Agenda item 9

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BACKGROUND NOTE

Addressing inequalities in children and adolescents to end AIDS by 2030

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Executive summary

1. This is a moment of opportunity. The widespread availability of safe HIV treatment options for mothers living with HIV has resulted in a dramatic reduction in new HIV infections and AIDS-related deaths among children and adolescents since 2010. We now have a highly effective dolutegravir-based antiretroviral regimen to treat HIV in children that is affordable, well-tolerated and increasingly available among low- and middle-income countries. New testing technologies and strategies have advanced for early infant diagnosis and testing of children. Long-acting injectable antiretrovirals offer potential for improved retention in care once they become more widely available. In addition, data that are being gathered for children in different age groups are showing where the remaining challenges are.[1]

2. However, this progress has stalled in recent years. We are not on track to meet the goal of ending AIDS in children by 2030. Children and adolescents lag behind adults and the inequalities are widening. Many of the affected children face economic disadvantages and marginalization.

3. Although children (0–14 years old) accounted for an estimated 3% of all people living with HIV in 2023, they represented at least 12% of all estimated AIDS-related deaths. Almost 600 000 children living with HIV were not on treatment. In low- and middle-income countries, one of the biggest gaps is the identification of older children living with HIV and linking them to treatment: most of the surviving children living with HIV and *not* on treatment are over five years of age. [2]

4. Globally, about 77% people aged 15 or older and living with HIV were on life-saving antiretroviral therapy in 2023, compared with 57% of children (0–14 years). While 73% of people aged 15 or older living with HIV had achieved viral load suppression, only 48% of children had done so.[3] A lack of more detailed, age-disaggregated data is also detracting from a more complete understanding of the situations of different age groups of children and adolescents living with HIV.

5. Many of the adolescents and young adults living with HIV currently acquired HIV in infancy; in the next decade, many children living with HIV will transition into adolescence and adulthood. Adolescents face specific adherence challenges. Since data collection among people living with HIV does not routinely distinguish between horizontal and vertical HIV transmission, not enough is known about the long-term outcomes among people with perinatally acquired HIV infection compared with those who acquired HIV later in life. However, available research indicates that AIDS-related mortality rates are higher among adolescents who acquired HIV horizontally than among those who acquired it through vertical transmission.[4]

6. Adolescents aged 15–19 years account for 12% of new infections among all people older than 15 years of age. In sub-Saharan Africa in 2023, almost six times as many adolescent girls were newly infected with HIV than adolescent boys (aged 15–19 years). Gender, age and economic inequalities, unequal power dynamics, and intimate partner violence are some of the factors contributing to higher HIV infection rates among girls. In some other regions however, boys tend to be at greater risk of HIV infection. This reflects differences in the patterns and dynamics of the AIDS epidemic, which outside sub-Saharan Africa tends to put key populations and their sex partners at greatest risk.[5] In Asia and Pacific, for example, key populations and the sex partners accounted for an estimated 99% of new infections among young people (aged 15–24 years). Stigma, exclusion and hostile laws and policies render them more vulnerable.[6]

7. There are still serious gaps in the prevention of vertical transmission of HIV. Many pregnant and breast-feeding women living with HIV are not receiving antiretroviral therapy or not receiving sufficient adherence support. HIV is still being acquired during pregnancy and breast-feeding. Early infant diagnosis and prevention of vertical transmission are particularly lacking in low-prevalence settings where vertical transmission rates are higher.[7] In western and central Africa, a big gap remains in the prevention of vertical transmission and early infant diagnosis: in 2022, about one in five HIV-exposed infants acquired HIV.[8]

8. We know how to prevent and treat HIV in children, but we are not on track to meet the AIDS 2025 targets for children, nor the goal of ending AIDS in children by 2030. Health systems are not adequately responsive to children's needs, the structural inequalities that put them at risk are not adequately addressed, and leaders have not risen to the challenge.

9. Health workers have made enormous contributions to the HIV response and saved many lives. However, health systems are not always children- or youth-friendly, nor are they adequately integrated or adapted to the needs of pregnant and breast-feeding women and of children and adolescents. The transition to adult care for adolescents is not adequately coordinated and supported. Reproductive coercion and discrimination continue against people living with HIV and key populations. Fears among members of key populations that authorities might remove their children from their care are also a barrier to access.[9]

10. Structural inequalities fuel the spread of HIV and worsen the impacts of the epidemic. Poverty, stigma, discrimination and gender-based violence increase the likelihood of acquiring HIV and create obstacles to care—especially for women, girls and key populations and their children. The criminalization of key populations increases the HIV risk and laws requiring parental consent for adolescents to access HIV testing and treatment make it more difficult for adolescents living with HIV to discover their HIV status and receive HIV treatment. The recent surge of anti-rights, -gender and -democracy policies is intensifying inequalities.[10]

11. Gender-based violence increases HIV risk by limiting people's abilities to maintain healthy sexual relationships, refuse unwanted sex or negotiate condom use. It also deters people from seeking or accessing support and help.[11] Intimate partner violence is also tied to higher rates of vertical transmission of HIV, particularly among girls aged 15–19 years, who face high burdens of violence. Recent modelling in 46 African countries found that one in eight cases of vertical transmission could be attributable to intimate partner violence.[12]

12. Public debt is a major obstacle in sub-Saharan Africa and is among the reasons for underfunded HIV and other health programmes.[13] There is a funding gap of US$ 1 billion in low- and middle-income countries for the HIV response for children and adolescents. The largest funding gaps are for testing and treating older children, social and economic support, and programmes for the children of key populations.[14]

13. To accelerate and bring the HIV response to the fore to scale, the following actions are recommended:

    a. **Diagnose and provide treatment to children living with HIV.** Identify untreated children living with HIV and provide them with treatment. Efforts must include older children and children who are not in regular contact with health systems. This requires investing in community-based testing, early infant diagnosis, self-testing,

point-of-care testing, index testing for children and adolescents, and provider-initiated HIV testing in locations where sick children seek care, especially in high-burden settings.

b. **Providing integrated, decentralized, tailored, holistic and respectful health services for pregnant and breast-feeding women, children and adolescents.** Investment should include HIV primary prevention packages and differentiated models for linking pregnant and breast-feeding women, children, adolescents and young people to testing, treatment and care, and supporting them to stay in care. People of all ages, whether from general or key populations, should be treated with kindness and respect and be given nonjudgemental and accurate information on the full range of options available.

c. **Supporting communities to lead**. This includes organizations of adolescent girls and young women, key populations, people living with HIV, and other affected groups. Strengthen their representation at all levels where financing and programming decisions are made—from local governments to international donors. Remove legal and structural barriers that prevent nongovernmental organizations from serving and advocating for children and adolescents affected by HIV, including key population organizations. Directly support nongovernmental organizations with core, flexible funding that is predictable, long-term and disbursed at the start of each grant cycle. Ally with community organizations at local, national, regional and international levels to address gender-based violence and other structural factors that increase the vulnerability of children and adolescents to HIV, particularly young key populations, children of key populations and adolescent girls.

d. **Increasing targeted investment.** Domestic governments should increase resources allocated to children and adolescents affected by HIV to enable a more sustainable, stable and planned response that is not reliant on donor cycles. The IMF, World Bank and private lenders should alleviate the debt burdens of low-income countries to facilitate such resourcing. International donors must continue their support.

e. **Understand the HIV epidemic among children, adolescents and pregnant people.** Strengthen health information systems to collect cohort data that tracks mother-baby pairs and children living with HIV and use those data to improve programmes. Collect and report data that are disaggregated by gender and 5–year age ranges and that note high-risk groups such as the children of key populations and adolescent parents. Strengthen data on HIV prevalence in pregnant people and treatment retention among pregnant and breast-feeding women so “stacked bar” analyses can identify the causes of new HIV infections among infants. Use the data to guide effective and sustainable programme design and drive funding to where it is most needed.

Introduction

14. This is a moment of opportunity. The widespread availability of safe treatment options for mothers living with HIV has resulted in a dramatic reduction in new HIV infections and AIDS-related deaths among children and adolescents since 2010. We now have a highly effective dolutegravir-based antiretroviral (ARV) regimen to treat HIV in children that is affordable, well-tolerated and increasingly available in low- and middle-income countries. As of July 2024, 86 countries had adopted these new regimens, up from 35 in 2020.[15]

15. New HIV testing technologies and strategies are being used, including point-of-care tests for early infant diagnosis and community testing among the children of index

cases. When linked to rapid treatment initiation, these strategies have been shown to be highly impactful in low-resource settings.[16] Long-acting injectable ARVs offer potential for improved retention in care once they become more widely available. More age-disaggregated data are being gathered to determine the remaining challenges.

16. However, progress has been neither rapid enough nor equitable between and within countries. We are not on-track to meet the goal of ending AIDS in children by 2030. Children and adolescents lag behind adults and the inequalities are widening. Many of the affected children face economic disadvantage and marginalization, notably adolescent girls, and children of adolescent mothers and key populations. We know how to prevent and treat HIV in children, but health systems are not responsive enough to their needs, the structural inequalities they face are not adequately addressed, and leaders have not risen to the challenge.

17. If sufficient investments are made now, this would reduce the resources needed in the future. If older children living with HIV can be identified, if early infant diagnosis can be effectively implemented for all HIV-exposed infants, and if sustained coverage of effective prevention of vertical transmission can be achieved, the need for intensive case-finding will reduce. If vertical transmission is eliminated, resources required to treat and care for children with HIV will decrease. Political momentum is being generated by the Global Alliance to end AIDS in children,[17] the approaching deadline for the 2025 HIV targets for children, and wide acknowledgement that health systems must be fit for purpose as part of pandemic preparedness and response. Now is the time to invest to end AIDS in children by 2030.[18]

18. This background note will address three main questions:

    - What are the inequalities, gaps and barriers to access for children and adolescents?
    - What works to close the gaps at national, regional and global levels and accelerate progress to meet the 2030 targets?
    - How do we support countries to bring these interventions to the fore and to scale them for maximum impact?

19. The Global Alliance to end AIDS in children by 2030 has been working hard on these matters since its launch in 2022. It builds on previous collaborations such as the Global Plan, “Three Frees” and the “Double Dividend” to engage national programme managers, policy-makers, donors and international implementing partners in the HIV response for children and adolescents.[19] The Global Alliance currently focuses on 12 countries: Angola, Cameroon, Côte d’Ivoire, Democratic Republic of Congo, Kenya, Mozambique, Nigeria, South Africa, United Republic of Tanzania, Uganda, Zambia Zimbabwe.[20] Together these countries account for approximately 66% of new HIV infections and 64% of AIDS-related deaths among children. This background note builds on those initiatives and draws on the lessons learned.

Epidemiology and global health context

20. “Paediatrics” is a broad term that encompasses a complex range of life stages, each with its own unique characteristics, needs and potentials. Some of the assumptions regarding children with HIV that prevailed early in the AIDS epidemic have been revisited. For example, it was often assumed that children living with HIV had acquired HIV perinatally and that adolescents and young people with HIV had acquired it through unprotected sex. However, due to the success of widely available antiretroviral therapy (ART), increasing numbers of children who acquired HIV through vertical

transmission are living to adolescence and adulthood. It is also now clear that many paediatric ART patients struggle to remain in lifelong care. There is increasing awareness also about people living with HIV who disengage and then re-engage in care, though a clearer understanding of this phenomenon requires tracking the treatment and care histories of individual patients over time.

21. Different agencies collect and categorize age-related data for children and adolescents in different ways. UNICEF and WHO usually disaggregate the data into two groups (0–9-year-olds and 10–19-year-old adolescents), while UNAIDS disaggregates the data into three groups (under 15 years, 15–19-year–old adolescents, and young people aged 15–24 years). The standard UN definition of children is anyone under 18 years of age, while for epidemiological purposes, UNAIDS refers to children as those aged 0-14 years, and adults as anyone age 15 and up.[21]This background note uses the agreed definitions shown in the box below and it specifies the age range that is being discussed. At times, it uses overlapping age ranges to provide a comprehensive picture.

Age ranges

Newborn/neonate: younger than 4 weeks
Infant: younger than 12 months (including newborns)
Adolescents: 10–19 years
Younger adolescents: 10–14 years
Older adolescents: 15–19 years
Young people: 15–24 years

22. **Children aged 0–14 years**. Without effective interventions, the rate of vertical transmission of HIV to children during the perinatal and breast-feeding period ranges from 14% to 48%. Over half of babies with perinatally acquired HIV, if untreated, are expected to die before they are two years old. However, since 2010, new HIV infections among children (aged 0–14) have declined by 62%. Fewer new HIV infections in women and wider access to ART for pregnant and breast-feeding women living with HIV have been the main factors driving the decrease in vertical transmission of HIV.[22]

23. Progress has stalled in recent years, however. Approximately 120 000 children aged 0–14 years acquired HIV in 2023, over 80% of whom were in sub-Saharan Africa. Over one quarter of all children living with HIV globally are in western and central Africa and almost 4 in every 10 new infections in children occur there.[23] About one in five HIV-exposed infants in that region acquired HIV in 2022 and there is a major gap in early infant diagnosis.[24]

Figure 1. Estimated annual number of children aged 0–14 years acquiring HIV, by region, 2010–2023

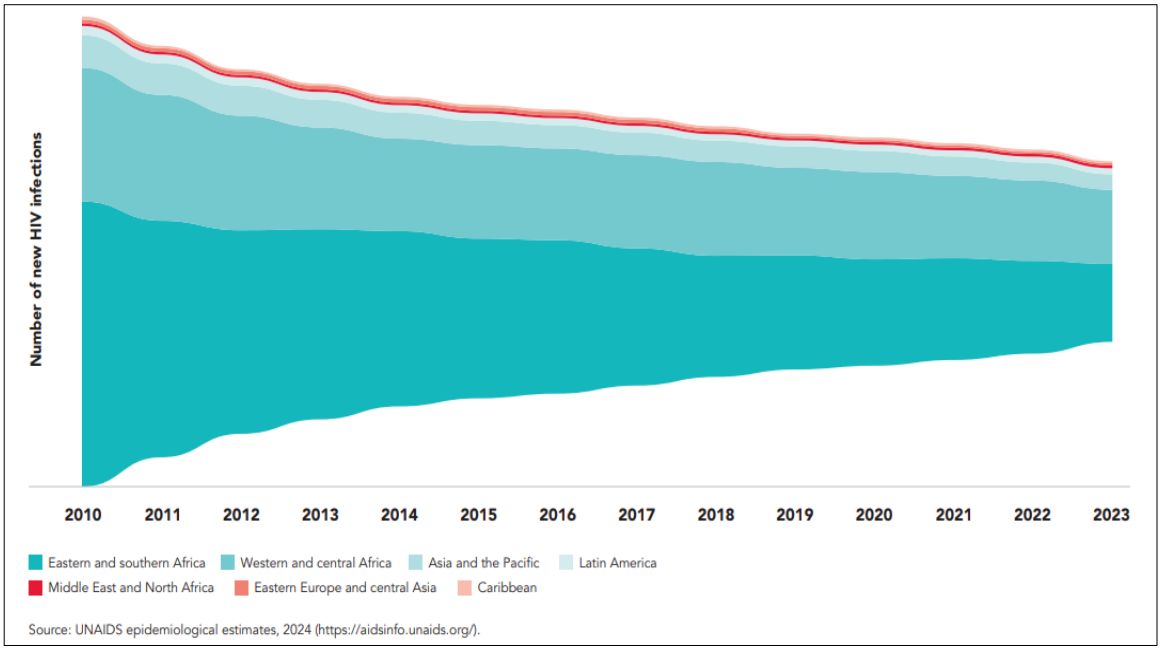
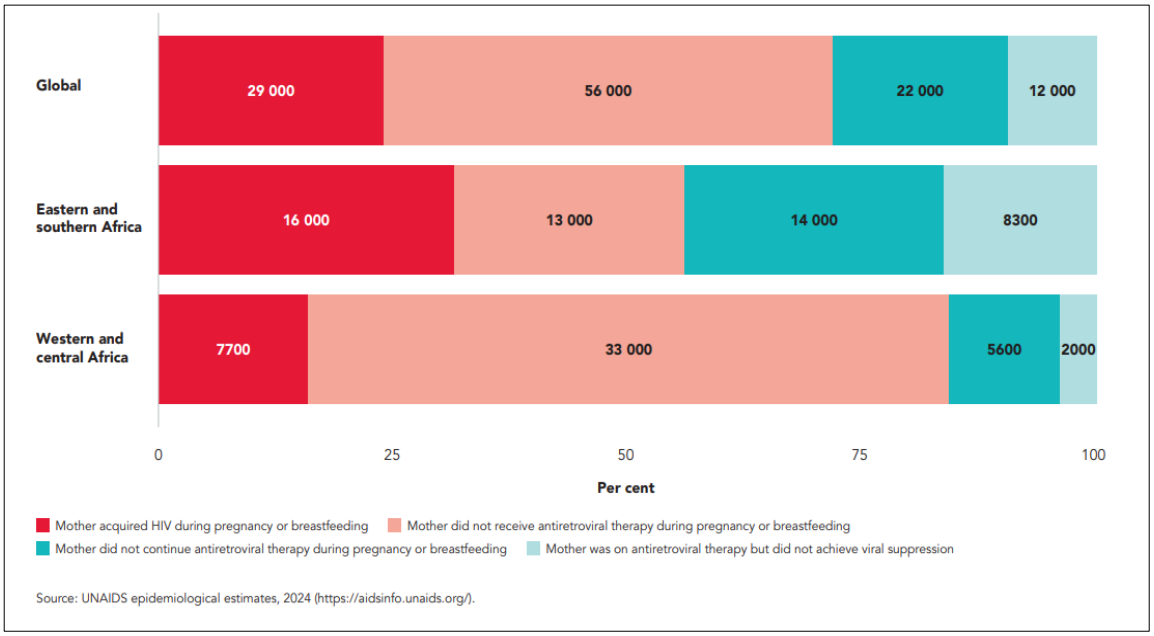


Figure 2. Estimated numbers and percentages of new vertical HIV infections by cause of transmission, global and selected regions, 2023



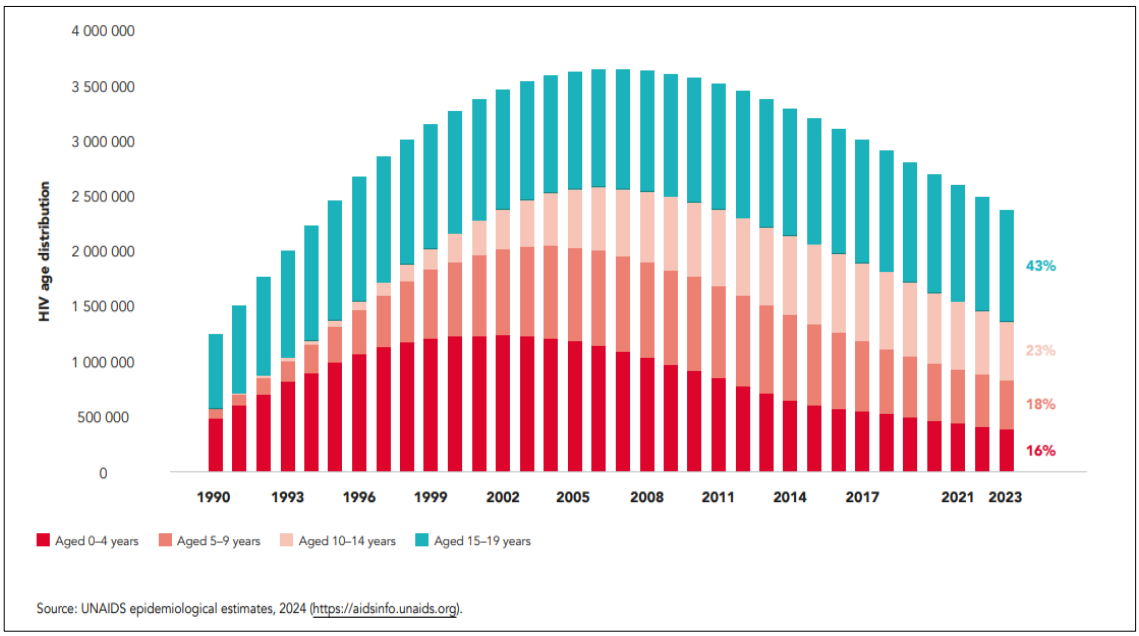
24. Globally, although children (0–14 years old) accounted for an estimated 3% of all people living with HIV in 2023, they represented at least 12% of all estimated AIDS-related deaths. Many children living with HIV continue to be left behind and disparities in life-saving treatment coverage and outcomes between adults and children have increased over time.[25] In 2023, HIV treatment coverage was significantly higher among people aged 15 and older (77%) than among children aged 0–14 (57%). Whereas 73% of people over age 15living with HIV had achieved viral load suppression, only 48% of under 15–year-olds had done so. Due to a lack of age-disaggregated data, not enough

is known about the situations of different age groups within these populations of children living with HIV.

25. **Adolescents aged 15–19 years.** HIV incidence has fallen in many of the most severely affected countries due to safer sexual behaviours among adolescents and young people and the fact that more young people living with HIV are accessing and remaining on treatment to lower their viral loads. In 2023, about one million adolescents (15–19 years) worldwide were living with HIV. Many of the adolescents and young adults living with HIV today acquired HIV in infancy and large numbers of children living with HIV are expected to transition into adolescence and adulthood in the next decade. About 83% of adolescents (15–19 years) living with HIV are in sub-Saharan Africa. Outside sub-Saharan Africa, the largest numbers of adolescents living with HIV (aged 15–19) are in Asia and in Latin America. Globally in 2023 there were an estimated 1.9 million adolescent girls and young women (15–24 years) living with HIV, compared with 1.2 million adolescent boys and young men.[26]

26. Adolescents (15–19 years) account for a growing share of people living with HIV worldwide, about 3% of all people living with HIV and about 12% of new HIV infections in people older than 15 years.[27] In sub-Saharan Africa in 2023, almost six times as many adolescent girls were newly infected with HIV than adolescent boys. Generally in eastern and southern Africa, western and central Africa, eastern Europe and central Asia, and the Middle East and North Africa, more girls than boys acquire HIV during adolescence. In East Asia and the Pacific, South Asia, and Latin America and the Caribbean, the reverse holds. This reflects differences in the dynamics and patterns of HIV epidemics.[28] In 2020, in Asia and Pacific, an estimated 99% of new infections were among young people aged 15–24 were among members of key populations and their sex partners.[29] In Latin America, the epidemic is also concentrated in key populations, particularly among transgender people and gay men and other men who have sex with men.[30]

Figure 3. Estimated global number of children (aged 0–19 years) living with HIV, by five-year age group, 1990–2023



27. The number of children under 5 living with HIV has decreased due to successful programmes to prevent vertical transmission. At the same time, the rising numbers and

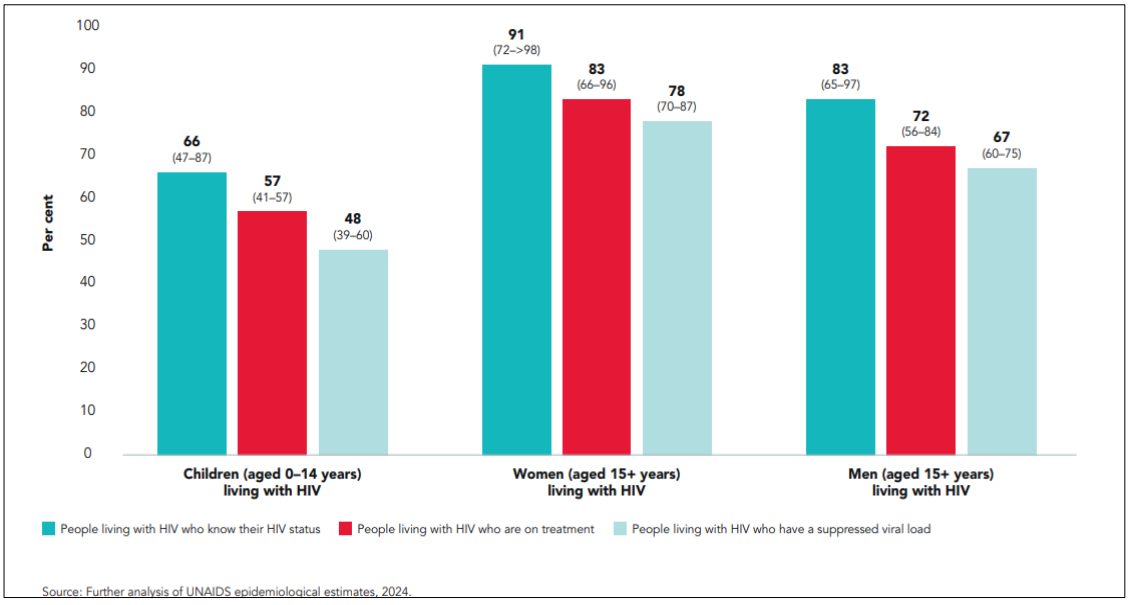
growing proportions of 5–9-year-olds and 10–14-year-olds living with HIV reflect higher survival rates of children who acquired HIV through vertical transmission and who receive and continue to take ARVs. Similarly, the number of older adolescents with HIV reflects the fact that children acquiring HIV through vertical transmission now tend to live longer, though some may have acquired HIV during unprotected sex. HIV monitoring in the adult population does not routinely distinguish between people who acquired HIV through vertical transmission and those who acquired it during sex or through sharing contaminated injecting equipment, which makes it difficult to distinguish between long-term outcomes in people with perinatally acquired HIV and those who acquired HIV later in life. However, the available research indicates that mortality rates are higher among adolescents who acquired HIV "horizontally" than those who did so through vertical transmission.[31]

Progress towards global targets

28. The 2025 HIV prevention targets emerged from the 2021 Political Declaration on HIV and AIDS, which the United Nations General Assembly adopted in June 2021. They are underpinned by the Global AIDS Strategy (2021–2026), which sets out the principles, approaches, priority action areas and programmatic targets for the global HIV response. The 95–95–95 targets require that 95% of people living with HIV know their status, 95% of people who know their status are ART, and 95% of people on ART have suppressed viral loads.[32]

29. **Children aged 0–14 years**. The gap between the current situation and achieving the 2025 targets is greater for children than for people aged 15 years and older. Almost 600 000 children living with HIV were not on treatment in 2023 and only 48% of children living with HIV were achieving suppressed viral loads (the 2025 target is 75%).[33]

Figure 4. Testing and treatment cascade among children, women, and men, global 2023



30. **Adolescents 10–19 years**. In regions with available data, HIV testing coverage remains below 25% for adolescents aged 15–19 years. Many adolescents and young people living with HIV therefore do not know their HIV status; adolescent boys are

consistently less likely to have been tested for HIV compared to girls.[34] Of the 1.5 million adolescents aged 10–19 living with HIV globally, only 65% (approximately 1.1 million) were receiving ART in 2023. Treatment coverage was the same about 65% for both boys and girls in this age group—higher than among children aged 0–14 years, but well below coverage levels for people aged 15 and older. ART coverage is lowest in eastern Europe and central Asia and East Asia and the Pacific (a little over 40%) and highest in eastern and southern Africa (71%).[35] It is not yet clear whether viral suppression levels differ significantly for adolescent boys and girls. But viral load suppression levels among adolescents appear to be much lower than for adults: recent surveys show a 20% gap between young people aged 15–24 years and all people aged 15 years and older.[36 37]

Table 1. Progress towards 2025 Global Targets and the impact of the Global Alliance: global and in Global Alliance countries, 2015, 2021 and 2023

PROGRESS TOWARDS 2030 MILESTONES		2015	2021	2023	2025 TARGET
Ensure that all pregnant and breastfeeding women living with HIV are receiving lifelong antiretroviral therapy					
Antiretroviral therapy coverage among pregnant and breastfeeding women	Global	81% [70% to >98%]	83% [70% to >98%]	84% [70% to >98%]	**100%**
	Global Alliance	86% [70% to >98%]	85% [70% to >98%]	85% [70% to >98%]	
Reduce the number of adolescent girls and young women acquiring HIV to less than 50 000 by 2025					
Adolescent girls and young women (15–24 years old) newly infected with HIV	Global	330 000 [220 000–450 000]	240 000 [150 000–320 000]	210 000 [130 000–280 000]	**50 000**
	Global Alliance	220 000 [140 000–300 000]	160 000 [97 000–210 000]	130 000 [81 000–170 000]	
Ensure that 90% of people living with HIV are accessing treatment					
Children living with HIV (0–14 years old) receiving treatment	Global	40% [28–52%]	54% [28–52%]	57% [28–52%]	**90%**
	Global Alliance	41% [28–52%]	54% [28–52%]	57% [28–52%]	
Ensure that 90% of people living with HIV are accessing treatment					
Adolescents (15–19 years old) who are on treatment	Global	30%	55%	64%	**90%**
	Global Alliance	32%	58%	68%	
Ensure that 75% of all children living with HIV have suppressed viral loads by 2023 and 86% by 2025					
Children living with HIV (0–14 years old) who have suppressed viral loads	Global	26% [22–33%]	43% [22–33%]	48% [22–33%]	**86%**
	Global Alliance	27% [22–33%]	43% [22–33%]	48% [22–33%]	

Source: UNAIDS epidemiological estimates, 2024 (https://aidsinfo.unaids.org).

Inequalities preventing progress in the HIV response for children and adolescents

31. Structural inequalities fuel the AIDS epidemic and worsen the impacts of the epidemic. Heavy public debt loads in sub-Saharan Africa and elsewhere are making it very difficult to fully fund health and HIV responses, including for children and adolescents.[38] Poverty and inequality are obstructing access to existing services. The criminalization of key populations and laws requiring parental consent for adolescents to access HIV testing and treatment further hinder access to services. In 2023, only three countries

(Bolivarian Republic of Venezuela, Netherlands and Uruguay) did not have laws criminalizing HIV or any of the four key populations.[39]

32. Stigma, discrimination, gender-based inequalities and violence increase the likelihood of acquiring HIV, and create obstacles to care, especially for women and girls, key populations and their children. United Nations (UN) Member States in 2021 committed to reaching the 10–10–10 targets by 2025: less than 10% of countries have restrictive legal and policy frameworks that lead to the denial or limitation of access to services by 2025; less than 10% of people living with HIV and people from key populations report experiencing stigma and discrimination; and less than 10% of women, girls, people living with HIV and people from key populations experience gender-based inequalities and violence. In 30 countries with data available over time, 11 showed declines in discriminatory attitudes followed by increases, and seven showed increases. We are not on track to achieve these goals and a surge of anti-rights, -gender and -democracy policies stands in the way of quicker progress.[40]

33. Children on the whole face inequalities in relation to HIV. Health systems tend to treat adults as the norm and do not always provide services that are tailored to children's needs. New medical innovations are slow in reaching children: for example, effective and palatable ARVs for children were only developed several years after comparable adult formulations had become available. The next section discusses some of the inequalities that increase the HIV vulnerabilities of specific child and adolescent populations.

34. **Girls.** Girls are disproportionately affected by multiple forms of gender-based violence, including sexual abuse, rape and intimate partner violence, early marriage and restrictions on bodily autonomy. They may drop out of or be excluded from schools due to pregnancy. The education of girls may also be deprioritized due to early marriage or unpaid care responsibilities in households and communities. Unequal power dynamics, disempowerment, gender, age and economic inequalities, as well as intimate partner violence, are some of the factors contributing to high HIV infection rates.[41] Pregnant and breast-feeding adolescent girls are more likely than older women to discover that they are HIV-positive only when they take an HIV test during pregnancy, and their access and adherence to ART tends to be low.[42] This is due largely to the economic and gender obstacles they face, and to a lack of girl- and youth-friendly holistic and differentiated health care. In some countries, adolescents face legal restrictions that prevent or restrict their access to certain health services, including HIV and sexual and reproductive health (SRH) services, without parental consent, and carers may be more controlling of girls' sexual and reproductive choices.[43]

35. **Boys.** Boys are more likely than girls to face violence such as physical punishment in school, which inhibits the positive effects of education on health and social integration.[44] Gender norms around masculinity may encourage risky behaviours and discourage health-seeking behaviours and self-care. Marginalization of boys and young men in SRH services, and stigma against young key populations such as gay men and other men who have sex with men and people who inject drugs (85% of whom are male)[45] contribute to the lower coverage of HIV testing and treatment among boys.[46]

36. **Orphans.** The number of children losing parents to AIDS-related causes is declining due to expanding access to effective ART. However, the AIDS pandemic has orphaned many millions of children already: by 2023, roughly 14.1 million children under the age of 18 years had lost one or both parents to AIDS-related causes.[47] These children face higher levels of poverty, malnutrition, disrupted education, social exclusion and stigma. Large proportions of these children are also living with HIV and they face obstacles

accessing treatment and adherence. Caregivers and adoptive or foster parents play vital roles supporting their resilience, but they also need social safety nets and protection systems to improve their well-being.

37. **Adolescent key populations.** There are specific vulnerabilities associated with being an adolescent member of a key population. In the United States of America (USA), for example, LGBTQI-identified people are estimated to comprise 20–40% of the more than 1.6 million homeless youth; family rejection, discrimination and violence are among the reasons for their homelessness.[48] In India, it is estimated that over 90% of transgender people leave or are expelled from their homes by the time they are 15-years-old; many have to survive on the street with no money or education, often relying on sex work.[49] Young people who sell sex may be more vulnerable than their older counterparts, have less power to negotiate condom use or other conditions of work or relationships, and be more susceptible to violence. Drug use often starts during adolescence or youth; young people may be more vulnerable and face greater risks associated with drug use than older counterparts, while harm reduction services may be less accessible to them.[50]

38. **Children of members of key populations.** Globally, many sex workers, drug users, transgender people, and gay men and other men who have sex with men are parents. Key populations continue to face stigma and discrimination, including criminalization, judgmental attitudes from health-care providers, denial of access to family support programmes, and the risk of having their children removed by the authorities.[51] [52] These realities may make parents less likely to register their children at birth or engage with health and other services, and their children often face exclusion from or bullying at school. Organizations and initiatives serving key populations, and related research and data collection rarely include their children.[53]

My child was raped when she was five years old. When I reported the man who did it to the local authorities I was told that, since I am a prostitute, I should not complain about what happened to my child.
- Female sex worker, Uganda.

I didn't have money to send my son to high school … I approached the government office that offers bursaries to disadvantaged children… but I couldn't I say I hustle as a sex worker and I am a man … so I gave up. Now my son is working on small farms in the village. I pity him. And I am upset that he missed out on high school education.
– Male sex worker, Kenya.

I just want to live and raise [my] children, [be a] loving husband and not be afraid to die or go to jail. I think I have that right, and really want to use it.
- Injecting drug user, Russian Federation.

Teachers and fellow scholars don't understand them. They bully and tease and see them as abnormal … This has major effects on their daily learning and the does not allow them the education received by their peers.
- Leigh Davids, independent expert on the children of transgender parents.

Source: Making the children of key populations a priority for equitable development. Coalition for Children Affected by AIDS; 2017 (https://childrenandhiv.org/wp-content/uploads/2017/06/Making-the-Children-of-Key-Populations-a-Priority-Advocacy-Briefing-FINAL.pdf).

Gaps, needs and challenges

Health systems

Vertical transmission

39. Globally, the failure to identify pregnant and breast-feeding people with HIV and to provide them with ARVs is the single biggest reason for vertical transmission of HIV. In eastern and southern Africa, however, the largest number of vertical transmissions results from mothers acquiring HIV while pregnant or breast-feeding but not being diagnosed, or mothers discontinuing ART during the pregnancy or breast-feeding periods.[54] A study in South Africa, for example, found that one quarter of women living with HIV had disengaged from care within a year of giving birth.[55]

40. There are many reasons why women discontinue ART or do not achieve viral suppression, ranging from economic and structural factors to health system-related ones, including disrespectful, judgmental and coercive services. The International Community of Women Living with HIV's global scan of coercive sexual and reproductive health practices found that nearly 20% of women living with HIV had encountered such practices during their lifetimes. Some medical professionals prioritize the prevention of vertical transmission of HIV over women's bodily autonomy and consent. Women living with HIV may also be subjected to increased surveillance, coercion and punishment, especially if they are young, sell sex, use drugs, are disabled or are migrants.[56]

> *When I got pregnant, I went to the maternity clinic to register, but there, during the examination, I found out about my HIV diagnosis. After the doctor found out that I had HIV, she took me to a separate room and told me to undress. I asked why. She said since I was living with HIV, why should I give birth to a sick child? It is better to have an abortion and live as long as I have left. When I refused, she called me names and screamed. I left.*
>
> - Woman living with HIV, Tajikistan
>
> *I experienced pressure not to breast-feed because HIV can be transmitted through breast-feeding, but since I had no way to feed the child, I gave him the breast and today my child is healthy.*
>
> - Woman living with HIV, Cameroon
>
> *I was denied certain laboratory tests aimed at planning pregnancy: You have HIV. Why do you need these problems and risks?*
>
> - Young woman living with HIV, Argentina
>
> *I was told I absolutely must be accompanied to SRH services by a partner or parent, and health workers asked them for opinions and decisions on my behalf.*
>
> - Young woman living with HIV, Cameroon
>
> *Source: Confronting coercion: A global scan of coercion, mistreatment and abuse experienced by women living with HIV in reproductive and sexual health services. International Community of Women Living with HIV; 2024 (https://www.wlhiv.org/_files/ugd/682db7_2fe9a24ef9454c6691e1cc06bee58165.pdf).*

Infants and children

41. The current still largely vertical model of HIV programming is not adequately child friendly, differentiated, nor integrated. Expertise in paediatrics remains limited and centralized, while adult providers frequently cite a lack of confidence as a reason for the low quality of care delivered to children living with HIV. Prevention of vertical transmission and early infant diagnosis are particularly lacking in settings with low HIV prevalence.[57]

42. In low and middle income countries, one of the biggest gaps in the HIV response for children is among older children living with HIV.[58] Almost 600 thousand children (0-14 years old) living with HIV are not on treatment.[59] Globally, over 60% of children living with HIV but not on treatment are aged 5–14 years.[60] Only 65% of needs are met for antiretroviral therapy treatment for older children.[61] This is not only because of funding constraints, but also because many older children living with HIV remain undiagnosed or out of care.[62] Older children need to be identified. Testing needs to be linked not just to initiation but also to longer term follow up to ensure retention in care, otherwise we do not know if we are repeatedly testing the same children.

Adolescents

43. In many settings adults can readily access testing, but this is not the case for children and adolescents because they need an adult to take them or give consent. This leads to major HIV testing gaps among pregnant adolescents.[63]

44. Adolescents also face many treatment adherence challenges. Those range from the disorienting experiences of adolescence, forgetfulness and low awareness of personal risk to HIV-related stigma, lack of social support, legal barriers, health system weaknesses (e.g. distant clinics, long waiting times, medicine stock-outs and hostile attitudes of health staff), unequal gender norms, and poverty. Insufficient counselling is another factor, with adolescents citing incomplete knowledge about ART and its possible side-effects, and confusion about dosages among the reasons for interrupting treatment.[64] They need support, not judgement, so they can maintain adherence or return to care.

45. Transitioning to adult care can also present challenges if youth and adult care services are not well-connected and when young people are unprepared for new sets of service requirements, procedures and protocols.

Data

46. Data gaps include a lack of longitudinal tracking of children living with HIV and of distinguishing between vertically or horizontally acquired HIV. In addition, HIV data are often insufficiently integrated into broader health data systems. Data on the cascade of HIV testing and treatment services are seldom linked to other health-related information (e.g. employment status and other socioeconomic indicators). Children of key populations are rarely studied in research. More comprehensive data systems and better collection and use of quality data are needed to identify where vertical transmission occurs and to determine how to close the remaining HIV-related gaps for children, adolescents and pregnant and breast-feeding people.

Structural inequalities

47. Economic crises, conflict and climate change result exacerbate poverty, disrupt health services, force school closures, worsen mental health conditions and can be associated with increased transactional sex and unplanned pregnancies. All those impacts are relevant to the AIDS epidemic and response. As one woman in Uganda explained in 2020: "I haven't even gone for antenatal at 7 months of my pregnancy, yet I am HIV-positive. I would want to go to hospital, but I imagine walking is not possible because the facility is far and using my money savings to travel to hospital means I will not have food for my kids for two days and I can't risk it. I will use a traditional birth attendant." [65]

48. Gender-based violence increases HIV impacts by limiting people's abilities to maintain healthy sexual relationships, refuse sex, negotiate condom use and seek help and support. Intimate partner violence is correlated with higher rates of vertical transmission of HIV, particularly among girls aged 15–19 years, who face the highest burden of violence. Recent modelling in 46 African countries found that one in eight cases of vertical transmission could be attributable to intimate partner violence.[66]

49. Many countries retain laws which require parental consent for adolescents to access sexual and reproductive health and rights (SRHR) services, criminalize adolescent sexual activity or mandate reporting by service providers. HIV testing coverage among adolescents aged 15–19 years in countries requiring parental consent for people aged under 18 years was, on average, 9% lower for girls and boys, compared with countries where the age requirement for testing was set at 16 years or younger. HIV transmission is higher in countries with laws that criminalize key populations.[67]

50. Criminalization and stigma also impact the children of key populations. Their parents may keep their occupation or drug use secret from their children, at some cost. In interviews, South African sex workers often said their greatest fear was not a client raping them, or police violence, but that their children would find out what they do. This is connected to the criminalization of and stigma around sex work, and the possibility of children being removed by social services. Avoidable health risks and preventable deaths appear to be high among children of members of key populations.[68]

51. Globally, almost 80% of young people use the Internet, as do a little over 50% in Africa. In South-east Asia, over 99% of young people use social media, with young women spending more time on these platforms compared with men.[69] Globally, social media is the second most popular source of information about bodies, sex and relationships. Online media platforms are profit- and algorithm-driven. They can be influential sources of both misinformation and accurate, empowering sexuality education, and they can promote bigotry as well as counter stigma.[70]

Leadership and resources

52. A recent analysis by the Coalition Community for Children Affected by AIDS on gaps in global HIV funding for children and adolescents concluded that in lower- and middle-income countries, the HIV response for children is underfunded by US$ 1 billion and there is a 90% funding gap for children of key populations (a gap of US$ 168 million). Other major gaps are around testing and treating older children, and social and economic support.[71]

53. There has been a noted decline in HIV response spending since 2017 in western and central Africa, from 0.3% of gross domestic product in 2017 to just 0.12% in 2022. A significant obstacle to domestic financing is debt. Debt servicing now exceeds 50% of government revenues in Angola, Kenya, Malawi, Rwanda, Uganda and Zambia. Even after debt relief measures are introduced, Zambia will be paying two-thirds of its national budget on debt servicing between 2024 and 2026.[72]

54. The issue, however, is not just a lack of resources, but political will and leadership. Child health and paediatric AIDS are being neglected in global and regional debates. In addition, anti-rights, -democracy, -gender movements are promoting policies that further threaten people living with HIV and key populations and that deprive children, adolescents and young people of the knowledge and services they need to live healthy, fulfilling lives. These movements claim to protect children while in fact causing them harm.

What works in the HIV response for children and adolescents

55. What works to close the gaps at national, regional and global levels to accelerate to meet the 2030 targets? This section addresses this question at the level of health systems, structural challenges and leadership and resources.

Health systems and services

Integration, decentralization, primary health care and community-led services

56. The HIV response is more effective where systems are integrated with maternal and child health services, primary health care and universal health care, and promote consistency in quality of care at all levels. There are different models of integration and what works best depends on the context.[73] Integrated, coordinated care for mother-baby pairs has contributed to Global Alliance countries' progress in reducing vertical transmission of HIV .[74] Integrating HIV care with care that addresses comorbidities such as tuberculosis is particularly important for younger children, who face high risks of AIDS-related morbidity and death.[75] Adolescents, in particular, benefit from HIV service integration with universal access to SRHR, as well as mental health support. Integration can produce positive synergies for HIV and other care, for example with the "triple Elimination" initiative which combines efforts to eliminate the vertical transmission of HIV, syphilis and hepatitis B.

57. Decentralizing care and making HIV prevention, testing and treatment available at primary health care facilities is key to making it easier for children and their carers to access services.[76] For example, shifting from centralized laboratory testing to point-of-care testing for children has increased testing numbers and improved the reporting of results to caregivers.[77]

58. For key populations, HIV care is more effective when it is effectively integrated with holistic community-led care that targets relevant needs. For example, coordination between community-based sex worker programmes and facility-based programmes to prevent vertical transmission has been shown to facilitate successful linkage of pregnant sex workers to antenatal services, as well as differentiated care.[78] Pregnant people using drugs need comprehensive harm reduction, substitution therapies, mental health support,[79] as well as HIV and antenatal care to optimize outcomes for their babies as well as themselves.[80] Peer-led youth oriented harm reduction approaches can support safer behaviors by young drug users.[81]

Preventing vertical transmission

59. Global Alliance countries are applying both service and technological innovations to reduce the rate of vertical transmission, including mentor mother programmes and more frequent viral load screening of mothers. They are also planning for the potential future scale-up of long-acting injectable ARV medicines to improve retention in care. Strategies being rolled out in those countries to strengthen HIV prevention among pregnant and breastfeeding adolescents and women include partner testing, HIV self-testing, pre-exposure prophylaxis (PrEP) and various social, structural and behavioural interventions.[82]

Community-led monitoring improves access to ante-natal care in South Africa

NACOSA (Networking HIV and AIDS Community of Southern Africa), in partnership with a community-led organization, is leading a community-led monitoring programme in the West Rand district, near Johannesburg in South Africa. After the country joined the Global Alliance to end AIDS in children in February 2023, NACOSA began tracking vertical transmission indicators to better understand barriers to early antenatal care access. Interviews with health-care workers revealed difficulties in finding and engaging migrant women. Challenges included language barriers, lack of documents and mobility. As a result, many pregnant people living with HIV were delayed in receiving ART. It was also challenging to track and follow up with undocumented individuals or those using borrowed identity documents, which affected their ongoing care.

NACOSA engaged clinic committees to seek solutions. They made greater use of a telephone system to trace foreign care recipients lost by the services and they worked with facility managers to document and file the reasons for late antenatal care visits. Subsequently, early antenatal care visits rose from 71% to 75% within six months in the community monitored sites.regnant people at the community-led monitoring sites were twice as likely to deliver their babies in a health facility compared with pregnant people at non-monitored sites.

- Case study submitted by NACOSA, South Africa.

60. Peer and mentorship programmes for mothers, care-givers, children and adolescents have a huge impact. Rates of vertical transmission of HIV have been found to be three times lower when mentor mother programmes are in place.[83] The African nongovernmental organization mothers2mothers reached more than 700 000 people with health services in 2023 across 10 countries in sub-Saharan Africa. Founded in 2001, mothers2mothers uses a tried-and-tested model of training, employing and supporting women living with HIV to serve as community health workers (or mentor mothers). Across all mothers2mothers programmes, only 0.45% of clients who were HIV-negative at enrolment acquired HIV in 2022.[84]

Emak “Mom’s club” reduces vertical transmission in Indonesia

In Indonesia, ARV coverage for pregnant people with HIV is just 17%. Indonesia Positive Women Network Emak (Mom’s) Club companions, all women living with HIV, provide individual counseling, lead WhatsApp-based peer support groups, and tackle stigma. After counseling, companions refer clients to public health services for HIV treatment and link survivors of violence to support. The Emak Club also helps mothers navigate Indonesia’s national health insurance system and assists in obtaining birth certificates and paperwork needed for babies to access health care. Receipt of those documents is often delayed due to bureaucratic inefficiencies and discrimination against mothers with HIV, which hinders access to care for babies during their crucial early weeks of life. From 2018 to 2020, the Emak Club supported 455 women living with HIV, all of whose babies were born HIV-negative. EMAK has expanded to cover 28 districts across five provinces.

- Case study submitted by UNAIDS Indonesia.

63. The full range of prevention choices—including condoms, all modalities of pre-exposure prophylaxis (PrEP), voluntary medical male circumcision, the dapivirine vaginal ring—underpinned by sex-positive programming[85] can help prevent vertical transmission during pregnancy and breastfeeding. People living with HIV need to be fully supported with services for testing, treatment, adherence and viral suppression, ideally before they conceive children.

64. People are more likely to take an HIV test and to access and adhere to HIV treatment when they are treated with kindness and respect, are able to access clear and non-judgmental advice and information, and receive psychosocial and peer support.[86] The International Community of Women (ICW) Living with HIV Eastern Africa has worked with other regional ICW networks to empower women and girls living with HIV in the 12 Global Alliance countries, including training women on how to access and analyze data to monitor services and improve quality.[87]

Testing babies and children and linking to treatment

65. Global Alliance countries in 2023 had higher coverage of early infant diagnosis (an estimated 71%) than global average (an estimated 67%). Point-of-care testing for newborns with rapid turnaround of results provides information needed for treatment strategies. In addition, continuous monitoring of children with testing at 18 months and after cessation of breast-feeding is needed. To reach infants and children who are not identified during routine early infant diagnosis with additional opportunities to test for HIV, South Africa, a Global Alliance country, now has a policy of universal HIV testing of children at 18 months, regardless of documented HIV exposure. National testing guidelines for children and adolescents need to be harmonized to minimize missed diagnoses.[88]

66. More strategic testing can identify older, undiagnosed children living with HIV. In high-burden settings, this should include provider-initiated HIV testing whenever where sick children seek care (e.g. at child health clinics and outpatient primary care services for children with malnutrition and severe infectious illnesses). Other effective strategies include linking testing to vaccination programmes, family-based index testing (e.g. of children of parents who are living with HIV), school-linked testing, and screening as part of other child health services, as is occurring in Mozambique, Nigeria, Uganda and other countries. Closer collaboration with community systems can also help connect the missed children with the HIV and other services they need.

67. Early disclosure to children and adolescents about their HIV status has been shown to have health benefits and improve adherence and self-esteem. Disclosure must be fully supported with counselling and mental health services. National guidelines vary on which age the process of disclosure should start, and at what age children’s HIV status should be fully disclosed to them. Some guidelines recommend the process of disclosure should start from as early as age 5 or when children start asking questions about their health or medications and are able to comprehend the information being disclosed to them.[89] WHO recommends disclosure once children reach school age, and definitely by the age of 10–12; it has produced guidelines on disclosure counselling for children up to 12 years of age.[90]

National rapid result initiative addresses gaps in testing and treatment for children and pregnant and breastfeeding mothers in Kenya

Data from Kenya indicate that, in 2022, 98% of pregnant people visited health facilities at least once for antenatal care. However, a significant number of mothers and children were missed by services for preventing vertical transmission of HIV and by services for children and adolescents living with HIV.

As a member of the Global Alliance, Kenya in 2023 launched the HIV Rapid Result Initiative, which was introduced at 1,688 health facilities across all 47 counties in the country. Service quality audits captured site-level commodity stock-outs and capacity gaps among health-care workers, while data quality audits revealed the use of old and improvised data tools. Further, longitudinal mother-infant pair follow-up was limited, and opportunities were missed to optimize treatment for children and suppress viral loads. Action was then taken to address the gaps.

Identification of children and adolescents living with HIV increased from 4,104 in 2022 to 4,283 in 2023. Accelerated screening for HIV exposure status was conducted at the Pentavalent 1 vaccine visit at week 6 of life, contributing to the identification of 985 HIV-positive infants in 2023. Country team ownership and the use of accountable processes were key.

- Case study submitted by the Kenya National AIDS and STI Control Programme.

Meeting the needs of adolescents

68. A more holistic approach, encompassing HIV SRHR services and addressing child marriage and school drop-out, is needed to serve the needs of adolescents. Also needed is coordination and other support to help adolescents transition to adult health services, including transition readiness assessments and clear transition protocols.

69. Mental health support is vital to enable effective treatment for adolescents newly diagnosed with HIV and who have difficulty accepting their diagnosis. Mental health services can improve ART adherence among youth, including for those who acquired HIV vertically and previously had been taking ARVs under care-giver supervision.

70. Peer-driven interventions can be effective. An example is the “Resilient and Empowered Adolescents and Young People” initiative, which has improved HIV testing and diagnosis rates among young people. It also advocates for changing HIV testing consent laws in over 39 countries.[91] It is vital to take guidance from youth leaders in the field and listen to the needs and desires of adolescents themselves.

Adolescent champions improve linkage to care in Nigeria

In Nigeria in 2020, only 34% of adolescents newly diagnosed with HIV were initiated on ART. In response, the Clinton Health Access Initiative supported the state ministries of health to operationalize peer-led HIV services for adolescents in the Akwa Ibom and Anambra states. An “adolescent champion”, usually an existing community/peer leader, was trained for each health facility. The champions received outcome-based incentives for making phone calls and home visits, and provided escort services, peer counselling, disclosure and appointment tracking support.

Across the supported facilities, champions successfully tracked and returned to care 85% of clients (2,588 of 3,045) who had missed clinic appointments and 81% (1,946 or 2,403) of those who had missed viral load appointments during 2021. The Initiative successfully transitioned support for “adolescent champions” to implementing partners with expanding coverage in Akwa Ibom and Anambra. Subsequently, 20 states have reported adopting a similar model, which also has been incorporated countrywide into the National Adolescent Package of Care .

- Case study submitted by Clinton Health Access Initiative.

71. A central challenge for universal health coverage is to ensure that services are trusted, accessible and appropriate for people from marginalized communities. In many countries, including Colombia, Côte d'Ivoire, Jamaica and Thailand, HIV investments have facilitated the creation of trusted, community-led services that deliver holistic care to communities which often are not well-served by mainstream health facilities.[92] Such services can be vital for preventing vertical transmission among key populations and for supporting their children. However, some key population-led organizations are inhibited from working with children due to stigma or other restrictions. They need to be enabled and supported to offer age-appropriate services to adolescents and young people.

Data

72. More and better age- and sex-disaggregated data and tracking can guide effective and sustainable programme design and draw funding to where it is most needed. Necessary improvements include strengthening data collection on overall service quality and the availability of child-specific treatment options, and gathering data on mental health, stigma and social support to better serve the needs of children with HIV. In the United Republic of Tanzania, for example, improved documentation of HIV-exposed children was achieved by linking registration with each infant's first immunization. From 2022 to 2023, the percentage of HIV-exposed children who were registered in the national tracking system increased from 7% to 66% and the proportion of HIV-exposed children tested within their first two months of life rose from 81% to 92%. Early registration of HIV-exposed infants also drove timely access to services. Children of members of key populations should be identified in these data collection exercises where this can be done safely, ethically, with anonymity considerations taken into account, and without putting them at risk.[93]

Structural inequalities

73. Addressing structural barriers and creating an enabling environment are vital for an effective HIV response. This includes tackling stigma and discrimination, addressing unequal social norms and practices and structural barriers that hinder access to HIV prevention, treatment and care services. This can be done by enabling girls to continue attending school; through the engagement and leadership of adolescents; by creating legal environments that are conducive to public health; by removing laws requiring parental consent to access SRH services; and by outlawing domestic violence, marital rape, child marriage, female genital mutilation, and corporal punishment in schools.

HIV Justice Network and International Community of Women Living with HIV-Argentina challenge criminalization of breastfeeding

The HIV Justice Network describes itself as a "community-based NGO building a coordinated, effective global response to punitive laws and policies that impact people living with HIV in all our diversities".[94] WHO guidance recommends breast-feeding for pregnant women who are on ART and whose viral loads are suppressed within four weeks of delivery (placing them at very low risk of transmitting HIV to their infant).[95] Yet health services and authorities are often not up to date with this guidance. At least 14 women living with HIV have been criminally charged for alleged breastfeeding and many others experience surveillance, stigma, abuse or child protection interventions.

In 2021, the Health Justice Network launched a new section of their HIV Justice Toolkit, the Breastfeeding Defence Toolkit, which provides materials to support lawyers and advocates supporting people living with HIV who face criminal charges or other punitive measures for breast-feeding, chest-feeding, or comfort nursing. In 2022, in Argentina a breastfeeding criminalization case was dismissed on appeal following intervention from International Community of Women Living with HIV (ICW)-Argentina.

- Case studies submitted to UNAIDS PCB by HIV Justice Network and ICW Argentina.

74. Tackling poverty with system-level changes as well as with cash transfers and other forms of social protection and economic support are also essential to ending HIV for children and adolescents.[96]

Holistic economic and health support for families in Honduras

The Montana de Luz Healthy Family Honduras programme supports families affected by HIV with micro-loans, mentorship and business training; mental health support and improved access to healthcare; literacy training and educational opportunities; and combatting stigma and misinformation surrounding HIV. Since the programme started in June 2018, it has helped keep families together, preventing 38 children living with HIV from entering an orphanage. They have supported over 200 people living with HIV access treatment, 94 of whom have now reached viral suppression. Workshops combating stigma and promoting understanding of HIV have reached over 5,000 individuals, leading to earlier diagnosis and better treatment outcomes. Literacy, self-sufficiency and resilience have increased. Over 20 families have opened small businesses. Families from key populations and the rest of the population are being supported.

- Case study submitted by Montaña de Luz.

75. Preventing violence against women, gender-based violence and intimate partner violence is the most cost-effective and long-term way to stop violence. This requires focusing on early education, healthy relationships, working with people of all genders, and empowering communities to mobilize. Norms need to shift at all levels. Increasing access to health and justice services for survivors is also part of the solution.[97] In 2021, the United States President's Emergency Plan for AIDS Relief (PEPFAR) and UN Women announced a partnership for "Investing in Adolescent Girls and Young Women's Leadership and Voice in the HIV Response" by building coalitions between feminist and HIV movements in sub-Saharan Africa. The initiative develops the leadership of adolescent girls and young women through training, mentoring and intergenerational dialogues, while creating opportunities to access decision-making spaces and push for policy change and better services, including services supporting survivors of violence.[98]

76. Comprehensive family-centered programming for key populations works to mitigate barriers to prevention and care.[99] Coordination between community organizations and

health services can help make these services more respectful and responsive and link key populations and their children to prevention and care.[100]

77. Community-led organizing by key populations and their children can challenge the stigma and inequalities that render them vulnerable to HIV. Mothers for the Future, a support group for sex workers with children in South Africa, is a rare example of organizing around children of members of key populations. Founded in Cape Town in 2013, it has expanded to five other provinces in the country. Mothers for the Future challenges stigma and provides safe spaces where mothers can support one another. They run trainings in prevention of vertical transmission, sexual and reproductive health, child safety, parenting skills and other relevant topics. The coordinators perform home visits and offer direct support to mothers and their children. They assist in obtaining birth certificates and identity documents, getting children back into school, accessing social grants, as well as provide support for ART adherence.

I was a sex worker and peer educator and a mother. A lot of the work we were meant to do was about HIV education and prevention. But we all felt the same thing: HIV and safe sex were not the only problems I and other mums faced. We worried about our children's education, getting enough food for them, struggling with breastfeeding when at work, childcare, what happens to the kids if I die, our problems with their fathers. We also worried about other aspects of our healthcare, getting pap smears, safe abortions. So, we formed Mothers for the Future.

– Dudu Dlamini, founder of Mothers for the Future, 2022[101]

78. Education is an important opportunity for tackling structural barriers. Making schools safe, healthy and happy for all pupils, and offering comprehensive sexuality education can reduce stigma, gender inequalities and HIV risk. Enabling girls to continue their schooling can help reduce HIV transmission among adolescent girls. Enabling every child to go to school and linking needed services to schools is part of the solution. School health and nutrition programmes can improve health. Strengthening school health systems and the links between health, education and social protection systems also benefits children and adolescents.[102] [103]

Preventing school-related gender-based violence in Botswana, Eswatini, Lesotho, Malawi, United Republic of Tanzania and Zambia

Since 2018, UNESCO has been implementing the "Connect with Respect" toolkit, which integrates gender equality and violence prevention into school teaching. The toolkit empowers adolescents with the knowledge and skills they need to foster respectful relationships and reduce violence, which is a known risk factor for HIV. The curriculum promotes critical thinking about gender norms and builds skills for seeking help and support when faced with violence. Additionally, the programme's multisectoral approach strengthens collaboration between education and other sectors to provide adolescents with integrated support, including access to gender-based violence and HIV support services.

The pilot led to improved relationships and shifts in attitudes towards gender equality and violence prevention, with 77% of students reporting improved relationship skills after the programme. There were also fewer incidents of boys making sexual comments about girls. Enhanced school safety policies and increased student confidence in accessing SRHR services were also recorded.

- Case study submitted by UNESCO.

79. Social media and other information technologies can pose dangers, but they also can be used as sources of sexuality education and for challenging stigma around HIV, disability and other intersecting inequalities.[104] For example, some young people living with HIV have become social influencers against stigma by deploying platforms such as

Tiktok and Instagram. Online digital sexuality education platforms can reach large audiences with youth-created and engaging content. Online violence needs to be controlled, not online sexuality education.

Leadership and resources

80. Country ownership and participation of women living with HIV are key to the successes of the Global Alliance, with national ministries of health, rather than development partners or UN agencies, leading the development of country action plans and reports. Progress in Global Alliance countries are the result of intensified national leadership and commitment, as well as the collaboration of diverse partners to support innovation and the scale-up of proven tools and strategies. The Dar es Salaam Declaration to end AIDS in children by 2030, signed by Global Alliance countries, networks of people living with HIV, UN and other partners, makes strong commitments to mobilizing the resources and action needed.

81. **Building on momentum around child health**. The current political momentum around child health presents an opportunity to push for global leadership on paediatric AIDS as one of the ways to advance child health and health equity. Advocacy for stronger political leadership around child health can resonate in countries and accelerate the HIV response, especially if its emphasizes the HIV into maternal and child health systems, the adoption of a people-centered approach, and the adaptation of health systems to the needs of children. Mobilizing child health champions among influential people in diverse global contexts (e.g. First Ladies and religious leaders) can further accelerate progress.

82. **Increasing funds and using them more efficiently**. PEPFAR provides 47%, the Global Fund 14% and domestic governments 33% of funding for the HIV response for children and adolescents in low- and middle-income countries.[105] UNITAID plays a key role, including by making the ARV dolutegravir more accessible.[106] Yet there is a huge funding gap. More resources are needed from national governments (which, in many countries, requires debt relief) and from international donors. However, more money is not the only answer. We can achieve more with the funds we have.

Resourcing the HIV response for children in low- and middle-income countries

People working in HIV and broader social and economic development urgently need information on funding gaps for children and HIV, and how to raise additional funds. In 2022–2024, the Coalition for Children Affected by AIDS led a partnership analyzing these questions. They identified a US$ 1billion annual spending gap to achieve the HIV targets for children and adolescents in low- and middle-income countries. Half of the gap was in sub-Saharan Africa. The largest gaps were for paediatric testing and treatment, economic support, members of key populations under 18 years of age and children of members of key populations. However, insufficient funding was not the only factor limiting coverage of key interventions. Other factors include health system constraints, difficulties finding the many undiagnosed children living with HIV, and political and social barriers.

The analysis proposed several ways to maximize efficiencies and achieve the greatest return on investment, including: re-focusing funds towards community-based service provision; prioritizing excluded populations; putting communities in the driving seat of funding decisions; and improving coordination among donors. Also called for was more domestic funding for children and adolescent programming, reauthorization of PEPFAR retaining the 10% set-aside for orphans and vulnerable children and mobilizing funds for HIV services that are integrated with the broader health system and other sectors. Governments, donors and UNAIDS should annually publish disaggregated data on expenditures for HIV-affected children and adolescents.

- Case study submitted by the Coalition for Children Affected by AIDS.

83. **Adolescent and youth leadership, ownership and ability to hold the response to account**. Youth action is helping make the HIV response more relevant, inclusive and effective for adolescents and young people. This is particularly the case for people who are at high risk, including adolescent parents and the children of members of key populations. Adolescents' groups and advocates, including adolescent girls and young women, have been at the forefront of the response and their essential work must be supported and sustained.

84. In October 2023, the Global Forum for Adolescents launched the "Agenda for Action for Adolescents", which calls for stronger action for adolescent health and well-being. In Latin America, the youth network Red Juvenil LAC links HIV and sexual health with other youth priorities such as unemployment and climate change.[107] The HER (HIV Epidemic Response) Voice Fund, implemented by the Global Network of Young People Living with HIV (Y+ Global), was launched in 2019 to support adolescent girls and young women in sub-Saharan Africa to have a meaningful voice in decisions that affect their lives. It has supported over 34 000 adolescent girls and young women affected by HIV.[108]

85. **Responding to anti-gender, -rights and -democracy movements**. Anti-gender, -rights and -democracy movements are surging. They claim to protect children while in fact promoting harmful policies that further threaten people living with HIV, key populations and young people, and that endanger children's and adolescents' access to vital health information and services. Organizations at the frontline of struggles for the rights of children, women and key populations are developing strategies in response, including raising awareness and changing norms, protest-based actions, legal reforms and strategic litigation, as well as policy advocacy, coalition building, service provision and capacity building. Different strategies are effective in different contexts. However, many of these organizations are struggling to survive in the face of increased risk and lack of resources. Core funding and support with risk management can help counter anti-gender movements. Countries need to uphold their human rights commitments, conventions and frameworks and adopt human rights-based approaches to programmes, especially for children, women and key populations.[109]

Table 2. Summary of needs, gaps and challenges and what works

	Needs, gaps and challenges	What works
Health systems	User fees a barrier to access	Universal health care
	Services not adequately friendly or adapted to children, adolescents, pregnant and breast-feeding women, or people living with HIV. Children's health systems centralized. Delivery innovations not implemented for children.	Differentiated, tailored, integrated, holistic services combining HIV with SRH, mental health, antenatal, child health and primary care services. Address comorbidities (e.g. tuberculosis, malnutrition). Decentralize care and task shift. Multimonth dispensing of ARVs to children with HIV if stable on treatment.
	Pregnant and breast-feeding women not receiving ART or not supported for adherence. HIV acquired during pregnancy and breast-feeding. Inadequate early infant diagnosis, especially in low-prevalence settings.	Testing before conception, during pregnancy and breast-feeding, and immediate link to life-long ART for women living with HIV. Provide full range of prevention options to HIV-negative women. Test and treat partners. Introduce mentor-mother programmes. Provide point-of-care testing for newborns and older babies.
	Older children living with HIV not identified.	Index testing and point-of-care testing for older children. Provider-initiated HIV testing in all locations where sick children seek care, e.g. child health clinics and outpatient primary care services, targeting children with malnutrition and severe infectious illnesses, especially in high-burden settings. Link to treatment and longer-term follow up to ensure retention in care.
	Adolescents have high HIV infection rates and face specific adherence challenges. Transitions to adult care not adequately coordinated and supported.	Holistic adolescent-friendly services, integrated with mental health. Supported and coordinated transitions to adult care.
	Reproductive coercion and discrimination against women, people living with HIV and key populations, leading to lack of trust in health systems. Fears of key populations that authorities will remove their children from their care hinder uptake of services.	Reproductive rights and justice. Community monitoring of services, and community-run services for key populations and their children.
	Lack of age-disaggregated HIV-related data for children.	Improve data gathering, tracking and use to optimize programmes and interventions; include data on children of key populations.

Structural	Intimate partner violence, gender-based violence, child marriage. Online gender-based violence and stigma not controlled; online sexuality education censored. Exclusion from school; stigma and violence in schools. Criminalization of people with HIV and key populations; stigma against them and their children. Restrictive age-of-consent laws preventing adolescents from accessing HIV testing and SRH services. Economic crises, poverty, insecurity, conflict and climate change. Unpaid care work affect adolescent girls' abilities to engage in education and employment.	End violence and harmful social norms; end child marriage; empower girls and women. Deploy online and social media to educate; empower and destigmatize; control online violence. Safe and inclusive schools; provisions that enable girls to complete their schooling; comprehensive sexuality education. Decriminalize HIV and key populations; provide comprehensive family-centered programming to support children of key populations. Review age-of-consent laws; implement laws making child marriage, domestic and sexual violence illegal. Economic support and social protection, including economic empowerment of adolescent girls and young women.
Leadership and resources	National budgets spent on debt repayments instead of health. Decline in HIV spending, including in western and central Africa. Funding gap of US$ 1 billion in low- and middle-income countries for HIV response for children and adolescents. Largest funding gaps in testing and treating older children, social and economic support, and the children of key populations. Anti-gender, -rights, -democracy movements promoting policies and practices that discriminate against women and girls; criminalize people living with HIV and key populations; and endanger children's access to information and services.	Governments, IMF, World Bank and private lenders alleviate the debt burdens of low-income countries. Increased, targeted, efficient investment, including from domestic governments. Country ownership of HIV response. Better donor coordination. Build global leadership around child health. Refocus funds to community-based provision. Involve communities in funding decisions and enable them to have ownership and hold institutions accountable at local, domestic and international levels. Core funding for organizations at the frontline of struggles for the rights of children, youth, women and key populations. Implement commitments to protect children's human rights. Implement the Dar-es-Salaam Declaration. Support leadership and meaningful engagement of adolescent girls and young women, including those living with HIV.

Recommendations

86. We have a huge amount of evidence on what works to close the gaps at national, regional and global levels and accelerate progress to meet the 2030 AIDS targets. How do we support countries to bring interventions to the fore and scale for impact? The recommendations below respond to this question.

a. **Diagnose and get treatment to children.** Identify the untreated children living with HIV and initiate them on treatment. These efforts must reach older children and children who are not in regular contact with health systems. That requires investing in community-based testing, early infant diagnosis, self-testing, point-of-care testing, index testing for children and adolescents, and provider-initiated HIV testing in locations where sick children seek care, especially in high-burden settings.

b. **Provide integrated, decentralized, tailored, holistic and respectful health services for pregnant and breast-feeding people, children and adolescents.** Investment should include HIV primary prevention packages and differentiated models for linking pregnant and breast-feeding people, children, adolescents and young people to testing, treatment and care, and supporting them to remain in care. Services should be integrated in ways suited to the context. Efforts should be combined to eliminate vertical transmission of HIV, syphilis and hepatitis B virus. People of all ages and genders, whether from general or key populations, should be treated with kindness and respect, and be given non-judgemental and accurate information on the full range of options available.

c. **Support communities to lead**. This includes organizations of adolescent girls and young women, key populations and people living with HIV, as well as other affected groups. Strengthen their representation at all levels where financial and programming decisions are made—from local government level to international donors. Make financial and strategic information accessible to them and build their capacity to participate. Remove legal and structural barriers that prevent NGOs from serving and advocating for children and adolescents affected by HIV, including key population organizations. Directly support NGOs, with core, flexible and advocacy funding that is predictable, long-term and disbursed at the start of each grant cycle. Prioritize smaller community-based organizations that are at the forefront of integrated service provision to excluded populations. Ally with community organizations at local, national, regional and international levels to address gender-based violence and other structural factors that increase the vulnerability of children and adolescents to HIV, particularly young key populations, children of key populations and adolescent girls.

d. **Increase targeted investment.** Domestic governments should increase the resources allocated to children and adolescents affected by HIV to enable a more sustainable, stable and planned response that is not reliant on donor cycles. The IMF, World Bank and private lenders should alleviate the debt burden of low-income countries to facilitate this resourcing. International donors must continue their support.

e. **Understand the HIV epidemic among children, adolescents and pregnant people.** Strengthen health information systems to collect cohort data that tracks mother-baby pairs and children living with HIV and use those data regularly to improve programmes. Report data that are disaggregated into five-year age ranges (or finer age disaggregation when needed) and by gender and that note high-risk groups such as adolescent parents and the children of members of key populations, while ensuring safety, ethics and anonymity considerations in data collection and management processes. Strengthen data on HIV prevalence among pregnant people and treatment retention among pregnant and breast-feeding women to

enable “stacked bar” analyses that allow for identifying the causes of new HIV infections among infants. Support communities to collect data on experiences of stigma, discrimination and mistreatment among women living with HIV in prevention of vertical transmission and health services. Use the data to guide effective and sustainable programme design and drive funding to where it is most needed.

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