ADVOCACY TOOLKIT

FREE TO SHINE

AFRICA UNITED AGAINST CHILDHOOD HIV

FREE TO SHINE
AFRICA UNITED AGAINST CHILDHOOD AIDS

OAFLAD
Organization of African First Ladies for Development
OPDAD
Organisation des Premières Dames d'Afrique pour le Développement

SUPPORTED BY
UNAIDS AND THE
ELIZABETH GLASER
PEDIATRIC AIDS
FOUNDATION

THE FREE TO SHINE CAMPAIGN

The Free to Shine campaign[1] is an initiative of the African Union, the Organization of African First Ladies for Development (OAFLAD) and partners to address the growing complacency in the response to childhood HIV in Africa. The campaign aims to leverage the unique engagement and advocacy of first ladies in Africa, reinforcing the political commitment of African leadership, to end childhood HIV and keep mothers healthy.

The Free to Shine campaign has three goals:

1. Reduce new HIV infections among women in their reproductive years.
2. Prevent vertical (mother-to-child transmission) of HIV.
3. Ensure that children born with HIV get treatment.

WHAT IS NEEDED NEXT TO ACCELERATE PROGRESS?

This toolkit proposes three areas for advocacy for first ladies to take the Free to Shine campaign forward, bearing in mind the specific needs of their country:

ADVOCACY FOCUS 1:

Keeping women and girls HIV-free.

ADVOCACY FOCUS 2:

Preventing vertical transmission of HIV.

ADVOCACY FOCUS 3:

Finding missing children and adolescents living with HIV and ensuring that they receive HIV services.

This toolkit shows how to take the advocacy focus areas forward, recalling international and regional commitments relevant to the Free to Shine campaign.

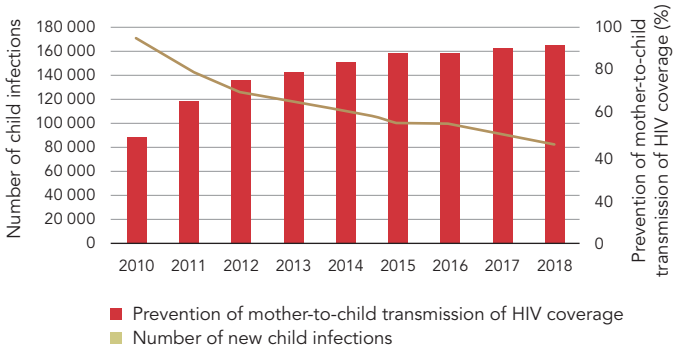
SIGNIFICANT GAINS HAVE BEEN MADE, BUT PROGRESS HAS STALLED ACROSS THE CONTINENT IN THE PAST THREE YEARS

Preventing new HIV infections and AIDS-related deaths among children, adolescent girls and women remains hugely important, and the commitment of OAFLAD, the African Union and their partners is essential to advancing this global goal.

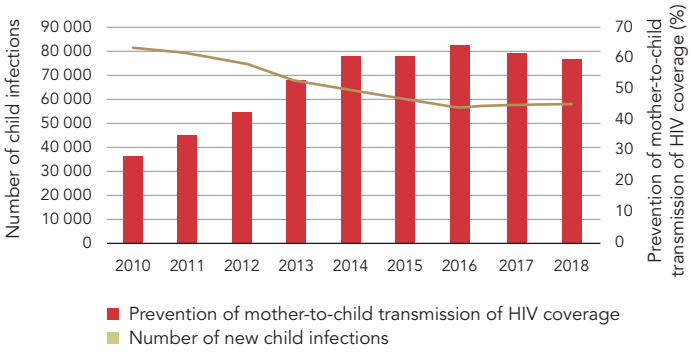
Important gains have been made in the AIDS response for women and children. An estimated 1.5 million new HIV infections among children aged 0–14 years have been averted since 2010 in Africa. The proportion of pregnant women living with HIV receiving antiretroviral therapy has increased from 44% in 2010 to 84% in 2018. Nine countries—Benin, Botswana, Burkina Faso, Malawi, Mauritius, Mozambique, Namibia, Rwanda and Zambia—have achieved the 2018 coverage target of 95% of pregnant women living with HIV on antiretroviral therapy.

However, challenges remain across Africa. Progress in preventing new HIV infections and AIDS-related deaths among children has stalled. AIDS remains the leading cause of death among women of reproductive age. Only half of all children living with HIV have access to antiretroviral therapy. Coverage of services to prevent vertical transmission of HIV has stalled in eastern and southern Africa and decreased in western and central Africa in the past three years.

Gains in preventing vertical transmission, eastern and southern Africa



Gains in preventing vertical transmission, western and central Africa



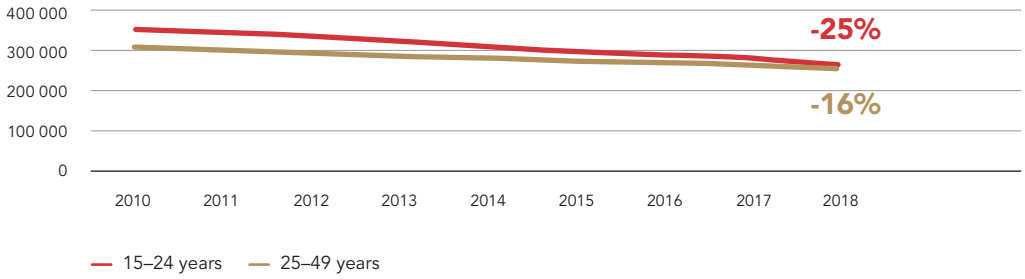
ADVOCACY FOCUS 1

KEEPING WOMEN AND GIRLS HIV-FREE

Women and girls are substantially more affected than boys and men by the HIV epidemic in Africa. There were an estimated 5100 new HIV infections among adolescent girls and young women every week on the continent in 2018. AIDS is still the leading cause of death among women of reproductive age in sub-Saharan Africa.

Progress is being made, however. The decline in new HIV infections is greater among adolescent girls and young women than among women 25 years and older—we know what works in preventing new HIV infections among adolescent girls and young women. However, the total number of new HIV infections among girls and women aged 15–24 years each year is still greater than among women in the rest of their reproductive lives (25–49 years). Every year, there are 270 000 new HIV infections among women under the age of 25 years, compared to 260 000 new HIV infections among women aged 25 years and older.

New HIV infections among women aged 15–49 years, Africa



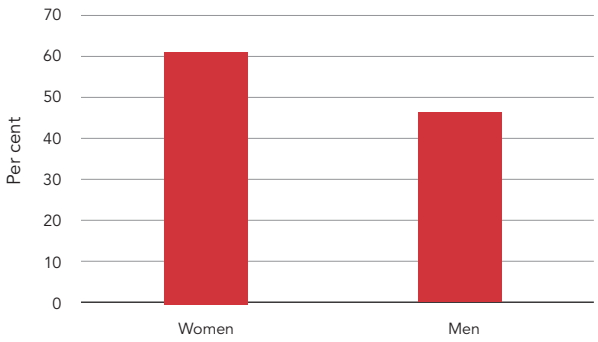
New HIV infections can be prevented among adolescent girls and young women, but it requires the right combination of interventions—these may include cash transfers, the empowerment of young women and girls and the provision of free primary and secondary education (keeping girls in school), comprehensive sexuality education, pre-exposure prophylaxis (PrEP),[2] post-exposure prophylaxis, condoms, HIV testing and treatment, and contraception and other sexual and reproductive health services. The prevention needs of young women change as they grow older. At each stage of their life, having access to the right combination of prevention options increases their ability to protect themselves from HIV.

Progress for adolescent girls and young women also requires empowering them to make their own decisions about their health. Too often they are not able to receive or use sexual and reproductive health services and need the consent of their spouse or parents to take an HIV test or access contraception. Adolescent autonomy and decision-making need to be respected, women need to be empowered and gender norms and laws need to be changed in order to improve the availability of and demand for HIV prevention services among adolescent girls and young women.

Maternal and sexual health and HIV prevention cannot be the sole responsibility of women—men also need to take action to protect themselves and their families from HIV. In Africa, men living with HIV are much less likely than women to be on treatment and virally suppressed, often because they don't know that they're HIV-positive. In some countries, the average time from infection to diagnosis is twice as long for men than women. In other countries, young men (aged 15–24 years) living with HIV are on average diagnosed more than four years after infection, compared to just one year for young women living with HIV.

Many HIV transmissions occur when people are not aware that they are living with HIV, are not on HIV treatment and are not virally suppressed. When people are on effective HIV treatment and virally suppressed (or "undetectable"), they cannot transmit HIV ("untransmittable")—known as "U = U". Men who don't know their status or who are not receiving effective treatment will continue to fall ill and die from AIDS and they can inadvertently pass on HIV to their partners in the absence of consistent condom use. Like women, men also need consistent support to encourage them to test for HIV and to receive treatment if they test positive. Men also need to know that an HIV-positive diagnosis is not a death sentence for them or for their female partners or children.

Viral load suppression among people living with HIV, Africa, 2018



KEY MESSAGES

Gains have been made, but more work is needed to prevent HIV among women and adolescent girls

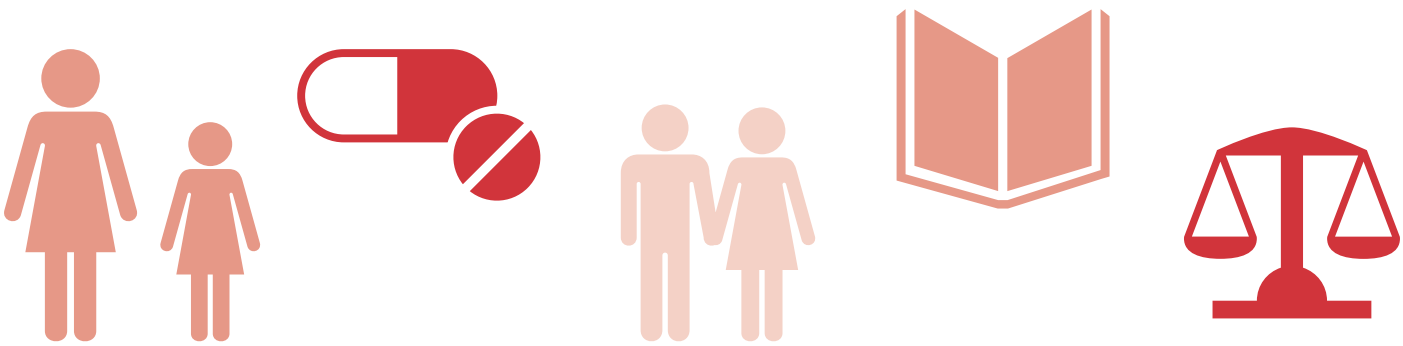
- **Women and girls must be able to access combination HIV prevention programmes. We know what works and progress is being made, but combination HIV prevention programmes are still insufficient.** Young women and girls require the right combination of programmes, including education, cash transfers, condoms, PrEP and comprehensive sexuality education. Less than half of the areas with high HIV prevalence in Africa have dedicated comprehensive HIV prevention programmes for adolescent girls and young women.
- **Social, legal and economic barriers to the health of women and adolescent girls must be lifted.** Laws and policies upholding the human rights of women and girls must be more than words on paper. It is essential to strengthen the legal and policy environment in order to protect women and girls from gender inequality and violence, which create barriers to HIV services, including laws on the age of consent for adolescent girls and young women to test for HIV.

Women and girls need knowledge and services to protect themselves from HIV

- **Free primary and secondary education must be provided. Free primary and secondary education for all young people, including young women and girls, is a game-changer.** Evidence from high-prevalence countries in Africa shows that keeping girls in school reduces their risk of HIV infection by half. The empowerment of women and girls through incentives such as cash transfers linked to school attendance is shown to reduce new HIV infections and increase the likelihood of young women and girls staying in or going back to school.
- **Women and girls must be educated about HIV prevention options and such options must be made available. Effective HIV prevention options exist for women and girls to protect themselves from HIV.** Condoms, access to PrEP and sexual and reproductive health services, including comprehensive sexuality education, empower women and girls to protect themselves from HIV. When vulnerable women and girls are fully informed of the benefit of PrEP and given access, demand for PrEP rises. In some countries where PrEP has been made available, 80% of new PrEP users are young women.
- **Age-appropriate sexuality and life skills education programmes and support for peer groups of women and girls must be provided.** Community-led groups of women and of young people have the trust of their peers and are the best way to reach vulnerable people.
- **HIV viral load among men must be suppressed in order to reduce new HIV infections among women in a sustainable way. A call to action for men is needed.** HIV prevention, testing and treatment services are needed for everyone, including men. Men need to know that their partner's HIV status is not a proxy for their HIV status. Even if their partner is HIV-negative, they might still be HIV-positive and need to take their own HIV test. Until men get tested, treated and are virally suppressed, women and children will continue to be more at risk than they need to be. Innovations such as HIV self-testing have shown promising results in reaching people who have never taken a test before, including men.

Legal barriers and gender inequality need to be addressed

- **Age of consent laws for HIV testing must be lowered for adolescents and restrictions removed for adult women.** In 38 countries in sub-Saharan Africa, girls below the age of 18 years still need consent from their parents or guardian before they can take an HIV test. Every young woman or girl has the right to look after her own health without seeking permission from her parents or guardian. The age of consent for an HIV test must be lowered to 15 years or younger. Married women should not need permission from their spouse. Parental consent laws for adolescents to access sexual and reproductive health services, including for contraception and HIV testing, prevention and treatment, are a major barrier and a threat to public health and must be removed.
- **Gender-based violence is unacceptable and must be ended.** It is essential to strengthen the legal and policy environment to protect women and girls from gender inequality and violence, which create barriers to HIV services. Adolescent girls and young women who have experienced gender-based violence are 1.6 times more likely to acquire HIV than those who have not.
- **African governments must uphold their commitment to protect women's rights and to ending AIDS by 2030.** African Union member states have made strong commitments to uphold, protect and fulfil the human rights of women and girls and to ending AIDS, including through the Sustainable Development Goals (SDGs), the United Nations General Assembly 2016 Political Declaration on Ending AIDS and several declarations of the African Union.



ADVOCACY FOCUS 2

PREVENTING VERTICAL TRANSMISSION OF HIV

Significant progress has been made in reducing paediatric HIV infections. New HIV infections among children have declined by 76% since 2010 in Africa. However, in the past two or three years progress has stalled, and we are far from reaching the global target of virtual elimination.

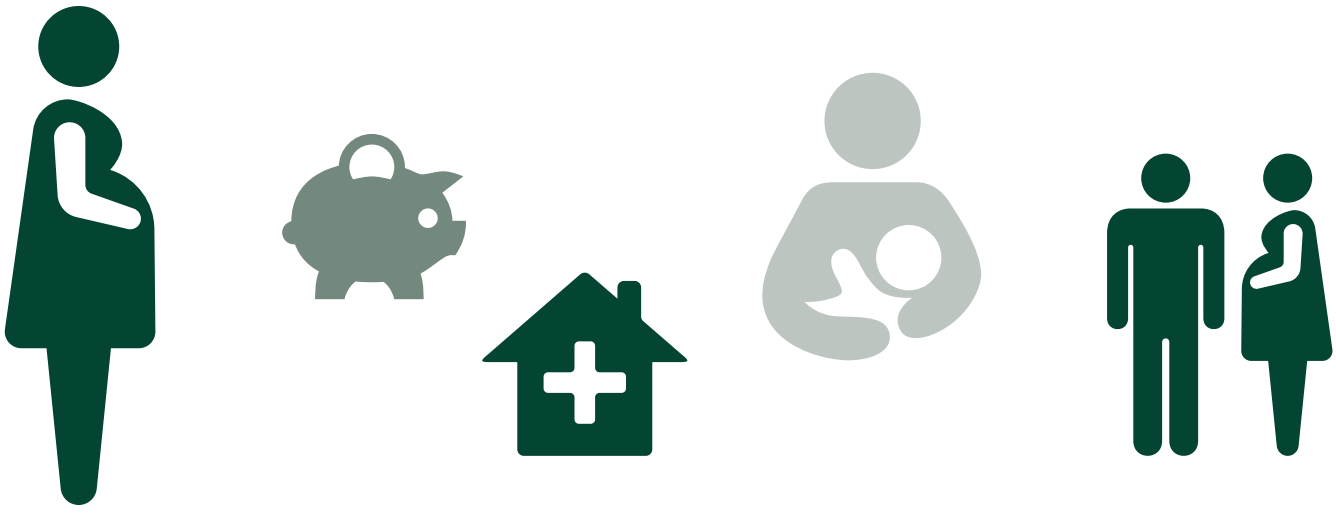
- In 2018, there were 160 000 new HIV infections among children, 87% of which were in Africa. This is four times higher than the 2018 target.
- In 11 western and central Africa countries, more than half of new HIV infections of children occurred because their mother did not use health services or receive antiretroviral therapy during their pregnancy and/or breastfeeding.

For advocacy to be effective, understanding the country data, national challenges and current programming efforts is important. The main causes for vertical transmission include the following:

- Women haven't received antenatal and prevention of vertical HIV transmission services during pregnancy or breastfeeding.
- Women start antiretroviral treatment but fall out of care during pregnancy or breastfeeding.
- Women become infected with HIV during breastfeeding or pregnancy.

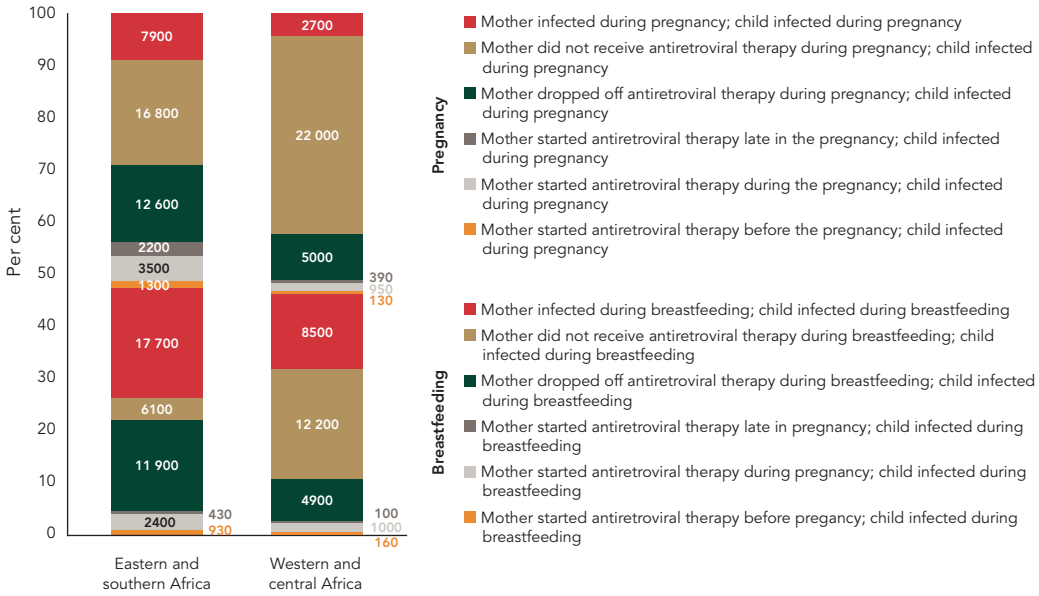
However, UNAIDS analysis shows that not all countries face the same challenges. To make rapid progress, it is crucial to choose the area that is contributing to the most new HIV infections among children in a country. When there is enough progress in the chosen area, other areas may be prioritized.

What one country needs to do to prevent vertical transmission is most likely different from another country.



Summary stack-bar analysis of the causes of vertical transmission in Africa

Distribution of new child HIV infections by cause. Eastern and southern Africa and western and central Africa, 2018



Source: UNAIDS 2019 estimates.

In many countries, especially in western and central Africa, most new HIV infections occur because pregnant women do not get antenatal care. As a result, these women do not learn their HIV status or benefit from antenatal care, preventing them from receiving the benefit from antiretroviral therapy during pregnancy or breastfeeding, if HIV-positive.

Vertical transmission also occurs when women stop taking antiretroviral therapy during pregnancy or breastfeeding. Women who start antiretroviral therapy must stay on treatment during pregnancy and breastfeeding and for the rest of their lives. It is good news that 60% of pregnant women living with HIV who come for vertical HIV transmission prevention services are already taking HIV treatment. They need to continue to do so during their whole pregnancy and breastfeeding period and stay on HIV treatment for the rest of their lives.

In other countries, particularly in eastern and southern Africa, a large number of new HIV infections among children occur because women were newly infected with HIV while they were pregnant or breastfeeding. Understanding who is most at risk of new HIV infection during pregnancy and making sure that HIV prevention services such as condoms or PrEP are also available for HIV-negative women during the pregnancy or breastfeeding period is important.

Each country has a stack bar that shows where most remaining infant HIV infections are coming from, which can be accessed through the national HIV programme. Ask your HIV programme what your country's stack bar looks like and what it indicates for prioritization.

Action can be taken to support women if it is focused on their needs, whether vertical transmission occurs because pregnant women are not receiving health care at all or because they are not receiving HIV services or because they are falling out of care.

KEY MESSAGES

Focus where the needs are

- **Pregnant women must receive antenatal care.** Vertical transmission of HIV can be prevented—antenatal care services are the gateway to providing and receiving HIV prevention services. This is the first step to protecting the health of women and their children. If women are not accessing antenatal care, they miss opportunities to prevent vertical transmission of HIV. By taking HIV treatment, a woman can prevent HIV transmission to her child. A call to action is needed to make sure that antenatal care is available to all women.
- **Quality antenatal care services should include HIV testing and the provision of treatment for pregnant women living with HIV.** HIV transmission from a woman to her child can be prevented with the right care and follow-up throughout pregnancy and breastfeeding and for the rest of her life. Where needed, antenatal care should also include prevention information and services such as condoms and PrEP for HIV-negative pregnant women who may be at risk. Vulnerable HIV-negative women and their partners must be informed that HIV infection is still a risk while they are pregnant or breastfeeding and that they could then pass HIV on to their child.
- **Women living with HIV who start treatment must be supported to stay on treatment and be virally suppressed[3] throughout their pregnancy and breastfeeding and for the rest of their lives.** Keeping women on treatment ensures the health and well-being of women and prevents vertical transmission. Currently, one in three new HIV infections among children, particularly in eastern and southern African countries, occur among women who stop taking treatment during their pregnancy.
- **Husbands, fathers and partners must be informed of the risk of HIV transmission to their partner and child.** Men must take responsibility and learn their HIV status, access treatment and reduce their viral load in order to protect their own health and that of their family.

Communities make a difference

- **Peer support groups of women living with HIV, such as mentor mothers, are an effective way of supporting women throughout pregnancy and breastfeeding.** Peer support groups carry out home visits, helping women and men to get tested and stay on HIV treatment and making it easier for women to stay on treatment. Community-based programmes provide an excellent opportunity to provide differentiated services to prevent new HIV infections, encourage HIV testing and promote adherence to treatment. Peer support groups can provide pregnant women living with HIV with support and adherence assistance throughout the pregnancy and breastfeeding period. All types of health-care providers should be informed and enabled to promote HIV prevention.
- **Young women living with HIV need comprehensive health services.** Young women living with HIV require youth-friendly HIV, family planning and maternal care services. Young women living with HIV also need support with parenting training, counselling and resources for their health and that of their child.
- **Women living with HIV from vulnerable groups are particularly susceptible to violence, stigma and discrimination and require dedicated peer support.** Adolescent girls and women in situations of vulnerability require dedicated programmes that are community-led and are best placed to provide services that have the trust of the communities they serve.

Structural barriers need to be addressed

- **User fees must be removed. Women face too many financial barriers to protecting their health.** Barriers to women accessing health care, such as the need for their spouse's consent, user fees at the local clinic or countries not prioritizing women's health, must end.
- **Health-care settings must not discriminate.** Stigmatizing behaviour towards women living with HIV or young sexually active women prevents them from accessing health services. Health-care settings should be welcoming to women and ensure that all women are treated with respect, dignity and privacy.
- **Men need to have health services too.** Men should play an essential role in protecting their own health and the health of their partner and child and in ensuring that women are in a supportive environment throughout their pregnancy. Strategies that call on men to take responsibility for their health by getting tested and treated for HIV and to work to prevent violence against women and empower women are essential for improving maternal and child health.

ADVOCACY FOCUS 3

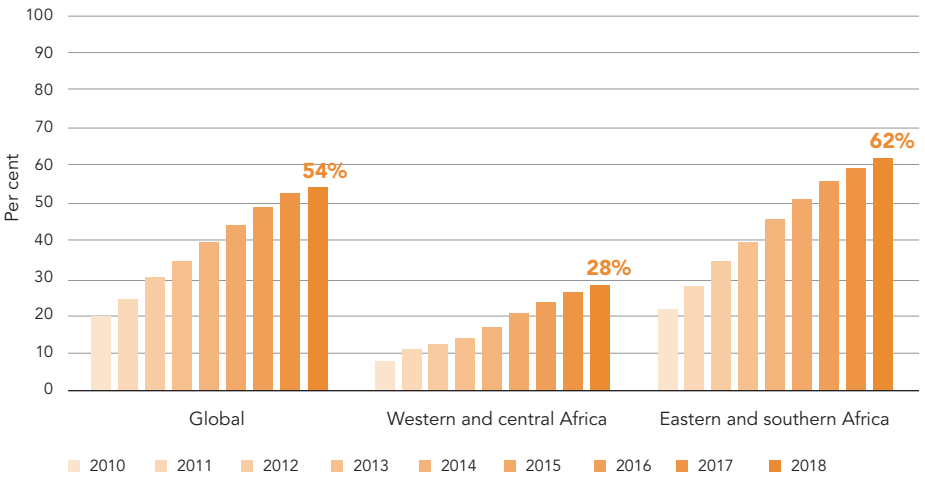
FINDING MISSING CHILDREN AND ADOLESCENTS LIVING WITH HIV AND ENSURING THAT THEY RECEIVE HIV SERVICES

Children living with HIV are being left behind in the AIDS response—overall, they have less access to HIV treatment. There are 3 million children and adolescents living with HIV in Africa today.

Far too few children are receiving treatment, particularly in western and central Africa

Antiretroviral therapy coverage among children, by region, 2010–2018

Only 28% of the children who need treatment in western and central Africa, and 62% of those who need treatment in eastern and southern Africa, are on antiretroviral therapy.



A major challenge in improving access to HIV treatment for children is ensuring that infants are diagnosed early. Women, infants and children are often lost to follow-up after delivery, with the HIV status of the child remaining unknown. Children need to be tested within two months of delivery and regularly re-tested up to the end of the breastfeeding period.

It is urgent to find missing children living with HIV. Many children are not diagnosed in the first months of life and therefore grow up without HIV treatment and care. There are an estimated 742 000 children living with HIV who are not on antiretroviral therapy today, who are at great risk of AIDS-related illness and death. Not all of these children are babies—they include children up to 14 years old. Diagnosing these children requires awareness-raising and HIV testing within health and social services that do not traditionally provide HIV services.

Children living with HIV should have HIV treatment as quickly as possible. It is important that children receive the latest treatment regimens and that there are no stock-outs. This will help families in caring for themselves and their child.

Stigma and discrimination in health-care settings and in schools is a major challenge for women and children living with HIV and can jeopardize their access and adherence to HIV treatment. Communities of children and young people living with HIV play an important role in supporting each other. Policy and legal protections, as well as advocacy to change social norms, are needed to ensure that families can thrive in an enabling environment.

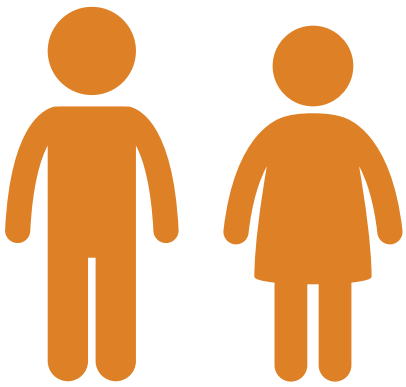
KEY MESSAGES

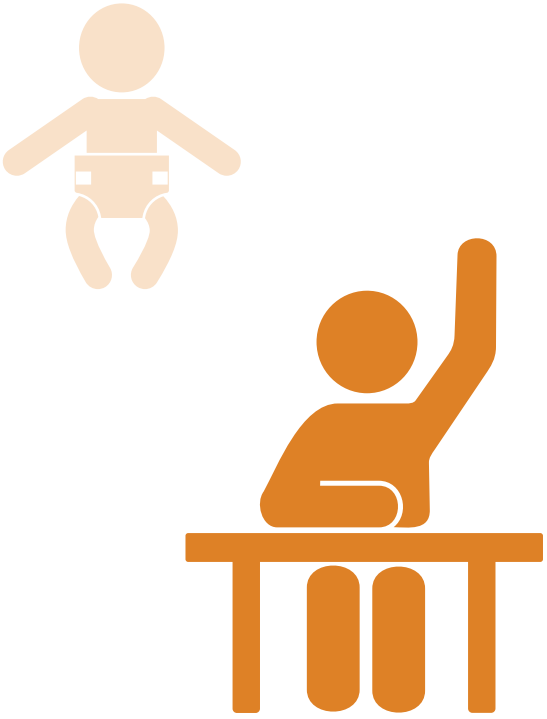
Children are being left behind in the AIDS response

- **The HIV treatment gap for children must be closed.** There are 3 million children and adolescents living with HIV in Africa today. In western and central Africa, only 28% of children have access to HIV treatment. In eastern and southern Africa, only 62% of children are on treatment.

Many children go untested and therefore untreated

- **HIV-exposed babies must be tested for HIV. Early HIV testing for infants within two months of their birth can be life-saving for the child.** Fifty per cent of children living with HIV who are untreated die by their second birthday and mortality risk is highest at six to 10 weeks of life. Early testing and prompt linkage of children living with HIV to treatment could have avoided 100 000 AIDS-related deaths among children aged 0–14 years in 2018.
- **HIV-exposed babies must be tested for HIV at the end of breastfeeding.** Knowing the final HIV status of HIV-exposed children after the end of breastfeeding or at around 12–18 months of age is also crucial, as there is always a chance of transmission during the breastfeeding period.
- **It is urgent to find older children living with HIV, aged 5–14 years.** Focused HIV testing at different entry points wherever children are seen—such as at antenatal care and nutrition clinics, when accessing tuberculosis, sexual and reproductive health, family planning, immunization, and orphan and other vulnerable children services and at health centres and hospitals—will help to identify children living with HIV who were not diagnosed at birth.
- **Every opportunity to inform parents living with HIV of the importance of HIV testing for themselves and for their child should be seized.** All parents living with HIV should ensure that their children are tested for HIV. In countries where most adults living with HIV are on HIV treatment, children who are undiagnosed can be found through index or family testing.[4]





Innovation in testing is a game-changer and treatment should be guaranteed

- **New technologies, such as point-of-care diagnosis, which allow for same-day results of an HIV test for an infant, can be game-changers.** Family or index testing and self-testing can make a difference for men and women.
- **Effective treatment is available for children who are diagnosed with HIV, which allows healthy growth and development.** Access to antiretroviral therapy for all children living with HIV from 0 to 14 years old should be ensured and there should be no stock-outs.

Lifting legal, financial and social barriers will be essential to progress

- **Legislation to ban discrimination against people, including children, living with HIV is essential in order to support access to health services and education.** Legal aid, protection of confidentiality and prevention of discrimination against children living with HIV in schools must be included in such legislation.
- **Social protection programmes are needed for vulnerable children**. Such social protection programmes should include nutrition, education and housing, and there should be specific programmes for girls that protect them from sexual violence.
- **Communities of people living with or affected by HIV play an important role in retaining children, adolescents and young people, including young vulnerable populations, in care by responding to the needs of children and young people.**

FRAMEWORK FOR ACTION

First ladies are in a unique position to address the challenges of HIV among women, girls and children. The following outlines a framework to guide future action in countries.

RAISING AWARENESS

Speaking out is an important part of reducing HIV stigma and discrimination and changing social norms. First ladies can use their influential position to raise awareness around HIV and normalize conversations about AIDS and maternal and reproductive health in order to remove fear, stigma and discrimination.

CONVENE

First ladies have significant convening power. They can bring together stakeholders and urge them to act. First ladies can use their visibility to provide a platform and give a voice to women who may not otherwise have access to such opportunities. By making a point of meeting and hearing from children, youth groups and women living with HIV and providing visibility to the work of communities of women living with HIV, they can make a difference.

ACT

First ladies can make a public commitment to address the AIDS response in their country and act on stigma and discrimination, improve gender equality, call for policy change where it is needed and mobilize resources.

COMMUNITY LEADERSHIP AT THE CENTRE

Throughout their work, first ladies can promote community organizations of women living with or affected by HIV that play a major role in ensuring that women can access the care they need.

INTERNATIONAL AND REGIONAL COMMITMENTS

The United Nations and the African Union have made several high-level commitments that are relevant to furthering the response to HIV for women and children. These include the following:

SDGs 3, 5 and 16[5]

SDG 3, target 1
By 2030, reduce the global maternal mortality ratio to less than 70 per 100 000 live births.

SDG 3, target 3
By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases.

SDG 3, target 7
By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.

SDG 3, target 8
Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

SDG 5, target 2
Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation.

SDG 5, target 6
Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences.

SDG 16, target 6
Develop effective, accountable and transparent institutions at all levels.

Addis Ababa Declaration on Population and Development in Africa Beyond 2014[6]

- **Article 33**
  Intensify efforts to achieve universal access to HIV prevention, treatment, care and support for people living with HIV and to eliminate mother-to-child transmission.
- **Article 37**
  Eliminate preventable maternal mortality and neonatal mortality through ensuring that births are attended by skilled health personnel and that there is universal access to prenatal and postnatal care and family planning, emergency obstetric and neonatal care, and management of pregnancy-related complications and preventable complications arising from unsafe abortion in order to protect the health and safeguard the lives of women, adolescent girls and neonates.

- **Article 34**
  Achieve universal access to sexual and reproductive health services, free from all forms of discrimination, by providing an essential package of comprehensive sexual and reproductive health services, including through the primary health-care system for women and men, with particular attention to the needs of adolescents, youth, older persons, persons with disabilities and indigenous people, especially in the most remote areas.

Addis Ababa Declaration on Accelerating the Implementation of the Beijing Platform for Action (Beijing + 20)[7]

- **Paragraph 3.g**
  Improve access for all women and girls to prevention, treatment and drugs to reduce the negative impact of HIV among women.
- **Paragraph 3.h**
  Scale up combined preventive HIV measures for young women and girls and expand programmes to eliminate mother-to-child transmission.

Maputo Protocol[8]

- Fifty-one out of 54 African countries have signed a ground-breaking legal framework known as the Maputo Protocol; 41 have ratified it. The Maputo Protocol is a powerful instrument enshrining women's and girls' rights. Fifteen years after the Maputo Protocol was conceived, progress has been made, yet many women and girls are still deprived of their fundamental human rights.

Catalytic Framework to End AIDS, TB and Eliminate Malaria in Africa by 2030[9]

- With the significant progress made and the remaining challenges that can put the continent off-track in responding to the three biggest diseases on the continent, the Catalytic Framework to End AIDS, TB and Eliminate Malaria in Africa by 2030 provides a business model for investing for impact. The framework emphasizes the need for each country to place a specific focus on increasing domestic health financing and underscores the need to ensure that available resources should be invested and targeted where the disease burden is the highest.

United Nations General Assembly 2016 Political Declaration on Ending AIDS[10]

- Commit to taking all appropriate steps to eliminate new HIV infections among children and ensure that their mothers' health and well-being are sustained through immediate and lifelong treatment, including for pregnant and breastfeeding women living with HIV through early infant diagnosis, dual elimination with congenital syphilis, and treatment of their male partners, adopting innovative systems that track and provide comprehensive services to mother–infant pairs through the continuum of care, expanding case-finding of children in all health-care entry points, improving linkage to treatment, increasing and improving adherence support, developing models of care for children differentiated by age groups, eliminating preventable maternal mortality and engaging male partners in prevention and treatment services, and taking steps towards achieving WHO certification of elimination of mother-to-child HIV transmission.

NOTES

[1] https://freetoshineafrica.org/.

[2] PrEP is the use of antiretroviral medicines to prevent people from acquiring HIV (https://www.unaids.org/sites/default/files/media_asset/UNAIDS_JC2765_en.pdf).

[3] If a person living with HIV's antiretroviral therapy is effective and the virus is fully suppressed, the person living with HIV cannot transmit the virus to others. For this reason, monitoring of the suppression of the viral load is recommended as part of ongoing care for people living with HIV.

[4] Index testing refers to the testing of all biological children of the person living with HIV, whereas family testing involves the testing of everyone in the household of a person living with HIV, including but not limited to biological children (https://www.unaids.org/sites/default/files/media_asset/28112019_UNAIDS_PCB45_Thematic-Segment-Background-Note_EN.pdf).

[5] https://www.un.org/sustainabledevelopment/sustainable-development-goals/.

[6] https://www.unfpa.org/resources/addis-ababa-declaration-population-and-development-africa-beyond-2014.

[7] https://www.uneca.org/sites/default/files/PublicationFiles/beijing_20_addis_declaration.eng_.pdf.

[8] maputoprotocol.com/about-the-protocol.

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