2014 PROGRESS REPORT ON THE GLOBAL PLAN

towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive

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CONTENTS

PREFACE

This report reflects the results of data for the calendar year 2013. For the first time since the 1990s, the number of new HIV infections among children in the 21 Global Plan priority countries[1] in sub-Saharan Africa dropped to under 200 000 [170 000–230 000]. This represents a 43% decline in the number of new HIV infections among children in these 21 countries since 2009, providing reasons for optimism as the Global Plan pushes towards its 2015 goals of 90% reduction. However, there are also reasons for concern. Between 2012 and 2013 the pace of progress in reducing new HIV infections among children across the priority countries slowed substantially. While a number of countries made impressive gains, others stagnated or lost ground.

In 2013, twice as many (68%) pregnant women living with HIV in the priority countries had access to antiretroviral medicines to reduce the risk of HIV transmission to their children as in 2009 (33%). This success must be commended and improved upon. Yet, data show a significant slowdown between 2012 and 2013, when the percentage of women receiving antiretroviral medicines rose by only 4% (from 64% to 68%). Of particular concern, six countries registered lower coverage in 2013 than they had in 2012, showing that gains are uneven and fragile. The reasons for this slowdown should be urgently examined and addressed in order to get back on track towards achieving the Global Plan's goals by 2015.

In 2013, the priority countries had a collective six-week mother-to-child transmission rate of 7%; however, this rose to 16% after breastfeeding ended, signifying the importance of continued prophylaxis during this period of risk for mother-to-child transmission and the weakness of many programmes to provide effective postpartum antiretroviral medicines. Without systematic support to maintain good adherence to HIV medicines in the postnatal period, substantial transmission will occur during the breastfeeding period. UNAIDS estimates that more than half of HIV transmission to infants in 2013 occurred during breastfeeding, in part because many countries have placed greater emphasis on antiretroviral medicines during pregnancy and delivery, linked with antenatal care, but less emphasis on systematic follow-up for retention in care during lengthy breastfeeding. Breastfeeding for women living with HIV can be made safer by providing antiretroviral medicines throughout the nursing period, by using Option B[2] or B+[3] recommended regimens. Therefore, more-rapid adaptation of regimen policies, roll-out of these medicines and support to retain mothers in care are all needed in order to ensure that children can breastfeed safely.

A focus on women of reproductive age in the priority countries remains central to the AIDS response. However, the number of new HIV infections among them remains high, having declined by only 17% since 2009. More effort should be made to lower the risk of women acquiring HIV. This is not only important for the woman's health, but would also achieve the goal of eliminating new HIV infections among children. More effort should also be made to provide treatment to pregnant women living with HIV. Only 34% of pregnant women in the 21 countries reported here were receiving lifelong antiretroviral therapy in 2013.

In 2013, 3.2 million children under the age of 15 were living with HIV globally, 91% of whom were in sub-Saharan Africa. Yet, only 22% of these children were receiving antiretroviral therapy in the priority countries. Globally, children living with HIV are one-third less likely to receive treatment compared to adults. These are urgent disparities that must be addressed. Without treatment, half

[1] The Global Plan prioritized 22 countries where 90% of pregnant women living with HIV resided. At the preparation of this report, data were not available for India. The remaining 21 sub Saharan countries for which data were available are referred to in this report as "priority countries."
[2] Option B refers to triple antiretroviral medicines provided to all pregnant and lactating women living with HIV, beginning in the antenatal period and continuing throughout the duration of breastfeeding.
[3] Option B+ refers to life-long antiretroviral therapy given to all pregnant women living with HIV, regardless of their CD4 count.

of the children living with HIV will die before their second birthday.

As the Global Plan makes the final push towards 2015, it is critical to consolidate the significant gains that have been made in many countries, to accelerate progress where results have stalled or reversed direction and to redouble our collective efforts towards the elimination of new HIV infections among children and keeping their mothers alive.

OVERVIEW

The *Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive* (Global Plan) was launched in July 2011 at the United Nations General Assembly High Level Meeting on AIDS. It prioritizes 22 countries with the highest number of pregnant women living with HIV in need of services, specifically Angola, Botswana, Burundi, Cameroon, Chad, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Ghana, India, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, South Africa, Uganda, United Republic of Tanzania, Swaziland, Zambia and Zimbabwe. During the preparation of this report, data for India were not available, and so the report presents the result from the 21 remaining priority countries, all of which are located in sub-Saharan Africa.

In 2013, a number of the priority countries continued their important strides in expanding and improving access to HIV services for women and children. For the first time, all these countries have guidelines officially endorsing the more efficacious antiretroviral medicines (Option B or B+) and the phasing out of Option A, which is no longer recommended by the World Health Organization (WHO).

Over the past year, countries worked to further identify and address bottlenecks, to take stock of results and to find ways to improve their programmes. The Ministers of Health from these countries met on the margins of the May 2014 World Health Assembly in Geneva to discuss progress and create ways to improve outcomes. Key issues included the need for accelerated scale-up of the WHO-recommended prevent mother-to-child transmission (PMTCT) regimens and the need to urgently address the low coverage of paediatric treatment. Various actions are now being taken to address this unmet need.

FEWER CHILDREN ARE ACQUIRING HIV

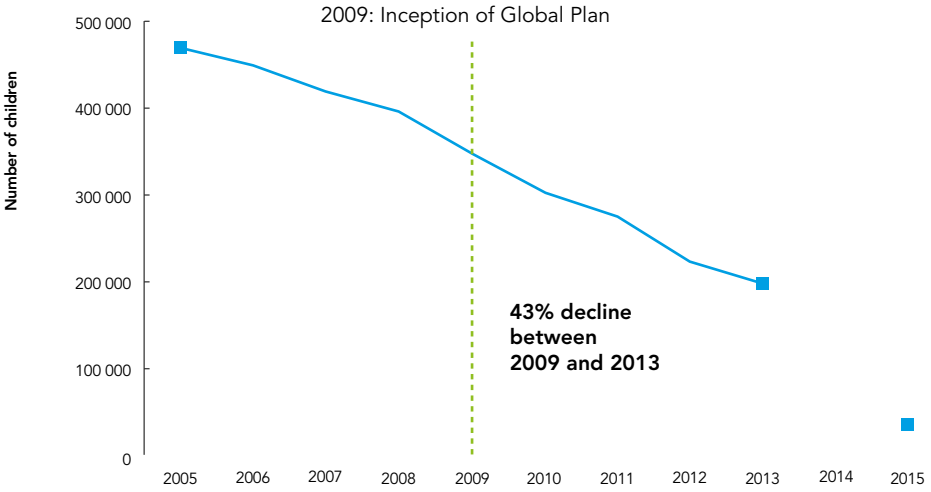
Since 2009, there has been a 43% decline in new HIV infections among children in the priority countries, from 350 000 [310 000–380 000] in 2009 to 199 000 [170 000–230 000] in 2013.[4] This is the first time since the 1990s that the number of new infections among children in these countries has dropped to under 200 000. Declines in new HIV infections were recorded in all priority countries between 2009 and 2013, but at varying rates. Malawi had the largest decline, at 67% (although they started from a higher transmission rate than many other countries), while new HIV infections among children fell by 50% or more in seven other countries: Botswana, Ethiopia, Ghana, Mozambique, Namibia, South Africa and Zimbabwe. However, between 2012 and 2013 the pace of progress in reducing new HIV infections among children across the 21 Global Plan countries slowed. While a number of countries made impressive gains, others stagnated or lost ground. On aggregate, countries recorded a 12% reduction in new infections between 2009 and 2010, a 9% reduction between 2010 and

[4] A major challenge in measuring the progress of the Global Plan is that most of the priority countries do not have a direct measurement of the number of new HIV infections among children. Measuring other indicators, such as mother-to-child transmission rates is difficult as surveillance systems may be weak, and other methods are costly. In most countries, models, that use programme data as inputs, are required to estimate the progress made towards the 2015 target of the Global Plan. Therefore unless otherwise mentioned, the data in this report are based on modelled estimates.

2011, and a 19% reduction between 2011 and 2012 (when a number of countries switched to more effective regimens based on the 2010 WHO guidelines). However, the 21 countries recorded an 11% reduction between 2012 and 2013. Nigeria continues to carry the highest burden of new HIV infections among children, which has declined by only 19% since 2009. The country is home to one quarter of all new HIV infections among children in the priority countries in 2013 – nearly 51 000 [44 000–60 000] cases.

Fig. 1

Number of new HIV infections among children, 2005-2013 in 21 Global Plan Countries



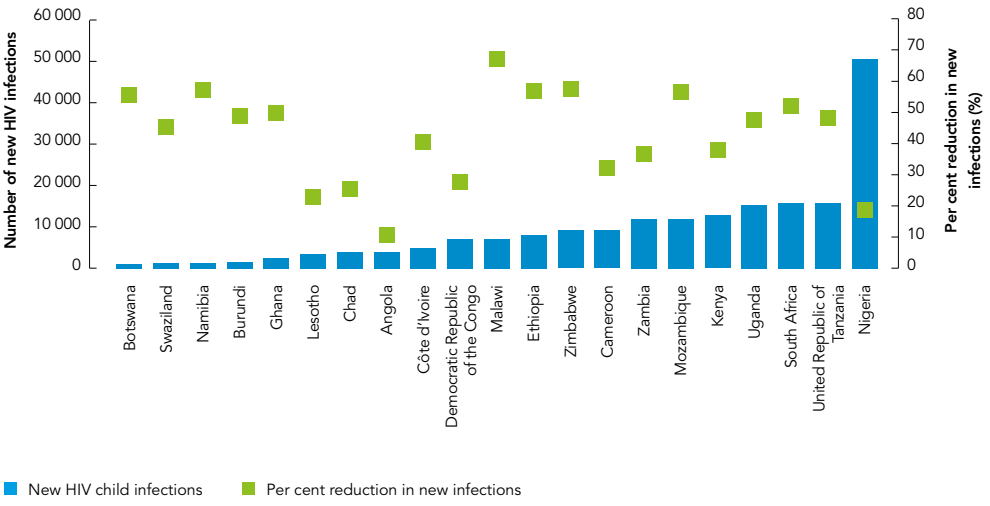
Source: UNAIDS 2013 Estimates, 21 countries.

PREGNANT WOMEN LIVING WITH HIV ARE GETTING SERVICES, BUT IMPORTANT GAPS REMAIN

The proportion of pregnant women living with HIV who received antiretroviral medicines for PMTCT has doubled over the past five years, from 33% [31–35%] to 68% [64–74%] and the regimens being received are now more efficacious. In Botswana, Namibia, South Africa and Swaziland 90% or more of pregnant women living with HIV were receiving antiretroviral medicines in 2013. In addition, Namibia, South Africa and Swaziland are moving to Option B+, so more progress is anticipated. However, there is concern about stagnation: between 2012 and 2013, the percentage of women receiving antiretroviral medicines rose only marginally, from 64% to 68%. In the same period, only 37 000 additional pregnant women living with HIV were reached with antiretroviral prophylaxis or treatment, compared to nearly 97 000 between 2011 and 2012. In some countries there has been a stalling and in some cases a decrease. Stalling was documented in Botswana, South Africa, United Republic of Tanzania, Uganda and Zimbabwe, while declines of at least 10% were documented in Chad, Ghana, Lesotho and Zambia. The reasons for these observed changes differ – countries like Botswana and South Africa already have high coverage and may be reaching a saturation point. Other countries may be experiencing programming fluctuation, while others have made improvements to monitoring systems that allow for more accurate estimates.

Fig. 2

Number of new HIV infections among children in 2013 and per cent reduction in new infections since 2009 in 21 Global Plan priority countries



Source: UNAIDS 2013 estimates.

PERCENTAGE DECLINE IN NEW HIV INFECTIONS AMONG CHILDREN IN 21 GLOBAL PLAN PRIORITY COUNTRIES, 2009–2013

>50% decline

Botswana
Ethiopia
Ghana
Malawi
Mozambique
Namibia
South Africa
Zimbabwe

26–50% decline

Burundi
Cameroon
Côte d'Ivoire
Democratic Republic of the Congo
Kenya
Swaziland
Uganda
United Republic of Tanzania
Zambia

<25% decline

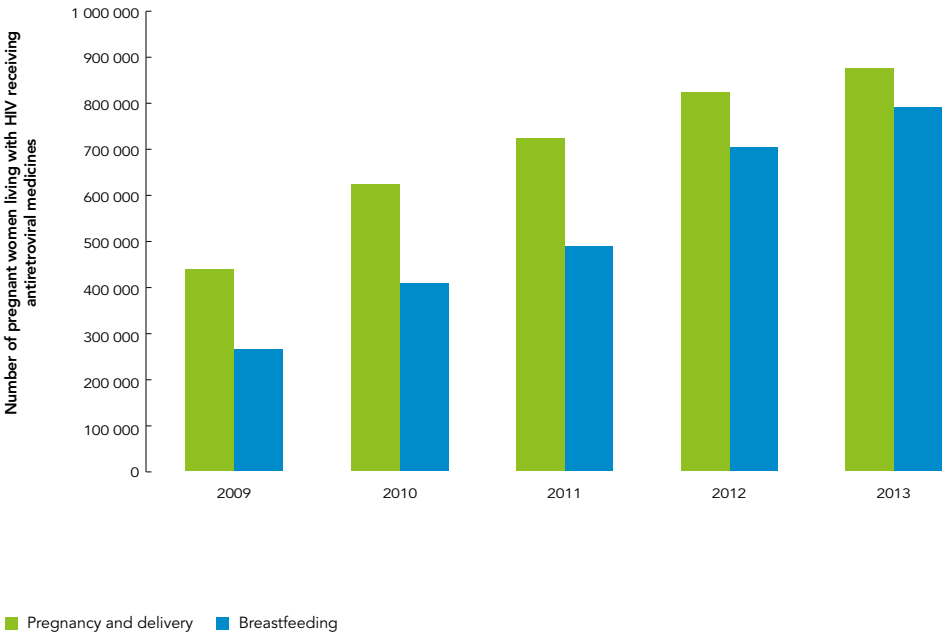
Angola
Chad
Lesotho
Nigeria

Source: UNAIDS 2013 estimates.

The 2013 WHO Consolidated Guidelines on the Use of Antiretroviral Drugs for Treating and Preventing HIV Infection[5] (WHO, 2013) recommend breastfeeding women continue taking antiretroviral medicines until the end of breastfeeding when HIV transmission risk to the child ends, and that women either continue if they are eligible for antiretroviral treatment (Option B), or that all pregnant and breastfeeding women living with HIV continue lifelong antiretroviral treatment (Option B+). Encouragingly, between 2009 and 2013, there was a sharp increase in the percentage of women reportedly receiving antiretroviral medicines (prophylaxis or lifelong therapy) during breastfeeding, from 20% to 61%. Although there are some concerns on the accuracy of data on ARV coverage during breastfeeding, this is a remarkable improvement but more work remains to ensure all women have similar access.

Fig. 3

Number of pregnant women living with HIV receiving antiretroviral medicines in 21 Global Plan priority countries, 2013



Source: UNAIDS / UNICEF / WHO estimates, 2013.

[5] WHO Consolidated Guidelines on the Use of Antiretroviral Drugs for Treating and Preventing HIV Infection; 2013 http://www.who.int/hiv/pub/guidelines/arv2013/en/

MOTHER-TO-CHILD HIV TRANSMISSION RATES

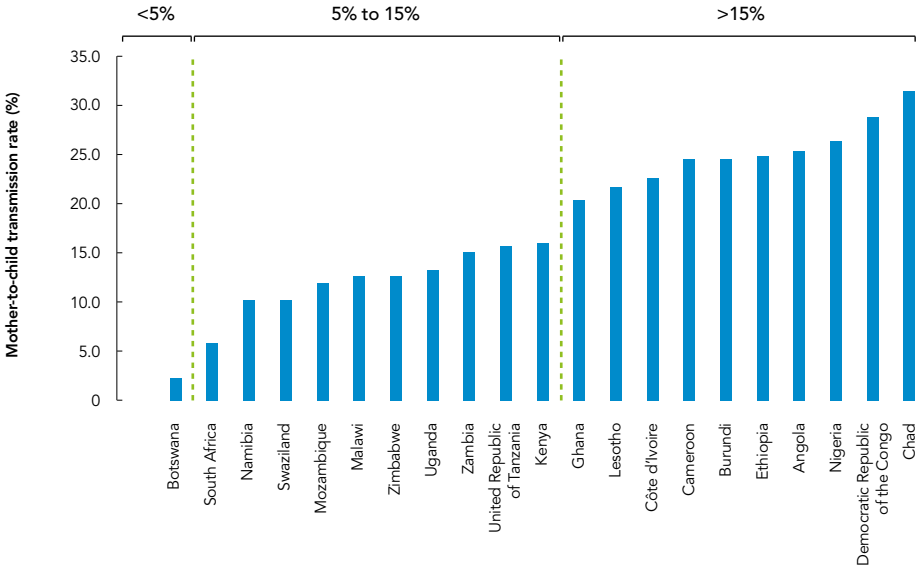
The rate of HIV transmission from an HIV-positive mother to her child if she is not receiving any antiretroviral medicines ranges between 30% and 45% depending on the duration of breastfeeding. One of the main goals of the Global Plan is to reduce this rate to less than 5% among breastfeeding populations, and to less than 2% among non-breastfeeding populations. In 2009, prior to the launch of the Global Plan, the overall transmission rate (including breastfeeding) was 26% in the 21 Global Plan countries. Since the roll-out of the Global Plan, the rate has dropped to 16%. While this progress is encouraging, it remains short of the 5% goal of the Global Plan. The individual national transmission rates reflect the situation for all pregnant women living with HIV in a country (i.e. population-based estimates) and are not limited to those who receive services.

With a modelled transmission rate of 2% in 2013, Botswana appears to have accomplished the goal of virtual elimination of mother-to-child transmission, and South Africa is not far behind at 6%. The remaining 19 priority countries have transmission rates of over 10%, with ten of them having transmission rates of over 20%. Considerable efforts, including high HIV testing and counselling, high coverage with effective PMTCT regimens and support for adherence are needed to achieve the Global Plan goals. This is particularly important during breastfeeding.

Analysis of 2013 data shows that the priority countries have a six-week mother-to-child transmission rate of 7%, but this rises to 16% after breastfeeding ends. Because the scale-up of PMTCT and more effective regimens have reduced the risk of HIV transmission during the pregnancy and delivery periods, the risk of HIV transmission is now concentrated during the breastfeeding period. Therefore, it is urgent that programmes provide effective PMTCT regimens during this period, in order to prevent children acquiring HIV.

Fig. 4

Final mother-to-child HIV transmission rates after breastfeeding in 21 Global Plan priority countries, 2013



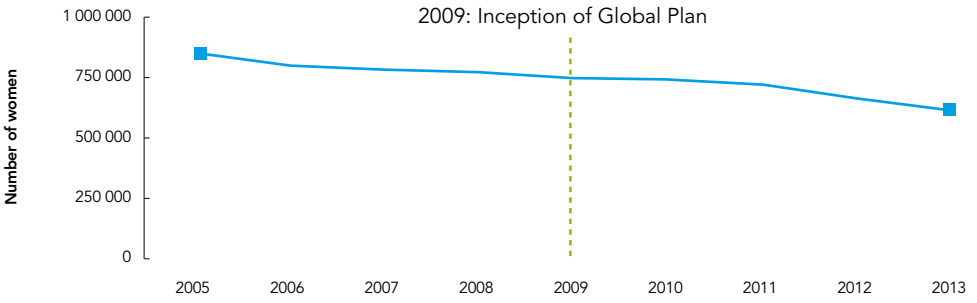
Source: UNAIDS 2013 estimates.

NEW HIV INFECTIONS AMONG WOMEN

In order to eliminate mother-to-child transmission among children and also keep women healthy and well, it is important to reduce new HIV infections among women of reproductive age, especially among adolescents and young women. Therefore, the Global Plan aspired to reduce this number by 50% between 2009 and 2015 in the priority countries. The data show that only marginal progress has been made – in 2009, 740 000 [680 000–800 000] women became infected with HIV, compared to 620 000 [560 000–680 000] in 2013, a reduction of only 17%. These numbers are added to the existing pool of women who were infected earlier, and when they desire child bearing, need services to prevent mother-to-child transmission. Consequently, the total number of women requiring these services remains high at 1.3 million [1.2–1.4 million] among the priority countries. In addition, access to antiretroviral therapy means that more women living with HIV are healthy and able to have children, a key goal for women's rights. Continued investment in PMTCT services and access to antiretroviral medicines is required, due to the slow decline in new HIV infections among women, and the growing number of women living with HIV who are still healthy and alive because of treatment. At the same time countries should intensify initiatives to help pregnant women who test negative to remain negative by ensuring they have access to adequate information and antenatal care, as these women are already within the health care system. Programmes can encourage partner engagement and access to testing, ensuring that partners in need of treatment can access antiretroviral medicines, and provide information to sero-discordant couples to reduce risk of transmission. Programmes should also provide information and services for women and their partners to avoid unintended pregnancies.

Fig. 5

Number of women of reproductive age newly infected with HIV, 21 Global Plan priority countries



Source: UNAIDS 2013 Estimates, 21 countries.

UNMET FAMILY PLANNING NEEDS AMONG WOMEN

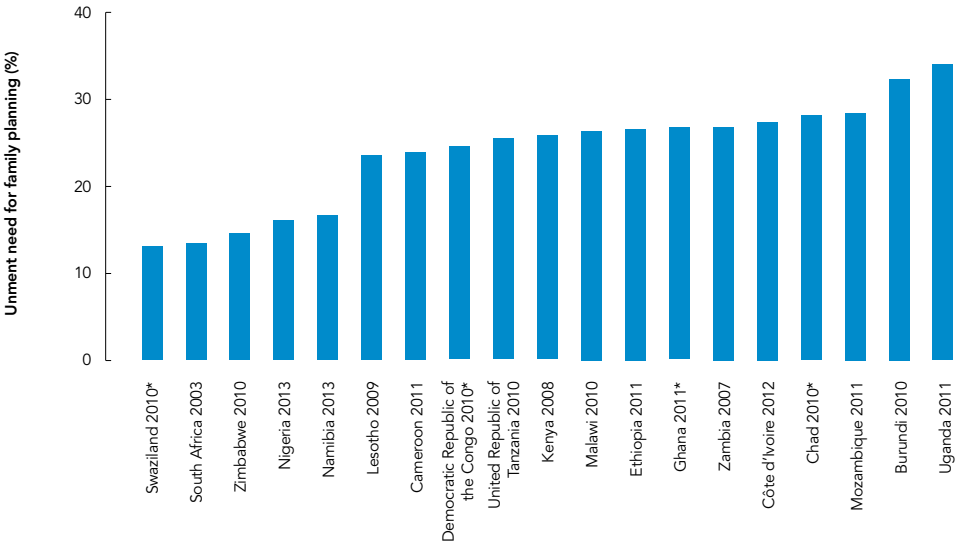
All women, including women living with HIV, should be given the opportunity to plan their pregnancies. This is particularly important for adolescent women, who are at greater risk for pregnancy-related complications. Family planning is one of the four pillars of guidance on the prevention of the mother-to-child transmission of HIV. Providing appropriate counseling, support and contraceptives to women living with HIV to meet their family planning goals will optimize health outcomes for women and reduce the potential for HIV transmission to their children. In addition, spacing of pregnancies is beneficial to the health of all woman and their children.

The Global Plan aims to eliminate all unmet need for family planning among all women, including women living with HIV, in the priority countries, thereby ensuring that all women who desire contraception can have access to it. However, according to most recent population-based surveys, more than half of the priority countries are failing to meet the needs for family planning among at least 25% of all married women. This is the case in Burundi, Côte d'Ivoire, the Democratic Republic of the Congo, Ethiopia, Ghana, Kenya, Malawi, Mozambique, the United Republic of Tanzania, Uganda and Zambia.

Data assessing unmet need for family planning are extracted from household surveys, which are conducted every three to five years, with varying timelines across countries. Some of the data reported here were collected as far as five years ago, and some earlier. There is need to develop other measures of unmet need for family planning, in order to provide more real-time information about the fertility desires of women. In addition, the results presented here are not specific to women living with HIV. Survey data frequently are not available by HIV status or the numbers among women living with HIV are too small to provide reliable measures. There is need to develop population-based mechanisms to assess differences by HIV status, in order to inform programmes.

Fig. 6

Unmet need for family planning among currently married women regardless of their HIV status in 21 Global Plan priority countries



Source: Most recent nationally-representative household survey, 2003-2013.

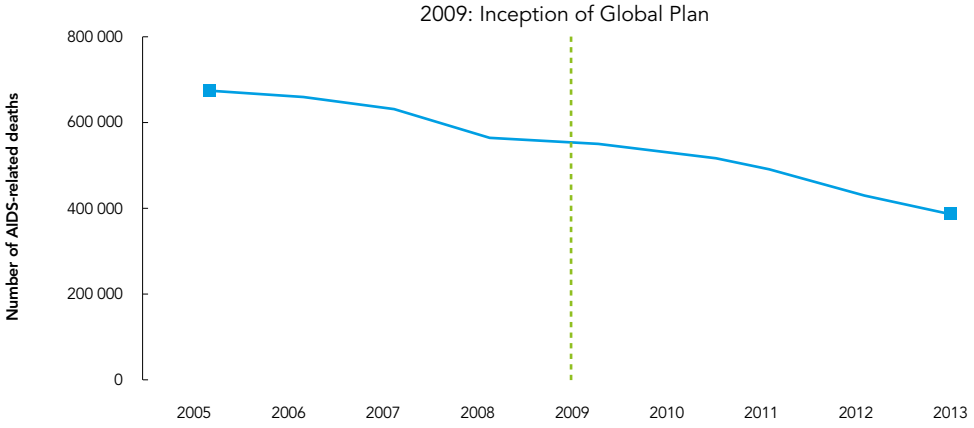
* Multiple Indicator Cluster Surveys are based on a slightly different definition of unmet need for family planning.

KEEPING MOTHERS ALIVE

During the last five years, there has been a 29% decline (and 43% since 2005) in the number of AIDS-related deaths among women of reproductive age; however, there is a long way to go. Ensuring that women of reproductive age who are living with HIV are on appropriate antiretroviral therapy with viral suppression, are appropriately diagnosed and treated for tuberculosis and are assured safe perinatal care and delivery will further decrease mortality.

Fig. 7

AIDS-related deaths among women of reproductive age (15–49 years) in 21 Global Plan priority countries, 2005–2013



Source: UNAIDS 2013 Estimates.

ACCESS TO HEALTH CARE FOR THE POOREST

In their recent *Countdown to 2015* report, the United Nations Children's Fund (UNICEF) and WHO highlight pronounced inequities in coverage for many essential health services such as antenatal and postnatal care, childhood immunization and family planning, whereby women from wealthier households are more likely to receive these services than those from poorer households. This pattern is particularly evident for services that require a functional health system, which includes personnel such as skilled birth attendants.[6] Consequently, women in the poorest quintile are two to three times less likely than those in the richest households to have access to, or use, these vital interventions. Data show that countries achieving rapid progress in the coverage of essential interventions have accomplished this primarily by improving coverage among the poorest wealth quintiles. This is, in part, due to the recognition that these populations have the greatest potential for gains.

Pregnant women in the lowest wealth quintiles who reside in rural areas and have the lowest education levels are more likely to lack access to services than other women. Pregnant adolescent women in resource-constrained communities are further disadvantaged by their youth and lack of experience. Therefore, specific efforts must be made to address their HIV-related needs, including by bringing health services closer to them. This requires decentralizing services to the lowest levels, and the inclusion of equity considerations in order to target vulnerable women when developing strategies for scaling up interventions.[7]

[6] Narrowing the Gaps to Meet the Goals. New York: United Nations Children's Fund; 2010 (http://www.unicef.org/publications/files/Narrowing_the_Gaps_to_Meet_the_Goals_090310_2a.pdf, accessed 4 July 2014).
[7] UNICEF/WHO. Countdown to 2015: Maternal, Newborn and Child Survival. Accountability for Maternal, Newborn and Child Survival. The 2013 Update.

INFANT DIAGNOSIS

WHO recommends that children exposed to HIV be tested within four to six weeks of birth, so that those who are already infected can start treatment immediately. This is, in part, because babies who are infected in-utero or during the intrapartum period have worse prognosis; the earlier they are identified and placed on therapy, the better their clinical outcomes. Infants less than 18 months of age still have their mothers' antibodies, which means that the normal rapid HIV test used to diagnose adults is not appropriate. In this population, HIV infection can only be definitively confirmed using a virological test.

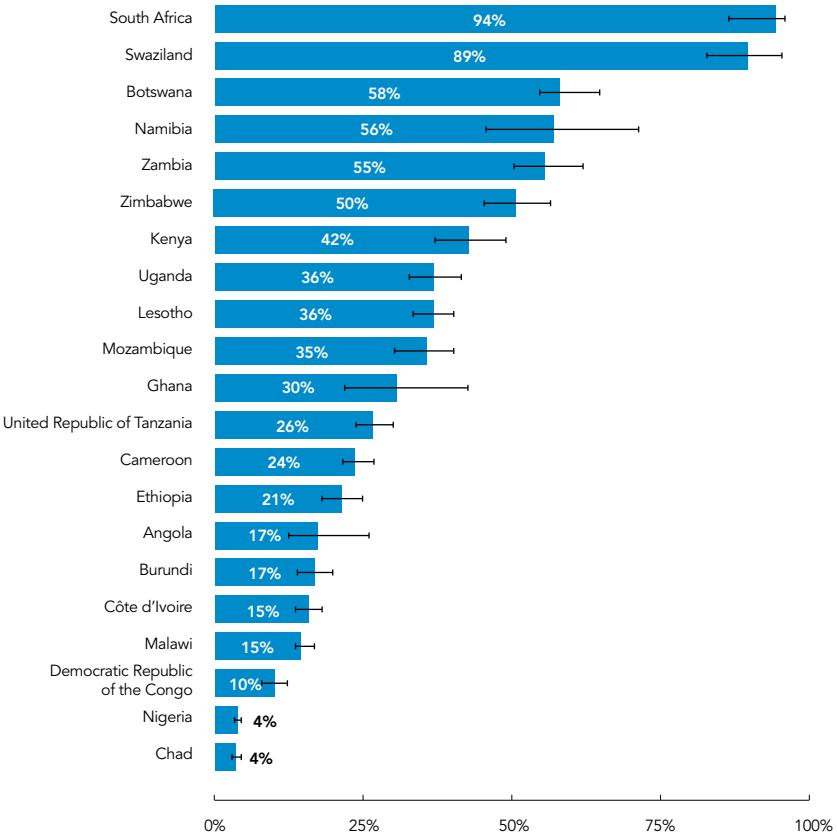
Currently the virological test is performed on dried blood spot specimens collected at local sites and then transported and tested in large centralized laboratories. This has sometimes led to long waiting periods before the results are returned to the caregiver, and have led to high rates of loss to follow-up and failure to start on treatment even among those diagnosed as infected. However, there has been considerable development in the field of infant diagnosis in the last two years, including the development of point-of-care devices that are on the verge of being launched in 2014–2015. In addition, the cost of early infant diagnosis (EID) testing has decreased, and sample transport networks have been improved (UNITAID, 2014).[8] WHO has also been examining the feasibility of testing at birth, which may provide an important adjunct to detecting and treating infected infants earlier.

Infant diagnosis rates (both early diagnosis and final diagnosis after 18 months) remain poor in many countries, creating a bottleneck to scaling up treatment for children especially those younger than 18 months of age. Despite significant investment, among the priority countries, only 39% of children exposed to HIV received HIV virological testing within the first two months of life. Only six of the priority countries were providing early infant diagnosis to more than 50% of children exposed to HIV in 2013: South Africa (94%), Swaziland (89%), Botswana (58%), Namibia (56%), Zambia (55%) and Zimbabwe (50%). In the remaining priority countries, the number of infants receiving virological testing was less than 50%, and was unchanged or decreased slightly from previous years. In nine priority countries, the number of children exposed to HIV receiving virological testing was less than 25% (WHO, 2014).[9] Follow-up care for mothers and their children must be strengthened post-partum throughout breastfeeding, using appropriate opportunities in child health services, immunization and nutrition programmes for infant testing, in order to determine final HIV transmission status at the end if the risk period.

[8] UNITAID: HIV/AIDS Diagnosis Technology Landscape, 4th Edition. Geneva, June 2014. http://www.unitaid.org/images/marketdynamics/publications/UNITAID-HIV_Diagnostic_Landscape-4th_edition.pdf.
[9] WHO: Global Update on the Health Sector Response to HIV, 2014. Geneva, WHO, July 2014.

Fig. 8

Percentage of infants born to pregnant women living with HIV receiving a virological test for HIV within two months of birth in 21 Global Plan countries, 2013



Source: Number of infants receiving a virological test for HIV within two months of births reported by countries: Global AIDS Response Progress Reporting (WHO/UNICEF/UNAIDS); number of pregnant women living with HIV as a proxy for HIV-exposed infants: UNAIDS 2013 estimates.

PAEDIATRIC HIV TREATMENT

Because infants and young children who acquire HIV have exceptionally high risk of morbidity and mortality, WHO and UNICEF are encouraging countries to fast-track diagnosis and treatment of children. Without treatment, up to 52% of children who have HIV die before their second birthday. The 2013 Consolidated Guidelines on the Use of Antiretroviral Drugs for Treating and Preventing HIV Infection (WHO, 2013) promote simplicity and efficacy, in order to save more lives and improve clinical outcomes. WHO also now recommends that antiretroviral therapy be initiated in all HIV-infected children under five years of age, and for all older HIV-infected children with CD4 cell count < 500 cells/mm^3. The previous (2010) guidelines had made this recommendation only for diagnosed children under two years of age.

WHO now recommends that antiretroviral therapy be initiated in all children living with HIV under five years of age, and for older children living HIV, with CD4 cell count <500 cells/mm^3. In addition, antiretroviral therapy should be initiated for all children living with HIV with severe or advanced symptomatic disease (WHO Clinical Stage 3 or 4), regardless of age and CD4 cell count. Moreover, antiretroviral therapy should be initiated in any child younger than 18 months of age who has been given a presumptive diagnosis of HIV infection.[10]

Effective 2013, UNAIDS estimates for paediatric HIV treatment are based on a denominator of all children living with HIV, and not only those eligible for HIV treatment, as was done previously. This is to allow greater comparability across countries with different antiretroviral eligibility criteria and to account for changes in those criteria over time. The results show that since 2009, the number of children receiving antiretroviral therapy has increased in all priority countries. Botswana has achieved universal access (defined as 80% coverage), with 84% of infected children receiving HIV treatment. Three priority countries – Namibia, South Africa and Swaziland – are providing treatment to nearly half the children living with HIV. However, most priority countries have a long way to go – Cameroon, Chad, Côte d'Ivoire, the Democratic Republic of Congo and Ethiopia provide treatment to less than 10% of their children living with HIV. Only 22% of children living with HIV are receiving HIV treatment in the 21 priority countries. Although this represents an increase from the 8% baseline in 2009, it is much lower than the 34% of pregnant women living with HIV who are currently on treatment in the priority countries or 39% among all adults living with HIV in the 21 priority countries. Although the number of newly infected children requiring HIV treatment will decline as new HIV infections are prevented, there is an urgent need to identify the children currently living with HIV and link them to care and treatment services so that their morbidity and mortality is reduced over time.

Low treatment coverage for children living with HIV is related to multiple factors, including challenges unique to children's medicines, diagnosis, case-finding and linkage, and retention in care. There are fewer options of age-appropriate antiretroviral drugs available for use by children and the cost of treatment for children is higher. Treatment can only be successful if children receive WHO-recommended regimens and are assisted in adhering to their medication, but this is challenging in many settings. There is also an urgent need for paediatric antiretroviral formulations that are heat stable, palatable and easy for parents to administer.

Medication supply issues further hinder paediatric treatment. Complex formulations complicate pricing and ordering decisions and are contrary to a public health approach that focuses on the uptake of a limited number of optimized regimens. The 2013 WHO guidelines have recommended a more simplified approach to paediatric antiretroviral therapy, and work is ongoing to further simplify and harmonize paediatric regimens.

CO-TRIMOXAZOLE PREVENTIVE THERAPY

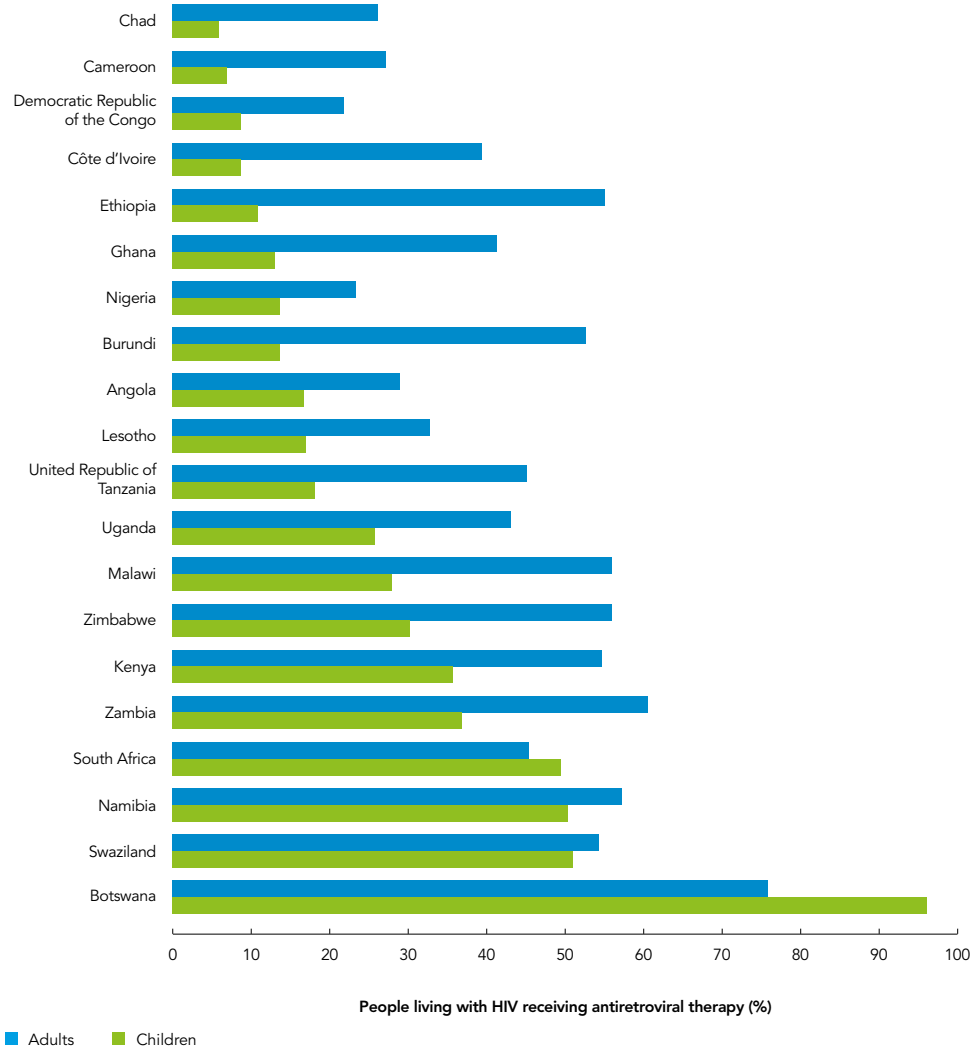
Several co-infections and health conditions are common among children exposed to HIV. The *2013 WHO consolidated guidelines* recommend co-trimoxazole preventive therapy (CPT) among children for prevention of pneumocystis pneumonia, toxoplasmosis and bacterial infection. CPT is a simple, well-tolerated and cost-effective intervention which can extend and improve the quality of life of children exposed to HIV, including those on antiretroviral therapy. However, data suggest low

[10] WHO: Consolidated Guidelines on the Use of Antiretroviral Drugs for Treating and Preventing HIV Infection. Geneva, WHO, June 2013.

utilization of this highly-efficacious therapy. A total of five priority countries provided CPT to at least 50% of such infants including Swaziland (90%), Botswana (80%), South Africa (78%), Mozambique (68%) and Zimbabwe (55%). There is need for countries to reprioritize co-trimoxazole prophylaxis as part of the paediatric HIV treatment package, as recommended by WHO since 2006. This will require a set of interrelated interventions, including strengthening links between HIV testing and treatment, as well as follow-up infants and children exposed to HIV. CPT is recommended to be started in all HIV-exposed infants at 6 weeks of age, at the same time as the recommended early diagnosis test.

Fig. 9

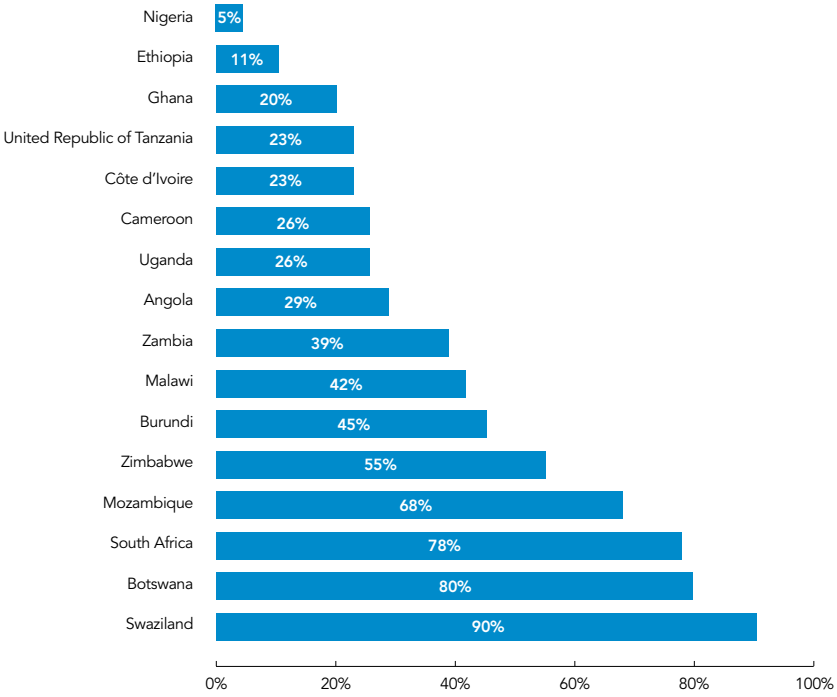
Percentage of adults (aged 15+) and children (aged 0–14) living with HIV who were receiving antiretroviral therapy in 2013, in 21 Global Plan priority countries



Source: UNAIDS/UNICEF/WHO 2013 Estimates.

Fig. 10

Per cent of children exposed to HIV who received co-trimoxazole in 2013 in 16 Global Plan priority countries



Among the 16 reporting priority countries
Source: UNAIDS/WHO/UNICEF estimates, 2013.

THE REMAINING 500 DAYS

The Global Plan represents the commitment of governments, implementing partners, civil society, women living with HIV and other stakeholders. This partnership is based on a collective desire to eliminate new HIV infections among children and keep their mothers alive. The Global Plan also aims to accelerate women's and children's access to quality life-saving HIV prevention, treatment and care services. It is grounded on respect for rights of women, families and communities, and places women living with HIV at the centre of the response.

The Global Plan set the ambitious goal of reducing new HIV infections among children by 90% between 2009 and 2015, as well as to halve AIDS-related maternal and paediatric mortality. The results of this report show that the 21 Global Plan countries have made important but varied progress. Collectively, these countries have reduced new HIV infections among children by 43% since 2009. During this period, eight priority countries have realized declines of 50% or more; yet, in the other 13, progress has been more gradual or stalled.

As the Global Plan enters its final 15 months, there is an urgency that all partners work together to consolidate the significant gains that have been made; remove key obstacles that have slowed, stalled or reversed progress; and redouble our collective efforts towards the elimination of new HIV infections among children and keeping their mothers alive. It is also critical to examine the implications of the partnership as we enter the post-2015 era, and to formulate strategies to address the unfinished business of ending new HIV infections among children and keeping their mothers alive and healthy.

A NOTE ON MEASUREMENT

With less than 500 days remaining to achieve the 2015 Global Plan targets, measuring progress and addressing obstacles is critical. Countries are urged to closely monitor the targets and to provide accurate, timely data to their policy-makers and programme implementers. Since most of the priority countries do not have direct measurements for several Global Plan indicators – such as new child infections, mother-to-child child transmission rates, and PMTCT and antiretroviral therapy coverage rates – models are used to provide the best estimates. Therefore unless otherwise mentioned, the data in this report are based on modelled estimates.

These estimates are created by country teams using UNAIDS-supported software. The country teams are comprised primarily of epidemiologists, demographers, monitoring and evaluation specialists and technical partners. Country-submitted files are reviewed at UNAIDS, and selected HIV service data contained in the files are reviewed and validated in partnership with WHO and UNICEF. UNAIDS review aims to ensure comparability of results across regions, countries and over time. These models require high-quality, accurate national data from PMTCT programmes. Significant progress has been made in the past decade in improving monitoring systems, including better data on antiretroviral coverage for women living with HIV during pregnancy and delivery. However, monitoring of antiretroviral coverage for mothers during breastfeeding remains weak or non-existent in some countries, as well as follow-up of children exposed to HIV through the full breastfeeding period. In addition, many systems cannot identify which women are double-counted when they change regimen, or move clinics. Focused efforts are needed to improve these components of data collection.

IMPROVEMENTS TO THE 2013 UNAIDS ESTIMATES MODEL

Country teams create new Spectrum files every year. Files from one year to the next may differ for two reasons. First, new surveillance and programme data are entered into the model, which can change HIV prevalence and incidence trends over time, including for past years. Second, improvements are incorporated into the model based on the latest available science and understanding of the epidemic. Between the 2012 estimates and the 2013 estimates, the following changes were applied to the model under the guidance of the UNAIDS Reference Group on Estimates, Modelling and Projections:

- updated population data from the United Nations Population Division 2012 World Population Prospects;
- revised calibration of HIV prevalence from antenatal clinics to the general population in countries with generalized epidemics without national surveys;
- calculation of incidence among people aged 15–49 years is no longer informed by the number of persons on antiretroviral therapy aged 15+ years, now it is informed by the number of persons on antiretroviral therapy who are aged 15–49 years.

Because there are improvements to the data and methods used to create the estimates each round, users of the data should not compare results from one round to the next. A full historical set of estimates is created for each round allowing for estimation of trends over time from within the same round. For more information, please see the Frequently Asked Questions here. http://www.unaids.org/en/resources/documents/2014/name,97468,en.asp.

Summary tables

Summary tables on the progress toward achieving the goals of the *Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive*, 21 Global Plan priority countries

	NUMBER OF HIV-POSITIVE WOMEN DELIVERING					
21 GLOBAL PLAN COUNTRIES IN SUB-SAHARAN AFRICA	**2009**	**Low**	**High**	**2013**	**Low**	**High**
Angola	13 000	8 900	19 000	16 000	11 000	22 000
Botswana	13 000	12 000	14 000	11 000	9 900	12 000
Burundi	7 500	6 400	8 700	5 300	4500	6 300
Cameroon	43 000	38 000	48 000	38 000	34 000	43 000
Chad	15 000	12 000	18 000	12 000	9 200	15 000
Côte d'Ivoire	28 000	24 000	31 000	21 000	18 000	25 000
Democratic Republic of the Congo	29 000	24 000	35 000	26 000	21 000	32 000
Ethiopia	50 000	43 000	58 000	33 000	28 000	39 000
Ghana	15 000	11 000	20 000	12 000	8 400	16 000
Kenya	81 000	72 000	91 000	79 000	69 000	90 000
Lesotho	16 000	14 000	17 000	16 000	14 000	17 000
Malawi	72 000	65 000	78 000	58 000	52 000	65 000
Mozambique	100 000	91 000	120 000	100 000	88 000	120 000
Namibia	11 000	9 300	14 000	10 000	8 300	13 000
Nigeria	200 000	180 000	230 000	190 000	170 000	220 000
South Africa	270 000	250 000	300 000	260 000	230 000	280 000
Swaziland	10 000	9 400	11 000	10 000	9 400	11 000
Uganda	96 000	85 000	110 000	120 000	100 000	130 000
United Republic of Tanzania	110 000	100 000	130 000	100 000	89 000	110 000
Zambia	78 000	71 000	85 000	78 000	70 000	87 000
Zimbabwe	70 000	63 000	77 000	70 000	63 000	78 000
PMTCT High Burden Countries	**1 300 000**	**1 200 000**	**1 400 000**	**1 300 000**	**1 200 000**	**1 400 000**

Sources: UNAIDS 2013 Estimates.

OVERALL TARGET 1: NUMBER OF NEW CHILD INFECTIONS

21 GLOBAL PLAN COUNTRIES IN SUB-SAHARAN AFRICA	2009	Low	High	2013	Low	High
Angola	4 400	2 800	6 400	4 000	2 100	6 400
Botswana	<1 000	<1 000	<1 000	<500	<500	<500
Burundi	2 600	2 200	3 000	1 300	<1 000	1 700
Cameroon	14 000	12 000	16 000	9 500	7 700	11 000
Chad	4 900	3 900	6 100	3 700	2 800	4 900
Côte d'Ivoire	8 200	7 000	9 600	4 900	3 700	6 200
Democratic Republic of the Congo	10 000	8 300	13 000	7 400	5 600	9 600
Ethiopia	20 000	17 000	23 000	8 300	6 200	11 000
Ghana	4 800	3 300	6 700	2 400	1 000	4 500
Kenya	21 000	17 000	25 000	13 000	9 200	17 000
Lesotho	4 400	3 800	4 900	3 400	2 800	3 900
Malawi	23 000	20 000	25 000	7 400	5 100	9 800
Mozambique	27 000	23 000	33 000	12 000	8 500	19 000
Namibia	2 400	1 800	3 200	1 100	<1 000	1 800
Nigeria	63 000	55 000	72 000	51 000	44 000	60 000
South Africa	33 000	24 000	43 000	16 000	14 000	19 000
Swaziland	1 900	1 700	2 200	1 100	<1 000	1 200
Uganda	30 000	26 000	33 000	16 000	10 000	21 000
United Republic of Tanzania	31 000	26 000	36 000	16 000	12 000	20 000
Zambia	19 000	16 000	21 000	12 000	9 800	15 000
Zimbabwe	21 000	19 000	24 000	9 000	6 200	12 000
PMTCT High Burden Countries	**350 000**	**310 000**	**380 000**	**200 000**	**170 000**	**230 000**

2015 target: 90% reduction in new infections among children

Sources: UNAIDS 2013 Estimates.

PRONG 1 TARGET: NEW HIV INFECTIONS AMONG WOMEN 15-49

21 GLOBAL PLAN COUNTRIES IN SUB-SAHARAN AFRICA	2009	Low	High	2013	Low	High
Angola	10 000	6 800	15 000	13 000	8 400	20 000
Botswana	5 900	5 000	6 800	4 500	3 700	5 400
Burundi	<500	<100	1 000	<500	<200	<1000
Cameroon	22 000	20 000	25 000	20 000	17 000	24 000
Chad	5 800	4 300	7 900	4 700	3 200	6 700
Côte d'Ivoire	5 800	3 900	8 000	7 200	4 300	11 000
Democratic Republic of the Congo	15 000	12 000	20 000	14 000	11 000	18 000
Ethiopia	4 500	1 800	8 500	7 800	4 600	13 000
Ghana	6 200	3 500	9 900	3 000	<500	6 800
Kenya	52 000	44 000	60 000	48 000	37 000	63 000
Lesotho	13 000	12 000	15 000	12 000	10 000	14 000
Malawi	22 000	19 000	25 000	14 000	11 000	17 000
Mozambique	55 000	47 000	66 000	54 000	43 000	70 000
Namibia	5 300	3 800	7 500	5700	4 000	8 000
Nigeria	120 000	100 000	140 000	88 000	72 000	110 000
South Africa	220 000	200 000	240 000	160 000	150 000	180 000
Swaziland	6 800	6 200	7 400	5 200	4 500	6 000
Uganda	66 000	58 000	73 000	67 000	58 000	79 000
United Republic of Tanzania	40 000	34 000	46 000	30 000	25 000	37 000
Zambia	26 000	23 000	30 000	20 000	17 000	24 000
Zimbabwe	39 000	35 000	44 000	33 000	28 000	38 000
PMTCT High Burden Countries	**740 000**	**680 000**	**800 000**	**620 000**	**560 000**	**680 000**

2015 target: 50% reduction in incidence among women 15-49 years of age

Sources: UNAIDS 2013 Estimates.

PRONG 2 TARGET: UNMET NEED FOR FAMILY PLANNING FOR WOMEN

21 GLOBAL PLAN COUNTRIES IN SUB-SAHARAN AFRICA		Year
Angola		
Botswana		
Burundi	32	2010
Cameroon	24	2011
Chad	28.3	2010
Côte d'Ivoire	27	2012
Democratic Republic of the Congo	24.2	2010
Ethiopia	26	2011
Ghana	26.4	2011
Kenya	26	2008–09
Lesotho	23	2009
Malawi	26	2010
Mozambique	29	2011
Namibia	18	2013
Nigeria	16	2013
South Africa	13.8	2003
Swaziland	13	2010
Uganda	34	2011
United Republic of Tanzania	25	2010
Zambia	27	2007
Zimbabwe	15	2010–11
PMTCT High Burden Countries		

2015 target: Reduce unmet need for family planning to zero

Source: Household surveys, 2003-2013. The revised definition of unmet need for family planning among currently married women (15–49 years) was used. See: http://dhsprogram.com/topics/Unmet-Need.cfm.

PRONG 3 TARGET: FINAL MOTHER TO CHILD TRANSMISSION RATE

21 GLOBAL PLAN COUNTRIES IN SUB-SAHARAN AFRICA	2009	Low	High	2013	Low	High
Angola	33	19	46	25	12	39
Botswana	5	4	5	2	2	3
Burundi	34	29	40	25	18	32
Cameroon	32	28	36	25	20	29
Chad	34	26	41	32	23	41
Côte d'Ivoire	29	25	34	23	17	29
Democratic Republic of the Congo	36	28	43	29	21	37
Ethiopia	39	33	46	25	18	32
Ghana	32	21	43	21	6	35
Kenya	26	21	30	16	11	21
Lesotho	27	24	31	22	18	25
Malawi	32	28	35	13	9	17
Mozambique	26	22	31	12	7	17
Namibia	22	15	28	10	4	16
Nigeria	31	27	35	26	22	31
South Africa	12	9	16	6	5	7
Swaziland	19	17	22	10	9	11
Uganda	31	27	35	13	9	18
United Republic of Tanzania	27	23	32	16	11	20
Zambia	24	21	27	15	12	18
Zimbabwe	30	27	34	13	9	17
PMTCT High Burden Countries	**26**	**23**	**28**	**16**	**13**	**18**

2015 target: Reduce the final mother-to-child HIV transmission rate to <5%h

Sources: UNAIDS 2013 Estimates.

PRONG 3 TARGET: PER CENT OF WOMEN RECEIVING ANTIRETROVIRAL MEDICINES (EXCLUDING SINGE DOSE NEVIRAPINE) TO PREVENT NEW INFECTIONS AMONG CHILDREN

21 GLOBAL PLAN COUNTRIES IN SUB-SAHARAN AFRICA	2009	Low	High	2013	Low	High
Angola	23	16	34	39	28	58
Botswana	92	85	>95	>95	87	>95
Burundi	19	16	22	58	49	69
Cameroon	14	13	16	61	54	69
Chad	7	6	8	19	15	24
Côte d'Ivoire	40	35	45	75	64	88
Democratic Republic of the Congo	4	3	5	33	27	41
Ethiopia	9	7	10	55	47	65
Ghana	24	18	33	62	44	86
Kenya	37	33	42	63	55	72
Lesotho	41	37	45	53	49	59
Malawi	17	16	19	79	71	88
Mozambique	36	31	40	84	71	>95
Namibia	51	42	62	90	73	>95
Nigeria	13	12	15	27	24	31
South Africa	63	59	69	90	83	>95
Swaziland	63	59	68	>95	>95	>95
Uganda	25	22	28	75	68	85
United Republic of Tanzania	28	25	31	73	65	83
Zambia	47	43	52	76	68	84
Zimbabwe	9	8	10	78	70	87
PMTCT High Burden Countries	**33**	**31**	**35**	**68**	**64**	**74**

2015 target: 90% of pregnant women living with HIV receive perinatal antiretroviral therapy or prophylaxis

Sources: UNAIDS 2013 Estimates.

PRONG 3 TARGET: PER CENT OF WOMEN OR INFANTS RECEIVING ANTIRETROVIRAL MEDICINES DURING BREASTFEEDING

21 GLOBAL PLAN COUNTRIES IN SUB-SAHARAN AFRICA	2009	Low	High	2013	Low	High
Angola	0	0	0	39	28	58
Botswana	31	28	34	>95	87	>95
Burundi	0	0	0	22	18	26
Cameroon	8	8	9	16	14	18
Chad	7	6	8	19	15	24
Côte d'Ivoire	6	6	7	20	18	24
Democratic Republic of the Congo	0	0	0	17	13	20
Ethiopia	2	2	2	55	47	65
Ghana	0	0	0	30	22	42
Kenya	17	15	20	63	55	72
Lesotho	11	10	13	41	38	46
Malawi	4	4	5	79	71	88
Mozambique	7	7	9	84	71	>95
Namibia	11	9	14	56	45	70
Nigeria	4	3	4	19	17	22
South Africa	63	59	69	90	83	>95
Swaziland	18	17	20	49	46	53
Uganda	0	0	0	75	68	85
United Republic of Tanzania	28	25	31	73	65	83
Zambia	16	14	17	43	39	48
Zimbabwe	1	1	1	78	70	87
PMTCT High Burden Countries	**20**	**19**	**21**	**61**	**57**	**66**

2015 target: 90% of breastfeeding infant-mother pairs receive antiretroviral therapy or prophylaxis

Sources: UNAIDS 2013 Estimates.

PRONG 4 TARGET: ANTIRETROVIRAL THERAPY COVERAGE AMONG CHILDREN <15 YEARS

21 GLOBAL PLAN COUNTRIES IN SUB-SAHARAN AFRICA	2009	Low	High	2013	Low	High
Angola	7	5	10	14	10	22
Botswana	43	40	48	84	79	91
Burundi	9	8	11	12	10	14
Cameroon	3	3	4	6	5	7
Chad	2	2	3	5	4	6
Côte d'Ivoire	5	4	6	8	7	9
Democratic Republic of the Congo	8	7	10	8	6	9
Ethiopia	4	3	4	9	8	11
Ghana	4	3	5	11	8	16
Kenya	12	10	13	31	27	36
Lesotho	11	10	12	15	13	16
Malawi	8	8	9	24	22	27
Mozambique	8	7	9	22	18	26
Namibia	34	28	42	45	36	56
Nigeria	5	4	6	12	10	13
South Africa	8	7	9	44	40	48
Swaziland	23	21	25	46	42	49
Uganda	9	8	10	22	20	26
United Republic of Tanzania	4	4	5	16	14	18
Zambia	13	12	15	33	29	36
Zimbabwe	10	9	11	27	24	30
PMTCT High Burden Countries	**8**	**7**	**8**	**22**	**21**	**24**

2015 target: Provide antiretroviral therapy for all HIV-infected children

Sources: UNAIDS 2013 Estimates.

21 PMTCT GLOBAL PLAN COUNTRIES	PRONG 4 TARGET: PER CENT OF DEATHS AMONG CHILDREN 1–59 MONTHS DUE TO HIV 2013
Angola	1%
Botswana	6%
Burundi	1%
Cameroon	3%
Chad	2%
Cote dIvoire	2%
Democratic Republic of the Congo	1%
Ethiopia	2%
Ghana	1%
Kenya	4%
Lesotho	20%
Malawi	12%
Mozambique	7%
Namibia	7%
Nigeria	3%
South Africa	17%
Swaziland	15%
Uganda	7%
United Republic of Tanzania	6%
Zambia	6%
Zimbabwe	9%
PMTCT High Burden Countries	

2015 target: Reduce AIDS-related infant deaths by >50 percent

Sources: Child Health Epidemiological Reference Group (CHERG) provisional 2014 estimates.

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