Children and AIDS

Fifth Stocktaking Report 2010

Summary

UNITE FOR CHILDREN
UNITE AGAINST AIDS

The Fifth *Stocktaking Report*, produced by UNICEF, in partnership with UNAIDS, WHO, UNFPA, and UNESCO is an annual report that examines data on progress, emerging evidence, case studies of best practices and current knowledge and practice for children as they relate to four programme areas known as the 'Four Ps':

- **Preventing mother-to-child transmission of HIV**
- **Providing Paediatric care and treatment**
- **Preventing HIV infection among adolescents and young people**
- **Protecting and supporting children affected by HIV and AIDS**

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The story of how the AIDS epidemic is affecting children is being rewritten

For nearly three decades, HIV and AIDS have devastated individuals and families. Children have been overshadowed by the very scale of the epidemic in the adult population. Thanks to improved evidence and accelerated action, however, the story of how the AIDS epidemic is affecting children is being rewritten. Children are now central to the HIV response and investments on behalf of children have had an impact. The goal of virtual elimination of mother-to-child transmission by 2015 appears within reach.

- *In 2009, 53% of HIV-positive pregnant women low- and middle-income countries in need received antiretrovirals for prevention of mother-to-child transmission (PMTCT) of HIV, up from 15% in 2005.*
- *Today, approximately 356,400 children under 15 in need received antiretroviral treatment, an increase from only 75,000 in 2005.*
- *Today, there are an estimated 5.0 million young people aged 15–24 were living with HIV down from 5.2 million in 2005.*
- *Before 2005 in many sub-Saharan African countries, children who had lost both parents to AIDS were much less likely to be in school than children whose parents were alive; today, in most places they are almost equally likely to be in school.*

Efforts to help children are part of the broader HIV response and contribute towards the Millennium Development Goals. Providing prevention, treatment, care and support for children affected by AIDS has contributed to better approaches – and results – in other areas such as maternal and newborn health testing of adults; outreach to excluded populations; support for social welfare and protection systems; and increased attention to the vulnerability of girls and young women.

However, for every problem solved or advance made, new challenges and constraints have arisen.

Equity: Universal access means serving those who are hard to reach

There are millions of women and children who are falling through the gaps because of inequities rooted in gender, economic status, geographical location, education level and social status. Everyone, everywhere has the right to the highest available standard of health. Unfortunately, in the AIDS response, as in other MDG areas, overall progress towards goals has often masked inequities in achievement.

Health indicators from all regions of the world indicate disparities between rural and urban populations as well as disparities related to poverty or social factors. Strengthening health systems is important to ensure a more effective and sustainable response, and must include investments in social protection systems to overcome these disparities and ensure that women and children can access these lifesaving responses.

Reaching the poorest, most marginalized and least served has been at the core of successful AIDS programming. That imperative is even greater in an era of static resources and ever more complex competing priorities.

The evidence: Much is known about children and AIDS

Despite the many gaps, the knowledge base of evidence on children and AIDS has improved. Globally the UN and partners have used this evidence to issue new guidance for the global HIV response.

There continues to be a gap between the level of funding needed to accelerate progress towards HIV-related goals and the level of funding available. Globally there is a positive merging of investments for HIV and AIDS within broader health responses with further investments needed in both areas.

The AIDS-free generation that is now in sight can be achieved - but only if we accelerate the scale-up of proven measures, and only if we see them as part of a rights-based, results-focused drive to reach all those in need.

unicef UNAIDS World Health Organization UNFPA United Nations Educational, Scientific and Cultural Organization

P1 - PREVENTION OF MOTHER TO CHILD TRANSMISSION

Virtual elimination of mother-to-child, or vertical, transmission of HIV by 2015 has now become a reachable goal. Many countries in Eastern and Southern Africa, Latin America, East Asia, and Central and Eastern Europe are close to meeting the 2010 universal access target for PMTCT coverage. However, high coverage has not necessarily resulted in low transmission. The goal of virtual elimination of vertical transmission requires re-focusing on outcomes and impact.

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Virtual elimination means doing better what we already know how to do: Country experiences show that reaching the goal of virtual elimination of mother-to-child transmission of HIV requires closing gaps in geographic coverage, in efficacy and quality, and in the demand for PMTCT services.

Quality interventions are the cornerstone of virtual elimination of mother-to-child transmission: Revised WHO guidelines call for improving the quality of PMTCT services. This requires improving CD4 assessment of all HIV-positive pregnant women for their ART eligibility, offering highly efficacious ARV regimens for PMTCT and promoting safer infant feeding.

The Mother-Baby Pack is one innovation expected to expand access to the more efficacious regimens for PMTCT. Developed by UNICEF and WHO with support from UNITAID and other partners, the pack contains all the medicines for a pregnant mother and her infant to stop the vertical transmission of the virus.

Attention to the economic, social and cultural barriers that prevent women from making *use of available services can help increase demand:* Obstacles to women accessing PMTCT services include the high cost of antenatal and delivery care services, long waiting time, inability to pay for transportation to health centres, lack of partner support and HIV-related stigma and discrimination.

Understanding the costs of PMTCT programming is crucial: Everywhere, there is an urgent need to make health spending more effective and efficient. Innovative funding mechanisms for sub-national activities and allocating local resources complemented by external funding is crucial to increasing access to quality and integrated HIV services.

P2 - PAEDIATRIC CARE AND TREATMENT

To ensure that HIV-infected children and adolescents do not progress to AIDS and die, it is necessary to identify them early, provide them with timely access to care and treatment, and document and follow their progress. Scale up of early infant diagnosis has demonstrated both the promise and the challenge of treating paediatric HIV.


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Better methods to identify children have put many more children on life-saving treatment. In 2009, there were 2.5 million children under age 15 living with HIV. Although the number of children in low- and middle-income countries receiving ART increased from 275,300 in 2008 to 356,400 in 2009, this is still only 28 per cent of the 1.27 million children.

Paediatric HIV testing is the gateway to care and treatment: Early testing and initiation of treatment is crucial to improve infant survival and reduce neurocognitive impairment and developmental delay that can occur before treatment is started. Mother and children will remain in the health system to receive the treatment they need through improved care planning, counselling, case management and mother-infant pair tracking at the service delivery sites and in surrounding communities.

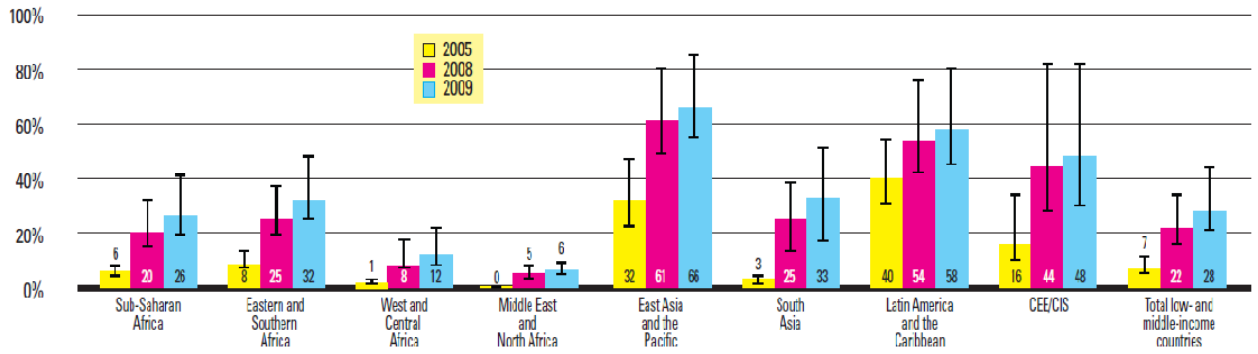
Removing systemic, social and financial barriers can improve treatment access and outcomes in children: Progress in decentralizing paediatric treatment and in training providers at all HIV treatment sites to treat infants and children as well as adults has been unacceptably slow. Research shows that ART adherence in children in low- and middle-income countries was as good as or better than in children living in affluent countries and therefore an effective investment.

Basic preventive care is crucial: Scaling up simple and proven preventive interventions is essential to increasing the survival of children living with HIV. Such basics include providing the antibiotic cotrimoxazole to all HIV exposed infants, case management of common infections and implementation of the new WHO infant feeding guidelines.

Children need access to essential commodities: Children are often a low priority when it comes to drug development and financing. Paediatric drugs are typically tested and approved many years after the same medicines for adults, if ever.

Adolescents living with HIV are a 'hidden epidemic': Many adolescents with HIV do not access treatment because they have never been tested. Legal and policy barriers in many countries require consent from guardians before adolescents can be tested, and this can delay or prevent their being tested and treated in a timely fashion.

Figure 2: Percentage of children under 15 in need receiving antiretroviral therapy , 2005–2009



Note: The bar indicates the uncertainty range around the estimate.

Source: WHO, UNAIDS and UNICEF, *Towards Universal Access. Scaling up priority HIV/AIDS interventions in the health sector – Progress Report 2010.* WHO, Geneva, September 2010.

P3 - PREVENTING INFECTION AMONG ADOLESCENTS AND YOUNG PEOPLE

Progress has been made in preventing new HIV infections among young people aged 15–24. In countries where declines in prevalence have been noted, they have been most marked among young people. However, no single prevention strategy has proved optimal in all circumstances, and many young people remain vulnerable to HIV infection.

In 2010, UNAIDS reported a decline in prevalence among young people of more than 25% in 22 key countries in sub-Saharan Africa between 2001 and 2008. In most parts of the world, new HIV infections are steadily falling or stabilizing. Nevertheless, these trends of decline in prevalence among young people are not universal. An estimated 890,000 new infections occurred among young people aged 15–24 in 2009.

Programmes need to confront the reality of new infections in young people: Sex, sexuality and injecting drug use among young people are highly sensitive topics. As a consequence, prevention programmes that provide an appropriate range of quality services designed specifically for young people cannot always guarantee that they will access them.

Table 2: Young people aged 15–24 living with HIV, 2009

Region	Female	Male	Total
Eastern and Southern Africa	1,900,000	780,000	2,700,000
Western and Central Africa	800,000	340,000	1,100,000
South Asia	150,000	170,000	320,000
East Asia and the Pacific	59,000	71,000	180,000
Latin America and the Caribbean	120,000	130,000	250,000
CEE/CIS	52,000	29,000	81,000
Middle East and North Africa	62,000	32,000	94,000
Total	3,200,000	1,700,000	5,000,000

Note: The estimates are provided in rounded numbers but unrounded numbers were used in the calculations, thus there may be discrepancies between the totals.

Source: Unpublished estimates from UNAIDS and WHO, *2010 Global Report on the AIDS Epidemic* (forthcoming).

Globally, comprehensive knowledge levels remain too low: Based on population-based surveys conducted between 2005 and 2009, only three countries have attained a level of knowledge of 50% or more in both young men and young women: Namibia, Rwanda and Swaziland.

Preventing infections in young people requires a commitment to condom programming for older adolescents and their partners: Based on data from 2005–2009, only 47% of the young men and 32% of the young women aged 15–24 in sub-Saharan Africa who reported that they had had sex with multiple partners during the previous 12 months claimed to have used condoms at their last intercourse. While still low, this does represent some progress in condom use and safer sex in young people.

Biomedical interventions can play a key role in advancing HIV prevention, but they are only part of the solution: Male circumcision and treatment as prevention offer a number of biomedical responses. Microbicides may soon offer much needed protection to young women. All of these depend on the sustainability and quality of behaviour-change programmes and health service delivery for young people, which can improve the uptake of services among those at risk of infection.

Sustaining HIV-related services in emergencies: Haiti, 2010

Prior to the earthquake in January 2010, an estimated 120,000 people were living with HIV and 12,000 children were living with HIV. Following the earthquake the Ministry of Health estimated that fewer than 40 per cent of people accessing treatment had been able to continue their treatment and many of the PMTCT service providers were affected. The mass post-earthquake displacement also increased the vulnerability of the affected population to HIV infection. Effective prevention, treatment, care and support services for people living with HIV depend on the reliability of service provision and continuity of access. Such continuity was sorely strained in Haiti in the aftermath of the earthquake that hit that country.

P4 - PROTECTION CARE AND SUPPORT FOR CHILDREN AFFECTED BY HIV AND AIDS

Over the last three decades, there has been growing interest and investment in the protection, care and support of children affected by AIDS. National monitoring data on children affected by AIDS indicate that the investments are now paying off, notably in reducing educational inequalities between orphans and non-orphans.

Who is the vulnerable child?: UNICEF-led research found that the level of education and household wealth were significantly associated with better school attendance and nutrition. The study found that whether a child has been orphaned or lives in a household where an adult is chronically ill is not the strongest marker of a child's vulnerability.

Social protection can improve HIV outcomes for children: Along with cash transfers, livelihood programmes – such as micro-financing, savings and loans, and the provision of agricultural inputs – can have a significant impact on poor households affected by AIDS.

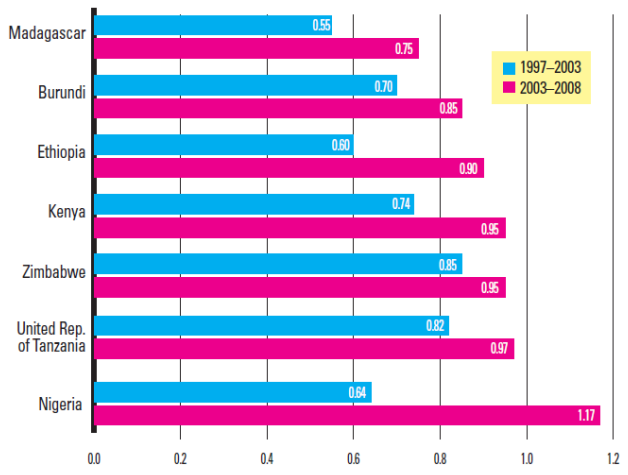
Social protection can help break the cycle of vulnerability that drives new infections in adolescents and adults: In Malawi, the use of cash transfers also led to a significant decline in child marriage, pregnancy and self-reported sexual activity among all beneficiaries. Additionally, the incidence of new HIV infections was found to be 60 per cent lower among girls who were enrolled in school at the start of the study.

Strengthening social protection and child protection systems can lead to more effective and more cost-effective responses: In South Africa, the Isibindi programme, supported by UNICEF and USAID, is a good example of how investment in community child protection systems can help vulnerable children and their parents gain access to child support grants as well as to antiretroviral treatment.

***Community demand and involvement is crucial to attaining quality and reaching scale*:** The Global Fund's support for community systems strengthening (CSS) aims at improving the accountability of community organizations to their communities and building their capacity to advocate for greater transparency and accountability on the part of public bodies and governments.

Investment in national monitoring and evaluation systems for orphans and vulnerable children remains a high priority to ensure an effective HIV response for children.

Figure 4: Trends in orphan and non-orphan school attendance ratios in selected sub-Saharan countries where the ratio has increased by at least 0.10 points, 1997–2008



Note: The orphan school attendance ratio is the ratio of the percentage of children 10–14 years old who have lost both parents and are currently attending school to the percentage of non-orphaned children of the same age, both of whose parents are alive and who are living with at least one parent and attending school, for the years 2005–2009.

Source: AIDS Indicator Surveys, Demographic and Health Surveys and Multiple Indicator Cluster Surveys, 1997–2008. Burundi and Ethiopia data are from 2000 and 2005; Kenya data are from 1999 and 2003; Madagascar data are from 1997 and 2003–2004; Nigeria data are from 2003 and 2008; United Republic of Tanzania data are from 2003 and 2007–2008; and Zimbabwe data are from 1999 and 2005–2006. The earlier Madagascar figure (1997) is based on small denominators (typically 25–49 unweighted cases).

CALL TO ACTION:

Now is the time to follow through on our commitments.

Virtual elimination of mother-to-child transmission of HIV and universal access goals will not be attained unless countries and communities reach the most marginalized members of society and serve their needs.

The welfare of individuals and families affected by HIV depends on their ability to effect change in their health and on their resilience in weathering the economic and social impact of the disease. The disparities in access, coverage and outcomes that exist across age, gender, geographic, wealth and educational spectra cannot be accepted as inevitable, and the AIDS response must seek to eliminate them. HIV does not discriminate, and neither should the AIDS response.

Children and AIDS: Fifth Stocktaking Report calls for several concrete actions that can be taken within the next one to three years to accelerate progress for children affected by AIDS:

1. **Change the PMTCT focus from coverage of ARV prophylaxis to the health of mothers and the HIV-free survival of children.**
2. **Make exclusive breastfeeding safe and sustainable.**
3. **Identify HIV-positive newborns, children and young people without delay and provide rapid access to ART for those eligible.**
4. **Make children and adolescents central to the development and implementation of promising new prevention initiatives.**
5. **Redress low levels of knowledge about HIV.**
6. **Increase access of children and adolescents living on the margins of society to health, education and social welfare services.**
7. **Provide economic support to poor and vulnerable women, children and adolescents.**
8. **Prevent violence and abuse of women and girls and enforce laws against it.**