Children and the Global Fund:

What is the HIV programming response to the needs of children, adolescents, and the youth?

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aidspan

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Aidspan (www.aidspan.org) is an international NGO based in Nairobi, Kenya, whose mission is to reinforce the effectiveness of the Global Fund. Aidspan performs this mission by serving as an independent watchdog of the Fund, and by providing services that can benefit all countries wishing to obtain and make effective use of Global Fund financing.

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Preface

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Abbreviations

AIDS	Acquired immune deficiency syndrome
AKP	Adolescent key population
ALHIV	Adolescents living with HIV
ART	Anti-retroviral therapy
BCC	Behavior change communication
CLHIV	Children living with HIV
FP	Family planning
FSW	Female sex workers
GAC	Grant approvals committee
GF	Global fund
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
HCW	Healthcare worker
HEI	HIV-exposed infant
HIV	Human immunodeficiency virus
HTC	HIV testing and counseling
IDU	Injecting drug users
IEC	Information education and communication materials
MARCY	Young MSM
MENA	Middle East and North Africa
MSM	Men who have sex with men
MTCT	Mother-to-child transmission
OST	Opioid substitution therapy
OVC	Orphans and vulnerable children
PITC	Provider-initiated testing and counseling
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission
PR	Principal recipient
PRC	Post rape care
PWID	People who inject drugs
SRH	Sexual and reproductive health
SSA	Sub-Saharan Africa
STI	Sexually transmitted infection
TB	Tuberculosis
TG	Transgender
TOT	Trainer of trainers
TRP	Technical review panel
VMMC	Voluntary medical male circumcision

Definition of Key Terms

Adolescent A person aged 10 to 19 years

Behavior change communication (BCC) is an interactive process with children which uses a variety of communication channels to develop positive behavior, promote and sustain individual, community and societal behavior change, and maintain appropriate behavior.

Child A child is defined as any person below the age of 18 years (0-17 years)

Young person An individual aged 10 to 24 years

Youth An individual aged 15 to 24 years

Key population These are groups of people who are at more at risk of HIV due to specific high-risk behavior and may also have limited access to HIV services. They include men who have sex with men (MSM), people who inject drugs (PWID), female sex workers (FSW), transgender persons, adolescent girls and young women, and prisoners. Key populations are disproportionately affected by HIV.

Executive Summary

There are 2.6 million children living with HIV globally with the majority (88%) living in sub-Saharan Africa. While new infections in children have declined over the years, there were 220 000 new infections in children aged between 0-14 years in 2012, with more than half of these infections occurring in sub-Saharan Africa. In 2013, there were 2.1 million adolescents living with HIV, with 80% of them in SSA. HIV accounts for the second largest number of deaths among adolescents globally and is the number one cause of deaths among adolescents in SSA.

In its *Strategy 2012-2016: Investing for Impact*, the Global Fund committed to strengthen content relating to maternal, newborn and child health in proposals. We conducted an in-depth analysis of HIV, HIV-TB, and integrated concept notes submitted by the countries under the NFM along with a selection of grant agreements. Our main aim was to determine the extent to which the needs of children were included in the countries' concept notes and indicators for monitoring performance. This will give us a picture of whether children are being prioritized by the countries. This review describes the breadth of HIV related child, adolescent, and youth programming which was proposed in submitted concept notes.

Analysis of 22 concept notes and 16 grant agreements indicate that children and young people are not being adequately prioritized under the new funding model. By far, the most common intervention to be included in concept notes and grant agreements was PMTCT. Pediatric treatment, care, and support was present in 73% of concept notes, with an emphasis on Prong 3 of the intervention. As with PMTCT, emphasis was on ART provision, with less than 50% of concept notes including other interventions which are important in supporting the care of HIV infected infants and children such as adherence counseling and nutritional support.

Adolescent-focused HIV interventions were poorly represented in the concept notes and grant agreements analyzed. Comprehensive HIV and SRH services targeting young people were rarely mentioned. Adherence support interventions for infected children and young people were also poorly represented. Utilization of popular media was rarely mentioned in the concept notes analyzed. Half of the concept notes analyzed did not propose any gender-specific interventions for young people. Interventions which would target adolescent key populations were rarely mentioned. Poor representation of prevention-related indicators for adolescents was a sign of low prioritization of young people. Further evidence of poor prioritization was indicated by the fact that the majority of community-based prevention activities which would improve the targeting of children and adolescents were placed in the above allocation portion of the funding request.

This study provides evidence of gaps in HIV programming with regards to children and young people. With recent calls to focus on the needs of the most vulnerable, including girls and young women, the Global Fund needs to provide better guidance on how recipient countries can improve their HIV response to do so. While the focus on biomedical interventions is important in the fight against HIV, more emphasis on interventions which support the success of biomedical interventions as well as those which reduce the likelihood of acquiring the virus is required.

1. Introduction

There are 36.9 million people living with HIV (PLHIV) globally. With an increase in the numbers of PLHIV receiving ART (current coverage is 41%); the number of new infections has reduced from 3.1 million in 2000 to 2 million in 2014, AIDS-related deaths have reduced from 2 million in 2005 to 1.2 million in 2014 [1]. There are 2.6 million children living with HIV globally with the majority (88%) living in sub-Saharan Africa [1]. While new infections in children have declined over the years [2,3], there were 220 000 new infections in children aged between 0-14 years in 2012, with more than half of these infections occurring in sub-Saharan Africa. ART coverage in children consistently lags behind that of adults [4] and as of 2014 coverage was 32% [1]. This is despite the fact that if left untreated 33% of children living with HIV will die by the end of the first year of life and 50% will die by their second birthday [2]. ART coverage in children ages 0-14 years ranges from a low of 15% in the Middle East and North Africa (MENA)[1] region to 54% in Latin America.

In 2013, there were 2.1 million adolescents living with HIV (ALHIV) [2], with 80% of them in SSA. Most ALHIV acquired the virus perinatally with an estimated 20% acquiring HIV during adolescence. The number of new infections among the youth has gone down by 45% since 2000 [3], although the number of AIDS-related deaths have increased by 50% in adolescents. HIV accounts for the second largest number of deaths among adolescents globally and is the number one cause of deaths among adolescents in SSA [3].

Young women aged 10-24 years are a key population in sub-Saharan Africa (SSA) and most especially in Southern Africa [5,6]. HIV prevalence among young women remains twice that of young men in SSA. Approximately 60% of infections in 2013 individuals aged 15-24 years occurred among young women [7]. In 2012, the number of new infections in girls aged 15-19 years was more than 80% of all infections in this age group in three countries in SSA; South Africa (82%), Sierra Leone (85%), and Gabon (89%) [8]. As the number of AIDS-related deaths declined globally, this number in adolescents increased by 50% between 2005 and 2013 [6]. Adolescent girls and young women have lower comprehensive knowledge of HIV and condom use compared to their male counterparts (30% vs. 37% and 40% vs. 59%, respectively) [3]. Barriers to access to HIV services among adolescent girls and young women include lack of access to youth-friendly services, sexual and gender based violence, low socio-economic status and poor quality education [4,9].

In its Strategy 2012-2016: Investing for Impact, the Global Fund committed to strengthen content relating to maternal, newborn and child health (MNCH) in proposals. This review describes the breadth of HIV related child, adolescent, and youth programming which was proposed by 22 countries in concept notes submitted to the Global Fund. While this is not an exhaustive analysis of all HIV, HIV-TB, and integrated concept notes submitted to the Fund, it does provide some insight into whether the needs of children, adolescents, and young people are being adequately addressed. The following sections provide descriptions of ideal child, adolescent, and youth HIV programs, the methods used in this review, the findings, and a conclusions section.

[1] Countries in MENA region include: Algeria, Djibouti, Egypt, Iran (Islamic Republic of), Morocco, Oman, Somalia, Sudan (the), Tunisia and Yemen

2. HIV Programming for Children and Young People

Children and HIV Programming

(A) Prevention of mother-to-child transmission (PMTCT)

Prevention of mother-to-child transmission (PMTCT) has been scaled up in most countries. In 2014 and average of 73% of pregnant women living with HIV received ART to prevent mother-to-child transmission. The rate of mother-to-child transmission (MTCT) in low- and middle-income countries has declined from 29% in 2009 to 17% in 2013 [10]. PMTCT coverage ranges from 13% (MENA region) to 89% (Caribbean). Despite HIV testing and counseling being an entry point for PMTCT services, only 48% of pregnant women in low- and middle-income countries received a HIV test in 2013 [10].

A four-pronged strategy was developed with the aim of maximizing PMTCT efforts [11,12]:

- **Prong 1:** Prevention of HIV among women of childbearing age
- **Prong 2:** Prevention of unintended pregnancies among women of child bearing age living with HIV
- **Prong 3:** Prevention of vertical transmission-receive ARVs to prevent transmission and infant feeding counseling
- **Prong 4:** Integration of HIV care, treatment and support for women who are HIV positive and their families

The third prong has received most of the attention in recent years. ART coverage for women living with HIV has increased over the years and this has translated to a decline in MTCT. However, gaps remain in the other prongs of PMTCT. Great progress in PMTCT can only be obtained if these interventions are combined.

To reduce the number of infants born with HIV, the prevalence in women of childbearing age also needs to decline. Comprehensive application of primary prevention has been shown to be effective in reducing the number of infections in infants. HIV primary prevention efforts need to be intensified; especially to young women aged 15-24 years, who have higher fertility rates. More focus is required on women's sexual and reproductive health. Women living with HIV need to be given the opportunity to plan the size of their families and space their children. A significant decline in HIV infections has been shown when family planning is integrated into other PMTCT programs [13]. Globally, 12.3% women living with HIV were not using any form of contraception despite being sexually active and not wanting to have another child or wanting to delay the next child [14]. There is a need to scale up family planning services especially in high HIV prevalence settings. It is also important to link family planning (FP) clients to HTC services so as to expand access to HIV services by women of reproductive age. Interventions in the third prong include HTC, ART provision, safe delivery and infant feeding counseling and support [12].

HIV-exposed infants (HEI) should be put on prophylaxis for 6 weeks after birth and undergo virological testing within the first two months of life. Infants and any child below 5 years

diagnosed with HIV should be initiated on lifelong ART. Babies, who continue breastfeeding after completion of prophylaxis, have a similar risk of HIV transmission as those who did not receive prophylaxis. Therefore, it is necessary to counsel mothers on the different infant feeding options and assist the mother to make an informed choice.

(B) Pediatric treatment, care and support

The WHO recommends virological testing of infants born from HIV positive mothers within 4-6 weeks of birth. If diagnosed with HIV, ART should be initiated immediately. Provider-initiated testing and counseling (PITC) is recommended to reach HEI who are missed out or lost to follow up. Ascertainment of HIV status is required when the baby stops breastfeeding. The latest ART guidelines recommend testing and counseling by the provider for children with malnutrition, hospitalized children, and children with TB [12]. Children under the age of five years diagnosed with HIV should be initiated on ART regardless of CD4 count and WHO clinical stage. In children aged 5 years and above, ART should be initiated when the CD4 count is less or equal to 500cells/mm^3 regardless of the WHO clinical staging. ART should also be initiated in children with severe or advanced symptomatic disease or in children who are presumed to have HIV.

The challenges in pediatric treatment, care and support include; poor linkage between early infant diagnosis and initiation of treatment, dependence on the caregiver, and loss to follow up (which is more pronounced in children who do not yet meet the criteria for ART initiation) [15]. Infant and child care depends on the commitment of the caregiver(s). Infants and children face unique challenges to adherence. Various factors can affect the rate of adherence of children to medication. These include; failure by caregivers to understand instructions on medication, adverse effects, lack of continuity of care, pill burden, and lack of variety of pediatric formulations.

Adolescent and Youth HIV Programming

Globally, there were 2.1 million new infections in 2013 [16] with third of these infections occurring among youth 15-24 years old [10]. In 2009, there were 5 million youth living with HIV. Of this, 65% (3.2 million) were young women between the ages of 15-24 years [17].

The level of comprehensive correct knowledge of HIV is still low among youth (15-24 years old) especially in sub-Saharan Africa. In 2014, only 30% and 37% of young women and men had comprehensive correct knowledge of HIV respectively [3]. Condom use amongst youth is also low with only 40% and 59% of young men and women aged reported to have used condoms during their last sexual encounter. Similarly, the uptake of HCT is low among young people. In sub-Saharan Africa, only 10% and 15% of young men and women aged between 15 and 24 years knew their HIV status [18]. It was estimated that only 29% of girls and 20% of boys aged between 15-19 years were aware of their HIV status in Eastern and Southern Africa in 2013 [4].

The transition to adulthood brings about various pressures that increase the risk of contracting HIV. It is at this stage that children start experimenting with drugs and alcohol, initiating sexual activity, and also experimenting and identifying with different sexual orientations [19]. Young people have a low perception of risk and may not perceive themselves to be vulnerable to HIV.

Adolescents face numerous barriers in accessing HIV services ranging from; stigma (from others and self) and discrimination especially in the adolescent key populations, strict testing laws and policies (where adolescents cannot access testing HIV services like testing without parental consent or presence), lack of adolescent-friendly HIV services, lack of pediatric-friendly ART formulations, and difficulties in transitioning from pediatric HIV services to adult services [20,21]. Challenges facing adolescents infected perinatally include disclosure, adherence to treatment, sexual and reproductive health issues, and transitioning from pediatric to adult HIV services [19].

UNAIDS recommends three categories of interventions in adolescent and young people HIV programming [22]:

1. **Basic programs:** Provision of ART, condom distribution, PMTCT, voluntary medical male circumcision (VMMC), Social and behavior change programs, and specific interventions for the key populations.
2. **Critical enablers:** HIV sensitive laws and policies, HTC, community engagement, cash transfers, capacity building and strategic planning for community organizations, increase access to legal services, strengthen laws and policies affecting access to HIV services (e.g. parental consent laws), social protection, and M&E focusing on adolescents and youth.
3. **Development synergies:** Interventions that reduce vulnerabilities and empowering the youth (e.g. education), incorporation of gender-sensitive interventions, addressing sexual and gender-based violence, and addressing violence towards young PWID by law enforcement.

(A) Youth-friendly services

Adolescents are usually left out in HIV services: they are too young to benefit from adult services and at the same time too old to utilize pediatric services. The increased number of AIDS-related adolescents is due to lack of prioritization of adolescent needs in national level plans, reduced access to appropriate youth HIV services and inadequate support to ensure adherence and retention in care [22]. There is a need to provide HIV services which are accessible and acceptable to young people, which are affordable, and in a convenient location where confidentiality is maintained [23]. An effective youth program is one which increases HIV knowledge and awareness and develops life skills, provides access to HIV services and creates an enabling environment which promotes human rights of young people, addresses gender inequalities, and ensures participation of adolescents including ALHIV [24].

(B) HIV Prevention

Prevention programs should be aimed at delaying sexual debut, promoting safer sex and reducing risky behavior. An effective and comprehensive prevention strategy entails programs aimed at school-going adolescents, health providers, and parents. It needs to include STI prevention and treatment, social marketing aimed at adolescents, building of skills, and case-finding and reduction among ALHIV [25]. Encouraging behavior change and increasing access to HIV services are vital in prevention of HIV among adolescents. The

needs of the youth vary from country to country and region to region. Successful HIV prevention for the youth requires a multi-sectoral approach.

Young people have low perception of HIV risk and require accurate information on the risks of HIV and how they can reduce their vulnerabilities. Access to this information early enough before initiation of sexual activity is important, especially for young women. This has been seen in several studies that report girls engaging in anal, oral and manual sex in an attempt to preserve their virginity, not knowing that anal sex increases the risk of acquiring HIV. Condom use among young people is remains low. Usage is especially lower among young women as compared to men (condom use at last sex was 40% vs. 59%) [3]. Age-disparate heterosexual relationships are common in SSA countries and are characterized by low condom use and risky sexual behavior [26]. Young women in these relationships are often unable to effectively negotiate condom use.

Sex education has been shown to reduce age of sexual debut and increase the use of contraceptives and condoms [27,28]. Risky sexual behavior is reduced when sex education is offered in schools by adults and integrated in the school curriculum. Sex education has also been shown to reduce number of sexual partners as well as high risk sexual behavior. Comprehensive sex education entails promotion of delayed sexual debut and information on family planning including use of condoms. Out-of-school programs are equally important. To date, 57 million of primary school age children are not enrolled in school [3]. In 2013, 124 million children aged 6-15 years never started or dropped out of school. More than half of these were young adolescents aged 12-15 years) [29]. The majority of out-of-school children aged 6-11 years are found in SSA (51%) while most out of school adolescents live in South and West Asia (40%). Thirty million out-of-school young adolescents are living in SSA. This group of out-of-school children and adolescents will not be reached by school programs. However, only 61% countries in 2008 with generalized epidemics had out-of-school sex education programs while less than 70% had no school based sex education [30].

Key characteristics of an effective sex education program [31] include: teaching by by trained teachers, adapted to the specific reproductive needs of the young people to receive the education, the activities are sensitive to the values of the community, it addresses barriers to protected sex and how to overcome these barriers, and involves participatory teaching methods.

(C) HIV Testing and Counseling (HTC)

HTC is the entry point for HIV services. Testing rates among the adolescents are low, with only less than 1% of adolescents aged 15-19 years having tested and gotten their results in South Asia in 2012; and 29% of girls and 20% of boys aged 15-19 years in Eastern and Southern Africa [4]. The age of HTC consent should be reduced to allow adolescents to access testing services. In the USA, the CDC recommended that HIV testing of adolescents to be incorporated into routine medical care [32]. This will lead to testing of more adolescents in the because informed consent from a guardian and pretesting counseling will no longer be necessary.

(D) Voluntary medical male circumcision (VMMC)

Research shows that circumcision of 15-49 years and ensuring 80% coverage could avert 3.36 million new HIV infections through 2025 [33]. Uptake of VMMC has been greater among adolescents 10-19 years than any other age group [34]. Increased uptake by adolescents can be explained by peer pressure, increased targeting of VMMC towards adolescents (increased campaigns during school holidays) and cultural appropriateness (VMMC is viewed as a rite of passage in traditionally circumcising communities) [35]. VMMC at this early age is beneficial because uptake is high among adolescents due to the lack of pressure from female partners or issues of abstinence before healing takes place [36-38]. VMMC can be utilized as an entry point for adolescent HIV and sexual and reproductive services.

Adolescents facing barriers when accessing services

Three groups of adolescents are more likely to face these barriers in accessing HIV services: adolescent girls, adolescent key populations, and ALHIV. When parents die or are ailing from HIV, some adolescents take up the role of caregiver for their families, especially for girls and young women. This usually impacts their physical and psychological development negatively and makes them more at risk of HIV [39].

(A) Adolescent girls

An estimated 380 000 adolescent girls and young women globally are newly infected with HIV annually. More than 80% of these are living in sub-Saharan Africa. In 2013, an estimated 40% of new infections in young people occurred among young men. Two-thirds of new infections among adolescents 15-19 years occur among adolescent girls [4]. Young men aged 15-24 years living in sub-Saharan Africa are half as likely to be living with HIV as compared to young women of the same age. Girls and young women are more vulnerable to HIV infection and poorer outcomes of HIV, with prevalence in adolescent girls aged 15-19 years increasing significantly by the ages of 20-24 years (Figure 1). This can be explained by the high rates of intergenerational relationships, especially in sub-Saharan Africa. In South Africa, one-third of adolescent girls who are sexually active are in a relationship with a partner who is more than five years older compared to 4% of adolescent boys. Low socioeconomic status, violence and high illiteracy levels have been associated with increased vulnerability to HIV. In South Africa, adolescent girls and young women who have experienced violence from their partners are 1.5 times more likely to acquire HIV as compared to young women who have not experienced violence [40].

Despite the high prevalence of HIV and higher number of new infections in adolescent girls compared to boys, girl-specific interventions have not been given much focus. Lack of sex age- and sex-disaggregated data also makes it difficult to determine high impact interventions for the adolescent girls. A multi-sectoral approach is required in designing and planning interventions for the adolescent girls. Interventions that are aimed at creating an environment that allows for provision of health services to girls, provision of girl-specific information and services, and provision of a good support system [41].

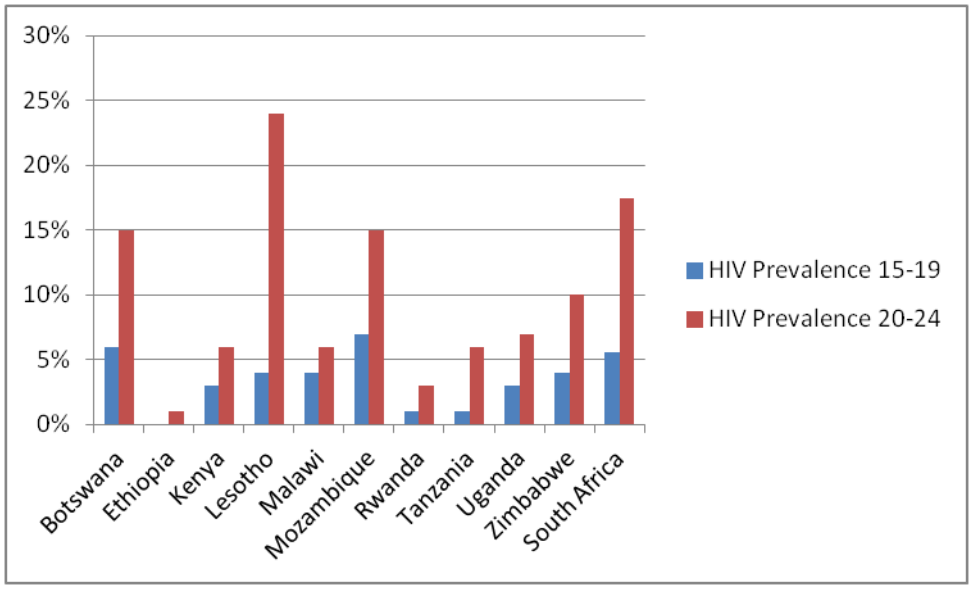

Figure 1 *Estimated HIV prevalence among adolescent girls and young women (2014 country estimates)*

Creating an enabling environment entails:

- **Increasing literacy levels of adolescent girls:** School fees and cash transfers (to both school going and out of school adolescents) reduce school dropout rates. Cash transfers have been shown to improve school attendance among school-going girls, reduce early marriages and pregnancy rates in out-of-school girls [42]. Increased literacy of girls reduces their vulnerability to HIV infection [43].
- **Promoting gender-equitable norms:** This requires interventions from the national level (policy makers) to the community level (community leaders and members) and the involvement of mass media. Interventions can be aimed at changing attitudes of people in regards to gender issues.
- **Legislation for girls' protection:** Early marriages are still prevalent in most developing countries. Niger, Mozambique, Malawi, Somalia, Zambia and Nicaragua are in the top twenty countries with high child marriage rates [44]. In Bangladesh, marriage below the age of 18 years in women is illegal however 78% and 88% of women aged 20-49 years were married before 18 years and 20 years of age respectively [45]. Laws should be put in place and reinforced to protect girls against early marriages which increase their vulnerability to HIV via reduced chances for continuing with education, intimate partner violence and lack of final say in health seeking behaviors. Laws on parental consent need to be revised: age of consent can be reduced to facilitate access to HIV services for adolescents.

(B) Adolescent key populations (AKP)

Adolescent key populations are adolescent males who have sex with other males, adolescents who inject drugs and sexually exploited adolescents [4]. Sexually exploited children and adolescents who sex in exchange for money, food, goods or other favors [46]. They should not be regarded as sex workers and need to be programmed for accordingly. Adolescent key populations have higher HIV prevalence as compared to other adolescents [47] and are more at risk of contracting HIV and other sexually transmitted infections (STI).

Due to the criminalization of sex between males, use of injectable drugs and sex in exchange for money or other benefits; adolescent key populations face stigma and discrimination, violence from the public and police, laws on age of consent which limit access HIV services, and have limited access to HIV services due to fear. HIV services for adult key populations are not usually customized to the needs of adolescent key populations while the adolescent services are oblivious of the needs of the adolescent key populations.

Service delivery towards the AKPs should be provided in a way that factors in the diverse needs and causes of vulnerabilities in adolescents. A combined approach is required in an effective response to HIV among the AKPs. WHO recommends a comprehensive package of interventions consisting of provision of essential health services interventions and creating an enabling environment for provision of the services.

Adolescents have low perception of risk and AKPs are more likely to get involved in activities that put them at risk of contracting HIV. This could be attributed to low comprehensive knowledge on HIV. Adolescents also have a strong urge to experiment at this stage but the decision making skills are still underdeveloped. HTC is pointless if adolescents found to be HIV positive are not linked to HIV treatment and care. Enrolment into HIV care services is faced with barriers like stigma associated with attending a HIV clinic, fear of disclosure and lack of family support [48].

(C) Adolescents living with HIV (ALHIV)

Only a few numbers of young people are aware of their HIV status. HIV programs have failed to effectively reach adolescents and retain them in care. HIV programs with no adolescent-friendly services have worse treatment outcomes [49]. With the scale up of ART among children, more children born with HIV are surviving into adolescence and are more likely to present with symptoms during this stage of life [39]. A comprehensive approach that addresses the needs and vulnerabilities of adolescents is required.

In adolescents, transition from childhood to adulthood can be a period of great turmoil. It can be especially difficult for ALHIV who have to live with the fear of disclosure, stigma and discrimination, thus the need for psychosocial support which includes adherence counseling. Adolescents seldom have a daily routine which makes it even harder to stick to a strict medication regimen. It is also at this age that the adolescents start experimenting with drugs which may negatively influence adherence to ART. Adverse effects due to drugs, lack of clear links between pediatric and adult HIV services, forgetting to take medication and lack of health insurance all affect adolescents' adherence to medication [50]. Capacity building of health workers in attending to adolescents and especially those from the key populations is necessary to facilitate treatment adherence and retention in care [51].

3. Methods

Global Fund recipient countries submit concept notes (proposals) detailing their funding request to the Global Fund. These concept notes, when recommended by the Technical Review Panel (TRP), proceed to the grant making stage where they are translated to disbursement-ready grants. The negotiated grants are then reviewed by the Grants Approvals Committee (GAC) before forwarding to the Global Fund Board for approval. When approved, grant agreements outline the program indicators of those interventions authorized for funding by the Global Fund.

We conducted an in-depth analysis of HIV, HIV-TB, and integrated concept notes submitted by the countries under the NFM along with their grant agreements. Our main aim was to determine the extent to which the needs of children were included in the countries' concept notes and indicators for monitoring performance. This will give us a picture of whether children are being prioritized by the countries.

Each concept note was reviewed to determine the inclusion of children-focused interventions. These are interventions which have been shown to be effective via studies or recommended by WHO, UNAIDS, and UNICEF amongst others. Interventions were identified via literature review. The interventions include: prevention of mother-to-child transmission (Prong 1-4); pediatric treatment, care and support; adolescent services including HTC, ART provision and BCC, family planning and VMMC; critical enablers like laws and policies; and development synergies like addressing sexual and gender based violence.

We analyzed a total of 22 concept notes[2] (HIV, HIV-TB, and integrated concept notes) which had been submitted to the Global Fund under the new funding model. Concept notes were picked at random while maintaining regional representation, and taking into account the regional burden of disease (Figure 2).

Twenty concept notes had been approved by the GF Board at the time of analysis. Two concept notes had not been approved at the time of analysis; Kenya and Malawi. Our analysis focused on the funding request and modular template (Section 3 of the concept note). Analyses did not include the epidemiologic situation of the countries, information on the national funding landscape, sustainability and implementation arrangements

We also analyzed all 16 available grant agreements[3]. Analysis of grant agreements focused on the Performance Framework Template which contains an overview of the program's goals, objectives, indicators and targets. The Fund uses the Template to measure performance of the principal recipient (PR) to ensure efficient use of funds. We screened the grant agreements for indicators which; (i) were child-focused including adolescents, (ii) mentioned children as part of the broader PLHIV community, and (iii) focused on pregnant women.

[2] Zambia, Zimbabwe, Malawi, Gambia, Senegal, Mozambique, Kenya, Tanzania, Uganda, Rwanda, Sudan, Niger, Somalia, Ukraine, Moldova, Russia, Thailand, Mongolia, Philippines, Nicaragua, Paraguay, and Costa Rica.

[3] Countries with grant agreements; Zambia, Zimbabwe, Gambia, Tanzania, Somalia, Senegal, Rwanda, Russia, Costa Rica, Thailand, Moldova, Ukraine, Philippines, Niger, Nicaragua, and Paraguay

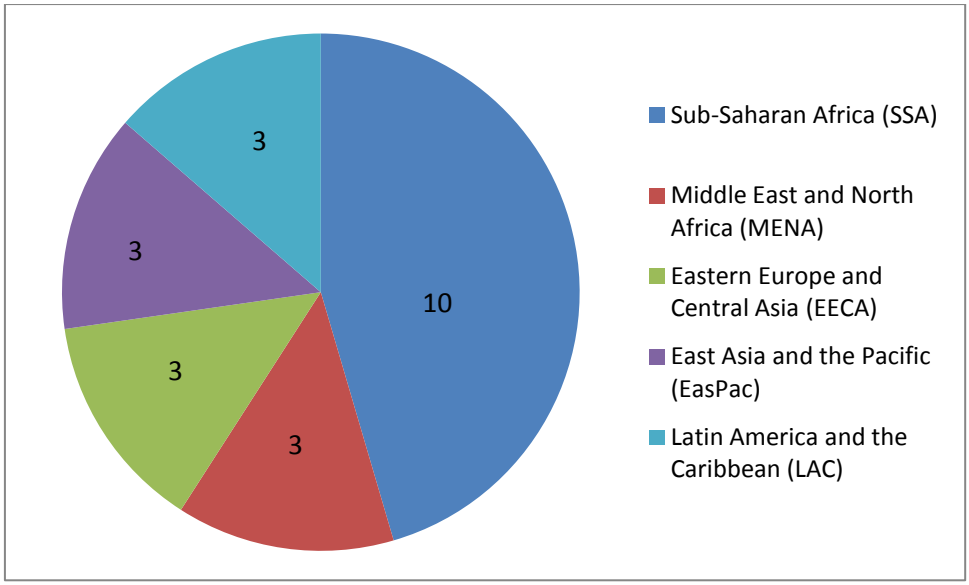

Figure 2 *Regional distribution of analyzed concept notes*

The following search terms were used to define the population of interest; child, children, under-five year old(s), pediatric, infants, babies, younger children, adolescent(s), adolescent girls, girl(s), boy(s), adolescent boys, young people, youth, young women, young men, young key populations, adolescent key populations, young MSM, young injecting drug users, young people who inject drugs, young most-at-risk persons, pregnant women, vulnerable children and orphans, school going children, out-of-school youths.

The following search terms were used to identify interventions of interest; prevention of mother-to-child transmission (PMTCT), voluntary medical male circumcision (VMMC), economic support, cash transfers, educational support, behavior change communication (BCC), psychosocial support, nutritional support, school programs, out-of-school programs, child protection, social protection, youth-friendly services, adolescent-friendly services, reproductive health, peer education, early sexual debut, condom use, transactional sex, age-disparate relationships, legislation, gender based violence.

The interventions were categorized into 5 broad intervention areas; (i) PMTCT, (iii) pediatric HIV treatment, care and support, (iii) adolescent services, (iv) laws and policies, and (v) gender-based violence. Each broad area contained a number of specific elements as outlined in Table 1. A total of 47 specific elements were defined (details in Table 1).

Table 1 *Broad intervention areas and specific elements*

Broad Intervention Elements	Specific Elements

PMTCT	• Prong 1
	  ○ Condom provision
	  ○ Information, education and communication regarding HIV prevention
	  ○ STI/Syphilis screening and management
	• Prong 2
	  ○ Family planning services
	• Prong 3
	  ○ HIV testing and counseling
	  ○ ART for pregnant and breastfeeding mothers
	  ○ Nutritional support for pregnant and breastfeeding mothers
	  ○ Early infant diagnosis
	  ○ Infant prophylaxis
	  ○ Infant feeding counseling and support
	  ○ Follow up of mother and child
	• Prong 4
	  ○ Family approach: Involvement of men/partner and/or children
	  ○ Support groups
	  ○ Capacity building of health workers
	• PMTCT among key populations

Pediatric HIV treatment, care and support	• HIV testing and counseling • PITC • ART • Adherence counseling • Cash transfers • Nutritional support • Transport allowance • Psychosocial support • Educational support
Adolescent services	• HIV testing and counseling • ART • Adherence and disclosure counseling • School programs • Out-of-school programs • Peer education and social groups • Use of mass media • Integrated HIV and sexual reproductive health services • Family planning • Voluntary medical male circumcision • Condom provision • Capacity building of health workers • Gender-specific interventions • IEC • Specific interventions towards adolescent key populations

Broad Intervention Elements	Specific Elements
Laws and policies	• Laws and policies
Gender-based violence	• Community sensitization • Health care workers sensitization • Policies and laws • Reporting mechanisms • Prevention programs • Management of sexual violence • Multi-sectoral approach • Psychosocial support

4. Findings

Distribution of broad and specific intervention areas

Of the 22 concept notes analyzed, 8 (36%) contained interventions which covered 3 broad intervention areas. Five (23%) concept notes included 4 broad interventions and only 4 (18%) concept notes contained all five broad intervention areas. None of the concept notes contained all 47 specific intervention elements. Only one concept note (Thailand) contained no interventions specific to children. Most (82%) concept notes included PMTCT although those grant agreements with corresponding indicators were fewer (56%). Pediatric treatment, care, and support indicators were the most prevalent (88%) and were present in 14 of the 18 analyzed grant agreements. While 16 (73%) concept notes mentioned broad adolescent services, only 9 (56%) of the corresponding grant agreements contained indicators for these services. GBV interventions were present in less than half (10) of the concept notes reviewed with no indicators in the grant agreements. Only 8 (36%) of the concept notes mentioned child-specific laws and policies with no corresponding indicators (Table 2).

Table 2 *Number and percentage of HIV-related concept notes and grant agreements containing broad child-focused intervention areas and indicators*

Broad intervention areas	No. of concept notes	% of concept notes	No. of grant agreements with indicators	% of grant agreements
PMTCT	18	82	9	56
Pediatric treatment, care, and support	17	77	14	88
Adolescent services	16	73	9	56
Laws and policies	8	36	0	-
GBV	10	45	0	-

Prevention of mother-to-child transmission (PMTCT)

Prong 3; which includes HTC, ART for pregnant and breastfeeding mothers, early infant diagnosis, and other elements was the most represented element of the overall PMTCT recommended set of interventions (Table 3). At least one element of Prong 3 was included in 77% (17) concept notes with 50% of the grant agreements including relevant programmatic indicators. ART for pregnant and breastfeeding mothers was the intervention with the most coverage in Prong 3. The least common intervention in Prong 3 was nutritional support during antenatal care, and was present in only 2 concept notes. No corresponding indicator was included in the grant agreements. Infant feeding counseling and support and infant prophylaxis were included in 3 and 8 concept notes respectively with indicators for infant prophylaxis present in only one concept note. Although at least one element of Prong 4 was included in 12 (55%) concept notes, only one element (the family approach - involvement of men/partner and/or children) had a corresponding indicator. This indicator was present in a

single grant agreement. Prongs 1 and 2 were present in 9 concept notes. Coverage of indicators for both these prongs was poor with only 1 grant agreement containing a single indicator (STI/syphilis screening). PMTCT amongst key population was mentioned in 2 concept notes but no indicators were present in the grant agreements analyzed (Table 3).

Table 3 *Number and percentage of concept notes with PMTCT elements, and number and percentage of grant agreements with indicators corresponding to the elements*

Recommended interventions	Number of concept notes	% of concept notes	No. of grant agreements with indicators	% of grant agreements
Prong 1 (at least one element is included)	9	41	1	6
• Condom provision	2	9	0	-
• IEC	4	18	0	-
• STI/Syphilis screening	4	18	1	-
Prong 2				
• Family planning	9	41	0	-
Prong 3 (at least one element is included)	17	77	8	50
• HTC	13	59	6	38
• ART for pregnant and breastfeeding mothers	17	77	7	44
• Nutritional support during antenatal care	2	9	0	-
• Early infant diagnosis	13	59	7	44
• Infant prophylaxis	8	36	1	6
• Infant feeding counseling and support	3	14	0	-
• Follow up of mother and child	8	36	0	-
Prong 4 (at least one element is included)	12	55	1	6
• Family approach: Involvement of men/partner and/or children	8	36	1	6
• Support groups	4	18	0	-
• Capacity building of health workers	9	41	0	-
PMTCT among key populations	2	9	0	-

More than half (50% or more) of all concept notes included HTC, ART for pregnant and breastfeeding mothers, and early infant diagnosis (Table 4). Less than 21% of concept notes analyzed contained, condom provision during PMTCT, distribution of PMTCT relevant IEC materials, syphilis screening, nutritional support, infant counseling and support, and PMTCT amongst key populations (Table 4).

Table 4 *Distribution of PMTCT elements in concept notes*

0%	1 - 20%	21 - 49%	50% +
	Condom provision	Family planning	HTC
	IEC materials on PMTCT	Infant prophylaxis	AR T for pregnant and breastfeeding mothers
	Syphilis screening	Follow up of mother and child	Early infant diagnosis
	Nutritional support during pregnancy	Family approach: involvement of male partners and children	
	Infant counseling and support	Capacity building of health workers	
	PMTCT among key populations		

Pediatric treatment, care, and support

Pediatric ART provision was present in 16 (73%) of the concept notes analyzed (Table 5). Corresponding indicators were present in 12 (75%) grant agreements. HTC and/or PITC was present in 7 (32%) concept notes although corresponding indicators were not present in any grant agreements. Though present in only 4 (18%) of concept notes, pediatric adherence counseling indicators were present in 88% of the grant agreements analyzed. Both psychosocial and nutritional support were present in more than a quarter of concept notes (36% and 27%) but had no indicators within the grant agreements. Other interventions which are designed to enable the caregiver to provide better support to the affected child, such as cash transfers, transport allowances, and educational support were present in less than 10% of all concept notes analyzed (Table 5).

Table 5 *Number and percentage of concept notes with pediatric-focused elements, and number and percentage of grant agreements with indicators corresponding to the elements*

Recommended interventions	No. of concept notes	% of concept notes	No. of grant agreements with indicators	% of grant agreements
HTC/PITC	7	32	0	-
ART provision	16	73	12	75
Adherence counseling	4	18	14	88
Cash transfers	1	5	0	-
Nutritional support	6	27	0	-
Transport allowance	1	5	0	-
Psychosocial support	8	36	0	-
Educational support	2	9	0	-

Pediatric ART was by far the intervention with the most coverage (Table 6). Nutritional and psychosocial support, as well as both voluntary and provider initiated HTC were present in more than 20% of all concept notes (Table 6).

Table 6 *Distribution of pediatric elements in concept notes*

0%	1 - 20%	21 - 49%	50% +
	Adherence counseling	Nutritional support	ART provision
	Cash transfers	Psychosocial support	
	Transport allowance	HTC/PITC	
	Educational support		

Adolescent services

Adolescent-focused HIV interventions were mentioned far less than PMTCT and pediatric interventions. The most popular intervention for this group was school programs, with 10 (45%) concept notes mentioning them (Table 7). This contrasted with only 3 (19%) of the grant agreements containing any indicators for these programs. Out-of-school programs, and peer education/social groups were the second most common interventions mentioned. Both were present in 8 (36%) concept notes although neither had indicators in the grant agreements. Although the range of adolescent interventions was quite diverse, HTC indicators were the most common, they were present in only 4 (25%) grant agreements. condom provision, integrated HIV/SRH services, family planning, and capacity building of health workers are all important in the prevention, care, and treatment of adolescent HIV. These interventions did not have any indicators in the grant agreements (Table 7).

Although mentioned in 6 (27%) concept notes, the use of mass media (social, print, electronic) to reach adolescents did not have any corresponding indicators. 17 (77%) concept notes did not describe the production of IEC materials aimed at adolescents, while 11 (50%) did not mention any gender-specific interventions - which are very important within this age-group.

Table 7 *Number and percentage of concept notes that contain specific adolescent-focused elements, and number and percentage of grant agreements with indicators corresponding to the elements*

Recommended interventions	**Number of concept notes**	**% of concept notes**	**No. of grant agreements with indicators**	**% of grant agreements**
HIV Testing and Counseling	6	27	4	25
ART services focusing on adolescents	4	18	0	-
Adherence and disclosure counseling	4	9	0	-
School programs	10	45	3	19
Out-of-school programs	8	36	0	-
Peer education and social groups	8	36	0	-
Use of mass media (social, print or electronic media)	6	27	0	-
Integrated HIV and SRH services	5	23	0	-
Family planning	4	18	0	-
VMMC	2	9	1	6
Condom provision	7	32	0	-
Capacity building of health workers	7	32	0	-
Gender-specific interventions				
Girls	8	36	0	-
Boys	1	5	0	-
Non-specified	2	9	0	-
None	11	50		

Recommended interventions	Number of concept notes	% of concept notes	No. of grant agreements with indicators	% of grant agreements
IEC				
Girls	1	5	0	-
Boys	0	0	0	-
Non-specified	4	18	0	-
None	17	77		
Adolescent key populations				
Female sex workers and sexually exploited children	0	0	0	-
Men who have sex with men(MSM)	3	14	1	6
Injecting drug users (IDUs)	1	5	0	-
Transgender (TGs)	1	5	0	-

None of the defined adolescent specific elements were present in more than 49% of the concept notes reviewed (Table 8). Less than 21% of the concept notes contained interventions for adolescent key populations. None of the concept notes contained interventions focused on the needs of sexually exploited adolescent girls.

Table 8 *Distribution of adolescent specific elements in concept notes*

0%	1 - 20%	21 - 49%	50% +
Interventions towards sexually exploited adolescent girls	Adherence counseling	HTC	
IEC materials focused on adolescent boys	Family planning	Gender-specific interventions (Girls)	
	VMMC	School programs	
	Gender-specific interventions (Boys and non specified)	Out-of-school programs	
	IEC materials for both boys and girls	Use of mass media	

0%	1 - 20%	21 - 49%	50% +
	Interventions for adolescent key populations (MSM, IDUs, TGs)	Integrated HIV and SRH services	
	ART services	Condom provision	
		Capacity building of health workers	

Some countries described other interventions which would also target adolescent key populations:

- **Paraguay** Plans to implement prevention programs for MSM and transgender adolescents, as well as implement activities to scale up access of health services by men and **adolescents**.
- **Moldova** A prevention program for PWID and their partners will expand services to provide needle exchange, condom distribution, targeted information for PWID and their sexual partners, overdose prevention, and would specific services for females and **adolescent PWID**. This program would also provide counseling and referral to VCT, STI prevention, OST, legal advice, and provision of on-site integrated services
- **Philippines** A program to develop of preventive behaviors amongst MSM which reduces the risk of HIV infection would include activities aimed at delaying sexual debut amongst **young men aged between 12-17 years**.
- **Nicaragua** Amongst MSM and TG individuals, planned activities aimed at which strengthening a network of promoters leading the sexual majority diversity movement including **young people** and **adolescents**; others at strengthening a network of **student counselors**; and strengthening community networks of **adolescents and young people**.

Critical enablers

Critical enablers enhance the HIV response for optimal effectiveness. With the presence of these enablers, the impact of HIV interventions may be reduced. The development and/or implementation of laws and policies which protect human rights were described in 8 (36%) of the concept notes reviewed (Table 9). Details included:

- **Zambia** Removing legal barriers such as the prohibition on the distribution of condoms in school settings below tertiary level, and the legal age of consent for HIV testing.
- **Philippines** Advocating for legislation which would reduce the legal age for anonymous HIV testing (currently those under 18 years of age need parental approval).
- **Rwanda** Providing legal services to protect human rights of PLHIV and OVCs
- **Ukraine** Removing legal barriers in receiving reproductive health services and adopting children for PLHIV.

- **Uganda** Addressing harmful socio-cultural and gender norms.
- **Senegal** Providing legal assistance to children living with HIV (CLHIV) ALHIV.
- **Malawi** Development and dissemination of gender transformative and rights based guidelines and tools targeting girls, women, and boys to combat GBV, early child marriage, intergenerational and transactional sex, masculinity, and culture. Sensitization of police on the importance of appropriately addressing domestic and sexual violence cases in the context of HIV, training HCWs and police on GBV prevention
- **Gambia** High level advocacy to lobby the National Assembly to pass the HIV Prevention and Control Bill into law. In the bill ministries responsible for Basic and Secondary Education, Higher Education and Health shall ensure that students are educated on HIV/AIDs in public and private schools at basic, secondary and higher levels, including formal, non-formal and indigenous learning systems.[4]

None of the grant agreements contained any indicators for the suggested laws and policies (Table 9).

Table 9 *Number and percentage of concept notes with critical enablers and number and percentage of grant agreements with indicators*

Recommended critical enablers	No. of concept notes	% of concept notes	No. of grant agreements	% of grant agreements
Laws and policies to protect human rights (e.g. age of consent, child protection)	8	36	0	-
Gender based violence interventions				
Community sensitization	7	32	0	-
HCW sensitization	7	32	0	-
Policies and laws	4	18	0	-
Reporting mechanisms	0	-	0	-
Prevention programs	2	9	0	-
Management of sexual violence	5	23	0	-
Multi-sectoral approach	5	23	0	-
Psychosocial support	3	14	0	-

With regards to the response to GBV, sensitization of the community and HCW were the most commonly mentioned interventions (Table 9 and 10). Reporting mechanisms for GBV were not described in any of the concept notes analyzed. Management of sexual violence and a multi-sectoral approach were describe in 5 (23%) concept notes. Psychosocial

[4] http://observer.gm/hivaids-prevention-control-bill-2015-passed

support was described in only 3 (14%) concept notes (Table 9). None of the GBV interventions had any indicators in the grant agreements.

Table 10 *Distribution of critical enablers in concept notes*

0%	1 - 20%	21 - 49%	50% +
Reporting mechanisms	Laws and policies	Laws and policies (child protection, age of consent)	
	Psychosocial support	Community sensitization (GBV)	
	Prevention programs	HCW sensitization (GBV)	
		Management of sexual violence (GBV)	
		Multi-sectoral approach (GBV)	

Child- and Adolescent-focused indicators

Grant agreements were searched for indicators specific to children and/or adolescents. In many cases the indicators for these age groups were included as part of broader age groups (shaded gray) (Table 11). Most indicators were treatment and care indicators with few prevention-related indicators. Two (13%) of the grant agreements had no specific indicators for children, while 7 (44%) had none for adolescents (Table 11). PMTCT was best represented when it came to indicators; 50% (8) of the grant agreements contained the indicator "Percentage of HIV-positive pregnant women who received ART to reduce the risk of mother-to-child transmission". Most indicators which would provide information on children were concerned with ART and were for adults and children. 14 (88%) of the grant agreements included the indicator "Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy". HIV prevention-related indicators for adolescents were present in less than 15% of all grant agreements reviewed. Only 2 (13%) of the grant agreements included indicators for HIV education in schools, while a single grant agreement contained an indicator for both in and out of school programs.

Table 11 *Number and percentage of grant agreements that contain children-focused indicators*

Indicators	**No. of grant agreements**	**Percentage (%)**
Children		
No indicator	2	13%
Percentage of children 0-14 currently receiving antiretroviral therapy among all children living with HIV	3	19%
Percentage of orphans and vulnerable children (until 17 years old) who benefited from free external support for treatment according to national guidelines	1 (Senegal)	6%
AIDS-related mortality (Children less than 5 years)	1 (Zimbabwe)	6%
Percentage of adults and children currently receiving antiretroviral therapy among all adults and children living with HIV	11	69%
Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	14	88%
Number of adults and children living with HIV who receive care and support services outside facilities	1	6%
Percentage of adult and children living with HIV enrolled in HIV care and support at the end of the reporting period	1	6%
Percentage of adults and children living with HIV with an undetectable viral load	1	6%
Percentage of adults and children that initiated ART, with an undetectable viral load at 12 months	2	13%
Adolescents		
No indicator	7	44%
Percentage of young people aged 15–24 who are living with HIV	6	38%
Percentage of young people aged 10–24 years reached by life skills–based HIV education in schools	2	13%
Number of MARCY (young MSMs) reached by HIV/AIDS prevention activities	1 (Philippines)	6%
Percentage of young people aged 15-19 years reached by life skills–based HIV education in and out of schools	1 (Nicaragua)	6%
Percentage of orphans and vulnerable children (until 17 years old) who benefited from free external support for treatment according to national guidelines	1 (Senegal)	6%

Indicators	No. of grant agreements	Percentage (%)
Number of male circumcisions performed according to national standards	1	6%
Number of women and men aged 15+ who received an HIV test and know their results	4	25%
% of women and men aged 15-49 years who have had more than one sexual partner in the past 12 months who used a condom during their last sexual intercourse	3	19%
% of women and men aged 15-49 who have had sexual intercourse with more than one sexual partner in the last 12 months	2	13%
HIV incidence among 15-49 age group	2	13%
PMTCT		
No indicators	7	44%
Percentage of HIV-positive pregnant women who received ART to reduce the risk of mother-to-child transmission	8	50%
Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	7	44%
Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months	3	19%
Percentage of pregnant women who know their HIV status	6	38%
Percentage of infants born to HIV-infected mothers who are infected	1	6%
New HIV infections among children	1	6%
Percentage of antenatal care attendees tested for syphilis	1	6%
Percentage of exposed infants who are HIV-free by 18 months	1	6%
Percentage of male partners tested for HIV whose pregnant women attended antenatal care	1	6%
Percentage of women attending antenatal care	1	6%

☐ Child-/adolescent-specific indicators

▒ Indicators where children/adolescents are included as part of the broader age groups

Allocation and above allocation distribution of interventions

Eleven concept notes; 9 from SSA (Malawi, Senegal, Mozambique, Zimbabwe, Zambia, Rwanda, Kenya, Tanzania, and Uganda) and 2 from MENA (Somalia and Sudan), were reviewed for where children- and adolescent-related activities and programs were placed. Activities placed within the country's allocation are most likely to be funded. Activities placed within the above allocation part of the funding request are subject to further justification and the availability of extra funding. This means that above allocation requests are less likely to be supported, and can be considered a rough indicator of the country's priorities. Most community based prevention activities were places in the above allocation request for Malawi (Table 12). These activities included those that promoted uptake of PMTCT, youth friendly services, and development of guidelines and tools targeting women and girls. In Somalia, economic support to OVC was placed in the above allocation request. While BCC, family planning, and GBV for youth was placed within the allocation in Mozambique, this was in a limited area. Expansion of these services into 14 additional districts was placed in the above allocation request. In the Zimbabwe concept note, the only within allocation activities for adolescents were capacity building of school health masters and BCC. Sudan placed their entire adolescent service activity in the above allocation request (Table 12).

Table 12 *Description of elements included under the allocation or above allocation of the funding request by various countries (Some countries have not been included because they did not specify if the interventions were under the allocation or above allocation)*

Country	Broad intervention area	Allocation	Above allocation
Malawi	PMTCT	HTC/PITC; Follow-up of mother and child; Early infant diagnosis; and implementation of option B+; Training and supporting mother groups;	Community based activities to promote uptake of PMTCT; Peer support groups; and male involvement interventions
	Pediatric treatment, care and support	Procurement of ARVs; PITC in immunization and under 5 clinics and OVC;	
	Adolescent services		Promotion of youth friendly services in health facilities
	Laws and policies & GBV	Sensitization of police on importance of appropriately addressing domestic and sexual violence cases in the context of HIV; training of HCWs and police on GBV prevention	Developing and disseminating gender transformative and rights based guidelines and tools targeting girls, women and boys to combat GBV, early child marriage, intergenerational and transactional sex, masculinity and culture
Senegal	Pediatric treatment, care and support	ART provision	

Somalia	Pediatric treatment, care and support		Economic support to OVC
Mozambique	Adolescent services	Behavior change for in and out of school youth, Family planning, GBV	Expanding coverage of the same interventions to an additional 14 districts
Zimbabwe	PMTCT	Implementation of option B+; early infant diagnosis and early infant treatment; procurement of commodities; testing and counseling of male partners; behavior change interventions	Promoting sexual and reproductive health rights of women living with HIV; mobile HTC; FP counseling services; disseminating messages via SMS to increase uptake of treatment services for infants; motorbikes for transportation of EID samples in hard to reach places; peer-to-peer support to reduce loss to follow up; SMSs to mothers (both pregnant and non-pregnant), their partners and the community; capacity building of health workers on PMTCT including KPs; community ambulances for PMTCT
	Pediatric treatment, care and support	Scaling up pediatric ART; HTC	Transition to WHO treatment guidelines 2013 to cover more children; training of primary counselors to provide quality counseling for VMMC, child counseling and eMTCT; OVC support; Training of child care workers in psychosocial support for CLHIV
	Adolescent services	Capacity building of School health masters, BCC	In school and out of school youths (HIV prevention, treatment and care); training of trainer of trainers (TOT) and behavior change facilitators in tertiary and higher learning institutions;
Sudan	Adolescent services		Youth module-targeting youth at universities and higher education institutes: information; BCC; STI diagnosis and management; HTC ($810 699)
	Pediatric treatment, care and support	Increasing Rx coverage for children, adherence; nutritional support	Complete procurement of pediatric ART; school fees; pediatric ART training for medical doctors
	PMTCT		PMTCT-Prong 1 ($116789); Prong 3 ($3828027); Prong 4 (85 335)

Zambia	Adolescent services	HTC among in- and out-of-school youth in high risk areas; VMMC targeting 15-34 year-olds ($3.7m); Use of innovative counseling SMS platform; Sexual and reproductive kits (male and female condoms, water-based lubricants, an emergency pill and IEC leaflets on combination prevention); capacity building in advocacy, demand creation, and peer-to-peer service provision of the sexual and reproductive health kits; peer-to-peer training in social and behavioral change communication (SBCC);	VMMC($15.7m)
	PMTCT (All interventions under allocation request)	Implementation of option B+; Follow up and adherence counseling; capacity building; Family planning counseling and referral; strengthening community engagement to promote early ANC attendance; EID	
	Pediatric treatment, care and support	Scaling up of pediatric ART; adherence counseling; psychosocial support including disclosure counseling;	Pediatric ARVs; expand Mwana project to accelerate ART access for children and adolescents by improving commodity security for BDS bundles shortening turnaround time for results; procure mobile phones for SMS technology, payment for SMS costs; outsource a courier system for transporting BDS bundles
	Laws and policies	Review of legal and regulatory framework in the HIV context with respect to stigma and discrimination; women and gender; children and young people	
	GBV	Gender awareness training for key stakeholders; strengthening coordination mechanism to address gender equality, human rights, and women's empowerment; empowering young women and girls as catalysts of change; implementation of prioritized strategies	
Rwanda	PMTCT	ART for HIV positive pregnant mothers; Follow up of exposed infants for 18 months; family planning; training and production of new tools according to new PMTCT guidelines	Rehabilitation of infrastructure (maternity and health centers; CHWs support; IEC materials and community outreach activities for general population.

	Adolescent services		Institutional support for youth friendly centers; activities targeting youth and support to Anti-AIDS Clubs
	Pediatric treatment, care and support	Educational support to OVCs;	
	Laws and policies	Legal services to protect human rights of PLHIV and OVCs	Implementation of startup capital for selected cooperatives including PLHIV and institutional support to the National Commission for Children, the national agency in charge of coordinating OVC support
Kenya	Adolescent services	HTC testing including young women and girls; "keeping girls in school" campaign; BCC($2.3m): mass media (electronic and print); promoting condom use;	
	GBV	Addressing issues around GBV and multiple concurrent partnerships; sensitize the police on Post Rape Care (PRC) and PEP; train service providers on Post Rape Care	
	PMTCT	Family planning; integrating FP services, PMTCT, reproductive health care, TB screening and MCH services; capacity building of health workers; IEC materials and job aids targeting FP; Implementation of option B+; Prong 4;	Not requested
	Pediatric treatment, care and support	All interventions are supported for the high burden countries	Above allocation is for the national level
Tanzania	Adolescent services	SBCC; HTC; condoms; STI screening; (Interventions in 10 high prevalence regions) Others with no above allocation: in- and out-of-school programs	Same interventions in 6 regions with rising prevalence
Uganda		ARVs for PMTCT (life-long ART for HIV infected pregnant women)	Life-long ART for additional HIV infected pregnant women; treatment irrespective of CD4 count for selected populations including children; Primary prevention interventions for MARPs and youth in- and out of school;

Zambia included comprehensive adolescent and youth services within their allocation request (Table 12). The activities described included HTC for in and out of school youth, SMS counseling, SRH kits, and peer training. Zambia also included a review of the legal

and regulatory framework in the context of HIV, and various GBV activities within the country's allocation request. In Rwanda, adolescent services were placed in the above allocation request although educational support and legal services to OVCs were placed with the allocation request. Kenya placed various adolescent services and GBV interventions in the allocation request. These included a campaign to keep girls in schools and sensitizing the police on post rape care (PRC). Tanzania placed some adolescent services, and in- and out-of-school programs in their allocation request whereas Uganda placed their youth activities in the above allocation request.

5. Conclusions

In a recent analysis in the Lancet, investments in child health programs has led to 34 million children's lives being saved since 2000 [54]. With the rise of new HIV infections in children and young people and HIV being the cause of the second most common cause of adolescent death globally, it is imperative that HIV programs are designed to respond to the unique needs of children and young people as well as given priority in country responses to HIV/AIDS. The Global Fund is one of the largest contributors of funding for the fight against HIV. With its participatory and country-led model of funding, the Global Fund expects recipient countries to prioritize and rationalize their funding requests for the best health outcomes.

Analysis of 22 concept notes and 16 grant agreements indicate that children and young people are not being adequately prioritized under the new funding model. Interventions which have proven to be effective in addressing the needs of children and young people (from birth to 24 years) were categorized. Concept notes and grant agreements were analyzed for the inclusion and rationalization of these interventions.

By far, the most common intervention to be included in concept notes and grant agreements was PMTCT. Although PMTCT was present in 82% of concept notes, the single component (Prong 3) which includes HTC and ART for pregnant and breast feeding mothers was the most represented element. Other components of PMTCT which are not biomedical but support the success of biomedical interventions were not covered in the majority of concept notes. Pediatric treatment, care, and support was present in 73% of concept notes. As with PMTCT, emphasis was on ART provision, with less than 50% of concept notes including other interventions which are important in supporting the care of HIV infected infants and children such as adherence counseling and nutritional support.

Adolescent-focused HIV interventions were poorly represented in the concept notes and grant agreements analyzed. While in-school programs were mentioned in 45% of concept notes, those interventions aimed at adolescents and young people out-of-school were less common. Comprehensive HIV and SRH services targeting young people were rarely mentioned. Adherence support interventions for infected children and young people were also poorly represented. Communication on health and HIV to young people needs to be highly targeted and requires modes of transmission which are popular with this demographic. Utilization of popular media was rarely mentioned in the concept notes analyzed. As well as being influenced by their peers, the vulnerabilities of young people are heavily affected by their gender. The role of gender norms and vulnerability to HIV is well documented. Despite this evidence, 50% of the concept notes analyzed did not propose any gender-specific interventions for young people. Only four concept notes proposed interventions which would target adolescent key populations, none of which were from SSA countries. Although eight of the concept notes proposed activities which would improve critical enablers such as laws and policies which protect the rights of young people and those affected by HIV, these activities did not have any indicators in the grant agreements.

The inclusion of children and adolescents in general treatment and care indicators in grant agreements points to the poor prioritization of this demographic. Poor representation of

prevention-related indicators for adolescents (present in only 15% of grant agreements) is another sign of low prioritization of young people. Further evidence of poor prioritization was the indicated by the fact that the majority of community-based prevention activities which would improve the targeting of children and adolescents were placed in the above allocation portion of the funding request.

While this study analyzed only 22 concept notes and 16 grant agreements, the regional representation of the concept notes, along with the comprehensive review of proposed interventions provides insight into whether the HIV-related needs of children and young people are likely to be met. This study provides evidence of gaps in HIV programs which agrees with those that were mentioned by stakeholders during Global Fund partnership forums held in 2015. With recent calls to focus on the needs of the most vulnerable, including girls and young women, the Global Fund needs to provide better guidance on how recipient countries can improve their HIV response to do so. While the focus on biomedical interventions is important in the fight against HIV, more emphasis on interventions which support the success of biomedical interventions as well as those which reduce the likelihood of acquiring the virus is required.

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