ADVOCACY BRIEFING

End inequity for children and adolescents affected by HIV and AIDS: New data on financing

New research reveals, for the first time, what funds are being spent on children and adolescents affected by HIV and AIDS, where, how much, by whom, and where the gaps are—in low- and middle-income countries (LMICs) across the world, including the 21 countries that account for 80% of the burden of disease for them. And for three countries—Kenya, Uganda, and Cameroon—this research provides especially detailed insights.

This briefing summarizes these research findings[2] and sets out an advocacy agenda in response to them. It was created by the Coalition for Children Affected by AIDS[3] (the Coalition), in partnership with WHO; UNICEF and UNAIDS; Avenir Health; the Global Alliance to End AIDS in Children[4]; and in collaboration with the the Governments of Kenya, Uganda and Cameroon, the *Global Working Group on Financing for Children and Adolescents Affected by HIV*, communities, PEPFAR, the Global Fund and private trusts and foundations.

The Coalition especially thanks and acknowledges all people living with and affected by HIV, in particular children, adolescents and caregivers who continue to bear the brunt of inequitable funding gaps and their consequences.

This is an equity issue: Children lag far behind adults in the fight against HIV and AIDS, and many come from populations facing social and structural exclusion, such as young families or key populations. The overall lack of their prioritization is the root cause of low investment in them: Data on children and adolescents are not routinely collected, their needs are invisible, they are not a political or funding priority, and as a result, their needs are not met. This is a travesty, not least because HIV in children and adolescents is now entirely preventable and treatable, and exposure to HIV and its wider social and economic impacts are holding back generations.

Those working in HIV and broader social and economic development urgently need this information. Children and adolescents living with and affected by HIV are a vast and growing global population with distinct needs. HIV remains a major barrier to achieving many of Sustainable Development Goals (SDG), and preventing and treating HIV infection in children is a cornerstone of global goals to end AIDS for all by 2030. Yet we are far off track: Indeed, in many countries, progress is slowing down or at risk of reversal. If we do not invest now, we run the risk of undoing the hard-won gains achieved in recent years—leading to far greater adversity and higher costs to society.

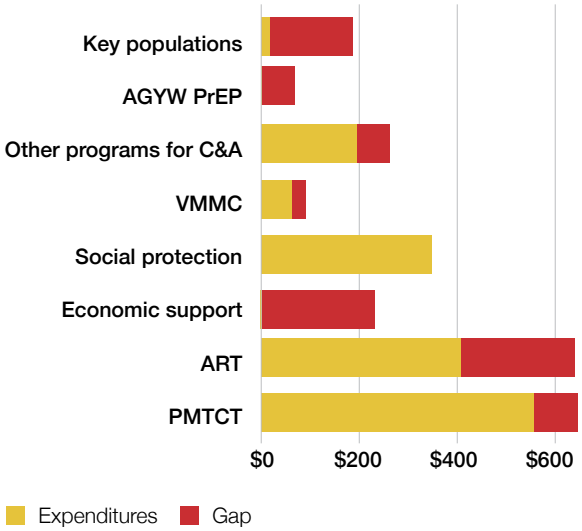
More money is not the only answer: We can achieve more with the funds we have by innovatingand investing wisely. For example, by finding and treating the many undiagnosed children living with HIV; integrating HIV prevention, testing and treatment services with broader health, social and economic interventions to maximize efficiency, share costs and achieve the greatest return on investment; refocusing funds towards community-based provision and leveraging their networks to reach excluded populations; putting communities in the driver's seat for funding decisions; improving donor coordination; and targeting funding to where it is most needed

We must not miss this moment. We have unprecedented political momentum and strong partnerships, reinforced by the Global Alliance to End AIDS in Children as well as universal acknowledgement that health systems must be fit for purpose to achieve better and more sustainable health outcomes and prepare for future pandemics. Here is our window of opportunity for change. Let's use it.

KEY RESEARCH FINDINGS

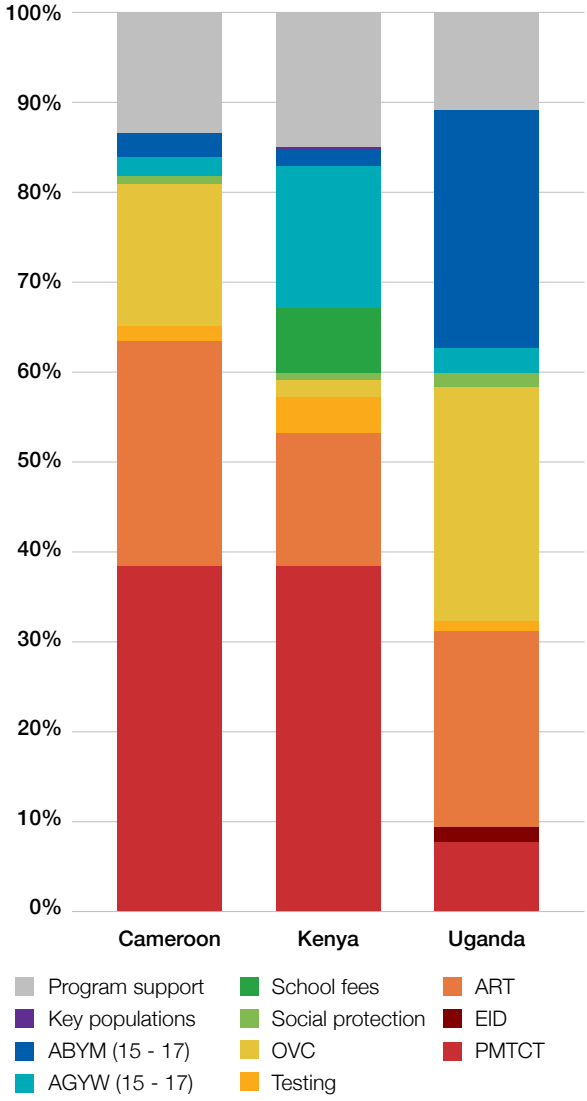
1. In all LMICs across the world, the annual spending gap to achieve HIV targets for children and adolescents is about US$1 billion. An estimated US$1.8 billion was spent in 2023, but US$2.8 billion is required.
2. Half of this gap (US$505 million) is in the 21 sub-Saharan African countries that together account for 80% of all child and adolescent HIV.
3. The largest gaps are in pediatric testing and treatment, economic support, and key populations under age 18.
4. Three-quarters of all spending for children and adolescents is for prevention of mother-to-child transmission (PMTCT), pediatric testing and treatment, and social protection. PMTCT funding almost equals need.
5. PEPFAR contributes almost half (47%) of total HIV spending, with domestic governments contributing 33%, the Global Fund 14%, the private sector 3%, households 2%, and other donors 1%.
6. Data in Uganda, Kenya, and Cameroon show that these global trends are echoed at the country level: The total expenditure gaps are US$41 million in Uganda, US$49 million in Kenya, and US$14 million in Cameroon.
7. The greatest area of spending in Kenya is PMTCT, adolescent boys and young men in Uganda, and treatment for children in Cameroon.
8. All three countries are highly dependent on donor financing, with a greater percentage of funds coming from donors in Cameroon and Uganda.
9. Other factors beyond insufficient funding also contribute to this lack of universal coverage for key interventions, such as health system.

Figure 1. Expenditures and gaps in all LMICs in 2023



AGYW = adolescent girls and young women; ART = antiretroviral therapy; C&A = children and adolescents; PrEP = pre-exposure prophylaxis; VMMC = voluntary medical male circumcision

Figure 2. Expenditures in Cameroon, Kenya, and Uganda in 2023



ABYM = adolescent boys and young men; AGYW = adolescent girls and young women; ART = antiretroviral therapy; EID = early infant HIV diagnosis; OVC = orphans and other vulnerable children

Data Points

As noted in the 2024 Global AIDS Update[5]

- Almost half (43%) of children living with HIV are not in treatment.
- While children (0–14 years old) represent only 3% of people living with HIV, they account for 12% of AIDS-related deaths—one in eight people who died due to AIDS in 2023 was a child.
- An estimated 120,000 children acquired HIV in 2023, bringing the total number of children living with HIV globally to 1.4 million, 86% of whom are in sub-Saharan Africa.

RECOMMENDATIONS

Many people living with HIV, representatives of civil society, donors, governments and academic institutions helped to create these recommendations. They will deliver impact across HIV targets and SDGs, and are fundamental to closing the treatment gap for children and adolescents affected by HIV. They have been grouped here into two steps for ease of reference. However, all can happen concurrently, and action should begin today.

STEP ONE - The building blocks underpinning smart funding

1. Make incremental increases year by year to the amount of domestic resources that governments allocate to children and adolescents affected by HIV—at all health, administrative and political levels - local to national. This government-driven agenda will pave the way to more sustainable progress, foster political and societal support, and enable long-term planning independent from global trends or donor cycles. Achieving this change requires political commitment as well as action by the International Monetary Fund, World Bank, and private lenders to alleviate the debt burden of low-income countries.
2. Support communities to lead. Programs will be far more impactful and efficient if communities—especially those at highest risk of HIV, including adolescent parents and the children of key populations—are in the driver's seat. Increase their representation at all levels of financial and programming decision making—from local governments to the boards of international donors. Make financial and strategic information accessible to them, and build their capacity to participate. Remove legal and structural barriers that prevent communities from serving and advocating for children and adolescents affected by HIV, including key populations, and strengthen their capacity to do so with long-term, flexible advocacy funding disbursed at the start of each grant cycle. Smaller communitybased organizations are especially critical, as they are at the forefront of integrated service provision to excluded populations.
3. Find the missing children. Identify the many undiagnosed children living with HIV and put them on life-saving treatment. This is vital to reduce both mobidity mortality and will produce myriad cost savings in the future. It needs innovative and aggressive testing strategies, including community-based testing, early infant diagnosis, selftesting, and index testing for children and adolescents. At a minimum, all children born of, living with, or exposed to someone living with HIV should be tested and linked to appropriate health services. Efforts must target infants as well as older children outside regular contact with the health system—since most surviving children currently living with HIV are over five years of age. A shared methodology for costing this work would help countries to plan and fund it.
4. Know the HIV epidemic for children. This step will direct funding to where it is most needed and guide effective program design. Incorporate data on children and adolescents (ages 0–19) living with HIV and exposed to it during pregnancy and breastfeeding into routine data collection processes, including Population-based HIV Impact Assessments and national community-led monitoring. All countries should seek to use a common approach, including WHO's universal definition of childhood (ages 0–9) and adolescence (10–19) and to disaggregate data based on five-year age bands, gender, and association with high-risk groups, such as the children of key populations and adolescent parents.

STEP TWO - Invest wisely and efficiently

1. Integrate services. HIV, health, social, economic, and humanitarian sectors must deliver as one: that is, simplify and coordinate services into a holistic package of tailored support for each HIV-affected child, adolescent, and caregiver. This will achieve multiple outcomes simultaneously and be far more impactful and cost-effective than each sector delivering in siloes. For example, antenatal care and education are key service points for integration, and social protection and cash transfers, mental health, and early childhood development services have an especially important role to play. This step must be evidence-informed to ensure a high return on investment. Pooling funding from different sectors behind a common system has been proven to make integration easier, and government ownership and leadership should be central to these efforts.
2. Grow funding for HIV-specific interventions within this integrated system. As part of the integrated service provision described above, there must be dedicated service delivery points for the children of key populations, adolescent parents and others facing barriers to accessing generalized health services; information and behavior change campaigns for children, adolescents, caregivers, communities, and service providers on HIV and tackling the stigma around it; and biomedical interventions to find, test, and treat HIV, including cuttingedge technologies such as long-acting cabotegravir and lenacapavir, treatment as prevention in adolescence, better antiretroviral drugs, and better postnatal prophylaxis.
3. Mobilize more funding from diverse donors in and beyond the health sector. Funders, re-grantors, and implementers of HIV resources as well as wider social, economic, and humanitarian resources must make HIV-affected children and adolescents a budget priority and a target population against whose progress they measure their impact. They must also use data to direct funding to where it is most needed—a crucial step to filling in the gaps in expenditure and fostering innovation. In addition, PEPFAR must be reauthorized for another five years and retain the 10% set aside for orphans and other vulnerable children.

4. Know expenditures for children and adolescents. Governments, donors, and UNAIDS should publish annually disaggregated data on expenditure for HIV-affected children and adolescents in order to ensure that money is being used wisely on the priorities identified by epidemic data in accordance with agreed-upon purposes and budgets. Expenditures should be tracked and reported using a common, low-burden data collection method.

Donors Have a Special Role to Play

Many LMICs are heavily reliant on donor funding—whether from PEPFAR, the Global Fund, or private trusts and foundations. We urge these donors to continue to play an important strategic role in the following ways:

- Supporting efforts to challenge social and structural inequalities that perpetuate child and adolescent HIV. This means balancing investments in governments and UN agencies with direct investments in civil society, especially smaller community-based organisations working at the front line with excluded populations. There has been a concerning decrease in direct funding to civil society: We cannot assume that broader investments are trickling down to them, and such a model hinders community independence, debate, and, ultimately, progress.
- Mobilising diverse funders focused on broader social, economic, and humanitarian goals to direct resources towards HIV-affected children and adolescents.
- Coordinating with each other and consciously targeting grants to fill the gaps
- Sponsoring research, collaboration, and innovation to understand children's needs and how best to meet them

This advocacy agenda is part of the Coalition's longer-term efforts to improve financing for children and adolescents affected by HIV and AIDS. Since 2021, we have hosted the *Global Working Group on Financing for Children and Adolescents Affected by HIV* to foster dialogue and shape our research. Prior to this new report, we published a global analysis of donor expenditures.[6] We are now exploring next steps and welcome ideas and collaboration.

The Coalition for Children Affected by AIDS

JOIN THE MOVEMENT

You can find out more about the Coalition and become an Advocate Member for free at www.childrenandHIV.org.

What is the Coalition for Children Affected by AIDS?

Founded in 2004, the Coalition (www.childrenandHIV.org) is an independent global advocacy and learning group positively shaping global policy in response to HIV, health rights, and equity issues. Our 28 Core Members are senior leaders from various sectors from UN, donor, NGO, and academic organizations. We also have over 300 Advocate Members—mainly community champions—whom we support via the Vibrant Young Voices movement.

CRS Catholic Relief Services · Robert Carr Fund for civil society networks · University of Oxford · aidsfonds · unicef · Elizabeth Glaser Pediatric AIDS Foundation · Conrad N. Hilton Foundation · PATA · ICW WA · ViiV Healthcare · Global Network of Young People Living with HIV · UCL · VIBRANT Young Voices · REPSSI · GNP+ Global Network of People Living with HIV · Frontline AIDS · sweat · Save the Children · Mothers for the Future · firelight · RATT

[1] Stover, J. & Csaky, C. et al., (2024) Children and Adolescents Affected by HIV and AIDS: Expenditures, needs and resource gaps, The Coalition for Children Affected by AIDS
[2] Ibid. https://childrenandhiv.org/our-priorities/improved-financing
[3] https://childrenandhiv.org/
[4] https://www.childrenandaids.org/global-alliance
[5] UNAIDS (2024) 2024 Global AIDS Report—The Urgency of Now: AIDS at a Crossroads, Geneva: UNAIDS, https://www.unaids.org/en/resources/documents/2024/global-aids-update-2024.
[6] Stover, J. & Csaky, C. et al., (2022) Donor Commitments to Children and Adolescents Affected by HIV and AIDS, The Coalition for Children Affected by AIDS, https://childrenandhiv.org/wp-content/uploads/2022/11/CCABA-policy-report-Final.pdf.