THEIR FUTURE IS ON THE LINE

THE COST OF INACTION ON HIV FOR CHILDREN



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Acknowledgements

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Maria, 5, walks with her parents, Nataliia and Yevhen, after taking part in a UNICEF health session in Ukraine.
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Cover Photo
Christine Banda (20 years old) with her son Anff Sakala (2) outside Chainda Urban Health Centre in Lusaka, Zambia. The clinic plays a vital role in supporting young mothers through free HIV testing, counselling, and services to eliminate HIV transmission from mother to child. For young women like Christine, Chainda provides trusted, compassionate care close to home, helping them stay healthy and protect their children. ©UNICEF/UNI905831/Holing

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Foreword

For more than three decades, the world has responded to the HIV epidemic with compassion, determination, and unity. Together, we have prevented millions of new HIV infections and saved countless mothers and children from AIDS-related deaths. These achievements stand as a testament to what global solidarity can accomplish.

Yet, despite the progress we have made, too many children are still being left behind. Every day, new mothers become infected with HIV during pregnancy or breastfeeding, and their children are born into risk — too many without access to testing or treatment. The consequences are heartbreaking. Without treatment, half of all children perinatally infected with HIV will die by the age of two. Four out of five will not live to see their fifth birthday. In 2024 alone, approximately 200 children died every single day from AIDS.

The findings of *The Cost of Inaction on HIV for Children* are both urgent and devastating. At the current rate of progress, by 2040 we would still have 1.9 million new HIV infections and 990,000 AIDS-related deaths in children. But if funding for HIV prevention and treatment continues to fall as current trends suggest, the world could face an *additional* 1.1 million new HIV infections and 820,000 *additional* deaths by 2040. In this worst-case scenario, by 2040, three million children would acquire HIV and nearly 1.8 million would die of AIDS-related causes — the vast majority in sub-Saharan Africa. These are not statistics; they are children with dreams, families, and futures. They represent our shared humanity — and our collective failure if we do not act.

We know what works. We have the tools, the science, and the knowledge to end AIDS in children. What we lack is the unwavering political and financial commitment to finish the job. We must safeguard the gains we have made in the HIV response, and we must re-ignite the drive and commitment that helped make progress possible.

This report serves as a call to action — and a warning that we could be facing a possible resurgence of increased infection and catastrophic numbers of deaths. The health, dignity, and survival of children living with or affected by HIV depends on our collective resolve to sustain and expand the progress of recent years. Governments, donors, civil society, and the private sector must come together with renewed purpose and investment.

Children should never pay the price of global inaction. With unwavering commitment, shared responsibility, and sustained investment, we can and must deliver on the promise of a future free from HIV for every child, everywhere.

Executive summary

In the past two decades, HIV prevention and treatment programmes have reduced the numbers of children acquiring HIV or dying of AIDS-related causes, with the strongest gains made in Eastern and Southern Africa. Without sufficient resources allocated to HIV prevention and treatment, these gains are at risk of being lost. UNAIDS, UNICEF and Avenir Health examined the potential impact of a 50% reduction in intervention coverage – a plausible outcome if current funding cuts and related disruptions continue – on new HIV infection in children through vertical transmission and AIDS-related deaths in children.

The study quantifies the potential human cost of reduced HIV programme coverage for children by examining different scenarios. In the best-case scenario, resources for the HIV response are sufficient to achieve global targets and an estimated 410,000 [350,000 – 530,000] HIV infections and 520,000 [460,000 – 570,000] AIDS-related deaths in children would be *averted* between 2025 and 2040.

A second scenario highlights that at the current rate of progress, we would have 1.9 million new HIV infections and 990,000 AIDS-related deaths in children over 15 years.

In the worst-case scenario, a 50 per cent reduction in intervention coverage for prevention and treatment programmes would result in an estimated *additional* 1.1 million [1 million – 2 million] children acquiring HIV, and an *additional* 820,000 [720,000 – 920,000] children dying from AIDS-related causes by 2040.

If we consider the current rate of progress and a 50 per cent reduction in intervention coverage, the world would see three million children acquire HIV and nearly 1.8 million die of AIDS-related causes by 2040 — the vast majority in sub-Saharan Africa.

Investments to prevent vertical transmission of HIV and AIDS-related deaths in children yield enormous benefits for children, families and societies. In 2025, sudden and unexpected external funding cuts by major donors to the HIV response began undermining intervention coverage and impacting children's health and wellbeing. While affected countries and communities are responding with resilience, renewed global commitment, a strengthened and more sustainable global health architecture, continued growth in domestic expenditures, and sustained external financing combined with responsible transition planning are required to protect these hard-won gains. Children deserve nothing less.

The cost of inaction on HIV for children

Steady gains made towards ending AIDS in children in the last 25 years

By the end of 2024, the world had made tremendous progress to end AIDS in children. Decades of hard work, global solidarity, and innovation had reduced the numbers of children (<15 years) acquiring HIV or dying of AIDS-related causes to their lowest points since the 1980s. HIV prevention and treatment services averted an estimated 4.4 million HIV infections in children and 2.1 million child AIDS-related deaths between 2000 and 2024[1]- one of the great public health feats of recent decades.

The total number of children acquiring HIV fell from over half a million (560,000) [390 000 – 820 000] in 2000 to about 120,000 [82 000 – 170 000] in 2024 and AIDS-related deaths among children were reduced from 370,000 [240 000- 510 000] to 75,000 [50 000- 110 000] in the same period.[2] Those gains were especially significant in sub-Saharan Africa, where 86 per cent of children living with HIV reside, and which globally accounts for 83 per cent of new infections in children and 84 per cent of AIDS-related deaths in children.[3] In eastern and southern Africa, which has almost 60 per cent of the global HIV burden in children, HIV infections in children were reduced by 85 per cent and AIDS-related deaths in children by 86 per cent between 2010 and 2024.[4]

As of late 2025, 21 countries and territories had been certified for eliminating vertical transmission of HIV and/or syphilis,[5] and Maldives became the first country in the world to achieve elimination of vertical transmission of all three diseases in October 2025. Two countries with large epidemics have been certified as being on the path to elimination (Botswana and Namibia), a major feat considering the scale of this undertaking in countries with a high burden of HIV.

Evolving trends in funding for the HIV response

The contribution of external funding support to the HIV response cannot be underestimated.

Country Responses

Despite significant funding cuts, countries are demonstrating remarkable leadership and innovation to safeguard hard-won gains in the paediatric HIV response—examples of these efforts are highlighted on page 13.



Impact of U.S. President's Emergency Plan for AIDS Relief (PEPFAR)

The United States (U.S.) government has provided the largest bilateral funding for the global HIV response, including through its flagship HIV programme, the President's Emergency Plan for AIDS Relief (PEPFAR). PEPFAR has been a major contributor to progress toward achieving an AIDS-free generation. Since its launch in 2003, PEPFAR has saved 26 million lives and prevented 7.8 million new infections in children across 55 countries.[6] As of September 2024, PEPFAR was supporting antiretroviral treatment (ART) for 20.6 million people, including 566,000 children; providing HIV testing services for 64.7 million people; reaching 2.9 million adolescent girls and young women with HIV prevention services[7]; and supporting 270,000 health workers.[8]

PEPFAR's rigor in programme design, implementation and monitoring contributed to strengthening health systems in partner countries. These investments in health system strengthening have been of particular importance as countries address new public health crises, including COVID-19 and Ebola.

Total funding for HIV in low- and middle-income countries held relatively steady from 2013 to 2022 and began dipping in 2023–2024, with the decline accelerating sharply in 2025 because of sudden reductions in key external financing (see Figure 1). Hidden in that general trend, though, were two profound shifts. First, domestic funding for HIV rose significantly to exceed 50% of resources available for HIV programmes in those countries. Second, bilateral funding for HIV programmes from donor governments other than the U.S. and those contributing to the Global Fund to Fight AIDS, Tuberculosis and Malaria fell steeply, from US$ 2 billion in 2011 to US$ 370 million in 2023, particularly as several major donors (the U.S., France, the United Kingdom, Germany, Japan) and other countries channelled funds through the Global Fund. Overall financing for HIV programmes therefore would have been considerably lower were it not for high levels of funding from the U.S. Government, countries contributing to the Global Fund, and rising domestic funding.[9,10]

According to reports from 68 low- and middle-income countries on programme level spending to the Global AIDS Monitoring, the U.S. government provided nearly half (49.2%) of all external funding for efforts to prevent vertical transmission of HIV.[11] Analysis of data from 22 low- and middle-income countries (2019–2024) shows that about 60 per cent of their HIV testing services and almost 80 per cent of their prevention programmes were primarily funded by the U.S. government.[12]

Evidence indicates that, contrary to the assumption that external donor financing discourages domestic investment, many countries supported by external donors progressively assumed greater fiscal responsibility for HIV services.[13] For example, a 52 per cent rise in financial contributions from the U.S. government between 2010–2024 was accompanied by a 62 per cent growth in domestic resources for HIV among countries supported by the U.S. government.[14] This suggests that donor support has been a catalyst for domestic financing of both HIV and broader health systems. Domestic financing slowed after the COVID-19 pandemic in 2020, with only a modest uptick observed in 2024.



Community Health Group Ebolowa District, Cameroon showcasing Community mentors' work.
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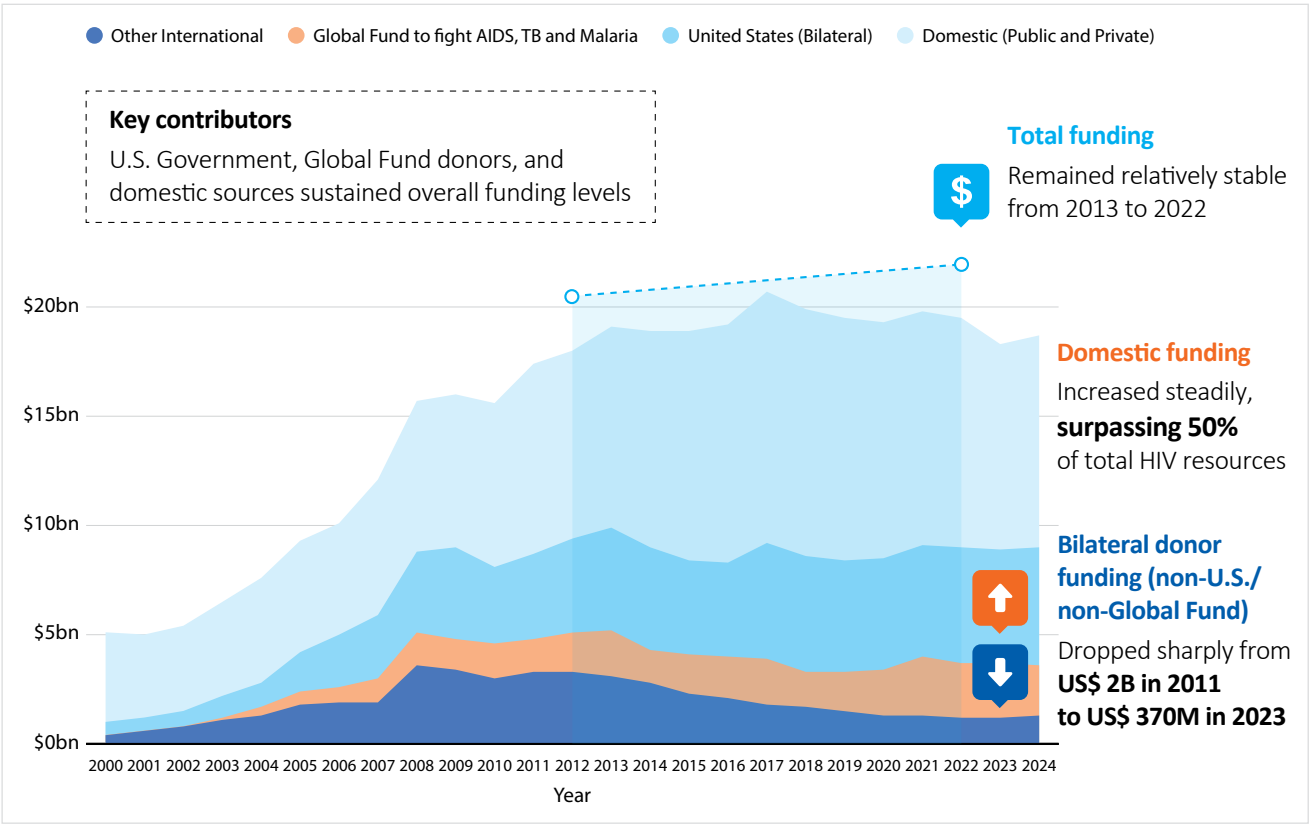
Figure 1. Trends in resource availability for HIV by funding source (constant 2019 US $ BN) – all low- and middle-income countries



Source: UNAIDS Financial estimates July 2025

Modelling the impact on children of HIV funding

The projected toll of reduced HIV investment on children

Recent modelling studies highlight the importance of continued funding for the HIV response.[15,16,17,18,19] One study estimated that discontinuing U.S. funding could result in 4.1 million additional AIDS-related deaths from 2025 to 2030 across 55 countries, with 350,000 of these deaths occurring in children.[20] The study also estimated an additional 7.5 million new HIV infections, of which 820,000 would occur in children.

Concerned about both the immediate and longer-term impact of sustained HIV funding cuts and programme slow-downs on children's health and well-being, UNAIDS, UNICEF, and Avenir Health modelled different scenarios using data from historical programme coverage and 2025 UNAIDS epidemiological estimates. (See Annex 1 for more detail on the methodology and different scenarios).

The study compares different levels of coverage for key high-impact interventions, including prevention of vertical transmission (PVT)[21], antiretroviral therapy (ART) for children and adults, condom availability, and voluntary medical male circumcision (VMMC). The results are in line with similar analyses.[22,23] From best- to worst-case scenario, the modelling demonstrates the dramatic impact that reduced resources, driven by ongoing funding cuts and related disruptions, leading to reduced intervention coverage can have for children (see Figures 2 and 3). Details of all scenarios, including scenarios based on PMTCT and paediatric ART scale up only are elaborated in Annex 1.

The modeled scenarios

Best-case scenario: Global targets met (full scale-up of interventions)

Coverage for all interventions (PVT, Paediatric ART, Adult ART, Condoms, VMMC) reaches the target values proposed for the next Global AIDS Strategy (2026–2031) by 2030 and is maintained through 2040.[24]

If these high-impact interventions are scaled up to meet global targets, then 410,000 [350,000 – 530,000] new HIV infections and 520,000 [460,000 – 570,000] deaths in children would be averted and we will be closer to ending AIDS for children.

Trend: Steep decline

410,000 [350,000–530,000] **infections averted**

520,000 [460,000–570,000] **deaths averted**

Status quo scenario: Current coverage maintained

Adequate resources allow for coverage for all interventions to remain constant at a 2024 level through 2040.

In this status quo scenario, 1.9 million new HIV infections and 990,000 deaths would occur in children.

Trend: Flat trend | **1.9 million infections projected** | **990,000 deaths projected**

Worst-case scenario: Intervention coverage reduced by 50%

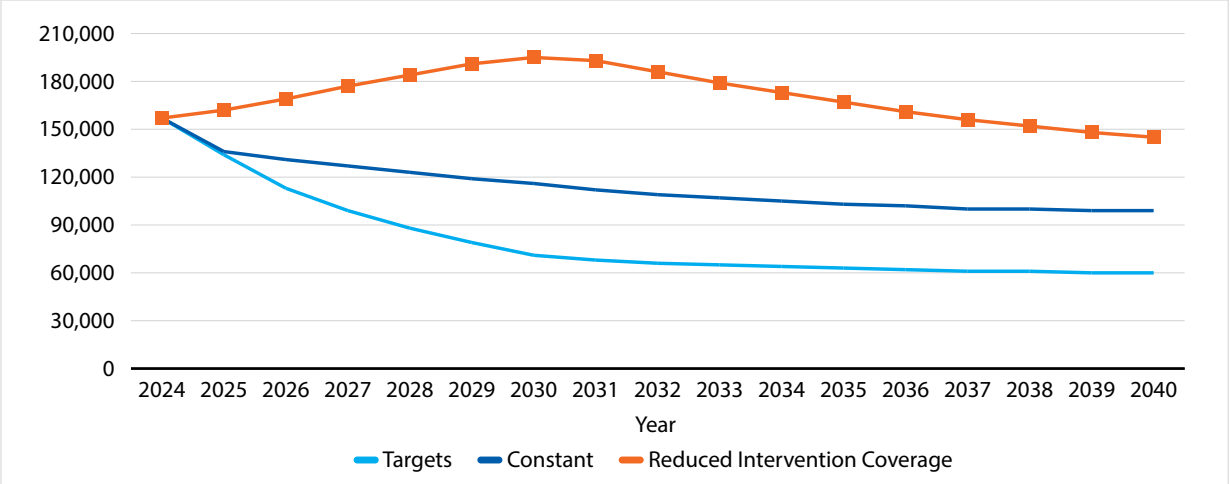
Reduced resources leading to reduction in coverage for all interventions by 50 per cent by 2030 and remains at that level through 2040.

In this worst-case scenario, funding cuts and related disruptions persist, leading to significant declines in service delivery and reduced coverage of all interventions. As a result, beyond the status quo scenario, an *additional* 1.1 million [1 million – 2 million] children could acquire HIV by 2040. The vast majority - 910,000 - of those additional HIV infections would occur in sub-Saharan Africa.

In this worst-case scenario, an *additional* 820,000 children [720,000 – 920,000] could die of AIDS-related causes by 2040. Almost 65 per cent of those deaths would occur in sub-Saharan Africa. This would represent an estimated *75 per cent increase* from 75,000 [50,000-110,000] (<15 years old) in 2024 to a total of 1.7 million children's lives lost between 2025-2040.

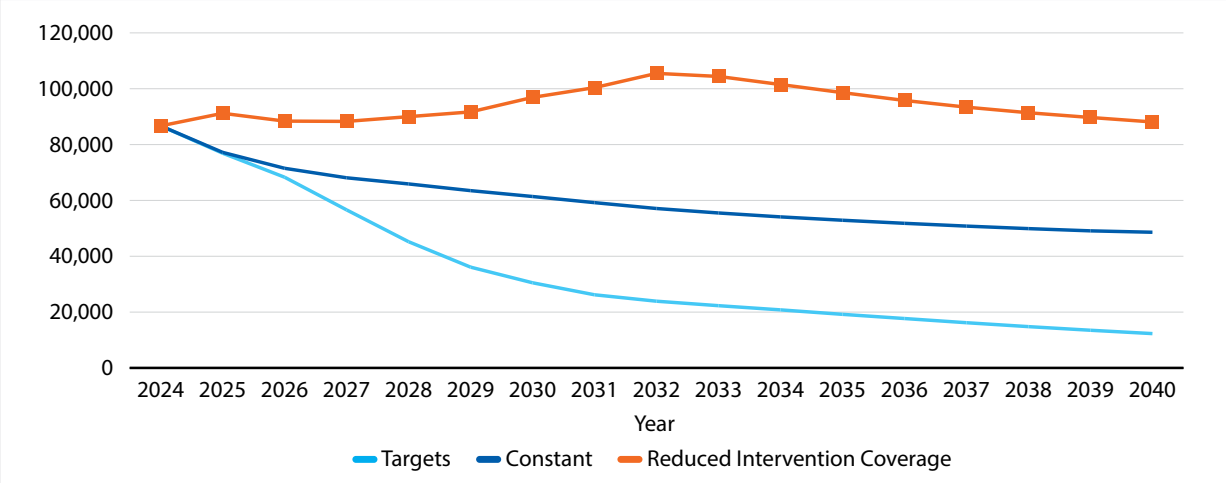
Trend: Sharp rise | **1.1 million additional infections** 910,000 in sub-Saharan Africa | **820,000 additional deaths** 65% in sub-Saharan Africa

Figure 2. Estimated numbers of **new HIV infections in children** (0-14 years) annually across **three** scenarios



Source: Projections by Avenir Health using 2025 UNAIDS epidemiological estimates

Figure 3. Estimated numbers of **AIDS-related deaths in children** (0-14 years) annually across **three** scenarios



Source: Projections by Avenir Health using 2025 UNAIDS epidemiological estimates

If funding for HIV prevention and treatment continues to fall as current trends suggest...

...the world could face an *additional* **1.1 million** new HIV infections and **820,000** *additional* **deaths**.

By 2040 in this worst case scenario...

3 million
children would acquire HIV

1.8 million
would die of AIDS-related causes

UNAIDS has estimated that, if U.S. funding for HIV programmes (including via the Global Fund) were to end *entirely*, international assistance for HIV responses in low- and middle-income countries would fall by 73 per cent,[25] equivalent to ~35–50 per cent of total HIV resources when factoring in domestic shares. There are also concerns that the decrease in U.S. funding for HIV might be accompanied by further reductions in funding from other major donors, including via the Global Fund (which has been reducing country budgets in recent years during its "grant cycle 7").[26,27] In light of these developments, the analysis's assumption of a possible 50 per cent reduction in overall intervention coverage (accounting for partial mitigations) was prescient.

It is important to note that the modeling provides conservative estimates of the likely impact of reduced intervention coverage. The analysis did not explicitly factor in secondary consequences such as the loss of health-care staff due to terminated contracts, stock-outs of essential HIV drugs and other products, delays in laboratory services, closures or erratic functioning of health facilities, loss of confidence in the health care system, disrupted community systems, and more – all of which can undermine the availability, quality and continuity of a broad range of health services. Consequently, the actual impact of the coverage reduction scenario on children's overall health and well-being is likely to be even more severe than that shown in the analysis.

Reduced funding is impacting efforts to end AIDS in children

The progress made over the past 25 years in preventing vertical transmission of HIV and saving the lives of children who do acquire HIV has been due mainly to three impressive accomplishments:

- vastly expanded access to life-saving antiretroviral medicines for women living with HIV
- reductions in the numbers of women of reproductive age who acquire HIV thanks to prevention efforts
- a steady, though slower, increase in access to paediatric HIV testing and treatment

While these achievements were impressive, paediatric HIV outcomes still fell short of global goals and urgent acceleration was needed to end AIDS as a public health threat for children. Instead, programmes have been derailed.

A sudden reduction in external funding in early 2025 for the HIV response is having a profound impact on the availability, affordability and quality of HIV and health services in many countries and threatens to undo decades of progress against the HIV pandemic in children. If left unremedied, the consequences could be devastating for efforts to protect children against AIDS.

Essential diagnostic, prevention, care, and treatment services, information systems, and supply chains are being defunded, scaled back, or badly disrupted.[28] The effects extend beyond HIV and are adding a strain to health programmes generally, putting the health and lives of mothers and children at risk.[29,30]

Countries in sub-Saharan Africa report that staffing at hospitals and clinics and within communities has fallen precipitously. Donor support helped train and remunerate cadres of health assistants and community health workers who perform HIV testing, link individuals to treatment and prevention services, and support them to take their daily medicines.

Community-based peer support has been widely scaled back or discontinued, making it more difficult for mothers and children to access HIV services and support.[31] The loss of community outreach is especially difficult for pregnant adolescents and young women in eastern and southern Africa who represent approximately one-quarter of PMTCT clients[32] and who face unique barriers to accessing HIV diagnosis, care and treatment.[33]

Funding and staff losses have weakened laboratory services, including samples transport, that are essential for HIV diagnosis and treatment and the information systems that are necessary for planning, procurement, service provision and monitoring. The uncertainty of future supplies has led to some countries rationing HIV medicines and related commodities.

In the absence of treatment, children with HIV face high mortality rates...

1 out of 2

children perinatally infected will die by age two

4 out of 5

will die before their fifth birthday [34]



Maria in Gunde, Malawi who is living with HIV with her two children Joyous 6, and Eliza, 2. Thanks to ART through UNICEF supported programmes, both her children were born without HIV. © UNICEF/UNI272920/Schermbrucker

HIV prevention, testing and treatment programmes have been disrupted

High-impact HIV prevention programmes have succeeded in reducing by half the number of adolescent girls and young women acquiring HIV since 2010.[35] However, prevention programmes, including those focused on protecting adolescent girls and young women against HIV, have lost significant funding.[36]

Individuals at risk, including women, can protect themselves against acquiring HIV by taking antiretrovirals as a pre-exposure prophylaxis (PrEP), but reductions in donor funding have reduced availability and access for this prevention tool, with an exception for pregnant and breastfeeding women. Almost one quarter of 56 countries surveyed in late April of 2025 reported having less than six months of condom or PrEP stocks and almost half reported having supply chain management difficulties.[37] PrEP provision has fallen in Botswana, Burundi, Ghana, and Lesotho and steeply declined in Nigeria, Togo, and Uganda (among nine African countries reporting recent monthly data).[38]

HIV treatment coverage among pregnant women living with HIV rose to a remarkable 93 per cent [81% - >98%] in eastern and southern Africa in 2024.[39] The situation is very different in western and central Africa, where only about 56 per cent [47–71%] of pregnant women living with HIV were receiving antiretroviral therapy in 2024.[40] Governments have committed to increasing access to HIV testing and treatment, but the sudden funding changes stand in the way.

Instead, women are experiencing reduced access to testing, delayed HIV diagnosis and treatment initiation, and disrupted prevention services.[41] The number of pregnant women diagnosed with HIV and new initiations on treatment has declined in several countries.[42,43] These declining numbers do not reflect a decline in HIV prevalence, but in access to services.

In many settings, HIV testing and treatment for mothers and children are offered through maternal and child health services, an integrated service modality that has contributed to high rates of HIV diagnosis and treatment for pregnant and breastfeeding women and HIV-exposed children. Reduced donor funding to these essential services jeopardizes efforts to provide these critical services.

Paediatric diagnosis and treatment are at risk

In 2024, globally an estimated 620,000 children living with HIV were not receiving ART. While treatment coverage has improved to 55 per cent [40-73%] in 2024 compared to 17 per cent [12-22%] in 2010, it



Njara, leading a game with his group of friends in Madagascar. © UNICEF/UN0262960/Andrinivo

falls far short of the global target of 90 per cent of children on treatment by 2030. It also indicates an alarming disparity with treatment coverage among adults (78 per cent [62-91%] in 2024).[44]

Early diagnosis of HIV in children, rapid linkage to care and initiation on effective treatment for children who have acquired HIV, and reengagement for those who drop out of care may be top priorities, but in the months following reduced funding, preliminary data from several countries in sub-Saharan Africa reported declines in diagnostic and treatment coverage for children.[45]

Low treatment coverage and high mortality among younger children who are living with HIV can be addressed through wider use of early infant diagnosis (EID) within the first two months after birth for children who have been exposed to HIV. Coverage of EID in eastern and southern Africa reached 74 per cent in 2024 but was a mere 30 per cent in western and central Africa. Since the steep funding cuts in early 2025, levels of EID, viral load monitoring, and initiation to treatment have declined across several countries in both regions of sub-Saharan Africa, increasing the risk of illness and death among children living with HIV.[46, 47]

A little over 80 per cent of children living with HIV are older than two years of age and over one-third (39%) are undiagnosed.[48] Many of the diverse approaches needed to identify, diagnose and link older children living with HIV to treatment are also at risk. They include family-based testing and index testing (which require community outreach services), self-testing and integrating HIV testing with maternal and child health services, all of which have been negatively impacted by reduced funding.

For those children already on treatment, interrupting treatment can be deadly.[49] An assessment in seven African countries found decreasing or stagnant numbers of children receiving treatment during the first quarter of 2025.[50] Rapid assessments also reveal a heightened risk of stock-outs of medicines leading to loss to follow up and drug resistance for children and delays in shifting to newer, more effective HIV medicines. Staff losses, weakened information systems and reduced community outreach make it more difficult to track mother-baby pairs and ensure that children can keep taking their antiretroviral drugs.[51]

Sustaining progress and reimagining the HIV response

Although the sudden reduction in funding took countries by surprise, they are responding with immediacy and innovation, including calling for transformative investments in the HIV response.

Governments are accelerating their pivot toward sustainability and an integrated financing framework that leverages donor investments as a bridge towards self-reliance. Ministries of Health (MoH) are adapting programmes to avoid or reduce service disruptions and assure quality care, including changes to service delivery models, commodity management, resource allocation and data systems.

Despite slow economic recoveries following the COVID-19 pandemic and rising debt repayment burdens,[52] many countries have been increasing their domestic HIV financing and have signalled their intention to continue doing so.[53] Several countries have introduced other mitigating measures, such as amassing buffer stocks of diagnostic test kits, transitioning health workers to the public sector payroll, and training and mentoring remaining health workers to help compensate for staffing shortfalls.[54] Nonetheless, while the resumption of essential life-saving services for children is underway, they are not fully back on track.

Preventing vertical transmission of HIV: A regional call to action

Prevention of vertical transmission of HIV was highlighted as Health Ministers from twenty African Union Member States, development partners and civil society organisations convened at a High-Level Ministerial Conference on Triple Elimination (21-23 June 2025). The Health Ministers issued a Call to Action to address systemic gaps in the prevention, diagnosis and treatment of HIV, Hepatitis B and Syphilis. Emphasizing continental ownership and regional cooperation, meeting participants focused on integration of testing and treatment across antenatal care and maternal, newborn and child health platforms; innovation to strengthen diagnostics, data systems, and delivery; and investment in sustainable domestic financing and local manufacturing.

Country responses

Despite significant funding cuts, countries are demonstrating remarkable leadership and innovation to safeguard hard-won gains in the paediatric HIV response.

Angola

The Government of Angola developed a plan to reallocate domestic funds and prioritise vulnerable populations. The MoH reviewed the national HIV response based on the impact of reduced funding and prioritised interventions focused on ending AIDS in children and medicine supply chain forecasting for **uninterrupted access to essential medicines and supplies**.

Côte d'Ivoire

The Government of Côte d'Ivoire has pledged to allocate **USD 60–65 million** in 2025 and **USD 80–85 million** from 2026 onwards to maintain vital HIV services.

Democratic Republic of the Congo

The Democratic Republic of the Congo (DRC) launched its National Initiative to End Paediatric AIDS, and mobilised **USD 18 million** to close critical funding gaps and scale up interventions to prevent new HIV infections in children, improve paediatric HIV diagnosis and treatment, and strengthen integrated health systems. All 26 provincial governors agreed to dedicate 15% of provincial budgets to health, and 20% of health budgets to HIV programmes, with a focus on children.[55]

Kenya

The Government of Kenya has committed about **USD 9 million** for the distribution of PEPFAR-procured commodities and approximately **USD 60 million** to bridge the commodity gap. Additional HIV funding will be sought through a supplementary budget. An HIV Service Delivery Summit resulted in government-led integration of HIV, including EMTCT, into primary and community health care, with funding support from Social Health Insurance.

Lesotho

The Government of Lesotho convened a special session of Parliament and the Ministry of Finance to endorse and budget for the absorption of health workers onto the government payroll and proposed long-term health insurance to stabilise funding for health services. UNICEF is supporting the MoH to scale up integration of HIV and TB services into primary health care with new training packages. The government and partners accelerated a sustainability plan and adopted a holistic **"child-friendly communities approach"** The National Triple Elimination of Vertical Transmission Strategy 2025-2029 was published, prioritising integrated services despite reduced funding. Collaboration with Botswana and Madagascar continued with the potential transfer of surplus paediatric ARVs to ensure that no child is left behind.

Malawi

Malawi adjusted budget lines to allocate additional funding to HIV and plans to hire **6,000 workers** to offset the funding cuts.[56] The government redeployed and retrained staff from maternal, newborn and child health and paediatric clinics to provide HIV services and restructured the national logistics management system to cover all health commodities, including an integration of sample transports.

Mozambique

Mozambique is transitioning youth-friendly service provider training to a **telehealth format** to reduce training costs and reassigning National Health Service nurses to youth-friendly services, HIV and maternal and child health sites where partner-funded contracts ended.

Nigeria

The Government of Nigeria approved **USD 3.12 million** for procuring HIV treatment and plans an AIDS Trust Fund. MoH simplified data management and reporting systems and harmonized supply chain systems for HIV, TB, and malaria and mobilised state resources to provide support, reassigned human resources, and adjusted drug quantities to limit the risk of stock outs.

South Africa

South Africa allocated emergency funds to close gaps in service delivery. The government's 2025 budget review includes a **3.3% annual increase for HIV and TB**. South Africa plans to upgrade its patient information systems, introducing centralized medicine distribution and stock surveillance.[57] Other efforts include engaging the National Lotteries Commission, advocating for corporate investment, generating local evidence of peer-led models for government adoption, and prioritising high-impact interventions.

United Republic of Tanzania

The United Republic of Tanzania committed to raising more than half of its multisectoral HIV response funding from domestic resources[58] and passed legislative amendments to **introduce new domestic revenue streams**. Under the proposed framework, 70% of additional revenue generated will be remitted to the AIDS Trust Fund to support HIV epidemic control and 30% will be allocated to the universal health fund (inclusive of the HIV response). MoH is committed to maintaining the ARV supply and absorbing retrenched health workers to ensure continuity of care. Civil society and government collaborated to expand capacity to fill service gaps.

Uganda

Uganda secured government commitment of **USD 8.8 million** through June 2025 and **USD 165.4 million** for the fiscal year 2025/2026 to manage the impact of the U.S. funding cuts on its national HIV response.[59] Uganda's integration of HIV into chronic care platforms intensified, as the MoH transitioned to integrated outpatient and chronic care models, reduced reporting, and reorganized clinic spaces to support integrated services. MoH improved forecasting, redistribution, and emergency stock use; prioritised preventing vertical transmission, treatment retention, and pediatric HIV; and leveraged real-time data to close service gaps and guide resources.

Zambia

Zambia expedited developing an **HIV Response Sustainability and Transition Plan** to ensure national ownership of data management systems and other priorities. The MoH developed a costed, Minimum Package for Sustainable HIV Service Delivery which outlines how to sustainably deliver HIV services. The MoH also conducted a costing of all HIV-related services and commodities in order to secure domestic funding.

Zimbabwe

Zimbabwe accelerated development and implementation of its **HIV Response Sustainability and Transition Plan**. Policy Briefs developed with support from UNICEF, UNAIDS and CHAI under the leadership of the Ministry of Health and Child Care (MoHCC) and National AIDS Council include key considerations that would expand human resources for health through a phased domestic financing plan and formalise and strengthen community health cadres into the health system. UNICEF is supporting the MoHCC to roll out integrated outreach and service delivery for paediatric HIV, maternal/child, immunization and nutrition in one province to address the funding problems in paediatric care and to intensify efforts towards closing the paediatric treatment gaps.



An urgent call to action

Governments and the international community need to build on impressive progress and strengthen systems that support life-saving prevention and treatment programmes. The U.S. government's pledge to "prioritize ending mother-to-child transmission of HIV/AIDS" in several high burden countries,[60] bolstered by PEPFAR waivers for essential services, is a critical step, as is the Global Fund's guidance to prioritise elimination of vertical transmission of HIV and maintain investments in treatment.[61]

Countries responded to the sudden funding cuts with quick initial reactions that included some of the mentioned additional financing measures to avoid the worse impacts in the short term, but building a transformed resilient system requires responsible and equitable transitions. The option of increasing domestic HIV funding is not immediately or equally available to all countries. Combinations of debt distress, slow economic growth and underperforming tax systems leave some countries, notably in sub-Saharan Africa, with limited fiscal space.

Changes in funding are a sobering reality that now needs to be used as an opportunity for an accelerated transformation of the HIV response and the health system and services, securing the maximum efficiency going forward, including through the use of Government systems for the deployment of all remaining inflows of foreign aid, and incorporating community services into the public system.

Call to action for countries

Political leadership, commitment, and coordination are essential to protecting the health of children. Countries need to prioritise safeguarding the services and interventions that protect women and children against HIV in all national mitigation, transition and sustainability plans.

A promising new tool in the HIV response

In 2025, twice-yearly injectable Lenacapavir became the first long-acting PrEP option approved by the FDA (June 2025) and several African regulatory authorities for adults and adolescents (≥35 kg). Interim data from the PURPOSE 1 trial showed 100% efficacy in preventing HIV acquisition among pregnant and breastfeeding participants, while PURPOSE 2 confirmed excellent efficacy and tolerability in adolescent girls and young women aged 16–25. With PEPFAR and the Global Fund committing to procure up to 2 million doses by 2028 and explicitly prioritising pregnant and breastfeeding women, Lenacapavir offers a discreet, highly effective option that could accelerate elimination of vertical transmission by averting new maternal seroconversion — provided funding and implementation are sustained. Once roll-out begins, continued commitment to reach tens of millions of people will be required for greater impact.[62]

> Africa's health future must be shaped by African leaders, for African people. To get there, we must ignite a revolution in health financing, one that invests in regional institutions, accelerates local manufacturing, and ensures sustainable systems that serve our communities." [63]

Dr Jean Kaseya
Director General of the Africa Centres for Disease Control and Prevention

More effort and support need to go towards institutionalizing HIV financing within national health budgets, including in emerging financing mechanisms such as health insurance schemes and in evolving health packages, and ensuring that children are considered in all health benefit packages discussions.

Ultimately, domestic financing will be the bedrock of sustainable HIV responses, including for children. Increased domestic financing for health and HIV can be sought through enhanced and innovative revenue collection, improvements in tax administration systems, expanded health insurance schemes, and by ring-fencing budget lines for health. Those adaptations will take time. Blended finance models, which leverage both public and private capital, and debt swaps and relief are among other options for boosting domestic HIV and health funding.[64]

Evidence-based prioritisation is more vital than ever. Countries need to carefully prioritise and allocate resources to programmes, based on both their epidemiological impact and the impact on children.

Programmes to eliminate vertical transmission of HIV and provide paediatric HIV treatment must be treated as core, ring-fenced investments, and paediatric (and other key) HIV interventions must be safeguarded in national health plans.

Funding gaps can be addressed by integrating paediatric HIV programmes more extensively with broader child health and primary health care platforms, without sacrificing quality, as well as selectively pursuing integration to boost the use and efficiency of HIV services.[65]

Call to action for donors, multilateral organisations and other partners

Donors, including global funds and bilateral donors, can and must prioritise allocation of funding and support to ensure HIV funding and programmes prioritise pregnant women living with HIV, children and adolescents.

Donors can protect prevention of vertical transmission programmes for pregnant and breastfeeding women living with HIV and paediatric HIV programmes (including the human resource, capacity-building and supply chain elements) in funding packages.

Donors can work with national governments as true partners on a more sustainable, shock-proof global health model, including predictable funding and innovative financing. Donors can align with countries' priorities by providing supplementary support that expands the packages of services being funded from domestic budgets and serves as a bridge towards greater self-reliance.[66]

Donors can support countries' efforts to progressively expand domestic HIV financing, including through clear, timebound transition compacts that reliably commit funding and other support. Donor support can take a variety of forms, including through the provision of debt relief, debt pauses and debt swaps, and blended financing arrangements.

Donors can lend technical expertise and tools, such as population-based surveys and HIV impact assessments that are applicable across countries and regions.

Non-governmental organisations that supplement governmental services can diversify funding streams (especially with the private sector), streamline operations, and partner with other organisations to pool resources, share costs, and collaborate on action for children.

Multilateral and regional organisations can facilitate regional cooperation, including by promoting and financing pooled procurement and regional manufacturing, improving the negotiating power for the price of commodities and supply chain management of essential HIV commodities, including antiretrovirals.

The U.N. family is uniquely placed to convene and broker agreements between donors and recipient countries that align with national priorities and support evidence-based initiatives at scale. The U.N. needs to strengthen strategic alliances between countries, donors and other stakeholders and mobilise leadership and funding, generate evidence, share technical expertise and learning, and support implementation of accountability mechanisms. The U.N. should increase joint initiatives that build on agencies' comparative strengths and establish synergies that maximise results for children.

Call to action for communities and young people

Communities and young people can continue to spearhead advocacy efforts, especially advocating to remove social and structural barriers that hinder children, adolescents and young people, and pregnant and breastfeeding women's access to services.

These are not statistics; they are children with dreams, families, and futures. They represent our shared humanity — and our collective failure if we do not act.



Mercy and her child Blessing outside the Chainda Health Centre in Lusaka, Zambia.
© UNICEF/UNI905832/Holing

Communities and young people can continue to engage with governments and provide leadership on social accountability, monitoring programmes, providing feedback, and helping to define solutions.

Communities and young people can continue to speak up on key platforms at all levels, ensuring that children's, caregivers', and young people's voices are heard and their concerns are addressed.

Choosing to support or fail children

Having advanced farther than ever to achieving the goal of ending AIDS in children, the world now risks seeing its hard-won gains set back by decades. Such a tragedy must be avoided—and it can, as the "Cost of Inaction" analysis shows. The modelled scenarios demonstrate the stark realities of reduced funding (regardless of the source), stalled progress, and the catastrophic consequences of failing to implement life-saving interventions. The data are clear: the choices donors and governments make today will decide the fates of millions of women and children. It will take continued global solidarity, regional cooperation, increased domestic HIV investments, public-private sector partnerships, and more efficient ways of working to revive the push to end AIDS in children.

Global investments in the HIV response have prevented millions of new infections and deaths – but the job is not yet done. In 2024, an estimated 200 children died every day from AIDS. This loss of life is unacceptable. The time to act is now. We must close the current funding gap and prevent future funding shortfalls to ensure that every child, adolescent, and mother has access to life-saving HIV prevention and treatment services. This study provides the evidence needed to guide policymakers, donors, and global health leaders toward urgent, sustained investment—because action for children is the only option. Their future – and ours – depends on it.



Christophe and Theodette hold their son Kevin, 2 in Rwanda.
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Annex. Methodology and additional scenarios

Data and modelling approach

The analysis used the Goals model within the Spectrum software suite (developed by Avenir Health), a deterministic compartmental model that simulates the impact of HIV interventions. The model was applied to 110 low- and middle-income countries, accounting for 97% of all new HIV infections and AIDS-related deaths in children globally. Regional results were generated to identify the highest-burden settings.

Inputs included:

- Demographic trends from the UN Population Division
- HIV prevalence, incidence, and mortality estimates from national Spectrum files, results of which are available at https://aidsinfo.unaids.org/
- ART and PMTCT coverage from national service providers, Demographic and Health Surveys, and national Population-based HIV Impact Assessments
- Model assumptions validated with national stakeholders and country teams

Eight scenarios were modelled:

- Three historical scenarios (2000–2024): actual trend, no PMTCT, and no HIV programme
- Constant: Constant coverage to 2040
- Global targets: PMTCT scaled to 95%, ART to 90% by 2030
- PMTCT-only scale-up: 95% PMTCT
- PMTCT + paediatric ART: 95% PMTCT and 90% ART by 2030
- Reduced intervention coverage: 50% reduction in all coverage levels by 2030

Limitations

The analysis is based on modelled projections using national-level data. It assumes intervention effectiveness based on existing literature and previous models. Real-world implementation may vary based on health system capacity, sociopolitical factors and service coverage fluctuations.

Also considered was a "100% external funding withdrawal with waiver" scenario, which in practical terms aligns most closely with the "Status quo," or constant scenario in this analysis. That was because, in many settings, external HIV funding ceased but antiretroviral services continued to be provided through waivers. It is important to note that the Goals model does *not* explicitly capture critical secondary impacts observed in real-world contexts, including significant health worker attrition due to termination of contracts, stockouts of essential HIV commodities, widespread facility closures, reduced community- and peer-led support, and more. Those documented disruptions are known to severely undermine service quality and continuity, leading to greater morbidity and mortality than is reflected in the model's assumptions. Consequently, the projected infections and deaths presented under this scenario likely represent *conservative estimates*, and the true impacts are expected to be more severe.

Data ownership and acknowledgements

These data are based on nationally produced epidemiological estimates supported by UNAIDS. This analysis was jointly developed by UNICEF, UNAIDS, WHO, and Avenir Health, using those estimates to produce different scenarios. All projections are derived using Spectrum v6.42 as of July 2025.

Additional scenarios with PMTCT and paediatric ART scale up 2024-2040

Five total future-looking scenarios were modelled to assess the impact of interventions. The two additional scenarios that were modelled included PMTCT scale-up only and PMTCT and paediatric ART scale-up. Details of the two additional scenarios are noted below.

Additional scenario 1
PMTCT and paediatric ART scale-up

PMTCT and pediatric ART coverage increases to 95 per cent and 90 per cent, respectively, by 2030 and is maintained through 2040, while all other interventions remain at 2024 levels.

In this scenario, 335,000 new HIV infections and 420,000 deaths in children would be averted.

Additional scenario 2
PMTCT scale-up only

PMTCT coverage increases to 95 per cent by 2030, then remains at 95 percent through 2040, while all other interventions remain at 2024 levels.

In this scenario, 370,000 new HIV infections and 300,000 deaths in children would be averted.

Figure 4. Estimated numbers of **new HIV infections in children** (0-14 years) annually across **five** intervention coverage scenarios

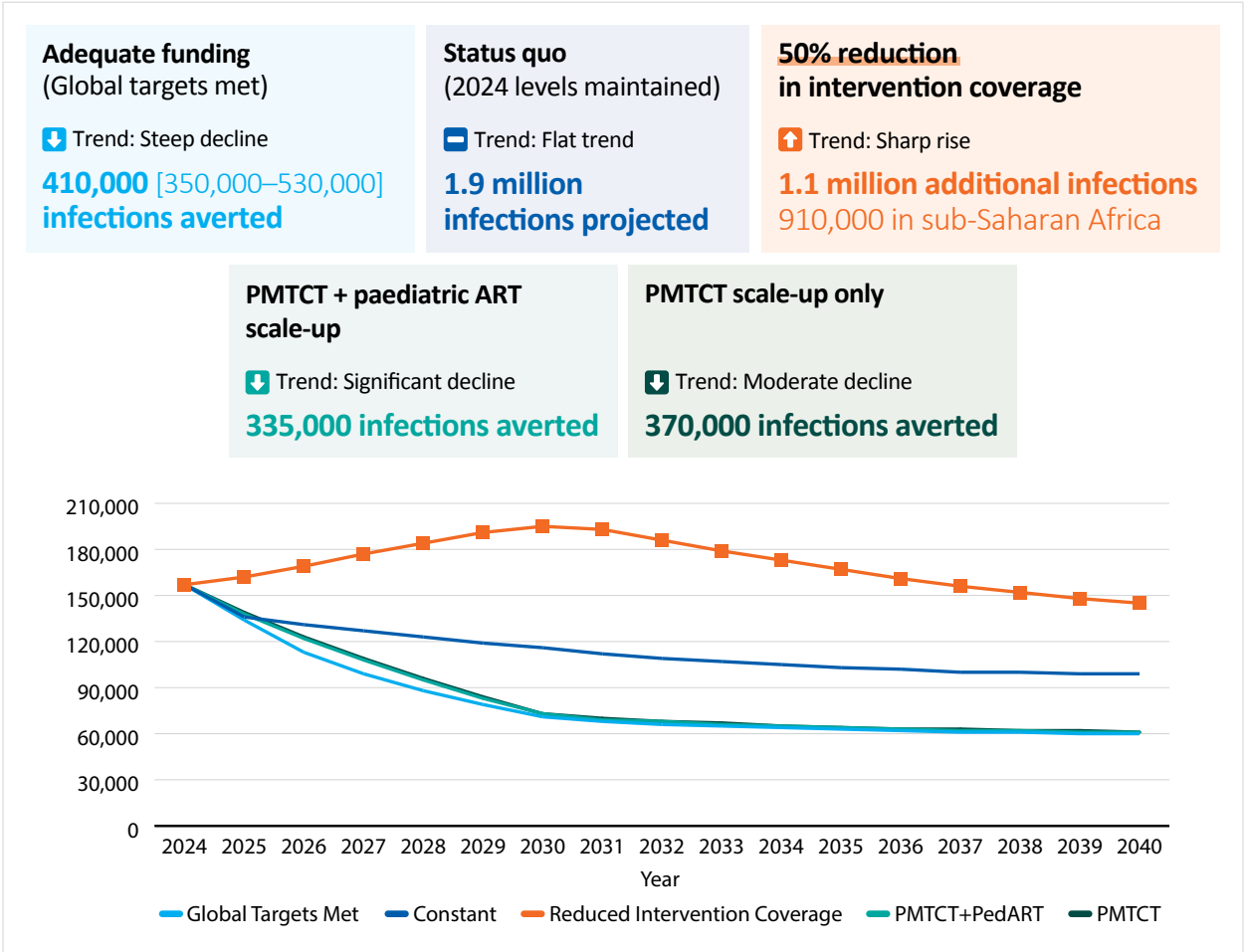
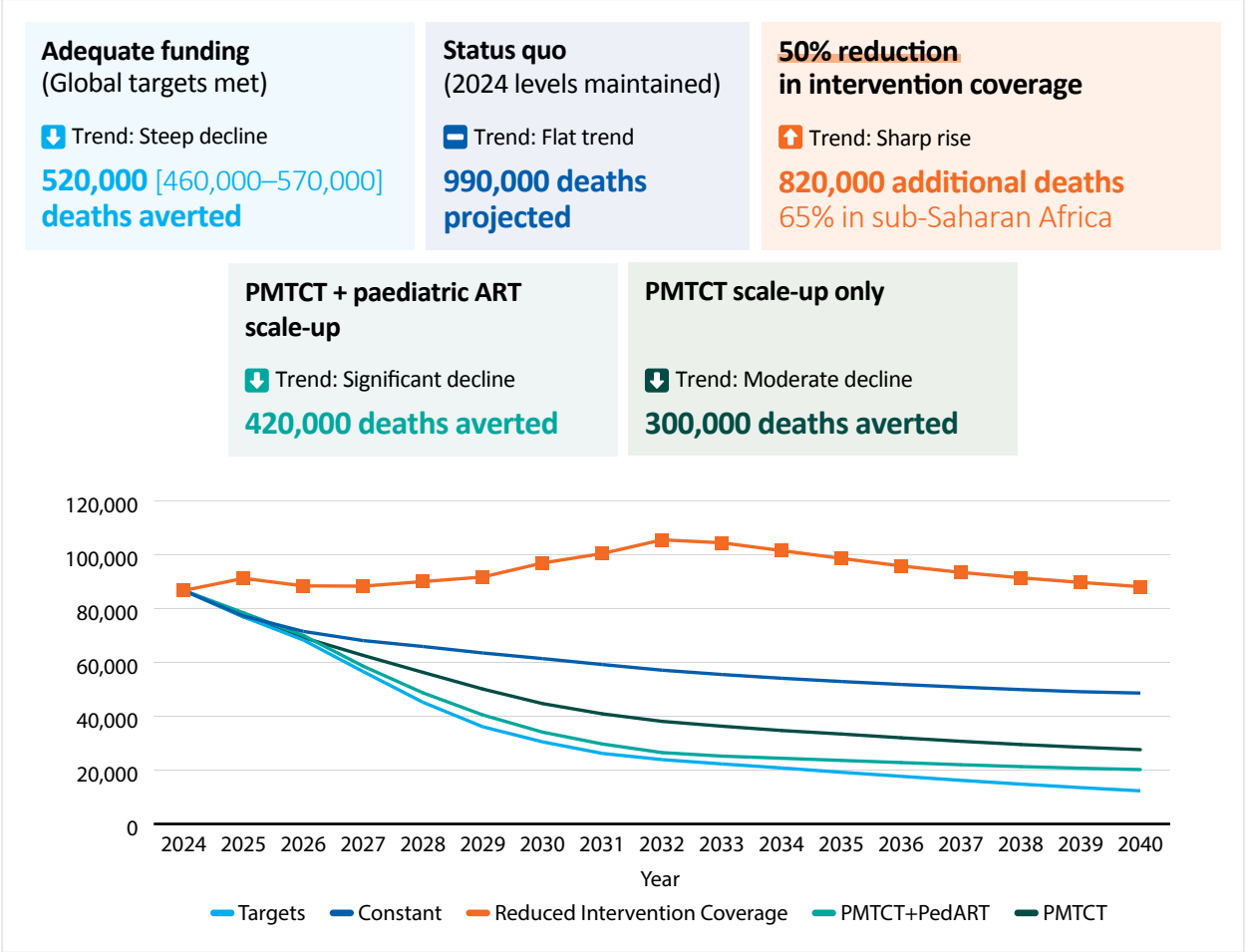


Figure 5. Estimated numbers of **AIDS-related deaths in children** (0-14 years) annually across **five** scenarios

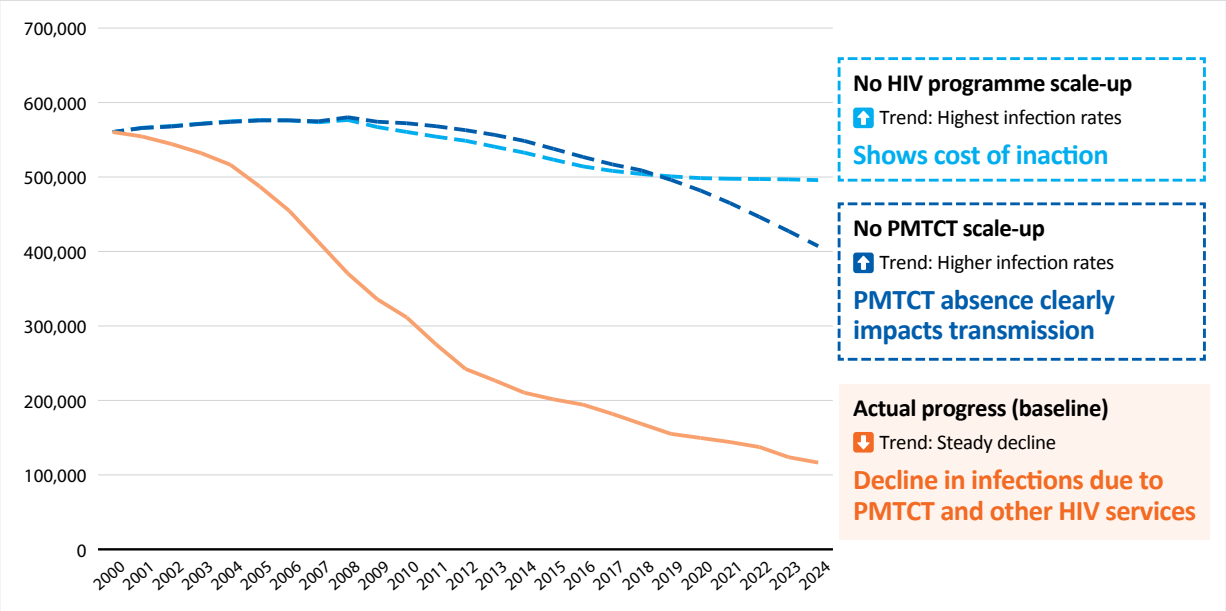


Additional scenario with no scale-up of programmes post-2000

In addition to modeling the future impact of interventions, the "Cost of Inaction" analysis modelled the impact of past (historical) interventions between 2000 and 2024, comparing three scenarios: actual trends of service coverage; a scenario with no scale-up of programmes to prevent vertical transmission after 2000, but actual scale-up of antiretroviral therapy, condom programmes and voluntary medical male circumcision; and a scenario with no scale-up of any of those programmes after 2000 (see Figure 4).

UNAIDS has estimated that, if U.S. funding for HIV programmes (including via the Global Fund) were to end *entirely*, international assistance for HIV responses in low- and middle-income countries would fall by 73%.[67] There are also concerns that the decrease in U.S. funding for HIV might be accompanied by further reductions in funding from other major donors, including via the Global Fund (which has been reducing country budgets in recent years during its "grant cycle 7").[68,69] In light of these developments, the "Cost of Inaction" analysis's assumption of a possible 50% reduction in HIV funding and interventions was prescient.

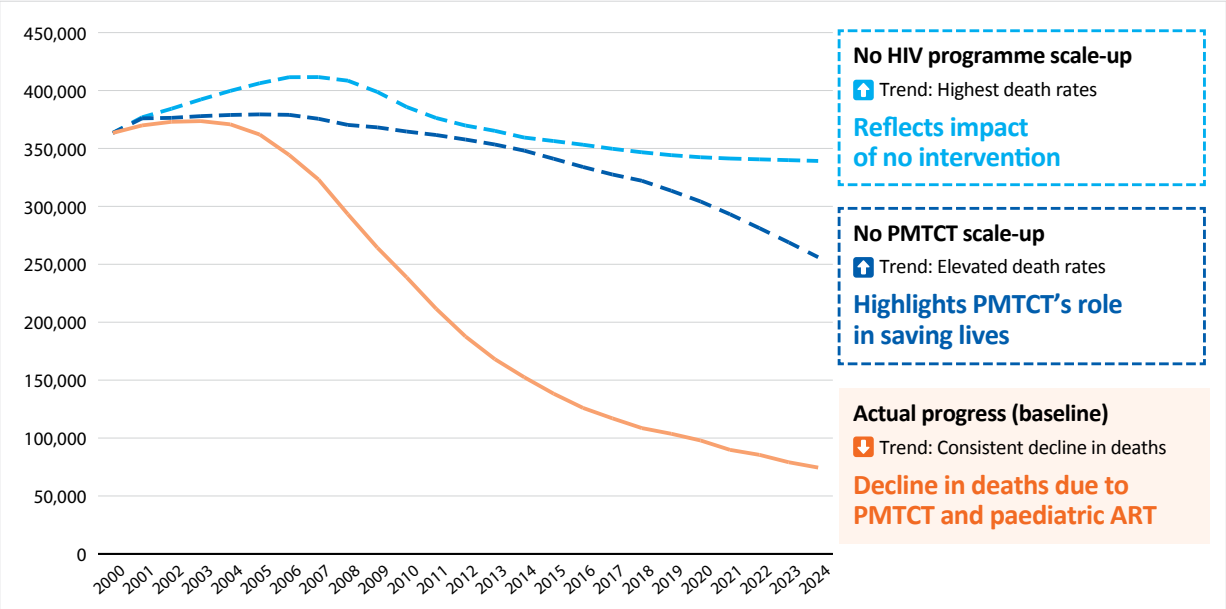
Figure 6. Estimated number of **new HIV infections in children** (0-14 years) annually across **three** historical scenarios (2000–2024)



Source: Projections by Avenir Health using UNAIDS epidemiological estimates

Note: "Actual progress" depicts the actual trend from 2000 to 2024; "no PMTCT" shows a scenario in which there is no scale-up of programmes to prevent vertical transmission after 2000, but actual scale-up of ART, condom programmes and voluntary male medical circumcision; and "no historical programme" shows a scenario with no scale-up of any of those programmes after 2000.

Figure 7. Estimated annual number of **AIDS-related deaths in children** (0-14 years) annually across **three** historical scenarios (2000–2024)



Source: Projections by Avenir Health using UNAIDS epidemiological estimates

Note: "Actual progress" depicts the actual trend from 2000 to 2024; "no PMTCT" shows a scenario in which there is no scale-up of programmes to prevent vertical transmission after 2000, but actual scale-up of ART, condom programmes and voluntary male medical circumcision; and "no historical programme" shows a scenario with no scale-up of any of those programmes after 2000.

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For every child, End AIDS