

Step Up the Pace: Towards an AIDS-free generation in West and Central Africa



Throughout this report, the term 'children' applies to all children below the age of 18 years, including adolescents, as defined in the Convention on the Rights of the Child. The United Nations defines adolescents as persons aged 10–19 years, and young people as persons aged 15–24 years.

Because HIV-related stigma persists, UNICEF takes steps to safeguard the identities of children and their mothers in accordance with their wishes and with global standards of child rights and protection. UNICEF obtains written consent from people living with the virus before identifying them as such in photographs and other media. Unless otherwise stated, people depicted in this publication, and in the accompanying materials online, should not be assumed to be living with HIV.

Note on the data: Unless stated otherwise, the data cited throughout this report are based on a UNICEF analysis of UNAIDS 2017 estimates. The numbers in square brackets are confidence bounds, indicating the lower and upper values of estimates.

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Please contact:
United Nations Children's Fund
West and Central Africa Regional Office
HIV and AIDS Section
P.O. Box 29720
Dakar-Yoff, Senegal

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Front cover: A boy takes a break from playing football at the Happy Kids and Adolescents centre in Kenema, Sierra Leone, where UNICEF supports the non-governmental organization in providing services to children affected by HIV and AIDS. © UNICEF/UN073038/Phelps

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Foreword

The West and Central Africa region has one of the world's highest HIV burdens among children and adolescents, second only to that of Eastern and Southern Africa. Yet, due to its lower HIV prevalence rate, the epidemic in this region has received less attention and has not been the main focus of major regional and global HIV initiatives. While the countries in West and Central Africa collectively lag behind nearly every other region in meeting the needs of children and adolescents living with and vulnerable to HIV, a sense of urgency seems to be missing.

Although progress has been made in recent years, especially in terms of reducing HIV transmission from mothers to infants, insufficient attention and support have been directed to children now living with HIV. About 8 out of 10 of the estimated 540,000 children now living with HIV in West and Central Africa are not accessing life-saving medicines because the majority have not yet been diagnosed. Every year, an estimated 51,000 children and adolescents die from AIDS in the region, and more than twice that number are newly infected with HIV. Adolescent girls and young women remain the most affected: nearly three out of five of all adolescents aged 10–19 years living with HIV in the region are women. This is unacceptable.

Every child deserves to be born free of HIV (Start Free) and to stay HIV-free while growing into adolescence (Stay Free), and children living with HIV deserve to live free of AIDS (AIDS Free). It is our duty to make the Three Frees framework a reality for all children.

Progress has been too slow, and we have become too complacent. It is true that West and Central Africa has faced many challenges over the past few years, including recurrent humanitarian crises linked to conflicts, terrorism and epidemics in several countries. But these circumstances should not be justification for the lack of progress in the HIV response for children in the region.

HIV and AIDS pose direct threats to the lives of 820,000 children and adolescents today in West and Central Africa. Yet we know what works, and this report provides a deeper understanding of key bottlenecks that continue to slow our progress. It outlines strategic directions and innovations to help us catch up with the pace, fast-track progress and get closer to the UNAIDS targets of eliminating new HIV infections among children and adolescents, and optimizing HIV treatment, care and protection for children, adolescents and their parents by 2020.

The global HIV response has offered some valuable insights that can inform the response in West and Central Africa. Understanding the unique epidemiologic and local contexts,

as well as the needs of each population group, should drive a more tailored approach to respond to the risks and vulnerabilities of children, adolescents and young women throughout the life cycle. Special attention must be paid to adolescent girls and young women, who continue to be disproportionately affected by HIV and AIDS in the region. Addressing HIV and AIDS in adolescence means addressing the root causes of gender inequality in our communities, empowering our adolescent girls to make informed choices, and protecting them against abuse and exploitation.

There are reasons to be hopeful. In 2015, 19 countries in West and Central Africa endorsed the Dakar call to action for accelerating the elimination of new HIV infections in children and access to treatment for children and adolescents living with HIV by 2020. That same year, the All In to #EndAdolescentAIDS initiative was launched and has now been rolled out in nine countries. More recently, the African Union and political leaders in the region endorsed the West and Central Africa 'catch-up' plan, which aims to drastically improve HIV treatment for adults and children by 2018.

This stronger political commitment should be amplified through renewed global solidarity and more effective partnerships. Beyond money, this region requires a revival of the HIV and AIDS movement, with greater involvement of community actors and civil society to tackle stigma and keep national HIV and AIDS programmes more accountable. Fast-tracking and sustaining HIV results will also require commitments to strengthen fragile health systems and address the social determinants of children and adolescent survival and development in each country. No country in the region can afford to lag behind in its HIV response any longer.

Ending AIDS starts with children. Each country should strive for a world in which all children and adolescents are guaranteed the support they need against HIV and AIDS, so that we can keep our collective promise for an AIDS-free generation by 2030.

Let's step up our pace.



Marie-Pierre Poirier
Regional Director, West and Central Africa, UNICEF



Dr. Djibril Diallo
Director, Regional Support Team for West and Central Africa, UNAIDS



1

INTRODUCTION

To be a child, adolescent or young woman in West and Central Africa is to be vulnerable to HIV. In the region, approximately 165 children aged 0–14 years and approximately 170 adolescents aged 15–19 years become infected with HIV every day.¹

Of an estimated 540,000 [confidence range: 380,000–710,000] children aged 0–14 years living with HIV across the region, 420,000 – or nearly 8 in 10 of them – have no access to the antiretroviral medicines (ARVs) that can save their lives, as the majority have not been identified due to poor access to HIV testing services.

The 24 countries that make up the West and Central Africa region are home to 25 per cent of children aged 0–14 years and 16 per cent of adults aged over 15 years living with HIV worldwide.² These countries have historically reported lower HIV prevalence compared with other parts of Africa.

That may explain why over the years, West and Central Africa has not been the focus of major regional and global initiatives when the world has been focused on Eastern and Southern Africa.³ To date, West and Central Africa has made less progress than most other regions on nearly every measure of HIV prevention, treatment and care programmes relevant for children and adolescents.

This report takes stock of the progress and shortfalls in the HIV response in the region, offers an analysis of the challenges that continue to slow progress, and outlines several strategic directions that can accelerate the pace of progress towards the targets defined in the ‘Three Frees’ framework for ending AIDS among children, adolescents and young women by 2020.

Left behind: The current fate of the region’s children and adolescents living with and vulnerable to HIV

Sub-Saharan Africa shares 86 per cent of the global HIV burden among children and adolescents (aged 0–19 years). In terms of sheer numbers alone, Eastern and Southern Africa continues to have the largest HIV burden by far in children and adolescents: nearly two thirds of all children and adolescents living with HIV are in these two regions. Nigeria, located in West and Central Africa and the most populous country on the continent, has the second-largest number of

children and adolescents living with HIV in the world, after South Africa.

Given that West and Central Africa’s overall burden is lower than that of Eastern and Southern Africa, one might expect the HIV response in West and Central Africa would outpace that in Eastern and Southern Africa. In reality, the pace of response has been fast in Eastern and Southern Africa and slow in West and Central Africa. Children and adolescents in West and Central Africa have not benefited as substantially from HIV responses compared with their counterparts in most other regions.

The world has celebrated several countries that received World Health Organization (WHO) certification of elimination of new HIV infections in children since 2015,⁴ but none of them are from sub-Saharan Africa.

Since 2010, the number of new infections among children in West and Central Africa has decreased by 32 per cent, compared with 56 per cent in Eastern and Southern Africa. Yet in 2016, only about half (49 per cent [36–63 per cent]) of pregnant women living with HIV in West and Central Africa had access to ARVs for preventing the mother-to-child transmission (PMTCT) of HIV to their children. By contrast, 88 per cent of pregnant women living with HIV have accessed ARVs for PMTCT in Eastern and Southern Africa.

West and Central Africa’s coverage of life-saving antiretroviral therapy (ART) among children living with HIV (21 per cent [13–29 per cent]) is the lowest in the world. Eastern and Southern Africa’s coverage is 51 per cent [36–62 per cent]. Such low treatment coverage rates help explain why in 2016, about 43,000 [26,000–62,000] AIDS-related deaths occurred among children aged 0–14 years in West and Central Africa. From 2010 to 2016, West and Central Africa recorded a slower decrease in the number of AIDS-related deaths among children of that age (31 per cent) compared with Eastern and Southern Africa (54 per cent). Today, West and Central Africa accounts for 37 per cent of the world’s AIDS-related deaths among children.

Lilianne, who lives in Côte d’Ivoire, learned she was HIV-positive when she was pregnant with her second child. Her oldest child, 13, has tested negative, as has her 2-year-old son. Liliane says she is very disciplined about taking her medication.

Access to early infant diagnosis (EID) of HIV increases the likelihood of early treatment and care, which can directly influence a child's survival if he or she is born with HIV or acquires it during breastfeeding. In 2016, for example, EID coverage was about 20 per cent in West and Central Africa, whereas in Eastern and Southern Africa, it was more than twice as high (52 per cent).⁵ Many countries in the West and Central Africa region have limited capacity to perform the tests needed for EID. Without knowing a child's HIV status, his or her family is less likely to seek the treatment that could prevent the tragedy of a child's death from HIV.

The annual number of new HIV infections among adolescents aged 15–19 years in the region now exceeds that of children (aged 0–14 years), having reached 62,000 in 2016.⁶ This is attributed to the decrease in new child infections as a result of an increase in PMTCT coverage. That annual number has not changed since 2010, while the annual number of new HIV infections in adolescents in Eastern and Southern Africa has decreased by 21 per cent. These new infections occurred mostly through unprotected sexual contact and mostly among adolescent girls.

Since 2010, West and Central Africa has recorded a 15 per cent increase in the number of annual AIDS-related deaths among adolescents (aged 10–19 years), with 16,000 deaths recorded in 2016 alone. By contrast, in Eastern and Southern Africa, the annual number of AIDS-related deaths decreased by 14 per cent between 2010 and 2016, with 34,000 deaths recorded in 2016. AIDS is the fourth leading cause of death among adolescents (aged 10–19 years) in sub-Saharan Africa and the ninth leading cause globally.⁷

Adolescents (aged 10–19 years) are the only age group in West and Central Africa in which the number of AIDS-related deaths increased between 2010 and 2016. In West and Central Africa, the increase was largely due to the increasing number of vertically infected children surviving into adolescence, often despite contexts characterized by poor ART coverage, adherence and retention.

The Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates that in 2016, only US\$2.1 billion was invested in the HIV response in West and Central Africa, while about \$9.6 billion was invested in Eastern and Southern Africa.⁸ There remains a high dependency on external funding in the region, with two thirds of the resources available for the HIV response coming from non-domestic sources. By contrast, in Eastern and Southern Africa, almost half the resources are from non-domestic sources. The Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) and the Government of the United States of America are the major external donors in both regions.

This analysis has underlined several inequities between the two African regions that share the largest global HIV burden. However, another equity concern lies in the coverage gaps between children and adults in West and Central Africa. For example, while ARV coverage among pregnant women living with HIV increased from 21 per cent [16–27 per cent] in 2010 to 49 per cent [36–63 per cent] in 2016, among children living with HIV (aged 0–14 years), it increased

only from 7 per cent [4–9 per cent] to 21 per cent [13–29 per cent] during the same period. Among adults it increased from 14 per cent [10–18 per cent] to 35 per cent [25–46 per cent].

The equity gaps have many causes, some of which are context-specific – including differences in the levels of political will and commitment to introducing innovation to overcome bottlenecks; financial and human resource opportunities and challenges; and the quality and functioning of health and other essential systems such as supply chains. In many West and Central African countries, these constraints are exacerbated by conflict, humanitarian crisis and political instability.

Regardless of which reasons are relevant or why, the repercussions have been severe among children, adolescents and adults in West and Central Africa. Broadly speaking, governments and other important players in the region's HIV responses can and should do much more in taking aggressive, comprehensive steps to fighting the HIV epidemic.

The issue is important because the concepts of equity and 'leaving no one behind' are at the core of the 2030 Agenda for Sustainable Development. They call for better programme data for decision making and efficiency in resource allocations, the prioritization of vulnerable populations and people-centred differentiated responses.

Efforts to reverse course: Messages of urgency and priority

The challenges facing the region and its children are complex, but that is not an excuse to ignore them. Children and adolescents in West and Central Africa deserve special attention in the global HIV response, as the pace of the response will determine whether the world achieves the targets by 2020 or 2030. Their futures could rely in part on regularly reminding governments, civil society actors, United Nations agencies and donors that more effective approaches to HIV epidemics can be designed, funded and implemented at scale in West and Central Africa, building on the more promising and expansive results in Eastern and Southern Africa and other regions of the world.

Such action is essential: The consequences of no or limited improvement in HIV responses across West and Central Africa will mean more AIDS-related deaths among children and adolescents, and rates of mother-to-child transmission of HIV and new infections in adolescents and young women will stagnate or could even increase.

The already dire and worrying situation among children and adolescents should be a major impetus for such action. Demographic realities provide additional urgency to put in place and sustain comprehensive HIV prevention and treatment targeted at them. Africa today is the youngest continent by far, with children under 15 years accounting for 41 per cent of the total population and those aged 15–24 years for an additional 19 per cent. The continent's population is projected to double by 2050, to more than 2.5 billion people.⁹ Children and young people, therefore, will account for the majority of people across Africa for years to come.

Around one quarter of the estimated 478 million people living in West and Central Africa in 2015 were adolescents (aged 10–19 years).¹⁰ Many of the countries expected to have the most extensive ‘youth bulges’ are in West and Central Africa, including the Democratic Republic of the Congo and Nigeria.

There are welcome indications that policymakers, donors and stakeholders are stepping up their efforts to ensure that children and adolescents in the region will no longer be left behind. Major donors, including the Global Fund, United States President’s Emergency Plan for AIDS Relief (PEPFAR), UNITAID, Initiative 5%, the World Bank and European Union countries are increasing their focus on addressing the specific bottlenecks in the West and Central African response to HIV. More countries are increasing their share of domestic resources to combat HIV. Organizations of people living with HIV and the broader civil society are strengthening their engagement to tackle AIDS-related stigma and promote approaches to HIV prevention, treatment, care and support that are centred on people, families and communities.

The UNICEF/UNAIDS-led platform, All In to #EndAdolescentAIDS, for example, has been leveraging initiatives from different stakeholders and donors and has helped in aligning their investments to accelerate national responses to HIV in adolescents. Launched in 2015 in Cameroon, Côte d’Ivoire, the Democratic Republic of the Congo and Gabon, the initiative had expanded to nine countries in the region by 2017.

Dakar call to action

The 2015 Dakar call to action was endorsed as a blueprint of priority actions to fast-track the elimination of mother-to-child transmission of HIV and improve access to paediatric HIV treatment by 2020. It was the outcome of a regional consultation held in Dakar (Senegal) in November 2015 with experts from 19 countries, convened in part in response to concerns of insufficient progress towards the UNAIDS ‘90-90-90’ targets: ensuring that 90 per cent of people (children, adolescents and adults) living with HIV know their HIV status; 90 per cent of people who know their HIV-positive status are accessing treatment; and 90 per cent of people on treatment have suppressed viral loads.

The call to action appealed to all stakeholders to renew “our commitment to the achievement of the 90-90-90 objectives, the elimination of new HIV infections in children and universal access of HIV-infected children to ART in West and Central Africa.” It has been used in advocacy at regional and country levels and informed a regional HIV programme for the Economic Community of Central African States. A regional follow-up consultation was held in N’Djamena (Chad) in 2016.

Catch-up plan for West and Central Africa and community health worker initiative

At the 29th African Union Summit in June–July 2017, leaders renewed their political commitment to combating HIV and AIDS by endorsing two landmark initiatives: a high-profile ‘catch-up’ plan for West and Central Africa and an initiative to recruit, train and deploy 2 million community health workers across Africa by 2020.¹¹ The catch-up plan provides a framework for political advocacy and accelerated action for countries of the region to adopt and scale up effective approaches and innovations to reduce inequity in access to HIV treatment. One notable goal is to increase the number of people on treatment from 1.8 million in 2015 to 2.9 million by 2018, with 120,000 children among the additional 1.1 million people reached if the target were to be met.

As of September 2017, a total of 11 countries in the region were implementing operational plans based on priority actions informed by the catch-up plan with the support of UNAIDS, UNICEF, WHO, PEPFAR, the Global Fund and Médecins Sans Frontières: Benin, Burkina Faso, Cameroon, the Central African Republic, Côte d’Ivoire, the Democratic Republic of the Congo, Guinea, Liberia, Nigeria, Senegal and Sierra Leone.¹² Formal monitoring processes will track progress with the involvement of key stakeholders, including local and regional advocates from the community and civil society sector.

‘Three Frees’: Start Free, Stay Free, AIDS Free

In 2016, UNAIDS, UNICEF, WHO, PEPFAR and the Elizabeth Glaser Pediatric AIDS Foundation launched the ‘Three Frees’ framework, which defines priority actions towards achieving super-fast-track targets for children and adolescents and young women by 2018 and 2020. The framework aims to prevent new HIV infections among children (Start Free) and among adolescents and young women (Stay Free), and to substantially scale up HIV treatment services for children and adolescents living with HIV (AIDS Free).

Most countries in West and Central Africa have aligned their national HIV strategic frameworks and operational plans to the ‘Three Frees’ framework, and annual regional consultations on the Dakar call to action provide a useful platform for monitoring progress, sharing lessons learned and best practices, and harmonizing efforts.

Such collaborative efforts at regional and global levels are needed to galvanize support for closing the equity gaps that continue to constrain HIV responses for children, adolescents and young women in West and Central Africa. The messages of urgency and practicality could help to make people, policies and systems in the region and the world more accountable to the needs of children and adolescents.



2

EPIDEMIOLOGY AND DEMOGRAPHICS

According to recent estimates, West and Central Africa's share of the global totals of children and adolescents living with HIV, newly infected with HIV and dying of AIDS-related causes is second only to Eastern and Southern Africa.

Table 2.1 summarizes HIV and AIDS-related indicators concerning children. A UNICEF analysis of UNAIDS 2017 data indicates that West and Central Africa is home to at least 16 per cent of the world's adult population living with HIV (aged over 15 years), but that share is much higher (about 25 per cent) among children aged 0–14 years. The region's share of the estimated number of children newly infected by HIV that year is even higher: 38 per cent. West and Central Africa accounts for nearly the same share of AIDS-related deaths in children: 37 per cent.

Table 2.2 summarizes indicators concerning adolescents aged 10–19 years. As with the numbers of children, West and Central Africa's share is second only to Eastern and Southern Africa. In 2016, about 450,000 adolescents were living with HIV in West and Central Africa. That same year, about 30 per cent (16,000 adolescents) of the global total of deaths due to AIDS-related causes in this age group were in West and Central Africa.

Table 2.2 clearly illustrates the gender gaps in West and Central Africa. The data indicate that HIV affects adolescent girls more than adolescent boys in terms of those living with HIV, newly infected with HIV and dying of AIDS-related causes. Girls aged 0–14 years accounted for less than half (49 per cent) of all new infections in 2016 among all children in that age group, while adolescent girls aged 15–19 years accounted for more than two thirds (69 per cent) of estimated new infections that year among all adolescents in that age group. This age-sex distribution of new infections points to the need to further prioritize efforts to address the specific HIV prevention needs of girls.

Regional detail: Age and sex

There is a surge after the age of 14 years in the total number of children, adolescents and young people living with HIV in the West and Central Africa region. Those aged 15–19 years and 20–24 years, respectively, represented 21 per cent and 40 per cent of children, adolescents and young people living with HIV in 2016. Together, these groups represented nearly two thirds of all children, adolescents and young people living with HIV (Figure 2.1).

Table 2.1

Summary of HIV epidemic among children (aged 0–14), global and West and Central Africa, 2016

	GLOBAL	WEST AND CENTRAL AFRICA	REGION'S PER CENT OF GLOBAL TOTAL
Estimated number of children (aged 0–14) living with HIV	2,100,000	540,000	25%
Estimated number of children (aged 0–14) newly infected with HIV	160,000	60,000	38%
Estimated number of children (aged 0–14) dying of AIDS-related causes	120,000	43,000	37%

Note: Values may not sum to total due to rounding.
Source: UNICEF analysis of UNAIDS 2017 estimates.

Table 2.2

Summary of HIV epidemic among adolescents (aged 10–19), global and West and Central Africa, 2016

	GLOBAL		WEST AND CENTRAL AFRICA		
	FEMALE	MALE	FEMALE	MALE	PER CENT OF GLOBAL TOTAL
Estimated number of adolescents (aged 10–19) living with HIV	1,200,000	900,000	260,000	190,000	22%
Estimated number of adolescents (aged 15–19) newly infected with HIV	170,000	86,000	43,000	19,000	24%
Estimated number of adolescents (aged 10–19) dying of AIDS-related causes	26,000	29,000	7,700	8,500	30%

Note: Values may not sum to total due to rounding.
Source: UNICEF analysis of UNAIDS 2017 estimates.

Figure 2.1

Estimated number of people living with HIV, by five-year age groups, West and Central Africa, 2016



Source: UNICEF analysis of UNAIDS 2017 estimates.

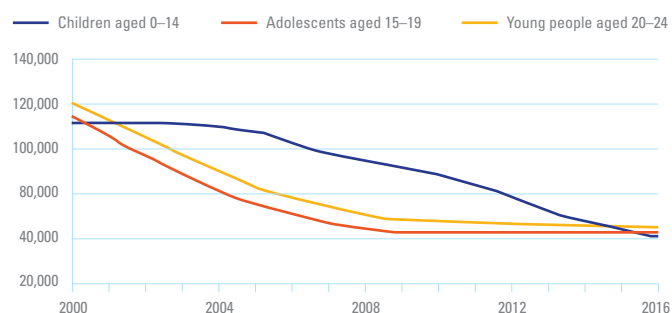
The share of adolescent girls and young women also increased dramatically after the age of 14 years, rising from less than 50 per cent in lower age groups to 62 per cent and 64 per cent among all those in the region aged 15–19 years and 20–24 years, respectively.

One clear indication of the diverging impact of HIV between children, adolescents and young people is illustrated in Figure 2.2. In 2016, the numbers of new infections among adolescents aged 15–19 years and young people aged 20–24 years were both higher than that of children for the first time in 15 years. This was likely due primarily to a continued decline over the past decade in the annual number of new HIV infections among children aged 0–14 years, with an accelerated pace more recently. The total number of new infections among children in 2016, estimated at 60,000, is 32 per cent lower than in 2010. This means that the number of new infections in children aged 0–14 years has been decreasing at an average rate of 6 per cent each year since 2010. The decline is due primarily to efforts to scale up effective PMTCT services.

Similar progress has stalled among older adolescents aged 15–19 years and young people aged 20–24 years, however. The figure of 62,000 new infections in 2016 among those aged 15–19 years is about the same it was each year since 2010, showing no rate of reduction. Stagnation has also occurred among those aged 20–24 years in the region, a group with an estimated 65,000 new HIV infections in 2016.

Figure 2.2

Estimated number of new HIV infections among children aged 0–14, adolescents aged 15–19 and young people aged 20–24, West and Central Africa, 2000–2016



Source: UNICEF analysis of UNAIDS 2017 estimates.

Since 2010, the number of new infections among those aged 20–24 years has decreased by less than 1 per cent on average each year.

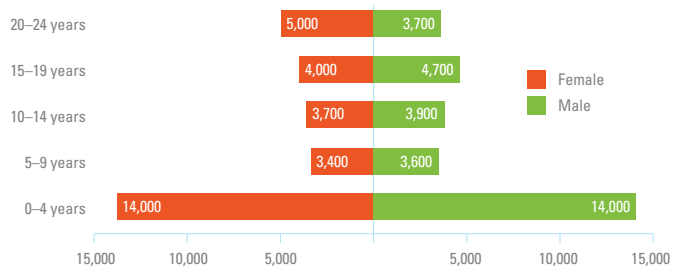
The huge gap between new infections among adolescent boys and girls (aged 15–19 years) has persisted since 2000. An estimated 69 per cent of new infections in 2016 occurred among adolescent girls, about the same share as in 2010 and only slightly lower than in 2000.

Figure 2.3 and Figure 2.4 offer additional perspective on AIDS-related deaths among children, adolescents and young people (aged 0–24 years) in the region. As indicated in Figure 2.3, by far the largest share (28,000) of the 60,000 deaths due to AIDS in 2016 occurred among children aged 0–4 years. This reflects the low coverage of early HIV diagnosis and treatment for children in the region. Without treatment, infants born with HIV may die before the age of 1. Out of the 52,000 infants born with HIV in West and Central Africa in 2016, 15,000 died from AIDS-related causes before their first birthday. The number of AIDS-related deaths in each of the other five-year age groups was relatively similar, between 7,000 and 8,700.

Differences in the number of sex-specific AIDS-related deaths are more pronounced as children get older. Among all those aged 15–19 years dying of AIDS-related causes, a majority (54 per cent) were adolescent boys. By contrast, in the oldest age group (aged 20–24 years), the majority of deaths were young women (58 per cent)

Figure 2.3

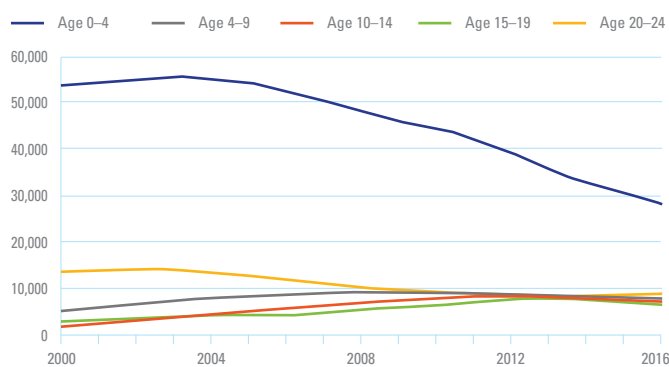
Estimated number of AIDS related deaths, by five-year age groups, West and Central Africa, 2016



Source: UNICEF analysis of UNAIDS 2017 estimates.

Figure 2.4

Estimated number of AIDS-related deaths, by five-year age groups, West and Central Africa, 2000–2016



Source: UNICEF analysis of UNAIDS 2017 estimates.

reflecting their share of the burden in that age group. The latter likely reflects the disproportionate share of the HIV burden among young women and the overall low coverage of ART and PMTCT programmes.

As seen in Figure 2.4, the number of AIDS-related deaths among children aged 0–4 years is much higher than in other age groups, and in 2016 they accounted for fully 47 per cent of all deaths associated with AIDS in all people aged 0–24 years. Yet the gap is narrowing. The number of AIDS-related deaths among the 0–4 age group has declined the most rapidly in recent years, by 37 per cent since 2010, partially due to the roll-out of PMTCT resulting in fewer children infected with HIV as well as the roll-out of ART to children living with HIV. By contrast, the number of AIDS-related deaths among adolescents aged 15–19 years has increased over the same period, by 35 per cent. Most of these adolescents were vertically infected.

Wide disparity in HIV prevalence and burden within the region

The epidemic is heterogeneous in West and Central Africa. Region-wide, HIV prevalence among adults (aged 15–49 years) is 2.0 per cent, with large differences from one country of the region to another, and within countries. Adult HIV prevalence ranges from less than 0.4 per cent in the Niger to 6.2 per cent in Equatorial Guinea. Five countries have an HIV prevalence between 3 per cent and 5 per cent: Guinea-Bissau (3.1 per cent), the Congo (3.1 per cent), Gabon (3.6 per cent), Cameroon (3.8 per cent) and the Central African Republic (4.0 per cent).

As illustrated in Figure 2.5, nearly half (49 per cent) of the 540,000 [380,000–710,000] children aged 0–14 years living with HIV in the

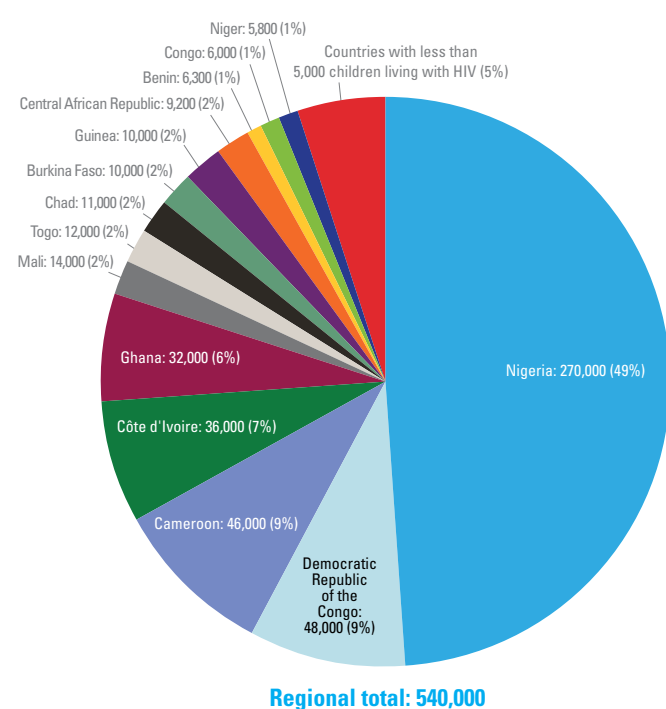
region are in Nigeria. Cameroon and the Democratic Republic of the Congo each are home to the second-largest share, 9 per cent. The ranking of countries is slightly different when it comes to new HIV infections among children aged 0–14 years. Among countries of the region, Nigeria still has the largest share, followed by Cameroon, Côte d’Ivoire and Ghana. The Democratic Republic of the Congo ranks fifth in terms of share of new HIV infections among children; it ranked second in terms of children living with HIV. This can be seen in the estimates shown in Figure 2.6, which illustrates annual new infections among children aged 0–14 years.

One immediate observation from the estimates in Figures 2.5 and 2.6 is Nigeria’s prominence. To a major extent this is due to the country being the most populous in Africa; it is home to 182 million people, more than one third (about 38 per cent) of West and Central Africa’s entire population. Yet even taking that into consideration, the HIV impact among children and adolescents often is disproportionately greater in Nigeria compared with most other countries in the region.

The sheer size of Nigeria and its absolute HIV burden can obscure understanding of significant heterogeneity. For example, among Nigerian states, the number of children aged 0–14 years living with HIV ranges from fewer than 200 [<100–<500] in Ekiti to 22,000 [13,000–34,000] in Lagos. The median among all states is 5,800. Similar variation can be observed among adolescents. Fewer than 500 [<100–<500] adolescents aged 10–19 years in Ekiti are estimated to be living with HIV, compared with some 29,000 [13,000–52,000] in Lagos. The median among all states in Nigeria is 4,300 adolescents living with HIV.

Figure 2.5

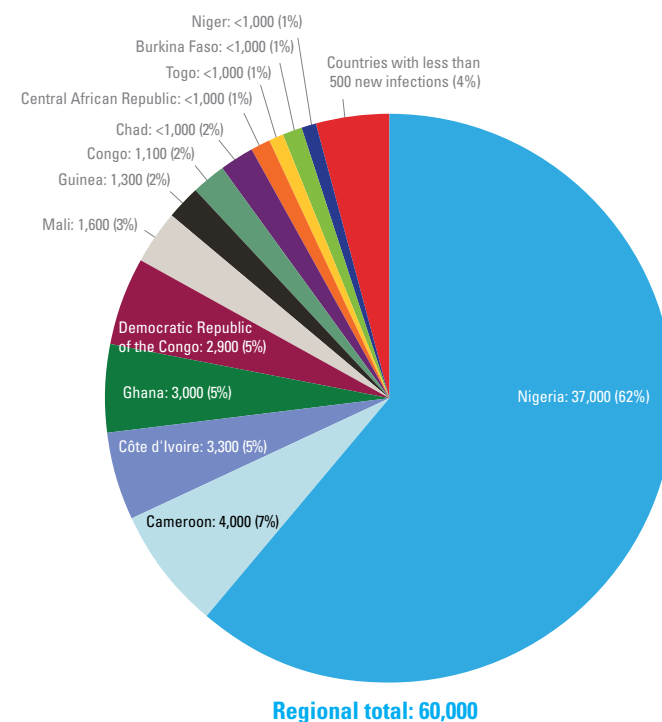
Estimated number and percentage of children (aged 0–14) living with HIV, West and Central Africa, 2016



Note: Data for Sao Tome and Principe are not available.
Source: UNICEF analysis of UNAIDS 2017 estimates.

Figure 2.6

Estimated number and percentage of new HIV infections among children (aged 0–14), West and Central Africa, 2016



Note: Data for Sao Tome and Principe are not available.
Source: UNICEF analysis of UNAIDS 2017 estimates.



3

ELIMINATION OF NEW HIV INFECTIONS IN CHILDREN

The West and Central Africa region has made encouraging progress towards eliminating new HIV infections among children and keeping mothers alive and healthy. Overall, the annual number of new HIV infections among children aged 0–14 years decreased by 32 per cent from 2010 to 2016. Lifelong ART for pregnant and breastfeeding women living with HIV has been formally adopted into treatment guidelines and is being implemented in all countries of the region.

PMTCT services expanded within the region during the implementation of the Global Plan towards the elimination of new HIV infections among children and keeping their mothers alive (Global Plan) between 2010 and 2016.¹³ A few countries have sustained high coverage of PMTCT interventions, including Benin, Burkina Faso, Cabo Verde, Central African Republic, Equatorial Guinea, Guinea-Bissau, Sierra Leone and Togo, where more than 80 per cent of pregnant women living with HIV are receiving ART.

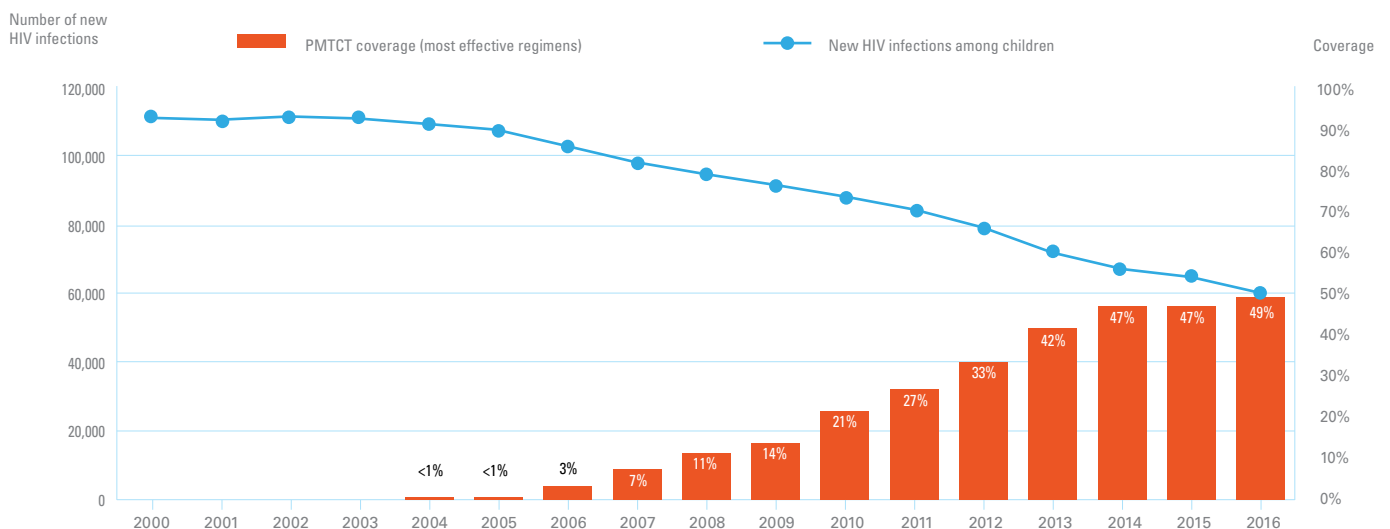
But only about half (49 per cent [36–63 per cent]) of the 330,000 [240,000–420,000] pregnant women living with HIV in the region

were reached with ARVs to prevent vertical transmission in 2016. The region faces key challenges that constrain the rapid scale-up of PMTCT services that is required for the elimination of vertical transmission of HIV by 2020 under the ‘Start Free’ component of the UNAIDS Three Frees framework.¹⁴

The adoption of the Three Frees framework and other initiatives discussed in Chapter 1, including country catch-up plans for improved provision of treatment, are indications of greater political commitment in the region to fast-track progress towards eliminating new HIV infections in children.

Figure 3.1

Percentage of pregnant women living with HIV receiving most effective antiretroviral medicines for PMTCT and new HIV infections among children (aged 0–14), West and Central Africa, 2000–2016



Note: Excludes single-dose nevirapine.

Source: UNICEF analysis of UNAIDS 2017 estimates.

Celeste and her son Emmanuel, aged 15 months, live in the Democratic Republic of the Congo. Celeste, who is HIV-positive, had Emmanuel tested for HIV when he fell ill. He is now on treatment for HIV and doing well. © UNICEF/UN0147630/Schermbrucker

SITUATION ANALYSIS

New HIV infections in children aged 0–14 years

The number of annual new infections among children aged 0–14 years decreased from 110,000 [82,000–140,000] in 2000 to 60,000 [35,000–88,000] in 2016 (Figure 3.1). This represents a 46 per cent reduction, most of which occurred since 2010 (32 per cent) and is due to expansion of PMTCT programmes across the region. In 2016 alone, 37,000 new paediatric infections were averted.

But within this overall pattern of success, there is wide variation between countries. Guinea-Bissau observed the largest decrease (73 per cent) from 2010 to 2016, with an estimated 200 new infections among children in 2016. By contrast, the Congo observed an increase of 16 per cent, with an estimated 1,100 new infections among children in 2016 (Figure 3.2).

Among the countries with a high HIV burden, the Democratic Republic of the Congo had the largest reduction (64 per cent), followed by Chad (49 per cent), Ghana (46 per cent), Cameroon (44 per cent), Côte d'Ivoire (41 per cent) and Nigeria (16 per cent).

In 2016, Nigeria alone accounted for the largest proportion (62 per cent) of the 60,000 [35,000–88,000] new infections among children in the region. That same year, 37,000 [22,000–56,000] children became infected with HIV in Nigeria. The Democratic Republic of the Congo, Ghana, Côte d'Ivoire and Cameroon each had between 2,900 and 4,000 new child infections in 2016 (see Figure 2.6 in Chapter 2).

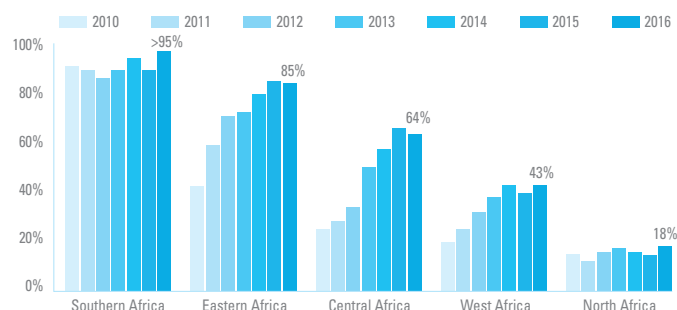
Maternal ARV coverage, trends and disparity

Coverage of maternal ARVs to prevent HIV transmission during pregnancy, delivery and breastfeeding in the West and Central Africa

region increased from 21 per cent [16–27 per cent] in 2010 to 49 per cent [36–63 per cent] in 2016. Steady progress was observed between 2010 and 2014 during the implementation of the Global Plan in most countries,¹⁵ including adoption of the use of lifelong ART for all pregnant and breastfeeding women living with HIV, as recommended by WHO. However, coverage of effective ARVs for PMTCT among pregnant and breastfeeding women in West and Central remains at just below 50 per cent for the third consecutive year, lagging behind Eastern and Southern Africa, where coverage has been above 85 per cent for the past three years. Within West and Central Africa, access to effective ARVs for PMTCT is higher in Central Africa (64 per cent) than in West Africa (43 per cent) (Figure 3.3).

Figure 3.3

Percentage of pregnant women living with HIV receiving most effective antiretroviral medicines for PMTCT, by African geographic region, 2010–2016

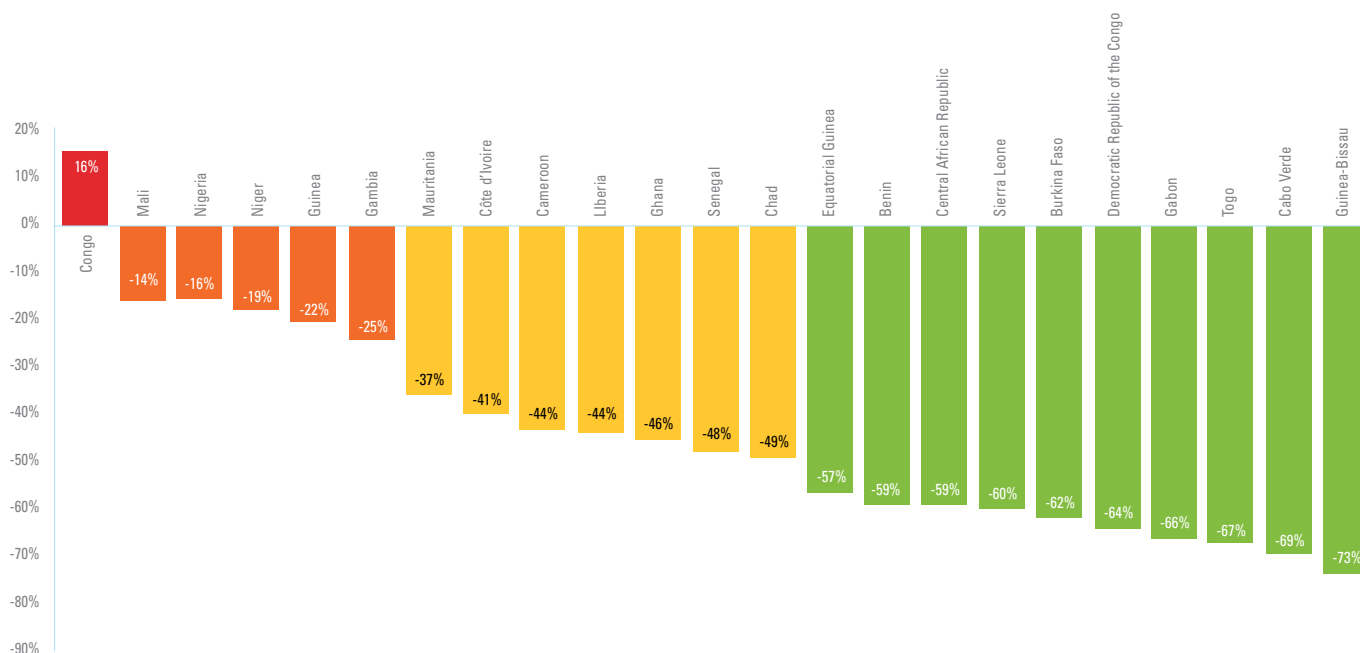


Note: Excludes single-dose nevirapine.

Source: UNICEF analysis of UNAIDS 2017 estimates.

Figure 3.2

Per cent reduction in the estimated number of new HIV infections among children (aged 0–14), West and Central Africa, 2010–2016



Note: Data for Sao Tome and Principe are not available.

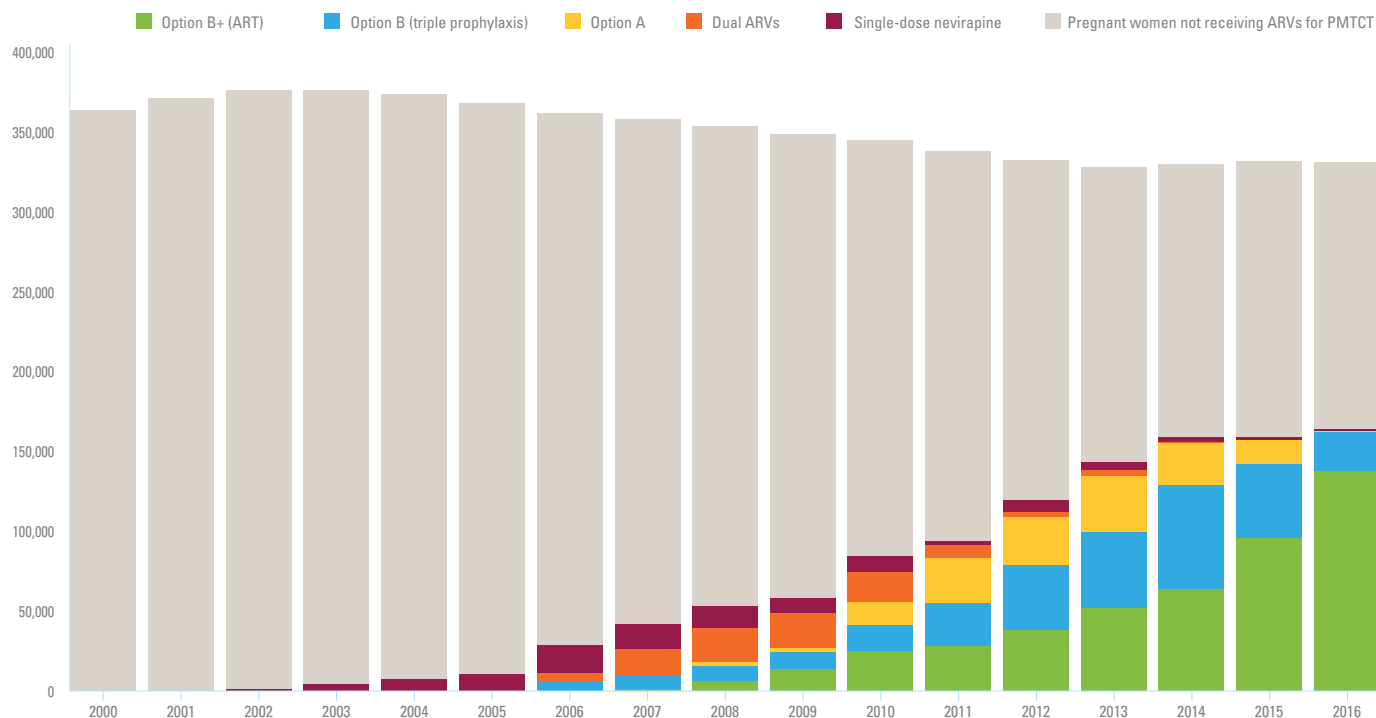
Source: UNICEF analysis of UNAIDS 2017 estimates.

Figure 3.4 depicts the transition over time to more effective ARV regimens for PMTCT. By 2016, the use of single-drug prophylaxis during pregnancy combined with daily infant nevirapine during breast-feeding (Option A) had become almost obsolete, with only 1,200 women receiving Option A in West and Central Africa. ART used for life (Option B+) or as short-course prophylaxis (Option B) accounted for virtually all of the ARV regimens used for PMTCT by 2016 (85 per cent for Option B+ and 15 per cent for Option B).

Again, there is substantial variation among countries in terms of the level of coverage of effective maternal ARVs, from at least 95 per cent in Benin and Cabo Verde to a low of 16 per cent in the Congo. Among the Start Free priority countries, Cameroon, Côte d'Ivoire and the Democratic Republic of the Congo recorded coverage of or above 70 per cent, followed by Chad (63 per cent) and Ghana (56 per cent), while Nigeria recorded the lowest coverage (32 per cent) (Figure 3.5).

Figure 3.4

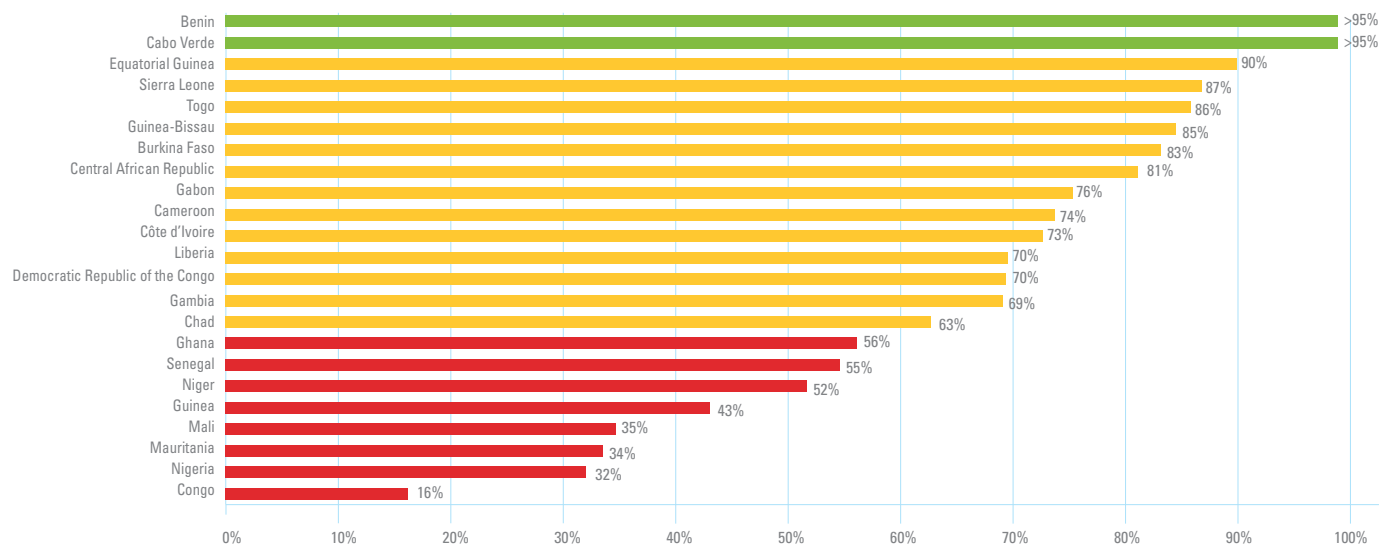
Distribution of the number of pregnant women living with HIV receiving most effective antiretroviral medicines for PMTCT, by regimen, West and Central Africa, 2010–2016



Source: UNAIDS/UNICEF/WHO Global AIDS Monitoring and UNICEF analysis of UNAIDS 2017 estimates.

Figure 3.5

Percentage of pregnant women living with HIV receiving most effective antiretroviral medicines for PMTCT, West and Central Africa, 2016



Note: Excludes single-dose nevirapine; data for Sao Tome and Principe are not available.

Source: UNICEF analysis of UNAIDS 2017 estimates.

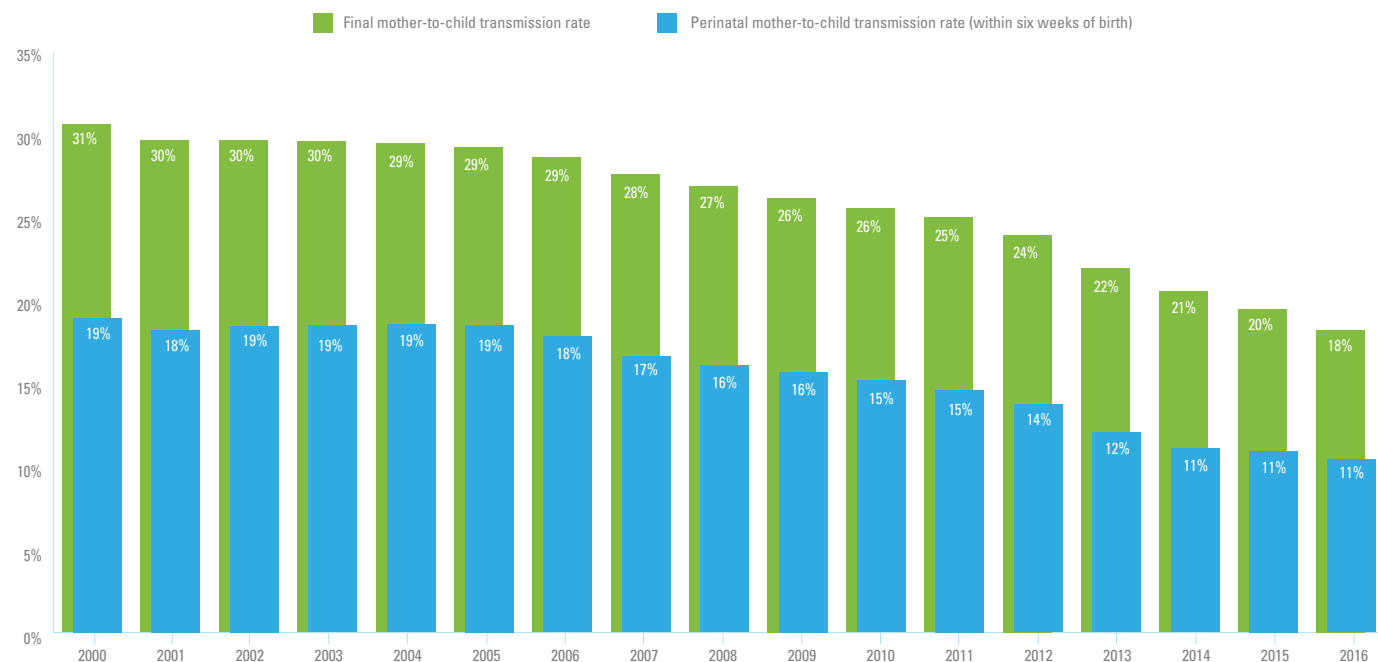
Mother-to-child transmission of HIV and coverage of early infant diagnosis

For about 10 years, the rates of mother-to-child transmission of HIV have been steadily declining. In 2016, the overall transmission rate of both perinatal and postnatal (final) infection reached an all-time low of 18 per cent, down from 26 per cent in 2010. Perinatal mother-to-child transmission decreased from 15 per cent to 11 per cent during the same period (Figure 3.6).

At 20 per cent, West and Central Africa's coverage of early infant diagnosis (EID) of HIV within two months of birth is the second lowest in the world – slightly higher than in South Asia (17 per cent) and much lower than in Eastern and Southern Africa (52 per cent).¹⁶ Coverage of EID varies across West and Central African countries, from 3 per cent in the Congo to 81 per cent in Cabo Verde (Figure 3.7).

Figure 3.6

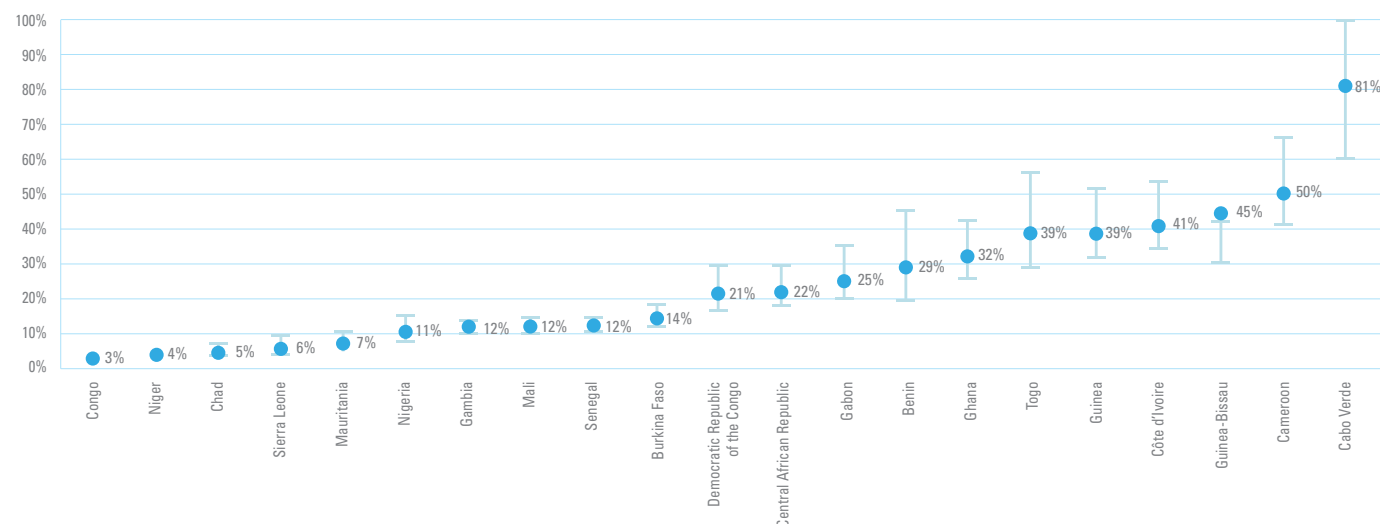
Estimated percentage of infants born to pregnant women living with HIV who become vertically infected with HIV, West and Central Africa, 2000–2016



Source: UNICEF analysis of UNAIDS 2017 estimates.

Figure 3.7

Percentage of infants born to pregnant women living with HIV receiving a virological test for HIV within two months of birth, West and Central Africa, 2016



Note: Data for Equatorial Guinea, Liberia, and Sao Tome and Principe are not available.

Source: UNAIDS/UNICEF/WHO Global AIDS Monitoring and UNICEF analysis of UNAIDS 2017 estimates.

CHALLENGES FACING THE REGION

Progress towards the elimination of new HIV infections in children in West and Central Africa will remain limited unless programmes take into account the challenges summarized below.

Fragile health systems

Health systems in West and Central Africa, particularly outside the big cities, are characterized by limited numbers of trained health workers, weak procurement and supply management systems, and barriers to service utilization among the most vulnerable – many of whom are not reached by any health systems or can only access poor-quality services. Countries experience regular stockouts of HIV commodities, including HIV testing kits, ARVs and other medicines, such as those needed to treat opportunistic infections.¹⁷

Challenging operating environments have a negative impact on the delivery of PMTCT services. In 2016, the Global Fund identified seven countries in the region (the Central African Republic, Chad, the Democratic Republic of the Congo, Guinea-Bissau, Mali, the Niger and Nigeria) as having challenging operating environments characterized by weak governance, poor access to health services and human-made or natural crises.¹⁸ The Organisation for Economic Co-operation and Development (OECD) has classified 19 out of 24 countries in the region, plus Burundi, as 'fragile states'.¹⁹

There is limited availability of quality data to measure progress and design tailored and integrated PMTCT and paediatric ART programmes. Many countries do not have sufficient capacity for real-time monitoring of HIV and maternal, newborn and child health (MNCH) services, including both routine monitoring and where HIV and MNCH services intersect.²⁰

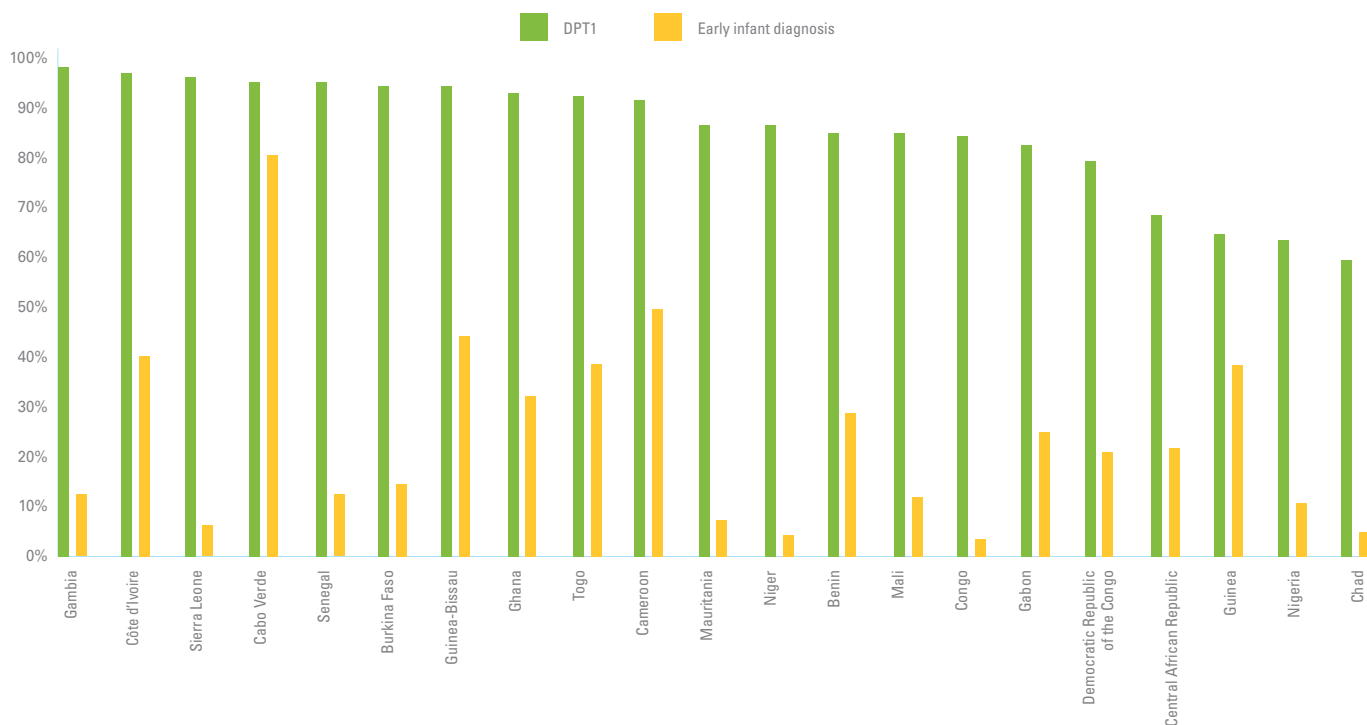
Limited integration of HIV testing and treatment into routine health systems

The rates of antenatal care coverage are high in the region. The latest surveys have found that the share of women who attended at least one antenatal care visit during their most recent pregnancy was above 80 per cent in most West and Central African countries. Only four countries (the Central African Republic, Chad, Mali and Nigeria) had coverage rates below 80 per cent.²¹ However, antenatal care services could be further utilized to expand routine HIV testing and initiation of lifelong ART to pregnant and breastfeeding women diagnosed with HIV.

Similar opportunities might be found by linking HIV detection with immunization programmes. For example, in Chad and Ghana, DPT1 and DPT3 coverage rates are high, while EID within two months of birth remains low. Such data could be used to drive the integration of HIV services into child survival platforms and could help identify cases of HIV among children missed by PMTCT and overall ART programmes (Figure 3.8).

Figure 3.8

Percentage of infants receiving DPT1 immunization and HIV testing within two months of birth, by country, West and Central Africa, 2016



Note: Data on early infant diagnosis for Equatorial Guinea, Liberia, and Sao Tome and Principe are not available.

Source: DPT1 data are from WHO/UNICEF estimates of national routine immunization coverage, 2016 revision (completed July 2017); early infant diagnosis data are based on UNAIDS/UNICEF/WHO Global AIDS Monitoring and UNICEF analysis of UNAIDS 2017 estimates.

Poor retention of mother-infant pairs

With the roll-out of ARV regimens for PMTCT, there are concerns about poor retention among pregnant and breastfeeding women who have initiated ARVs. For long-term treatment, retention in ART programmes can be limited by stockouts of ARVs and other commodities, stigma, fear of disclosure, user fees and other costs, system inconveniences, and socio-economic factors such as poverty.²²

Limited capacity for early infant diagnosis of HIV

EID coverage remains relatively low in West and Central Africa, compared with most other regions. This represents a missed opportunity to identify the majority of children perinatally infected by HIV and initiate life-saving ART. A multi-country assessment in 11 West and Central African countries found limited capacity to perform virological testing in at least 4 of the countries.²³ Even when machines for virological testing are available, they are limited in number and concentrated in major cities, posing challenges in transportation of blood samples and causing long delays in returning test results to clinics, particularly in rural and hard-to-reach areas. The average time between sample collection and receipt of HIV results was 1.4 months in Nigeria; 1.7 months in Cameroon; 2.2 months in Togo; 2.3 months in the Democratic Republic of the Congo; and 3.5 months in Ghana.²⁴ Such lags are a major concern because late detection increases the likelihood of death in HIV-infected infants.

Limited engagement of community health workforce in HIV/AIDS service delivery

A recent report from Médecins Sans Frontières on HIV treatment services in the West and Central Africa region documented underutilization of community services despite their critical role in improving adherence for patients on ART.²⁵ This trend could accelerate as external funding for HIV responses stagnates or declines, unless sufficient domestic support is forthcoming.

SUGGESTIONS FOR HIGH-IMPACT CHANGES

To eliminate mother-to-child transmission of HIV and achieve the Start Free targets, West and Central Africa as a region needs to reduce the number of new infections among children by 87 per cent – from 60,000 new infections estimated in 2016 to 8,000 new infections in 2020 (Figure 3.9).

Summarized below are some promising practices and solutions from West and Central Africa and other regions that hold potential for the rapid scale-up of ARVs for pregnant and breastfeeding women living with HIV, their retention in care and EID for their children.

Effective integration of PMTCT interventions in MNCH programmes and service delivery platforms:

MNCH programmes in the region should build on the relatively high utilization of antenatal care and integrate HIV interventions for PMTCT within national MNCH policies, guidelines and standard packages of services at all levels. Effective integration would entail routine HIV testing of pregnant and breastfeeding women – and promoting

male partner testing when applicable – as part of the minimum antenatal care package; provision of ARVs, diagnostic monitoring (e.g., routine viral load tests) and adherence support for all pregnant and breastfeeding women diagnosed with HIV; EID for exposed children and antiretroviral prophylaxis for newborns diagnosed with HIV; and infant feeding support to the mother-baby pair.

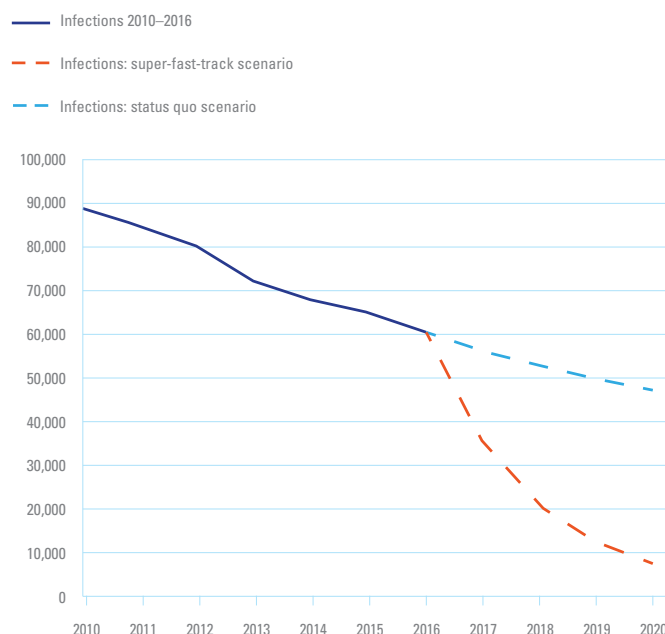
Countries in the region should further decentralize ART to lower-level health facilities to reduce the barriers to access, and continue to scale up task shifting to trained nurses of ART initiation for pregnant women. Where feasible, countries should consider innovative HIV testing strategies, such as dual rapid diagnostic testing in children for HIV and congenital syphilis.

Service delivery innovations to improve retention

Adding structured peer support to routine health system interventions for ART initiation among pregnant women can significantly improve postpartum PMTCT retention and viral suppression rates among women, as reported in a multi-country study including Malawi, Nigeria and Zimbabwe.²⁶ A separate study of Mother Mentor (MoMent) programmes in Nigeria found that mothers who received structured peer support from trained, supervised mentor mothers were more likely to remain in care at six months postpartum, compared with women receiving the standard of care (62 per cent

Figure 3.9

Estimated number of new HIV infections among children (aged 0–5); 2010–2016 trends with 2016–2020 projections and targets, West and Central Africa



Note: Targets have been approximated by determining the contributions of the West and Central Africa region to the global target (20,000 new infections among children) based on the region's share of the burden in 2016. Projections have been calculated by calculating the average annual rate of reduction from 2010 to 2016 and applying that rate through 2020. Projection trends towards each target assume an average annual rate of increase from 2016 to 2020.

Source: UNICEF analysis of UNAIDS 2017 estimates.

vs. 25 per cent).²⁷ Such approaches should be adapted and eventually scaled up to address the growing number of women in the region who need lifelong ART.

Community engagement is one of the most effective ways to monitor, track and support those who miss appointments, have difficulties with adherence, or drop out of care entirely. A UNICEF-commissioned study through the Optimizing HIV Treatment Access initiative, which included Côte d'Ivoire and the Democratic Republic of the Congo, documented 11 promising practices associated with increased service uptake, adherence or retention along the continuum of care in PMTCT programmes. Key operational considerations include engaging all relevant stakeholders; strengthening community health cadres; building on existing community initiatives; ensuring the quality of community-level health communication and services; increasing accountability of facilities and communities; and enhancing local capacity for the scale-up of community-facility linkages.²⁸

Decentralize capacity for viral load monitoring and EID

With the roll-out of lifelong ART and the increased need for differentiated care, routine viral load monitoring should be a priority for all ART clients. Countries should prioritize pregnant and breastfeeding women in the roll-out of viral load monitoring services, and national laboratory systems should strengthen capacity at the subnational level to provide near point-of-care and point-of-care (PoC) viral load testing.

Where implemented, new and innovative PoC diagnostic technologies have helped to substantially reduce turnaround time for the return of EID results. EID results are available the same day, and treatment can be offered and initiated immediately.²⁹ This is especially critical to reduce early infant mortality from HIV, which peaks at 2–3 months of age in the absence of HIV treatment.³⁰ Three countries in West and Central Africa (Cameroon, the Democratic Republic of the Congo and Senegal) are introducing PoC technologies in national HIV diagnostics programmes with support from UNITAID, the Clinton Health Access Initiative and UNICEF.³¹

CASE STUDY

Decentralized planning and integration of PMTCT within MNCH to expand service coverage in Chad

In 2011, Chad had one of the lowest PMTCT coverage rates among the Global Plan priority countries in the West and Central Africa region. Of the 7,500 pregnant women living with HIV, only 26 per cent had received effective ARV interventions for PMTCT. Limited access to PMTCT services was driven by low geographical coverage and poor integration of HIV within maternal and child health services.

Guided by the Global Plan, the Government of Chad launched a decentralized planning process to inform the scale-up of PMTCT services in 2011–2012. First, there was an in-depth assessment of the main bottlenecks to service access, utilization and effective coverage. A national elimination of mother-to-child transmission (EMTCT) of HIV coordination team was established, which leveraged contributions and resources provided by the government and partner organizations. District teams collected data to inform the analyses. The findings from these analyses were translated into evidence-informed strategies and key activities within priority district action plans. These plans were monitored every six months in the first two years and revised as new data became available.

A total of 36 district plans were developed and implemented, with a focus on integration of PMTCT with reproductive, maternal, newborn, child and adolescent health platforms and task shifting of ART initiation from doctors to nurses. The number of health facilities integrating PMTCT services within routine antenatal care services increased from 144 in 2011³² to 463 in 2014³³ and to 799 in 2016.³⁴ Nationwide, PMTCT coverage increased from 26 per cent in 2011 to 63 per cent in 2016, respectively. Yet, EID coverage hardly improved, from 2 per cent in 2011 to 5 per cent in 2016.³⁵

In Chad, decentralized planning in 36 districts has fuelled the notable expansion in PMTCT coverage and enabled more women and children to access the services they need, particularly maternal testing and ART, but EID services require more attention. This strategy is particularly useful in settings with widely dispersed populations. The decentralized approach, including task shifting, is being extended to other districts, especially those in the Sahel.



4

PAEDIATRIC AND ADOLESCENT TREATMENT AND CARE

Without treatment, children born with HIV are particularly vulnerable, so it is urgent that every child and adolescent living with HIV has access to life-saving medication. Yet, in the West and Central Africa region, only 21 per cent [13–29 per cent] of the 540,000 [380,000–710,000] children (aged 0–14 years) living with HIV received ART in 2016. This is the lowest regional paediatric ART coverage rate of any region in the world.

For those children on treatment in 2016, as for all others who are accessing ART, optimal outcomes require them to adhere to their medications and be supported to remain in care. However, many children are not receiving the adherence support they need, particularly as they transition to adolescence.

SITUATION ANALYSIS

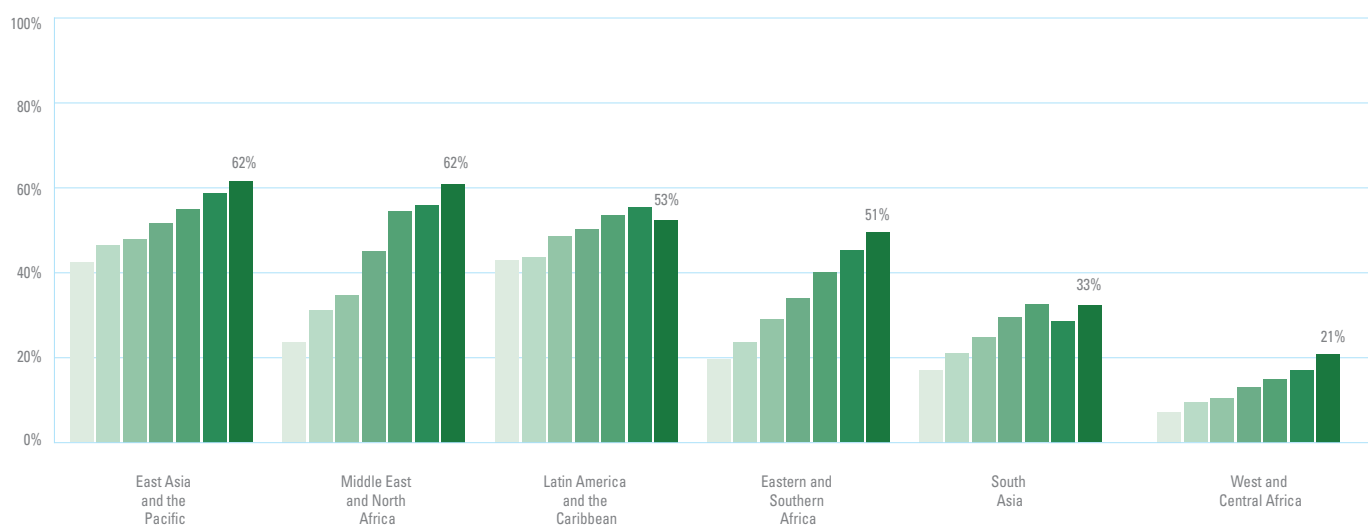
An estimated 540,000 [380,000–710,000] children aged 0–14 years are living with HIV in the region and about 8 in 10 of them are not

accessing ART. The estimated 120,000 children who were on ART in 2016 reflect the increasing coverage of paediatric ART in recent years (Figure 4.1). Some 18,000 more children were on treatment in 2016 than in 2015, 7,900 more children in 2015 than in 2014, and 11,000 more children in 2014 than in 2013.

ART coverage ranged from 11 per cent to 65 per cent for children in countries of West and Central Africa in 2016. No country of the region has achieved ART coverage above 40 per cent for children aged 0–14 years, except for Cabo Verde (65 per cent) (Figure 4.2).

Figure 4.1

Percentage of children (aged 0–14) living with HIV receiving ART, by UNICEF region, 2010–2016



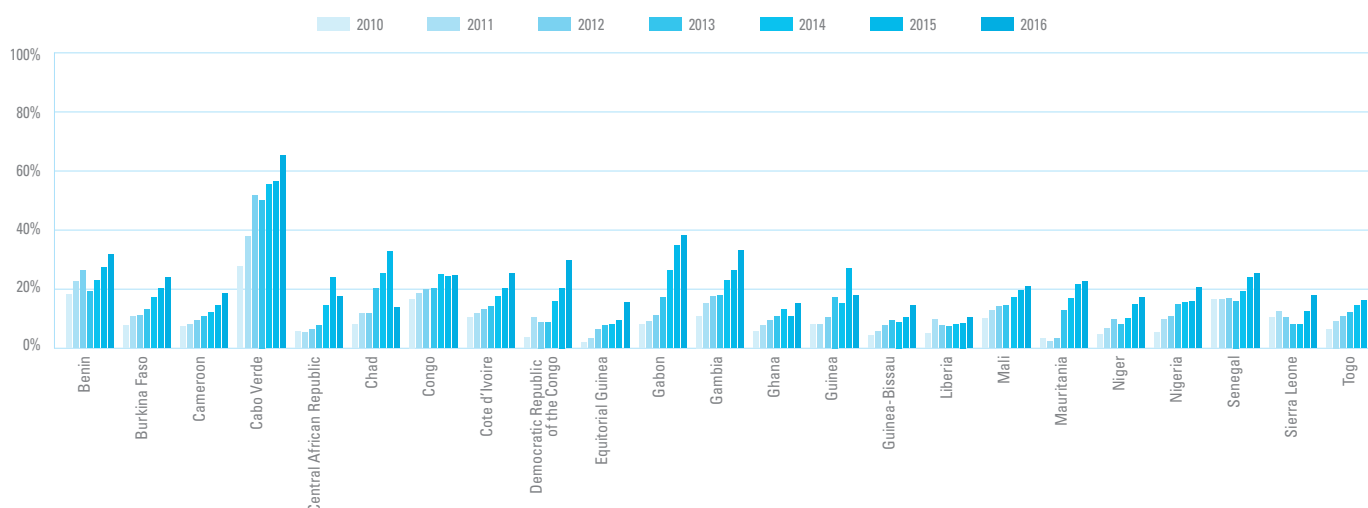
Note: Data for Eastern Europe and Central Asia, North America and Western Europe are not available.

Source: UNICEF analysis of UNAIDS 2017 estimates.

Doumbia lives in Côte d'Ivoire. She is seven months pregnant with her fourth child. After finding out she was HIV-positive during a prenatal check-up in her third pregnancy, she enrolled in a PMTCT programme and her baby tested HIV-negative. © UNICEF/UN061612/Dejongh

Figure 4.2

Percentage of children (aged 0–14) living with HIV receiving ART, West and Central Africa, 2010–2016



Note: Data for Sao Tome and Principe are not available.
Source: UNICEF analysis of UNAIDS 2017 estimates.

In addition, the gap in access to ART between children and adults is growing. While ART coverage in adults living with HIV increased from 14 per cent [10–18 per cent] to 35 per cent [25–46 per cent] between 2010 and 2016, it increased among children (aged 0–14 years) only from 7 per cent [4–9 per cent] to 21 per cent [13–29 per cent] during the same period (Figure 4.3).

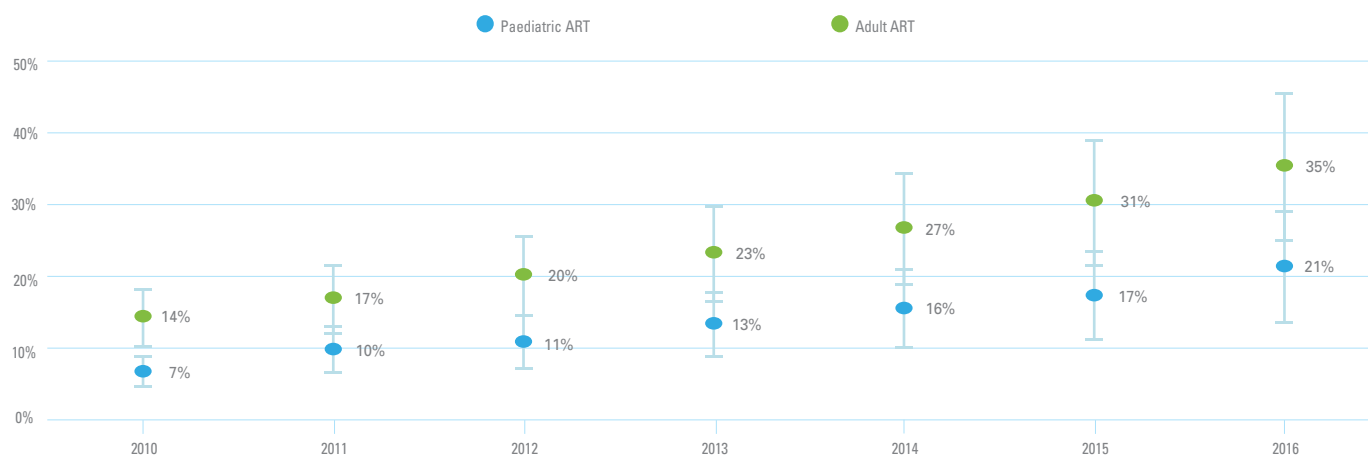
The lack of access to ART is of particular concern for adolescents. A UNICEF analysis of 41 countries in all regions with coverage data for adolescents aged 10–19 years found that a median of 36 per cent of adolescents living with HIV received ART in 2016. Among the eight countries in West and Central Africa that were part of the analysis, median coverage was just 26 per cent. For those eight countries, ART coverage rates for adolescents ranged from 7 per cent in Mali to 61 per cent in Gabon (Figure 4.4).

In 2015 and 2016, several countries in the region conducted national assessments of paediatric HIV services and developed national acceleration plans to fast-track HIV testing and treatment in children by 2020. One of the strategic interventions was to intensify the early identification of children living with HIV outside PMTCT programmes, through more effective HIV case-finding approaches.

For example, Cameroon, the Central African Republic, the Democratic Republic of the Congo and Togo are expanding family-centred approaches (whereby undiagnosed family members, including children and adolescents, of parents living with HIV are traced, tested and referred to treatment and care as needed) as an innovative strategy to increase uptake of paediatric HIV testing among undiagnosed children and extend comprehensive support to families affected by HIV.^{36–38} More recently, Adamawa state in Nigeria

Figure 4.3

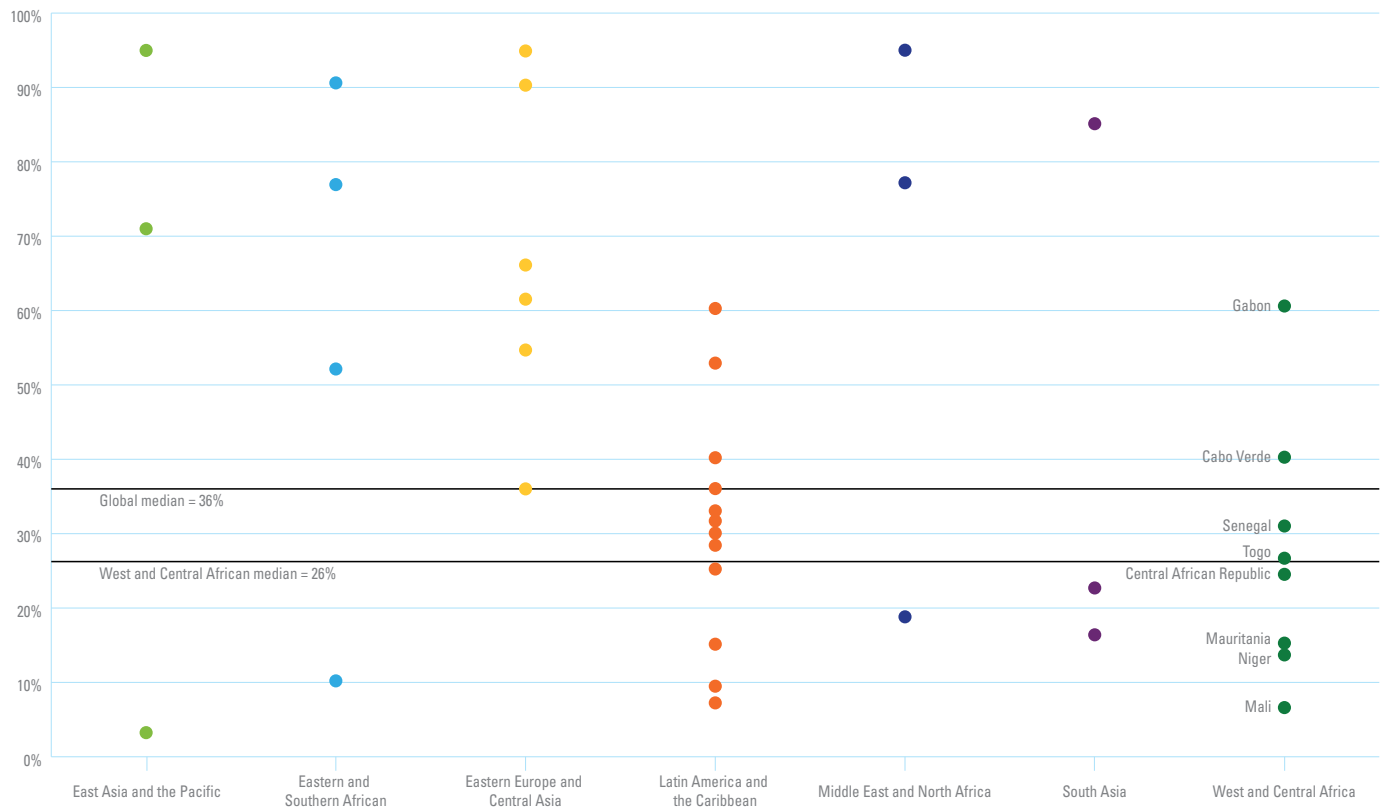
Percentage of adults (aged 15+) and children (aged 0–14) living with HIV receiving ART, West and Central Africa, 2000–2016



Source: UNICEF analysis of UNAIDS 2017 estimates.

Figure 4.4

Percentage of adolescents (aged 10–19) living with HIV who are receiving ART, 41 countries reporting by UNICEF region, 2016



Note: Global reporting of numbers for ART by five-year age group began in 2014, and not all countries are yet able to report such numbers disaggregated to this level of age specificity. As a result, the values above represent the 41 countries that were able to report adolescent ART data for 2016 (either for the full year or for the first six months of the year). These 41 countries accounted for 7 per cent of all adolescents (aged 10–19) living with HIV globally in 2016.

Source: UNAIDS/UNICEF/WHO Global AIDS Monitoring and UNICEF analysis of UNAIDS 2017 estimates.

implemented an HIV/tuberculosis (TB) integrated community case management (iCCM) approach and reported that trained community health volunteers could identify children at risk of HIV and with TB exposure and refer them to health facilities.³⁹ To increase opportunities for EID for children outside the PMTCT cohort, Cameroon and the Congo started tracking information on the HIV exposure of children on their immunization cards/child health cards.

CHALLENGES FACING THE REGION

West and Central Africa continues to face many challenges in optimizing early identification of children and adolescents living with HIV and linking them to care and treatment services.

Missed opportunities in identifying HIV-positive children outside PMTCT settings

Within family settings: Given that most HIV transmissions in children aged 0–14 years are from mother to child, the children and partner of an adult diagnosed with HIV should be offered HIV testing services (referred to as index case testing).⁴⁰ However, there is little evidence that national ART programmes have integrated family testing into their routine care delivery models.

Some small-scale initiatives in the region illustrate the benefits of index case testing. A recent study in the Democratic Republic of the Congo reviewed HIV test results of family members of 266 children and adults on ART. Of those tested, 36 per cent were found to be HIV-positive and were then enrolled in care and treatment. The majority of those enrolled (59 per cent) were aged under 19 years, and half were children aged under 5 years.⁴¹ In Togo, family testing was found to be one of the most efficient and cost-effective ways to identify children living with HIV, as evidenced by an HIV prevalence rate of 20 per cent among family members of people already diagnosed with HIV.⁴²

Children orphaned due to AIDS in communities and institutions:

West and Central Africa accounts for 4.9 million [3.7–6.3 million] children orphaned by AIDS. Facility data from large paediatric treatment centres in Cameroon and the Democratic Republic of the Congo indicate that close to half of the HIV-positive children enrolled in care have lost at least one parent.^{43, 44} Many of these children are likely to be in contact with social workers in care institutions or extended families.⁴⁵ However, there is little evidence of effective referral systems to expand HIV testing to these children.

Where children and adolescents present in health settings:

Although most countries in West and Central Africa have adopted routine provider-initiated testing and counselling in health facilities, there are persistent bottlenecks for effective roll-out, including

recurrent stockout of test kits and weak monitoring and accountability systems at the health facility level.⁴⁶ Studies show the value of improving HIV testing uptake in such settings. Recent research conducted in Nigeria shows that 22 per cent of children who tested positive for HIV were identified through outpatient clinics (compared with 5 per cent of children found through PMTCT clinics).⁴⁷ In Togo, outpatient clinics were also shown to be the main entry point to find children with HIV (52 per cent).⁴⁸

Children and adolescents co-infected with TB and HIV: The above findings underscore the urgent need to provide HIV testing for children and adolescents who visit health facilities for any condition or concern. Tuberculosis remains the most common opportunistic infection and leading cause of death of people living with HIV in the West and Central Africa region.⁴⁹ Studies of HIV/TB co-infection rates among children found that 16 per cent and 14.7 per cent of children with TB are co-infected with HIV in the Democratic Republic of the Congo⁵⁰ and in Nigeria,⁵¹ respectively.

Malnutrition and HIV: West and Central Africa has the highest prevalence of chronic malnutrition in the world, and malnutrition centres are widespread throughout the region. While there are few data points on HIV prevalence among children with severe acute malnutrition (SAM) in West and Central Africa, average rates taken from various hospitals indicate that about 20 per cent of children with SAM are living with HIV.⁵² In the Niger, which has relatively low prevalence of HIV but widespread malnutrition, about 9 per cent of children hospitalized for SAM were found to be HIV-positive.⁵³ A study in Nigeria examining children living with HIV across several states found that 18 per cent also suffered from wasting.⁵⁴

Adolescent sexual and reproductive health: There are dual benefits of integrating HIV services with sexual and reproductive health services. Adolescents living with HIV can be counselled about pregnancy and family planning, while those with unknown status can be offered an HIV test when attending family planning services and sexually transmitted infection clinics.⁵⁵ However, there is little evidence from countries in the region of routine HIV testing for adolescents attending sexual and reproductive health services.

Initiating ART, monitoring treatment and retaining children in care

Limited decentralization of paediatric ART services: A regional situation analysis of paediatric HIV services conducted in 11 high-burden countries found limited availability of paediatric ART services in the 399 health facilities offering PMTCT services – ranging from 2 per cent in Chad to 56 per cent in Togo.⁵⁶ When available, paediatric ART services were mostly concentrated in urban health facilities (73 per cent). In the countries analysed, there were not enough physicians trained to manage paediatric HIV, and nurses were not always equipped and empowered to manage children living with HIV.⁵⁷ Discrimination by health services and the high cost of baseline laboratory tests were also reported.

An assessment in Nigeria in 2014 found that the main barriers to initiating ART included inadequate training of physicians on HIV treatment; the high cost of baseline laboratory tests; lack of appropriate ART formulations; poor access to CD4 count screening (in Anambra state); and issues with ART dosing, stockouts of drugs, prolonged waiting times at facilities and discrimination by health staff.⁵⁸ Monitoring services are also substandard. In Nigeria, only 6 per cent of children followed in HIV services had viral load results at six months after ART initiation.⁵⁹

Poor retention among children on ART: Drop-out rates tend to be high for children initiating ART in West and Central Africa. In Nigeria, 21 per cent of children were lost to follow-up after 24 months following the initiation of their treatment, and 6 per cent of them had died.⁶⁰ Loss to follow-up rates were highest in Lagos state (42 per cent at 24 months). The reported barriers to retention – poverty, relocation, poor community tracking, lack of comprehensive and consistent care, and adolescent-related issues, such as dropping out of school – are common challenges found in other countries of the region.⁶¹

Managing disclosure of HIV status in children and the transition during adolescence

In West and Central Africa, many parents do not inform their children of their HIV status until they are in their late teenage years, while health-care workers receive little support in providing appropriate counselling to parents and their children, regardless of whether the latter are aware of their status.⁶² Participants in mother support groups in Burkina Faso said they did not want to traumatize their children; mothers also feared that children might reveal their secret to others.⁶³

A recent study in the Democratic Republic of the Congo shows that in half of cases, HIV disclosure is made by health providers alone and that only 5 per cent of children in health care were informed by their parents directly. In addition, this study showed negative mental and emotional consequences for adolescents where disclosure took place in the absence of peer support.⁶⁴ A study conducted in Burkina Faso reported that children were often informed in an indirect way that they or a parent were HIV-positive, and were often told that they would die if they didn't take their treatment.⁶⁵

The insufficient support provided to adolescents living with HIV is of concern given the increasing mortality rates in this age group. Some 16,000 adolescents aged 10–19 years died of AIDS-related causes in West and Central Africa in 2016, 52 per cent of them boys.

As noted previously, retention of adolescents in treatment and care is a major concern. The reasons for it are complex. Recent research in the Democratic Republic of the Congo found that among adolescents who had given up their treatment, 45 per cent had done it for religious purposes or in belief of miraculous recovery, while more than one third of them indicated wanting to die and thinking of suicide.⁶⁶ Another challenge observed throughout the region is the

management of adolescents' transition into adult services, where they generally face longer waiting times, increased isolation and anxiety from seeing more adults with advanced stages of the disease.⁶⁷

SUGGESTIONS FOR HIGH-IMPACT CHANGES

Scaling up the provision of comprehensive HIV treatment to children and adolescents in West and Central Africa will require specific policy and programme directions. Some key considerations are summarized below.

Countries in the region must revise existing task-shifting policies to account for the treatment needs of children living with HIV. Effective management of decentralized ART for children should go hand in hand with that of adults, and country policies should foster a family-centred approach to lifelong treatment.

Countries should define ambitious targets for paediatric ART in national catch-up plans and acceleration plans in line with super-fast-track targets. Countries should adopt test-and-treat WHO guidelines and ensure timely registration of paediatric drugs.

High-burden countries must maximize opportunities for HIV testing during immunization, visits to child health clinics and nutrition treatment centres, care services for hospitalized and sick children, and community and home testing campaigns where appropriate. Family-centred approaches must be enhanced, and parents, families, faith-based organizations and local communities should be engaged in creating momentum to increase uptake of services.

The HIV/TB iCCM modelled in Nigeria demonstrated that the community is an important entry point to screen and link children at risk for TB and for HIV. However, such integration needs to happen within a system-strengthening approach to referral management and accountability so children who are referred receive the necessary services and are retained in care.

HIV testing in sexual and reproductive health services is a critical priority. Screening in such settings can not only lead to an adolescent living with HIV being provided with early treatment, but in the case of adolescent pregnancy, PMTCT services can be immediately offered for the mother's well-being and that of her baby. An effective integrated approach will also require strong linkages to other sectors, such as social welfare and education, for additional support to be made available to orphans, vulnerable children and adolescents.

More work is needed to identify optimal ways of supporting children, adolescents and their families during the disclosure process. Youth-led support systems and other community approaches can support adolescents to remain in care as well as boost their mental and emotional well-being.

CASE STUDY

Where are the children? Identifying children with HIV during routine health visits in Togo

In Togo, while 86 per cent of pregnant women living with HIV are receiving effective ARVs, only 26 per cent of children living with HIV are receiving treatment. Low rates of HIV testing rates among infants and children largely contribute to low rates of ART initiation. One potential solution to expand access to EID is to offer HIV testing at multiple entry points where children and their caregivers access routine care. These include paediatric inpatient and outpatient wards, EID/PMTCT and nutrition clinics, immunization facilities and TB clinics.

Togo's Ministry of Health has implemented provider-initiated testing and counselling to expand testing to infants and children. To assess the situation and measure the impact of the strategy, the Ministry conducted a retrospective study from 2012 to 2014.⁶⁸ HIV testing data were collected from the records of 22,656 children aged under 15 years, at five different entry points of care in 20 hospitals in six regions. The study found a threefold increase in the uptake of HIV testing among children aged under 15 years between 2012 and 2014, and a 2.5-fold increase in the number of children diagnosed with HIV in the same period, following the implementation of provider-initiated testing and counselling.

Paediatric outpatient wards identified more than half of the paediatric HIV cases (1,029) in the period 2013 to 2014, followed by the family-centred approach (where children of HIV-positive pregnant women in maternity wards are tested) and EID/PMTCT of infants 2 months of age, with respective yields of 330 cases and 247 cases. These three testing platforms accounted for 82 per cent (18,638) of children screened for HIV in the selected hospitals and 87 per cent (1,606) of the HIV cases in hospitals participating in the study.

Testing children for HIV outside of the conventional EID/PMTCT platforms was effective in determining the HIV status of children and identifying a significant number of children with HIV. However, the large proportion of children diagnosed with HIV in paediatric outpatient wards means that many children are already sick before they are tested. This points to the need to strengthen EID and to address the challenges that prevent children from being tested and treated earlier.



5

HIV PREVENTION AMONG ADOLESCENTS

With more than half of its people under the age of 18 years, West and Central Africa has the youngest population in the world. The number of adolescents (aged 10–19 years) in the region is projected to increase to 167 million by 2030 – from 114 million in 2016.⁶⁹ This demographic trend – the so-called ‘youth bulge’ – will determine the future of the HIV epidemic and the response among adolescents.

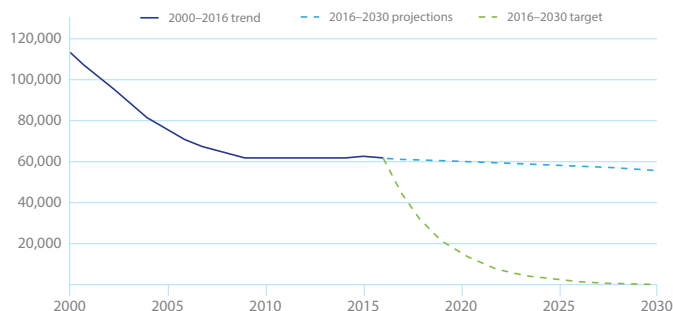
New HIV infections overall are decreasing in the region, but not among adolescents, as they comprise ever-larger shares of the total population. Due to the ‘youth bulge’ surge in the adolescent population, the number of new HIV infections among adolescents (aged 15–19 years) is expected to remain flat, at about 60,000 (Figure 5.1). Priority approaches should include stepping up prevention efforts in national HIV programmes and aligning country targets with global prevention and ‘All In!’ targets.

SITUATION ANALYSIS

The 62,000 adolescents aged 15–19 years who became infected with HIV in West and Central Africa in 2016 accounted for a quarter (24 per cent) of the world’s new HIV infections among this age group that year. Just five countries – Nigeria, Cameroon, Ghana, the Democratic Republic of the Congo and Côte d’Ivoire – were home to 84 per cent of the regional total (Figure 5.2).

Figure 5.1

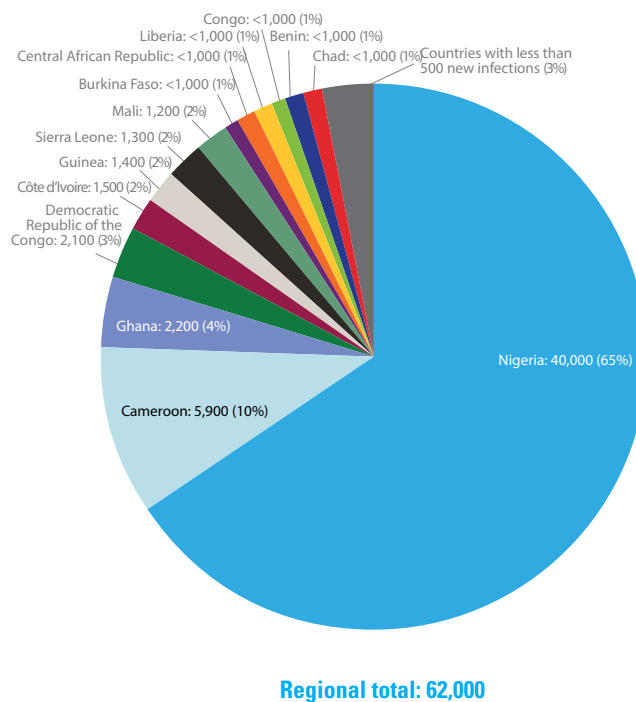
Estimated number of new HIV infections among adolescents (aged 15–19), 2000–2016, with 2016–2030 projections and targets, West and Central Africa, 2016



Source: UNICEF analysis of UNAIDS 2017 estimates.

Figure 5.2

Estimated number and percentage of new HIV infections among adolescents (aged 15–19), West and Central Africa, 2016



Note: Data for Sao Tome and Principe were not available.
Source: UNICEF analysis of UNAIDS 2017 estimates.

The relative lack of progress in reducing new infections in this population is exemplified by the fact that new HIV incidence among adolescents aged 15–19 years has changed little between 2010 and 2016: a 4 per cent increase among boys and a 2 per cent decrease among girls (Figure 5.3).

As in Eastern and Southern Africa, there is a gendered dimension to the epidemic among adolescents in West and Central Africa. Girls have long been disproportionately at risk of infection, as indicated by estimates that they accounted for 69 per cent of new infections among adolescents in 2016.

A gender gap in the other direction appears to have emerged in the number of AIDS-related deaths among adolescents aged 10–19 years. While boys and girls had about an equal share of the burden of AIDS-related deaths in 2010, the annual number of deaths among boys increased by a larger rate than that of girls through 2016 (21 per cent compared with 8 per cent, respectively) (Figure 5.4). Among boys aged 15–19 years living with HIV, most were infected at birth. Among girls aged 15–19 years living with HIV, a greater proportion was infected recently through sexual transmission. Since adolescent girls living with HIV tend to acquire the infection later in their lives than adolescent

boys, they suffer fewer AIDS-related deaths before they reach 19 years of age.

Another factor assumed to be responsible for this trend is that adolescent boys living with HIV in the region are less likely than adolescent girls to be aware of their HIV status or to have access to treatment and care. Another factor is that many girls and young women become pregnant while still teenagers and then engage with antenatal care services, where they are routinely offered HIV tests and HIV treatment services for PMTCT.

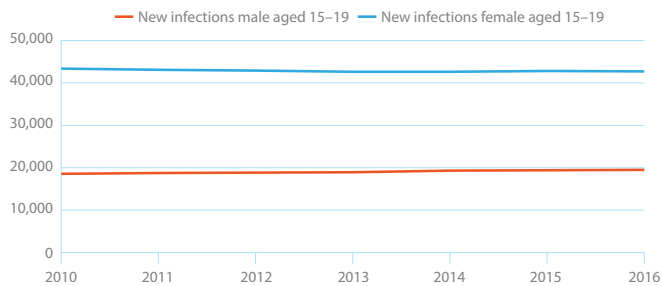
UNICEF has led the adoption in West and Central African countries of the global All In! initiative to end AIDS in adolescents by 2030 (see *pane*). All In! seeks to fast-track the HIV response for adolescents in a transformative agenda for social change, with the engagement of multiple stakeholders. It promotes a data-driven planning approach to improve strategic prioritization, foster innovation and influence advocacy and partnerships; and it drives a cross-sectoral programming approach from key sectors that have an impact on the lives and well-being of adolescents (health, education, child protection, social policy and employment).



A 20-year-old student living in Côte d'Ivoire found out she was HIV-positive after feeling sick and weak. She says she and her boyfriend always have sex with a condom, and she is living her life like any other adolescent.
© UNICEF/UN061625/Dejongh

Figure 5.3

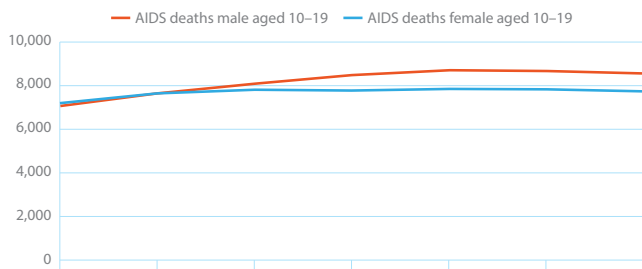
Estimated number of new HIV infections among adolescents (aged 15–19), West and Central Africa, 2010–2016



Source: UNICEF analysis of UNAIDS 2017 estimates.

Figure 5.4

Estimated number of AIDS-related deaths among adolescents (aged 10–19), West and Central Africa, 2010–2016



Source: UNICEF analysis of UNAIDS 2017 estimates.

PANEL

All In! for adolescents in West and Central Africa

UNICEF and UNAIDS launched the global All In! initiative in 2015 with the targets of reducing adolescent AIDS-related deaths by 65 per cent and new HIV infections among adolescents by 75 per cent by 2020. As of late 2017, nine countries of West and Central Africa (Burkina Faso, Cameroon, Chad, Côte d'Ivoire, the Democratic Republic of the Congo, Gabon, Guinea-Bissau, Liberia and Nigeria) have participated in the initiative.

Through All In!, these countries conducted adolescent-specific analyses and sharpened strategic approaches to fast-track the reduction of HIV incidence and AIDS-related deaths among adolescents. Burkina Faso, Cameroon, Côte d'Ivoire and the Democratic Republic of the Congo defined adolescent-specific indicators in their national HIV/AIDS strategic plans, and subsequently prioritized allocation for adolescent girls and young women within their Global Fund Concept Notes (for the 2016–2019 funding cycle) while leveraging other donors.

All In! also has fostered age-disaggregated data collection and analysis and the introduction of new technology for HIV prevention, including pre-exposure prophylaxis (PrEP) and HIV self-testing, targeting the most at-risk adolescents. Several countries of West and Central Africa are developing specific policy and operational procedures for introducing HIV self-testing. According to the policy mapping compiled by WHO in the platform <www.hivst.org>, three countries have adopted explicit policy allowing HIV self-testing (the Democratic Republic of the Congo, Ghana and the Niger) and four other countries have a policy under development (Benin, Gabon, Mali and Nigeria). In Nigeria, partners have prioritized a targeted behavioural change campaign in high HIV burden areas, reaching out to adolescents using youth-friendly media channels.

In Cameroon, Côte d'Ivoire, the Democratic Republic of the Congo and Nigeria, All In! has advocated for increased allocation of resources towards high-burden geographic areas. In subnational operational plans, these countries have introduced innovative approaches to identify adolescents and young people who are most vulnerable and at higher risk of HIV, and to track their utilization of high-impact HIV prevention services. These countries are also exploring the use of UNICEF's U-Report to assess the risk and vulnerabilities of adolescents and young people in real time and track their utilization of prevention services over time.

CHALLENGES FACING THE REGION

Limited access to comprehensive HIV prevention services

HIV testing in high-risk populations and geographies is an entry point for comprehensive sexual and reproductive services that include HIV. Yet, access remains low among adolescents (aged 15–19 years) across countries in West and Central Africa, although girls have better access than boys (Figure 5.5). Barriers to HIV testing among adolescents include age of consent laws and parental consent requirements; fears (e.g., of stigma, of family reactions, of receiving

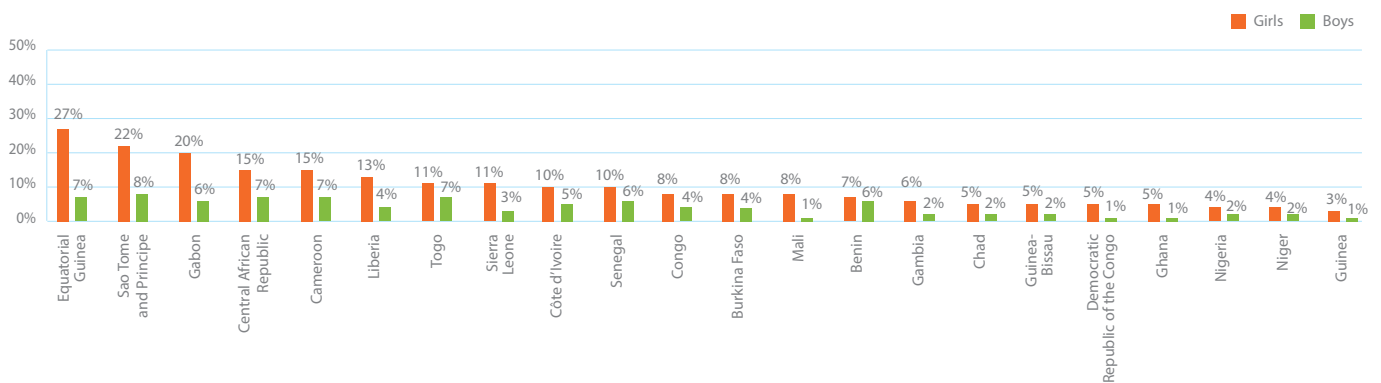
a positive diagnosis); low perceived risk of sexual exposure and HIV; and negative attitudes of health-care providers.⁷⁰

Gender norms and practices that increase girls' vulnerability to HIV

Gender is a major factor influencing and reflecting limitations in access to comprehensive, quality prevention services. In most West and Central African countries, adolescent girls have limited comprehensive knowledge about HIV compared with adolescent boys and are less equipped to make informed decisions about HIV prevention (Figure 5.6).

Figure 5.5

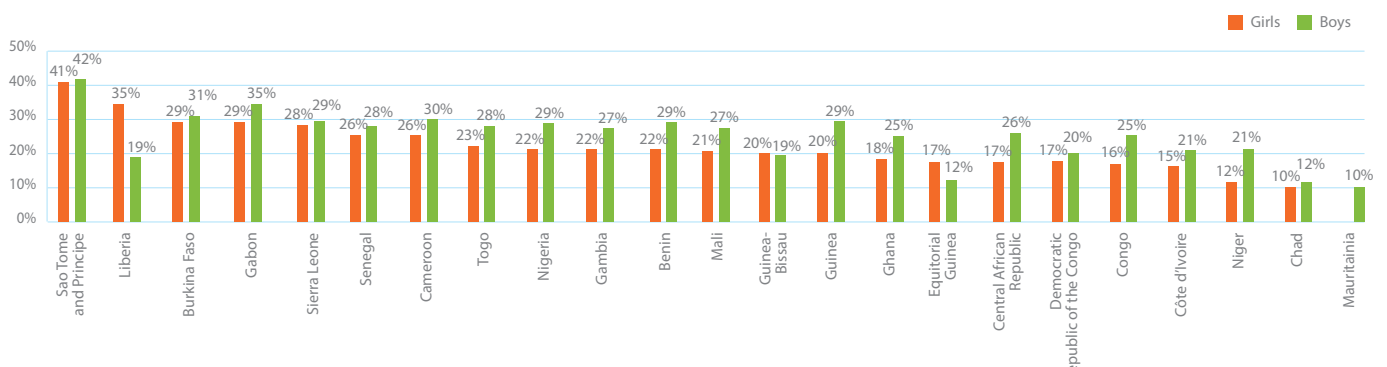
Percentage of adolescent girls and boys (aged 15–19) who have been tested for HIV and received results in the past 12 months, West and Central Africa, 2010–2016



Source: UNICEF global HIV and AIDS databases (June 2016) based on Multiple Indicator Cluster Surveys (MICS), Demographic and Health Surveys (DHS), AIDS Indicator Surveys (AIS) and other nationally representative household surveys, 2010–2016.

Figure 5.6

Percentage of adolescent girls and boys (aged 15–19) with comprehensive, correct knowledge of HIV, West and Central Africa, 2010–2015



Note: Comprehensive, correct knowledge about HIV and AIDS is defined as correctly identifying the two major ways of preventing the sexual transmission of HIV (using condoms and limiting to one faithful, uninfected partner), rejecting the two most common local misconceptions about HIV transmission, and knowing a healthy-looking person can transmit HIV.

Source: UNICEF global HIV and AIDS databases (June 2016) based on Multiple Indicator Cluster Surveys (MICS), Demographic and Health Surveys (DHS), AIDS Indicator Surveys (AIS) and other nationally representative household surveys, 2010–2016.

Condom use among sexually active adolescents (aged 15–19 years) with multiple partners remains low among girls compared with boys in most countries of West and Central Africa (Figure 5.7). Evidence from high-prevalence settings indicates that adolescent girls engaged in relationships with older men, who might have acquired HIV previously, are at greater risk of HIV infection.⁷¹

Adolescent girls are further disadvantaged because of gender norms that limit their ability to negotiate safe sex and the impact and threat of gender-based violence, which remains highly prevalent in the region. A UNICEF analysis (2014) showed that adolescent girls (aged 15–19 years) in the region were at greater risk of sexual violence than boys.

Identifying, preventing and addressing sexual violence remains a challenge throughout West and Central Africa due to persistent negative social norms and national child protection systems that are weak or poorly funded. Many adolescent girls who are victims of violence and abuse do not have the support they need, including services for the prevention of HIV and other sexual transmitted infections, and legal and social services. A 2014 survey in Nigeria showed that half of young people (aged 18–24) who had sex and experienced sexual abuse prior to the age of 18 had never been tested for HIV.⁷²

In most countries of the region, girls' access to education remains a challenge – and keeping girls in school as they transition to secondary education is an even greater one. In 2010, close to 17 million children

aged 6–11 years were out of school, and 52 per cent of them were girls.⁷³ Across the region, about 3 out of 10 girls become pregnant before the age of 18 years, while an even greater share (4 out of 10) get married before that age.⁷⁴ The three countries with the world's highest rates of child marriage are in this region: the Central African Republic (68 per cent), Chad (68 per cent) and the Niger (76 per cent).⁷⁵

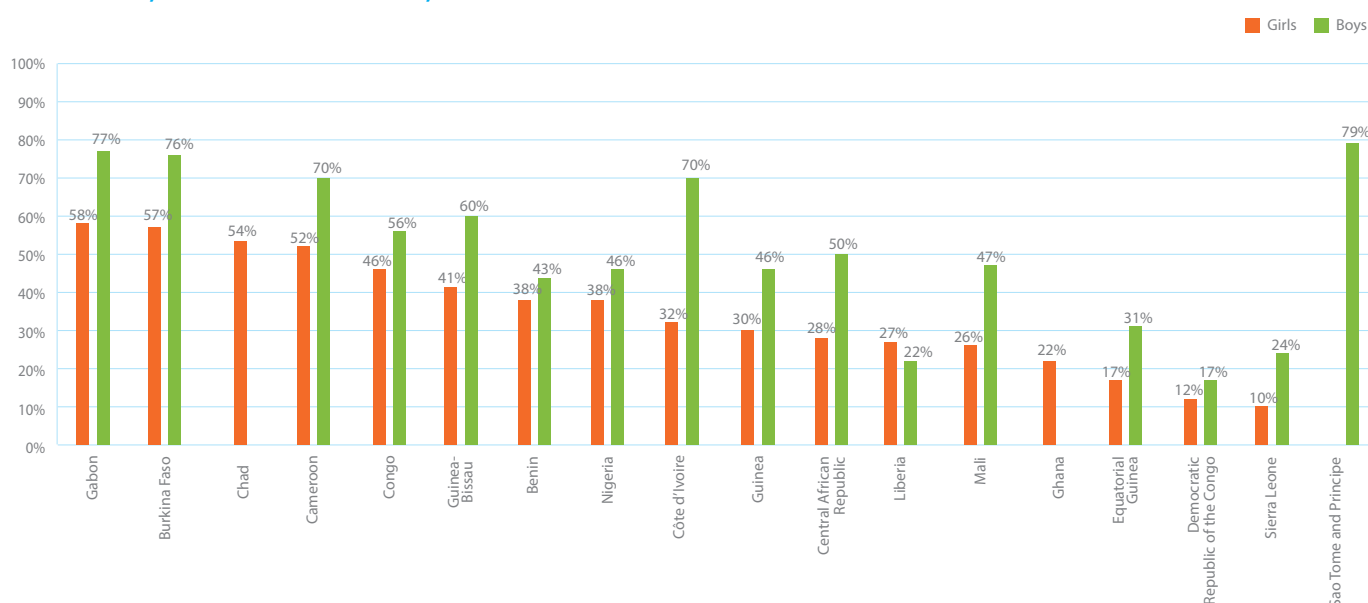
Prevalence and risk among adolescent key populations

In most West and Central African countries, HIV prevalence is high among key populations (gay and bisexual men and boys, people who are sexually exploited and sell sex, and people who inject drugs).⁷⁶ Yet, there are limited data on the coverage of services and the barriers to access to services among adolescents within these groups. In Burkina Faso, almost 28 per cent of adult female sex workers reported having started selling sex before the age of 18 years.⁷⁷ Data show that roughly 35 per cent of female sex workers and 18 per cent of men who have sex with men in the region are living with HIV.⁷⁸

Same-sex practices and the sale of sex are illegal and punishable by law in many countries in the region, such as Cameroon and Togo. Little is known about people who inject drugs and about transgender persons. Regardless of whether they are criminalized, key populations face high levels of stigma and discrimination and exclusion from services.⁷⁹

Figure 5.7

Percentage of adolescent girls and boys (aged 15–19) with multiple partners who used a condom at last sexual intercourse, West and Central Africa, 2010–2015



Source: UNICEF global HIV and AIDS databases (June 2016) based on MICS, DHS, AIS and other nationally representative household surveys, 2010–2016.

SUGGESTIONS FOR HIGH-IMPACT CHANGES

Protecting adolescents and young women from HIV infection – the ‘Stay Free’ component of the UNAIDS Three Frees framework to end AIDS in children – requires a combination prevention approach, bringing together biomedical and behavioural interventions complemented by cross-sectoral interventions that address the structural determinants of adolescents’ vulnerability, particularly that of adolescent girls in Africa and key populations everywhere. In the context of the West and Central Africa region, implementing an effective combination prevention approach for adolescents should be based on the four following pillars:

1. Strengthen data systems, building on the All In! momentum and lessons learned

All In! analyses in several countries show the critical need for reliable and robust data, disaggregated by age and sex, from multiple sectors across all components of the HIV response for adolescents, including HIV service coverage and quality. Similar data also are needed for factors that have an impact on adolescent risk of HIV acquisition, such as HIV knowledge and behaviour, school attendance and completion, early marriage and early pregnancy, and experiences with violence. HIV epidemiological data, including HIV prevalence and incidence data, should inform efforts to estimate the size of adolescent populations, map adolescent girls and boys at high risk of acquiring HIV, and set programme targets.

Amid the momentum around All In!, national stakeholders increasingly recognize the need for adolescent-specific data and the use of these data in the programming cycle for adolescents, and the value of involving adolescents in the data-gathering process. Countries should be encouraged to scale up data-driven programming for adolescents as part of the All In! framework and be provided with the technical support that is necessary for its implementation.

2. Integrate HIV with sexual and reproductive health services for girls and boys

Adolescents’ overall poor retention in care makes it critical to ensure that those receiving HIV services are supported to remain in care and be linked to the various points of service delivery. This will require investment in technology-based platforms to share information with adolescents on available services and to engage with them on how to improve such services; and in making sure the tools and commodities (e.g., condoms) that adolescents need to better care for themselves are provided. It will also require the orientation of health workers, caregivers, teachers and social workers, so that they listen to and support adolescents with sensitivity and counsel them in an appropriate way.

Building health workers’ counselling skills on reproductive health is a key intervention that often needs to be strengthened. Offering peer support services is a good practice, especially for adolescents who have experienced violence.⁸⁰ Other important considerations in increasing adolescents’ access to information and services include promoting policies and services that allow adolescents to have access to a broad range of health services, including sexual and reproductive health, and conducting implementation research on the delivery of services for adolescents.

3. Accelerate provision of combination HIV prevention for adolescents at highest risk of HIV infection, promoting both programmatic and technology innovations

Some countries in West and Central Africa have started introducing new combination prevention methods such as HIV self-testing and PrEP to enhance current responses. While interest from countries is growing, the scale remains limited and access is restricted primarily to adults.

Home-based or mobile HIV testing (linked to care and treatment) and HIV self-testing offer at-risk adolescents autonomy and confidentiality, one of the main challenges to their access to health services. Linkages to care and treatment should be immediately available as part of all HIV testing interventions.

PrEP has unique value among adolescents and young women at high risk of infection because it does not need to be taken at the time of sex. Delivering PrEP ‘in a safe space’ to adolescents at high risk of HIV infection can bring substantial cost savings, when compared with the cost of treatment for life.⁸¹ Because the effective use of PrEP among adolescents and others requires their retention in care and adherence to medication, countries adopting PrEP will need to enhance care, treatment and support efforts alongside the delivery of this preventive intervention.

Social media and associated technologies are already well integrated into the lives of young people in much of the world, including in West and Central Africa. They can increase adolescent engagement in decision making about their own health and improve their access to HIV services. Several useful and promising initiatives have been introduced to take advantage of this growing ‘connectedness’ and provide HIV awareness messaging for both prevention and retention in treatment (reminders to take antiretroviral drugs, among other interventions).⁸²

For example, U-Report, a social platform developed by UNICEF in 2011 that is based on short message service (SMS) technology, is increasingly being used by seven countries in the region. In addition, new applications are being introduced to improve adolescents’ access to prevention, testing and treatment services and help increase uptake. Nigeria’s upgraded National Call Centre will include SMS messages to enable two-way interactive counselling and referrals for adolescents and young people on issues related to HIV and sexual and reproductive health.

4. Address the structural factors contributing to vulnerability

Adolescents face a multitude of vulnerabilities to HIV, including gender-based violence, barriers to attending/completing secondary school, early marriage and pregnancy, and a lack of opportunities for income generation. Preventing HIV in adolescent girls and young women requires ending gender-based discrimination and violence as a priority.

Countries must promote HIV-sensitive norms and policy reforms in the relevant social sectors that will reduce HIV/AIDS vulnerabilities and risks, especially among adolescent girls and young women; and ensure that laws, policies and practices uphold the rights of women in all their diversity, including women living with HIV, sexually exploited girls, female sex workers, transgender women, indigenous women and women in conflict settings.⁸³

Countries should invest in and scale up social and justice services as part of functioning national child protection systems to provide prevention, response and rehabilitation services to girls who are victims of child marriage and abuse, or who have been isolated because of teenage pregnancy. This requires strengthening linkages with health and education systems through referral programmes for appropriate case management, and supporting changes in discriminatory and restrictive laws and policies at regional, national and community levels.

Programmes that enable adolescent girls to remain in secondary school are key to the HIV response in this region. But where adolescent girls (and boys) remain out of school, countries must do more to promote alternative education options for adolescents or to offer them other channels to receive information and support on sexuality education, gender, parenting practices, non-violent communication, peacebuilding and social accountability.

As a cross-sectoral approach, cash transfers can achieve multiple outcomes that affect adolescent girls' risk of HIV. Declines in early marriage and teenage pregnancy have been demonstrated in several countries of Eastern and Southern Africa where cash transfers were introduced, either as a measure of HIV prevention or where HIV was added to an existing cash transfer programme.⁸⁴

CASE STUDY

Expanding HIV testing and counselling among adolescents and young people in Benue State, Nigeria

In Nigeria's Benue State, a 2013 baseline assessment showed that about 70 per cent of adolescents and young people (aged 15–24 years) in rural communities did not utilize HIV services. Access to HIV testing and counselling (HTC) is limited because most testing sites are in hospitals far from where adolescents congregate. As a result, access to treatment among adolescents and young people living with HIV also remains low.⁸⁵

From 2014 to 2016, UNICEF, the National Agency for the Control of AIDS and the Benue State Agency for the Control of AIDS piloted an initiative to provide comprehensive HIV service delivery for adolescents and young people using HTC as an entry point in two local government areas of the state. The pilot was designed to test HTC models and to strengthen linkages to follow-up services for prevention, treatment, care and support. This was coupled with generating demand for HIV testing by targeting out-of-school adolescents through mobile HTC as well as facility-based services.

Overall, 39,677 adolescents and young people were tested – exceeding the target of 35,000 for the pilot. Of those tested, the majority were young people aged 20–24 years and about 64 per cent were males 15–24 years of age. More than 96 per cent of the test results were negative, which opens the way to active prevention.⁸⁶ Based on the results of the pilot, recommendations to improve HTC models include expanding the provision of HTC to primary health-care facilities, conducting mobile outreach, and scaling up the use of peer escorts to support adolescents and young people who tested positive to get access to care and treatment.



6

STRATEGIC DIRECTIONS FOR PROGRAMMING

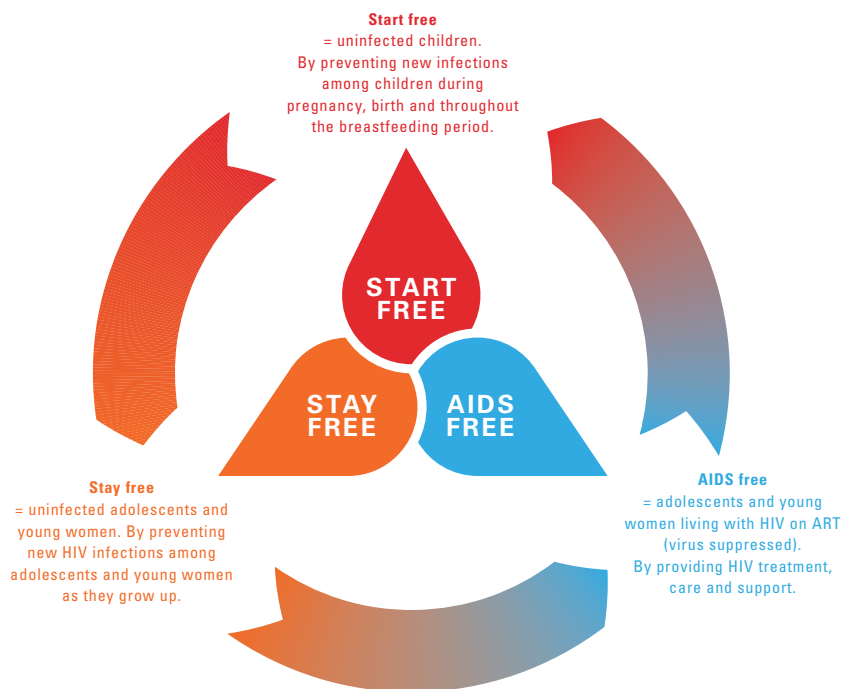
To end AIDS in children, the UNAIDS super-fast-track framework for children, adolescents and young women calls for an ambitious scale-up of programmes to meet the following targets:⁸⁷

- Providing lifelong ART to 95 per cent of pregnant women living with HIV by 2018;
- Reducing new HIV infections in children to fewer than 40,000 per year by 2018 and 20,000 per year by 2020;
- Reducing new infections in adolescents and young women to fewer than 100,000 per year by 2020; and
- Providing treatment to 95 per cent of all children and adolescents living with HIV by 2018.
- Providing voluntary medical male circumcision to 25 million additional men aged 15–29 years, including 11 million in the geographic areas of highest HIV burden.

These targets are the basis of the ‘Three Frees’ framework – Start Free, Stay Free, AIDS Free – which connects HIV prevention in adolescent girls and young women to the prevention of vertical transmission of HIV and the treatment and care of children and adolescents living with HIV (Figure 6.1).

Figure 6.1

Super-fast-track to end AIDS for children, adolescents and young women: Three Frees in the life cycle of a child



Source: UNICEF adaptation of UNAIDS Three Frees Framework, 2017.

Mary learned she was living with HIV when she became pregnant with her first child at 16. She benefited from a PMTCT programme and the child is free of HIV. She is now in care to prevent HIV transmission to her second child. © UNICEF/UN042019/Menezes

At the current pace of response, the West and Central Africa region will miss all super-fast-track targets (Figure 6.2). Achieving the targets for pregnant women, for example, would require that the region more than double the current level of treatment coverage, from 42 per cent in 2016 to 95 per cent in 2018. Maintaining the current pace would result in an estimated 75 per cent coverage by the end of that target year. Treatment coverage for children under the age of 15, meanwhile, would need to more than quadruple from the 21 per cent reported in 2016 to reach the 95 per cent target for 2018. The 95 per cent

target is nearly three times higher than the 32 per cent estimate for coverage in 2018 if the current pace continues.

For Nigeria, a country with half the region's people living with HIV, achieving the super-fast-track targets would require treatment coverage in pregnant women to more than quadruple, from 20 per cent in 2016 to 95 per cent in 2018. Treatment coverage among children under the age of 15 would need to increase by more than four times, from 21 per cent in 2016 to 95 per cent in 2018.

Figure 6.2

Trends and projections of super-fast-track targets in 2018 and 2020, West and Central Africa, 2010–2020



Notes:

1. Targets have been approximated by determining the West and Central Africa region's contributions to the global target (20,000 new infections among children) based on its share of the burden in 2016. Projections have been calculated by calculating the average annual rate of reduction from 2010–2016 and applying that rate through 2020. Projection trends towards each target assume an average annual rate of increase from 2016 to 2020.

2. Projections have been calculated by calculating the average annual rate of increase in treatment coverage from 2010–2016 and applying that rate through 2020. Projections do not take into account changes in population or changes in the HIV epidemic, such as incidence or mortality rates. Projection trends towards each target assume an average annual rate of increase from 2016 to 2018 and 2020, respectively.

3. Targets have been approximated by determining the West and Central Africa region's contributions to the global target (100,000 new infections among adolescent girls and young women) based on its share of the burden in 2016. Projections have been calculated by calculating the average annual rate of reduction from 2010 to 2016 and applying that rate through 2020. Projection trends towards each target assume an average annual rate of increase from 2016 to 2020.

4. Projections have been calculated by calculating the average annual rate of increase in treatment coverage from 2010 to 2016 and applying that rate through 2020. Projections do not consider changes in population or changes in the HIV epidemic, such as incidence or mortality rates. Projection trends towards each target assume an average annual rate of increase from 2016 to 2018 and 2020, respectively.

Source: UNICEF analysis of UNAIDS 2017 estimates.

The super-fast-track targets are ambitious, and keeping up a sense of urgency is important if they are to be met. The wide range of barriers and challenges should be addressed and eliminated and not used as an excuse to tolerate the inequity children living with HIV are facing with regard to access to treatment. Whether or not the targets are achieved within a specific time period, they provide an optimal benchmark to work towards and advocate for. They should prompt stronger, concentrated action by governments and other stakeholders in the HIV response. Stakeholders must recognize that rapidly expanding and comprehensive HIV responses for children, adolescents and young women are possible and urgently needed throughout West and Central Africa.

Several strategic directions are proposed below to help create a policy and implementation environment that will enable all countries of the region to accelerate progress towards the UNAIDS super-fast-track targets for children and adolescents by 2018 and 2020. Aspects of these strategic directions have been discussed in earlier chapters of this report; here, they are reiterated and brought under four broad headings: (1) differentiate the HIV response; (2) promote the integration of services; (3) prioritize community ownership and local governance; and (4) invest in innovation and learning. Together,

they represent a menu of promising approaches to programming in individual country contexts in West and Central Africa.

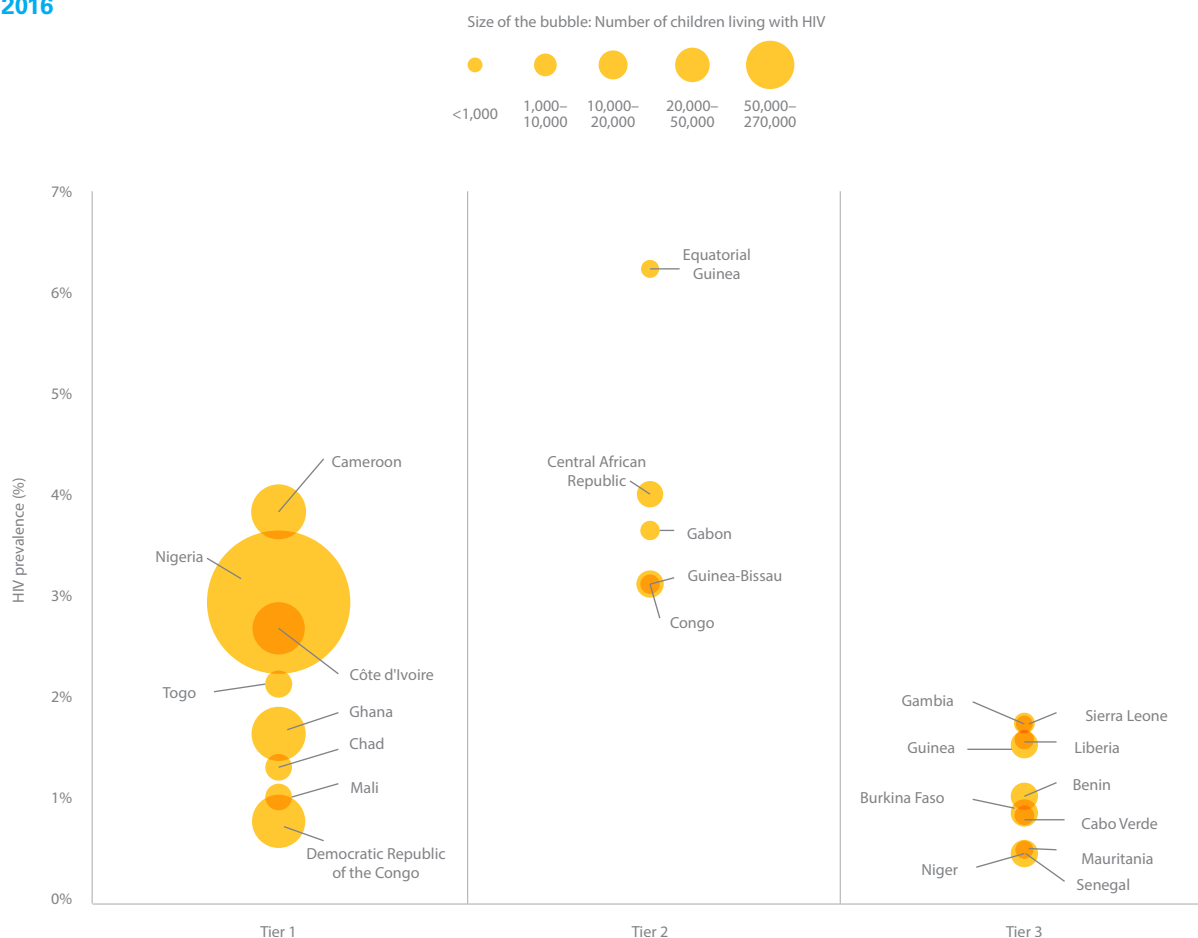
All of the following approaches are evidence-based, and some have been implemented successfully in other regions.

1. Differentiate the HIV response to accelerate progress towards the targets.

Because the HIV epidemic in West and Central Africa varies from country to country, and even within most countries, differentiated responses are required. In practice this refers to prioritizing resources based on geographical location and population in greatest need. Focus is placed on the countries, subnational areas, districts and municipalities most affected by HIV; and services are tailored to children, adolescents and mothers at higher HIV risk, including those from key populations and those living in challenging or fragile contexts. Implementing and sustaining a differentiated response requires better use of sub-national epidemiological and programmatic data (e.g., data on service coverage and resource allocation) to guide activities and interventions in local contexts (Figure 6.3).

Figure 6.3

HIV prevalence among adults (aged 15–49) and number of children living with HIV (aged 0–14), by tier, West and Central Africa, 2016



Note: The diagram depicts three tiers of countries according to the HIV burden (children living with HIV) and HIV prevalence in the general population. Tier 1 includes countries that carry together 85 per cent of the regional burden of children living with HIV. Tier 2 includes countries with a lower burden of children living with HIV but a prevalence of HIV above 3 per cent (significantly higher relative to regional adult [15–49 years] HIV prevalence average of 2.05 per cent [1.58–2.59 per cent]). Tier 3 includes countries with both lower HIV prevalence and burden of children living with HIV.

Source: UNICEF analysis of UNAIDS 2017 estimates.

The first step towards a differentiated HIV response in West and Central Africa is to cluster countries into three main tiers, with further differentiation within countries:

- **Countries with a high burden of children living with HIV – carrying 85 per cent of the region’s burden** (*Nigeria, Cameroon, Chad, Côte d’Ivoire, the Democratic Republic of the Congo, Ghana, Mali and Togo*). It is in these countries that HIV programmes for children and adolescents should most urgently be intensified, given their large share of the HIV burden. Investments should focus on removing persistent policy and systems barriers and bottlenecks to programme scale-up, and introducing innovative programme approaches.
- **Countries with a low HIV burden of children living with HIV but a high HIV prevalence (greater than 3 per cent) in the general population** (*the Central African Republic, the Congo, Equatorial Guinea, Gabon and Guinea-Bissau*). Programmes in these countries should emphasize a targeted approach, prioritizing geographic locations with high HIV incidence and prevalence in the general population aged 15–49 years, and addressing the systemic barriers to rapid scale-up of services with a focus on the most vulnerable children and adolescents, including adolescents in key populations.
- **Countries with lower HIV prevalence and low-to-moderate burden of children living with HIV** (*Benin, Burkina Faso, Cabo Verde, the Gambia, Liberia, Mauritania, the Niger, Senegal and Sierra Leone*). Programmes in these countries should sustain their focus on prevention among adolescents and young women, particularly from key populations, and country national plans should set more ambitious targets for children in line with Start Free and AIDS Free. Some countries (e.g., Burkina Faso and Cabo Verde) could become an example in the region in the coming years for eliminating new HIV infections in children.⁸⁸

In a differentiated approach, greater emphasis should be placed on analysing and using disaggregated HIV data at subnational levels to monitor equity, identify bottlenecks and advocate for their removal, and inform corrective actions, particularly for the most vulnerable populations (children, adolescents and women). Decision making should be based on a subnational-level analysis of the HIV burden and disparities in HIV programme coverage for children, adolescents and women, with a focus on equity, thus encompassing situation analyses of more specifically defined populations and sub-populations. This subnational analysis should inform resource allocation and geographic and population focus for intensified programme implementation, monitoring and evaluation. Efforts should focus on building capacity to use the data and shift the response.

For all countries, whether in Tier 1, Tier 2 or Tier 3, strengthening the integration of children and HIV programming within the health sector and the relevant social sectors is an essential condition for the design, implementation and positive impact of differentiated responses.

2. Promote the integration of HIV services within a resilient and sustainable development response.

HIV-specific services. The HIV-specific needs of pregnant women, children and adolescents must be met in the context of their broader health, education and protection needs throughout their life cycle. Countries should promote family-centred approaches to programme scale-up.⁸⁹ HIV-specific services should be integrated into the various platforms and service packages, including those focusing on antenatal care and maternal health, sexual and reproductive health, and education. The goals of such efforts would be to accomplish the following:

- **Identify pregnant women, children and adolescents living with HIV.** HIV testing should be part of the routine package of health services for mothers, children and adolescents in all settings. When children, adolescents and pregnant women test positive, they should immediately be linked to lifelong treatment and care services. Delivery platforms should include health facilities as well as communities, and systems should ensure effective and complementary linkages between them. Fast-tracking the reduction of new HIV infections in all settings will require increasing access by at-risk adolescents and young people to sexual and reproductive health services offering innovative HIV-specific interventions such as PrEP and HIV self-testing.
- **Treat and retain children, adolescents and pregnant and breastfeeding women living with HIV in comprehensive care and support services.** This requires aligning national guidelines with the 2016 WHO ‘test and treat’ policy and effectively decentralizing ART services to lower-level health facilities. In most countries of the region, task-shifting policies have enabled trained nurses to manage ART in PMTCT services, and this approach should be expanded to accommodate the treatment needs of children and adolescents. Countries should further engage communities of women living with HIV in providing support to women in PMTCT programmes, and adolescents as peers to improve adherence to treatment and retention in care. West and Central African countries can learn from the experiences of other regions with more robust, expansive and successful HIV treatment programming and services.

West and Central Africa’s heterogeneity and low HIV prevalence relative to other regions require that countries strengthen the use of data to assess platforms and services where integration of HIV-specific services will be most effective. A better use of data will help sharpen geographic focus (for example, for intensified HIV case identification) and optimize approaches for integrated service delivery.

HIV-relevant policies and interventions. Children, adolescents and young women in West and Central Africa face multiple and overlapping vulnerabilities, including susceptibility to HIV infections and poor treatment outcomes. That is why integrating HIV-specific services, as mentioned above, is such a critical priority. Improved access and results will further require addressing the structural and

social drivers of their vulnerabilities, including by countries investing in strengthening key social services (health, education and protection) and integrating HIV-relevant and child-sensitive interventions into their social sector development response. The latter is critical, particularly in countries with greater HIV burdens or higher rates of HIV infection.

HIV-relevant interventions can have the added benefits of empowering and protecting the most vulnerable children, adolescent girls and young women. For example, there is recent evidence from high-burden countries in Eastern and Southern Africa of the significant effect of combination protection packages (including child-focused grants, free schooling, school feeding, teacher support and parental monitoring) in reducing HIV-risk behaviour among adolescents.⁹⁰⁻⁹³ Cash transfers and education grants have been shown to help reduce the age of sexual debut and child marriage.⁹⁴ Such targeted support can be pursued in West and Central African countries as part of policy frameworks to keep adolescent girls in school and keep learning environments safe for them.

Other gender-responsive policies and programmes include the involvement of men as 'change agents' to address the persisting gender norms that continue to expose adolescent girls and young women to abuse, exploitation and increased HIV risk. Similarly, as countries move towards developing universal health coverage policies and programmes, they should ensure that HIV services for women, children and adolescents are included in the basic package of services covered.

3. Prioritize community ownership and local governance of the HIV response.

Families and community members remain best placed to address the enduring HIV-related stigma that has inhibited progress towards ending AIDS in West and Central Africa and all over the world. This emphasis reinforces the differentiated approach to the HIV response that is described above. An intensified response will be needed at subnational and community levels, driven by community leaders and local authorities and centred in a package of high-impact interventions, such as ART, designed locally for the specific needs of children and adolescents living with HIV and those at a significantly higher risk of HIV acquisition.

To that effect, one conceptual framework – the child-friendly community – is being rolled out in West and Central African countries with UNICEF support (*see panel*). Local authorities at village or municipality level will be working across sectors to promote bottom-up systems of shared accountability. If implemented effectively, the approach could foster greater community ownership and strengthen local governance and accountability for a super-fast-track response.

Young people can and should drive social change. They can mobilize networks and advocate with friends, sexual partners and other stakeholders to commit to adolescent health and well-being by holding them to account. West and Central African countries should promote and support the meaningful engagement of adolescents, including those living with HIV and from key populations, in shaping the HIV response both nationally and in their communities. Countries

PANEL

Features of the child-friendly community concept

- **Focuses on the child's needs (child-centred) using an equity lens and data to identify the most deprived communities with the most vulnerable children**, and addresses the multiple overlapping deprivations of children in an integrated way, instead of limiting responses to a single programme or sector needs.
- **Fosters multisectoral convergence of geographies, systems and operations** to holistically address the needs of the child and get more value for money.
- **Adopts the life cycle approach** to address the unique needs of the child at each stage of development, enable the individualized longitudinal follow-up from conception to adolescence, and contribute to improving well-being in adult life.
- **Empowers communities to own and lead** for the survival, development and transformation of the child. The well-being of the child becomes a truly shared responsibility of the community with support from the technical line ministries.
- **Supports a bottom-up mutual accountability mechanism** with joint multisectoral planning and monitoring systems that enable communities to measure to what extent children in their community their rights have been fulfilled and their needs have been met.
- **Establishes a community-based certification (and/or rating) system** that functions both as a pull system due to demand creation and a push system that mobilizes vulnerable communities in particular. The certification criteria, methodology and frequency will need to be context-specific alongside modalities to support communities in the process of certification.

should build on the existing networks of people in the region and globally to strengthen their capacities and engage them in fast-tracking results for children, adolescents and families.

4. Invest in innovations to remove the barriers to scale-up.

West and Central Africa must leverage innovations and foster collaborative learning to improve efforts to identify infants, children, adolescents, pregnant and breastfeeding women living with HIV; link them to treatment; and retain them in care. Innovative new diagnostic and biomedical approaches such as PoC technology, HIV self-testing and PrEP have been described in earlier chapters of this report. PoC tools can improve access to early infant HIV diagnosis and viral load monitoring at lower-level facilities and create system efficiencies. HIV self-testing has the potential to increase access among hard-to-reach adolescent girls, young women and men, particularly from key populations, by eliminating barriers to HIV testing and providing faster test results. PrEP can effectively reduce the acquisition of HIV and should be offered as an additional prevention option for people at substantial risk of HIV infection, including adolescent girls, as part of combination HIV prevention approaches. WHO recently launched toolkit to support the implementation of PrEP.

Countries in West and Central Africa should also adopt proven technology-based innovations, and adapt these to their local contexts. The rapid penetration of mobile phones and the internet is transforming the HIV programming landscape by equipping clients with the means to play an active role in ensuring their personal

health and well-being and in programme monitoring more generally. SMS-based mobile health applications can improve the efficiency of information transfer and patient adherence; increase HIV awareness and comprehensive knowledge of HIV; stimulate demand for high-impact prevention services; and engage adolescents and young people in the real-time monitoring of service quality. The U-Report, described in Chapter 5, which has already been implemented in nine countries (Burkina Faso, Cameroon, the Central African Republic, Côte d'Ivoire, Guinea, Mali, Nigeria, Senegal and Sierra Leone) in the region, has the proven potential to more extensively involve adolescents and young people in national HIV responses.⁹⁵

Developing, testing and implementing all of the technical and programmatic innovations noted above, as well as others that are determined to be important in the future, is a huge task and commitment. The financial requirements are notable enough, although strong cases can likely be made that many of the innovations will be cost-effective over time – including from the broader perspective of preventing new infections. Meeting the human resources requirement, which of course is also a financial issue, will be especially challenging. A greater number of health-care personnel and civil society partners on the ground will be needed, especially if scale-up accelerates while innovations are introduced. These personnel and partners will need to be trained on a regular basis. Ultimately, therefore, innovation can only have the promised impact when commitment to improvement and the sustainability of HIV responses are clearly stated and followed up with action. Given where the region is currently, it will be important to foster timely sharing and learning of emerging best practices and tools using a variety of platforms within and across countries.



Sylla sits in front of her house in Côte d'Ivoire with her youngest child, Ladji, 5, and her oldest child, Djona, 10. Sylla did not find out she was HIV-positive until she was pregnant with her fourth child.
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7

THE WAY FORWARD

This report has highlighted how, why and where children and adolescents in West and Central Africa remain vulnerable to HIV, including in unfavourable comparison with most other regions. They are behind at every age and in nearly every core data point and indicator, from access to life-saving treatment for pregnant women and children living with HIV, to trends in AIDS-related deaths among older adolescents.

Yet, as the report also notes, the lagging HIV responses in the region are facing increased scrutiny locally, regionally and globally. There is growing recognition that the rights and needs of all people living with and at higher risk for HIV, including children and adolescents, are being neglected in the region. The vulnerability of girls and young women is no longer seen as tolerable. Governments, civil society partners, donors, multilateral agencies such as UNICEF and other stakeholders in HIV responses are being challenged internally and externally to find solutions that can lead to lasting improvements.

Translating acknowledgement of the problems and gaps into credible action is an essential, immediate priority. Four strategic directions for programming were noted previously in this report, under the headings of a differentiated HIV response, integrated services, community ownership and innovation. Beyond these programme directions, however, it is critical that actions and advocacy in the HIV response be guided by the following overarching principles:

- **Urgency:** Between now and 2030, the population of West and Central Africa is projected to increase by about 50 per cent, according to a recent report from the United Nations Department of Economic and Social Affairs, and children and adolescents under the age of 18 could represent at least half the population. Due to this 'youth bulge', the demographic growth could mean continued high numbers of children and adolescents becoming infected with HIV and dying from AIDS, unless the HIV response – both prevention and treatment – improves. Given these projections, the current slow progress in responding to HIV in the region is simply unacceptable, and governments and the global community can no longer allow it to continue.
- **Equity:** The inequitable prioritization of the HIV response and its correlated slower regional progress must be corrected. There are too many disparities and gaps that characterize and weaken the HIV response among children and adolescents, including disparities in access to ART that favour younger children over adolescents and adolescent girls over adolescent boys. Other gaps also exacerbate the inequity experienced across the region, including between

countries with lower prevalence (e.g., the Niger) and higher prevalence (Equatorial Guinea) relative to the regional average; within countries, such as significant differences in impact and risk in Nigerian states; and West and Central Africa in relation to Eastern and Southern Africa and other regions.

- **Resilient systems:** Health systems in the region must be strengthened to overcome current limitations, including the bottlenecks in many countries that prevent the effective decentralization of services and the integration of HIV testing and treatment into routine MNCH systems and sexual and reproductive health services. Accelerating progress in the region requires enhanced integration and cross-sectoral synergies based on collaboration among ministries of health and other line ministries and partners, to strengthen the systems that offer an entry point for the delivery of HIV services for children. Given the relatively low prevalence in some parts of countries of this region, HIV cannot afford to have standalone systems. Integrated services, especially those locally designed and driven, can make it simpler and quicker to identify pregnant women, children and adolescents living with HIV, and then link them to treatment. Progress also depends on supporting the development of strong community systems that can facilitate supply, demand creation and service delivery.
- **Data:** In West and Central Africa, as in other regions of the world, more must be done to use and analyse HIV subnational data, disaggregated by a wider range of factors and background characteristics – such as geographically, by age, by gender and by at-risk populations (e.g., sex workers, men who have sex with men, and people who use drugs) – to focus efforts where the most vulnerable children and young people are likely to live. In a differentiated approach to the HIV response in the region, the data generated must be complemented by their real-time analysis and dissemination to inform appropriate action and accountability at all levels. This is critical for

purposes of monitoring progress towards the scale-up of programmes and as the basis for evidence for use in policy advocacy. If needed, quicker and more targeted course correction can then be implemented.

- **Gender:** Adolescent girls and young women are particularly vulnerable to HIV and inordinately affected by the epidemic. Often, girls' knowledge about HIV is limited, and they are less equipped than boys to make informed decisions about HIV prevention. The challenges many girls are facing include lack of access to education and the inability to stay in school; gender norms that put them at a disadvantage to negotiate safer sexual relationships; and gender-based violence that is common in many countries in the region. Gender norms also affect boys and men, who are expected to take risks (which often results in injury and illness) and who are facing taboos when it comes to seeking health services. As a result, men are less likely than women to get tested and treated for HIV, which weakens overall HIV prevention efforts. Unless these structural, behavioural and cultural issues are also addressed, the HIV response in West and Central Africa will remain insufficient and unsustainable.
- **Humanitarian crises in some countries:** Political crisis, conflict and natural disasters in the region have disproportionate impacts on children and women and have negatively influenced HIV programming. This situation was underscored in 2014–2015, when Ebola epidemics in Guinea, Liberia and Sierra Leone stressed health systems to the point that the people living with HIV, particularly women and children, were not served. Another example is the Central African Republic, where repeated conflicts since 2012 have destroyed many health facilities and displaced thousands of families, including people and children living with HIV, whose treatment was disrupted. Because HIV infection leads to chronic infection and insufficient adherence can lead to drug resistance, it is critical that adequate measures be undertaken in humanitarian situations to preserve HIV prevention and treatment programming. UNICEF and partners in their

core commitments for children in humanitarian action have committed to ensure access to information about HIV and access to HIV prevention, care and treatment services for children, young people and women without interruption during humanitarian crisis situations. This principle should be adopted and taken seriously by all actors in HIV responses throughout the region.

- **Partnerships:** UNAIDS' super-fast-track of the global response for children, adolescents and young women by 2020 calls for a full programme scale-up in West and Central Africa by 2018. There are many partners on the ground in the region that are responding to this call, and doing remarkable work in often difficult circumstances. This work should be supported and expanded. One of the constraining factors is the situation with HIV funding, which has not met the level of need and is limited to a few major donors. This situation and the broader fact that external financing for HIV globally is declining have implications in terms of funding flexibility and opportunities to diversify programmes on the ground.
- **High-level political commitment:** A super-fast-track HIV response for children requires that West and Central African political leaders renew their political commitments to an AIDS-free generation. There are reasons to be hopeful in the region, as many leaders have endorsed a catch-up plan, which aims to drastically improve HIV treatment for adults and children by 2018. They must continue such efforts and go much further, including by ensuring that the treatment gap between children and adults is eliminated. Another priority is for leaders to equally embrace a fast-tracked HIV prevention road map, building on the momentum from the All In! initiative to sustain the current momentum in HIV prevention among adolescents and young women. As West and Central African countries strive to provide hard-to-reach children, adolescents and women with high-impact HIV interventions, commitment to increase domestic allocation to their HIV responses should translate into more locally driven approaches to scale up and sustain the response to HIV across the region.

ABBREVIATIONS

AIDS	acquired immunodeficiency syndrome	MICS	Multiple Indicator Cluster Surveys
AIS	AIDS Indicator Surveys	PEPFAR	United States President's Emergency Plan for AIDS Relief
ART	antiretroviral therapy	PMTCT	prevention of mother-to-child transmission (of HIV)
ARVs	antiretroviral medicines	PoC	point-of-care
CD4	cluster of differentiation or designation 4: white blood count measure of eligibility for ART treatment	PrEP	pre-exposure prophylaxis
DHS	Demographic and Health Surveys	SAM	severe acute malnutrition
DPT1	first dose of diphtheria, pertussis and tetanus vaccine	SDG	Sustainable Development Goal
DPT3	three doses of combined diphtheria/pertussis/tetanus vaccine	SMS	short message service
EID	early infant diagnosis (of HIV)	TB	tuberculosis
HIV	human immunodeficiency virus	UNAIDS	Joint United Nations Programme on HIV/AIDS
HTC	HIV testing and counselling	UNICEF	United Nations Children's Fund
iCCM	integrated community case management	WHO	World Health Organization

ENDNOTES

- 1 Unless stated otherwise, the statistics cited throughout this report are based on a UNICEF analysis of UNAIDS 2017 estimates. The UNICEF classification of the West and Central Africa region includes the following 24 countries: Benin; Burkina Faso; Cameroon; Cabo Verde; Central African Republic; Chad; Congo; Côte d'Ivoire; Democratic Republic of the Congo; Equatorial Guinea; Gabon; Gambia; Ghana; Guinea; Guinea-Bissau; Liberia; Mali; Mauritania; Niger; Nigeria; Sao Tome and Principe; Senegal; Sierra Leone; and Togo.
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Annex

STATISTICAL TABLES

NOTES ON THE DATA

DATA SOURCES

2017 Global AIDS Monitoring: In an effort to harmonize data collection and minimize the reporting burden on countries, UNAIDS, WHO and UNICEF have developed a joint reporting tool. The list of indicators was revised in 2016 to enable country-level reporting for the HIV monitoring framework for 2016–2021. Accompanying guidelines support countries in using the tool and provide detailed descriptions of the indicators used. In March 2017, countries reported administrative data and any new survey data from 2016. After data cleaning and validation, select indicators are made available at aidsinfo.unaids.org.

UNAIDS 2017 estimates: UNAIDS, WHO and UNICEF use Avenir Health modelling software, Spectrum/EPP, to generate estimates for select HIV indicators. These mathematical models use national and subnational administrative and survey data to estimate past, current and future figures for HIV.

Nationally representative surveys, 2010–2016: Multiple Indicator Cluster Surveys (MICS), Demographic and Health Surveys (DHS), AIDS Indicator Surveys (AIS), reproductive health surveys, sexual behaviour surveys and other nationally representative surveys are currently used to collect data on knowledge, attitudes and behaviour related to HIV and AIDS. HIV-related biomarkers may also be collected through some HIV-specific population-based surveys.

More information on the data and complete statistical tables can be found at data.unicef.org.

Table 1

HIV epidemiology indicators, West and Central Africa, 2016

Countries	SDG 3.3.1: HIV incidence (new HIV infections per 1,000 uninfected population)			Estimated number of people living with HIV				Estimated number of new HIV infections				Estimated number of AIDS-related deaths			
	Total (all ages)	Children (aged <5)	Adolescents (aged 15–19)	Total (all ages)	Children (aged 0–14)	Adolescent girls (aged 10–19)	Adolescent boys (aged 10–19)	Total (all ages)	Children (aged <5)	Adolescent girls (aged 10–19)	Adolescent boys (aged 10–19)	Total (all ages)	Children (aged 0–14)	Adolescent girls (aged 10–19)	Adolescent boys (aged 10–19)
Benin	0.34	0.25	0.58	67,000	6,300	2,800	2,300	3,600	<500	<500	<500	2,400	<500	<100	<100
Burkina Faso	0.19	0.18	0.47	95,000	10,000	6,600	5,200	3,400	<1,000	<1000	<500	3,100	<500	<200	<500
Cabo Verde	-	-	-	2,800	<200	<100	<100	<200	<100	<100	<100	<100	<100	<100	<100
Cameroon	1.39	1.09	2.41	560,000	46,000	25,000	15,000	32,000	4,000	4,900	1,100	29,000	3,200	<1,000	<1,000
Central African Republic	1.80	0.80	1.51	130,000	9,200	4,800	3,900	8,700	<1,000	<1000	<500	7,300	<1,000	<500	<500
Chad	0.34	0.38	0.38	110,000	11,000	4,400	3,300	4,800	<1,000	<500	<200	2,800	<1,000	<200	<200
Congo	1.65	1.39	1.38	91,000	6,000	2,400	1,700	7,600	1,100	<500	<200	3,800	<1,000	<100	<100
Côte d'Ivoire	0.86	0.87	0.60	460,000	36,000	14,000	11,000	20,000	3,300	1,300	<200	25,000	2,600	<1,000	<1,000
Democratic Republic of the Congo	0.17	0.21	0.24	370,000	48,000	18,000	14,000	13,000	2,900	1,700	<500	19,000	2,800	<1,000	<1,000
Equatorial Guinea	2.71	1.35	2.36	35,000	2,400	<1,000	<1,000	2,300	<200	<200	<100	<1,000	<200	<100	<100
Gabon	0.92	0.95	1.57	48,000	3,700	1,800	1,100	1,700	<500	<500	<100	1,500	<500	<100	<100
Gambia	0.65	0.47	0.23	20,000	1,600	<500	<500	1,300	<200	<100	<100	1,100	<200	<100	<100
Ghana	0.78	0.79	0.83	290,000	32,000	14,000	9,600	20,000	3,000	1,900	<500	15,000	2,500	<500	<1,000
Guinea	0.67	0.68	1.08	120,000	10,000	5,400	3,300	8,300	1,300	1,100	<500	5,800	<1,000	<200	<200
Guinea-Bissau	0.72	0.72	0.56	36,000	4,200	1,100	<1,000	1,300	<500	<100	<100	2,000	<500	<100	<100
Liberia	0.66	0.47	1.49	43,000	4,200	2,900	2,000	2,900	<500	<1000	<200	2,800	<500	<200	<200
Mali	0.33	0.51	0.62	110,000	14,000	5,600	4,300	5,900	1,600	<1000	<500	6,100	<1,000	<200	<200
Mauritius	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Niger	0.09	0.13	0.18	48,000	5,800	2,400	2,000	1,800	<1,000	<500	<200	3,400	<500	<200	<200
Nigeria	1.23	1.19	2.18	3,200,000	270,000	130,000	100,000	220,000	37,000	26 000	15 000	160,000	24,000	3,800	4,200
Sao Tome and Principe	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Senegal	0.08	0.16	0.12	41,000	4,800	1,500	1,300	1,100	<500	<200	<100	1,900	<500	<100	<100
Sierra Leone	-	-	-	67,000	4,400	3,100	1,900	5,300	<500	<1000	<500	2,800	<500	<100	<100
Togo	0.59	0.65	0.49	100,000	12,000	4,200	3,400	4,100	<1,000	<500	<100	5,100	<1,000	<200	<500
West and Central Africa	0.78	0.74	1.25	6,100,000	540,000	260,000	190,000	360,000	60,000	43,000	19,000	300,000	43,000	7,700	8,500

For a complete list of countries and areas in the region, subregions and country categories, visit data.unicef.org/regionalclassifications.

It is not advisable to compare data from consecutive editions of HIV/AIDS statistical updates.

DEFINITIONS OF THE INDICATORS

HIV incidence per 1,000 uninfected population: Estimated number of new HIV infections per 1,000 uninfected population, 2016. Data reported for children (aged <5), adolescents (aged 15–19) and all ages.

People living with HIV: Estimated number of people living with HIV, 2016. Data reported for children (aged 0–14), adolescent girls (aged 10–19), adolescent boys (aged 10–19) and all ages.

New HIV infections: Estimated number of new HIV infections, 2016. Data reported for children (aged 0–14), adolescent girls (aged 15–19), adolescent boys (aged 15–19) and all ages.

AIDS-related deaths: Estimated number of AIDS-related deaths, 2016. Data reported for children (aged 0–14), adolescent girls (aged 10–19), adolescent boys (aged 10–19) and all ages.

MAIN DATA SOURCE

UNAIDS 2017 estimates, July 2017.

NOTES

- Data not available.

Table 2

Coverage of core interventions for HIV, West and Central Africa, 2016

Countries	Per cent of pregnant women living with HIV receiving effective antiretroviral medicines (ARVs) to prevent mother-to-child transmission of HIV (PMTCT)	Per cent of people living with HIV on antiretroviral therapy (ART)			Per cent of adolescents (aged 15–19) who reported having multiple sexual partners in the past 12 months who reported condom use at last sex		Per cent of adolescents (aged 15–19) tested for HIV in the past 12 months and received the results of the last test		Per cent of adolescents (aged 15–19) with comprehensive, correct knowledge of HIV							
		Total (all ages)	Children (aged 0–14)	Adolescents (aged 10–19)	Male	Female	Male	Female	Male	Female						
Benin	>95	57	32	-	43.3	-	38.1	-	5.6	-	7.3	-	29	-	21.6	-
Burkina Faso	83	60	24	-	76.4	x,y	57.3	x,y	4	x	7.9	x	30.9	x	28.8	x
Cabo Verde	>95	57	65	40	-	-	-	-	-	-	-	-	-	-	-	-
Cameroon	74	37	18	-	69.6	-	52	-	6.9	-	14.5	-	29.8	-	25.7	-
Central African Republic	81	24	18	25	49.8	x	28.1	x	6.8	x	14.6	x	26.4	x	17.1	x
Chad	63	39	14	-	-	-	53.6	-	1.5	-	5.3	-	11.6	-	10.2	-
Congo	16	23	25	-	56	-	45.5	-	3.8	-	8	-	25	y	15.7	-
Côte d'Ivoire	73	41	25	-	70.1	-	31.8	-	5.2	-	9.7	-	20.9	-	15	-
Democratic Republic of the Congo	70	42	30	-	17.3	-	12.1	-	1.4	-	4.5	-	20.3	-	17.1	-
Equatorial Guinea	90	43	16	-	31.4	-	17.4	-	6.8	-	26.9	-	12.3	-	17.3	-
Gabon	76	63	39	61	77.3	-	58.3	-	6.1	-	20.4	-	34.8	-	28.8	-
Gambia	69	30	33	-	-	x	-	x,y	1.9	-	5.9	-	26.5	-	21.9	-
Ghana	56	34	15	-	-	-	21.6	y	1.3	-	4.5	-	24.5	-	18.1	-
Guinea	43	35	18	-	46.2	y	29.7	-	0.9	-	2.5	-	28.7	-	19.8	-
Guinea-Bissau	85	33	15	-	59.5	-	40.9	-	1.8	-	4.8	-	19.3	-	20.3	-
Liberia	70	19	11	-	21.6	y	27.1	-	3.6	-	13.1	-	19	-	34.6	-
Mali	35	35	21	7	47	-	25.7	-	1.3	-	7.6	-	26.7	-	20.7	-
Mauritius	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Niger	52	32	17	14	-	-	-	-	1.5	-	4.1	-	21.3	-	12.3	-
Nigeria	32	30	21	-	46.1	y	38.1	-	2.3	-	4.2	-	29.3	-	22.4	-
Sao Tome and Principe	-	-	-	-	78.5	-	-	-	8	-	22.1	-	42	-	40.5	-
Senegal	55	52	26	31	-	-	-	-	6	-	9.6	-	28.2	-	26.1	-
Sierra Leone	87	26	18	-	23.5	-	9.7	-	3	-	11	-	28.5	-	28	-
Togo	86	51	26	27	-	-	-	-	6.7	-	11.2	-	27.9	-	22.8	-
West and Central Africa	49	34	21	-	42.7	-	31.8	-	2.7	-	6.0	-	25.6	-	20.3	-

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It is not advisable to compare data from consecutive editions of HIV/AIDS statistical updates.

DEFINITIONS OF THE INDICATORS

Pregnant women living with HIV receiving ARVs for PMTCT: Per cent of the estimated number of pregnant women living with HIV receiving effective regimens (excludes single-dose nevirapine) of antiretroviral medicines (ARVs) for preventing mother-to-child transmission (PMTCT) of HIV, 2016.

People living with HIV receiving ART: Per cent of the estimated number of people living with HIV receiving antiretroviral therapy (ART), 2016. Data reported for children (aged 0–14), adolescents (aged 10–19) and all ages.

Condom use among adolescents with multiple partners: Percentage of adolescent boys and girls (aged 15–19) who reported the use of a condom the last time they had sex with any partner, among those who reported having had more than one sexual partner in the past 12 months, 2011–2016.

Adolescents tested for HIV in the past 12 months and received test results: Percentage of adolescent boys and girls (aged 15–19) who were tested for HIV in the past 12 months and received the result of the most recent test, 2011–2016.

Comprehensive correct knowledge of HIV among adolescents: Percentage of young men and women aged 15–19 who correctly identify the two major ways of preventing the sexual transmission of HIV (using condoms and limiting sex to one faithful, uninfected partner), who reject the two most common local misconceptions about HIV transmission and who know that a healthy-looking person can be HIV-positive.

MAIN DATA SOURCES

Pregnant women living with HIV receiving ARVs for PMTCT; people living with HIV receiving ART: UNAIDS 2017 estimates, July 2017.

Condom use among adolescents with multiple partners; adolescents tested for HIV in the past 12 months and received test results; comprehensive knowledge of HIV among adolescents: UNICEF global databases based on MICS, DHS, AIS and other national household surveys.

NOTES

- Data not available.

x Data fall outside the indicated time period and are not included in the regional calculations.

y Based on small denominators.

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