Addressing inequities in the global AIDS response for children and adolescents

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It is unacceptable that only half of all children living with HIV are on antiretroviral treatment, while more than three quarters of adults are treated. And it is a tragedy that girls are three times more likely to get HIV than their male peers. This is an equity issue, and we are failing the next generation. Let us pledge to equalize service access and support for every child and adolescent affected by HIV.

– Catherine Russell,
UNICEF Executive Director

A snapshot of the AIDS epidemic in children and adolescents

Within the global HIV response, targets have been something of a double-edged sword. On the one hand, they have galvanized attention, support and resources and led to substantial improvements in access to services. But they have also been a source of disappointment when targets were missed, or when achieving them seemed implausible or inconceivable even from the outset. In such situations, it might seem more pragmatic to downsize them because of concerns that they set unrealistic expectations and might end up leaving all stakeholders dissatisfied.

The global HIV response for children in 2022 can be viewed through both these perspectives. In the four decades since the HIV epidemic began, millions of HIV infections have been averted and deaths prevented through dedicated partnership-driven programmes to offer antiretroviral treatment (ART) to pregnant and breastfeeding women, and to children and adolescents living with HIV. Yet, the targets for 2020 were not met, and the goals defined in the 2021 high-level political declaration of the 76th United Nations General Assembly seem far out of reach. At the halfway point of the 2030 Agenda for Sustainable Development, it is increasingly likely that some, if not most, of the key health-related Sustainable Development Goals (SDGs) will not be achieved across much of the world for women, children and adolescents affected by HIV.

And yet, these ambitious targets *have* had an impact. Much of the progress that we have seen has resulted from the momentum and commitment that global targets generate. Furthermore, we have come to appreciate that the impact of the HIV targets goes beyond HIV outcomes. Ending AIDS in children and adolescents is both a goal in itself and a means to strengthen health systems, address discrimination in societies and build capacity in communities to make them more resilient to future crises. The targets to end AIDS in children are more important now than ever before and we must continue to strive towards achieving them – ambitious though they are. At the same time, we must also change the way we do business and recognise that we will not end AIDS for children and adolescents without a better understanding of the inequities that are driving the HIV epidemic among them.

In 2021, there were an estimated 2.7 million children and adolescents (0–19) living with HIV – accounting for only 7 per cent of all people living with HIV. But the number of deaths due to AIDS and the numbers of new HIV infections are greatly over-represented in this population. At 110,000 deaths (17 per cent of the total) and 310,000 new infections (21 percent of the total), these figures translate to 850 new infections and 301 AIDS-related deaths every day in children and adolescents 0–19 years (Figure 1).

As devastating as these data are, they represent impressive progress from the status in 2010, when there were an estimated 320,000 children aged 0–14 newly infected with HIV and 240,000 deaths from

Figure 1: Global situation of children and adolescents with HIV and AIDS, 2021

Epidemiology	Estimate	Lower	Upper
Number of children and adolescents living with HIV	2.7 million	2.1 million	3.5 million
Children aged 0–9	1.0 million	820,000	1.3 million
Adolescents aged 10–19	1.7 million	1.2 million	2.2 million
Number of new HIV infections, children and adolescents	310,000	150,000	530,000
Children aged 0–9*	160,000	110,000	230,000
Adolescents aged 10–19	160,000	46,000	300,000
Adolescent girls	120,000	24,000	220,000
Adolescent boys	40,000	7,700	100,000
HIV incidence per 1,000 population, adolescents aged 15–19	0.26	0.08	0.49
Adolescent girls	0.39	0.08	0.73
Adolescent boys	0.13	0.02	0.32
Number of AIDS-related deaths, children and adolescents	110,000	80,000	160,000
Children aged 0–9	85,000	58,000	120,000
Adolescents aged 10–19	29,000	22,000	37,000
Number of children aged 0–17 who lost one or both parents due to AIDS	14.9 million	11.9 million	18.3 million
Number of pregnant women living with HIV	1.3 million	1.0 million	1.6 million
Mother-to-child transmission rate of HIV	11.9	9.5	14.7
Perinatal transmission	6.8	5.1	9.0
Post-natal transmission	5.1	4.4	5.7

Note: Numbers may not add up due to rounding off
Source: UNAIDS 2022 estimates

HIV-related causes in this population. By the launch of the Sustainable Development Goals in 2015, these numbers had already fallen considerably. New infections in children had reduced by 38 per cent to 200,000 and AIDS deaths in children had fallen by 42 per cent to 140,000. However, soon after, progress for children began to flatline across the board. Prevention of vertical transmission was most affected. Treatment coverage among pregnant and breastfeeding women living with HIV stood at 81 per cent in 2015, the same level as in 2021. Meanwhile, after initial success in increasing paediatric ART coverage from only 18 per cent in 2010 to 47 per cent in 2017, progress slowed considerably and has stalled since 2019. In 2021, only 52 per cent of the estimated 1.7 million children under age 15 living with HIV were on ART, leaving roughly 800,000 without treatment.

Unequal access mars progress in the HIV response for children and adolescents

The state of the HIV epidemic among children and adolescents in 2022 is one characterized not only by stagnation and missed opportunities, but also by persistent inequities in access to high quality services. The failure to do better on behalf of children has also represented a failure to confront the longstanding structural and societal barriers that leave them further behind in the HIV response. The gaps are evident across the HIV treatment cascade. According to the 2021 global estimates, only 59 per cent of children (aged 0–14) living with HIV know their status, only 52 per cent are on ART, and of those on treatment, one in five are not virally suppressed. These are shockingly poor results as the world enters the fifth decade of the epidemic and more than 25 years have passed since lifesaving ART regimens first became available. They also underscore how disadvantaged children are within the community of all those living with HIV. Although the comparable global estimates for adults 15 years and older also fell short of the targets, adult ART coverage is substantially better: 86 per cent of adults living with HIV know their status, 76 per cent are on ART, and among those on treatment, 92 per cent are virally suppressed.

The viral suppression indicator offers an example of how stark the inequities are where children are concerned. The global HIV treatment targets set at the 2021 Political Declaration are for 75 and 86 per cent of all children living with HIV to have suppressed viral loads by 2023 and 2025 respectively. The fact that in 2021, only three of five children living with HIV have even been diagnosed, let alone started on ART makes it clear that these targets will be missed by a wide margin.

Taken together, these gaps explain why children and adolescents living with HIV continue to experience a disproportionate share of AIDS-related deaths.

Adolescents at risk of HIV are very likely to be marginalized and to experience inequitable access to services. Moreover, the global effort to prevent HIV among adolescents has also fallen far short of key targets and this failure highlights the fact that adolescents are being left behind in all contexts. The estimated 160,000 new infections among those aged 10–19 worldwide in 2021 was about 40 per cent lower than the level in 2010, but well above the target of 100,000 new infections that had been set for 2020.

Key Facts for children and adolescents 0-19 years in 2021

2.7 million living with HIV (**7%** of all living with HIV)

310,000 newly infected with HIV (**21%** of all new infection)

110,000 died of AIDS-related causes (**17%** of all deaths)

For the most part, three inequities related to geography, gender and poverty exert the greatest impact on children and adolescents affected by HIV. Where a child is born, his or her gender, and their access to resources are key predictors of how vulnerable that child is to HIV, how healthy and safe they are in general, what access they have to education and how likely they are to remain in poverty. As a group, girls have three times the rate of new HIV infections when compared with their male peers. But perhaps the greatest disparities remain among regions. For pregnant and breastfeeding women, ART coverage in 2021 in West and Central Africa, for example, was only 60 per cent compared with 89 per cent in Eastern and Southern Africa. This gap is a key reason why West and Central Africa has a disproportionate share of the new infections in children (33 per cent of the global total) even though the overall HIV burden in the region is relatively low.

Emerging threats to achieving more equitable results for children

Three years into the COVID-19 pandemic, there is considerable evidence that SARS-CoV-2 infection causes less severe illness and fewer deaths in children compared with adults. But although this is a favourable outcome from the perspective of children, the pandemic's many indirect effects – from school closures to health systems disruptions to steep increases in household poverty – have harmed them disproportionately. The COVID-19 pandemic has deepened many of the existing inequities across the HIV response among children. And more recent

challenges have made the situation even worse for children. Increases in food insecurity, the war in Ukraine, global inflation and the rising number of humanitarian crises and natural disasters have all had an impact on HIV by hampering efforts to reach children and their families with critical HIV testing, prevention and treatment services. The residual effects of the COVID-19 pandemic are profound, and the consequences are still being felt. The risk of vertical transmission increases when pregnant and breastfeeding women cannot be tested for HIV and started on ART due to a lack of accessible high-quality antenatal care. And the risk of new infections in adolescents increases when girls have dropped out of school, or when they live in food insecure households. Women and children on ART face grave threats to their health when their access to treatment is intermittent or non-existent.

The instability and uncertainty across much of the world in the past few years have also had a worrying impact on the financial and human resources available for HIV responses. Fiscal constraints related to COVID-19 and poor economic outlooks (at least in the short term) are affecting governments' ability and willingness to increase or even sustain domestic funding for HIV, including in places where the inequities that children experience are the most severe.

Putting goals and targets to use in challenging times

In addition to the programmatic setbacks, structural barriers and financial constraints, one of the key drivers of the poor response in children is waning political will. A consequence of this waning interest could be to downsize our ambition and put aside the 2025 goals for children set out in the Global AIDS Strategy – but this would be a mistake. Ambitious targets drove the unprecedented improvements through 2015 and helped to influence partners to develop, implement and finance the interventions that largely prevented major reversals in HIV services even during the darkest periods of the COVID-19 crisis. The COVID-19 pandemic also forced us to rethink how we deliver services. Innovations such as multi-month prescription refills, community-based follow up and telemedicine enabled many women, children and adolescents affected by HIV to continue to receive the support they needed. These innovations offer a pathway to a future in which health systems are re-imagined, more responsive to communities and more resilient to future health crises. Now is the time to use the

Adolescent key populations and girls in sub-Saharan Africa are at higher risk of HIV. Girls account for three quarters of all new HIV infections in adolescents.

global AIDS targets to promote a more coordinated and collaborative effort to unlock the political will, attention and resources needed to accelerate progress in HIV and make that progress more equitable for children.

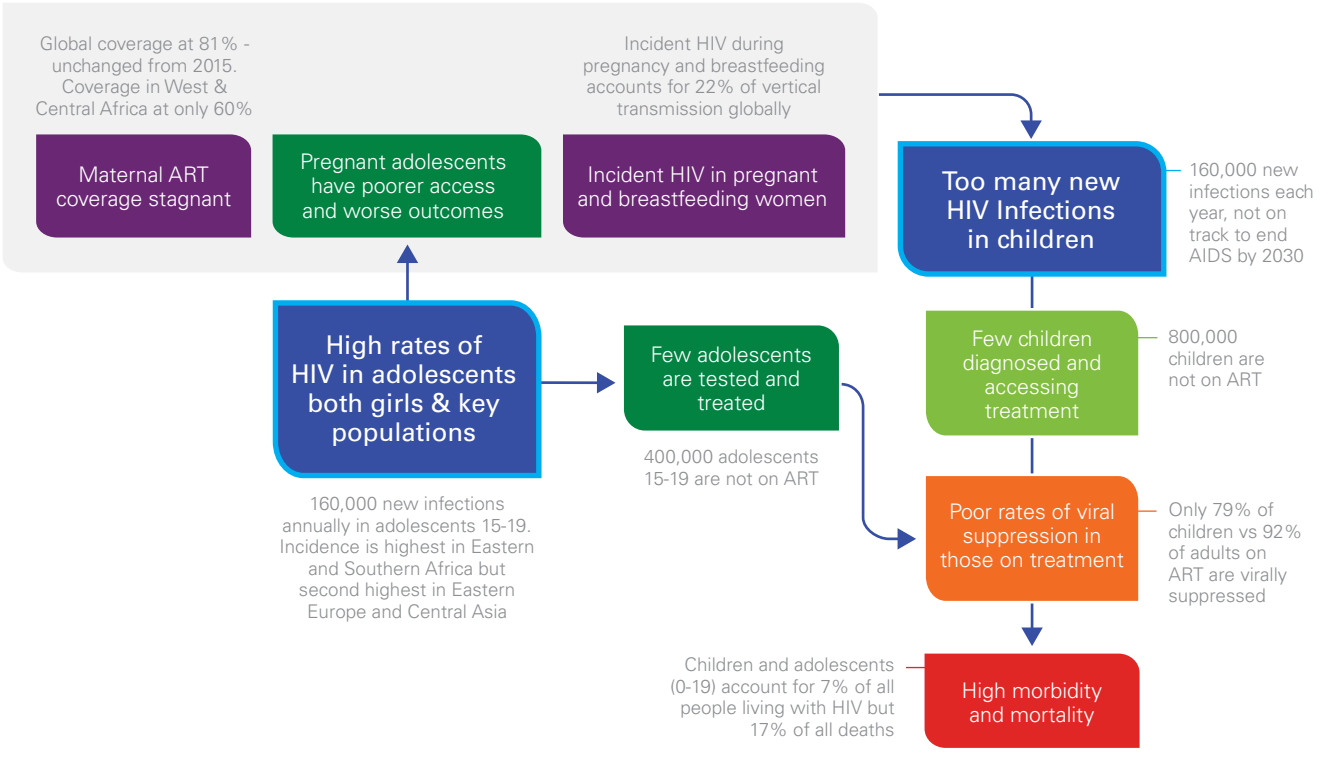
COVID-19 has shown us that when countries and partners make a health threat a priority, they can act forcefully. Globally, we have unlocked hundreds of billions of dollars for COVID tests, vaccines, personal protective equipment, health system strengthening, among other areas. If distributed to the right places, at the right time and for the right people, a relatively small share of such resources could bend the trajectory of ending AIDS among children towards the SDG targets. And unlike COVID-19, there is no need to start from scratch because the tools and knowledge about how to do this already exist.

Looking at what has worked, even in some of the most difficult circumstances, is cause for optimism. In 2021, for example, Botswana became the first HIV high-burden country to be recognized as on the 'path to elimination' of vertical transmission of HIV. The country is part of the Eastern and Southern Africa region, which has collectively managed to ensure that 89 per cent of all pregnant and breastfeeding women living with HIV are on ART, close to the 2025 target of 95 per cent coverage. In South Asia, 92 per cent of all children living with HIV were on ART in 2021, also not far from the 2025 target of 95 per cent and a five-fold increase from just 18 per cent in 2010. These impressive successes are proof that the global effort to end AIDS among children is achievable.

The HIV data in synopsis

Figure 2 shows how the latest data for children links together to shape the inequitable response for children and adolescents. See Annex for a full update on the current statistics at global and regional level.

Figure 2: A schematic representation of the global HIV response among children and adolescents in 2021



Source: UNICEF, data derived from UNAIDS estimates 2022

Equalising the HIV response for children and adolescents: Challenges and opportunities

Traditionally, every World AIDS Day focuses on a specific theme. This year, that theme is Equalize and for UNICEF the theme serves as a charge to address the inequities that stand in the way of progress to end AIDS for children and adolescents everywhere. The global HIV response figures point to some challenges that disadvantage children and leave many of them behind, but the true scope of the unequal results can be seen by further disaggregating estimates and trends by sex, region, and age. Collecting and examining paediatric and adolescent data in a way that allows for more extensively disaggregated analyses is an essential step in the prioritization approach necessary to drive progress.

Children and adolescents experience some of the worst outcomes in the HIV response. They have less access to treatment and bear a disproportionate share of new HIV infections and AIDS-related deaths.

Some of the challenges are evident from the results observed consistently over several years. As with adults, children and adolescents are most vulnerable to HIV in sub-Saharan Africa, which was home to six out of seven (86 per cent) of all children and adolescents aged 0–19 living with HIV in 2021. Of those, three quarters were living in Eastern and Southern Africa alone. In another example, compared with the overall population of those living with HIV, children are less likely to be diagnosed, on treatment or virally suppressed. Also, coverage of services to prevent vertical transmission and to diagnose and treat children and adolescents living with HIV varies considerably by region, within regions and often even within countries.

Where a pregnant or breastfeeding woman, child or adolescent lives is intrinsically linked to the challenges they experience. The two regions of West and Central Africa and Eastern and Southern Africa accounted for a staggering 92 per cent of the estimated 800,000 children living with HIV aged 0–14 who were not on treatment in 2021. Most worldwide AIDS-related deaths among children occurred in Eastern and Southern Africa (47 per cent of the total) and West and Central Africa (39 per cent of the total).

Other factors that disadvantage children and adolescents may be less evident and can be more difficult to quantify, or have not received much attention but need to be better understood to improve HIV responses among children. They include poor access to high-quality antenatal care (including HIV testing and treatment) for pregnant adolescents, especially those from key and marginalized populations, and worrying trajectories of new HIV infections in adolescents and young people in regions outside of sub-Saharan Africa.

Preventing vertical transmission

Globally, over the period from 2010 to 2021, there has been a greater than 50 per cent decrease in new HIV infections in children aged 0–14 resulting from vertical transmission. However, the data vary considerably by region (Figure 3). The 55 per cent decline observed across sub-Saharan Africa was driven by the 60 per cent fall in Eastern and Southern Africa, with a much smaller decrease, at 39 per cent, in West and Central Africa. Progress was poor in East Asia and the Pacific, where a decline of just 4 per cent in new child infections was seen from 2010 to 2021. In the Middle East and North Africa, new infections were estimated to be 10 per cent higher in 2021 than in 2010, although that estimate is based on limited data sets.

These variations in the number of new HIV infections averted among children is closely correlated with the regional variation in access to HIV treatment for pregnant and breastfeeding women. In 2021, treatment coverage for pregnant and breastfeeding women ranged from a high of 89 per cent in Eastern and Southern Africa to a low of 28 per cent in the Middle East and North Africa. In West and Central Africa, the region with the second highest overall burden, ART coverage among pregnant women was only 60 per cent (Figure 4). This low coverage, along with the population size, is the main reason why West and Central Africa accounts for a disproportionate share, about 43 per cent, of all the world's pregnant women living with HIV who were *not* on ART in 2021. In the South Asia region as well as in East Asia and the Pacific there were significant drops in coverage in 2020 due to COVID-19. Recent trends suggest a partial recovery in South Asia but persistent declines in East Asia and the Pacific.

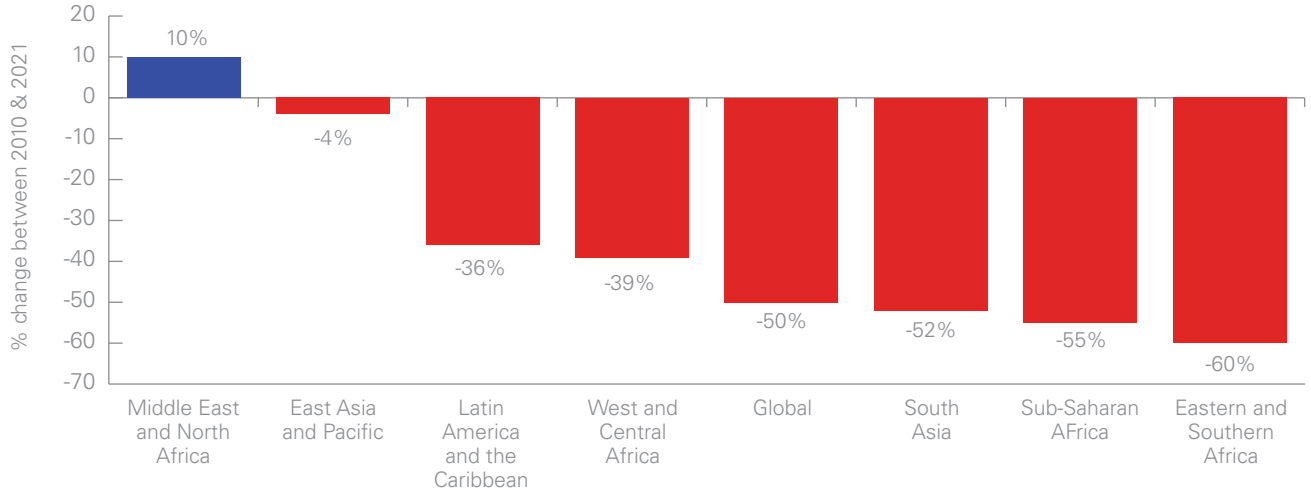
Global targets for children and adolescents by 2025

Reduce the number of new HIV infections among **adolescent girls and young women** to below **50,000**

Ensure that **95% of children and adolescents living with HIV know their status**, 95% of those that are positive are accessing treatment and 95% of those on treatment have suppressed viral loads

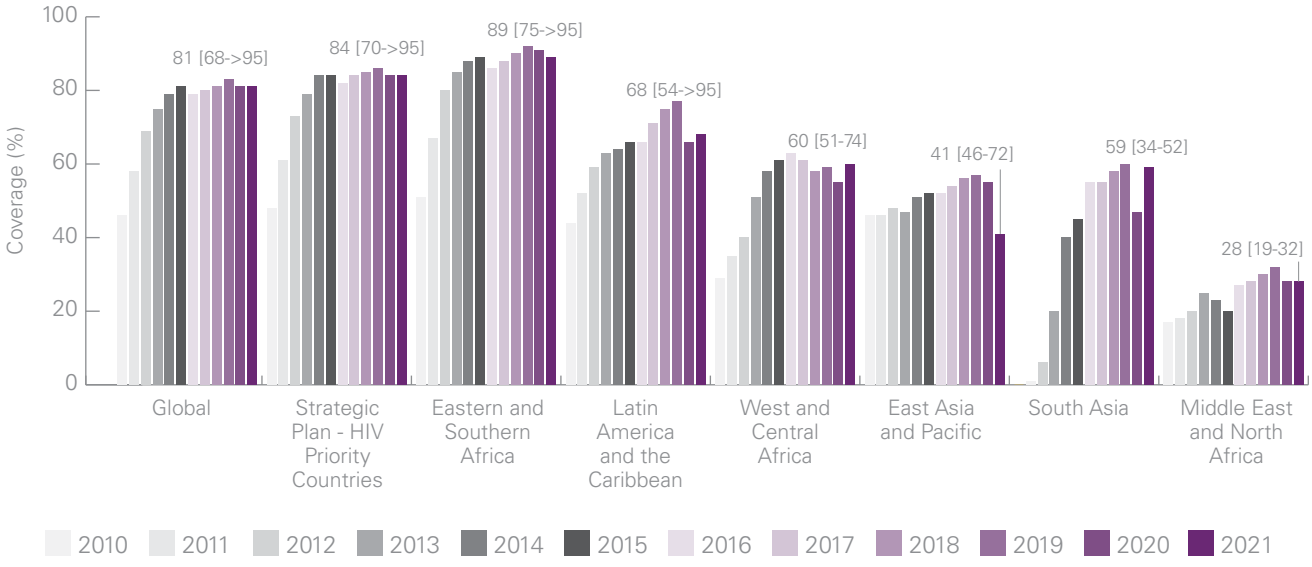
Ensure that all pregnant and breastfeeding women living with HIV are receiving life-long antiretroviral therapy, with **95% achieving and sustaining viral suppression** before delivery and during breastfeeding by 2025

Figure 3: Percentage change in the estimated number of new HIV infections among children (aged 0–14), by region, 2010–2021



Source: UNAIDS 2022 estimates

Figure 4: Percentage of pregnant women living with HIV receiving effective ART for prevention of vertical transmission of HIV, by region, 2010–2021



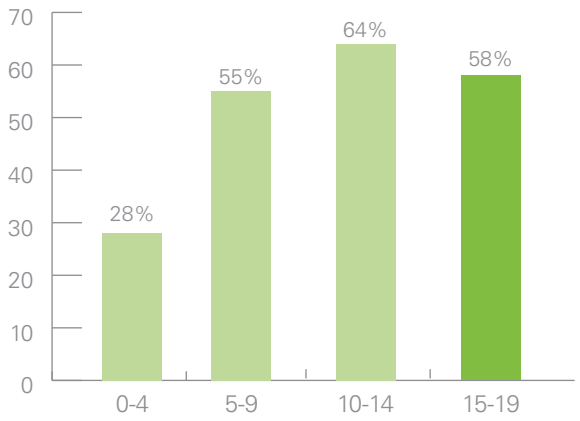
Note: Data are not available for Eastern Europe and Central Asia, North America, and Western Europe. Effective antiretrovirals exclude single dose nevirapine
Source: Global AIDS Monitoring and UNAIDS 2022 estimates

Treatment for children and adolescents living with HIV

Inequities can also be seen in the notable differences in treatment access by age group in those younger than 20 years of age living with HIV. Among 70 countries reporting data by five-year age bands, more than two thirds (72 per cent) of children living with HIV aged 0–4 years were *not* on ART in 2021. This dismal statistic, which corresponds to 324,000 children aged 0–4 living with HIV in 2021 not receiving potentially lifesaving treatment, stands in sharp contrast to the relatively higher levels of coverage in other age groups (Figure 5).

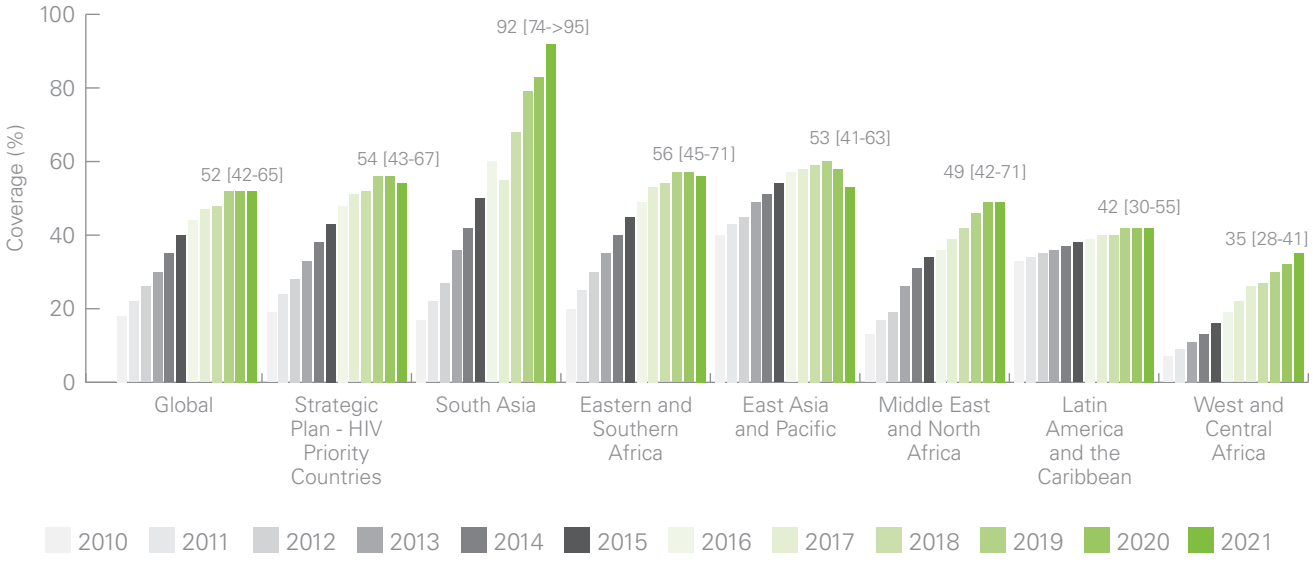
By country, the coverage of ART in children under 15 varied widely, ranging from under 10 per cent in some countries to over 95 per cent in others. Regionally, ART coverage for children was lowest in West and Central Africa at 35 per cent, much higher in Eastern and Southern Africa at 56 per cent and highest of all (92 per cent) in South Asia (Figure 6). Given that Eastern and Southern Africa and West and Central Africa combined have a 88 per cent share of all children living with HIV, rapid improvements in ART access are required in sub-Saharan Africa to lift global coverage and close the treatment gap.

Figure 5: Per cent of children and adolescents living with HIV on ART, by age group, 2010–2021



Source: Global AIDS Monitoring and UNAIDS 2022 estimates

Figure 6: Percentage of children aged 0–14 years living with HIV receiving ART by region, 2010–2021



Note: Data not available for Eastern Europe and Central Asia, North America, and Western Europe.
Source: Global AIDS Monitoring and UNAIDS 2022 estimates

It is of course not enough to ensure that all children living with HIV are on ART; equally important is that the treatment works as intended and prevents the harm caused by unchecked viral replication. According to available data, significant shortcomings exist in this critical area. Globally, about 79 per cent of children aged 0–14 on ART were virally suppressed. By comparison, in adolescents and adults (age 15 and older) the rates of viral suppression are 92 per cent among those on treatment.

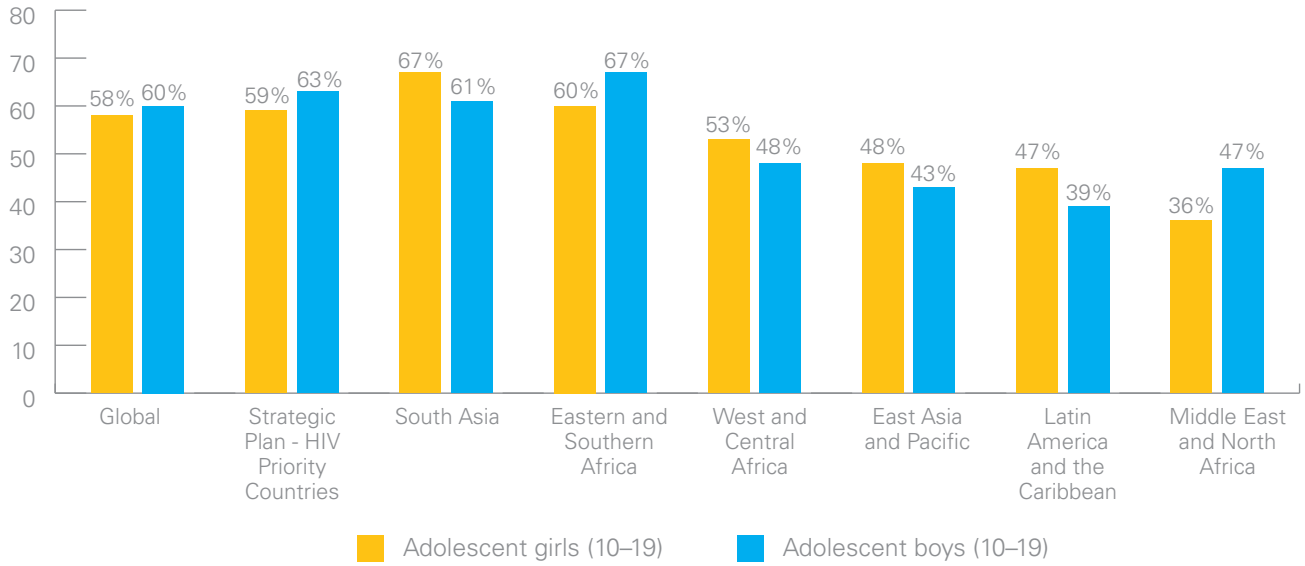
For adolescents living with HIV, there was no significant difference in ART coverage globally between adolescent girls (58 percent) and adolescent boys (60 per cent). However, as with younger children, ART coverage among adolescents aged 10–19 years was highly variable across regions, with the lowest treatment coverage in West and Central Africa (48–53 per cent) and the highest in South Asia (61–67 per cent) (Figure 7).

Overall, in 2021, the estimated global ART coverage level among adolescents aged 10–19 was 59 per cent. This is a nearly five-fold increase since 2010, when it was just 11 per cent, but it is important to note that these statistics are based on a relatively small number of countries that contribute adolescent data to the Global AIDS Monitoring database.

In sub-Saharan Africa, HIV remains a leading cause of death in adolescents largely because of the delay in identifying and treating adolescents (including those who were infected through vertical transmission). In addition, adolescents face unique challenges with adherence. The treatments they are prescribed are often sub-optimal, and most treatment sites offer poor support to adolescents to help them stay in care and adherent to treatment.

Addressing these challenges is essential. As it is, we lose too many adolescents to HIV. Moreover, poor adolescent treatment outcomes negate hard won gains for children living with HIV. Increasingly, large numbers of children living with HIV are 'aging out' and transitioning into adolescence and adulthood. Nearly 140,000 children with HIV reached the age of 15 in 2021, with 67 per cent of them in Eastern and Southern Africa and 20 per cent in West and Central Africa. These adolescents need access to tailored services to facilitate their transition to adult treatment programmes and prevent them from falling out of care which could lead to treatment failure and death.

Figure 7: ART coverage among adolescent boys and girls aged 10–19 years, by gender, by region, 2021



Source: Global AIDS Monitoring and UNAIDS 2022 estimates

Prevention of HIV among adolescents

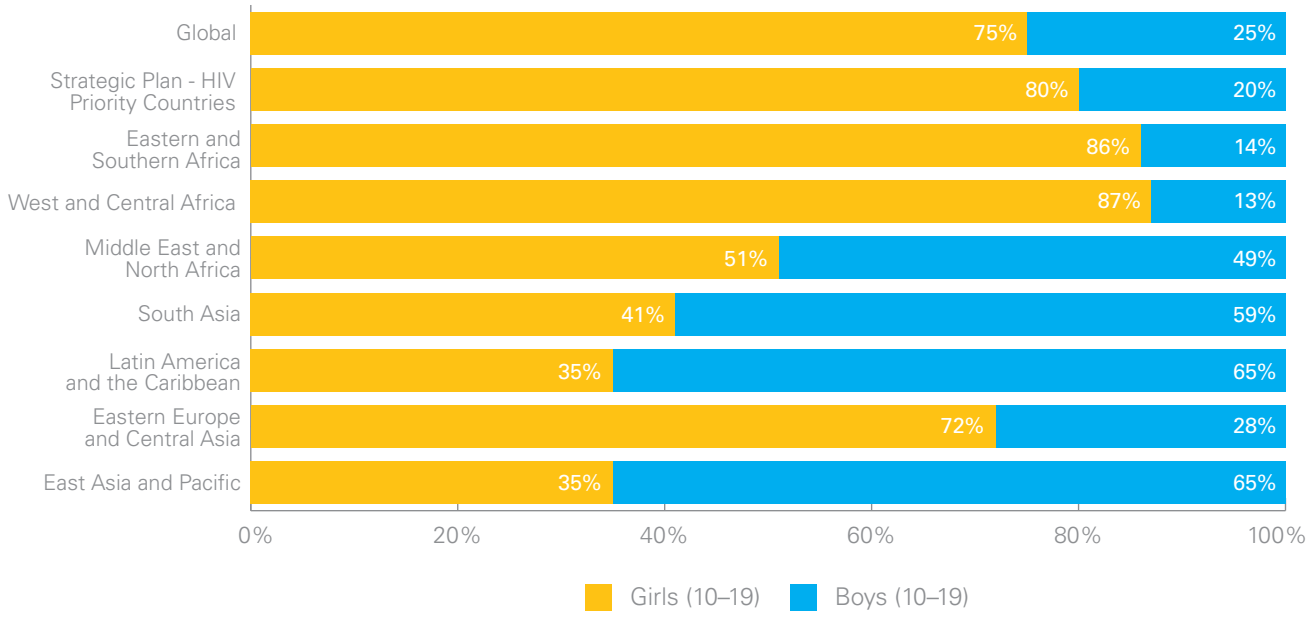
For adolescents aged 10–19 years, gender disparities shape the HIV response. At the end of 2021, girls aged 10–19 years accounted for about 75 per cent of new infections in that age group globally. As a result, close to two thirds of the estimated 1.7 million adolescents living with HIV are girls. Despite this disparity, roughly the same number of adolescent girls and boys died of AIDS-related causes in 2021, which suggests that more targeted attention is also needed to identify and retain in care adolescent boys who are living with HIV.

The gender balance between boys and girls is not uniform across regions. In Eastern Europe and Central Asia, Eastern and Southern Africa and West and Central Africa, most new infections among adolescents aged 10–19 years occurred in girls (Figure 8). Taken together, in these three regions, girls accounted for 79 per cent of new infections in adolescents. By contrast, new infections were split almost equally between the genders in South Asia and Latin America and the Caribbean, while adolescent boys comprised a significant majority (62 per cent) of new infections among adolescents in East Asia and the Pacific.

These differences are an important reminder that context matters in terms of designing and implementing programmes and approaches that will reach those most vulnerable to HIV. The global focus on prevention among adolescent girls and young women is clearly necessary based on overall data, but in many places, boys are at greater risk – including the estimated 12 million adolescent and young males who have sex with males, and an indeterminate number of young injecting drug users, incarcerated young men, and other adolescent and young key populations who need effective HIV prevention services and social support.[1]

It is essential that adolescents possess the skills, attitudes, values and above all the knowledge that will empower them to realize their own health, develop respectful social and sexual relationships and protect themselves from HIV infections. However, rates of comprehensive knowledge about HIV among adolescents remain below 50 per cent in most countries with available data.

Figure 8: Gender disparities in new HIV infections emerge in adolescents aged 10–19 years, by region, 2021



Note: Data not available for North America and Western Europe
Source: UNAIDS 2022 estimates

[1] https://pubmed.ncbi.nlm.nih.gov/36103481/

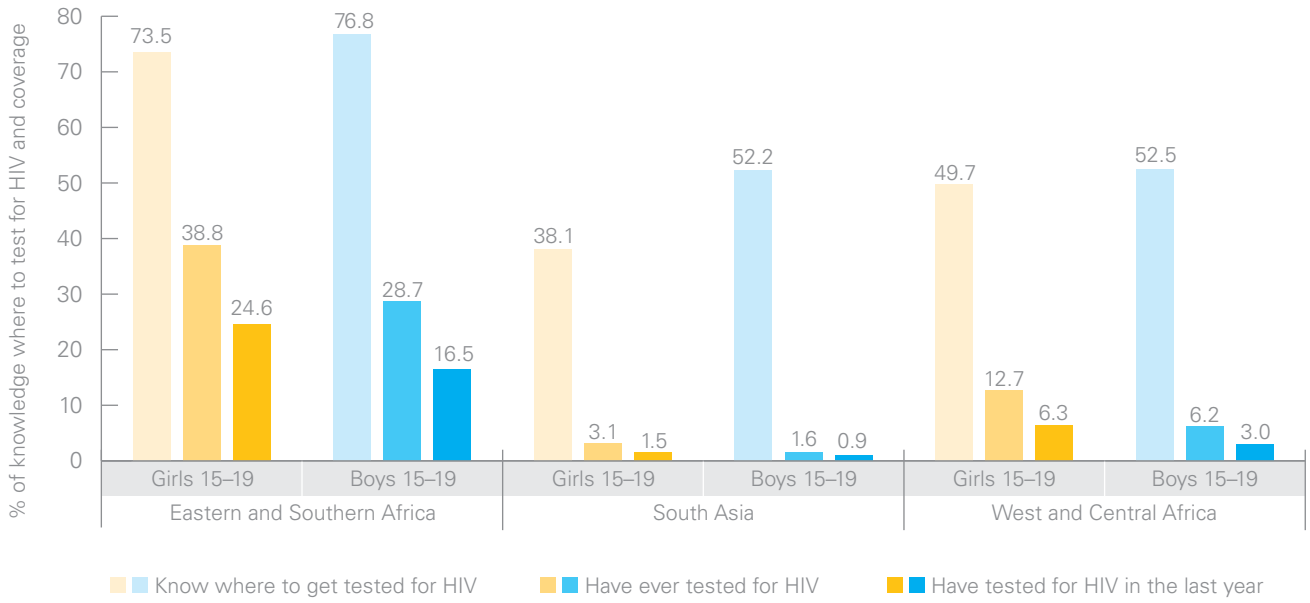
A lack of knowledge is not the only barrier to adolescent testing. The need for parental consent, parental resistance to disclosing their own HIV status in HIV-affected households and the perception that children living with HIV are unlikely to survive into adolescence all contribute to poor uptake of HIV testing among adolescents, including those living in relatively high-risk contexts. Even as countries and partners have made demonstrably successful efforts to widely disseminate the information that HIV testing is free and confidential, only 25 per cent of girls and 17 per cent of boys aged 15–19 years in Eastern and Southern Africa – the region most affected by HIV – received the result of their most recent test in 2021. Testing rates in West and Central Africa are even lower, at only 3 per cent for boys and 6 per cent for girls aged 15–19 years (Figure 9).

Adolescent key populations are increasingly being recognised as some of the most vulnerable of all people at risk of HIV. The unequal access, stigma, criminalization, and repression they experience as key populations is compounded by the generally poor access to health services and health information that adolescents must contend with worldwide. In 2021,

Broad gains in the global HIV response mask deep and long-lasting inequities between child and adult outcomes.

key populations and their sexual partners accounted for 94 per cent of new HIV infections outside of sub-Saharan Africa – but also more than half (51 per cent) of new infections within that region. In all parts of the world, the risk of contracting HIV among adolescent and young key populations including males who have sex with males, young people engaged in selling sex and exploited in commercial sex, transgender individuals and people who inject drugs is far greater than in the general population.

Figure 9: Percentage of adolescents aged 15–19 years who know where to get HIV testing, have been tested for HIV in the last 12 months and received the result of the last test, by region, 2015–2021



Note: Regional aggregates from survey data for HIV testing are shown only if countries with available survey data represent at least 50 per cent of the relevant population in the region
Source: Nationally representative population-based surveys, 2015–2021

Data are limited, often because countries are unable or unwilling to collect information on key populations. What little is known suggests that controlling HIV among key populations is critical to achieving an end to AIDS globally and underscores the importance of reaching key populations including adolescent and young key populations with age-appropriate, innovative, community-linked HIV prevention and care services. Failure to adapt HIV responses to meet the needs of adolescent and young key populations will prolong the HIV epidemic and further exacerbate inequities. Building programmes that reach adolescent key populations is especially challenging but it is also a critical unmet need. Stigmatisation, including self-stigmatisation, bullying and violence experienced by these children make them especially vulnerable to mental health issues. They are more likely to report symptoms of depression, anxiety, self-harm and suicidal thoughts and behaviours. There is little love, support, and protection for them. No refuge or safe place – not in schools, not at home and not on the streets, where many end up. Among the underserved, adolescent key populations are perhaps the most disadvantaged of all.

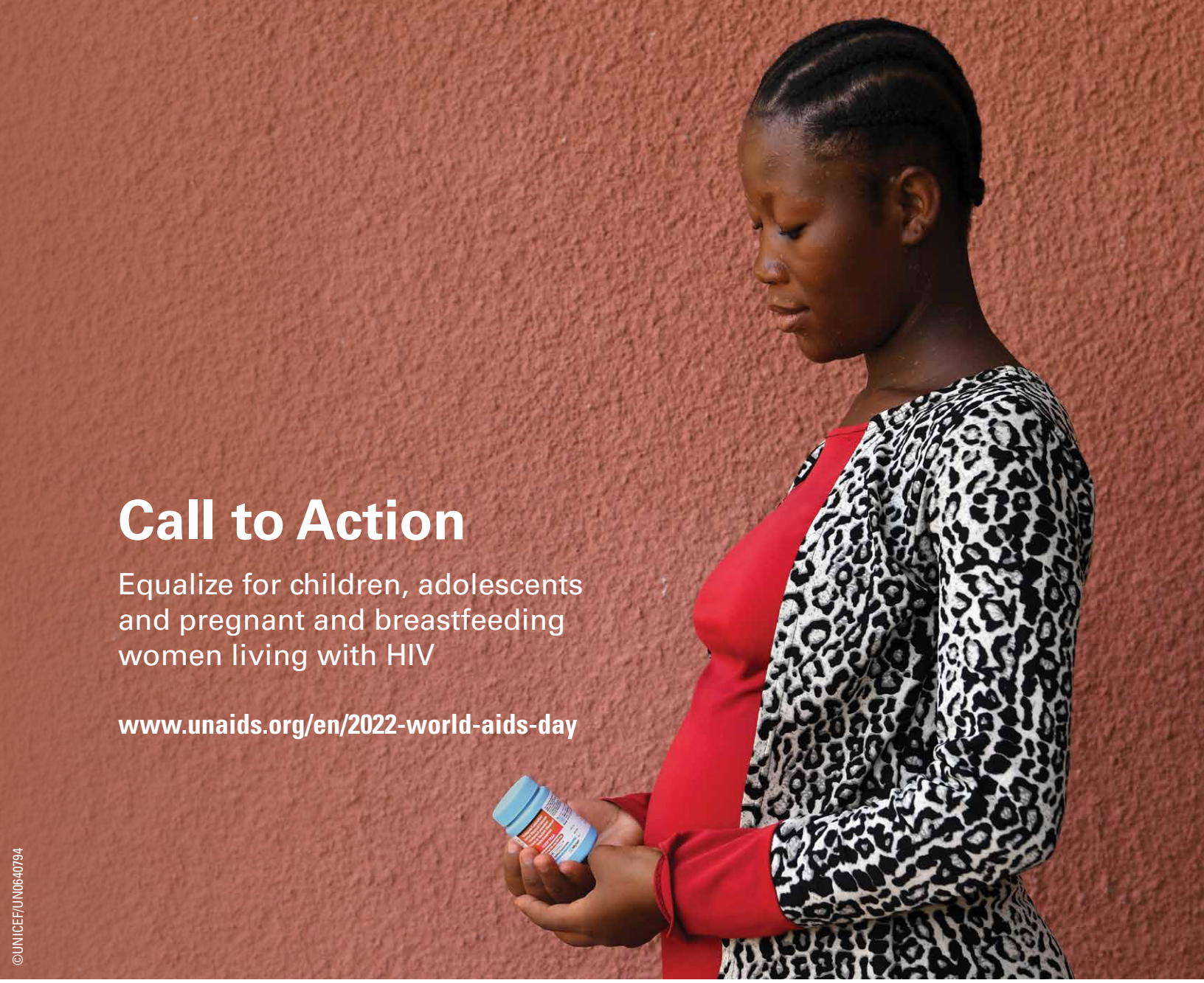
Conclusion

The poor HIV outcomes that children and adolescents experience relative to adults is not news. Year on year, the data tell the same story of children and adolescents being left behind in the global HIV response. Despite overall improvements over the past several decades, the gap between adults and children in terms of access to HIV prevention and treatment services has not narrowed and in some settings seems to be getting worse. Forty-eight per cent of all children living with HIV are not on life saving treatment – and most of these are not even aware of their HIV status. Combination prevention services for HIV are not reaching adolescent key populations or adolescent girls. In 2021 new HIV infections among adolescent girls accounted for three out of four of all new infections in 10 to 19-year olds globally. Overcoming these and other inequities that disadvantage children and adolescents requires greater political will, allocating resources to meet their needs, implementing normative guidance and scaling up interventions that have been shown to work in a variety of contexts.

Below we highlight 7 approaches in a Call to Action aimed at 'equalizing' the HIV response for children and adolescents and changing its trajectory to meet global targets. The approaches span the continuum of care - from prevention to treatment and encompass a mix of evidence-based policy and programmatic recommendations. All of these recommendations are important, but the specific combination of approaches must be prioritized and adapted to local context because there is no one-size-fits-all package that is appropriate for all settings. UNICEF has long advocated for differentiated programming – a multistep process that uses data to pinpoint need, builds consensus among stakeholders on 'what' and 'who' to prioritize, and drives targeted action to effect change.

There are many threats to the attainment of the right to health for children and adolescents across the world, but HIV no longer needs to be one of them. We have the tools and approaches we need to equalize HIV outcomes for children and adolescents and end AIDS in this population once and for all.

Significant differences in political commitment and resource allocation between regions drive unequal responses. Compared with Eastern and Southern Africa, pregnant women and children living with HIV in West and Central Africa, East Asia and the Pacific or the Middle East and North Africa are far less likely to be on treatment.



Call to Action

Equalize for children, adolescents and pregnant and breastfeeding women living with HIV

www.unaids.org/en/2022-world-aids-day

Eliminate

1. **Eliminate vertical transmission of HIV, syphilis and hepatitis B** by going the Last Mile and integrating testing and treatment for the three diseases for pregnant and breastfeeding women everywhere.

2. **Eliminate harmful laws and policies** to ensure safety and dignity in seeking HIV services. Amending and repealing harmful laws will lead to a more conducive, non-discriminatory legal environment, including challenging 'age of consent' policies that restrict adolescents' access to sexual and reproductive health information, and condoms, pre-exposure prophylaxis and self-directed testing.

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Integrate and Innovate

3. **Implement innovative models of care** within facilities and communities to protect girls and women from acquiring HIV during pregnancy and breastfeeding and promote retention in care for those living with HIV. Pregnant women everywhere, especially adolescents and marginalized women should have access to female-controlled HIV prevention and high quality treatment services.

4. **Ensure roll out and scale up of game changing approaches** to improve the quality of HIV care for children and adolescents:

    - Implement multi-modal testing strategies (such as family-based testing, routine facility-based testing, self-testing and home-based testing among others)
    - Optimize antiretroviral treatment regimens to promote use of dolutegravir in pregnant women, children and adolescents.
    - Implement viral load testing for children and adolescents.
    - Integrate mental health into HIV care services especially for adolescents.

5. **Establish services for adolescent and young key populations** using tools collated by youth-led organizations in the Adolescent and Young Key Populations Toolkit.

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Empower

6. **Empower adolescents to take charge of their health.** Create an environment where adolescents are protected from harmful gender roles and practices, gender-based discrimination and violence, and can access dedicated resources, so they can be their own independent agents of change.

7. **Build the capacity of health workers and community actors** to reduce stigma, enhance quality of care and provide support to women, children and adolescents at risk of and living with HIV.

Annex

Trends, gaps and successes: Summary of progress

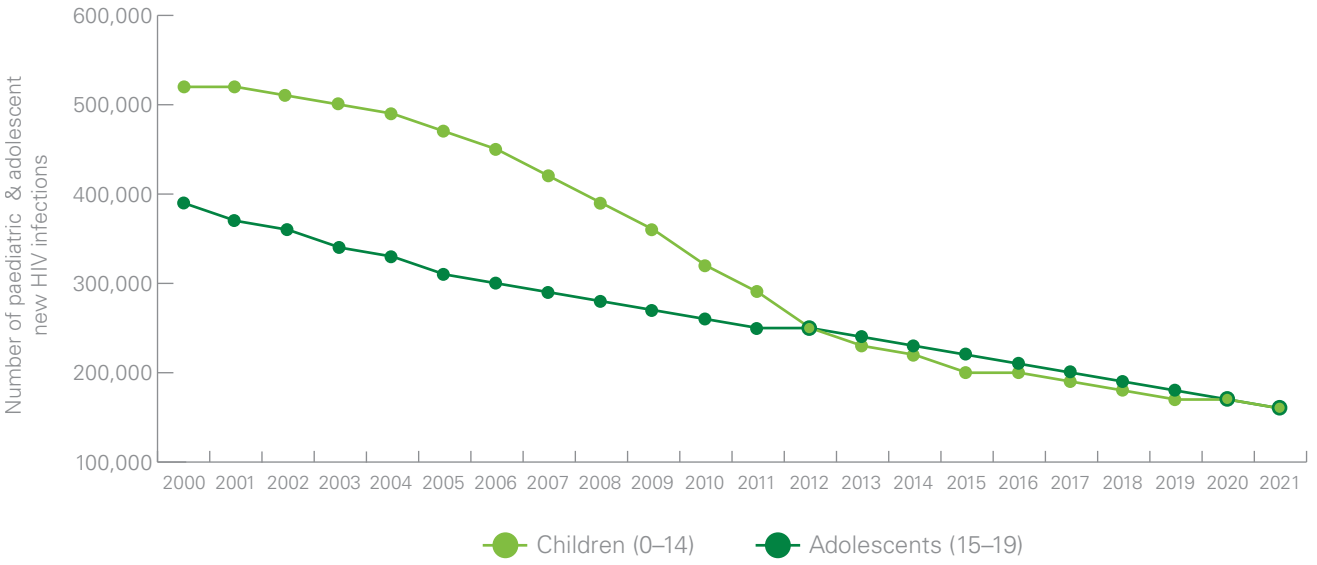
KEY GLOBAL RESULTS

The most recent global data show that the total number of people under 20 years of age living with HIV in 2021 was about 2.7 million, slightly lower than the previous year and 24 per cent lower than in 2010. Children and adolescents aged 0–19 account for about 7 per cent of all people living with HIV, compared with 12 per cent in 2010. They are represented far more significantly in two other important overall indicators: 21 per cent of all new HIV infections in 2021 and 17 per cent of all AIDS-related deaths that year.

New infections are a signal of where current gaps exist and, therefore, where improvement is most needed. In 2021, around 160,000 younger children (aged 0–14 years) were newly infected with HIV, the vast majority due to vertical transmission of HIV from mother to child. This is a considerable decline of 52 per cent since 2010. By contrast, for adolescents aged 15–19 years, the number of new HIV infections in 2021 was only about 40 per cent lower than in 2010 (Figure i).

Both of these improvements based on 2021 estimates were far greater than the decline in adults (29 per cent) from 2010. However, progress in preventing vertical transmission slowed over the past several years, with only a 22 per cent decline in new infections from 2016 to 2021 among those aged 0–14.

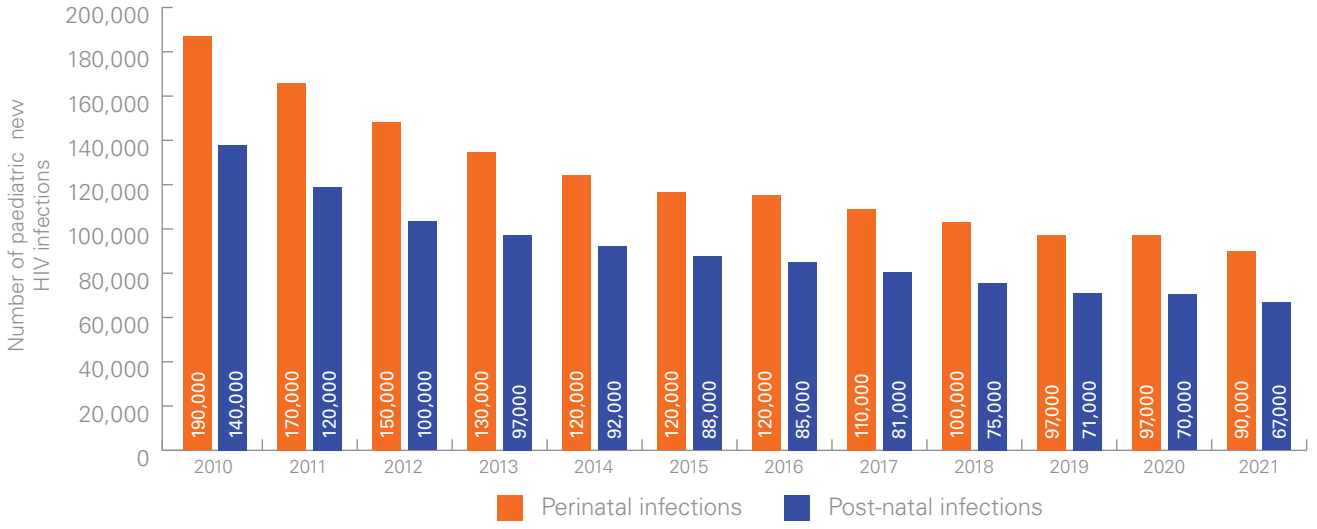
Figure i: Number of annual new HIV infections among children aged 0–14 years and adolescents aged 15–19 years, 2010–2021



Source: Global AIDS Monitoring and UNAIDS 2022 estimates

The reduction since 2010 in child infections was about the same rate by period of transmission, perinatal (during birth) and postnatal (primarily through breastfeeding). In 2021, about 42 per cent of all cases of vertical HIV transmissions occurred during the breastfeeding/postnatal period (Figure ii), which is about the same share as in previous years. Regardless of the period of infection, the global HIV response remains far behind the target of reducing total new HIV infections from mother-to-child transmission by 95 per cent, to under 20,000.

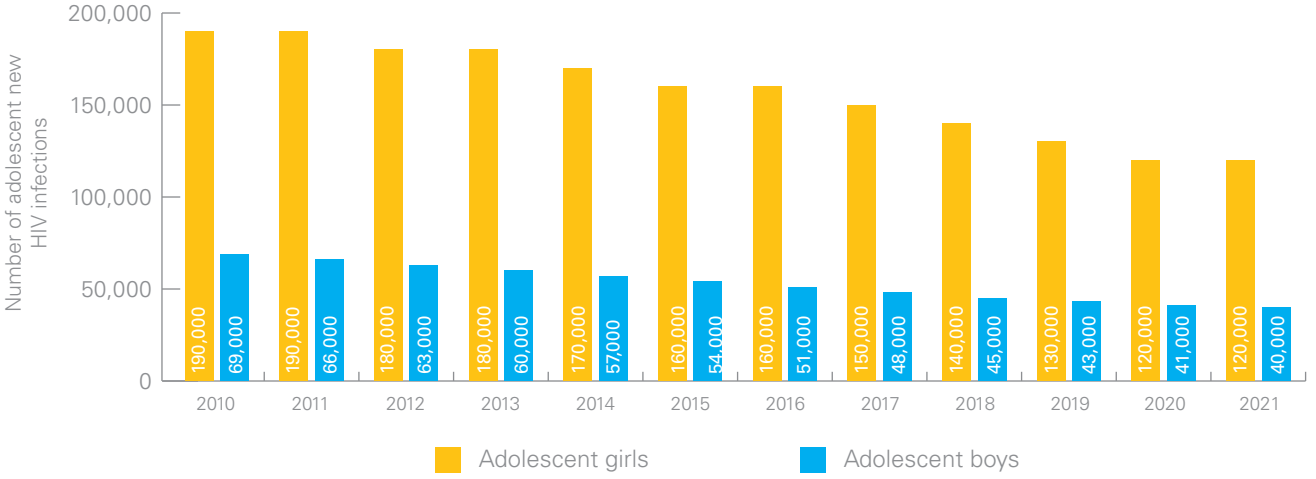
Figure ii: Annual number of new HIV infections among children aged 0–14 years, by period of transmission, 2010–2021



Note: Almost all new HIV infections among younger children occur in those aged 0-4 years, either through pregnancy, birth or breastfeeding
Source: Global AIDS Monitoring and UNAIDS 2022 estimates

Globally, about three quarters (77 per cent) of new infections among adolescents occur in girls. That share has remained relatively consistent since 2010, as new HIV infections have declined similarly for girls and boys in the last 11 years (Figure iii).

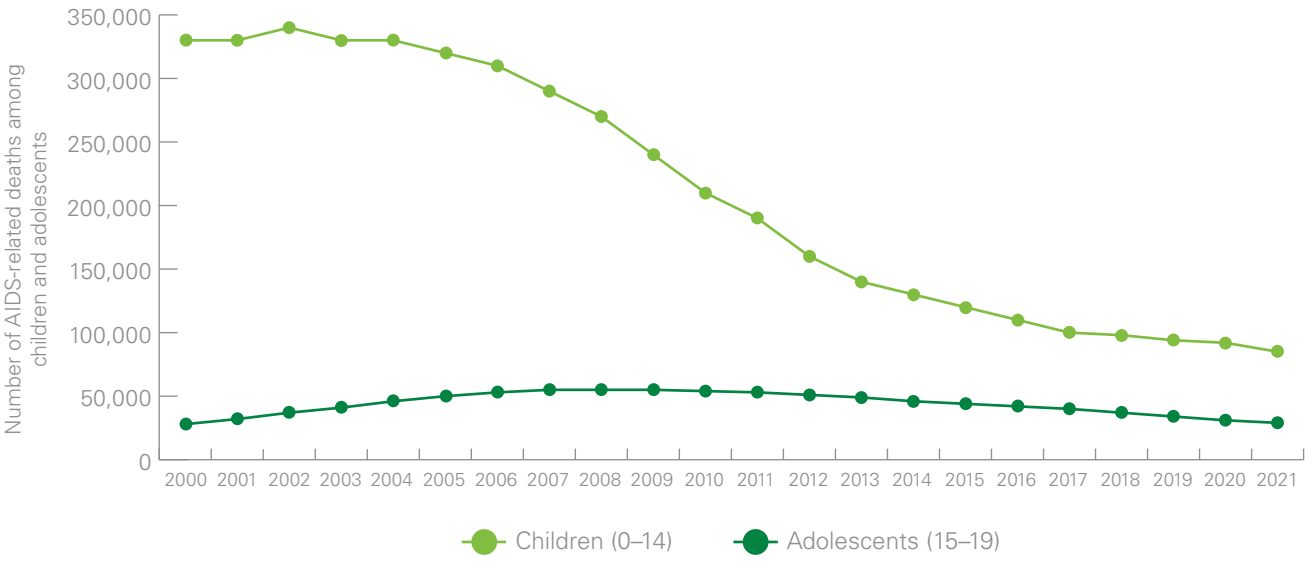
Figure iii: Annual number of new HIV infections among adolescents aged 10–19 years, by sex, 2010–2021



Note: Almost all sexually transmitted HIV infections are assumed to occur after age 14, since negligible numbers of sexually transmitted infections occur before age 15
Source: Global AIDS Monitoring and UNAIDS 2022 estimates

At about 110,000, the number of deaths from AIDS among children (aged 0–9 years) in 2021 was 59 per cent lower than in 2010. The decline was smaller, about 46 per cent, over the same time period for AIDS-related deaths among adolescents aged 10–19 (Figure iv). Much of the progress in reducing deaths in both age groups occurred before 2015.

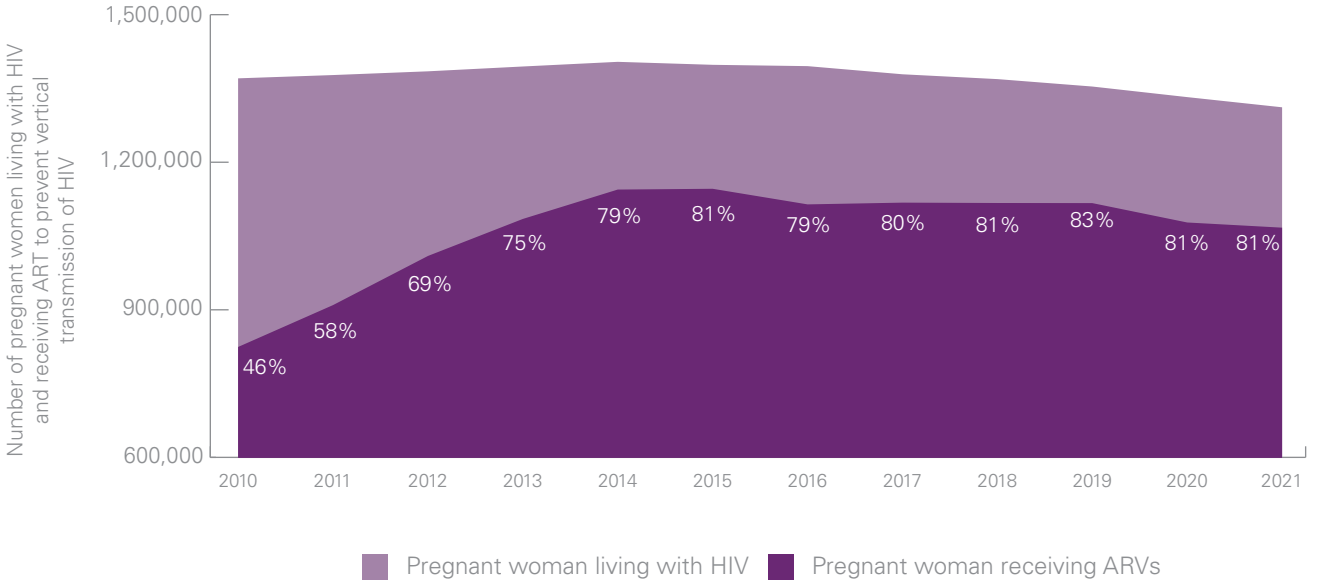
Figure iv: Number of AIDS-related deaths among children aged 0–9 years and adolescents aged 10–19 years, 2000–2021



Source: Global AIDS Monitoring and UNAIDS 2022 estimates

Great gains have been made since 2010 to ensure that pregnant women living with HIV are on lifelong ART to safeguard their own health and to prevent vertical transmission. In 2021, an estimated 81 per cent of them globally were receiving ART, nearly double the 46 per cent coverage level in 2010 (Figure v). However, progress has stalled since 2015. Prevention of mother-to-child transmission coverage reached 81 per cent that year and inched up to 83 per cent in 2019 before falling back to 81 per cent again the following two years. The failure to move closer globally to the 95 per cent target for 2025 has occurred even as the total estimated number of pregnant women living with HIV has fallen annually over the past few years.

Figure v: Number of pregnant women living with HIV and number receiving ART for prevention of vertical transmission of HIV, 2010–2021

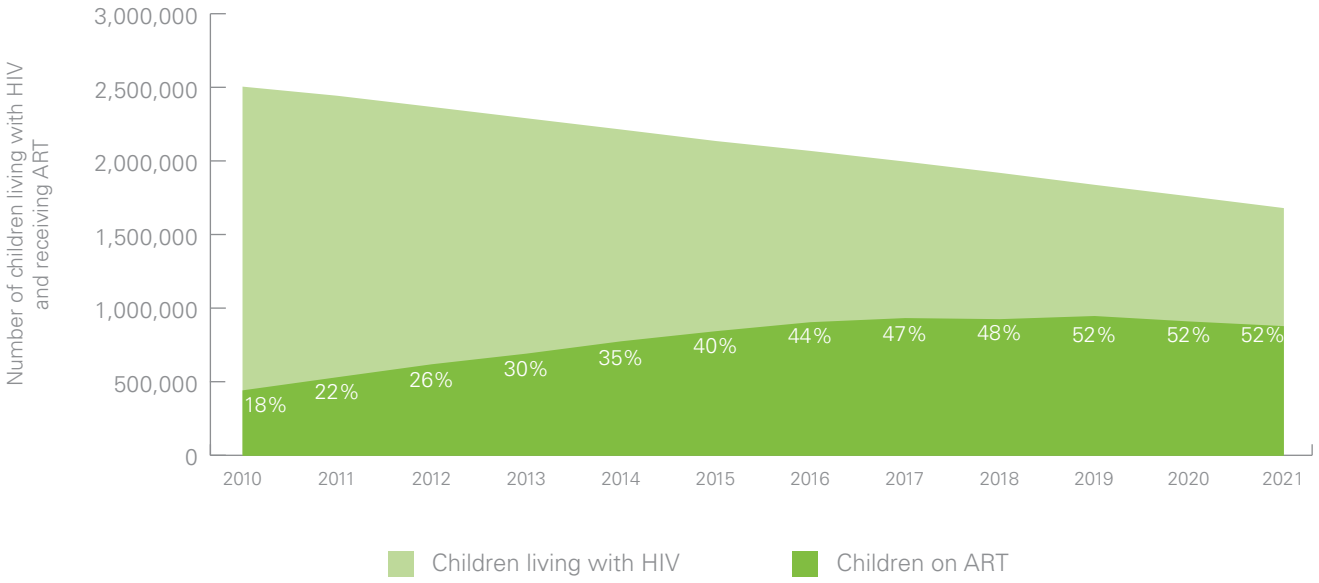


Source: Global AIDS Monitoring and UNAIDS 2022 estimates

In 2021, an estimated 878,000 of the 1.68 million children under age 15 living with HIV worldwide were receiving ART, which translated into 52 per cent coverage (Figure vi). That share has not changed since 2019 after years of substantial improvements from just 18 per cent in 2010.

Gaps in diagnosing HIV among infants in particular is one reason for the low treatment coverage level. In 2021, an estimated 62 per cent of infants exposed to HIV globally were tested for the virus within two months of birth, as recommended by the World Health Organization (WHO). That is nearly twice the rate in 2010 (34 per cent), but it has edged up only slightly since reaching 57 per cent in 2018.

Figure vi: Number of children aged 0–14 years living with HIV and number receiving ART, 2010–2021



Source: Global AIDS Monitoring and UNAIDS 2022 estimates

Data sources and methodology

1.1 GLOBAL AIDS MONITORING 2021

In order to monitor the HIV response and progress towards achieving global goals, countries submit national and subnational data on a host of indicators to the Global AIDS Monitoring (GAM) system. Annual submissions are reviewed and validated. Data consist of programmatic data for HIV prevention, testing and treatment. Other indicators require data from population-based surveys and surveys focused on key populations at risk of HIV infection.

For more information, https://www.unaids.org/en/global-aids-monitoring

1.2 UNAIDS ESTIMATES AND SPECTRUM'S AIDS IMPACT MODEL

Each year, countries update their AIDS Impact Model in Avenir Health's Spectrum software to develop the latest estimates for the HIV epidemic. Supported by UNAIDS, WHO and UNICEF, these estimates are used to inform programme and policy decisions for the HIV response.

1.3 NATIONALLY REPRESENTATIVE SURVEYS

Multiple Indicator Cluster Surveys (MICS), Demographic and Health Surveys (DHS), AIDS Indicator Surveys (AIS), Population-based HIV Impact Assessments (PHIA) reproductive health surveys, sexual behaviour surveys and other nationally representative surveys are currently used to collect data on HIV and AIDS.

For every child, End AIDS