



REALISING THE RIGHTS OF CHILDREN & ADOLESCENTS LEFT BEHIND 2021 UN Political Declaration on HIV and AIDS

Key Messages & Recommendations 17 May 2021

We have the evidence, we know what works; what we need now is leadership!

Introduction

These key messages and recommendations are for policy makers negotiating the 2021 UN Political Declaration on HIV and AIDS. They are the consensus view of [the Coalition for Children Affected by AIDS](https://www.childrenandhiv.org)¹ (the Coalition) - 28 global thought leaders from organisations operating around the world, including young people and caregivers directly affected by HIV (see Annex). They are based on scientific and programmatic evidence on what is needed and what works.

The Coalition is committed to supporting the 2021 UN Political Declaration on HIV and AIDS. To find out more please contact its Manager, Corinna Csaky Corinna.csaky@childrenandhiv.org.

Key Messages

1. **We have the evidence, we know what works; what we need now is leadership!** Children, adolescents, families, policy makers, practitioners and scientists are united behind what is needed and what works. The Global AIDS strategy sets out targets and priority actions to end AIDS in children and adolescents (see Annex). This Political Declaration is a key opportunity for governments to deliver on it.
2. **The global response for children and adolescents living with HIV has been gravely inadequate.** Even prior to the COVID-19 pandemic, the paediatric targets set by the 2016 High Level Meeting (HLM) were either missed or well off-track. UNAIDS recently acknowledged that the gap between the treatment coverage rate for children (53%) and adult treatment coverage 68% “represents nothing less than a global failure.”²
3. **COVID-19 has exacerbated inequalities and barriers to HIV services for children and adolescents**³. COVID-19 is creating an unprecedented disruption in services for children and families. This threatens decades of progress made in reducing vertical transmission and improving access to paediatric testing and treatment. And threatens the broader health, well-being and education of children and adolescents – the impacts of which will be felt across their lifetime.
4. **Excluded children and adolescents must be prioritised.** This includes adolescent parents affected by HIV and their children⁴, and the children of key populations⁵. They are at far greater risk of HIV infection as well as inter-relating physical, social and economic challenges. They face a double burden of stigma – associated with both HIV and their broader status in society. And they are often left out of health, social and economic development interventions.
5. **Change happens in families and communities.** Strong national policies and laws are important. However, these are only effective when complemented by supportive and resourced communities and families.

¹ www.childrenandhiv.org

² UNAIDS, 2020, Evidence Review - Implementation of the 2016–2021 UNAIDS Strategy: on the Fast-Track to end AIDS - https://www.unaids.org/en/Global_AIDS_strategy

³ The Coalition for Children Affected by AIDS (2021) *Prioritising Children, Adolescents and Caregivers Affected by HIV in the COVID-19 Response* <https://childrenandhiv.org/covid-19-resources-related-to-hiv-affected-children/>

⁴ The World Health Organization & the Coalition for Children Affected by AIDS (2020) *Report of the Global Learning Session on Adolescent Mothers Affected by HIV* <https://childrenandhiv.org/wp-content/uploads/2020/06/Report-of-Teen-Mothers-Learning-Session-Final-May-2020.pdf>

⁵ The Coalition for Children Affected by AIDS (2017) *Making the Children of Key Populations a Priority for Equitable Development* <https://childrenandhiv.org/making-children-key-populations-priority-equitable-development/>

Moreover, the COVID-19 pandemic has highlighted yet again how local community-based organisations are highly effective service providers for excluded children, adolescents and families left behind.

6. **A holistic approach is more effective, feasible and affordable.** The days of working in siloed sectors are over; rather we must combine services and support on HIV, health, education, protection, poverty, gender and other areas, in a tailored, integrated programme. Social protection and support for mental health and early childhood development are especially important. Any service in contact with a vulnerable child or adolescent is a window to provide this holistic support.
7. **Start early.** What happens to children during pregnancy and in their first 1000 days determines their path through life. Equally, comprehensive sexuality education and positive gender messaging from early childhood are key to tackling the harmful practices and social norms. A life-cycle approach is essential for delivering transformative change.
8. **The participation of children and adolescents is essential.** They know what they need; they are critical for providing peer support to each other; and they must have a voice in platforms where decisions are made – at all levels, global to local. As UNAIDS states in its new global strategy: “without a voice in the response, they [*children*] have an unequal opportunity to call for solutions to their needs”⁶.

Policy Recommendations

The Political Declaration must agree new and ambitious targets for children and adolescents living with HIV that deliver on the UNAIDS Global AIDS Strategy 2021-2026 (See Annex). In particular:

1. Adolescent Parents Affected by HIV and their Children

Adolescent parents affected by HIV and their children are a critical and growing population that need more support if we are to end AIDS and achieve many of the Sustainable Development Goals. There were an estimated 11.4 million adolescent mothers in Sub Saharan Africa before COVID-19⁷. Anecdotal evidence suggests this figure is now far higher, in part due to increases in rape during lockdowns and the lack of sexual and reproductive services and products.

Adolescent parents affected by HIV, and their children, face many challenges that limit generations across a lifetime. They are at far greater risk of HIV infection as well as poor education, poverty, poor mental health, violence, exclusion, and early childhood developmental delays.

They can beat HIV and thrive in life. But they need to be empowered rather than discriminated against.

The Coalition is calling for the Political Declaration to commit to:

- 1.1 Prioritise adolescent parents affected by HIV and their children strategies, programs and performance indicators.
- 1.2 Value them as an integral part of society, community and family.
- 1.3 Create strong laws and policies that promote and protect their rights.
- 1.4 Support them to stay in school and to realise their full potential.
- 1.5 Provide them with holistic support that addresses their biomedical, social and economic needs together. In particular, financial support and economic empowerment; maternal and child health services; HIV prevention, testing and treatment; childcare; mental health support; support for early childhood development; and support to prevent and respond to intimate partner violence.
- 1.6 Ensure services are friendly, welcoming and available in the community.
- 1.7 Invest in local community organisations, including those led by children and young people, and make funding more accessible to them.
- 1.8 Support adolescent parents to have a voice in decision-making at all levels and to deliver support to their peers.
- 1.9 Teach girls and boys, men and women about sexual and reproductive health and rights and make contraceptives, information and other sexual health services widely available to them.

⁶ UNAIDS, 2021, End Inequalities. End AIDS. Global AIDS Strategy 2021-2026: <https://www.unaids.org/en/resources/documents/2021/2021-2026-global-AIDS-strategy>

⁷ UNICEF (2017) Children and AIDS: Statistical Update

- 1.10 Involve men and boys. Champion positive gender norms that promote equality and respect amongst girls and boys, men and women. And tackle harmful norms and practices, stigma and discrimination against them.

2. Prevention of Vertical Transmission

Despite increased availability of ART to pregnant mothers in many countries, new infections in children persist with many infections occurring during the breastfeeding period. New paediatric HIV infections are on the rise in several countries, jeopardizing the gains made towards eliminating paediatric AIDS. Progress has been uneven across geographic regions and sub-populations. For example, 43% of incident infections among pregnant and breastfeeding women occur among adolescent girls and young women, age 15-24, indicating a need for more tailored services for this already vulnerable population.

Greater emphasis on comprehensive HIV prevention during pregnancy and breastfeeding is needed, including access to PrEP and other new prevention technologies. Per WHO guidelines, pregnant women need be tested for HIV multiple times during pregnancy, and women who test positive for HIV should immediately initiate ART for their own health and the health of the child. Increasing access to viral load testing for pregnant and breastfeeding mothers living with HIV is another important step for countries to take to ensure the health of the mother and potentially reduce vertical transmission.

The Coalition is calling for the Political Declaration to commit to:

- 2.1 Urgently intensify tailored prevention service delivery for pregnant and breastfeeding women while they remain at risk of HIV, including increased utilization of PrEP and new prevention technologies.
- 2.2 Implement repeat HIV testing during pregnancy and breastfeeding per guidelines to identify women newly infected for rapid intervention with HIV treatment and prevention of vertical transmission.
- 2.3 Provide all pregnant and breastfeeding women living with HIV optimized treatment regimens that allow women to quickly achieve and sustain viral load suppression.
- 2.4 Scale-up use of point-of-care viral load testing among pregnant and breastfeeding women to enable faster action in response to poor viral load results.
- 2.5 Utilize differentiated and community-led services that meet the needs of women of reproductive age in all their diversity, including tailored PMTCT service delivery to meet the needs of the most vulnerable pregnant populations, such as pregnant key populations and adolescent girls and young women.
- 2.6 Tackle stigma, discrimination and unequal gender norms that prevent pregnant and breastfeeding women, especially adolescent girls, young women and key populations, from accessing HIV testing, prevention and treatment services for themselves and their children.
- 2.7 Target adolescents and young people with a complete package of combination HIV prevention services that is tailored to their evolving needs and is integrated with comprehensive sexuality education (both in and out of school); sexual and reproductive health (including contraception) and rights for people of reproductive potential; HIV treatment and care; education; support for mental health; social protection; and support for early childhood development.

3. Paediatric HIV Testing and Treatment

In 2019, 1.8 million children (aged 0-14 years) were living with HIV globally, of which 1.2 million were in Eastern and Southern Africa (ESA). Only 53% of children living with HIV globally are on treatment – compared with 68% for adults. The urgency for ensuring that all children exposed to HIV are tested and those living with HIV are initiated on HIV treatment within 6 weeks of birth, is because peak mortality occurs at 6-8 weeks and without treatment 50% will die before they reach 2 years of age.

The excessive number of children living with HIV but not receiving treatment stems primarily from two testing gaps: (1) low coverage of early infant diagnostic (EID) services; and (2) the lack of testing options for older children who are missed by EID efforts, especially children who acquire HIV during breastfeeding.

Point-of-care (PoC) early infant diagnosis can reduce delays in sharing results, significantly decreasing the time before antiretroviral therapy is initiated (from a median of nearly two months to the same day) and significantly

increasing the proportion of infants initiating therapy, as well as being cost-effective compared with laboratory-based testing.

Index family-based testing is a high-yield and efficient strategy for identifying the children of adults living with HIV and initiating antiretroviral therapy. Offering HIV testing to all children living in the household of an adult living with HIV can identify children living with HIV who have been missed through earlier testing modalities.

Children living with HIV must navigate multiple transitions, including the transition from paediatric to adolescent care and then from adolescent to adult services. There is a need for innovations and child-centred support to facilitate smooth transitions, ensure continuity of care and tailor support as children grow older and develop.

The Coalition is calling for the Political Declaration to commit to:

- 3.1** Ambitious testing and treatment targets:
 - 3.1.1** 95% of HIV-exposed children are tested by two months of age and again after cessation of breastfeeding
 - 3.1.2** At least 95% of infants tested for HIV receive their test results no later than 15 days after blood sample collection
 - 3.1.3** At least 95% of infants diagnosed with HIV infection initiate ART no later than 15 days after receiving their test results
 - 3.1.4** 85% of all CLHIV on ART have suppressed VL by 2023 and 95% by 2025
- 3.2 Scale-up point-of-care EID early infant diagnostic testing starting with the hard-to-reach areas.
- 3.3 Scale-up efforts to actively track mother-baby pairs using a digital register of positive results.
- 3.4 Commit to greater use of family-based index testing and use of HIV oral tests for children 2-11 years of age.
- 3.5 Prioritize the rapid introduction and scale-up of access to the latest WHO recommended, optimized, child-friendly HIV treatment in order to achieve sustained viral load suppression
- 3.6 Prioritise viral load and toxicity monitoring and provision of comprehensive packages of care transitioning for those children and adolescents who present with advanced HIV disease, disabilities or mental health issues.

4. Forging an Effective Global Framework for Ending AIDS in Children and Adolescents

There is currently no global plan for ending HIV and AIDS in children and adolescents. The recent expiration of the Start Free Stay Free AIDS Free framework and its predecessor - the Global Plan - means that countries around the world are lacking in a unified framework against which they can plan, deliver and monitor results. Without this framework, there is a risk that children and adolescents will fall off the political agenda, and that efforts will be disparate and less effective.

COVID-19 has made the need for such a plan even more urgent. This new pandemic is having catastrophic and lasting consequences for millions of children, adolescents and caregivers affected by HIV and AIDS. We must act now. If not, the precious gains made in the fight against HIV and AIDS will be reversed. And those already made vulnerable by HIV and AIDS will be further impacted by both COVID-19 and its consequences.

An effective global framework will help ensure that children and adolescents affected by HIV are not left out of the COVID-19 response, and maintain political and resource commitments to ending HIV and AIDS.

The Coalition is calling for the 2021 Political Declaration to commit to:

- 4.1** An urgent consultative process to develop a framework to end AIDS in children and adolescents.
- 4.2** Mobilize the political leadership and global solidarity needed to secure the resources needed to get the response on-track to end AIDS as a public health threat and to realize the right to health
- 4.3** Maintain and increase donor funding, including for addressing the root causes of inequalities through community-led responses, particularly for low-income countries with limited fiscal ability, and for key population- and community-led responses, including in middle- and upper-middle income countries
- 4.4** Recognise the importance of ring-fencing resources for paediatric HIV and AIDS response in order to sustain the gains achieved so far

4.5 Promote the continuation and scale-up of promising interventions developed during the pandemic after COVID-19, including: multi-month dispensing of ARVs, shifting testing services to community-based services, prioritising HIV self-testing, telemedicine and strengthening virtual support groups.

Annex: End Inequalities. End AIDS. Global AIDS Strategy 2021-2026

The following targets and priority actions relate to ending AIDS in children and adolescents are included in the Global AIDS Strategy:

Paediatric HIV Testing and Treatment

2025 High Level Targets:

- *95–95–95 testing and treatment targets are achieved within all subpopulations, age groups and geographic settings, including children living with HIV.*
- *95% of HIV-exposed children are tested by 2025.*
- *75% of all children living with HIV have suppressed viral loads by 2023 (interim target)*

Early Infant Diagnosis:

- *95% of HIV-exposed children are tested at two months and after the cessation of breastfeeding*
- *95% of HIV-exposed infants receive a virologic test and parents are provided with the results by age 2 months*
- *95% of HIV-exposed infants receive a virologic test and parents are provided with the results after cessation of breastfeeding*

The Global AIDS Strategy includes the following priority action on early infant diagnosis and paediatric and adolescent treatment:

- *Implement innovative tools and strategies to find and diagnose all children living with HIV, including point-of-care early infant diagnostic platforms for HIV-exposed infants and rights-based index, family and household testing and self-testing to find older children and adolescents living with HIV not on treatment.*
- *Prioritize rapid introduction and scale-up of access to the latest WHO-recommended, optimized, child-friendly HIV treatment and achieve sustained viral load suppression.*
- *Support transitioning of children through adolescence to adult care and address their complex, multiple and changing needs, including peer adherence counselling and psychosocial support.*

Prevention of Vertical Transmission

2025 high level and disaggregated targets:

- *95% of pregnant and breastfeeding women living with HIV have suppressed viral loads:*
- *90% of women living with HIV on antiretroviral therapy before their current pregnancy All pregnant women living with HIV are diagnosed and on antiretroviral therapy, and 95% achieve viral suppression before delivery*
- *All breastfeeding women living with HIV are diagnosed and on antiretroviral therapy, and 95% achieve viral suppression (to be measured at 6–12 months)*
- *95% of pregnant women are tested for HIV, syphilis and hepatitis B surface antigen at least once and as early as possible. In settings with high HIV burdens, pregnant and breastfeeding women with unknown HIV status or who previously tested HIV-negative should be retested during late pregnancy (third trimester) and in the post-partum period*
- *95% of pregnant women have access to maternal and newborn care that integrates or links to comprehensive HIV services, including for prevention of the triple vertical transmission of HIV, syphilis and hepatitis B virus*

Priority Actions for Adolescents and Young People

- *Scale up the meaningful engagement and leadership of young people in all HIV-related processes and decision-making spaces.*
- *Accelerate investments in youth leadership (particularly adolescent girls and young women and young key populations), capacity building and skills development at all levels in all aspects of the HIV response.*
- *Foster solutions and partnerships between youth-led organizations and governments, private sector, faith-based organizations, and other traditional and non-traditional partners to ensure sustainable investment in financing of programmes for young people.*
- *Strengthen access to high-quality, gender-responsive, age-appropriate comprehensive sexuality education programmes, both in school and out of school, particularly for adolescent girls and young women and young key populations in settings with high HIV incidence.*

- *Support policies and programmes focused on increasing the enrolment and retention in secondary schools for adolescent girls and young key populations in high-incidence locations, and provide linkages to social protection, “cash plus” initiatives, financial incentives, pathways to employment, and interventions to transform unequal gender norms and prevention of violence against adolescent girls and young women.*
- *Remove legal and policy barriers, including age-of-consent laws and policies, for adolescents and youth to access HIV services, and ensure access to other health and social services, including sexual and reproductive health services, condoms and other contraceptives, and commodities and wider health and social services relating to young people’s wellbeing.*
- *Redesign HIV services to meet the needs of young people and ensure adolescents and young people (particularly adolescent girls and young women and young key populations in settings with high HIV incidence) can access a full range of youth-centred and -led HIV services that*
- *holistically address their needs, including other health, protection and social services.*

Annex: Members of The Coalition for Children Affected by AIDS

Steering Committee

1. Ms. Luann Hatane, Paediatric-Adolescent Treatment Africa
2. Ms. Lisa Bohmer, Conrad N. Hilton Foundation
3. Dr. Shaffiq Essajee, Unicef
4. Ms. Lazeena Muna-Mquay, Unicef
5. Ms. Cecilia Kihara, ViiV Healthcare
6. Ms. Catherine Connor, Elizabeth Glaser Pediatric AIDS Foundation
7. Mr. David Ruiz, Elizabeth Glaser Pediatric AIDS Foundation
8. Ms. Lynette Mudekanye, REPSSI
9. Mr. Thomas Fenn, Catholic Relief Services
10. Ms. Sabrina Ern , Aidsfonds
11. Ms. Tumie Komanyane, Frontline AIDS
12. Ms. Nina Blackwell, Firelight Foundation
13. Ms. Sadaf Shallwani, Firelight Foundation
14. Ms. Felicia Wong, Frontline AIDS
15. Ms. Shana Pfeiffer, Save the Children US
16. Mr. Stuart Kean, RIATT-ESA

17. Ms. Dephin Mpofu, RIATT-ESA and World Vision International
18. Mr Anock Kapira, RIATT-ESA and REPSSI

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21. Ms. Duduzile Dlamini, SWEAT Mothers for the Future (South Africa)
22. Ms Miriam Hasasha, UNYPA (Uganda)

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23. Ms. Kate Powis, Harvard Medical School
24. Ms. Amy Slogrove, Stellenbosch University
25. Mr. Mark Tomlinson, Stellenbosch University
26. Ms. Linda Richter, University of the Witwatersrand
27. Ms. Tamsen Rochat, University of the Witwatersrand

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