Children and AIDS

Fifth Stocktaking Report, 2010

UNITE FOR CHILDREN
UNITE AGAINST AIDS

CHILDREN AND AIDS: FIFTH STOCKTAKING REPORT, 2010

This *Children and AIDS: Fifth Stocktaking Report* is dedicated to the memory of Thembi Ngubane.

Cover photo: Thembi Ngubane, 19 years old in the photograph, with her boyfriend and their 16-month-old daughter outside Thembi's home in Cape Town (South Africa). At 17, Thembi became pregnant and chose to be tested after learning that a former boyfriend had become ill. She discovered she was HIV-positive, then enrolled in a PMTCT programme. Her baby was born HIV-free. Later, she became an active peer educator, promoting the use of prevention services among young people. In 2006, Thembi and her AIDS diary were featured in a documentary broadcast by National Public Radio in the United States. In 2009, she died of drug-resistant TB, at the age of 24.

UNAIDS, the Joint United Nations Programme on HIV/AIDS, brings together the efforts and resources of 10 UN system organizations to the global AIDS response. Co-sponsors include UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODC, ILO, UNESCO, WHO and the World Bank. Based in Geneva, the UNAIDS secretariat works on the ground in more than 75 countries worldwide.

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I. INTRODUCTION

For nearly three decades, HIV and AIDS have been devastating individuals and families with the tragedy of untimely death and medical, financial and social burdens. Although children's concerns have always been present within the great spectrum of need associated with HIV, they have to some extent 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.

No longer a sidebar crowded out by the broader compelling narrative of HIV and AIDS, children are now central to strategies and actions to avert and address the consequences of the epidemic. It is estimated that more than 1,000 babies continue to be born with HIV every day, many of them destined to die before age two if they do not receive medication.[1] Mothers are still dying. Adolescents are still becoming infected with HIV because they have neither the knowledge nor the access to services to protect themselves, and those infected at birth are struggling to reconcile their emerging adulthood with their HIV-positive status.

But advocacy and investment on behalf of children have had an impact, and the goal of virtual elimination of mother-to-child transmission by 2015 appears within reach. In 2005, for example, only 15 per cent of HIV-positive pregnant women in low- and middle-income countries received antiretrovirals for the prevention of mother-to-child transmission (PMTCT) of HIV; in 2009, 53 per cent of women in need received antiretrovirals for PMTCT.[2] In 2005, only 75,000 children under 15 in need received antiretroviral treatment. Today, that figure is approximately 356,400, around 28 per cent of those in need.[3] In 2005, 5.2 million young people aged 15–24 were living with HIV; today, an estimated 5.0 million are.[4] Before 2005 in many sub-Saharan African countries, children who had lost both

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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.[5]

Efforts to help children are, of course, part of the broader response to the AIDS epidemic. Work to provide prevention, treatment, care and support for children affected by AIDS has contributed to better approaches – and results – in a variety of areas: women needing and getting treatment for their own health; new adult infections identified through services for the prevention of mother-to-child transmission; the role of fathers and men generally in HIV prevention, treatment and care; outreach to socially excluded populations; renewed focus on social welfare and child protection systems; and increased attention to the vulnerability of girls and young women, to name a few.

However, for every problem solved or advance made, new challenges and constraints have arisen. PMTCT services are established – but they are not fully utilized. Progress has been made towards targets – but it has been inequitable. More children are diagnosed with HIV early in their lives – but their test results may not be picked up, they may not be enrolled in treatment, and many of them are likely to die. So a deeper story must necessarily be told.

As the response to AIDS moves forward, it needs to address emerging, sometimes complicated, 'second generation' issues to assure quality, coverage and equity and to drive the demand for services that will lead to universal access for children, and for everyone. Eliminating mother-to-child transmission of HIV requires adopting a holistic approach that builds on the maternal and newborn health platform and ensures impact.

- Maternal and child health systems must be functioning and must offer all relevant services for effective follow-up of HIV-infected pregnant women and their babies.
- Families must be able to pay for their children's transport to clinics for follow-up, and able to buy or grow food to keep their children healthy.
- Health-care workers must be given a mandate and incentives for the integration and linkage of services, as well as for task-shifting to achieve greater workforce effectiveness where health systems resources are limited.
- Gender roles, gender inequality, gender-based violence and barriers to access to services must be addressed in order to reduce girls' and women's disproportionate vulnerability to HIV infection.
- Deep-seated 'cultural scripts' that dictate how women and men negotiate sexual behaviour must be well understood and, in some cases, changed;[6] the social and structural drivers of HIV infection must be addressed alongside biomedical interventions in order to have a lasting positive impact on prevention.
- A sustainable way to provide lifelong care and treatment for all children must be found; a generation of adolescents living with HIV is coming of age, necessitating new pathways to prevention, care and support that specifically address their needs.
- Obstacles to preventing tuberculosis (TB)-HIV co-infection among children (and their parents) must be overcome; isoniazid preventive therapy is one such preventive measure, as is the expansion of antiretroviral therapy (ART).
- Young people must be engaged in the fight against AIDS, given their important role in behaviour change and service uptake.

Table 1: Essential statistics, 2005 and 2009

	2005		2009	
	Per cent	Number	Per cent	Number
HIV-positive pregnant women in need of ARVs for PMTCT	15	1,500,000 (est.)	53	1,400,000 (est.)
Women assessed for ART eligibility for their own health	–	–	51	457,000
Infants receiving early infant diagnosis	–	–	6	88,200
Infants receiving antiretroviral prophylaxis	12	173,200	35	483,300
Children under 15 years old receiving ART	7	75,000	28	356,400
Children under 15 years old in need of ART	–	1,000,000 (est.)	–	1,270,000 (est.)
Initiation of cotrimoxazole prophylaxis within two months of birth	–	–	14	187,500
Young people (15–24 years old) living with HIV	–	5,200,000 (est.)	–	5,000,000 (est.)
New infections among young people (15–24 years old)	–	–	–	890,000 (est.)

Note: The statistics in this table refer to low- and middle-income countries except for the number of young people (15–24 years old) living with HIV, which is global. All numbers are reported except where indicated as estimates.

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

Additional sources: Number of HIV-positive pregnant women receiving ARVs for PMTCT is from WHO, UNAIDS and UNICEF, *Towards Universal Access: Scaling up priority HIV/AIDS interventions in the health sector – Progress Report*, April 2007, WHO, Geneva, 2007. Number of infants receiving ARV prophylaxis is from WHO and UNICEF, *A Report Card on Prevention of Mother-to-Child Transmission of HIV/AIDS and Paediatric HIV Care and Treatment in Low- and Middle-Income Countries: Progress on scaling up, 2004–2006*, WHO, Geneva, November 2007. Estimated numbers of young people living with HIV are from UNAIDS, 2010.

These are only a few examples of how efforts to save and improve the lives of women and children have evolved into policy and programme work that addresses the very cornerstones of development. This points the way for the AIDS response to take its place as a necessary, but specific, part of country-led efforts to achieve not only MDG 6 – halt and reverse the spread of the HIV epidemic – but all the Millennium Development Goals (MDGs).

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

While children in general have benefited enormously from the substantial progress the AIDS response has made, there are millions of women and children who have been passed over because of inequities rooted in gender, economic status, geographical location, education level and social status.

Women, children and adolescents who are poor, living in rural areas or at the margins of society should have as much access to the benefits of the AIDS response as those who are wealthy, living in urban areas, well-educated and in the cultural mainstream. Strategies designed to reach only the more accessible populations can never be optimal. 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.

Data from all regions of the world indicate disparities between rural and urban populations as well as disparities related to poverty or such social factors as women's financial dependence and young people's lack of access to services. Health indicators most likely to reveal inequalities include the number of women making antenatal care visits to medically trained personnel, the proportion of home births and skilled attendance at delivery, and the extent of women's unmet contraceptive needs;[7] birth registration is another indicator where there is significant disparity. Yet the services related to maternal and reproductive health that correspond to these inequalities are important entry points for HIV-related prevention, treatment and care.

Strengthening health systems is important to ensure a more effective and sustainable response, and the offer of HIV testing and counselling must increase markedly if universal access goals are to be met. But in themselves these components are not sufficient to ensure access and equity. In fact, evidence shows that simply adding resources to existing health systems can exacerbate inequalities in health outcomes that already exist between rich and poor.[8] Investments in social protection systems may help mitigate this, by enabling women's and children's access to services.

The evidence: Much is known about children and AIDS

Despite the many gaps, the knowledge base of evidence on children and AIDS has improved tremendously in a few short years. The body of scientific evidence and programme evaluation has grown to the point where clarity is emerging on how, exactly, countries can create their paths to universal access.

An accumulation of evidence led the World Health Organization (WHO) in 2010 to revise guidelines on the use of antiretrovirals for preventing mother-to-child transmission and on ART for HIV infection in adults and adolescents and in infants and children.[9] These guidelines represent a new standard of treatment based on highly efficacious regimens. New guidelines on infant feeding in the context of HIV reflect WHO's recommendation that HIV-exposed infants be breastfed for at least 12 months with appropriate ARV prophylaxis in country settings where breastfeeding is the safest infant feeding option. WHO also recommends intensified TB case finding and isoniazid preventive therapy for people living with HIV.[10] The United Nations Educational, Scientific and Cultural Organization (UNESCO) and others recently issued the first-ever sexuality education technical guidance focused on children and young people in school and out-of-school contexts; [11] and UNICEF and partners issued an updated guidance document on the care, protection and support of children affected by HIV and AIDS.[12] In 2010, WHO also issued guidance on preventing intimate partner violence and sexual violence against women, including girls and adolescents.[13]

Guidance, however, is only part of the solution. It is still difficult to talk about sexuality with children in school and at home, or about intimate partner violence. Where women's access to finances is limited, it has an impact on their independence; stigma and discrimination towards people living with HIV (or whose behaviour puts them at risk for HIV) still lead to their disparagement and criminalization rather

than their treatment and care using the best evidence-informed methods.

Efforts to accelerate action towards achieving the health-related MDGs must position HIV as a central element of the strategy – particularly in the hardest-hit regions of Africa, South Asia and the Caribbean and in sub-national concentrated epidemics that often affect the most marginalized in society. It is important to demonstrate how success in fighting HIV depends on and contributes to improved systems for mothers, children and families and has a positive impact on all the MDGs.

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In sub-Saharan Africa, 9 per cent of maternal mortality is due to HIV and AIDS,[14] and in some countries AIDS contributes significantly to under-five mortality. In Eastern Europe, stigma, social exclusion and criminalization compound the distress of women and children at the margins of society and increase their vulnerability to HIV and AIDS. In that context, HIV interventions provide a relevant gateway to work with the most marginalized, especially those who are often neglected by health campaigns in urban areas.[15] It is critically important to drive demand from the bottom up – by empowering communities through the use of communication and by addressing stigma – so that interventions are accessed in an equitable manner.

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. The United States, the largest global funder of the AIDS response, has folded the President's Emergency Plan for AIDS Relief (PEPFAR) into its broader Global Health Initiative. The Global Fund to Fight AIDS, Tuberculosis and Malaria is likewise encouraging proposals to strengthen health systems to improve results for AIDS, TB and malaria.

Increasing funds for maternal, newborn and child health and reproductive health services will have an important, positive impact on HIV and AIDS outcomes. But if overall resources are fixed, and if the number of people newly eligible for access to treatment is limited, then this could disproportionately affect mothers identified during PMTCT and their newborns, the very people whom higher-quality, integrated services should benefit. Integration of AIDS-related services into the maternal, newborn and child health continuum requires more money for both.

The elimination of new HIV infections and AIDS-related deaths in children is possible, but it will require vision, leadership and system-wide improvements in health-care delivery, as well as deep-seated social change and continued implementation of best practices. In all four of the *Unite for Children, Unite against AIDS* priority areas – the four 'Ps' of preventing mother-to-child transmission, providing paediatric care and treatment, preventing infection among adolescents and young people, and protecting and supporting children affected by HIV and AIDS – integrating interventions into existing systems without losing the capacity to address the specific needs of children affected by AIDS is a challenge.

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 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.

II. 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.

The body of scientific and programmatic evidence has grown tremendously since the first clinical trials demonstrated the efficacy of antiretroviral drugs in reducing mother-to-child transmission of HIV. Building on this evidence, remarkable progress has been made in providing HIV prevention, care and treatment services to women and children in low- and middle-income countries.

In 2010, WHO revised guidelines on PMTCT, HIV and infant feeding, and antiretroviral therapy (ART), calling for the provision of highly efficacious antiretroviral regimens for PMTCT, including ART for pregnant women in need of treatment for their own health, and, for the first time, prophylaxis to mother or baby during breastfeeding, where breastfeeding is judged to be the safest option.[16] The revised guidelines offer an opportunity for even more dramatic achievements in averting new HIV infections in infants and improving maternal and child health and survival.

Equally important, programme data from several countries in sub-Saharan Africa, Asia and Latin America demonstrate that universal access to PMTCT services is feasible with strong political leadership and commitment, harmonized partnerships and sound programming. In May 2010, at a workshop in Nairobi co-hosted by the Global Fund, the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA) and WHO, representatives from 20 countries highly affected by the epidemic met to review their PMTCT targets and strategies, adapt them to the revised WHO guidelines and reprogramme their existing Global Fund grants to give additional resources to the goal of virtual elimination. [17]

Yet, despite remarkable gains in coverage and uptake of PMTCT services, and despite the strong momentum towards virtual elimination, AIDS is still one of the leading causes of death among women of reproductive age globally and one of the major causes of maternal mortality in generalized epidemic settings.[18] Global initiatives to improve maternal and child health outcomes related to Millennium Development Goals 4, 5 and 6 – such as the Secretary-General's Global Strategy for Women's and Children's Health, launched in September 2010, and the 'H4+' commitment by WHO, UNICEF, UNFPA, the World Bank and UNAIDS to reducing maternal and newborn mortality in the most affected countries – highlight PMTCT as a priority, particularly in countries with a high HIV burden.

Routine, voluntary HIV testing and counselling of all pregnant women is the key entry point for PMTCT services. The proportion of pregnant women tested for HIV in low- and middle-income countries increased from 7 per cent in 2005 to 26 per cent in 2009. By the end of 2009, 27 out of all low- and middle-income countries had already reached the

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2010 UNGASS (United Nations General Assembly Special Session on HIV/AIDS) target of 80 per cent of all pregnant women having access to HIV testing and counselling.[19]

In some high-burden countries of sub-Saharan Africa (Botswana, Namibia, South Africa and Zambia) and in some countries of Central and Eastern Europe (Russian Federation and Ukraine) and East Asia (Thailand), HIV testing rates in pregnant women are above the 80 per cent target. In Latin America and the Caribbean, 57 per cent of pregnant women received an HIV test in 2009 compared to 29 per

In low- and middle-income countries in 2009, 53 per cent of pregnant women living with HIV received antiretrovirals (ARVs) to prevent mother-to-child transmission of HIV, compared to 45 per cent in 2008.[21] In sub-Saharan Africa, this proportion increased from 45 per cent in 2008 to 53 per cent in 2009. One of the most significant increases occurred in Eastern and Southern Africa, where the proportion jumped from 58 per cent in 2008 to 68 per cent in 2009. In West and Central Africa the increase was from 16 per cent to 23 per cent over the same period.[22]

About one third of infants born to HIV-positive mothers receive ARVs for PMTCT; coverage has increased only slightly, from 32 per cent in 2008 to 35 per cent in 2009 in low- and middle-income countries.[23] For many countries, 80 per cent coverage was the universal access target for both HIV testing and the provision of highly efficacious ARVs for PMTCT. Reaching the goal of elimination of mother-to-child transmission requires a more substantial effort – towards universal testing and at least 95 coverage of ARVs for PMTCT – particularly for countries with generalized epidemics.

UNAIDS has made PMTCT one of its priority outcome areas and has called for the virtual elimination of mother-to-child transmission by 2015 ('virtual elimination' meaning that less than 5 per cent of children born to HIV-positive mothers are infected). To ensure accountability and monitor progress towards this goal, the 10 UNAIDS co-sponsors, under the leadership of UNICEF, WHO and UNAIDS, developed a business case for PMTCT that sets out three bold results to be achieved by 2011 in 10 of the 22 countries with the greatest number of HIV-positive pregnant women: attain at least 80 per cent coverage of effective ARVs for PMTCT; provide antiretroviral treatment to at least 50 per cent of HIV-positive pregnant women eligible for treatment for their own health under the 2010 WHO guidelines; and reduce by 50 per cent the current unmet need for family planning among all women.[24]

Reaching the new goal of virtual elimination will require full implementation of the United Nations comprehensive approach to PMTCT, including primary prevention of HIV