The Global Plan Towards the Elimination of New HIV Infections Among Children by 2015 and Keeping Their Mothers Alive
Prepared for the iERG
By UNAIDS
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I. Background

This is a preliminary report to the independent Expert Review Group (iERG). It provides our most recent complete data (2013) and updates on 2014 implementation activities reflecting the progress of the Global Plan towards the elimination of new HIV infections among children and keeping their mothers alive (Global Plan). Data cleaning and country validation of 2014 progress is ongoing, and the final country data sign-off will be in mid-June 2015. However we are aware that this may be too late for the iERG, and thus we have prepared a preliminary report for this purpose.

Our report to you is informed by your post-2015 vision for the future of women’s and children’s health and for the future accountability arrangements needed to ensure that commitments to that vision are met. http://apps.who.int/iris/bitstream/10665/132673/1/9789241507523_eng.pdf?ua=1.

II. About the Global Plan

The Global Plan aims to eliminate new HIV infections among children by 2015 and keep their mothers alive. There are now approximately 230 days to the end of 2015, when the Global Plan’s full achievements can be assessed (these data will be available in 2016). When it was developed, the Global Plan recognized the need to revolutionize approaches towards preventing mother-to-child transmission of HIV. However significant challenges remain but there are also opportunities for these to be overcome. In 2009, the baseline year on which the Global Plan bases its progress, an estimated 15.7 million women above the age of 15 were living with HIV globally, of whom 1.4 million became pregnant. Nearly 90% of these expectant mothers were from 22 countries in sub-Saharan Africa and India. To provide prevention, care and support for these women, several simultaneous actions were needed:

1. Extraordinary leadership
2. Up-to-date national plans
3. Sufficient financial investment
4. Comprehensive and coordinated approach to HIV prevention and treatment for mothers and their children
5. Greater programmatic synergies and strategic integration
6. Adequate human resources for health
7. Structural impediments to scale up addressed
8. Access to essential supplies strengthened
9. Simplification

1 The 22 Global Plan countries are as follows: 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. Together these countries accounted for 90% of new HIV infections among children in 2009, the baseline year of the Global Plan.
The Global Plan was officially launched at the UN General Assembly High Level Meeting on AIDS, held in June 2011. It is implemented by countries, supported by a consortium of partners co-chaired by UNAIDS and PEPFAR. Its goal is to eliminate new HIV infections among children and keeping their mothers alive. The Global Plan has two targets:

- Global Target #1: Reduce the number of new HIV infections among children by 90%
- Global Target #2: Reduce the number of AIDS-related maternal and paediatric deaths by 50%

This year (2015), the Global Plan management opted not to convene the ministerial accountability meeting, normally held on the sidelines of the World Health Assembly; options are under review to hold a similar event later in the year. The data pertaining to the 2014 Global Plan activities will be presented at the UNAIDS MDG report, embargoed for planned release in July 2015. Countries are in the middle of validating the data, and the validation process will end in mid June. Therefore the results presented in our report to you focuses on 2013, acknowledging it does not yet reflect the newest in-coming information.

## III. Key results from 2013

**Prophylaxis and treatment among pregnant women:** The Global Plan continued to make progress in 2013, although gains were fragile and greater momentum is still needed. For the first time since the 1990s, the number of new HIV infections among children in the 21 Global Plan priority countries in sub-Saharan Africa dropped to under 200,000 ([170,000–230,000]; note that data for India was not available). This represented a 43% decline in the number of new HIV infections among children in these 21 countries in Year 3 of this accelerated effort, relative to the 2009 baseline, providing reasons for optimism as the Global Plan pushes towards its 2015 goals of 90% reduction. It is anticipated that the results for 2014, which are being validated, will show even greater progress. In 2013, eight of the 21 high-burden countries had already achieved over 50% reduction in new HIV infections among children, including Botswana, Ethiopia, Ghana, Malawi, Mozambique, Namibia, South Africa, and Zimbabwe.

However, there were also some reasons for concern, as the pace of progress slowed between 2012 and 2013. In 2013, although twice as many (68%) pregnant women living with HIV in the priority countries received antiretroviral medicines to reduce the risk of HIV transmission to their children, this represented a gain of only 4 percentage points above 64% in 2012. Progress appeared to stall in several countries including Botswana, South Africa, Tanzania, Uganda and Zimbabwe. Progress reversed in several other countries including Chad, Ghana, Lesotho and Zambia. The reasons for these outcomes vary, including bottle-necks in service delivery and supply systems. Improvements in data systems may also have allowed for more accurate estimates in 2013 compared to previous years. Countries such as Botswana and South Africa had ARV coverage of nearly 90 percent among eligible women in 2012 already, and large additional gains may have become difficult to achieve.

Countries have kept abreast of innovations in PMTCT and have quickly adopted the 2013 WHO guidelines that recommend the most efficacious antiretroviral medicines through breastfeeding (Option B), or life-long treatment for pregnant women living with HIV (Option B+). WHO no longer recommends Option A and countries are in various stages of phasing this regimen. At the end of 2014, all 22 Global Plan countries had officially endorsed Option B or B+. Sixteen (16) of these had adopted Option B+, five of which have now achieved full nationwide implementation (see Table 1).
Table 1: ART National Policy for Pregnant and Breastfeeding Women Among 22 Global Plan Priority Countries, February 2015

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<td>1. Angola</td>
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<td>B+ (2013)</td>
<td>Scale-up</td>
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<td>6. Cote d'Voire</td>
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<td>Planning, pilots</td>
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<td>9. Ghana</td>
<td>A</td>
<td>B</td>
<td>Scale-up</td>
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<td>10. India</td>
<td>A</td>
<td>B+ (2014)</td>
<td>Scale-up</td>
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<td>12. Lesotho</td>
<td>A</td>
<td>B+ (2013)</td>
<td>Full implementation</td>
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<td>22. Zimbabwe</td>
<td>A</td>
<td>B+ (2013)</td>
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Source: IATT Annual Report, March 2015

The risk 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 important goals of the Global Plan is to reduce this risk 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% (2013 data). Further analysis suggests that priority countries had achieved a six-week mother-to-child transmission rate of 7%, but this rose to 16% by the end of breastfeeding. 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 to breastfeeding mothers during this period, in order to prevent children who are HIV-free at birth from acquiring the infection during breastfeeding.

With a modelled transmission rate of 2% in 2013, Botswana appears to have reached the Global Plan milestone of under two percent. South Africa was close behind, with a final transmission rate of 6%. The remaining 19 countries have a 2013 HIV transmission rate of over six percent, including ten with transmission rates of over 15 percent (data not available for India).

Prophylaxis and treatment among infants
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 intra-partum period have worse prognosis; the earlier infants 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 standard 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 most often performed on dried blood spot specimens collected at local sites and then transported and analyzed in large centralized laboratories. This has sometimes led to long waiting periods before the results are returned to the caregiver, resulting in increased rates of loss to follow-up and failure to initiate treatment among those diagnosed as seropositive.

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 39% of children exposed to HIV received HIV virological testing within the first two months of life (2013 data). Only six of the priority countries were providing early infant diagnosis to more than 50% of children exposed to HIV: South Africa (94%), Swaziland (89%), Botswana (58%), Namibia (56%), Zambia (55%) and Zimbabwe (50%) (see Figure below). In the remaining priority countries, the number of infants receiving virological testing was less than 50%, unchanged or decreasing slightly from previous years. In nine priority countries, the number of children exposed to HIV receiving virological testing was less than 25%. Follow-up care for mothers and their children must be strengthened post-partum and for the duration of 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 of breastfeeding.
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 had increased in all priority countries. Botswana had achieved universal access (defined as 80% coverage), with 84% of infected children receiving HIV treatment. Three priority countries – Namibia, South Africa and Swaziland – were 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 provided treatment to less than 10% of their children living with HIV. In total, only 22% of children living with HIV were 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 39% adult treatment coverage of in the 21 priority countries.
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, a challenge 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 and regimens complicate pricing and ordering decisions 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.

IV. Update on implementation during 2014

The bulk of effort during 2014 was devoted to technical assistance to countries. Technical assistance to countries is implemented and coordinated by the Inter-agency Task Team for the Prevention and Treatment of HIV Infection in Pregnant Women, Mothers and Children (referred to here at the IATT). The IATT is co-chaired by WHO and UNICEF, and is housed at UNICEF New York. It comprises of 33-member organization and has the following mandate within the Global Plan:

- To coordinate and track the provision of technical assistance
- To monitor and track progress of country-led implementation of the Global Plan; and
- To develop, update and disseminate operational and normative tools and guidance

The IATT supports countries to ensure that the needed building blocks for the elimination of mother-to-child transmission of HIV (eMTCT) are in place, and aims for more effective, coordinated national planning for service delivery with PEPFAR, Global Fund and other multilateral and bilateral support. It has representatives in each of the 22 priority countries and provides day-to-day technical support at country level. It also implements global activities and missions, and below is a sampling of those implemented during 2014:

**Nigeria country mission**

PMTCT coverage remains low in Nigeria. Low numbers and capacity of health cadres trained in essential ARVs for eMTCT has been identified as a critical issue, which can be mitigated in part through a task shifting policy. The IATT Secretariat and the Human Resources for Health (HRH) Working group (represented by EGPAF, Intrahealth and WHO) conducted a joint mission to Nigeria to hold consultations with the Federal Ministry of Health (FMOH), National AIDS Control Programme (NASCOP), partners and professional organizations in May 2014 to assess key bottlenecks to task shifting and advocate for policy change. The task shifting policy has since been revised and adopted by the FMOH.

The Finance and Economic Working Group (FEWG) members provided in-country support to cost Options A, B, and B+ with MoH staff from 12+1 States with a high burden of HIV in pregnant women (Abia, Akwa Ibom, Anambra, Bayelsa, Benue, Cross River, Federal Capital Territory, Kaduna, Lagos, Nasarawa, Plateau, Rivers). This consisted of an initial meeting to outline the process and collect data and a second capacity building workshop to apply the costing models and train PMTCT and M&E staff from the States to conduct the costing exercise. These cost projections have been used to inform programmatic decision-making to adopt new PMTCT guidelines and development of state implementation plans.
Democratic Republic of Congo country mission
UNICEF/WHO provided technical assistance to help revise the Global Fund concept note to better articulate TB/HIV integration. UNICEF supported the Katanga Department of Health to review 6 months of data on Option B+ implementation and provided recommendations on M&E systems strengthening through the process. As a result of this work, UNICEF will support the Katanga Department of Health to undertake an assessment in 6 zones looking at health systems constraints, models of care, patient support services and demand creation activities as part of UNICEF’s Optimizing HIV Treatment Access (OHTA) for pregnant women project.

Mozambique country mission
The IATT secretariat supported revision of national M&E registers to introduce cohort reporting and monitor implementation of Option B+.

Tanzania country mission
The IATT Secretariat M&E Specialist, in collaboration with Centers for Disease Control (CDC) Atlanta, supported protocol development and data analysis for evaluation of the early experiences in the Option B+ rollout, including retention of mothers in antenatal care. The Secretariat also participated in the dissemination of the results in Tanzania and supported editing of the final report that was released by the Ministry of Health in May 2014.

Cote D’Ivoire country mission
At the request of the MoH, a joint mission by the UN regional and headquarters’ technical advisers was conducted to review the PMTCT/paediatric HIV programme in light of the slow progress towards achieving eMTCT goals, and to advocate for adoption of Option B+. The transition from Option B to B+ has not yet started but following the joint mission, a task-shifting policy has been approved, to be piloted in 2015.

Zimbabwe country mission
UNICEF/WHO and IATT partners supported many facets of the strategic dialogue and national evaluation of Option B+ roll out and paediatric ART services. As a result of this effort, Zimbabwe rapidly moved from pilot and planning of Option B+ to full national implementation and monitoring in 2014. Discussions of paediatric ART scale up are still ongoing.

South Africa
UNICEF and WHO supported midterm review of the National RMNCH Strategic Plan in June 2014.

Global
The IATT also provided multi-country support for the development of Global Fund concept notes. This consisted of supporting the development of tools and guidance on how to integrate MNCH and PMTCT into concept notes. This was facilitated at a regional meeting held in Johannesburg in July 2014 in collaboration with the Global Fund, UNICEF, WHO and UNFPA and 10 country teams. Of the 22 Global Plan countries, 12 had submitted concept notes by December 2014, while 8 planned to submit in the early part of 2015.

2014 Meeting of Global Plan Partnership
In November 2014, the Global Plan partnership held its annual consultations to take stock of country progress, and to plan for 2015. There were two adjacent meetings, which brought together national country Focal Points, IATT delegates, implementing partners, networks of
women living with HIV, and Global Plan core partners and management. These consultations examined the technical, programmatic and political barriers to greater progress, and how to address them. Delegates prioritized the following actions:

1. Strategic high-level advocacy missions to countries for sustained commitment to eMTCT and resource mobilization especially for domestic resources, including public-private partnerships

2. Strengthening PMTCT leadership at national level, including leadership by networks of women living with HIV.

3. Political support for civil society organizations and persons living with HIV in planning, implementation and monitoring of performance

4. Documentation of the promising experiences, particularly on expansion of post-natal mother-baby pair cohort follow up, optimal use of viral load monitoring and related clinical practices

5. Advocacy to strengthen human resources including better remuneration, in order to enable improved staff retention

6. Prioritize actions to increase pediatric diagnosis and treatment

7. Promote adoption of normative guidance, develop “how-to” guidance and tools to operationalize WHO normative guidance and roll-out of Option B/B+

8. Provide operational guidance: Support country implementation on re-testing of pregnant women, birth testing of children, and confirmatory maternal HIV testing before ART initiation.

9. Effective integration and provider-initiated testing and counselling at child health entry points to optimize yield of positive children

10. Support community engagement activities to improve access and retention

V. A word about women and communities

At the core of the Global Plan has always been the role of communities and networks of women living with HIV, in both the design, implementation and assessment of this initiative. The Global Plan embodies the principle that the rights of women living with HIV are respected, and that women, their families and communities are empowered to fully engage in ensuring their own health and especially the health of their children. Therefore, since inception, national plans for eliminating new HIV infections among children and keeping their mothers alive were firmly grounded in the best interests of the mother and child, and a growing recognition of the role of communities in supporting them. Countries have been encouraged to ensure meaningful participation of communities and women living with HIV in the process of developing and implementing programmes, as true partners in providing care. The Global Plan also strives to ensure that women living with HIV have access to family planning services and commodities, in order to prevent unintended pregnancies. These aims have remained part of the Global Plan and will continue to guide its activities in 2015 and beyond.