

Annual Results Report 2016

HIV and AIDS

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



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

The following report summarizes how UNICEF and its partners contributed to HIV and AIDS in 2016 and reviews the impact of these accomplishments on children and the communities where they live. This is one of nine reports on the results of efforts during the past year, encompassing gender and humanitarian action as well as each of the seven Strategic Plan outcome areas – health, HIV and AIDS, water, sanitation and hygiene, nutrition, education, child protection and social inclusion. It complements the 2016 Executive Director Annual Report (EDAR), UNICEF's official accountability document for the past year.



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Livey Van Wyk, pictured with her son, was supported by UNICEF to enrol in a PMTCT programme as a young mother living with HIV.

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EXECUTIVE SUMMARY

As the number of annual new HIV infections has stabilized and the number of people accessing life-saving drugs has soared in recent years, there has been an increasing sense of excitement in the global HIV response. There have indeed been many gains to combat the HIV and AIDS epidemic, with more than 18 million people currently accessing antiretroviral therapy¹ – about half of the estimated global population of people living with HIV – and 1.6 million new infections among children (0–14 years old) averted since 2000.² However, the excitement is premature, because progress has been uneven globally, and millions of children, particularly adolescents, still do not have the information, skills or financial capacity to be protected from HIV or to protect themselves. Successful efforts to force the epidemic into irrevocable decline depend on all stakeholders – including UNICEF – continuing to highlight the challenges and needs across all areas of the HIV response.

While programmes for the prevention of mother-to-child transmission of HIV have been expanded and improved upon in the past decade, stark regional differences exist, with women and children in some countries having little

access to the services that have transformed the lives and futures of their counterparts elsewhere.

Moreover, among the adolescent population, the annual number of new HIV infections has barely moved over the past five years even as the comparable number has plunged for children under 5 years of age. An estimated 250,000 adolescents aged 15–19 were newly infected with HIV in 2015, and an incipient demographic trend – an impending ‘youth bulge’ in sub-Saharan Africa due to high population growth – points to ominous concerns that the number of annual new infections will rise in the foreseeable future to 390,000 annually by 2030.

Despite critical advances, the AIDS epidemic remains one of the major human rights issues of our time. UNICEF recognizes that the burden falls disproportionately on women and girls, who currently account for about two thirds of all new infections among adolescents in the 15–19 age group. Failure to substantially improve their chances to live healthy and secure lives will jeopardize their overall progress.



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Livey van Wyck was open about her HIV status in a difficult environment, but overcame prejudice to become the mayor of Witvlei Village in Namibia at age 26.

“If we want to end AIDS, we need to recapture the urgency this issue deserves – and redouble our efforts to reach every child and every adolescent.”

UNICEF Executive Director Anthony Lake

In 2016, UNICEF and partners conceived a ‘super fast-track’ approach for HIV prevention and treatment for children, adolescents and young women that was endorsed at the United Nations High-Level Meeting on Ending AIDS in June. The name of the framework, Start Free, Stay Free, AIDS Free, reflects its ambitious targets for 2018 and 2020: eliminate mother-to-child transmission of HIV; reduce the rate of new HIV infections among adolescents and young women; and increase HIV treatment for both children and adolescents.

That framework complements and guides UNICEF’s leadership and work since 2015 in the collaborative **ALL IN to End Adolescent AIDS** initiative, which focuses on ramping up targeted advocacy and policy work in 25 priority countries that are home to the majority of adolescents living with and at risk for HIV. The initiative represents a core mechanism through which UNICEF is realizing its Strategic Plan 2014–2017, including results areas that correlate closely with progress towards meeting the ‘90-90-90’ targets of the Fast-Track initiative of the Joint United Nations Programme on HIV/AIDS.

Those ambitious treatment targets, which countries formally have committed to meet, call for the following to be achieved by 2020:

- 90 per cent of people (children, adolescents and adults) living with HIV know their HIV status;
- 90 per cent of people who know their HIV-positive status are accessing treatment; and
- 90 per cent of people on treatment have suppressed viral loads.

On the prevention front, a main global target of the Fast-Track initiative is to reduce new HIV infections to fewer than 500,000 a year by 2020, which would represent a steep drop from the current level of an estimated 2 million annual new infections. Expanded global targets within the initiative call for 90 per cent of people at risk of HIV, especially young women and adolescent girls in high-prevalence countries and key populations, to have access to ‘combination prevention options’.³

These promising top-level initiatives and targets require policy and programming action and follow-through. One that is cause for cautious optimism is the implementation by most countries of the revised World Health Organization (WHO) treatment guidelines to ‘treat all’, which means offering all people who are living with HIV the opportunity

to initiate antiretroviral therapy, immediately after diagnosis. Evidence shows that people who are on antiretroviral therapy and have fully suppressed viral loads do not transmit HIV. If scaled up effectively and comprehensively, leaving no populations or individuals behind for any reason, the ‘treat all’ approach could progressively and sustainably transform HIV treatment and prevention responses around the world. ‘AIDS Free’ would not be just hopeful rhetoric if this were to happen.

Country- and community-led efforts will be vital to expanding awareness and access to treatment and prevention. Throughout 2016, UNICEF engaged with countries around the world to help bolster local response. In 2016, for example, with considerable support from UNICEF, Armenia, Belarus and Thailand received WHO certification for the elimination of mother-to-child transmission of HIV. Several other countries are similarly on track to achieve this goal within a few years.

Building on such achievements is part of scaled-up efforts to meet the ambitious global treatment and prevention targets. Such efforts require additional financial investments, however, and UNICEF and its partners at global, regional and national levels face funding gaps just to maintain the current pace, let alone scale up. Many lower- and middle-income countries with high HIV burdens have been boosting their domestic budget support for HIV programming, but most have insufficient financial resources to drastically increase such funding – especially considering numerous other pressing development priorities. Yet trends indicate that much-needed external donor support, which in some countries covers up to 90 per cent of HIV programming, has little or no room to grow in the future.

UNICEF cannot fund the response itself. But it continues to advocate for greater resources for HIV response by donor countries and agencies as well as domestic governments in those countries with the greatest HIV burdens. Perhaps more importantly, its wide-ranging interventions continue to yield valuable lessons and results aimed at improving the lives of children and adolescents at risk or living with HIV. A UNICEF-supported study in South Africa, for example, has provided valuable proof that social protection provisions can boost antiretroviral therapy adherence among adolescents.

Much of this patient, careful and consistent work in countries is laying the groundwork for the kind of overall success that is still out of reach. UNICEF’s strong and valuable position as a pillar to these efforts was clearly seen, felt and heard in 2016.

STRATEGIC CONTEXT

Overview

The year 2016 represented a transition in many ways for the global HIV response. Some changes and developments were unequivocally positive, while the impact of others remains uncertain.

Significant gains were made in expanding access to and availability of services; coordinated, global action and attention; and efforts to develop and use innovative products and tools to address critical bottlenecks to effective HIV care.

As a result of years of persistent, steady efforts, an estimated 18.2 million people worldwide now have access to HIV treatment, which corresponds to about half of all people currently living with the virus.⁴ An aggressive scaling up of treatment is directly responsible for the 45 per cent decline in AIDS-related deaths from a peak of 2 million in 2005 to 1.1 million in 2015.⁵ An even steeper decline of 60 per cent occurred in the number of AIDS-related deaths among children under 15 years of age from 2000 through 2015.⁶ This accomplishment is due in large part to the

combined effect of successful prevention of mother-to-child transmission (PMTCT) programming and dramatically improved access to paediatric treatment.

These achievements are remarkable by any standard. But the urgency and need to do more, and more quickly, is clear when other critical epidemiological trends are considered. Although the number of annual AIDS-related deaths among children has fallen over the years, an estimated 110,000 child deaths occurred in 2015.⁷ Moreover, efforts to reduce the number of overall new HIV infections have been only partly successful, stagnating recently at about 2.1 million annually.⁸ About 150,000 of the new infections were among children under the age of 15, the majority of whom contracted HIV through vertical transmission in 2015,⁹ highlighting the need for a strengthened global focus on actions to eliminate mother-to-child infection. The importance of this goal should be underscored by the estimated 1.4 million pregnant women living with HIV globally in 2015.¹⁰ The risks to their health and that of their infants are considerable unless they know their status and receive antiretroviral therapy (ART).



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Ruslan (the name has been changed) attends a child-friendly centre to receive treatment in Tajikistan for HIV-positive children and their caregivers.

Current trends among adolescents are especially sobering. As a group, they are becoming even more vulnerable and affected. Globally, an estimated 250,000 adolescents aged 15–19 were newly infected with HIV in 2015. That number reflects only a 6 per cent decline in annual new infections since 2005. An estimated 1.8 million adolescents aged 10–19 were living with the virus worldwide in 2015,¹¹ a number that is 28 per cent higher than in 2005.¹² More children acquiring HIV vertically are transitioning to adolescence, when the need to strengthen and improve HIV prevention efforts is critical. The burden and need are particularly pronounced in India, Kenya, Mozambique, Nigeria and South Africa. These five countries account for nearly half of the 1.8 million young people living with HIV.

Young women continue to be at greatest risk, and thus most in need of targeted prevention interventions and support. Globally, these women accounted for 55 per cent of the total number of those aged 10–19 living with HIV in 2015. An even larger share (65 per cent) of new HIV infections among adolescents aged 15–19 years was among girls, a level little changed from the 67 per cent estimate in 2000.¹³

Prevention is the key not only to overall health gains, but to economic success as well.

New infections delay a top goal of advocates and policymakers worldwide: a consistent and comprehensive treatment for all people living with HIV. The revised World Health Organization (WHO) treatment guidelines targeting the expansion of treatment services at the moment of diagnosis represent a dramatic shift towards making that goal a reality.

Shifting policy and funding priorities

In 2016, diminished funding for the AIDS response threatened continued global success. Based on progress made towards the Millennium Development Goals, the international community adopted an ambitious target, within the 2030 Agenda for Sustainable Development, to end the AIDS epidemic by 2030. To reach this target, a Fast-Track strategy for the AIDS response, developed with UNICEF's support, was adopted by the board of the Joint United Nations Programme on HIV/AIDS (UNAIDS) and subsequently affirmed by the United Nations High-Level Meeting on Ending AIDS in June 2016.

UNAIDS estimates that the Fast-Track agenda requires about \$26 billion per year by 2020, after which the cost would decrease dramatically as the numbers of new HIV infections and people needing HIV treatment decline.¹⁴ Yet initial funding needed to launch and successfully complete this ambitious agenda is lacking. Instead of building momentum towards the goal of ending AIDS, external support is decreasing. In 2015, donor government funding to support HIV responses in low- and middle-income countries totalled \$7.5 billion, a steep decline from

\$8.6 billion in 2014.¹⁵ There is no indication that this trend will reverse or even stabilize.

Financial pressures cause concern that reduced external funding will halt or reverse the progress made in PMTCT coverage and impact. Negative impacts can already be seen in programming and support for key populations in many parts of the world. Targeted programming and services for sex workers and men who have sex with men – many of whom are adolescents – have been cut back in countries ranging from the former Yugoslav Republic of Macedonia to the United Republic of Tanzania. Reductions in international support for programming and advocacy are having a debilitating impact on efforts to reach and support highly vulnerable key populations.

Global solidarity and leadership

Global action, coordination and solidarity can serve as important counterweights to the dispiriting trends in HIV financing.

In June 2016, United Nations Member States met at the General Assembly for the High-Level Meeting on Ending AIDS. The outcome of this meeting was an unprecedented Political Declaration addressing progress, lessons learned and pending gaps in the HIV response. It also reaffirmed countries' commitment to concrete Fast-Track targets and set a goal of reducing the number of new infections among young women (15–24 years old) to fewer than 100,000 by 2020.¹⁶

“We are motivated to fight AIDS because we know that every child deserves care, every person deserves treatment and all vulnerable groups deserve protection from stigma and abuse. Tolerance and awareness help stop AIDS. Speaking out protects life.”

Former United Nations Secretary-General Ban Ki-Moon

New or expanded initiatives strive to raise awareness that will increase financial resources – and ideally spur innovation to improve efficiency, scope and impact. Several initiatives focus specifically on adolescents and children, effectively drawing attention to these high-risk populations.

UNICEF has played a leading role in several high-profile initiatives, including **ALL IN to End Adolescent AIDS**, which focuses on the 25 countries where 80 per cent of all new HIV infections among adolescents occur. Dedicated fast-track targets for 2020 through this agenda include (1) reducing new HIV infections among adolescents by at

THE PROMISE OF UNIVERSAL 'TREAT ALL': BENEFITS AND CHALLENGES

The commitment by most countries in 2016 to implement the 2015 revised WHO treatment guidelines to 'treat all' was perhaps the most momentous development in 2016 from a policy and programming standpoint. The clarity of the new approach is reflected in the range of terms used to refer to it, including universal 'test and treat' and 'test and offer to treat', in addition to 'treat all'. Eligibility criteria is reduced to knowing one's HIV status and a willingness to start ART – everyone in need can positively benefit without waiting.

For UNICEF, the heart of the issue is to improve country capacity to locate and 'treat all' pregnant and lactating women, children and adolescents living with HIV. 'Treat all' allows all people living with HIV to immediately enrol in HIV treatment after being diagnosed to safeguard their own health. They now have the right to demand life-prolonging medicines and associated HIV services, which could also encourage more people to get tested for HIV.

UNICEF helped pioneer the universal 'treat all' concept through its advocacy, policy and programming support for Option B+ over the past several years. Option B+ aims to provide all pregnant women with access to ART, as a core strategy to eliminate mother-to-child transmission of HIV. The revised WHO treatment guidelines essentially expand that same right and offer to all people living with HIV. The lessons learned and disseminated by UNICEF through its championing and support for Option B+ will help achieve similar success with the 'treat all' initiative.

A successful 'treat all' focus will sharply reduce HIV transmission at population levels. Increasing access to ART will benefit entire communities, particularly adolescents, who are at heightened risk for contracting HIV due to factors such as age and inability to negotiate safer sex, sexual practices, and social, economic and educational circumstances. Raising awareness that HIV is a chronic and manageable condition, rather than a threat, is likely to reduce HIV-related stigma and discrimination and encourage regular HIV testing.

But such wide-ranging benefits of 'treat all' may be further in the future than optimists care to acknowledge. The majority of countries that most need improved HIV treatment access continue to face dire financial and human resources gaps in their health systems. A lack of equal access to treatment also diminishes HIV prevention efforts, leaving entire segments of the population at risk.

Underfunded health systems suffer from structural and implementation challenges that prevent successful identification and provision of the critical support services needed for effective HIV treatment. For example, the value of ART lies in its simplicity: one pill, once a day. But HIV medicines control the virus only with consistent use. For many people living with HIV, adherence is critically compromised by social factors, including fear of disclosure, insufficient understanding of HIV and treatment and/or lack of support. This is a particular challenge for adolescents and children.

UNICEF recognizes that psychosocial support, testing outreach, adherence support and targeted efforts to reach highly vulnerable populations and reduce HIV stigma must be done in tandem with simply making medicines more widely available. All such efforts cost money and require dedicated human and technical resources.

UNICEF must work to ensure that the promising rewards of 'treat all' do not bypass children and adolescents. Identifying and initiating consistent treatment among this population remains a persistent challenge. Improving outcomes will require reversing trends that have seen adolescent infections continue to rise even as adult incidence declines.

The challenges that have contributed to such dispiriting trends require new and targeted financial and human resources and enlightened and transparent approaches. UNICEF plays a central role in developing such approaches through its leadership role in the ALL IN to End Adolescent AIDS initiative, which was launched in 2015 and focuses on 25 priority countries. The initiative is helping pave the way for more rapid and effective 'treat all' scale-up among adolescents by, among other things, generating better country data about risk and access to services and designing and implementing more efficient and effective strategies for HIV testing that target adolescents at high risk of infection.

least 75 per cent; (2) reducing AIDS-related deaths among adolescents by at least 65 per cent; and (3) ending stigma and discrimination.¹⁷

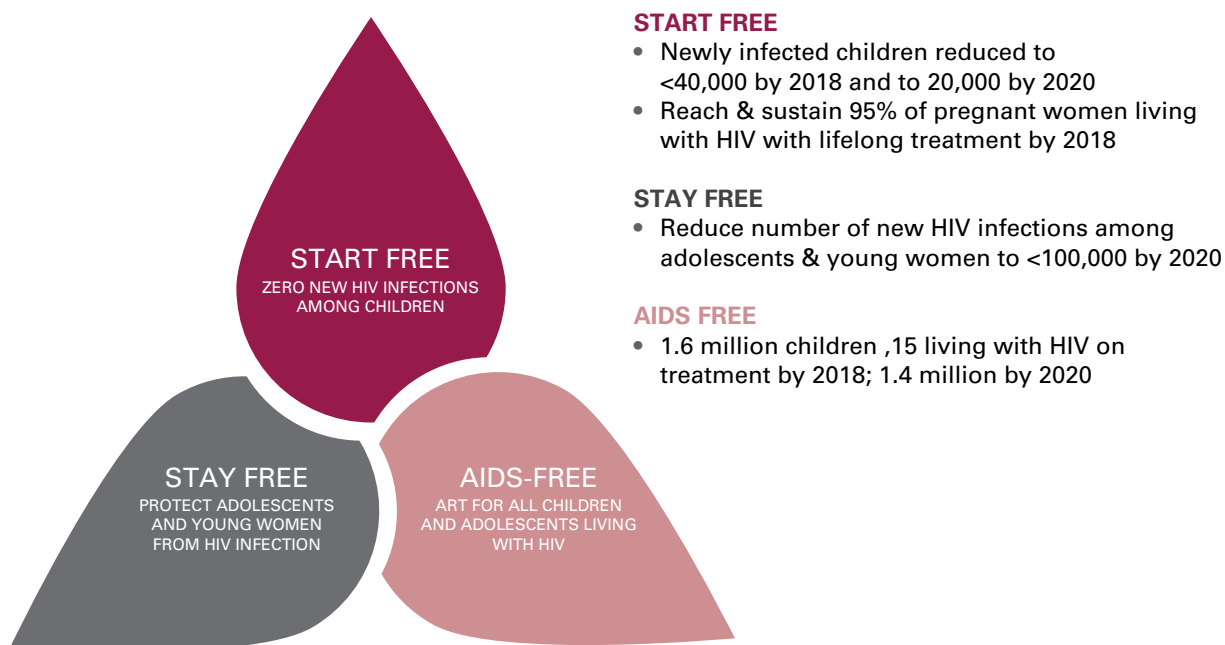
Along with other partners, UNICEF worked in 2016 to further drive these goals by proposing a 'super fast-track' approach to HIV prevention and treatment for children, adolescents and young women, the Three Frees Framework, whose pillars are 'Start Free, Stay Free, AIDS Free'. They highlight fast-track targets for 2018 and 2020 that were agreed at the June 2016 United Nations High-Level Meeting on Ending AIDS to (1) eliminate mother-to-child transmission of HIV (Start Free); (2) reduce the rate of

new HIV infections among adolescents and young women (Stay Free); and (3) increase HIV treatment for both children and adolescents (AIDS Free). *(More detail on UNICEF's work in 2016 is provided in the Results by Programme Area section below.)*

UNICEF will address existing and future challenges by maximizing interventions that fall within its comprehensive Strategic Plan for HIV, with the aim of improving and expanding use of proven HIV prevention and treatment interventions by pregnant women, mothers and their children and adolescents.

FIGURE 1

Super fast-track to end AIDS for children, adolescents, young women and expectant mothers



Source: Elisabeth Glaser Pediatric AIDS Foundation, United States President's Emergency Plan for AIDS Relief (PEPFAR), UNAIDS, UNICEF and WHO, <https://free.unaids.org/>.

RESULTS BY PROGRAMME AREA

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

The specific outputs from the Strategic Plan 2014–2017 that 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 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.

Programme scope

UNICEF's HIV programme, working alongside health, nutrition, early childhood development, Communication for Development (C4D), gender, human 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, while the second decade focuses on adolescents. Across both decades, UNICEF promotes equitable social protection interventions, including efforts to address acute and chronic emergencies and their impacts on people living with or affected by HIV and AIDS.

The following section details the results achieved in 2016 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 countries prioritized under the Global Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping Their Mothers Alive (Global Plan), and countries affected by emergencies.

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

Pregnant women, new mothers and their babies were the focus of the first aggressive global HIV prevention and treatment drive, before ART was available to most people in the general population in lower-income, high-burden areas such as sub-Saharan Africa. Concentrated efforts by UNICEF and partners have helped avert an estimated 1.6 million new HIV infections among children since 2000.¹⁸ One direct result of this rapid global improvement in PMTCT coverage is the sharp decline in the number of AIDS-related deaths among children over the past 15 years.

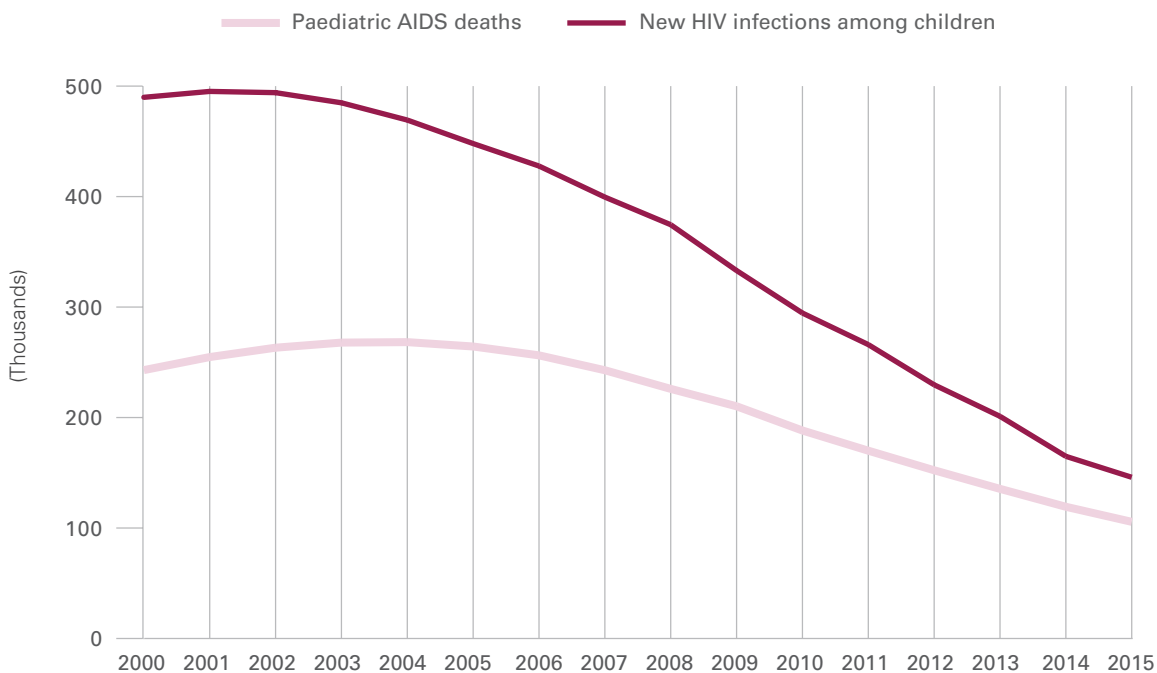
UNICEF's ability to leverage often scarce or limited funding to achieve transformative change was praised in a 2016 independent evaluation of its PMTCT and paediatric HIV care and treatment programme. UNICEF has played a critical role, with partners, in programme scale-up through its targeted advocacy and the provision of substantive financial and technical support to country-level partners. Such work has taken place across a broad range of areas, spanning policy development, programme planning, and support for knowledge-building activities. The evaluation found strong evidence of UNICEF's leadership on issues related to HIV in children, especially in programme areas. The evaluation concluded that UNICEF is seen as a 'trusted and reliable partner' in initiatives aimed at strengthening coordination at global and country levels.



In 2015, 1.1 million pregnant women received antiretroviral drugs to help prevent mother-to-child transmission of HIV. Queen, 34, discovered she was HIV-positive when she was 26 years old, but thanks to a PMTCT programme, she gave birth to Neo, who is free of HIV. They live near Johannesburg, South Africa

FIGURE 2

Estimated number of new infections and number of AIDS-related deaths among children (aged 0-14), Global, 2000-2015



Source: UNAIDS 2016 estimates.

Prevention of mother-to-child transmission of HIV

The scale-up of PMTCT service coverage, particularly in the past five years, is one of the greatest public health achievements in recent times. With UNICEF's technical assistance, services have grown increasingly integrated, with new methods of delivery and strengthened support for antiretroviral regimens improving HIV prevention and health among children and mothers.

Throughout 2016, the Inter-Agency Task Team on Prevention and Treatment of HIV Infection in Pregnant Women, Mothers and their Children secretariat at UNICEF headquarters and the UNICEF focal points in country offices coordinated the provision of technical assistance support to track key milestones; strengthen longitudinal monitoring and tracking systems for mother-infant pairs; and share tools and lessons learned to catalyse global, regional and country action.

Option B+

The Global Plan demonstrated that with political commitment and resources, remarkable progress in addressing HIV among women and children worldwide can be achieved. In 2015, an estimated 1.4 million pregnant women were living with HIV. More than 1 million received the most effective regimens of antiretroviral medications for PMTCT, with an estimated 79 per cent coverage in sub-Saharan Africa. These results occurred as countries rapidly transitioned to the 'test and start' approach using the simplified 'one pill once a day' fixed-dose combination treatment delivered for life (known as Option B+). UNICEF was instrumental in supporting countries to scale up the 'test and start' approach for pregnant and lactating women using Option B+. The extraordinary impact of Option B+ implementation was a major influence on WHO's 2015 treatment guidelines, which expanded the approach to cover all people living with HIV through the 'treat all' standard.

In 2016, UNICEF supported the evaluation of a modelling project for facility-community linkages and monitoring of Option B+ in Côte d'Ivoire and the province of Katanga in the Democratic Republic of the Congo. Findings from this project influenced the national scale-up approach to roll out Option B+. UNICEF also worked with Malawi and Uganda to strengthen Option B+ programming, supporting innovative community-based efforts around male involvement and longitudinal monitoring to improve retention of pregnant women and mothers living with HIV and their babies. This work will be documented and disseminated throughout the region during 2017.

As of mid-2016, all 22 Global Plan countries had adopted the 'test and start' approach, leading to a dramatic scale-

up of access to ART. In 2015, 6 countries out of the 22 had achieved greater than 90 per cent PMTCT ART coverage. The global effort to forcefully respond to mother-to-child transmission resulted in a 60 per cent decline in new HIV infections among children in 21 Global Plan countries in sub-Saharan Africa between 2009 and 2015. The decrease, from 270,000 to 110,000 cases, signals the success of the approach.

UNICEF, supported by the Swedish International Development Cooperation Agency and the Norwegian Agency for Development Cooperation, signed an agreement to adopt and scale up Option B+ through the Optimizing HIV Treatment Access initiative. Interventions in Côte d'Ivoire, the Democratic Republic of the Congo, Malawi and Uganda focused on strengthening community capacity and linkages to health-care facilities. Effort was made to improve demand for PMTCT services and HIV treatment, as well as retention in the care of pregnant and breastfeeding women on ART for life. The initiative concluded its fourth and final year in 2016.

Results from the initiative in 2016 identified promising practices that led to increased service uptake, adherence and retention in PMTCT. Additional support, such as access to participatory women's groups and targeted food assistance, proved effective. Innovative communication strategies were used to expand outreach and return to care those clients lost to follow-up. Engaging with local organizations to improve the care-seeking environment through male partners and supporting access to community-based HIV testing and ART distribution also bolstered results.

By 2015, more than 44,000 pregnant women were receiving lifelong ART as a result of the initiative, with retention rates at six months ranging from 73 per cent to 94 per cent in the Democratic Republic of the Congo. Also, slight improvements in early antenatal care 1 coverage were achieved, with a subsequent rise in antenatal care 4 coverage. Most notably, modelling suggests that more than 50,000 new paediatric infections were averted as a result of efforts during the three-year period of the initiative. Following those impressive results, Norway and Sweden extended their support to UNICEF in 2016 for an extra year so that countries could consolidate gains and share knowledge for increased uptake.

UNICEF supported a number of countries, including Rwanda and Zimbabwe, in reviewing early evidence obtained in Eastern and Southern Africa suggesting that PMTCT clients under 25 years of age had poorer uptake and outcomes along the PMTCT continuum than older PMTCT clients. Other interventions focused on the critical issue of reliable data. UNICEF country offices, with support from regional offices, continued to support bottleneck analyses to improve data-driven planning. In the Democratic Republic of the Congo, Ghana and South Africa, monitoring

systems for the timely removal of barriers identified through data analysis contributed to the scale-up of PMTCT and paediatric HIV services.

In South Sudan, UNICEF continued to support the Ministry of Health in the provision of PMTCT services across the country using a maternal and neonatal health platform. More than 150,000 pregnant women accessed at least one antenatal care service and more than 32,000 pregnant women were counselled and tested for HIV. As a result, nearly 500 pregnant women who tested positive for HIV were enrolled on ART.

In the East Asia region, vital technical assistance in this area directly supported PMTCT scale-up in Viet Nam and a national PMTCT assessment in Myanmar. Also in the region, UNICEF, in partnership with WHO's Western Pacific Regional Office and South East Asia Regional Office, supported efforts using information and communication technology to strengthen linkages between maternal, newborn and child health and HIV programmes. The focus was on the PMTCT cascade and how best to prevent loss to follow-up and strengthen referral mechanisms.

ARMENIA, BELARUS AND THAILAND FOLLOW CUBA IN REACHING ELIMINATION OF MOTHER-TO-CHILD TRANSMISSION OF HIV

After decades of progress, and with considerable support from UNICEF, in 2016 Armenia, Belarus and Thailand, like Cuba in 2015, received WHO certification for elimination of mother-to-child transmission of HIV. These important achievements moved the world closer to an AIDS-free generation.

In Thailand, this success is due to a range of complementary health policies addressing underlying issues that impede prevention. Along with investing in primary prevention, stigma and discrimination among health-care providers was directly addressed. Strong outreach to migrant populations and robust peer support services were prioritized as a complement to expanded ART access to pregnant women living with HIV. Health officials demonstrated their commitment to underlying equity principles by making PMTCT services available not only to Thai women and children, but also to non-Thai migrants. The extension of universal health care to the 3-4 million migrants residing in Thailand served as a remarkable example of integrating human rights with health. The special health-care scheme that enabled migrants and their children to access testing and treatment for HIV and sexually transmitted infections – and at an affordable annual fee – represents a recognition that communicable diseases know no borders.

As a result of such enlightened policies, Thailand is the first country in Asia where the rate of HIV transmission from pregnant mothers to their newborns has fallen below 2 per cent.

Armenia, Belarus and Cuba have also worked hard to expand access to HIV testing, ART and supportive care. As with Thailand, they are now reaping the rewards.

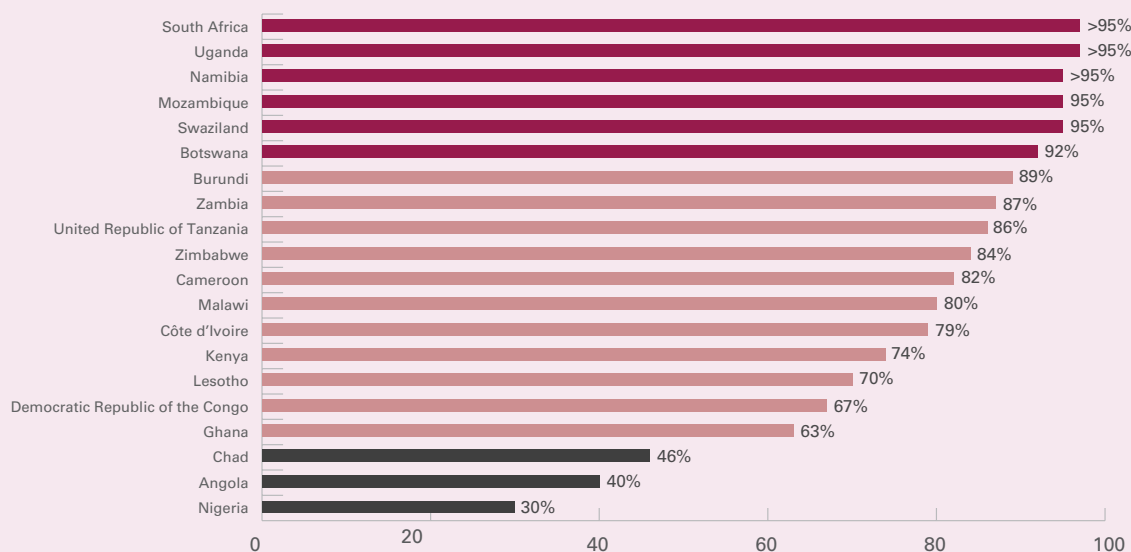
In Armenia, there has been no mother-to-child transmission of HIV in the past eight years. Despite a low HIV prevalence, there was strong national commitment to expand HIV testing and ART to antenatal care settings. Cuba officially became the first country in the world to eliminate mother-to-child transmission of both HIV and syphilis in 2015, and Belarus, which had one of the highest HIV prevalence figures in the region, achieved the milestone just one year later. In Belarus, services and support were provided for the most marginalized and socially excluded pregnant women, including those who use drugs or sell sex. Strong collaboration between AIDS centres and the maternal and child health systems was essential to this success.

The achievements of these countries are linked by tremendous efforts to reverse the stigma, discrimination and prejudice towards women living with HIV and provide equitable access to effective services. Women living with HIV hesitate to seek out the services they need if they do not trust the HIV care, antenatal and maternal and childcare systems. Fostering an atmosphere of respect and dignity is key to increasing participation in these life-changing programmes.

The successes summarized above are likely to spread to other countries in the next few years, and with them, hope for eliminating mother-to-child transmission. These steady victories provide optimism as the global community works to accelerate progress towards the goal of ending the AIDS epidemic by 2030.

FIGURE 3

Percentage of pregnant women living with HIV receiving most effective ARVs for PMTCT, 21 sub-Saharan Global Plan countries, 2015



Source: UNAIDS 2016 estimates.

Note: excludes single dose nevirapine; Ethiopia not available.

Notable progress is being made even in countries with higher overall burdens and fewer resources. South Africa slashed the number of new paediatric infections from 58,000 to just over 5,000. With UNICEF's support, the country has launched its 'last mile' plan for 2016–2021.¹⁹ The plan, which is costed, is aligned with national timelines and sets five-year benchmarks towards the elimination of mother-to-child transmission.

In 2016, UNICEF, with funding from the Centers for Disease Control and Prevention, supported South Africa's National Department of Health to build and strengthen referral and linkage systems between communities and health facilities through a community mentor mother programme in four districts (Amatole, OR Tambo, Waterberg, Zululand). The initiative focuses on supporting in-country strategies to scale up high-impact interventions related to PMTCT, paediatric care and treatment. Among its goals are the integration of maternal, newborn and child health services, the implementation of assessments on violence against children and the facilitation of adolescent HIV and risk-informed programming. In addition to South Africa, three other countries (Cameroon, Namibia and the United Republic of Tanzania) implemented activities through the initiative in 2016.

Support through the initiative enabled the Government of Cameroon to organize the first National Conference on

the elimination of mother-to-child transmission of HIV and paediatric HIV care and treatment. What became known as the 'Yaoundé call' was adopted by all participants at the conference, which was held in October 2016. This call to action was a statement of commitment from 10 regions of Cameroon, health experts and professionals, representatives of civil society organizations, community leaders and technical and financial partners, to make the 90-90-90 Vision of Cameroon a reality for pregnant and breastfeeding women and their partners, children and adolescents by 2020.

In East Asia and the Pacific, UNICEF provided normative guidance for the Government of China's first national consultation on the triple elimination of mother-to-child transmission of HIV, syphilis and hepatitis B. In 2016, at the 10th Asia-Pacific Prevention of Mother-to-Child Transmission of HIV and Syphilis Task Force meeting in Beijing, 12 of 19 countries in the region committed to eliminating mother-to-child transmission of HIV and syphilis by 2020.

In Latin America and the Caribbean, UNICEF collaborated and coordinated with the Pan American Health Organization on the development of the framework and strategy for monitoring and evaluation of the elimination of mother-to-child transmission of HIV, publication of annual regional progress reports, development of a comprehensive field guide to support countries' progress towards elimination,

REAL-TIME INNOVATION TO SUPPORT SOUTH AFRICA IN THE 'LAST MILE' TO ELIMINATE VERTICAL TRANSMISSION

South Africa has made tremendous gains in preventing mother-to-child transmission of HIV over the past decade. Most notably, the vertical transmission rate fell from 8 per cent in 2008 to 1.5 per cent as per programme data in 2015. That improvement contributed to a 79 per cent decline in the number of new infections among children, from an estimated 78,000 infections in 2004 to 16,000 infections in 2013.

Working closely with the National Department of Health, provincial health departments and the National Institute of Communicable Diseases, UNICEF led the conceptualization, design and roll-out of a tracking project supporting government efforts to obtain even better results. The project used RapidPro, a UNICEF-developed open-source platform of applications that can help governments deliver vital real-time information and connect communities to life-saving services.

Under the initiative, mobile technology is used to gather key information regarding each infant PCR positive laboratory test that will be analysed to identify localized gaps contributing to HIV transmission. Later, the collective data and information gathered can be used to design responses to address those gaps, targeting public resources more effectively.

The pilot project was implemented from May to September 2016 in three districts of KwaZulu-Natal, the South African province with the highest overall HIV prevalence. A total of 400 infants in those three districts tested HIV PCR-positive for the first time during the five-month period, and 367 (91.8 per cent) had data for analysis. Among the notable findings were that 60 per cent of mothers were first diagnosed prior to conception or at their first antenatal clinic visit. More than one third (37.3 per cent) transmitted despite receiving more than 12 weeks of ART, and of those, almost one half had been diagnosed before conception. A high share (70 per cent) of all women had no viral load result documented.

Overall, two thirds of mothers who transmitted HIV to their infants did so despite receiving PMTCT services. This highlights the critical need to improve services during antenatal care and to prevent post-partum infections. Moreover, the results suggest that the focus of maternal care needs to shift towards viral load monitoring and retention in treatment and care.

and the creation of standardized validation tools and guidelines for Regional Validation Teams. As part of its work, for example, UNICEF Peru helped identify deficiencies in follow-up services for HIV-positive mothers and reactivation to monitor these services. One key result has been a decrease in the number of children exposed to HIV.

Integration continued to be an underlying priority for UNICEF in its work with and for mothers and children. In West and Central Africa, UNICEF provided guidance and advocacy for Ghana as it launched a policy and guidelines review process to strengthen HIV integration within reproductive, maternal, newborn, child and adolescent health. In India, more than 4,000 HIV-positive mothers in the state of Karnataka are being monitored through an enhanced mother-child tracking system that aims to improve child survival and maternal health outcomes. UNICEF is supporting this initiative through a partnership with the MAC AIDS Fund.

UNICEF has continued to seek potentially useful options that can have substantial, and sometimes unexpected, results at the community and grass-roots levels in particular. In Nigeria, for example, an unusual intervention took place based on the idea that effective outreach occurs

in settings where women are comfortable – in this case, group baby showers held in local churches. Specialized training was provided to members of faith-based organizations that were well established in communities covered by the project. These volunteer health advisers counselled women on HIV and sexual and reproductive health when they attended baby showers, which are culturally important events. The women were also offered testing for HIV and six additional conditions, thereby strategically removing the stigma associated with HIV-only testing.

PMTCT challenges

Despite indisputable progress, UNICEF and its partners must accelerate efforts to protect the health of all pregnant women, mothers and their children. Persistent gaps and shortcomings remain a danger to the most vulnerable populations. In 2015, an estimated 150,000 children (aged 0–14 years) were newly infected with HIV globally, with nearly 85 per cent occurring in sub-Saharan Africa.²⁰

It is important to note that major disparities in access and uptake by region, and also within countries exist.

Globally, 80 per cent of pregnant women living with HIV accessed the most effective antiretroviral medicines for PMTCT in 2015. Though this result met the target specified in the Global Plan,²¹ regional and country variations are striking. In 2015, coverage exceeded 95 per cent in countries such as Namibia and Uganda, but fell below 50 per cent in other places including Chad and the Niger and Chad (46 per cent and 28 per cent, respectively).²² As illustrated in Figure 5, coverage was only 15 per cent across the entire Middle East and North Africa region, compared with 89 per cent in Eastern and Southern Africa and 88 in Latin America and the Caribbean.²³ In West and Central Africa, the region with the second-highest HIV burden and need, coverage was just 48 per cent.

PMTCT programmes continue to face challenges retaining pregnant women and mothers diagnosed as HIV-positive. Strengthened interventions along the continuum of care, including antenatal care, HIV testing, treatment initiation, continued care (retention), and support for adherence are needed. Unsupported, many women in PMTCT programmes are likely to drop out of care, particularly in the weeks immediately following initiation of treatment or delivery of the baby.

Poor retention is one reason that the majority of paediatric HIV infections are now occurring during the breastfeeding period. The shift in the timing of HIV transmission from mother to child has created a new urgency for focusing on adherence to ART and retaining mothers and infants in care to the end of the breastfeeding period.²⁴ Comprehensive care must continue after delivery, providing infant HIV testing (early and through the end of breastfeeding), optimal infant feeding practices and antiretroviral prophylaxis for the exposed infant. Initiation of ART and continued support in adherence is vital for the health of infants diagnosed with HIV and continuation of ART in mothers.

Obstacles to successful follow-up are many: unwelcoming and disorganized health facilities; user fees for services; transport difficulties and expenses; insufficient routine counselling and support; and competing priorities for the mother, such as work and family responsibilities. Male partner involvement (as a means of addressing gender dynamics) is one intervention that has shown promise in reducing HIV transmission from mother to child.²⁵ Stigma, which seems to have a disproportionate impact on women, is another major impediment that must be addressed to improve retention.

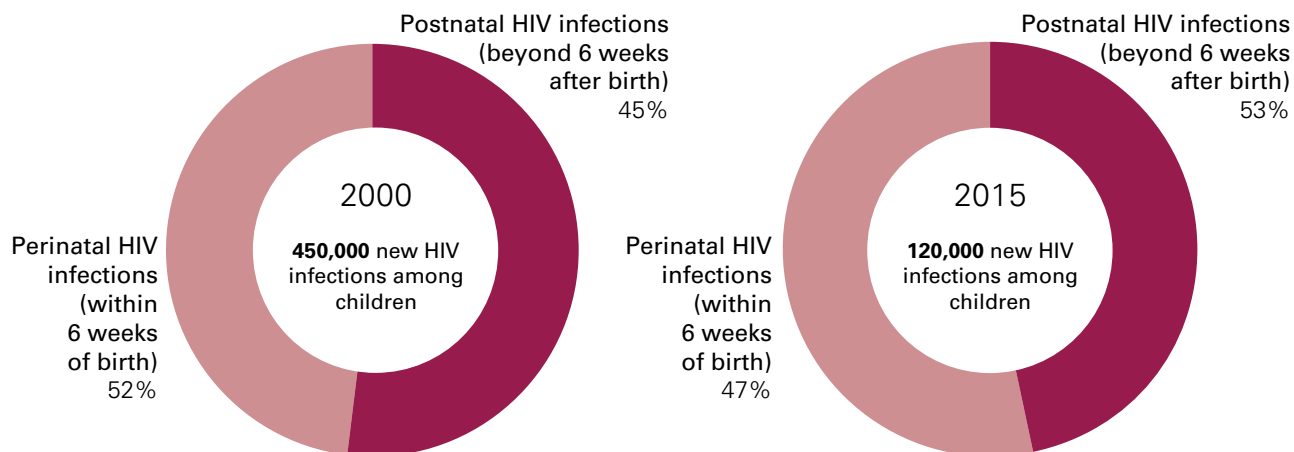


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Lexina Lungu, a 26-year-old woman from Kasungu, Malawi, who is living with HIV, learned she was HIV-positive while pregnant with her second child and was immediately put on lifelong antiretroviral therapy. Lexina decided to exclusively breastfeed her child, Chimango, to give him the best start in life.

FIGURE 4

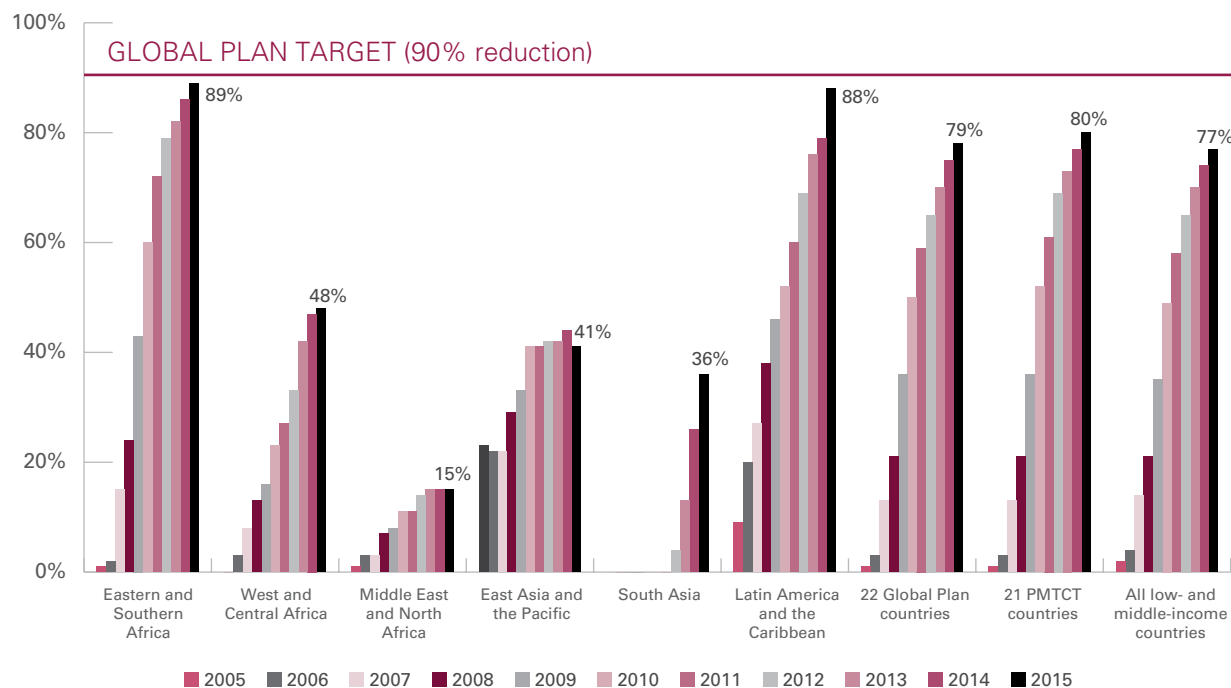
Estimated number of new HIV infections among children (aged 0-14), sub-Saharan Africa, 2000 vs. 2015



Source: UNICEF analysis of UNAIDS 2016 estimates.
Note: Values may not sum to total due to rounding.

FIGURE 5

Percentage of pregnant women living with HIV receiving most effective antiretroviral medicines for PMTCT, by UNICEF Regions, 2005-2015



Source: UNAIDS/UNICEF/WHO Global AIDS Response Progress Reporting and UNAIDS 2016 estimates.
Note: excludes single dose nevirapine; data not available for Central and Eastern Europe and the Commonwealth of Independent States (CEE/CIS)



© UNICEF/Tajikistan/ Nooran/2014

A child living with HIV in Tajikistan learns about the medication that, if taken consistently, offers a long, healthy life.

Paediatric HIV

Challenges to PMTCT underscore the fact that much work remains along all steps of the HIV continuum of care, starting with diagnosis of children born to mothers living with HIV. To address this, UNICEF has been supporting countries to improve paediatric HIV case finding and ART uptake and retention.

Diagnostics

Globally, only half of all HIV-exposed babies are tested by the recommended age of 2 months (Figure 6). In West and Central Africa and South Asia, where millions of women of childbearing age are living with HIV, such early testing reaches only an estimated 15 per cent of exposed babies.

But access to an HIV test alone is not enough. Immediate follow-up HIV treatment and initiation of ART is particularly critical for infants: without treatment, one in three of these children will die before his or her first birthday, half by 2 years of age, and 80 per cent by the time they are 5 years old.^{26,27}

Despite the urgent need for immediate treatment, it often takes weeks, if not months, for test results to get back to clients or their clinics. Sometimes they are lost entirely. Recent estimates indicate that in the case of early infant diagnosis, roughly 43 per cent of conventional test results are never received by clients – and of those that are, the time between taking a test and receiving results averages more than 30 days. In many cases, this is too late to save the life of an HIV-positive baby.

Gaps in standard of care infant diagnosis also occur in what is known as the ‘final test’. This HIV antibody test should

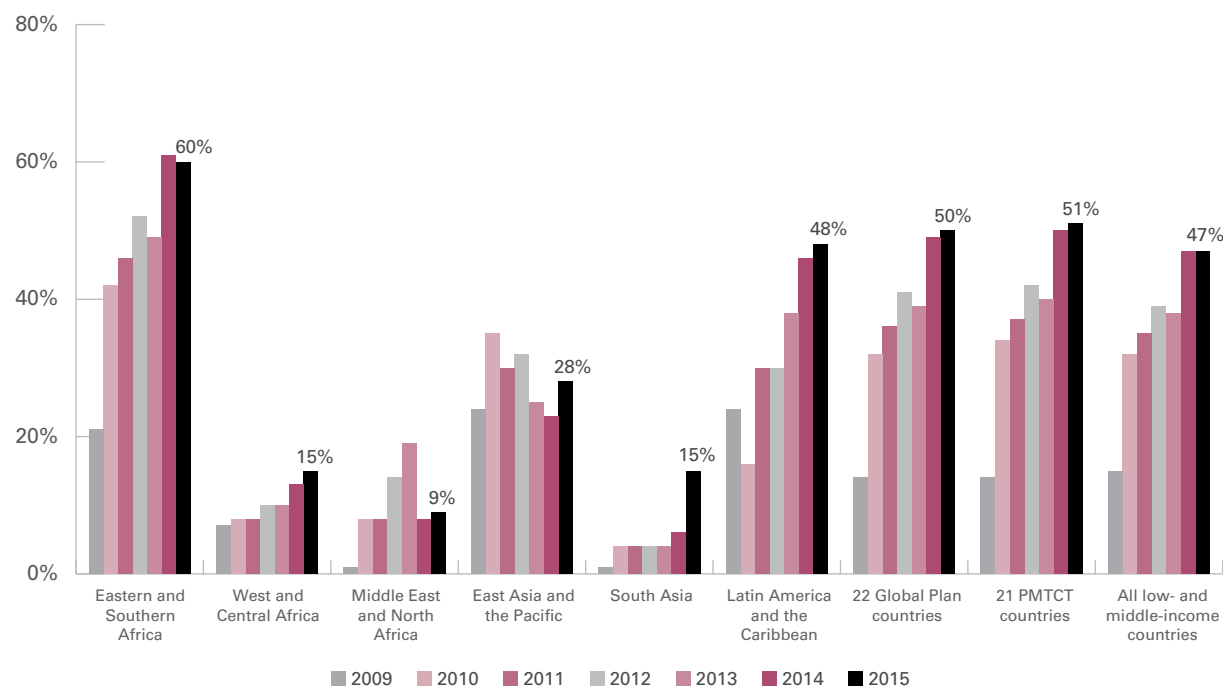
be administered to all HIV-exposed babies at 18–24 months of age, even if they tested negative through early infant diagnosis. Comprehensive, ongoing case-finding efforts among older infants and children are vital to improving retention so that no child slips through the cracks without treatment.

Such dire diagnostics numbers led UNICEF to prioritize the diagnosis of young children in order to eliminate the paediatric treatment gap. Some of the interventions advanced in 2016 focused on integration approaches, including using community platforms as part of the integrated management of childhood illnesses and other child platforms (in both outpatient and inpatient services) and nutrition clinics. In West and Central Africa, with UNICEF support, lessons learned and best practices on paediatric HIV case finding through index case were disseminated during a webinar organized in collaboration with a Kenyan research team with six countries (Cameroon, Chad, Côte d’Ivoire, the Democratic Republic of the Congo, Nigeria and Togo).

As part of the drive to simplify and integrate approaches, UNAIDS extended its financial support to UNICEF and the Clinton Health Access Initiative to strengthen the capacity in 10 priority countries, (Cameroon, the Democratic Republic of the Congo, Ethiopia, Kenya, Malawi, Mozambique, Senegal, Uganda, the United Republic of Tanzania and Zimbabwe) to introduce point-of-care HIV diagnostic technology in national HIV laboratory systems. Point-of-care testing can speed up clinical decision making and reduce turnaround time, substantially increasing ART initiation rates, while reducing morbidity and saving lives.

FIGURE 6

Percentage of infants born to pregnant women living with HIV receiving a virological test for HIV within 2 months of birth (early infant diagnosis), by UNICEF Regions, 2009-2015



Source: UNAIDS/UNICEF/WHO Global AIDS Response Progress Reporting and UNAIDS 2016 estimates.
Note: CEE/CIS not available.



On 10 November 2015 in Malawi, a health worker draws and inserts blood from a baby's heel into a cartridge, for a rapid HIV diagnostic blood test, at the Ntaja Health Centre, in Machinga District. Every day, about eight women living with HIV travel long distances with their babies to the health centre, for diagnosis, treatment and care. Early infant diagnosis is integrated into the maternal and child care programme. Early diagnosis in the first weeks of life and immediate initiation of treatment is especially critical as HIV advances to AIDS very quickly in infancy.

INNOVATION IN DIAGNOSTICS: UNICEF'S SUPPORT FOR POINT-OF-CARE SOLUTIONS

Current gaps in HIV prevention and treatment thwart efforts to reach the UNAIDS 90-90-90 targets, especially for children. New, emerging and innovative tools and approaches are needed to improve treatment and prevention outcomes. In 2016, UNICEF worked to develop and increase access to point-of-care HIV diagnostics, including for the early identification of children with HIV and more effective and convenient monitoring of people on treatment.

In many countries, HIV-related blood tests, including early infant diagnosis, can only be done at centralized laboratories. Logistical and tracking complications often cause long delays, yet timely initiation of ART is especially critical for infants because their mortality peaks in their first two to three months of life.

But point-of-care tests can be done at lower-level health facilities with results available immediately. This tool can greatly reduce delays between diagnosis and clinical decision making (including initiation of ART), thereby helping more children and their mothers access life-saving care.

Point-of-care tools also offer critical opportunities to identify clients whose viral loads are not suppressed, an indicator of poor adherence or failure of an existing regimen. The earlier treatment-related problems are observed, the sooner new strategies, tests or regimens can be implemented. Some clients might benefit from adherence support, for example, while others might need to switch to a different regimen. Point-of-care options would allow this crucial identification to be done much earlier and quicker than is now possible, thereby benefiting ART clients and others affected by HIV.

The educational image below offers simple, clear messaging about two essential HIV diagnostics processes that can be enhanced with the availability of point-of-care options.

With support from UNICEF and the Clinton Health Access Initiative, in 2012 UNITAID launched a point-of-care diagnostics project in seven sub-Saharan African countries. Through technical guidance and expanded partnership at global and regional levels, the seven countries (Ethiopia, Kenya, Malawi, Mozambique, Uganda, the United Republic of Tanzania and Zimbabwe) were equipped with knowledge and skills to develop policy and regulatory frameworks to introduce and integrate point-of-care HIV diagnostic technology for early infant diagnosis in national HIV laboratory systems.

Over the course of the project, UNICEF and the Clinton Health Access Initiative worked with health ministries and in-country and global partners to overcome four main challenges: unclear regulatory pathways, lack of normative guidance, high market-entry prices, and implementation barriers such as limited understanding of how and where to use point-of-care effectively. This project highlighted best practices in point-of-care connectivity and management, supported processes that accelerate point-of-care product registration, and developed tools and guidance to implement point of care technology.

The project's success prompted UNITAID to expand it to three additional countries: Cameroon, the Democratic Republic of the Congo and Senegal. Efforts in all 10 project countries will focus on strengthening national diagnostics systems to improve the effectiveness of point-of-care and other HIV diagnostics for early infant diagnosis and viral load. Long-term sustainability is a main objective.



Alongside the UNITAID-supported work, UNICEF provided technical and programming support to Ethiopia, Kenya, Malawi, Mozambique, Uganda, the United Republic of Tanzania and Zimbabwe on point-of-care diagnostics. Such support included South-South exchanges and learning, a review of the national point-of-care plan in Kenya, and the development of an implementation toolkit for the seven countries.

In 2016, UNICEF worked with the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), UNITAID, the Clinton Health Access Initiative, the Elizabeth Glaser Pediatric AIDS Foundation and Médecins Sans Frontières to prepare a point-of-care HIV procurement strategy for joint market-shaping activities. This effort resulted in an increase in the procurement value (and funding approval) for the project, from \$21 million (2013 to 2016) to \$94 million (to 2020), and the signing of a partnership memorandum of understanding for information sharing. The Supply Division also hosted a joint industry consultation meeting on point-of-care HIV diagnostics organized by a consortium of procurement partners.

In a number of countries, including Cameroon, Chad, Gabon, Ghana, Liberia and Nigeria, UNICEF introduced a 'family centred approach' to help identify undiagnosed children by engaging households affected by HIV and AIDS.

In the Democratic Republic of the Congo, Nigeria and Zimbabwe, this work has included family centred testing of children in households by using an 'index HIV case' (either a child or parent found to be HIV-positive) to promote the testing of all the children in the family. In 2016, operational research was conducted in the Democratic Republic of the Congo on the family centred approach as a driver of the uptake of paediatric HIV services. Preliminary results indicated the need for greater care and support to increase uptake of and retention in paediatric HIV services. Findings also confirmed that increased skills are needed to support HIV disclosure to children and for the inclusion of fathers/ male guardians in children's HIV testing and lifelong care.

Paediatric treatment

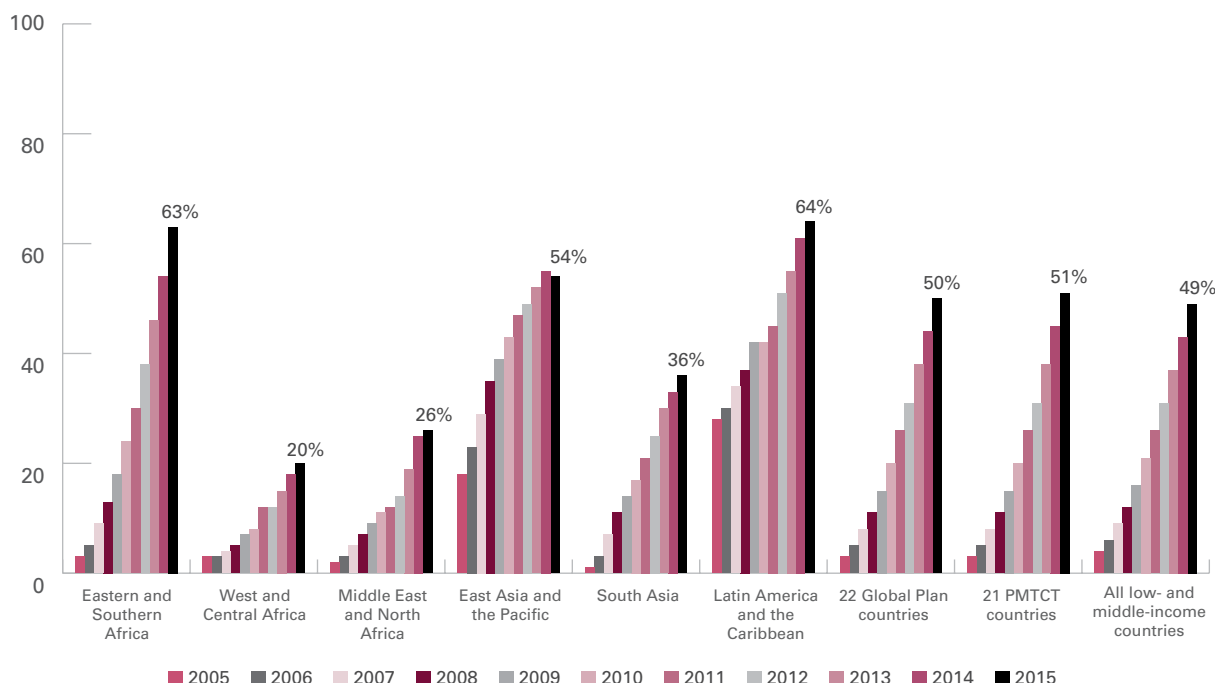
Further along the HIV continuum of care, effective use of antiretrovirals lagged. As many as one half of the 1.8 million children living with HIV globally did not receive ART in 2015.²⁸ For the children who did, treatment often came late, initiated at an average age of 3.8 years in sub-Saharan Africa.²⁹ Renewed focus on timely access to ART among children and retention in care through adolescence and into adulthood will be key to overall success rates going forward.



Longezo is 3 and living with HIV in Nkhuloawe Village, Malawi. His life was saved when Bizwick, a health worker pictured right, visited his home and discovered he was very ill and in need of medical attention.

FIGURE 7

Percentage of children (aged 0-14) living with HIV receiving antiretroviral therapy (ART), by UNICEF Regions, 2005-2015



Source: UNAIDS/UNICEF/WHO Global AIDS Response Progress Reporting and UNAIDS 2016 estimates.
Note: CEE/CIS not available.

“Reaching ambitious global health targets will require us to take calculated risks in order to make the best health products widely available to those most in need.”

UNITAID Executive Director, Lelio Marmora

A lack of safe, tolerable and acceptable ART options (paediatric formulations) for children presents an ongoing challenge in HIV response. For example, only 10 of the 29 antiretroviral medicines approved for use in adults have also been approved for use in children under 2 years old.³⁰ This may be one reason why about 40 per cent of the children on ART globally are on a regimen that is suboptimal, resulting in decreased effectiveness, a higher pill burden and increased side effects.³¹

Finding solutions has been hampered by a lack of research on dosing levels for children.³² Additionally, few generic versions of child-friendly antiretroviral drugs have been

developed, making some existing regimens expensive and often unaffordable.

There is still much work to be done to achieve treatment parity with adults. However, in its latest treatment guidelines, WHO added new alternative regimens for children, expanding options in countries that rely on the agency’s guidance and offering hope for an improved future.³³

UNICEF, in collaboration with the Elizabeth Glaser Pediatric AIDS Foundation, the Clinton Health Access Initiative and WHO, supported the Inter-Agency Task Team paediatric working group to finalize operational guidance on the use of a new paediatric formulation of the drugs lopinavir and ritonavir in the form of oral pellets, that can be mixed into a young child’s food, which is recommended by WHO for the youngest infants.

UNICEF continued to support efforts to significantly improve access to ART for children and their retention in care. For example, UNICEF mobilized funds to support the Central African Republic, Chad, Côte d’Ivoire and Togo in the design of an HIV paediatric monitoring and evaluation framework, in line with the WHO 2015 Strategic HIV Information Guide. That framework allowed for the

introduction of longitudinal monitoring and evaluation tools for HIV paediatric treatment to help reduce loss to follow-up and address the lifelong need for treatment and changes in doses as children grow.

In Malawi, UNICEF work since 2015 (in collaboration with WHO) led to the development of the National Roadmap for Paediatric/Adolescent HIV Prevention, Care and Treatment. This framework will guide the implementation of interventions aimed at reducing new paediatric and adolescent HIV infections, thereby accelerating access to care and treatment. Also in Africa, three priority countries (Cameroon, Côte d'Ivoire and Nigeria) successfully began implementing paediatric and adolescent HIV case finding models that included effective and timely linkage to HIV treatment.

In Namibia, a UNICEF-supported project helped to increase access in 2016 to government-provided HIV services, including comprehensive PMTCT and paediatric treatment

and care. This was achieved through capacity development for health staff and expansion of services, such as the roll-out of child-friendly services in four ART clinics.

In 2016, UNICEF also provided procurement services to Ukraine to help ensure the timely provision of supplies for HIV treatment, including for the PMTCT and paediatric AIDS programmes. Savings from large-quantity procurement through UNICEF allowed the Government of Ukraine to re-programme an emergency fund grant from the Global Fund to secure additional antiretroviral drugs and thereby increase access to ART for many clients. Overall, UNICEF procured antiretroviral drugs to ensure uninterrupted treatment for up to 45,000 people who receive ART in Ukraine. The procurement included antiretroviral drugs for 3,000 children who previously did not have access to paediatric formula.

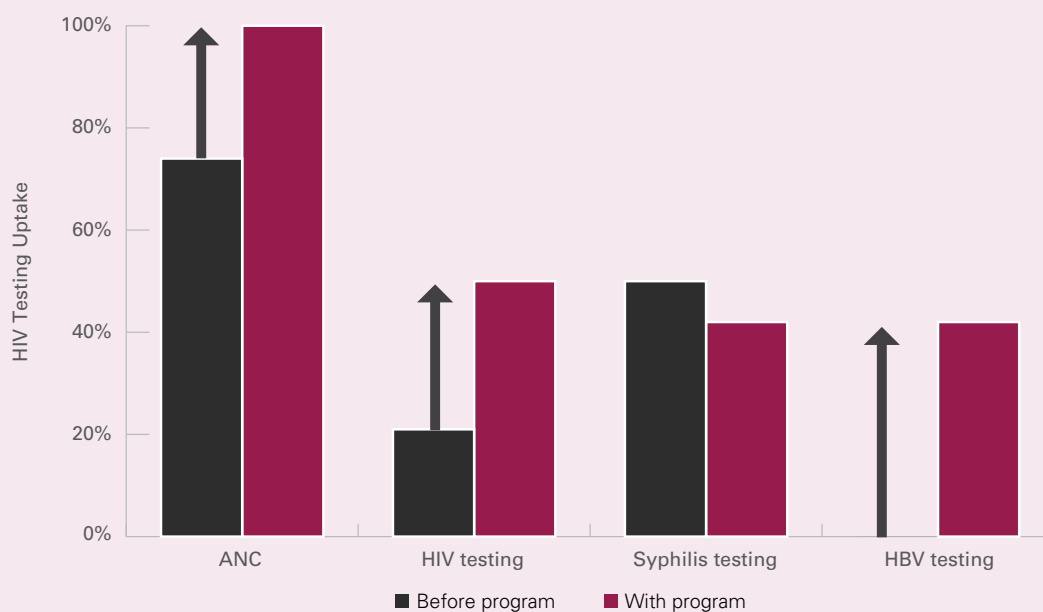


A Mothers 2 Mothers health worker at Mitundu Community Hospital in Malawi holds Rahim Idriss, 8 months old. Rahim's mother, Martha Jere, 19, is living with HIV. Six weeks after he was born, Rahim was tested for HIV for the first time. He tested negative, but will undergo testing for the entire time he is breastfeeding.

SPECIALIZED EFFORTS TO REACH WOMEN, CHILDREN AND ADOLESCENTS IN INDIGENOUS COMMUNITIES IN GUATEMALA AND PERU

The guiding principle of 'leave no one behind' compels UNICEF to seek out gaps in HIV services coverage that are not commonly recognized, understood or addressed. Examples of this effort can be found in UNICEF's work in two Latin American countries in 2016, where it supported several targeted interventions aimed at indigenous communities, which tend to have more limited information about or access to HIV services than the general population.

Mobile antenatal care, referrals and triple point-of-care testing Guatemala



Source: Smith, A., et al., *International Journal of Gynecology and Obstetrics*, June 2015.

In Guatemala, UNICEF collaborated with the Ministry of Health and the Pan American Health Organization to implement a community-based screening for HIV, syphilis and hepatitis B among pregnant women of indigenous and rural populations. The model engages midwives to accompany pregnant women to health facilities for rapid testing, which was made available at peripheral health services. In two provinces, 1,145 women were tested in the health areas with no access to rapid tests. An additional 110 couples also received voluntary HIV testing, demonstrating that the project generated greater awareness among a wide audience.

UNICEF also supported Peru's first HIV testing and treatment services for indigenous communities in the province of Condorcanqui. The initiative adapted health services and a behaviour change strategy, with an intercultural focus aimed at pregnant women and adolescents.

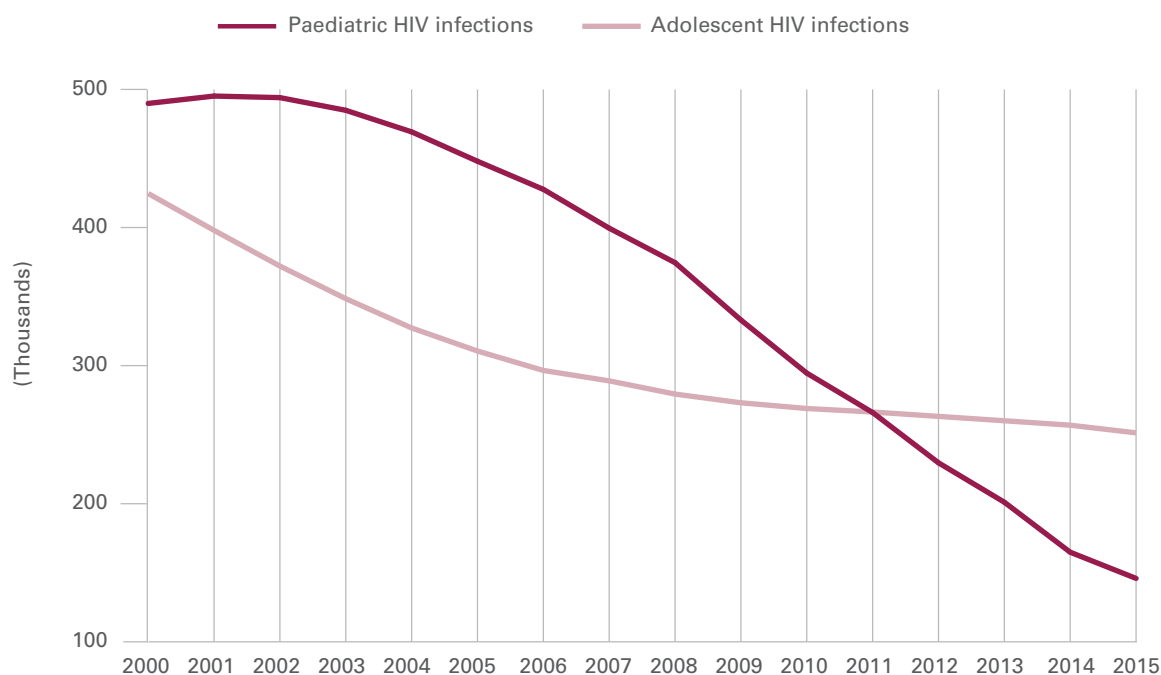
PROGRAMME AREA 2: SECOND DECADE – ADOLESCENTS

As parts of the HIV response, UNICEF and its partners must accelerate efforts and innovations to reach adolescents, who are particularly at risk and faring poorly in HIV responses in nearly every context. Efforts to reduce HIV infections and link those vulnerable to quality services have been relatively unsuccessful when compared with the general population or other highly vulnerable groups. As noted in Figure 8, for example, the decline in the annual number of new HIV infections among children has been much steeper since 2000 than that of adolescents, which has instead plateaued over the past five years or so.

AIDS is the leading cause of death among adolescents in Africa and one of the leading causes of death among adolescents globally. More than 100 adolescents died of AIDS every day in 2015.³⁴ Alarming, adolescents represent the only age group where deaths due to AIDS are not decreasing. **The annual number of AIDS-related deaths among adolescents has held steady more or less since 2012, even as the comparable figure for adults has declined.** At the current pace, a projected 35,000 adolescents aged 10–19 will die from AIDS-related illnesses in 2020 in the 25 lead countries of the UNICEF-supported ALL IN initiative.³⁵

FIGURE 8

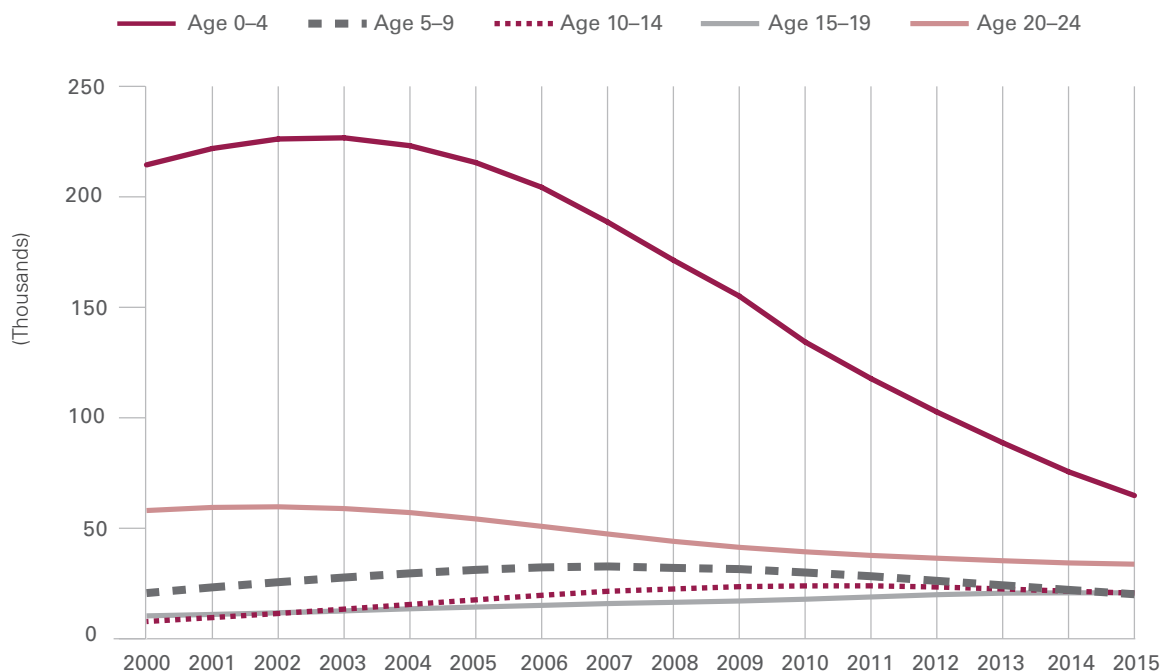
New HIV infections among children aged 0–14 and adolescents aged 15–19, Global, 2000–2015



Source: UNAIDS 2016 estimates.

FIGURE 9

Globally, AIDS-related deaths have decreased significantly among all age groups except adolescents (aged 10-19)



Source: UNAIDS 2016 estimates.



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HIV is not over in any part of the world. In 2015, almost one third of new infections among adolescents aged 15-19 occurred outside of sub-Saharan Africa. At an event to promote sexual and reproductive health among adolescents, supported by the Chinese Center for Health Education and the UNICEF China Country Office, young people are playing the 'HIV knowledge' monopoly game.



Globally, girls make up 65 per cent of new HIV infections among adolescents aged 15–19. A pregnant teenager living with HIV in Côte d'Ivoire represents opportunities for improving knowledge about sexual reproductive health and preventing new infections in both adolescents and babies

There are indications that the situation could get even worse in the absence of redoubled efforts to reach them with effective prevention and treatment services. Among the countries with the highest burden of HIV in adolescents, the number of adolescents living with HIV has increased by between twofold and fourfold since 2000.³⁶

Even countries with lower absolute burdens continue to report limited progress in reducing HIV prevalence among adolescents. In Brazil, for example, from 2005 to 2015 there was a national increase of 68 per cent in the HIV detection rate among young men 15–19 years old and a 47 per cent increase among those 20–24 years old.³⁷ This trend reflects the combined effect of steady rates of new infections, mortality rates that are lower than new infections in adolescents, and maturing of vertically infected adolescents.

Today, thanks to scale-up of ART for children, an increasing number of children living with HIV who were vertically infected are entering adolescence. But the consequences of limited treatment options and poor or inconsistent access can be seen in the significant number of adolescents who were vertically infected, survived into adolescence and then died.³⁸ According to recent estimates, 41,000 adolescents aged 10–19 years (the majority of whom were vertically infected) died in 2015.³⁹ Keeping these children in their second decade of treatment during adolescence poses great challenges. Adolescents living with HIV have among the highest rates of poor adherence to ART and treatment failure.⁴⁰

Ensuring adolescents maintain quality of treatment and support during the transition from paediatric to adult care

was a priority in several UNICEF programmes in 2016. Many initiatives and interventions, for example, aimed to support adolescents learning to oversee their own treatment and care.

Improved access and adherence to ART will help many adolescents, but the realities of young people's lives must be considered. Support structures are needed to increase the likelihood that ART will benefit them. For example, multiple studies have shown that adherence is a major challenge for prevention, treatment and care in adolescents.⁴¹

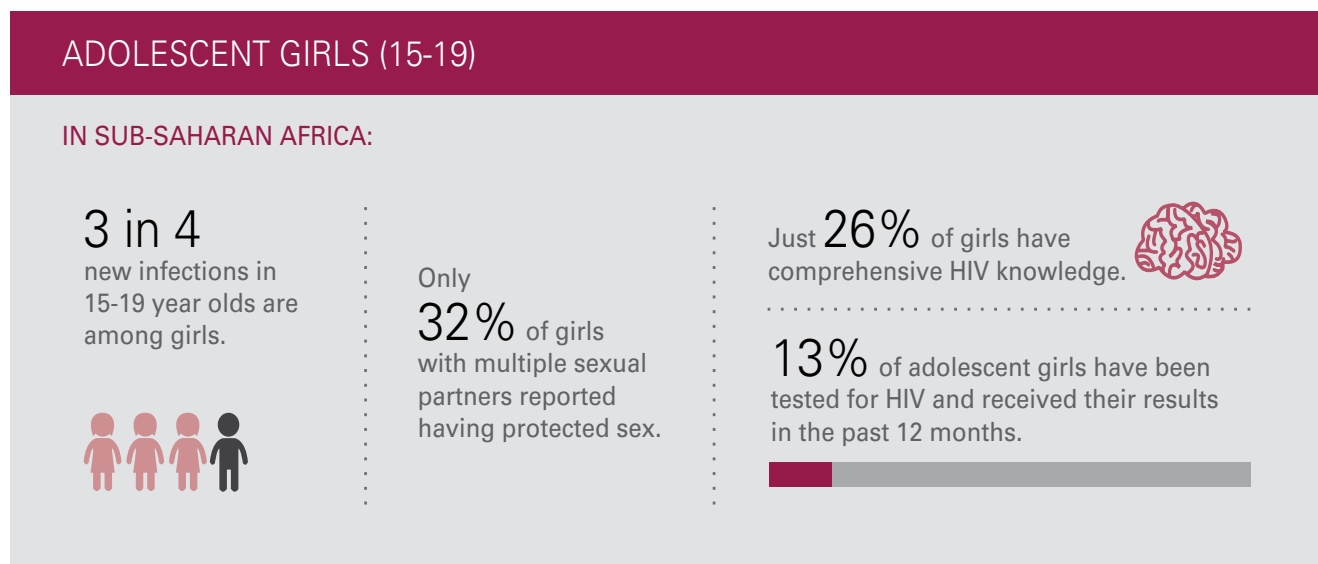
UNICEF has continued to examine and document the complex and multifaceted factors that limit adolescents' successful initiation and retention in care. One ongoing initiative with WHO, the Government of South Africa and other partners seeks to develop and test free, evidence-based, child abuse-prevention programmes that can better support HIV-positive children and young people.

"Gender inequality is not a medical issue. We will not end AIDS if we don't end gender inequality. We need an equal world."

Mark Dybul, Executive Director, Global Fund to Fight AIDS, Tuberculosis and Malaria

FIGURE 10

Adolescent girls in crisis in sub-Saharan Africa



UNICEF recognizes that adolescent girls continue to be disproportionately affected by HIV. Around the world, an estimated 1,100 young women aged 15–24 are infected every day. According to one study in South Africa, some 2,400 women in that age range are infected with HIV each week.⁴² Achieving that goal will require intensified efforts that focus on overcoming substantial and persistent gaps in knowledge and use of available services. Adolescent girls and young women are less likely than older women to be tested for HIV; access sexual and reproductive care (including antenatal care); utilize skilled assistance during childbirth; or access PMTCT services.⁴³

Demographic realities – in particular, the emerging ‘youth bulge’ resulting from high population growth in many lower- and middle-income countries – pose another challenge. The youth population of sub-Saharan Africa – the region most affected by HIV – is surging. In 2010, there were about 200 million Africans between 15 and 24 years of age; that number could rise to more than 450 million by 2050.⁴⁴ (In many countries, such as Chad, Nigeria, Uganda and Zambia, more than 40 per cent of all people are younger than 15 years old⁴⁵). These demographic shifts pose significant challenges to health systems and raise questions about whether and how existing services can meet the expected increase in demand.

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 the global epidemic response must tackle the deeply rooted social issues, including exclusion and gender inequality, that are most resistant to change. The urgency

to address these barriers has never been more evident. In nearly all regions of the world, HIV will increase in this age group unless the world sees a dramatic shift in the response.

The global HIV epidemic among adolescents has not received adequate focus where it matters most – in the lives of adolescents themselves. However, new global public health commitments for adolescents provide hope. With renewed focus on prevention through biomedical social and behavioural interventions of new HIV infections and testing and treatment, no adolescent should die an AIDS-related death, and those who are free of HIV should remain that way.

In 2016, UNICEF continued to support new interventions to address and overcome the huge barriers to improved HIV responses among adolescents. Context priorities differ, but it remains essential to ensure that programmes and responses truly reflect the needs of those who are meant to benefit: adolescents at widely varying stages of life and sexual development, and with regularly shifting understanding and expectations of what is needed regarding HIV prevention and care services.

In the United Republic of Tanzania, UNICEF trained 240 health-care providers from the central, southern and lake zones to provide adolescent-friendly services, and an additional 90 providers on the use of effective tracking tools. Preparatory work for development of the national standard package of services for adolescents living with HIV initiated is under way.

Training was also a priority in Mongolia. UNICEF adapted and introduced training modules on prevention of HIV



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Condom use and testing uptake are low among young key populations in East Asia and the Pacific, often due to low perceptions of risk. Services must be designed and delivered with these adolescents in mind. Adolescent boys of Zamboanga City, in the Philippines, are protecting themselves from HIV by sharing correct knowledge and skills with their peers.

and other sexually transmitted infections, enabling peer educators to reach more than 4,000 students with key messages. The outreach experience was presented at a regional forum and selected for replication in six provinces with local government support.

In East Asia and the Pacific, UNICEF engaged in advocacy and new partnerships, such as a five-year workplan with the Government of China and civil society organizations to address HIV prevention, treatment and care for adolescents at high risk. The plan's focus areas include service gaps, capacity building, and legal, policy and social environments, as well as data generation and technical support.

UNICEF also supported a youth-led testing week in China in 2016. The development of guidelines and programme documents alongside thematic advocacy and communications efforts helped facilitate access of adolescents to HIV testing and counselling services. These included a district municipality services manual in Cambodia jointly developed with the United Nations Population Fund (UNFPA) and a protocol for proxy consent to be used by social workers in the Philippines.

In 2016 in West and Central Africa, UNICEF worked with several countries to develop a fast-track approach to integrate HIV in national policies of strategies on adolescent health, and efforts to prevent and mitigate the impact of gender-based violence. Six countries conducted bottleneck analyses to identify the critical capacity gaps and structural barriers preventing adolescents from accessing information and services for HIV prevention and treatment and support. Findings are shaping models for community-based HIV testing and counselling and the adaptation of mHealth for HIV response in adolescents.

Across Latin America and the Caribbean, UNICEF collaborated closely with other United Nations agencies (in this case, UNFPA, the United Nations Development Programme (UNDP) and UNAIDS) to support the development of 17 country fact sheets with information on adolescents and young people. The partners also updated the

regional review conducted in 2014 on existing legal barriers to access sexual and reproductive health services among adolescents.

In 2016, UNICEF continued to consider how best to launch, implement and sustain voluntary medical male circumcision, an HIV prevention intervention promoted among adolescent boys and young men in high-burden settings. In collaboration, with the United States Agency for International Development (USAID) and the Johns Hopkins Health Communication Collaborative, UNICEF supported a multi-country assessment on voluntary medical male circumcision and adolescents that it also commissioned at the global level. The initiative was an effort to gain better understanding of whether voluntary medical male circumcision programmes adequately meet adolescent needs in age-appropriate ways by exploring counselling, communication and client-provider interaction.

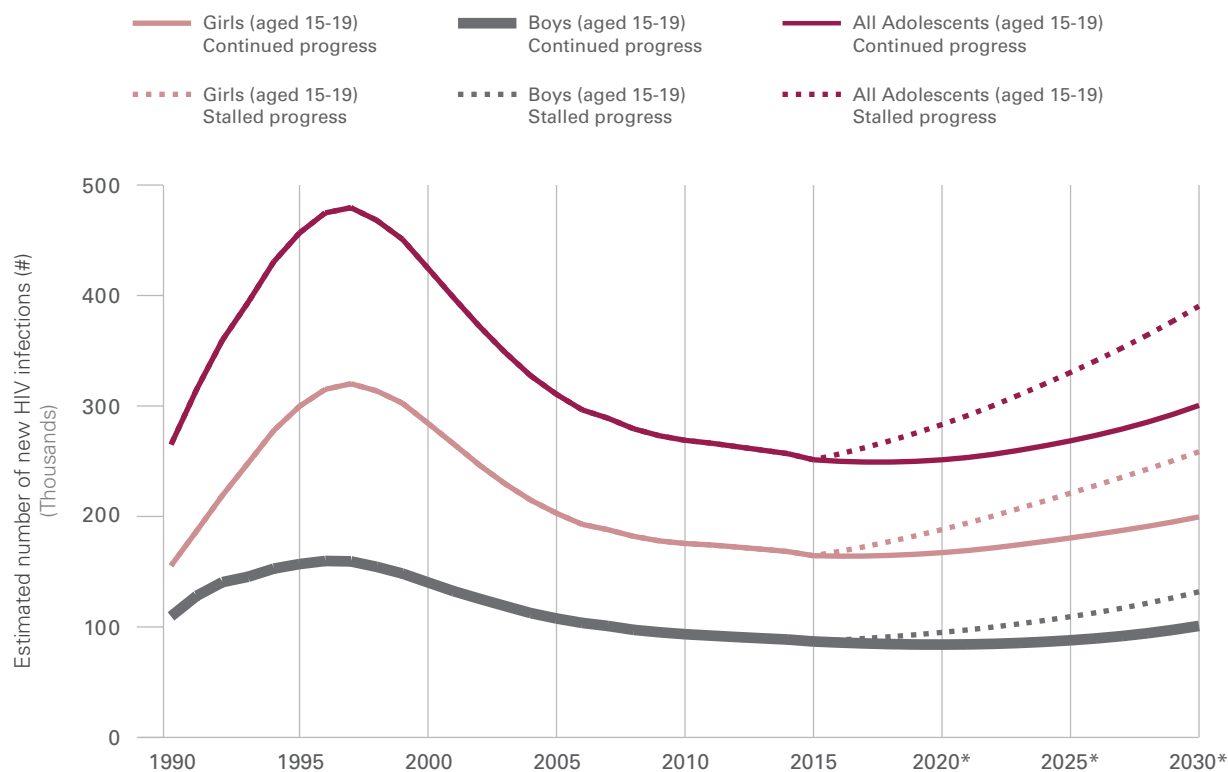
The results revealed that the voluntary medical male circumcision decision is heavily influenced by peer pressure, but adolescents also reported transportation costs, parents' schedules and taking time off school as major barriers. A need for more age-appropriate approaches to counteract missed opportunities for combination HIV prevention was identified, along with improved counselling for younger age groups.

Targeted support for adolescent key populations⁴⁶

As is the case with adults, adolescents who are members of key populations face even greater risks and barriers. Adolescent key populations are especially vulnerable because of punitive laws and restrictions on the ability of many non-governmental organizations (NGOs) to work with children who have not reached the legal age of majority. Despite the availability of effective tools, stigma and discrimination are obstacles that prevent many young key populations from obtaining the support that can keep them healthy.

FIGURE 11: Global

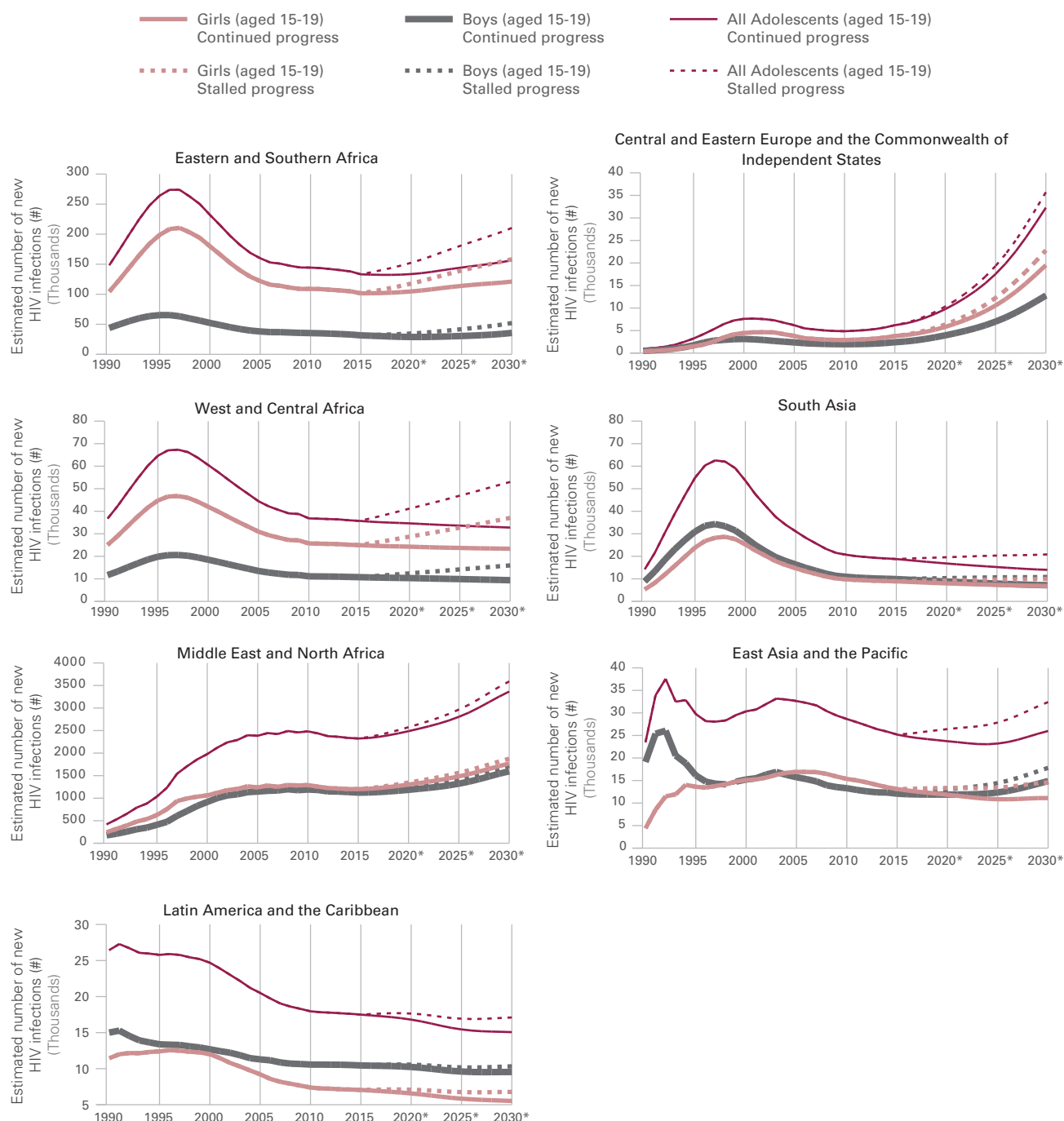
Trends in the estimated number of new HIV infections among adolescent girls and boys (aged 15-19), global, 1990-2015 with 2016-2030 projections accounting for demographic shift



Source: UNICEF analysis of UNAIDS 2016 estimates, July 2016.

*Notes: 2016-2030 projections are based on the 2009-2015 average annual rate of change in incidence rates (new HIV infections out of the non-HIV-infected population). Two scenarios are presented: (1) "Continued progress" shows the continuation of the average annual rate of change in incidence rates; and (2) "Stalled progress" sees only the latest incidence rate (2015) continued through 2030. In countries where the incidence rate was increasing between 2009-2015, the average annual rate of change is employed in both scenarios. Only ages 15-19 were analyzed because current models do not account for behavioural transmission prior to age 15.

FIGURE 12: Trends in the estimated number of new HIV infections among adolescent girls and boys (aged 15-19), ESAR, 1990-2015 with 2016-2030 projections accounting for demographic shift



Source: UNICEF analysis of UNAIDS 2016 estimates, July 2016.

*Notes: 2016-2030 projections are based on the 2009-2015 average annual rate of change among the incidence rates (new HIV infections out of the non-HIV-infected population) by sex for each country. "Current trend" refers to the continuation of the 2009-2015 average annual rate of change in incidence rates where as "stalled progress from 2015" continues to use the 2015 incidence rate through 2030 in countries with declining incidence. In countries where the incidence rate was increasing between 2009-2015, the average annual rate of change in incidence rates is continued in both projections so as not to underestimate the projected number of new infections by using the lower 2015 rate. Only ages 15-19 were analyzed (and not ages 10-14) because current models do not account for any behavioural transmission prior to age 15.

UNICEF will dedicate particular attention to the discrete needs and challenges of key populations, designing, implementing or supporting interventions specifically geared towards them to address underlying vulnerabilities, increase access to services and create space for their voices to be heard.

In 2016, UNICEF developed a technical guidance note to support country offices to strengthen programming for adolescent key populations in Eastern and Southern Africa. In Kenya, Malawi and the United Republic of Tanzania, UNICEF helped generate evidence on adolescent key populations and policy dialogue, as well as integrate adolescent key population interventions into broader adolescent programming.

In 2016, with resources from the Global Fund and MAC AIDS Fund, UNICEF partnered with the Indonesian Network of Young Key Populations to expand a demonstration project called LOLIPOP (Linkages of Quality Services for Young Key Populations). The programme, begun in 2015, works to strengthen service delivery to adolescent key populations. To address the barrier created through the legal requirement for parental consent, health services agreed to provide testing to adolescents younger than 18 years old, based on consent provided by an NGO serving in the role of a guardian. As part of national coordination and training to bolster the initiative, 38 health workers and local AIDS commissions from six cities (Bandung, Denpasar, Makassar, Medan, Surabaya and West Jakarta) were trained by the Ministry of Health and partners on HIV services for young key populations and adolescents.

UNICEF also led work throughout East Asia and the Pacific to prepare an advocacy brief highlighting the HIV situation among adolescents and young key populations. The document cited analysis of available data informing a model that was successfully piloted and expanded to other cities. Better data analysis led to strengthened regional buy-in and local commitment to interventions for adolescent/young key populations by governments in HIV high-burden cities.

As these examples indicate, UNICEF targets settings where adolescent key populations face massive social, legal, economic and political obstacles to vital HIV services. In Pakistan, UNICEF, along with Global Fund, UNAIDS and UNFPA, supported the fifth round of mapping and integrated biological and behavioural surveillance. The mapping was completed in 2015, with the training of field teams and the data collection for the surveillance conducted in 2016 in 23 cities. For this surveillance, the minimum age was reduced to 13 years in order to generate expanded evidence on adolescent key populations. The data will be used to create and implement evidence-based HIV services.

In 2016, efforts in Central and Eastern Europe and the Commonwealth of Independent States (CEE/CIS) were focused on improving access to opioid substitution therapy, an essential priority in a region where the HIV epidemic

remains largely associated with injecting drug use. UNICEF also participated in capacity-building initiatives for health-care workers who offer support adherence to ART among children and adolescents. Such ongoing efforts centre on the development and distribution of tools and materials, such as books, cartoons, calendars and mobile apps, to be used for outreach and education.

These targeted interventions and support will expand as UNICEF addresses the more intractable and lagging components of the adolescent HIV response. Particular emphasis will be placed on educating adolescents about HIV and supporting children transitioning to adolescent/adult care. By analysing lessons learned from demonstration projects that focus on these priorities, UNICEF will use new science to shape effective approaches in order to best bring innovations to scale.

Partnerships for adolescents

In February 2015, UNICEF and UNAIDS launched the **ALL IN** initiative to fast-track global and country efforts to end the AIDS epidemic among adolescents. This multi-stakeholder effort, which includes United Nations partners, the Global Fund, governments, civil society, private-sector partners and adolescent and youth networks, brought the crisis of adolescents and AIDS to the attention of global policymakers. The goals include reducing AIDS-related mortality by 65 per cent; reducing new infections among adolescents by 75 per cent; and eliminating stigma and discrimination by 2020. As a result of this initiative, data are now available to inform HIV programmes for adolescents in the 25 countries that have undertaken **ALL IN** assessments.

UNICEF has provided technical assistance across all regions to mobilize national partners and identify bottlenecks to high-impact HIV interventions for adolescents. Through the **ALL IN** initiative, these multi-sectoral assessments have now been supported in more than 25 countries and are leading to strengthened adolescent response.

Building on the momentum of the **ALL IN** assessments, some countries (Botswana, Jamaica, Lesotho, Namibia, the Philippines and Swaziland) negotiated the reprogramming of Global Fund resources towards more strategic priorities, including community-based targeting; the engagement and empowerment of the most vulnerable adolescent populations; and targeted subnational assessments on equity-based planning across the country. In 2016, Ukraine aimed to increase the knowledge and capacity of service providers on how to effectively work with adolescents living with HIV. This effort included piloting a series of training seminars and creating materials on psychosocial support and communication with HIV-positive adolescents, not only to improve care but also to reduce stigma and discrimination.

ALL INTO END ADOLESCENT AIDS

In February 2015, UNICEF and UNAIDS launched the **ALL IN** platform to galvanize global action to prevent and treat HIV in adolescents, a population that has largely been neglected in the global AIDS response.

ALL IN focuses on 25 lead countries that contribute to 80 per cent of all new HIV infections in adolescents. The initiative has three targets for the year 2020:

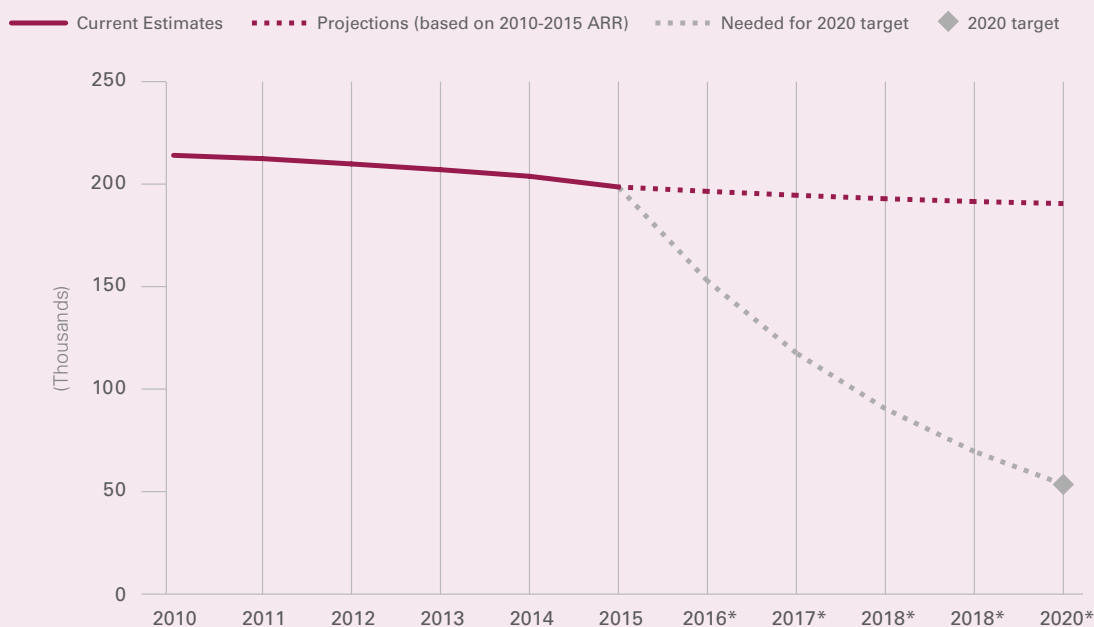
1. Reduce new HIV infections among adolescents by at least 75 per cent;
2. Reduce AIDS-related deaths among adolescents by at least 65 per cent; and
3. End stigma and discrimination.

The need for this type of targeted and focused initiative is crucial. Globally, in 2015 there were an estimated 250,000 new HIV infections in adolescents aged 15–19. Of these, nearly 200,000, or 80 per cent, occurred in the 25 lead countries in the **ALL IN** initiative. Globally and within these 25 countries, the decline in new HIV infections in adolescents has been unacceptably slow since 2010.

The **ALL IN** initiative urges an immediate shift in programme focus, quality and leadership to accelerate the response. Collectively, these 25 countries are not on track to achieve the first target of a 75 per cent reduction by 2020. As illustrated in the figure below, the number of new infections in adolescents will barely decline by 2020 unless there is a strong programme pivot, a dramatic change in leadership support and financing of prevention, and better targeting of effective interventions for prevention in the populations at the greatest risk of infection. The current status quo suggests that 190,000 adolescents will be newly infected with HIV in 2020 in the 25 **ALL IN** core countries, out of a projected 250,000 new infections in adolescents globally.

FIGURE 13

Estimated number of new HIV infections among adolescents (aged 15-19), 2010-2015 with 2016-2020 projections and ALL IN targets, 25 ALL IN core countries



Source: UNICEF analysis of UNAIDS 2016 estimates, July 2016 and United Nations, Department of Economic and Social Affairs, Population Division (2015). World Population Prospects: The 2015 Revision, custom data acquired via website.

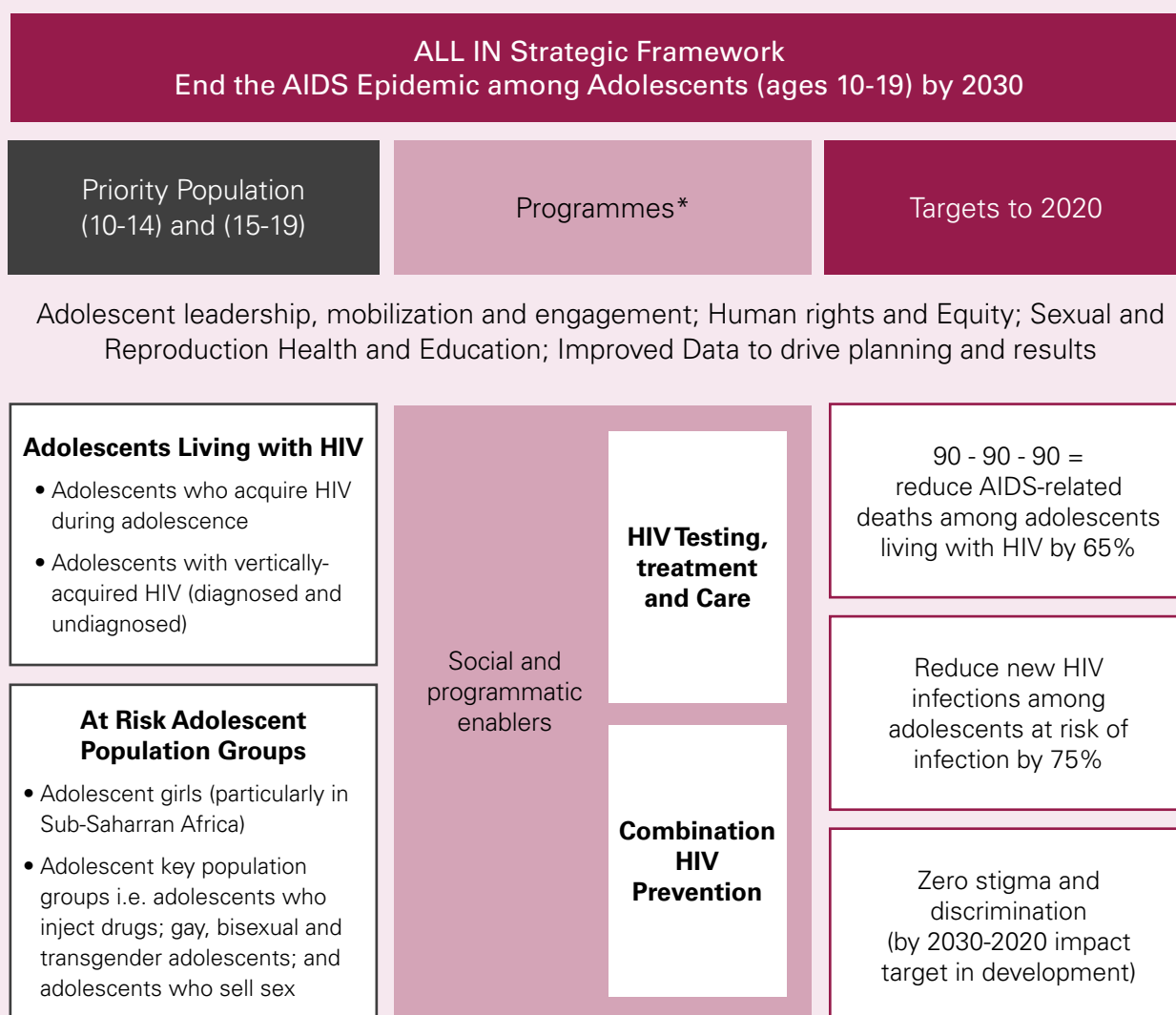
*Notes: Projections were made by calculating the HIV incidence rate (infections per uninfected adolescent) and determining the annual rate of reduction (ARR) of the incidence rate between 2010 and 2015 and applying that to the projected uninfected population of adolescents in 2016-2020.

To date, key areas of engagement have included advocacy, training, support and social mobilization. In 2016, **ALL IN** specifically helped identify equity gaps in the HIV response among adolescents; raised awareness and increased engagement of stakeholders; fostered better coordination and focus on adolescents globally, regionally and nationally; and provided a crucial platform for adolescents to make their voices heard.

The initiative has also been catalytic in forging a global alliance dedicated to adolescents and HIV, as well as in increasing donor attention and commitment to prevention, care and support for this highly vulnerable population.

In general, **ALL IN** demonstrates that collaboration, innovation and engagement will be central to efforts to improve adolescent HIV responses and meet the 2020 targets.

Vision: ZERO New Infections; ZERO Deaths; ZERO Discrimination



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

In the Middle East and North Africa region, the **ALL IN** initiative's engagement in Djibouti, Iran, Morocco, Tunisia and the United Arab Emirates led to the development of national strategic frameworks using information gained through adolescents and HIV situation assessments.

ALL IN has also been used to strengthen action plans and solicit additional funding to address identified gaps and challenges. In the Philippines, for example, local governments in counties with the highest burdens have used the assessment to design an HIV prevention programme for gay and bisexual adolescent boys. The programme includes the use of social media and mobile health to improve access to information, ensure adolescent-friendly support from available prevention services, and collect better age-disaggregated data for planning.

In Nigeria, **ALL IN** helps operationalize the national strategy on adolescents and young people and leverage national and partner resources in order to improve allocations for adolescent programming. To ensure clear accountability

and coordinated action to address the identified gaps and bottlenecks, action plans have been developed by 17 local governments in two high-burden states.

In Côte d'Ivoire and Zimbabwe, the adolescent assessment led to the targeted promotion of adolescent HIV testing. As a result, a total of 200,000 adolescents received counselling, and nearly 7,700 adolescents were diagnosed with HIV and subsequently linked to care.⁴⁷ In Eastern and Southern Africa, adolescent engagement and empowerment is promoted through the **ALL IN** process, as UNICEF supports countries to better understand the situation of adolescents and HIV through data assessments. These activities have moved countries to mobilize resources for adolescents and HIV programming, and also critically assess programming effectiveness.

In Jamaica, data collected through the **ALL IN** assessment was successfully used to advocate for increasing investments on adolescent programming and funds within the existing Global Fund grant.

PRAGMATIC AND EFFECTIVE COLLABORATION: UNICEF AND DREAMS IN ZAMBIA

UNICEF has historically embraced partnerships as an effective way to maximize expertise and results towards improving HIV outcomes among pregnant women, mothers, children and adolescents.

Through the **ALL IN to End Adolescent AIDS initiative**, UNICEF recently entered a new phase of close collaboration with PEPFAR, the main external HIV programme of the Government of the United States. In 2015, PEPFAR launched DREAMS, an initiative that allocates some \$400 million towards a concentrated effort to sharply reduce HIV infections among adolescent girls and young women in 10 sub-Saharan African countries that account for about half of all annual HIV infections globally among adolescent girls and women.

Developments in Zambia offer another example of the type of collaboration between **ALL IN** – which also was launched in 2015 – and DREAMS that are now occurring in all 10 countries. Through the DREAMS initiative in Zambia, PEPFAR has contributed \$16 million to accelerating the response to HIV in adolescent girls and young women. UNICEF and other national partners will incorporate **ALL IN** coordination around DREAMS, and study results of the initiative in order to strengthen the standardization and harmonization of the HIV response with and for adolescents.

Zambia's National AIDS Council established a DREAMS Technical Working Group, whose members include adolescent representatives and a cross-section of government and civil society partners (including UNICEF). An evidence-based operational plan was designed to provide 64,000 high-risk adolescent girls and young women in three high HIV-prevalence districts with a package of prevention activities. UNICEF will continue to work closely with DREAMS and other partners to implement, analyse and monitor this plan.

The National AIDS Council also supported the creation of the Adolescent HIV Advisory Committee, which has many of the same partners, including UNICEF, DREAMS ambassadors, and key international and national NGO partners that are working on DREAMS. By mid-2016, this committee had transitioned into the programming advisory body for all partners around adolescents and HIV.

Through its lead advisory role, the Adolescent HIV Advisory Committee oversees the technical working groups reviewing and addressing policy issues related to adolescent clients. For example, the HIV Testing and Counselling Technical Working Group is reviewing the age of consent for HIV testing and counselling, particularly the feasibility of reducing it from 15 to 12. This change is considered a priority given that nearly 5 per cent of adolescent girls aged 15 years in Zambia have started childbearing and 2.1 per cent are already married.

In Ukraine, the voices of adolescents living with HIV have grown louder through the work of Teenergizer!, a network of HIV-positive adolescent activists advocating for increased awareness and dialogue about HIV among adolescents. Teenergizer! has worked to develop leadership skills among HIV-positive adolescents throughout the country, facilitating their participation in public events and policy dialogue, as well as through social media channels.

Iran was the first country in the Middle East and North Africa region to participate in **ALL IN**. A close partnership has been established with the Ministry of Health to promote youth and adolescent health centres implementing the initiative. Private addiction treatment and psychological counselling centres, the military, police, NGOs and academic partners are among the organizations working together towards this end. Efforts to increase

awareness and coordination have included engagement with neighbourhood councils, offices, religious venues and parent-teacher councils. In Tehran, the **ALL IN** programme was introduced to the AIDS Committee of the Tehran governor's office and received the support of member organizations and ministries.

Innovations for adolescents

New science and innovations, along with experience on the ground, continue to guide approaches, making ending AIDS by 2030 a real possibility. As HIV science continues to advance, UNICEF supported work examining how innovations – technological and social – can support HIV prevention, treatment and care and be brought to scale.

ENABLING SCALE-UP OF PRE-EXPOSURE PROPHYLAXIS AND LINKAGE TO TESTING AMONG SEXUALLY ACTIVE OLDER ADOLESCENTS WITH SUBSTANTIAL HIV RISK

Adolescents have proven most resistant to progress in the HIV epidemic across much of the world. Globally, the number of annual new HIV infections among adolescents aged 15–19 is 8 per cent lower than in 2009. But by comparison, the decline among children (ages 0–14) over that same period is nearly 60 per cent.

New HIV prevention approaches and tools are urgently needed. Oral PrEP is one critical component of a broader prevention package that has the potential to greatly contribute to decreasing HIV incidence among adolescents. In 2015, WHO recommended PrEP as a prevention tool for general populations of 'high risk', including adolescents in most contexts.

PrEP's potential game-changing value is indicated by results from several demonstration projects among adolescents as well as the general population more broadly. The findings confirm the safety, acceptability and efficacy of longer-term use of PrEP, and also strong adherence and protection against HIV infection. At least 10 studies are under way in sub-Saharan Africa that provide PrEP to adolescent girls and young women.

Whether PrEP should be given to eligible adolescents is no longer debated. The question now is *how best to do so* in light of the pervasive challenges related to engaging adolescents in care. Experts suggest that to be effective, PrEP should be embedded in the broader sexual reproductive health services, where adolescents are more likely to seek health care. Adherence strategies, such as peer clubs or navigators, and provider training are also required to ensure that adolescents take PrEP as prescribed.



Niluka Perera from Youth Voices Count holds a promotional PrEP bottle

Applying implementation science to investigate effective operational approaches to bring innovations to scale

In partnership with UNITAID, UNICEF will support the implementation of public health programmes to provide PrEP to sexually active older adolescents at substantial risk of HIV infection.

Lessons learned will help develop global guidance to combine HIV prevention and the use of PrEP for sexually active older adolescents aged 15 to 19 years who are at substantial risk of HIV acquisition. The intended outcome is to increase access to PrEP for eligible adolescents, including by improving the legal, ethical and regulatory environment; demonstrating the effective use of PrEP in adolescents; and generating knowledge on PrEP use among eligible adolescents to foster the expansion of PrEP in the focus countries and beyond.

HIV self-testing offers users autonomy and confidentiality, an advantage for reaching people who do not routinely (if at all) access health services.⁴⁸ Self-testing is not currently provided in many parts of the world, for either adults or young people. But if made available in a convenient and careful manner, self-testing could be a high-impact, low-

cost intervention that drives down diagnosis gaps in older adolescents.⁴⁹ In 2016, UNICEF began to prepare a multi-country, multi-regional proposal to examine whether, how, when and where HIV self-testing might best be accessible to the adolescent population.

Similarly, home-based or mobile HIV testing and counselling can make testing easier for adolescents. Linkages to care and treatment should be immediately available, with incorporated consent, confidentiality concerns and adolescent-specific counselling, as part of any and all HIV testing interventions.

Several efforts have already yielded positive results towards boosting case finding among adolescents overall and key populations, in particular. In Fortaleza, Brazil, for example, UNICEF has been supporting the Youth Aware project with the MAC AIDS Fund. The project focuses on mobile outreach to expand HIV testing and improve linkage to care. Of 1,410 people tested by the mobile unit during an 18-month period ending in June 2015, 609 (43 per cent) were adolescents aged 13–19 years (356 male and 253 female), 102 were adolescent (13–19 years) men who have sex with men, and 264 were adolescent boys and girls (13–19 years) in conflict with the law.⁵⁰

IDENTIFYING PROMISING HIV TESTING OPTIONS FOR YOUNG PEOPLE THROUGH UNICEF'S U-REPORT SOCIAL MESSAGING TOOL

In 2016, UNICEF continued to build and expand U-Report, a global social messaging tool that encourages adolescents and young people to speak out on issues that affect them. U-Report, which is free, also allows its users to anonymously text questions about HIV and AIDS. In doing so, it provides a critical communications and education source to youth. Today, U-Report has more than 2.4 million registered users and is live in more than 25 countries.

U-Report offers UNICEF and country-level programme designers direct perspective on the challenges young people face regarding HIV information and support. In December 2015, a U-Report poll of 10 countries found that fear was a key barrier to HIV testing among young people. In June 2016, a follow-up poll in more than 15 countries seeking to better understand the basis of the fear elicited nearly 80,000 responses from around the world.

The poll revealed that 68 per cent described receiving a positive diagnosis as their biggest fear about HIV testing. Adolescents and young people still perceive HIV as a death sentence, either (or both) socially or literally. When asked what they would be most afraid of if they tested positive, the majority of respondents cited social stigma (48 per cent) and death (34 per cent).

Further responses revealed factors that could help overcome barriers to testing, including proximity to a nearby health facility (38 per cent) and anonymity (22 per cent). Most respondents also indicated that they would not choose to be tested for HIV at school, a useful result for policymakers and one that runs counter to many observers' assumptions.

The poll also yielded important data for UNICEF and country-level stakeholders specifically seeking to increase uptake of testing among adolescents: Nearly two thirds (59 per cent) of 70,000 respondents said they were 'very likely' to take a self-test for HIV if made available to them.



AGE OF CONSENT AND ETHICAL, SOCIAL AND CULTURAL BARRIERS TO ACCESS TO SERVICES AMONG ADOLESCENTS

Legal barriers such as age of consent legislation and policies are among the many obstacles adolescents face in accessing HIV services and support. Age of consent laws and policies guide decision makers and service providers as to the minimum age at which they can offer certain services and support to an individual. In principle, these provisions are established to protect children, adolescents and individuals and are based on whether the individual is able to understand the service, its related conditions and consequences.

Many national guidelines provide discretionary authority to service providers to offer services to those under the age of consent, based on their judgment of the client's ability to give fully informed consent. But many providers, fearing potential legal consequences, are reluctant to use this discretionary authority even when serving adolescents in clear and immediate need.

The impact can be devastating. By requiring parental consent for service provision for underage individuals, some of the most vulnerable adolescents are turned away from crucial points of contact with health, protection and support services. Recent WHO guidance, including the 2013 'HIV and Adolescents: Guidance for HIV testing and counselling and care for adolescents living with HIV' and technical briefs for young key populations, recommended that countries address any age-related barriers to access and uptake of services created through these legal provisions.

UNICEF, in collaboration with the Southern African AIDS Trust and with support from law firms in the Thomson Reuters Network, conducted a legal review of consent laws and policies in 22 countries. An additional review of ethical, social and cultural barriers was undertaken in 11 countries to understand the context behind the laws, policies and practice. The legal review focused on legislation and practice in relation to the following: sexual activity, contraception, ART, PrEP, post-exposure prophylaxis, abortion, antenatal care, HIV testing, the vaccine for the human papillomavirus, and cervical cancer screening and treatment.

The review used three frames of reference – each based on ethics and morality, social factors, and cultural factors – to understand the context for the legal provisions and general practice around consent for adolescents.

The following are among some of the key findings from the reviews:

- Most countries have set the age of consent to sex at 16 years, although in some countries the age is higher for girls and for sex between males (if it is acknowledged at all). Exceptions to the legal age of consent exist in many countries – for example, if the underage person and his or her sexual partner are married – and are usually done for cultural or religious reasons. These often present a major challenge to the goal of ending child marriage and sexual exploitation.
- Most countries do not stipulate specific age of consent for individual HIV and sexual and reproductive health services including ART, post-exposure prophylaxis and contraception. In most cases in the absence of specific guidance, the age of consent for these services is taken to be the same as the age of consent to medical treatment (ranging from 12 to 18 years, with 16 years being the most common age).
- The age of consent to HIV testing varies across countries but is mostly between 16 and 18 years.

These legal and ethical, social and cultural reviews are part of a broader effort supported by agencies to inform advocacy and country-level actions for social change through the **ALL IN** initiative to end the AIDS epidemic in adolescents. The findings from this review and complementary work by UNDP, UNFPA, UNAIDS and the PACT will be used to raise awareness and address contradictions and gaps identified in laws and policies that create critical barriers to HIV response in adolescents.

Through the Youth Aware partnership, MAC AIDS Fund provided a one-year allocation of \$2.4 million to support innovations and enhance service delivery for adolescents in six focus countries in addition to Brazil: China, India, Indonesia, South Africa, Thailand and Ukraine. The funding has enabled the development of innovative technologies and approaches, including telemedicine in the state of Maharashtra, India, to provide paediatric clinical expertise in rural areas; the MomConnect mobile phone texting application, which helps reduce loss to follow-up in maternal, newborn and child health services for pregnant women and mothers living with HIV in South Africa; and mobile clinic HIV testing conducted by young people living with HIV in Brazil and Ukraine.

UNICEF partnered with the Praekelt Foundation in Nigeria to strengthen the national use of mobile health applications to identify and reach vulnerable adolescents and link them to services and retain them in care. A pilot experience working with the National Call Centre on HIV/AIDS and Related Diseases in Nigeria was used to develop a blueprint for the integration of mobile health applications in national systems for HIV outreach, empowerment and data gathering. The call centre aims to provide all people with easy access to information on HIV and AIDS and other health issues. The centre currently offers operator-assisted responses for 46,000 calls per year. The upgrades recommended in the blueprint would immediately expand its reach to 53 million people, 11 million of whom would be adolescents. Further proposed upgrades would expand its reach to 110 million people, doubling the number of adolescents reached to 23 million and accelerating improvements in knowledge, demand and linkage to services.

A report released in 2016 through a project between UNICEF and the MAC AIDS Fund indicates the use and value of mobile technology and related innovations to reach and support adolescents. The information and recommendations in the report, 'mHealth and Young People in South Africa', is based on focus group discussions with young people and an online survey tool to better understand content and audience reach for digital platforms in South Africa. Mobile technology was revealed to have a high impact at low cost, connecting adolescents to health services with the touch of a button. Yet the findings also indicated that reliance on mobile phones alone, or even primarily, could not be successful without considering the impact of cost for young people; 84 per cent of respondents were open to obtaining sexual health information using their mobile phones if it was free.

Addressing legal barriers in access for adolescents

In 2016, UNICEF worked in collaboration with the Southern African AIDS Trust, and with support from law firms affiliated with the Thomson Reuters Foundation, to address legal barriers to HIV testing. Its efforts supported a legal

review of consent laws and policies in 22 countries⁵¹ and, in order to⁵² understand the context behind their laws, policies and practices, an additional review of ethical, social and cultural barriers in 11 countries. The legal review examined consent in relation to sexual activity, contraception, ART, post-exposure prophylaxis, PrEP, abortion, antenatal care, the human papillomavirus vaccine and cervical cancer screening and treatment, and HIV testing.

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

Since 2002, at least 10 million children younger than 18 years old have lost one or both parents to AIDS. This number peaked in 2009, when an estimated 15 million children had lost one or both parents to AIDS.⁵³ Although this number has gradually fallen, in 2015, there were still more than 13 million children who had lost one or both parents to AIDS (*Figure 14*).⁵⁴

Remarkable gains have been achieved over the past decade in mitigating the economic and social impact of HIV and AIDS on children and families. Still, children orphaned by AIDS, or living with sick caregivers, continue to face an increased risk of physical and emotional neglect and abuse as compared with other children in sub-Saharan Africa, including other orphans.⁵⁵

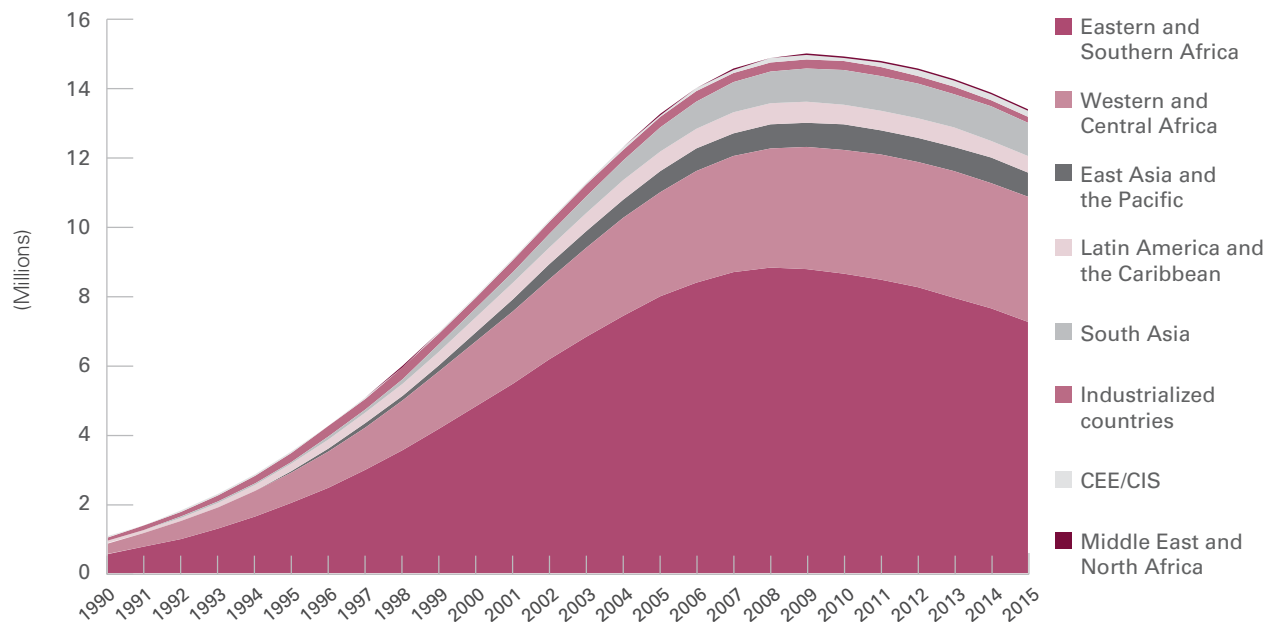
Investments for economic and psychosocial support remain critical. A comprehensive strategy should include strengthening linkages to testing children (and their families) who have lost one or both parents to AIDS; HIV treatment for those who need it; and community and health facility linkages to ensure that the most vulnerable are reached. Stronger partnerships are needed between HIV programming, national social protection efforts and community-based services to ensure that more children and families receive the support they need.

Evaluations have established that national social protection programmes (in particular, cash transfers) improve access to health, education and nutrition, strengthen social networks, increase access to HIV and AIDS treatment and prevention, and reduce adolescent vulnerability and risk-taking.

In addition, much research now informs the pathways between multiple childhood deprivations and subsequent HIV outcomes. Investing in social protection programmes will improve the access, reach and utilization of high-impact biomedical interventions to achieve reductions in HIV-related morbidity and mortality as well as reducing new infections.

FIGURE 14

Estimated number of children (ages 0-17) who have lost one or both parents to an AIDS-related cause, by UNICEF regions, 1990-2015



Source: UNAIDS 2016 estimates.

“Our efforts are not just about giving pills to people living with HIV. Our work is about restoring dignity. It is about fighting for social justice. It is about bringing equity to everyone, everywhere.”

UNAIDS Executive Director Michel Sidibé

HIV-sensitive social protection

UNICEF has led the way in strengthening systems to respond to the needs of vulnerable children affected by HIV around the world, and especially in Eastern and Southern Africa, where the highest burden of HIV and AIDS among children, adolescents and their families exists. In collaboration with governments in four countries in the

region (Malawi, Mozambique, Zambia and Zimbabwe), UNICEF conceived Cash Plus Care, an initiative designed to strengthen the link between HIV and AIDS services and social protection programmes. The project is funded by the Government of the Netherlands and aims to generate evidence and promote scale-up and policy integration.

As its name suggests, Cash Plus Care refers to a two-pronged approach of providing cash transfers with access to comprehensive care to reduce psychosocial problems and HIV risk behaviours. As of 2016, all four countries had made considerable progress in combining HIV services with cash transfer provisions.⁵⁶ In Zimbabwe, the project reached 23,000 children across two districts. Community partnerships were established between the Ministry of Health and Child Welfare and community volunteers, enhancing referral and links to services for families receiving cash transfers. Through these partnerships, community volunteers provide psychosocial support to HIV-positive adolescents and assist them with referrals to health services, while the Ministry of Health and Child Welfare distributes cash transfers to the adolescents and

their households through pay points. Plans to expand the project by introducing internal savings and lending systems will aim to help households overcome economic barriers that prevent them from accessing health services.

Social protection provisions are a proven boost to ART adherence among adolescents. A community-based study in South Africa, supported by UNICEF, found that three specific provisions were associated with improved adherence: food security, attending an HIV support group, and high parental/caregiver supervision. Adolescents who benefited from all three social protection types fared best in the study, a finding that should help programme and policy designers better serve and support young people living with and at risk of HIV infection.

In a project with some similar characteristics and priorities, UNICEF in South Africa collaborated with Oxford University researchers to produce six peer-reviewed articles on social protection and HIV and six subsequent briefs on research implications for policy. The briefs, highlighting the value of comprehensive HIV prevention, care and treatment approaches that include direct efforts to support

adolescents in dealing with a much wider range of social, health and economic challenges, will help guide policy dialogues at country and national level. And while the context was specific to South Africa, the programming and results are relevant to other countries in the region.

Advocacy, partnerships and knowledge generation

In 2016, UNICEF continued to lead the way in effectively advocating for the inclusion of women, children and adolescents affected by HIV and AIDS.

UNICEF's work through **ALL IN** has been catalytic in forging a global alliance around adolescents and HIV/AIDS. **ALL IN** has also been instrumental in increasing donor attention and commitment to prevention, care and support for adolescents and HIV and AIDS, most notably through PEPFAR's DREAMS initiative and the Global Fund's increased attention, commitment and resource tools to support investments for adolescents.

SOCIAL PROTECTION

Action beyond testing and treatment is needed to target the underlying social, economic and political barriers that impede HIV and broader development outcomes. Nearly 385 million children currently live in extreme poverty.⁵⁷ Cash transfers for adolescents have been found to improve access to health, education and nutrition. Cash transfers also strengthen social networks and improve HIV and AIDS outcomes by increasing access to treatment and prevention and reducing adolescent vulnerability and risk-taking.⁵⁸

UNICEF continued supporting governments to further expand social protection coverage and capacity to strengthen social protection systems. Key results include an increase in the number of children who benefit from cash transfer programmes, which are one of the most common forms of social protection, from 155 million in 2015 to 179 million in 2016. UNICEF contributed advocacy, technical support and guidance to expansion efforts in a wide range of countries.

In 2016, 61 countries undertook impact assessments of national social protection programmes; of those, 88 per cent demonstrated positive impacts on child well-being. Additionally, UNICEF published *From Evidence to Action: The story of cash transfer programmes and impact evaluation in sub-Saharan Africa*, which compiled the results of impact evaluation in eight African countries (Ethiopia, Ghana, Kenya, Lesotho, Malawi, South Africa, Zambia and Zimbabwe). The overall results contribute to a large global body of evidence that highlight the positive effects of cash transfer programmes on various child outcomes, including, among others, food security and school enrolment.

In Zimbabwe, UNICEF supported the country's flagship programme, Harmonized Social Cash Transfer, to raise HIV awareness on prevention, especially among children, adolescents and pregnant women. In addition, UNICEF promoted the effective referral of cash transfer beneficiaries to other specialized HIV-related care and support services offered by health and social workers.

UNICEF's advocacy has ensured that women (particularly pregnant women), mothers, girls, children and adolescents are solidly reflected in the new UNAIDS 2016–2021 Strategy.

In June 2016, UNICEF engaged with partners and member states at the United Nations General Assembly's High-Level Meeting on Ending AIDS. The meeting's outcome was an unprecedented Political Declaration, which took stock of progress made, lessons learned and pending gaps in the HIV response. The declaration also renewed concrete targets to end the AIDS epidemic by 2030, including a 95 per cent reduction of new HIV infections among adolescents aged 10–14, and an 81 per cent increase in those receiving treatment. Member States also committed to a 75 per cent reduction of new HIV infections among young people aged 15–24 with a goal of limiting the number of new HIV infections to less than 100,000 among young women aged 15–24 by 2020. In addition, Member States committed to tackling the root causes of risk and vulnerability among adolescents, including the review and reform of legislation that may create barriers or reinforce stigma and discrimination, such as age of consent laws.

The launch of the Three Frees Framework, which was modelled to a large degree on the Global Plan towards the Elimination of New Infections among Children by 2015 and Keeping Their Mothers Alive, was among the most notable advocacy achievements at the High-Level Meeting in 2016. UNICEF played a central role in the launch of that framework, in partnership with UNAIDS, PEPFAR and WHO. Created to further maximize parts of the UNAIDS fast-track agenda for HIV responses overall, this joint initiative has been described as a 'super fast-track' and will accelerate efforts to reach the 90-90-90 targets and end AIDS among children, adolescents, young women and expectant mothers.

"If the successful Global Plan was Act I, Start Free, Stay Free, AIDS Free is Act II."

Elizabeth Glaser Pediatric AIDS Foundation Executive Director, Chip Lyons

The Three Frees, a model of comprehensive partnership and evidence-based implementation, is grounded at the grass-roots and national levels. A diverse group of stakeholders is currently developing workplans setting out milestones and deliverables at 3, 6 and 12 months, clearly articulating how their proposed global-level priority actions will support accelerated and sustained country-level progress towards the framework's goals and targets.

Each country will receive a tailored plan that is adapted to its local context and aligned with HIV and reproductive, maternal, newborn, child and adolescent health national strategies. The framework's pillars will be driven by the latest available scientific and country-level data (including at the subnational level). Ideally, they will be influenced

by successful strategies for accelerating access to – and retention in – HIV prevention, treatment and care services, and identifying opportunities and actions for reaching all children, adolescents and young women in need as quickly as possible. This approach intends for the most critical work to happen within countries and communities, given that successful efforts to improve HIV responses among adolescents rely on local support at all stages.

UNICEF and its partners consider the Three Frees Framework a necessary and vital stand-alone approach to forcefully confront the entrenched and difficult challenges associated with children and adolescents, in particular. One main underlying assumption is that HIV responses overall can only improve if substantial progress is made among these two populations. Extra attention and resources should therefore be directed towards solutions, strategies and services that break down persistent barriers that affect this population, including insufficient education and awareness about HIV and sexual health, stigma, inadequate adherence support, and substandard HIV testing and counselling access and outreach

The partnership aims to strengthen linkages across a life cycle approach, and provides a roadmap for the urgent work ahead, elevating and amplifying key initiatives that are already accelerating progress for children, adolescents and young women. These include, among others, **ALL IN**, the DREAMS partnership and the Accelerating Children's HIV/AIDS Treatment initiative, which is funded by PEPFAR and the Children's Investment Foundation and allocated \$200 million to help support children living with HIV receive ART over a two-year period through the end of 2016. Adolescents are now prioritized in a way they have never been in the global AIDS response.

UNICEF has not been directly involved in designing or overseeing DREAMS or the Accelerating Children's HIV/AIDS Treatment initiatives, but much of its HIV work (including through the Three Frees) has been aligned with their objectives and priorities.

As the adolescent population expands globally, new HIV infections will rise unless the world acts now.

On World AIDS Day (1 December 2016), *UNICEF released For Every Child, End AIDS: Seventh Stocktaking report on children and AIDS.*

The report called for dramatic improvements in prevention, treatment and care for children, adolescents and women. It highlighted the dangers of decreasing attention and funding for HIV and AIDS, urging policymakers to act swiftly and boldly in order to end the AIDS epidemic. The report used

new data analysis to justify why investments in adolescent prevention must not only be maintained but increased:

- In 2010, there were about 200 million Africans between 15 and 24 years of age; that number could rise to more than 450 million by 2050.
- In Africa, one of the regions most heavily impacted by HIV, the number of adolescents newly infected is projected to increase in coming decades, even if the current rate of progress is maintained. If progress slows or stalls, the results could be devastating.
- If the HIV incidence rate remains at 2015 levels (instead of continuing at its current rate of decline), new HIV infections among adolescents aged 15–19 are projected to increase to 280,000 annually by 2020, to 330,000 annually by 2025, and to 390,000 annually by 2030 – or a cumulative total of 740,000 additional adolescents infected with HIV between 2016 and 2030.



UNICEF AND THE GLOBAL FUND

UNICEF considers its partnership with the Global Fund critical in advancing the rights of children, women and girls. The partnership is based on clearly defined comparative advantages:

The Global Fund provides an essential funding mechanism to support health programmes, which benefit pregnant women, mothers and children, and UNICEF adds its in-country presence, multi-stakeholder convening power and technical expertise, a valued asset in strengthening the development and implementation of Global Fund grants.



Since 2002, UNICEF has implemented more than \$380 million in Global Fund grants in more than 30 countries. UNICEF engages most often in challenging operating environments where governments are not able to directly implement Global Fund grants, but where UNICEF is well positioned as a strong and trusted partner on the ground. UNICEF has facilitated the implementation of Global Fund grants either as a direct recipient or implementer: for example, it currently is a principal recipient in the Democratic People's Republic of Korea, Somalia and Ukraine and a sub-recipient in 10 additional countries. UNICEF also provides technical assistance, including as an active participant on country coordinating mechanisms, supporting maternal, newborn and child health programmes, integrated community case management platforms, and supply chains/procurement and logistics.

In 2014, UNICEF entered into a joint memorandum of understanding to maximize the impact of Global Fund investments in combating HIV, tuberculosis and malaria on broader maternal, newborn and child health outcomes. This first memorandum of understanding has proven successful in jointly advancing this agenda, and in 2016 UNICEF and the Global Fund agreed on a renewal of the through 2019. The new framework, with a broadened scope addressing additional areas of concern, lays out six priority areas to further strengthen collaboration through specific joint actions, mechanisms for working, and channels of communications, including:

- Health and community systems strengthening;
- Adolescent health, with a focus on girls;
- Procurement and supply chain management;
- Operating in challenging environments;
- Monitoring and evaluation/data systems/learning; and
- Operations

CROSS-CUTTING ISSUES

Adolescent development and participation

The world is home to 1.2 billion adolescents aged 10–19, nearly 90 per cent of whom live in low- and middle-income countries. Persistent inequities leave millions of young people without the foundational skills, tools or opportunities they need for a decent life.

Mortality rates for adolescents are still unacceptably high, with 1.3 million dying every year. Adolescents aged 15–19 are the only age group among which AIDS-related deaths are increasing, and AIDS remains the leading cause of death among adolescents (10–19 years old) in sub-Saharan Africa. *For Every Child, End AIDS*, UNICEF's recently released global report, warns that based on current trends and demographic projections, HIV will rise among adolescents in nearly every region, including in sub-Saharan Africa, the region most affected by the epidemic.

Numerous cultural, social, economic and political factors – many of which are linked or otherwise exacerbate risk – are behind these grim figures and estimates. In the younger age group (10–14-year-olds), AIDS is the leading cause of

death globally. Among women aged 20–24 worldwide, one in four were child brides (married below the age of 18). The total number of adolescents aged 10–19 living in countries or areas currently affected by an armed conflict is approximately 125 million, of which an estimated 64 million are boys and 61 million are girls. Adolescents are the age group most often recruited or used by armed groups and targeted for sexual violence, abuse and exploitation, dramatically increasing their risk of HIV infection. Humanitarian assistance is often focused on meeting the survival needs of young children, with limited social services provided for adolescent girls and boys.

As part of efforts to reverse these trends, UNICEF has been providing critical global leadership, particularly in the area of HIV. Since the launch of **ALL IN** initiative, UNICEF has prioritized programming for comprehensive HIV prevention, treatment and care among adolescents in all regions. In light of a clear understanding that reducing adolescent risk to HIV and improving health outcomes requires a strong multi-sectoral response, UNICEF's HIV and adolescent work in 2016 continued to be closely aligned with other focus areas.

FIGURE 15

UNICEF's core areas of work with and for adolescents



In many regions, including Latin America and the Caribbean, the Middle East and North Africa and CEE/CIS, the HIV programme is located within the broader Adolescent Development and Participation team. A matrix approach to multi-sectoral collaboration has been established and increasingly adopted in regions and countries. The HIV team provided substantive input into a number of Adolescent Development and Participation products and initiatives in 2016, including new programme guidance for adolescents on principles and approaches needed for UNICEF's adolescent-related work; a multi-sectoral analytical paper on global challenges facing adolescents; and, as further described below, the Adolescent Country Tracker and the General Comment on Adolescents.

The Adolescent Country Tracker, finalized and field-tested in 11 countries in 2016, is a global tool that provides a set of outcome-level indicators to track the progress of adolescent well-being, including HIV and AIDS. It aims to strengthen accountability and mobilize resources for adolescents across the SDGs.

The launch of the General Comment on Adolescents, developed to enhance practical implementation and monitoring of the United Nations Convention on the Rights of the Child, is the most important articulation of adolescent rights since the Convention in 1989. When adolescents are refused services, denied a choice in matters that affects their lives or are unable to claim their rights, their well-being is jeopardized. The General Comment on Adolescents represents a powerful new tool for the HIV programme's work on adolescents in particular because of its recommendations on people who identify as lesbian, gay, bisexual, transgender or intersex, and on minimum age-legislation. General Comment on Adolescents age-related recommendations most relevant to HIV include:

- **States should set an age according to national context:** access to sexual and reproductive health services (article 39); sexual consent (article 40).
- **States should remove age-related requirements:** consent to medical treatment (article 39); access to confidential medical counselling (article 39); sexual and reproductive health service (article 61).
- **States are encouraged or recommended to set a minimum age of 18 years:** marriageable age without consent (article 40); recruitment to armed services (article 40); hazardous or exploitative work (article 86).

The General Comment on Adolescents also addresses lesbian, gay, bisexual, transgender and intersex adolescents, stating:

The Committee emphasizes the rights of all adolescents to freedom of expression and respect for their physical and psychological integrity,

gender identity and emerging autonomy. It condemns the imposition of so-called 'treatments' to try to change sexual orientation and forced surgeries or treatments on intersex adolescents.

Along with a specific focus on girls, those with disabilities, minorities and indigenous adolescents, the General Comment on Adolescents provides a significant step forward in ensuring that the Convention on the Rights of the Child remains evolving, relevant and credible as we approach its 30th anniversary.

"When the human rights of LGBT people are abused, all of us are diminished. Every human life is precious – none is worth more than another."

Former Secretary-General of the United Nations, Ban Ki-moon

Communication for Development

All adolescents, regardless of socio-economic status, need to be educated about HIV, including risk behaviours and best prevention practices for keeping themselves and others safe. Increasing awareness and education is necessary not only to prevent HIV infection but also to reduce stigma and discrimination towards people affected by HIV.

A recent United Nations General Assembly report concluded that accurate and comprehensive knowledge about HIV has stagnated among young people.⁵⁹ In sub-Saharan Africa, just 26 per cent of adolescent girls and 33 per cent of adolescent boys aged 15–19 years have comprehensive HIV knowledge. Levels of condom use also remain very low, with only 32 per cent of sub-Saharan adolescent girls with multiple partners reporting condom use at last sex.⁶⁰ To address this, in 2016 UNICEF continued to support the roll-out of popular and proven awareness-raising initiatives such as MTV Shuga (*see box on page 51*) to reach adolescents and young people across the African continent with information about HIV and AIDS.

Early childhood development and participation

The integration of HIV and early childhood development has become ever more important. Adversity in the first five years of life, including exposure to HIV, can cause lifelong effects on a child's learning and behaviour. With support from the Conrad N. Hilton Foundation, UNICEF has been working with the Governments of Kenya, the United Republic of Tanzania and Zambia to advocate for the importance of early childhood development, especially within the context of HIV-affected populations.

COMMUNICATION FOR CHANGE IN MOZAMBIQUE: ADOLESCENT-LED HEALTH AND VIOLENCE PREVENTION AND COUNSELLING INITIATIVE

UNICEF's C4D efforts aim to identify the multiple factors behind a problem and determine which communication approach – advocacy, social mobilization, social change communication or behaviour change communication – will be most effective in addressing the identified causes. Mozambique is among the countries where ongoing C4D initiatives are showing clear signs of success.

SMS Biz was launched in 2015 through Geração Biz (Busy Generation), the national youth-focused sexual and reproductive health and HIV prevention programme. It works to provide adolescents and young people with comprehensive access to personalized HIV information through Short Message Service (SMS). UNICEF Mozambique and three government ministries (Health, Education, and Youth and Sport), UNFPA and the youth association Coalizão (Coalition) have adapted UNICEF's U-Report platform to create a comprehensive national HIV communication programme centred on peer-to-peer education.

The core of the initiative is a counselling hub with 24 trained peer counsellors that Coalizão set up and manages with the support of other project partners. The counsellors use specialized information and communication tools and reference guides to respond to adolescents' questions about sexual and reproductive health, HIV and gender-based violence.

SMS Biz has exceeded expectations. Initial projections anticipated that the project would reach and connect 50,000 adolescents and young people aged 10–24 by the end of 2016; instead, project partners successfully registered more than 64,000. All were engaged in discussions addressing, among other things, uptake and linkages to HIV and gender-based violence services and misconceptions about HIV and sexual and reproductive health. The 24 counsellors currently receive and respond to about 400 questions each day. To date, more than 9,200 positive feedback messages have been spontaneously sent by U-Reporters on the quality and appropriateness of the counselling services received.

The success of SMS Biz clearly demonstrates the value of partnerships, including inter-agency (e.g., with UNFPA), and, in particular, locally (e.g., Coalizão,) in support of C4D programming. The need for continuous innovations in order to make the most of new communication platforms is also evident, and towards this end, the SMS Biz/U-Report initiative will be customized to monitor the level of satisfaction of health facility users.

Due in large part to the strong impact and progress of SMS Biz, UNICEF will scale up the initiative at national level in 2017.

In July 2016 at the International AIDS Conference, UNICEF headquarters, with support from the Hilton Foundation and in conjunction with UNICEF's Eastern and Southern Africa Regional Office, introduced a framework – Using the Science of Human Development and HIV to Improve Outcomes for Young Children Affected by HIV and AIDS – demonstrating the links between early childhood development and HIV programming and science, with a focus on delivering effective co-interventions as a 'core package'.

UNICEF headquarters also conducted the first in a series of webinars – 'Interventions that work: Parenting and HIV/AIDS' – which highlighted successes and drew connections between early childhood development and HIV and AIDS. In addition to the regional ECD trainings convened by the UNICEF Eastern and Southern Africa Regional Office, evidence-based practices linking HIV and early childhood development were shared at six key events in 2016, including the New York University TIES Summit in Abu Dhabi in March 2016 and the HIV Conference and Coalition for Children Affected by AIDS in July 2016.



Elango Ramachandar and his wife Asha Ramaiah, who are both HIV-positive, play with their two-year-old son Yathin in their home in Bangalore. Yathin has tested negative for HIV.

MTV SHUGA 'EDUTAINMENT': HIV AND SEXUAL AND REPRODUCTIVE HEALTH OUTREACH FOR ADOLESCENTS

Providing effective HIV education and outreach and to young people is a difficult yet critical task. UNICEF continues to work to identify the successful settings and formats for raising awareness, with an end goal of prompting behaviour that will keep young people healthy. MTV Shuga is one example of innovative outreach that addresses this challenge.

Shuga, an initiative that combines entertainment media, social media, print media, mobile (SMS and Interactive Voice Response), and live performance targets adolescents and young people in Africa by embracing an approach sometimes termed 'edutainment'; the use of high-quality and engaging popular entertainment to deliver important information about health and other issues. Developed by the MTV Staying Alive Foundation, and supported by UNICEF, PEPFAR and the Bill & Melinda Gates Foundation, among others, MTV Shuga fuses sexual-health messaging with gripping storylines. The show, a television soap opera, first aired in November 2009 and is currently broadcast in more than 70 countries, reaching as many as 750 million people.

The third and fourth seasons of MTV Shuga were produced in Nigeria and starred local actors. HIV was the centrepiece of the eight-episode season, with violence against women a secondary theme. Both topics were addressed explicitly and openly. Prior to the fourth season, researchers decided to use the show to study whether embedding messages related to health in popular entertainment can be an avenue for promoting positive behaviour change.

The research consisted of a randomized controlled trial that aimed to evaluate the effects of MTV Shuga on knowledge, attitudes and behaviours related to HIV and AIDS and gender-based violence. It was among the first attempts to rigorously measure the effects of a commercial production on adolescent and youth behaviour.



The cluster randomized trial was conducted in 80 locations in urban and peri-urban areas in southwest Nigeria. Young people aged 18–25 were visited at home and invited to see a movie. Some of those individuals were shown two screenings of four 20-minute episodes of MTV Shuga in community screenings (i.e., with other youth). Control communities were shown a placebo movie lacking messages of sexually risky behaviour. Baseline, interim and six-month follow-up surveys were administered to both groups.

Preliminary results provide experimental evidence that the show improved knowledge and attitudes among viewers. For example, the experimental evaluation shows that MTV Shuga improved knowledge about how HIV is transmitted and debunked persistent myths about transmission. Individuals in the treatment group were 35 per cent less likely to think that HIV is a punishment for sexual activity (13.7 per cent vs 8.9 per cent). The improvement in knowledge about HIV testing was also substantial: respondents in the treatment group were 43 per cent more likely to be aware of the three-month window after transmission when HIV is not usually detected because sufficient antibodies have yet to be produced (10.1 per cent in the control versus 14.5 per cent in the treatment group).

Most importantly, the study demonstrated that MTV Shuga led to behaviour change on the primary goals of reducing risky sexual behaviours and increasing uptake of HIV testing. Individuals who watched MTV Shuga were also 35 per cent more likely to report receiving HIV tests in the previous six months (9.3 per cent versus 6.9 per cent in the control group). Moreover, individuals in the treatment group were 14 per cent less likely to report having had concurrent sexual partners in the six months prior to the follow-up survey (18 per cent versus 22 per cent in the control group) and also reported fewer partners at the time of the follow-up survey.

UNICEF in the United Republic of Tanzania participated in and coordinated with the Elizabeth Glaser Pediatric AIDS Foundation, a Hilton partner, an introduction to early childhood development for government stakeholders in March 2016. Government involvement was critical for advocacy and resulted in an agreement that prioritized the most vulnerable and disadvantaged children, including children affected by HIV. A future preparatory activity will be the review of existing efforts to integrate interventions that improve early childhood development in health, PMTCT and nutrition programming in the United Republic of Tanzania.

The issue is a high-priority one elsewhere in the region. In May and June 2016, UNICEF in Kenya conducted high-level advocacy meetings with county governments of Siaya and Homa Bay on integrated early childhood models for replication and sustainability. Issues of child rights and HIV and AIDS were discussed with the aim of enhancing child protection, as well as testing and treatment for HIV-affected children. Overall, the early childhood development models were well-received nationally. Furthermore, in Malawi UNICEF convened inter-sectoral stakeholders to provide orientation and training of facilitators to break sectoral barriers which limit child development, specifically HIV and AIDS.

Gender

UNICEF recognizes that achieving gender equality is crucial to reaching the SDGs and achieving the 2020 targets set in the 2016 Political Declaration to End AIDS and the UNAIDS Strategy 2016–2021. UNICEF and numerous partners demonstrate strong global commitment to advocacy efforts that advance gender equality across all 17 goals as well as in the 2016 Political Declaration and the UNAIDS Strategy, both of which prioritize gender equality and the elimination of gender-based violence.

Urgent work is needed to ensure that women and girls are not left behind in ongoing and future HIV responses. Pervasive gender inequalities, often intricately woven into the sociocultural, economic and political fabric of society, undermine their progress in the HIV response. These gender inequalities exacerbate women's and girls' physiological vulnerability to HIV, with young women and adolescent girls facing a heightened vulnerability to HIV infection. Gender biases also influence access to services for both women and men. Unequal gender norms undermine effective HIV responses for men, as prevailing concepts of masculinity encourage men's sexual risk-taking and discourage men from seeking health and HIV services.

In 2015, young women (aged 15–24) accounted for 60 per cent of young people living with HIV and, in the most heavily affected region of sub-Saharan Africa, accounted for approximately two thirds of new HIV infections among youth and 25 per cent of new infections among adults in 2015.

Among adolescent girls aged 15–19, the gender discrepancy is particularly pronounced, with adolescent girls accounting for 75 per cent of new HIV infections among adolescents in sub-Saharan Africa. Globally, just 3 in every 10 adolescent girls and young women (aged 15–24) have comprehensive knowledge of HIV. In some settings, less than 20 per cent of adolescent girls and young women 15–24 have a final say on their own health care.

For an effective HIV response, gender-based violence must also be addressed. According to WHO, one in three women worldwide has experienced physical and/or sexual violence by an intimate partner, or sexual violence by a non-partner, in her life. Studies from some regions show that women who experienced physical or sexual intimate partner violence were 1.5 times more likely to acquire HIV.

In 2016, UNICEF worked closely with partner agencies and the Secretariat to ensure that the UNAIDS Strategy 2016–2021 addressed the higher risks faced by women and girls. The new strategy urges a fast-track approach for advancing gender equality and sexual and reproductive health and rights and eliminating gender-based violence.

The 2016 Political Declaration also advocates for a strong focus on women and girls and acknowledges the interconnectedness of HIV with gender inequality, and the empowerment of women, sexual and reproductive health and reproductive rights and gender-based violence. UNICEF and partners will work to achieve gender equality by investing in women's leadership, promoting sexual and reproductive health, and ending all forms of violence and discrimination against women and girls, in order to increase their capacity to protect themselves from HIV.

Humanitarian: HIV in emergencies

Targeting HIV-related risks in emergency and conflict environments that increase exposure to HIV infection, such as sexual violence and transactional sex, is a key component to ending the HIV epidemic. It is crucial that people affected by humanitarian emergencies are included in the fast-track response to ending the AIDS epidemic and achieving the SDGs. Yet, HIV is rarely among the priorities in humanitarian response, frequently leaving those affected without access to prevention, treatment, care and support.

Effective HIV response is challenged in times of disease outbreaks, conflict, natural disasters, and economic and political crises. UNICEF includes HIV services in its Core Commitments for Children in Humanitarian Action to improve access to HIV prevention and treatment for children, adolescents, pregnant women and mothers in risk-prone and emergency settings. Food security is critical for adherence to HIV treatment and retention in care. Mortality is two to six times higher for children living with HIV who begin treatment when they are severely malnourished. A 2014 study of 18 countries in sub-Saharan

Africa, including Lesotho, Malawi, Mozambique, Swaziland, Zambia and Zimbabwe, among the El Niño-affected countries in southern Africa, found that infection rates in HIV-endemic rural areas increased by 11 per cent for every recent drought. Income shocks further impacted nearly 20 per cent of the variation in HIV prevalence across African countries.

In 2016, the UNICEF nutrition and HIV sections, together with WHO and the Emergency Nutrition Network, organized a technical consultation in Geneva with governments, NGOs and other stakeholders. The consultation focused on developing a framework and key principles around infant feeding and HIV in emergencies in the context of the WHO and UNICEF 2016 publication *Guideline: Updates on HIV and infant feeding*.

A guidance note on ordering supplies to address the clinical management of sexual assault against women and children is now being finalized.

As a response to emergencies in parts of Ukraine, UNICEF worked with the Global Fund to ensure the continued supply of antiretroviral drugs for 45,000 people. Twenty-three tons of antiretroviral drugs and HIV diagnostics were delivered to the non-government controlled areas of Donetsk and Lugansk in four shipments between October 2015 and June 2016.

UNICEF led advocacy and technical assistance efforts in West and Central Africa and other regions to keep HIV high on the agenda in all existing and emerging regional emergency programmes. In Eastern and Southern Africa, UNICEF developed and disseminated a guidance document encouraging country offices in El Niño-affected countries – Lesotho, Mozambique, Namibia, Swaziland and Zimbabwe – to strengthen HIV programming during the drought crisis. UNICEF provided support and guidance to country offices to better monitor the impact of drought on HIV prevention and treatment, bolster ART adherence and retention strategies, increase HIV testing of children at nutrition treatment centres, and enhance prevention activities for adolescents in high-burden, drought-affected areas. It also mobilized funding to support similar work in Mozambique and Zimbabwe and provided technical assistance and guidance through a joint HIV and Nutrition mission to Lesotho to support better monitoring and programming during the drought.

Human rights

UNICEF recognizes that a human rights-based approach to HIV is essential to ending AIDS. With the adoption of the 2030 Agenda for Sustainable Development and the SDGs, United Nations Member States have committed to leaving no one behind, including young key populations most at risk of HIV. This commitment reaffirmed the pledge of the

2011 Political Declaration on HIV and AIDS to eliminate stigma and discrimination against children living with and affected by HIV; address laws impeding effective HIV response; and implement specific programmes to increase access to justice. However, progress has been insufficient. Today, human rights issues – stigma and discrimination, gender-based inequality and violence, denial of sexual and reproductive health and rights, and misuse of criminal and punitive laws affecting key populations – remain obstacles to effective HIV response.

To support the UNAIDS 2016–2021 Strategy and the recommendations of the Global Commission on HIV and the Law, UNICEF is working to translate political commitments for human rights and gender equality into concrete actions at global, regional and country levels.

Accelerated action is needed to improve both the legal and social environments around HIV and specifically ensure that law enforcement and access to justice are enabling, not punitive.

As of April 2016, 35 countries, territories and areas imposed restrictions on the entry, stay and residence of people living with HIV. Moreover, some 72 countries have adopted legislation that specifically allows for criminalization, while prosecutions for HIV non-disclosure, exposure and transmission have been recorded in at least 60 countries. Compulsory detention for drug users has been reported in 27 countries, often without due process or minimum standards of detention or treatment. Additionally, approximately 75 countries criminalize or penalize consensual same-sex sexual relations between adults, and the vast majority of countries, territories and areas criminalize drug use and aspects of sex work. Only 11 countries recognize the gender identity of transgender people.

UNICEF is committed to the elimination of HIV-related stigma and discrimination and the promotion of laws and policies that ensure the full realization of all human rights and fundamental freedoms for people living with and vulnerable to HIV.

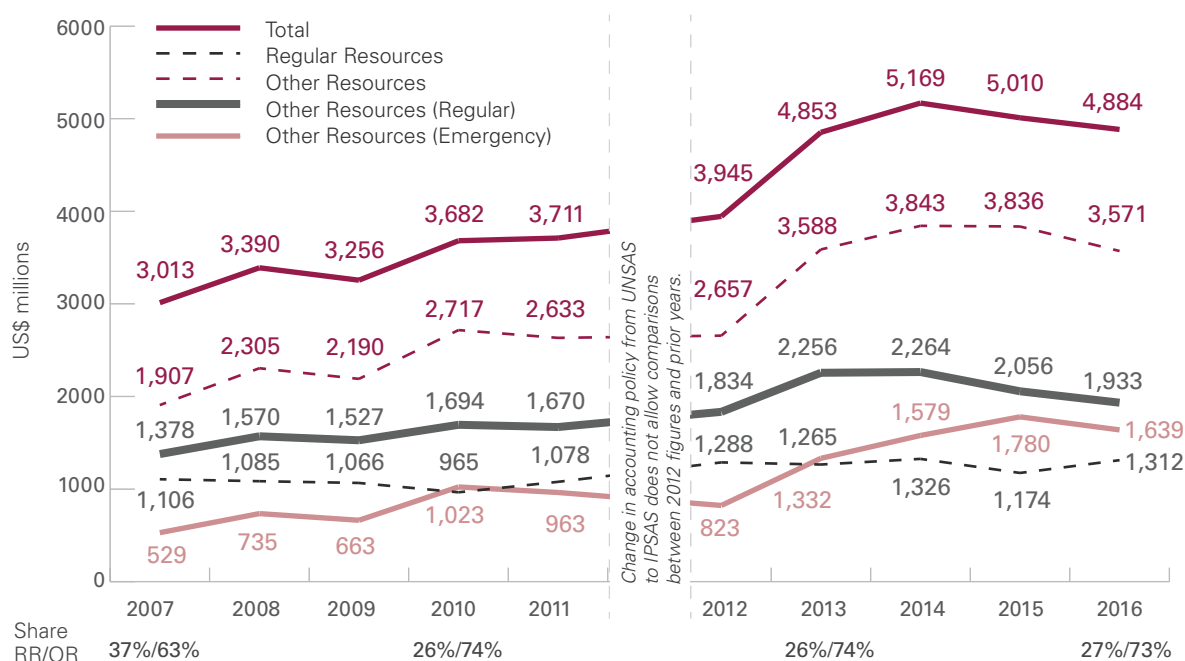
FINANCIAL ANALYSIS

The 2030 Agenda for Sustainable Development envisions a world that invests in its children, recognizing the need to mobilize financial resources and commitment from partners for the achievement of its goals.

For UNICEF specifically, the SDG agenda has highlighted the increasing importance and volatility of its flexible funding models. Regular resources, which are un-earmarked and unrestricted funds allocated to deliver programmes on the basis of formulas and appears prescribed by the Executive Board, play a vital role in maintaining programme continuity in inequitable and

fragile contexts, as well as building preparedness and resilience to future shocks. Of the nearly US\$4.9 billion UNICEF received in 2016, US\$1.3 billion (27 per cent) were regular resources. This 12 per cent increase in regular resources from 2015 was due to growth in contributions from individual (US\$629 million compared with US\$530 million in 2015), as well as a sizeable one-time increase from the Government of Sweden, which contributed US\$117 million, 87 per cent more than the previous year. This was second only to the United States, which contributed US\$132.5 million.⁶¹

FIGURE 16
Regular resources share by resource category, 2007–2016



Regular resources: Un-earmarked funds that are foundational to deliver results across the Strategic Plan.

Other resources: Earmarked contributions for programmes; supplementary to the regular resources and made for a specific purpose, such as an emergency response or a specific programme in a country/region.

Other resources – regular: Funds for specific, nonemergency programme purposes and strategic priorities.

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

*All revenue data as of 3 April 2017.

Contributions made by donors earmarked to a specific programme or thematic area, including multi-year funding, decreased by 7 per cent over 2015 to US\$3.6 billion in 2016. Contributions to the nine thematic funding pools dropped to US\$326 million, a 16 per cent decrease from the previous year. Of the thematic funding pools, funds softly earmarked for humanitarian action against appeals were US\$145.4 million, a 29 per cent decrease from 2015, despite growing humanitarian needs. This specific funding mechanism is a vital complement to regular resources, often used to address inequities that the allocation of regular resources is not able to address. Thematic funding is also used to build capacities of countries, partners and UNICEF to mitigate the impact of, and respond to, current and future emergencies, bridging development and humanitarian work.

The scope, pace and sustainability of treatment and prevention scale-up are threatened by financing challenges. Currently, around 85 per cent of the estimated US\$22 billion spent each year on HIV responses in lower- and middle-income countries (LMICs) comes from three sources: domestic resources, the US President's Emergency Plan for AIDS Relief (PEPFAR), and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund). In recent years, however, the total amount of external financing for HIV responses – including that provided by the Global Fund, PEPFAR and other bilateral donors, and

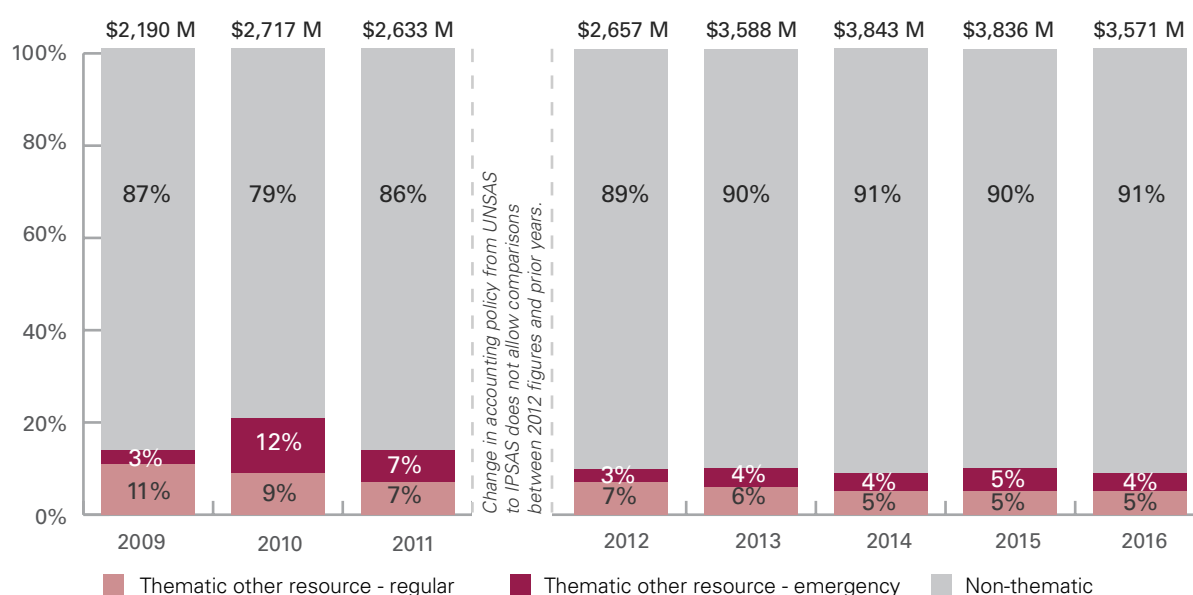
all other non-domestic sources – has plateaued, and most signs indicate that such funding is more likely to decline or remain stagnant rather than increase again in the short term at least. Domestic resources already account for more than 50 per cent of overall HIV response financing, and most countries are being urged by UNAIDS, other multilateral partners, and global and local advocates to allocate more budget support to HIV treatment and other related services. Many LMICs, however, have limited financial capacity to increase domestic resources.

In 2016, UNICEF received US\$52 million dedicated to HIV and AIDS, a 2 per cent increase from the previous year (see Figure 18). The top four resource partners in this area of UNICEF's work were UNAIDS, the Global Fund, the Government of Sweden and the Korean Committee for UNICEF (see Table 1). Seventeen per cent of all earmarked funding for HIV and AIDS was contributed by UNAIDS, followed by the 16 per cent from the Global Fund specifically earmarked for HIV-related activities in Somalia.

Although UNAIDS remained a major donor for this area of UNICEF's work, substantial cuts to the Joint Programme in 2016 presented a significant challenge to UNAIDS and its co-sponsors. Shortly after the UNAIDS board adopted the Fast-Track Strategy and a two-year budget, several major donors significantly reduced their contributions to

FIGURE 17

Other resources revenue, 2009–2016: Thematic versus non-thematic (US\$)



the United Nations system, including the Joint Programme. The contributions fell well short of the board-approved budget for 2016–2017, severely impacting the capacity of co-sponsors, including UNICEF, to deliver the level of support described within the UNAIDS Strategy. The lack of funding severely threatens the sustainability of the Joint Programme’s unique model.

The Unified Budget, Results and Accountability Framework of UNAIDS includes a US\$485 million core budget for the 2016–2017 biennium, as well as budget allocations for the co-sponsors and the secretariat at 2014–2015 biennium levels (UNICEF received US\$24 million for that biennium).

In 2016, fund-raising challenges affected the Unified Budget, Results and Accountability Framework, and allocations to UNICEF and other co-sponsors were reduced by 50 per cent. The Programme Coordinating Board recommended further cuts to 75 per cent against funds raised for 2017. At a November 2016 meeting with co-sponsor principals, the UNAIDS Executive Director committed to maintaining the 2016 co-sponsor allocation (a reduction of 50 per cent) as a result of the savings achieved through cuts to both staffing levels in the secretariat and 2016 activity budgets.

To mitigate these reductions and reorient the UNICEF response towards new global strategies, partnerships and changes in funding, UNICEF undertook three actions, including:

1. The review, update and calibration of the UNICEF Programme Strategy on HIV and AIDS;
2. A financial analysis of HIV resource requirements for the period 2016–2021; and
3. An assessment by UNICEF, in collaboration with UNAIDS and co-sponsors, of the impacts of the Unified Budget, Results and Accountability Framework cuts and the projected shortfalls for 2016 and 2017 on the delivery of the UNAIDS 2016–2021 Strategy.

This financial crisis poses immediate and far-reaching implications for UNICEF’s work. Analysis conducted in late 2016 suggests that reduced funding could prevent countries from accelerating and sustaining access to paediatric and adolescent ART. Technical support to low-level and concentrated epidemics will be limited and the number of UNICEF staff members dedicated to HIV programming at the country, regional and headquarters levels will be seriously affected. In 2016, UNICEF had 111 full-time staff members on fixed-term contracts working in HIV programming, compared with 173 in 2015, a decrease of 36 per cent. Only four out of seven regions have maintained a regional adviser at the senior level, compared with seven regions in 2014. Headquarters reduced its staffing levels by more than 50 per cent in 2016.

FIGURE 18
HIV and AIDS other resources funding trend, 2007–2016

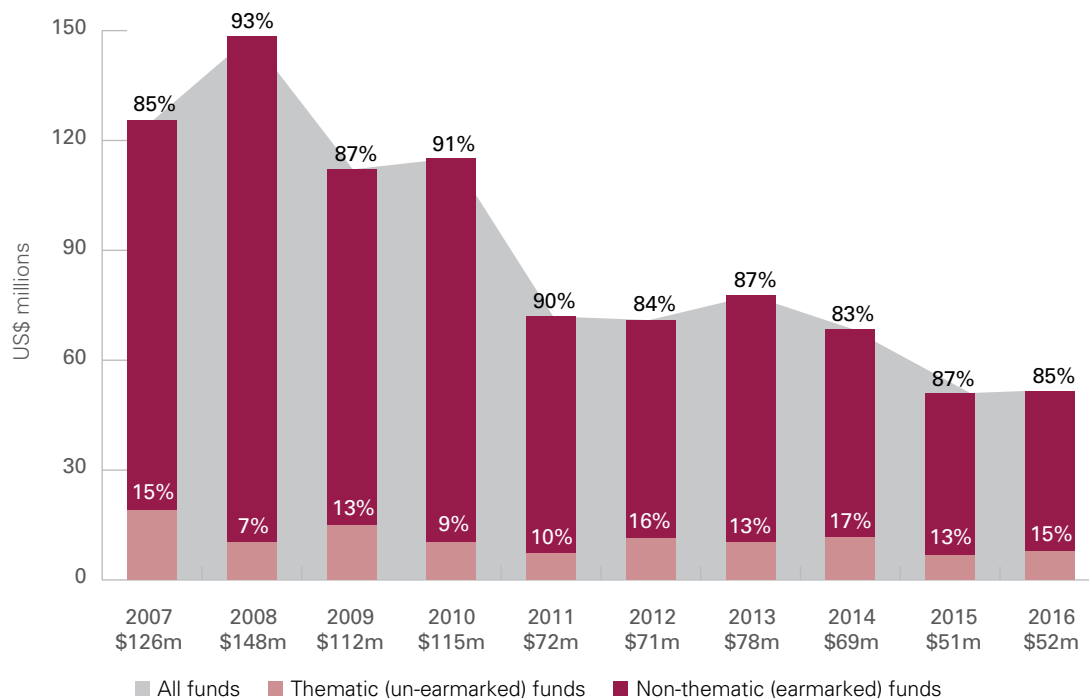


TABLE 1

Top 20 resource partners to HIV and AIDS, 2016*

Rank	Resource partners	Total (US\$)
1	UNAIDS	9,078,256
2	The Global Fund to Fight AIDS, Tuberculosis and Malaria	8,061,865
3	Sweden	5,117,872
4	Korean Committee for UNICEF	4,415,333
5	United States of America	2,921,666
6	Norway	2,743,700
7	Netherlands	2,023,811
8	German Committee for UNICEF	1,636,909
9	Hong Kong Committee for UNICEF	1,366,047
10	Dutch Committee for UNICEF	917,428
11	Swedish Committee for UNICEF	847,458
12	United Kingdom Committee for UNICEF	769,230
13	Joint Programmes managed by UNICEF as an Administrative Agent	744,240
14	French Committee for UNICEF	703,684
15	United States Fund for UNICEF	464,736
16	Canada	385,208
17	Finnish Committee for UNICEF	343,044
18	Pooled funds administered by Multi-Partner Trust Fund Office (MPTF Office)	289,523
19	Australian Committee for UNICEF	278,705
20	Canadian Committee for UNICEF	249,149

* Figures include financial adjustments.

TABLE 2

Top 10 contributions to HIV and AIDS, 2016*

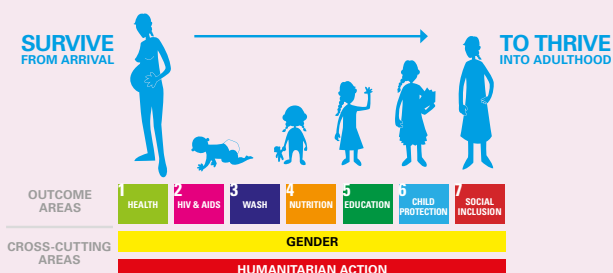
Rank	Resource Partners	Grant Description	Total (US\$)
1	UNAIDS	HIV and AIDS	9,000,000
2	The Global Fund to Fight AIDS, Tuberculosis and Malaria	Reducing New HIV Infections and HIV Related Mortality and Morbidity, Somalia	8,061,865
3	Sweden	Elimination of Mother to Child Transmission of HIV	4,420,378
4	Korean Committee for UNICEF	HIV and AIDS, Global Thematic Funding	4,015,333
5	Norway	UNFPA-UNICEF Joint Program on RBA for Youth Phase II, Ethiopia	2,743,700
6	Netherlands	Expansion and Scale-Up of HIV-Sensitive Social Protection, ESARO	2,023,811
7	German Committee for UNICEF	Achieving Health for Women, Children and Adolescents, Malawi	1,084,599
8	Dutch Committee for UNICEF	HIV and AIDS, Global Thematic Funding	917,428
9	Joint Programmes managed by UNICEF as an Administrative Agent	Adolescent Health and HIV and AIDS Prevention, Honduras	767,127
10	Sweden	HIV and AIDS, Global Thematic Funding	622,114

*Figures include financial adjustments.

THE VALUE OF THEMATIC FUNDING

While regular resources remain the most flexible contributions for UNICEF, thematic resources 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 2014–2017 outcome areas as well as for humanitarian action and gender. Resource partners can contribute thematic funding at the global, regional or country level.

UNICEF Strategic Plan 2014-17
Thematic Windows:



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.

PARTNER TESTIMONIAL

With Sweden's priority on maternal and child health as well as on sexual and reproductive health and rights, UNICEF is a strategic partner to the Swedish International Development Cooperation Agency (Sida) – not only in scaling up coverage and quality of services for women, children and adolescents, but also for strengthening health systems in low-income countries. Sida has as a main priority an increased respect for human rights, including the rights of the child. As the United Nations agency with an operational mandate to implement the United Nations Convention on the Rights of the Child, UNICEF is uniquely positioned to use the resources of Sweden not only in long-term development cooperation, but also for its engagement in humanitarian action for children.

Thematic funding enhances effectiveness, as it enables UNICEF to reach the most excluded and most vulnerable children, as well as strengthens the ability to support long-term strategic activities. Through its flexibility, thematic funding also promotes innovation, sustainability and better coordination, and reduces transaction costs. Over the years, Sida's support to UNICEF has increasingly been channelled as thematic funding, reflecting Sida's confidence in UNICEF as an effective actor and strong advocate for the implementation of children's rights.

– Lennart Båge,

Assistant Director General of Sweden's International Development Cooperation Agency

FIGURE 19

Thematic revenue share by outcome area and humanitarian action, 2016: US\$326.3 million

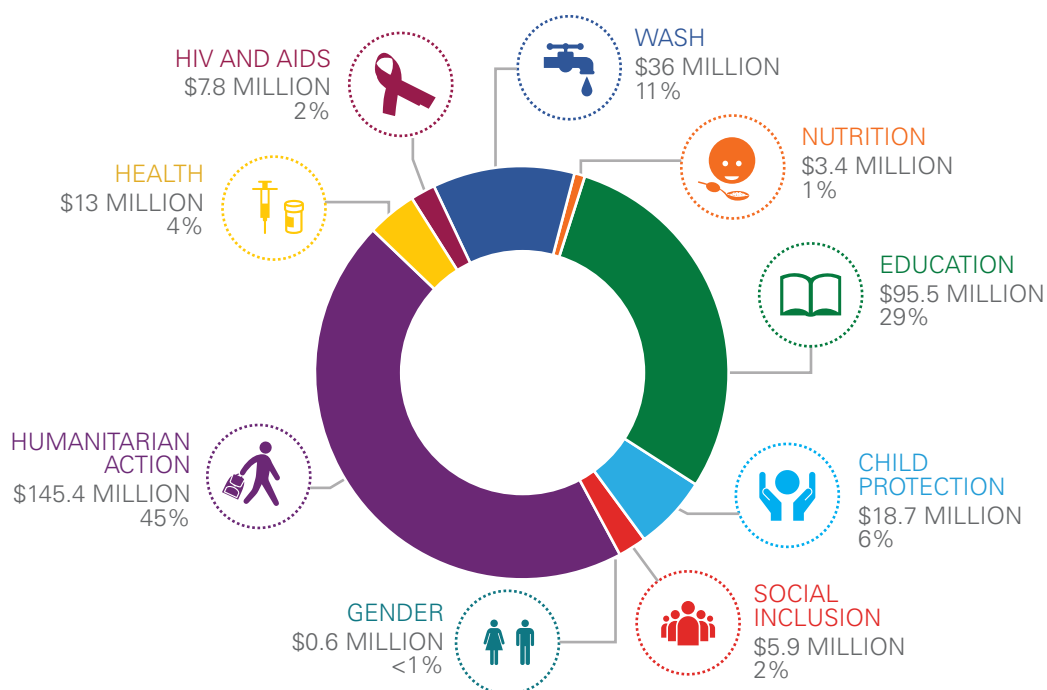
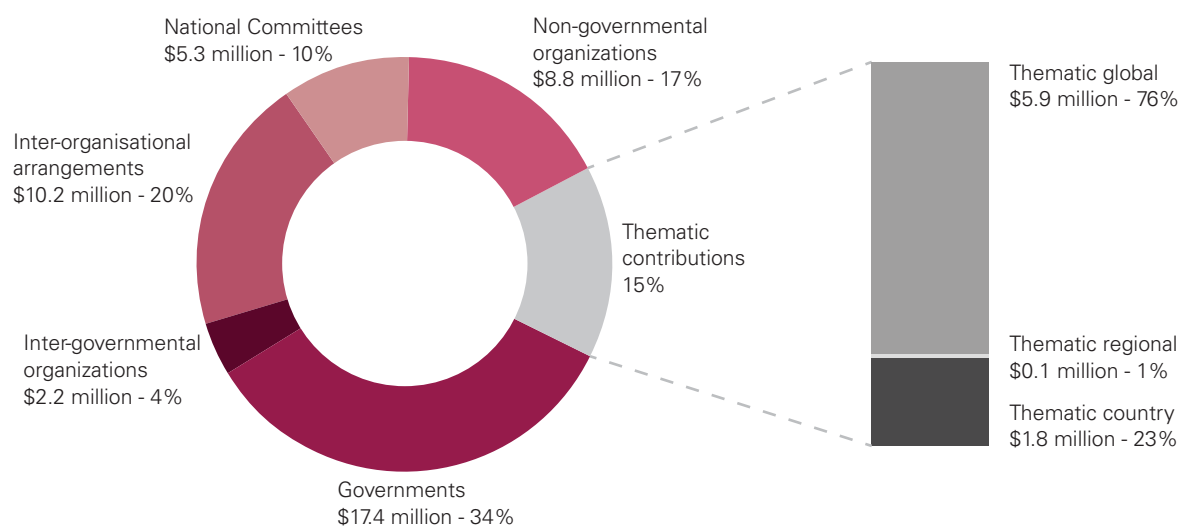


FIGURE 20

Other resources to HIV and AIDS by funding modality and partner group, 2016: US\$52 million*



* Figures include financial adjustments.

Ninety per cent of thematic contributions dedicated to HIV and AIDS came from National Committees, 56.5 per cent most flexibly as global thematic funding from the Korean Committee for UNICEF, followed by an additional 12 per cent from the Dutch Committee for UNICEF (see Table 3).

The majority of the remaining 10 per cent of thematic contributions received for HIV and AIDS came from two

governments: the Government of Sweden earmarked its contribution at the country level in the Plurinational State of Bolivia and Zimbabwe, while the Government of Liechtenstein earmarked its contribution at the regional level for CEE/CIS (see Table 3).

TABLE 3

Thematic revenue to HIV and AIDS by resource partner, 2016*

Resource Partner Type	Resource Partner	Total (US\$)	Percentage
Governments 10%	Sweden (SC1499020018, SC1499020058)	697,494	8.93%
	Liechtenstein (SC1499020055)	98,717	1.26%
National Committees 90%	Korean Committee for UNICEF (SC1499020037, SC1499020046)	4,415,333	56.54%
	Dutch Committee for UNICEF (SC1499020057)	917,428	11.75%
	United Kingdom Committee for UNICEF (SC1499020052)	553,761	7.09%
	Hong Kong Committee for UNICEF (SC1499020033)	469,516	6.01%
	Finnish Committee for UNICEF (SC1499020049, SC1499020059)	343,044	4.39%
	Danish Committee for UNICEF (SC1499020050)	104,966	1.34%
	Andorran National Committee for UNICEF (SC1499020040)	79,618	1.02%
	Norwegian Committee for UNICEF (SC1499020045, SC1499020056)	68,014	0.87%
	United States Fund for UNICEF (SC1499020042)	37,599	0.48%
	Japan Committee for UNICEF (SC1499020043)	23,738	0.30%
Grand Total		7,809,228	100%

* Figures do not include financial adjustments.

Grant numbers are provided for IATI compliance.

Global thematic funds remain the most flexible source of funding to UNICEF after regular resources. The allocation and expenditures of thematic contributions can be monitored on UNICEF's transparency portal, open.unicef.org, and the results achieved with these funds against Executive Board-approved targets and indicators at the

country, regional and global levels are consolidated and reported on across the suite of Annual Results Reports. Specific reporting for country and regional thematic contributions are provided separately for partners providing flexible multi-year thematic funding at those levels.

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



Note: Expenses are higher than the income received because expenses comprise 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 2016 to the same.

Expenses for HIV and AIDS by region are reflective of disease burden, with expenses in West and Central Africa and Eastern and Southern Africa the highest (see Figure 21).

Expenses versus expenditure

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

FIGURE 21
UNICEF expenses for HIV and AIDS by region, 2016

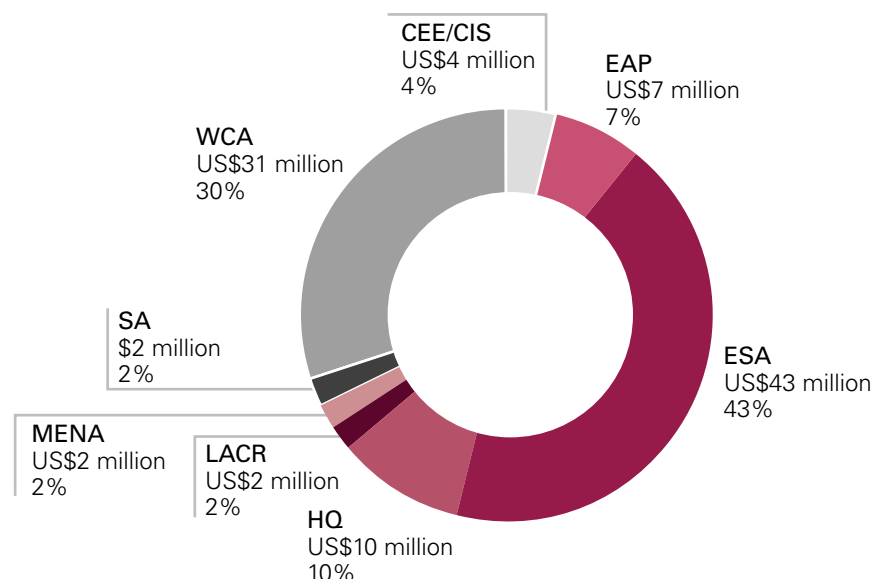
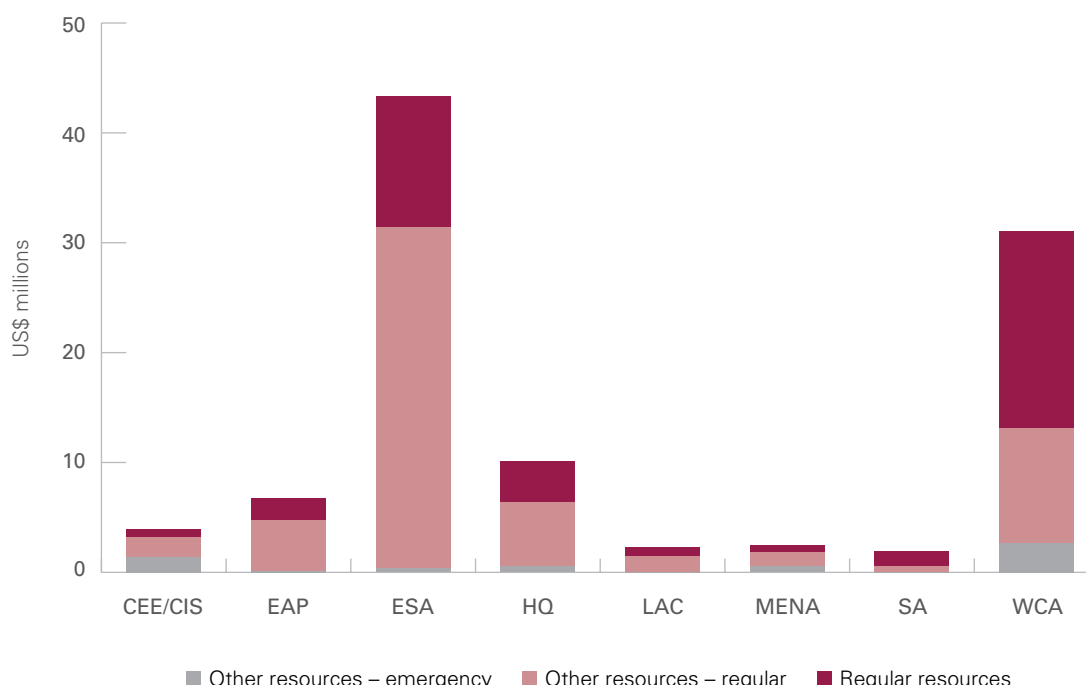


FIGURE 22

Expenses for HIV and AIDS by region and funding source, 2016



In terms of spending on various technical aspects of UNICEF's HIV and AIDS programming, the most was spent on PMTCT. The second-highest expenses were in the area of adolescents, followed by care and treatment (see Figure 23).

Despite impressive gains in the HIV response, as outlined in this report, progress remains uneven. UNICEF must help countries sustain their gains and expand their response. Losing momentum now risks the reversal of hard-won results. As the world transitions to the SDG era, global attention to HIV is diminishing – along with traditional donor funds, including those for UNAIDS. Consequently,

tapping into available funding will require an innovative and creative approach.

Planning and strategies should be guided by new technologies, treatments and approaches that promise improved outcomes for children and for the response more broadly. It is in this context that UNICEF will enter the last phase of the 2014–2017 Strategic Plan.

UNICEF will work closely with its partners to meet these funding needs and fulfil the shared commitments and results called for by the 2030 Agenda.

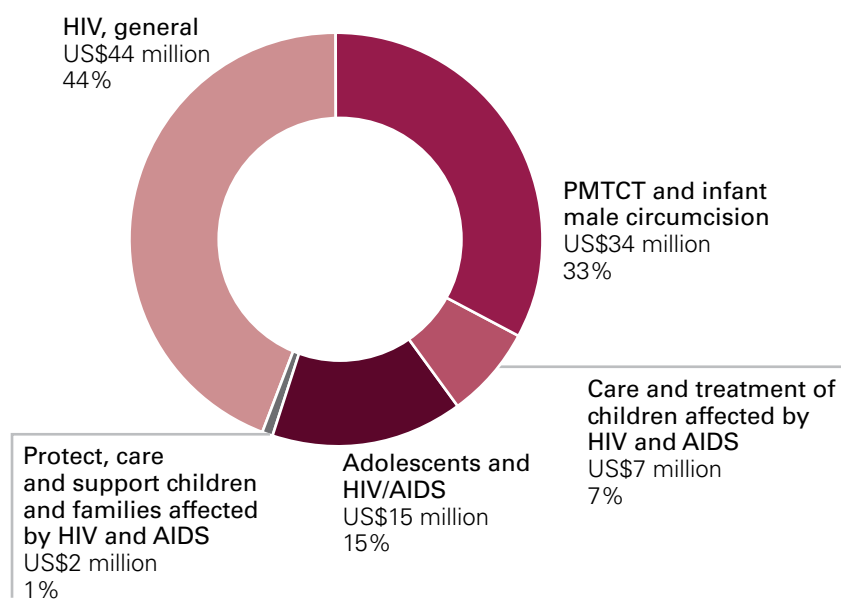


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On 7 June 2016, in Makhewu, Swaziland, UNICEF Goodwill Ambassador David Beckham meets Sebenelle, 14, who receives 7 Fund support as part of the management of malnutrition in HIV-positive children. Beckham travelled to Swaziland to see how 7: The David Beckham UNICEF Fund is helping UNICEF provide life-saving treatment, care and support to HIV-positive children. During his visit, Beckham learned how the worst drought in decades – now taking hold on vast swathes of Eastern and Southern Africa – is threatening to wreak havoc on the lives of children and families already made vulnerable by HIV.

FIGURE 23

Expenses for HIV and AIDS by programme area, 2016



FUTURE WORKPLAN

The global AIDS response is a great success story of the Millennium Development Goals. UNICEF is proud to have been a central partner in actions that saved the lives of millions of children, pregnant women and mothers.

However, even with extraordinary progress, UNICEF unequivocally believes that HIV and AIDS remains a global threat to children and their families. The epidemic acts as a magnifying glass on some of the most complex child rights issues of our time which continue to impact broader development goals. UNICEF must and will play a part in protecting all children affected by HIV and AIDS and securing their right to an AIDS-free generation.

UNICEF's HIV work in 2017 and beyond cannot help but be influenced by the decline in funding levels, and ensuing budget cuts introduced in 2016. Yet through a combination of targeted and leveraged approaches and activities, UNICEF is committed to play an essential role in supporting countries, communities and other partners in navigating an

HIV world facing both great opportunities (e.g. 'treat all') and challenges (e.g. faltering political will and funding resources).

UNICEF will utilize new science and innovations, identify and recognize political courage and leadership, promote learning among community health-care workers and continue to provide insight on the distinct cultural and economic barriers which challenge child health, protection, education and ending AIDS as a public health threat by 2030.

New global health initiatives in the SDG era require that UNICEF reframe an effective way forward for the AIDS response as it pertains to children. UNICEF will build on its multiple maternal and child health, protection and education platforms, and utilize its strong brand and convening power to drive equitable investments (domestic and international) and bring the voices of children and adolescents to decision-making tables around the world.



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The promise of an AIDS-free generation is one that can and must be kept. Innovative and proven strategies will reach the youngest and most vulnerable. Children in Malawi look on, amazed, in the community demonstration of unmanned aerial vehicles, or drones, flying in Lilongwe. The Ministry of Health and UNICEF launched the first 10-kilometre auto programmed flight in a trial to speed up diagnosis of HIV in infants.

Moving forward, UNICEF objectives and targets will be aligned with the new Fast-Track Strategy and the globally agreed benchmarks in the [Start Free, Stay Free, AIDS Free framework](#). UNICEF's two proposed high-level goals are: (1) fast-track the HIV response by 2020 for pregnant women, mothers, children and adolescents; and (2) build resilient government and community systems that will decrease HIV service inequities among pregnant women, mothers, children and adolescents and reduce gender, age and socio-economic HIV-related vulnerabilities. These goals contribute to [SDG 2 \(Health\)](#); [5 \(Gender Equality\)](#); [10 \(Reduced Inequities\)](#); and [17 \(Partnerships for the Goals\)](#).

UNICEF will re-ignite efforts to prevent HIV in adolescents, with a goal of decreasing HIV infections by 75 per cent, while initiating and retaining 2.4 million infants and adolescents living with HIV in life-saving treatment. UNICEF and partners will also strive to 'finish the job' for PMTCT by decreasing mother-to-child transmission of HIV globally to no more than 20,000 annually, and also ensuring that greater than 95 per cent of mothers living with HIV initiate and retain treatment.

UNICEF will achieve these goals by utilizing scientific innovations, capitalizing on the creativity ingenuity of youth to create and bring to scale innovations, and strengthening partnerships to build more resilient and sustainable maternal and children health, protection and education systems. Responding to the diversity in the HIV epidemic, and its social and economic determinants, will continue to be the foundation of UNICEF's HIV programming.

Adolescents

UNICEF will harness resources to target progress for adolescents, the only age group with increasing death rates due to AIDS and signifies high rates of new infections. This will involve continued leadership and commitment to the **ALL IN** partnership, along with improving data systems, promoting HIV prevention for HIV-positive and HIV-negative adolescents, and creating innovative approaches to HIV testing and treatment for adolescents. Increased efforts will focus on HIV self-testing; adherence support to HIV treatment; transition programming for children being transferred to adult care; PrEP; post-exposure prophylaxis, voluntary medical male circumcision and harm reduction; promotion of condoms; and cash transfers and behaviour change interventions that acknowledge the power adolescents have to decrease stigma and discrimination and influence their peers.

UNICEF will seek to increase participation of adolescents, including adolescents living with HIV and adolescents with disabilities, in detailed planning and implementation at country level. Social media and emerging communication innovations will be used to connect broader initiatives that are mobilizing young people to take forward the Sustainable Development Agenda, creating practical spaces for mutual support and learning.

Pregnant women, mothers and infants

Despite the tremendous gains for pregnant women living with HIV in accessing ART and reducing transmission to children, population-based and geographical inequities persist, and impede global efforts to 'get the job done' and eliminate new HIV infections in children. The number of children acquiring HIV during the breastfeeding period is growing disproportionately because of poor retention in antenatal and post-natal care and adherence support. Early infant diagnosis rates remain low and rare outside of PMTCT programmes, preventing children living with HIV from accessing ART. Of these untreated children, 50 per cent will die by the age of 2. Those who do survive will likely not be identified until early adolescence. Providing access to quality and timely PMTCT services to all women, including those who are socially excluded or marginalized due to their drug dependence, undocumented migrant status or ethnicity, is a goal yet unmet.

UNICEF addresses these challenges using integrated platforms in child health (e.g., immunization, community outreach including integrated community case management, substance abuse and nutrition centres), and through decentralized planning that brings together all relevant constituencies to identify and solve problems. UNICEF recognizes that inclusive ways of working, and uniting diverse services and constituents around the needs of children, are as critical as innovations in promoting children's health, development and rights.

Mothers, children and adolescents at risk of HIV in concentrated epidemics

More than half of all estimated new infections in 88 out of 159 countries occur among key populations.⁶² In sub-Saharan Africa, more than 20 per cent of new infections in 2015 were in key populations – men who have sex with men, sex workers and their clients, and people who inject drugs.⁶³ Adolescent key populations remain especially vulnerable because of punitive laws and the inability of many civil society organizations and NGOs to work with children yet to reach the age of majority.

In countries with concentrated epidemics, the risk of HIV in key populations – especially men who have sex with other males, transgender people, people who inject drugs, and adults and children involved in or exploited by the sex industry – is as much as 19 times higher than in the general population.

UNICEF will use its skills, innovative ideas and relationships of trust to stand up for the mothers, children and adolescents who fall between the cracks. These socially marginalized groups need a voice to advocate for and ensure their access to available health and development services; UNICEF is the logical partner to remind government and non-governmental partners of this right. The Know Your Epidemic/Know Your Response model



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Siphive Khumalo, 37, and her baby, Lundiwe. Siphive was already on life-long antiretroviral therapy when she became pregnant with Lundiwe. This is her fifth pregnancy – all of her previous babies died shortly after birth. Siphive suspects they died of AIDS-related illnesses, although at the time, she didn't know her status and never got her babies tested. Lundiwe is a happy and healthy baby, always smiling and very curious. Immediately after birth, Lundiwe tested negative for HIV, to the joy of her mother.

examines all modes of transmission at subnational level and reveals a mosaic of epidemics in all regions and countries. Use of social media and communication innovations which engage and enable key populations to communicate with peers, helpful mentors, officials and other human rights duty bearers will be central to driving results.

In 2017, UNICEF will implement four operational shifts to drive efficiency, effectiveness and equity, including:

1. A differentiated response for country and programme prioritization. UNICEF will apply three differentiated responses across all countries: (a) track and advocate; (b) target; and (c) intensify.

- **Track and advocate** (63, or 50 per cent of, countries): UNICEF country offices will know 'the HIV epidemic and response for children' and advocate with partners to address concerns.
- **Target** (27, or 22 per cent of, countries): UNICEF will recognize the challenges and opportunities presented by variable functioning health, protection and education systems, and programmatically respond with partners to inequities, especially among marginalized groups, in the HIV response which fuel the epidemic's spread; and
- **Intensify** (35, or 28 per cent of, the countries in which UNICEF works): UNICEF will programmatically address issues of scale where epidemiologic evidence indicates the need for improved coverage, access and/or quality HIV services to mount an appropriate public health response and meet global, regional and country goals.

2. Targeted integration with joint results and clear accountabilities. UNICEF's maternal and child health, protection and educational sectors will have clear, funded and monitored indicators to drive HIV efforts, and the HIV-specific programme will demonstrate and document their impacts on child survival, protection and education.

3. Intensified partner leveraging. Currently, nearly 85 per cent of global HIV financial investment is from domestic resources, PEPFAR and the Global Fund. UNICEF will engage these partners at a sufficient senior technical level on behalf of children. People living with and affected by HIV, especially mothers, children and adolescents, will be UNICEF's partners in leveraging resources.

4. Strengthened UNICEF leadership to facilitate ongoing learning through a learning collaborative. UNICEF will promote and support the generation and dissemination of programme evidence and experiences, including new innovations to improve performance and quality as well as to sustain and accelerate the response.

To operationalize these shifts within and outside of UNICEF, the organization will embed, with clear accountabilities, HIV outcomes across all UNICEF country programmes of cooperation with increasing accountabilities outside of the HIV sector. UNICEF will maintain HIV-specific competencies and technical expertise at global and regional levels to compliment county-specific HIV needs and leverage resources and action from key partners. UNICEF country and regional offices will continue to fulfil UNICEF's mandate to monitor and report on the coverage, quality, equity and impact of HIV interventions for mothers, children and adolescents. UNICEF will identify high-value partnerships and innovations to strengthen the response

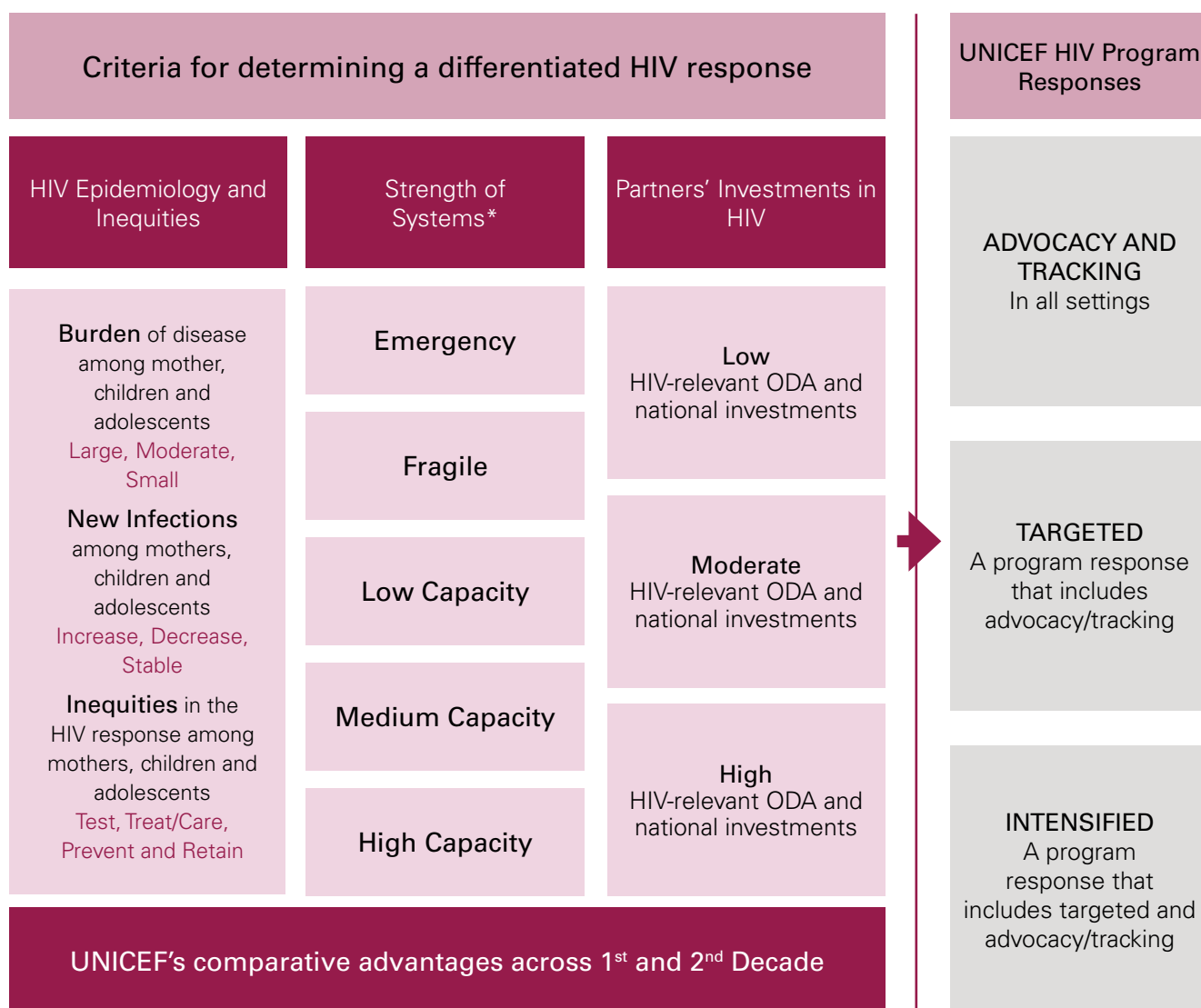
for children, focusing on local responses tailored to the needs of women and children, and it will do so increasingly in new, more selective and efficient ways that emphasize integration with accountability and results.

Despite the immediate effects of the reduction in resources in 2016, UNICEF is committed to addressing resource gaps and will continue to contribute to the HIV response. The Executive Director has undertaken exceptional measures to maintain critical staff capacity at headquarters in 2017.

The Global Management Team met to discuss the future of the Programme Strategy on HIV and AIDS in June 2016 and unanimously agreed that UNICEF would not abandon its responsibilities regarding HIV programming. Both Private Fundraising and Partnerships and the Public Partnerships Division have committed to facilitating fund-raising efforts around HIV programming and exploring new partnerships for innovative work.

FIGURE 24

Differentiated response for country programme prioritization



• UNICEF Health Strategy, 2016-2030



EXPRESSION OF THANKS

UNICEF expresses its deep appreciation to all resource partners who contributed to our work on HIV and AIDS throughout 2016. Thematic funding has allowed UNICEF to provide technical, operational and programming support to countries in all regions for both upstream and decentralized work and deliver quality services to marginalized children, adolescents, mothers and communities. Thematic funding provides greater flexibility, longer-term planning and the sustainability of programmes. It reflects the trust resource partners have in the ability of UNICEF to deliver quality support under all circumstances and has made possible the results described in this report.

We would particularly like to emphasize our gratitude to the following resource partners for their generous contributions to our flagship programmes and innovations:

Conrad N. Hilton Foundation
Global Fund to Fight AIDS, Tuberculosis and Malaria
Government of Canada
Government of the Netherlands
Government of Norway
Government of Sweden
Government of the United States of America
Estée Lauder Companies, MAC AIDS Fund
UNAIDS
UNITAID

ABBREVIATIONS AND ACRONYMS

ART	antiretroviral therapy	LAC	Latin America and the Caribbean
ANC	antenatal care	MENA	Middle East and North Africa
C4D	Communication for Development	MPTF	Multi-Partner Trust Fund
CEE/CIS	Central and Eastern Europe and the Commonwealth of Independent States	NCDs	noncommunicable disease
DRC	Democratic Republic of the Congo	NGO	non-governmental organization
DREAMS	PEPFAR's Partnership to reduce HIV infection in among adolescent girls and young women: Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe women.	PEPFAR	United States President's Emergency Plan for AIDS Relief
EAP	East Asia and the Pacific	PCR	polymerase chain reaction for HIV
ECD	early childhood development	PMTCT	prevention of mother-to-child transmission of HIV
EID	early infant diagnosis	PrEP	pre-exposure prophylaxis
EMTCT	elimination of mother-to-child transmission of HIV	SA	South Asia
ESA	Eastern and Southern Africa	SDG	Sustainable Development Goal
Global Fund	The Global Fund to fight AIDS, Tuberculosis and Malaria	SMS	Short Message Service
Global Plan	Global Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping Their Mothers Alive	UNDP	United Nations Development Programme
HBV	Hepatitis B	UNFPA	United Nations Population Fund
IPSAS	International Public Sector Accounting Standards	UNAIDS	Joint United Nations Programme on HIV/AIDS
		USAID	United States Agency for International Development
		WCA	West and Central Africa
		WASH	Water, Sanitation and Hygiene
		WHO	World Health Organization

ENDNOTES

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ANNEX: DATA COMPANION

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 & AIDS

Average achievement rate:

71% 

Impact Indicator	Baseline*	2017 Target	2016 Update**
2a. Number of new HIV infections among children under 15 years (2011 Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS (General Assembly resolution 65/277, annex)	230,000 (2012)***	93,000	150,000 (2015)

2b. Percentage of children under 15 years living with HIV receiving antiretroviral therapy	31% (2012)***	50%	49% (2014)
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Outcome Indicator	Baseline*	2017 Target	2016 Update**
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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: 6 out of 38 UNAIDS High Impact countries (2015) 10-19 years old: data not available (2015)
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P2.2 Countries providing at least 80% coverage of lifelong ART for all pregnant women living with HIV	0 (2012)***	9 Global Plan for EMTCT priority countries	11 out of 22 Global Plan for EMTCT priority countries (2015)
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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)
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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 19 UNAIDS priority countries with data (2009-2016) Female: 1 out of 19 UNAIDS priority countries with data (2009-2016)
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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

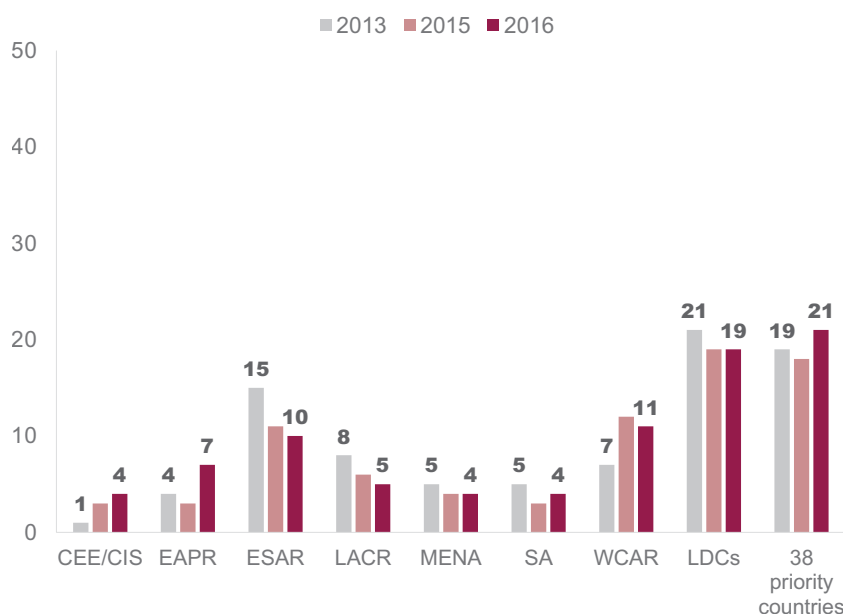
Average output achievement

35%

P2.a.1

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

2013 Baseline	19
2014 Result	10
2015 Result	18
2016 Result	21
2016 Milestone	30
2017 Target	38

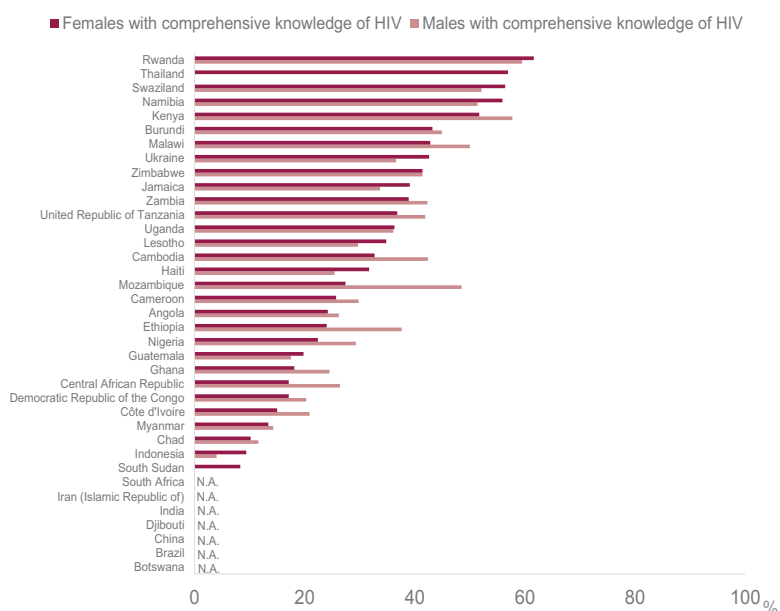


Achievement 70%

P2.a.2

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

2013 Baseline	0
2014 Result	0
2015 Result	0
2016 Result	0
2016 Milestone	3
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

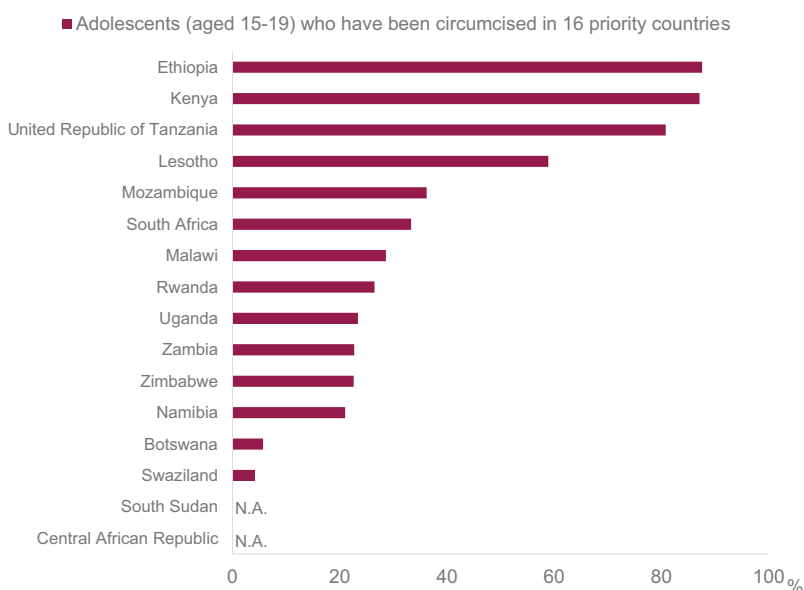
69%

P2.b.1

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

2013 Baseline	0
2014 Result	0
2015 Result	0
2016 Result	0
2016 Milestone	9
2017 Target	16

Achievement 0%

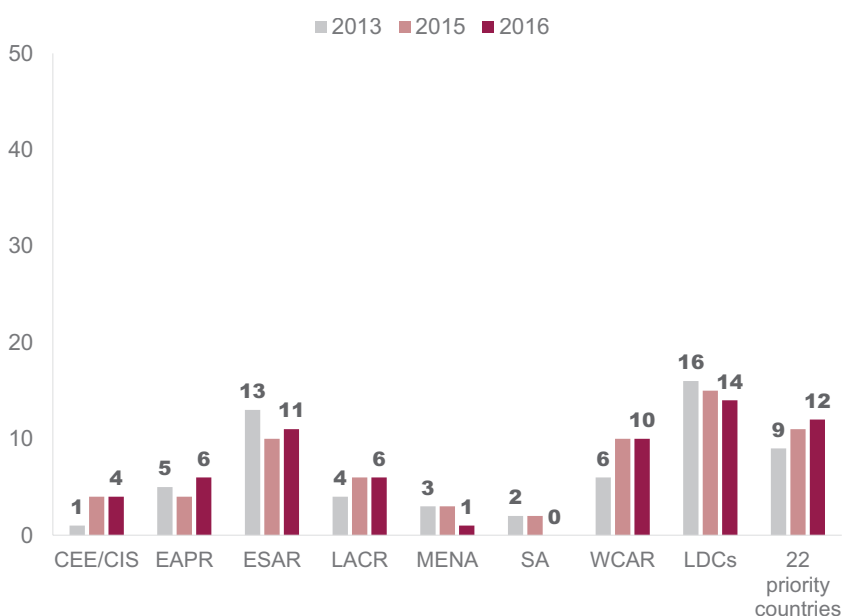


P2.b.2

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

2013 Baseline	9
2014 Result	8
2015 Result	11
2016 Result	12
2016 Milestone	17
2017 Target	22

Achievement 71%

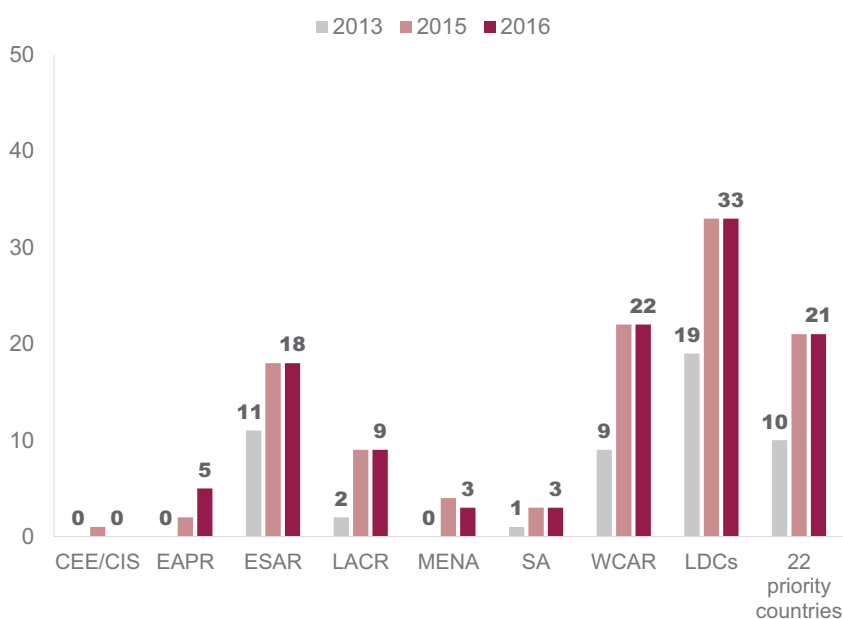


P2.b.3

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

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

Achievement 100%

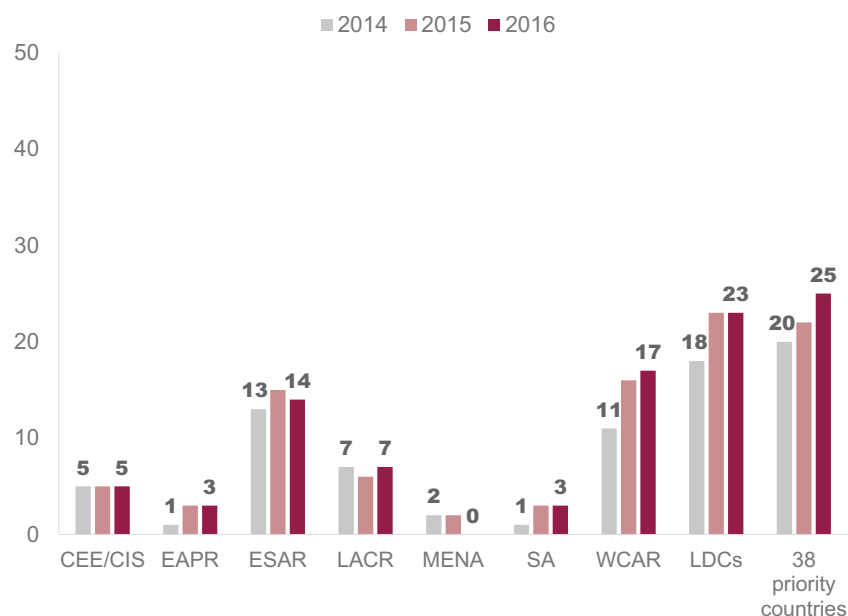


P2.b.4

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

2014 Baseline	20
2015 Result	22
2016 Result	25
2016 Milestone	32
2017 Target	38

Achievement 78%

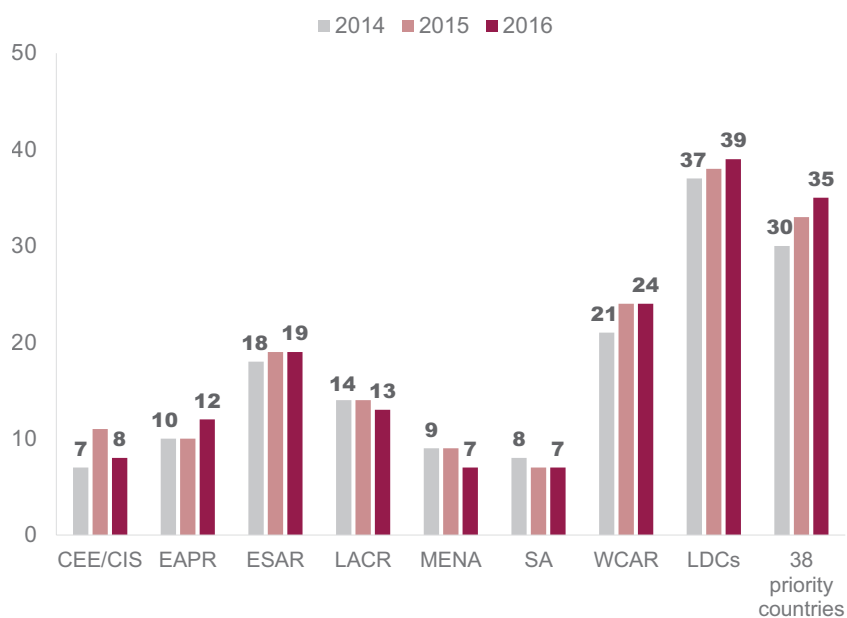


P2.b.5

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

2014 Baseline	30
2015 Result	33
2016 Result	35
2016 Milestone	36
2017 Target	38

Achievement 97%

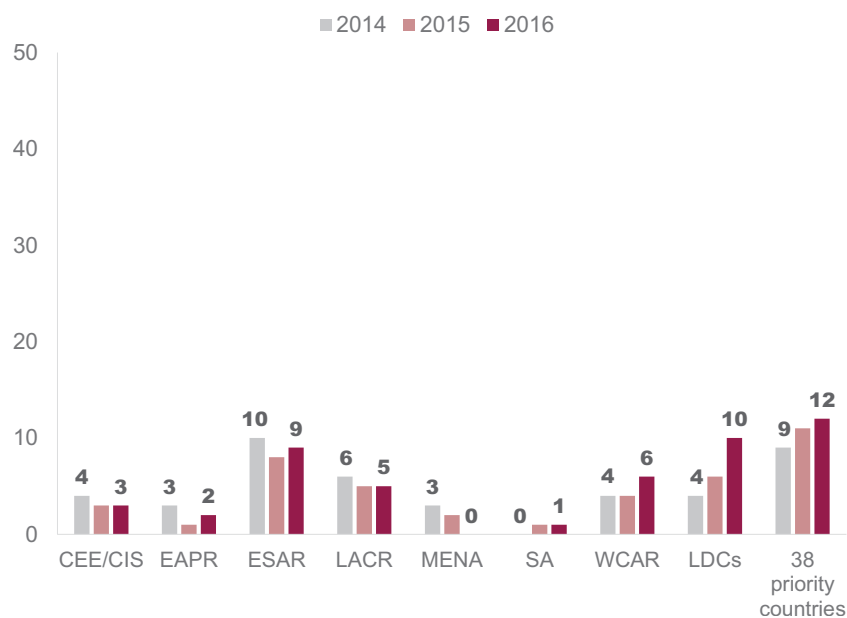


P2.b.6

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

2014 Baseline	9
2015 Result	11
2016 Result	12
2016 Milestone	17
2017 Target	22

Achievement 71%



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

87%

P2.c.1

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

2013 Baseline	18
2014 Result	24
2015 Result	23
2016 Result	23
2016 Milestone	33
2017 Target	38

Achievement 70%

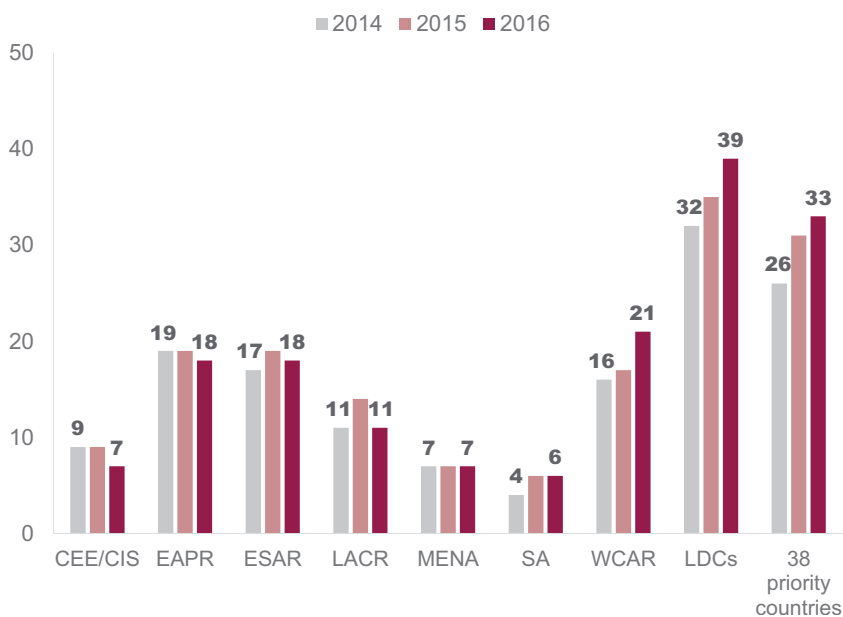
Disaggregated data available		Disaggregated data not available
Burundi	Lesotho	Angola
Cambodia	Malawi	Botswana
Cameroon	Mozambique	Brazil
Central African Republic	Namibia	China
Chad	Nigeria	Djibouti
Côte d'Ivoire	Rwanda	Guatemala
Democratic Republic of the Congo	Swaziland	India
Ethiopia	Uganda	Indonesia
Ghana	Ukraine	Iran (Islamic Republic of)
Haiti	United Republic of Tanzania	Jamaica
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
2016 Result	33
2016 Milestone	34
2017 Target	38

Achievement 97%

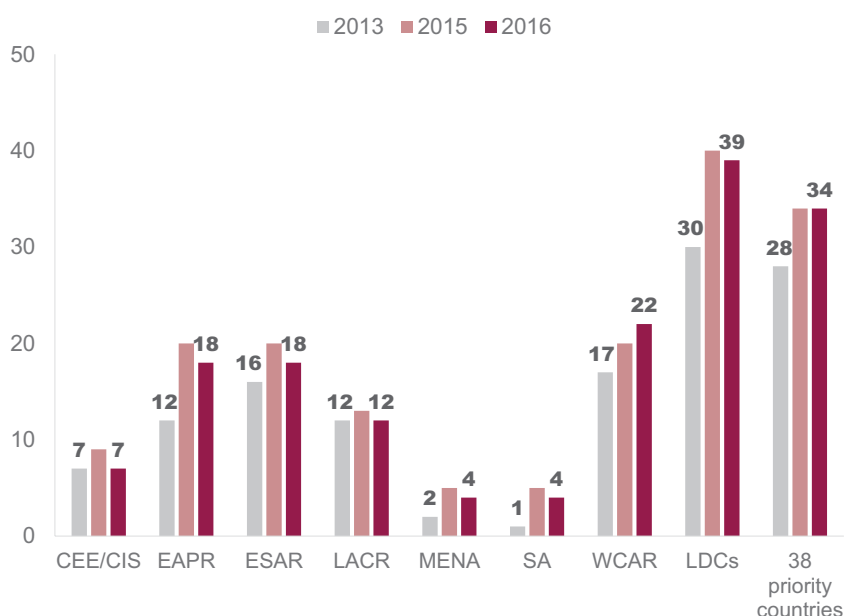


P2.c.3

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

2013 Baseline	28
2014 Result	32
2015 Result	34
2016 Result	34
2016 Milestone	36
2017 Target	38

Achievement 94%

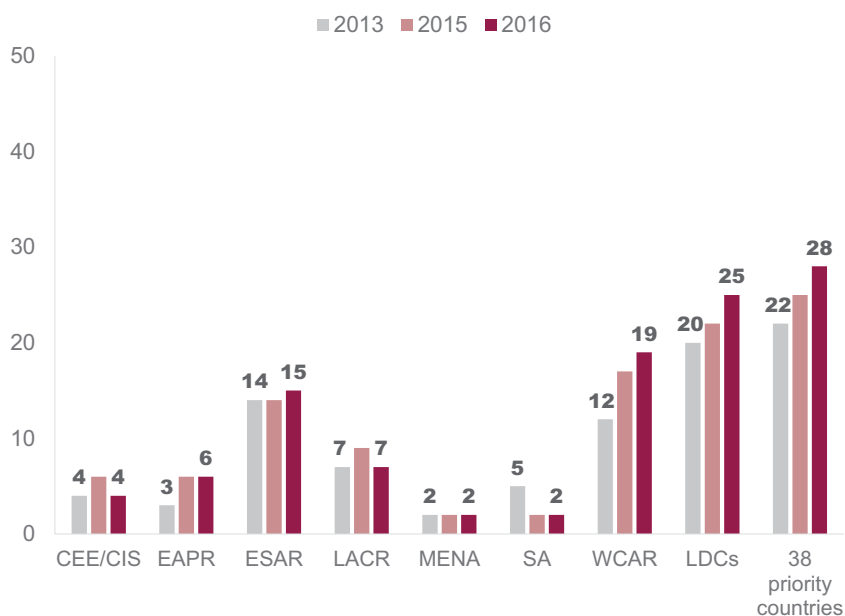


P2.c.4

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

2013 Baseline	22
2014 Result	23
2015 Result	25
2016 Result	28
2016 Milestone	33
2017 Target	38

Achievement 85%



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

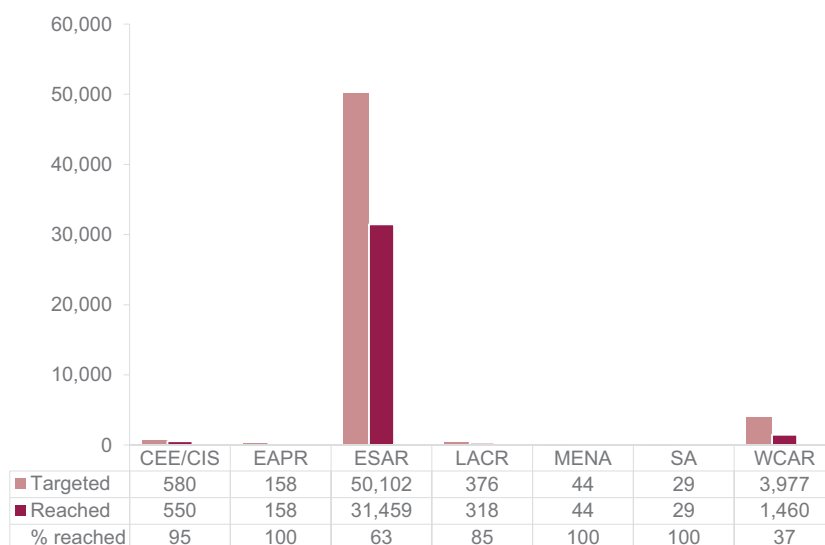
65%

P2.d.1

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

2014 Baseline	54%
2015 Result	59%
2016 Result	62%
2016 Milestone	70%
2017 Target	80%

Achievement 88%

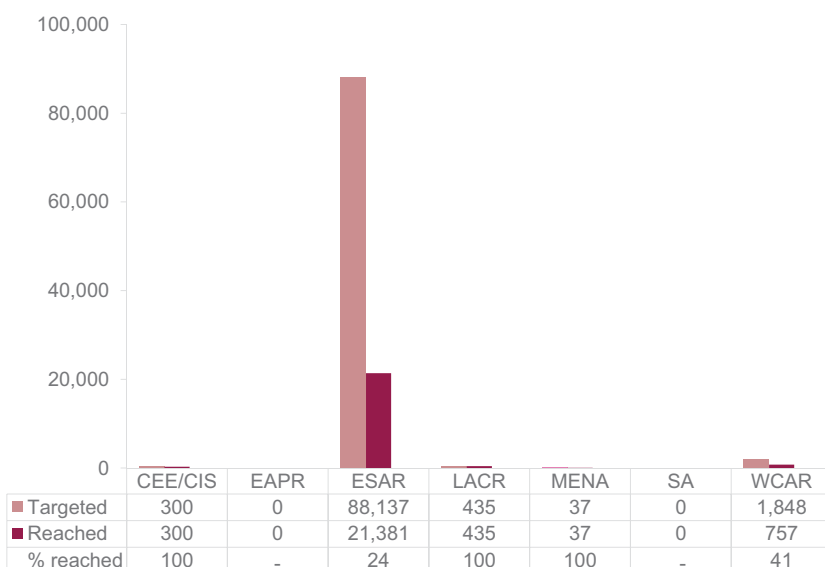


P2.d.2

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

2014 Baseline	34%
2015 Result	20%
2016 Result	25%
2016 Milestone	60%
2017 Target	80%

Achievement 42%



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

52%

P2.e.1

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

2013 Baseline	18
2015 Result	17
2016 Result	17
2016 Milestone	30
2017 Target	38

Achievement 57%

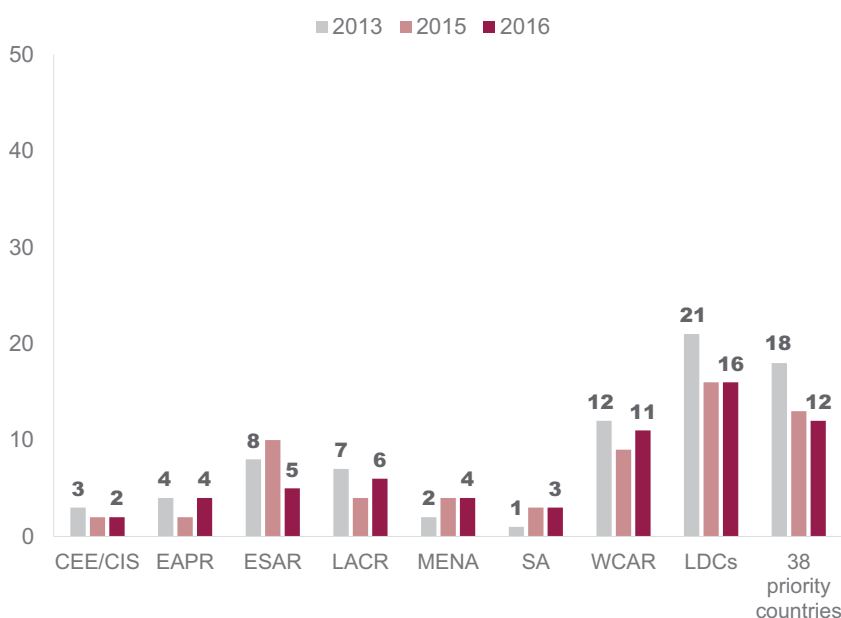
Data available		Data not available	
Burundi	Kenya	Angola	Iran (Islamic Republic of)
Cameroon	Malawi	Botswana	Jamaica
Central African Republic	Namibia	Brazil	Lesotho
Côte d'Ivoire	Rwanda	Cambodia	Mozambique
Democratic Republic of the Congo	South Africa	Chad	Myanmar
Ethiopia	Uganda	China	Nigeria
Ghana	United Republic of Tanzania	Djibouti	South Sudan
Haiti	Zambia	Guatemala	Swaziland
	Zimbabwe	India	Thailand
		Indonesia	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
2016 Result	12
2016 Milestone	25
2017 Target	38

Achievement 48%



Output f

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

Average output achievement

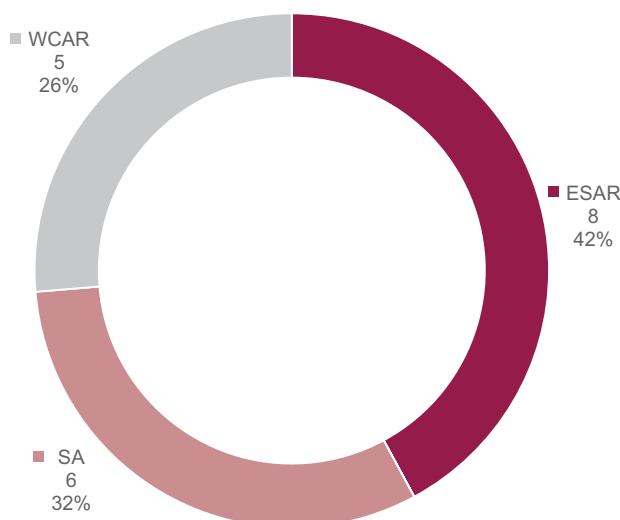
108% ●

P2.f.1

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

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

Achievement 100% ●



P2.f.2

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

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

Achievement 117% ●

Global partnerships and initiatives

- *ALL IN* to #EndAdolescentAIDS initiative
- Inter-Agency Task Team on HIV Prevention and Young People
- Inter-Agency Task Team on the Prevention and Treatment of HIV Infection in Pregnant Women, Mothers and Children
- Optimizing HIV Treatment Access for Pregnant and Breastfeeding Women Initiative
- Promoting access and shaping markets to point-of-care HIV diagnostics (early infant diagnosis and viral load)
- Social Protection, Care and Support Working Group
- Start Free, Stay Free, AIDS Free – A super-fast-track framework for ending AIDS among children, adolescents and young women by 2020



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