for UNICEF	180,769	2.67%
	Danish Committee for UNICEF	130,632	1.93%
	Andorran Committee for UNICEF	82,418	1.22%
	Japan Committee for UNICEF	15,839	0.23%
	Canadian UNICEF Committee	11,196	0.17%
	Australian Committee for UNICEF	7,776	0.11%
	Belgian Committee for UNICEF	4,945	0.07%
	Norwegian Committee for UNICEF	1,738	0.03%
Individuals (Others) <1%	Other	11,513	0.17%
Grand total		**6,779,934**	**100.00%**

**Figures do not include financial adjustments.*

From a peak of US$187 million in 2008, UNICEF's expenditures on HIV and AIDS have steadily declined by 43 per cent. In 2015, UNICEF's total expenditure on HIV and AIDS was approximately US$107 million, by far the lowest compared to other outcome areas, at just 2.25 per cent of UNICEF's total expenditures on all Strategic Plan outcome areas. The increase in expenditure of 'other resources emergency' from US$4.0 million to US$6.2 million is attributable to a single contribution by the Global Fund of US$3.7 million for Ukraine. In the same period, expenditures in regular resources decreased from US$37.4 million to US$35.2 million, while expenditures in 'other resources regular' increased marginally from US$65.6 million to US$65.7 million.

Note: Expenses are higher than the income received because expenses are comprised of total allotments from regular resources and other resources (including balances carried over from prior years) to the outcome areas, while income reflects only earmarked contributions from 2015 to the same.

TABLE 4
UNICEF expense by outcome area (US$)

Prorated outcome area	Other resources – emergency	Other resources – regular	Regular resources	Total
Health	338,059,808	717,316,904	223,258,479	1,278,635,191
Education	321,097,543	521,573,717	157,763,280	1,000,434,540
WASH	435,792,883	322,797,427	110,088,929	868,679,239
Child protection	264,753,532	222,439,310	156,420,873	643,613,715
Nutrition	256,609,393	216,904,867	129,963,864	603,478,124
Social inclusion	63,365,554	84,179,498	118,870,107	266,415,159
HIV and AIDS	6,215,775	65,209,301	35,683,399	107,108,474
Grand total	**1,685,894,488**	**2,150,421,024**	**932,048,930**	**4,768,364,442**

FIGURE 18
Total expenses by Strategic Plan outcome area, 2015

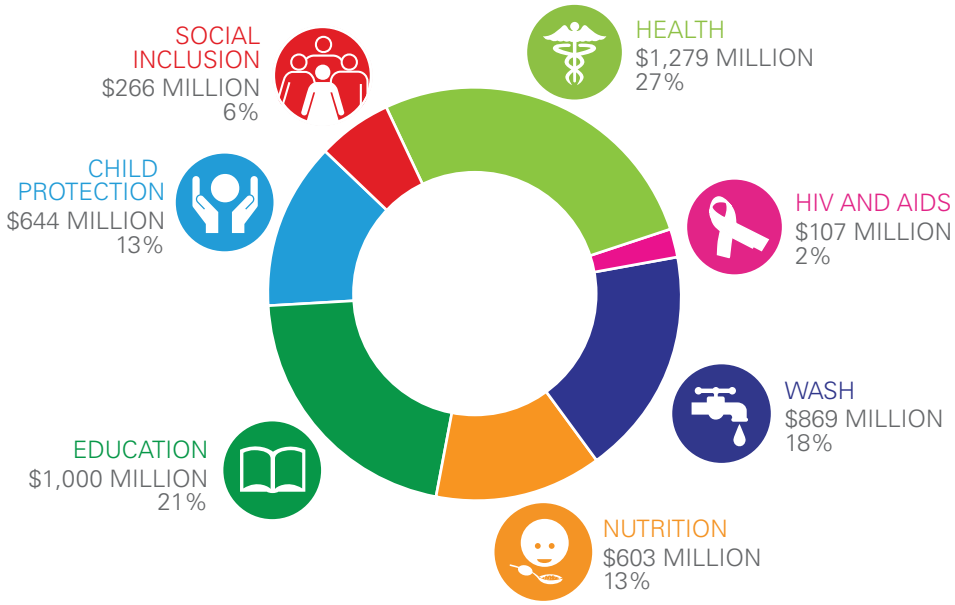


TABLE 5

Expenses by year for HIV and AIDS, 2014–2015 (US$)

Year	Other resources – emergency	Other resources – regular	Regular resources	Total
2014	4,030,935	65,633,899	37,451,004	107,115,838
2015	6,215,775	65,209,301	35,683,399	107,108,474
Grand total	**10,246,710**	**130,843,200**	**73,134,403**	**214,224,313**

Table 5 shows that total expenditure on HIV and AIDS was about equal in 2014 and 2015. However, as noted above, the 2015 expenditure amount includes a grant of emergency funds (ORE) for Ukraine. In addition, there was a US$2,243,776 decrease in regular resources for HIV and AIDS between 2014 and 2015. So, despite the apparent flat expenditure trend from 2014 to 2015, the level of the regular and non-earmarked expenditure in fact decreased.

Expenditures by region are reflective of disease burden, with expenditures in the West and Central Africa and Eastern and Southern Africa the highest. The 10 UNICEF country offices spending the most on HIV are in Africa; the top three are Nigeria (US$11.7 million), Kenya (US$6.4 million) and Malawi (US$5.7 million).

TABLE 6

Total expenses by region for HIV and AIDS, 2015 (US$)

Region	Other resources – emergency	Other resources – regular	Regular resources	Total
WCAR	4,816,652	16,751,687	16,857,377	38,425,716
ESAR	110,126	25,532,230	9,432,271	35,074,627
EAPR	50,506	6,389,193	3,127,850	9,567,548
HQ	147,642	6,628,852	1,578,338	8,354,831
LACR	199,038	3,748,561	1,251,290	5,198,889
ROSA	103,004	1,956,461	1,822,608	3,882,073
CEE/CIS	123,133	2,512,704	706,838	3,342,675
MENA	665,673	1,689,613	906,828	3,262,114
Grand total	**6,215,775**	**65,209,301**	**35,683,399**	**107,108,474**

FIGURE 19
Total expenses by region for HIV and AIDS, 2015

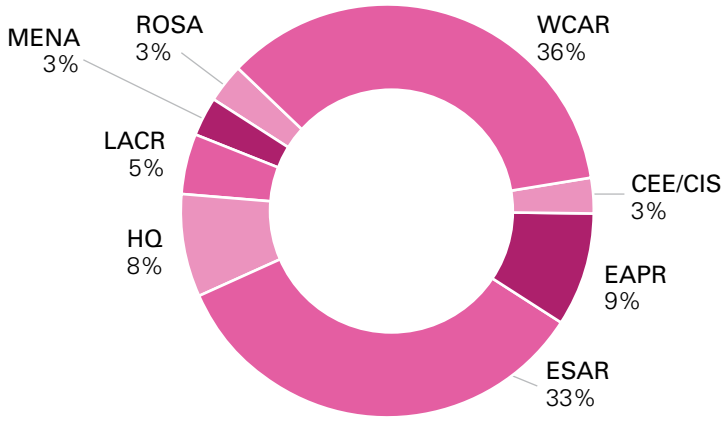


TABLE 7
Top 20 country or regional offices, by expense for HIV and AIDS, 2015 (US$)

Country	Other resources – emergency	Other resources – regular	Regular resources	Grand total
Nigeria	17,275	5,187,196	6,525,074	11,729,545
Kenya	15,739	5,373,096	1,091,561	6,480,396
Malawi	23,692	4,110,601	1,660,242	5,794,534
Chad	189,948	2,731,196	1,481,736	4,402,880
Somalia	6,603	4,043,927		4,050,531
United Republic of Tanzania		1,243,982	2,754,730	3,998,712
Uganda	15,763	2,704,859	1,004,467	3,725,089
Côte d'Ivoire	(329,481)	1,732,314	1,657,055	3,059,888
Central African Republic	1,664,944	551,554	704,242	2,920,739
Guinea	1,658,587	922,734	243,594	2,824,916
Cameroon	119,399	705,108	1,989,862	2,814,369
China		1,833,628	820,265	2,653,894
Zimbabwe	0	1,856,507	533,811	2,390,318
West and Central Africa Regional Office	268,148	1,585,310	202,355	2,055,813
Mozambique	113	920,085	921,107	1,841,305
Eastern and Southern Africa Regional Office	0	1,767,967	1,035	1,769,002
Regional Office for South Asia	102,166	1,360,151	(69)	1,462,248
Sierra Leone	947,561	443,278	54,604	1,445,443
Myanmar		413,462	994,050	1,407,512
CEE/CIS Regional Office	113,898	1,281,320	6,770	1,401,989
Total top 20	**4,814,355**	**40,768,277**	**22,646,491**	**68,229,124**

The Nigeria country office had the highest expenditure on HIV and AIDS, and it also spent more regular resources for HIV in 2015 than it did other resources. Other country offices following this same trend were Cameroon, the Central African Republic, Mozambique, Myanmar and the United Republic of Tanzania. Among UNICEF's regional offices, those in West and Central Africa, Eastern and Southern Africa, South Asia and the CEE/CIS featured as the top spenders on HIV. Notably, with the exception of three countries (Côte d'Ivoire, Mozambique and Zimbabwe), all of the country offices listed in the Top 20 table below had humanitarian appeals in 2015.

In terms of spending on various technical aspects of UNICEF's HIV and AIDS programming, the most was spent on PMTCT. Within this area, other resources expenditures in PMTCT were nearly double the regular resources expenditures. The second highest expenditures were in the area of adolescents, followed by care and treatment. Noteworthy is that most expenditures across the programme areas came from other resources. Regular resources were the biggest source of expenditure only in the area of adolescents.

TABLE 8

Expenses by programme area for HIV and AIDS, 2015 (US$)

Programme area	Other resources – emergency	Other resources –regular	Other resources – regular	Total
PMTCT and infant male circumcision	1,769,259	22,860,002	12,396,364	37,025,625
Care and treatment of children affected by HIV and AIDS	214,356	6,494,856	3,194,837	9,904,049
Adolescents and HIV and AIDS	145,501	6,735,674	7,047,657	13,928,832
Protect, care and support children and families affected by HIV and AIDS	11,422	1,968,889	640,138	2,620,450
HIV general	4,075,237	27,149,880	12,404,402	43,629,519
Grand total	**6,215,775**	**65,209,301**	**35,683,399**	**107,108,474**

FIGURE 20

Expenses by programme area for HIV and AIDS, 2015

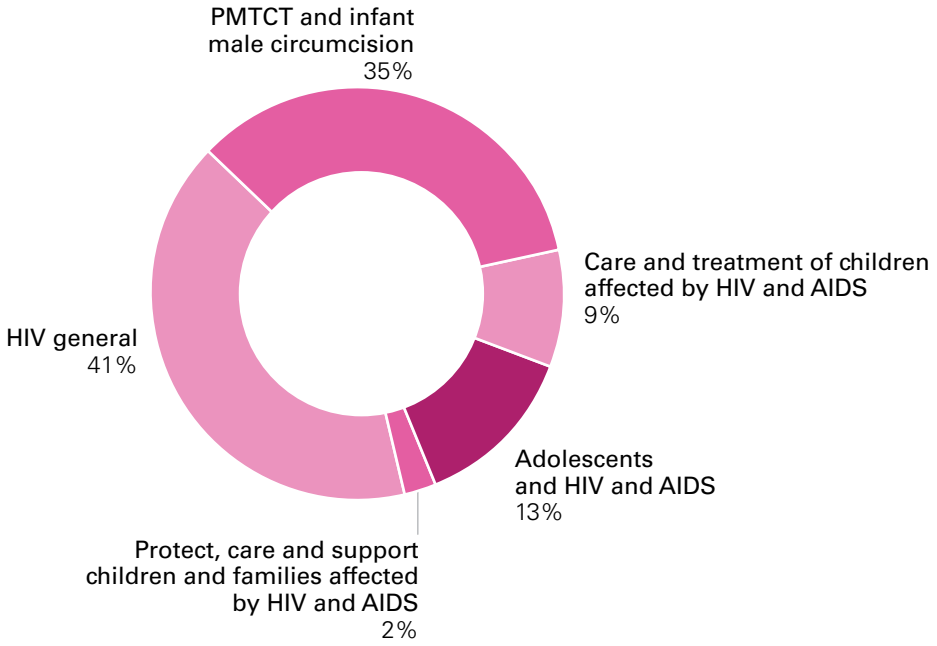


TABLE 9

Expense by cost category and year for HIV and AIDS, 2014–2015 (US$)

Cost category	Other resources – emergency	Other resources – regular	Regular resources	Total
Contractual services	**87,484**	**8,921,594**	**4,272,573**	**13,281,651**
2014	250,433	4,925,393	2,086,450	7,262,276
2015	(162,949)	3,996,201	2,186,123	6,019,375
Equipment, vehicles and furniture	**114,878**	**119,123**	**661,294**	**895,295**
2014	28,138	64,303	261,635	354,075
2015	86,741	54,820	399,659	541,220
General operating and other direct costs	**673,154**	**6,952,745**	**8,576,719**	**16,202,617**
2014	241,779	3,794,503	4,564,281	8,600,563
2015	431,374	3,158,242	4,012,438	7,602,054
Incremental indirect cost	**793,744**	**7,867,405**		**8,661,149**
2014	309,300	3,937,728		4,247,028
2015	484,444	3,929,677		4,414,121
Staff and other personnel costs	**3,607,801**	**25,655,246**	**25,471,496**	**54,734,542**
2014	1,328,039	12,776,234	13,391,705	27,495,977
2015	2,279,762	12,879,012	12,079,791	27,238,565
Supplies and commodities	**1,751,081**	**18,888,317**	**4,597,264**	**25,236,663**
2014	610,255	7,350,212	2,098,130	10,058,596
2015	1,140,826	11,538,106	2,499,135	15,178,066
Transfers and grants to counterparts	**2,633,376**	**56,268,802**	**25,128,064**	**84,030,242**
2014	983,356	29,547,039	12,693,403	43,223,797
2015	1,650,020	26,721,763	12,434,661	40,806,445
Travel	**585,192**	**6,169,967**	**4,426,994**	**11,182,153**
2014	279,636	3,238,488	2,355,402	5,873,525
2015	305,556	2,931,480	2,071,592	5,308,628
Grand total	**10,246,710**	**130,843,200**	**73,134,403**	**214,224,313**

Follow the flow of funds from contribution to programming by visiting open.unicef.org

At the half point of the current Strategic Plan, by the end of 2015, expenses reached close to 50 per cent of the revised planned amounts by outcome area. By using expenses as a proxy for revenue, the Strategic Plan remains 50 per cent unfunded. Specifically for HIV and AIDS, the funding gap is 75 per cent up to the end of 2015 for the 2014–2017 planned period. While we have witnessed impressive gains in the HIV response as outlined in the report, the success is uneven and UNICEF's job is now to support countries in sustaining the gains and expand the response. This risk of not doing so could reverse hard-won results. As the world transitions to the SDG era, global attention to HIV is diminishing – and so are traditional donor funds, including those for UNAIDS. Consequently, tapping into available funding will require an innovative and creative approach. This should be informed by new technologies, drugs and approaches that promise improved outcomes for children and for the response more broadly. It is in this context that UNICEF will enter the second phase of the 2014–2017 Strategic Plan.

UNICEF looks forward to working closely with its partners to meet these funding needs and fulfil the shared commitments and results towards Agenda 2030.

TABLE 10

Strategic Plan integrated results and resources framework by outcome area, 2014–2017: Updated planned amounts, actual expenses and funding gap (US$ millions)*

Outcome	Planned 2014–2017			Actual expenses			Funding gap		
	Regular resources	Other resources	Total resources	Regular resources	Other resources	Total resources	Regular resources	Other resources	Total resources
Health	1,023	3,760	4,783	473	2,035	2,508	550	1,725	2,275
HIV and AIDS	183	671	854	73	141	214	109	530	640
WASH	548	2,014	2,562	211	1,385	1,596	336	630	966
Nutrition	365	1,343	1,708	196	892	1,088	170	451	620
Education	730	2,686	3,416	293	1,533	1,827	437	1,153	1,590
Child protection	438	1,611	2,050	302	856	1,158	136	756	892
Social inclusion	365	1,343	1,708	244	265	509	121	1,078	1,199
Totals	**3,652**	**13,429**	**17,081**	**1,792**	**7,107**	**8,899**	**1,860**	**6,322**	**8,182**

**Expenses as a proxy for revenue received.*

FUTURE WORKPLAN

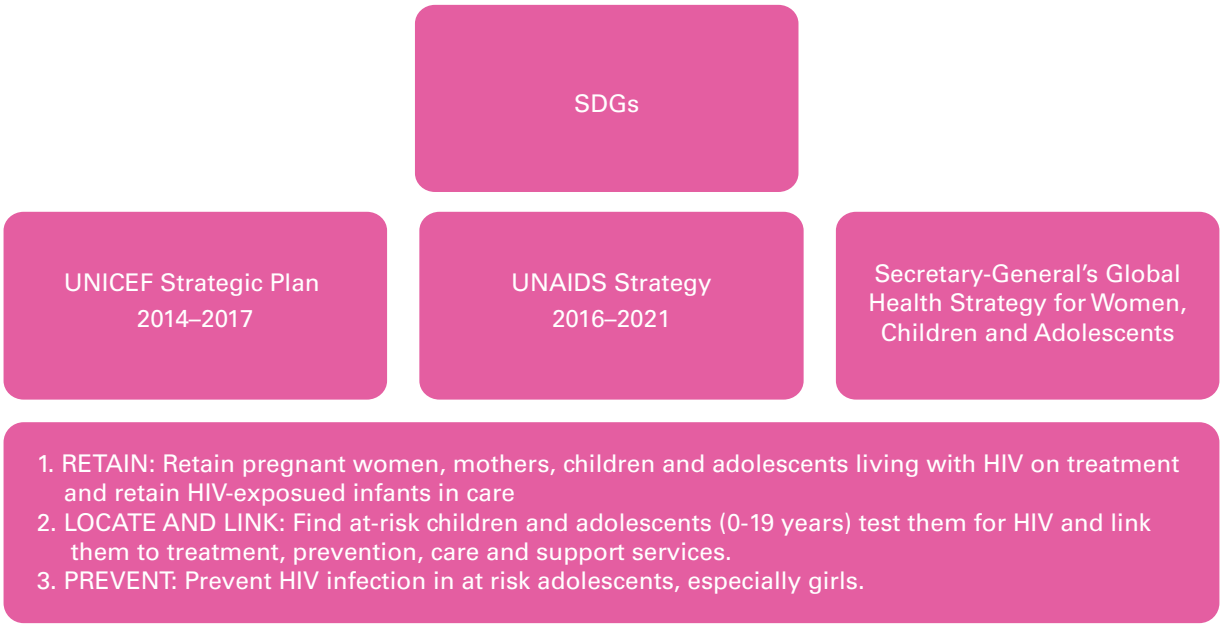
A 50 per cent cut in funding from UNAIDS announced at the end of 2015, from US$12 million to US$6 million, significantly affects the financial outlook for 2016–2017. As a result, the HIV section has started a transition period during which the headquarters team will review the scope and scale of its programme to address the new reality. In close consultation with UNICEF's senior management and partners, the HIV team is in the process of analysing how HIV and AIDS should be positioned in 2017 and beyond to best support UNICEF's accountabilities to fast-track the HIV response in children in support of the global goal of ending the AIDS epidemic by 2030. Following the announcement of the budget reduction, the Committee of Cosponsoring Organizations (CCO) and the UNAIDS Secretariat established a Working Group on resource mobilization to address the financial constraints and shifting resource partner priorities in the SDG era.

With an eye on ending the AIDS epidemic by 2030, the new UNAIDS 2016–2021 Fast-Track strategy sets out an ambitious set of targets for 2020: reducing AIDS-related deaths and new HIV infections to below 500,000, respectively, and eliminating HIV-related stigma and discrimination. The new global UNAIDS 2016–2021 Strategy urges greater focus on children and adolescents through integrated programming across five SDGs, improving health, achieving gender equality, reducing inequalities while expanding inclusive societies and strengthened partnerships. Achieving these ambitious 2020 targets, and the 2030 goals, require greater resources, not fewer. The challenge now lies in leveraging funding for broader work across the SDGs to achieve results.

Maintaining control over the epidemic is critical. New 2015 WHO guidelines recommend immediate initiation of ART upon diagnosis for all ages and population groups. UNICEF is working with countries to implement these new guidelines by expanding testing, including at birth for HIV-exposed infants, in-home approaches for families and self-testing for adolescents and adults. Multiple clinical trials showing the HIV-prevention benefit of pre-exposure prophylaxis (PrEP) among adults resulted in new WHO guidelines in 2015 recommending PrEP for all populations with a 3 per cent local incidence. There are limited data regarding the use of PrEP among adolescents. UNICEF is embarking in 2016 on operational research in Brazil, South Africa and Thailand to study the use of PrEP among the highest-risk sexually active older adolescents (aged 15–19). PrEP will be used in combination with other biomedical, behavioural and structural interventions among girls and adolescent MSM.

Evidence from 2015 that the majority of new vertical infections among children occur post-partum during breastfeeding requires even greater focus in retaining

FIGURE 21
Future work pyramid



breastfeeding mothers, who are living with HIV on treatment and in care. In 2016 UNICEF will work to expand links between health facilities and communities to improve retention in care. Evidence of increasing ARV drug resistance among individuals and communities in sub-Saharan Africa has further reinforced the need to ensure adherence among children and their families on ART. The UNICEF HIV team at headquarters, in collaboration with regional offices, will also use data-driven research to prioritize countries with the highest HIV burden for children, pregnant women, mothers and adolescents across regions, with specific attention on countries where disparities and inequities persist for vulnerable populations.

In conclusion, considering the trends outlined in this report, and UNICEF's unique niche and comparative advantage as a multi-sectoral agency for children, UNICEF has identified three central focus areas in the HIV response moving forward post-2015 in order to reach an AIDS-free generation for children.

1. Retain: Retain pregnant women, mothers, children and adolescents living with HIV on treatment and retain HIV-exposed infants in care.

A great global success in the HIV response has been the massive scale up of ARV coverage among pregnant and breastfeeding women to prevent vertical transmission. Over time, more effective ARV regimens have been identified, and today 21 of the 22 high-burden Global Plan priority countries have adopted lifelong ART for all pregnant or lactating women living with HIV. In 2014, 77 per cent of pregnant women living with HIV in the Global Plan priority countries were receiving the most effective antiretrovirals for PMTCT.

However, retaining women, adolescents and children in treatment and care remains a significant challenge. Retaining HIV-infected infants in care through 18 months until their final HIV status is determined is equally difficult. In order to eliminate vertical transmission of HIV and ensure the best possible outcomes for women, adolescents and children living with HIV, future efforts must focus on both retention and improving adherence to treatment over the long term.

What is UNICEF's comparative advantage?

UNICEF's programmes for supporting children and adolescents living with HIV offer unique opportunities for high-impact results. UNICEF works to strengthen health systems for better integration of HIV into broader SRH and MNCH programs and ensure that ART services are maintained as part of humanitarian preparedness and response. Effective technology-based systems offer innovative ways to follow up and integrate messages for breastfeeding and child health practices with information on PMTCT and ART.

2. Locate and link: Find at-risk children and adolescents (aged 0–19 years), test them for HIV and link them to treatment, prevention, care and support services.

Globally, 2.6 million children under 15 years of age live with HIV. Only one in three are on treatment. The vast majority of these children were infected vertically, slipping through weak spots in PMTCT programmes. Among adolescents, 61 per cent (1,200,000) live in eastern and southern Africa. Finding these children and adolescents and providing them with treatment and care services is an urgent priority. Yet, barriers to paediatric and adolescent HIV testing are many, including long turnaround time for infant testing, reluctance on the part of health care workers to test children for HIV, age of consent laws and stigma. These social factors prevent adolescents from seeking an HIV test and hinder swift progress in a successful AIDS response.

What is UNICEF's comparative advantage?

By leveraging multi-sectoral approaches, as well as strong partnerships in countries, UNICEF can improve the way children and adolescents at risk of HIV are located and linked to testing and treatment. Multiple platforms, including child and adolescent immunization programmes, inpatient wards, nutrition care clinics, ECD centres, social protection schemes and schools, as well as VAC surveys, provide ample opportunities for UNICEF to support identification and follow-up services. Creating adolescent-friendly health services will also help to identify and better support adolescents at risk and living with HIV.

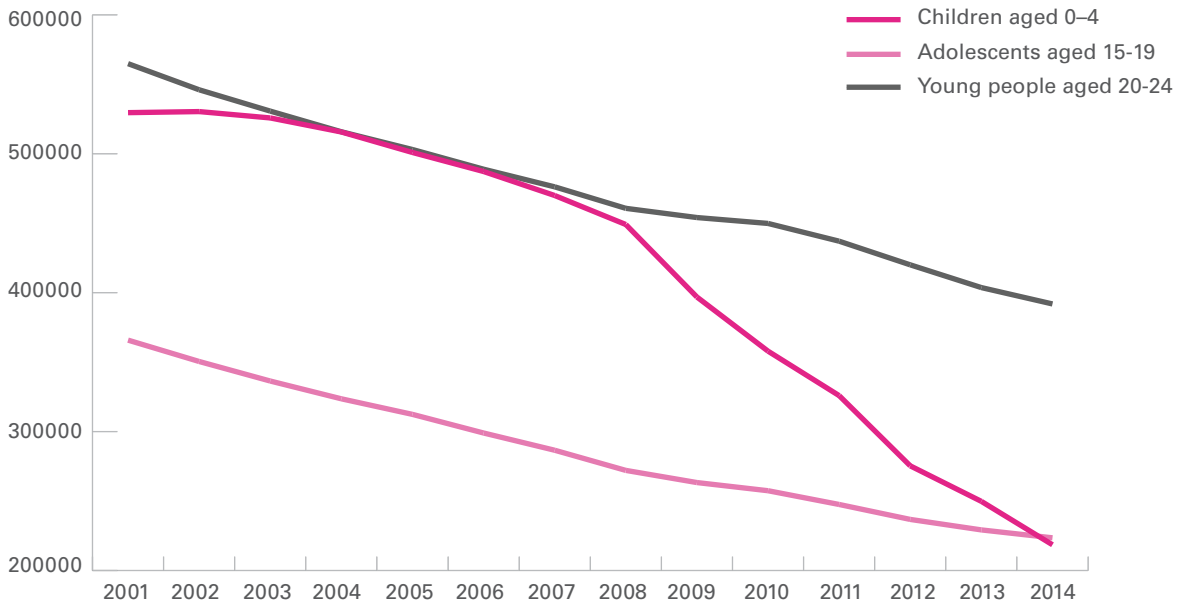
3. Prevent: Prevent HIV infection in at-risk adolescents, especially girls.

While there was a steady decline in new HIV infections among adolescents between 2001 and 2014, projections show that new infections among this age group will continue to fuel the HIV epidemic and have a devastating impact on the lives of millions of vulnerable young people and communities.

We know that adolescents aged 10–19 years and young people aged 20–24 are especially vulnerable to HIV infection. Yet this has been a blind spot in data collection, which has resulted in inadequate and ad hoc

FIGURE 22

Estimated number of new HIV infections among children aged 0–14, adolescents aged 15–19 and young people aged 20–24, 2001–2014



Source: UNAIDS 2014 HIV and AIDS estimates, July 2015.

programming. Far too many children enter adolescence without the knowledge and services to protect themselves against HIV infection.

This is especially critical for adolescent girls, who are at greatest risk of infection. Older adolescent girls (15–19 years) account for 62 per cent of new infections in Africa. High-impact strategies can prevent these infections and save lives, but are not reaching the adolescents most at risk, including adolescent girls, young men who have sex with men, and those who are sexually exploited.

What is UNICEF's comparative advantage?

UNICEF must continue to provide leadership in improving the availability and use of data on adolescents and HIV. Opportunities for integration across UNICEF's sectoral programmes to help prevent new HIV infections among adolescents exist and must be pursued. For example, UNICEF is well placed to support efforts that take into account biomedical interventions such as the availability of HIV testing and counselling, provision of treatment, and response to sexual violence, particularly in emergency contexts. Additionally, interventions that work to overcome structural barriers, including social protection and cash transfer programmes, and initiatives to reduce violence will reduce vulnerability and generate community outreach, mobilisation and engagement. To aid the adolescent girls who comprise up to 30 per cent of antenatal care clients in some countries, UNICEF can enhance the synergy between PMTCT programmes and HIV prevention for adolescents by ensuring that PMTCT programmes effectively serve their youngest clients with HIV testing and link to prevention, treatment and care services. Efforts to gather and use age- and sex-disaggregated data to inform policies and programmes that meet the needs of adolescents are essential to future success in ending this epidemic.

An adolescent girl in Malawi.

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EXPRESSION OF THANKS

UNICEF expresses its deep appreciation to all resource partners who contributed to our work on HIV and AIDS throughout 2015. Thematic funding enables UNICEF to provide technical, operational and programming support to countries in all regions and to deliver quality services to vulnerable children and communities. Thematic funding also provides greater flexibility and allows for longer-term planning and sustainability of programmes. It reflects the trust resource partners have in the ability of UNICEF to deliver quality HIV and AIDS programmes for children, adolescents, pregnant women and mothers, and has made the results described in this report possible. We would particularly like to emphasize our gratitude to the following resource partners for their generous contributions to our flagship programmes and innovations:

The Conrad N. Hilton Foundation

The Global Fund to Fight AIDS, Tuberculosis and Malaria

The Government of Canada

The Government of the Netherlands

The Government of Norway

The Government of Sweden

The Government of the United States of America

Estée Lauder Companies, The M*A*C AIDS Fund

UNAIDS

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ABBREVIATIONS AND ACRONYMS

AIDS	acquired immunodeficiency syndrome
ART	antiretroviral therapy
ARV	antiretroviral (drug)
CDC	Centers for Disease Control and Prevention
CEE/CIS	Central and Eastern Europe and the Commonwealth of Independent States
EAPRO	East Asia and the Pacific Regional Office (UNICEF)
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
EID	early infant diagnosis (of HIV)
EMTCT	elimination of mother-to-child transmission (of HIV)
ESARO	Eastern and Southern Africa Regional Office (UNICEF)
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HCT HIV	counselling and testing
HIV	human immunodeficiency virus
IATT	Inter-Agency Task Team
LACRO	Latin America and the Caribbean Regional Office (UNICEF)
MCH	maternal and child health
MDG	Millennium Development Goal
MENA	Middle East and North Africa Regional Office (UNICEF)
MICS	Multiple Indicator Cluster Surveys
MNCH	maternal, newborn and child health
MoRES	Monitoring Results for Equity System
NGO	non-governmental organization
OHTA	optimizing HIV treatment access for pregnant and breastfeeding women
PEPFAR	(United States) President's Emergency Plan for AIDS Relief
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child transmission (of HIV)
PrEP	pre-exposure prophylaxis
ROSA	Regional Office for South Asia (UNICEF)
SDG	Sustainable Development Goals
SRH	sexual and reproductive health
STD	sexually transmitted disease
STI	sexually transmitted infection
TB	tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNHCR	Office of the United Nations High Commissioner for Refugees
UNITAID	International Drug Purchase Facility
UNODC Crime	United Nations Office on Drugs and
USAID	United States Agency for International Development
WCARO	West and Central Africa Regional Office (UNICEF)
WFP	World Food Programme
WHO	World Health Organization

ENDNOTES

1. UNAIDS has identified 38 priority countries based on epidemiology, need, capacity and other factors which all co-sponsoring agencies support. UNICEF internal monitoring data look at subsets of these countries: Angola, Botswana, Brazil, Burundi, Cambodia, Cameroon, the Central African Republic, Chad, China, Côte d'Ivoire, the Democratic Republic of the Congo, Djibouti, Ethiopia, Ghana, Guatemala, Haiti, India, Indonesia, Islamic Republic of Iran, Jamaica, Kenya, Lesotho, Malawi, Mozambique, Myanmar, Namibia, Nigeria, Russian Federation, Rwanda, South Africa, South Sudan, Swaziland, Thailand, Uganda, Ukraine, the United Republic of Tanzania, Zambia and Zimbabwe.

2. Botswana, Burkina Faso, Chad, Cameroon, Côte d'Ivoire, Haiti, Iran, Jamaica, Kenya, Lesotho, Mozambique, Namibia, Nigeria, Philippines, Rwanda, Swaziland, Ukraine, Zimbabwe and Thailand.

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8. The 22 Global Plan priority countries include 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.

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13. Joint United Nations Programme on HIV/AIDS*, 2014 HIV and AIDS Estimates*, UNAIDS, Geneva, July 2015.

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17. UNICEF, Social Cash Transfers and Children's Outcomes: A Review of Evidence from Africa, 2015.

18. United Nations Children's Fund, *Community-Facility Linkages to Support the Scale Up of Lifelong Treatment for Pregnant and Breastfeeding Women Living with HIV*, UNICEF, New York, June 2015.

19. United Nations Children's Fund East Asia and Pacific Regional Office, *Adolescents under the Radar in the Asia-Pacific AIDS Response*, UNICEF, December 2015.

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ANNEX: DATA COMPANION/ SCORECARD

Visualizing achievements

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

Green

Indicator level

Achievement of the indicator is at or above 100% of the milestone

Outputs and outcome area level

Average achievement of indicators in the output or outcome area is at or above 100%

Amber

Indicator level

Achievement of the indicator is between 60% and 99% of the milestone

Outputs and outcome area level

Average achievement of indicators in the output or outcome area is between 60% and 99%

Red

Indicator level

Achievement of the indicator is less than 60% of the milestone

Outputs and outcome area level

Average achievement of indicators in the output or outcome area is less than 60%

HIV and AIDS

Average achievement rate:

81% 

Impact Indicator	Baseline*	2017 Target	2015 Update**
2a. Number of new HIV infections among children under 15 years (2011 Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS (General Assembly resolution 65/277, annex)	280,000 (2012)	93,000	220,000 (2014)
2b. Percentage of children under 15 years living with HIV receiving antiretroviral therapy	23% (2012)	50%	32% (2014)

Outcome Indicator	Baseline*	2017 Target	2015 Update**
P2.1 Countries with at least 80% coverage of ART among all children aged 0-14 years and adolescent girls and boys aged 10-19 years living with HIV	0-14 years old: 0 (2012) 10-19 years old: data not available (2012)	9 UNAIDS priority countries	0-14 years old: 2 out of 38 UNAIDS High Impact countries (2014) 10-19 years old: data not available (2014)
P2.2 Countries providing at least 80% coverage of lifelong ART for all pregnant women living with HIV	1 (2012)	9 Global Plan for EMTCT priority countries	4 out of 22 Global Plan for EMTCT priority countries (2014)
P2.3 Countries in which at least 50% of overall HIV and AIDS spending is funded through domestic resources	32% (2010-2014)	40%	32% (2010-2014)
P2.4 Countries with at least 60% coverage in condom use at last sexual encounter among adolescents aged 15-19 years reporting multiple partners in past year, disaggregated by sex	Males: 10 out of 14 Females: 1 out of 13	38 UNAIDS priority countries	Male: 10 out of 20 UNAIDS priority countries with data (2007-2014) Female: 1 out of 17 UNAIDS priority countries with data (2007-2014)

*2013 unless otherwise indicated. **or data from the most recent year available.

Output a

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

Average output achievement

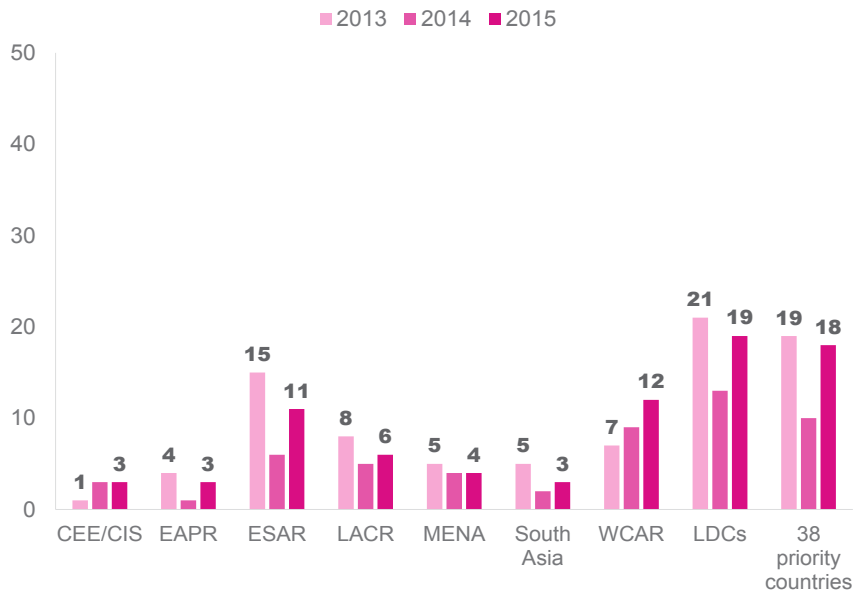
45%

P2.a.1

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

2013 Baseline	19
2014 Result	10
2015 Result	18
2015 Milestone	20
2017 Target	38

Achievement 90%

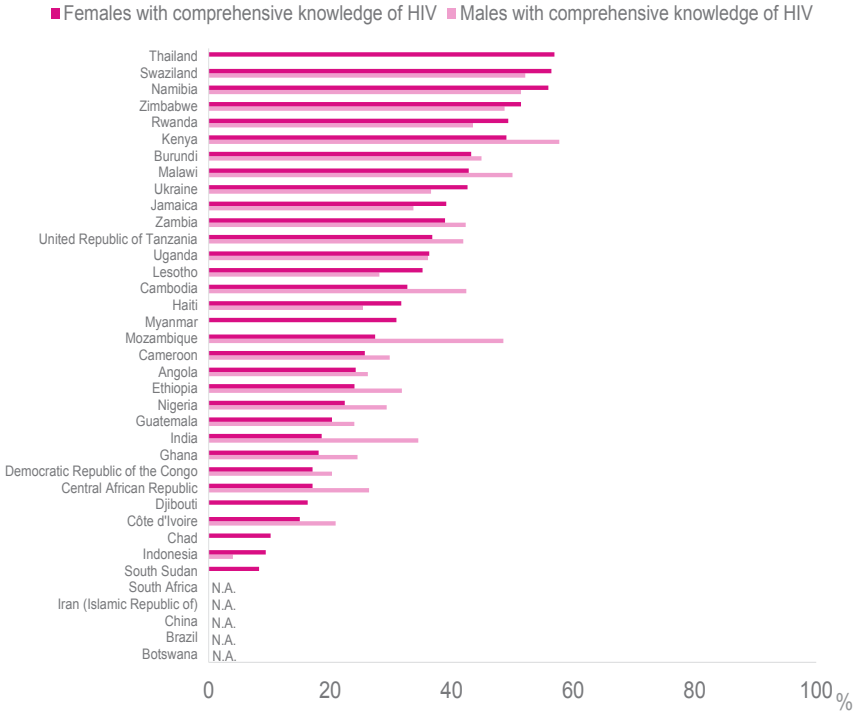


P2.a.2

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

2013 Baseline	0
2014 Result	0
2015 Result	0
2015 Milestone	2
2017 Target	6

Achievement 0%



Output b

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

Average output achievement

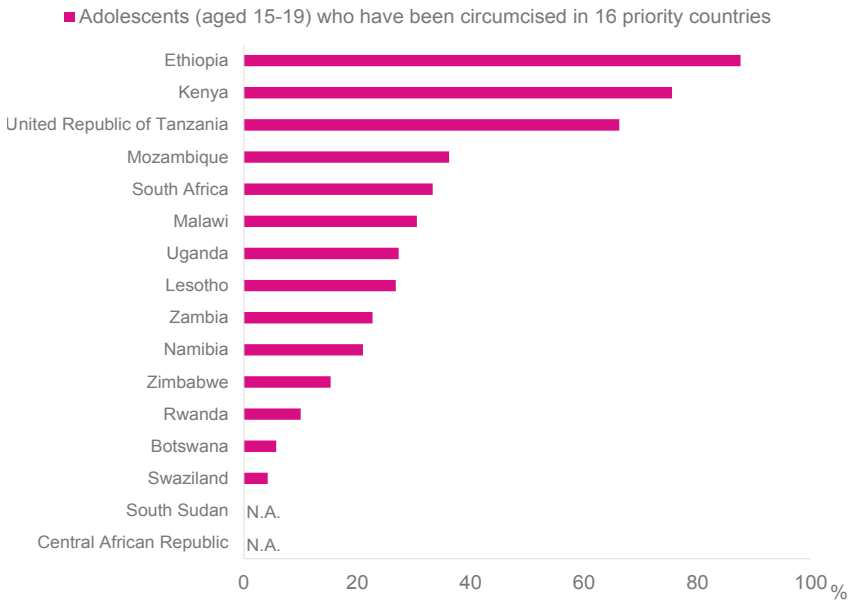
78%

P2.b.1

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

2013 Baseline	0
2014 Result	0
2015 Result	0
2015 Milestone	2
2017 Target	16

Achievement 0%

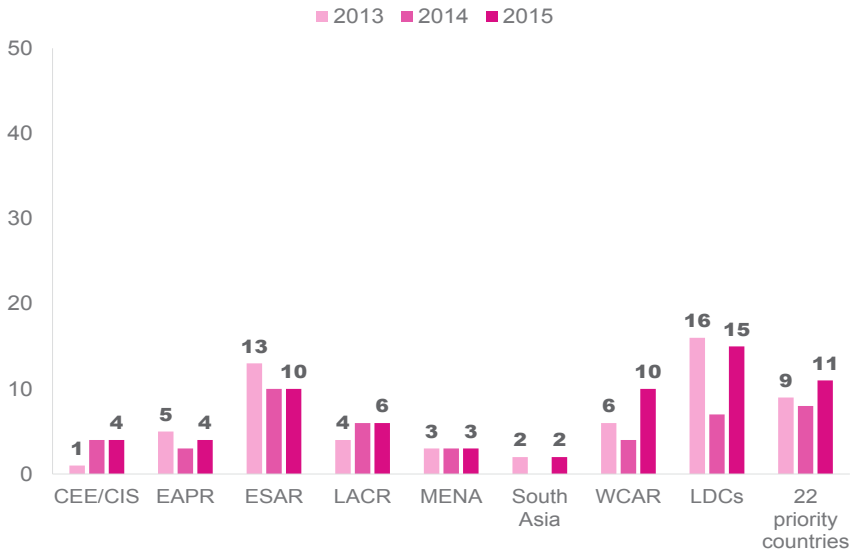


P2.b.2

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

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

Achievement 92%

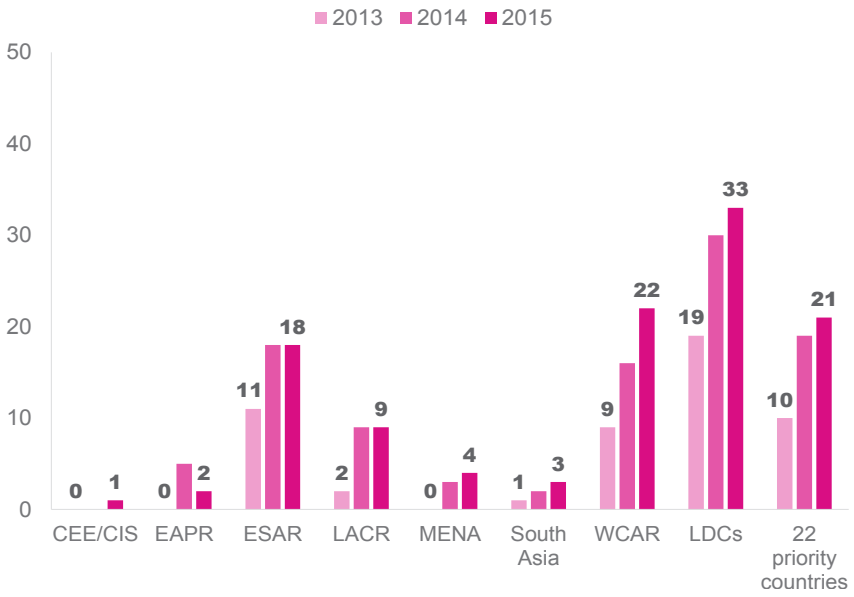


P2.b.3

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

2013 Baseline	10
2014 Result	19
2015 Result	21
2015 Milestone	20
2017 Target	22

Achievement 105%

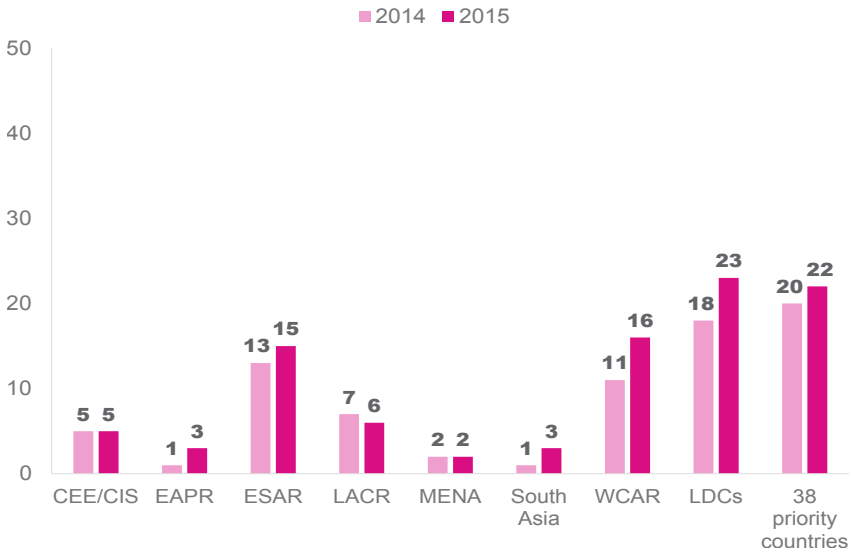


P2.b.4

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

2014 Baseline	20
2015 Result	22
2015 Milestone	26
2017 Target	38

Achievement 85%

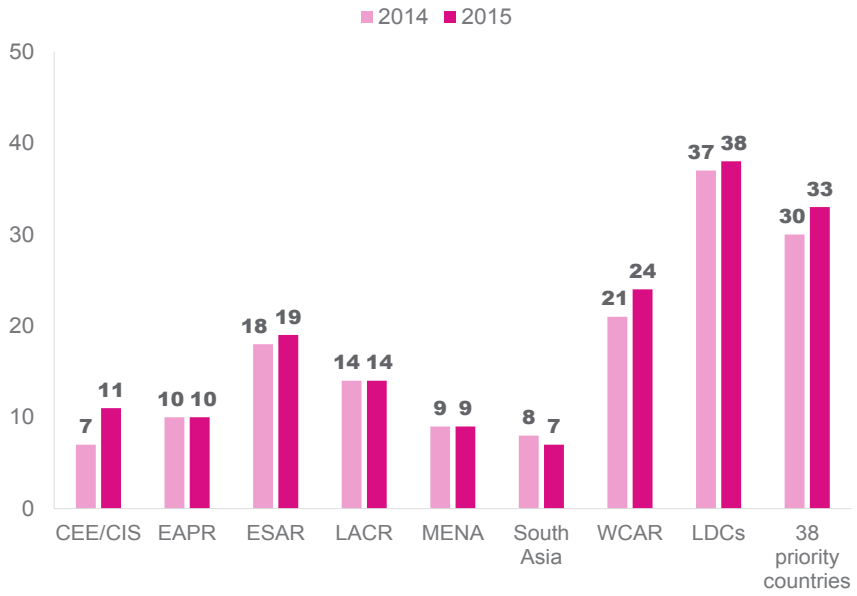


P2.b.5

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

2014 Baseline	30
2015 Result	33
2015 Milestone	33
2017 Target	38

Achievement 100%

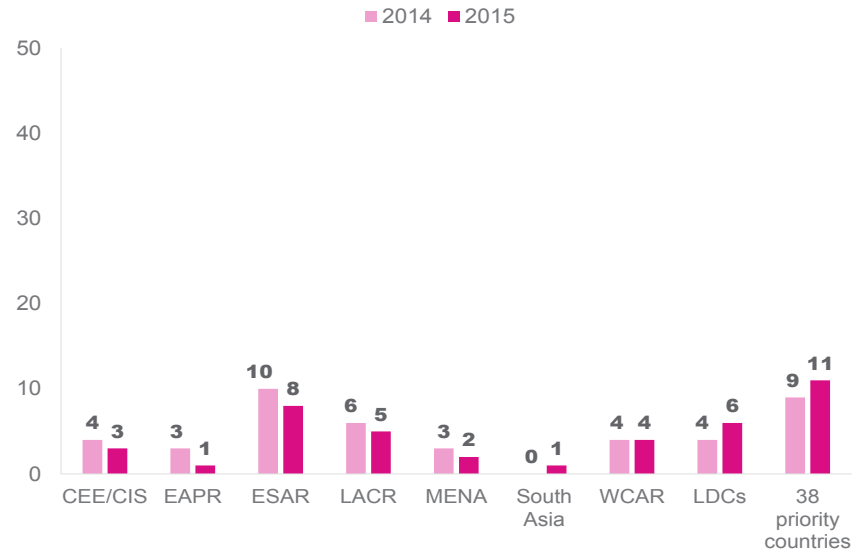


P2.b.6

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

2014 Baseline	9
2015 Result	11
2015 Milestone	13
2017 Target	22

Achievement 85%



Output c

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

Average output achievement

93%

P2.c.1

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

2013 Baseline	18
2014 Result	24
2015 Result	23
2015 Milestone	29
2017 Target	38

Achievement 79%

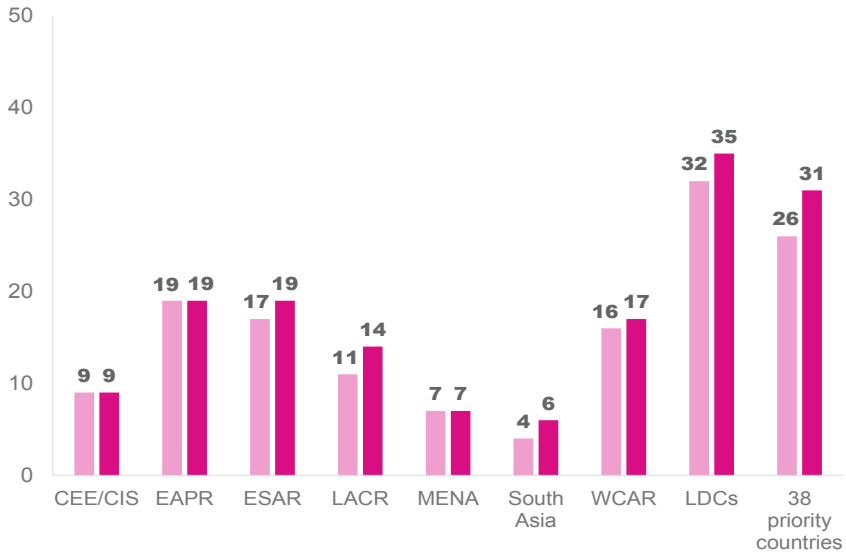
Disaggregated data available		Disaggregated data not available
Burundi	Lesotho	Angola
Cambodia	Malawi	Botswana
Cameroon	Mozambique	Brazil
Central African Republic	Namibia	Chad
Côte d'Ivoire	Nigeria	China
Democratic Republic of the Congo	Rwanda	Djibouti
Ethiopia	Swaziland	Guatemala
Ghana	Uganda	India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

P2.c.2

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

2014 Baseline	26
2015 Result	31
2015 Milestone	30
2017 Target	38

Achievement 103%

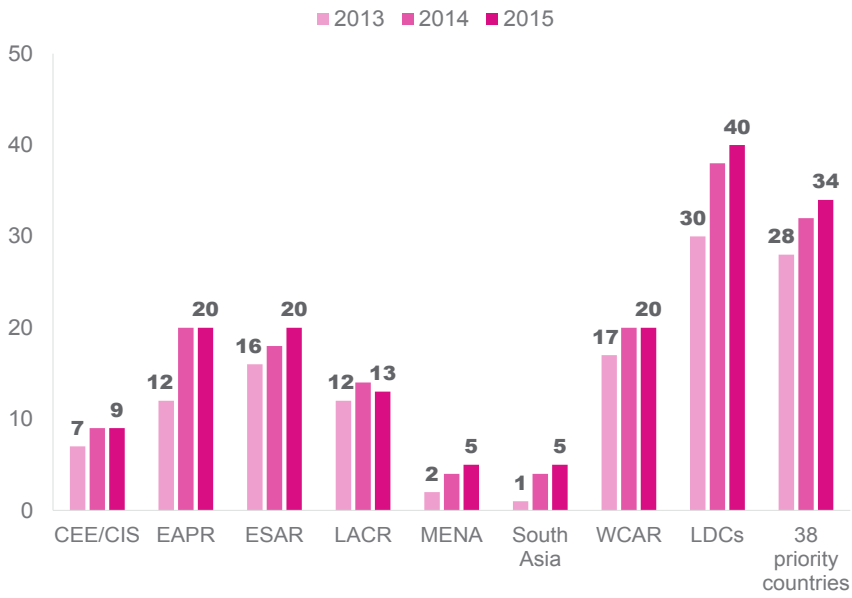


P2.c.3

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

2013 Baseline	28
2014 Result	32
2015 Result	34
2015 Milestone	34
2017 Target	38

Achievement 100%

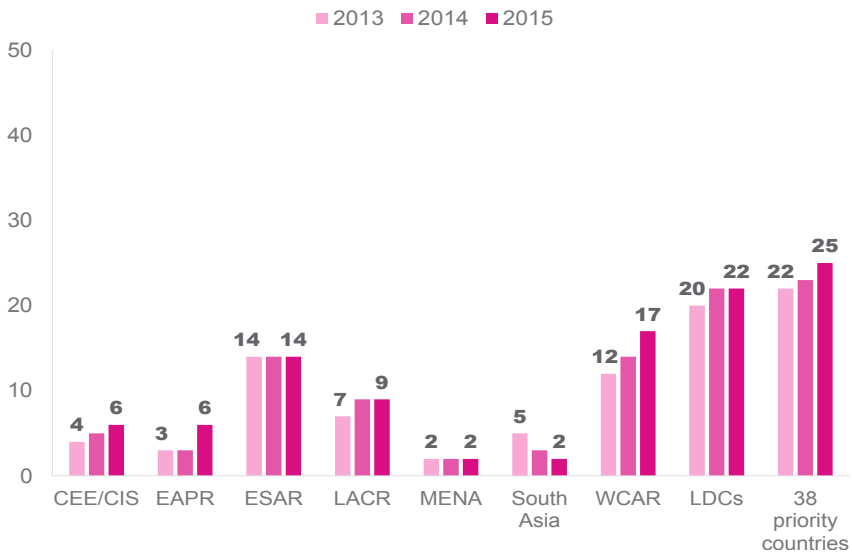


P2.c.4

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

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

Achievement 89%



Output d

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

Average output achievement

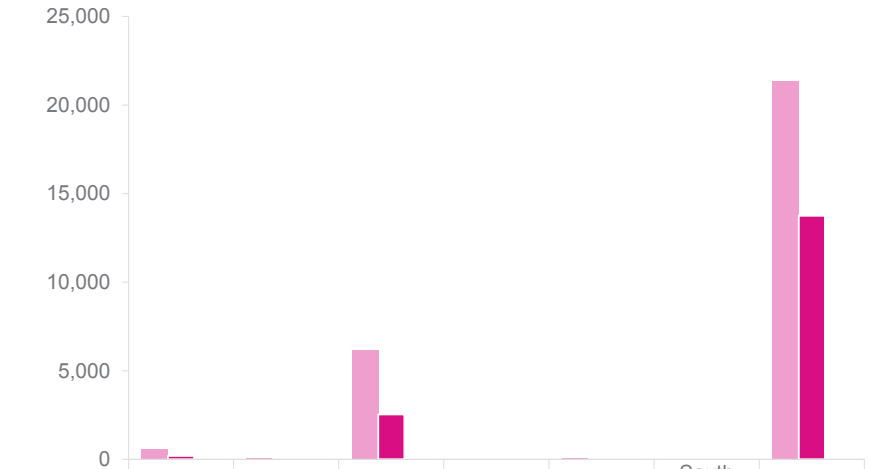
71%

P2.d.1

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

2014 Baseline	54%
2015 Result	59%
2015 Milestone	60%
2017 Target	80%

Achievement 98%



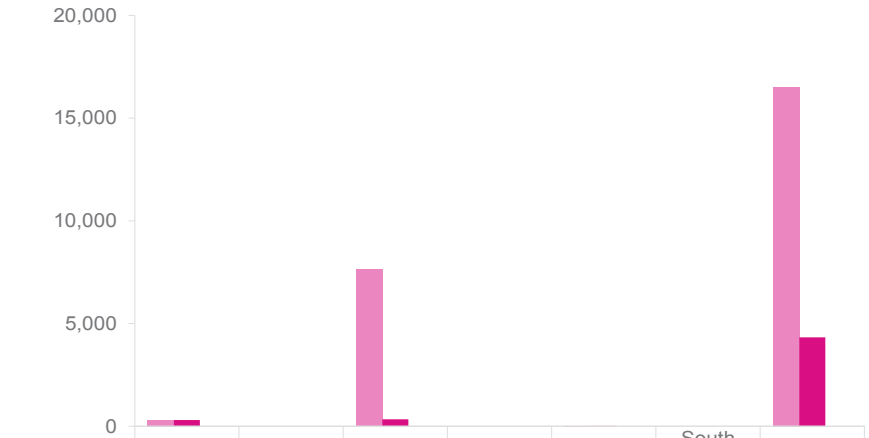
	CEE/CIS	EAPR	ESAR	LACR	MENA	South Asia	WCAR
Targeted	580	48	6,187	0	44	31	21,324
Reached	200	48	2,536	0	25	31	13,753
% reached	34	100	41	-	57	100	64

P2.d.2

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

2014 Baseline	34%
2015 Result	20%
2015 Milestone	46%
2017 Target	80%

Achievement 43%



	CEE/CIS	EAPR	ESAR	LACR	MENA	South Asia	WCAR
Targeted	300	0	7,617	0	16	0	16,517
Reached	300	0	335	0	16	0	4,328
% reached	100	-	4	-	100	-	26

Output e

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

Average output achievement
69%

P2.e.1

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

2013 Baseline	18
2015 Result	17
2015 Milestone	23
2017 Target	38

Achievement 74%

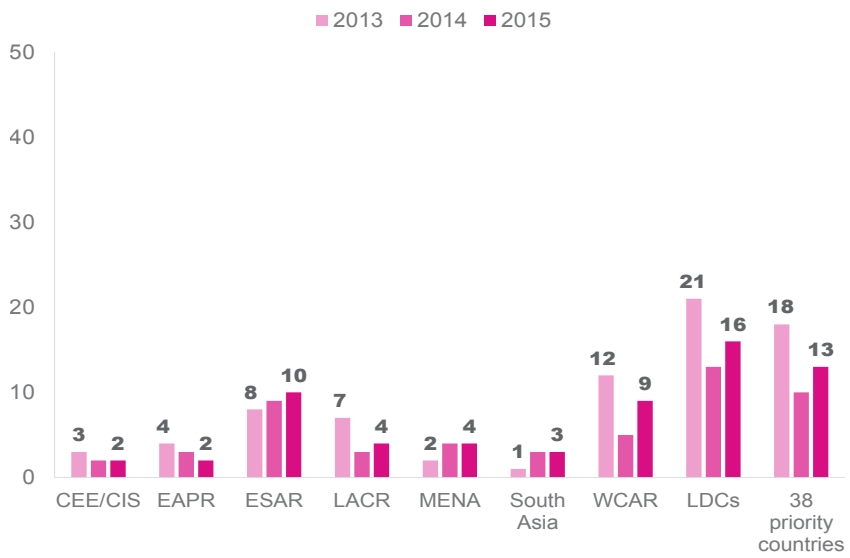
Data available		Data not available	
Burundi	Kenya	Angola	Indonesia
Cameroon	Malawi	Botswana	Iran (Islamic Republic of)
Central African Republic	Namibia	Brazil	Jamaica
Côte d'Ivoire	Rwanda	Cambodia	Lesotho
Democratic Republic of the Congo	South Africa	Chad	Mozambique
Ethiopia	Uganda	China	Myanmar
Ghana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

P2.e.2

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

2013 Baseline	18
2014 Result	10
2015 Result	13
2015 Milestone	20
2017 Target	38

Achievement 65%



Output f

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

Average output achievement

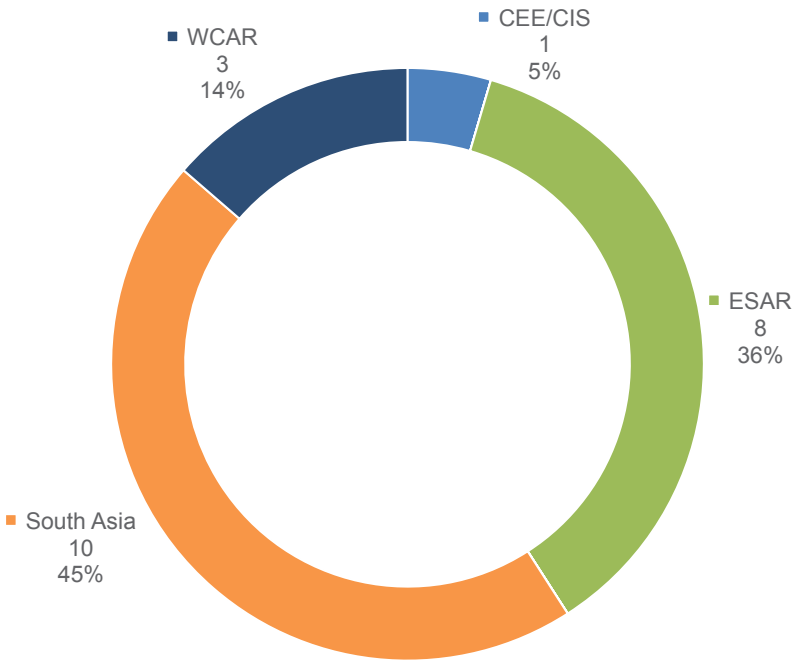
128%

P2.f.1

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

2014 Baseline	17
2015 Result	22
2015 Milestone	18
2017 Target	20

Achievement 122%



P2.f.2

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

2013 Baseline	6
2014 Result	6
2015 Result	8
2015 Milestone	6
2017 Target	6

Achievement 133%

Global initiatives

- *ALL IN* to #EndAdolescentAIDS initiative
- "Double Dividend" – action to improve the survival of HIV-exposed children in the era of elimination of mother-to-child transmission of HIV and renewed child survival campaigns
- Optimizing HIV Treatment Access in Pregnant and Lactating Women
- Promoting access and shaping markets to point-of-care HIV diagnostics (early infant diagnosis and viral load)
- Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive
- Inter-Agency Task Team on the Prevention and Treatment of HIV Infection in Pregnant Women, Mothers and Children
- Inter-Agency Task Team on HIV Prevention and Young People
- Social Protection, Care and Support Working Group

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