

# Reimagining a resilient HIV response for children, adolescents and pregnant women living with HIV



**2.8 million**

children and adolescents  
living with HIV

**880**

children and adolescents  
becoming infected with  
HIV every day

**310**

children and adolescents  
dying from AIDS-related  
causes every day



## Introduction

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The year 2020 has been an especially difficult one for the majority of the children, adolescents, and pregnant women living with HIV worldwide. A new virus, COVID-19, has seized the world's attention and further jeopardized their health and well-being. Vital HIV treatment and prevention services have been disrupted in many countries. Necessary restrictions on travel and gathering in groups have prevented or limited access to health clinics, schools, and a range of facilities for social welfare support. The COVID-19 pandemic has almost certainly stalled the global HIV response and led to the reversal of many critical gains.

Women and children are bearing the brunt of the COVID crisis in many of the same ways that they have borne that of the decades-long fight against HIV. While the pandemic is a health crisis at its core, the surging poverty and domestic violence it has caused are greatly impacting the lives of women and children and increasing their vulnerabilities.

Yet the challenges of COVID-19, profound and extensive as they have been and continue to be, are not the main message of this year's World AIDS Day report. The emphasis instead is on being resilient, identifying challenges, understanding the data, and reimagining responses in solidarity, as one global community.

This report presents 2019 key global data and an overview of the HIV epidemic among children and adolescents, focusing on UNICEF's contribution to HIV prevention, treatment and care services in the global HIV response. Because it is 2020, the report also includes the impact of the COVID-19 pandemic on UNICEF's results and achievement.

Finally, the report concludes with a proposed way forward that highlights fighting stigma, which has been a persistent and debilitating challenge to people living with and vulnerable to HIV over the past four decades.



## The global community is still far from ending AIDS as a public health threat by 2030. But it remains an achievable and important goal.

The HIV response for pregnant women, children, and adolescents has reached a pivotal juncture at the end of 2019 because little progress had been documented in many key areas in the preceding four years. Well before the COVID-19 pandemic, it was clear that the world was far from achieving the global 2020 paediatric HIV targets.

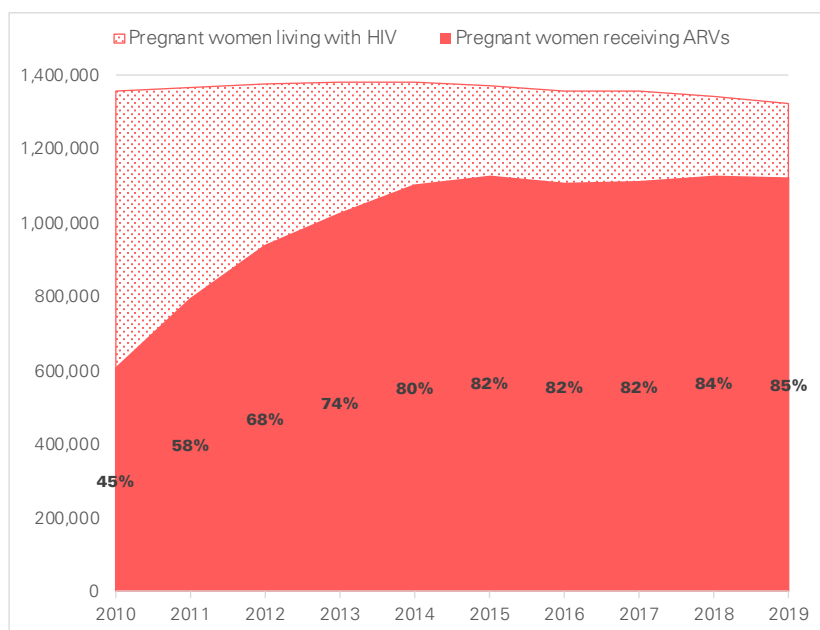
In the first decades of fight against HIV, the global community came together in extraordinary ways to reach women living with HIV with antiretroviral treatment (ART), allowing them to stay alive and in good health and to stop the **transmission of HIV to their children** during pregnancy, delivery, or breastfeeding. In the 10 years from 2010 to 2019, **ART coverage among pregnant women with HIV** nearly doubled, from 45 per cent to 85 per cent (see Figure 1). The overall growth in ART coverage for women living with HIV, however, slowed considerably in the second half of that decade, after 2014, leaving a significant gap in reaching the ambitious, fast-tracked global target of 95 per cent by 2020.

Furthermore, the unique and context-specific challenges of travelling ‘the last mile’ on the path to an AIDS-free generation make the prospect of reaching the global target of reducing the annual number of new HIV infections from mother-to-child transmission to under 20,000 unlikely. As a result, the longstanding global ambition of **eliminating mother-to-child transmission** (EMTCT) of HIV remains out of reach for the immediate future. A total of 13 countries had been validated for EMTCT by the World Health

Organization (WHO) through 2019<sup>1</sup>. None of these countries are in sub-Saharan Africa, which is home to 88 per cent of the world’s children under 15 years of age living with HIV.

Persistent coverage challenges in a handful of countries in that region and elsewhere are largely responsible for the stalled global PMTCT effort. Of the 23 focus countries that account for more than 85 per cent of women living with HIV, the share of pregnant women living with HIV who are receiving ART is less than 50 per cent in Angola, Nigeria, the Democratic Republic of the Congo and Indonesia. At the other end of the spectrum in that focus group, several countries are on the pathway to eliminating mother-to-child transmission of HIV, including Botswana, Eswatini, Namibia, South Africa, Malawi and Uganda – all of which have reported ART coverage exceeding 95 per cent among pregnant women living with HIV.

Figure 1: Number of pregnant women living with HIV and number receiving antiretrovirals (ARVs) for the prevention of mother-to-child transmission, 2010–2019



Data source: Global AIDS Monitoring 2020, UNAIDS 2020 estimates

Globally, pregnant women, children and adolescents living with HIV are in desperate need of **newly energized and catalytic HIV responses centred on human rights and equity.**

At the global level, we have fallen short of every one of the super-fast-track targets for children and adolescents that were set for 2018 and 2020. Collectively, the global community must examine the gains made, identify what stalled the progress, and reimagine new ways of addressing the challenges with renewed energy against the background of COVID-19.

## If current trends continue, key global targets in reducing new infections from mother-to-child transmission will not be reached.

The number of AIDS-related deaths among children aged 0–19 has fallen by more than one-half (53 per cent) since 2000 (see Figure 2). In addition, younger children infected with HIV at birth are now more likely to survive into adolescence or adulthood. But even though the

share has declined, deaths in young children under five still account for the majority of deaths (60 per cent in 2019) among children aged 0–19 (see Figure 2).

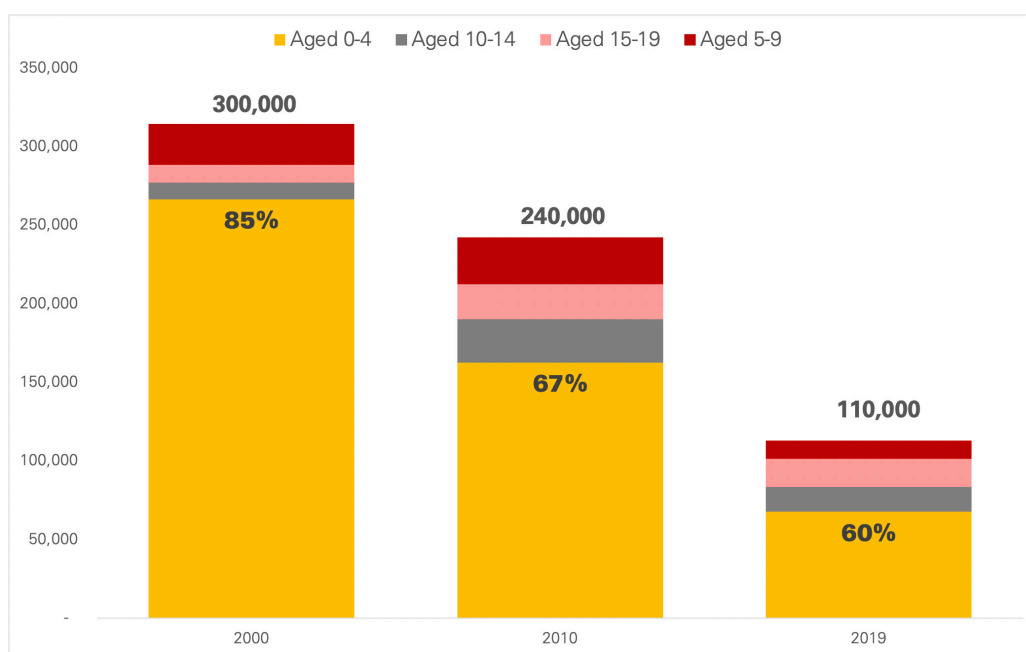


Figure 2: Annual number of AIDS-related deaths among children aged 0–19, by five-year age group, 2000, 2010 & 2019

## Progress in paediatric treatment has been significantly slower, which points to the urgent need to narrow the treatment gap among infants, children and adolescents.

The AIDS-related death figures underscore the relatively slow progress in **paediatric HIV treatment**, which is the result of the decentralisation of ART services for children being frequently inadequate and lacking the quality required for the optimum outcome. Globally, only about 53 per cent of children living with HIV had access to ART in 2019. This is only an increase of 12 percentage points since 2015 (see Figure 3).

For the better part of the last decade, mothers living with HIV have had better access to testing

and treatment than children (see Figure 4). Globally, paediatric ART coverage has continued to lag behind both treatment coverage for PMTCT (85 per cent) and all adults living with HIV (62 per cent) in 2019. Narrowing the treatment gap for children is considered an urgent priority by UNICEF, including the use of evidence-based strategies to test and treat infants, children, and adolescents and retain them in lifelong care.

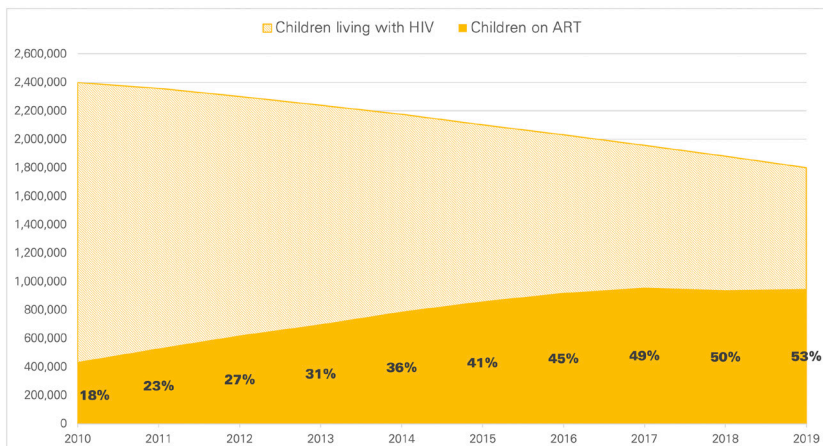


Figure 3: Number of children age 0–14 living with HIV and number receiving antiretroviral therapy, 2010–2019

Data source: Global AIDS Monitoring 2020, UNAIDS 2020 estimates

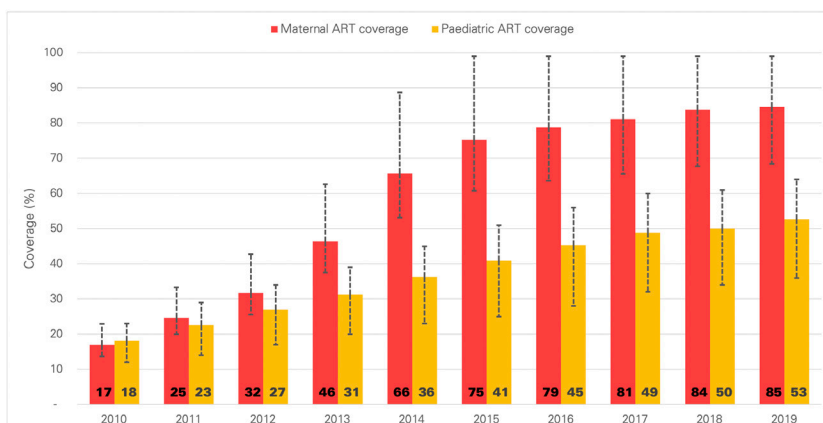


Figure 4: Percentages of children aged 0-14 living with HIV and pregnant women with HIV receiving ART, 2010-2019

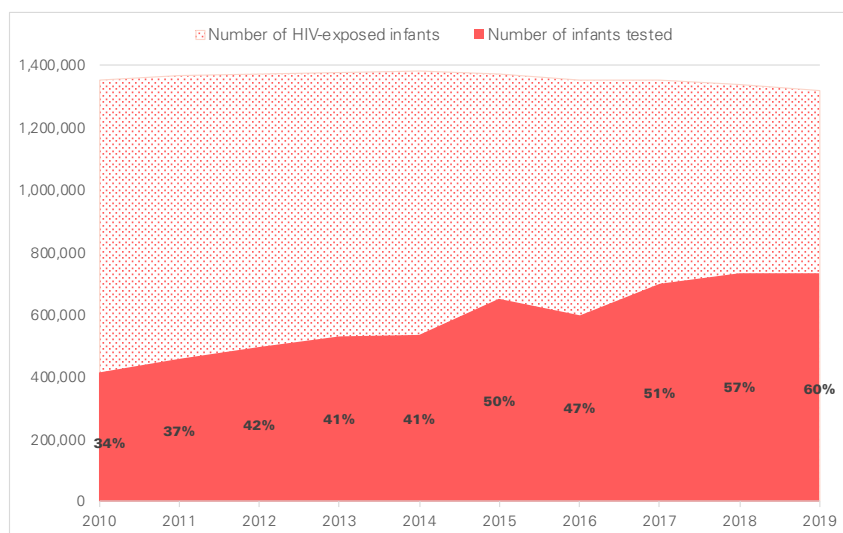
Data source: Global AIDS Monitoring 2020, UNAIDS 2020 estimates

## HIV treatment options for children must meet adequacy with quality of services.

Testing challenges remain acute for many children, as seen in the difficulties faced in more rapidly advancing **access to early infant diagnosis (EID) at 6-8 weeks of age per WHO guidelines**. In 2010, global EID coverage was 34 per cent. By 2019 it had edged up to 60 per cent (see Figure 5). This level of coverage, although improving, points to remaining challenges to effectively expand EID access and is compounded by delayed turnaround time on results when only conventional laboratory systems are used.

Making better progress in improving EID coverage and reducing other HIV prevention and treatment gaps require that a range of different solutions be rolled out more widely. Promising ones based on evidence include using point-of-care (POC) diagnostics to more rapidly get results and convey them to clients; family or 'index' testing to identify missing cases; HIV self-testing (especially for adolescents) to overcome confidentiality and legal concerns, among other common barriers; and more involvement and support by communities (e.g., through peer-led support programmes) to help people get access to HIV services and to remain successfully on treatment and in care. These solutions can greatly contribute to the building of service-delivery frameworks that are more accommodating and effective for pregnant women, children and adolescents everywhere.

Figure 5: Number of HIV-exposed infants and number tested for HIV within two months of birth, 2010–2019



Data source: Global AIDS Monitoring 2020, UNAIDS 2020 estimates

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

Efforts to improve overall progress among children and adolescents living with HIV also should acknowledge and reflect the significant variations in key coverage indicators across regions and countries. For example, an infant born to a mother with HIV in Eastern and Southern Africa is more than twice as likely to be tested for HIV within two months of birth than one born in West and Central Africa or the Middle East and North Africa. Fewer than half of all children aged 0–14 living with HIV are receiving ART in Latin America and the Caribbean compared with nearly 8 out of 10 children in South Asia. An important underlying consideration is that sub-Saharan Africa was home to nine in 10 of the estimated 2.8 million children aged 0–19 living with HIV in 2019.

Eastern and Southern Africa has shown much greater progress in reaching and supporting children living with HIV than West and Central

Africa, where both EID access and ART coverage for those aged 0–14 are below 35 per cent (see Figures 6 and 7).

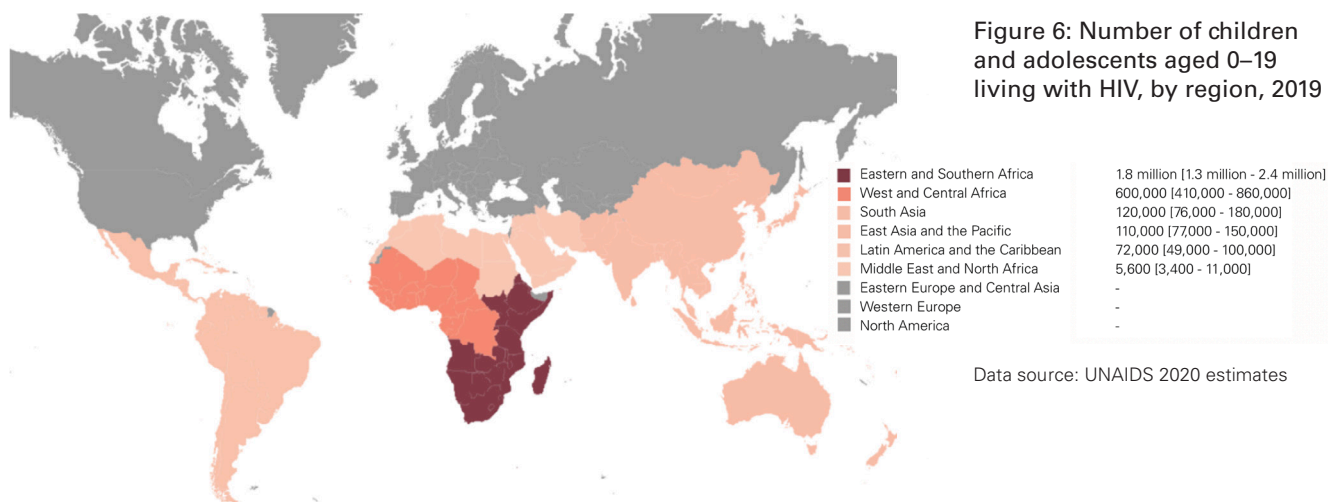


Figure 7: HIV Intervention coverage by region, 2019

Region	Mother-to-child HIV transmission rate (%)	HIV incidence per 1,000 adolescents, 10-19	PMTCT coverage (ART) (%)	Early infant diagnosis (%)	ART coverage among children 0-14 (%)	Tested for HIV in the last 12 months and received the result (%)		Condom use among those with multiple partners (%)		Comprehensive knowledge of HIV (%)	
						Girls aged 15-19	Boys aged 15-19	Girls aged 15-19	Boys aged 15-19	Girls aged 15-19	Boys aged 15-19
Eastern and Southern Africa	8.05 [6.52 - 10.49]	1.90 [0.51 - 3.81]	95 [71 - >95]	68 [57 - 91]	58 [40 - 66]	21.9	15.8	30.2	53.6	33	37.6
West and Central Africa	19.91 [15.62 - 23.95]	0.46 [0.11 - 1.04]	52 [32 - 89]	33 [25 - 47]	32 [22 - 45]	7.1	4.5	32.6	48.6	22.2	23.6
South Asia	30.79 [21.49 - 36.21]	0.04 [0.02 - 0.07]	54 [40 - 71]	36 [27 - 50]	76 [46 - >95]	1.7	0.6	36.3	29.9	15.2	23.6
Latin America and the Caribbean	13.94 [11.68 - 17.46]	0.11 [0.04 - 0.21]	77 [53 - >95]	46 [36 - 57]	46 [31 - 62]	-	-	-	-	-	-
East Asia and the Pacific	21.38 [18.15 - 23.92]	0.10 [0.05 - 0.17]	57 [45 - 70]	40 [33 - 50]	50 [36 - 62]	-	-	-	-	-	-
Middle East and North Africa	23.45 [16.33 - 32.01]	0.02 [<0.01 - 0.05]	52 [32 - 89]	29 [18 - 45]	81 [49 - >95]	-	-	-	-	-	-
Global	11.35 [9.06 - 14.20]	0.29 [0.09 - 0.57]	85 [68 - >95]	60 [49 - 81]	53 [36 - 54]	6.7	-	-	-	20.3	24.1

Source: Global AIDS Monitoring 2020, UNAIDS 2020 estimates and UNICEF Global Databases of nationally representative population-based surveys 2012-2019  
\*Aged 15-19 years



While regional data and comparisons are important, focusing primarily on them obscures important information about where the most children do not have access to essential HIV services. For example, six countries are home to more than 50% of all children living with HIV who are not on ART: South Africa, Mozambique, Nigeria, Kenya, Uganda and United Republic of Tanzania. Additional countries with less than 50 per cent paediatric coverage include Angola, Burundi, Cameroon, Chad, Côte d'Ivoire, DRC,

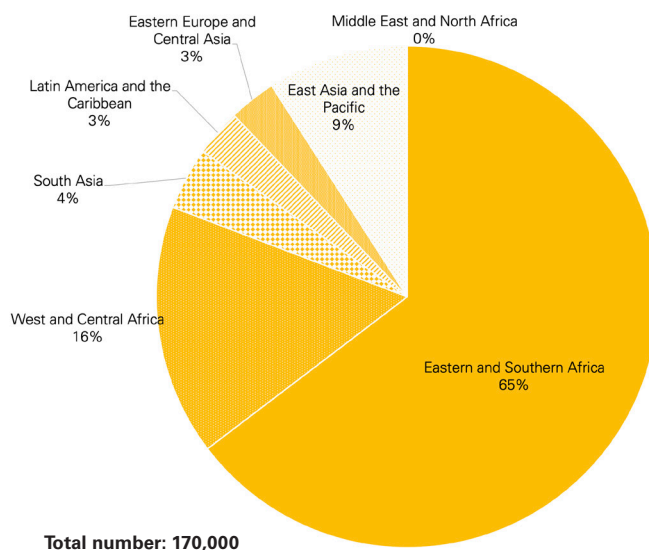
Djibouti, Dominican Republic, Ethiopia, Ghana, Haiti, Nigeria, Philippines, Rwanda and South Africa. The data therefore indicate two things about these and other countries with similar profiles: Faster global progress in reducing absolute numbers of unreached children is likely to be achieved by more targeted attention to these countries, and they also are uniquely positioned to provide best practice suggestions for how to proceed elsewhere, given their relative success, or challenges, in terms of coverage share.

There are glimmers of hope and progress, as momentum on HIV prevention for adolescent girls and young women has been accelerating in key affected countries. However, much remains to be done. **To achieve the global AIDS targets by 2030, ensuring rights to health and protection for young key populations is non-negotiable.**

New HIV infections among adolescents is an issue for all regions, with sub-Saharan Africa accounts for 83 per cent of them (see Figure 8).

Progress towards preventing HIV in adolescents and young people is significantly slower than for many other HIV response indicators (see Figure 7), as revealed by a review of regional data. This is especially troubling for the future ability to bend the epidemic's trajectory downward. West and Central Africa is home to one of the fastest-growing adolescent populations in the world, and if the current trend is maintained over the next decade, the number of new HIV infections in adolescents will not decline fast enough to end AIDS as a health threat even by the year 2050. This is one of several signs suggesting that overall, the burden of unmet need is shifting from the longstanding epicentre of the global HIV epidemic in Eastern and Southern Africa to lower prevalence regions of the world, especially West and Central Africa.

Figure 8: Proportion of new HIV infections among adolescents (15–19 years), by UNICEF region, 2019



Data source: UNAIDS 2020 estimates

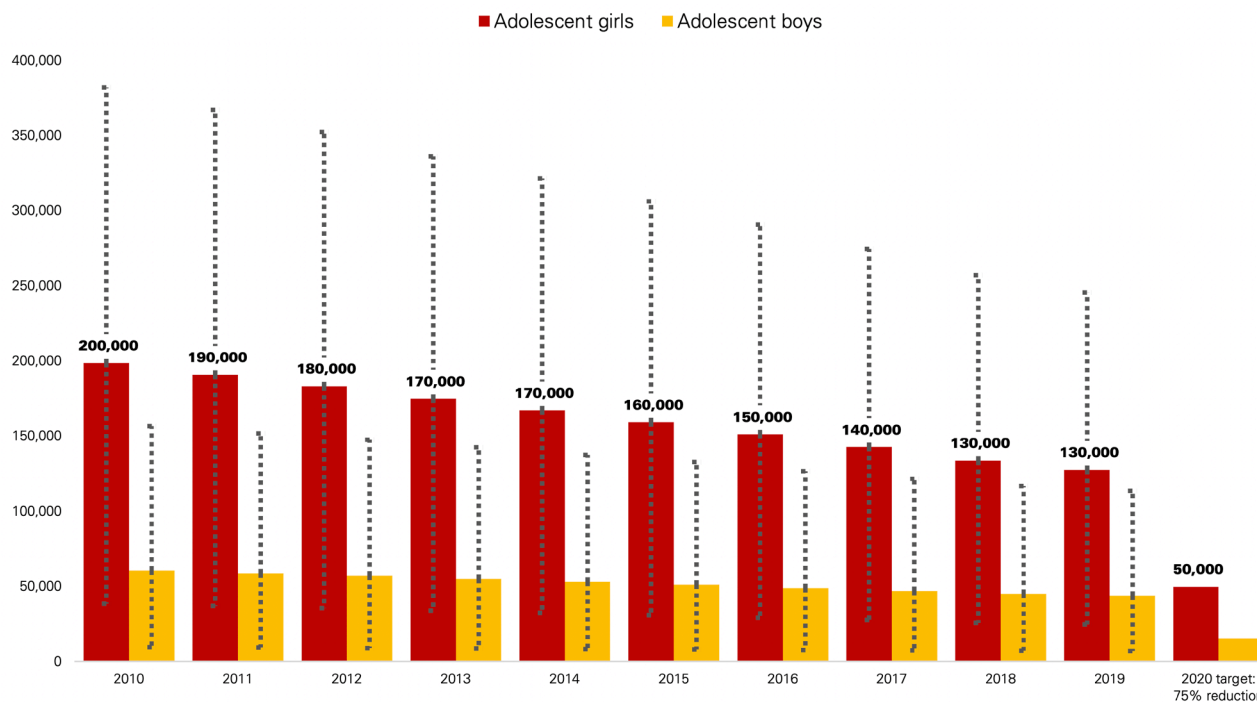


The annual number of new HIV infections among adolescents (aged 10–19 years) worldwide has fallen by about one-third (34 per cent) since 2010, to an estimated 170,000 in 2019. In the case of adolescent girls, the annual number of new HIV infections fell from 200,000 in 2010 to 130,000 in 2019, a decline of more than one-third (35 per cent). The comparable decline among boys of this age group, from 61,000 to 44,000, was smaller at 28 per cent. Overall, this progress is still far too slow to meet the global target of reducing annual new infections among all adolescents by 75 per cent (see Figure 9).

Within these overall declines, however, there are some worrying trends. Vulnerability remains heavily skewed against girls, who accounted for three in four of those new adolescent infections. The share among girls is higher still, at four out of five (82 per cent), in sub-Saharan Africa, home to most of the world’s high-prevalence countries. Also, due to resource constraints and the challenges of gathering information from key populations who are highly marginalized,

stigmatized and discriminated, there is very little age disaggregated data available for these groups. This is a huge concern given the degree of vulnerability among young key populations and their sexual partners in general. According to the UNAIDS 2020 Global AIDS Update report, key populations accounted for more than 60 per cent of new adult HIV infections globally. In Eastern Europe and Central Asia, one of only three regions where the HIV epidemic is growing, 99 per cent of new HIV infections in adults are among key populations and their sexual partners. The lack of differentiated programmatic attention for adolescents by the global community, criminalization of transgender identity and same-sex sexual acts, stigma in health facilities, denying rights to information and HIV services, including the need for parental consent to test for HIV, and the lack of mental health support, all remain major concerns for the future HIV responses to achieve the global AIDS targets by 2030, especially in Eastern and Central Europe and Middle East and North Africa.

Figure 9: Annual number of new HIV infections among adolescents aged 10–19, by sex, 2010–2019



Data source: UNAIDS 2020 estimates

## Slow progress made worse by COVID-19, further exposing inequities in access to critical HIV services for children, adolescents and women across different regions and countries, as well as within individual countries.

The COVID-19 pandemic has added further challenges to efforts to build on and sustain gains. With mothers and children being unable to access the care they need due to lockdowns, curfews, and fear of contracting the virus that causes COVID-19, the number of clients attending HIV treatment clinics, especially pregnant women and children, declined in many countries. Although coverage is improving, one-third of 29 HIV priority countries responding to a recent UNICEF survey acknowledged that service coverage for women, children and adolescents living with and vulnerable to HIV is lower by 10 per cent or more compared with before the pandemic (see Figure 10).

Additional indications of the scope of the impact can be seen in UNAIDS HIV service disruption data (September 2020) coming from 13 out of 86 reporting countries. In the 13 countries, at least 50 per cent of facilities reported coverage, there

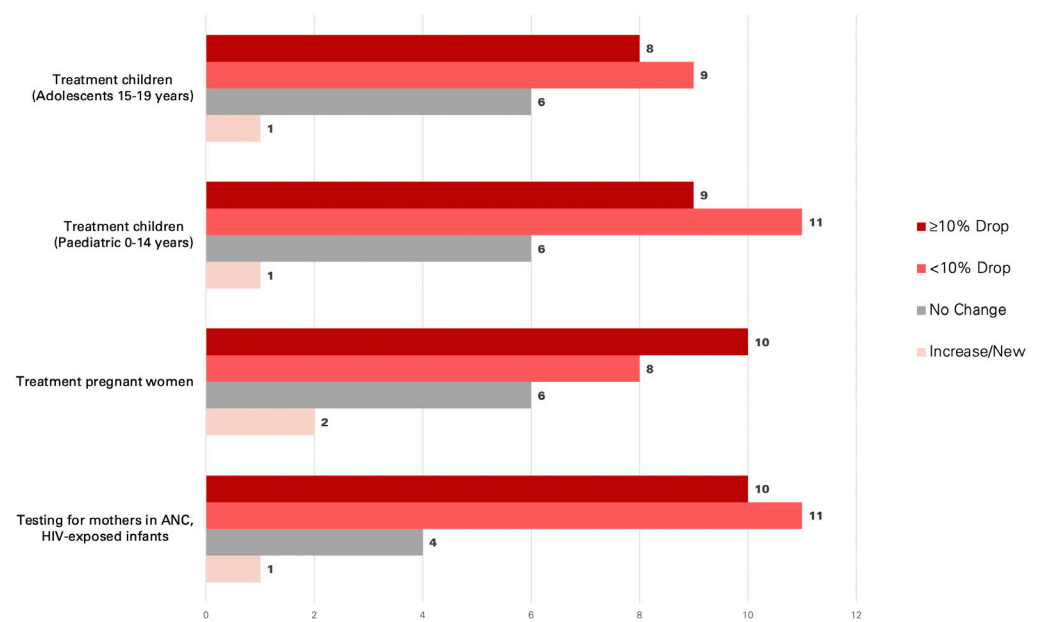
was an observed disruption of provision of testing and treatment services among children and pregnant women living with HIV in the months of April and May. This resulted from a combination of partial or full lockdown measures, decreased demand, limited availability of personal protective equipment (PPE), supply chain disruption and redeployment of healthcare workers to fight COVID-19 primarily or solely.

Coverage of paediatric HIV treatment and viral load testing in children showed the greatest declines in those 13 countries, between 50 per cent and 70 per cent (median 35 per cent – 45 per cent). New treatment initiations in children were down by 25 per cent to 50 per cent (median 25 per cent – 45 per cent). Infant HIV testing services were also affected but relatively less so, with a median decline of 10 per cent.

**Figure 10: Changes in HIV services in priority countries**

COVID-19-related change in HIV treatment and testing services coverage as compared to this time last year in HIV priority countries

*HIV priority countries responding = 29 of 35*



Source: UNICEF Rapid Situation Tracking for COVID-19 Socioeconomic Impacts, October 2020



Health facility deliveries and maternal treatment reduced by 20 per cent – 60 per cent, with a median reduction of 15 per cent – 25 per cent, whereas maternal HIV testing and ART initiations reduced by 25 per cent – 50 per cent (median 15 per cent – 20 per cent). In a number of countries, the uptake of HIV services rebounded in June as a result of the easing of lockdown measures as well as strategic efforts to prioritize the health needs of pregnant women and children. However, coverage levels are still far from expected numbers prior to COVID-19.

The full extent of the pandemic on HIV programmes overall, and for women and children, in particular, will not be known any time soon. But it is clear that both the short and longer-term

impacts could be significant, including an increase in HIV infections, especially among adolescent girls and young women.

Other challenges observed in 2020 that affect people living with and vulnerable to HIV no matter where they live include stigma and discrimination. They are arguably among the most critical barriers to more effective HIV responses, and they have remained highly prevalent. This report does not present any data on the prevalence or impact of stigma, as there are none collected routinely to report. Yet the high medical, psychological, social and financial costs are undeniably clear from substantial anecdotal and observational accounts as well as experiences with other stigmatizing health issues.

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## Stigma around HIV silently impacts our health and well-being. **We must invest in building a conducive, non-discriminatory legal environment.**

Time and again, the history of epidemics, including leprosy and cholera, confirms the high cost of stigma both to individuals/clients and to societies as a whole. In the case of HIV, 40 years of work has yielded one of the most remarkable public health accomplishments of our time – with more than 25 million people living with HIV on lifelong treatment and millions of infections averted in adults and children. But stigma has continued to negatively affect programmes and HIV responses in general by making it difficult or impossible for

many people to know about the risks they are facing and how to protect themselves, or how to comfortably, safely and conveniently get the services they need. **Stigma around HIV bolsters the myth that it is a disease to be shunned and ashamed of, encourages those affected and their families and communities to conceal the illness and avoid treatment, perpetuates victim blaming, intensifies stress and anxiety, and reinforces inequality.**

Stigma has begun to feature in COVID-19 narratives, with some striking parallels with the challenges faced in the fight against HIV. We must recognize this and learn from our mistakes with HIV. HIV lessons tell us that relevant national laws and policies must be founded on the concept that every human being is equal in rights and dignity, regardless of their ethnicity, race, socio-economic background, sexual orientation or gender identity. This concept must also lie in the hearts and minds of policymakers, programme implementers, and the public at large. Stigma shapes our ideas,

policies, and laws. It is time that we begin to focus on measuring stigma and its impact on our gains, especially regions where stigma weighs significantly—for example, in Eastern Europe and Central Africa, Middle East and North Africa, and South Asia. Above all, we must protect the rights of the most marginalized populations, including those living with HIV, in the face of COVID-19-related health and economic challenges. Failure to do this will prolong the impact and longer-term consequence of both pandemics.

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## **Global solidarity, strategic partnerships, optimized funding and health system strengthening must be placed at the centre** while reimagining HIV responses for children, adolescents and pregnant women in the world of paired pandemics of HIV and COVID-19.

Another lesson from the experience of the global HIV epidemic is that greater interconnectedness and interdependence of the global community is needed to respond to the COVID-19 crisis. Indeed, as we design differentiated responses, we must forge shared partnerships for advocacy; collaborate through networks, coalitions, and movements on the ground; and channel the incredible resilience of communities into building the next phase of preventing resurgence of HIV while fighting COVID-19. The theme for World AIDS Day 2020 –**global solidarity and shared responsibility**– could not be more fitting. COVID-19 tells us that we are one global community, divided primarily by invisible political lines, mountains and seas.

This spirit of one global community and resilience reflects the kind of collective drive and energy that fuelled a more effective and humane global

HIV response three decades ago and was instrumental in saving the lives of tens of millions of people. To get back on track for children, adolescents, and women living with HIV, it is important to **support the ingenuity, resilience, and solidarity of communities** in finding ways to confront the restrictions and other challenges of the COVID-19 crisis. The lessons learned can help to design and drive programming that more forcefully tackles longstanding gaps by highlighting and responding to the equity and human rights challenges that create them. The central element of this response is, arguably, the **partnership of the global community**, which is value-based, innovative, trusting, integrated, and results-oriented. Only through global partnership and real dialogue among partners can we **reimagine a more resilient HIV response in a world living with COVID-19**.

### **Endnotes**

1. [www.who.int/reproductivehealth/congenital-syphilis/WHO-validation-EMTCT/en/](http://www.who.int/reproductivehealth/congenital-syphilis/WHO-validation-EMTCT/en/)



# Global Data 2019

<b>Epidemiology</b>	<b>Estimate</b>	<b>Lower</b>	<b>Upper</b>
Number of children and adolescents living with HIV	2,800,000	1,900,000	3,700,000
Children aged 0–9	1,100,000	780,000	1,300,000
Adolescents aged 10–19	1,700,000	1,100,000	2,300,000
Number of new HIV infections, children and adolescents	320,000	150,000	580,000
Children aged 0–9*	150,000	94,000	240,000
Adolescents aged 10–19	170,000	53,000	340,000
Adolescent girls	130,000	25,000	250,000
Adolescent boys	44,000	6,800	110,000
HIV incidence per 1,000 population, adolescents aged 15–19	0.29	0.09	0.57
Adolescent girls	0.44	0.08	0.85
Adolescent boys	0.14	0.02	0.36
Number of AIDS-related deaths, children and adolescents	110,000	74,000	180,000
Children aged 0–9	79,000	51,000	130,000
Adolescents aged 10–19	34,000	23,000	50,000
Number of children aged 0–17 who lost one or both parents due to AIDS	13,800,000	10,200,000	17,900,000
Number of pregnant women living with HIV	1,300,000	980,000	1,600,000
Mother-to-child transmission rate of HIV, final	11.3	9.1	14.2
Perinatal transmission	6.2	4.6	8.3
Postnatal transmission	5.2	4.4	5.9
<b>HIV response</b>	<b>Estimate</b>	<b>Lower</b>	<b>Upper</b>
PMTCT coverage (%)	85	68	>95
Early infant diagnosis (%)	60	49	81
ART coverage, children aged 0–14 (%) **	53	36	64

Data source: Global AIDS Monitoring 2020, UNAIDS 2020 estimates

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

Indicator definitions: Mother-to-child transmission (MTCT) rate: Number of children aged 0–4 newly infected with HIV per 100 pregnant women living with HIV. HIV incidence per 1,000 adolescents: Number of new HIV infections among adolescents aged 15–19 per 1,000 adolescents at risk of HIV infection. PMTCT coverage: Percentage of pregnant women living with HIV who received antiretrovirals to prevent mother-to-child transmission of HIV. Early infant diagnosis: Percentage of infants born to HIV-positive mothers who were tested for HIV within two months of birth. ART coverage among children aged 0–14: Percentage of children aged 0–14 living with HIV who are receiving antiretroviral treatment

## Regional Data

### Number of children and adolescents aged 0-19 living with HIV, by region, 2019

Region	Estimate	Lower	Upper
Eastern and Southern Africa	1,900,000	1,300,000	2,400,000
West and Central Africa	600,000	410,000	860,000
South Asia	120,000	76,000	180,000
Latin America and the Caribbean	72,000	49,000	100,000
East Asia and the Pacific	110,000	77,000	150,000
Middle East and North Africa	5,600	3,300	11,000
<b>Global</b>	<b>2,800,000</b>	<b>1,900,000</b>	<b>3,700,000</b>

Data are not available for Eastern Europe and Central Asia, Western Europe, and Middle East and North Africa.

Data source: UNAIDS 2020 estimates

Note: Lower and upper estimates refer to the confidence interval.

### HIV intervention coverage, 2019

Region	PMTCT coverage (%)	Early infant diagnosis (%)	ART coverage among children 0-14 (%)
Eastern and Southern Africa	95 [71 – >95]	68 [57 – 91]	58 [40 – 66]
West and Central Africa	52 [32 – 89]	33 [25 – 47]	32 [ 22 – 45]
South Asia	54 [40 – 71]	36 [27 – 50]	76 [46 – >95]
Latin America and the Caribbean	77 [53 – >95]	46 [36 – 57]	46 [31 – 62]
East Asia and the Pacific	57 [45 – 70]	40 [33 – 50]	50 [36 – 62]
Middle East and North Africa	52 [32 – 89]	29 [18 – 45]	81 [49 – >95]
<b>Global</b>	<b>85 [68 – &gt;95]</b>	<b>60 [49 – 81]</b>	<b>53 [36 – 54]</b>

Data are not available for Eastern Europe and Central Asia, Western Europe, and Middle East and North Africa.

Data source: Global AIDS Monitoring 2020, UNAIDS 2020 estimates

Note: Numbers in brackets refer to the confidence interval.



## Key Terminology Guide

For the purposes of epidemiological monitoring, UNAIDS' estimates refer to children as those aged 0 to 14 years, adolescents as those aged 10 to 19 years, young people as those aged 15 to 24 years, and adults as those older than 15 years.

**Children:** Persons below the age of 18  
Convention on the Rights of the Child

**Adolescents:** Persons between the ages of 10 and 19  
United Nations Children's Fund (UNICEF) / World Health Organization (WHO) / United Nations Population Fund (UNFPA)

**Youth:** Persons between the ages of 15 and 24  
United Nations General Assembly resolution A/ RES/50/81

**Young people:** Persons between the ages of 10 and 24  
United Nations Children's Fund (UNICEF) / World Health Organization (WHO) / United Nations Population Fund (UNFPA)



# Ending AIDS for children by 2030

UNICEF celebrates the resilience of people who overcome barriers, achieve ambitious programmatic goals, and advocate for rights in the fight against HIV. We support resilience in mothers, children and adolescents, health care providers, government officials, communities and advocates as we strive to ensure PMTCT for every pregnant woman, optimal ART for every child, and multiple prevention services for every adolescent. We also support strengthening health systems that ensure that every child not only survives, but also thrives. Over the past 40 years, we have seen many examples of resilience in the face of challenges posed by the HIV epidemic – a key element of the most extraordinary public health responses in history.

We have come a long way in the fight against HIV but have a fair distance still to go – especially in the wake of the COVID-19 pandemic. Now, more than ever, we must continue to fund HIV responses for children and adolescents and support the scale-up of HIV prevention, treatment and care. To end AIDS for children by 2030, a meaningful meeting of minds – decision makers, advocates, programme implementers and children – must take place to understand the needs on the ground, brainstorm catalytic responses, and stand in solidarity as we agree on shared responsibilities.

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