



EXECUTIVE SUMMARY

TRANSFORMING VISION INTO REALITY

**The 2024 Global Alliance Progress Report on
Ending AIDS in Children by 2030**

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Happiness Mbewe, 18 years old, living with HIV, plays with her children at home in Blantyre, Malawi. She receives HIV-related treatment and care services offered by UNICEF and its partners.

FOREWORD



WINNIE BYANYIMA

UNAIDS Executive Director

We can end AIDS in children.

With the medicines and science available, we can ensure that all babies are born – and remain – HIV-free, and that all children who are living with HIV get on and stay on treatment.

Yet shockingly, whilst roughly three-quarters of adults living with HIV globally are on lifesaving antiretroviral therapy, only about half of children are. If they don't receive treatment, almost half of children living with HIV will die before the age of two.

We can be inspired by the progress advanced by the coming together of communities, governments, the UN and partners in the Global Alliance to End AIDS in Children. Spearheading the Alliance are 12 African countries that, together, are home to two-thirds of new HIV infections and AIDS-related deaths in children. They have united in their commitment to end AIDS in children by 2030, working to improve access to treatment and prevention services for children and for pregnant and breastfeeding women, and to address the lack of rights that hinder young women's access to health care.

The data included in this report shows how the Global Alliance is saving and transforming children's lives. It shows how globally new HIV infections in children are decreasing and are decreasing relatively faster in Global Alliance countries than outside. In several Global Alliance countries, more than 90% of pregnant and breastfeeding women were on antiretroviral therapy in 2023, though other countries lagged behind. The number of adolescent girls and young women who acquire HIV each year has decreased, and the number of children who die from AIDS-related causes each year has also decreased.

But, as the report sets out, progress is not fast enough and not inclusive enough. That is why it also points to where, and how, leaders need to accelerate progress to reach agreed and collective goals. There is an urgent need to increase access to HIV prevention, testing, treatment, and comprehensive care services for infants, children, and adolescents. This requires stepping up action on preventing and detecting new HIV infections among pregnant and breastfeeding mothers and ensuring treatment, and support, for all pregnant and breastfeeding mothers who are living with HIV. It requires tackling gender-based violence and promoting gender equality to protect young women's health and safety.

In this report you will find accounts of inspiring and innovative community and government programmes across Global Alliance countries. These include peer education, early infant diagnosis, and programmes to increase children's access to essential medicines.

The report shows how a range of Global Alliance countries have succeeded in overcoming significant obstacles to enhance the health and well-being of children, adolescents, and young women.

It is time now to apply all lessons to all Global Alliance countries.

The death of any child from AIDS-related causes is not only a tragedy, but also an outrage. Where I come from, *all* children are *our* children. We must be the generation that ends AIDS in children. This report shows what we can achieve, together, and guides us how.

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Ending AIDS among children is feasible, but it is a critical piece of unfinished business in the global fight against HIV.

The Global Alliance to End AIDS in Children (Global Alliance), launched in July 2022, works with women living with HIV and their families, national governments and partners to mobilize leadership, funding and action to end AIDS in children as a public health threat by 2030. The Global Alliance supports efforts to end AIDS in children across 12 countries, which together account for 66% of new HIV infections and 64% of AIDS-related deaths among children.

This status report shows how far we have come—and how much further we must go—if we hope to meet the global commitments to end AIDS in children. It offers a snapshot of global progress and permits an early assessment of the impact of the Global Alliance's work. This report highlights the transformative work that is being undertaken in Global Alliance countries to accelerate gains towards ending AIDS in children, underscoring the urgent need to apply good practices, emerging innovations and critical lessons learned to overcome the barriers that slow progress.

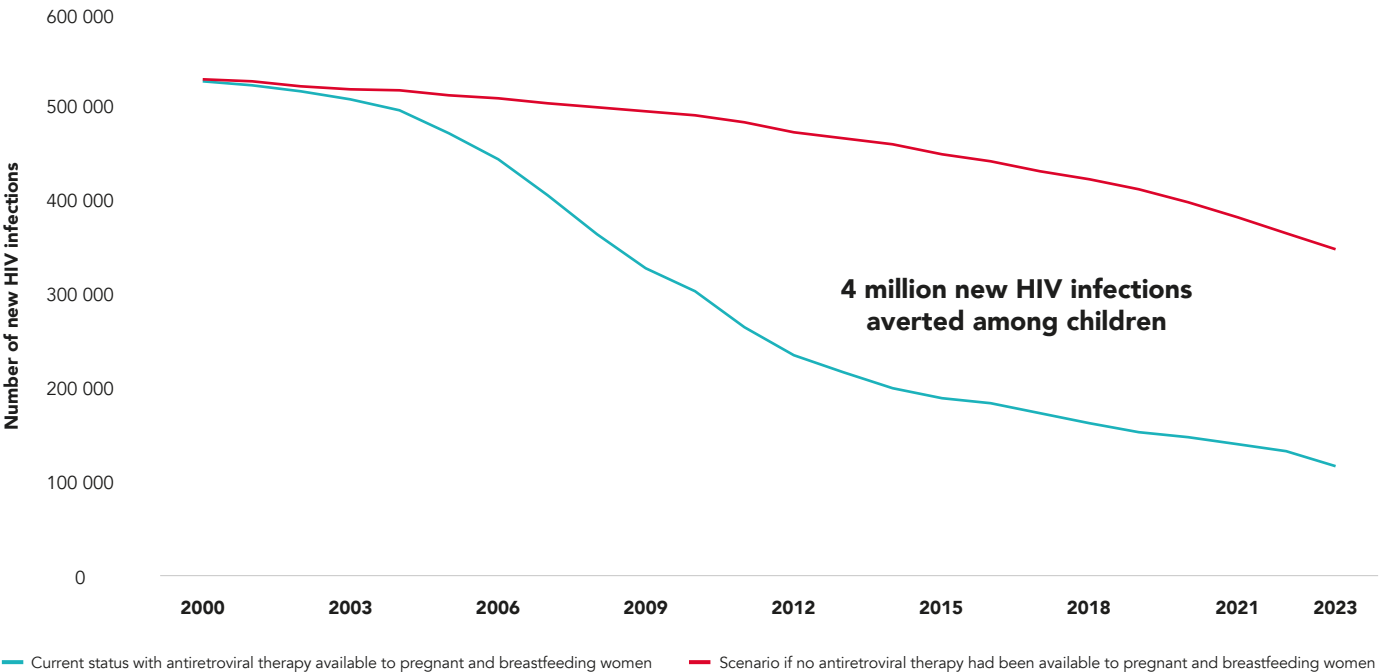
Important progress is being made towards ending AIDS in children globally.

The number of new infections among children (0–14 years old) living with HIV is declining as a result of the impact of HIV prevention efforts. Globally, since 2000, vertical transmission programmes have averted an estimated 4 million [2.9 million–5.8 million] infections among children 0–14 years old (Figure 1).

The number of new HIV infections among children in 2023 (an estimated 120 000 children [83 000–170 000] globally, including 77 000 [55 000–110 000], or 66%, in the Global Alliance countries) represents a 38% decline since 2015 and a 17% decline since 2021. The number of older adolescents (15–19 years old) who acquired HIV in 2023 (an estimated 140 000 [39 000–240 000] adolescents, including 77 000 [14 000–130 000], or 56%, in the Global Alliance countries) represents a 33% decline since 2015 and an 11% decline since 2021 (Table 1).

Globally, since 2000, vertical transmission programmes have averted an estimated 4 million infections among children 0–14 years old

Figure 1 Number of new HIV infections among children (0–14 years old) versus scenario without antiretroviral therapy available to pregnant and breastfeeding women, global, 2000–2023



Source: UNAIDS special analysis of epidemiological estimates, 2024.

AIDS-related deaths among children (0–14 years old) have decreased. In 2023, an estimated 76 000 children (0–14 years old) [53 000–110 000] died from AIDS-related causes, including 49 000 [34 000–66 000], or 64%, in the Global Alliance countries. Globally, this represents a 43% decline since 2015 and a 14% decline since 2021 (Table 1).

AIDS-related deaths among children (0–14 years old) have decreased.

Globally, the proportion of HIV-exposed children who receive HIV testing within the first two months of life has increased from 50% [43–61%] in 2015 to 67% [58–83%] in 2023. The transition to dolutegravir (DTG)-based regimens, along with enhanced efforts in adherence and retention, is helping to improve rates of viral suppression. Further innovation—including through improved service delivery and emerging biomedical approaches (such as administration of long-acting injectable options)—has the potential to increase children’s rates of HIV viral suppression.

Table 1 Progress in reducing new HIV infections and AIDS-related deaths among children (0–14 years old) and adolescents (15–19 years old), global and in Global Alliance countries, 2015, 2021 and 2023

PROGRESS IN REDUCING NEW HIV INFECTIONS AND AIDS-RELATED DEATHS		2015	2021	2023	PERCENTAGE CHANGE FROM 2021 TO 2023
New HIV infections					
Children (0–14 years old)	Global	190 000 [140 000–270 000]	140 000 [100 000–200 000]	120 000 [83 000–170 000]	–17%
	Global Alliance	120 000 [89 000–180 000]	94 000 [68 000–130 000]	77 000 [55 000–110 000]	–18%
AIDS-related deaths					
Children (0–14 years old)	Global	130 000 [93 000–190 000]	89 000 [62 000–120 000]	76 000 [53 000–110 000]	–14%
	Global Alliance	85 000 [60 000–120 000]	57 000 [40 000–78 000]	49 000 [34 000–66 000]	–15%
New HIV infections					
Adolescents (15–19 years old)	Global	200 000 [58 000–350 000]	150 000 [43 000–260 000]	140 000 [39 000–240 000]	–11%
	Global Alliance	130 000 [24 000–220 000]	92 000 [17 000–160 000]	77 000 [14 000–130 000]	–16%
AIDS-related deaths					
Adolescents (15–19 years old)	Global	18 000 [13 000–24 000]	16 000 [11 000–21 000]	14 000 [10 000–19 000]	–9%
	Global Alliance	12 000 [8800–15 000]	11 000 [8100–14 000]	10 000 [7400–13 000]	–8%

Source: UNAIDS epidemiological estimates, 2024 (<https://aidsinfo.unaids.org>).

Several Global Alliance countries have achieved robust coverage of lifelong antiretroviral therapy among pregnant and breastfeeding women living with HIV, exceeding 90%, with Uganda nearing 100%, United Republic of Tanzania at 98% and South Africa at 97%. A subset of countries range between 80% and 90% coverage, including Mozambique at 90%, Zambia at 90%, Angola at 89%, Kenya at 89%, Zimbabwe at 88% and Côte d'Ivoire at 84%. Efforts to prevent vertical HIV transmission are a key element of the triple elimination initiative, which aims to prevent vertical transmission of HIV, syphilis and hepatitis B.

Intensified efforts to curb HIV infections have helped to reduce the number of adolescent girls and young women (15–24 years old) who acquired HIV in 2023 globally and in Global Alliance countries (Table 2). Strategies being rolled out to strengthen HIV prevention among pregnant and breastfeeding adolescents and women include partner testing, HIV self-testing, pre-exposure antiretroviral HIV prophylaxis (PrEP) and various social, structural and behavioural interventions.

Progress towards eliminating AIDS in children tends to be greater in Global Alliance countries than in non-Global Alliance countries. Since 2021, declines in new HIV infections among children are similar in Global Alliance countries (18%) and globally (17%), as are declines in AIDS-related deaths among children (15% versus 14%). Likewise, since 2021, the reduction in new HIV infections among older adolescents (15–19 years old) has been greater in Global Alliance countries, with a 16% decline, versus the global average of 11% (Table 1).

Global Alliance countries in 2023 had higher coverage of early infant diagnosis (71% [62–88%]) than the world as a whole (67% [58–83%]), and coverage of antiretroviral therapy for pregnant and breastfeeding women living with HIV in 2023 was modestly higher in Global Alliance countries (85% [74% to >98%]) than the global average (84% [72% to >98%]). Improvements in Global Alliance countries are the result of intensified national leadership and commitment as well as the collaboration of diverse partners to support innovation and the scale-up of proven tools and strategies.

Global Alliance countries are innovating to overcome barriers and accelerate progress towards ending AIDS in children. To reach infants and children who were not identified during routine early infant diagnosis with additional opportunities to test for HIV, South Africa, a Global Alliance country, now has a policy of universal HIV testing of children at 18 months, regardless of documented HIV exposure. Global Alliance countries are applying both service and technological innovations to reduce the rate of vertical transmission, including mobilizing mentor mothers, integrated and coordinated care for mother–baby pairs and more frequent viral load screening of mothers and also beginning planning for the potential future scale-up of long-acting injectable antiretroviral medicines to improve retention in care. Case studies in this report highlight ways that Global Alliance countries are leveraging innovation to close critical service gaps.

But progress is far too slow, with an array of barriers impeding efforts to end AIDS in children.

Despite the progress achieved, neither the world nor Global Alliance countries are currently on track to reach the HIV-related commitments for children and adolescents, and the pace of progress in preventing new HIV infections and AIDS-related deaths among children has slowed in recent years (Table 2).

Only 48% of children living with HIV globally and in Global Alliance countries achieved viral load suppression, versus 73% of adults globally and 79% in Global Alliance countries.

Although early infant diagnosis coverage is higher in Global Alliance countries than globally, only four Global Alliance countries have achieved at least 80% coverage—South Africa (90% [75–99%]), Kenya (87% [76–99%]), Zimbabwe (84% [75–99%]) and Uganda (82% [74–95%])—while some have much lower rates, including Nigeria (18% [16–22%]) and Angola (14% [11–17%]).

In 2023, only 57% [41–75%] of children living with HIV were receiving life-saving treatment versus 77% [62–90%] of adults globally (Table 2). An estimated 590 000 [430 000–920 000] children globally were not receiving life-saving treatment in 2023, including 400 000 [300 000–640 000] (or 68%) living in Global Alliance countries. Among these children, 60% were older than five years.

An estimated 590 000 children globally were not receiving life-saving treatment in 2023, including 400 000 (or 68%) living in Global Alliance countries.

Only 48% [39–60%] of children living with HIV globally and in Global Alliance countries achieved viral load suppression, versus 73% [66–81%] of adults globally and 79% [72–87%] in Global Alliance countries. This is well short of the 2023 goal of achieving 75% viral suppression among children receiving HIV treatment, towards the 2025 target of 90% viral suppression (Table 2). Key factors contributing to continued new infections among children include challenges relating to maternal access to antiretroviral therapy during pregnancy or breastfeeding, HIV transmission during pregnancy or breastfeeding, cessation of antiretroviral therapy during pregnancy or breastfeeding and the failure to achieve viral suppression.

Over the past decade, both globally and in Global Alliance countries, the proportion of pregnant and breastfeeding women living with HIV who access antiretroviral therapy has remained stagnant—reaching 84% globally and 85% in Global Alliance countries in 2023 (Table 2). Although this notable coverage has reduced the number of new HIV infections among children, it falls short of the goal of ensuring universal (100%) coverage.

Given the breastfeeding period, the vertical transmission is not declining and exceeds 20% in two Global Alliance countries—Nigeria (23% [21–26%]) and the Democratic Republic of the Congo (26% [22–30%]).

Gaps in HIV prevention among reproductive-age women also slow progress towards ending AIDS in children. The number of adolescent girls and young women (15–24 years old) who were newly infected with HIV in 2023 (210 000 [130 000–280 000]) is more than four times higher than the global goal of reducing the annual number of new infections in this population to less than 50 000 (Table 2).

Gender inequalities increase women's vulnerability to HIV and diminish their ability to access essential services. Globally, nearly one in three women have encountered some form of violence during their lifetime, with adolescent girls and young women disproportionately affected by intimate partner violence. The four Global Alliance countries with available data are not currently on track to achieve the target of ensuring that by 2025 less than 10% of women, key populations and people living with HIV experience gender-based inequalities and gender violence.

Table 2 Progress towards 2025 Global Targets and the impact of the Global Alliance: global and in Global Alliance countries, 2015, 2021 and 2023

PROGRESS TOWARDS 2030 MILESTONES		2015	2021	2023	2025 TARGET
Ensure that all pregnant and breastfeeding women living with HIV are receiving lifelong antiretroviral therapy					
Antiretroviral therapy coverage among pregnant and breastfeeding women	Global	81% [70% to >98%]	83% [70% to >98%]	84% [70% to >98%]	100%
	Global Alliance	86% [70% to >98%]	85% [70% to >98%]	85% [70% to >98%]	
Reduce the number of adolescent girls and young women acquiring HIV to less than 50 000 by 2025					
Adolescent girls and young women (15–24 years old) newly infected with HIV	Global	330 000 [220 000–450 000]	240 000 [150 000–320 000]	210 000 [130 000–280 000]	50 000
	Global Alliance	220 000 [140 000–300 000]	160 000 [97 000–210 000]	130 000 [81 000–170 000]	
Ensure that 90% of people living with HIV are accessing treatment					
Children living with HIV (0–14 years old) receiving treatment	Global	40% [28–52%]	54% [28–52%]	57% [28–52%]	90%
	Global Alliance	41% [28–52%]	54% [28–52%]	57% [28–52%]	
Ensure that 90% of people living with HIV are accessing treatment					
Adolescents (15–19 years old) who are on treatment	Global	30%	55%	64%	90%
	Global Alliance	32%	58%	68%	
Ensure that 75% of all children living with HIV have suppressed viral loads by 2023 and 86% by 2025					
Children living with HIV (0–14 years old) who have suppressed viral loads	Global	26% [22–33%]	43% [22–33%]	48% [22–33%]	86%
	Global Alliance	27% [22–33%]	43% [22–33%]	48% [22–33%]	

Source: UNAIDS epidemiological estimates, 2024 (<https://aidsinfo.unaids.org>).

Reforms in laws and policy frameworks are essential to mitigate the vulnerability of women and girls to violence and human rights violations.

Reforms in laws and policy frameworks are essential to mitigate the vulnerability of women and girls to violence and human rights violations. Three Global Alliance countries lack legislation addressing various forms of domestic violence, nine lack laws or provisions criminalizing marital rape without conditions and eight countries allow exceptions to age-of-marriage laws. These legal reforms should be accompanied by investments in girls' education and initiatives aimed at reshaping inequitable gender norms.

Although it is clearer than ever that we can end AIDS in children, it is equally clear that critical gaps are undermining our efforts. It will be essential to support continued gains in high-performing countries while drawing on the contributions of diverse partners to focus on addressing the well-documented barriers to swifter progress. Leveraging technological advances and sharing lessons learned on strategies for overcoming service bottlenecks will be vital to success.

Leveraging technological advances and sharing lessons learned on strategies for overcoming service bottlenecks will be vital to success.

REFERENCES

1. UNAIDS, WHO, UNICEF. The Global Alliance to End AIDS in Children. Geneva: UNAIDS; 2022 (<https://www.unaids.org/en/topic/alliance-children>, accessed 3 July 2024).
2. Global AIDS Strategy 2021–2026: end inequalities. End AIDS. Geneva: UNAIDS; 2021 (<https://www.unaids.org/en/resources/documents/2021/2021-2026-global-AIDS-strategy>, accessed 3 July 2024).
3. Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030. Geneva: UNAIDS; 2021 (https://www.unaids.org/en/resources/documents/2021/2021_political-declaration-on-hiv-and-aids, accessed 3 July 2024).
4. Mavhu W, Willis N, Mufuka J, Bernays S, Tshuma M et al. Effect of a differentiated service delivery model on virological failure in adolescents with HIV in Zimbabwe. *Lancet Glob Health*. 2020;8:e264–75. doi: 10.1016/S2214-109X(19)30526-1.
5. READY+: valuing our work. Brighton: Frontline AIDS; 2023 (<https://frontlineaids.org/resources/ready-valuing-our-work>, accessed 3 July 2024).
6. Newell ML, Coovadia H, Cortina-Borja M, Rollins N, Gaillard P, Dabis F. Mortality of infected and uninfected infants born to HIV infected mothers in Africa: a pooled analysis. *Lancet*. 2004;364:1236–43. doi: 10.1016/S0140-6736(04)17140-7.
7. Bianchi F, Cohn J, Sacks E, Bailey R, Lemaire J-F, Machekano R et al. Evaluation of a routine point-of-care intervention for early infant diagnosis of HIV: an observational study in eight African countries. *Lancet HIV*. 2019;6:e373–81. doi: 10.1016/S2352-3018(19)30033-5.
8. Frank SC, Cohn J, Dunning L, Sacks E, Walensky RP, Mukherjee S et al. Clinical effect and cost-effectiveness of incorporation of point-of-care assays into early infant HIV diagnosis programmes in Zimbabwe: a modelling study. *Lancet HIV*. 2019; 6:e182–90. doi: 10.1016/S2352-3018(18)30328-X.
9. le Roux S, Odayar J, Sutcliffe CG, Salvatore PP, de Broucker G, Dowdy D et al. Cost-effectiveness of point-of-care versus centralized, laboratory-based nucleic acid testing for diagnosis of HIV in infants: a systematic review of modelling studies. *Lancet HIV*. 2023;10:e320–31. doi: 10.1016/S2352-3018(23)00029-2.
10. Sacks E, Katirayi L, Kaeberle B, Mafaune HW, Chadambuka A, Tachiwenyika E et al. ‘The baby will have the right beginning’: a qualitative study on mother and health workers views on point-of-care HIV birth testing across 10 sites in Zimbabwe. *BMC Pediatr*. 2022;14:546. doi: 10.1186/s12887-022-03601-x.
11. Understanding measures of progress towards the 95–95–95 HIV testing, treatment and viral suppression targets. Geneva: UNAIDS; 2024 (<https://www.unaids.org/en/resources/documents/2024/progress-towards-95-95-95>, accessed 3 July 2024).

12. Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach, 2021 update. Geneva: World Health Organization; 2021 (<https://iris.who.int/handle/10665/342899>, accessed 3 July 2024).
13. Turokova A, White E, Mujuru HA, Kekitilwa AR, Kityo CM, Violari A et al. Dolutegravir as first- or second-line treatment for HIV-1 infections in children. *N Engl J Med*. 2021;385:2531–43. doi: 10.1056/NEJMoa2108793.
14. Davendra A, Kohler M, Letsika M, Khoosa H, Motaboli L, Leretholi M et al. HIV viral suppression in children and adolescents 2 years after transition to dolutegravir: a multicentre cohort study. *AIDS*. 2024;38:1013–23. doi: 10.1097/QAD.0000000000003835.
15. Waalewijn H, Szubert AJ, Wasmann RE, Wiesner L, Chabala C, Bwakura-Dangarembizi et al. First pharmacokinetic data of tenofovir alafenamide fumarate and tenofovir with dolutegravir or boosted protease inhibitors in African children: a substudy of the CHAPAS-4 trial. *Clin Infect Dis*. 2023;77:875–82. doi: 10.1093/cid/ciad267.
16. Bacha JM, Diamini S, Anabwani F, Gwimile J, Kanyw JB, Farirai J et al. Realizing the promise of dolutegravir in effectively treating children and adolescents living with HIV in real-world settings in 6 countries in eastern and southern Africa. *Pediatr Infect Dis J*. 2023;42:576–81. doi: 10.1097/INF.0000000000003878.
17. Gill MM, Khumalo P, Chouraya C, Kunene M, Diamini F, Hoffman HJ et al. Strengthening the evidence: Similar rates of neural tube defects among deliveries regardless of maternal HIV status and dolutegravir exposure in hospital birth surveillance in Eswatini. *Open Forum Infect Dis*. 2023;10:ofad441. doi: 10.1093/ofid/ofad441.
18. Zash R, Holmes LB, Diseko M, Jacobson D, Mayondi G, Mabuta J et al. Update on neural tube defects with antiretroviral exposure in the Tsepamo Study, Botswana. 24th International AIDS Conference, Montreal, Canada, 29 July–2 August. (Abstract PELBB02; <https://programme.aids2022.org/Abstract/Abstract/?abstractid=12759>, accessed 3 July 2024).
19. Kourtis AP, Zhu W, Lampe MA, Huang YA, Hoover KW. Dolutegravir and pregnancy outcomes including neural tube defects in the USA during 2008–20: a national cohort study. *Lancet HIV*. 2023;10:e588–96. doi: 10.1016/S2352-3018(23)00108-X.
20. Tukei VJ, Herrera N, Masitha M, Masenyetse L, Mokone Maj, Mokone Maf et al. Optimizing antiretroviral therapy for children living with HIV: experience from an observational cohort in Lesotho. *PLoS One*. 2023;18:e0288619. doi: 10.1371/journal.pone.0288619.
21. Persaud D, Bryson Y, Nelson BS, Tierney C, Cotton MF, Coletti A et al. HIV-1 reservoir size after neonatal antiretroviral therapy and the potential to evaluate antiretroviral therapy-free remission (IMPACT P115): a phase 1/2 proof-of-concept study. *Lancet HIV*. 2024;11:e20–30. doi: 10.1016/S2352-3018(23)00236-9.
22. Nelson BR, Tierney C, Persaud D, Jao J, Cotton MF, Bryson V et al. Infants receiving very early antiretroviral therapy have high CD4 counts in the first year of life. *Clin Infect Dis* 2023;8:76:e744–7. doi: 10.1093/cid/ciac695.
23. Shapiro RL, Ajibola G, Maswabi K, Hughes M, Nelson BS, Niesar A et al. Broadly neutralizing antibody treatment maintains HIV suppression in children with favorable reservoir characteristics in Botswana. *Sci Trans Med* 2023;5:15. doi: 10.1126/scitranslmed.adh0004.
24. Kirlane AR, Abouzeid Om, Minahan D, Bensen T, Hill AL, Selinger C et al. Development of an oral once-weekly drug delivery system for HIV antiretroviral therapy. *Nat Commun*. 2018;9:2. doi: 10.1038/s41467-017-02294-6.

25. Naschman S, Townsend CL, Abrams EJ, Archary M, Capparelli E, Clayden P et al. Long-acting or extended-release antiretroviral products for HIV treatment and prevention in infants, children, adolescents, and pregnant and breastfeeding women: knowledge gaps and research priorities. *Lancet HIV*. 2019;6:e552-e558.
26. Girdwood S, Pandey M, Machila T, Warriar R, Gautam J, Mukumbwa-Mwenechanya M et al. The integration of tuberculosis and HIV testing on GeneXpert can substantially improve access and same-day diagnosis and benefit tuberculosis programmes: a diagnostic network optimizing analysis in Zambia. *PLoS Glob Public Health*. 2023;3:e0001179. doi: 10.1371/journal.pgph.0001179.
27. The official guide to the Kanban method. Houston (TX): Kanban University; 2024 (<https://kanban.university/kanban-guide>, accessed 3 July 2024).
28. Abrams EJ, Capparelli E, Ruel T, Mirochnick M. Potential of long-acting products to transform the treatment and prevention of human immunodeficiency virus (HIV) in infants, children, and adolescents. *Clin Infect Dis* 2022;75(Suppl. 4):S562–70. doi: 10.1093/cid/ciac754.
29. Gaur AH, Capparelli EV, Calabrese K, Baltrusaitis K, Marzinke MA, McCoig C et al. Safety and pharmacokinetics of oral and long-acting injectable cabotegravir or long-acting injectable rilpivirine in virologically suppressed adolescents with HIV (IMPAACT 2017/MOCHA): a phase 1/2, multicentre, open-label, non-comparative, dose-finding study. *Lancet HIV*. 2024;11:e211–21. doi: 10.1016/S2352-3018(23)00300-4.
30. Lowenthal ED, Chapman, J, Ohrenschall R, Calabrese K, Baltrusaitis K, Heckman B et al. Acceptability and tolerability of long-acting injectable cabotegravir and rilpivirine in the first cohort of virologically suppressed adolescents living with HIV (IMPAACT 2017/MOCHA): a secondary analysis of a phase 1/2, multicentre, open-label, non-comparative dose-finding study. *Lancet HIV*. 2024;11:e222–32. doi: 10.1016/S2352-3018(23)00301-6.
31. Kankasa C, Menncier A, Sakana BLD, Molès J-P, Mwiya M, Chunda-Liyoka C et al. Optimised prevention of postnatal HIV transmission in Zambia and Burkina Faso (PROMISE-EPI): a phase 3, open-label, randomized controlled trial. *Lancet*. 2024;403:1362–71. doi: 10.1016/S0140-6736(23)02464-9
32. Ruel T, Penazzato M, Zech JM, Archary M, Cressey TR, Goga A et al. Novel approaches to postnatal prophylaxis to eliminate vertical transmission of HIV. *Glob Health Sci Pract*. 2023;11:e2200401. doi: 10.9745/GHSP-D-22-00401.
33. Van de Perre P, Scarlatti G, Moore PL, Molès J-P, Nagot N, Tyllieskär et al. Preventing breast milk HIV transmission using broadly neutralizing monoclonal antibodies: one size does not fit all. *J Immun Inflamm Dis*. 2024;12:e1216. doi: 10.1002/iid3.1216.
34. Dugdale CM, Ufio O, Alba C, Permar SR, Stranix-Chibanda L, Cunningham CK et al. Cost-effectiveness of broadly neutralizing antibody prophylaxis for HIV-exposed infants in sub-Saharan African settings. *J Int AIDS Soc*. 2023;26:e26052. doi: 10.1002/jia2.26052.
35. Cohn J, Owiredun MN, Taylor MM, Easterbrook P, Lesi O, Francoise B et al. Eliminating mother-to-child transmission of human immunodeficiency virus, syphilis and hepatitis B in sub-Saharan Africa. *Bull World Health Organ*. 2021;99:287–95. doi: 10.2471/BLT.20.272559
36. Brittain K, Brown K, Phillips T, Zerbe A, Pellowski J, Remien RH et al. Why do integrated maternal HIV and healthcare services work? A secondary analysis of a randomized controlled trial in South Africa. *AIDS Behav*. 2023;27:3831–43. doi: 10.1007/s10461-023-04097-x.
37. Thomson KA, Hughes J, Baeten JM, John-Stewart G, Celum C, Cohen CR et al. Increased risk of HIV acquisition among women throughout pregnancy and during the postpartum period: a prospective per-coital-act analysis among women with HIV-infected partners. *J Infect Dis*. 2018;218:16–25. doi: 10.1093/infdis/jiy113.

38. Stat Compiler. Rockville (MD): Demographic and Health Surveys (DHS) Program; 2024 (<https://statcompiler.com>, accessed 3 July 2024).
39. Wango CN, Chakrabarti A, Bair EF, Thirumurthy H, Ochillo M, Okumu O et al. Access to oral fluid-based human immunodeficiency virus self-tests increases testing among male partners of adolescent girls in Kenya: a randomized controlled trial. *J Adolesc Health*. 2023;73:632–9. doi: 10.1016/j.jadohealth.2023.02.031.
40. Gottert A, Pulerwitz J, Conserve DF. Providing HIV self-tests to adolescent girls to promote partner and couples testing: a welcome addition to the HIV prevention toolkit (with caveats). *J Adolesc Health*. 2023;73:614–5. doi: 10.1016/j.jadohealth.2023.07.005.
41. Kabami J, Koss CA, Sunday H, Biira E, Nyabuit M, Balzer LB et al. Randomized trial of dynamic choices HIV prevention at antenatal and postnatal care clinics in rural Uganda and Kenya. *J Acquir Immune Defic Syndr*. 2024;95:447–55. doi: 10.1097/QAI.0000000000003383.
42. Nakalega R, Mukiza N, Menge R, Kizito S, Babirye JA, Kuteesa CN, Maawanda D et al. Feasibility and acceptability of peer-delivered HIV self-testing and PrEP for young women in Kampala, Uganda. *BMC Public Health*. 2023;16:1163. doi: 10.1186/s12889-023-16081-0.
43. Saul J, Cooney C, Hosseini PR, Beamon T, Toiv N, Bhatt S et al. Modeling DREAMS impact: trends in new HIV diagnoses among women attending antenatal care clinics in DREAMS countries. *AIDS*. 2022;36(Suppl. 1):S51–9. doi: 10.1097/QAD.0000000000003259.
44. UN Women, AVAC, Athena Initiative, Salamander Trust. Key barriers to women's access to HIV treatment: a global review. New York: UN Women; 2021 (<https://www.unwomen.org/en/digital-library/publications/2017/12/key-barriers-to-womens-access-to-hiv-treatment#:~:text=The%20most%20frequently%20cited%20barriers,related%20employment%20refusal%2C%20and%20other>, accessed 3 July 2024).
45. Violence against women and girls—what the data tell us. Washington (DC): World Bank; 2022 (<https://genderdata.worldbank.org/en/data-stories/overview-of-gender-based-violence>, accessed 3 July 2024).
46. Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. Geneva: World Health Organization; 2013 (<https://iris.who.int/handle/10665/85239>, accessed 3 July 2024).
47. Gender data portal: all indicators [online database]. Washington (DC): World Bank; 2024 (<https://genderdata.worldbank.org/en/indicators>, accessed 3 July 2024).
48. Explore the data [online database]. New York: UN Women; 2024 (<https://data.unwomen.org/data-portal>, accessed 3 July 2024).
49. Patton GC, Sawyer SM, Santelli JS, Ross DA, Afifi R, Allen NB et al. Our future: a Lancet commission on adolescent health and wellbeing. *Lancet*. 2016;387:2423–78. [https://doi.org/10.1016/S0140-6736\(16\)00579-1](https://doi.org/10.1016/S0140-6736(16)00579-1).
50. Children and adolescents affected by AIDS: expenditures, needs and resource gaps. New York: Coalition for Children Affected by AIDS; in press.



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