Agenda item 3

UNAIDS/PCB (56)/25.5

FOLLOW-UP TO THE THEMATIC SEGMENT FROM THE 55TH PCB MEETING

Addressing inequalities in children and adolescents to end AIDS by 2030

UNAIDS

24–26 June 2025 | Geneva, Switzerland
UNAIDS Programme Coordinating Board
Issue date: 5 May 2025

Additional documents for this item: N/A

Action required at this meeting—the Programme Coordinating Board is invited to:

- *Note with concern* that there were still 120,000 new HIV infections in children in 2023, particularly in Sub-Saharan Africa; 600 000 children (aged 0-14) living with HIV are currently not on HIV treatment; that more than one third (36%), or 370 000, of older adolescents aged 15–19 years living with HIV are not receiving antiretroviral therapy; that children accounted for 12% of all AIDS-related deaths, even though they constitute only 3% of people living with HIV; and that children and adolescents are much less likely to be virally suppressed compared to adults due to inadequate services and support;
- *Take note* of the background note (UNAIDS/PCB (55)/24.34) and the summary report (UNAIDS/PCB (56)/25.5) of the Programme Coordinating Board thematic segment on "Addressing inequalities in children and adolescents to End AIDS by 2030";
- *Request* Member States, in close collaboration with community-led HIV organizations and other relevant civil society organizations and partners, with the support of the Joint Programme, to fast-track targeted and measurable actions towards the 2030 targets for children:
    a. Scale up high quality, integrated, person-centered, HIV prevention and treatment interventions for pregnant and breast-feeding women, children and adolescents including through community-led service delivery models within primary health care and community settings;
    b. Implement context-determined, evidence-based case finding strategies to identify undiagnosed children and adolescents living with HIV and ensure their timely initiation, as well as retention, on treatment;
    c. Further support communities to lead, including community-led and youth-led HIV organizations and particularly relevant civil society organizations of adolescent girls and young women, key populations and people living with HIV, by strengthening their representation at all levels where financial and programming decisions are made;
    d. Strengthen health information systems to collect cohort data that tracks mother-baby pairs, children living with HIV, high-risk groups such as adolescent parents and the children of members of key populations, increase the use of programme data analyses that allow for identifying the causes of new HIV infections among infants, and utilize those data to guide effective and sustainable programme design and drive funding to where it is most needed;
    e. Increase targeted investments in ending AIDS among children and adolescents for a response that is sustainable and planned beyond 2030;

Cost implications for the implementation of the decisions: none

Thematic segment: Addressing inequalities in children and adolescents to end AIDS by 2030

1. The thematic segment discussed the inequities and other factors that are barriers to progress in ending AIDS in children and adolescents by 2030.

Introduction and keynote addresses

2. The moderators for the session were: **Shaffiq Essajee**, Senior Adviser on HIV and specialist on child health at UNICEF, and **Ikpeazu Akudo**, Team Lead for HIV, Tuberculosis, Hepatitis & STIs at the WHO Regional Office for Africa.

3. **Angeli Achrekar**, Deputy Executive Director for Programmes, UNAIDS, introduced the first session by saying that there had been major progress with vertical transmission programmes, averting some four million new infections in children since 2000. Yet the HIV response was not performing well enough for adolescents and children. Every HIV infection in a child was preventable, she said, yet 120 000 children acquired HIV in 2023, more than 80% of them in sub-Saharan Africa. Almost half the children living with HIV were not yet on treatment. As a result, children who account for only 3% of people living with HIV, unfortunately account for 12% of AIDS-related deaths, she added.

4. This amounted to more than a biomedical challenge, Dr Achrekar said. Children and adolescents' rights had to be upheld and the inequities, gender-based violence and HIV-related stigma affecting them had to be addressed as well as behavioral and structural barriers. Funding gaps were also holding back vertical transmission programmes. Spending on HIV programmes for children and adolescents in low- and middle-income countries was US$ 1 billion below the level needed, she noted.

5. A video was screened with a contribution from South Africa's Minister of Health, **Aaron Motsoaledi**. He said the ambition to end AIDS by 2030 was under threat if countries did not overcome the inequalities that lead to inadequate services, care and support for the young. Children living with AIDS had to be a bigger priority.

6. Mr Motsoaledi reminded the PCB that South Africa had the largest HIV burden in the world and said the drivers of the epidemic were multifaceted. The country had made big strides against the epidemic, though. Its programme for preventing the vertical transmission of HIV was the largest in the world and had reduced the vertical transmission rate from 31% in 2000 to a little over 2% in 2024. However, treatment and care services were not reaching all the children and adolescents in need. South Africa's treatment cascade for adults stood at 96–79–95 in 2023, but for children and adolescents it was 87–80–70. More than 150 000 children were living with HIV in 2023 and more than 6500 children acquired HIV in that year.

7. Referring to the creation of the Global Alliance to End AIDS in Children by 2030, he said the collaboration had led to the launch of South Africa's national plan to accelerate and refocus its HIV response for children and adolescents. After describing improvements made in South Africa's HIV programme, he said 80% of children receiving treatment had been transitioned to new Dolutegravir regimens, treatment had been simplified, and treatment adherence support was being strengthened. Stigma and discrimination remained pervasive barriers, however, and were impeding full access to services and undermining adherence to treatment. He described the multisectoral approach taken in South Africa and the tools and programmes that were being used to try and reduce HIV-related stigma.

8. Mr Motsoaledi noted that adolescents living with HIV faced numerous intersecting

challenges, with girls especially affected. By empowering them through education, skills and economic opportunities, the cycle of poverty and inequality could be broken. He described the steps taken to protect adolescent girls in schools, as well as an extensive social protection system that includes large school feeding schemes. Comprehensive sexuality education was being implemented in schools in all nine provinces so adolescents could have the age-appropriate knowledge and skills for making informed decisions.

9. **Sitsope Adjovi Husunukpe**, Executive Director of the Positive Children, Adolescents and Youth Network, Togo, said ART coverage was only 35% among children living with HIV in western and central Africa. She said societies claimed to cherish their children, while excluding their voices at the same time. A lack of suitable policies, programmes and interventions was killing children and adolescents, she said.

10. After paying tribute to Patrick-Alain Fouda, an AIDS activist who had died recently, Ms Husunukpe said people living with HIV were determined to change the laws, structures and policies that discriminated against them and denied them their rights and dignity. She described discovering, at the age of nine years, that she was HIV-positive and realizing that her parents had died of AIDS-related causes. The solidarity and support of her peers had enabled her to survive and helped build her resolve, she told the PCB. A new generation of young people was committed to ending inequalities and oppression, she said and called for more investment in the most effective approaches for preventing new infections, bridging treatment gaps and educating adolescent girls and young women. It was imperative to support the Global Alliance to End AIDS in Children, she said, including its regional hub in western and central Africa.

11. In closing, Ms Husunukpe insisted that affected populations had to be actively involved in the decisions impacting them and should have the necessary resources to participate in HIV-related programmes. According to her, adolescents were not “beneficiaries”, but people that were engaged in activities to improve their lives.

Session overview

12. This session provided the main highlights from the thematic segment background note. It included an analysis of the needs, gaps and challenges of an accelerated response to AIDS in children and adolescents, as well as an update on the epidemiological status of HIV among pregnant and breastfeeding women, children, and adolescents.

13. **Mary Mahy**, Director of the Data for Impact Department at the UNAIDS Secretariat, highlighted vital data for holding countries accountable for their response. She reminded that the data presented emerged from countries but were also a “global good” for advocacy, fund-raising, and enhancing programmes and interventions.

14. Referring to the field visits ahead of the PCB meeting, she said even in strong health systems there were gaps, which especially affected disadvantaged people. She insisted that it was possible to end AIDS in children. The biomedical interventions existed for achieving that goal, but the societal and structural gaps had to be closed. She highlighted four elements: reducing HIV incidence in women; preventing vertical transmission of HIV; testing HIV-exposed children; and closing the gaps for children who are living with HIV but are not yet on treatment.

15. Much of the burden of paediatric AIDS was in sub-Saharan Africa, Ms Mahy said. In 2023, there had been an estimated 50 000 new paediatric HIV infections in eastern and southern Africa, 48 000 in western and central Africa, and 19 000 children in the rest of the world. As HIV incidence drops, she explained, fewer women living with HIV are bearing children—and fewer children are exposed to HIV. A strong decline in new

HIV infections in women was underway in eastern and southern Africa, but progress was slower in western and central Africa. Vertical transmission can also be prevented by ensuring that women living with HIV are on treatment, she said, but ART coverage was much lower in western and central Africa (54%) than in eastern and southern Africa (94%). Consequently, the reduction in vertical transmission differed widely in those two regions.

16. Most new infections in children in southern and eastern Africa were related to mothers acquiring HIV during pregnancy or breastfeeding or not getting ART, Ms Mahy explained. That could be prevented with PrEP, counseling and testing, and referral to treatment, she said. In western and central Africa, most new infections were due to pregnant women living with HIV not getting ART. That could be addressed by expanding access to antenatal care and ensuring women can access HIV testing and receive treatment if needed. However, antenatal care and HIV testing access in western and central Africa remained low.

17. Ms Mahy highlighted the need to identify HIV-exposed children by two months of age and said there were huge gaps in testing HIV-exposed children early in life. About 600 000 children living with HIV were not receiving ART; almost two thirds of them were aged 5–14 years. Treatment coverage among children with HIV was 42% for 0–4-year-olds, 60% for 5–9-year-olds, 67% in 10–14-year-olds, and 64% for 15–19-year-olds. Furthermore, approximately 63% of adolescents (15–19 years) living with HIV had been perinatally infected, which meant that HIV services were missing them across much of their lives.

18. It was crucial to address the continued risk of HIV infection, especially among adolescent girls and young women and among pregnant and breastfeeding women, she stressed. The HIV-related disadvantages affecting adolescent girls and young women were evident already among 15–19-year-olds. Globally, they were twice more likely to acquire HIV compared with their male counterparts and in sub-Saharan Africa they were five times more likely to do so. Adolescent girls and young women were also heavily affected by intimate partner violence, which has been shown to increase the risk of HIV acquisition, she said. Condom use among non-regular partners was low for women, with a lack of HIV education and comprehensive sexuality education and poor access to services among the main reasons.

19. Priorities included reducing inequalities and providing stigma-free HIV and health services, along with combining HIV testing services with antenatal care and improving maternal care for breastfeeding women living with HIV. Children exposed to HIV should be tested early and often, said Ms Mahy, and the cost of testing had to be reduced for pregnant women and children. Greater support was also needed to help with the difficult transition from childhood to adolescence and adulthood for children on treatment.

20. **Meg Doherty**, Director, Department of Global HIV, Hepatitis and Sexually Transmitted Infections Programmes at WHO, presented highlights from the thematic session background note. She highlighted five action areas that should be stepped up: access to diagnostics and treatment for children and adolescents; provision of integrated services; support to communities to lead; increase in targeted investments; and understanding of the evolving epidemic among children, adolescents and pregnant women.

21. Among the main gaps and barriers, Ms Doherty cited limited training for paediatric care; services that are too centralized and not tailored for the needs of adolescents; consent issues for testing and sexual and reproductive health services; limited services for young key populations; and data gaps, including a lack of cohort data

which has limited follow-up efforts. Structural inequalities included gender inequalities, intimate partner violence and barriers blocking access to sexual and reproductive health services for adolescents and young adults. Funding gaps and insufficient commitment from leaders added to the difficulties, she said. Programmes in low- and middle-income countries were underfunded by about US$ 1 billion annually.

22. Ms Doherty highlighted several proven ways to close the gaps, such as testing infants and children who have been exposed to HIV and linking them to care and treatment, if needed. Many innovations were at hand, she said, including early infant diagnosis and improved paediatric case-finding through index testing and provider-initiated testing in settings where sick children present for care. Programmes were not using those opportunities to the full, even though they could achieve rapid results (as seen in a case study from Kenya, where over 4,000 HIV-exposed children had been tested in 2023). For children who test HIV-positive, highly effective Dolutegravir regimens were the standard-of-care and triple fixed-dose combinations were now available. If used to the full, this would cause viral suppression rates to rise.

23. Secondly, said Ms Doherty, services should be decentralized and integrated more thoroughly with primary health care. Zimbabwe, for example, was beginning to provide long-acting PrEP to pregnant young women; in a case study, there had been no seroconversions during pregnancy among some 600 women. The triple elimination initiative was an opportunity to take this work forward, she said and noted that Namibia had become the first high-burden country to apply for validation of triple elimination. For key populations, HIV care would be more effective when integrated with community-led care that provides one-stop-shop services, she added.

24. Thirdly, it was important to support communities to lead activities. This was evident in studies from South Africa, Nigeria (where psychosocial support and peer-driven interventions were available) and the United Republic of Tanzania (where a family-centred approach was used). Fourthly, targeted investments had to be increased, Ms Doherty said. This called for more domestic resources and for more funds to be allocated for PrEP for adolescent girls and young women, for key population programmes and for economic support. Fifthly, countries had to keep track of their evolving epidemics; disaggregate the data; follow mother-infant pairs over time; and link health data across health services. A large body of case study evidence showed what worked to close the gaps, Ms Doherty said: those actions had to be scaled up for maximum impact. The Global Alliance was mobilizing 12 countries to do so and was seeing improvements, she told the meeting.

25. Speaking from the floor, members and observers thanked the presenters and said it was unacceptable that 120 000 children were acquiring HIV each year when the tools for preventing those infections existed and that so many children living with HIV were not receiving treatment. HIV programmes still seemed to be oriented primarily towards adults, they said. The situation of children and adolescents living with HIV in western and central Africa was highlighted, as were the intense challenges faced by adolescent girls, especially those with children, and their need for supportive and tailored services.

26. Speakers referred to the special challenges faced in countries with low HIV prevalence and where health-care providers have less experience with HIV in children. This could be overcome by recognizing that children with HIV require dedicated care services. The presenters were asked whether there were positive examples of paediatric training for health-care workers to help them provide services in stigma-free ways. They were also asked how stigma can be avoided when services are integrated.

27. Some speakers (including China, Dominican Republic and the Islamic Republic of Iran) shared information about their efforts to end AIDS in children, including improved

access to new paediatric diagnostics and treatment, as well as social protection support that was being provided for children living with HIV. Botswana's representative reminded the meeting that the country was the first in sub-Saharan Africa to achieve gold tier certification for vertical transmission elimination.

28. In reply, Ms Doherty said stigma (including self-stigma) remained a problem. She acknowledged that it was proving difficult to reduce stigma in the health-care workforce, but noted some examples of success (e.g. Zvendari in Zimbabwe).

29. Other speakers noted the need for comprehensive sexuality education and for removing the structural barriers preventing progress for children and adolescents but asked how this could be done effectively in the current political climate. They underscored their concern about the anti-rights drive and its effect on achieving the goal of ending AIDS in children and adolescents by 2030. Speakers also highlighted the importance of health literacy and mental health, especially for adolescents and young people living with HIV and said WHO was increasing its focus on this area of work.

Round table 1: Addressing remaining barriers to eliminating vertical transmission of HIV

30. This session discussed solutions for specific challenges to eliminating vertical transmission of HIV, including triple elimination, with a focus on data use, improved outreach to marginalized women, improving outcomes in adolescent girls and young women, and tackling incident HIV infection in pregnant and breastfeeding mothers.

31. **Mariana Iacono**, International Community of Women Living with HIV Latina, Argentina, discussed how pregnant and breastfeeding women remain engaged in treatment, care and support services, including through using family and community-centred approaches. After recapping the evolving advice and policies for eliminating vertical transmission of HIV, she said more holistic approaches were needed. It was crucial to deal with violence against women, which prevented women from using services and adhering to treatment. Mental health support—including for women dealing with post-partum depression, and for children and adolescents with depression—was also key but remained scarce. Pregnant women's and mothers' right to health information had to be realized so they can take informed decisions know where services are available, Ms Iacono said.

32. **Dvora Joseph Davey**, from the Desmond Tutu HIV Foundation & University of Cape Town, South Africa, said there was too little focus on pregnant and lactating women. She detailed the heightened risks of acquiring HIV for pregnant and breastfeeding women due to a range of factors, including violence, stigma and gender inequality. However, innovative products for preventing HIV acquisition during pregnancy and breastfeeding existed, including long-acting PrEP.

33. Ms Davey called for a stronger focus on primary prevention, including access to long-acting PrEP. She referred to mathematical modeling showing that provision of long-acting Cabotegravir during pregnancy could reduce HIV incidence in pregnant and breastfeeding mothers by 40%. In addition, the Purpose-1 trial had shown Lenacapavir to be safe for use during pregnancy. Only two doses were required to cover the pregnancy and breastfeeding period and would prevent HIV acquisition in both mother and infant, she said. Women should also be able to make different prevention choices over time, she said, noting that sexual behaviours often change during pregnancy and the postpartum period.

34. In addition, primary prevention was vital for controlling the hepatitis B and STI epidemics. Noting that syphilis rates were rising in many countries, she reminded the

meeting that syphilis was associated with adverse pregnancy outcomes, including stillbirths and neonatal deaths, and increased risk of HIV acquisition and vertical transmission. Comprehensive syphilis screening during pregnancy, including the use of dual HIV and syphilis testing, and timely treatment were critically important and had to be integrated with antenatal care, she said. In closing, Ms Davey called for rapid access to cost-effective prevention options such as long-acting PrEP agents and for simplified guidelines for prescribing and using diagnostics and treatment.

35. **Artur Olhovetchi Kalichman**, from the National Department of HIV/AIDS, Tuberculosis, Viral Hepatitis, and Sexually Transmitted Infections in Brazil, said there were approximately 1.1 million people living with HIV in Brazil and the country's HIV treatment programme spanned 27 federal units and over 500 municipalities. After describing the HIV services and commodities provided by the health system, including for eliminating vertical transmission of HIV (and syphilis), he said about 60% of pregnant women with HIV knew their HIV status ahead of attending antenatal care. A subnational process for the elimination of vertical transmission, starting at municipal levels, was underway and was based on the PAHO and WHO certification process. Seven federal units and 151 municipalities had been certified either for the elimination of HIV and/or syphilis and hepatitis B.

36. **Soeurette Policar**, of the Civil Society Forum Observatory in Haiti, discussed the barriers hindering the elimination of vertical transmission in her country. She said Haiti was experiencing very difficult political and security conditions and that many health centres and hospitals had been closed. Over 800 000 people had been displaced and many of them were struggling to get medication and services in extremely unsafe conditions. Doctors and health workers were being attacked, killed, raped and kidnapped.

37. The Ministry of Public Health, with international partners, had set up a crisis unit to find people who were missing from HIV treatment programmes. Because it was very difficult for displaced people in camps to keep taking their treatment, centres had also been set up to assist them. Her organization was providing both PrEP and ARVs for women, including pregnant and breastfeeding women. Ms Policar appealed for international support to assist the health services and provide protection for health workers and citizens.

38. Speaking from the floor, members and observers thanked the presenters for their contributions. Several members (including Cambodia and Kenya) described their progress in reducing vertical transmission of HIV and/or syphilis and affirmed their determination to end AIDS in children. The representative from Kenya, for example, said it had achieved steep reductions in vertical transmission rates and described the main elements of its national plan for the elimination of AIDS in children by 2027.

39. The meeting was told that Cambodia's national programme was achieving very high ART coverage among adults, but the vertical transmission rate was still 8% and treatment coverage among children was low. Several initiatives were being introduced, including a cash transfer system for impoverished pregnant women, social protection support for people living with HIV and improved linkages with other health services, including reproductive health. Mechanisms were also being introduced to incorporate data from private care providers in the national health information system (about 78% of births in Cambodia occur in public facilities); track mother-child pairs throughout the service continuum; and end stigma and discrimination in health-care facilities. U=U was also being promoted among pregnant and breastfeeding women living with HIV.

40. Speakers insisted that sexual and reproductive health was a fundamental right and had to be integrated with services for HIV and for reducing gender-based violence, as

this was essential for protecting the health of women and girls and achieving the triple elimination of vertical transmission of HIV syphilis and hepatitis B. Integration of services promoted open dialogue about sexual health, helped reduce the stigma surrounding HIV and sexual health, boosted service use, and improved health outcomes, they said. The value of integrating mental health in HIV service delivery was also noted, along with the importance of using a person-centred approach to service delivery and meaningfully engaging adolescent girls and young women, including as mentors, so services reflect their actual needs.

41. Ultimately, speakers said, the elimination of vertical transmission of HIV required addressing the challenges faced by women and girls. They said health systems still failed to uphold the dignity and rights of women and girls and too often prioritized control over care, and they stressed thatthe elimination of vertical transmission requires that women can make informed decisions about their body without fear of coercion or force. They highlighted the importance of education, enabling girls to remain in school, the integration of sexual and reproductive health and rights education, and boosted access to economic opportunities.

42. In reply to a question regarding the availability of tools and guidance on children's and adolescents' health, the WHO representative said extensive normative guidance and other publications for children and adolescents were available. This included new guidance based on evidence-based interventions for young adults and adolescents living with HIV. The documents were available online and were updated regularly based on new evidence.

43. Replying to a question, Mr Kalichman said the treatment cascade for children and adolescents in Brazil performed more poorly than for adults. However, once children living with HIV had been identified, diagnosed and linked to treatment, coverage was very high.

Round table 2: Addressing inequalities in access to treatment and care services for children and adolescents

44. The session discussed solutions to challenges in identifying and effectively treating children and adolescent girls and boys living with HIV.

45. **Umahi Godwin**, Paediatric and Adolescent HIV Services, Nigeria National Programme Implementing Partner, Nigeria, discussed ways to improve HIV diagnosis among infants and young children exposed to HIV. In 2020, only 35% of pregnant women accessed antenatal care at health facilities that also provided services for preventing vertical transmission; the vertical transmission rate was 23%; and only 35% of children living with HIV had been diagnosed. A dashboard had been introduced to track testing data for pregnant women at health facilities.

46. Mr Godwin described how a data-driven process was used to improve access to testing for HIV-exposed infants at 11 health-care facilities that were experiencing major service gaps. The root causes of the problems were identified and the capacities of 70 health-care workers were strengthened, he said. This was done through improvements in the district health information system to enhance data capture and link the data to continued training when issues were identified. At the targeted facilities, early infant diagnosis rates rose from 66% to 83%. Mother-baby pairs were also being tracked as part of the initiative, with a focus on understanding what factors were preventing them from using antenatal and HIV services. He said the improved collection and more strategic use of data would help ensure that all HIV-exposed children have access to testing and treatment.

47. **Gibstar Makangila**, Circle of Hope, Zambia, discussed best practices from faith-based

organizations for facilitating access to HIV testing treatment and care for children. Citing forecasts that there will be up to one billion children living in Africa by 2050, he said “relationship capital” had to be tapped more effectively to improve the lives and prospects of children. Faith-based structures, he reminded the meeting, had great reach, trust and local knowledge—they were the biggest “low-hanging fruit” available to the HIV response, yet were underutilized, he said.

48. Mr Makangila urged HIV programmes to foster partnerships with churches and mosques to build awareness and demand for the kinds of services his organization, Circle of Hope, provided. In addition to treatment, children living with HIV needed psychosocial support, schooling, protection from poverty and hunger and more, he said. His organization was partnering with Zambia’s Ministries of Health and Education on national holidays to offer testing services, for example.

49. **Tumie Komanyane**, Frontline AIDS, Botswana, focused on finding adolescents living with HIV and linking them to treatment through family- and community-centered care and support. She said the lives and circumstances of adolescents and young people were constantly changing and emphasized the value of meaningfully engaging them. She cited as an example the Ready Plus project, which provided multilayered and differentiated interventions for adolescents and engaged with their communities and caregivers.

50. Programmes should draw on indigenous systems of knowledge when deciding what types of services and approaches to use, she advised. Also highlighted was the value of improved data collection and advocacy for adolescents and young people, and of linking them to livelihood and income-generating activities. In closing, she said adolescent peer work needed funding to operate properly. She also asked UNAIDS to consider moving the thematic segment to Day One of future PCB meeting to ensure better attendance.

51. **Ayu Oktariani**, Indonesia Positive Women Network, Indonesia, discussed some of the inequalities causing the treatment gaps for children in her country. Stigma was pervasive and had a huge impact on children living with HIV, she said, and was forcing some children to leave school, while caregivers often lacked the knowledge to advocate for children due to their own fears and self-stigma, which left the children without social support. A lack of palatable ARVs for children undermined treatment adherence, she continued, while mothers were often blamed for transmitting HIV to their children, which isolated them and their children further from the support they needed. She said education systems and curricula should help ensure that children living with HIV are safe from stigma and victimization and can have the same education opportunities as their peers.

52. In discussion, speakers commended the presentations and personal testimonies and insisted that every child and adolescent living with HIV must get the treatment and care they need, as levels of ART coverage and viral suppression among children were much too low. The necessary resources had to be allocated to the most effective programmes to end AIDS among children, they urged. But the meeting was also asked to consider which interventions were so impactful that they could not be sacrificed, and which may be dispensable if very difficult decisions had to be taken due to funding constraints.

53. A speaker described the work of the Gap-f network, which had been created to accelerate the treatment roll-out for children, including by facilitating timely transitions to the best available ARV regimens. An important recent development (given the supply problems for optimal paediatric ARV regimens) was the approval granted to a generic manufacturer to produce paediatric Abacavir/Lamivudine/Dolutegravir (ALD),

which brought to four the number of pre-qualified licensed generic manufacturers for this breakthrough ARV. Speakers also pointed to research showing the efficacy of long-acting ARVs for treatment and PrEP and called for equitable access so women could be protected from HIV during pregnancy and breastfeeding.

54. Other comments touched on the value of stronger coordination between providers of paediatric and adult HIV services to prevent treatment interruptions; the roles of stigma and legal and policy barriers in limiting access to testing, treatment and prevention services; and the importance of systematically addressing coinfections of HIV, hepatitis B and C, and syphilis.

55. Also noted was the absence of HIV awareness raising and education on radio, TV and other media. Speakers asked whether this could be revived and pointed out that social media could also be used more effectively to raise awareness among young people and tackle stigma and discrimination. Peer support was vital, including for helping people facing stigma and for providing support for treatment adherence, they said.

56. Replying to a remark that not all faith leaders supported the use of HIV prevention tools, Mr Makangila called for closer collaboration between different faiths around common values such as empathy, love and compassion. Each faith system could advance those values in the ways that fit it best, he said. Replying to a question about how best to inform children about their HIV status, Ms Oktariani said it depended on the person and their situation, but it was generally easier when parents had support from their social networks.

57. Responding to the question regarding which interventions and approaches may be dispensable, panelists said short-term funding cycles should be abandoned, along with working in isolation and competition. If programmes were integrated more effectively at community and facility levels, resources could be managed and used better, they said. They emphasized the importance of improving access to HIV testing and diagnosis for children and making supply chains more resilient and efficient, and said multilayered and multidimensional programmes for children and adolescents worked best.

58. Investments in the lives and wellbeing of children, adolescents and mothers were investments in their communities and societies for the future, panelists said. They urged donors and governments to earmark and ring-fence funding for children and adolescents.

Round table 3: Financing the response to AIDS in children and adolescents

59. This panel discussed financial investments in ending AIDS in children, the funding gaps and opportunities.

60. **Thembisile Xulu**, National AIDS Council, South Africa, said her country was making strong progress towards ending AIDS among children but faced a dilemma of how to ensure ethical financing in the face of budget constraints and competing priorities.

61. South Africa, which has the world's biggest ART programme, had reduced perinatal transmission to under 2.5%, Ms Xulu said, and had expanded early infant diagnosis and access to child- and youth-friendly clinics and services. The national government funded 75% of the HIV response, which included providing ART to over 5.6 million people for free and funding HIV prevention. However, when piloting new technologies and methods, it still relied significantly on PEPFAR and Global Fund support, she explained. But donor-driven programmes were not always affordable once they transitioned into nationally funded ones. National programmes tended to prioritize adult-focused services due to the size of the adult epidemic, which often left paediatrics and adolescent services underfunded and deprioritized.

62. Several steps could be taken, Ms Xulu said, starting with generating evidence on cost-effective interventions and packaging it as investment cases that can be "sold" to the national treasury. Other steps include doing costing and integration studies to determine the cost of delivering priority interventions (currently funded by donors) through existing government delivery platforms; and advocating for public financial management reforms, such as creating discrete budget lines and conditional grants that are tied to improved health outcomes so child- and youth-focused spending can be earmarked. It is also possible to prioritize districts for HIV funding, based on indices that include HIV epidemiological, poverty and population welfare data, she told the PCB.

63. **Annah Page Sango**, GNP+ and a member of the Coalition for Children Affected by AIDS, Zimbabwe, focused on inequities in funding for mothers, children and adolescents. Referring to a recent three-country report, she said the inequities in HIV testing and treatment for children were due largely to structural barriers. Finding the "missing" children should not be difficult: they were in local communities, in schools and their parents attended churches or mosques. However, stigma and discrimination remained huge problems. Children and adolescents did not fall out of care, she said, they were bullied out of care. Gender-based violence and intimate partner violence were a further challenge; they heightened the risk of HIV acquisition for women and exposure to HIV for children, compromised their care, and traumatized them. Legal barriers also made it very difficult for programmes to reach the children of key populations, she added.

64. **Hilary Wolf**, PEPFAR, discussed some of the ways in which US funding for global health was helping end AIDS in children. She said PEPFAR funded about 47% of the HIV response for children and adolescents in low- and middle-income countries. The support included US$ 210 million for prevention, care and treatment for adolescents; the Lift-up initiative for activities in 12 high-burden western and central African countries; US$ 150 million for the elimination of vertical transmission; and a 10% allocation annually for orphans and vulnerable children care and support. Highly committed partnership like the Global Alliance were a big priority for PEPFAR, she said.

65. Ms Wolf told the PCB that PEPFAR intended to narrow its focus so PEPFAR-supported countries can reach the goal of ending AIDS in children by 2030. In order to improve the impact and efficiency of existing funding, it aimed to emphasize interventions such as case finding and use innovative and evidence-based strategies, including for monitoring and evaluation and for social and economic support. It also intended to promote partnerships, including with government ministries, the faith-based sector and the private sector to have a more coordinated and effective response. Other focus areas include identifying policy and legal barriers and advocating and planning for their removal; and improving collection and analysis of paediatric-specific data to identify and resolve gaps. She said PEPFAR data showed that children younger than five years of age and living with HIV still had a higher risk of death than all other children living with HIV.

66. **Yogan Pillay**, from the Bill and Melinda Gates Foundation, said the Foundation provided catalytic support, especially for innovations and approaches that can be taken to scale and that are practical and affordable. He said new initiatives supported by the Foundation included exploring models for mother-infant care post-delivery; the launch of HIVE, which involves supporting six countries to share lessons and take elimination initiatives to scale; and support for the roll-out of dual HIV-syphilis testing at programme level, including through addressing supply chain issues. Other activities included supporting the South African government's push to have a further 1.1 million people living with HIV (including children) on ART in order to reach the second "95"

target; working with the Global Fund and Gilead on the procurement of Lenacapavir and making generic versions available at the most affordable price; and working with specific countries to place greater emphasis on children and adolescents in their Sustainability Roadmaps.

67. Speaking from the floor, participants lamented the funding shortage for ending paediatric AIDS, as every dollar invested in children and adolescents made a difference for them, their communities and the future. d. It was also noted that donors were often asked to provide unearmarked funding so that organizations could decide how best to use the support. However, that also meant the funding would not necessarily be used for children and adolescents. The meeting asked whether it was possible to balance the call for unearmarked funding with the perceived need for targeted funding.

68. Speakers said age-of-consent restrictions were limiting access to health services and putting adolescents at risk. They called for the greater involvement of children and adolescents in HIV programmes and said social media could be used more effectively to reach them with information.

69. In reply, the panelists agreed that the necessary commodities had to be available for children. They appealed to donors to coordinate their efforts and target the biggest HIV funding gaps for children. They also urged greater efforts to remove structural and societal hindrances. Regarding the question about earmarked funding, speakers stressed the need to protect and prioritize funding for paediatric and adolescent HIV services. They also highlighted the huge need for African-based pharmaceutical manufacturing and for ensuring early access to new technologies.

Conclusion

70. **Lucy Wanjiku Njenga**, Executive Director, Positive Young Women Voices, Kenya, recalled the high rates of AIDS-related deaths among adolescents and young people in Kenya in the 1990s and early 2000s, which had led to the creation of many new HIV organizations and initiatives. She emphasized that programmes had to reach adolescents before they acquired HIV, intimate partner violence had to be reduced, stronger awareness about the epidemic was needed, and U=U had to be promoted more widely. Ms Njenga called for increased investment, including for peer support systems and community-led organizations.

71. **Christine Stegling**, Deputy Executive Director for Policy, Advocacy and Knowledge at the UNAIDS Secretariat, thanked the panelists and participants. She said the global HIV response had come far but progress was stalling for children and adolescents, with sub-Saharan Africa still bearing a disproportionate burden of vertical transmission.

72. Ms Stegling noted the remarks and advice about which interventions funders should prioritize and agreed that ending paediatric AIDS must be a bigger priority. She also noted the emphasis on a multisectoral approach and on multilayered, long-term interventions, as well as the reminders that services and programmes had to reflect the fact that children and adolescents are constantly changing as they grow older. Recalling the remark that people do not leave HIV care, but are bullied out of it, she deplored that stigma remained such a huge hindrance.

73. It was important to translate the discussions into concrete action, she urged. That could be done by strengthening existing partnerships and forging new collaborations (especially with the faith sector); mobilizing new resources for the HIV response with regards to children and adolescents (and protect the existing funding); and doing more to remove the underlying inequalities, she suggested. Overall, it was

clear that communities had to be in the lead, she added. Speakers had vividly shown the power of community-led work, including peer support activities. In closing, Ms Stegling thanked the moderators and organizers and called for renewed urgency and commitment to ending AIDS in children.

Proposed decision points

The Programme Coordinating Board is invited to

74. *Note with concern* that there were still 120,000 new HIV infections in children in 2023, particularly in Sub-Saharan Africa; 600 000 children (aged 0-14) living with HIV are currently not on HIV treatment; ; that more than one third (36%), or 370 000, of older adolescents aged 15–19 years living with HIV are not receiving antiretroviral therapy; that children accounted for 12% of all AIDS-related deaths, even though they constitute only 3% of people living with HIV; and that children and adolescents are much less likely to be virally suppressed compared to adults due to inadequate services and support;

75. *Take note* of the background note (UNAIDS/PCB (55)/24.34) and the summary report (UNAIDS/PCB (56)/25.5) of the Programme Coordinating Board thematic segment on “Addressing inequalities in children and adolescents to End AIDS by 2030”;

76. *Request* Member States, in close collaboration with community-led HIV organizations and other relevant civil society organizations and partners, with the support of the Joint Programme, to fast-track targeted and measurable actions towards the 2030 targets for children:

    a. Scale up high quality, integrated, person-centered, HIV prevention and treatment interventions for pregnant and breast-feeding women, children and adolescents including through community-led service delivery models within primary health care and community settings;

    b. Implement context-determined, evidence-based case finding strategies to identify undiagnosed children and adolescents living with HIV and ensure their timely initiation, as well as retention, on treatment;

    c. Further support communities to lead, including community-led and youth-led HIV organizations and particularly relevant civil society organizations of adolescent girls and young women, key populations and people living with HIV, by strengthening their representation at all levels where financial and programming decisions are made;

    d. Strengthen health information systems to collect cohort data that tracks mother-baby pairs, children living with HIV, high-risk groups such as adolescent parents and the children of members of key populations, increase the use of programme data analyses that allow for identifying the causes of new HIV infections among infants, and utilize those data to guide effective and sustainable programme design and drive funding to where it is most needed;

    e. Increase targeted investments in ending AIDS among children and adolescents for a response that is sustainable and planned beyond 2030;

[End of document]