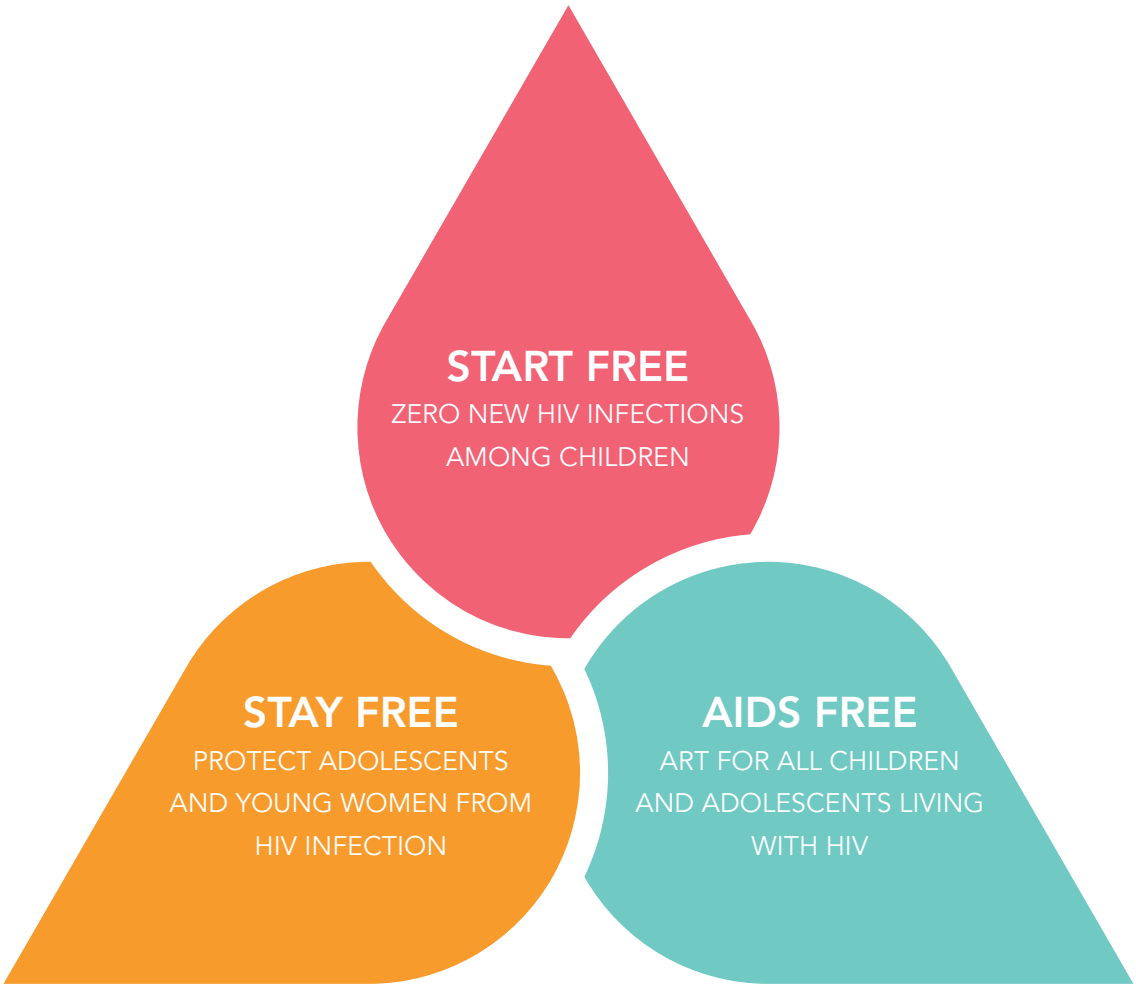
START FREE, STAY FREE, AIDS FREE

A SUPER-FAST-TRACK FRAMEWORK FOR ENDING AIDS AMONG CHILDREN, ADOLESCENTS AND YOUNG WOMEN BY 2020



2016

PREAMBLE

START FREE

Every child should be born and remain HIV free, every pregnant woman/mother living with HIV should have access to lifelong HIV treatment.

STAY FREE

Every adolescent and young woman should be able to protect themselves from HIV infection and realize their full potential without fear of sexual violence, abuse or exploitation.

AIDS FREE

Every child and adolescent living with HIV should have access to quality HIV treatment, care and support and realize their full potential without stigma and discrimination.

TABLE OF CONTENTS

THE FRAMEWORK AND ACTION PLAN

The 'Start Free, Stay Free, AIDS Free' Super-Fast-Track framework and action plan builds on remarkable success achieved between 2011 and 2015 in reducing the number of new HIV infections among children as well as increasing the number of children with HIV on treatment.

It provides a menu of policy and programmatic actions designed to enable countries and partners to close the remaining HIV prevention and treatment gap for children, adolescents young women, and expectant mothers.

Success will depend on concerted and coordinated country led action that is backed by global support. The framework recognises that every country needs a tailor-made acceleration and implementation plan. Each plan should respond to the country context, building on successful strategies for systems strengthening, and identifying critical opportunities and actions that can expand access to lifesaving HIV treatment and prevention services for all children, adolescents and young women as quickly as possible.

The framework establishes three blocks of programme activity that are closely interrelated; they should move forward together, recognizing the reality and variability of country, government and partner priorities. Some partners may have more expertise, interest and ability to move in one block but not another. This is encouraged, along with full transparency and accountability.

To support implementation, the framework also calls on industry, civil society and international partners to focus on investing in and finding new, efficient and cost effective solutions that simplify and innovate to maximize programme outcomes.

THE SUPER-FAST-TRACK APPROACH

The AIDS epidemic among children, adolescents and young women can be ended by 2020.

Children, adolescents and young women have a right to Start Free, Stay Free, and be AIDS Free.

START FREE

by preventing new HIV infections among children during pregnancy, birth and throughout the breastfeeding period.

STAY FREE

by preventing new HIV infections among adolescents and young women as they grow up.

AIDS FREE

by providing HIV treatment, care and support to children and adolescents living with HIV.

Today, 60% fewer children are newly infected with HIV annually than just six years ago in 21 countries* in sub-Saharan Africa who implemented the Global Plan to eliminate new HIV infections among children and keeping their mothers alive (Global Plan). Since 2009 1.2 million new HIV infections among children have been averted in these countries.

The progress made under the Global Plan is worth celebrating as it is one of the greatest public health achievements of recent times. It took all partners pulling together for the shared aim to be realized. Political commitment led to action, action led to results—saving lives.

Since the Global Plan roll out five years ago, HIV programmes have been expanded, services are better integrated, new ways of delivering those services have been introduced and antiretroviral regimens to keep children safe from HIV and maintain maternal health have improved.

Adolescents and young women who have been reached by programmes are beginning to be empowered. HIV prevention and treatment services are becoming available to an increasing number of people.

However many children, adolescents and young women are still being left behind. There is no time to waste. The need to reach young children quickly is more critical than for adults as they are more likely to die more quickly of AIDS-related causes without immediate access to HIV treatment and prevention services.

In 2015, 110 000 [84 000–130 000] children (aged 0–14) and 21 000 [17 000–26 000] adolescents (aged 15–19) died of AIDS-related causes. In the same period, 150 000 [110 000–190 000] children and 250 000 [180 000–340 000] adolescents (aged 10–19) were newly infected with HIV. There were 160 000 [12 000–22 000] new HIV infections among adolescent girls (aged 10–19), 77% of them in sub-Saharan Africa. In 2015, 920 000 children were without HIV treatment and millions more at risk of HIV infection.

There were approximately 350 AIDS-related deaths among children and adolescents (aged 0–19) every day in 2015, 86% of them in sub-Saharan Africa and 11% in Asia and the Pacific.

* Angola, Botswana, Burundi, Cameroon, Chad, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Ghana, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, South Africa, Uganda, United Republic of Tanzania, Swaziland, Zambia and Zimbabwe.

SUPER-FAST-TRACK TARGETS FOR CHILDREN, ADOLESCENTS AND YOUNG WOMEN

These call for full programme scale up by 2018, leading to 2020.

START FREE

— Eliminate new HIV infections among children (aged 0–14) by reducing the number of children newly infected annually to less than 40 000 by 2018 and 20 000 by 2020.
— Reach and sustain 95% of pregnant women living with HIV with lifelong HIV treatment by 2018.

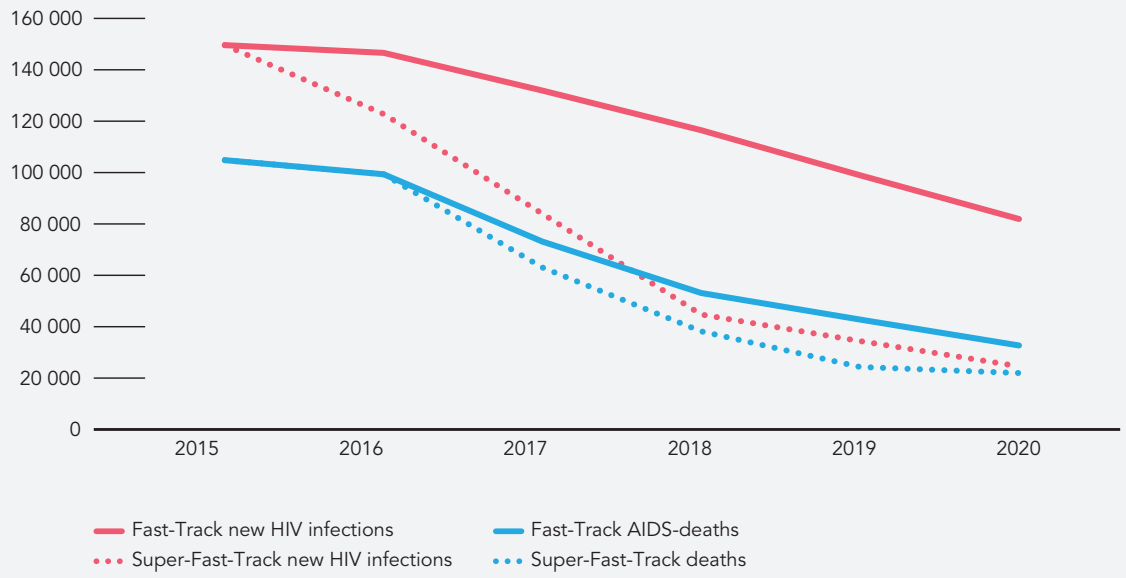
STAY FREE

— Reduce the number of new HIV infections among adolescents and young women (aged 10–24) to less than 100 000 by 2020.
— Provide voluntary medical circumcision for HIV prevention to 25 million additional men by 2020, with a focus on young men (aged 15–29).

AIDS FREE

— Provide 1.6 million children (aged 0–14) and 1.2 million adolescents (aged 15–19) living with HIV with lifelong antiretroviral therapy by 2018. [Reach 95% of all children living with HIV]
— Provide 1.4 million children (aged 0–14) and 1 million adolescents (aged 15–19) with lifelong HIV treatment by 2020. [Reach 95% of all children living with HIV]

SUPER-FAST-TRACK DOUBLE DIVIDEND:
REDUCES NEW HIV INFECTIONS AND AIDS-RELATED DEATHS AMONG CHILDREN (AGES 0–14)



Source: UNAIDS 2016 estimates

In 2015, there were approximately 1100 new HIV infections everyday among children and adolescents (aged 0–19), just 30% less than in 2010. Although young people aged 15–24 account for 22% of the adult population, they represent 35% of adults acquiring HIV each year. There were approximately 3.9 million [3.6 million–4.2 million] young people (aged 15–24) living with HIV globally in 2015, most of them in sub-Saharan Africa (2.8 million [2.6 million–3.2 million]). However, in this region only 10% of young men and 15% of young women aged 15–24 are aware of their HIV status.

Among young people aged 15–24, young women bear a disproportionate burden of new HIV infections, accounting for up to 58% globally, and 66% in sub-Saharan Africa, where HIV prevalence among young women (aged 15–24) is twice as high as their male peers.

Harmful norms and practices such as early and forced marriage and forced sexual experience increase the risk of HIV among adolescent girls and young women. In sub-Saharan Africa, less than one out of four young women have the final say in decisions regarding their own healthcare. In some settings, up to 45% of adolescent girls report that their first sexual experience was forced.

Reaching the end of the AIDS epidemic among children, adolescents and young women requires ambitious targets and a Super-Fast-Track approach. Immediate accelerated scale up of access to treatment, prevention, care and support services to children, adolescents and their parents is needed in the next two and a half—rather than five—years, to have a maximum impact. Thereafter, the programmes have to be sustained at high levels through 2020 and beyond. These targets are

accelerated and complementary to 90-90-90 targets, and are to be achieved in a shorter time frame.

Immediate action is required on four fronts:

1 Political commitment and policy change

Political commitment is required in order to reach the maximum numbers of children, adolescents and young women in record time. From the beginning when ambitious targets are set; and throughout the process, by ensuring accountability, revising policies for the rapid integration of innovations that improve efficiency and ease service access—including sexual and reproductive health services and streamlining registration of new medicines.

Leadership is critical for policy change. Policies that impact access to services include spousal and minimum age for consent to HIV testing and access to sexual and reproductive health. Legal barriers can pose obstacles to advancing gender equality and women's empowerment. Policies that slow the registration and procurement of quality medicines and effective diagnostics should never be the main reason that a child, adolescent or young woman did not get HIV treatment or combination prevention services in time.

2 Service delivery

One important way to reduce the numbers of children and adolescents requiring HIV treatment in the future is to stop new HIV infections among women of reproductive age. Women already living with HIV need testing to learn their status and have access to lifelong antiretroviral therapy. They must also be able to access family planning services to avoid unintended pregnancies.

Extra efforts have to be made to ensure reaching all the children and adolescents living with HIV with antiretroviral therapy and maintaining them in care. This requires paying particular attention to how services are delivered and accessed.

Ensuring zero stock outs of HIV test kits, antiretroviral medicines and other prevention commodities is critical. Removing supply chain bottlenecks and strengthening procurement and distribution systems are essential to these efforts to reach pregnant women, children, adolescents and young women.

It is necessary to innovate to reach adolescents, women and children with HIV testing using multiple strategies and building on lessons learned. For example, routinely offering testing in maternal and child health care settings to identify previously unrecognized HIV exposed children, and developing alternative testing strategies for adolescents.

National strategies should expand service delivery through community structures and providers to greatly increase the number of people being reached in communities, and retain them in care in ways that are more accessible and acceptable to them.

Services specifically designed to be youth-friendly, non-judgmental and free from stigma, discrimination and violence are needed to meet the particular needs of adolescents and young women.

3 Community engagement

A successful AIDS response hinges on community leadership and engagement. Communities have to create an enabling space where all the rights of women, children and adolescents are respected, protected and promoted, and there is no stigma and discrimination in accessing HIV treatment and combination prevention services. Communities have played a key role in delivering HIV treatment and prevention services and this role should assume more prominence. At the same time, societies have a pivotal

role in stopping sexual and gender-based violence against women and girls, challenging harmful gender norms and practices, and advancing gender equality. Experience shows that adolescents and young women can be leaders themselves and play a key part in empowering their peers to protect themselves from HIV as well as to access treatment. Engaging adolescents and young people as beneficiaries, partners and stakeholders will ensure greater ownership, accountability and the sustainability of the HIV response.

4 Innovation and new products

It is vital to roll out innovative products, diagnostics and HIV treatment options that are specific to needs of children, adolescents and young women. Some examples include easy to use point-of-care technologies to detect HIV and monitor health status; and child-friendly palatable fixed-dose combinations. Newer and better options for use in second and third line therapies are also urgently needed. Innovation in service delivery is required to ensure that scale up is not hindered by the constraints of the existing delivery models.

PARTNERSHIPS

Start Free, Stay Free, AIDS Free is about galvanizing a global movement around a shared and ambitious agenda which can only be achieved through a Super-Fast-Track approach to ensuring children, adolescents, young women and expectant mothers can access the HIV prevention, treatment, care, and support services they need, and deserve.

It will take the strengths of all partners working together to reach the bold goals of Start Free, Stay Free, AIDS Free. Everyone has a role to play—and everyone must do their part. Partnership must include governments; communities and civil society, faith-based organizations and leaders; UN agencies; donors and philanthropies; the private sector; and implementing partners.

BUILDING ON SUCCESS

The world has made enormous progress in reducing new HIV infections and AIDS-related deaths among children since 2011 through the efforts of the Global Plan. Globally, new HIV infections among children (aged 0–14) are at a record low, with an estimated 150 000 [110 000–190 000] compared to 290 000 [250 000–350 000] in 2010, a 50% reduction. In 2015, 77% [69–86%] of pregnant women living with HIV have access to antiretroviral medicines. Cuba, Armenia, Belarus and Thailand have been validated as having eliminated new HIV infections among children. Another 80 countries have fewer than 50 children infected with HIV each year, making them close to eliminating new HIV infections among children.

Continued gains are being made in bridging the treatment gap for children. In the last five years alone, treatment scale-up for children grew two-fold, and AIDS-related deaths among children were reduced by 44%. One in two children needing HIV treatment are now receiving it, but far too many children are still in need.

CLOSING THE GAP

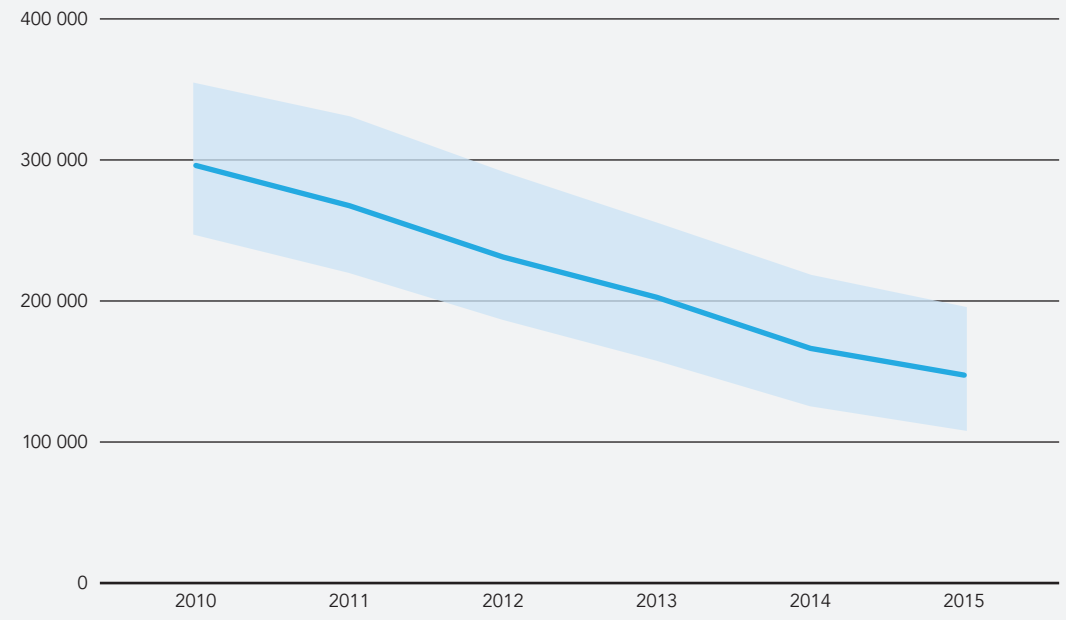
The success in reducing new HIV infections and AIDS-related deaths among children gives hope that the remaining gap can be closed if placed on Super-Fast-Track priority. The need to act immediately is urgent, given that most HIV infections among children are acquired during pregnancy and the breastfeeding period. In 2015, 150 000 [110 000–190 000] children were infected with HIV, half of whom acquired it during the breastfeeding period.

In 2015, 920 000 children (aged 0–14)—about half of the 1.8 million [1.5 million–2.0 million] children living with HIV—did not have access to HIV treatment at the end of 2015. Those who did have access are still starting treatment too late. Data from sub-Saharan Africa suggest the average age of antiretroviral therapy initiation is age 3.8 years. Without treatment, 50% of children infected with HIV at birth will die by the age of two.

Adolescents and young women still carry a disproportionate burden of new HIV infections and AIDS-related deaths. Only 36% of young men and 30% of young women (aged 15–24) in sub-Saharan Africa have comprehensive and correct knowledge of how to prevent HIV. The lack of knowledge and skills reflect the current status of the epidemic among young people. In 2015 there were roughly 1800 new HIV infections everyday among young people (aged 15–24), just 6% less than in 2010. Although young people aged 15–24 account for 22% of the global adult population, they represent 35% of adults who acquired HIV in 2015.

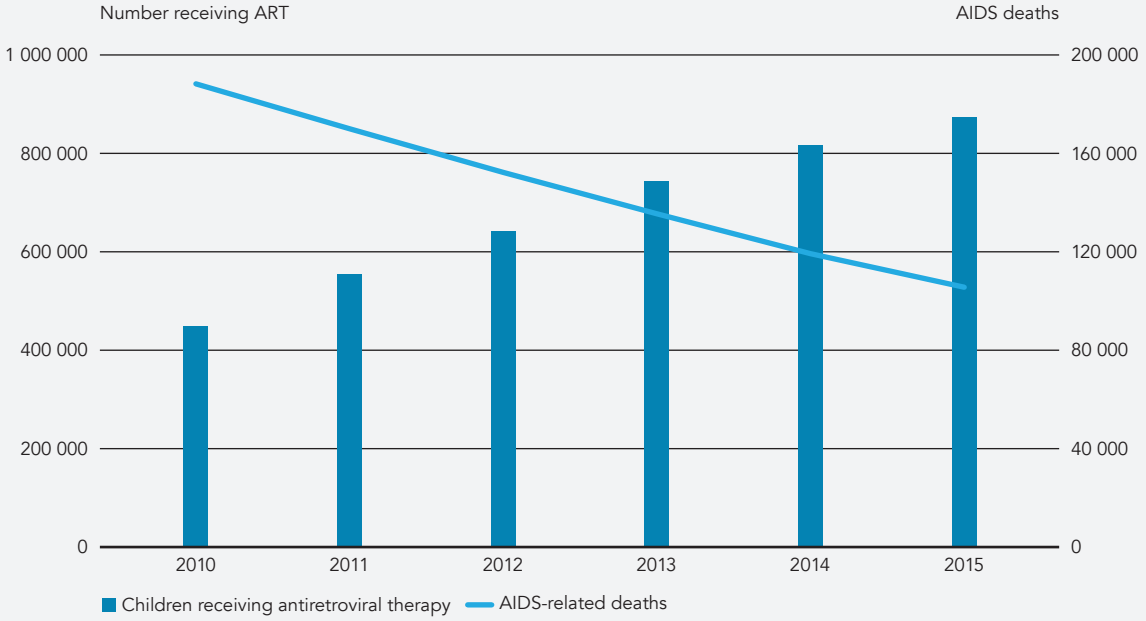
Adolescents (aged 10–19) are the only age group among whom AIDS-related deaths are increasing. Adolescent girls and young women aged 15–24 years are at particularly high risk of HIV infection, accounting for 20% of new HIV infections among adults globally in 2015, despite accounting for just 11% of the adult population. In geographical areas with higher HIV prevalence, the gender imbalance is more pronounced. In sub-Saharan Africa, adolescent girls and young women accounted for 25% of new HIV infections among adults, and women accounted for 56% of new HIV infections among adults. Harmful gender norms and inequalities, insufficient access to education and sexual and reproductive health services, poverty, food insecurity and violence, are at the root of the higher HIV risk of young women and adolescent girls.

NEW HIV INFECTIONS AMONG CHILDREN AGED 0–14, GLOBALLY, 2010–2015



Source: UNAIDS 2016 estimates

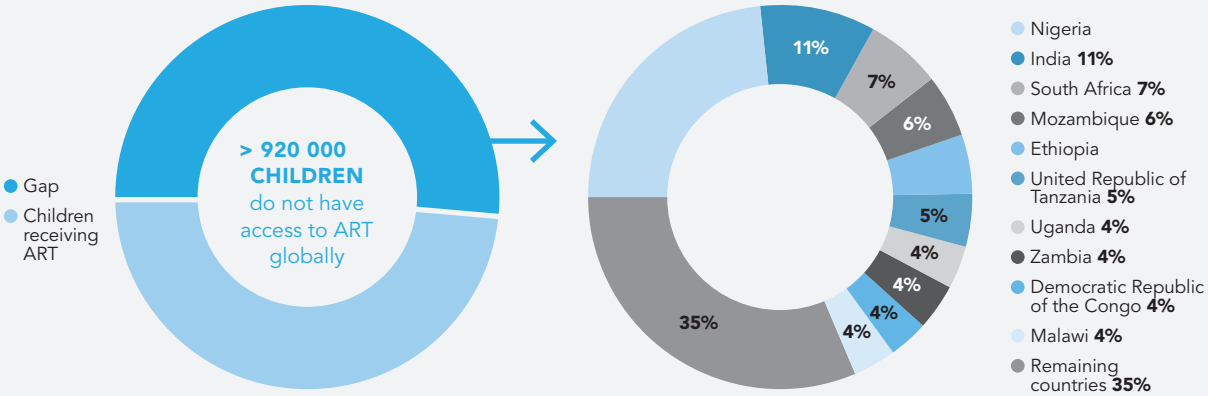
NUMBER OF CHILDREN RECEIVING ANTIRETROVIRAL THERAPY AND AIDS DEATHS AMONG CHILDREN AGED 0–14, GLOBALLY, 2010–2015



Source: 2016 Global AIDS Response Progress Reporting

TREATMENT GAP FOR CHILDREN AGED 0–14 LIVING WITH HIV

TOP 10 COUNTRIES WITH THE LARGEST NUMBER OF CHILDREN LIVING WITH HIV NOT RECEIVING ART, 2015



Source: UNAIDS, 2016 estimates

IMPLEMENTATION FRAMEWORK

COUNTRY LEADERSHIP

The success of the Global Plan to eliminate new HIV infections among children and keeping their mothers alive and the scale up of paediatric treatment in recent years came as a result of sustained leadership and focused action at the country level. In country after country dedicated plans were developed and all partners acted in concert to achieve the goals set. While regional and global collaborations and partnerships provided support to countries; the leadership and accountability remained firmly in the hands of on the ground implementers and local authorities.

The Start Free, Stay Free, AIDS Free framework aims to harness and further strengthen these existing mechanisms at country level to deliver on the results agreed. A broad set of partners will be welcomed within the fold to expand the reach of services.

POPULATION AND LOCATION FOCUS

All countries need to take steps to ensure that all children, adolescents and young women have access to HIV treatment and prevention services. However the implementation will vary from country to country taking into account the epidemiological status, as well as the progress already made.

START FREE

The focus for Start Free will continue to be the 22 Global Plan countries*. Special attention will be given to additional countries to support further scale up of services so that they reach dual elimination of HIV and syphilis certification status.

STAY FREE

For Stay Free, the primary focus will be on eight high burden countries in East and Southern Africa and two countries in West and Central Africa. These are: Cameroon, Kenya, Malawi, Mozambique, Nigeria, South Africa, Uganda, United Republic of Tanzania, and Zambia.

AIDS FREE

For AIDS Free, similar to the Global Plan approach, priority countries will be identified on a sub-regional basis.

TOP FIVE FOCUS COUNTRIES: COUNTRIES WITH LARGEST GAP

More than half of the treatment gap for children living with HIV is in five countries—Ethiopia, India, Mozambique, Nigeria, and United Republic of Tanzania.

Nigeria now has the largest number of children living with HIV, although the overall number of people living with HIV is half that of South Africa. Coverage of ART for children aged 0-14 remains very low. In Asia, India has the largest number of children living with HIV.

* Angola, Botswana, Burundi, Cameroon, Chad, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Ghana, India, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, South Africa, Uganda, United Republic of Tanzania, Swaziland, Zambia and Zimbabwe.

While the epidemiological context and capacities vary between these five countries, in each, the size and spread of HIV is concentrated in a few states, cities and districts. A special focus on scaling up PMTCT and paediatric HIV services in these countries is required. The efforts already made in the highest-burden areas of these countries to increase PMTCT services and scale up paediatric ART in recent years can serve as the basis for scale up.

HIGH BURDEN COUNTRIES WITH > 50% COVERAGE

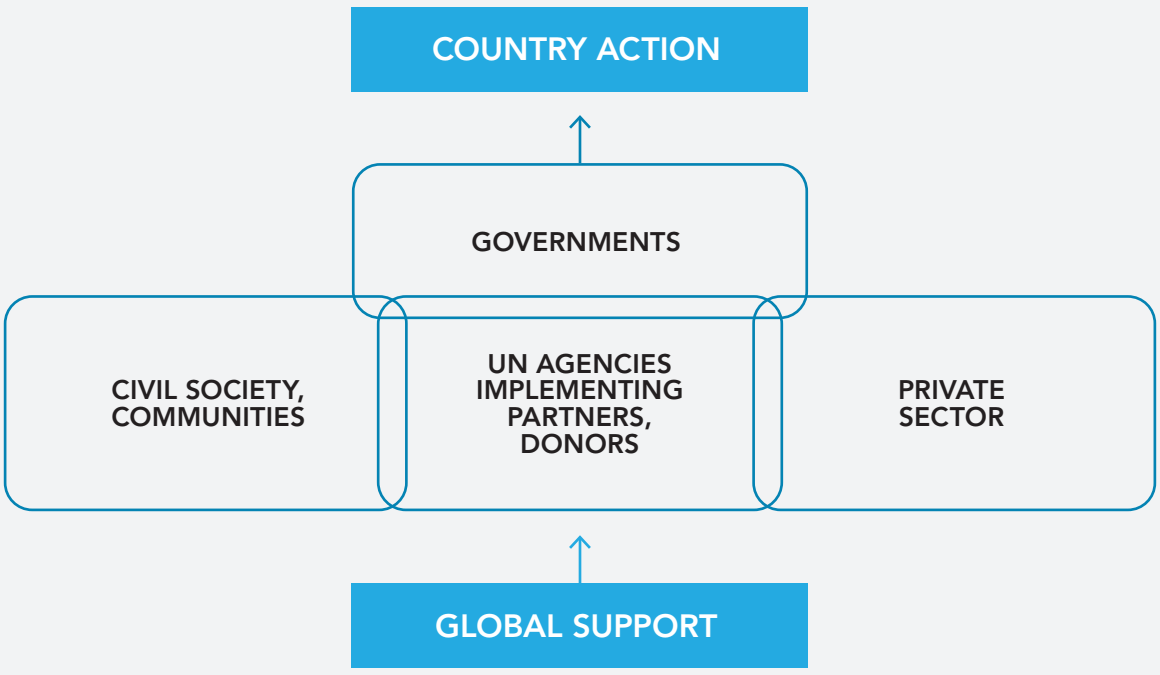
In Eastern and Southern Africa, where 58% of all children living with HIV live, 63% [56%–71%] of children aged 0-14 are already on antiretroviral therapy. However despite large numbers of children on HIV treatment, significant numbers of children in these countries still do not have access to antiretroviral therapy because of the high burden of HIV. As countries have well-functioning systems and capacity to scale up services with minimal effort, the approach here will be to build upon and sustain the good work already underway.

In Eastern and Southern Africa—of an estimated 1 million [930 000–1.2 million] children (aged 0–14) living with HIV, 390 000 were not receiving treatment in 2015.

COUNTRIES WITH LOW COVERAGE (<50% coverage)

In countries where there has been less than 50% coverage of HIV treatment for children, special efforts have to be taken to review operational plans and

SUPER-FAST-TRACK IMPLEMENTATION FRAMEWORK



strengthen the delivery systems in an emergency mode. For example in West and Central Africa, six countries with the largest number of children living with HIV— Cameroon, Chad, Côte d'Ivoire, The Democratic Republic of the Congo, Ghana, and Nigeria—coverage of antiretroviral therapy for children is less than 27%. In many of these countries significant challenges remain in reaching pregnant women living with HIV as well in identifying children and adolescents living with HIV.

CONSIDERATIONS FOR INVESTING IN CITIES AND PRIORITY DISTRICTS

In recent years, the focus of HIV programme implementation has shifted to major cities, urban areas and the priority districts where the burden of HIV is disproportionately higher than in other parts of a country. Many cities, under the leadership of their Mayors, have embarked upon special initiatives to scale up HIV prevention and treatment services. These plans present an opportunity to integrate HIV prevention and treatment programmes for children, adolescents and young women within them. In each country, priority cities will be identified where there are large numbers of unreached children and adolescents living with HIV and special campaigns and strategies will be designed to reach them in record time.

START FREE

EVERY CHILD SHOULD BE BORN AND REMAIN HIV FREE, EVERY PREGNANT WOMAN AND MOTHER LIVING WITH HIV SHOULD HAVE ACCESS TO LIFELONG HIV TREATMENT.

START FREE

Every child deserves an HIV-free beginning. The Global Plan spurred remarkable progress, reducing new HIV infections among children by 60% in 21 of the highest burden countries in sub-Saharan Africa. Yet, the job is far from done. In 2015, 110 000 [78 000–150 000] children (aged 0–14) were newly infected with HIV in 21 countries, and 150 000 [110 000–190 000] worldwide. Elimination of new HIV infections among children is possible. It starts with preventing new HIV infections among women. It also requires a special focus on initiating pregnant women and women of childbrearing age who are living with HIV on lifelong antiretroviral therapy and ensuring that breastfeeding mothers are retained in care during the breastfeeding period.

START FREE TARGETS

- Eliminate new HIV infections among children (aged 0–14) by reducing the number of children newly infected annually to less than 40 000 by 2018 and 20 000 by 2020.
- Reach and sustain 95% of pregnant women living with HIV with lifelong HIV treatment by 2018.

POLICY ACTIONS

POLITICAL COMMITMENT AND INVESTMENT IN PROGRAMMES FOR PREVENTION OF MOTHER-TO-CHILD HIV TRANSMISSION

ISSUE Despite the massive success in reducing new HIV infections among children, too many new infections still occur because of high incidence of HIV among young women including during pregnancy, lack of PMTCT services for all women living with HIV and poor retention in postnatal care. Even in countries which have eliminated new HIV infections, PMTCT programmes must be continued and sustained. HIV tests should be routinely offered to pregnant women. PMTCT needs to remain an integral part of the AIDS response. In high burden countries, women living with HIV will continue to need services throughout their reproductive years. For example in South Africa, even if there were no more new HIV infections among women of reproductive age, approximately 10% of reproductive age women would need PMTCT services in 2025.

ACTION Continue a sustained political commitment and investments for PMTCT programmes.

COMMITMENT TO PROVIDE 95% OF PREGNANT WOMEN LIVING WITH HIV WITH PMTCT SERVICES

ISSUE Coverage of PMTCT services globally has reached 77% [69%–86%], and varies from country to country. Several countries have reached coverage levels of 95% or more. To reach the targets of reducing new HIV infections among children, all countries have to commit to reaching 95% of pregnant women living with HIV by 2018 or earlier.

ACTION Revise the operational plans for PMTCT programmes and set new annual targets where appropriate.

FULL IMPLEMENTATION OF TREAT ALL

ISSUE The World Health Organization (WHO) recommends that all pregnant women living with HIV be offered lifelong HIV treatment. This policy helps to retain women living with HIV on treatment both before an during pregnancy, which is very effective for reducing HIV transmission to children. It also provides opportunities for follow-up with children exposed to HIV, meeting the overall health needs of both women and children.

ACTION All countries should adapt their policies to ensure full implementation of Option B+ and move to Test and Treat.

DELIVERY ACTIONS

INTEGRATION OF ANTENATAL CARE AND PMTCT SERVICES

ISSUE Health services for pregnant women are often fragmented and cause an unnecessary burden on women and often lead to loss of follow up and interrupted care. Integration of HIV services with antenatal care (ANC) services leads to better outcomes for both women and their children.

ACTION Ensure that all ANC services have integrated PMTCT services.

ROBUST LABORATORY SYSTEMS TO SEND AND RECEIVE TIMELY TEST RESULTS

ISSUE A major reason for loss to follow up is the delay in sending HIV and related test results between laboratories, health care providers and clients.

ACTION Establish or strengthen systems for a real time flow of information between laboratories and the people who need their test results.

RETENTION IN CARE THROUGHOUT ANTENATAL AND BREASTFEEDING PERIOD

ISSUE Approximative half of all new HIV infections among children take place during breastfeeding. While there has been success in retaining pregnant women on antiretroviral therapy during pregnancy, there has been inadequate focus on follow up and support to mothers during the breastfeeding period.

ACTION Establish systems for real time monitoring, tracking and support of pregnant and breastfeeding women living with HIV.

ACTION Put in place linked clinic and community support systems for pregnant and breastfeeding women.

INNOVATION ACTIONS

REAL TIME TRACKING OF MOTHERS AND BABIES IN THE HEALTH CARE SYSTEM

ISSUE Separate medical registers for women and children after birth can contribute to loss to follow up and infants not getting timely early infant diagnosis.

ACTION Integrate one reporting system that includes longitudinal information on both mother and baby.

STAY FREE

EVERY ADOLESCENT AND YOUNG WOMEN SHOULD BE ABLE TO PROTECT THEMSELVES FROM HIV INFECTION AND REALIZE THEIR FULL POTENTIAL WITHOUT FEAR OF SEXUAL VIOLENCE, ABUSE OR EXPLOITATION.

STAY FREE

When children have an HIV-free start, they must be supported to stay that way as they enter adolescence and age into adulthood. This requires an intensified focus on reaching and empowering adolescent girls and young women. It also requires an emphasis on reducing the vulnerabilities of adolescent girls and young women, and youth from key populations by engaging men and boys, as well as ensuring young men have access to key prevention services, including voluntary medical male circumcision. Globally, 390 000 [340 000–450 000] adolescent girls and young women (aged 10–24) are infected every year, and in sub-Saharan Africa, girls account for 75% of new HIV infections occurring among adolescents annually.

STAY FREE TARGET

- Reduce the number of new HIV infections among adolescents and young women (aged 10–24) to less than 100 000 by 2020.
- Provide voluntary medical circumcision for HIV prevention to 25 million additional men by 2020, with a focus on young men (aged 15–29).

POLICY ACTIONS

HIV EDUCATION FOR YOUNG PEOPLE

ISSUE Most young people lack the knowledge required to protect themselves from HIV. In sub-Saharan Africa, survey data from 35 countries show that only 36% of young men and 30% of young women correctly identified ways of preventing the sexual transmission of HIV and rejected major misconceptions about HIV transmission. In 23 countries outside of sub-Saharan Africa, just 13.8% of young men and 13.6% of young women had correct and comprehensive knowledge about HIV.

ACTION Ensure that the design and implementation of behavior change programmes for young people are based on solid evidence of what works and provide them with information and skills to protect themselves from HIV infection.

EARLY AND FORCED MARRIAGE

ISSUE Many girls are married as children and assume adult roles of motherhood. Adolescent girls and young women are often prevented from seeking services and making decisions about their own health. These factors drives both their risk of acquiring HIV and their vulnerability to HIV.

ACTION Reform laws and policies, and challenge harmful practices that support early or forced marriage and take adequate steps to enforce the laws.

ACCESS TO SECONDARY AND HIGHER EDUCATION FOR YOUNG WOMEN

ISSUE A significant proportion of young women drop out of school after primary education. Retaining young women in school has been shown to have a protective effect on stopping new HIV infections. School also provides an opportunity for adolescent girls to acquire the skills and knowledge to protect themselves from HIV infection and unintended pregnancies.

ACTION Promote policies that encourage all young people, particularly young adolescent girls and young women in secondary education and higher, such as removing school fees.

REACHING YOUNG MEN WITH VOLUNTARY MEDICAL MALE CIRCUMCISION FOR HIV PREVENTION

ISSUE Voluntary medical male circumcision (VMMC) is one of the most effective HIV prevention interventions for young men. VMMC can reduce the risk of female-to-male HIV transmission by at least 60 percent. By reducing new HIV infections among young men, VMMC also helps to reduce new HIV infections among young women who are their sexual partners. The impact of VMMC has been demonstrated to be the greatest when focused on young men aged 15–29 in the geographic areas of highest HIV burden.

ACTION Expand access to VMMC services for HIV prevention, with a particular focus on reaching young men aged 15–29 in the geographic areas of highest HIV burden.

PRE-EXPOSURE PROPHYLAXIS (PREP) FOR YOUNG WOMEN AT RISK

ISSUE The lack of a female-controlled prevention method has hampered young women's ability to protect themselves from HIV infection. Recent studies have shown that using oral antiretroviral medication by people not infected with HIV provides them with more than 90% protection. For young women who are not able to decide whether, when, and with whom to have sex, or fully negotiate condom use, the provision of PrEP to young women at risk has the potential in some circumstances to provide them with an additional tool for HIV prevention.

ACTION Countries with a high burden of HIV infection among young women should consider introducing PrEP for young women at risk in line with WHO recommendations.

DELIVERY ACTIONS

INTEGRATION OF SEXUAL AND REPRODUCTIVE HEALTH SERVICES AND HIV SERVICES FOR ADOLESCENTS AND YOUNG WOMEN

ISSUE Substantial available evidence shows that integrating HIV services with family planning, maternal health care or within primary facilities can increase uptake of HIV testing and treatment and other reproductive health services. Providing family planning counselling and information about voluntary contraceptive use as part of routine HIV services (and vice versa) can increase contraceptive use as well as increase HIV testing. By scaling up PMTCT programs within antenatal care, more women gain knowledge about HIV and also know their status. Early postpartum visits can result in increased contraceptive uptake and condom use when these services are readily available.

ACTION Identify opportunities for integration of health services and increase cross-issue collaboration to provide holistic health services.

LIMITED ACCESS TO COMBINATION PREVENTION

ISSUE No single HIV prevention approach alone can reduce new HIV infections. Combination prevention strategies that include condom provision, PrEP, and other proven interventions that address the social and structural drivers of new HIV infections are needed. However, there is limited implementation of combination prevention strategies that effectively target and reach adolescents and young women. Recent modelling found that in Kenya a uniformly distributed combination of prevention approaches could reduce new HIV infections by 40% over 15 years. New infections could be reduced by another 14% if a prevention strategy with the same budgetary resources focused on people and locations of greatest risk.

ACTION Countries must focus efforts, mix appropriate HIV prevention interventions together and bring these to scale with adequate resources to increase coverage of combination HIV prevention for adolescents and young women.

DELIVERING PREP

ISSUE PrEP is a new HIV prevention option that has not been rolled out extensively for young people at high risk. If proven effective for this population, it will require that health delivery systems be adapted to ensure that where PrEP is rolled out, there is adequate capacity within health and community systems to promote adherence as well as periodic HIV testing.

ACTION Innovation in service delivery models to ensure that uptake of PrEP is easy, non-intrusive, poses no additional burden on young people and at the same time ensures adherence.

AIDS FREE

EVERY CHILD AND ADOLESCENT LIVING WITH HIV SHOULD HAVE ACCESS TO QUALITY HIV TREATMENT, CARE AND SUPPORT AND REALIZE THEIR FULL POTENTIAL WITHOUT STIGMA AND DISCRIMINATION.

AIDS FREE

Everyone who is living with HIV should have access to antiretroviral treatment to stay AIDS Free and reduce their risk of onward transmission to an uninfected partner. Children and adolescents are easily left behind and the impact is devastating.

Without treatment, children born with HIV are particularly vulnerable; 50% of them will die before their 2nd birthday, and 80% will die before age 5.

AIDS FREE TARGETS

- Provide 1.6 million children (aged 0–14) and 1.2 million adolescents (aged 15–19) living with HIV with lifelong antiretroviral therapy by 2018. [Reach 95% of all children living with HIV]

- Provide 1.4 million children (aged 0–14) and 1 million adolescents (aged 15–19) with lifelong HIV treatment by 2020. [Reach 95% of all children living with HIV]

POLICY ACTIONS

ADOPTION OF WHO RECOMMENDED REGIMENS FOR CHILDREN AND ADOLESCENTS.

ISSUE The treat all policy is currently being adopted by countries but introduction in the national policies doesn't always happen alongside measures to address the specific needs of children and adolescents. The majority of children are currently receiving suboptimal treatment regimens due to lack of adequate formulations and the need to minimise regimen complexity. Treatment is often provided to adolescent without the adequate support that meets their specific needs.

ACTION Adoption of WHO preferred regimens for children and adolescents and introduction of adolescent friendly services to support treat all in adolescents.

ARV MEDICINES REGISTRATION

ISSUE It takes several years on average for a new medicine to be registered in a country. In many high burden countries, lifesaving new paediatric formulations have still not been registered despite being approved by the WHO. This delay hinders countries' procurement of these medications, staff training and provision of the medicine to children in need. There is need for simplification of the national regulatory frameworks for paediatric commodities.

ACTION Establish systems for speedy registration of WHO prequalified medications for children.

TASK SHIFTING FOR CHILDREN AND ADOLESCENTS

ISSUE While adults services have been decentralized and effectively task-shifted to scale up ART programmes, paediatric treatment and care has been left in the hands of specialists that are more comfortable with paediatric managment.

ACTION Ensure introduction of task-shifting and task-sharing policies that promote decentralization and integration of services for children and adolescents.

DELIVERY ACTIONS

EARLY INFANT DIAGNOSIS

ISSUE It is recommended that HIV exposed infants have HIV virological testing at four to six weeks of age. Many infants who are exposed to HIV are not routinely tested for HIV and as a consequence do not receive treatment when necessary. In addition, linkage to treatment or further testing to confirm diagnosis is poor resulting in many infants falling through the HIV testing net and dying before receiving ART.

ACTION Strengthen the delivery system to ensure that all HIV exposed children are tested for HIV according to WHO recommendations and promptly linked to treatment and care.

CARE CLOSER TO HOME

ISSUE Many health care providers at the primary care level are reluctant to provide care for children living with HIV and often refer them to secondary or tertiary care centres. This leads to children not being able to access care in time and in many instances no care at all.

ACTION Build capacity of health care providers at primary level to manage paediatric AIDS cases through training and continuous supported supervision.

ACTIVE CASE FINDING

ISSUE A large number of children living with HIV do not know their status for a variety of reasons including a lack of access, stigma and ignorance. It is important to implement proactive case finding strategies to identify and provide treatment to all children and adolescents. The WHO guidelines provide a good basis for expanding HIV testing for children through provider initiated testing and counseling for children at different entry points.

ACTION In high burden countries, maximize opportunities for HIV testing during immunization, visits to child health services, nutrition services, services for hospitalized and all sick children as well as community and home testing campaigns where appropriate. Children of individuals living with HIV should receive an HIV test to identify those needing treatment. Engage parents, families, faith and local communities in creating momentum for increased uptake of testing in maternal and child health facilities.

VIRAL LOAD MONITORING

ISSUE Viral suppression is the end goal of HIV treatment. Effective systems should be in place to ensure that viral load is monitored for all children and adolescents on HIV treatment. This will require services that are easily accessible by children and adolescents together with availability of second line medicines for those that fail a first line regimen.

ACTION Children and adolescents on treatment are regularly followed up and viral load monitored as part of the roll out of the 90-90-90 target.

NEEDS OF ADOLESCENTS ARE DIFFERENT FROM THOSE OF CHILDREN AND ADULTS

ISSUE Adolescents are often lost to follow-up when transitioning from child-oriented care to adult care. Community-based approaches can improve treatment adherence and retention in care of adolescents living with HIV.

ACTION Integrate services, facilitating comprehensive care onsite; decentralize, bringing ART and other treatment and support services and interventions closer to home; expand community approaches such as youth-led support systems that can support adolescents to remain in care. Advance the adoption, adaptation and implementation of adolescents friendly health services and WHO recommended standards for adolescents health services.

INNOVATION ACTIONS

LACK OF CHILD FRIENDLY FIXED-DOSE COMBINATION FOR CHILDREN

ISSUE There is a lack of child-friendly antiretroviral regimens. No fixed dose combinations exist to provide the WHO recommended first line regimen for children aged 0–10 years. As a result non-optimal formulations are used with impact on administration, adherence and supply management. In addition, paediatric antiretroviral medicines are more expensive than those of adults.

ACTION Develop affordable age-appropriate fixed dose formulations across the age spectrum.

POINT OF CARE DIAGNOSTICS FOR EARLY INFANT DIAGNOSIS

ISSUE HIV infection among infants and children under 18 months can only be detected by virological testing. The early infant diagnostic challenge presents unique opportunities to leverage emerging new point of care technologies that provide same-day test results with the possibility of expanding their use to testing at-birth, outreach screening and routine screening through different high yield entry points for immediate initiation of HIV treatment.

ACTION Ensure access to point-of-care diagnostic services to enable prompt and timely testing of infants, and the results be communicated quickly.

CROSS CUTTING ACTIONS

There are several policy, delivery, community engagement and innovations actions that cut across START FREE, STAY FREE, AIDS FREE. These have near universal application, but should be adapted to suit local contexts. This menu of crosscutting actions seek to create a strong policy and implementation environment that enables access to lifesaving HIV prevention and treatment services for children, adolescents and young women,

POLICY ACTIONS

POLITICAL LEADERSHIP FOR PROMOTING INTEGRATED SERVICES

ISSUE A review of existing national and international strategies to integrate sexual and reproductive health and HIV services in sub-Saharan Africa, found that the main challenges relate to a lack of coordinated leadership and unified national integration policies; separate financing streams for sexual reproductive health and HIV services, and inadequate health worker training, supervision and retention.

ACTION Accountability for integration should be a key measure of programme delivery.

LACK OF HUMAN RESOURCE CAPACITY

ISSUE Several countries either lack capacity or are operating at the maximum capacity of their health workforce. This has led to fewer pregnant women and children being diagnosed with HIV in time and inadequate support provided to retain women and children on treatment.

ACTION Countries should consider task-shifting of certain functions and empowering health workers and community members to initiate HIV testing and treatment especially among paediatric patients.

AGE OF CONSENT FOR HIV TESTING

ISSUE In many countries children, adolescents and young women are not able to take an HIV test without parental or spousal consent. This leads to a large number of children, adolescents and young people not being able to know their HIV status, access information and health services.

ACTION Reduce the age of consent to HIV testing and remove requirements for spousal consent to enable children, adolescents and young people to seek care and treatment without fear, stigma or discrimination.

HIV TESTING POLICY

ISSUE In many countries HIV testing can only be done by health care providers or at health facilities. With advancement in technology, pilot programmes show that community or home-testing can expand the number of people who know their HIV status. HIV self-testing could be an important option to be considered when combined with strong community support, particularly in discordant couples, adolescents, and other groups at high risk.

ACTION Review national HIV testing policies and align these with WHO guidelines

DELIVERY ACTIONS

SUPPLY CHAIN MANAGEMENT

ISSUE One of the major factors for lack of access to HIV treatment and preventions services are weak supply chain management systems. Periodic stock outs or availability in sufficient quantities of HIV test kits, reagents, condoms, and antiretroviral medicines lead to many people being missed out. This disrupts continuity of antiretroviral treatment and prevention services, and creates missed opportunities for HIV testing.

ACTION Ensure zero stock out of essential supplies for HIV treatment and prevention services.

CONSTRAINTS IN HEALTH CARE PROVIDER WORKFORCE

ISSUE Insufficient supply of physicians to provide treatment to children.

ACTION Task-shifting with appropriate training and supervision, with clearly defined roles for nurses and other health care workers commensurate with training.

MONITORING, EVALUATION AND RESEARCH

ISSUE There is limited age- and sex-disaggregated programme data. These evidence gaps obscure a clear picture of the risks, vulnerabilities and challenges that adolescents face accessing HIV and sexual and reproductive health services.

ACTION Ensure age- and sex-disaggregated data are collected and analysed to identify age- and sex-specific gaps. Prioritize adolescent HIV issues in research; involve adolescents in research; at the facility level, service delivery sites must know more about the adolescents who are using HIV services, in order to measure the impact of their programmes.

SERVICES ARE NOT ADOLESCENT-FRIENDLY

ISSUE Services are often not adequately equipped, nor accessible for adolescents, making them hard to reach with sexual and reproductive health and HIV services.

ACTION Ensure that services for adolescents are equitable, accessible, acceptable, appropriate and effective.

COMMUNITY ENGAGEMENT ACTIONS

DEMAND CREATION FOR ANTENATAL AND POST NATAL CARE AND RETENTION IN CARE

ISSUE Some women living with HIV are less likely to seek care because of limited awareness or inaccurate information on the availability and/or effectiveness of treatment and care, or knowledge of how to access services. This also is a barrier for those who do not know their status. Support within the community can help to translate information into accessible messages, guide women on how to access the health system and retain in antenatal care, as well as reach women that have not presented to health facilities.

ACTION Support community networks and civil society organizations including faith communities and their health care networks to develop information on what antenatal care is available and its value to a woman and her family.

EFFECTIVE SERVICES CLOSER TO HOME/WHERE PEOPLE LIVE

ISSUE Women from key or marginalized populations, or living in rural or hard to reach areas, face many barriers to access that require innovative strategies for outreach and delivery of services.

ACTION Integrate community service delivery into national plans, starting from the planning phase and budget allocation. Promote collaborative models of care between health facilities and community-based health workers, who in partnership can educate, support, refer and follow up women, children and adolescents from testing through retention in care. Bring care into communities with mobile vans where geographic or transportation barriers are high.

ADOLESCENT FRIENDLY TREATMENT SERVICES

ISSUE Adolescents living with HIV, in particular adolescents born with HIV, need support in accessing and adhering to treatment and care, but also accessing age-appropriate and stigma-free sexual and reproductive health education and services..

ACTION Invest in peer support groups with training for adolescent leaders; offer SRHR support as part of primary care and train health workers on the unique needs of adolescents.

REDUCING STIGMA AND DISCRIMINATION

ISSUE Stigmatizing and discriminatory attitudes from care providers towards women living with HIV and their children, or towards people from marginalized populations, leads to loss to follow up and deters people from accessing services. In some contexts, HIV related stigma and discrimination practices in health care settings have led to the coerced and involuntary sterilization of women living with HIV as well as abortions.

ACTION Support stigma-reduction community programmes such as peer-support, community monitoring and partnerships between community networks and care providers organizations including faith communities and their health care networks to develop stigma-free and non-judgmental service delivery that increase uptake and protect human rights.

ENGAGING MEN TO PROMOTE HEALTH SEEKING BEHAVIOURS

ISSUE Male partners' attitudes towards health care services provided in facilities can limit women's ability to access prenatal care and remain on treatment for herself and her baby. In many countries with a high burden of HIV, men have higher rates of death from HIV than women as they often present at a later stage of disease.

ACTION Encourage engagement of men in seeking HIV prevention, testing, treatment and otherhealth services for their own health and wellbeing.

REDUCING DISCRIMINATION OF ADOLESCENTS FROM KEY POPULATIONS

ISSUE Homophobia and homophobic bullying undermine educational and learning opportunities for adolescents from key populations, including lesbian, gay, bisexual and transgender students.

ACTION Implement policies that tackle homophobic bullying in school settings.

ENGAGING MEN AND BOYS TO FAST TRACK THE HIV RESPONSE

ISSUE Gender inequalities drive the systematic denial of women's rights, and block the advancement and empowerment of women. In addition, the dynamics of gender and HIV interweave the health and wellbeing of women and men.

ACTION Engage men and boys to challenge harmful dynamics of gender and power norms, and address the specific needs of women and men in the context of HIV, not in isolation but in a holistic manner.

ISSUE Sexual and gender based violence has a significant impact on vulnerability to HIV infection. It also impedes uptake of HIV prevention, testing and treatment. Adolescent girls, young women and young boys and men can be subjected to sexual and intimate partner violence. The rates of sexual violence are often higher in situations of conflict.

ACTION Engage communities, including religious leaders, faith communities and young people's organization in campaigns/speaking out to condemn sexual and intimate partner violence, and condemn impunity, creating communities of zero tolerance of sexual exploitation and violence.

STRENGTHENING ADOLESCENT AND YOUNG PEOPLE LED NETWORKS

ISSUE Adolescents and young people are not engaged in decision-making processes that have implications for their own health. This often results in inadequate programming that does not address their specific needs in the context of sexual and reproductive health and HIV services. Services for adolescents and young-people are often not user-friendly and the message is not age-appropriate or culturally/age-sensitive.

ACTION Engage adolescents and young people as beneficiaries, partners and leaders in the HIV response. Support youth-led service delivery programmes, including peer support. This will result in more accessible and acceptable information, knowledge building and effective linkage to treatment and care.

INNOVATION ACTIONS

HEALTH

ISSUE Reaching people with timely and user-friendly health information in an appealing way.

ACTION Engage public private partnerships to expand innovative use of telecommunications platforms to send health information encouraging HIV testing and benefits of treatment, reminder messages for scheduled appointments.

IMPROVING STRATEGIC INFORMATION

ISSUE Efforts to measure the impact of PMTCT programmes do not exist in countries.

ACTION Countries need to link mother and child pairs and follow them until the end of the breastfeeding period making sure that the mother has support for adhering to ART and ensuring that the child is tested regularly and started on treatment as needed.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