

FOLLOW-UP TO THE THEMATIC SEGMENT FROM THE 45TH PROGRAMME COORDINATING BOARD MEETING

Additional documents for this item: UNAIDS/PCB (45)/19.35; UNAIDS/PCB (45)/19.36; UNAIDS/PCB (45)/CRP3

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

See the decisions in paragraphs:

104. *Take note* of the background note (UNAIDS/PCB (45)/19.36) and the summary report of the Programme Coordinating Board thematic segment on the impact of AIDS on children and youth (UNAIDS/PCB (47)/20.27);
105. *Ensure* that the next UNAIDS Strategy beyond 2021 contains a focus on the critical gaps in the HIV response for children, adolescents and youth;
106. *Call on Member States to:*
 - a. Prevent new vertical (mother-to-child) HIV infection by ensuring delivery of optimal services for pregnant and breast-feeding women;
 - b. Close the gaps in HIV diagnosis, treatment and viral load suppression for infants, children, adolescents and pregnant women living with HIV through the use of differentiated and community service delivery models;
 - c. Optimize service delivery for children, adolescents and youth by using data to identify the gaps in HIV diagnosis, prevention and treatment; increasing the quality and access to age-appropriate and evidence-informed diagnosis, prevention, treatment, and social protection services; and engaging affected communities in all parts of service design and delivery;
 - d. Accelerate their collaboration with the UNAIDS Joint Programme and other key partners (Global Fund, PEPFAR and others) to address structural factors that increase the vulnerability to HIV of adolescent girls and young women and young key populations; and
 - e. Review the annual UBRAF results reporting on progress made towards reducing new HIV infections and the impact of AIDS on children, adolescents, and young people.

Cost implications for the implementation of the decisions: none

INTRODUCTION

1. The Chair of the UNAIDS Programme Coordinating Board (PCB), introduced the Thematic Segment on children and youth by reminding the meeting that 2019 marked the 30th anniversary on the Convention of the Rights of the Child.
2. Chewe Luo, HIV Section Chief and Associate Director, UNICEF moderated the thematic segment. She said the reductions in new HIV infections among children (which were steeper than among adults) showed that success was possible. Even though the pace of the decline was slowing, important lessons were being learnt.
3. Too many children were still acquiring HIV, she said, and too many of them remained undiagnosed and were not on HIV treatment. There were still too many new infections among adolescent girls. Current approaches were not working everyone, Ms Luo noted, partly because of structural barriers.
4. Winnie Byanyima, Executive Director of UNAIDS, reminded the PCB that the Convention of the Rights of the Child applied to all children, including adolescent girls and key populations.
5. New infections among children were declining, but there were still 160 000 new infections among children aged 0–14 years in 2018, and 300 children living with HIV died each day, she said. Systems were failing to reach all pregnant mothers living with HIV and they were not protecting them against infection during pregnancy and breastfeeding.
6. Part of the problem, Ms Byanyima said, was that many women struggled to stay on antiretroviral therapy. Social and structural barriers were often the cause, including poverty, gender-based violence and other human rights violations. These had to be addressed.
7. Services were not diagnosing and treating children living with HIV. Of the estimated 1.7 million children (0–14 years) living with HIV in 2018, almost half did not receive treatment. Even when diagnosed and on treatment, children often have poorer health outcomes than adults.
8. Large numbers of young women were acquiring HIV infection, she added: 3 in 4 adolescents (10–19 years) who acquired HIV in sub-Saharan Africa in 2018 were girls. Their vulnerability was due to gender inequality and inequity, gender-based violence and because HIV prevention and sexual and reproductive health services were not reaching them.
9. Young people also accounted for a large number of new infections among key populations, largely due to stigma, discrimination and criminalization. It' was not good enough to have services in place and assume that people would use them. People's rights had to be upheld, Ms Byanyima told the meeting. Parental consent laws that block access to reproductive services and supplies should be removed or reformed. Children should remain in school and should receive comprehensive sexuality education. The tools for doing all this existed, but they must be taken to scale and the barriers must be removed.
10. The meeting then heard a recorded message from Henrietta Fore, Executive Director of UNICEF. She said the Thematic Segment came at a critical time. Large numbers of children were dying due to lack of access to services and new HIV infections were

declining too slowly to end the AIDS epidemic by 2030. She appealed to countries to work together more effectively to close the gaps for everyone.

11. A young woman living with HIV from HONDURAS shared her experiences of growing up with HIV, including her struggles to obtain HIV treatment and experiences of stigma and discrimination. Widespread misconceptions about HIV transmission persisted, she said.
12. The programme she participated in focused on building awareness and knowledge about HIV in communities to reduce stigma and discrimination. It was important to involve young people, especially those living with HIV, because they knew how to communicate with their peers, she said.
13. Stigma and discrimination remained huge problems, though. Ms Ramirez said she was afraid someone at her university would discover that she was HIV-positive; she had not disclosed her HIV status to her friends yet, because she did not feel safe doing so in her country. Although a law existed to protect people living with HIV, it was not enforced properly, she told the PCB. People also experienced problems with confidentiality in medical institutions. Access to HIV medicines and tests had improved hugely, she said, but discrimination continued.
14. Shannon Hader, Deputy Executive Director, Programme, at UNAIDS, introduced the overview session. She said that coverage of programmes to prevent vertical transmission had increased dramatically since 2010. However, progress was uneven and it had stalled in the past couple of years.
15. Eastern and southern Africa had scaled up coverage of these programmes to 92%, but coverage was much lower (59%) in western and central Africa. Fewer children were acquiring HIV during pregnancy and breast-feeding, but the 160 000 new infections in 2018 were four times the target of 40 000. Every new paediatric infection was a failure of the system to deliver the services needed, she said.
16. Different programmes were struggling with different issues, Ms Hader said, but there were three main reasons why new paediatric HIV infections occurred: pregnant women were not accessing services; they were falling out of care; or women were acquiring HIV during pregnancy or breast feeding. Programmes had to identify who the "missed" women were and how to provide them with the services they needed.
17. Children who were exposed to HIV or newly infected were not being diagnosed early enough. Testing coverage at 8 weeks was still very low and only identified children who had been infected during pregnancy (not breastfeeding), Ms Hader noted. Finding and testing all HIV-exposed infants, including those exposed to HIV during breastfeeding, was a priority.
18. Globally approximately 700 000 children (0–14 years) were not receiving antiretroviral therapy in 2018. Treatment coverage had increased, but not as quickly as needed. It also varied widely. Coverage was especially low in western and central Africa (28% compared with the global average of 54% and with 62% coverage in eastern and southern Africa).
19. In addition, children accessing treatment were not benefitting fully: their rates of viral load suppression were not as high as for adults. This was partly due to the use of suboptimal antiretroviral medicines. Improved paediatric antiretroviral options were a necessity, Ms Hader insisted. Partnerships had been created to speed up the

development and introduction of improved paediatric antiretrovirals; these would hopefully soon show results.

20. Ms Hader then discussed possible "game changers". Programme improvements should focus on areas where new infections were occurring, she said. Case-finding should improve so children living with HIV were diagnosed and put on treatment quickly (including through improved early infant diagnosis, scaled-up point-of-care testing technologies etc.). The best-possible HIV treatment should be provided throughout. Community-centred, decentralized, differentiated services models should be used, and they should include education and actions to reduce stigma and discrimination.
21. Among young women, Ms Hader continued, new HIV infections were declining more quickly than among older women, but there were still more than 6000 new infections each week among women aged 15-24. She reminded the meeting that the epidemic varied across settings and time: in Africa, young women were at highest risk, whereas in Indonesia, for example, young men in key populations had a higher risk of acquiring HIV infection.
22. This meant that programmes had to use approaches that were appropriate for their settings and they had to deliver services that young people wanted—which was why community-led interventions were so important, she said.
23. It was equally important to address the structural factors (including changing parental consent requirements, reducing gender-based violence, and ensuring access to sexual and reproductive health services and to education). Another "game changer", she said, was wider adoption of innovations such as pre-exposure prophylaxis and self-testing for adolescents and young people at high risk of HIV infection.
24. Ren Minghui, Assistant Director-General at the World Health Organization, focused on six ways to reach the paediatric and adolescent treatment targets: eliminate new paediatric infections; quicker and better-targeted diagnosis; improved antiretroviral drugs; strengthened differentiated care; stronger primary prevention; and dealing with structural factors.
25. HIV testing had to occur throughout pregnancy and women who tested HIV-positive had to receive and stay on the best-possible treatment. Infant diagnosis should not be a "one-off" event, he said. Quicker diagnosis was needed, using new testing technologies (including at relevant entry points, e.g. tuberculosis clinics), and family-based index case testing had to be promoted, along with HIV self-testing for adolescents.
26. Children found to be living with HIV should receive the best-quality treatment and care, Mr Minghui continued. This called for treatment monitoring and support for adherence; provision of optimal antiretroviral regimens for different age groups; and preventing and treatment diseases associated with HIV (e.g. TB).
27. Services had to be tailored for different age groups and communities, he said, and the intended beneficiaries had to be engaged in designing the services. "One-size-fits-all approaches" did not work, he emphasized. The specific needs of children and adolescents had to be addressed, and this was best achieved by drawing on community leadership and knowledge.
28. New infections could be prevented bringing together biomedical, behavioural and structural approaches. HIV primary prevention packages were vital, including

comprehensive sexuality education, pre-exposure prophylaxis and condoms, voluntary medical male circumcision, and eliminating stigma and discrimination.

29. Structural barriers, many of which also block Universal Health Coverage, had to be removed, Mr Minghui said in conclusion. They included gender inequalities, sexual and gender-based violence, laws that hinder access to services (e.g. parental consent laws), poverty and limited educational opportunities.

PANEL 1: PREVENTING NEW HIV INFECTIONS AND FINDING CHILDREN, ADOLESCENTS AND YOUNG PEOPLE LIVING WITH HIV

30. The first panel discussion focused on identifying priority actions and “game-changers” that would enable countries to improve the prevention of mother-to-child transmission (PMTCT) of HIV, prevent new HIV infections in adolescents and young people, including among key populations, and diagnose infants, children, adolescents and youth living with HIV to ensure timely initiation of treatment.
31. Angela Mushavi, National PMTCT and Paediatric HIV Care and Treatment Coordinator at Zimbabwe's Ministry of Health and Child Care, told the meeting that her country had achieved high coverage of PMTCT services, but that rates of vertical transmission of HIV were higher than expected. The country was using "stacked bar" analysis to identify gaps with greater precision and finetune its programmes, she said.
32. This method showed that new infections in children were due mainly to three factors. Some pregnant women living with HIV were not receiving antiretroviral therapy (they did not come into antenatal care, or were not linked to treatment services), or they interrupted their treatment. Service coverage was high but that did not necessarily mean the women remained in care. New HIV infections during pregnancy and lactation were a third contributing factor.
33. Ms Mushavi said interventions had to be scaled up and the quality of people's interactions with clinics had to improve. Clinics and communities need to work together. Pre-exposure prophylaxis could be used more effectively, as well, and couples counselling and testing had to be scaled up. The last mile was turning out to be the hardest, she said.
34. The moderator, Ms Luo, summarized the presentation. She noted the progress made in adult treatment programmes and in preventing vertical transmission, partly due to decentralized services and to quicker and more effective linkages from testing to treatment and care. However, when it came to treatment for children, progress was much slower, she said.
35. The moderator then introduced Jennifer Cohn, Senior Director for Innovation at the Elizabeth Glazer Pediatric AIDS Foundation (EGPAF), which is piloting point-of-care HIV testing for children with same-day linkage to treatment.
36. Ms Cohn said major barriers existed along the testing, treatment and care cascade. Testing rates among infants were very low and linkage to treatment was poor, due to a variety of factors. EGPAF's data show that, even when HIV-exposed children were tested at 6 weeks, only 19% of them received their test results within the WHO-recommended period and a small percentage of those children were started on treatment within 60 days.
37. Point-of-care testing and treatment could dramatically improve the situation, she said, as shown in several countries in sub-Saharan Africa. The percentage of children

diagnosed with HIV infection who started antiretroviral therapy within 60 days increased from 41% to over 93%, Ms Cohn told the PCB. This was a sustainable intervention which was being implemented across 9 countries, and it could be scaled up, she said. She described some implementation details, including the use of task-shifting to trained nurses, which had proved cost-effective.

38. Ms Cohn predicted that improved paediatric antiretroviral formulations would be available in the next few years but stressed the need to ensure sustainable access as soon as they become available. Tools for supporting viral load suppression were important, she added. Point-of-care viral load testing could provide rapid information and facilitate same-day, life-saving treatment decisions. Political, programmatic and financial commitments were needed to seize these opportunities, she said.
39. The Moderator introduced Doan Thanh Tung, director of the Lighthouse Social Enterprise in Viet Nam, and a young LGBT and HIV activist. Mr Tung noted that young key populations were at the centre of the epidemic in Asia and the Pacific. It was important to engage them in the entire process of programme design, implementation, monitoring and documentation. To succeed, programmes had to understand the communities they were meant to serve—including where, how and from whom people wanted to receive services.
40. Integrated services would encourage people to use HIV services, he said, and it was important for people to feel safe when approached. Services could be incorporated into community events, and at bars and saunas, for example. Lighthouse also operated an online platform providing information and counselling, where people can register for services or be referred to other services. Services had to meet people's different needs: one size did not fit all, Mr Tung said.
41. Macanjana Motsa, from the Ministry of Education and Training in Eswatini, told the meeting that her country had taken several steps to make it easier for girls to remain in school—including free primary education in grades 1 and 2, mechanisms to reduce violence, provision of sanitary products to girls, and processes for reintegrating young mothers into the school system. Students could report cases of violence on a toll-free line or at schools, she said, and school chiefs were obliged to investigate reported cases and report the findings to regional educational directors.
42. Ms Motsa said Eswatini had integrated comprehensive sexuality education into school curricula. Comprehensive sexual education was being offered in grades 8–12 and was evidence-based, while taking local culture into account, which emphasized abstinence until marriage. Puberty and menstruation were discussed in the curriculum. Pregnancy rates among school-age girls appear to have declined. However, since comprehensive sexuality education was not an exam subject, examinable, teachers tended to focus less effort and time on comprehensive sexual education, she noted.
43. The Moderator opened the discussion for remarks from the floor.
44. Speakers thanked the panellists and presenters, and noted that the presentations and the background paper highlighted the many ways in which countries and programmes were failing children, adolescents and women.
45. The meeting was reminded that children and youth were still among the most vulnerable in the HIV epidemic, with high infection rates persisting among young women and girls and among key populations. HIV infection remained the single-biggest cause of death for women aged 15–49 years. There were calls for more candid

discussion about children younger than 15 years of age who were living with HIV and who comprised a significant percentage of AIDS-related deaths.

46. Improvements required several forms of action, members said: differentiation, integration, innovation (of drugs and diagnostics), and engagement (placing children and adolescents at the centre of the response).
47. They emphasized approaches that address societal, economic and structural barriers, and reduce gender inequalities and gender-based violence. The solutions were not simple, which was why affected populations had to guide the approaches. The impact of social protection programmes was highlighted, including school feeding schemes, cash transfers programmes and education subsidies.
48. Speakers said that all young people must receive comprehensive sexuality education. They reminded the meeting that UN guidance on sexuality education includes abstinence, but that young people have made it clear that they also needed to be educated on other important issues related to sexuality.
49. All women, including young women, must have access to sexual and reproductive health services, speakers urged. This required removing discriminatory laws, including parental consent laws, and expanding community-based services. Age of consent was singled out as a substantial barrier in some countries, with about 45 countries maintaining laws requiring parental consent for HIV testing, for example. Financial barriers to service use also had to be removed.
50. Members were reminded that high HIV incidence rates among adolescent girls and young women were partly due to strategies missing many men who were living with HIV. Those men were not diagnosed and linked to treatment, and therefore continued to transmit the virus. If more men knew they were living with HIV and received and stayed on treatment, women would not be as vulnerable to infection.
51. The meeting was warned against unrealistic hopes that paediatric HIV would end soon: there was unfinished business requiring urgent action. Speakers emphasized the need to diagnose infants and young children living with HIV and to link them rapidly to treatment and care. They called on the international community to join forces to fast-track access to optimal antiretroviral medicines for children.
52. Speakers shared evidence of the impact of point-of-care testing technologies and called on countries to introduce these innovations more widely. Despite the evidence, they said, the pace of adoption of these technologies was stalling. Speakers called on UNAIDS to address the issue in its next strategy.
53. Infant diagnosis was not a one-time event and had to extend to the end of the breast-feeding period, speakers noted. Testing strategies needed to include index family testing and other targeted approaches, including testing children who presented with illnesses.
54. Existing guidelines were very clear on these matters, speakers said, and should be reflected in the concept notes which countries present to the Global Fund. They noted with concern that the antiretroviral drug Nevirapine had not been recommended for several years and was meant to be phased out, yet some programmes were still providing it. Guidelines and commitments had to be translated into action at all levels of the system, speakers said.

55. Some Members (e.g. Brazil, Japan, Mexico, Russian Federation) shared information about their respective national or community-led programmes.

PANEL 2: RETAINING CHILDREN AND YOUNG PEOPLE IN TREATMENT AND CARE

56. This panel discussed how to introduce and scale-up programmes that retain children, adolescents and young people in HIV treatment and care, and that improve health outcomes.
57. Job Odoyance Akuno, programme manager at *Jielimishe Uzazi na Afya* in Kenya, discussed his experiences helping young people remain in care. He described the programme, which was aimed supporting adolescents and young women who have difficulties navigating the health-care system.
58. It provided adolescent girls with needs-based assessments and developed individual plans so they could access the particular services they needed (e.g. appointment-keeping plans). An important lesson, he said, was that health-care workers had to be more responsive to the needs of adolescents.
59. The programme attempted to assist women and girls in overcoming barriers at the individual, household and community levels, e.g. service referrals and by escorting women to appointments. It was important to work with households and schools, as well as with individuals, he said. Women and girls received support to remain in or return to school, for example. Cash transfer support also helped young mothers remain or return to school, by enabling them to pay for day-care services.
60. The active engagement of adolescents in the design of the programme had proved very important. It had highlighted, for example, the impact of stigma (including within households) and the need to involve male partners in positive ways. Creating supportive environments in households was crucial, Mr Akuno said.
61. Eleanor Namusoke-Magongo, Coordinator of Paediatric and Adolescent HIV Care & Treatment in Uganda's Ministry of Health, shared some lessons learnt for improving children's access to antiretroviral therapy. She said Uganda had revised its paediatric treatment guidelines, and had carried out accurate forecasting and put in place mechanisms to ensure the required drugs were procured and distributed.
62. The Ministry of Health had also strengthened the capacities of health-care providers, including for using monitoring tools (which are essential for reporting to donor partners and future planning). A dashboard had been developed, which was updated every week, and a core team in the Ministry met once a week to review the optimizing process and to report and discuss challenges, she explained.
63. Dolutegravir was now the preferred antiretroviral drug, a decision which had required engaging the drug regulatory system (to speed up approval) and performance of active pharmacovigilance. The latter was done at selected facilities and their experiences were then used to guide the roll-out to other facilities. Ms Namusoke-Magongo said Uganda had developed an advanced care package, which included treatment for tuberculosis, malaria and other bacterial infections. This was being rolled out across the country, including through a 100-day campaign.
64. It was also important to integrate HIV-related services with routine childhood services, for example immunization. A next step was to ensure that those services were also included at HIV clinics. The aim was to provide "one-stop-shop" services or, where that was not possible, to ensure strong linkages and referral pathways. Ms Namusoke-

Magongo also stressed the importance of strong political will and called on pharmaceutical corporations to support pharmacovigilance programmes.

65. The Moderator handed the floor to Father Rick Bauer, who told the PCB that strong retention in care for children required comprehensive, holistic services. Viral load suppression levels for children were much lower than for adults, he noted.
66. He described an example of such a holistic service, which involved a complete assessment (including for nutrition) by a nurse, as well as screening of the entire family for mental health issues, gender-based violence and abuse. Social work staff conducted interviews to understand the needs of children and to provide appropriate psychosocial support. The support took many forms, he said, including day-long activities, peer support, participation in Whatsapp groups, weekly meetings, and home visits by an assigned community health worker. Electronic medical records were kept. The data were important, but ultimately it was the holistic care, treatment and support that made the difference.
67. In his presentation, Aaron Zea, from the Network of Young People Living with HIV, Latin America and the Caribbean, focused on the value of youth-friendly services.
68. Young people had to be heard and involved, he said, but it was important to recognize that today's generation of youth saw HIV as a "thing of the past". Youth were preoccupied with other issues and concerns, yet health-care systems did not seem to factor that into their services, he said. The language and terminology used by doctors and nurses, for example, felt alien to youth, and issues of sexuality were not discussed openly enough.
69. Stigma and discrimination were ongoing concerns, Mr Zea added, as was the momentum of conservative and religious movements in many countries and their impact on public health policies, including access to accurate sexuality education.
70. Hu Yiyun, Director of the Division of Exchange and Cooperation at China's National Center for AIDS/ STD Control and Prevention, described a programme for reaching out to college and university students, which he was involved in.
71. An important feature was the strong collaboration among relevant government sectors, which is where the necessary resources were located. Thus the National Commissions on Health and on Education worked jointly to strengthen HIV prevention in schools. There was also a focus on strengthening scientific planning and technical support, with sectors working together to develop tailored plans based on local epidemic contexts.
72. Practical changes were introduced, he said. The layout of testing clinics was changed and improved, and rapid testing kits and services were provided in colleges and at health services. A national knowledge strengthening programme was implemented at over 7000 universities, with booklets distributed in hard copy and online, while HIV prevention courses were introduced at some institutions. Student associations were involved and were being supported to provide education about sexual health. More than 500 student associations were involved and were training peer educators.
73. Dr Yiyun added, however, that it was proving more difficult to strengthen HIV prevention outside of campuses. Given the limited reach of traditional media among youth, computer and mobile phone apps, social media platforms, and internet and video games were being used. In summary, he said China had set up a government-led prevention system, which was helping contain HIV transmission among students. It was keen to share its experience and to learn from the experiences of other countries.

74. The Moderator invited comments from the floor.
75. Speakers urged PCB members to face up to the fact that large numbers of children younger than 15 years were living with HIV, and that health-care systems continued to fail many women and children.
76. Members stressed that it was important to base decisions and strategies on the actual needs of communities and to involve them in designing and implementing programmes. This was especially important for overcoming stigma and discrimination and to reach marginalized populations, such as migrants. Some speakers described how they had introduced differentiated programmes in such a manner.
77. Speakers underscored the need for wider use of point-of-care HIV diagnostics for infants and for age-appropriate, optimal antiretroviral regimens for children. They noted the need for coordinated national and local approaches, training of health-care workers, and monitoring to identify gaps. An accelerated response needed strong, smart collaboration between key stakeholders, they emphasized.

INTERACTIVE DIALOGUE: SCALING UP INTERVENTIONS TO ADDRESS STRUCTURAL BARRIERS AND TO HELP CHILDREN, ADOLESCENTS AND YOUNG PEOPLE THRIVE

78. Jayathama Wickramanayake, UN Secretary-General's Envoy on Youth, addressed the PCB via video message. She said young people demanded change and accountability. The HIV response among adolescents and young people had lagged consistently, with women and girls and young key populations especially affected. Changing this required adjusting programmes to the needs of young people and engaging them in decision-making—not to "tick the box", but to draw on their experience and expertise.
79. Around the world, young people were proving they can be crucial partners, leaders and implementers of the HIV response, Ms Wickramanayake said. Comprehensive youth programmes that addressed multiple Sustainable Development Goals (SDGs) were important and had to be mainstreamed. Digital technologies had to be used to reach young people and harmful norms had to be confronted and changed. She reminded the meeting that the AIDS movement had always been about social justice and said the UN was committed to a world where everyone's human rights and potentials were realized.
80. The Moderator then introduced the final panel, which focused on ways to overcome some of the challenges identified in the earlier panel discussions.
81. Lucie Cluver, Professor of Child and Family Social Work at the University of Cape Town, said that providing antiretroviral therapy to adolescents living with HIV was essential but not enough. A range of other needs and capacities also had to be addressed, most of which were part of the SDGs.
82. She said data from a major, four-year study done at 72 clinics showed that large percentages of adolescents who had been linked to HIV treatment programmes failed to remain on antiretroviral therapy for the first year. By year four, only 35% were still adhering to antiretroviral therapy. Adolescent mothers living with HIV faced even bigger challenges, according to the study, including having poor knowledge of safe conception. In the study, 11% of them had an HIV-positive child, 25% had defaulted on antiretroviral therapy, 16% had not taking antiretrovirals during pregnancy or breastfeeding and 48% had a detectable viral load.

83. To understand those realities, Ms Cluver explained, researchers examined salient clinic-level factors, which they grouped into five categories (and nicknamed "STACK"): were the clinics stocked with medications; did staff allot enough time to teens during consultations; were women accompanied to clinics; did they have cash for transport to clinics; and were staff kind and considerate.
84. When all five needs were met, Ms Cluver said, levels of retention in care rose to 70%, compared with only 3% when none of the factors was met. She pointed out that two of the factors were external to clinics.
85. Study findings also showed that combinations of peer and parenting support, and food support increased treatment adherence to 82% (compared with 46% when no such support was available). Violence perpetrated by parents, teachers or at clinics also dramatically affected antiretroviral therapy adherence, the meeting was told. Similarly, for HIV prevention among adolescent girls, incidence rates declined steeply if the girls were protecting from violence, could access school subsidies, had supportive parenting and received HIV education.
86. HIV should not be seen as a stand-alone issue or objective, Ms Cluver emphasized. Well-planned HIV interventions interacted powerfully with actions aimed at other SDG priorities (e.g. reduced violence, improved nutrition and educational achievement). This fitted with the idea of "development accelerators". Studies had identified three such "accelerators": cash transfers, parenting support and safe schools (without violence). Each was associated with a range of other desirable outcomes; when combined, the effects were magnified across seven SDG targets, she said.
87. Legee Tamir, a law student who works with Youth LEAD in Mongola, highlighted the importance of nongovernmental organizations for engaging and supporting young people in HIV responses. She said young people needed safe spaces and needed protection from stigma, discrimination and violence. She support the activities her organization provided to meet those needs, including training, peer education, mentoring and coaching.
88. Asked whether her organization had encountered legal or policy constraints, Ms Tamir said such restrictions were affecting the delivery of certain services. Age of consent requirements were a hindrance, including for HIV testing. Access to comprehensive sexuality education was difficult, especially for youth in rural areas, she said.
89. Ousmane Diaby, Director International Cooperation in Cameroon's Ministry of Health, discussed his country's decision to remove user fees. He said programme data had indicated that user fees were hindering people from remaining in care and benefiting from antiretroviral therapy. The Government decided to reduce user fees, with women and children targeted in the first phase. Antiretroviral drugs were being provided free of charge, but the Government also wanted to remove any other financial obstacles for people living with HIV, he explained.
90. Stakeholders, including UNAIDS and USAID, assisted in costing the removal of user fees and in lobbying for the necessary funding. The removal of user fees was credited with increasing diagnoses among women living with HIV and with improvements in linking them to treatment and care services. Challenges remained, however. The Government was working with stakeholders to determine whether the new policies were working entirely as intended and whether coverage was sufficient.
91. Michelle Madamombe, a teenage DREAMS Ambassador in Zimbabwe, told the meeting that her parents had died when she was very young and that her relatives had

seized the family's assets, leaving her in dire straits. Her life changed, she said, when the DREAMS programme was implemented at her high school, providing girls with a range of guidance, counselling and other support. DREAMS also paid her school and exam fees, enabling her to successfully complete high school. She was now a trained out-of-school club facilitator and had started a small business to finance her university education.

92. Ms Madamombe said interventions had to occur at three levels to support teenage girls: in-school, out-of-school and in communities. Gender-based violence, for example, affected girls in all those settings and had to be tackled in all of them.
93. In schools, teachers needed training so that they could provide comprehensive sexual education with an emphasis on HIV and violence. Similarly, girls needed safe spaces in their communities where they could share their experiences, receive information and support, and be linked to services (e.g. for economic empowerment activities and training). Girls who ran their own businesses or had paid work, she said, were less reliant on intergenerational relationships which often lead to abuse.
94. Ms Madamombe described specific activities that were being introduced to deliver family planning information and services to adolescent girls, confront harmful norms in the community, reduce gender-based violence and promote positive parenting.
95. In discussion from the floor, speakers thanked the panellists for sharing their experiences and for their courage. They reiterated the need to remove barriers and make it much easier for young people to get the information and services they needed and wanted, including sexual and reproductive health and rights services. This entailed also confronting the community and other norms that disempowered young people, speakers said.
96. Young people had to be engaged in real and meaningful ways; there was no room for tokenism, they said. This also required providing funding support to youth movements so that they can conduct meaningful activities.
97. Some members described steps they were taking to improve the access of adolescents to health-care services. In Namibia, for example, the age of consent for adolescents to access confidential HIV testing without the consent of their parent or guardian to ensure independent access to services and timely initiation to ART for those newly infected. Adolescents diagnosed with HIV receive continuous support, including psychosocial counselling, in addition to ART. Participants also emphasized the need to tailor services for the specific needs of different age groups and settings. In Mexico, for example, women living with HIV could access transport subsidies for their clinic visits, which had increased retention rates by 52%. Another programme paid impoverished young people a stipend while they attended skills-building training. These experiences showed the importance of linking HIV and health interventions to other forms of support, such as food, housing and jobs training.
98. Speakers emphasized the need to think and act holistically, and to "layer" services and support. Some recalled the origins of the DREAMS programme as a multifaceted undertaking, with HIV as one impact indicator, and described how it had grown into the multicountry programme with major impact (including big declines in HIV incidence among adolescent girls and young women). The challenge was to scale up this kind of programme even further. A comparatively modest investment was having a huge impact, the meeting was told.

99. The importance of gender inequality was highlighted, along with the need for comprehensive sexuality education and for sexual and reproductive health and rights services. Women and girls had to be able to choose whether, when and with whom to have children, speakers insisted.
100. The meeting was also updated about recommendations made by a WHO-convened advisory group of women living with HIV. The recommendations included strengthening a robust research agenda on paediatric HIV; prioritizing tailored interventions for young key populations and linking them with policy interventions; building critical awareness of gender and power dynamics; linking HIV services with other health services (e.g. mental health and sexual and reproductive health and rights); and recognizing that community engagement was crucial for unlocking the potentials of biomedical and other interventions.

SUMMARY AND CONCLUSION

101. Ms Hader concluded the session and thanked the Moderator, the PCB and the panellists for the insightful and powerful session. UNAIDS was looking at ways to build the kinds of "layered" interventions mentioned during the session into its next strategy, she said.
102. Thanking the young participants for sharing their experiences and knowledge, Ms Hader said she hoped to see their knowledge and solutions turned into policies and political actions. She assured the meeting that the Joint Programme was committed to help countries make those efforts and that it would redouble its efforts to uphold the rights of the child and help young people thrive.
103. The PCB Chair closed the Thematic Segment of the 45th PCB meeting.

DECISION POINTS

The PCB is invited to:

104. *Take note* of the background note (UNAIDS/PCB (45)/19.36) and the summary report of the Programme Coordinating Board thematic segment on the impact of AIDS on children and youth (UNAIDS/PCB (47)/20.27);
105. *Ensure* that the next UNAIDS Strategy beyond 2021 contains a focus on the critical gaps in the HIV response for children, adolescents and youth;
106. *Call* on Member States to:
 - a. Prevent new vertical (mother-to-child) HIV infection by ensuring delivery of optimal services for pregnant and breast-feeding women;
 - b. Close the gaps in HIV diagnosis, treatment and viral load suppression for infants, children, adolescents and pregnant women living with HIV through the use of differentiated and community service delivery models;
 - c. Optimize service delivery for children, adolescents and youth by using data to identify the gaps in HIV diagnosis, prevention and treatment; increasing the quality and access to age-appropriate and evidence-informed diagnosis, prevention, treatment, and social protection services; and engaging affected communities in all parts of service design and delivery;

- d. Accelerate their collaboration with the UNAIDS Joint Programme and other key partners (Global Fund, PEPFAR and others) to address structural factors that increase the vulnerability to HIV of adolescent girls and young women and young key populations; and
- e. Review the annual UBRAF results reporting on progress made towards reducing new HIV infections and the impact of AIDS on children, adolescents, and young people.

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