



## **THE GLOBAL ALLIANCE TO END AIDS IN CHILDREN**

A GLOBAL STRATEGIC INITIATIVE TO END AIDS IN  
CHILDREN BY 2030

# DRAFT OPERATIONAL FRAMEWORK



## VISION

An end to AIDS in children, achieved through a strong, strategic, and action-oriented alliance of multisectoral stakeholders at national, regional, and global levels that works with women children and adolescents living with HIV, national governments, and partners to mobilize leadership, funding, and action to end AIDS in children by 2030.

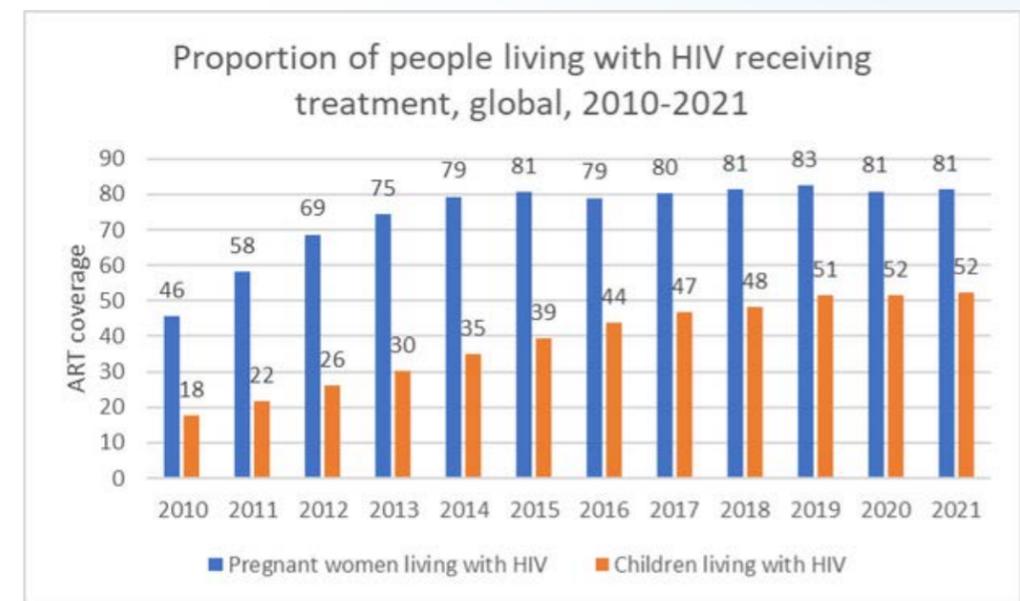
## WHY IS A NEW ALLIANCE NEEDED?

There has been remarkable progress in some countries in providing antiretroviral therapy (ART) to pregnant women living with HIV. By the end of 2021, 12 countries in sub-Saharan Africa reached the target of 95% ART coverage in pregnant women; and Botswana was the first high prevalence African country to be validated as on the path to eliminating vertical transmission of HIV.

However, at the global level, we are far from ending new HIV infections in children and ensuring quality care for women living with HIV. There are HIV high burden countries and locations where progress in preventing vertical transmission has flatlined. In addition, challenges with the quality of care persist, with poor uptake of testing, gaps in ART initiation, low retention rates and poor adherence to HIV treatment. The COVID-19 pandemic has thrown us further off track – between 2019 and 2021, ART coverage among pregnant and breastfeeding women declined in some countries. In areas of high HIV incidence where the general risk of HIV acquisition among women is high, retesting and HIV prevention options throughout the antenatal and postnatal periods are not routinely offered to HIV negative pregnant and breastfeeding women. As a consequence, infection rates in this population remain high and mothers who acquire HIV during pregnancy often remain undiagnosed – resulting in high rates of vertical HIV transmission.

One of the most glaring disparities of the AIDS response to date is the failure to provide life-saving treatment to children and adolescents living with HIV. While 81% of pregnant women living with HIV and 76% of adults overall were receiving antiretrovirals in 2021, only 52% of children (0-14 years) were accessing ART. (Figure 1)

**Figure 1: ART Coverage in children 0-15 and pregnant women 2010 to 2021**



Source: UNAIDS 2022 Epidemiological Estimates

There is also a significant treatment coverage gap in adolescents 15-19 years. Although data in this population is limited, among 21 sub-Saharan countries reporting in 2021, only 55% of adolescents were on treatment. It is estimated that 800,000 children (0-14 years) are untreated, even though new testing technologies including point of care EID and HIV self-tests are more widely available, and recently approved paediatric ART options are better tolerated, more effective and cheaper than ever before. An additional estimated 400,000 adolescents (15-19 years), many of whom are likely recently infected, are not receiving treatment. The lack of case-finding is a key problem—HIV testing strategies that are known to be effective and can identify children before they become sick, such as family-based index testing, are still not implemented to scale in many countries.

For those children and adolescents living with HIV whose status is known and who are on treatment, many are still receiving older sub-optimal drugs, and when this is combined with poor adherence support systems, the result is low rates of viral suppression. In a recent multi-country analysis, 79% of adults were virologically suppressed after 1 year on treatment, compared with only 64% of children and adolescents[1].

Stigma, discrimination, punitive laws and policies, violence and entrenched societal and gender inequalities hinder access to care for women, adolescents and children. Robust global, national, and local political support for preventing vertical transmission of HIV and paediatric and adolescent treatment is often lacking, with correspondingly low prioritization of these activities in national strategies, plans, and budgets. Insufficient investment in community-based or -led services also hampers access to testing, treatment and retention in care, especially for the most vulnerable populations such as adolescent key populations, sex workers and their children and women and children living in rural areas.

Over the past decade, the global community of HIV stakeholders has coordinated efforts to address these inequities and challenges launching two major global initiatives to eliminate vertical HIV transmission and end paediatric AIDS. From 2011 to 2015, the Global Plan towards the Elimination of New HIV Infections Among Children by 2015 and Keeping Their Mothers Alive (“Global Plan”) was largely successful in increasing national and global attention to the prevention of vertical transmission. Although targets were not met, and the context at the time was very different to today, the period of Global Plan did witness a significant decline in rates of HIV vertical transmission worldwide. Its impact was due to the engagement of communities, an effective operational structure, with a small secretariat (led by PEPFAR and UNAIDS), the exceptional commitment of partner governments, and an interagency task team (IATT, convened by WHO and UNICEF), that tracked progress and provided technical support to countries through a set of active working groups and regular technical and strategy meetings with country programme managers.

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[1] WM Han et al. Global estimates of viral suppression in children and adolescents and adults on antiretroviral therapy adjusted for missing viral load measurements: a multiregional, retrospective cohort study in 31 countries. *The Lancet HIV* (2021)





Following the end of the Global Plan, in 2016, the Start Free Stay Free AIDS Free Partnership (3-Frees) was created to build on the initial success and expand the focus to include treatment for children and HIV prevention among adolescents and young women. The 3-Frees partnership was led by a global steering group (convened by PEPFAR and UNAIDS) and supported by working groups dedicated to each of the framework's thematic areas. The partnership prioritized 23 countries and established a bold set of super fast-track goals for 2020, including 95% coverage of maternal treatment, fewer than 20,000 new child infections per year and fewer than 100,000 new infections in adolescent girls and young women. However, despite some successes the 3-Frees partnership had limited global impact due to challenges in sustaining long-term leadership, lack of consistent funding, and insufficient engagement with national leaders and communities of women living with HIV. At the end of the 5-year term none of the targets were met, and for several of the key treatment and prevention indicators, there was a flatlining of the response.

Year on year, the same poor progress has been reported towards global and national targets for children and adolescents. Despite available, affordable and highly effective tools and programming strategies to diagnose and treat HIV among children, adolescents and pregnant and breastfeeding women, large service gaps for these populations remain.

The launch of a new Global AIDS Strategy in 2021 and last year's Political Declaration on HIV and AIDS provides an opportunity to redirect our attention and redouble our efforts to end AIDS in children. But, without a mechanism and a plan to coordinate our work across global, regional, national and community levels, we risk missing the next set of global targets including the interim 2023 target only a year away. Respondents to a recent UNAIDS survey identified the pressing need to build new political commitment and leadership to eliminate vertical transmission and end AIDS in children once and for all.

To this end, UNAIDS, networks of people living with HIV, UNICEF and WHO together with technical partners, PEPFAR and Global Fund propose a new Global Alliance to end AIDS in children, which seeks the broad participation of stakeholders, national governments, implementing agencies, regional and country-based organizations, faith-based and community partners including women children and adolescents living with HIV. It will measure progress towards the bold targets of the SDGs and focus on the priority actions for children defined in the new Global AIDS Strategy 2021-2026. The Alliance will seek to apply the lessons learned from the Global Plan and the Three-Frees framework to amplify what worked and avoid some of the pitfalls of past initiatives. The work of the Alliance will be aligned to four pillars:

- 1) Early testing and optimized comprehensive, high quality treatment and care for infants, children, and adolescents living with and children exposed to HIV;**
- 2) Closing the treatment gap for pregnant and breastfeeding women living with HIV and optimizing continuity of treatment towards the goal of elimination of vertical transmission;**
- 3) Preventing and detecting new HIV infections among pregnant and breastfeeding adolescents and women and;**
- 4) Addressing rights, gender equality and the social and structural barriers that hinder access to services.**

#### **Populations of focus**

- Children (0-14 years) and Adolescents (15-19 years) Living with HIV
- Children exposed to HIV
- Pregnant and Breastfeeding Girls and Women who are Living with HIV including marginalized and key populations
- Pregnant and Breastfeeding Girls and Women who are HIV-negative but at risk of HIV



## WHAT WILL THE ALLIANCE DO?

In line with the commitments and recommendations of the Global AIDS Strategy and the 2021 Political Declaration of the UN High Level Meeting, and in keeping with the findings of the stakeholder survey that was distributed globally to inform the need for a new initiative for children, the Alliance will:

1. Advocate for and mobilize worldwide<sup>[1]</sup> leadership, political commitment and resources for urgent action to address inequities and end AIDS in children;
2. Galvanize action in partner<sup>[2]</sup> countries at national government and community levels by assessing and addressing inequalities, programme gaps and structural barriers across the four pillars of work;
3. Stimulate innovation and technical excellence within and among countries by promoting the sharing of knowledge and experience among affected communities and country programmes and across relevant sectors;
4. Create and implement a mutual accountability framework around shared targets and commitments.

## WHAT WILL THE ALLIANCE DO?

The Alliance will incorporate learning from the successes and shortcomings of past initiatives such as the Global Plan and the 3-Frees and country programmes by:

- Building momentum over a longer period – 9 years from 2022 to 2030 in three phases, each of which will be characterized by the involvement and leadership of different regional and national partners;
- Promoting more inclusive leadership and country ownership with the active participation of national programmes as well as affected communities – especially children, adolescents, pregnant women and mothers living with HIV, to jointly lead, develop and execute implementation plans;

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[1] The term “worldwide” in this and other contexts is used to signify leadership coming from global, regional, country and community levels.

[2] Partner countries are priority countries that have opted-in to take on a leadership role in the Alliance. Over the 9-year period from 2022 to 2030, three phases are envisaged with each phase led by a different set of partner countries.

- Boosting existing initiatives to end AIDS in children<sup>[1]</sup>, with the commitment to coordinate and collaborate and celebrate shared successes, promoting advocacy and ensuring senior high-level engagement from key partners including UNAIDS, PEPFAR, WHO, UNICEF, GF and global networks of people living with HIV and affected communities to drive support for the initiative;
- Ensuring countries have the resources they need through resource mobilization across partners, donor coordination and innovative financing;
- Increasing accountability at global and country levels through supporting development of data dashboards and a monitoring and evaluation framework that emphasizes the shared responsibility of all actors in the success of the Alliance including the community;
- Harnessing the collective reach of the Alliance, to advance global advocacy and re-energize international and national commitments ending AIDS among children.

## HOW WILL THE ALLIANCE BE ORGANIZED?

Actors at community, national, regional and global level will work together in a process of co-creation to implement the work of the Alliance. This broad set of actors will participate in one or more of the Alliance’s four structures:

- 1) Worldwide Leadership Forum to guide the Alliance, ensure accountability and political commitment, mobilize resources and conduct advocacy. A steering committee comprised of representatives of networks of people living with HIV, partner countries, UNAIDS, WHO, UNICEF, PEPFAR, Global Fund and key stakeholders will headline the leadership group, but all alliance members will be represented within the group. The importance of community engagement, involvement and participation is a key organizing principle for the Alliance. To that end a Community Oversight Taskforce is envisaged within the Leadership Forum, whose role will be to ensure the meaningful representation of communities across the Alliance’s four groups and to support community-led monitoring to assess the effectiveness of the Alliance from a community perspective;

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[1] Examples of ongoing initiatives: the Eastern and Southern Africa Regional Inter-Agency Task Team on Children Affected by AIDS; Education Plus; the Global Accelerator for Paediatric-formulations; the Global Prevention Coalition; the Paediatric Adolescent HIV Learning Collaborative for Africa, the Rome Action Plan and the Triple Elimination Initiative.

2) Regional Hubs led by regional community partners, organizations and institutions and supported by the respective UNAIDS, WHO and UNICEF regional offices. The regional hubs will work in close collaboration with relevant regional economic and political bodies and provide hands-on technical support to partner countries and support reporting and progress monitoring;

3) Partner Country Teams will be constituted in-country under the leadership of the Health Ministry to direct implementation. Country Teams will include community representatives, members of the in-country HIV technical working group (TWG) and lead implementing partners;

4) Global Working Groups organized around specific themes such as technical and programme guidance for the four pillars of the Alliance, M&E approaches, advocacy efforts, increasing community engagement, challenging structural barriers etc. The working groups will be constituted as needed, coordinate with the regional hubs to pool expertise, to be mutually supportive and avoid duplication of efforts, and will evolve year-by-year to address emerging gaps.

**Figure 2: The working structure of the Alliance**



A secretariat, comprising UNAIDS, WHO and UNICEF will support these structures and ensure consistent and clear communication between the different working parts of the Alliance

## HOW WILL PROGRESS BE TRACKED?

To facilitate progress monitoring and increase accountability to the pediatric, adolescent and vertical transmission targets of the new global AIDS Strategy, a dashboard will be developed to capture the key data points relevant to track the success of the Alliance. The dashboard and associated monitoring and evaluation framework will be co-created by a working group of the Alliance and will include both data elements (such as testing coverage, treatment access, retention in care and viral load outcomes) as well as policy elements (such as adoption of norms and recommendations and use of optimized ART regimens measured by dispensed-to-patient data). To the extent possible, the dashboard will be populated with elements that are already part of ongoing data gathering efforts including the Global AIDS Monitoring (GAM) database, WHO policy surveillance systems developed for the AIDS Free initiative, UNICEFs annual country questionnaires, UNAIDS national commitments and policy instrument (NCPI), and existing in-country databases. However, an additional and important approach will be to enhance data capacity within countries and communities to improve the quality of data collection and promote community data gathering to measure progress from an end-user perspective, particularly with regards to assessing access to services for marginalized populations, and adolescents. Progress will be reported on an annual basis. At the beginning of each new phase of the Alliance, an overall strategy review and alignment will take place.



**Table1: Provisional dashboard structure**

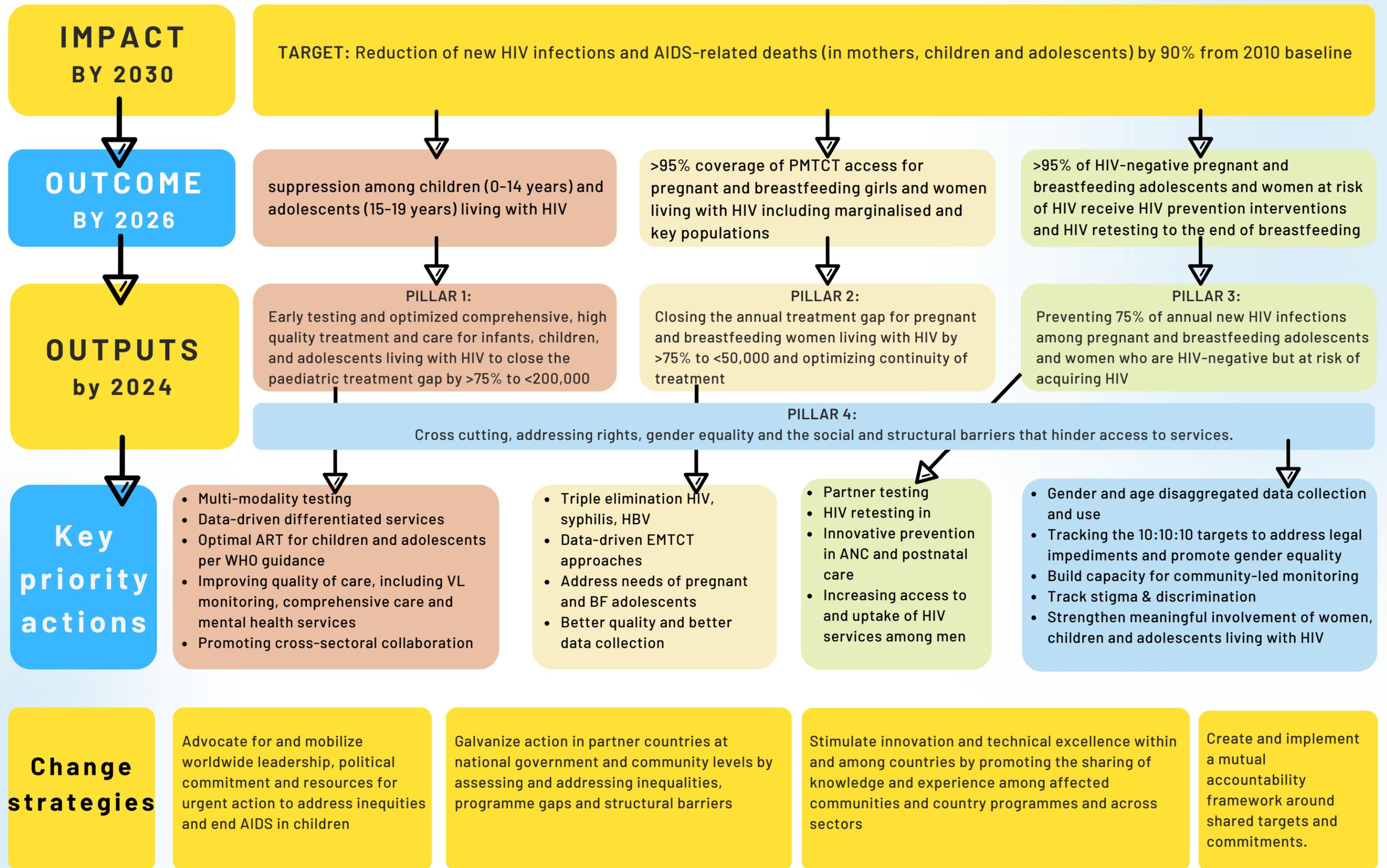
Pillars	Data Indicators	Policy elements
1) Early testing and optimized treatment for infants, children, and adolescents living with HIV	<ul style="list-style-type: none"> <li>EID Coverage up to 6 weeks</li> <li>18m Final Status for HIV-exposed infants</li> <li>ART coverage for children</li> <li>ART coverage for adolescents</li> <li>VLS in children/adolescents</li> </ul>	Adoption and roll out of DTG for children and adolescents
2) Closing the treatment gap for pregnant/breastfeeding women living with HIV and improving continuity of treatment	<ul style="list-style-type: none"> <li>ART coverage for pregnant and breastfeeding women</li> <li>Retention in care</li> <li>VLS in pregnant and breastfeeding women</li> </ul>	
3) Preventing new HIV infections among pregnant/breastfeeding adolescents and women.	Access to PrEP	Adoption and implementation of HIV prevention interventions in PMTCT programmes
4) Addressing rights, gender equality and the social and structural barriers to access services and promote participation	<ul style="list-style-type: none"> <li>Gender and age disaggregated data on coverage of HIV treatment and prevention services</li> <li>Community-led monitoring of participation of PLHIV in the response</li> <li>Data from the Stigma Index</li> </ul>	<ul style="list-style-type: none"> <li>Adoption and implementation of policy elements to promote gender equity</li> <li>Social protection policies</li> <li>Adoption and use of standardized community-led monitoring (CLM) processes, tools and indicators</li> </ul>



## HOW DO THE PROPOSED ACTIVITIES AND STRATEGIC APPROACHES LINK TO THE RESULTS?

The figure below illustrates the Results Framework which links the overarching goals of the Alliance to the targets and the specific interventions and change strategies which will be prioritized. The targets listed are global, in keeping with the intent of the Alliance to foster global action

Figure 3: Results Framework



## HOW WILL WE ADVOCATE WITHIN AND BEYOND THE ALLIANCE?

A key tool to enhance the work of the Alliance will be robust, multilayered advocacy, at global and national levels to sustain and increase public and private sector investments, build political will, mobilize resources, help to change laws and policies that are barriers to care, sensitize communities, and promote the role of networks of PLHIV. Advocacy efforts will be important within all the structures of the Alliance and will be embedded at every stage of implementation. For example—communications and social media engagement around the launch of the alliance, national dialogue to develop advocacy roadmaps in-country, tools for community outreach and involvement, advocacy materials for fundraising and resource mobilization etc. An important principle underpinning the advocacy work will be that of working jointly across partners and communities. The regional hubs will also support south-south sharing of advocacy materials.



## WHAT INTERVENTIONS WILL BE PRIORITIZED?

A key principle of the Alliance is to follow a “bottom up” approach to country support and focus on those activities that best respond to the needs identified by in-country communities and partners. For each of the pillars, countries will be able to select from a small set of proven best-practice interventions to prioritize for scale up. In addition, the Alliance will champion a number of broader, more systems-focused interventions that are important across all the four pillars. During Phase 1 of the Alliance, these cross-cutting interventions will include:

- Enhancing the collection and use of subnational and age-disaggregated data, to target interventions to the populations and in the localities where they are most needed;
- Strengthening integrated health systems across clinic and community health care providers, including electronic medical records and individual patient identifiers linking mother-baby pairs;
- Ensuring frontline healthcare workers, including community service providers, have adequate knowledge capacity and competency to deliver HIV prevention, diagnosis and treatment for mothers, children and adolescents;
- Prioritizing the uninterrupted supply of optimized treatment regimens and testing products through formal and tracked commitments of governments and their partners to bridge the gap of identified but untreated women, children and adolescents;
- Considering the social and structural factors that drive poor outcomes, designing interventions to address them and expanding access to societal enablers;
- Focusing on those left furthest behind by the response in particular marginalized groups and key populations and their families;
- Defining mechanisms for South-South collaboration to bring local ideas and innovations, to the regional and global level. Within countries this could be achieved by hosting regular “situation room” calls led by the Partner Country teams and government focal points;
- Supporting and strengthening community leadership and advocacy to promote meaningful engagement of communities and community-led monitoring and accountability.

Within each of the four pillars, Alliance members will identify a short-list of proven high-impact interventions to be prioritized to bring them to scale as rapidly as possible.

**PILLAR 1: Accessible testing, optimized treatment and comprehensive care for infants, children, and adolescents living with and exposed to HIV**

- a. Implementing robust multi-modality testing programmes to find and link all infants, children and adolescents living with HIV (through early infant diagnosis, index-testing, population-specific case finding, routine opt-out testing of children with unknown status in outpatient clinics, congregation-based testing, community outreach in geographic areas with high unmet need, community- facility- or family-based testing and self-testing)
- b. Expanding differentiated service delivery including multiple monthly dispensing and family-centred care; supporting disclosure
- c. Monitoring the uptake of and addressing barriers to optimal antiretroviral therapy for children and adolescents per WHO recommendations
- d. Improving quality of care, promoting viral load monitoring, providing better systems for referral of complex cases and strengthening age-appropriate mental health and psychosocial support to improve continuity of treatment
- e. Addressing the unique needs of adolescents living with HIV, such as supporting transition and integration of HIV with SRH services.
- f. Promoting cross-sectoral collaboration, for example with early childhood development, nutrition, education, mental health, child protection and social protection.

**PILLAR 2: Closing the treatment gap for pregnant and breastfeeding adolescent girls and women living with HIV and optimizing continuity of treatment**

- a. Promoting integrated approaches and interventions towards elimination of vertical transmission of HIV, syphilis and hepatitis B, including for mothers and their infants
- b. Adopting distinct approaches to identify, link, and treat: 1) pregnant women presenting to ANC; 2) pregnant and breastfeeding women with newly acquired HIV, and; 3) pregnant and breastfeeding women who do not seek ANC care
- c. Addressing the specific testing, treatment and care needs of pregnant or breastfeeding adolescent girls and young women
- d. Improving quality of care, sharpening longitudinal data collection and promoting viral load monitoring and psychosocial support to improve continuity of care

**PILLAR 3: Preventing and detecting new HIV infections among pregnant and breastfeeding adolescent girls and women**

- a. Implementing partner testing and HIV retesting in HIV-negative pregnant and breastfeeding women and girls.
- b. Utilizing innovative prevention technologies including: PrEP for women at higher risk of infection and male partner engagement
- c. Improving quality of care and strengthening mental health and psychosocial/peer support for pregnant and breastfeeding adolescent girls and young women
- d. For adult men, increasing access to and uptake of HIV testing and HIV prevention information and services

**PILLAR 4: Addressing rights, gender equality and the social and structural barriers that hinder access to services.**

- a. Implementing gender- and age-disaggregated data on coverage of HIV treatment and prevention services to adapt and transform services
- b. Supporting countries to adopt and jointly track the 10:10:10 targets defined in the Global AIDS Strategy to remove legal and policy impediments to care, increase access to justice, promote gender equality and build a society free of stigma and discrimination[1]
- c. Building awareness and capacity among communities to monitor progress and hold governments accountable
- d. Resource adequate community-led monitoring of laws and policies, including through documentation of human rights violations and experiences of quality of services at health facility and utilize data and findings to improve service delivery
- e. Utilize data from the PLHIV Stigma Index (or similar processes in-country) to strengthen advocacy that progresses human rights and gender equality and challenges stigma, discrimination and criminalization of key populations and people living with HIV
- f. Strengthen meaningful representation of women living with HIV, adolescents and guardians of children affected by HIV in decision making processes

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[1] A parallel GSI seeks to promote the 10:10:10 targets

## HOW WILL THE ALLIANCE WORK WITH PARTNER COUNTRIES?

While all countries are invited to join the Alliance, during Phase 1, the focus will be on countries with a high overall burden of HIV, with low coverage of testing and treatment among pregnant and breastfeeding women living with HIV or with significant gaps in identifying and treating children living with HIV.

During each three-year phase of the term of the Alliance, the strategic focus of the Alliance will shift. In Phase 1 which runs from 2022 through 2024, partner countries will be from among those that contribute a significant burden of unmet need for the global paediatric epidemic. They will include those that are already making good progress and can share their experience, and those that are further behind and have gaps in the response including for example in treatment coverage or viral load outcomes. In subsequent phases, there will be a stocktaking of progress and if needed an adjustment of country and strategic focus. It is anticipated that over the term of the Alliance, the needs of all countries, including lower burden countries and those with concentrated epidemics will be addressed to scale up treatment and prevention for pregnant women, children and adolescents. This phased approach over the course of the initiative will serve to promote a truly equitable response, one that addresses the needs of women children and adolescents living in all regions and all countries. No child should be left behind.

Partner countries who wish to join the Alliance are asked to submit an expression of interest which commits to supporting the goals of the Alliance and nominates a focal point in-country for ongoing discussions.

Partner Countries will have the opportunity to shape the Alliance through their leadership, and to highlight their successes and challenges in a global forum. Countries will benefit from innovative evidence-based technical assistance and expertise to alleviate bottlenecks and accelerate progress, advocacy, south-south sharing of best practices and resource mobilization efforts. Partner Countries will be asked to provide high-level political commitment to the vision and principles of the Alliance and specifically to:

(a) convene a country team to participate in relevant Alliance working groups and activities and lead the in-country work;

(b) ensure that country teams include national representatives of women children and adolescents living HIV, representatives of relevant faith communities, and relevant programmatic leads including paediatric and adolescent HIV, vertical transmission (or elimination of vertical transmission, digital health systems, supply chain/commodities;

(c) at an early stage, undertake consultations with key stakeholders working at community, district and national levels to get their views about the challenges they are facing that are preventing them from achieving the current national targets and what actions they can take to achieve the 2023 and 2025 targets;

(d) measure and share data relative to the key indicators of the Alliance, and;

(e) implement WHO recommended guidance and policies to achieve global targets.

## HOW WILL INCLUSIVE PARTICIPATION BE ENSURED?

The Alliance will ensure a from-the-ground-up approach which promotes the leadership and engagement of national partners and affected communities – especially communities of women, mothers, adolescents and young people living with HIV to jointly spearhead and direct the initiative. To this end, a first step will be to convene a consensus building meeting of key partners together with civil society and national governments. The aim of this meeting will be to come to broad areas of agreement on the strategic focus and structure of the Alliance and to outline a set of next steps towards a formal launch of the Alliance at the International AIDS Conference in Montreal on 1st August, 2022.

