



UNICEF 2021 World AIDS Day Report
Stolen Childhood, Lost Adolescence



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Abbreviations and Acronyms

ART	Antiretroviral treatment
ARV	Antiretroviral drug
ANC	Antenatal care
CDC	United States Centers for Disease Control and Prevention
CHAI	Clinton Health Access Initiative
EMTCT	Elimination of mother-to-child transmission (of HIV)
Global Plan	Global plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive
UN HLM	United Nation's High-Level Meeting on HIV and AIDS
NVP	nevirapine
PEPFAR	United States President's Emergency Plan for AIDS Relief
PMTCT	Prevention of mother-to-child transmission (of HIV)
POC	Point-of-Care testing
SDG	Sustainable Development Goal
UHC	Universal Health Coverage
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNICEF	United Nations Children's Fund
WHO	World Health Organization



1. Reimagining a new normal to accelerate progress

The second World AIDS Day since the start of the global COVID-19 pandemic in early 2020 finds the world still mired in a perilous and uncertain state. The ongoing health crisis has exposed and often widened inequalities at all levels – global, regional, national and subnational – in the availability and quality of vital health care services. As a result, more people are being left further behind even as the 2030 deadline for achieving the Sustainable Development Goals (SDGs) and its promise of universal health coverage (UHC) comes closer.¹

Over the past four years, progress toward addressing the longstanding inequalities in access to treatment and prevention for mothers, children and adolescents has slowed, halted or even

reversed in some contexts.² In addition, the COVID-19 pandemic has illustrated how vulnerable women and children living with and at risk for HIV are.³ The sudden disruption of prevention and treatment services in many countries and communities resulted in significant negative consequences for these populations, including increased severe illnesses and deaths from AIDS, more new infections among adolescents, and more transmission of HIV from mothers to their children. These devastating outcomes were compounded by the impacts of broader health, social and economic developments related to the fight against COVID-19, including school closings, travel restrictions, loss of formal and informal income-generating activities, and upsurges in domestic violence.

The sense of crisis, if not the crisis itself, has eased in some parts of the world, but challenges persist in many countries – especially in those with poor access to COVID-19 vaccines and therapeutic options. This is yet another inequality that disproportionately affects people living with HIV, the majority of whom live in regions of the world where COVID-19 prevention and treatment options are very limited. Reducing the threat and burden of COVID-19 for everyone, wherever they live, is therefore an essential step toward reinvigorating HIV responses for women, children and adolescents.

1. United Nations Department of Economic and Social Affairs, 2015. Transforming our world: the 2030 Agenda for Sustainable Development [online] Available at: <<https://sdgs.un.org/2030agenda>> [Accessed 24 November 2021].

2. UNAIDS, 2021. Start Free, Stay Free, AIDS Free, Final Report on 2020 Targets. [online] Available at: <https://www.unaids.org/sites/default/files/media_asset/2021_start-free-stay-free-aids-free-final-report-on-2020-targets_en.pdf> [Accessed 24 November 2021]

3. Waterfield, K., Shah, G., Etheredge, G., et al., 2021. Consequences of COVID-19 crisis for persons with HIV: the impact of social determinants of health. BMC Public Health, 21(1). [online] Available at: <<https://bmcpublichealth.biomedcentral.com/track/pdf/10.1186/s12889-021-10296-9.pdf>>

Yet, this World AIDS Day also should be a reminder that focusing solely or primarily on COVID-19 is a dangerous and short-sighted strategy for safeguarding and improving the health and well-being of those most vulnerable to HIV. Even as we face the challenges of COVID-19, countries and their partners must simultaneously focus on all neglected health and development issues, and strengthen health systems in ways that 'build back better' not just for pandemic preparedness but to achieve universal health for all. Therefore, averting new HIV infections and boosting treatment access among children and adolescents can and should be a priority at the same time that COVID-19 is being tackled, to ensure that all HIV prevention and treatment interventions can be delivered safely, consistently and without fear of interruption.

Also, an emphasis on returning to 'normal', to where things were before the COVID-19 pandemic, is a worrying message for people living with and affected by HIV. The 'normal' in the 3 years before the pandemic was a time of slowed progress in reaching, supporting and sustaining HIV prevention, treatment and care services for women, children and adolescents. Many of the most pronounced inequalities were actually increasing in the years prior to the pandemic – especially in areas such as access to antiretroviral treatment (ART) for children and adolescents and addressing the vulnerabilities of adolescent girls to HIV infection.¹ There were also large differences among regions and countries in all key coverage indicators for HIV prevention, treatment and support services for children and

adolescents. Ending AIDS in children and adolescents requires going far beyond 'normal'.

Despite shortcomings and setbacks in recent years, there are plenty of reasons to be optimistic. We have undeniably made tremendous progress and many countries have shown that that it is possible to achieve sustainable improvements in HIV responses and save millions of lives. Seizing the opportunities we have already created and continue to create can yield major benefits, including from the lessons learned over the past three decades of the global fight against HIV and the innovative tools, strategies and approaches that have been developed, tested and proven over time. Improved data collection and analysis is showing us where the main inequalities, gaps and vulnerabilities are, thereby pointing to where the greatest gains can be achieved for maternal child and adolescent HIV health. With sufficient attention and resources, we can roar past 'normal' and resume the impressive progress that we saw prior to 2015, the inflection point when progress flatlined.

This World AIDS Day, the world should commit to reimagine what normal should be for children and adolescents everywhere and take the steps needed to reach it. This would be a world in which HIV is universally controlled and suppressed, so that it is no longer a threat to children; a world in which new HIV infections quickly dwindle to zero; a world where children on ART are cared for effectively and compassionately, and transition seamlessly to adult treatment services; a world where all people living with HIV are virally suppressed over their lifetime.

1. UNICEF, 2021. HIV/AIDS: Global and Regional Trends. [online] Available at: <<https://data.unicef.org/topic/hivaids/global-regional-trends/>> [Accessed 24 November 2021]

If we can achieve this ambitious goal, the stigma and discrimination that lies at the heart of almost all inequalities in HIV responses will begin to decline as well. More time, energy and resources can then be devoted to understanding and addressing other factors that contribute to the inequalities in health and well-being that women, children and adolescents have long experienced in much of the world. Dynamic, forceful and innovative responses to HIV will once again be at the centre of broader efforts to achieve major health and social change universally.



2. Where we have come from: advancements and setbacks in the battle against HIV among children and adolescents

3

The history of HIV/AIDS among mothers, children and adolescents is chequered. Children have always lagged behind adults ever since ART was first available, and despite some triumphant successes there have also been repeated setbacks that have maintained and sustained inequities. For almost the first two decades of the epidemic there seemed to be no remedy for the despair and hopelessness that children living with HIV faced. In the late 1990's the advent of highly effective ART that could also benefit children, brought renewed hope and since then there has been slow but continuous progress in coverage of treatment in children.¹ Advances in knowledge, in testing and in treatments have helped us to better

1. Vella, S., Schwartländer, B., Sow, S., et al., 2012. The History of Antiretroviral Therapy and of its Implementation in Resource-Limited Areas of the World. AIDS, 26(10), pp.1231-1241. Available at: <https://journals.lww.com/aidsonline/fulltext/2012/06190/the_history_of_antiretroviral_therapy_and_of_its.12.aspx> p.1235

understand risks, identify infants, children and adolescents living with HIV and offer both treatment and prevention services at all layers of the health system.

Results from the PACTG 076 study in 1994,¹ a decade or so after the first cases of AIDS in children were identified, proved that ARVs given to mothers and infants could significantly reduce the rate of vertical HIV transmission. But even after this prophylactic option was simplified with the use of single-dose nevirapine (NVP), this lifesaving approach was not implemented for years in most developing country settings. Failure to quickly put this learning into practical use resulted in a peak in the early 2000's of almost half a million new HIV infections globally among children 0–9 years old, 95 per cent of them occurring in sub-Saharan Africa.

A related key challenge in the first 15 years or so of the AIDS epidemic was that providers had little to offer children. HIV Testing was not available for infants, which meant that many children died even before a confirmed diagnosis. Treatment for children living with HIV was rarely accessed by clients not only because ARVs were in limited supply and too costly and complex, but also because of the lack of engagement with civil society and communities and, as a result, a lack of awareness of the efficacy and availability of paediatric ART.

Ultimately, it was civil society, which included men and women living with HIV in countries around the world, that played a critical role in turning the tide. Civil society groups and communities of people affected by HIV and were instrumental in ensuring the sustained and universal availability of generic ARVs and other lower-cost medicines and diagnostics critical for the HIV responses.

Both the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), founded in 2002, and the United States President's Emergency Plan for AIDS Relief (PEPFAR), introduced in 2003, emphasized paediatric treatment. Other partners with global reach, such as the Clinton Health Access Initiative (CHAI) and the United States Centers for Disease Control and Prevention (CDC), collaborated to scale up access to early infant diagnosis. Since 2006, Unitaid has supported projects and technical expertise aimed at finding innovative prevention, diagnostic and treatment tools and interventions. In 2011, UNAIDS, PEPFAR, UNICEF and WHO and partners across different sectors supported the launch of the Global plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive (Global Plan).² That agenda helped to spur political momentum for innovative service delivery approaches such as the so-called "Option B+", which called for the use of lifelong ART to all pregnant and breastfeeding women living with HIV.³

1. Connor, E., Sperling, R., Gelber, R., et al., 1994. Reduction of Maternal-Infant Transmission of Human Immunodeficiency Virus Type 1 with Zidovudine Treatment. *New England Journal of Medicine*, 331(18), pp.1173-1180. Available at: <https://www.nejm.org/doi/full/10.1056/NEJM199411033311801>

2. Global Plan URL for citation: www.unaids.org/en/resources/documents/2011/20110609_JC2137_Global-Plan-Elimination-HIV-Children_en.pdf
3. Chersich, M.F., Newbatt, E., Ng'oma, K. et al., 2018, UNICEF's contribution to the adoption and implementation of option B+ for preventing mother-to-child transmission of HIV: a policy analysis. *Global Health* 14(55) pp.1-13. Available at: <https://doi.org/10.1186/s12992-018-0369-2> p.11.

In retrospect Option B+ was perhaps the greatest single advance in the prevention and treatment of HIV in children. Indeed it could be argued that the rapid uptake of this intervention across the globe to both limit the transmission of HIV from mother to child and maintain the health of women living with HIV, was one of the crowning public health successes of recent decades. UNICEF played a pivotal role in this effort, developing operational guidance, mobilizing and in some cases redirecting donor resources and supporting governments on the ground.

Institutional partners, communities and governments came together and were collectively responsible for driving a remarkable and steep decline in the numbers of new infections in children while also reducing AIDS-related deaths among mothers. By 2015, when the SDGs were launched, it seemed entirely feasible that the ambitious goals and targets related to ending AIDS among these vulnerable populations would be met nearly everywhere.

However, progress began to level off at just around that time. Even as more and more children, adolescents and pregnant women had access to HIV prevention and treatment services, critical service delivery gaps persisted and, in some cases, new gaps emerged, especially when it came to linkage to care and ensuring lifelong retention and adherence to treatment. The failure to maintain the pace of progress while also ensuring quality and sustainability set back efforts to substantially narrow inequalities that negatively affected women, children and adolescents in most HIV responses.

3. Slowing down, missing targets and entrenched inequalities

The consequences of the 2015 slowdown are evident half a decade later. The world missed every single one of the 2020 super-fast-track targets set by the United Nations High-Level Meeting on Ending AIDS (HLM) in 2016 and adopted by the 'Three Frees' partnership that year.¹ At just 54 per cent, global paediatric ART coverage in 2020 was nearly 20 percentage points behind that of adults living with HIV.² Although many countries and territories have ART coverage of more than 90 per cent among all pregnant women living with HIV – and the average is 95 per cent for Eastern and Southern African countries – elimination of mother-to-child transmission (EMTCT) of HIV has only been achieved in a handful of places since 2015, most of them small countries with relatively low prevalence.

1. The 'super-fast-track' framework set global targets for the year 2020 for accelerated action on HIV prevention and treatment among pregnant children, adolescents and young women. The 'Three Frees' framework that sought to drive momentum for this agenda was centred on three main messaging areas: 'Start Free', 'Stay Free', 'AIDS Free'.

2. UNICEF, 2021. HIV/AIDS: Global and Regional Trends. [online] Available at: <<https://data.unicef.org/topic/hiv/aids/global-regional-trends/>> [Accessed 24 November 2021]

Equally important are the persistent inequalities across different regions and within different sub-populations. In terms of prevention of vertical transmission, as countries in Eastern and Southern Africa achieve coverage rates in excess of 90% for ART among pregnant and breastfeeding women living with HIV, the burden of unmet need is gradually shifting to West and Central Africa and other regions¹ with marginalized populations. Marginalized women are unreached wherever they reside; this includes women living in rural areas, migrant women, and women who belong to key populations or who are partners to men from key populations. Adolescents in general continue to be left behind in most HIV responses, with the lagging progress and relatively poor results especially concerning for highly vulnerable adolescent girls and young women in sub-Saharan Africa and adolescent and young key populations across the globe including in East Asia and the Pacific, Eastern Europe and Central Asia and the Middle East and North Africa.

How and why progress stalled in recent years for HIV responses among women, children and adolescents is not a mystery. Overlapping factors include dwindling political will, shifting donor priorities, attention being directed to other urgent development agendas (e.g. climate change), and a perception among some that HIV is already under control or gets enough resources and attention. These trends and challenges were evident long before the arrival of COVID-19, and the pandemic has only made them seem more entrenched and intractable.

1. UNAIDS, 2021. Confronting Inequalities: Lessons for Pandemic Responses from 40 Years of AIDS. [online] Available at: <https://www.unaids.org/sites/default/files/media_asset/2021-global-aids-update_en.pdf> [Accessed 24 November 2021] p.114.

Yet, although recent developments are certainly a setback, the groundwork has been laid for a brighter future. Innovations in the HIV response for treatment and prevention in children and adolescents, pioneered in many cases by UNICEF and partners, promise greater efficiency and effectiveness in reaching the most vulnerable and closing gaps in services. These include new technologies for diagnostics, such as point-of-care (POC) tests for infant diagnosis² and HIV self-tests; better drugs, especially dolutegravir and child-friendly fixed-dose combinations of lopinavir and ritonavir; and advances in service delivery, such as smarter use of programme data to target interventions where they are most needed or using technology to better reach and retain-in-care adolescents living with HIV. Scaling up these and other evidence-based interventions and approaches should be a priority for all partners engaged in the HIV response.

Through the new Global AIDS Strategy,³ which was endorsed by Member States at the UN HLM on AIDS in June 2020, the world has a new set of targets to focus on. They offer an opportunity to ‘reset’ after falling short of reaching the 2020 super fast-track goals. The historical trajectory of the HIV/AIDS epidemic among women, children and adolescents suggests that substantial and sustained success can be made toward ending AIDS as a public health threat through a renewed commitment to partnership, coordination, and dedication. If the clear and pressing needs are addressed with urgency and determination, we could achieve the end of AIDS among children and adolescents by 2025.

2. Dunning, L., Kroon, M., Hsiao, N. Y., & Myer, L. (2017). Field evaluation of HIV point-of-care testing for early infant diagnosis in Cape Town, South Africa. *PLoS one*, 12(12), e0189226. <https://doi.org/10.1371/journal.pone.0189226>
3. UNAIDS, 2021. Global AIDS Strategy 2021-2026. End Inequalities. End AIDS. [online] Available at: <https://www.unaids.org/sites/default/files/media_asset/global-AIDS-strategy-2021-2026_en.pdf> [Accessed 24 November 2021]

MILESTONES in the HIV epidemic among children and adolescents

1981

The United States Centers for Disease Control and Prevention publishes the first mention of what is later determined to be HIV.



1982

The first case of perinatal AIDS is reported to the CDC, about 18 months after the first case was reported in adults. By 1983, more reports of AIDS among children of parents with recognized risk factors are published.



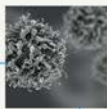
1983-84

HIV is identified as the cause of AIDS. A blood test is developed to screen for the virus.



1985

Every region in the world has reported at least one case of AIDS.



1990

The United States Food and Drug Administration approves zidovudine (AZT) to treat children with AIDS.



1992

The International Community of Women Living with HIV (ICW) is established.



1994

Landmark study PACTG 078 publishes in the New England Journal of Medicine, showing a marked reduction in mother to child transmission of HIV when a mother living with HIV and her baby are given AZT therapy. Within the same year, the evidence is translated to policy.



1997

First International Conference devoted to global strategies to prevent mother-to-child HIV transmission is held in the United States.



Learn more at www.unicef.org/hiv

1998

The total number of women living with HIV in sub-Saharan Africa surpasses that of men.



1999

The World Health Organization (WHO) reports AIDS to be the leading cause of death in Africa and the fourth most common globally.



1999

Uganda-United States study identifies nevirapine (NVP) as an effective and affordable way (single dose to mother and baby at birth) to reduce mother-to-child transmission (MTCT) of HIV.



1999

The second International Conference on Global Strategies for the Prevention of HIV Transmission from Mothers to Infants is held in Montreal, Canada.



2000

The United Nations adopts the Millennium Development Goals (MDGs), which include the specific goals of halting and beginning the reversal of the spread of HIV, malaria and tuberculosis.



2001

The orphans and other vulnerable children (OVC) framework, which 42 agencies endorsed, evolved from a process that began in 2000. The framework amplifies the broader global focus on "children affected by HIV" followed by several guidelines, documents and programmes.



2001

The World Trade Organization adopts the Doha Declaration, allowing developing countries to manufacture generic medications to combat public health crises like HIV, thereby helping to reduce drug prices.



2002

The Global Fund to Fight AIDS, Tuberculosis and Malaria is founded in response to a United Nations General Assembly call for coordinated support to combat the spread of HIV.



2003

United States President George W. Bush launches PEPFAR (President's Emergency Plan for AIDS Relief).
WHO announces the '3 by 5' initiative to bring HIV treatment to 3 million people by 2005.



2006

Unicef is founded and begins funding efforts to provide countries with paediatric ARVs.
Male circumcision is found to reduce the risk of HIV transmission by up to 60 per cent.



2011

The Global Plan to eliminate new HIV infections among children by 2015 and keep their mothers alive is launched.



2014

UNAIDS launches 90-90-90 targets, and the Fast-Track agenda aims at averting 28 million new infections and ending the epidemic as a public health issue by 2030.



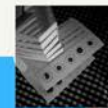
2015

One of the targets for MDG 6 to halt and reverse the spread of HIV is reached, as 15 million people are receiving ART.



2015

UNAIDS and Diagnostics Access Initiative negotiate a 40 per cent reduction in the global price ceiling for early infant diagnosis tests.



2016

UNAIDS, UNICEF, PEPFAR and partners launched the Start Free, Stay Free, AIDS Free initiative, defining priority actions towards achieving super-fast-track targets for children and adolescents and young women by 2018 and 2020.



2020

A record of 1.19 million pregnant women, approximately 0.92 million children (0-14) living with HIV, receive ART.



Learn more at www.unicef.org/hiv

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MILESTONES in the prevention of vertical transmission from mother to child

1982

The first case of perinatal AIDS is reported to the United States Centers for Disease Control and Prevention, about 18 months after the first case is reported in adults.



1985

The United States Public Health Service issues the first guidance for preventing mother-to-child transmission (PMTCT), recommending pregnant women in high-risk groups be offered counseling and voluntary HIV testing and that HIV-infected women not breastfeed.



1986

First report of postnatal transmission of HIV through breastfeeding. Jonathan Mann makes the first report of paediatric HIV in Africa.



1994

PACTG 076 (Pediatric AIDS Clinical Trials Group Protocol 076) trial to administer zidovudine (AZT) prophylaxis for PMTCT in the United States and France is so effective that it is stopped early. However, a WHO consultation concludes that AZT cannot be effectively implemented in resource-limited settings.



1998

Glaxo Wellcome cut the cost of AZT for developing countries by 75 per cent.



1999

Botswana launches Africa's first programme to combat MTCT with short-course AZT.



1999

HIVNET 012 study demonstrates the effectiveness of single-dose NVP in reducing MTCT by almost half.



1999

The Inter-agency Task Team (IATT) on the Prevention of Mother-to-Child Transmission of HIV is established by the UNAIDS Secretariat, UNFPA, UNICEF, and WHO.



Learn more at www.unicef.org/hiv

1999

UNICEF starts pilot projects in 11 countries to test the feasibility of introducing PMTCT services in antenatal care clinics in resource-constrained settings.



2001

The first WHO guidelines on the use of antiretroviral drugs (ARVs) for the prevention of mother-to-child transmission are released.



2002

South Africa's Constitutional Court orders the government to make NVP available to all HIV-positive pregnant women and their newborn children following a legal challenge by the Treatment Action Campaign.



2002

The United States Food and Drug Administration (FDA) approves the first rapid HIV test, which results in 20 minutes with 99.8 per cent accuracy.



2003

UNICEF-supported pilot PMTCT projects are evaluated in 11 countries (Botswana, Burundi, Côte d'Ivoire, Honduras, India, Kenya, Rwanda, Uganda, the United Republic of Tanzania, Zambia, and Zimbabwe) confirm implementation feasibility.



2004

A combination of short-course AZT with single-dose NVP is shown to reduce MTCT to nearly 2 per cent in the non-breastfeeding population in Thailand.



2008-09

Studies show that both antiretroviral drug (ARV) prophylaxis for the infant and combination ARVs for the mother can reduce postnatal transmission if taken during breastfeeding.



2010

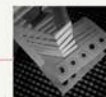
Mma Bana study shows a massive reduction in MTCT rates with maternal triple-combination antiretroviral treatment (ART) during pregnancy and breastfeeding. BAN study demonstrates that both maternal ART and infant NVP given for six months postpartum similarly reduce HIV transmission via breast milk.



Learn more at www.unicef.org/hiv

2011

Neshe Bana study shows that triple-combination ART during pregnancy and six months of breastfeeding is superior to short-course AZT and single-dose NVP for PMTCT. The Kilumu study reveals that maternal ART postpartum reduces transmission via breast milk however, breastfeeding transmission could still occur if maternal ART is stopped. Malawi is the first country to implement lifelong ART for all pregnant HIV-infected women, an approach known as Option B+.



2011

PEPFAR and UNAIDS launch the Global plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive (Global Plan).



2015

WHO validates the elimination of MTCT of HIV in Cuba, the first country to achieve this distinction after the validation protocol was established in 2014.



2016

WHO validates the elimination of MTCT of HIV in Armenia, Belarus and Thailand.



2016

PROMISE (Promoting Maternal and Infant Survival Everywhere) trial demonstrated that the use of standard three-drug combination ART regimens during pregnancy results in significantly lower MTCT than dual therapy.



2017

WHO validates the elimination of MTCT of HIV in six Caribbean territories (Anguilla, Antigua and Barbuda, Bermuda, Cayman Islands, Montserrat, St. Christopher and Nevis).



2017

South Africa's national birth testing programme reports an in-utero transmission rate of 1.1 per cent.



2018

PROMISE trial demonstrates that postnatal transmission rates of HIV via breast milk are similarly low with maternal ART or infant NVP, with the safety of both given through 18 months postpartum.



2018

WHO validates the elimination of MTCT of HIV in Malaysia.



2019

WHO validates the elimination of MTCT of HIV in the Maldives and Sri Lanka.



Learn more at www.unicef.org/hiv

MILESTONES in paediatric treatment, care and support

1990



• Three years after it was approved for use in adults, the first antiretroviral drug, AZT, is approved in children by the United States FDA.
• First United States guidelines for treating HIV-infected children recommend ART for any child with a definitive diagnosis of HIV infection with substantial immunodeficiency and/or HIV-associated symptoms.

1997-98



Clinical trials demonstrate the superiority of dual therapy over monotherapy for the treatment of children. Triple NNRTI (non-nucleoside reverse-transcriptase inhibitor)-based ART in infants is shown to be well tolerated and effective.

2001



The United Nations General Assembly Special Session on HIV/AIDS adopts a Declaration of Commitment, pledging to "care for all whose lives have been devastated by AIDS, particularly more than 13 million orphans."

2001



More than 11 million children under the age of 15 in sub-Saharan Africa are reported to have lost one or both parents to AIDS.

2003



• Efficacy of HIV treatment in children in Africa is reported.
• UNICEF convenes a forum to develop a Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS and launches OVC programmes funded by the UK Department for International Development.

2004



A study on mortality in African children living with HIV demonstrates the value of early ART initiation for infants. Mortality in the absence of treatment is found to be 52.5 per cent. Three or four drugs are safe in infants and provide effective viral suppression, with superior suppression if initiated before the age of 3 months. Coalition for Children Affected by AIDS is formed to help them survive and thrive at home, in school and in their communities.

2005



The number of children orphaned by AIDS reaches 15 million worldwide, but only 1 in 10 receives essential support services.

2006



Launch of the Children and AIDS Regional Initiative, a five-year programme to improve the well-being of orphans and vulnerable children affected by HIV and AIDS.

Learn more at www.unicef.org/hiv

2008



CHER study in South Africa demonstrates that ART initiation in asymptomatic infants aged 6-12 weeks significantly decreases morbidity and mortality.

2009



The number of children orphaned by HIV and AIDS reaches an estimated worldwide peak of 15.5 million.

2010-11



Lopinavir-ritonavir-based ART in children under three years of age is found to be superior to NVP-based ART.

2013



Report of "Mississippi baby" – the first paediatric "cure"/remission in an infant with very early treatment (first hours of life) – put the functional paediatric cure on the agenda.

2015



South Africa institutes routine virologic testing at birth into its early infant diagnosis programme in the national protocol, in addition to testing at 4-8 weeks.

2016



PEPFAR, the world's largest donor of OVC programmes, reaches more than 6.2 million OVC and their caregivers worldwide.

2016



UNAIDS announces that 18.2 million people are on ART (including 810 000 children, double the number five years earlier). However, increased ART access raises the risk of drug resistance, and WHO releases a report on this growing concern.

2018



WHO extends the recommendation for dolutegravir (DTG) as the preferred first-line treatment (10mg dispersible tablet formulation) to all children over the age of four weeks and 3kg in weight.

2020



A pricing agreement for the new formulation reduces the yearly cost of the drug from US\$400 to US\$36 per child, thereby helping to overcome prohibitive costs that had previously limited treatment access for younger children. The new dispersible formulation also has been shown to improve treatment adherence.

2020



The United States FDA approves a dispersible 5 mg formulation of DTG for use in infants and children living with HIV. The tablet, taken orally, is approved for use in paediatric patients older than four weeks of age and weighing at least 3 kg in combination with other antiretroviral drugs.

Learn more at www.unicef.org/hiv

MILESTONES in adolescent HIV prevention, treatment and care

1995



WHO, in collaboration with UNFPA and UNICEF, publishes Programming for Adolescent Health and Development, which includes recommendations for global action against HIV.

2000



The Millennium Development Goals (MDGs) are launched. MDG 6 includes indicators for measuring HIV prevalence and comprehensive, correct knowledge of HIV among young people (aged 15-24).

2001



The United Nations General Assembly Special Session on HIV/AIDS (UNGASS) is the first global declaration and commitment to specifically include HIV targets for young people aged 15-24 years.

2006



UNAIDS Inter-Agency Task Team (IATT) on Young People publishes a systematic review underscoring the need to decrease HIV incidence among young people.

2006



Male circumcision is found to reduce the risk of sexual transmission of HIV from females to males by up to 60 per cent.

2007



WHO and UNAIDS issue new guidance recommending "provider-initiated" HIV testing in health care settings. The guidance aims to increase knowledge of HIV status and significantly boost access to HIV treatment and prevention services.

2009



UNESCO publishes the first global guidelines on comprehensive sexuality education (CSE).

2010



The third phase of a PrEP trial reveals that drugs used to treat HIV might also effectively prevent infection.

2010



United Nations Secretary-General launches the Global Strategy for Women's and Children's Health.

Learn more at www.unicef.org/hiv

MILESTONES in adolescent HIV prevention, treatment and care

2010



UNAIDS releases a strategy describing combination HIV prevention, an approach that first entered the global discourse in 2003. UNAIDS defines it as rights-based, evidence-based, and community-based programmes that promote a combination of biomedical, behavioral, and structural interventions designed to meet the HIV prevention needs of specific people and communities.

2011



Results from HPTN 052 trial demonstrate that HIV treatment has significant prevention benefits.

2013



WHO issues the first-ever guideline addressing the specific needs of adolescents living with HIV.

2013



United Nations Secretary-General's High-Level Panel of Eminent Persons on the Post-2015 Development Agenda emphasizes equity, empowerment, and engagement of adolescents and youth.

2013



UNAIDS funds ACT2030 as a youth-led social action initiative to inspire a new wave of activism in the HIV response by using youth-led research and data collection to establish accountability mechanisms for sexual and reproductive health and rights.

2014



PEPFAR's DREAMS partnership is launched in 10 high-burden countries in sub-Saharan Africa. The initiative addresses the key factors that make adolescent girls and young women particularly vulnerable to HIV.

2014



Adolescent HIV Treatment Coalition (ATC) is established, supporting youth leadership and advocating for improved access to HIV treatment and care.

2015



UNAIDS, UNICEF and partners release a report on the clinical, ethical and operational considerations for making oral PrEP available to sexually active older adolescents (aged 15–19) at high risk of HIV infection.

2015



UNICEF and UNAIDS launch the 'All In' platform to galvanize global action around HIV and adolescents.

Learn more at www.unicef.org/hiv

2016



Launch of the Global Health Strategy for Women, Children and Adolescents (2016–2030).

2016



PrEP proves to decrease HIV transmission risk, especially among at-risk youth and adolescents.

2016



UNICEF, UNAIDS, PEPFAR, together with partners, launch Start Free, Stay Free, AIDS Free, a 'super-fast-track' framework with global targets for the year 2020 for accelerated action on HIV prevention and treatment among pregnant children, adolescents and young women.

2017



The Global HIV Prevention Coalition launches an HIV Prevention 2020 Road Map to accelerate the achievement of the targets of the 2016 United Nations Political Declaration on Ending AIDS.

2017



The new Global Fund Strategy 2017–2022 commits increased funding for programming support to women and girls.

2017



Global Accelerated Action for the Health of Adolescents (AA-HAI) is launched to guide countries setting priorities for adolescent health programmes based on best practices and lessons learned, including programme implementation, monitoring and evaluation.

2017



Launch of the Adolescent HIV Prevention and Treatment Implementation Science Alliance (AHISA), which is intended to facilitate information exchange between scientists and implementers to support evidence-based policy decisions and enhance research impact.

2017



'Undetectable = Untransmittable' (U=U), an anti-stigma slogan championed by the Prevention Access Campaign, is introduced. It is subsequently endorsed by many HIV and AIDS communities and organizations.

2018



UNESCO, UNAIDS, UNFPA, UNICEF, UN Women and WHO publish international technical guidance on CSE to young people in order to achieve the global Sustainable Development Goals (SDGs).

Learn more at www.unicef.org/hiv

2019



UNICEF and WHO redesign child and adolescent health programmes to achieve optimal health and well-being.

2020



UNICEF and the Interagency Task Team (IATT) on Young Key Populations in Asia and the Pacific launch a rapid response survey to assess the impact on mental health and quality of life among young key populations and young people living with HIV in the time of COVID-19.

2020



UNICEF and partners conduct analyses of evidence on the effects of COVID-19 on child and adolescent health, including the direct, indirect data on mortality and morbidity from the pandemic. Findings suggest that adolescents might be at an elevated risk of HIV infection.

2020



Results from a clinical trial are released showing that the long-acting injectable cabotegravir (CAB LA) for PrEP is highly effective in preventing sexual transmission of HIV to women. CAB LA has the potential to improve adherence to long-term biomedical HIV prevention.

2021



WHO recommends that the dapivirine vaginal ring (DPV-VR) be offered as a complementary prevention choice for women at substantial risk of HIV infection.

2021



WHO and UNICEF launch new tools for the promotion of adolescent mental health.

2021



The Education Plus initiative (2021–2025) is co-launched by UNAIDS, UNESCO, UNFPA, UNICEF and UN Women. This high-profile political advocacy agenda is centered on the empowerment of adolescent girls and young women and the achievement of gender equality in sub-Saharan Africa—with secondary education as the strategic entry point.

2021



UNESCO, UNAIDS, UNFPA, UNICEF, UN Women and the WHO publish a joint report on country progress toward providing high-quality, school-based CSE to all learners, including gaps and recommendations.

Learn more at www.unicef.org/hiv

5. What the data show: two decades of progress in infections, deaths and survival for children and adolescents

The history of our collective progress is best represented by looking longitudinally at key indicators spanning two decades of the response for children and adolescents. As most of the figures indicate, initial periods of steady and sometimes spectacular improvement occurred between 2005 and 2015, spanning the period of Option B+, the launch of the Global Plan and the widespread availability of child friendly paediatric ARV options for children. Since then, progress has slowed, stalled or even reversed in some settings. The direct and indirect impacts of the COVID-19 pandemic were important constraining factors in the results from 2020, but they did not precipitate the overall halt in progress.

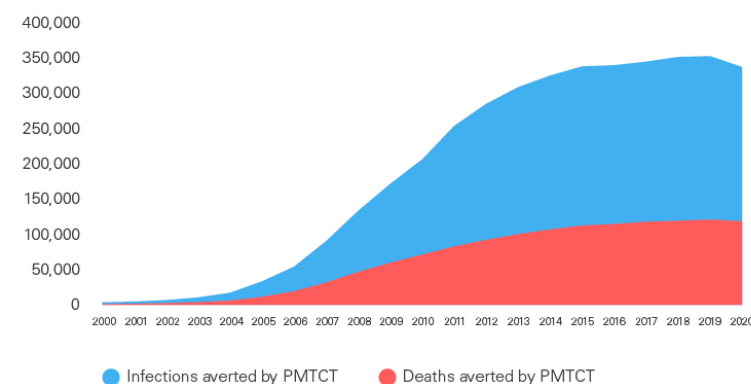
The good news is that even though the loss of momentum meant that the ambitious end-2020 super-fast-track goals for mothers children and adolescents were not met, millions of individuals and their families and communities worldwide have benefited from our collective action and the extraordinary commitment of frontline providers over the past 20 years.

Progress in Survival

Since 2000, when the first PMTCT programmes started being implemented and scaled up in the highest-burden countries of the world, 2.5 million HIV

HIV infections and 1.2 million deaths have been averted among infants and young children (aged 0–5) (see Figure 1). This remarkable result underscores the successes of the 2011 Global Plan, which focused on increasing access to ART for pregnant women living with HIV, and the 'Three Frees' framework from 2016, which aimed to address HIV in children using a life cycle approach that linked primary prevention in adolescent girls and young women, prevention of vertical transmission from mothers to their children, and treatment for children and adolescents living with HIV.

Figure 1: Number of infections and deaths averted among children under 5 years due to prevention of mother-to-child transmission, 2000–2020

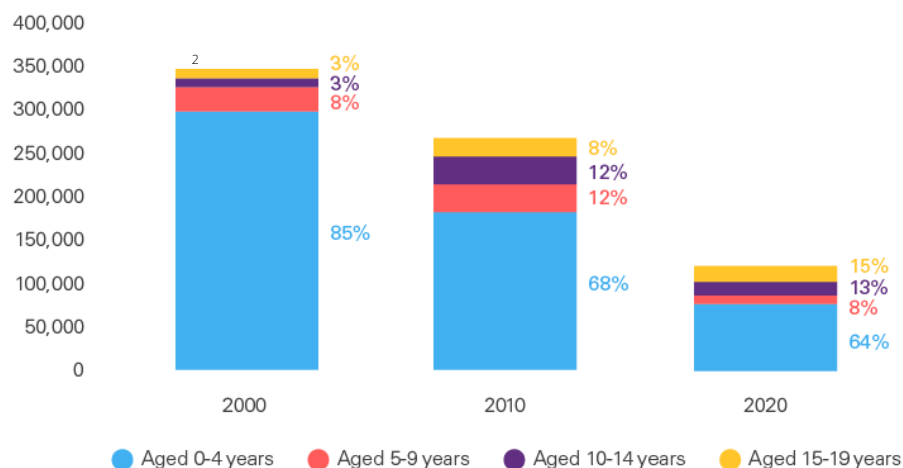


Source: UNAIDS 2021 estimates

In the early years of the response, prevention of vertical transmission was the only way to decrease HIV-related mortality in children, but as paediatric ARVs became more widely available from 2005 onwards, access to treatment also had a marked impact on child and adolescent mortality due to

HIV. As Figure 2 indicates, the number of AIDS-related deaths among children aged 0–19 fell by more than one half (53 per cent) from 2000 to 2020. An important trend is that younger children infected with HIV at birth are more likely to survive into older childhood, adolescence or adulthood. Yet, despite this progress, children under five still accounted for the majority of deaths (60 per cent) among those aged 0–19 in 2020.

Figure 2: Annual number of AIDS-related deaths among children aged 0–19, by five-year age group, for the years 2000, 2010 and 2019

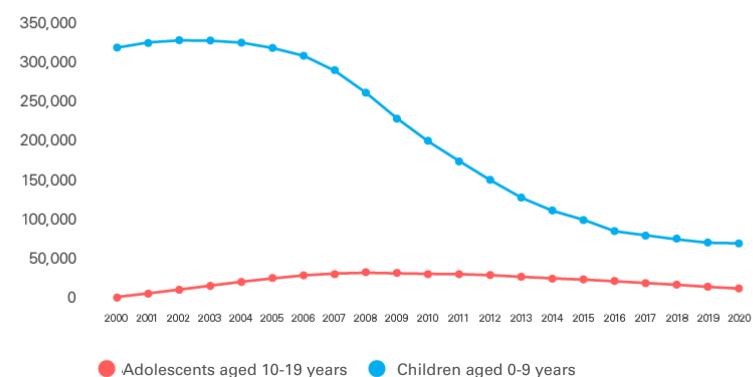


Source: UNAIDS 2021 estimates

Data illustrated in Figure 3 further underscore the notable differences in trends in AIDS-related deaths among children (0–9 years) and adolescents (10–19 years). The annual number of deaths globally in both age groups declined only slightly from 2016 through 2020. However, the improvements varied significantly over the course of the two decades.

The number of deaths declined by nearly three quarters (73 per cent) from a peak in the early 2000s for the younger age group, but the decline was only about 37 per cent in the older age group, from a peak of nearly 51,000 in 2008 to about 32,000 in 2020.

Figure 3: Number of AIDS-related deaths among children 0–9 years and 10–19 years, 2000–2020



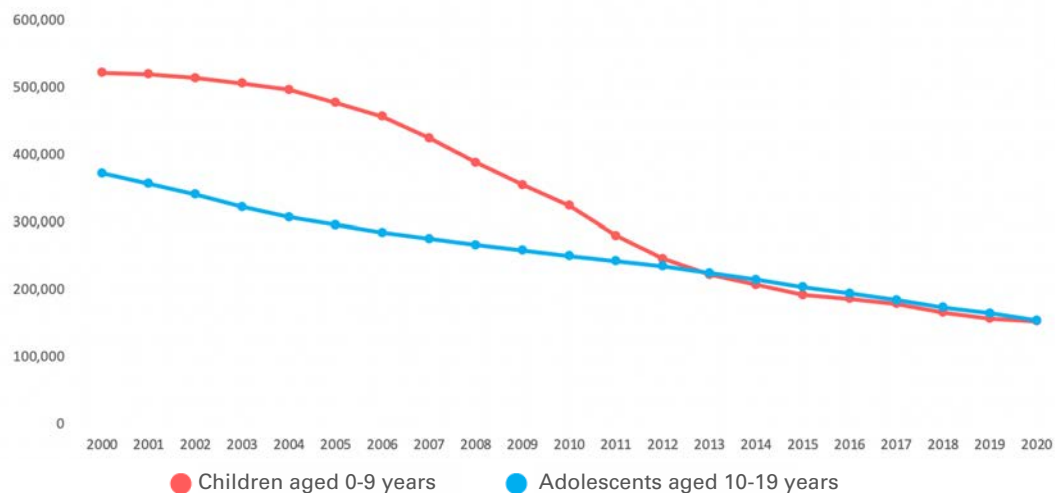
Source: UNAIDS 2021 estimates

Progress in prevention and treatment

Substantial progress overall has been made in reducing HIV infections among children of all ages since 2000. The relative success of PMTCT programmes is a main reason that progress has been much greater among the younger group (ages 0–9) compared with older children (ages 10–19), among whom infections are largely attributable to activities and behaviours that are more difficult to address and influence, such as sex and injecting drug use.

As illustrated in Figure 4, the number of new infections among those aged 0–9 fell by almost 70 per cent from 2000 to 2020, with the respective decline among the older group smaller at 57 per cent. Progress for both groups slowed considerably beginning around 2012, the first year there were roughly the same number of new infections in each (around 240,000). In the eight years from 2012 to 2020, annual new infections fell by just 36 per cent among those aged 0–9 and 34 per cent in the older 10–19 age group.

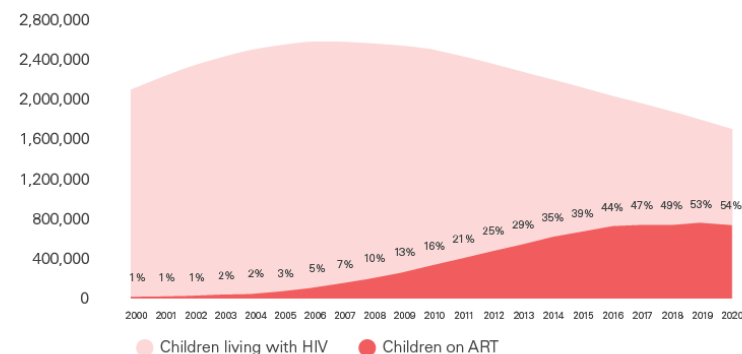
Figure 4: Number of annual new HIV infections among children 0–9 years and adolescents 10–19 years, 2000–2020



Source: UNAIDS 2021 estimates

Inequities in treatment access have always disadvantaged children and continue to do so today. It is lamentable that the most vulnerable of all people living with HIV, children under 5, have the fewest options and the poorest access to treatment. Even while the number of children living

Figure 5: Number of children aged 0–14 living with HIV and number receiving ART, 2000–2020



Source: Global AIDS Monitoring and UNAIDS 2020 estimates

Note: Countries reporting on infant testing represent 96 per cent of HIV-exposed infants.

with HIV is declining due to successes in preventing vertical transmission and children reaching 15 years and aging out of the paediatric age group, ART coverage among children (aged 0–14) continues to increase by just 2–5 percentage points each year. In 2020, just over half (54 per cent) of children living with HIV aged 0–14 years were on lifesaving ART (see Figure 5). By contrast among their mothers, coverage was much higher. For pregnant and breastfeeding women living with HIV, ART access in 2020 was in excess of 85 per cent globally, more than 30 percentage points higher than in children.

6. Moving forward: what do we need to do differently?

The two decades from 2000 through 2020 hold several lessons for how to move forward over the next 20 years to achieve the greatest possible benefit for women and children living with and at risk for HIV. An overarching one is the urgent need to recapture the commitment, spirit and focus that underpinned the relatively rapid progress until the mid-2010s. This requires more emphasis on coordination and partnership, including strengthening existing partnerships and creating new opportunities for collaborations especially with the private sector, with communities and with civil society.

Many of the solutions are clear: We need strong leadership, better data, smarter systems for monitoring and evaluation, more advocacy and accountability, scale up of key programme interventions, and the roll out of new tools, strategies and approaches that make HIV responses more efficient, effective and targeted. But it is also crucial to recognise that what has gotten us to this point will not take us to where we want to go. We must think and act differently to get past the stalled responses, backsliding and empty rhetoric of the last few years. One key lesson is that the era of siloed vertical programming for HIV is in the past. Acknowledging this and hastening the trend toward anchoring HIV more closely within broader health and development structures represents a new way of looking at the epidemic's many complex health, social, economic and political ramifications. For much of the previous two decades, HIV was often viewed and responded to as an 'exceptional' issue due in part to its epidemic nature, its complexity

and the availability of targeted funding through the Global Fund and PEPFAR. Some of these unique characteristics remain to a significant extent, but now in its fourth decade, HIV has become endemic and 'normalizing' HIV responses through integration could be a useful way to overcome existing obstacles and further pushing progress.

Moving beyond the stagnant statistics currently common in most paediatric HIV prevention and treatment programmes requires carefully and systematically integrating HIV into primary care. At the same time, COVID-19 has shown us that there is nothing more important than resilient high-quality health systems. Without a health system that is fit for purpose, all of our hard-fought gains in HIV will be at risk when the next global pandemic occurs.

Also guiding these priorities is the fact that integration, community engagement and resilient health systems are critical to achieve universal health coverage (UHC) as mandated by the SDGs. At the same time, policy makers and multisectoral partners that are leading and supporting the drive to UHC must also realize that they cannot be successful without significantly improved results in HIV treatment and prevention for all people. More forceful efforts to address the inequalities affecting women, children and adolescents in HIV responses therefore should be one of their main priorities as they seek to 'end AIDS' in the next decade as part of the 2030 Agenda for Sustainable Development.

7. A Call to Action and UNICEF's vision and priorities for the years ahead

On World AIDS Day 2021, UNICEF calls on all stakeholders, policy makers and programme managers to:

- Address inequalities in treatment access among children and adolescents by promoting integration of HIV into primary health care and ensuring availability of the best possible therapeutic options;
- Travel the 'last mile' to eliminate vertical transmission of HIV as well as syphilis and hepatitis B through data informed differentiated programming;
- Commit to realizing the new Political Declaration on HIV and AIDS, especially scaling up implementation of evidence-based prevention efforts for adolescents and young people all over the world in all their diversity

UNICEF will support these Calls to Action and over the next five years will build on and intensify the organization's strengths, expertise and historical impact. UNICEF has consistently championed many of the approaches and concepts that are recognised as having been critical to our progress. These include integrating PMTCT into ANC services, developing innovative data-driven approaches to locate link and retain children and adolescents living with HIV and reaching the most vulnerable populations of adolescents with smart digital technologies paired with top notch clinical services that are both approachable and acceptable to young people. UNICEF will double

down on these approaches along the four thematic pillars of its Strategic Plan 2022-2026 which are:

- 1.To innovate in service delivery, in new drugs, in smart diagnostics and in digital technologies;
- 2.To improve understanding of programmes through better and more disaggregated data that can permit differentiated, targeted evidence-based programming;
- 3.To integrate HIV into primary health in ways that strengthen health systems, improve health services at primary level, and enhance HIV programme results in terms of both access to care and quality;
- 4.To place mothers, children and adolescents living with and affected by HIV at the centre of UNICEF's work and partner with stakeholders, with other UN agencies and with affected communities to ensure that the organization's remains sensitive to the beneficiaries it is committed to serve.

These objectives are informed by the organization's strong belief that a key obstacle to improved HIV responses is that programme spending and focus is still not targeted where the deficiencies lie. So paediatric retention in care does not receive due attention, and vulnerable adolescents and young people are not reached by HIV services and marginalised pregnant women don't access sufficient ANC and PMTCT

care. UNICEF is leading the way in 'differentiated programming', an approach that seeks to link epidemiological and programme data with evidence-based best practices to promote the most targeted and effective solutions to achieve sustained results and improve the quality of care.

For example, although coverage of ART in pregnant women has now plateaued, new analytical tools developed by UNICEF in partnership with UNAIDS highlight how data can help uncover the ongoing drivers of new infections in children. Through its Last Mile to EMTCT framework,¹ UNICEF is mobilizing partners and national programmes to take a differentiated approach to testing, care, treatment and support for both HIV-negative mothers and those living with HIV. The framework provides a step-by-step approach for countries to review their data, identify sources of new infections and implement evidence-based solutions.

Across three countries in partnership with a coalition of implementers and community organizations, UNICEF has been using its innovative Paediatric Service Delivery Framework² to promote the model of differentiated services for infants, children and adolescents living with HIV through interventions such as testing the children of adults with HIV; testing sick children in outpatient, inpatient, tuberculosis and malnutrition services; scaling up HIV testing services for infants born to mothers living with HIV; and strengthening systems for linking those diagnosed with HIV to treatment.

Innovation is a core component of these and other approaches that will continue to be developed, implemented or supported by UNICEF. One area of work where the organization is highly focused is on expanding the use and flexibility of point-of-care (POC) diagnostic platforms. This will ensure quick turnaround of results and the potential same-day initiation of HIV treatment, a vital lifesaving step for HIV-positive infants who are uniquely vulnerable in terms of mortality due to HIV.

POC platforms also offer great promise for boosting and sustaining integration while also increasing efficiency and closing major gaps in disease diagnosis and monitoring beyond HIV. In November 2021, for example, a partnership was announced to make a POC rapid test to check for both HIV and syphilis affordable and available in low- and middle-income countries.³ Among the reasons this is important is that although many pregnant women know their HIV status, because it is part of routine testing in many countries, that is not the case for syphilis tests. Increasing the number of pregnant women who know their syphilis status will help to decrease the number of stillborn and newborn deaths.

UNICEF will not be pushing for and supporting differentiated programming, integration, innovation and resilient health systems on its own. It will continue to prioritize a partnership model that is both deep and wide when moving forward, aiming to include and collaborate with partners from small

1. UNICEF, 2021. Key Considerations for Programming and Prioritization. Going the 'Last Mile' to EMTCT: A Road Map for Ending the HIV Epidemic in Children. [online] Available at: <<https://library.unaids.org/wp-content/uploads/2020/08/1-EMTCT-Whitepaper-EN-WEB-hi-res.pdf>> [Accessed 24 November 2021]

2. UNICEF, 2020. Improving HIV Service Delivery for Infants, Children and Adolescents: A Framework for Country Programming. [online] Available at: <<http://www.childrenandaids.org/sites/default/files/2020-08/Service%20Whitepaper%20WEB%20v2.pdf>> [Accessed 24 November 2021]

3. Clinton Health Access Initiative, 2021. MedAccess, CHAI, and SD Biosensor Announce Partnership to make Dual Rapid Test for Syphilis and HIV Available for under US\$1 in over 100 Low- and Middle-Income Countries. [online] Available at: <<https://www.clintonhealthaccess.org/dual-syphilis-hiv-rdt-for-under-us1/>> [Accessed 24 November 2021]

community-based groups to multilateral institutions to private-sector firms to both donor and implementing governments. Much of this work will be coordinated through the new Global AIDS Strategy 2021–2026, which is using an inequalities lens to close the gaps that prevent greater progress toward ending AIDS.

As a co-sponsor, UNICEF was extensively involved in all aspects of developing, reviewing and approving the new Global AIDS Strategy. Although the organization will work toward achieving impact in all of the 10 results areas of the new Strategy, UNICEF has a specific accountability and co-convening role in the areas of EMTCT and Paediatric Treatment and Empowerment of young people.

As with all its work, UNICEF will lead and support programming in these areas that is grounded in evidence, human rights, gender equity and the reduction of stigma and discrimination. These are essential principles that underpin the organization's vision of ending inequalities in HIV responses among women, children and adolescents as a key strategic approach to ending AIDS as a public health threat in general. This vision and the technical, programming, financial and advocacy requirements needed to achieve it will guide all that UNICEF supports and promotes.



2021 HIV and AIDS Global Snapshot

Pregnant Women, Children and Adolescents November 2021

With a new Political Declaration adopted by the United Nations General Assembly in June 2021, this year's World AIDS Day will be observed with a renewed sense of commitment to reach the [95-95-95 targets](#), as we begin the third year of the COVID-19 pandemic and the fifth decade of the AIDS pandemic. The new targets underscore the need to fulfil the right to health and other human rights for people living with, at risk of, and affected by HIV by addressing societal and structural barriers, including economic and legal constraints, to access equitable HIV prevention, treatment and care. This renewed momentum is especially needed in a year in which the COVID-19 pandemic has led to severe setbacks for HIV programme responses.

None of the 2020 global targets for HIV treatment and prevention agreed by the General Assembly in the 2016 Political Declaration on Ending AIDS were reached, especially those for children, adolescents and pregnant mothers. Children under 15 years of age account for about 5 per cent of all people living with HIV, 10 per cent of new HIV infections and 15 per cent of all AIDS-related deaths, globally. The number of children aged 0–9 years who newly acquired HIV in 2020 was 150,000 – more than eight times higher than the 2020 target of fewer than 20,000 new infections for children in this age group. The vast majority of these children acquire HIV during infancy, at a time when children are most susceptible to HIV infection.

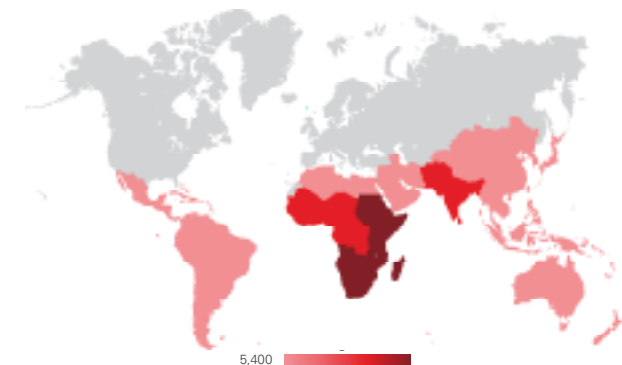
The COVID-19 pandemic has exacerbated these and other challenges, exposed inequalities and gaps in HIV services across the globe, and served as a startling reminder that pregnant women, children and adolescents living with and at risk of HIV remain among the most vulnerable of all populations that UNICEF and partners serve. Many reporting countries documented massive disruptions in the delivery of HIV prevention, testing and treatment services; limited access to maternal and child health and follow-up care; and stockouts of key commodities. As a result, HIV infant testing in high-burden countries declined by 50 to 70 per cent, with new treatment initiations for children under 14 years of age falling by 25 to 50 per cent. Moreover, the COVID-19 pandemic resulted in increased gender-based violence and mental health issues, underscoring their persisting importance in the HIV response.

Notwithstanding these challenges of two colliding pandemics, there is a silver lining that must be recognized and built on. While COVID has highlighted the stark social, economic and health inequities that exist, it has also brought a greater understanding of the need for better and more equitable and inclusive health systems and services, including COVID vaccine distribution, further affirming the message that the global AIDS community has been voicing over the past four decades.



In 2020, of the estimated 38.0 million people living with HIV worldwide, an estimated 2.78 million were children and adolescents aged 0–19 years. In the same year, 300,000 children and adolescents were newly infected with HIV and 120,000 children and adolescents died of AIDS-related causes.

Figure 1: Number of children and adolescents aged 0-19 years living with HIV, by region, 2020



Region	Estimate	Lower	Upper
Eastern and Southern Africa	1.85 million	1.24 million	2.33 million
West and Central Africa	600,000	440,000	800,000
South Asia	120,000	71,000	170,000
East Asia and the Pacific	93,000	66,000	130,000
Latin America and the Caribbean	62,000	42,000	90,000
Middle East and North Africa	5,400	4,300	8,600
Eastern Europe and Central Asia	-	-	-
Western Europe	-	-	-
North America	-	-	-
Global	2.8 million	1.9 million	3.6 million

Data source: UNAIDS 2021 estimates.

Note: This map does not claim any official position by the United Nations. Countries are classified according to nine geographic regions defined by UNICEF. Numbers of children and adolescents living with HIV in Eastern Europe and Central Asia, North America and Western Europe are not available. The numbers in brackets refer to the confidence interval.

Every day in 2020, approximately 850 children aged 0–19 years became newly infected with HIV and approximately 330 children aged 0–19 years died from AIDS-related causes, mostly because of inadequate access to high-quality HIV prevention, care and treatment services.

A decade of steady decline in annual new HIV infections, but far from achieving the targets for children and adolescents

For children and adolescents living with HIV, the burden of disease still sits squarely in sub-Saharan Africa, which is home to 88 per cent of all children and adolescents aged 0-19 years with HIV (Figure 2).

Figure 2: Global situation of children and adolescents with HIV and AIDS, 2020

Global	Estimate	Lower	Upper
Number of children living with HIV	2,780,000	1,890,000	3,590,000
Children aged 0–9 years	1,030,000	730,000	1,290,000
Adolescents aged 10–19 years	1,750,000	1,160,000	2,300,000
Number of new HIV infections	300,000	150,000	550,000
Children aged 0–9 years	150,000	100,000	240,000
Adolescents aged 10–19 years	150,000	43,000	310,000
Number of AIDS-related deaths	120,000	82,000	180,000
Children aged 0–9 years	86,000	59,000	140,000
Adolescents aged 10–19 years	32,000	23,000	46,000
Number of children under the age of 18 years who lost one or both parents to AIDS-related causes	15,400,000	10,600,000	20,900,000

Source: UNAIDS 2021 estimates

Note: Numbers may not add up due to rounding off

Note: Lower and upper estimates refer to the confidence interval. *Almost all new HIV infections among younger children occur among those aged 0–4, either through pregnancy, birth or breastfeeding. **Data on ART coverage are insufficient by five-year age group. Global and regional ART coverage is only reliably estimated for children aged 0–14. Where available, data are presented separately for younger children (aged 0–9) and adolescents (10–19).

Indicator definitions:

Mother-to-child transmission (MTCT) rate: Number of new HIV infections among children under five, per 100 pregnant women living with HIV in the last year

New HIV infections per 1,000 adolescents: Number of new HIV infections among adolescents age 15–19, per 1,000 adolescents

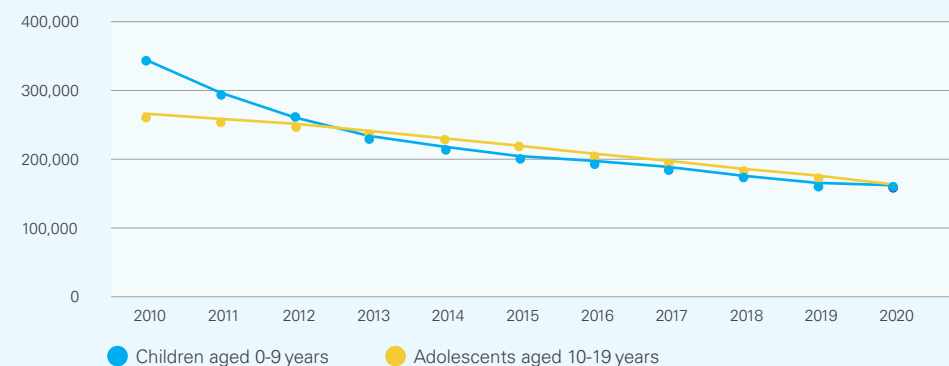
PMTCT coverage: Percentage of pregnant women living with HIV who received lifelong ART to prevent mother-to-child transmission of HIV

Early infant diagnosis: Percentage of infants born to HIV-positive mothers who were tested for HIV within two months of birth

ART coverage among children 0–14: Percentage of children age 0–14 living with HIV who are receiving antiretroviral treatment.

In 2020, around 150,000 younger children (aged 0–9 years) were newly infected with HIV, primarily due to vertical transmission of HIV from mother to child. This is a steep decline of 53 per cent since 2010. By contrast, for adolescents aged 10–19 years, the number of new HIV infections has declined at a slower rate of about 38 per cent since 2010 (Figure 3).

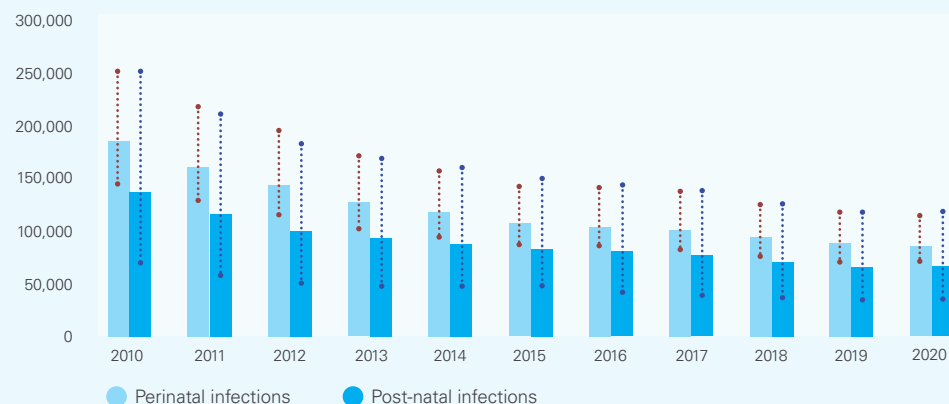
Figure 3: Number of annual new HIV infections among children aged 0–9 years and adolescents aged 10–19 years, 2010–2020



Source: UNAIDS 2021 estimates

In 2020, just under half of all cases of vertical HIV transmissions occurred during the breastfeeding / postnatal period (Figure 4).

Figure 4: Annual number of new HIV infections among children aged 0–14 years, by period of transmission, 2010–2020

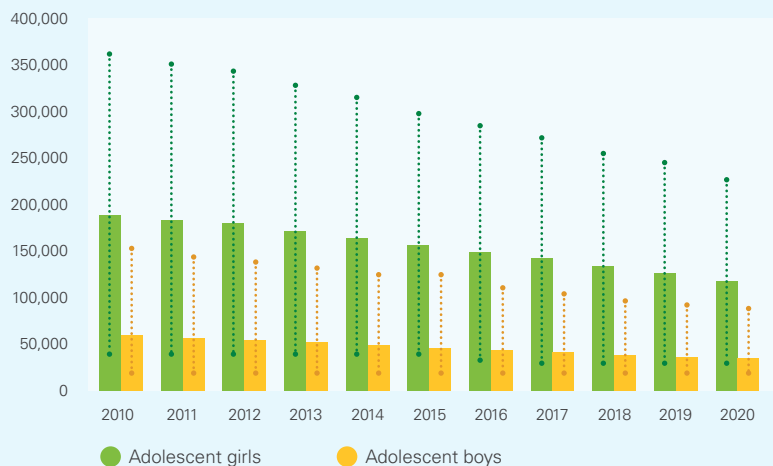


Data source: UNAIDS 2021 estimates.

Note: Almost all new HIV infections among younger children occur among those aged 0–4, either through pregnancy, birth or breastfeeding. The 95 per cent reduction by 2020 refers to Super-Fast-Track targets. The dotted lines above and below the numbers in the chart refer to the confidence interval.

While 77 per cent of new HIV infections among adolescents occur in girls, new HIV infections have declined more for girls than boys in the last ten years (Figure 5).

Figure 5: Annual number of new HIV infections among adolescents aged 10–19 years, by sex, 2010–2020

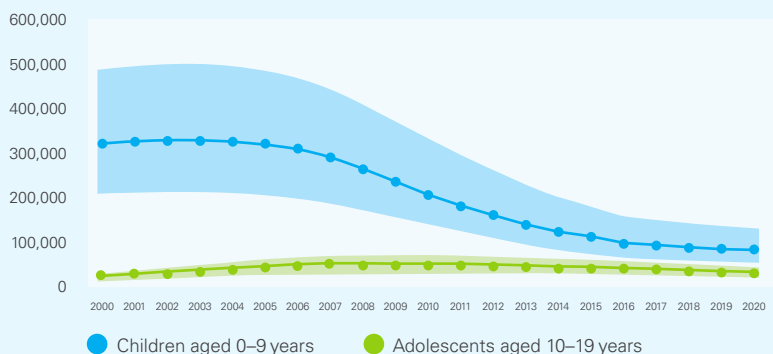


Data source: UNAIDS 2021 estimates.

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. The 75 per cent reduction by 2020 refers to Super-Fast-Track targets. The dotted lines above and below the numbers in the chart refer to the confidence interval.

Deaths among children have dropped by 58 per cent between 2010 and 2020 while those among adolescents have dropped by 36 per cent in the same time period (Figure 6).

Figure 6: Number of AIDS-related deaths among children aged 0–9 years and adolescents aged 10–19 years, 2000–2020

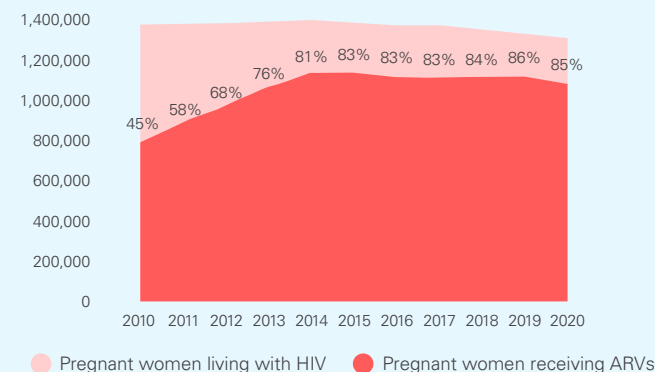


Data source: UNAIDS 2021 estimates.

Great gains have been made since 2010 to ensure that pregnant women are on lifelong ART to prevent vertical transmission

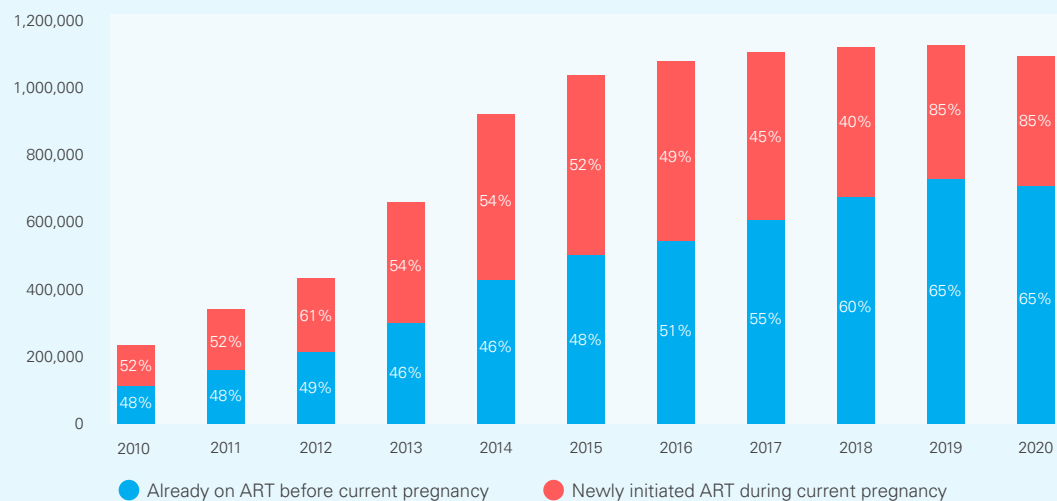
In 2020, an estimated 85 per cent of pregnant women living with HIV globally received antiretroviral HIV treatment (ART) for prevention of vertical transmission of HIV (mother-to-child transmission) and to keep them alive and well, up from 17 per cent in 2010 (Figure 7).

Figure 7: Number of pregnant women living with HIV and number receiving ART for the prevention of mother-to-child transmission, 2010–2020



About 2 in 3 of the 85 per cent pregnant women on ART were already on ART prior starting antenatal care for the pregnancy in 2020 (Figure 8).

Figure 8: Pregnant women already on ART for prevention of mother-to-child-transmission (PMTCT) before current pregnancy compared to those that started ART for PMTCT during current pregnancy, 2010–2020



Data source: UNAIDS 2021 estimates.

But, despite this success in previous years, more recently, the rate of progress has stalled. ART coverage for pregnant women living with HIV increased by 38 percentage points between 2010 to 2015 and only 2 percentage points from 2016 to 2020.

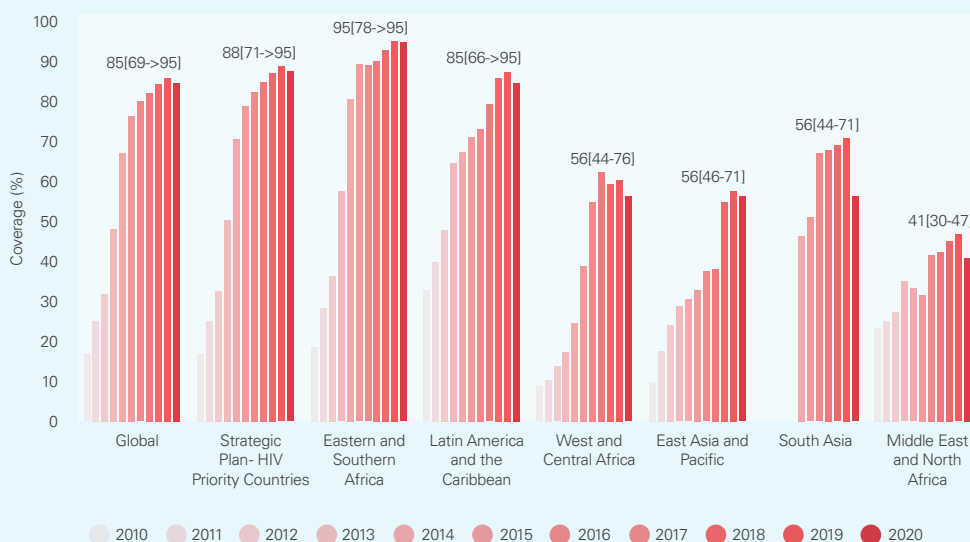
Regional variations exist in access to antiretroviral HIV treatment for pregnant and breastfeeding women

In 2020, access to ART for pregnant women ranged from a high of 95 per cent in Eastern and Southern Africa to a low of 41 per cent in the Middle East and North Africa. In West and Central Africa, the second most impacted region, ART coverage among pregnant women was only 56 per cent (Figure 9).

High coverage in Eastern and Southern Africa shows that political will, leadership and donor commitment can overcome stalled progress. Acceleration of treatment uptake among all pregnant and breastfeeding women living with HIV remains key to achieving elimination of new infections among children and ensuring the health and survival of pregnant women and new mothers.

ART coverage among pregnant women dropped drastically in South Asia in 2020, from 71 in 2019 per cent to 56 per cent, likely as a direct result of COVID-19 prevention and control measures that left many unable to access care (Figure 9).

Figure 9: Percentage of pregnant women living with HIV receiving effective ART for prevention of MTCT of HIV, by region, 2010-2020



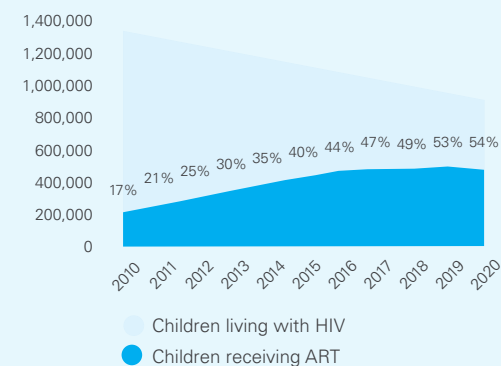
Source: Global AIDS Monitoring and UNAIDS 2021 estimates
Note: Data are not available for Eastern Europe and Central Asia, North America, and Western Europe. Effective ART excludes single-dose nevirapine.

Slightly more than half of children under 15 years of age living with HIV are on antiretroviral HIV treatment

In 2020, an estimated 924,000 children (of the 1.72 million children aged 0–14 living with HIV) were receiving ART globally, which is an up from approximately 417,000 in 2010 (Figure 10).

Evidence indicates that many children living with HIV are not starting ART during infancy. Most children entering treatment programmes are older, with only 20 per cent of all children (aged 0–14) on ART being under the age of 5 years in 2020 (Figure 11). There are many reasons for this including the persisting challenge of making a diagnosis in infancy and getting results back to the service provider in a timely manner.

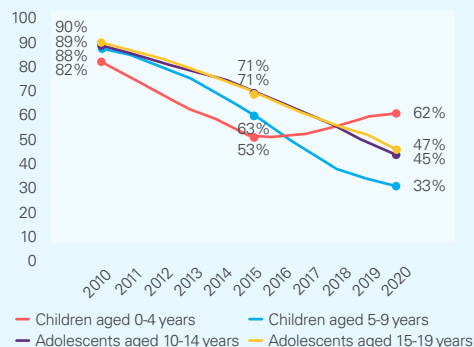
Figure 10: Number of children aged 0–14 years living with HIV and number receiving ART, 2010–2020



Data source: UNAIDS 2021 estimates.

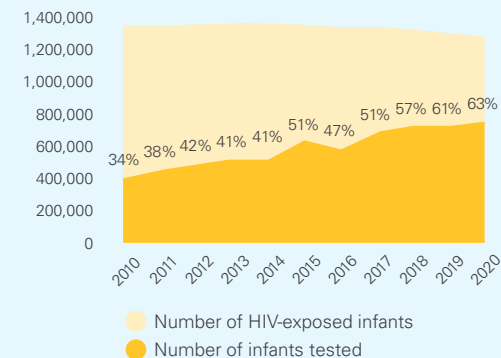
In 2020, an estimated 63 per cent of infants exposed to HIV globally were tested for the virus within two months of birth, as recommended by the World Health Organization (WHO). Over the past 10 years (2010–2020), the number of children tested for HIV within two months of birth has increased by 29 percentage point (Figure 12).

Figure 11: Per cent of children and adolescents living with HIV not on ART, by age group, 2010–2020



Data source: UNAIDS 2021 estimates.

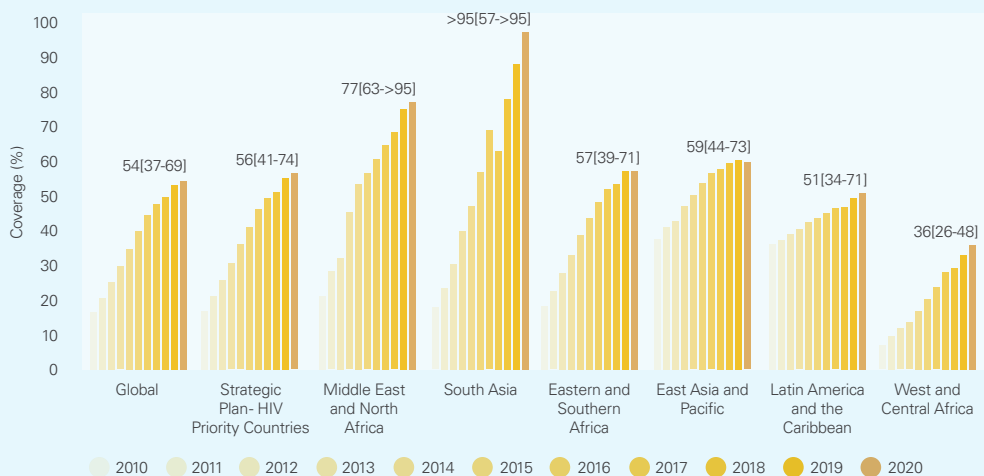
Figure 12: Number of HIV-exposed infants and number tested for HIV within two months of birth, 2010–2020



Data source: UNAIDS 2021 estimates.

Across the globe, coverage of ART in children under 15 years varied widely, ranging from under 10 per cent in some countries to over 95 per cent in others. Regionally, coverage of ART for children ranged from a low of 36 per cent, on average, in West and Central Africa to over 95 per cent in South Asia (Figure 13).

Figure 13: Percentage of children aged 0–14 years living with HIV receiving antiretroviral HIV treatment by region 2010–2020



Source: Global AIDS Monitoring and UNAIDS 2021 estimates
 Note: Data not available for Eastern Europe and Central Asia, North America, and Western Europe.

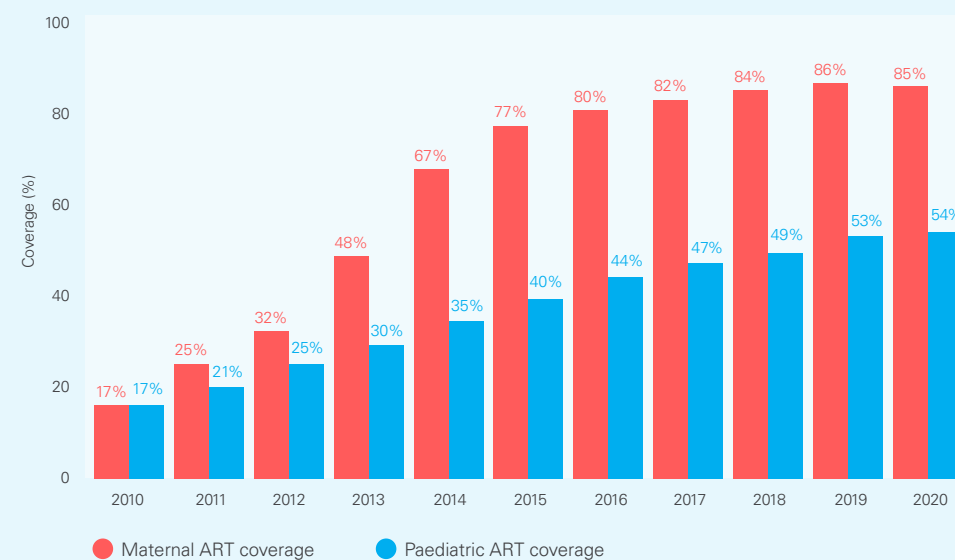
ART coverage for children in 2020 is a global failure that needs to be addressed with renewed urgency

Globally, only 54 per cent of children (aged 0–14 years) living with HIV had access to ART in 2020. While we are beginning to see an acceleration in treatment coverage of children with an increase of 13 percentage points (from 41 to 54 per cent) over the last four years, we are still off target.

Paediatric ART coverage in the last decade has persistently lagged behind the coverage for pregnant women (85 per cent in 2020), and all adults living with HIV (74 per cent in 2020) (Figure 14).

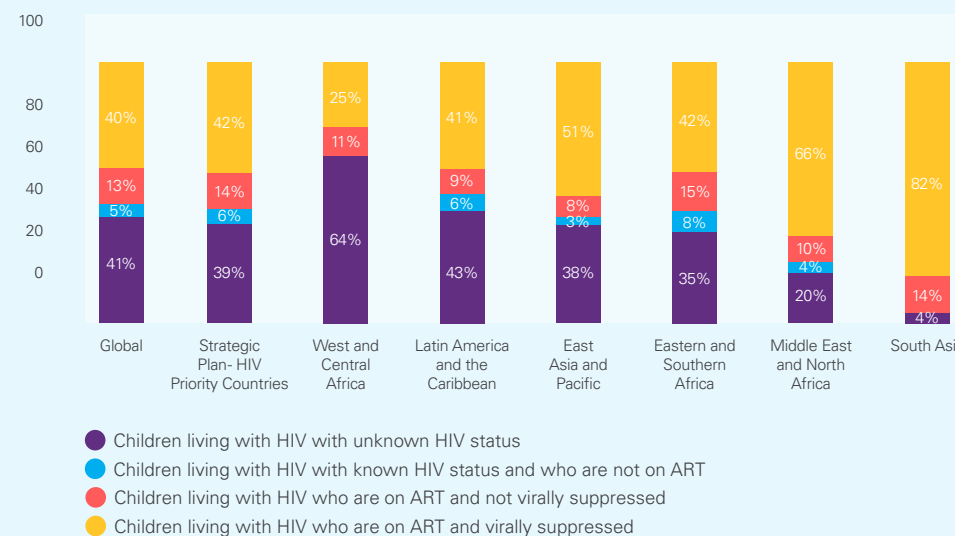
To make matters worse, the HIV status of 41 per cent of children globally remained unknown. Unsurprisingly, this proportion was highest in West and Central Africa, the region with the lowest treatment coverage in children. By contrast, in South Asia, which has the highest treatment coverage in children, only 4 per cent of children had an unknown HIV status (Figure 15).

Figure 14: Percentage of children aged 0–14 living with HIV and pregnant women living with HIV receiving ART, 2010–2020



Data source: Global AIDS Monitoring and UNAIDS 2021 estimates
 Note: Maternal antiretroviral treatment (ART) includes only Option B+ regimens

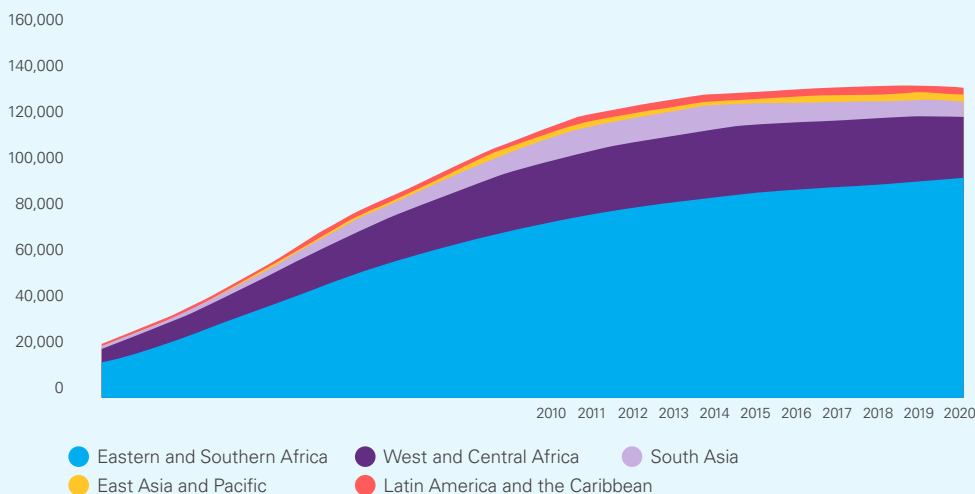
Figure 15: Knowledge of status, coverage of ART and viral load suppression among all children aged 0–14 years living with HIV, by region, 2020



Data source: UNAIDS 2021 estimates.

Increasingly, children on ART are 'aging out' and surviving into adolescence. In 2020, 136,000 children living with HIV globally reached the age of 15 years (Figure 16). These adolescents need access to tailored services to facilitate their transition to adult treatment programmes. Nowhere is this more important than in sub-Saharan Africa, where 90 per cent of surviving adolescents live, with 70 per cent in Eastern and Southern Africa and 20 per cent in West and Central Africa.

Figure 16: Number of children living with HIV reaching aged 15 by region, year and region, 2000–2020



Source: UNAIDS 2021 estimates
 Note: Data not available for Eastern Europe and Central Asia, North America, and Western Europe.

Last year, 400,000 young people between the ages of 10 and 24 years were newly infected with HIV. Of these, 150,000 were adolescents between the ages of 10 and 19 years (Figure 17), and 77 per cent were adolescent girls and the vast majority (90 per cent) were from sub-Saharan Africa.

Figure 17: Global summary of HIV epidemic among adolescents aged 10–19 years, 2020

Global	Adolescents aged 10–19 years	Girls aged 10–19 years	Boys aged 10–19 years
Estimated number of adolescents living with HIV	1,750,000 (1,160,000- 2,300,000)	1,000,000 (590,000- 1,370,000)	750,000 (550,000- 960,000)
Estimated number of adolescents newly infected with HIV	150,000 (43,000- 310,000)	120,000 (23,000- 230,000)	35,000 (6,200-92,000)
Estimated number of adolescents dying of AIDS-related causes	32,000 (23,000- 46,000)	16,000 (11,000- 24,000)	16,000 (12,000- 23,000)

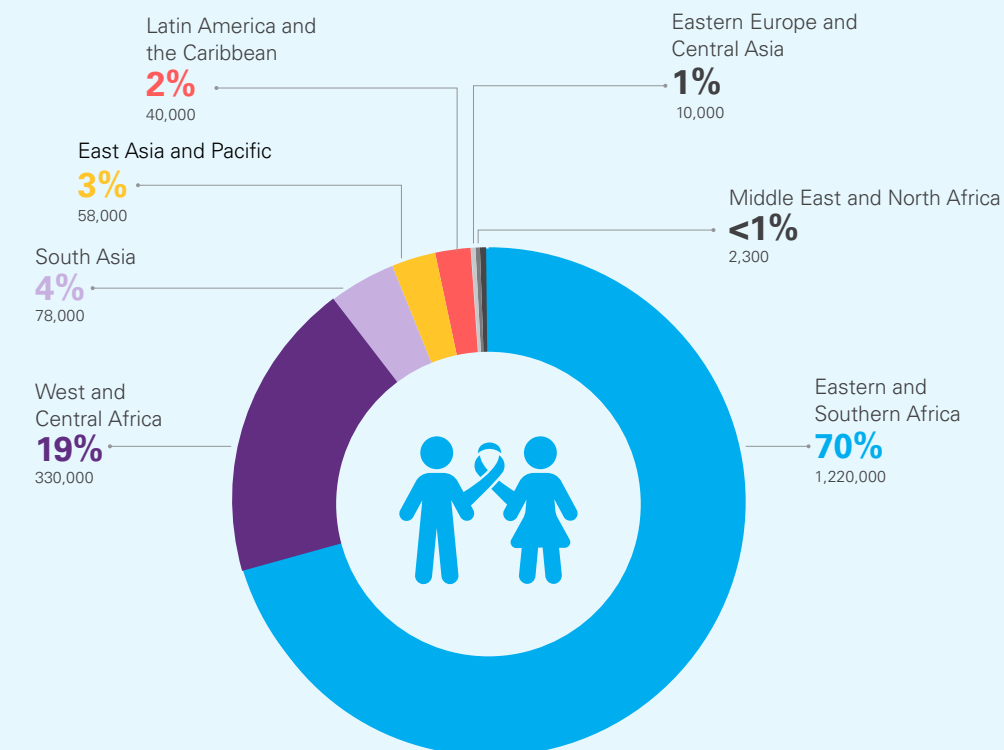
Source: UNAIDS 2021 estimates.
 Note: Values may not sum to total due to rounding

Adolescents represent a growing share of people living with HIV worldwide with limited access to prevention services

At the end of 2020, an estimated 1.75 million adolescents between the ages of 10 and 19 years were living with HIV worldwide, of these 70 per cent were girls. 90 per cent of all adolescents living with HIV are in Africa. Outside of Africa, the highest numbers are in East Asia and the Pacific (5 per cent), South Asia (4 per cent) and Latin America and the Caribbean (2 per cent) (Figure 18).

In Eastern and Southern Africa, annual new HIV infections among adolescents were decreased by 41 per cent since 2010, while in the Middle East and North Africa, infections were increased by 4 per cent over the same period.

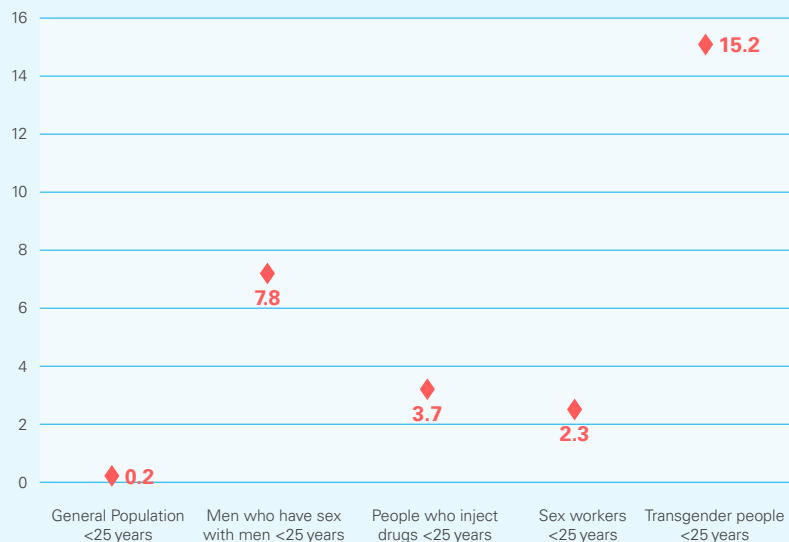
Figure 18: Estimated number and percentage of adolescents aged 10–19 years living with HIV, by region, 2020



Source: UNAIDS 2021 estimates.

Among young key populations below 25 years, globally, HIV prevalence continues to increase- from 2 percentage points among sex workers to 15 percentage points among transgender people. There is a significant difference between the general young population below 25 years and those represent key populations (Figure 19).

Figure 19: Median HIV prevalence (%) among key populations below 25 years and HIV prevalence among general population below 25 years, 2020



Source: Source: UNAIDS Key Populations Atlas.

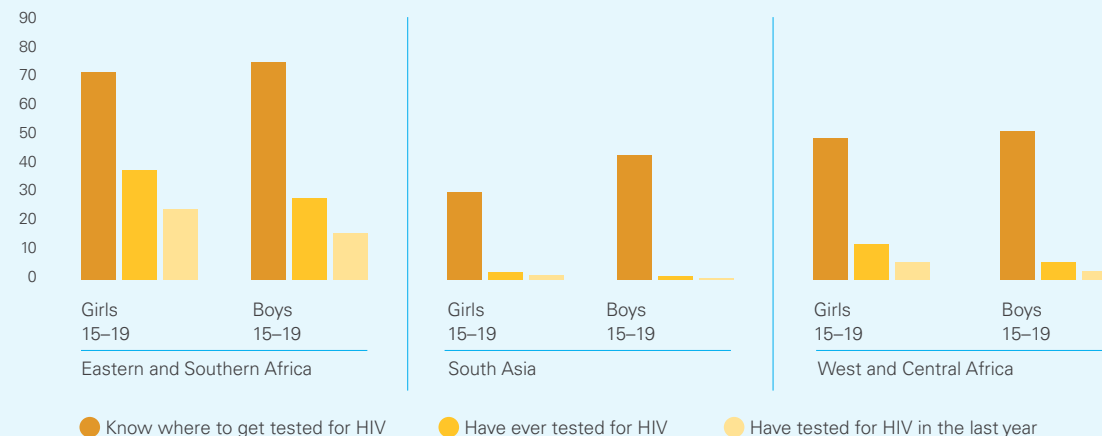
Note: Data included in this graph are nationally representative and from those countries that reported in 2020.

It is essential that adolescents possess comprehensive, correct and destigmatized knowledge of HIV transmission and risks in order to protect themselves from infection. However, rates of comprehensive knowledge remain below 50 per cent in most countries with available data.

Expanding adolescent-access to HIV testing (targeted and tailored testing strategies) continues to be a challenge, including index-linked testing, assisted partner notification, social network based testing and other novel modalities that boost the efficiency of testing programmes.

Despite the availability of tests being widely known, 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 2020. Testing rates in West and Central Africa and South Asia are even lower, at only 1 per cent for boys and 2.5 per cent for girls aged 15–19 years (Figure 20).

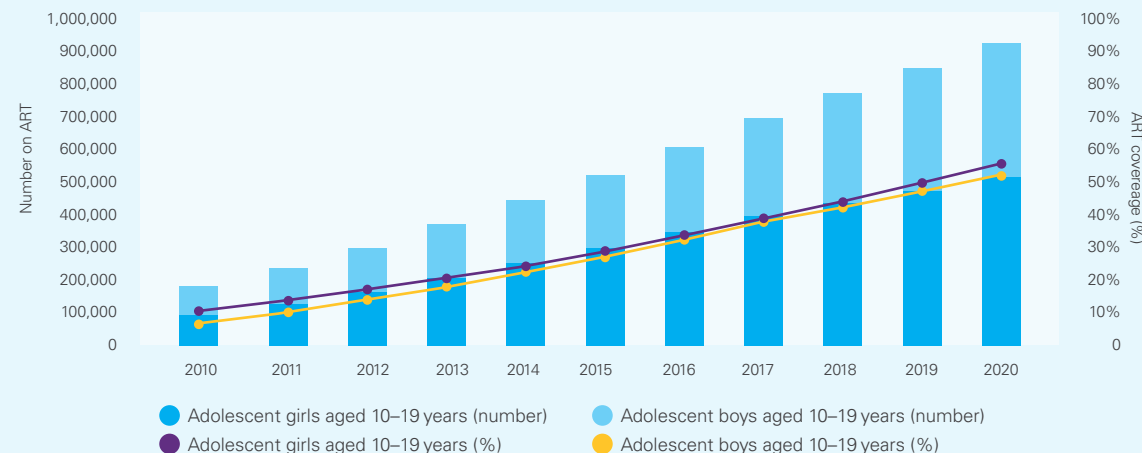
Figure 20: Per cent of adolescents aged 15–19 years who know where to get HIV testing, have been tested for HIV in the last 12 months and received the result of the last test, 2015–2020



Source: UNAIDS 2021 estimates.

Of the 1.75 million adolescents aged 10–19 years living with HIV, 54 per cent, or 940,000 adolescents, received ART in 2020, a steady increase since 2010. Despite stark gender disparities in adolescent infection rates, treatment coverage for adolescent girls (53 per cent) was nearly on par with that of boys (55 per cent) (Figure 21).

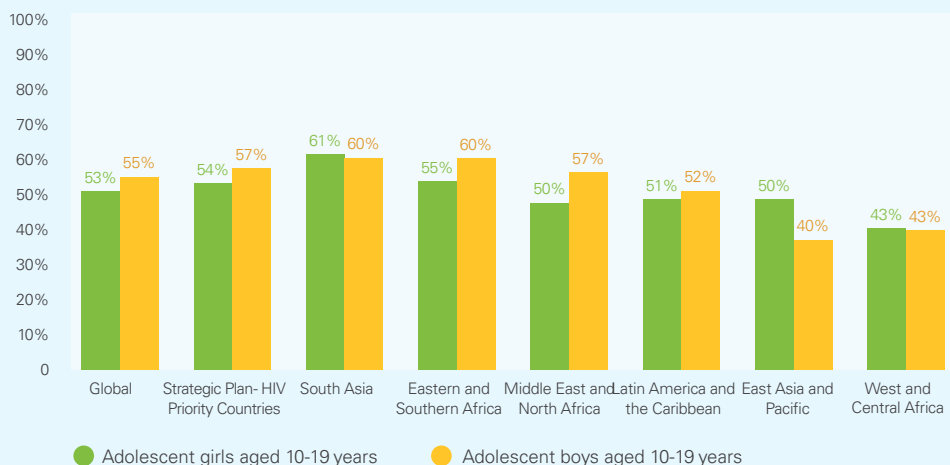
Figure 21: Number and coverage of ART among adolescents aged 10-19 years by gender, 2010-2020



Source: UNAIDS 2021 estimates.

ART coverage among adolescents aged 10–19 years varied across regions, with the lowest treatment coverage in West and Central Africa (43 per cent) and the highest in South Asia (61 per cent) (Figure 22).

Figure 22: ART coverage among adolescent boys and girls aged 10–19 years by gender, by region, 2020



Source: UNAIDS 2021 estimates

Note: Coverage data for Eastern Europe and Central Asia, North America and Western Europe are not available.

Gender inequality driving HIV disproportionately among adolescent girls

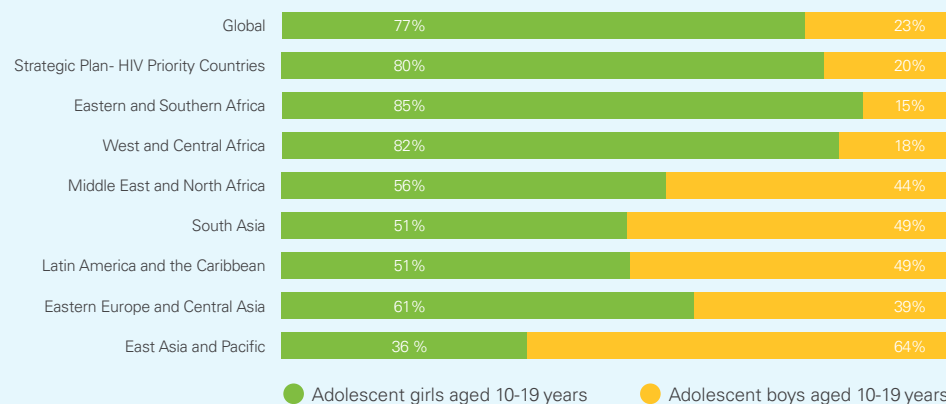
Adolescent girls accounted for over 77 per cent of all new HIV infections among adolescents in 2020.

In sub-Saharan Africa, during 2020, almost six times as many adolescent girls aged 10–19 years were newly infected with HIV than boys aged 10–19 years. This trend held true across all regions, with the exception of East Asia and the Pacific, where 64 per cent of new adolescent infections were in boys (Figure 23).

This disproportionate impact on girls reflects deeply rooted inequalities and biases in cultural, social and economic structures that reduce girls’ access to information, services and opportunities.

Promoting women’s rights to information and services related to sexual and reproductive health is essential to achieving equitable HIV-prevention outcomes.

Figure 23: Gender disparities in new HIV infections emerge in adolescents aged 10–19 years, by region, 2020



Source: UNAIDS 2021 estimates

Note: Data not available for North America and Western Europe.

In countries experiencing either generalized or concentrated epidemics, schools can be critical venues for reaching adolescents with the information and life-skills they need to avoid HIV infection. School-based comprehensive sex education is effective in promoting attitudes and practices that lead to positive health outcomes.

In addition, each incremental year of education beyond primary school generates health, social, and economic dividends. Completion of secondary school has multiple health, social and economic benefits for girls and their children, families and broader communities. These benefits ultimately reduce vulnerability to child marriage, teenage motherhood and HIV infection.

Preventing HIV among girls in countries with low prevalence, or in specific populations, is especially challenging since the spread of the virus is fuelled by compounding and intersecting vulnerabilities, especially those engaged in sex work, injecting drugs, or in prison.

Nearly half of women in low- and middle-income countries do not use the internet, creating gender data gaps and influencing the way people everywhere engage with digital tools.

It is essential to create safe spaces for girls and close the digital gap to maximize the engagement of girls. Digital programming is showing promise in enabling girls and women to receive reliable information and tailored support.

ANNEX

1. 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 an HIV epidemic 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.

2. USEFUL LINKS

2.1 Methods for HIV modelling are developed by the [UNAIDS Reference Group on Estimates, Modelling and Projections](#).

2.2 All available data on HIV estimates are available at aidsinfo.unaids.org

2.3 Super-Fast-Track Framework <https://free.unaids.org>

3. RESOURCES ON HIV/AIDS AND COVID-19

[Children and AIDS COVID-19 and HIV Knowledge Hub](#)