Advocacy Tool Kit
Children and Adolescents Living with and at Risk for HIV

PHOTO: ERIC BOND/EGPAF, 2017
# Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>01</td>
</tr>
<tr>
<td>Elimination of Mother-to-Child Transmission of HIV</td>
<td>03</td>
</tr>
<tr>
<td>Pediatric HIV Treatment</td>
<td>09</td>
</tr>
<tr>
<td>Adolescents and HIV</td>
<td>15</td>
</tr>
<tr>
<td>Action Needed by First Ladies</td>
<td>21</td>
</tr>
<tr>
<td>Tools for Engagement &amp; Opportunities for Regional and National Collaboration</td>
<td>23</td>
</tr>
</tbody>
</table>
Introduction

Purpose

We are at a critical point in the AIDS epidemic, where concerted efforts and investment now could result in the end of AIDS as a public-health threat by 2030.

To achieve the ambitious goal for HIV/AIDS as set out by the United Nations member states in the 2015 Sustainable Development Goals and the targets outlined in the 2016 United Nations Political Declaration on HIV and AIDS, those furthest behind must be reached first—this includes children and adolescents living with and affected by HIV/AIDS. Addressing HIV in children and adolescents can reverse and even halt the epidemic to create an AIDS-free generation.

Engagement at every level—including by presidents, first ladies, and parliamentarians—is needed to reach the children and adolescents most in need. Engagement by first ladies of countries where the HIV epidemic has hit hardest is especially essential to drive urgent action. First ladies are uniquely positioned to use their political and social influence to effect change in their countries and bring about better access to and uptake of prevention, care, and treatment services for children and adolescents living with and affected by HIV. Through policy reform, resource mobilization, and awareness raising, first ladies can have a profound impact on the lives of children and adolescents living with and affected by HIV; they can also usher in a shift in the response to the epidemic to help lead to the end of AIDS.

This tool kit provides statistics, messages, and key actions that first ladies can undertake to advocate for continued uptake of prevention of mother-to-child transmission (PMTCT) of HIV services, increased early infant diagnosis (EID) of HIV, and improved pediatric HIV treatment coverage. It will also help first ladies address the unique issues faced by adolescents both growing up with and at risk for HIV. This tool kit complements the recently launched African Union–Organisation of African First Ladies Against HIV/AIDS Elimination of Mother-to-Child Transmission of HIV (AU-OAFLA EMTCT) campaign by providing supplemental background information on technical areas and advocacy strategies that can then be tailored for individual use. Finally, the tool kit facilitates the achievement of the goals in OAFLA’s strategic plan of 2014–2018 and beyond.

About the Organisation of African First Ladies Against HIV/AIDS

OAFLA was founded by 37 African First Ladies in 2002 as a collective voice for Africa’s most vulnerable people: women and children infected and affected by HIV and AIDS.

OAFLA is guided by the vision of an Africa free from both HIV/AIDS and maternal and child mortality—an Africa in which women and children are empowered to enjoy equal opportunities. OAFLA works to enable African first ladies to advocate for effective policies and strategies aimed at ending the AIDS epidemic as a public-health threat, reducing maternal and child mortality, and empowering women and children through strategic partnerships in the spirit of solidarity. OAFLA’s mission is to cultivate the exchange of experiences among African first ladies and increase the capacity of first ladies and other women leaders to advocate for effective solutions to the AIDS epidemic, as well as to fight against HIV/AIDS-related stigma and discrimination. At the national level, the first ladies contribute to efforts in preventing, managing, and eliminating HIV and AIDS.

Given this obligation, the OAFLA secretariat has a mandate to increase the advocacy capacity of first ladies and to develop critical partnerships to mobilize resources; raise awareness; develop and support HIV/AIDS prevention; and promote treatment, care, and support programs. In this spirit, the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) and OAFLA collaborated to develop this tool kit to increase the ability of first ladies to promote effective solutions to reach the elimination of mother-to-child transmission of HIV, address the pediatric HIV treatment gap seen in African nations, and drive action to ensure that adolescents receive the services required to prevent and treat HIV.
About the Elizabeth Glaser Pediatric AIDS Foundation

Elizabeth Glaser, one of the co-founders of EGPAF, contracted HIV through a blood transfusion in 1981 while giving birth to her daughter, Ariel. She and her husband later learned that Elizabeth had unknowingly passed the virus on to Ariel through breast milk and that their son, Jake, had contracted the virus in utero.

In the course of trying to find treatment for Ariel, the Glasers discovered that drug companies and health agencies had no idea that HIV was prevalent among children. The only drugs on the market were for adults; nothing had been tested or approved for children.

Ariel lost her battle with AIDS in 1988. Fearing that Jake’s life was also in danger, Elizabeth rose to action. EGPAF originated from three mothers around a kitchen table in 1988. With her close friends, Elizabeth created a foundation that would raise money for pediatric HIV/AIDS research.

Elizabeth lost her own battle with AIDS in 1994. Today, EGPAF is a leading global nonprofit organization dedicated to preventing pediatric HIV infection and eliminating pediatric AIDS through research, advocacy, and prevention and treatment programs. Elizabeth’s legacy lives on through EGPAF and in her son, Jake, who is now a healthy young adult.

Figure 1. Countries in Africa Where EGPAF Works
Elimination of Mother-to-Child Transmission of HIV

More than 90% of all pediatric HIV infections are through mother-to-child transmission. Yet, 100% of these infections are preventable through successful PMTCT services.

EMTCT is defined as achieving a national mother-to-child transmission rate of less than 5% at 18 months among breastfeeding populations and 2% or less among non-breastfeeding populations. Meeting this target will require near universal testing, treatment, and viral suppression of pregnant and breastfeeding women. Additional targets and indicators relevant to elimination are structured along the four prongs of PMTCT that were reinforced in the 2016 United Nations Political Declaration on HIV/AIDS. To be validated by the World Health Organization (WHO) as achieving elimination of the vertical transmission of HIV (and syphilis), countries must meet several process and impact targets.

Prevention of Mother-to-Child Transmission of HIV

Mother-to-child transmission of HIV occurs when an HIV-positive woman passes the virus to her child during pregnancy, childbirth, or breastfeeding.

PMTCT includes a series of interventions to help prevent new HIV infections in children: prevention among adolescent girls and young women, testing and treatment of pregnant and breastfeeding women, and identifying HIV-positive children and linking them to treatment. PMTCT consists of four prongs that all together provide a comprehensive set of services to women and families:

1. Prevention of HIV infection among women of childbearing age and their partners.
2. Reproductive health support and prevention of unintended pregnancies among HIV-positive women.
3. Access to antiretroviral therapy (ART) to prevent new infections in infants from HIV-positive mothers.
4. Treatment, care and support services for HIV-positive mothers, infants, and families.

Prevention of HIV Infection Among Women of Childbearing Age and Their Partners

Primary prevention is a vital first step in the PMTCT process, as it provides women and their families with the services needed to stay HIV negative. HIV education, testing and prevention counseling, and pre-exposure prophylaxis (PrEP), where available, are important to ensure that HIV-negative women remain HIV-free. In addition, comprehensive prevention services, such as voluntary medical male circumcision, HIV testing and sexual health education, must be made available to male partners.

Unfortunately, accurate knowledge of how to prevent HIV acquisition remains low. For example, in a 37-country study between 2011 and 2016, it was reported that only 30% of young women aged 15–24 years had an accurate understanding of how to prevent HIV.
Prevention of HIV Infection Among Women of Childbearing Age and Their Partners (Continued)

More needs to be done to ensure that young women and their male partners have the tools and services they need to protect themselves from acquiring HIV and to know their HIV status. This PMTCT prong also includes continued testing for HIV-negative pregnant women throughout their pregnancy and breastfeeding to ensure that they remain HIV negative; this is especially significant for women in relationships with HIV-positive partners (sero-discordant couples) or partners whose HIV status is unknown. If a woman acquires HIV during pregnancy or breastfeeding, the risk of infecting her unborn or newborn baby will be even higher; therefore, she should be immediately initiated on ART to prevent transmission of HIV to her child.

Family Planning

It is important that women have access to the reproductive health services and information they need so they can plan how and when to have children. In addition to HIV testing and counseling, this PMTCT prong includes education on how to prevent unintended pregnancies and the use of family planning commodities, such as condoms, oral contraceptives, and intrauterine devices. Providing these services allows women the health benefits gained by spacing their pregnancies. Through family planning services, women and their partners are provided with information on their options for expanding their families while taking measures to protect both their partner and their baby, whether or not they are HIV positive.

Access to ART to Prevent HIV Transmission from Mother to Child

HIV-positive mothers should be provided with the treatment, counseling, and maternal health services needed to prevent the transmission of HIV to their baby. Treatment adherence during pregnancy, childbirth, and all of breastfeeding is crucial to prevent transmission from the mother to the baby. Continued monitoring of ART in new mothers is needed throughout the breastfeeding period to ensure that an HIV-negative infant remains HIV-free, as it is estimated that nearly half of all new infections in children occur during the breastfeeding period. Counseling should be provided to emphasize the importance of delivery at a health facility, where safe medical interventions are available, if necessary, and prophylaxis can be given to newborns. It also helps improve treatment adherence through the end of the breastfeeding period: Transmission rates of HIV from mother to child can be as high as 45% without any interventions. With appropriate interventions, however, this rate can be reduced to less than 5% for the breastfeeding population.

HIV Care and Treatment Services for HIV-Positive Mothers, Infants, and Families

WHO guidelines call for all HIV-positive pregnant women to remain on ART for life—not only to prevent HIV transmission to their infants but also to protect their own health. In addition, WHO recommends a treatment-for-all approach, in which all HIV-positive individuals are enrolled into care and initiated on treatment regardless of their age, gender, viral load or CD4 count. This means that HIV-positive women and their HIV-positive infants should be started on treatment and should have access to HIV care, treatment, and prevention services. This continuum of care allows families living with HIV to remain healthy and prevents those who are HIV negative from acquiring HIV.

Through this four-pronged approach to PMTCT, significant progress has been made. As a result of delivering ART to pregnant and breastfeeding women and their infants, more than two million new infections in children have been averted.
Challenges to Achieving PMTCT
Although great strides have been made, challenges still remain in reaching all women who are in need of PMTCT services.

Knowing HIV Status
Despite the established effectiveness of PMTCT, many pregnant women do not know their HIV status, and currently only three quarters (76%) of pregnant women living with HIV globally have access to ART. As a result, there were still 160,000 new infections in children younger than 15 years of age in 2016—the majority of which occurred in Africa.

Often, stigma, discrimination, cultural norms, and family dynamics impact a woman’s decision to seek and accept HIV testing. In addition, many HIV-negative women who are in relationships with HIV-positive partners, or partners whose HIV status is unknown, are usually not repeatedly tested for HIV throughout their pregnancy or during breastfeeding. This often results in newly infected HIV-positive pregnant or breastfeeding women not being identified and enrolled on ART. Because these so-called “incident infections” create a much higher risk of transmitting the virus to the fetus or an infant, early awareness and prompt initiation on ART are critical in preventing the transmission of the virus from the mother.

Finally, globally there are still many women who do not receive antenatal care at a healthcare facility and instead deliver at home, which means they do not receive proper antenatal care, HIV testing and PMTCT services, including preventive treatment for the newborn. Without accurate knowledge of their status, pregnant women cannot receive appropriate treatment to protect their child from acquiring HIV or take care of their own health.

Treatment Adherence
PMTCT is extremely effective if pregnant women are initiated on treatment immediately after they are diagnosed with HIV, adhere to treatment, and remain in care. Treatment adherence through pregnancy and the breastfeeding period is most imperative for PMTCT to be successful. However, many factors can cause women to not adhere to their treatment regimen, increasing the possibility of HIV transmission to their child. For instance, once an HIV-positive pregnant woman comes in for testing and receives her positive test results, she may face challenges in disclosing her HIV status to her partner and family. Many face stigma and discrimination from community members, who “speak poorly about antiretroviral therapy and look down on those using it.” Receiving support from partners, family and friends is associated with higher treatment adherence.

In addition to the mental and emotional challenges faced by a person living with HIV, antiretroviral drugs (ARVs) may occasionally cause physical adverse side effects, making people on ART question the need for taking medication. Separate locations and access to HIV and antenatal care services can also create challenges for pregnant women to remain in care, as they have to go to different points in the health facility to get the services they require; this can be time consuming and costly. Finally, an unclear understanding of how PMTCT and ART work may result in a lack of confidence in either the intervention or the health care provider, or can cause a misunderstanding of the importance of adherence during pregnancy and breastfeeding.
Treatment Adherence (Continued)

These challenges must be addressed in order to reach all those in need of PMTCT services. Achieving the end of AIDS, as outlined in the AU–OAFLA EMTCT campaign, and reaching the other WHO criteria for validation of the elimination of HIV will require full PMTCT coverage for all women, their partners, children and families. The WHO MTCT elimination criteria include a country having both (1) fewer than 50 new pediatric HIV infections per 100,000 persons and (2) an HIV transmission rate of less than 5% for breastfeeding populations and less than 2% for non-breastfeeding populations.\(^1\)

Failure to Reach Full PMTCT Coverage

Efforts to prevent MTCT begin before conception and extend through the end of the breastfeeding period, at which time children receive their final HIV test results. Many of the HIV-exposed children will be HIV-negative; children who test HIV-positive, however, should be referred immediately to HIV care and treatment services. Children living with HIV need to be initiated on ART without any delay and must remain in care and treatment programs for the rest of their lives.

Ending AIDS in children is possible, but it will require not only advocating for expanded services to eliminate pediatric HIV infection in the first place but also improving pediatric care and treatment services in each country.
Yet, 160,000 children were still newly infected with HIV in 2016—most of them in Africa. The Start Free goals of the Start Free, Stay Free, AIDS Free framework, launched in 2016, continue these efforts with a focus on the same priority countries, plus India and Indonesia. This framework emphasizes sustained PMTCT programs in countries where the elimination of MTCT has already been reached or is close to being attained.

**Start Free Goals**

- Reach and sustain 95% of pregnant women living with HIV with lifelong HIV treatment by 2018.
- Reduce new HIV infections in children (0–14 years) to less than 40,000 annually by 2018 and less than 20,000 annually by 2020.

An AIDS-free generation will not be reached without first achieving elimination of MTCT, ensuring that all pregnant women living with HIV have access to quality PMTCT services. WHO now recommends a test-and-treat approach to HIV services, according to which all people living with HIV should be offered lifelong HIV treatment. Retaining mothers on ART and in care through pregnancy and breastfeeding can help improve tracking of HIV-exposed infants and increase the likelihood of testing those infants for HIV. In addition, keeping the mother-baby pairs linked in health care services will help simplify the follow-up process and make tracking those who are lost to follow-up easier.

---

1. The 21 priority countries include: Angola, Botswana, Burundi, Cameroon, Chad, Côte d’Ivoire, Democratic Republic of the Congo, Ethiopia, Ghana, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, South Africa, Uganda, United Republic of Tanzania, Swaziland, Zambia, and Zimbabwe.

2. The Start Free, Stay Free, AIDS Free framework is led by the Joint United Nations Programme on HIV/AIDS (UNAIDS), the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR), the United Nations Children’s Fund (UNICEF), the World Health Organization (WHO), and the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF).
Key Messages

• Every child deserves the chance to start life HIV-free.

• Preventing mother-to-child transmission of HIV is possible.

• All pregnant women need access to quality antenatal care services that include PMTCT services for HIV-positive pregnant women.

• Treatment adherence by the mother and continued follow-up post-delivery and during breastfeeding are required to ensure that a baby is and remains HIV negative and that mothers stay healthy.

• Nations should adopt policies and laws that create an enabling environment and discourage stigma and discrimination based on HIV status.

• Community-based services and peer-provided support systems help women access and stay in PMTCT services.

Key Facts

• 90% of HIV infections in children are from mother-to-child transmission.

• With effective PMTCT interventions, the risk of HIV transmission from mother to child is reduced to less than 5%.

• In 2016, only 76% of the 1.4 million pregnant women living with HIV had access to ART to prevent mother-to-child transmission of HIV.

• In 2016, 160,000 children were newly infected with HIV.
Pediatric HIV Treatment

Children living with HIV must be prioritized. Focused global efforts to enroll more children living with HIV on lifesaving ART have led to significant gains—and yet more than half of children living with HIV are not receiving treatment.

Early Infant Diagnosis and Linkage to Care

To ensure that all children living with HIV are enrolled early into care and treatment services, children must first be diagnosed. However, identifying children living with HIV can be challenging. In 2016, less than 50% of HIV-exposed infants in high-burden countries received a required virologic test to determine HIV infection within two months of birth, as recommended by WHO. In 2016, only 43% of children living with HIV were enrolled in treatment. Without treatment, about one-third of children living with HIV will die by their first birthdays, and about half will die by the age of two years. With treatment, however, children living with HIV can grow and develop into healthy adulthood.

Early initiation of ART in infants living with HIV before their twelfth week of life has been shown to reduce mortality by 75% in low-resource settings. Early initiation of ART has shown increased growth benefits for children, including mitigating the negative impacts of HIV on nervous system development; it could also potentially reduce other long-term risks such as cardiovascular disease and chronic lung disease.

Early diagnosis and initiation of treatment among HIV-positive infants and children is therefore a critical step in addressing the HIV epidemic. To reach these children, several service areas must be improved.

1. Entry Points for Identifying HIV-Positive Children

The traditional entry point for identifying HIV-positive infants is through services provided to HIV-positive mothers—that is, through PMTCT services for HIV-positive pregnant and breastfeeding women. However, focusing on new mothers is not sufficient. With less than 50% of children accessing early infant diagnostic (EID) tests globally in 2016, focus also needs to be placed on identifying and testing HIV-positive children older than 12 months of age. This is why it is important to continue implementing and expanding provider-initiated HIV testing and counselling (PITC) outside PMTCT, such as at immunization clinics, maternal and child health centers, nutrition centers, inpatient wards, and tuberculosis clinics, as well as implementing outreach services within the community.

More active outreach needs to be done to test and identify older children, who tend not to interact with the health system as frequently as young children and infants. These HIV-positive children were not identified as infants or young children and may have slow-progressing HIV, which means they often do not access health facilities or discover their HIV status until years after initial infection, when they begin to suffer from HIV-related illnesses and growth delay. Although most children and adolescents living with HIV acquire the virus through MTCT, services “have rarely focused on improving strategies for identifying older children and adolescents growing up with HIV and linking them to treatment and care.”
2. HIV Testing and Delivery of the Results

Diagnosing HIV in infants is complex due to the presence in their blood of the antibodies transferred from their mother during their time in the womb. For this reason, it is important that all HIV-exposed infants receive a specialized virologic HIV test to confirm HIV status. This test is different from the rapid HIV antibody test used in adults, which provides results within hours. Laboratories with the capacity to conduct virologic HIV testing are limited and are primarily located in central and regional hubs; dried blood spot (DBS) samples must be taken from the infant and sent to a central laboratory for testing, with the results then being sent back to the decentralized location to be given to the child’s caregiver. Studies from sub-Saharan Africa reported that long delays in completing the testing cycle, which includes the return of the results from the laboratory to the clinic and caregiver, led to significant loss to follow-up of HIV-exposed infants. While EID networks have been improved in many countries, with significant reductions in turnaround time for test results, many countries continue to experience a delay of 16–23 weeks for infants between testing and ART initiation, which is well past the period of peak mortality for HIV-positive infants of 8–12 weeks of life. Implementing point-of-care testing (POCT) technologies at decentralized locations, providing short message service (SMS) printers to receive electronic test results, and supporting blood sample and test result courier services will result in more children receiving their HIV diagnoses in enough time to be quickly linked to care.

3. Linkage to Care and Retention

Once a child is diagnosed with HIV, the challenge becomes linking him or her to care and treatment services and keeping that child in those services. Some mothers may find it difficult to accept an HIV-positive diagnosis for their infants or to disclose the news to family members or others whose support could facilitate effective treatment of the child. If the mother does not already know her status, she needs to be tested for HIV and provided with support in disclosing her status at home. In addition, HIV treatment is for life; thus, children and their mothers must be linked to and enrolled in care and treatment services and retained in those services to keep them healthy. This becomes particularly important when considering the aforementioned weak linkages and substantial delays between diagnosis and initiation of pediatric care and treatment services. In sub-Saharan Africa, 3.8 years is the median age of children living with HIV to be initiated on treatment.

Once children are in care and treatment, it is imperative that they are not lost to follow-up to ensure that their health is monitored and treatment is adjusted as they age or if treatment failure occurs. Retention in care is hindered by many factors, including “busy clinics, long wait times, stigma, excessive turn-around times, weak referral systems, lack of integration services,” as well as the logistical and financial challenges of bringing children to the clinic on a regular basis. The low number of health care workers trained and skilled in identifying and managing pediatric HIV/AIDS and pediatric ART also limits access to HIV testing and subsequent linkage to care and treatment. Many health care workers stationed at facilities where infants seek care have limited knowledge of EID; are reluctant to recommend HIV testing for children and adolescents; lack the skills and confidence to identify and manage infants, children, and adolescents living with HIV; and are inexperienced in counseling children and families and prescribing ART for children. Children may therefore benefit from the innovative patient-centered service delivery models being developed for adults that reduce the frequency of clinical visits, allow for multi-month drug refills, provide community-based services, and otherwise facilitate access to care. Youth-friendly services, assistance with disclosure to children, and peer-led adherence support are also known to help with retention in care among adolescents and young adults.
Pediatric Formulations and Drug Resistance

An important barrier that contributes to children not being initiated in or retained on treatment is the limited availability of pediatric-friendly formulations of ARV drugs to treat HIV. Clinical studies on ARVs for use in the pediatric population often occur years after drugs are approved for adults, which limits the availability of safe and effective ARVs for children. The development of pediatric formulations and diagnostic tools is often considered an ineffective use of resources because the pediatric HIV market is small compared with the adult market. In addition, procuring pediatric ARVs can be arduous in resource-limited settings. Program data show that stock-outs of ARVs occur more frequently for pediatric formulations than for adult medicines.

Administering treatment to children can be particularly difficult. Pediatric ARV formulations for infants and toddlers are often produced in liquid or syrup form and are difficult for children to take because of the volume and poor taste. These formulations are also problematic for health care workers and caregivers because the drugs may require refrigeration, which is difficult in low-resource settings with limited access to electricity. ARVs are hard to store and transport due to the large volume, and they have complicated dosing. Formulations for older children who can swallow pills are also challenging because of the large pill size and heavy pill burden. The fact that ARV dosages for children depend on age and weight band categories makes it complicated for healthcare workers and caregivers to prescribe and administer.

In addition, children often need to switch to second- or third-line drugs because of drug resistance and treatment failure. According to a recent study in sub-Saharan Africa, pretreatment HIV drug resistance was higher in PMTCT-exposed infants compared to PMTCT-unexposed infants. In fact, nearly 98% of children living with HIV who fail first-line treatment have documented drug resistance. Drug resistance is an increasing area of focus and poses an added challenge to pediatric treatment that “if not addressed ... may reduce the durability and effectiveness of currently recommended first-line ART regimens.” New and improved first-, second-, and third-line drugs are required to better address the needs of children living with HIV. Several promising pediatric formulations are in the development pipeline; as they become available, it is important that countries work quickly to ensure they are registered, procured in country, and made available to all children living with HIV.

Stigma and Discrimination

It has often been noted that stigma and discrimination significantly affect access to HIV prevention, treatment, care, and support. According to research done by the International Center for Research on Women, stigma can result in loss of livelihood, poor care at health facilities, and withdrawal of care and support at home. This is particularly important because children living with HIV depend on their caregivers to bring them to the facility for testing, treatment, and care. Stigma and discrimination also deter older children and adolescents living with HIV from seeking care for themselves. The fear of stigma, discrimination, and even potential violence by family, peers, community members, teachers, and health care workers prohibits the access of children living with HIV to the services they need to survive. If an AIDS-free generation is to be reached, programs and policies must address the “social, cultural, economic, and legal barriers that inhibit access to health services for all people living with and affected by HIV/AIDS.”

Children living with HIV can face continued stigma and discrimination at home, at health facilities, within their communities, and at school. This can be particularly challenging for children who are already going through many other emotional changes as they develop from children to adolescents and into young adults. Children who face stigma and discrimination are at risk of not adhering to treatment, thus weakening their overall health outcome. To combat stigma and discrimination, “efforts to normalize HIV and ensure that adults and children have accurate information about the virus are essential.”
For children living with HIV, access to ART is a matter of life or death. A recent study across Africa, Asia, and the Americas concluded that many children younger than two years of age who are living with HIV begin treatment too late and already have significant immunodeficiency, leading to high mortality rates. As part of the Start Free, Stay Free, AIDS Free framework launched in 2016, it is imperative that all children living with HIV have access to ART for their own health and to reduce the risk of further HIV transmission.

**AIDS Free Goals**

- Provide 1.6 million children (0–14 years) and 1.2 million adolescents (15–19 years) living with HIV with ART by 2018.
- Provide 1.4 million children (0–14 years) and 1.0 million adolescents (15–19 years) living with HIV with ART by 2020.

The current response to the HIV epidemic is not on track to reach these crucial treatment targets for children. To reach the AIDS Free goals, countries need to address barriers to treatment access for children and adolescents in their specific country context, including making sure that the ARVs available in country are in line with WHO recommendations for optimal formulations; that services are tailored to the specific needs of children and adolescents; and that viral load monitoring is standard practice to better detect treatment failure. The ambitious AIDS Free goals aim to bring optimal treatment options to children and adolescents living with HIV and, in so doing, to help reduce the stigma and discrimination associated with HIV.

---

ii The Start Free, Stay Free, AIDS Free framework is led by the Joint United Nations Programme on HIV/AIDS (UNAIDS), the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR), the United Nations Children’s Fund (UNICEF), the World Health Organization (WHO), and the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF).
Key Facts

- In 2016, only 43% of children living with HIV received ART, compared with 54% of adults.
- In 2016, 120,000 children (0–14 years) died of AIDS-related causes.4
- Children make up around 6% of the population of people living with HIV but account for 12% of AIDS-related deaths.
- 98% of children failing first-line treatment for HIV have drug resistance.21
- The limited pediatric formulations for ART reduce the options for children living with HIV to access the treatment they require.
- Existing pediatric ARV formulations can be poor tasting and difficult to swallow, can be challenging to store, and can have complex dosing instructions.
- Approval of new pediatric ARV formulations lags behind that of adult ARV formulations, which means that children must wait years for these new and optimal drugs.
- Smaller markets for pediatric ARV formulations make new drug developments and procurement of approved pediatric formulations challenging.
- Stigma directly and indirectly affects the health of people living with HIV.

Key Messages

- Diagnosing children living with HIV and initiating them on treatment as early as possible is critical for their survival, growth, and development.
- Point-of-care EID, testing of older children at various health entry points, and community-based testing and treatment will help link more children living with HIV to treatment.
- Children must be retained in care and treatment services to monitor disease progression and overall health and to appropriately adjust treatment regimens.
- Efforts should be made to reduce loss to follow-up among HIV-positive mothers and their infants, including through better monitoring of mother-baby pairs and provision of services that are closer and more convenient for children and caregivers.
- Improved training of health care workers is needed to increase capacity for testing, counseling, and treating HIV-positive children.
- Countries should adopt and implement updated WHO treatment guidelines to ensure that optimal treatment regimens are provided to all children living with HIV.
- Increased efforts from pharmaceutical companies to prioritize pediatric drug research and manufacturing of approved generic formulations are needed to assist with drug availability in countries.
Adolescents and HIV

AIDS is a major cause of death among adolescents (10–19 years), both globally and in Africa.\textsuperscript{14}

Central to OAFLA’s strategic mission is improving the health and well-being of women and children living with and affected by HIV/AIDS, including adolescents. Experts are looking closely at populations that are most vulnerable to HIV/AIDS, resulting in more targeted approaches to addressing the pandemic. This approach means additional attention is being placed on adolescents who are both living with and at risk for HIV. While progress has been made and HIV is no longer the leading cause of death for adolescents, it is still a major threat and needs focused attention through a comprehensive approach in order for the risk to adolescents to continue to decline. Adolescence is in and of itself a sensitive time; adding the complexities of HIV makes things even more challenging.

Growing Up with HIV

With the recent progress made in identifying and enrolling younger children living with HIV on treatment, more children are surviving into adolescence and “living positively” than ever before. This generation of children who have been living with HIV most of their lives face unique challenges as they experience adolescence.

Treatment

As the global response to HIV continues to scale up, children living with HIV will be increasingly identified during infancy and enrolled on treatment early in life. While this is critical for the child’s survival, lifelong ART has many challenges. As seen in countries with successful EID and pediatric treatment, adolescents who have been enrolled on ART for years require ongoing medical care to identify, manage, and treat any health conditions associated with ART, such as bone health and renal health related issues.\textsuperscript{28} In addition, there are high rates of HIV treatment failure among adolescents\textsuperscript{5} and lower rates of viral suppression, according to population-based HIV impact assessments released in 2017.\textsuperscript{29} Viral suppression, in addition to helping lower the risk of transmission of HIV, has proven increased health benefits. This means that as children age into adolescence, it is vital that they remain in care and treatment services so they can have consistent disease monitoring to detect treatment failure and modify their treatment regimen appropriately to keep them healthy. This is particularly critical for adolescents as they may have less caregiver support, may be managing their own health, or may be less adherent to ART than adults and younger children.

Many older children and adolescents who have been on treatment for years may also be experiencing treatment fatigue. Children and adolescents who have not been made aware of their status may not understand why they have to take medicine every day. Children who feel healthy may not think it’s necessary to remain on treatment, since they do not feel sick. Others may be tired of the negative side effects caused by ARVs or the sheer volume of pills required.
**Treatment (Continued)**

Poor adherence leads to drug resistance, treatment failure, and the need to switch to second- and third-line drug regimens, which may be more burdensome, more expensive, or less available. Adolescence is a critical time to reinforce and support treatment adherence. AIDS-related adolescent deaths are preventable with early initiation of ART, adherence to treatment, and retention in care.

**Transition of Care**

The care children and adolescents receive needs to change and adapt with them as they grow and develop. Whereas young children are dependent on their caregivers for their overall health and well-being, older children and adolescents become increasingly independent and begin to take health decisions into their own hands. It is important that, during this transition, adolescents receive quality, age-appropriate care to support them in their health decisions. Training and sensitizing health care workers to engage with adolescents living with HIV can greatly improve the quality of care adolescents receive and, in turn, impact their willingness to seek health care services. Because adolescents are children whose maturity is quickly evolving, they must be supported in making the right health decisions. Adolescents require services that take into consideration their maturity and mental capacities to appropriately prepare them to successfully manage living with HIV. Yet, many countries do not permit children under 18 to access HIV treatment or counseling independently.30

**Stigma and Discrimination**

Stigma and discrimination have a substantial influence on adolescents, especially when it comes to ART adherence. Adolescents may not visit the clinic for health visits and may not adhere to their treatment regimens for fear of being identified as HIV positive. This fear prevents adolescents from disclosing their HIV status to their sexual partners, possibly putting others at risk. Negative and judgmental attitudes from health care workers toward adolescents living with HIV have a significant impact on retention in care and treatment services as well. Adolescents need support from their families, friends, communities, and health care providers so they can be empowered to seek out assistance and adhere to treatment. Psychosocial support groups specifically tailored to or led by adolescents can help those living with HIV come to terms with their diagnosis and understand the importance of treatment adherence, all in a safe and supporting environment.
At Risk for HIV

While many adolescents living with HIV were infected through MTCT, it is crucial to also address the HIV-negative adolescents at risk for acquiring HIV. Age-appropriate HIV prevention and sexual and reproductive health counseling and education are essential for those at risk of HIV to ensure that they have access to the quality services they need to remain HIV-free.

Access to Services and Information

Accurate HIV knowledge is critical for prevention measures to be successful. However, many adolescents lack the basic knowledge of HIV needed to inform their health decision making. Many of the factors that restrict adolescents’ access to information and services and that put them at risk for HIV are linked to prohibitive policies and structures. For example, some adolescents who seek HIV testing and counseling or sexual and reproductive health education may have difficulty accessing these services due to age-of-consent laws or requirement of a legal guardian to be present. This prohibits access to valuable services and information that could help adolescents keep themselves safe and healthy. WHO recommends that age-of-consent laws for HIV testing take into consideration maturity; it also calls for clear language on this issue in all of its health policies and legislation. Restrictive laws for age of consent or even vague language that does not provide clear guidance to health care workers on this issue further impede adolescents’ access to these lifesaving services.

Geography also plays a role in access to information, with those living in rural settings being less likely to have accurate knowledge of HIV. In addition, adolescents who are able to access services may be met with negative attitudes and judgment from health care workers, weakening the impact of these services and further hampering access.

One prevention service that has proven effective for young males is voluntary medical male circumcision (VMMC), which can reduce female-to-male sexual transmission of HIV by nearly 60%. VMMC is particularly appealing because it is a one-time intervention that can provide partial protection for men from HIV and other sexually transmitted infections. For this service to be effective, it must include not only the medical procedure but also the testing, counseling, and education on HIV transmission, as well as the importance of continued use of other preventative methods, such as condoms. All of these components complete the VMMC package and fully inform young males about their risks for HIV. If adolescents are to remain HIV-free, they need to be armed with the knowledge and tools necessary to do so.

Special Considerations for Adolescent Girls

Adolescent girls in particular face specific challenges that put them at additional risk for HIV. Studies have shown that women acquire HIV at a younger age than men, typically from older male partners. Age-disparate sexual relationships, sometimes forced by girls’ precarious economic situation or the practice of child marriage, and gender-based violence create an unequal power dynamic within a relationship, which can lead to the inability to negotiate safer sex practices. According to the Girls Not Brides partnership, child brides are often “deprived of their fundamental rights to health, education and safety” and are “at greater risk of experiencing dangerous complications in pregnancy and childbirth, contracting HIV/AIDS and suffering domestic violence.” Limited access to education impacts young girls’ ability to learn about HIV and sexual and reproductive health and to equip themselves with the tools and knowledge necessary to build economic opportunity and otherwise reduce the risk of HIV exposure. All of these risk factors further highlight why it is important to make HIV prevention—including PrEP (when available in country), care and treatment services, and sexual and reproductive health education programs—accessible and tailored to adolescents and, in particular, to girls.
As part of the Start Free, Stay Free, AIDS Free framework, launched in 2016, the Stay Free goals aim to reach adolescents and young people most vulnerable to acquiring HIV with prevention services to ensure that those who are born HIV-free, stay HIV-free.

**Stay Free Goals**

- Reduce new HIV infections in adolescents and young women (10–24 years) to less than 100,000 by 2020.
- Provide VMMC for HIV prevention to 25 million more men by 2020, with a specific focus on young men (10–29 years).

Accurate knowledge of HIV transmission and prevention is required for adolescents and young people to protect themselves. However, too few have an accurate understanding of HIV—in fact, a 37-country study between 2011 and 2016 demonstrated that only 36% of young men and 30% of young women aged 15–24 had an accurate understanding of how to prevent HIV being sexually transmitted. If achieved, the Stay Free goals will make sure this vulnerable population has access to the medical and educational programming they need to stay HIV-free. This includes ensuring that young girls have access to secondary and higher education, as well as sexual and reproductive health services, and that harmful practices like early and forced child marriage, which increase a girl’s vulnerability to HIV, are reformed.

---

*The Start Free, Stay Free, AIDS Free framework is led by the Joint United Nations Programme on HIV/AIDS (UNAIDS), the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR), the United Nations Children’s Fund (UNICEF), the World Health Organization (WHO), and the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF).*
Key Messages

- Adolescents need specific care and treatment services tailored to their unique needs as they transition from child care to adult care.

- Breaking down barriers, such as legal restrictions on the age of consent, will provide easier access for adolescents to prevention, care, and treatment services.

- Health care workers must be trained to adequately treat, counsel, and educate adolescents on HIV and to provide adolescent-friendly services.

- Emphasis must be placed on adherence to treatment, including through psychosocial support programs to help combat underlying reasons for poor adherence, such as stigma and discrimination.

- Young women and girls must be a priority in HIV and sexual and reproductive health programming if the end of AIDS by 2030 is to be reached.

- Ending new HIV infections in adolescent girls will require tackling tough issues like child marriage and gender-based violence.

Key Facts

- In 2016, there were 260,000 new HIV infections among adolescents (15–19 years).  

- The majority of adolescents living with HIV were infected through mother-to-child transmission.

- Treatment failure is highest among adolescents living with HIV, while treatment adherence is lowest among the same age group.

- AIDS-related illnesses are a leading cause of death among adolescents and for women of reproductive age.

- AIDS-related deaths have declined among all age groups except adolescents.

- In 2016, approximately 22% of new infections globally were among young women aged 15–24 years.

- In 2016, new infections among adolescent girls and young women (15–24 years) were 44% higher than among their male counterparts.

- In sub-Saharan Africa, girls account for three out of four new HIV infections among 15–19 year olds.
Action Needed by First Ladies

Africa’s first ladies can drive critically important changes in their respective countries, ensuring that progress is made toward achieving an AIDS-free generation.

First ladies have the power to influence the behavior of their citizens because they are regarded as “mothers of the nation.” They have significant clout that can result in positive change in the issues they are passionate about. First ladies are perceived as strong collaborators, able to bring different stakeholders to the table to drive action in a way that crosses the political divide and touches all citizens. First ladies undertake numerous HIV-related activities. This section identifies three broad areas that need action by African first ladies in order to drive the biggest change in addressing elimination of MTCT and successful pediatric and adolescent HIV prevention and treatment.

**Raise Awareness**

One way to improve pediatric and adolescent HIV prevention and treatment is by raising awareness of the issues. Because the first ladies can bring significant attention to the issues being addressed, they play an important role in changing the epidemic among children and young people. For example, by raising awareness at the community level, first ladies can help families and health care workers better understand the importance of PMTCT, EID, and initiation of treatment, leading to improved health outcomes for HIV-exposed and HIV-infected infants and their mothers. By raising awareness of the challenges of reaching adolescents with lifesaving services, first ladies can encourage ministries of health to change relevant policies, develop more youth-friendly services, and put out new guidelines or training manuals to sensitize health care workers on this issue. This, in turn, can lead to better care and result in increased uptake of services. Some ways to raise awareness are as follows:

- Meet with government officials, health care providers, and implementing organizations to disseminate the latest information about the HIV epidemic in country.
- Visit hospitals and service providers to gather firsthand knowledge of the challenges families face in getting testing and treatment for their children and to gain an understanding of how HIV testing of newborns, children, and adolescents is performed and followed up. While visiting facilities, take note of the achievements made in reaching families with these services and then use those as examples to further advocate for the scale-up of successful interventions at additional facilities throughout the country.
- Enhance public understanding of pediatric HIV and the barriers facing both children and adolescents in accessing care and treatment—for example, through public meetings, awareness-raising events, or media campaigns.
- Promote HIV testing of infants, children, adolescents, and adults as an important aspect of health services.
- Educate the public about the government’s commitment to ensuring universal access to HIV treatment by children and adolescents who need it.
- Speak out against HIV-related stigma and discrimination affecting children, adolescents, and their caregivers at home, in schools, and in the community.
- Encourage families and caregivers of HIV-exposed infants and children to go for testing and know their status; for those who are HIV-positive, encourage them to receive treatment and care and to adhere to their appointments and medications.
- Use social media to educate and raise awareness of these issues, especially to communicate with young people.
Mobilize Resources

Adequate funding is necessary to effectively reach children, adolescents, and their families with lifesaving HIV services. First ladies can use their influence to mobilize national and international resources to support service delivery, health care worker training, pediatric- and adolescent-specific HIV support groups, and other vital components of the HIV/AIDS response. Financial, material, and technical resources are paramount in addressing the pediatric HIV treatment gap. First ladies have the wherewithal to bring various partners and stakeholders together to ensure that there are adequate and sustainable resources to facilitate pediatric and adolescent HIV prevention and treatment. Public-private partnerships and corporate social responsibility are valuable approaches to consider and promote. The following items are also important ways to mobilize resources:

- A thorough understanding of resource gaps in the response to both pediatric and adolescent HIV in country will enable first ladies to advocate for necessary budget allocations to bolster treatment and prevention services for all children and adolescents who need it.
- First ladies can work with local organizations to advocate for additional domestic and international resources for community-based prevention, treatment, and support services for women, children, and adolescents.
- First ladies can collaborate with other like-minded leaders to advocate for increased resources for pediatric-focused HIV research and promote expedited registration, adoption, and availability of improved pediatric ARV formulations.
- Engaging in strategic partnerships with public and private actors will help address gaps in programs, services, or technologies.

Influence Policymakers and Agenda Setters

Instituting policies to better address the needs of infants, children, and adolescents is one way to improve HIV treatment and prevention in these vulnerable populations. First ladies have the ability to galvanize various stakeholders around an issue that they care about. Addressing pediatric and adolescent HIV prevention and treatment can result in tangible gains for the country by helping to create and maintain a healthy and developing young population. The following are some suggestions:

- Become familiar with the types of pediatric HIV treatment available and the gaps in country, as well as the areas where various stakeholders would require greatest support.
- Identify the key influencers and policymakers to champion pediatric and adolescent HIV prevention and treatment in country and have roundtable discussions with them to raise awareness of the issues and get them involved.
- Build support with appropriate stakeholders to address the needs of children living with HIV and explore what remedies can be put in place through government action.
- Advocate for changes in the policies and practices that allow inclusion of pediatric HIV testing in maternal and child health centers, nutrition centers, hospital inpatient wards, and other relevant health programs.
- Work with policymakers to encourage enrollment of girls in education through secondary school.
- Remove or improve age-of-consent laws that limit access to HIV and other health services for adolescents.
- Eliminate child marriage in both law and practice and work to enforce laws against gender-based violence.
- Promote social protection programs, such as cash transfers, to reduce environmental challenges such as food insecurity, which lead to risky behaviors.
Tools for Engagement

The following list of tools includes proposed steps for first ladies and their staff members to further the elimination of MTCT and foster pediatric and adolescent HIV prevention, care, and treatment efforts in country. Most of these actions are currently being used by first ladies to advance issues related to HIV and maternal, newborn, and child health. These tools will assist first ladies in adapting existing actions and in taking on new ones for issues pertaining to this tool kit. This is not a comprehensive list; rather, it is a compilation of potential opportunities for engagement.

Engagement with Diverse Leaders

First ladies can engage with many levels of leadership in their countries and communities to educate them on EMTCT and pediatric and adolescent HIV prevention, care, and treatment. By doing so, the first ladies can also gather further support for action. These levels of leadership include political figures, community leaders and members, religious authorities, civil society leaders, and members of the media, among others.

- Organize and participate in roundtable discussions with community leaders about pediatric and adolescent HIV/AIDS, including issues faced in the community, and emphasize the importance of antenatal care, including PMTCT services, early and continuous HIV testing of pregnant women, HIV testing of infants (including EID), early initiation of HIV treatment for both children and adults, retention in care, and continued access to age-appropriate testing, counseling, and additional health services as children grow into adolescents. This will help educate community leaders and provide them with an opportunity to express their concerns and suggest constructive solutions to the issues faced.

- Organize and lead meetings or workshops with political figures, religious leaders, civil society leaders, members of the media, and so on, on the importance of and challenges to PMTCT and pediatric and adolescent HIV treatment and prevention services. The first ladies can provide remarks at these workshops to encourage leaders to continue existing programs and strengthen programs that address these issues.

- Engage with partner organizations and stakeholders around program launch events or close-out events to provide remarks supporting this important work.

- Meet with the ministry of health, the ministry of finance, members of parliament, and other government officials to discuss the status of pediatric and adolescent HIV/AIDS in country and the steps taken to improve PMTCT and HIV testing, including EID, pediatric treatment, and adolescent prevention and treatment services. Discuss the opportunity for collaboration through public-speaking opportunities, joint campaigns on the issue, support of legislation, and so on.

Sport

Sporting events have been used over the years to break the barriers of age, color, tribe, and gender, among others, and can have the effect of focusing people on an issue they did not realize needed attention. With sport, the public cares about winning together as a nation—in succeeding. Sport offers a great opportunity to rally the public to raise awareness and funds to support EMTCT and pediatric and adolescent HIV prevention and treatment.

- Organize sporting events to raise awareness about the importance of antenatal care, HIV testing, and pediatric and adolescent HIV prevention and treatment, as well as the significance of early initiation of ART. Such events could include a run/walk or a community activity day that includes several sport activities for children and adolescents and that incorporates an education booth for parents and guardians. These events can even be fundraisers and could include a merchandising element to allow for longer-term impact of event messaging (e.g. through T-shirts, caps, bottles, and other items with pediatric HIV messaging).
Culture, Arts, and Music

Similar to sport, cultural events, art shows, and musical performances all have the ability to bring community members together for a common interest. These events can be both entertaining and educational for the whole family to enjoy. By incorporating educational messaging on health issues, such as pediatric and adolescent HIV, community members are provided with a unique opportunity to learn about lifesaving interventions they may otherwise have avoided due to such social barriers as stigma and discrimination.

• Host cultural events involving musicians, artists, and actors that raise awareness. Community members would attend these events for the entertainment while taking away lifesaving information on pediatric and adolescent HIV prevention, care, and treatment, as well as the importance of antenatal care, early HIV diagnosis, and early initiation on ART. These events could result in increased uptake in services due to community awareness. Such events may also be coupled with testing for HIV or other communicable or non-communicable diseases.

Community Events

Because many citizens appreciate the role of the first lady as the “mother of the nation,” her direction and mentorship are taken seriously at the community level. Thus, first ladies can engage in various community-level activities that raise awareness and increase uptake of HIV services due to reduced stigma and discrimination at home and in the community.

• Educate women, children, and families on the importance of pediatric and adolescent HIV prevention and treatment through participation in community days. These events provide an opportunity for the first ladies to engage directly at the community level. At community days, information is shared, questions can be answered, HIV testing may be offered, and families can be encouraged to attend antenatal care visits, to go to health facilities for delivery, and to bring their infants in early for HIV testing and initiation on treatment if they are living with HIV.

• Sensitize community members and leaders on HIV through other planned activities within the community to help reduce stigma and discrimination.

• Reduce stigma and discrimination through educational events at schools. First ladies can lead campaigns, develop educational material, and speak with students on the importance of HIV treatment and of adhering to ART. Reducing stigma in schools makes children more likely to remain in school and to be able to stay on treatment without fear of stigma or discrimination by their peers.

• Engage with teen mother support groups, providing motivational speeches and words of encouragement for continued engagement with the health system. First ladies can share their experience as mothers and emphasize the important role teen mothers will play in shaping the life and health of their child.
Media Engagement

By engaging with community members and leaders through print news, radio, and digital and social media, first ladies have the opportunity to spread an important message to a diverse audience with incredible reach. This helps further amplify important messages around HIV testing, care, and treatment and could result in increased uptake of services and reduced stigma and discrimination.

• Reach out to media outlets, including radio and TV, about giving interviews on the importance of PMTCT services, early pediatric HIV testing and treatment, and continued HIV prevention, counseling, and treatment services for adolescents in order to raise awareness across the country.

• Work with media outlets to author an opinion or lifestyle piece from the first lady on the issue of pediatric HIV treatment, the importance of EID and pediatric treatment, the persistent challenges with adolescent HIV prevention and treatment, and what still needs to be done regarding PMTCT. Media pieces authored by the first lady are likely to get significant attention because of her important stature in country.

• Reach out to media outlets to educate them on these important issues so that they are better informed when writing or speaking on the issue. When media personnel are educated on these issues, they will be able to produce more compelling pieces that will help shed light on the specific challenges of pediatric and adolescent HIV in country.

• Work with local media to host a Twitter chat, engaging with key issue champions and celebrities to discuss lifesaving interventions and the importance of treatment adherence. These events can also help sensitize the community in an effort to reduce HIV-related stigma and discrimination.

Issue-Specific Campaigns

First ladies have the incredible opportunity to leave a lasting legacy. One way to do this is through issue-specific campaigns. Making EMTCT and pediatric and adolescent HIV a landmark issue will help first ladies usher in an AIDS-free generation in country. This will not only resonate with citizens now but will also be remembered in years to come.

• Participate or take the lead in an awareness-raising campaign to garner political and community support through engagement with high-level political figures and celebrities.

• Visit health facilities and hospitals across the country to speak on the importance of EID, pediatric HIV treatment, and adolescent prevention, care, and treatment in support of issue-specific campaigns.

Raise Funding and Resources

By supporting resource mobilization for pediatric and adolescent HIV, first ladies can highlight the important role that funding plays in reaching an AIDS-free generation. Without resources, all the interventions that are proven successful will not be able to be implemented. Strong resources are crucial to address the treatment gap and ensure that children living with HIV have access to the care and treatment they need to survive and thrive. First ladies are in a position to help advocate in country for these needed resources.

• Mobilize funding for specific pediatric and adolescent HIV initiatives in country through the first lady’s foundation or office and the OAFLA secretariat. These resources could be used to scale up pediatric and adolescent HIV testing, treatment, and service delivery; fund research for new treatment; and support training for health care workers—among other activities.
Opportunities for Regional and National Collaboration

First ladies can work in their regions or collaborate at the continental level to motivate, educate, and communicate on issues related to maternal, pediatric and adolescent HIV. Many of the activities can be done jointly as part of a continent-wide approach or done individually by country.

OAFLA, which was primarily established to be a collective voice for some of Africa’s most vulnerable people, has evolved into an institution capable of providing continent-wide leadership through advocacy in the field of HIV and the wider scope of maternal and child health. By virtue of having a strong secretariat, OAFLA offers many opportunities for first ladies to work in concert with one another and to leverage one another’s knowledge and experience.

First ladies can also leverage the technical knowledge and experience of various implementing partners, such as EGPAF, to ensure they have current and accurate information to address the challenges highlighted in this document. By inviting partners to sit in their national steering committees, first ladies can benefit from the technical expertise of these partners. In addition, first ladies may be able to tap into other financial and material support to enable implementing partners to be effective in their work and to help the African continent end AIDS.
References


17. Inter-Agency Task Team (IATT) for Prevention and Treatment of HIV Infection in Pregnant Women, Mother and Children. EID IATT Laboratory and child survival working group (p. 3). Global Steering Group Mid-Term Review Meeting; Dec. 6–7, 2012.

18. IATT. EID IATT Laboratory and child survival working group (p. 2). GSG Mid-Term Review Meeting; Dec. 6–7, 2012.


For additional information contact:

Hanna Mekonnen  
*Programme Officer*  
Organisation of African First Ladies against HIV/AIDS (OAFLA)  
Tel:+251-115-508069/+251-118-962998  
Email: hanna@oafla.org  
Website: www.oafla.org

Rhoda Igweta Murangiri  
*Associate Director,*  
Public Policy and Advocacy  
Elizabeth Glaser Pediatric AIDS Foundation  
Tel: +254-204-454081/2/3  
Email: rigweta@pedaids.org  
Website: www.pedaids.org