



Start Free, Stay Free, AIDS Free
Final report on 2020 targets

July 2021

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GLOBAL STATUS OF PROGRESS TOWARDS THE START FREE, STAY FREE, AIDS FREE TARGETS

In the global quest to end the AIDS epidemic as a public health threat by 2030, meeting the HIV-related needs of children, adolescents and pregnant and breastfeeding women represents a critical piece of unfinished business. Progress towards eliminating new HIV infections among children (aged 0-14 years) has stalled, and the number of adolescents girls and young women (aged 10-24 years) who acquire HIV each year remains unacceptably high. In 2020, children accounted for 5% of all people living with HIV but comprised 15% of all people who died from AIDS-related causes.

To inject a sense of urgency in to global efforts to end the epidemic among children, adolescents and young women, global partners¹ joined together in 2015 to launch the Start Free, Stay Free, AIDS Free framework. Unveiled as the global community was embracing a series of 2020 targets intended to Fast-Track the HIV response, Start Free, Stay Free, AIDS Free called for a super-Fast-Track approach to end AIDS as a public health threat among children, adolescents and young women by 2020.

1 The United States President's Emergency Plan for AIDS Relief (PEPFAR), Joint United Nations Programme on HIV/AIDS (UNAIDS), United Nations Children's Fund (UNICEF) and World Health Organization (WHO), with support from the Elizabeth Glaser Pediatric AIDS Foundation and ICAP at Columbia University.



START FREE

Every child deserves an HIV-free beginning.

STAY FREE

When children have an HIV-free start, they must be supported to stay that way as they enter adolescence and progress into adulthood.

AIDS FREE

Everyone who is living with HIV should have access to antiretroviral therapy to stay AIDS free and reduce the risk of onward transmission to an uninfected person.



Bold goals and targets

The framework outlined a series of bold goals and related targets.

START FREE, by preventing children from acquiring HIV during pregnancy, birth and throughout the breastfeeding period.

- Eliminate new HIV infections among children by reducing the number of children newly infected annually to less than 40 000 by 2018 and 20 000 by 2020.
- Reach and sustain 95% of pregnant women living with HIV with lifelong HIV treatment by 2018.

STAY FREE, by preventing adolescent girls and young women from acquiring HIV as they grow up.

- Reduce the number of adolescent girls and young women newly infected with HIV to less than 100 000 by 2020.
- Provide voluntary medical male circumcision for HIV prevention to 25 million additional men by 2020, with a focus on young men aged 10-29 years.

AIDS FREE, by providing HIV diagnosis, treatment, care and support to children and adolescents living with HIV.

- Provide antiretroviral therapy to 1.6 million children (aged 0-14 years) and 1.2 million adolescents (aged 15-19 years) living with HIV by 2018.
- Provide antiretroviral therapy to 1.4 million children (aged 0-14) and 1 million adolescents (aged 15-19 years) living with HIV by 2020².

Progress towards the Start Free, Stay Free, AIDS Free targets

Since the framework was launched, UNAIDS and partners have reported annually on progress towards achieving these targets. Since the deadline for achieving the targets passed in December 2020, this is the final Start Free, Stay Free, AIDS Free progress report.

Although the targets were global, partners identified 23 countries for intensified focus under the framework. This report specifically highlights progress against the targets in focus countries. The only focus countries outside sub-Saharan Africa (India and Indonesia) do not report data on Start Free, Stay Free, AIDS Free targets and are not covered in this report. The 21 focus countries³ covered in this report accounted for 83% of the global number of pregnant women living with HIV in 2020, 80% of children living with HIV and 78% of young women aged 15-24 newly infected with HIV.

As Table 1 illustrates, none of the Start Free, Stay Free, AIDS Free targets were achieved by the 2020 deadline. However, the 21 focus countries appear to have made better progress than non-focus countries in reducing the number of children newly infected with HIV, reporting a 24% decline from 2015 to 2020 versus a 20% decline globally.

² Targets for antiretroviral therapy decline from 2018 to 2020 because the numbers of children and adolescents living with HIV are declining as children age into adulthood and fewer acquire HIV

³ Angola, Botswana, Burundi, Cameroon, Chad, Côte d'Ivoire, Democratic Republic of the Congo, Eswatini, Ethiopia, Ghana, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, South Africa, Uganda, United Republic of Tanzania, Zambia and Zimbabwe

Table 1. Progress towards targets, global and focus countries, 2015 and 2020

Targets		2015	2020	Target
START FREE				
Eliminate new HIV infections among children (aged 0–14 years) by reducing the number of children newly infected annually to less than 20 000 by 2020.				
Children newly infected with HIV	Global	190 000	150 000	40 000
	Focus countries	150 000	110 000	
Reach and sustain 95% of pregnant women living with HIV with lifelong HIV treatment by 2018.				
ART coverage among pregnant women	Global	83%	85%	95%
	Focus countries	87%	89%	
STAY FREE				
Reduce the number of new HIV infections among adolescents and young women (aged 15–24 years) to less than 100 000 by 2020.				
Adolescent girls and young women newly infected with HIV	Global	340 000	260 000	100 000
	Focus countries	280 000	220 000	
Provide voluntary medical male circumcision for HIV prevention to 25 million additional men by 2020, with a focus on young men aged 10–29 years).				
Number of voluntary medical male circumcisions				
	15 voluntary medical male circumcision priority countries	2.6 million	2.8 million	5 million ^a
	13 male circumcision priority countries that are also among the 21 focus countries	2.5 million	2.3 million	
AIDS FREE				
Provide 1.4 million children (aged 0–14 years) receiving HIV treatment by 2020				
Number of children receiving antiretroviral therapy	Global	840 000	920 000	1.4 million
	Focus countries	690 000	740 000	
Provide 1 million adolescents (aged 15–19 years) receiving HIV treatment by 2020				
Number of adolescents receiving antiretroviral therapy	Global	Data not available	Data not available	1 million
	Focus countries	Data not available	480 000 ^a	

^a Extrapolated from data from 18 of 21 focus countries.

Voluntary medical male circumcision focus countries include Botswana, Eswatini, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, South Sudan, Uganda, United Republic of Tanzania, Zambia and Zimbabwe. Rwanda and South Sudan are not included in the Three Frees focus countries.

Sources: UNAIDS epidemiological estimates and Global AIDS Monitoring 2021.

For other targets, however, progress in the 21 focus countries does not reflect intensified efforts and is comparable to global progress. HIV treatment coverage among pregnant women living with HIV is higher in the focus countries than globally, but the differences in progress between focus countries and the world as a whole are negligible. The 25% global decline in the number of adolescents and young women newly infected with HIV is comparable to the 27% decline in focus countries. Likewise, HIV treatment coverage among children in the focus countries is the same as the global coverage (54%).

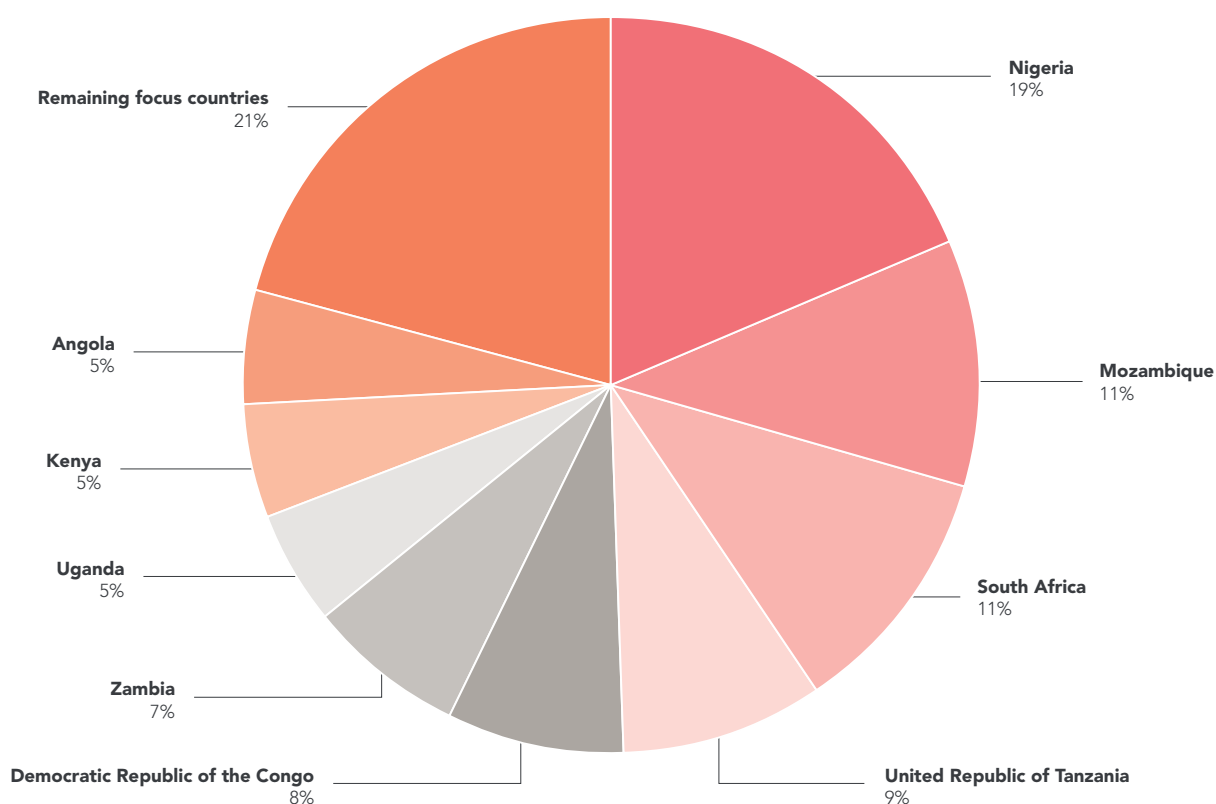
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3. BROWN	1-2-50		
4. WHITE	1-2-50		
5. GREEN	1-2-50		
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99. HAMILTON	1-2-50		



START FREE: PREVENTING VERTICAL TRANSMISSION

Momentum towards eliminating vertical transmission slowed in 2015–2020. In 2020, an estimated 110 000 children in the 21 focus countries acquired HIV (Figure 1). The number of children acquiring HIV in these 21 countries was nearly three times greater than the framework’s global target for 2020. Six countries (Nigeria, Mozambique, South Africa, United Republic of Tanzania, Democratic Republic of the Congo and Zambia) accounted for nearly two thirds of children acquiring HIV in 2020, with Nigeria accounting for almost one in five.

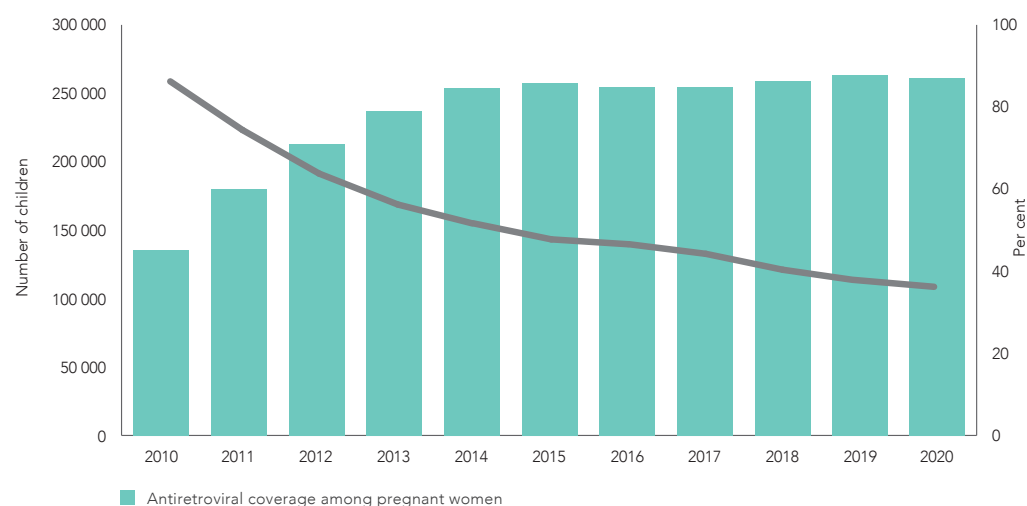
Figure 1. Distribution of children aged 0–14 years acquiring HIV by country among the focus countries, 2020



Source: UNAIDS epidemiological estimates 2021.

Although antiretroviral therapy coverage among pregnant and breastfeeding women is higher in the focus countries than it is globally, Although antiretroviral therapy coverage among pregnant and breastfeeding women is higher in the focus countries than it is globally, coverage in the focus countries has remained essentially flat since 2015 (Figure 2). The flattening of antiretroviral therapy use among pregnant and breastfeeding women is associated with a notable slowdown in the decline of the number of children acquiring HIV. The lack of progress in further expanding HIV treatment among pregnant and breastfeeding women suggests that even high-performing countries are experiencing challenges in going the last mile to eliminate vertical transmission.

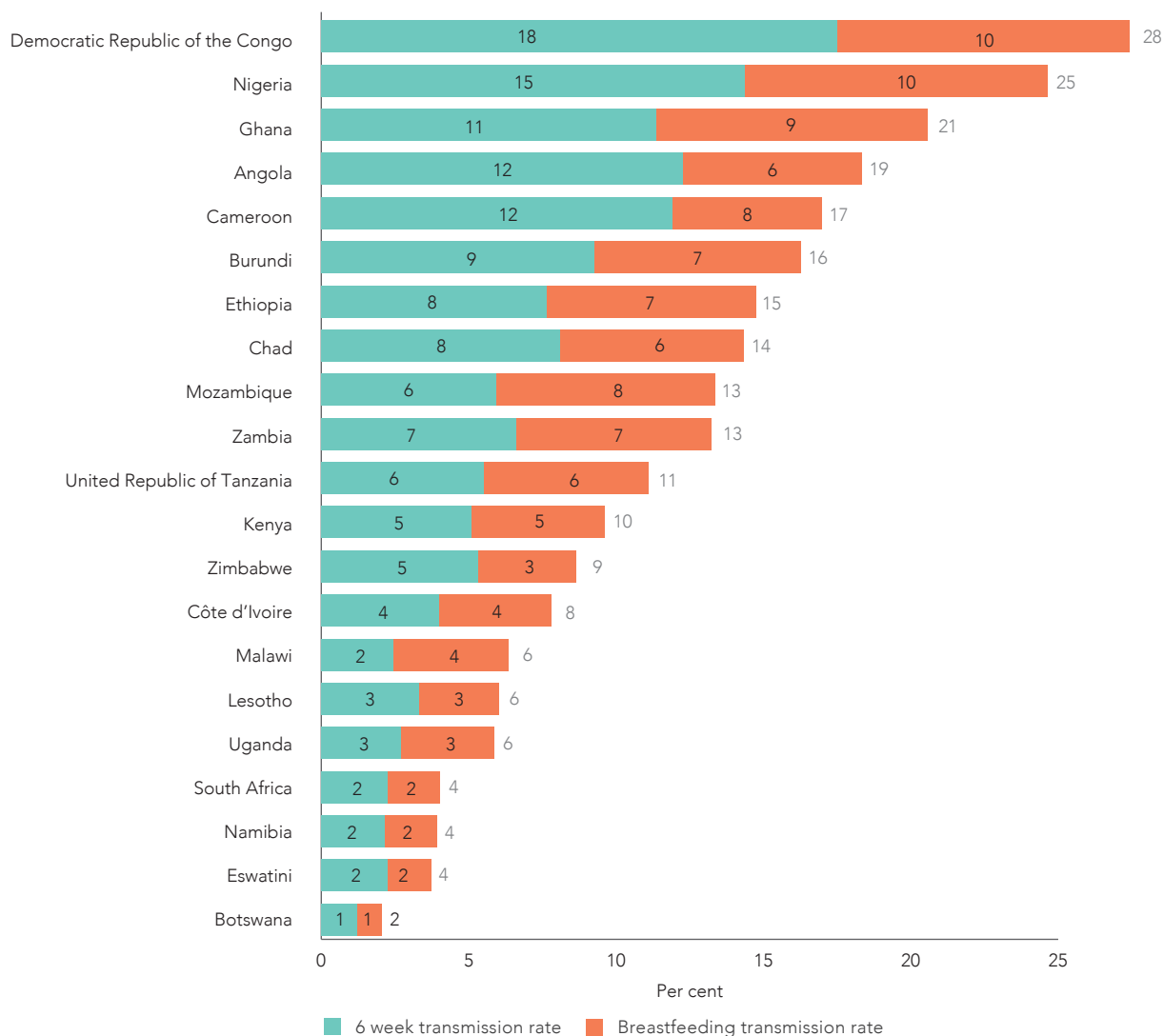
Figure 2. Number of children acquiring HIV and antiretroviral therapy coverage (%) among pregnant women and targets, focus countries, 2010–2020



Source: UNAIDS epidemiological estimates 2021.

Although antiretroviral therapy coverage among pregnant and breastfeeding women has remained relatively stable for the past seven years, this obscures marked variation in coverage and outcomes among the focus countries. As Figure 3 indicates, the rate of mother-to-child transmission (through both pregnancy and breastfeeding) ranges from 2% in Botswana to 28% in the Democratic Republic of the Congo. The variation reflects broader gaps in improving HIV treatment coverage among pregnant women, starting treatment early, supporting women to continue on treatment and achieve viral suppression during pregnancy, breastfeeding and throughout their lives, and reducing HIV incidence among pregnant and breastfeeding women. Botswana's very low 2% vertical transmission rate – comparable to the outcomes reported in high-income countries – is the direct result of the country's ability to support women to continue on treatment throughout pregnancy and breastfeeding. By contrast, in Nigeria, where only 44% of pregnant and breastfeeding women received antiretroviral therapy in 2020, the final vertical transmission rate was 25%.

Figure 3. Mother-to-child transmission of HIV, by timing of transmission, focus countries, 2020



Source: UNAIDS epidemiological estimates 2021.

Note: The numbers in the blue bars represent the six-week transmission rate, the numbers in the orange bar represent the breastfeeding transmission rate and the number at the end of the bar is the final transmission rate.
Source: UNAIDS epidemiological estimates, 2021.

Figure 3 also documents the important contribution of breastfeeding to the number of infants acquiring HIV. In 11 of 21 focus countries, half or more of the infants acquiring HIV results from transmission during breastfeeding. However, in the countries with the highest rate of vertical transmission, most infants who acquire HIV do so in the first six weeks of life.

Closing gaps in preventing vertical transmission

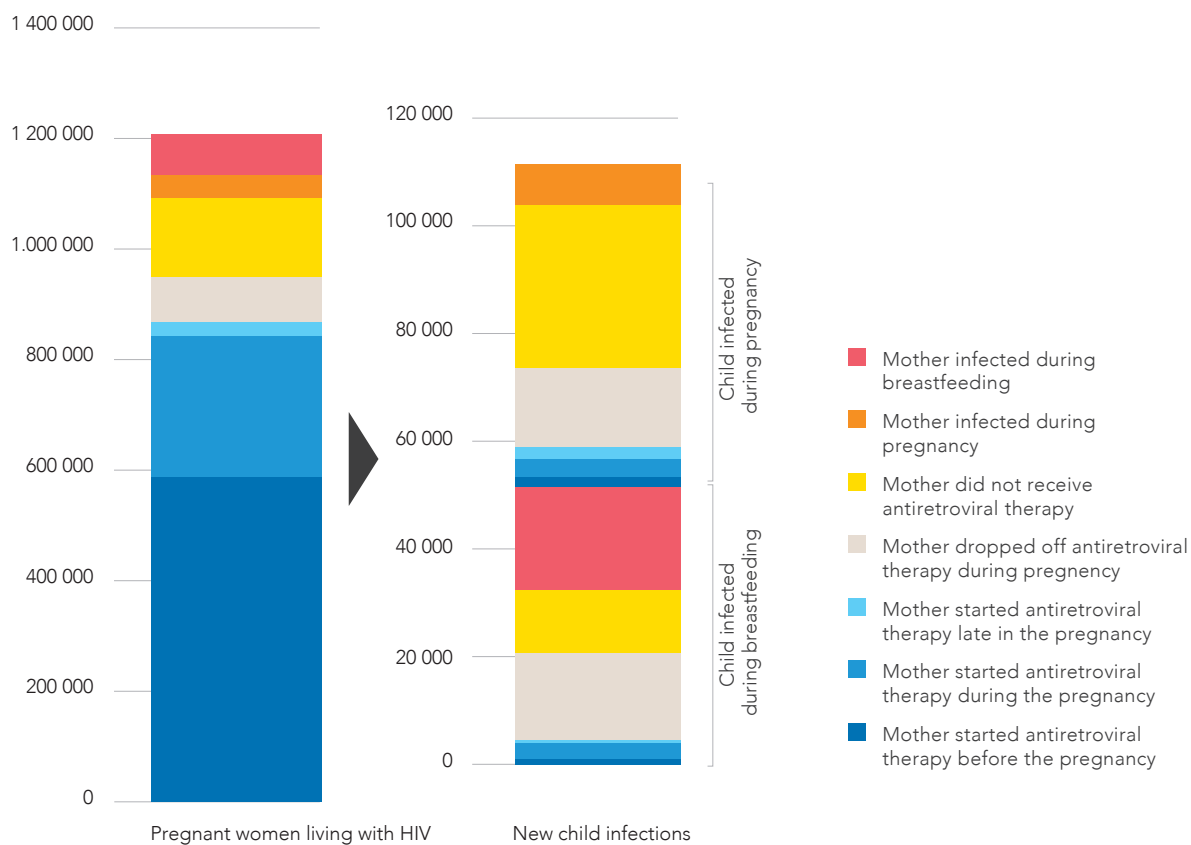
Highly effective interventions to prevent vertical transmission are not always translated into results for many reasons. Some pregnant women never access antenatal care or do so late in pregnancy. Many pregnant women living with HIV have not started antiretroviral therapy before pregnancy and only begin to do so weeks or months into their pregnancy. In South Africa, failure to achieve viral suppression among pregnant women has mainly been associated with late entry into antenatal care and late initiation of antiretroviral therapy (1). Some pregnant women are missed by testing services and never receive antiretroviral therapy. Others begin HIV treatment but do not remain engaged in care throughout pregnancy and breastfeeding – an important reason why WHO in 2021 issued recommendations emphasizing the importance of tracking and re-engaging people who drop out of care (2). Many women acquire HIV during pregnancy or breastfeeding and experience a spike in viral load, increasing the potential for vertical transmission.

The granularity of strategic information regarding the factors that contribute to infants acquiring HIV has substantially improved in recent years. This has enabled countries and programme implementers to develop innovative programmatic strategies focused on addressing the precise gaps and bottlenecks that slow progress towards the elimination target. For example, trained community focal mothers provide proactive, community-level support to mother-baby pairs living with HIV to ensure their retention in care – an approach that has increased retention in care at 12 months from 46% at baseline to 100% (3).

As Figure 4 illustrates in the bar on the left, there were about 1.1 million pregnant women living with HIV at the start of their pregnancy and an additional 120 000 pregnant or breastfeeding women who acquired HIV in the focus countries in 2020. About 140 000 of these women did not receive antiretroviral therapy and should have ideally been identified before they became pregnant. Support for continuity of treatment during pregnancy and breastfeeding was needed for 81 000 women who dropped off treatment either during pregnancy or breastfeeding.

As a result of these gaps in services (shown in the bar on the right in Figure 4), 41 000 children acquired HIV because women did not receive treatment, 31 000 because women did not remain engaged in care throughout pregnancy or breastfeeding and 27 000 because women acquired HIV during pregnancy or breastfeeding. Closing these gaps would put many of the focus countries on the pathway to eliminating mother-to-child transmission.

Figure 4. The missed opportunities to prevent children from acquiring HIV: pregnant women living with HIV and children acquiring HIV by missed opportunity, focus countries, 2020



Source: UNAIDS epidemiological estimates 2021.

The path to elimination

In 2014, WHO joined with UNAIDS, UNICEF and the United Nations Population Fund (UNFPA) to publish the first global guidance on validating the elimination of mother-to-child transmission of HIV and syphilis (4). Subsequently updated in 2017 (5), the criteria for elimination of vertical HIV transmission include a population case rate of no more than 50 per 100 000 live births and a mother-to-child transmission rate of no more than 5% in breastfeeding countries and no more than 2% in non-breastfeeding countries. As of June 2021, 15 countries and territories (Anguilla, Antigua & Barbuda, Armenia, Belarus, Bermuda, Cayman Islands, Cuba, Dominica, Malaysia, Maldives, Montserrat, Republic of Moldova (syphilis only), Saint Kitts and Nevis, Sri Lanka and Thailand) have been validated as having eliminated mother-to-child transmission of HIV and/or syphilis.

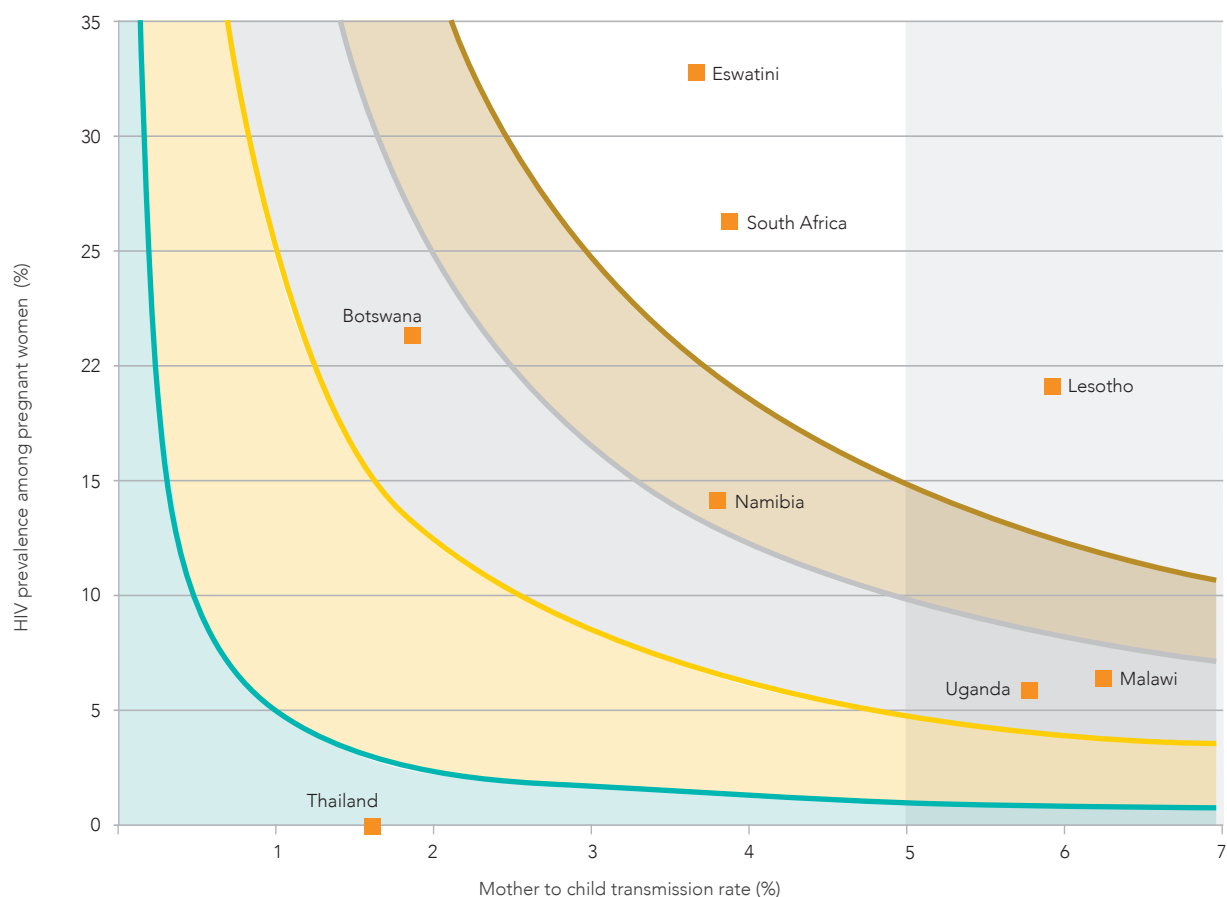
No country in sub-Saharan Africa has been validated for elimination of mother-to-child HIV transmission. Among focus countries, bringing the number of infants newly infected with HIV below the validation threshold will be virtually impossible because of these countries' high background HIV prevalence (see Figure 5).

The Global Validation Advisory Committee developed the Path to Elimination initiative to provide an incentive to countries with the highest HIV burden to recognize good country progress, encourage countries to give priority to strategic action to prevent vertical transmission and to celebrate national achievements towards the global elimination target.

Countries are deemed to be on the path to elimination if their mother-to-child transmission rate is less than 5%, their maternal antiretroviral therapy coverage rates are 90% or higher and they meet specified case rates (the number of children acquiring HIV per 100 000 births). Countries are categorized as "gold" if their case rate of acquiring HIV is less than 250 per 100 000 live births, as "silver" if their rate is less than 500 and as "bronze" if their rate is less than 750. The Path to Elimination initiative aims to support all focus countries in achieving "gold" status and ultimately elimination of mother to child transmission.

To achieve low case rates, a country needs to reduce both the HIV prevalence among pregnant women and the mother-to-child transmission rate. Since the case rate is derived by multiplying those two indicators, understanding how countries stand on these two indicators indicates actions needed to get on the path to elimination. Figure 5 illustrates how countries stood in 2020 in relation to the pathway to elimination targets, with Thailand added to show a country that has eliminated mother-to-child transmission and has a very low HIV prevalence among pregnant women.

Figure 5. Progress towards the path to elimination of mother-to-child transmission: HIV prevalence among pregnant women and transmission rate (which determines the case rate) and pathway status, focus countries and Thailand, 2020



Source: UNAIDS epidemiological estimates 2021.

Note: Countries in the green area have a case rate <50 per 100 000 births. Gold area: case rate 50–249 per 100 000 births. Silver area: case rate 250–499 per 100 000 births. Bronze area: case rate 500–749 per 100 000 births. Countries in the shaded area on the right have a mother-to-child transmission rate that is too high to qualify for the pathway to elimination. The figure only shows the impact indicators for achieving path-to-elimination status.

As Figure 5 indicates, four focus countries (Botswana, Eswatini, Namibia and South Africa) had mother-to-child transmission rates in 2020 of less than 5% but only two had low enough HIV prevalence to achieve the case rates required for path-to-elimination status. At least three additional countries (Lesotho, Malawi and Uganda) were within reach of bringing their rates under the 5% threshold. If Botswana is able to achieve the additional requirements for the path to elimination (antenatal care, maternal testing and treatment coverage, laboratory and data monitoring systems quality, community engagement, human rights and gender equality), the country could be eligible for silver status (with a case rate of 406 per 100 000 births in 2020). Similarly, Namibia could be eligible for bronze status (case rate of 542 per 100 000 births).

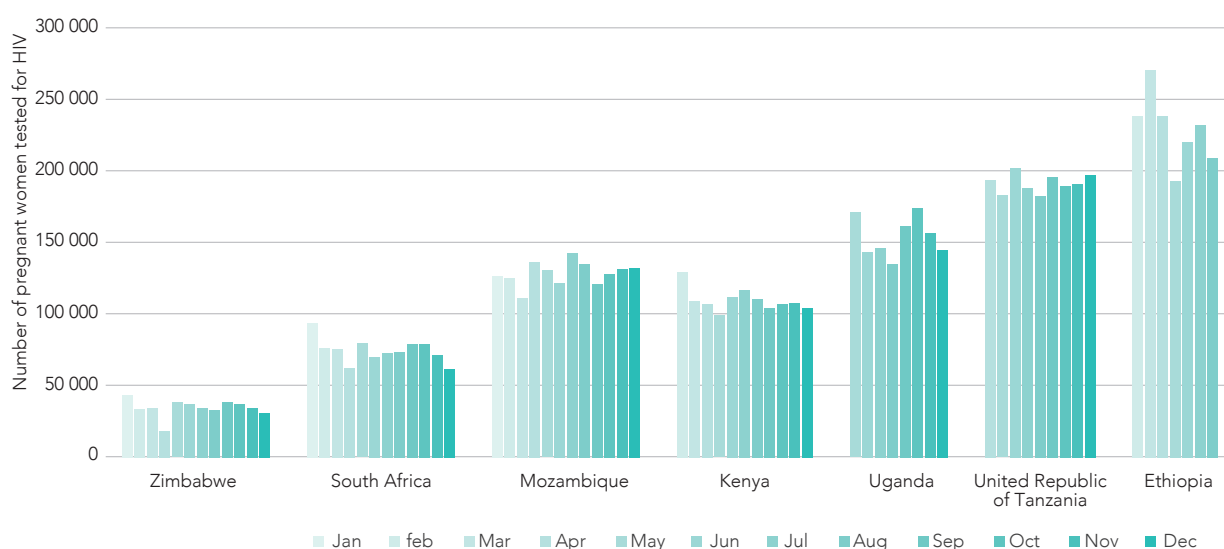
COVID-19 and preventing vertical transmission

The COVID-19 pandemic has disrupted virtually every aspect of life over the last 18 months, including efforts to accelerate progress towards eliminating vertical transmission. Beginning in March 2020, the number of women living with HIV who received antiretroviral therapy during pregnancy fell from pre-pandemic levels, with the sharpest decline occurring in April 2020 (Figure 6). Among the seven focus countries providing data to UNAIDS, four (Ethiopia, South Africa, Uganda and Zimbabwe) reported at least a 15% decline from January and February levels to April 2020

in the number of pregnant women tested for HIV at prenatal clinics.

Although testing and treatment services for pregnant women began to recover during 2020, service uptake was still below pre-COVID-19 levels as of August 2020 in four of the seven countries.

Figure 6. Number of pregnant women tested for HIV by month, select focus



Source: UNAIDS, WHO and UNICEF HIV service disruption data, 2020.

countries, 2020

At the same time that COVID-19 disrupted essential prevention, testing and treatment services, it also gave rise to a spirit of innovation and demonstrated the adaptability of HIV responses. For example, in Ethiopia, more than 80% of pregnant and breastfeeding women living with HIV are enrolled in multimonth dispensing services for their antiretroviral medicines. Multimonth dispensing should be scaled up in all countries, especially since differentiated service delivery strategies serve a growing proportion of women living with HIV and since pregnant women are deemed eligible for differentiated HIV service delivery under WHO guidelines. To support elimination efforts, family planning services need to be integrated into differentiated service delivery models. Integrating targeted HIV testing into family planning clinics, primary health care, and sexually transmitted infection clinics enables women living with HIV to be diagnosed before becoming pregnant and to plan pregnancies to minimize the risk of transmission to their children.

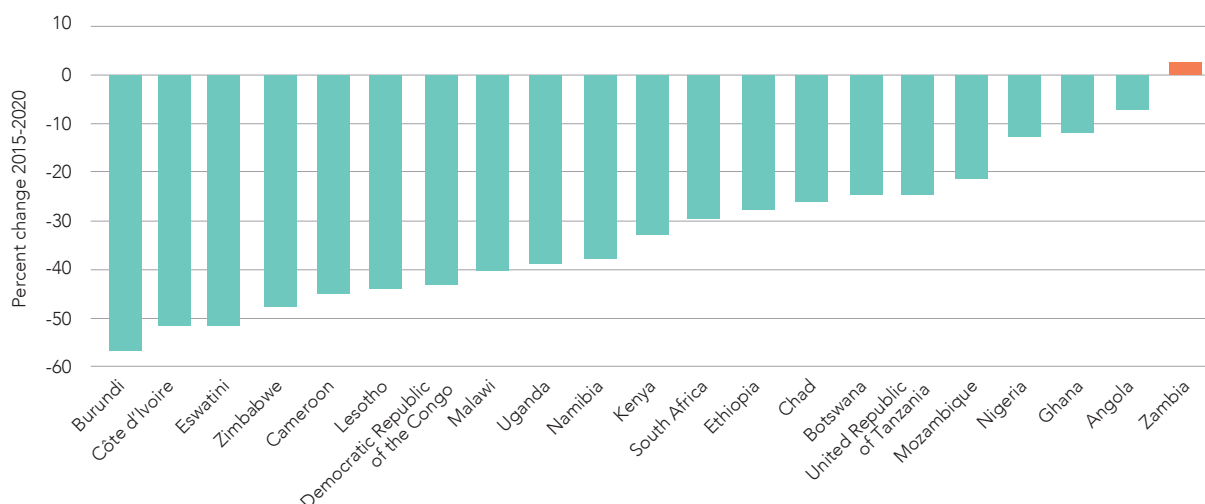


STAY FREE: PREVENTING HIV AMONG ADOLESCENT GIRLS AND YOUNG WOMEN

The epidemic continues to impose a heavy burden on adolescent girls and young women. In sub-Saharan Africa, adolescent girls and young women comprise 10% of the populations but in 2020 accounted for 25% of the people acquiring HIV. Multiple factors, including age-disparate sex, low condom use, sexual violence and coercion, gender norms and early sexual debut, contribute to the heightened risk of acquiring HIV.

There has been encouraging progress in preventing adolescent girls and young women from acquiring HIV. From 2015 to 2020, the annual number of adolescent girls and young women acquiring HIV fell from 280 000 to 200 000, or by 27%. As Figure 7 shows, the decline varies considerably by country, ranging from declines exceeding 50% in Burundi, Côte d'Ivoire and Eswatini to less than 10% in Angola and Zambia. In focus countries, the number of adolescent girls and young women acquiring HIV has declined more rapidly (27%) than among women 25 years and older (21%). However, the number of adolescent girls and young women acquiring HIV in the 21 focus countries was twice the global target for 2020 (100 000), underscoring the need for substantially more effective efforts to apply lessons learned from settings in which important prevention progress has been made and to redouble efforts to identify and address inequalities in access to HIV prevention.

Figure 7. Percentage change in women aged 15–24 years acquiring HIV in focus countries, 2015–2020



Source: UNAIDS epidemiological estimates 2021.

Strengthening HIV prevention among adolescent girls and young women

The Global AIDS Strategy gives priority to scaling up tailored combination prevention packages for all populations at risk of acquiring HIV. For adolescent girls and young women, there is growing recognition of the need for combination approaches that layer biomedical interventions with social and structural approaches that address key sources of vulnerability, including unequal gender norms, gender and sexual violence and inadequate educational and employment opportunities.

The array of biomedical tools for HIV prevention among adolescent girls and young women has expanded. In 2021, a study in seven African countries (6) found that cisgender women who received long-acting, injectable pre-exposure prophylaxis (PrEP) were significantly less likely to acquire HIV than women who took oral PrEP, which remains a highly effective, WHO-recommended prevention option for adolescent girls, young women and other populations at substantial risk of HIV infection (6). (WHO has not formally recommended long-acting PrEP for HIV prevention because of the lack of evidence on its effectiveness among adolescent girls, a gap that is being addressed by an ongoing bridging study, and because of the need to resolve implementation issues.) Also in 2021, WHO formally recommended using the dapivirine vaginal ring as part of a combination prevention package for women, and the European Medicines Agency issued a positive opinion on using this women-controlled prevention method in settings with a high burden of HIV infection (7).

The DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe) partnership led by the United States President's Emergency Plan for AIDS Relief (PEPFAR) in 15 countries⁴ links biomedical and behavioural HIV prevention for adolescent girls and young women with social protection, social asset building, violence prevention, interventions to change social norms and HIV interventions for men and boys (8). Likewise, the Global Fund to Fight AIDS, Tuberculosis and Malaria invests in combination prevention programmes for adolescent girls and young women, linking HIV testing and treatment services with programmes that keep girls in school, prevent gender-based violence, build girls' leadership, increase employment opportunities for adolescent girls and young women and provide comprehensive sexuality education (9). UNAIDS, UN Women, UNICEF, UNFPA and the United Nations Educational, Scientific and Cultural Organization (UNESCO) are co-leading a new initiative to advance gender justice in the HIV response through girls' education and empowerment alongside a comprehensive package of interventions designed to improve girls' life-course outcomes.

Schools play a pivotal role in the lives of adolescent girls and young women. In addition to the indirect health benefits of education, schools have the potential to play a more direct role in promoting the health of adolescent girls and young women. Schools often serve as a key source of health services for young people (10). WHO, UNESCO and partners in 2021 launched an initiative to make every school health promoting.

⁴ DREAMS countries include: Botswana, Côte d'Ivoire, Eswatini, Haiti, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, United Republic of Tanzania, Uganda, Zambia, and Zimbabwe

Health-promoting schools promote a safe environment, at school and in the surrounding communities; respect each individual's well-being and dignity; and engage diverse stakeholders in efforts to ensure that schools are healthy. WHO and UNESCO have issued standards (11) and implementation guidance (12) to ensure that all schools are health promoting.

Preventing adolescent girls and young women from acquiring HIV – a critical global health priority in its own right – is also closely linked with efforts to eliminate new HIV infections among children. In 2020, an estimated 66 000 adolescent girls and young women acquired HIV during pregnancy or breastfeeding in the focus countries. Although 26% of pregnant women living with HIV were aged 15–24 years, 42% of the pregnant and breastfeeding women acquiring HIV were in this age group. In 2020, WHO and the Coalition for Children Affected by AIDS convened 43 thought leaders from the fields of HIV, early childhood development, sexual and reproductive health, poverty reduction, rights, gender, exclusion and mental health. The learning session generated a series of recommendations to address HIV and other inequalities experienced by adolescent mothers and their children in sub-Saharan Africa, with an emphasis on increasing leadership, pursuing a holistic approach, engaging adolescents as key partners and focusing on men and boys as part of the solution (13). Integration of health services for young women such as family planning, sexually transmitted infection diagnoses and treatment, and primary health care will also improve outcomes for young women and reduce vertical infections.

Recovering ground lost because of COVID-19

COVID-19 resulted in the widespread disruption of many services for adolescent girls and young women (14). The pandemic deterred many adolescent girls and young women from seeking health services, impeded the ability of peer mentors to maintain contact and undermined educational opportunities as a result of school closures. PEPFAR's DREAMS partnership has used innovative means to maintain service access during the pandemic for young women and girls, such as a shift to telehealth and virtual forums which allowed for continued access to and an increase in PrEP initiation among adolescent girls and young women. Disparities in access to smartphones among adolescent girls and young women remains an important challenge that needs to be addressed.

In addition to disrupting essential prevention, testing and treatment services, COVID-19 has also exacerbated the underlying vulnerabilities of adolescent girls and young women (15). Before COVID-19, 132 million girls were out of school (16), and pandemic-related school closures have only increased girls' education gaps.

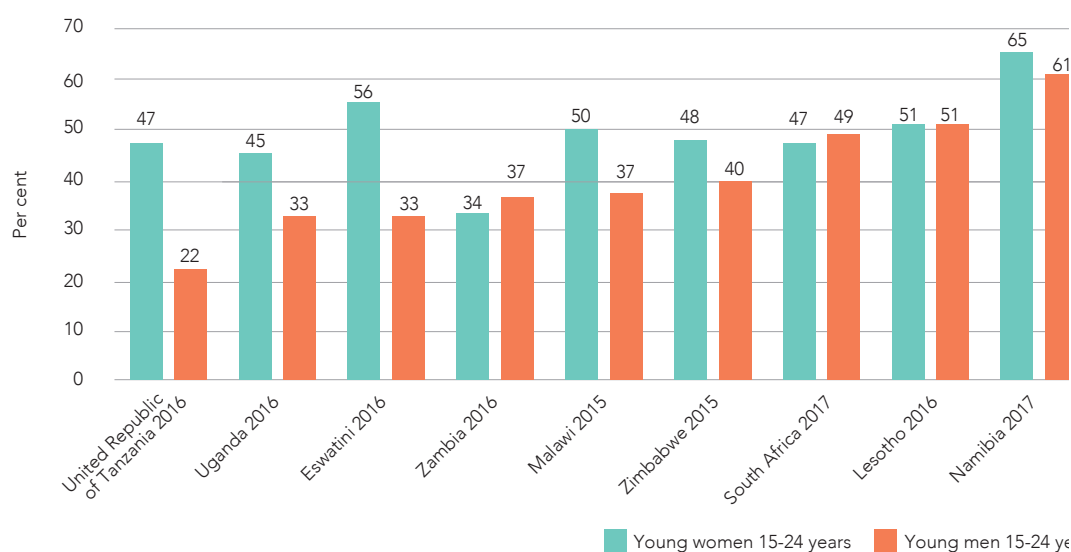
School closures increase the likelihood of early marriage, which in turn is associated with poorer long-term health outcomes for girls and their children. COVID-19 has led to increases in gender-based violence, worsened economic prospects for already vulnerable adolescent girls and young women and diminished access to sexual and reproductive health services (17). Helping adolescent girls and young women to recover ground lost during COVID-19 and to build back better the systems and policies needed to enable adolescent girls and young women to thrive requires a focused, multiyear effort. Generating and effectively using strategic information to guide these efforts will be essential, since evidence on the extent, nature and duration of the pandemic's impact on adolescent girls and young women remains weak in many cases.

Addressing the HIV-related needs of men and boys

Adolescent girls and young women typically become infected with HIV as a result of sexual intercourse with men in their late twenties and early thirties (18). Therefore, one way to protect adolescent girls and young women is through combination prevention approaches, including access to HIV testing and treatment, for men and boys.

Men have lagged behind women in progress towards achieving the global 90–90–90 testing and treatment targets for 2020. From 2015 to 2020, women’s outcomes for the HIV treatment targets increased from 79–73–85 to 92–91–90, while men increased from 70–64–82 to 86–84–90 over the same time period in focus countries. Young men living with HIV are less likely than young women their age to achieve suppressed viral loads (Figure 8). Among men living with HIV in focus countries, adolescent boys and young men are less likely to have suppressed viral loads than older men.

Figure 8. Percentage of young women and young men with suppressed viral loads, household surveys, 2015–2018



Source: Nationally representative household surveys, 2015–2018.

Men’s suboptimal viral suppression stems from both individual and structural issues that affect men’s ability or willingness to access services, including inconvenience of services and masculinity norms that diminish care-seeking behaviour. Programmes that have specifically designed services for men have improved HIV outcomes for men living with HIV, including younger men. Of the nearly 1.3 million men initiating antiretroviral therapy through PEPFAR’s MenStar initiative (19), 91% have suppressed viral loads. In rural communities in Kenya and Uganda, researchers with the Sustainable East Africa Research in Community Health (SEARCH) trial reached men by tailoring messaging, engaging men’s partners and using a streamlined and person-centred approach to service delivery (20).

Scaling up voluntary medical male circumcision also protects adolescent girls and young women from acquiring HIV by reducing the number of men who become infected (21). Given the high demand for voluntary medical male circumcision among younger adolescent boys (aged 10–14 years), WHO published updated guidelines on safe voluntary medical male circumcision for adolescent boys and men in high-burden epidemics (22). In the 13 focus countries that are also priority countries for voluntary medical male circumcision, uptake of voluntary medical male circumcision sharply declined in 2020, since COVID-19 lockdowns led to the suspension of these services between April and June 2020 (Figure 9).

Figure 9. Number of voluntary medical male circumcisions, focus countries, 2015–2020



Source: UNAIDS/UNICEF/WHO Global AIDS Monitoring, 2021.

Ensuring a robust recovery and the long-term sustainability of voluntary medical male circumcision services is a critical priority. Not only do these services protect girls, boys, women and men, but they also are at the forefront of reaching and engaging men in health services. Kenya, Zambia and Zimbabwe have developed sustainability plans for their voluntary medical male circumcision programmes – an important planning exercise that other priority countries should emulate. WHO and UNAIDS are currently undertaking a landscape analysis to identify longer-term actions to ensure programme sustainability in the 15 priority countries for voluntary medical male circumcision.

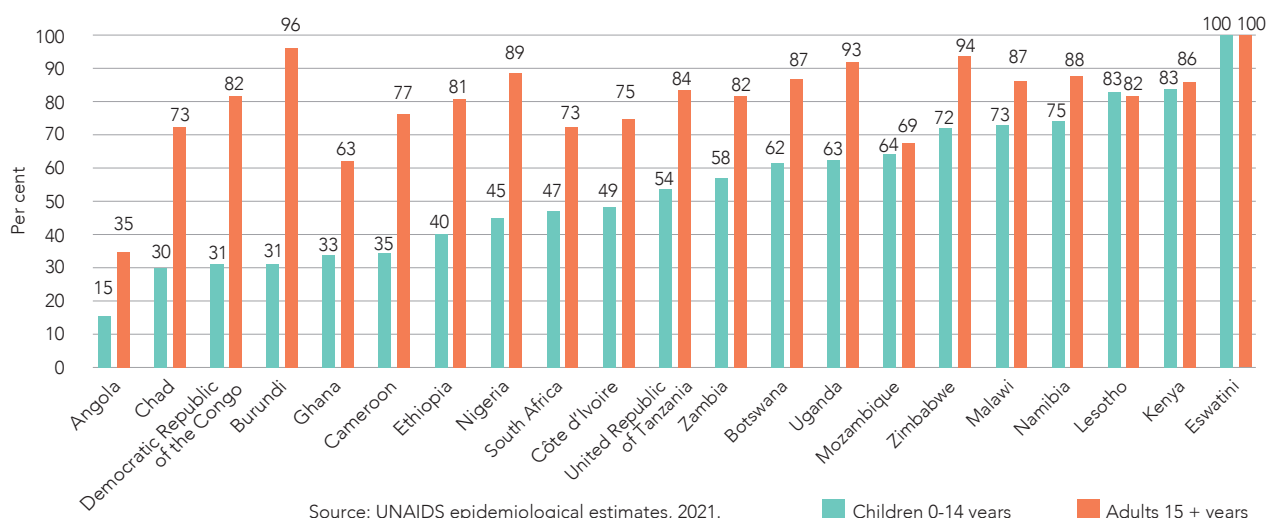
Recognition is growing that engaging men and boys in health services and optimizing their health and well-being requires a focused approach. In 2020, South Africa launched a national men's health strategy that provides a framework for delivering a comprehensive and integrated package of care for men and boys at all stages of their lives (23). WHO and UNAIDS have convened a global working group to coordinate global strategy, advocate and share best practices on men and HIV.



AIDS FREE: HIV TREATMENT FOR CHILDREN AND ADOLESCENTS

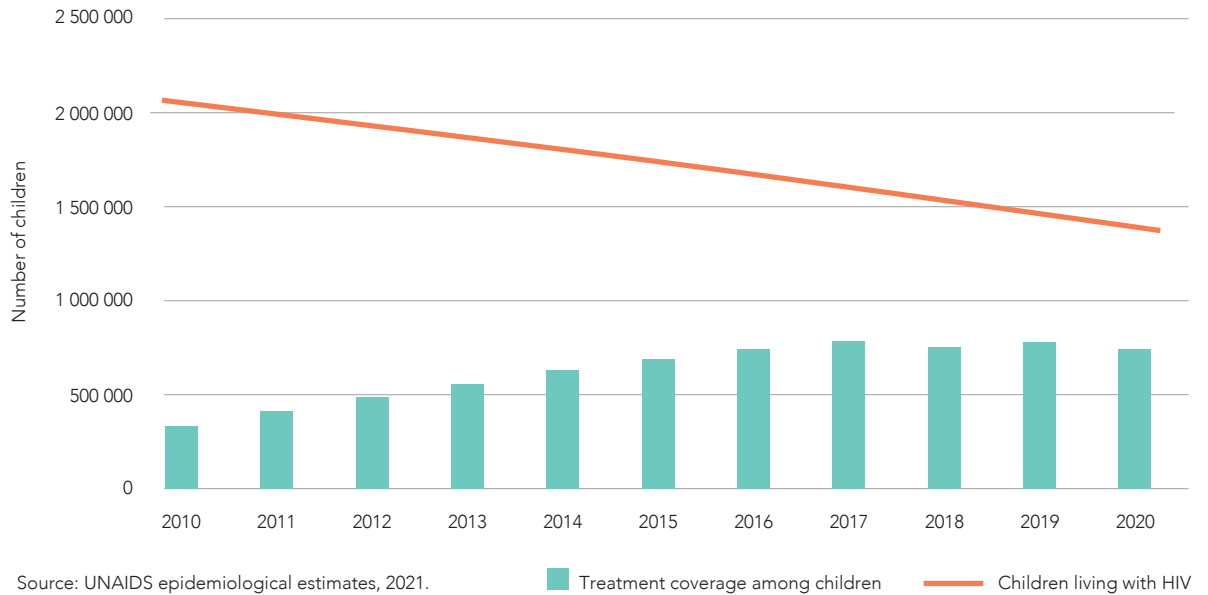
In the focus countries in 2020, 620 000 children living with HIV needed antiretroviral therapy but were not reached by treatment programmes. Focus countries, as well as the world as a whole, continue to struggle in identifying children living with HIV, linking to care and initiating antiretroviral therapy in a timely manner and sustaining lifelong viral load suppression. In 16 of 21 focus countries, HIV treatment coverage is higher among adults than among children, including several countries in which coverage among adults is more than twice as high as for children (Figure 10). Globally, 54% of children living with HIV received antiretroviral therapy in 2020 versus 74% among adults living with HIV. Only six focus countries (Kenya, Eswatini, Lesotho, Malawi, Namibia and Zimbabwe) provided antiretroviral therapy to at least 70% of children living with HIV in 2020.

Figure 10. Percentage of people living with HIV receiving treatment among children and adults, focus countries, 2020



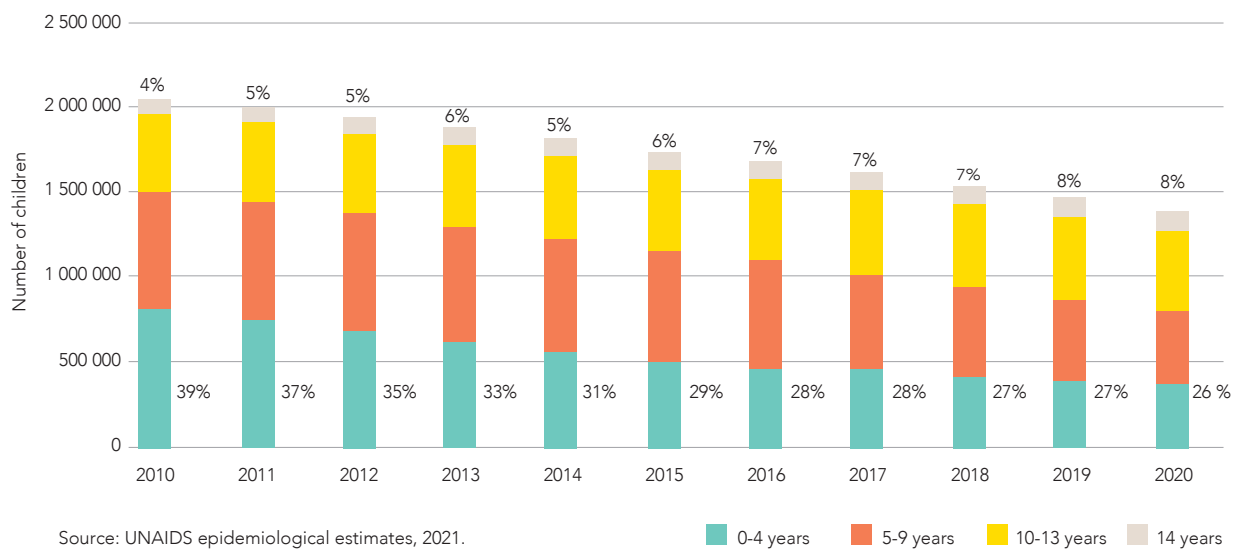
Despite the urgent need for actions to close the treatment gap for children, the actual number of children living with HIV receiving treatment declined in 2020. As Figure 11 demonstrates, although the gap between the number of children living with HIV and the number of children receiving antiretroviral therapy has diminished over the past 10 years, equitable HIV treatment coverage for adults and children can only be achieved by reaching substantially more children with HIV treatment services. The number of children living with HIV has declined because of continued “ageing out” of the cohort aged 0–14 years and improved prevention of mother-to-child transmission. However, with 620 000 children still needing life-saving treatment, these trends provide no grounds for complacency. The markedly higher HIV mortality among children younger than five years than among older children demands sharp, rapid improvements in timely diagnosis and linkage to treatment services.

Figure 11. Number of children living with HIV and receiving antiretroviral treatment, focus countries, 2010–2020



The age distribution of the children living with HIV has also changed over time (Figure 12). Because of the success of efforts to prevent vertical transmission and the high mortality among children living with HIV who are not diagnosed early, the proportion of children living with HIV aged 0–4 years fell from 39% in 2010 to 26% in 2020. By contrast, the number of 14-year-olds “ageing out” of the cohort of children each year has doubled – from 4% in 2010 to 8% in 2020.

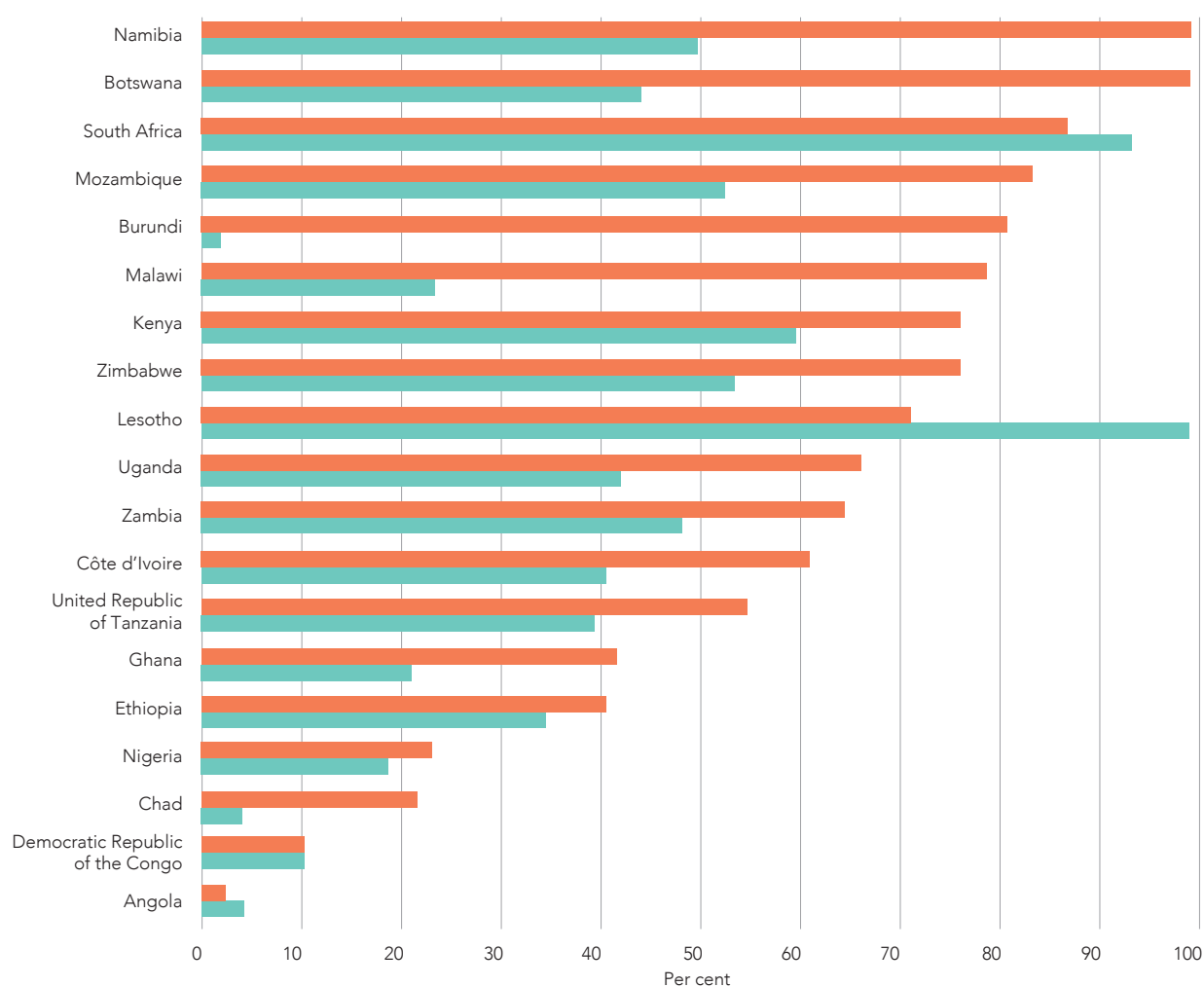
Figure 12. Age distribution of children living with HIV (%), focus countries, 2010–2020



Timely diagnosis of children living with HIV

The treatment gap for children starts with the failure to promptly identify infants and children living with HIV. Without treatment 50% of infants infected with HIV will die by two years of age (7). In 2020, only 67% [54–92%] of infants in the focus countries received the recommended HIV virological test within the first two months of life. Among focus countries, coverage of early infant diagnostic services varies considerably, from 2% to 99% (Figure 13). In nine focus countries, at least 70% of HIV-exposed infants were tested within the first two months of life. In at least six countries, less than half of HIV-exposed infants received early infant diagnostic testing. (Data were unavailable for Cameroon and Eswatini for 2020.) Monitoring indicates some disruptions in early infant testing in many countries as a result of COVID-19 testing needs. Important improvements have been made since 2015 in several focus countries in scaling up early infant diagnostic services, including in Botswana, Burundi, Malawi and Namibia.

Figure 13. Percentage of HIV-exposed infants tested by two months of age, focus countries, 2015 and 2020



*Data for 2015 were not available for Namibia; 2016 values were used in this figure.
Sources: UNAIDS, UNICEF and WHO Global AIDS Monitoring, 2021.

Traditionally, early infant diagnosis has relied on networks that collect and transport samples to centralized laboratories that conduct HIV nucleic acid tests. This process often results in considerable delays, with a recent systematic review finding that the median turnaround time from sample collection to results being returned to the clinical site is 44.5 days (24). In some focus countries, innovative efforts have been used to reduce turnaround time for early infant diagnostic results.

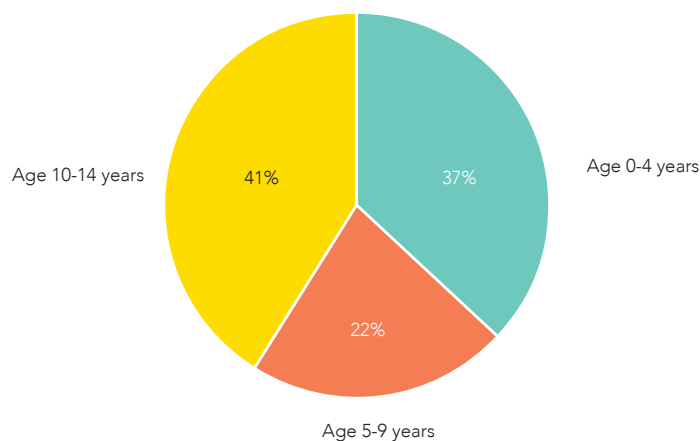
In recent years, point-of-care platforms have emerged that yield early infant diagnostic results on the same day the sample is collected. Unitaid, UNICEF, CHAI the Elizabeth Glaser Pediatric AIDS Foundation and other partners have worked to support the scale-up of point-of-care early infant diagnostic technologies in several countries with a high prevalence of HIV. Drawing on available evidence, including experience with early scale-up, WHO in 2021 updated its recommendations on infant diagnosis to strongly recommend using point-of-care technologies whenever possible (7). In 2020, all focus countries except Botswana and South Africa had updated policies to include point-of-care early infant diagnostic services, whereas in 2019, five countries had yet to implement point-of-care platforms.

Since more than half of all vertical infections occur after six weeks of age, testing children who are breastfeeding for potential transmission after the early infant diagnosis visit is essential. Updated WHO guidelines on early infant diagnosis mention the importance of testing at nine months of age and when breastfeeding ends (7). A policy for routine testing at nine months will increase the chances of identifying infants who might have been infected during breastfeeding, although testing at nine months might still miss some children who are breastfeeding beyond nine months. Twelve focus countries (Angola, Burundi, Cameroon, Democratic Republic of the Congo, Eswatini, Lesotho, Mozambique, Namibia, Nigeria, United Republic of Tanzania, Zambia and Zimbabwe) have a policy in place to offer testing to HIV-exposed children at nine months of age.

In the focus countries in 2020, 63% of children living with HIV who were not receiving HIV treatment were 5–14 years old (Figure 14). In addition to efforts to improve coverage of infant diagnostic testing, further efforts are needed to expand testing options for children who are missed by infant diagnostic services, including those who acquire HIV during breastfeeding and older children whose mothers may not have accessed services to prevent vertical transmission. Facility-based HIV testing in such health-care settings as sick child clinics, inpatient wards and malnutrition centres has the potential to reach undiagnosed children with HIV testing services.

Recent efforts by UNICEF in western and central Africa show promising results using family testing, which offers HIV testing to all household members of a person living with HIV. This approach can reach children who are living with HIV but not currently receiving HIV treatment. In the third quarter of 2020, more than 40 000 people living with HIV were offered family testing, resulting in more than 99 000 people tested and more than 2000 children linked to care. Screening tools currently used in countries such as Ghana and the United Republic of Tanzania enable a more efficient method for testing children up to age 15 years.

Figure 14. Children living with HIV not receiving treatment by age group, focus countries, 2020

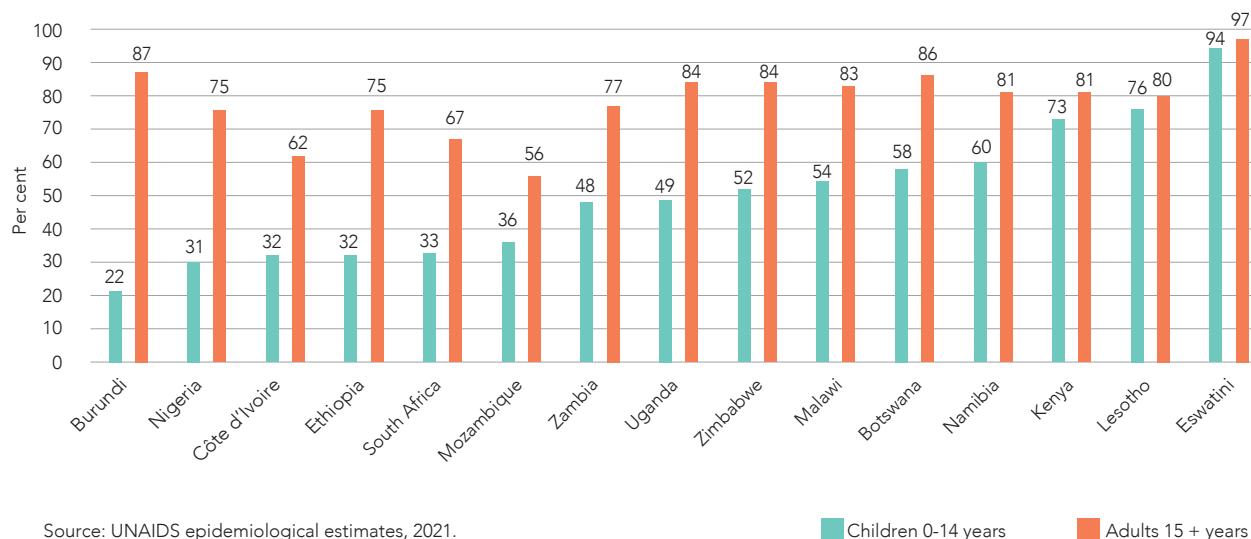


Source: UNAIDS epidemiological estimates, 2021.

Ensuring suppression of viral loads among children living with HIV

Among people tested, many fewer children living with HIV than adults living with HIV have suppressed viral loads in all focus countries with published data (Figure 15). At least 70% of children living with HIV had suppressed viral loads in only three focus countries (Eswatini, Kenya and Lesotho) in 2020. Among the focus countries, only 40% of children living with HIV (or 74% of children receiving antiretroviral therapy) had suppressed viral loads in 2020.

Figure 15. Percentage of children and adults living with HIV with suppressed viral loads, focus countries, 2020



Source: UNAIDS epidemiological estimates, 2021.

Children 0-14 years Adults 15+ years

The range of antiretroviral medicine formulations and regimens suitable for children has long been much more limited than those for adults. However, important progress has been made in optimizing treatment regimens for children. In particular, there has been a dramatic decline in the procurement of inferior nevirapine-based regimens for children in recent years, accompanied by progressive uptake of newer solid formulations of more potent regimens, including lopinavir/ritonavir for children weighing less than 20 kg and dolutegravir (DTG) for children weighing more than 20 kg (25).

In 2021, new evidence from the multicountry ODYSSEY trial found that children and adolescents living with HIV who received DTG-based regimens were more likely to have suppressed viral loads than those receiving non-DTG-based regimens (26). The ODYSSEY results echo the findings from a study of DTG roll-out for children in the United Republic of Tanzania, which was associated with a marked increase in suppressed viral loads among children living with HIV, with suppressed viral loads among 63% of children who were not previously suppressed and maintenance of suppressed viral loads among 95% of children who were previously suppressed (27). These findings strongly support existing WHO guidelines recommending a DTG-based regimen as the preferred regimen for first- and second-line therapy and encouraging rapid transition to DTG with the recently approved generic 10-mg scored dispersible tablets for children over 3kg and 4 weeks of age. As a result of an agreement negotiated by Unitaid and the Clinton Health Access Initiative, child-friendly DTG formulations have been made markedly more affordable. All of the focus countries have moved to DTG as the first line regimen for children weighing 20 kilograms or more however three countries (Chad, Mozambique and South Africa) have not yet adopted DTG as first line for children less than 20 kilograms.

Since 2016, WHO has recommended scaling up differentiated service delivery for all people living with HIV who are established and stable on antiretroviral therapy, including children and adolescents (2). These recommendations have been reconfirmed and strengthened in the 2021 WHO consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring (28), which strongly support the use of multimonth dispensing (3–6 months) of antiretroviral therapy for children and adolescents who are established on HIV treatment. In 2020, all focus countries except for Botswana and South Africa had endorsed multimonth dispensing, with Mozambique partly implementing multimonth dispensing for children two years and older. Although multimonth dispensing and other differentiated service delivery strategies were expanded in many countries in response to the COVID-19 pandemic, whether these moves notably increased treatment retention and suppression of viral loads among children as of 2020 is unclear.

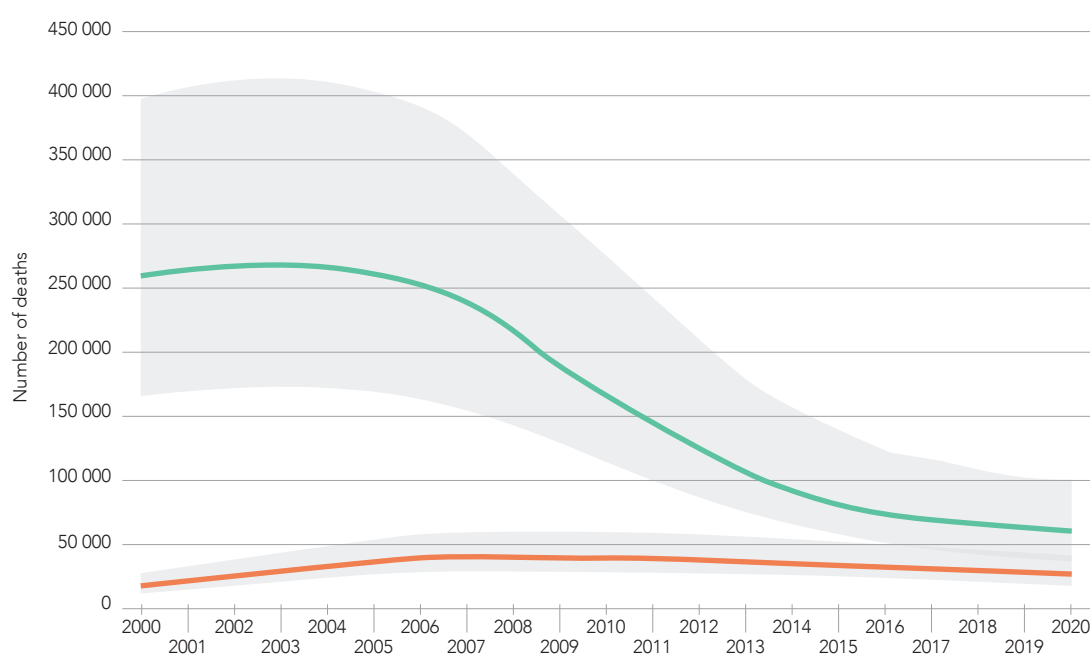
Eswatini has taken a proactive, multidimensional approach to improve the suppression of viral loads among children and adolescents living with HIV (29). These include innovative approaches to address mother–infant pairs, including mother–baby clubs, mentor mothers and clinical settings and clinic days specifically devoted to children who have high viral loads. Multidisciplinary teams provide holistic support and services to children and adolescents living with HIV, children and adolescents with high viral loads are actively followed up and family-centred models of care help to improve retention in antiretroviral therapy. Teen clubs and support services specifically focused on transitioning adolescents and young people help to address the unique needs of adolescents living with HIV. These approaches have been associated with consistent increases in suppression of viral loads among every age group of children, adolescents and young adults.

Operation Triple Zero, first implemented by Kenya but subsequently replicated in multiple countries, improves retention in care among adolescents living with HIV by engaging adolescents as key agents in managing their health (30). This approach tailors services for adolescents, increases adolescents' treatment literacy and involvement in their own health care, provides life skills and network building, invests in interventions to improve self-esteem and reduce stigma, trains health-care workers to deliver adolescent-tailored services and supports caregivers. Implementing the Operation Triple Zero approach has been associated with superior suppression of viral loads among young people versus standard HIV care.

HIV testing, treatment and retention for adolescents

Preventing vertical transmission and expanding access to treatment for children has led to striking reductions in the number of children aged 0–9 years dying from AIDS-related causes, but declines in AIDS-related mortality have been much more modest among adolescents (aged 10–19 years) (Figure 16). From 2010 to 2020, the number of adolescents dying from AIDS-related causes fell by 34% versus a 64% decline among children aged 0–9 years.

Figure 16. Children aged 0–9 years and adolescents aged 10–19 years dying from AIDS-related causes, focus countries, 2000–2020

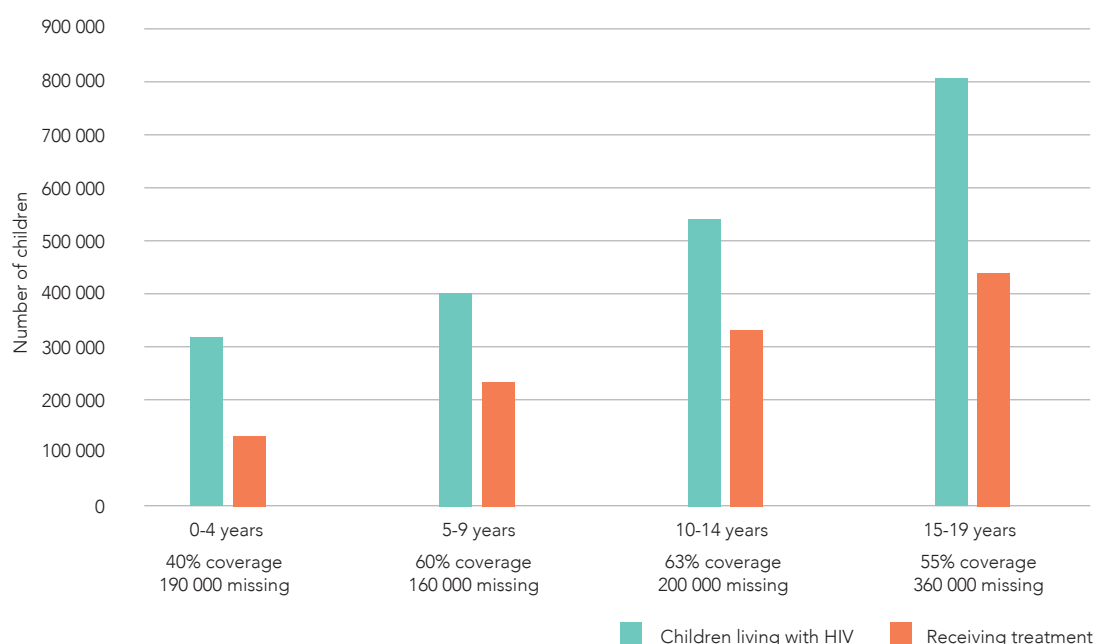


Source: UNAIDS epidemiological estimates, 2021. ■ AIDS-related deaths 0-9 years ■ AIDS-related deaths 10-19 years

Treatment coverage varies considerably by age group. Among the focus countries, 18 of the 21 countries had antiretroviral therapy coverage data available by age group (data were not available from Angola, the Democratic Republic of the Congo and Ghana). Based on the available data, treatment coverage was slightly higher among the younger adolescents (aged 10–14 years) than among children (aged 5–9 years) and older adolescents (aged 15–19 years) (Figure 17).

Reaching diverse adolescents with HIV testing, treatment and support services requires tailored approaches that recognize that different young people respond to different messages and approaches. For example, the needs and life experiences of older adolescents (aged 15–19 years) differ considerably from those aged 10–14 years (31). The UNAIDS estimates suggest that approximately 45% of adolescents living with HIV aged 15–19 years were infected sexually or through unsafe injections and will potentially have different characteristics and needs compared to children who were infected vertically. WHO recommends integrating psychosocial interventions in HIV services for all adolescents and young adults living with HIV, including adaptations to address the specific needs of subpopulations of adolescents and young people (2). In its adolescent-focused programmes in 13 African countries, the Elizabeth Glaser Pediatric AIDS Foundation differentiates its peer psychosocial support programmes by age bands to help ensure that young people living with HIV are able to benefit, learn from and receive the support of peers who share their lived experience (32). Adopting a life-course approach to HIV responses for adolescents enables programmes to account for the numerous transitions that occur during adolescence, such as onset of puberty, sexual debut, moving from one school to another, entering the workforce and transitioning from HIV services for children to services for adults.

Figure 17. Number of children and adolescents living with HIV receiving treatment and missing from treatment, focus countries, 2020



Note: The available data were extrapolated to produce estimates for all countries.

Source: special analysis of UNAIDS epidemiological estimates, 2021 and Global AIDS Monitoring data, 2021.

Ensuring that service sites are adolescent-friendly helps attract young people to services and keep them engaged in care. In Lesotho, among adolescents living with HIV enrolled in dedicated “adolescent corners” that are secluded from adult services in 11 clinical sites, 98% have suppressed viral loads, with retention rates ranging from 76% to 100%. Youth-tailored service delivery models include Kenya’s Red Carpet Programme, a facility- and school-based model that fast-tracks services for adolescents living with HIV, provides a suite of VIP service interventions for young people and integrates peer-led support for retention. In the United Republic of Tanzania, Timiza Ndoto (Achieving Dreams) provides enhanced adherence counselling for adolescents living with HIV, uses a multidisciplinary approach for delivery of support services, provides education on and support for adherence and viral load suppression in adolescent-only sessions and provides education and support for young people’s caregivers. Timiza Ndoto recipients are notably more likely to achieve suppressed viral loads (68%) than young people in the United Republic of Tanzania who receive the standard of care⁵

Engaging adolescents in all aspects of HIV programming not only improves young people’s utilization of services but also helps to ensure that these services respond to young people’s needs and preferences. Through the efforts of WHO, UNICEF and partners, adolescents and young people have been meaningfully engaged in the process for developing WHO guidelines.

5 https://pedaids.org/wp-content/uploads/2021/05/2021RCPKenyaBrief_0406.pdf



WHAT IS NEXT: LESSONS LEARNED AND FUTURE DIRECTIONS

The latest data on progress since the Start Free, Stay Free, AIDS Free framework was launched lead to several conclusions.

- **For focus countries as a whole, important progress was made but no Super-Fast-Track response emerged in 2015–2020.** None of the Start Free, Stay Free, AIDS Free targets were achieved. Important gains were made towards most of the targets, but progress fell far short of the aspirations.
- **Experience in numerous countries demonstrates that rapid gains for children, adolescents and young women are feasible.** Although overall progress in focus countries was insufficient, several countries, including some where gains had long lagged, achieved rapid advances in the HIV response for children, adolescents and young women. At least two focus countries are eligible for the path to eliminate vertical HIV transmission, three countries have ensured children's equitable access to antiretroviral therapy and the proportion of HIV-exposed infants who received early infant diagnostic services within the first two months of life doubled from 2015 to 2020 in at least six countries.
- **The lessons learned through the Start Free, Stay Free, AIDS Free framework urgently need to be built on to get national responses on track to end AIDS as a public health threat among children, adolescents and young women.** An estimated 620 000 children living with HIV are currently not receiving antiretroviral therapy in the 21 focus countries (and 800 000 globally), and the numbers of children and of adolescents who acquire HIV remain unacceptably high. To accelerate gains, good practices and lessons learned in countries that have achieved sustained progress over the past five years need to be applied and brought to scale in all countries. Gaps and weaknesses in responses must be addressed, and political leadership and commitment on ending AIDS as a public health threat among children, adolescents and young women needs to be reinvigorated.

The Start Free, Stay Free, AIDS Free framework: what we learned

The Start Free, Stay Free, AIDS Free framework contributed to valuable advances in the HIV response for children, adolescents and young women. Working groups formed under each of the framework's three pillars generated greater and more granular clarity on the key factors that are slowing progress as well as potential game-changers to rapidly expedite gains. For example, the AIDS Free team had periodic engagement with focus countries: initially with national technical working groups meetings convened by WHO in collaboration with health ministries, subsequently with monthly calls to follow up on policy adaptation and the status of policy implementation for HIV, ensuring that health ministry colleagues had clear, up-to-date guidance on the latest regimens and innovations to improve HIV treatment access and outcomes for children and adolescents. Participation by AIDS Free working group members in a broader working group on child survival facilitated the sharing of good practices on treatment for children to diverse global partners. WHO-led TeleEcho webinars provided expert guidance and enabled the sharing of country success stories addressing such issues as diagnosing HIV among infants, children and adolescents; the implications of new WHO clinical recommendations for infants, children and adolescents; drug optimization and introducing DTG-based regimens for children; and monitoring HIV services for children and adolescents. Finally, the high-level political engagement generated in collaboration with the Holy See through a series of high-level dialogues has elevated the technical discourse and fostered collaboration and accountability by many stakeholders, including regulators, researchers, implementers, donors, faith-based organizations, civil society organizations and relevant international organizations.

The five years of the framework have seen important progress in optimizing treatment regimens for children and adolescents, a substantially improved understanding of the relative contribution of various factors in vertical HIV transmission and normative guidance on standardizing scaled-up point-of-care early infant diagnosis and ensuring holistic treatment services for adolescent girls and young women. The Start Free, Stay Free, AIDS Free framework effectively shifted the global HIV discourse towards a life-course approach that tailors programmes and policies to the specific needs of different age groups and that works to ensure seamless, people-centred transitions in HIV services as young people grow up.

Start Free, Stay Free, AIDS Free provided a platform for greater collaboration among key partners. The framework also promoted greater accountability in the response for children, adolescents and young women through annual reports on progress towards specific targets.

However, Start Free, Stay Free, AIDS Free also fell short of the ambitions. Although the approach aimed to strengthen and sustain political leadership and commitment on ending AIDS as a public health threat among children, adolescents and young people, signs indicate that political commitment among high-level leaders in recent years may have declined. Working groups under each of the framework's pillars promoted intensified collaboration, but collaboration across the three pillars was limited. The engagement of country partners and communities in developing the Start Free, Stay Free, AIDS Free framework could have been stronger, and partner engagement in implementing the framework varied. Although the framework was associated with clear,

specific targets, these targets were inadequately integrated into national action plans and HIV targets. Much work remains to be done to spur a notable expansion of the partnership to end AIDS as a public health threat among children, adolescents and young women. These challenges are not unique to the Start Free, Stay Free, AIDS Free framework but are being grappled with by the broader HIV response, especially as it focuses on implementing the new Global AIDS Strategy 2021–2026 and achieving new targets endorsed by United Nations Member States in the 2021 Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030.

New global targets for children, adolescents and young women

The Global AIDS Strategy 2021–2026 gives priority to efforts to revive momentum and get the global response on track towards ending AIDS as a public health threat in all settings and populations, including children, adolescents and young women. Across all aspects of the response, the Global AIDS Strategy uses an inequalities lens, focusing action and priorities on the settings and populations being left behind and on the specific factors that contribute to inequalities in HIV service access and outcomes.

To lay the groundwork to end AIDS as a public health threat among children, adolescents and young women, the 2021 Political Declaration and the Global AIDS Strategy set ambitious new targets for 2025.

Preventing vertical transmission

- 95% of women of reproductive age have their HIV and sexual and reproductive health service needs met
 - 95% of pregnant women are tested for HIV, syphilis and hepatitis B surface antigen at least once and as early as possible. In settings with a high burden of HIV infection, pregnant and breastfeeding women with unknown HIV status or who previously tested HIV-negative should be retested during late pregnancy (third trimester) and in the postpartum period.
- 95% of pregnant and breastfeeding women living with HIV have suppressed viral loads.
 - 90% of women living with HIV are receiving antiretroviral therapy before their current pregnancy.
 - All pregnant women living with HIV are diagnosed and receiving antiretroviral therapy, and 95% have suppressed viral loads before delivery.
 - All breastfeeding women living with HIV are diagnosed and receiving antiretroviral therapy, and 95% have suppressed viral loads (to be measured at 6–12 months).
- The 95–95–95 testing and treatment targets are achieved for pregnant and breastfeeding women (and for all other populations).

HIV treatment for children

- 95% of HIV-exposed children are tested at two months and after breastfeeding ends.
 - 95% of HIV-exposed infants receive a virological test, and caregivers are provided with the results by age two months.
 - 95% of HIV-exposed infants receive a virological test, and caregivers are provided with the results after breastfeeding ends.
- The 95–95–95 testing and treatment targets⁶ are achieved among children living with HIV.
 - 75% of children living with HIV have suppressed viral loads by 2023 (interim target).

HIV prevention for adolescent girls and young women

- 95% of the people at risk of HIV infection use appropriate, prioritized, person-centred and effective combination prevention options (targets differentiated for adolescents and young adults by risk stratum and/or geography for condoms, PrEP, sexual transmitted infection screening and treatment, comprehensive sexuality education, access to post-exposure prophylaxis, economic empowerment and voluntary medical male circumcision (for adolescent boys and men).

Numerous additional targets and priority actions set out in the 2021 Political Declaration and the Global AIDS Strategy are pertinent to efforts to end AIDS as a public health threat among children, adolescents and young women. For example, the Strategy outlines specific service integration targets for children, adolescent boys and young men, school-aged young girls (aged 9–14 years), adolescent girls and young women and pregnant and breastfeeding women. The Strategy sets forth specific targets for key populations, which may include adolescent girls and young women as well as pregnant and breastfeeding women.

The Strategy also sets targets to address key social and structural factors that may increase vulnerability or diminish service uptake. Under the Strategy, fewer than 10% of countries have punitive legal and policy environments that deny or limit access to services; less than 10% of people living with HIV and key populations experience stigma and discrimination; and less than 10% of women, girls, people living with HIV and key populations experience gender inequality and violence. The Strategy gives priority to supporting community-led responses and actions to meet the HIV-related needs of people affected by humanitarian emergencies and includes targets for access to social protection benefits among people living with, at risk of and affected by HIV.

⁶ 95% of the people within each subpopulation who are living with HIV know their HIV status; 95% of the people within each subpopulation who are living with HIV and know their HIV status are receiving antiretroviral therapy; and 95% of the people within each subpopulation who are receiving antiretroviral therapy have suppressed viral loads.

Towards a new framework to catalyse political, financial, technical and programmatic action

The Start Free, Stay Free, AIDS Free partners clearly agree on the need for a new framework to guide and incentivize actions to get responses on track to end AIDS as a public health threat among children, adolescents and young women. The new framework should be linked to the targets, priority actions and commitments set forth in the new Global AIDS Strategy and the 2021 Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030. To inform the new framework, extensive consultations will be conducted with key stakeholders, including governments, community groups, regional organizations, implementing partners and civil society (including adolescent networks), with the expectation that the new framework will be launched towards the end of 2021.

Lessons learned from the Start Free, Stay Free, AIDS Free framework will inform the development and implementation of a new framework to end AIDS as a public health threat among children, adolescents and young women. High-level, visible and consistent support from political leaders, backed by sufficient resources, will be essential to get the response on track. Dedicated funding will be required to ensure that dedicated personnel are in place to oversee implementation, communication and intensified country-level focus.

From the outset, the new framework must fully engage national and regional partners and ensure their ownership and leadership. Greater involvement of communities, faith-based organizations and other civil society groups will be needed. The new framework must ensure broader, more inclusive membership and participation.

Robust accountability will be critical, with clear targets agreed by governments and global stakeholders, better integration of framework targets in national action plans and regular HIV reporting and a high degree of transparency regarding both progress and challenges. The framework will need to be complemented by a comprehensive communication plan that increases visibility and engages new partners, including through a dedicated website, effective use of social media and regular outreach to key partners and stakeholders.

REFERENCES

1. Woldensbet SA, Tendesayi K, Barron P, Chirombo BC, Cheyip M, Ayalew K et al. Viral suppression and factors associated with failure to achieve viral suppression among pregnant women in South Africa. *AIDS*. 2020;34:589–97.
2. Updated recommendations on service delivery for the treatment and care of people living with HIV. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/341052>, accessed 11 July 2021).
3. Improving mother-baby pair retention in integrated maternal and child health and HIV services in Eswatini. Washington (DC): PEPFAR; 2018 (<https://www.pepfarsolutions.org/solutions/2018/12/19/cfm-improving-mother-baby-pair-retention-in-interated-maternal-and-child-health-and-hiv-services-in-eswatini>, accessed 11 July 2021).
4. Global guidance on criteria and processes for validation: elimination of mother-to-child transmission of HIV and syphilis, 2014. Geneva: World Health Organization; 2014 (<https://apps.who.int/iris/handle/10665/112858>, accessed 11 July 2021).
5. Global guidance on criteria and processes for validation: elimination of mother-to-child transmission of HIV and syphilis. 2nd ed. Geneva: World Health Organization; 2017 (<https://apps.who.int/iris/handle/10665/259517>, accessed 11 July 2021).
6. Delany-Moretlwe S et al. Long acting injectable cabotegravir is safe and effective in preventing HIV infection in cisgender women: interim results from HPTN 084. HIV Research for Prevention Conference, virtual, 27 January 2021 (<https://www.084life.org/wp-content/uploads/2021/02/210123-HPTN-084-HIV-R4P-final-final.pdf>, accessed 11 July 2021).
7. Updated recommendations on HIV prevention, infant diagnosis, antiretroviral initiation and monitoring. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/340190>, accessed 11 July 2021).
8. Saul J, Bachman G, Allen S, Toiv NF, Cooney C, Beamon T (2018) The DREAMS core package of interventions: A comprehensive approach to preventing HIV among adolescent girls and young women. *PLoS ONE* 13 (12): e0208167. <https://doi.org/10.1371/journal.pone.0208167>
9. Step up the fight: ending HIV among adolescent girls and young women. Geneva: Global Fund to Fight AIDS, Tuberculosis and Malaria; 2019 (https://www.theglobalfund.org/media/1296/publication_womengirls_focuson_en.pdf, accessed 11 July 2021).
10. WHO, UNESCO. WHO guideline on school health services. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/341910>, accessed 11 July 2021).
11. WHO, UNESCO. Making every school a health-promoting school: global standards and indicators. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/341907>, accessed 11 July 2021).

12. WHO, UNESCO Making every school a health-promoting school: implementation guidance. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/341908>, accessed 11 July 2021).
13. Learning session on HIV-affected adolescent mothers and their children in sub-Saharan Africa: meeting report, Geneva, Switzerland, 13 December 2019. Geneva: World Health Organization; 2020 (<https://apps.who.int/iris/handle/10665/332160>, accessed 11 July 2021).
14. Fleischman J. Five years of DREAMS and what lies ahead: how to address the intersecting crises of HIV, gender inequality, and health security. Washington (DC): Center for Strategic and International Studies; 2021 (https://csis-website-prod.s3.amazonaws.com/s3fs-public/publication/210510_Fleischman_DREAMS_Five_Years.pdf?rbu98LOqCa5SPx0k60VJwlvvo7q.M5KP, accessed 11 July 2021).
15. Krubiner C, O'Donnell M, Kaufman J, Bourgault S. Addressing the COVID-19 crisis's indirect health impacts for women and girls. Washington (DC): Center for Global Development; 2021 (https://www.cgdev.org/sites/default/files/Addressing-Covid-19-indirect-health-impacts-women-and-girls_0.pdf, accessed 11 July 2021).
16. Girls' education: gender equality in education benefits every child. New York: United Nations Children's Fund; 2021 (<https://www.unicef.org/education/girls-education>, accessed 11 July 2021).
17. Policy brief: the impact of COVID-19 on women. New York: United Nations; 2020 (<https://www.unwomen.org/-/media/headquarters/attachments/sections/library/publications/2020/policy-brief-the-impact-of-covid-19-on-women-en.pdf?la=en&vs=1406>, accessed 11 July 2021).
18. de Oliveria T, Kharsany AB, Graf F, Cawood C, Khanyile D, Grobler A et al. Transmission networks and risk of HIV infection in KwaZulu-Natal, South Africa: a community-wide phylogenetic study. *Lancet HIV*. 2017;4:e41–50.
19. MenStar Coalition [website]. MenStar Coalition; 2021 (<https://menstarcoalition.org>, accessed 11 July 2021).
20. What helps men stay in HIV care in Kenya and Uganda? San Francisco: Bixby Center for Global Reproductive Health, University of California, San Francisco; 2019 (<https://bixbycenter.ucsf.edu/news/what-helps-men-stay-hiv-care-kenya-and-uganda>, accessed 11 July 2021).
21. Farley TMM, Samuelson J, Grabowski MK, Ameyan W, Gray RH, Baggaley R. Impact of male circumcision on risk of HIV infection in men in a changing epidemic context – a systematic review and meta-analysis. *J Int AIDS Soc*. 2020;23:e25490.
22. Preventing HIV through safe voluntary medical male circumcision for adolescent boys and men in generalized HIV epidemics: recommendations and key considerations: policy brief. Geneva: World Health Organization; 2020 (<https://apps.who.int/iris/handle/10665/333841>, accessed 11 July 2021).

23. The South African National Integrated Men's Health Strategy 2020–2025. Pretoria: South Africa National Department of Health; 2020 (<https://www.knowledgehub.org.za/system/files/elibdownloads/2021-02/Men%26%23039%3Bs%20Health%20Strategy.pdf>, accessed 11 July 2021).
24. Markby J, Boeke, C, Sacks, J, Wang M, Peter T, Vojnov L. HIV early infant diagnosis testing programmes in low- and middle-income countries: a systematic review and meta-analysis. In preparation.
25. HIV market report: the state of HIV treatment, testing, and prevention in low- and middle-income countries. Boston: Clinton Health Access Initiative; 2020 (<https://3cdmh310dov3470e6x160esb-wpengine.netdna-ssl.com/wp-content/uploads/2020/09/2020-CHAI-HIV-Market-Report.pdf>, accessed 11 July 2021).
24. Turkova A. Dolutegravir-based ART is superior to NNRTI/PI-based ART in children and adolescents. 28th Conference on Retroviruses and Opportunistic Infections, virtual, 3 June–3 November 2021 (<https://www.croiconference.org/abstract/dolutegravir-based-art-is-superior-to-nnrti-pi-based-art-in-children-and-adolescents>, accessed 11 July 2021).
27. Bacha JM, Mayalla B, Jiwa N, Mwita L, Campbell RL. The “DTGs” of DTG for children and adolescents living with HIV (CALHIV): descriptions, trends, and gaps in rolling out dolutegravir in CALHIV in Mbeya, Tanzania. 23rd International AIDS Conference, virtual, 6–10 July 2020 (<https://academicmedicaleducation.com/meeting/international-workshop-hiv-pediatrics-2020/abstract/dtgs-dtg-children-and-adolescents>, accessed 11 July 2021).
28. Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach – third edition, July 2021. Geneva: World Health Organization; 2021.
29. Achieving success of high viral load coverage, suppression & retention among children and adolescents living with HIV in Eswatini. Washington (DC): Elizabeth Glaser Pediatric AIDS Foundation; 2021.
30. Improving treatment outcomes for young Kenyans living with HIV. Washington (DC): United States Agency for International Development; 2019 (https://path.azureedge.net/media/documents/Improving_Treatment_Outcomes_For_Young_Kenyans_Living_With_HIV.pdf, accessed 11 July 2021).
31. Thematic segment on reducing the impact of AIDS on children and youth: background note. UNAIDS Programme Coordinating Board, 45th meeting. Geneva: UNAIDS; 2019 (UNAIDS/PCB (45)/19.36; https://www.unaids.org/sites/default/files/media_asset/28112019_UNAIDS_PCB45_Thematic-Segment-Background-Note_EN.pdf, accessed 11 July 2021).
32. Elizabeth Glaser Pediatric AIDS Foundation, AIDS-Free Generation Z. A call to action for improving youth-focused HIV programming. Washington (DC): Elizabeth Glaser Pediatric AIDS Foundation; 2020 (https://www.pedaids.org/wp-content/uploads/2020/07/2020YouthReport_0706.pdf, accessed 11 July 2021).



ANNEX 1. TABLE OF COUNTRY RESULTS FOR 2015 AND 2020

	2015		2020		2015		2020		2015	
	Births to women living with HIV	Uncertainty bounds	Births to women living with HIV	Uncertainty bounds	New HIV infections among children aged 0-14 years	Uncertainty bounds	New HIV infections among children aged 0-14 years	Uncertainty bounds	Antiretroviral therapy coverage among pregnant women	Uncertainty bounds
Global	1 400 000	[1 000 000-1 700 000]	1 300 000	[970 000-1 600 000]	190 000	[130 000-300 000]	150 000	[100 000-240 000]	83	[62-98]
Focus Countries	1 100 000	[840 000-1 400 000]	1 100 000	[790 000-1 300 000]	150 000	[94 000-240 000]	110 000	[72 000-180 000]	87	[65-98]
Angola	29 000	[23 000-35 000]	28 000	[22 000-35 000]	7700	[6200-9800]	5200	[3300-7400]	29	[24-36]
Botswana ***	13 000	[11 000-15 000]	11 000	[9300-13 000]	760	[<500-1100]	<500	[<200-<500]	83	[70-91]
Burundi	6200	[5200-7200]	5800	[4700-6700]	1200	[790-1600]	950	[640-1300]	62	[53-72]
Cameroon	30 000	[24 000-34 000]	26 000	[21 000-30 000]	4000	[2800-5300]	4500	[2900-5600]	89	[72-100]
Chad	7900	[6000-10 000]	7000	[5200-8800]	1700	[1100-2500]	1000	[600-1700]	59	[45-75]
Cote d'Ivoire	18 000	[14 000-22 000]	15 000	[12 000-18 000]	1700	[1300-2800]	1200	[510-2200]	97	[77-100]
Democratic Republic of the Congo	34 000	[27 000-41 000]	32 000	[25 000-38 000]	10 000	[7600-13 000]	8800	[6200-12 000]	42	[33-49]
Eswatini	11 000	[10 000-12 000]	9300	[8100-10 000]	730	[520-950]	<500	[<500-550]	90	[80-98]
Ethiopia	24 000	[17 000-32 000]	19 000	[13 000-25 000]	4500	[2300-7700]	2800	[1400-4700]	79	[57-100]
Ghana	18 000	[14 000-21 000]	18 000	[14 000-21 000]	4900	[3600-6200]	3700	[2400-5100]	44	[35-52]
Kenya	62 000	[49 000-76 000]	54 000	[43 000-67 000]	6800	[4800-12 000]	5200	[3700-9500]	96	[76-100]
Lesotho	9700	[8100-11 000]	7800	[6400-8900]	690	[630-860]	<500	[<500-710]	100	[90-100]
Malawi	46 000	[37 000-52 000]	40 000	[32 000-44 000]	6300	[4000-8000]	2500	[2100-3300]	82	[66-91]
Mozambique	95 000	[68 000-130 000]	94 000	[68 000-130 000]	16 000	[10 000-27 000]	13 000	[8300-22 000]	100	[76-100]
Namibia	11 000	[9300-13 000]	9900	[8300-11 000]	560	[<500-870]	<500	[<500-<500]	100	[86-100]
Nigeria	84 000	[57 000-120 000]	83 000	[57 000-120 000]	17 000	[9800-28 000]	21 000	[12 000-34 000]	62	[42-88]
South Africa	320 000	[200 000-420 000]	310 000	[190 000-400 000]	17 000	[9900-30 000]	12 000	[6900-31 000]	97	[61-100]
Uganda	95 000	[80 000-110 000]	91 000	[73 000-100 000]	11 000	[10 000-12 000]	5300	[4300-8100]	100	[100-100]
United Republic of Tanzania	92 000	[77 000-100 000]	91 000	[75 000-100 000]	16 000	[12 000-20 000]	10 000	[6000-14 000]	75	[63-84]
Zambia	62 000	[53 000-68 000]	62 000	[54 000-69 000]	11 000	[8600-13 000]	8300	[6200-11 000]	79	[68-87]
Zimbabwe	69 000	[54 000-81 000]	59 000	[46 000-69 000]	7700	[4700-12 000]	5100	[3100-8000]	83	[65-97]

* Estimates of the number of adolescent girls aged 10-14 years acquiring HIV are not available.

** Voluntary medical male circumcision is only given priority in 15 countries globally that have high levels of HIV prevalence and low circumcision prevalence.

	2020		2015		2020		2015		2020		
	Antiretroviral therapy coverage among pregnant women	Uncertainty bounds	Final transmission rate including breastfeeding period	Uncertainty bounds	Final transmission rate including breastfeeding period	Uncertainty bounds	New HIV infections among young women 15-24 years*	Uncertainty bounds	New HIV infections among young women 15-24 years*	Uncertainty bounds	
	85	[63→98]	14,1	[11.5–17.8]	11,8	[9.7–15]	340 000	[200 000–520 000]	260 000	[150 000–390 000]	
	89	[66→98]	12,9	[10.4–16.8]	10,4	[8.4–13.6]	280 000	[150 000–430 000]	200 000	[110 000–310 000]	Focus countries
	68	[54–84]	26,9	[25.4–28.5]	18,6	[14.9–21.6]	5500	[3200–8000]	5200	[2900–7600]	Angola
	100	[90–100]	5,7	[3–7.6]	1,9	[1.6–2.3]	3000	[1900–3700]	2200	[1300–3000]	Botswana ***
	55	[45–63]	19,1	[15–22.5]	16,4	[13.4–20.6]	<500	[<500–690]	<200	[<200–<500]	Burundi
	64	[50–74]	13,3	[11.2–15.4]	17,1	[14.3–19.2]	5900	[3500–7800]	3300	[1900–4500]	Cameroon
	87	[65–100]	21,7	[17.7–25.1]	14,5	[10.6–19.4]	1200	[680–1700]	860	[<500–1500]	Chad
	89	[70–100]	9,4	[7.9–12.9]	7,8	[3.9–12.2]	2800	[1700–3800]	1300	[760–2200]	Cote d'Ivoire
	39	[31–47]	29,3	[26.4–31.3]	27,8	[23.9–30.4]	6600	[3600–9000]	3800	[1900–6300]	Democratic Republic of the Congo
	95	[82–100]	6,4	[5–7.6]	3,7	[2.7–5.4]	3300	[2300–3800]	1600	[1100–2000]	Eswatini
	92	[66–100]	18,8	[13–23.8]	15	[10.4–18.9]	4000	[1800–7800]	2900	[1300–5600]	Ethiopia
	72	[57–86]	27,6	[25.2–30.1]	20,8	[16.7–24.1]	4900	[3000–7000]	4300	[2500–6500]	Ghana
	94	[74–100]	11,1	[8.8–16]	9,7	[7.7–13.9]	13 000	[7800–23 000]	9100	[5200–16 000]	Kenya
	96	[78–100]	7,1	[6.5–8.2]	6	[4.8–8.1]	3800	[2700–4700]	2100	[1400–2800]	Lesotho
	100	[84–100]	13,6	[10.7–15.5]	6,3	[5.5–7.4]	9800	[6500–12 000]	5900	[3800–7500]	Malawi
	100	[82–100]	16,4	[13.5–21.5]	13,5	[11.1–17.6]	36 000	[19 000–63 000]	28 000	[15 000–50 000]	Mozambique
	100	[100–100]	5	[4.4–6.7]	3,8	[3.5–4.4]	2100	[1400–2600]	1300	[820–1700]	Namibia
	44	[30–63]	20,1	[16.4–23.8]	24,9	[20.4–29.6]	18 000	[8500–36 000]	16 000	[7500–32 000]	Nigeria
	97	[60–100]	5,2	[4.4–6.9]	3,9	[3.2–7.5]	86 000	[42 000–130 000]	61 000	[30 000–93 000]	South Africa
	100	[80–100]	11,8	[11–12.9]	5,9	[4.9–7.8]	18 000	[11 000–22 000]	11 000	[6800–15 000]	Uganda
	84	[69–95]	17,8	[16–19.5]	11,1	[8.1–13.4]	20 000	[12 000–25 000]	15 000	[8900–20 000]	United Republic of Tanzania
	80	[70–89]	17,5	[15.9–19]	13,4	[11.1–16.1]	20 000	[13 000–25 000]	20 000	[13 000–27 000]	Zambia
	87	[68–100]	11,1	[8.2–14.8]	8,7	[6.4–11.6]	11 000	[6200–17 000]	5700	[3300–8700]	Zimbabwe

	2015	2020	2015		2020		2015	
	Voluntary male medical circumcision (all ages)	Voluntary male medical circumcision (all ages)	Children living with HIV aged 0-14 years	Uncertainty bounds	Children living with HIV aged 0-14 years	Uncertainty bounds	Antiretroviral therapy coverage among children aged 0-14 years	Uncertainty bounds
Global	not applicable	not applicable	2 100 000	[1 600 000–2 700 000]	1 700 000	[1 200 000–2 200 000]	39	[25–51]
Focus Countries	2 484 411	2 304 971	1 700 000	[1 300 000–2 200 000]	1 400 000	[980 000–1 700 000]	40	[25–51]
Angola	not applicable	Not applicable	39 000	[31 000–47 000]	39 000	[31 000–49 000]	11	[9–13]
Botswana ***	15 722	3 171	13 000	[9900–15 000]	7500	[5400–9200]	68	[53–79]
Burundi	not applicable	Not applicable	14 000	[11 000–16 000]	9700	[7300–12 000]	19	[15–22]
Cameroon	not applicable	Not applicable	45 000	[38 000–52 000]	35 000	[27 000–41 000]	16	[13–18]
Chad	not applicable	Not applicable	14 000	[11 000–19 000]	11 000	[7600–15 000]	11	[8–14]
Cote d'Ivoire	not applicable	Not applicable	37 000	[30 000–44 000]	21 000	[16 000–27 000]	21	[17–25]
Democratic Republic of the Congo	not applicable	Not applicable	82 000	[68 000–95 000]	71 000	[56 000–85 000]	13	[11–15]
Eswatini	12 952	8 639	13 000	[11 000–14 000]	8700	[7500–9700]	67	[59–72]
Ethiopia	9 744	34 786	65 000	[43 000–90 000]	44 000	[29 000–62 000]	31	[21–44]
Ghana	not applicable	Not applicable	35 000	[29 000–41 000]	29 000	[23 000–35 000]	10	[9–12]
Kenya	207 014	77 120	130 000	[100 000–160 000]	82 000	[67 000–100 000]	57	[46–73]
Lesotho	25 966	9 802	14 000	[12 000–16 000]	8700	[7500–10 000]	52	[45–59]
Malawi	108 672	47 316	98 000	[83 000–110 000]	62 000	[52 000–71 000]	37	[31–41]
Mozambique	198 340	113 227	140 000	[110 000–200 000]	130 000	[100 000–170 000]	42	[33–57]
Namibia	17 388	45 881	13 000	[11 000–15 000]	8400	[7300–9300]	67	[58–74]
Nigeria	not applicable	Not applicable	130 000	[89 000–200 000]	130 000	[85 000–190 000]	33	[22–50]
South Africa	485 552	164 699	380 000	[230 000–570 000]	310 000	[200 000–540 000]	42	[26–64]
Uganda	556 546	516 615	130 000	[120 000–140 000]	98 000	[88 000–110 000]	46	[41–50]
United Republic of Tanzania	435 302	539 859	140 000	[120 000–160 000]	110 000	[93 000–130 000]	37	[33–42]
Zambia	222 481	661 796	97 000	[88 000–110 000]	82 000	[73 000–93 000]	53	[49–59]
Zimbabwe	188 732	82 060	110 000	[91 000–130 000]	79 000	[66 000–92 000]	57	[48–66]

*Estimates of the number of adolescent girls aged 10–14 years acquiring HIV are not available.

**Voluntary medical male circumcision is only given priority in 15 countries globally that have high levels of HIV prevalence and low circumcision prevalence.

2020		2015		2020		2015		2020		
Antiretroviral therapy coverage among children aged 0-14 years	Uncertainty bounds	Annual AIDS deaths among children aged 0-14 years	Uncertainty bounds	Annual AIDS deaths among children aged 0-14 years	Uncertainty bounds	AIDS deaths among adolescents aged 15-19 years	Uncertainty bounds	AIDS deaths among adolescents aged 15-19 years	Uncertainty bounds	
54	[37–69]	140 000	[95 000–220 000]	99 000	[68 000–160 000]	20 000	[15000–29000]	17 000	[12000–25000]	
54	[37–68]	100 000	[72 000–170 000]	73 000	[50 000–120 000]	16 000	[12000–24000]	15 000	[11000–21000]	Focus countries
15	[12–19]	5500	[4400–6900]	4500	[3200–6100]	<500	[200–300]	<500	[300–500]	Angola
62	[44–76]	<500	[<500–620]	<500	[<200–<500]	<200	[100–200]	<200	[<100–200]	Botswana ***
31	[24–39]	1000	[720–1300]	680	[<500–940]	<500	[200–300]	<200	[<100–100]	Burundi
35	[27–41]	4100	[3100–5000]	3500	[2500–4400]	<500	[400–600]	<500	[400–500]	Cameroon
30	[21–41]	1300	[870–1900]	850	[520–1400]	<200	[100–200]	<200	[<100–200]	Chad
49	[37–63]	2400	[1900–3200]	800	[510–1200]	660	[500–800]	<500	[300–500]	Cote d'Ivoire
31	[24–36]	8700	[6900–10 000]	7200	[5200–9000]	1200	[1000–1400]	740	[600–900]	Democratic Republic of the Congo
>98	[89–100]	500	[<500–650]	<500	[<200–<500]	<100	[<100–100]	<200	[<100–100]	Eswatini
40	[27–56]	3600	[1800–6100]	2000	[980–3300]	870	[600–1400]	590	[400–900]	Ethiopia
33	[26–40]	3600	[2800–4500]	3000	[2200–3900]	530	[400–600]	<500	[300–500]	Ghana
84	[68–100]	6200	[3800–12 000]	3100	[1900–6000]	1500	[1000–2200]	920	[600–1300]	Kenya
83	[72–100]	850	[720–1100]	<500	[<500–570]	<200	[100–200]	<200	[100–200]	Lesotho
73	[61–84]	4700	[3400–5800]	1800	[1500–2200]	680	[600–800]	590	[500–700]	Malawi
64	[51–87]	10 000	[5800–19 000]	6800	[3900–13 000]	1100	[800–1600]	1300	[900–1800]	Mozambique
75	[65–82]	560	[<500–790]	<500	[<200–<500]	<100	[<100–100]	<200	[<100–<200]	Namibia
45	[30–68]	11 000	[6500–19 000]	12 000	[7000–21 000]	1200	[600–2100]	1300	[700–2400]	Nigeria
47	[30–81]	5700	[2100–11 000]	3900	[1200–11 000]	2700	[1200–5600]	3200	[1400–7000]	South Africa
63	[56–71]	9100	[7800–10 000]	4300	[3300–6200]	1100	[900–1300]	1100	[900–1300]	Uganda
54	[44–63]	11 000	[8500–13 000]	8300	[5600–11 000]	1100	[900–1300]	1000	[800–1200]	United Republic of Tanzania
58	[51–65]	6600	[5500–7800]	5300	[3900–7000]	910	[800–1100]	920	[700–1100]	Zambia
72	[61–84]	6100	[4100–9100]	3500	[2400–5300]	1100	[900–1300]	880	[700–1100]	Zimbabwe

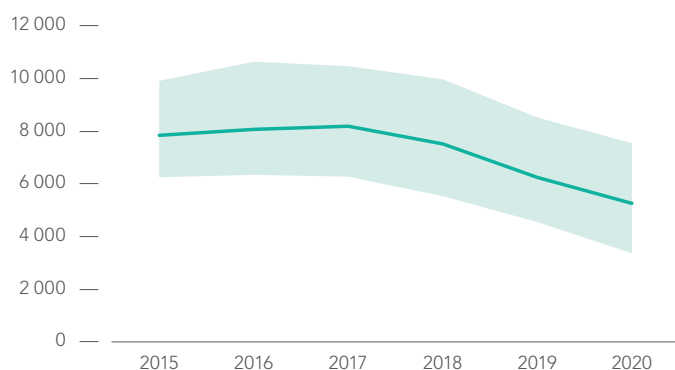
ANNEX 2. COUNTRY FACT SHEETS



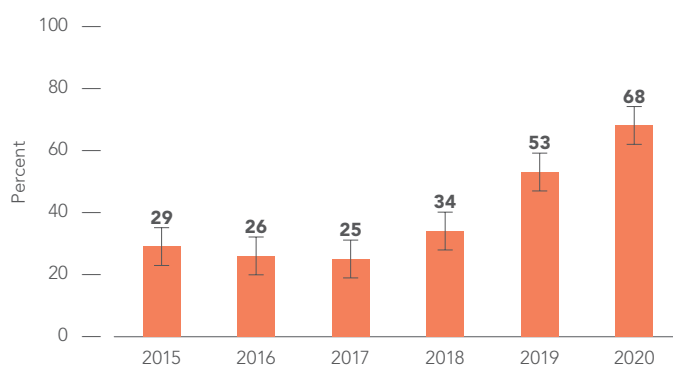


ANGOLA

Children aged 0-14 years acquiring HIV, 2015–2020



Antiretroviral therapy among pregnant women, 2015–2020



Six-week and final (after breastfeeding) transmission rate, 2015 and 2020



Six week transmission

2015
19% [17–20%]

2020
12% [9–15%]



Final transmission

2015
27% [25–29%]

2020
19% [15–22%]

Percentage of pregnant women who had at least one antenatal visit, most recent survey



2015
82%

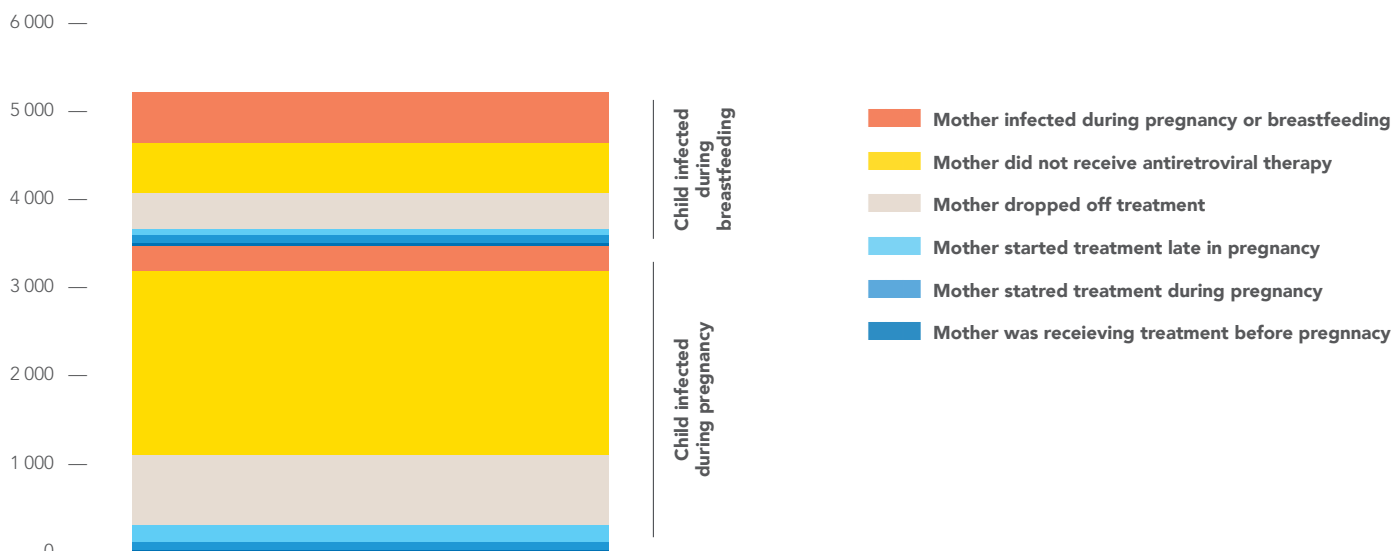
Percentage of HIV-exposed infants who received a virological test for HIV within two months of birth, 2015 and 2020



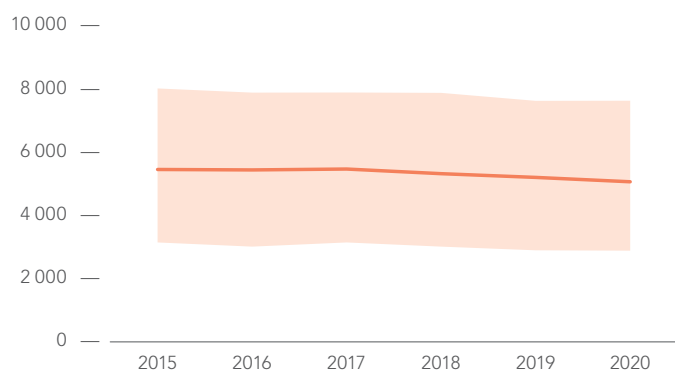
2015
4% [4–5%]

2020
2% [2–3%]

Children acquiring HIV by missed prevention opportunity, 2020



Young women aged 15-24 years acquiring HIV, 2015-2019



Condom use with most recent non-regular partner, young women and young men, most recent survey (%)

Men
52

Women
33



Knowledge of HIV prevention among young women and young men, most recent survey (%)

Men
32

Women
33



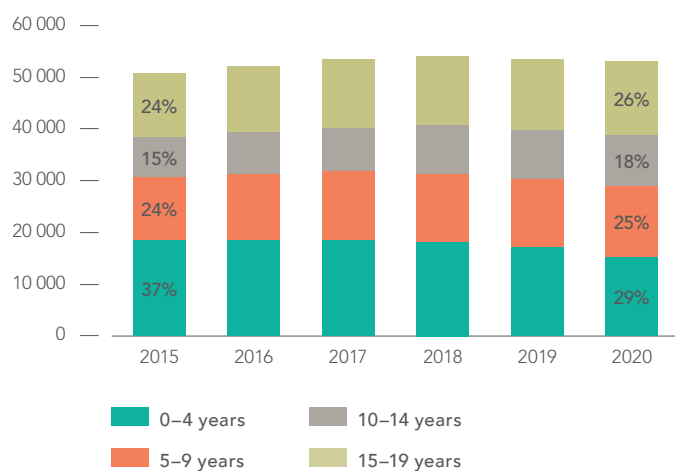
Number of voluntary medical male circumcisions, all ages

2015

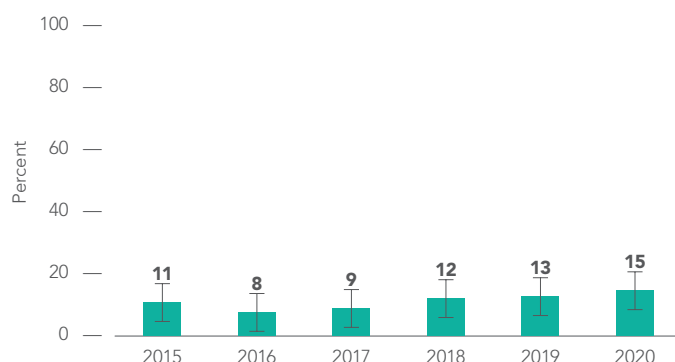
2020

Not applicable

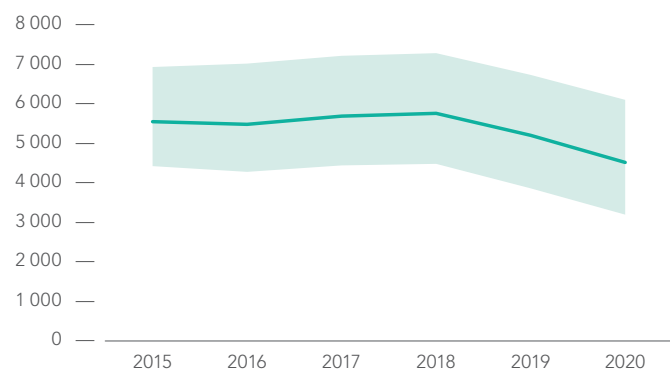
Children and adolescents living with HIV by age, 2015-2020



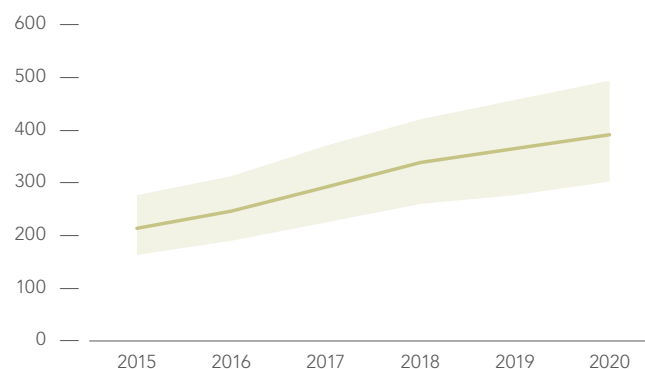
Antiretroviral therapy coverage among children aged 0-14 years, 2015-2020



Children aged 0-14 years dying from AIDS-related causes annually, 2015-2020

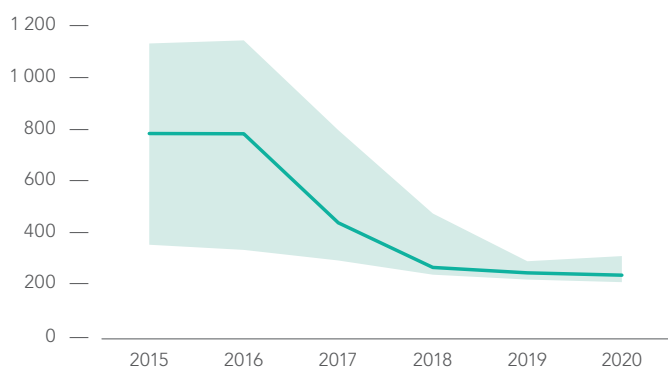


Adolescents aged 15-19 years dying from AIDS-related causes annually, 2015-2020

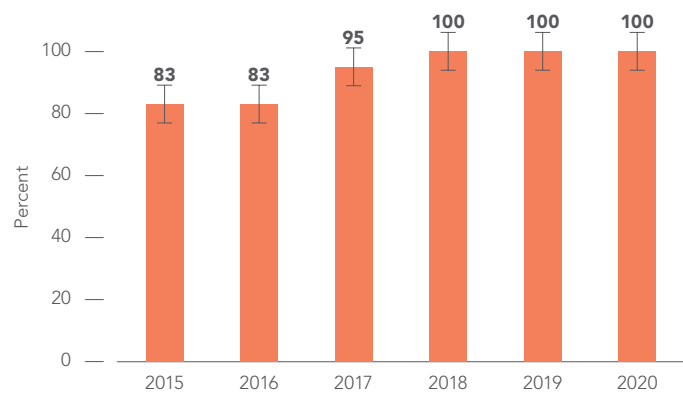


BOTSWANA

Children aged 0-14 years acquiring HIV, 2015–2020



Antiretroviral therapy among pregnant women, 2015–2020



Six-week and final (after breastfeeding) transmission rate, 2015 and 2020



Six week transmission

2015
4% [2–6%]

2020
1% [1–1%]



Final transmission

2015
6% [3–8%]

2020
2% [2–2%]

Percentage of pregnant women who had at least one antenatal visit, most recent survey



2015
Not available

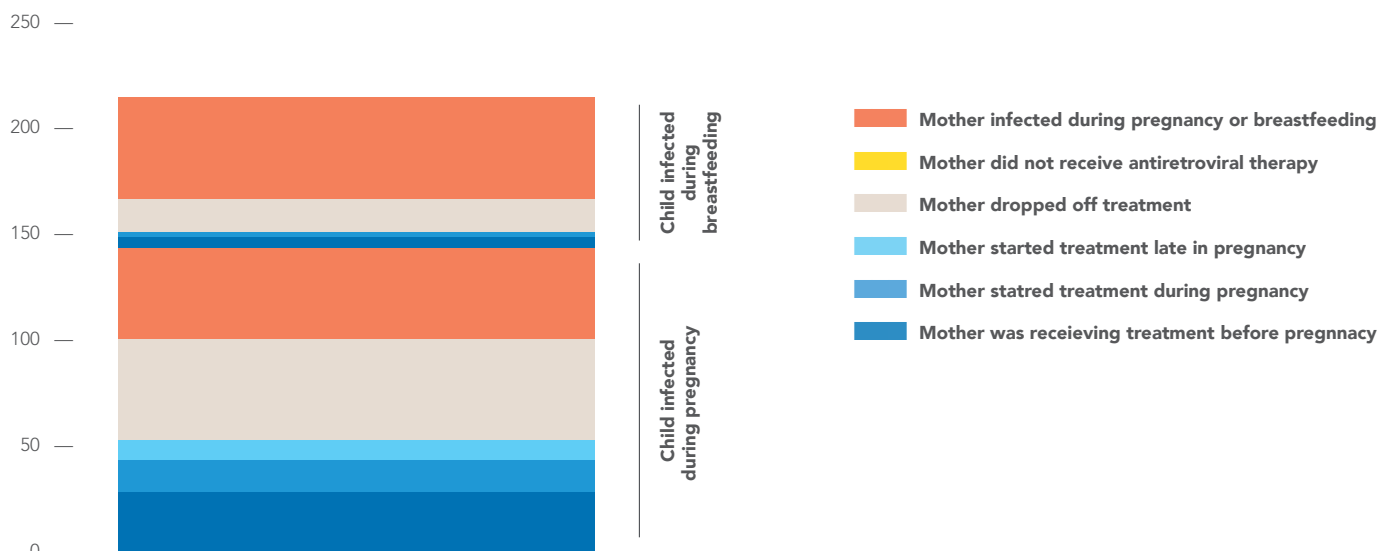
Percentage of HIV-exposed infants who received a virological test for HIV within two months of birth, 2015 and 2020



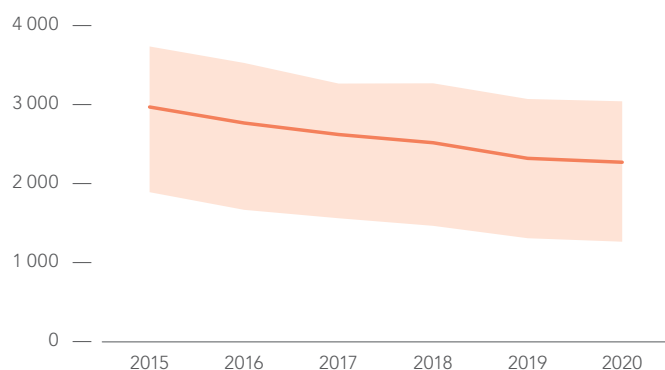
2015
40% [44–52%]

2020
99% [94–99%]

Children acquiring HIV by missed prevention opportunity, 2020



Young women aged 15-24 years acquiring HIV, 2015-2019



Condom use with most recent non-regular partner, young women and young men, most recent survey (%)

Men **Not available** Women **Not available** Men **Not available** Women **Not available**



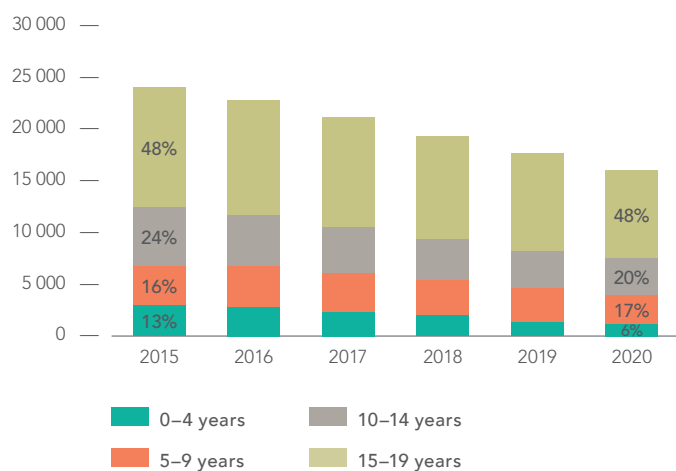
Knowledge of HIV prevention among young women and young men, most recent survey (%)

Number of voluntary medical male circumcisions, all ages

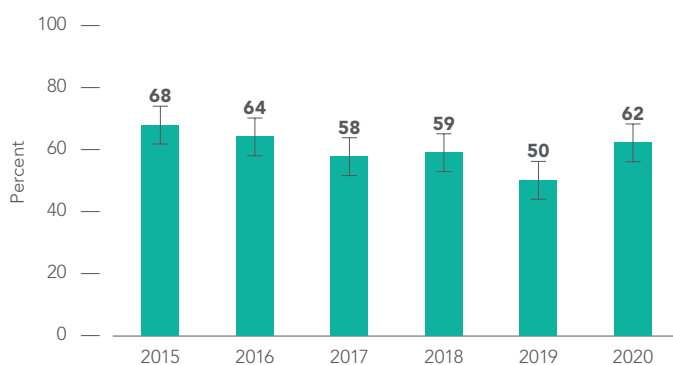
2015
15 722

2020
3 171

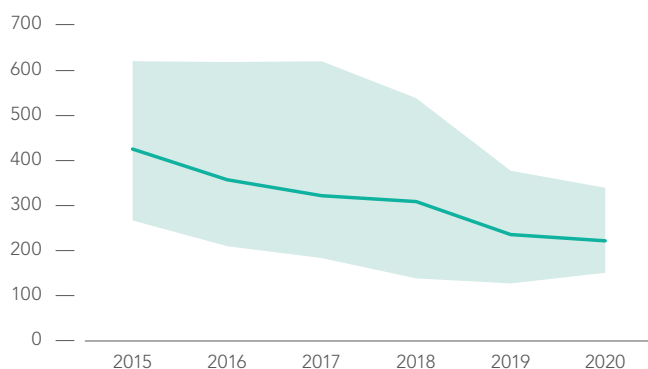
Children and adolescents living with HIV by age, 2015-2020



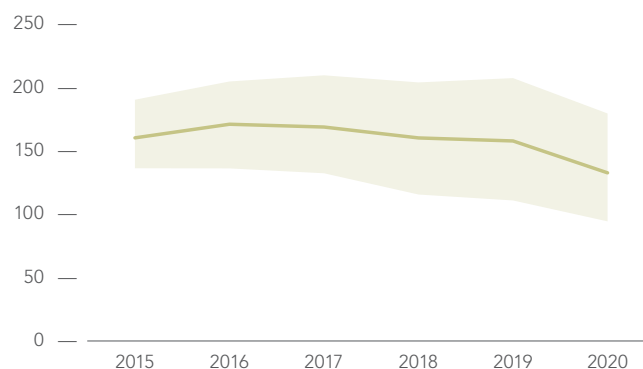
Antiretroviral therapy coverage among children aged 0-14 years, 2015-2020



Children aged 0-14 years dying from AIDS-related causes annually, 2015-2020

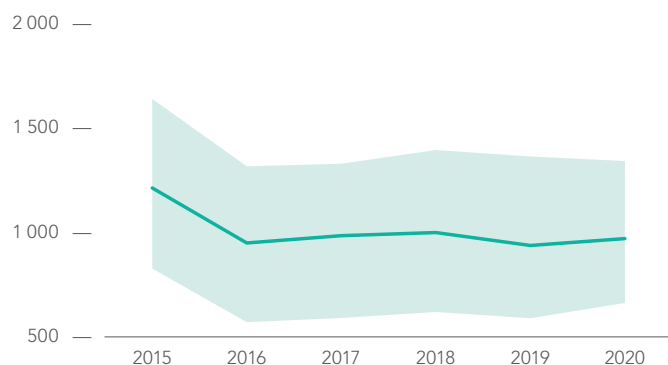


Adolescents aged 15-19 years dying from AIDS-related causes annually, 2015-2020

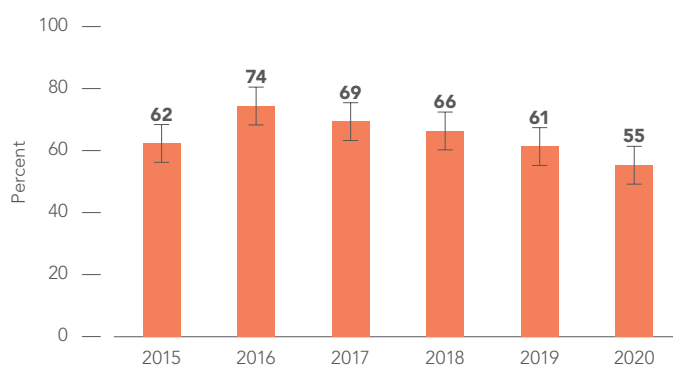


BURUNDI

Children aged 0-14 years acquiring HIV, 2015–2020



Antiretroviral therapy among pregnant women, 2015–2020



Six-week and final (after breastfeeding) transmission rate, 2015 and 2020



Six week transmission

2015
11% [8–13%]

2020
9% [7–12%]



Final transmission

2015
19% [15–22%]

2020
6% [3–1%]

Percentage of pregnant women who had at least one antenatal visit, most recent survey



2016
99%

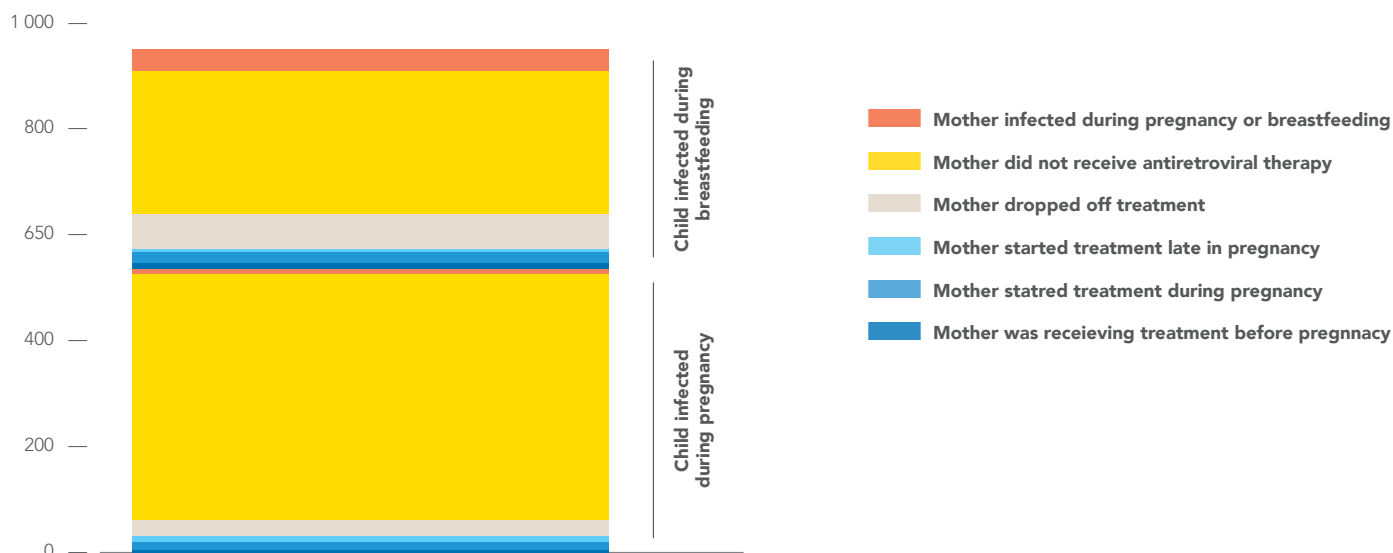
Percentage of HIV-exposed infants who received a virological test for HIV within two months of birth, 2015 and 2020



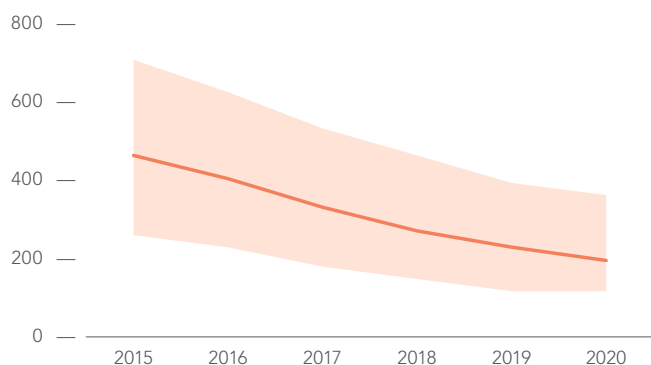
2015
1% [1–2%]

2020
2% [70–98%]

Children acquiring HIV by missed prevention opportunity, 2020



Young women aged 15-24 years acquiring HIV, 2015-2019



Condom use with most recent non-regular partner, young women and young men, most recent survey (%)

Men
53

Women
33



Knowledge of HIV prevention among young women and young men, most recent survey (%)

Men
55

Women
52



Number of voluntary medical male circumcisions, all ages

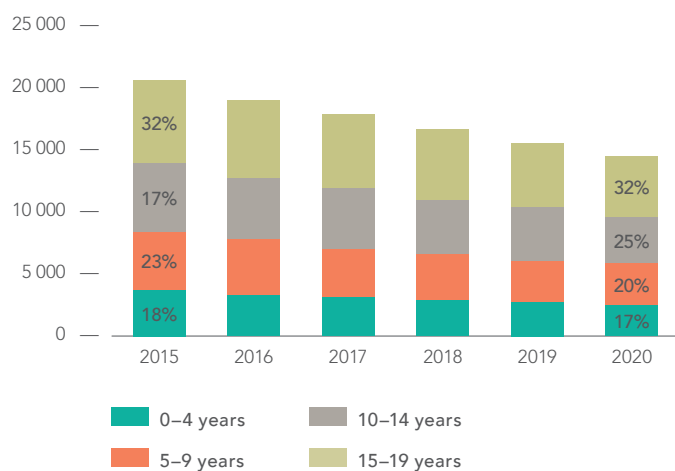
2015



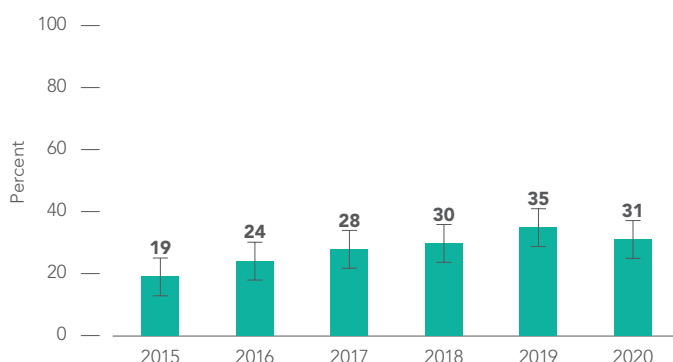
2020

Not applicable

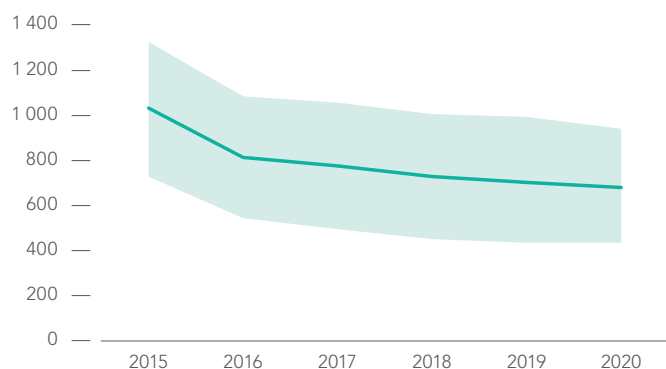
Children and adolescents living with HIV by age, 2015-2020



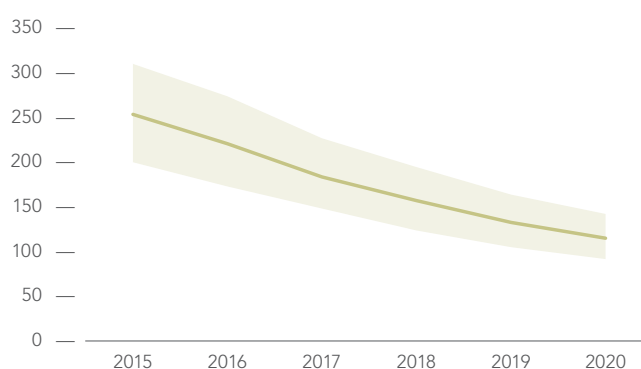
Antiretroviral therapy coverage among children aged 0-14 years, 2015-2020



Children aged 0-14 years dying from AIDS-related causes annually, 2015-2020

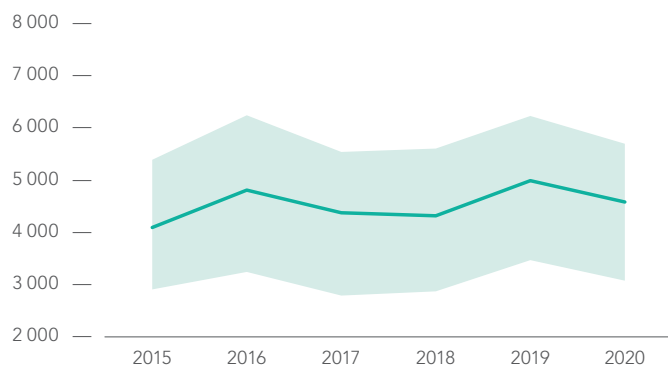


Adolescents aged 15-19 years dying from AIDS-related causes annually, 2015-2020

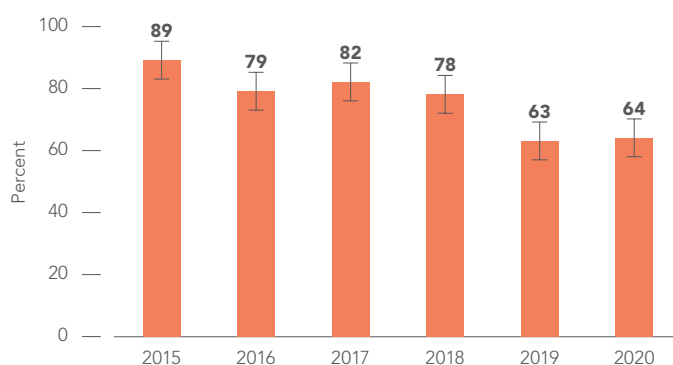


CAMEROON

Children aged 0-14 years acquiring HIV, 2015–2020



Antiretroviral therapy among pregnant women, 2015–2020



Six-week and final (after breastfeeding) transmission rate, 2015 and 2020



Six week transmission

2015
9% [6–10%]

2020
2% [0–4%]



Final transmission

2015
13% [11–15%]

2020
7% [4–19%]

Percentage of pregnant women who had at least one antenatal visit, most recent survey



2018
87%

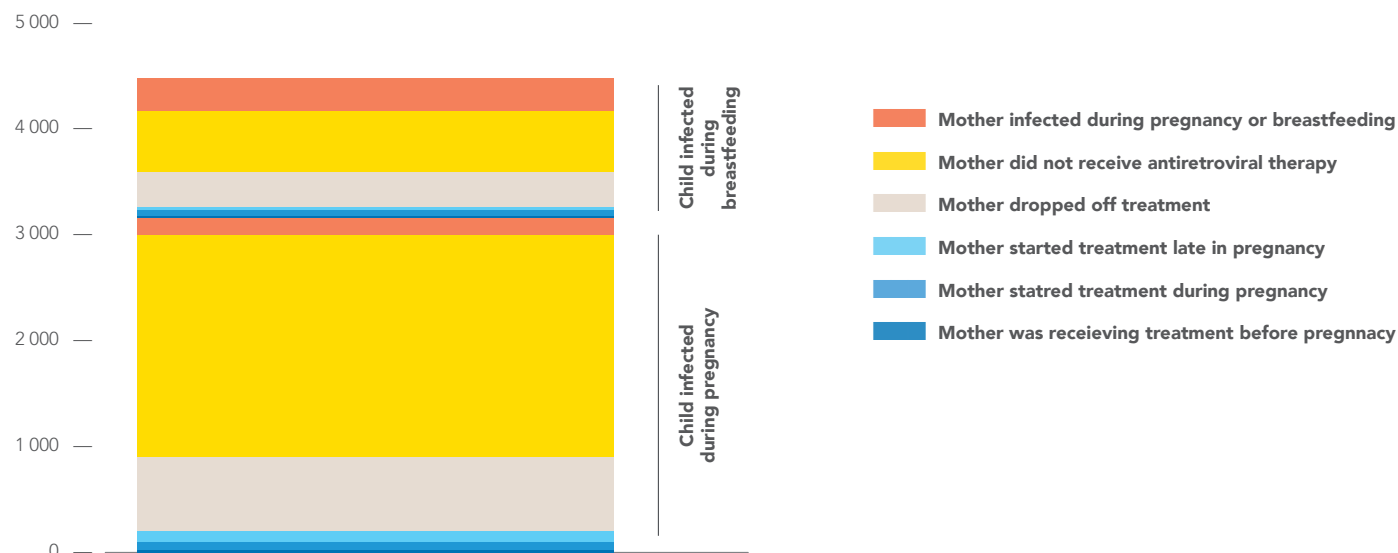
Percentage of HIV-exposed infants who received a virological test for HIV within two months of birth, 2015 and 2020



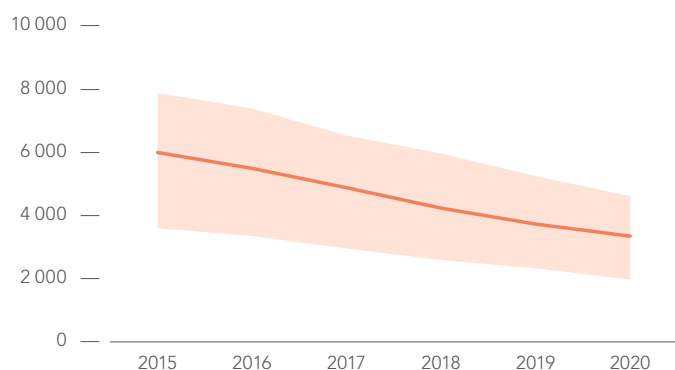
2015
29% [33–40%]

2020
0% [0–0%]

Children acquiring HIV by missed prevention opportunity, 2020



Young women aged 15-24 years acquiring HIV, 2015-2019



Condom use with most recent non-regular partner, young women and young men, most recent survey (%)

Men
65



Women
50

Knowledge of HIV prevention among young women and young men, most recent survey (%)

Men
36



Women
41

Number of voluntary medical male circumcisions, all ages

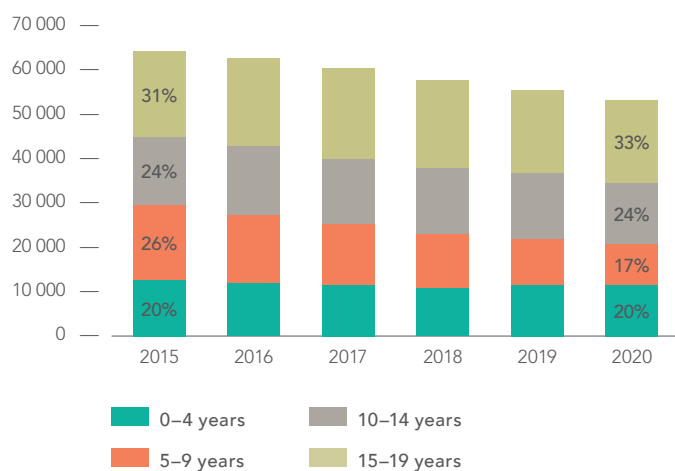
2015

—

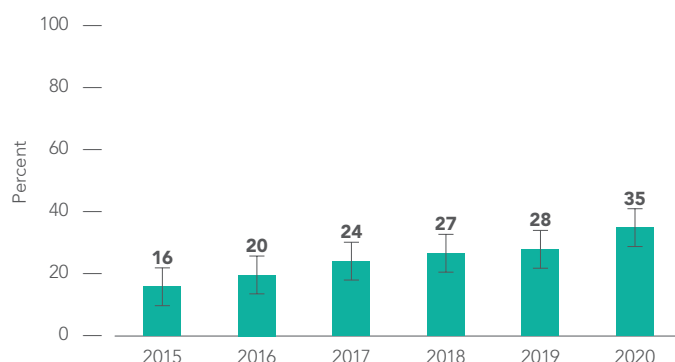
2020

Not applicable

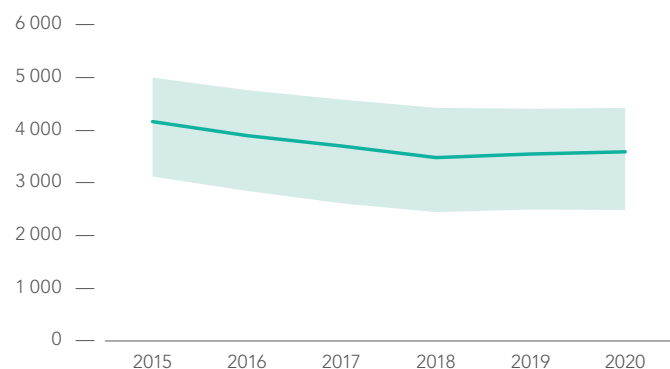
Children and adolescents living with HIV by age, 2015-2020



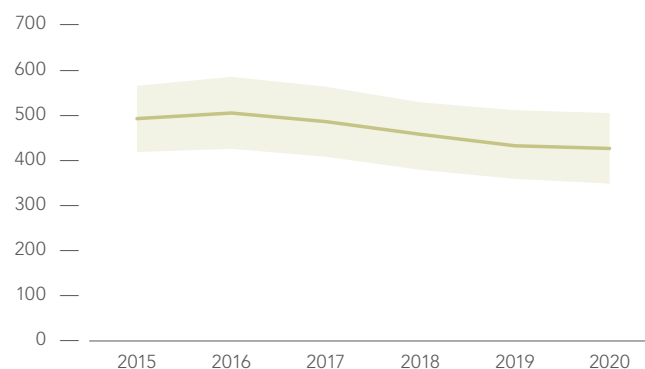
Antiretroviral therapy coverage among children aged 0-14 years, 2015-2020



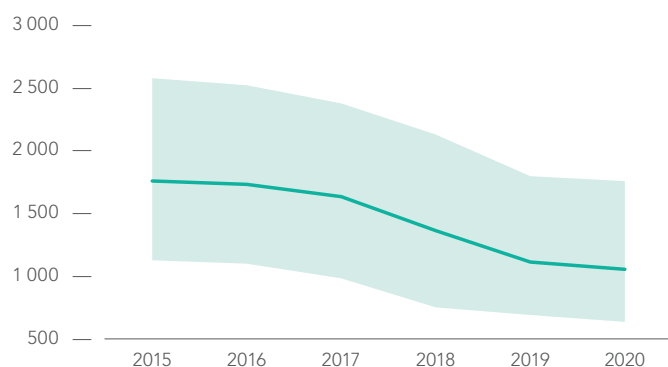
Children aged 0-14 years dying from AIDS-related causes annually, 2015-2020



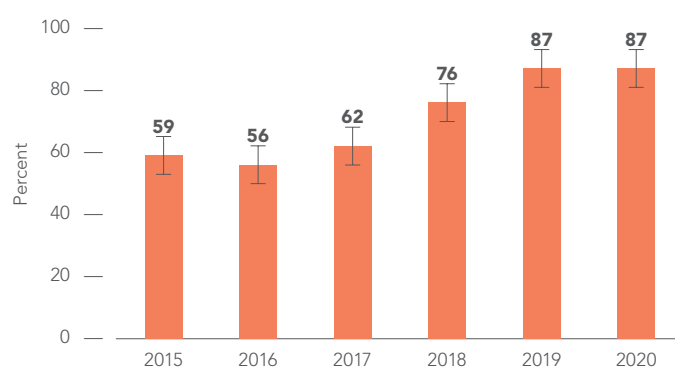
Adolescents aged 15-19 years dying from AIDS-related causes annually, 2015-2020



Children aged 0-14 years acquiring HIV, 2015–2020



Antiretroviral therapy among pregnant women, 2015–2020



Six-week and final (after breastfeeding) transmission rate, 2015 and 2020



Six week transmission

2015
13% [10-16%]

2020
8% [6-5%]



Final transmission

2015
22% [18-25%]

2020
15% [11-20%]

Percentage of pregnant women who had at least one antenatal visit, most recent survey



2014
65%

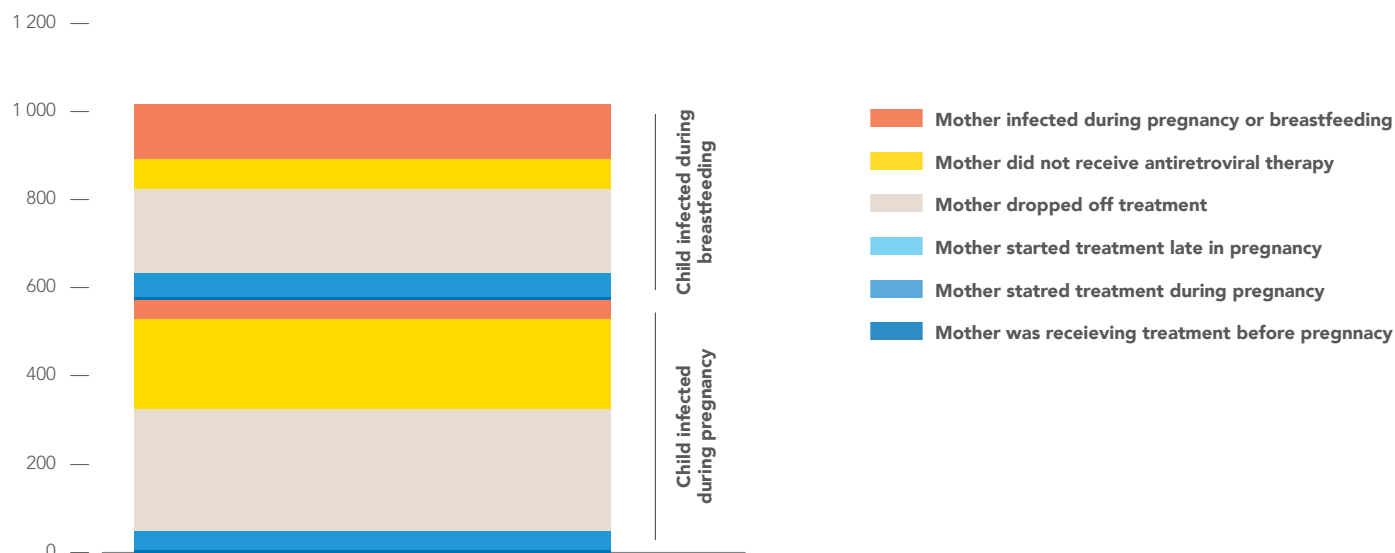
Percentage of HIV-exposed infants who received a virological test for HIV within two months of birth, 2015 and 2020



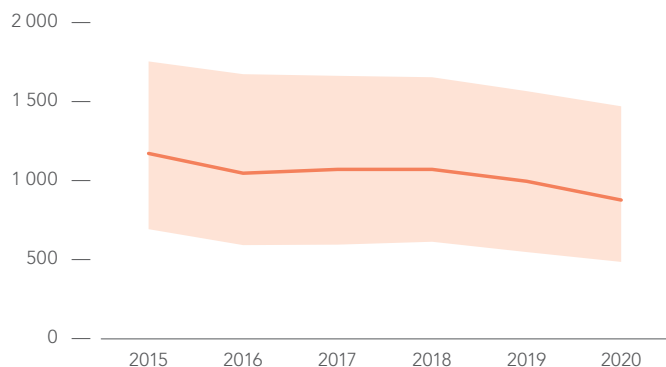
2015
3% [4-6%]

2020
23% [18-29%]

Children acquiring HIV by missed prevention opportunity, 2020



Young women aged 15-24 years acquiring HIV, 2015-2019



Condom use with most recent non-regular partner, young women and young men, most recent survey (%)

Men
42

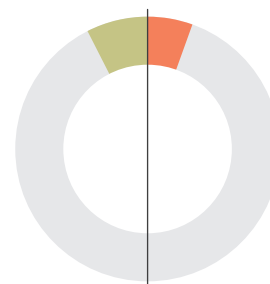
Women
37



Knowledge of HIV prevention among young women and young men, most recent survey (%)

Men
15

Women
11



Number of voluntary medical male circumcisions, all ages

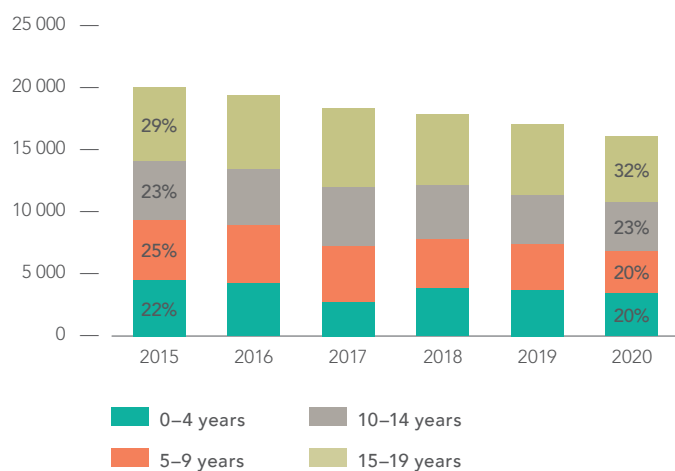
2015

—

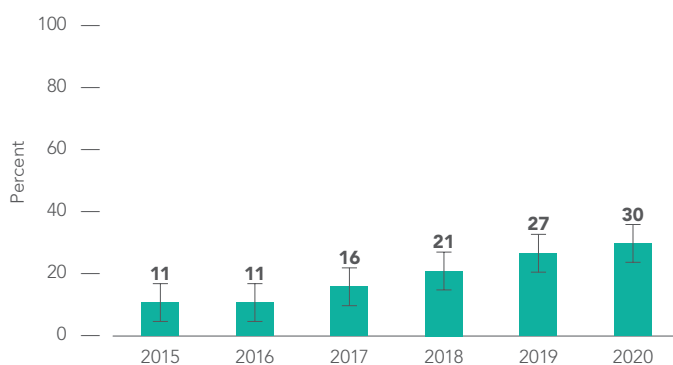
2020

Not applicable

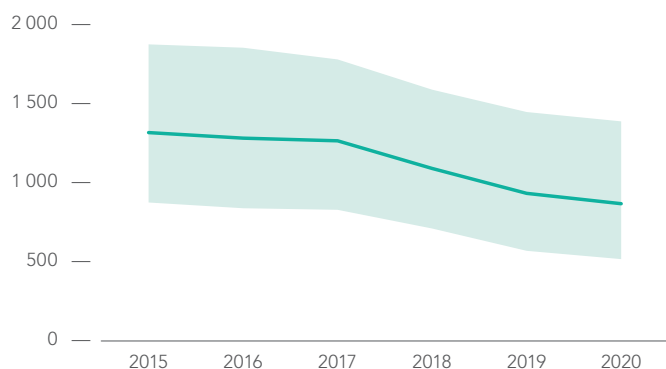
Children and adolescents living with HIV by age, 2015-2020



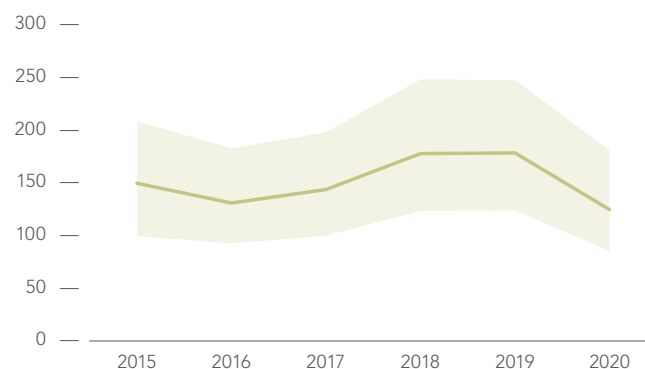
Antiretroviral therapy coverage among children aged 0-14 years, 2015-2020



Children aged 0-14 years dying from AIDS-related causes annually, 2015-2020

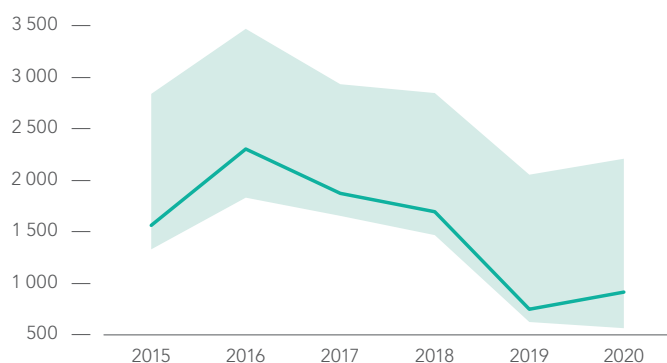


Adolescents aged 15-19 years dying from AIDS-related causes annually, 2015-2020

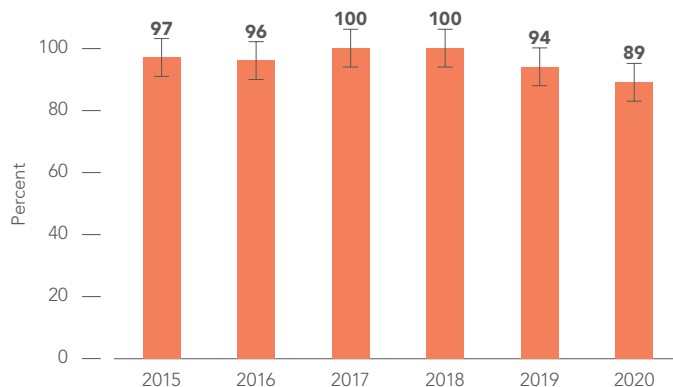


CÔTE D'IVOIRE

Children aged 0-14 years acquiring HIV, 2015–2020



Antiretroviral therapy among pregnant women, 2015-2020



Six-week and final (after breastfeeding) transmission rate, 2015 and 2020



Six week transmission

2015
5% [4-8%]

2020
4% [1-7%]



Final transmission

2015
9% [8-13%]

2020
8% [4-2%]

Percentage of pregnant women who had at least one antenatal visit, most recent survey



2011
92%

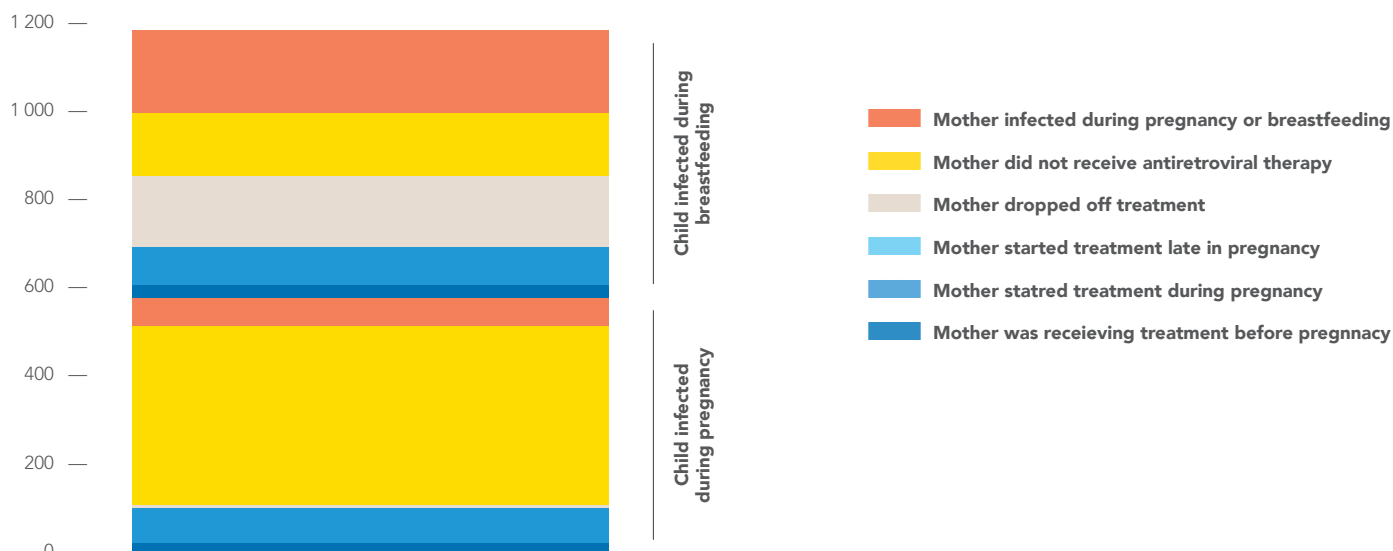
Percentage of HIV-exposed infants who received a virological test for HIV within two months of birth, 2015 and 2020



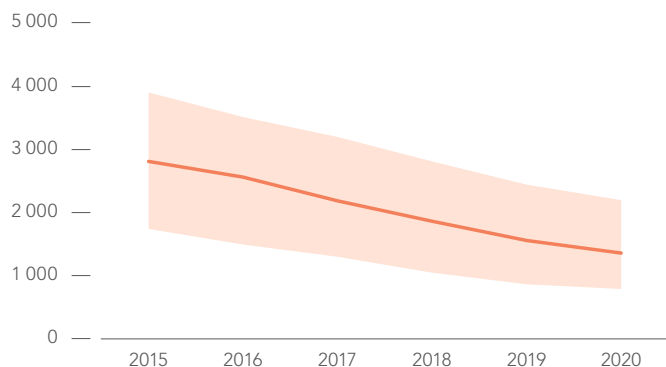
2015
34% [41-51%]

2020
80% [52-77%]

Children acquiring HIV by missed prevention opportunity, 2020



Young women aged 15-24 years acquiring HIV, 2015-2019



Condom use with most recent non-regular partner, young women and young men, most recent survey (%)

Men **Not available** Women **Not available** Men **Not available** Women **Not available**



Knowledge of HIV prevention among young women and young men, most recent survey (%)

Number of voluntary medical male circumcisions, all ages

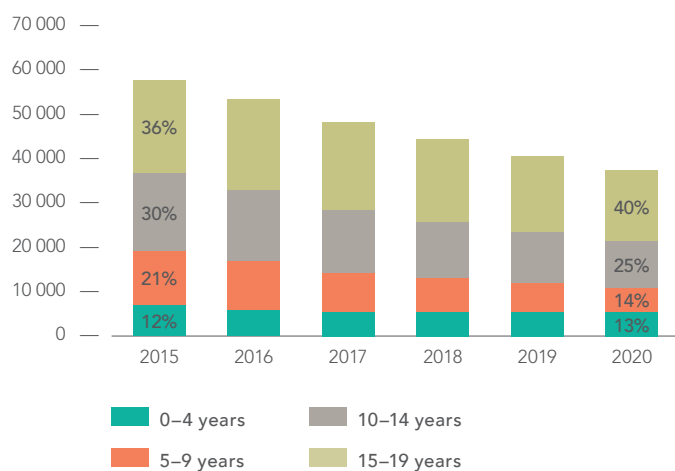
2015



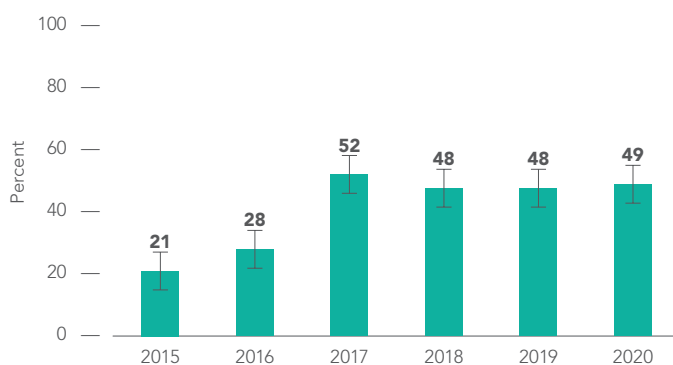
2020

Not applicable

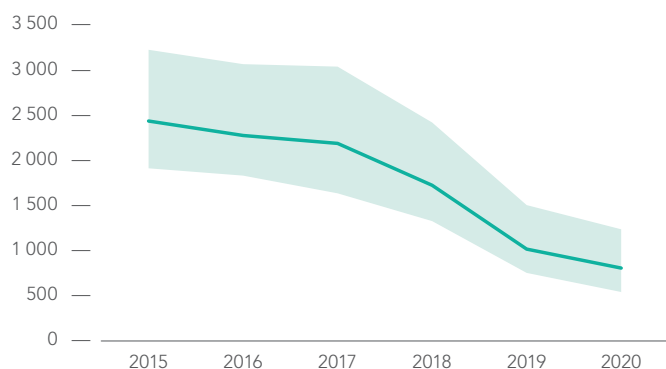
Children and adolescents living with HIV by age, 2015-2020



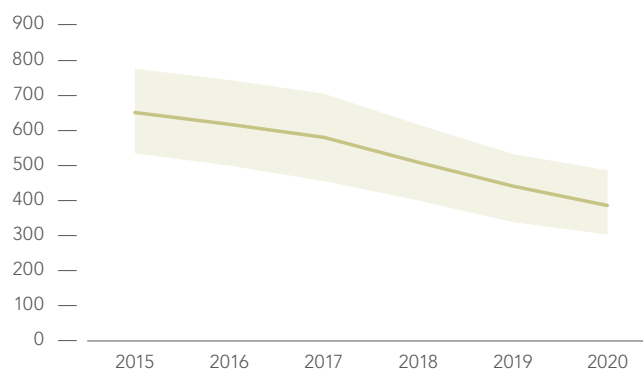
Antiretroviral therapy coverage among children aged 0-14 years, 2015-2020



Children aged 0-14 years dying from AIDS-related causes annually, 2015-2020

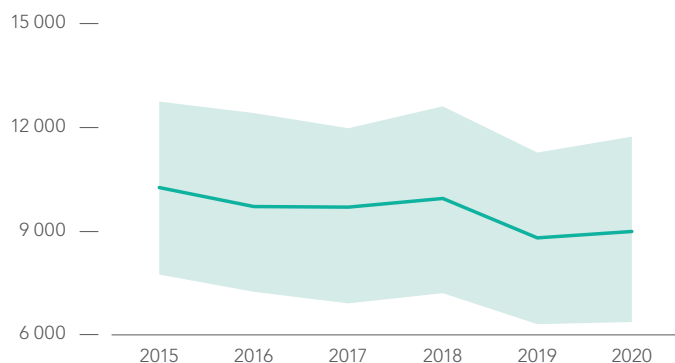


Adolescents aged 15-19 years dying from AIDS-related causes annually, 2015-2020

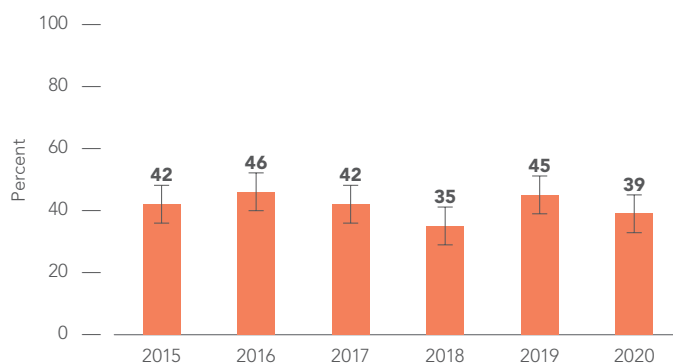


DEMOCRATIC REPUBLIC OF THE

Children aged 0-14 years acquiring HIV, 2015–2020



Antiretroviral therapy among pregnant women, 2015–2020



Six-week and final (after breastfeeding) transmission rate, 2015 and 2020



Six week transmission

2015
18% [16-19%]

2020
8% [5-20%]



Final transmission

2015
29% [26-31%]

2020
8% [4-30%]

Percentage of pregnant women who had at least one antenatal visit, most recent survey



2013
90%

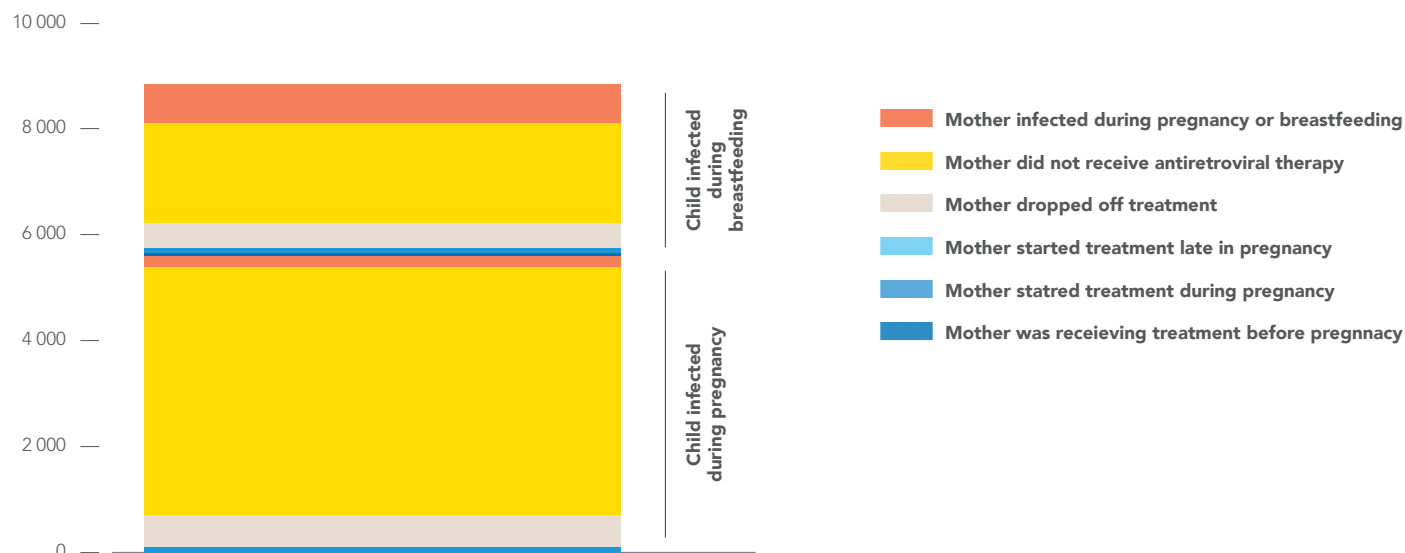
Percentage of HIV-exposed infants who received a virological test for HIV within two months of birth, 2015 and 2020



2015
9% [11-14%]

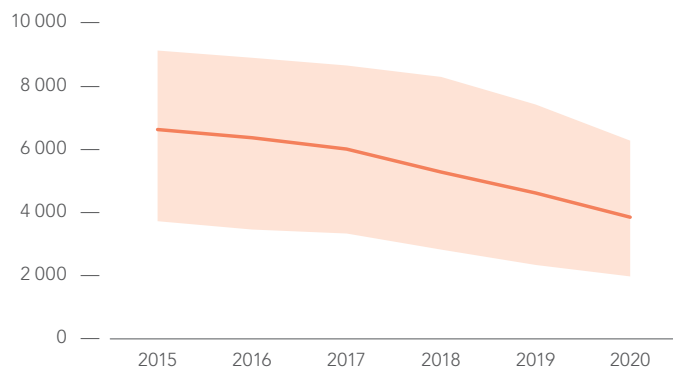
2020
11% [9-14%]

Children acquiring HIV by missed prevention opportunity, 2020



CONGO

Young women aged 15-24 years acquiring HIV, 2015-2019



Condom use with most recent non-regular partner, young women and young men, most recent survey (%)

Men **Not available** Women **Not available** Men **Not available** Women **Not available**

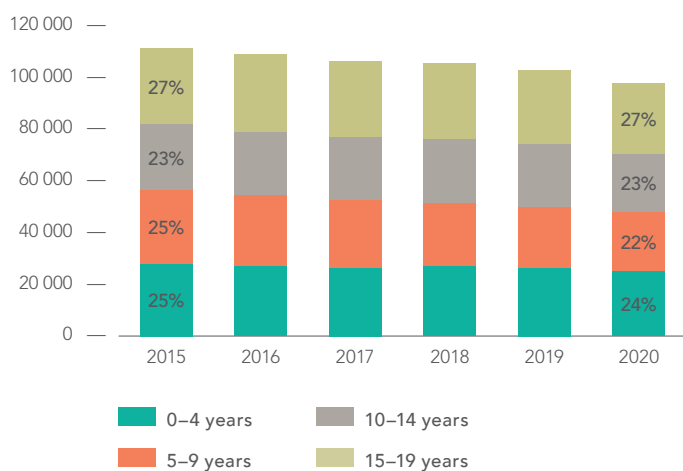


Knowledge of HIV prevention among young women and young men, most recent survey (%)

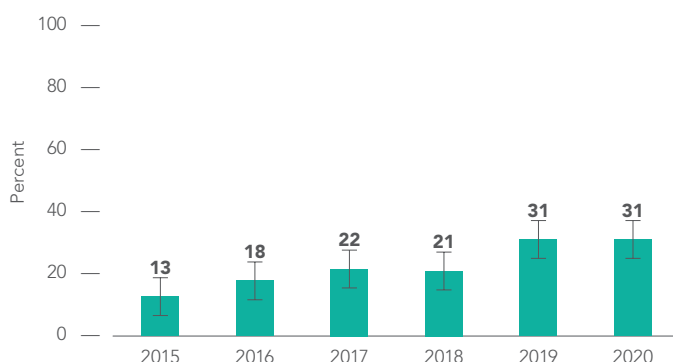
2015 **Not applicable** 2020 **Not applicable**

Number of voluntary medical male circumcisions, all ages

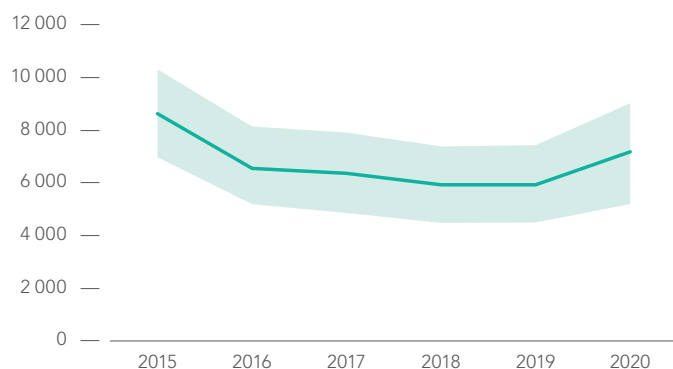
Children and adolescents living with HIV by age, 2015-2020



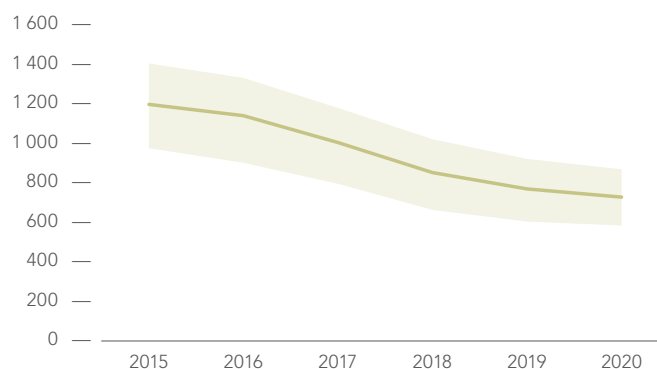
Antiretroviral therapy coverage among children aged 0-14 years, 2015-2020



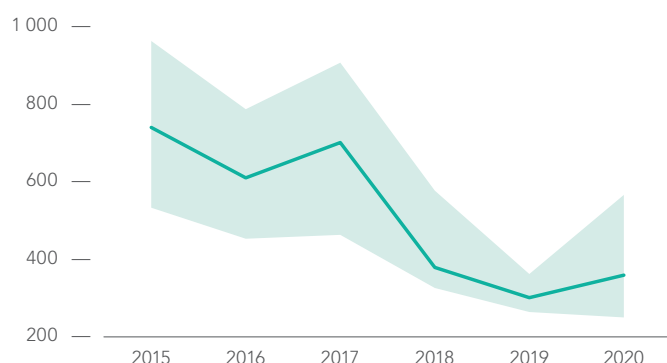
Children aged 0-14 years dying from AIDS-related causes annually, 2015-2020



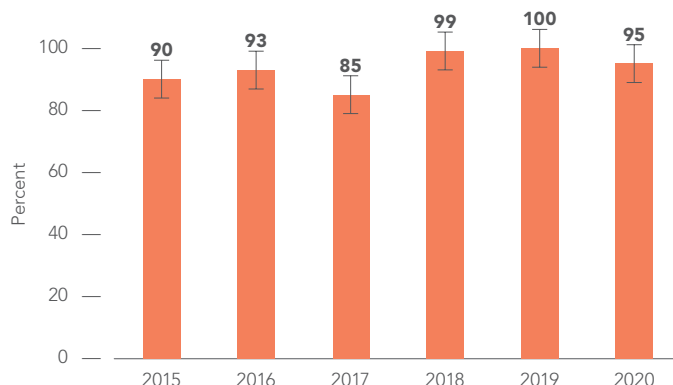
Adolescents aged 15-19 years dying from AIDS-related causes annually, 2015-2020



Children aged 0-14 years acquiring HIV, 2015–2020



Antiretroviral therapy among pregnant women, 2015–2020



Six-week and final (after breastfeeding) transmission rate, 2015 and 2020



Six week transmission

2015
4% [2-5%]

2020
2% [1-4%]



Final transmission

2015
6% [5-8%]

2020
4% [3-5%]

Percentage of pregnant women who had at least one antenatal visit, most recent survey



2016
99%

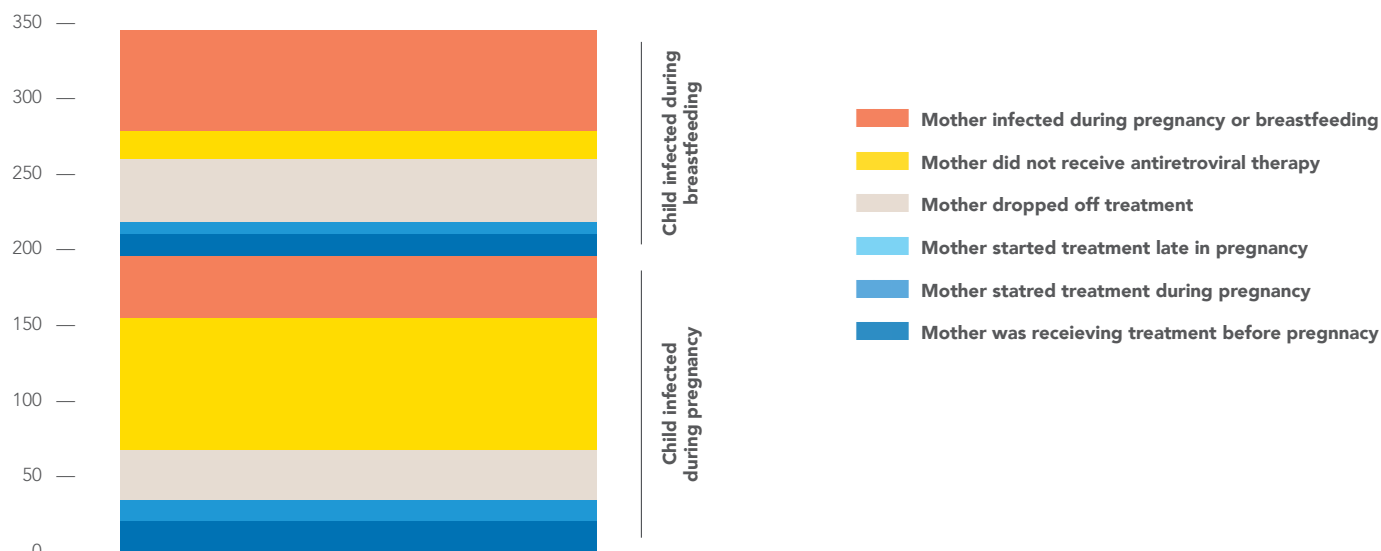
Percentage of HIV-exposed infants who received a virological test for HIV within two months of birth, 2015 and 2020



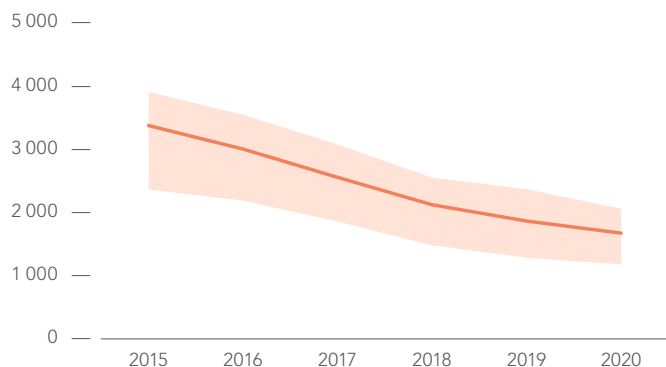
2015
0% [0-0%]

2020
23% [0-0%]

Children acquiring HIV by missed prevention opportunity, 2020



Young women aged 15-24 years acquiring HIV, 2015-2019



Condom use with most recent non-regular partner, young women and young men, most recent survey (%)

Men
77

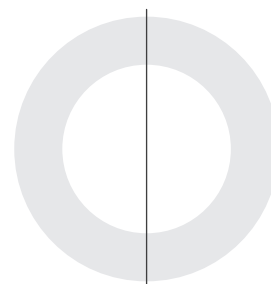
Women
65



Knowledge of HIV prevention among young women and young men, most recent survey (%)

Men
Not available

Women
Not available

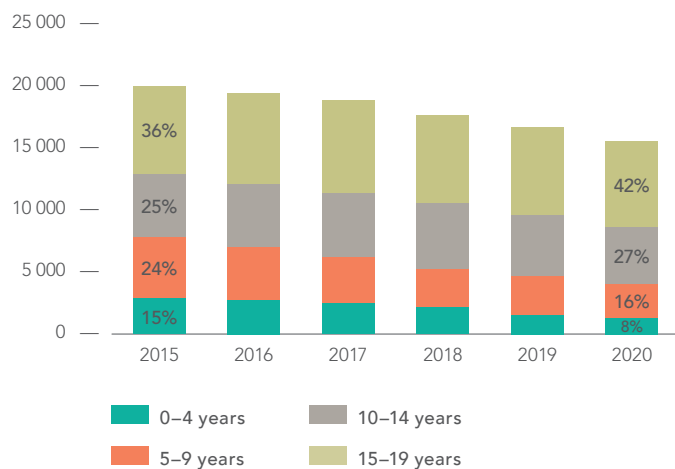


Number of voluntary medical male circumcisions, all ages

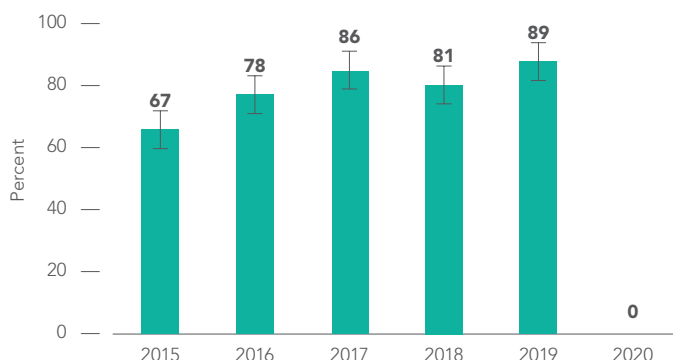
2015
12 952

2020
8 639

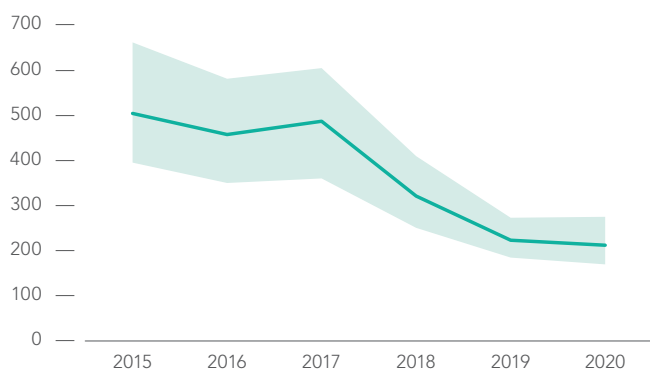
Children and adolescents living with HIV by age, 2015-2020



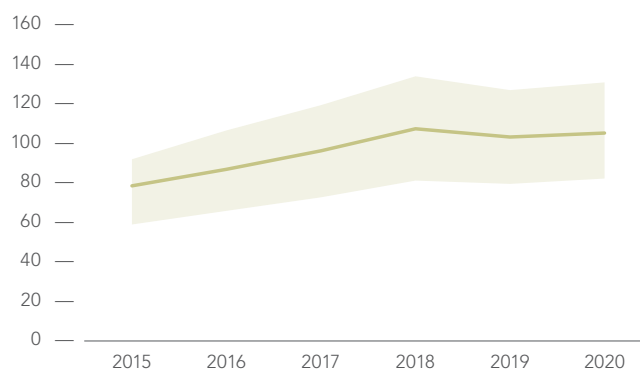
Antiretroviral therapy coverage among children aged 0-14 years, 2015-2020



Children aged 0-14 years dying from AIDS-related causes annually, 2015-2020

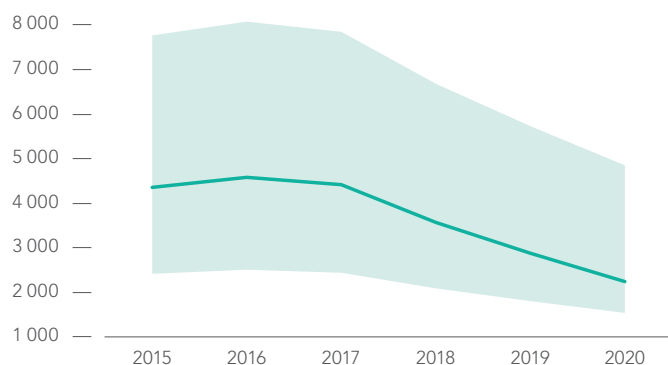


Adolescents aged 15-19 years dying from AIDS-related causes annually, 2015-2020

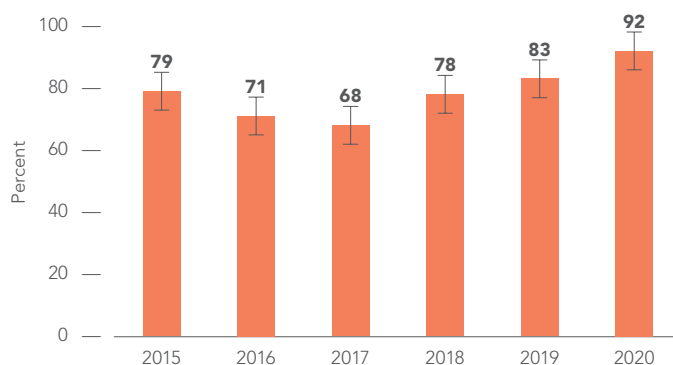


ETHIOPIA

Children aged 0-14 years acquiring HIV, 2015–2020



Antiretroviral therapy among pregnant women, 2015–2020



Six-week and final (after breastfeeding) transmission rate, 2015 and 2020



Six week transmission

2015
10% [6-13%]

2020
8% [5-0%]



Final transmission

2015
19% [13-24%]

2020
5% [0-19%]

Percentage of pregnant women who had at least one antenatal visit, most recent survey



2016
63%

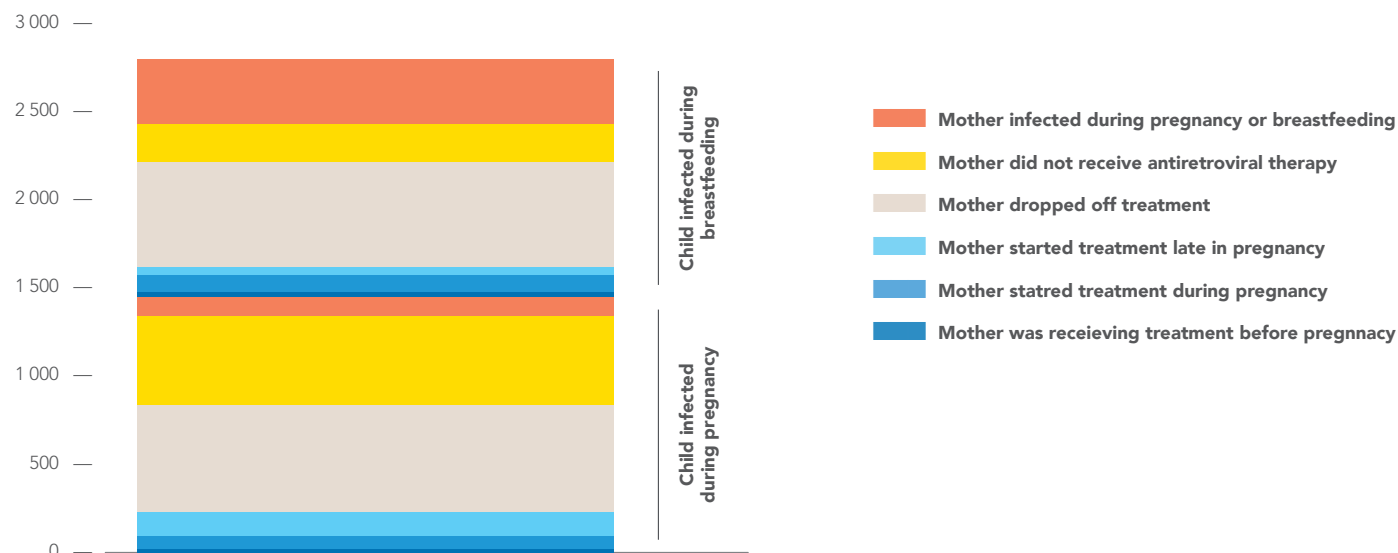
Percentage of HIV-exposed infants who received a virological test for HIV within two months of birth, 2015 and 2020



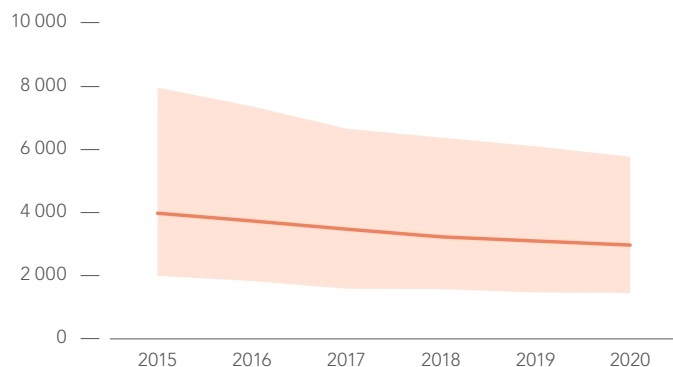
2015
27% [35-49%]

2020
11% [31-57%]

Children acquiring HIV by missed prevention opportunity, 2020



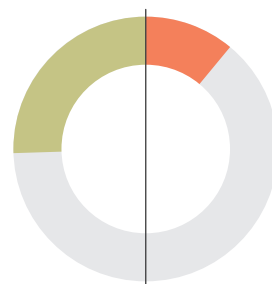
Young women aged 15-24 years acquiring HIV, 2015-2019



Condom use with most recent non-regular partner, young women and young men, most recent survey (%)

Men
51

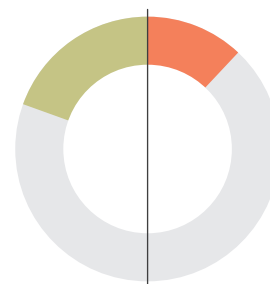
Women
22



Knowledge of HIV prevention among young women and young men, most recent survey (%)

Men
39

Women
24

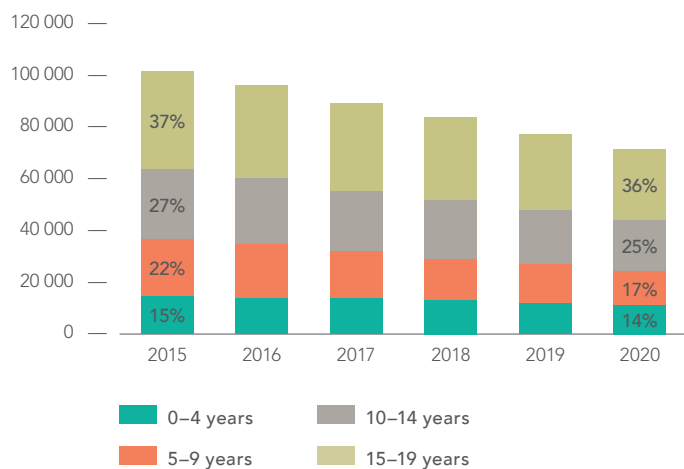


Number of voluntary medical male circumcisions, all ages

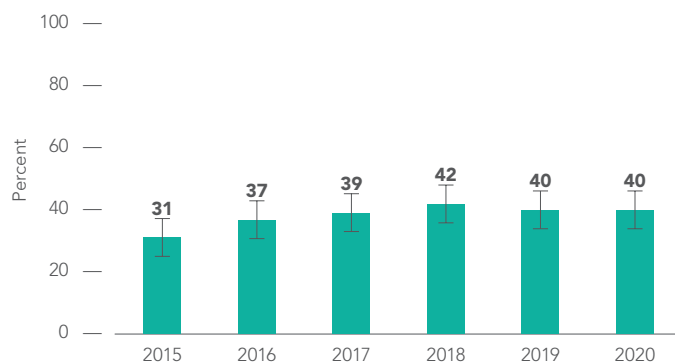
2015
9 744

2020
34 786

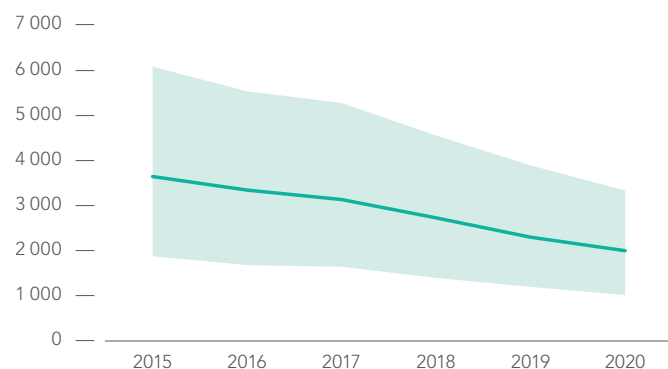
Children and adolescents living with HIV by age, 2015-2020



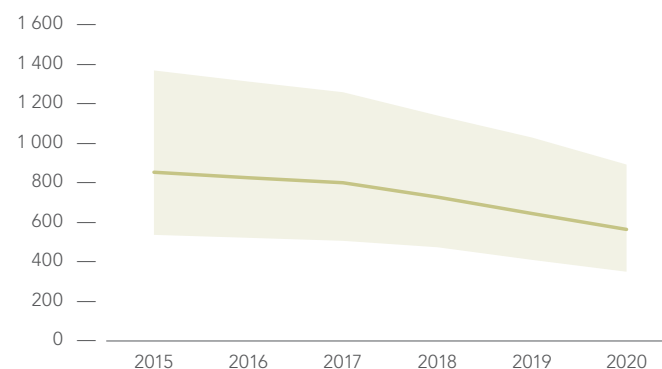
Antiretroviral therapy coverage among children aged 0-14 years, 2015-2020



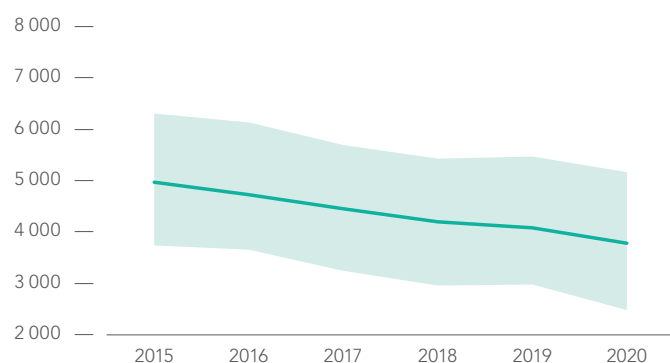
Children aged 0-14 years dying from AIDS-related causes annually, 2015-2020



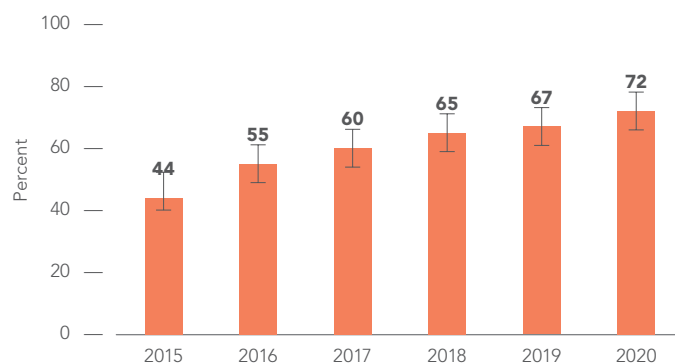
Adolescents aged 15-19 years dying from AIDS-related causes annually, 2015-2020



Children aged 0-14 years acquiring HIV, 2015–2020



Antiretroviral therapy among pregnant women, 2015–2020



Six-week and final (after breastfeeding) transmission rate, 2015 and 2020



Six week transmission

2015
16% [14-18%]

2020
1% [8-4%]



Final transmission

2015
28% [25-30%]

2020
1% [7-4%]

Percentage of pregnant women who had at least one antenatal visit, most recent survey



2014
97%

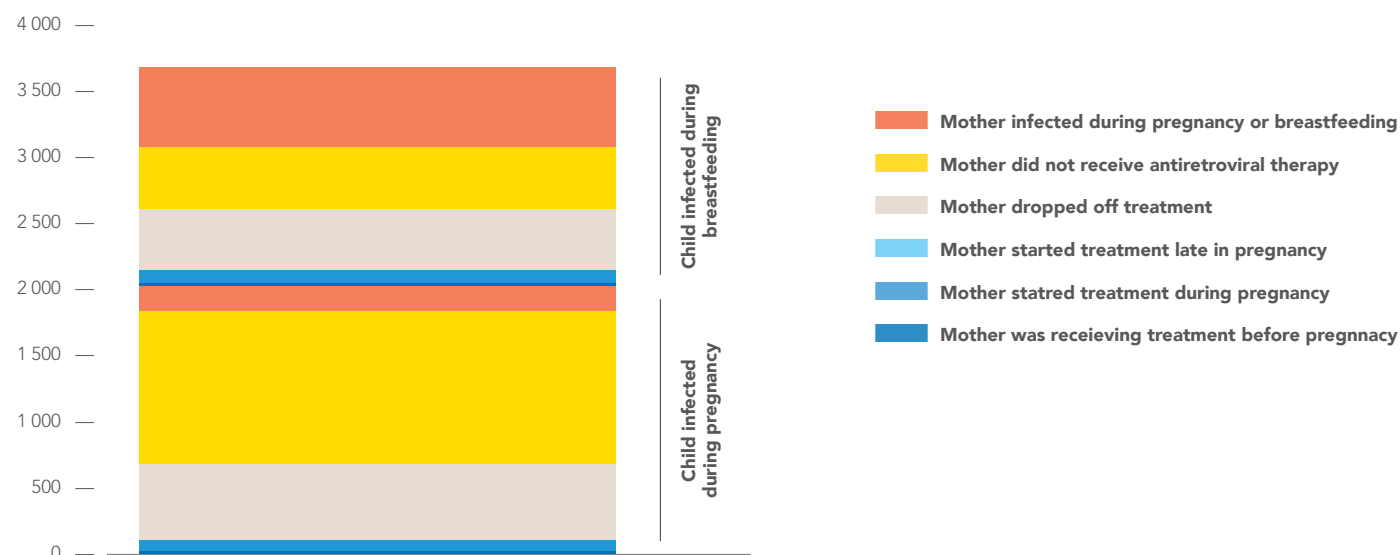
Percentage of HIV-exposed infants who received a virological test for HIV within two months of birth, 2015 and 2020



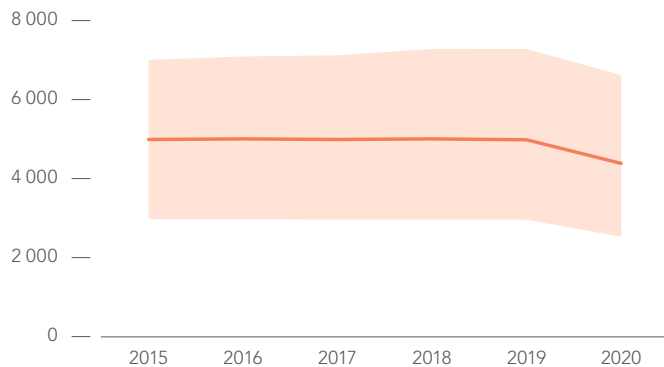
2015
18% [21-27%]

2020
41% [35-52%]

Children acquiring HIV by missed prevention opportunity, 2020



Young women aged 15-24 years acquiring HIV, 2015-2019



Condom use with most recent non-regular partner, young women and young men, most recent survey (%)

Men
39

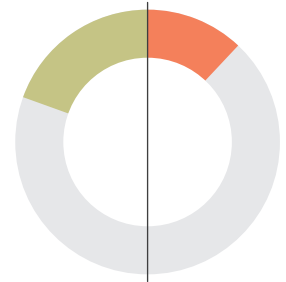
Women
19



Knowledge of HIV prevention among young women and young men, most recent survey (%)

Men
27

Women
20



Number of voluntary medical male circumcisions, all ages

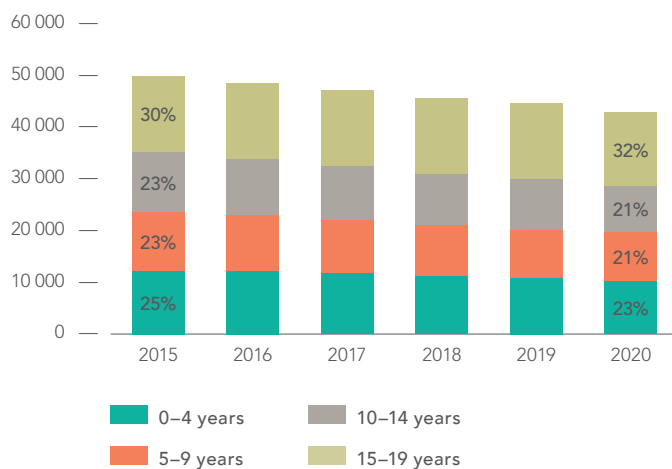
2015

—

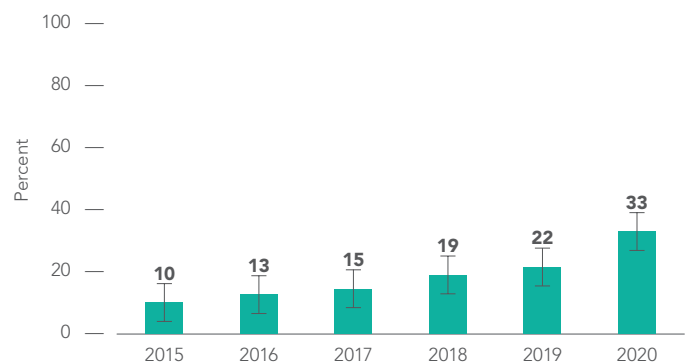
2020

Not applicable

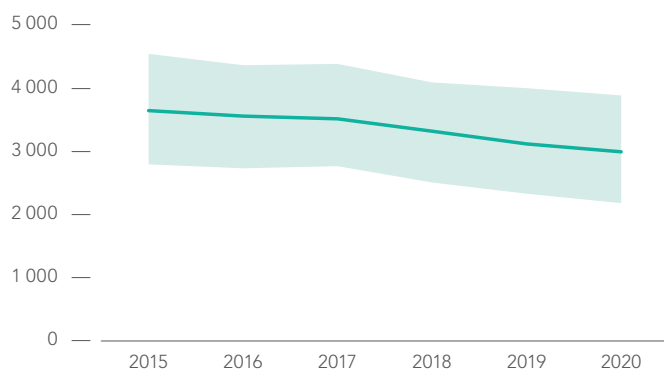
Children and adolescents living with HIV by age, 2015-2020



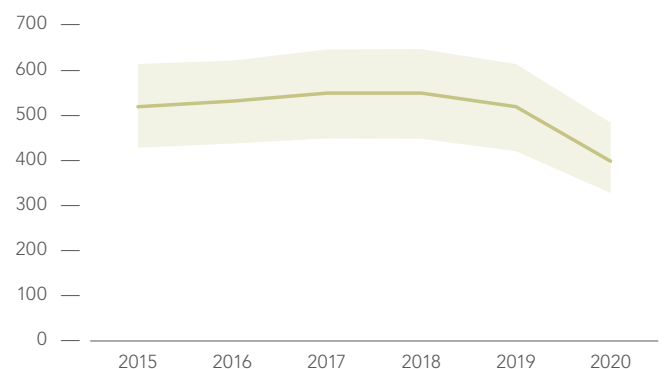
Antiretroviral therapy coverage among children aged 0-14 years, 2015-2020



Children aged 0-14 years dying from AIDS-related causes annually, 2015-2020

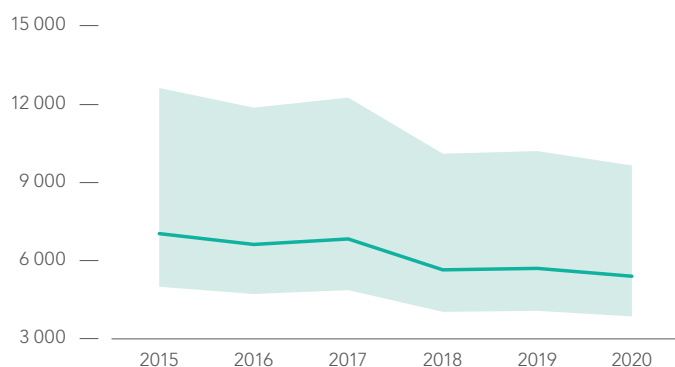


Adolescents aged 15-19 years dying from AIDS-related causes annually, 2015-2020

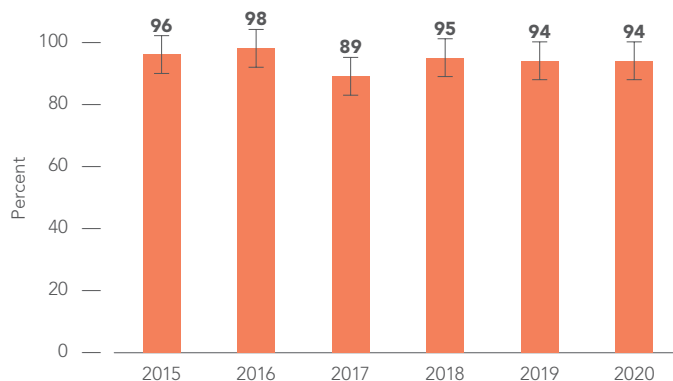


KENYA

Children aged 0-14 years acquiring HIV, 2015–2020



Antiretroviral therapy among pregnant women, 2015–2020



Six-week and final (after breastfeeding) transmission rate, 2015 and 2020



Six week transmission

2015
6% [4-9%]

2020
5% [4-8%]



Final transmission

2015
11% [9-16%]

2020
10% [8-14%]



Percentage of pregnant women who had at least one antenatal visit, most recent survey

2015
95%

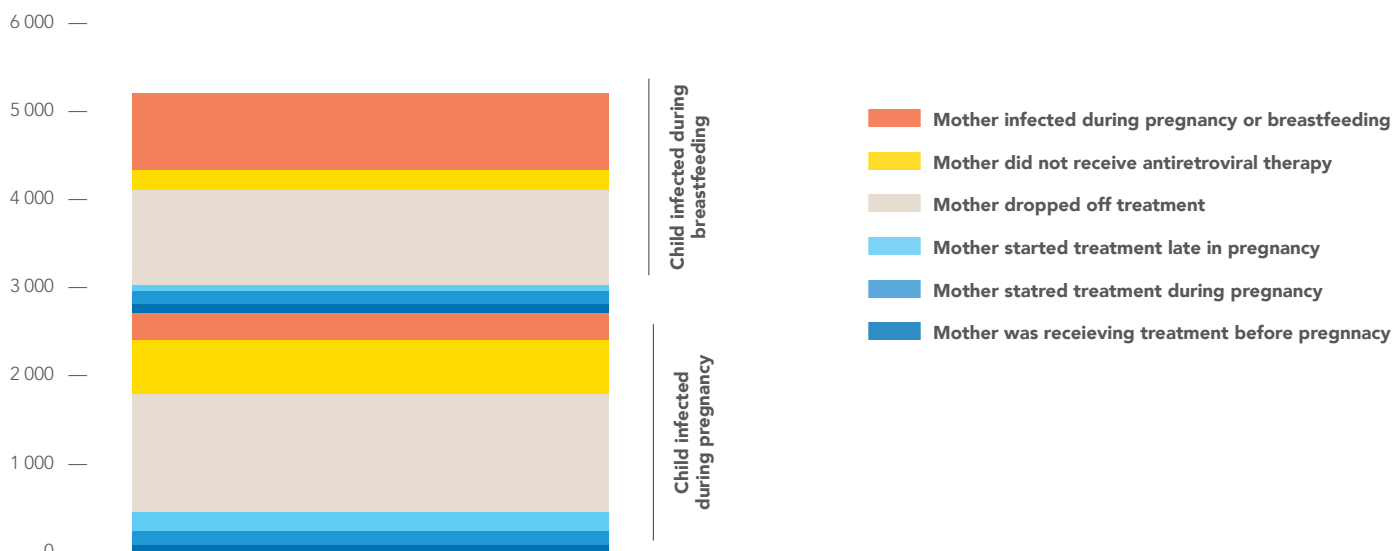
Percentage of HIV-exposed infants who received a virological test for HIV within two months of birth, 2015 and 2020



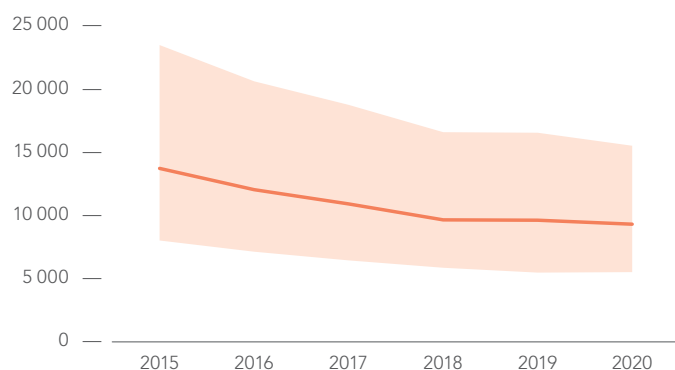
2015
48% [60-75%]

2020
76% [61-96%]

Children acquiring HIV by missed prevention opportunity, 2020



Young women aged 15-24 years acquiring HIV, 2015-2019



Condom use with most recent non-regular partner, young women and young men, most recent survey (%)

Men
77



Women
60

Knowledge of HIV prevention among young women and young men, most recent survey (%)

Men
64



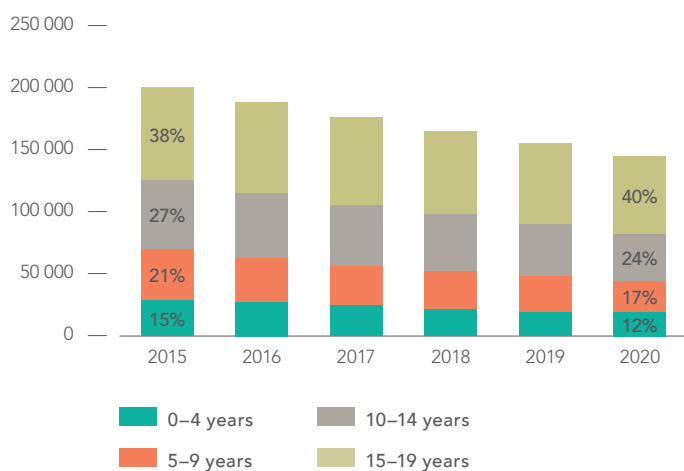
Women
54

Number of voluntary medical male circumcisions, all ages

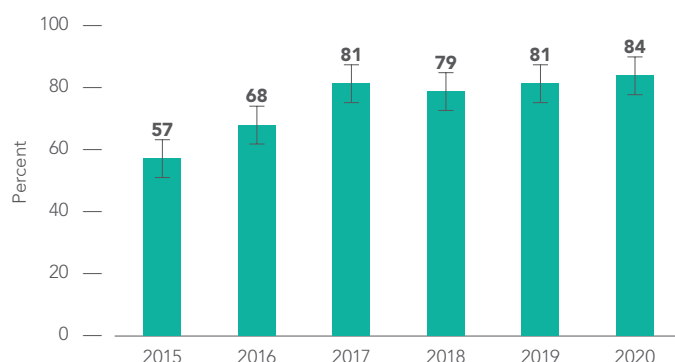
2015
207 014

2020
77 120

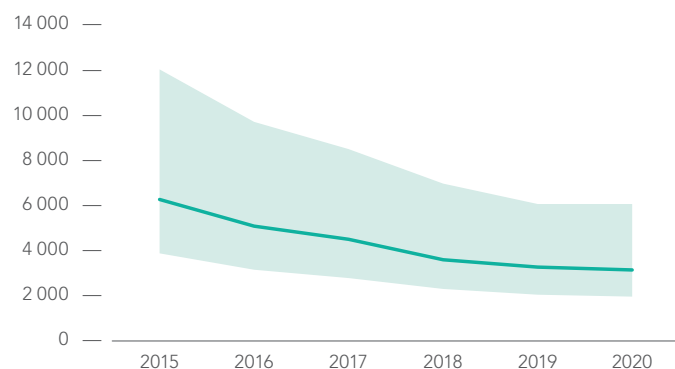
Children and adolescents living with HIV by age, 2015-2020



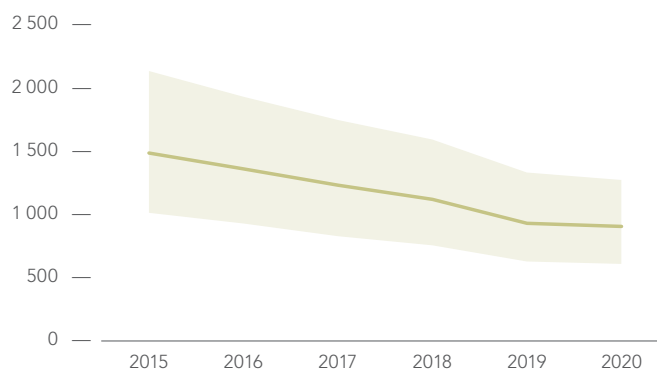
Antiretroviral therapy coverage among children aged 0-14 years, 2015-2020



Children aged 0-14 years dying from AIDS-related causes annually, 2015-2020

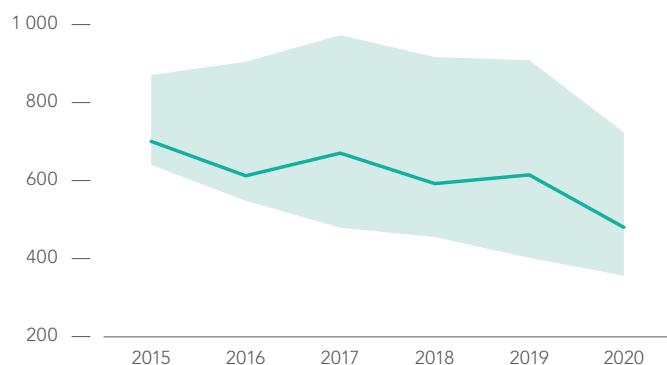


Adolescents aged 15-19 years dying from AIDS-related causes annually, 2015-2020

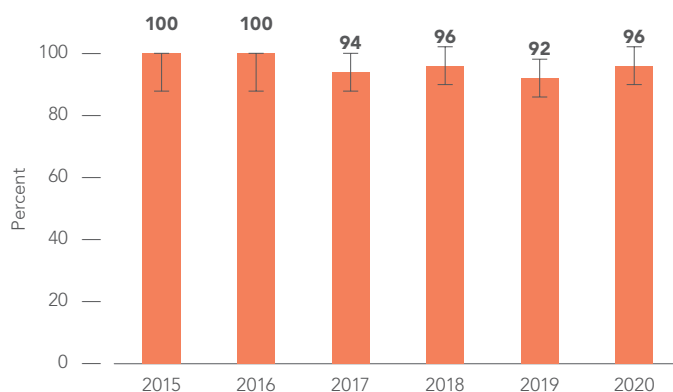


LESOTHO

Children aged 0-14 years acquiring HIV, 2015–2020



Antiretroviral therapy among pregnant women, 2015-2020



Six-week and final (after breastfeeding) transmission rate, 2015 and 2020



Six week transmission

2015
3% [3-4%]

2020
3% [2-5%]



Final transmission

2015
7% [7-8%]

2020
6% [5-8%]

Percentage of pregnant women who had at least one antenatal visit, most recent survey



2017
97%

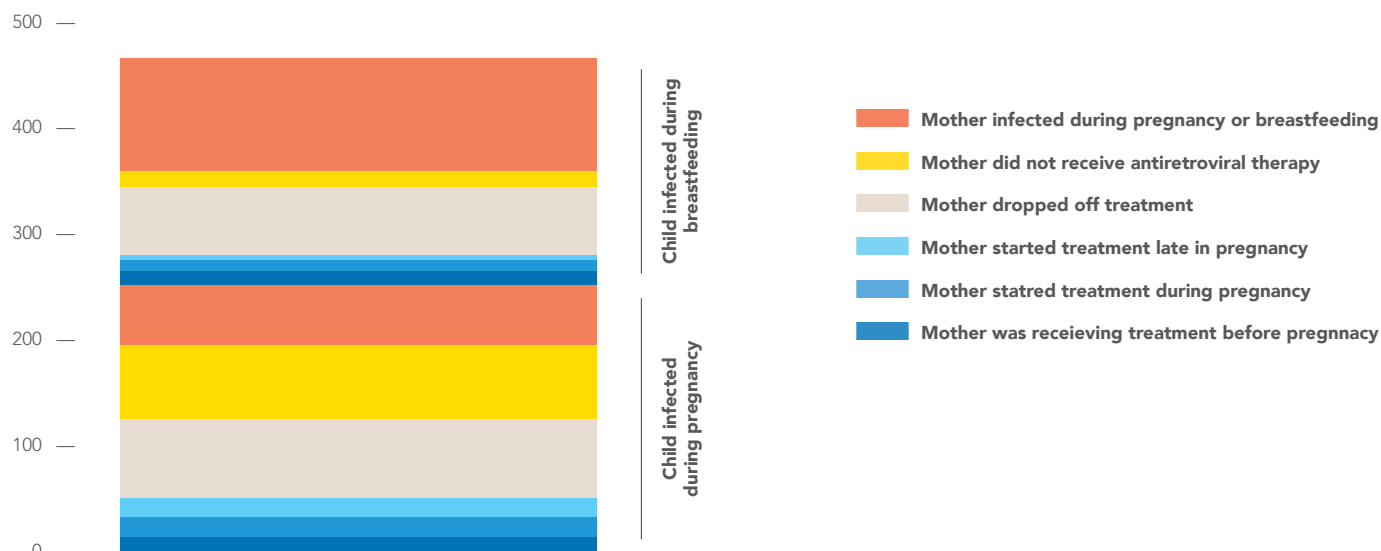
Percentage of HIV-exposed infants who received a virological test for HIV within two months of birth, 2015 and 2020



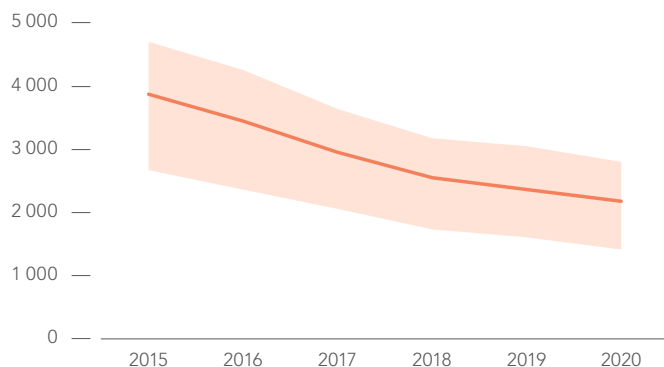
2015
97% [99-99%]

2020
71% [63-87%]

Children acquiring HIV by missed prevention opportunity, 2020

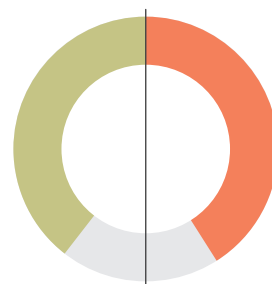


Young women aged 15-24 years acquiring HIV, 2015-2019



Condom use with most recent non-regular partner, young women and young men, most recent survey (%)

Men
79



Women
82

Knowledge of HIV prevention among young women and young men, most recent survey (%)

Men
31



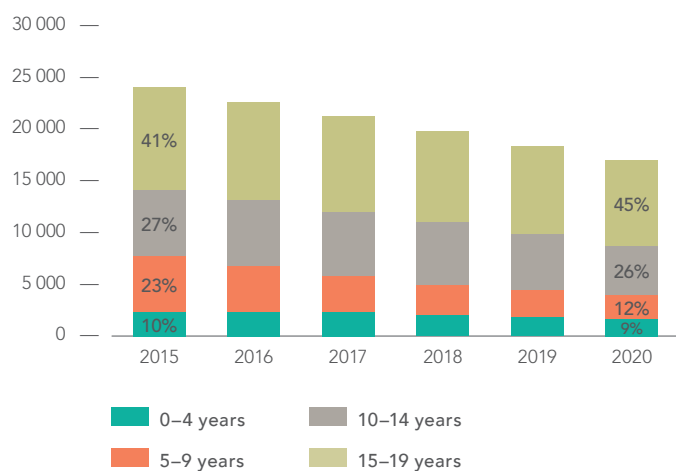
Women
38

Number of voluntary medical male circumcisions, all ages

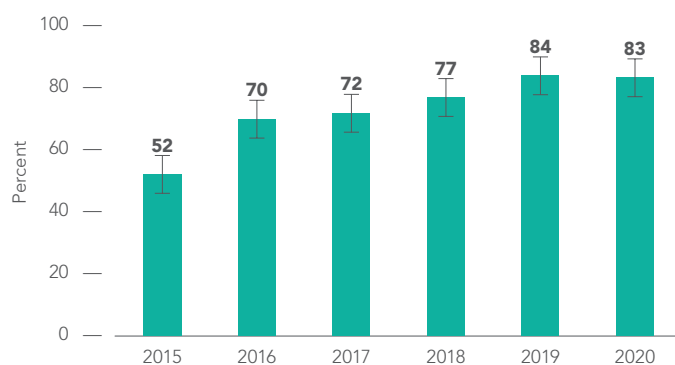
2015
25 966

2020
9 802

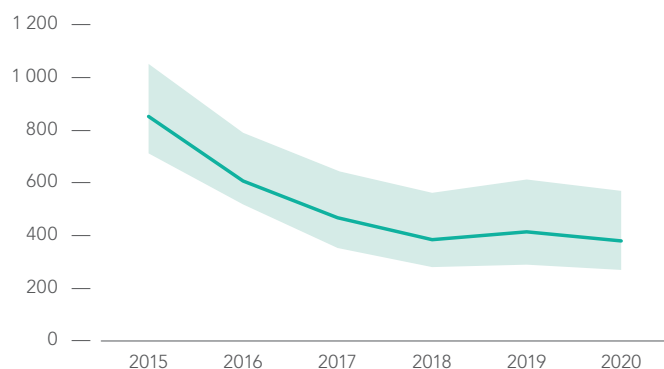
Children and adolescents living with HIV by age, 2015-2020



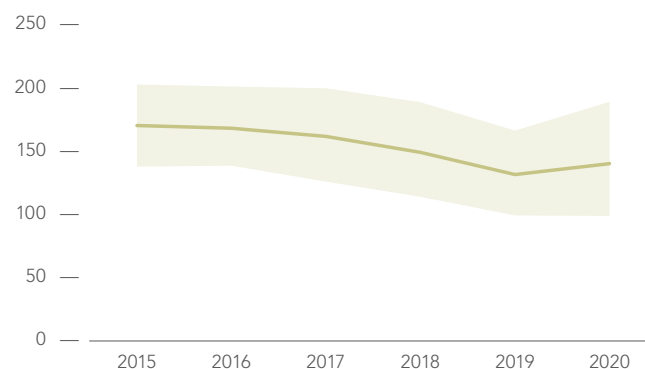
Antiretroviral therapy coverage among children aged 0-14 years, 2015-2020



Children aged 0-14 years dying from AIDS-related causes annually, 2015-2020

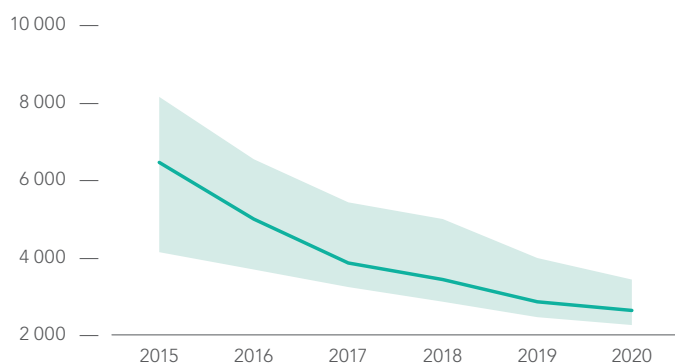


Adolescents aged 15-19 years dying from AIDS-related causes annually, 2015-2020

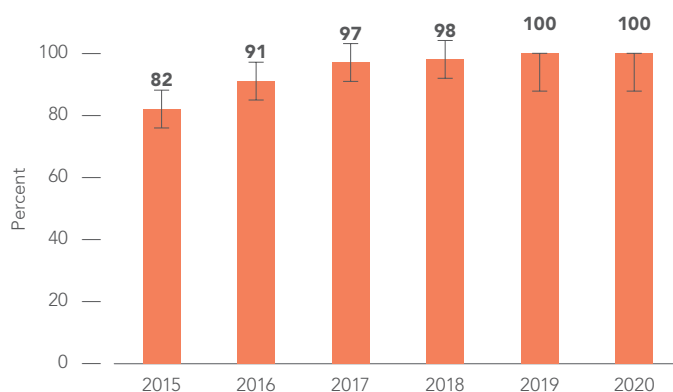


MALAWI

Children aged 0-14 years acquiring HIV, 2015–2020



Antiretroviral therapy among pregnant women, 2015–2020



Six-week and final (after breastfeeding) transmission rate, 2015 and 2020



Six week transmission

2015
7% [4-9%]

2020
2% [2-3%]



Final transmission

2015
14% [11-16%]

2020
4% [6-7%]

Percentage of pregnant women who had at least one antenatal visit, most recent survey



2015
98%

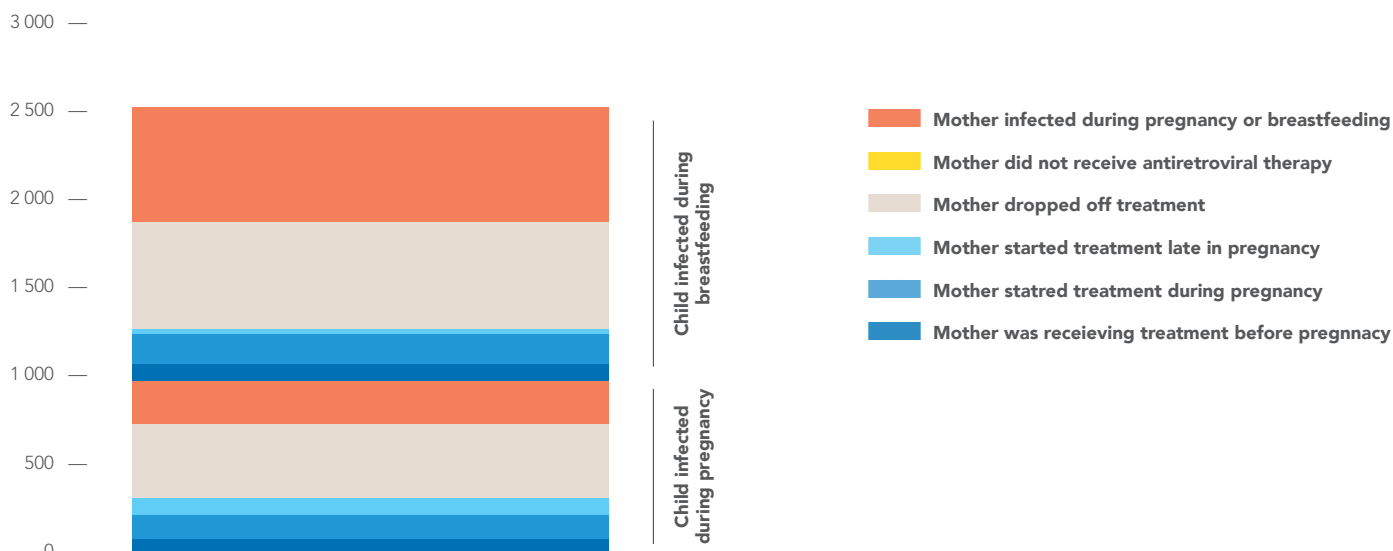
Percentage of HIV-exposed infants who received a virological test for HIV within two months of birth, 2015 and 2020



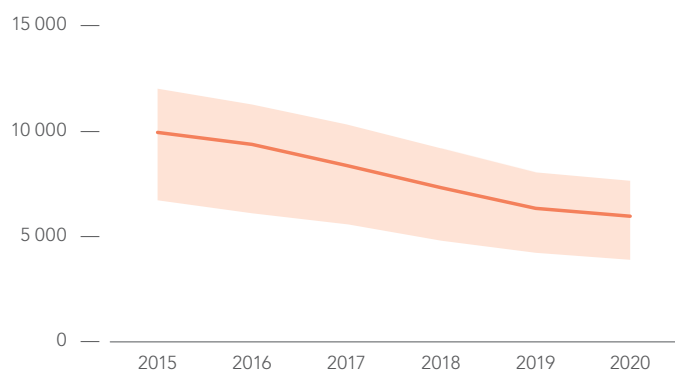
2015
21% [24-29%]

2020
79% [71-97%]

Children acquiring HIV by missed prevention opportunity, 2020



Young women aged 15-24 years acquiring HIV, 2015-2019



Condom use with most recent non-regular partner, young women and young men, most recent survey (%)

Men
73

Women
53



Knowledge of HIV prevention among young women and young men, most recent survey (%)

Men
44

Women
41

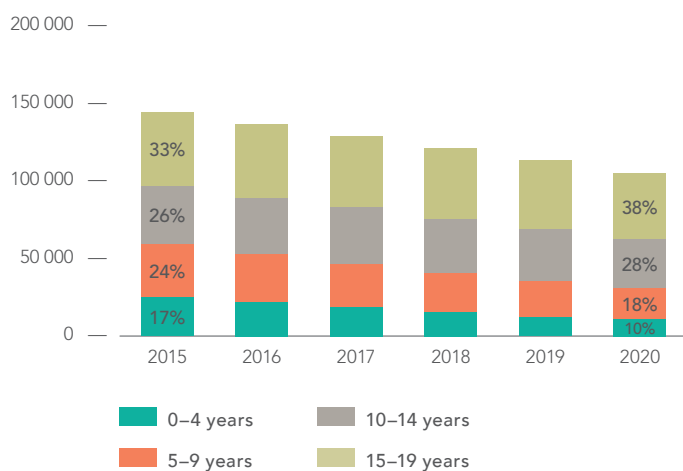


Number of voluntary medical male circumcisions, all ages

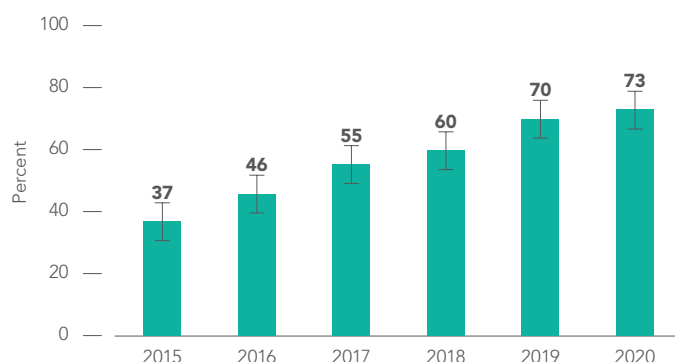
2015
108 672

2020
47 316

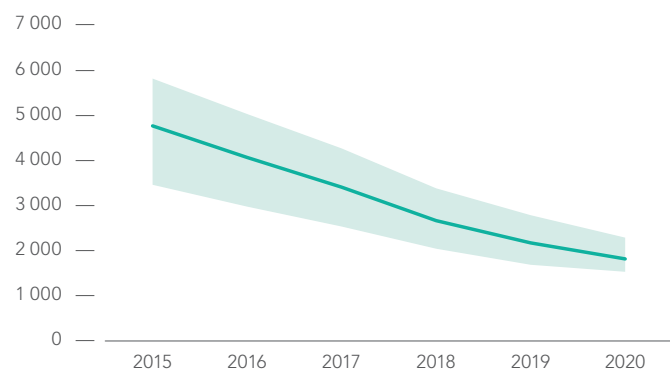
Children and adolescents living with HIV by age, 2015-2020



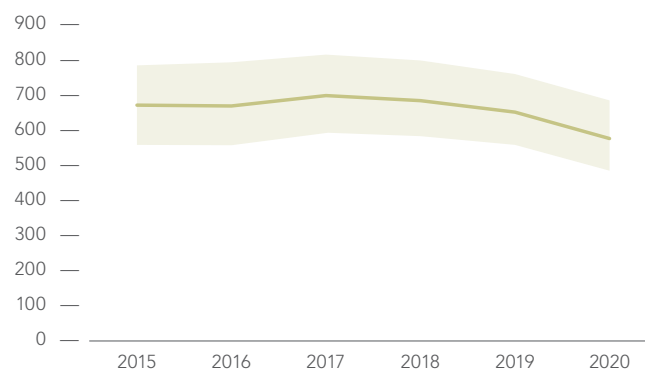
Antiretroviral therapy coverage among children aged 0-14 years, 2015-2020



Children aged 0-14 years dying from AIDS-related causes annually, 2015-2020

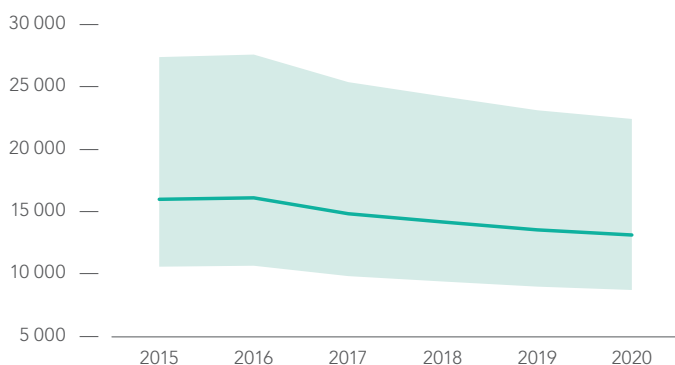


Adolescents aged 15-19 years dying from AIDS-related causes annually, 2015-2020

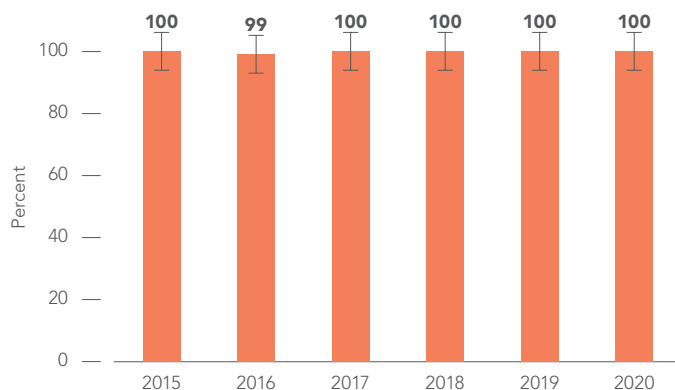


MOZAMBIQUE

Children aged 0-14 years acquiring HIV, 2015–2020



Antiretroviral therapy among pregnant women, 2015–2020



Six-week and final (after breastfeeding) transmission rate, 2015 and 2020



Six week transmission

2015
7% [6-10%]

2020
6% [5-9%]



Final transmission

2015
16% [14-2%]

2020
14% [11-18%]

Percentage of pregnant women who had at least one antenatal visit, most recent survey



2018
94%

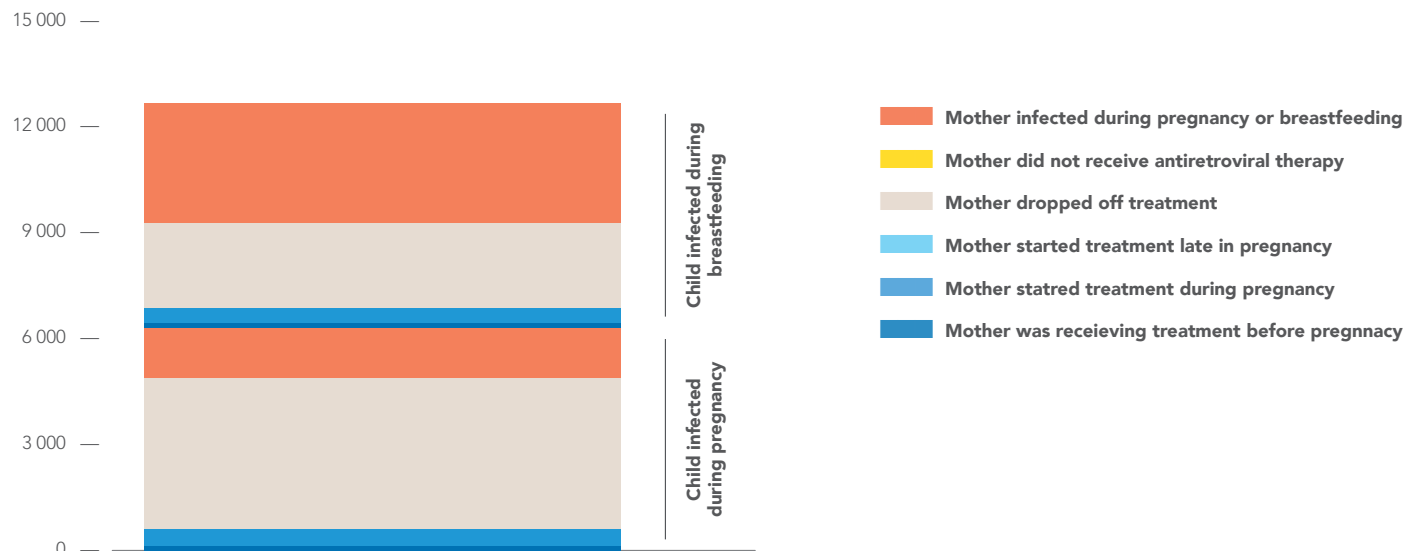
Percentage of HIV-exposed infants who received a virological test for HIV within two months of birth, 2015 and 2020



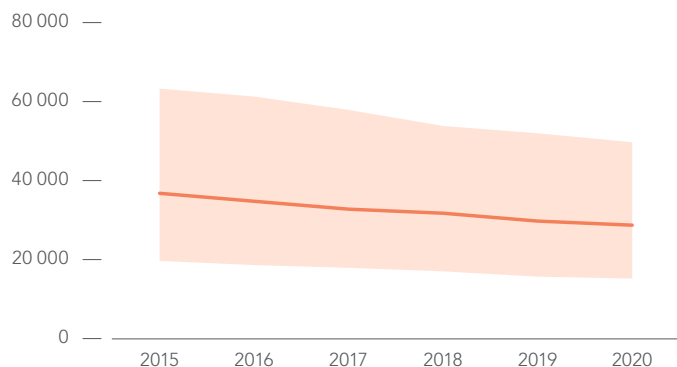
2015
39% [52-72%]

2020
71% [62-99%]

Children acquiring HIV by missed prevention opportunity, 2020



Young women aged 15-24 years acquiring HIV, 2015-2019



Condom use with most recent non-regular partner, young women and young men, most recent survey (%)

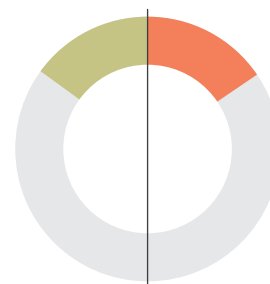
Men
48



Women
51

Knowledge of HIV prevention among young women and young men, most recent survey (%)

Men
30



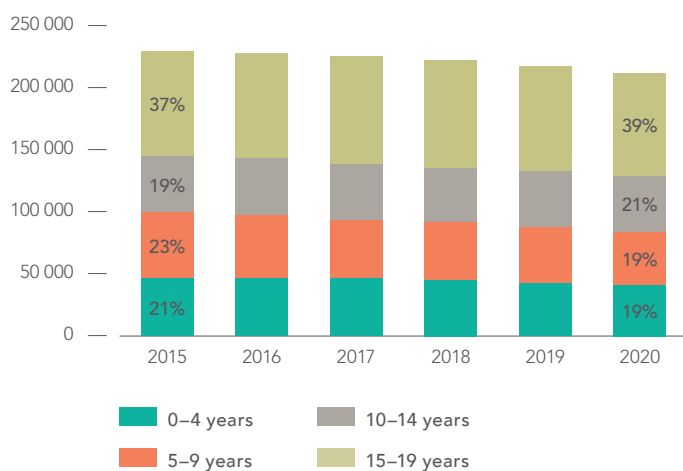
Women
31

Number of voluntary medical male circumcisions, all ages

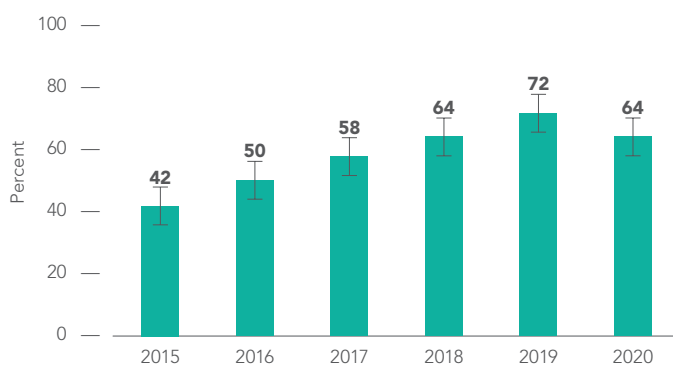
2015
198 340

2020
113 227

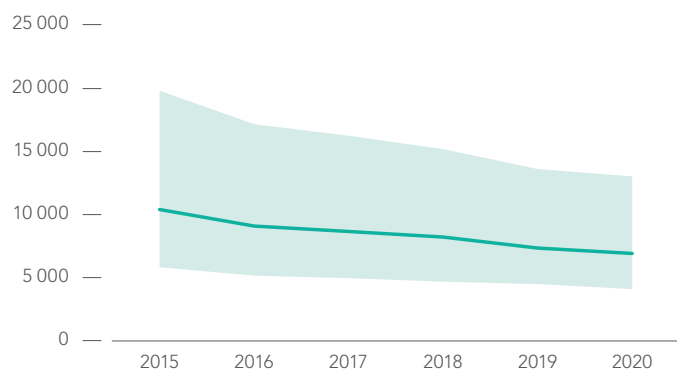
Children and adolescents living with HIV by age, 2015-2020



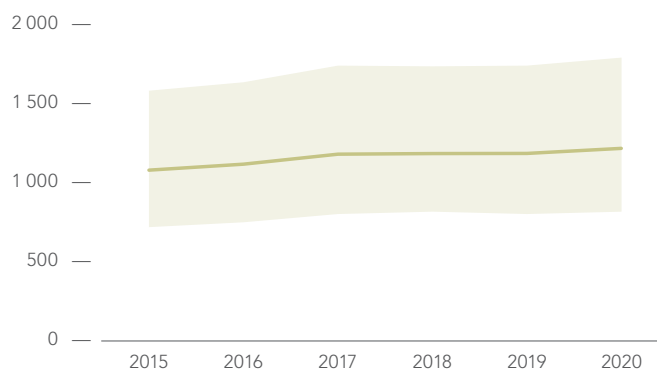
Antiretroviral therapy coverage among children aged 0-14 years, 2015-2020



Children aged 0-14 years dying from AIDS-related causes annually, 2015-2020

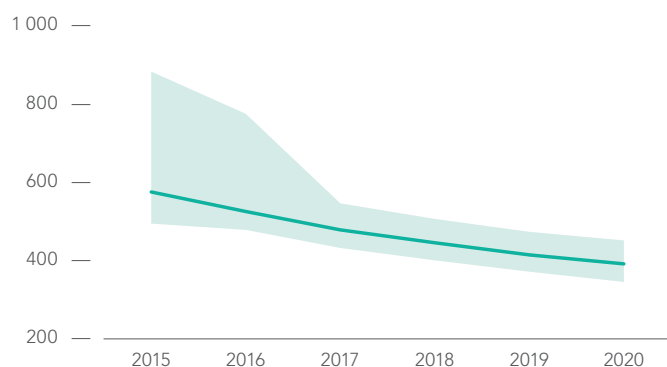


Adolescents aged 15-19 years dying from AIDS-related causes annually, 2015-2020



NAMIBIA

Children aged 0-14 years acquiring HIV, 2015–2020



Antiretroviral therapy among pregnant women, 2015–2020



Six-week and final (after breastfeeding) transmission rate, 2015 and 2020



Six week transmission

2015
3% [2-5%]

2020
2% [2-2%]



Final transmission

2015
5% [4-7%]

2020
4% [4-4%]

Percentage of pregnant women who had at least one antenatal visit, most recent survey



2017
98%

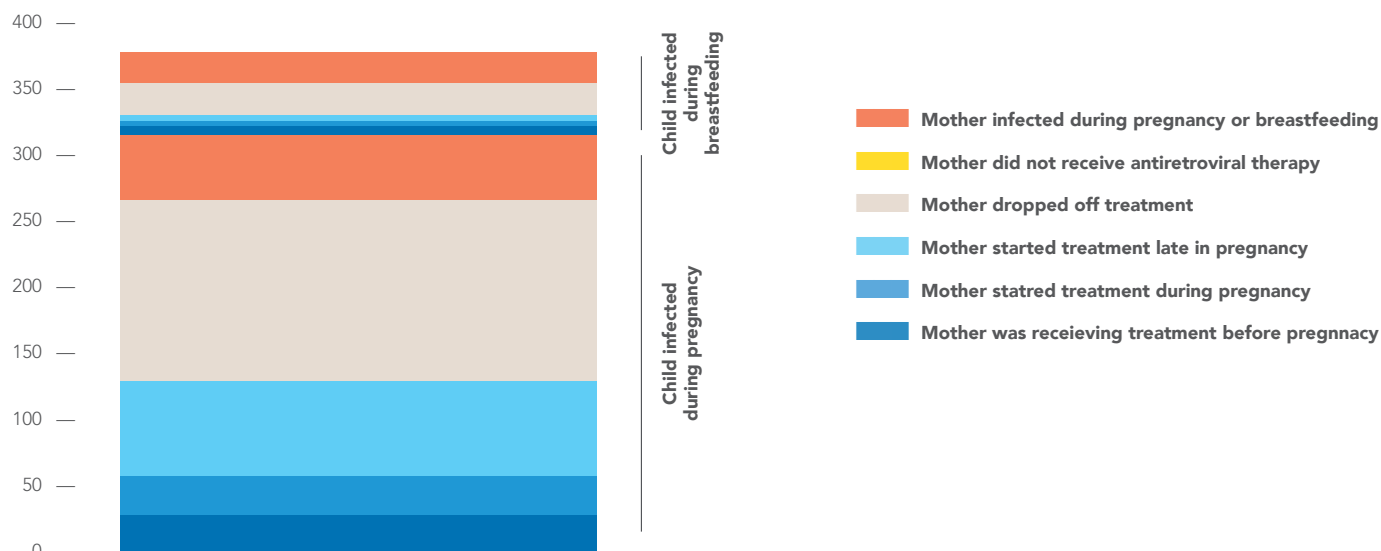
Percentage of HIV-exposed infants who received a virological test for HIV within two months of birth, 2015 and 2020



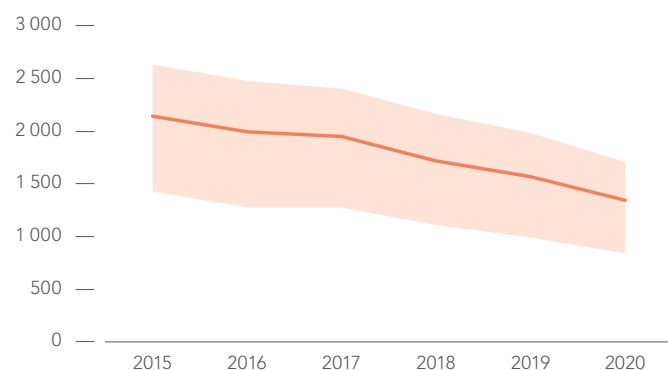
2015
14% [16-19%]

2020
99% [99-99%]

Children acquiring HIV by missed prevention opportunity, 2020



Young women aged 15-24 years acquiring HIV, 2015-2019



Condom use with most recent non-regular partner, young women and young men, most recent survey (%)

Men
78

Women
64



Knowledge of HIV prevention among young women and young men, most recent survey (%)

Men
61

Women
62

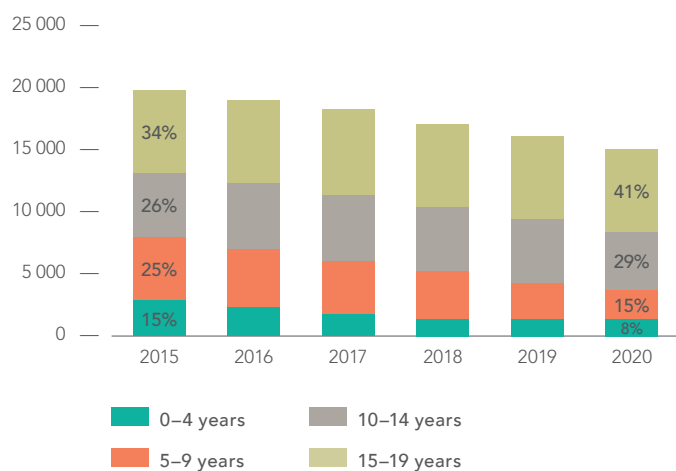


Number of voluntary medical male circumcisions, all ages

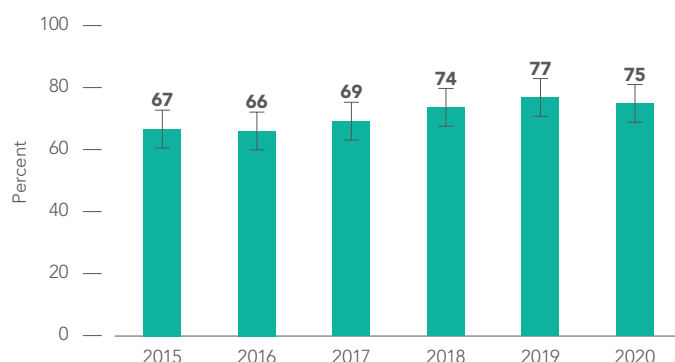
2015
17 388

2020
45 881

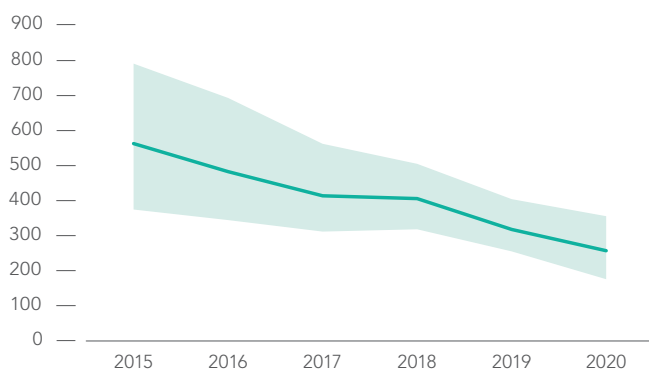
Children and adolescents living with HIV by age, 2015-2020



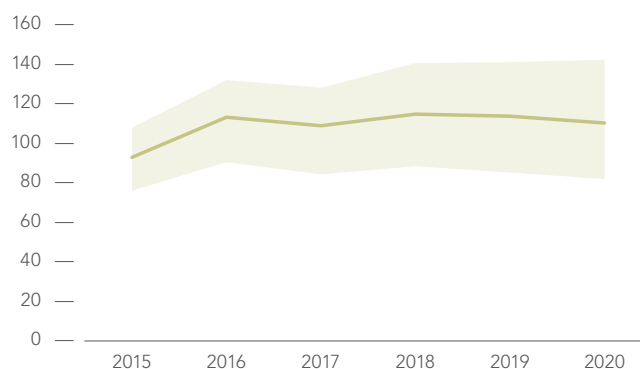
Antiretroviral therapy coverage among children aged 0-14 years, 2015-2020



Children aged 0-14 years dying from AIDS-related causes annually, 2015-2020

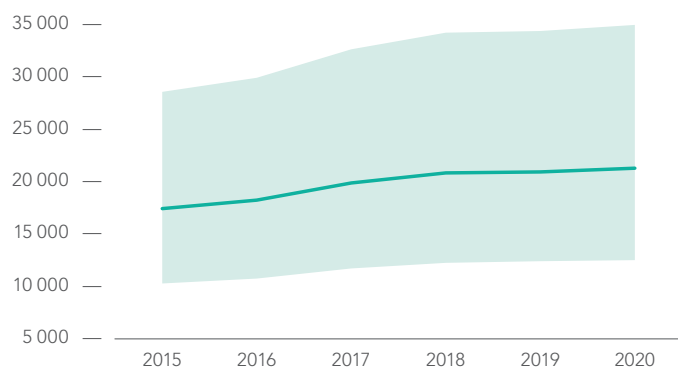


Adolescents aged 15-19 years dying from AIDS-related causes annually, 2015-2020

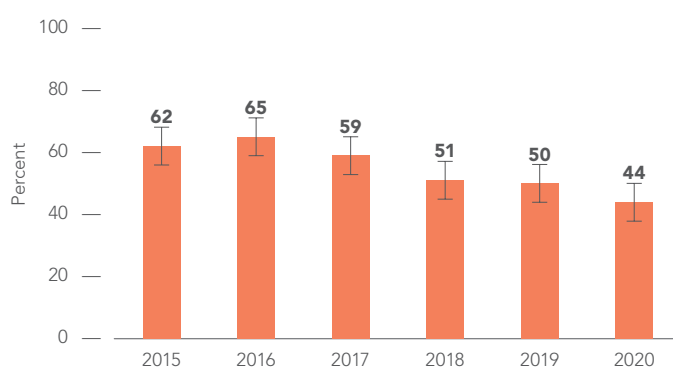


NIGERIA

Children aged 0-14 years acquiring HIV, 2015–2020



Antiretroviral therapy among pregnant women, 2015–2020



Six-week and final (after breastfeeding) transmission rate, 2015 and 2020



Six week transmission

2015
11% [9-13%]

2020
5% [2-8%]



Final transmission

2015
20% [16-24%]

2020
5% [20-30%]

Percentage of pregnant women who had at least one antenatal visit, most recent survey



2018
76%

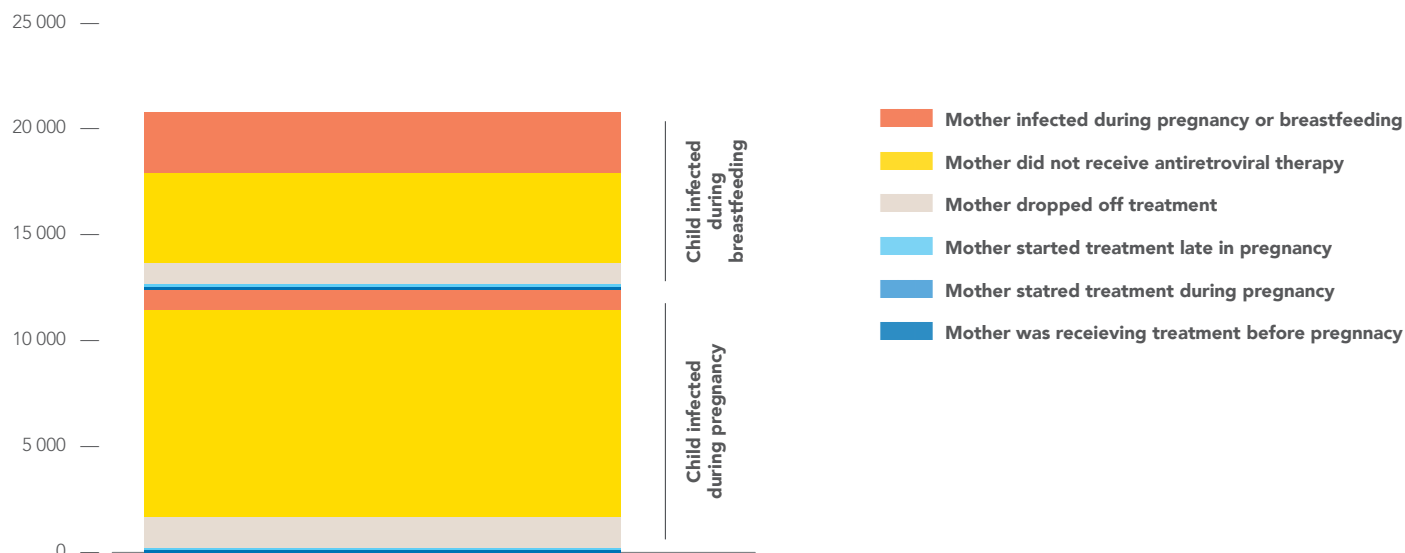
Percentage of HIV-exposed infants who received a virological test for HIV within two months of birth, 2015 and 2020



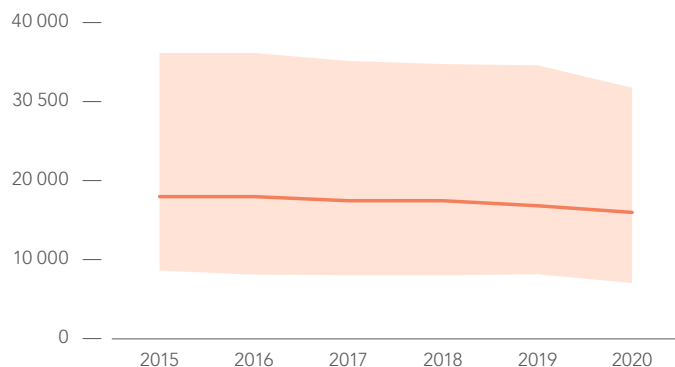
2015
13% [19-28%]

2020
23% [16-35%]

Children acquiring HIV by missed prevention opportunity, 2020



Young women aged 15-24 years acquiring HIV, 2015-2019



Condom use with most recent non-regular partner, young women and young men, most recent survey (%)

Men
62

Women
38



Knowledge of HIV prevention among young women and young men, most recent survey (%)

Men
34

Women
43



Number of voluntary medical male circumcisions, all ages

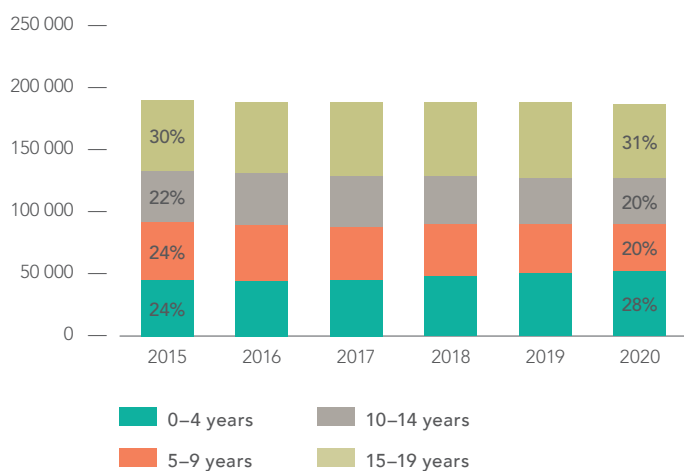
2015

2020

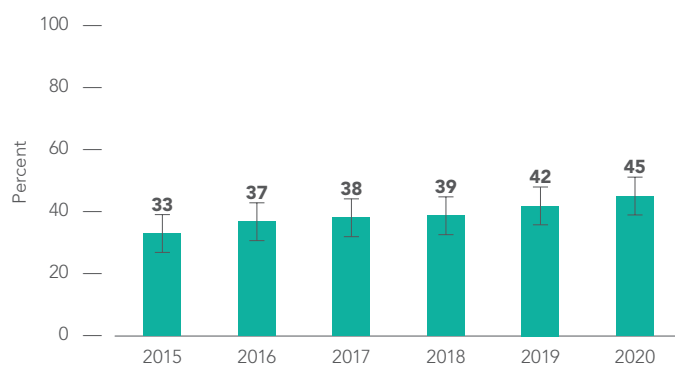
—

Not applicable

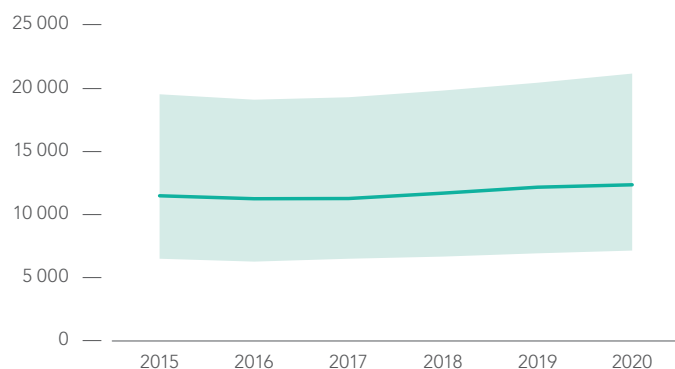
Children and adolescents living with HIV by age, 2015-2020



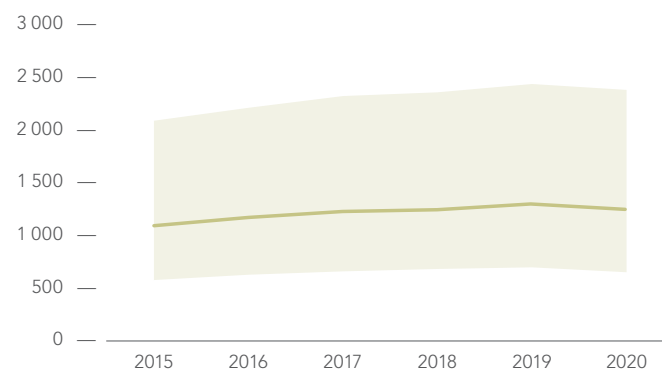
Antiretroviral therapy coverage among children aged 0-14 years, 2015-2020



Children aged 0-14 years dying from AIDS-related causes annually, 2015-2020

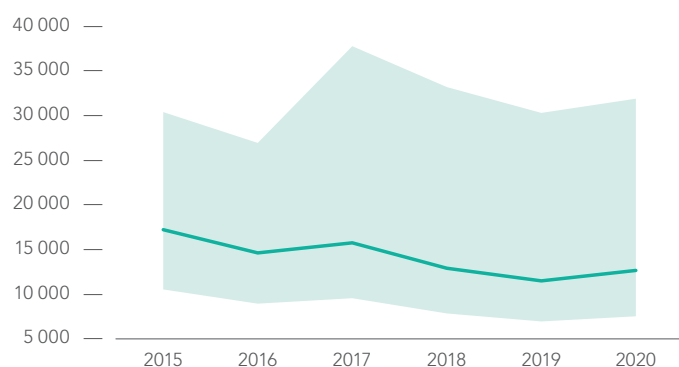


Adolescents aged 15-19 years dying from AIDS-related causes annually, 2015-2020

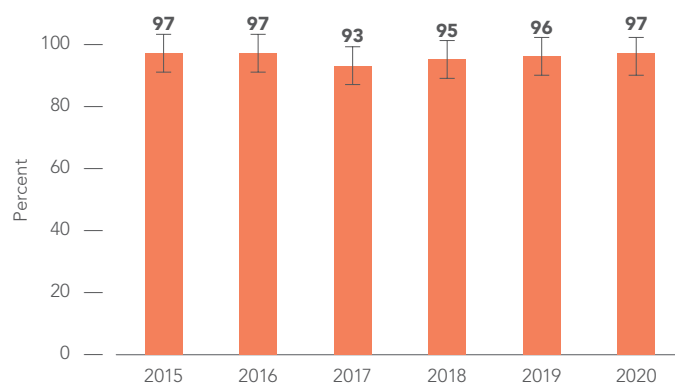


SOUTH AFRICA

Children aged 0-14 years acquiring HIV, 2015–2020



Antiretroviral therapy among pregnant women, 2015–2020



Six-week and final (after breastfeeding) transmission rate, 2015 and 2020



Six week transmission

2015
4% [3-5%]

2020
2% [2-6%]



Final transmission

2015
5% [4-7%]

2020
4% [3-8%]

Percentage of pregnant women who had at least one antenatal visit, most recent survey



2016
94%

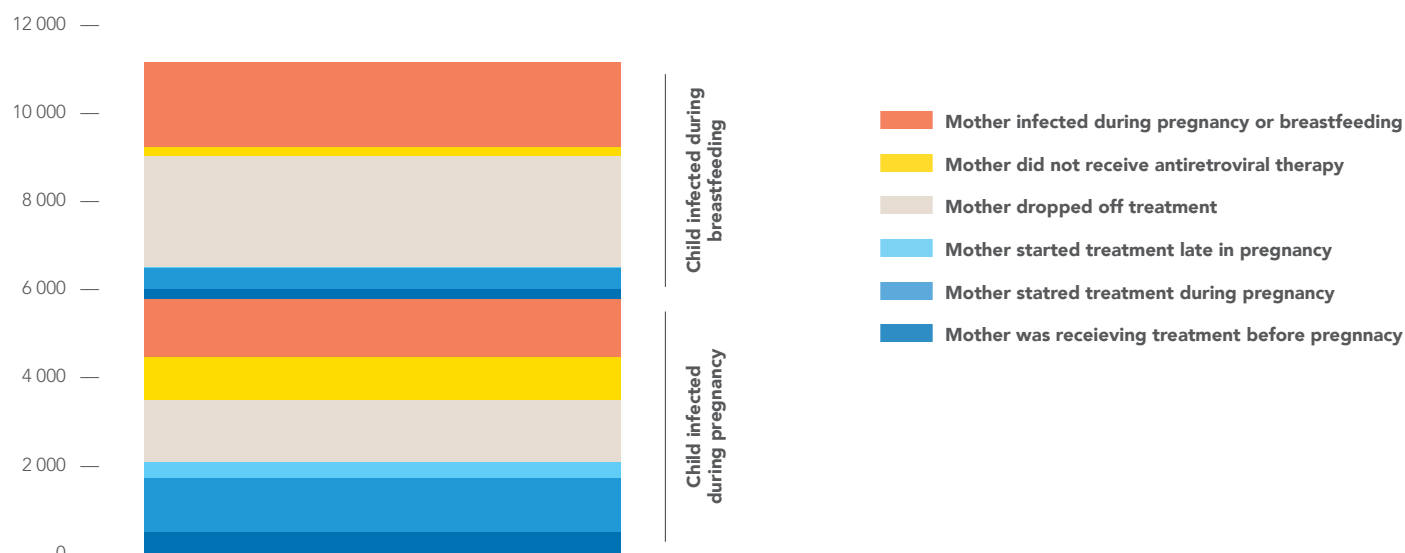
Percentage of HIV-exposed infants who received a virological test for HIV within two months of birth, 2015 and 2020



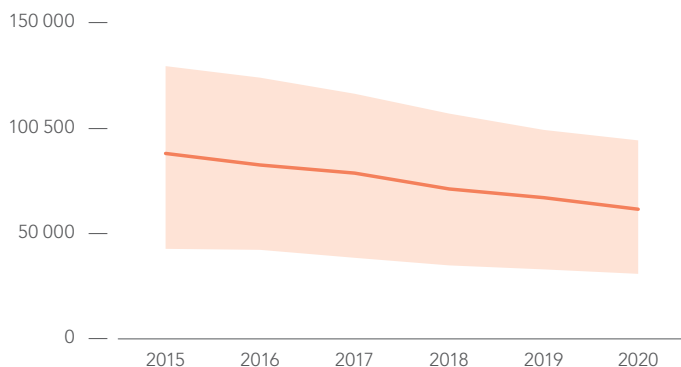
2015
71% [93-99%]

2020
55% [67-99%]

Children acquiring HIV by missed prevention opportunity, 2020



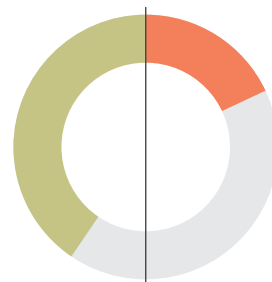
Young women aged 15-24 years acquiring HIV, 2015-2019



Condom use with most recent non-regular partner, young women and young men, most recent survey (%)

Men
81

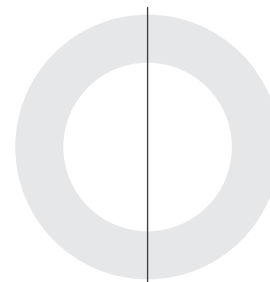
Women
64



Knowledge of HIV prevention among young women and young men, most recent survey (%)

Men
Not available

Women
Not available

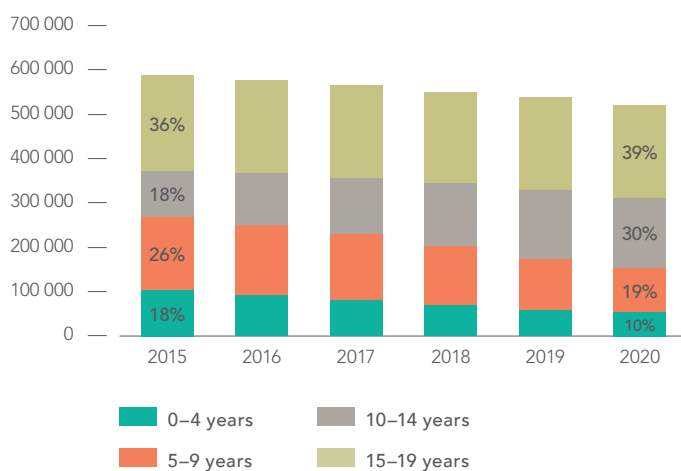


Number of voluntary medical male circumcisions, all ages

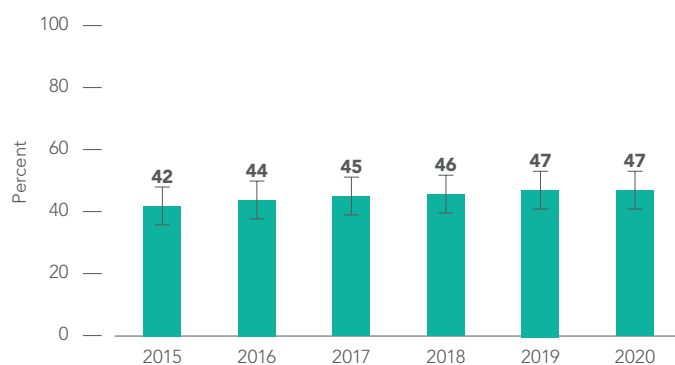
2015
485 552

2020
164 699

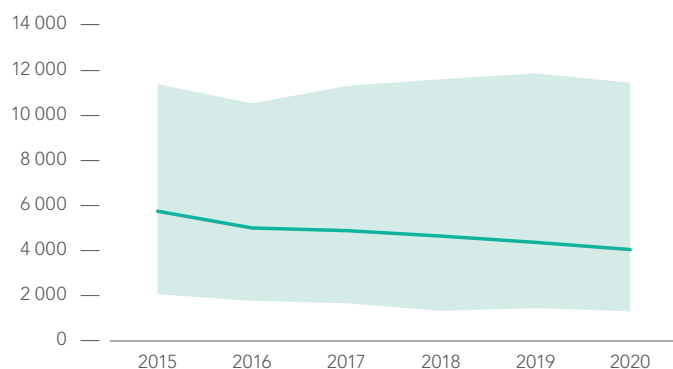
Children and adolescents living with HIV by age, 2015-2020



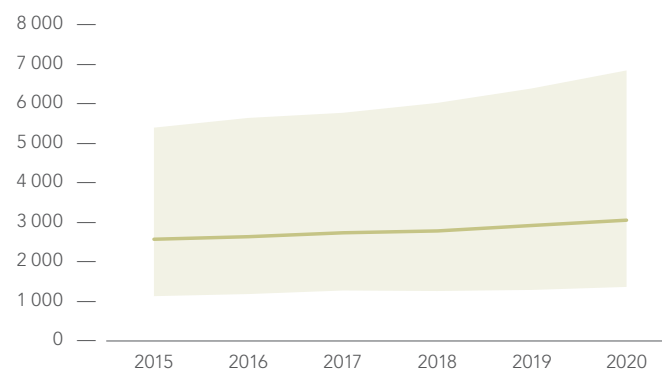
Antiretroviral therapy coverage among children aged 0-14 years, 2015-2020



Children aged 0-14 years dying from AIDS-related causes annually, 2015-2020

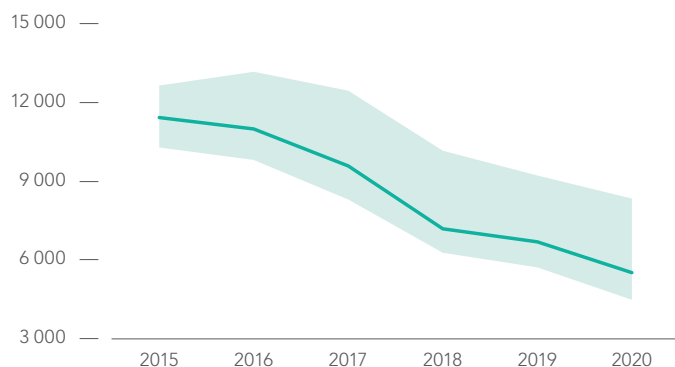


Adolescents aged 15-19 years dying from AIDS-related causes annually, 2015-2020



UGANDA

Children aged 0-14 years acquiring HIV, 2015–2020



Antiretroviral therapy among pregnant women, 2015–2020



Six-week and final (after breastfeeding) transmission rate, 2015 and 2020



Six week transmission

2015
6% [5-6%]

2020
3% [3-2%]



Final transmission

2015
12% [11-13%]

2020
6% [5-8%]

Percentage of pregnant women who had at least one antenatal visit, most recent survey



2018
98%

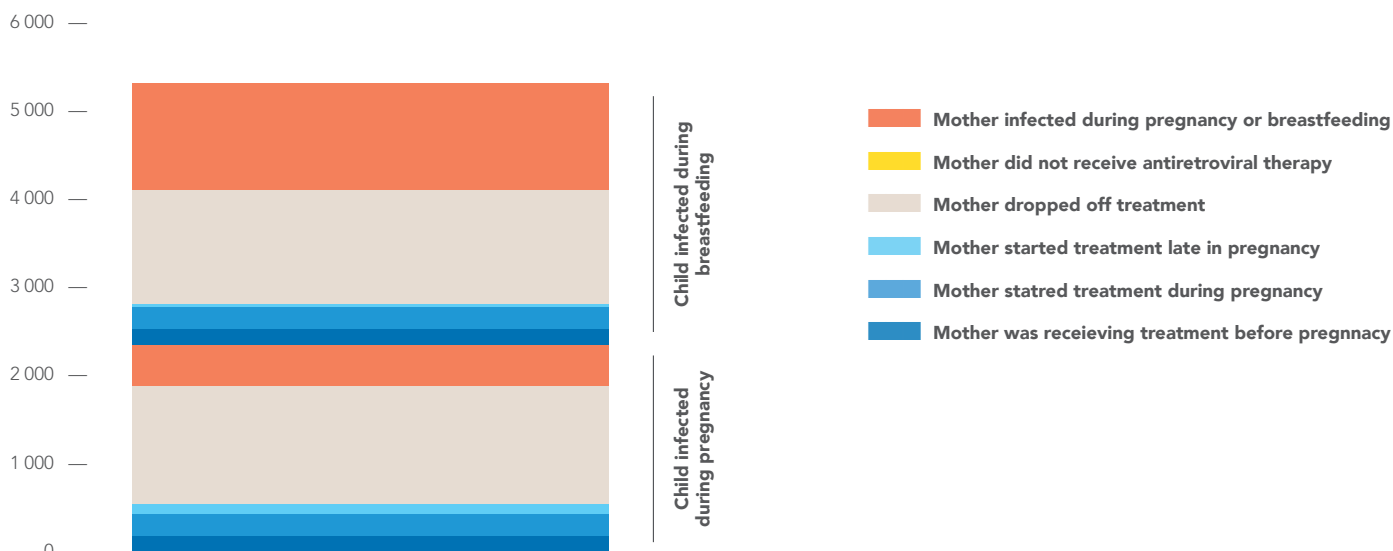
Percentage of HIV-exposed infants who received a virological test for HIV within two months of birth, 2015 and 2020



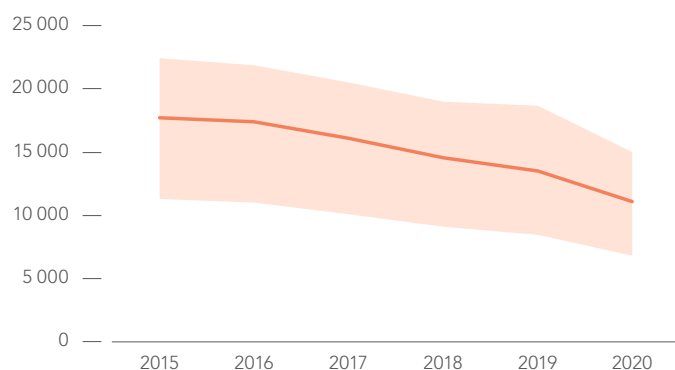
2015
38% [42-50%]

2020
55% [59-82%]

Children acquiring HIV by missed prevention opportunity, 2020



Young women aged 15-24 years acquiring HIV, 2015-2019



Condom use with most recent non-regular partner, young women and young men, most recent survey (%)

Men
63



Women
44

Knowledge of HIV prevention among young women and young men, most recent survey (%)

Men
45



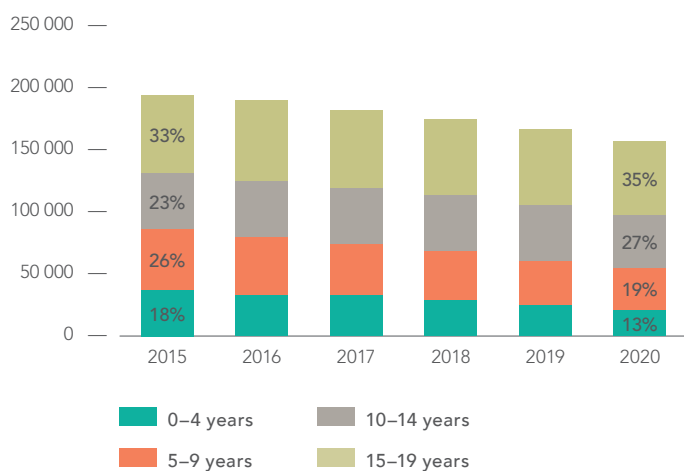
Women
46

Number of voluntary medical male circumcisions, all ages

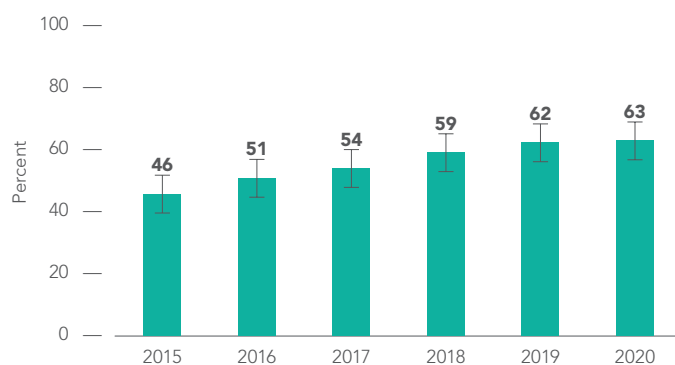
2015
556 546

2020
516 615

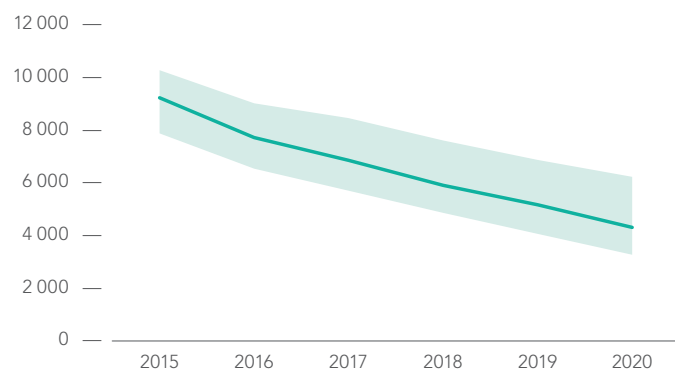
Children and adolescents living with HIV by age, 2015-2020



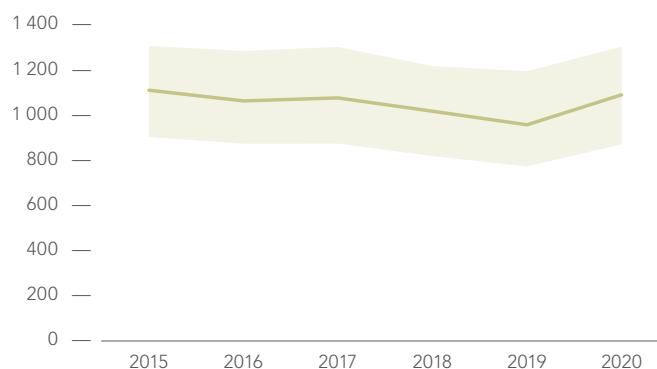
Antiretroviral therapy coverage among children aged 0-14 years, 2015-2020



Children aged 0-14 years dying from AIDS-related causes annually, 2015-2020

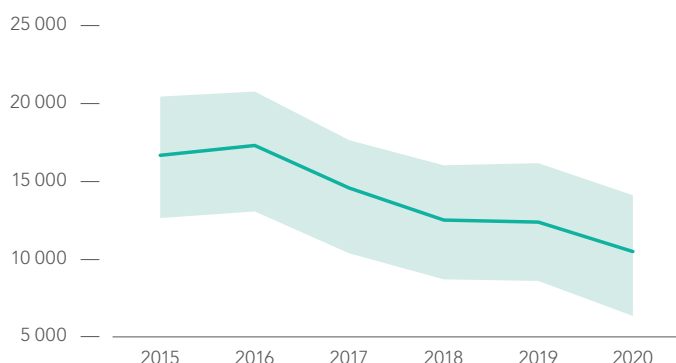


Adolescents aged 15-19 years dying from AIDS-related causes annually, 2015-2020

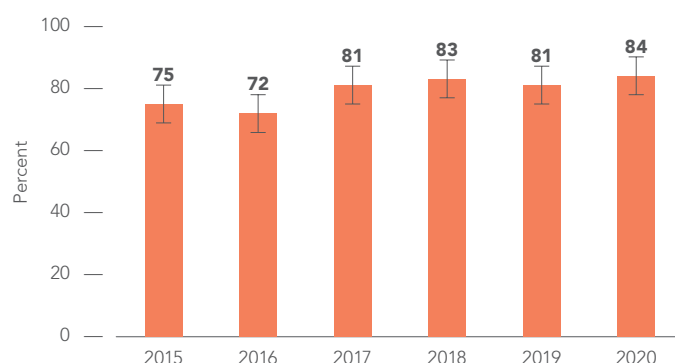


UNITED REPUBLIC OF TANZANIA

Children aged 0-14 years acquiring HIV, 2015–2020



Antiretroviral therapy among pregnant women, 2015–2020



Six-week and final (after breastfeeding) transmission rate, 2015 and 2020



Six week transmission

2015
10% [8-11%]

2020
6% [3-7%]



Final transmission

2015
18% [16-20%]

2020
1% [8-3%]



Percentage of pregnant women who had at least one antenatal visit, most recent survey

2017
99%

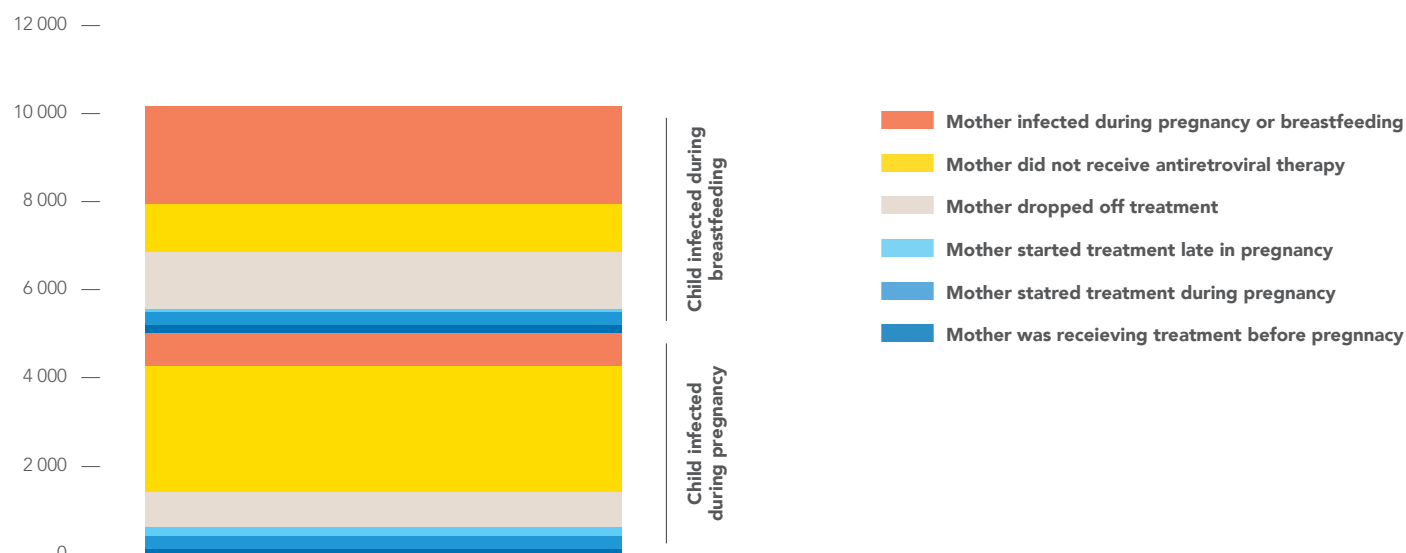
Percentage of HIV-exposed infants who received a virological test for HIV within two months of birth, 2015 and 2020



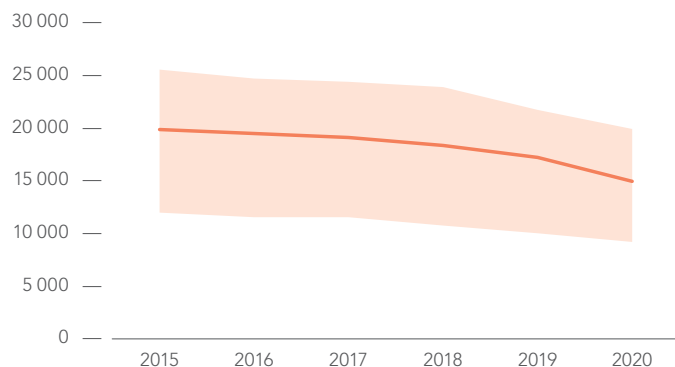
2015
35% [40-47%]

2020
55% [49-67%]

Children acquiring HIV by missed prevention opportunity, 2020



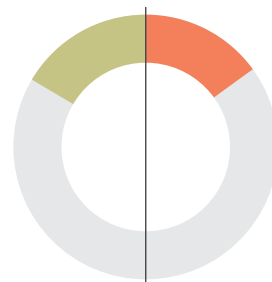
Young women aged 15-24 years acquiring HIV, 2015-2019



Condom use with most recent non-regular partner, young women and young men, most recent survey (%)

Men
33

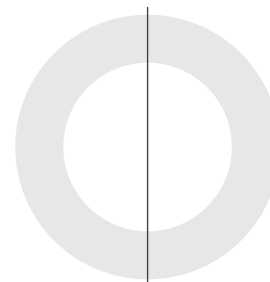
Women
30



Knowledge of HIV prevention among young women and young men, most recent survey (%)

Men
Not available

Women
Not available

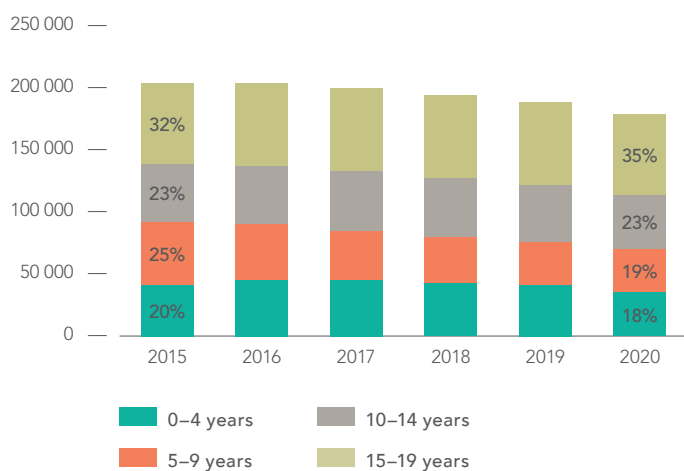


Number of voluntary medical male circumcisions, all ages

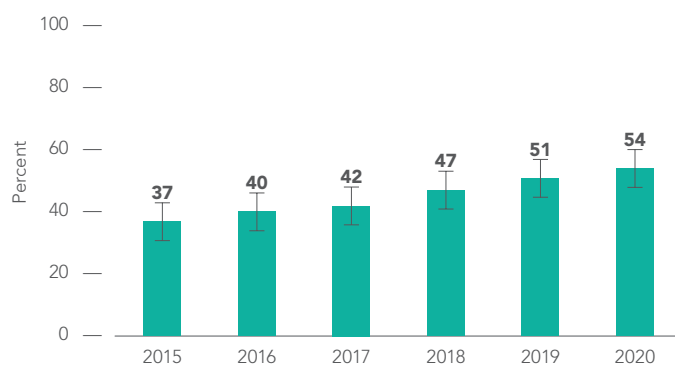
2015
435 302

2020
539 859

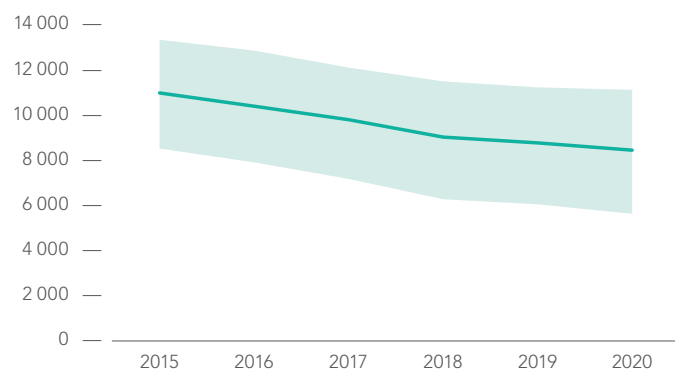
Children and adolescents living with HIV by age, 2015-2020



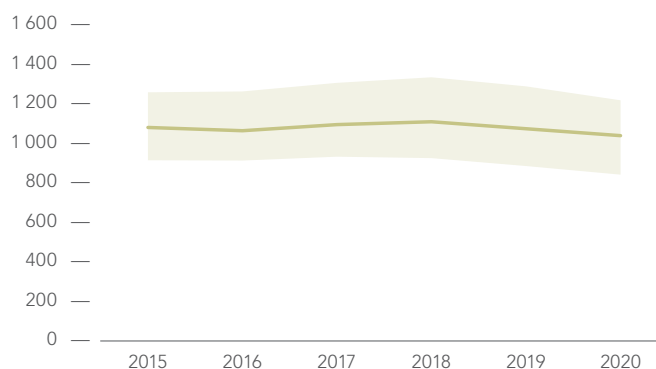
Antiretroviral therapy coverage among children aged 0-14 years, 2015-2020



Children aged 0-14 years dying from AIDS-related causes annually, 2015-2020

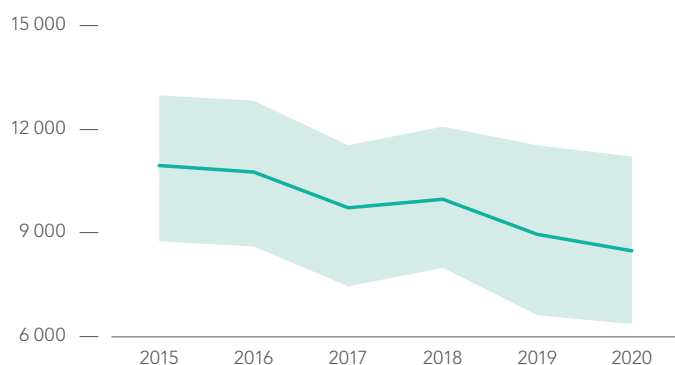


Adolescents aged 15-19 years dying from AIDS-related causes annually, 2015-2020

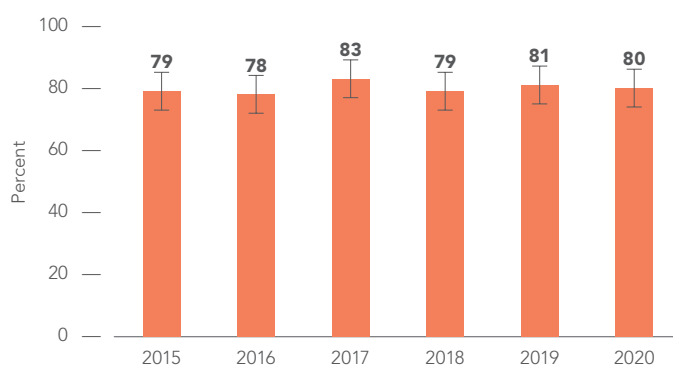


ZAMBIA

Children aged 0-14 years acquiring HIV, 2015–2020



Antiretroviral therapy among pregnant women, 2015-2020



Six-week and final (after breastfeeding) transmission rate, 2015 and 2020



Six week transmission

2015
9% [7-10%]

2020
7% [5-9%]



Final transmission

2015
18% [16-19%]

2020
3% [1-6%]



Percentage of pregnant women who had at least one antenatal visit, most recent survey

2018
99%

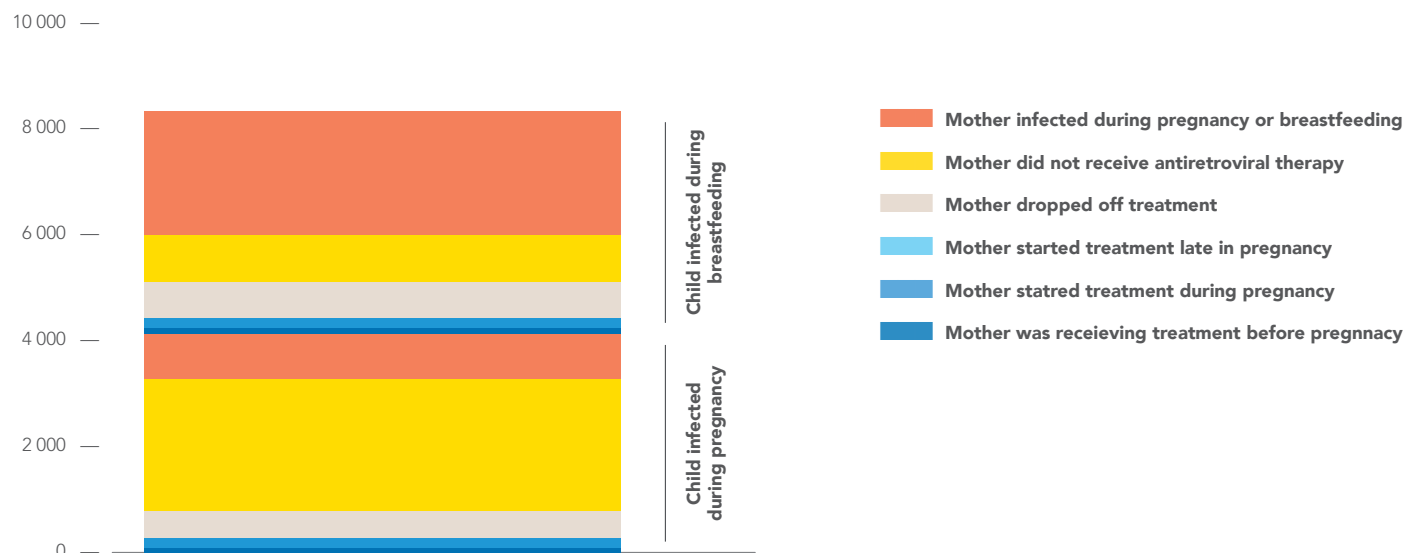
Percentage of HIV-exposed infants who received a virological test for HIV within two months of birth, 2015 and 2020



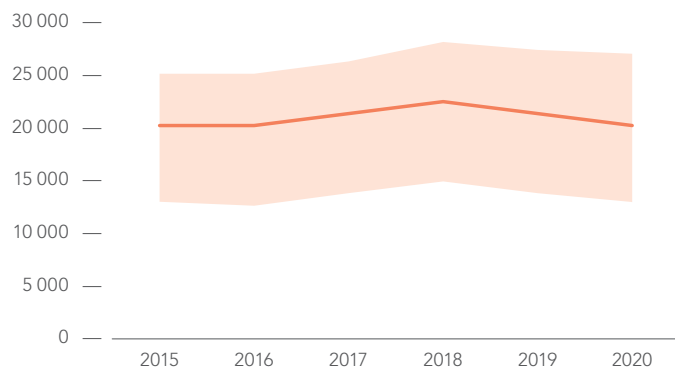
2015
44% [48-56%]

2020
65% [58-75%]

Children acquiring HIV by missed prevention opportunity, 2020



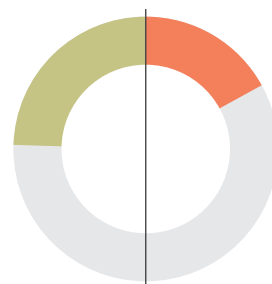
Young women aged 15-24 years acquiring HIV, 2015-2019



Condom use with most recent non-regular partner, young women and young men, most recent survey (%)

Men
49

Women
34



Knowledge of HIV prevention among young women and young men, most recent survey (%)

Men
41

Women
43

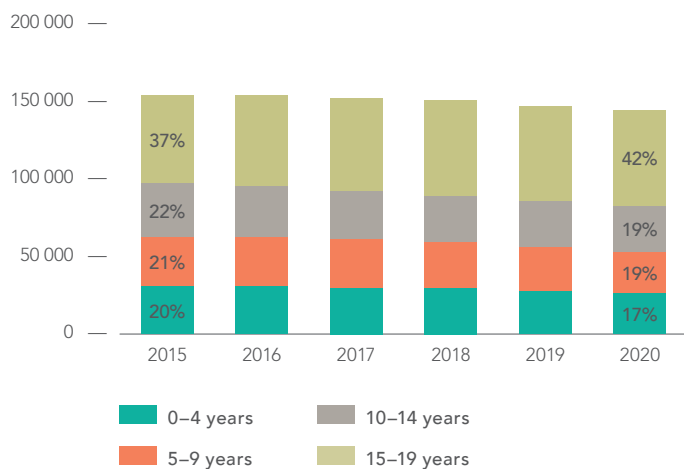


Number of voluntary medical male circumcisions, all ages

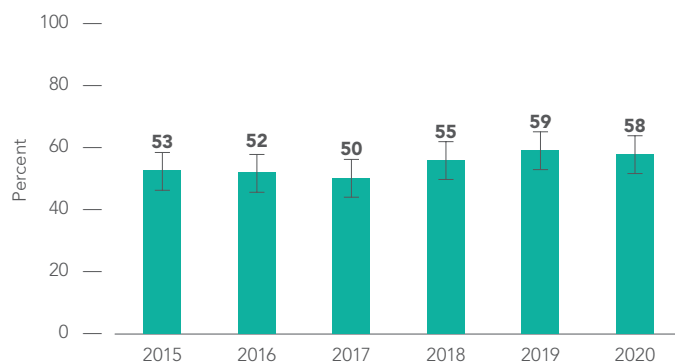
2015
222 481

2020
661 796

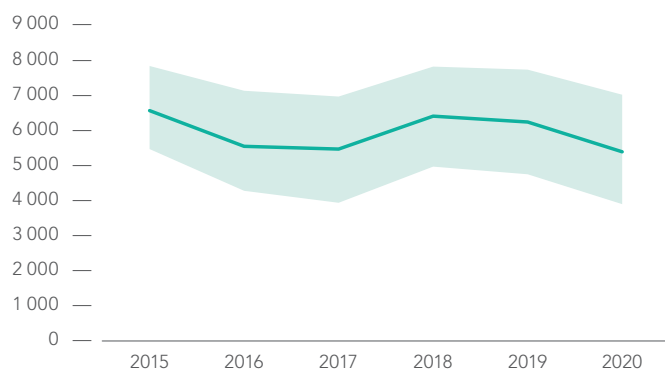
Children and adolescents living with HIV by age, 2015-2020



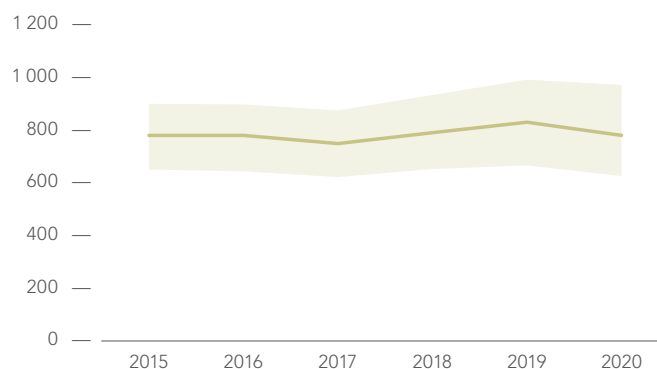
Antiretroviral therapy coverage among children aged 0-14 years, 2015-2020



Children aged 0-14 years dying from AIDS-related causes annually, 2015-2020

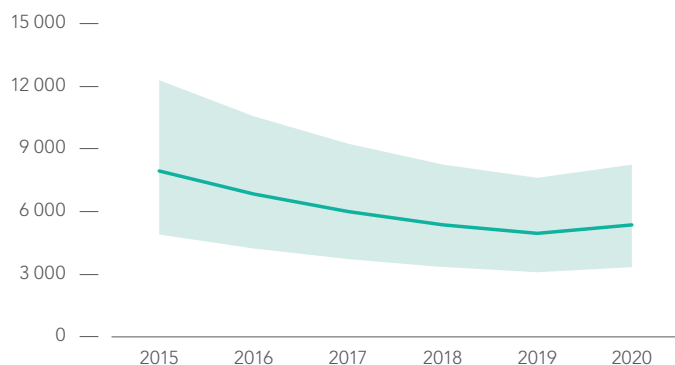


Adolescents aged 15-19 years dying from AIDS-related causes annually, 2015-2020

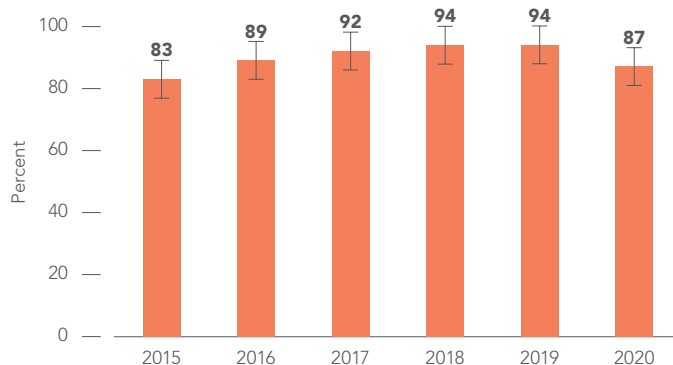


ZIMBABWE

Children aged 0-14 years acquiring HIV, 2015–2020



Antiretroviral therapy among pregnant women, 2015–2020



Six-week and final (after breastfeeding) transmission rate, 2015 and 2020



Six week transmission

2015
7% [4-9%]

2020
5% [4-8%]



Final transmission

2015
11% [8-15%]

2020
9% [6-12%]

Percentage of pregnant women who had at least one antenatal visit, most recent survey



Not available
94%

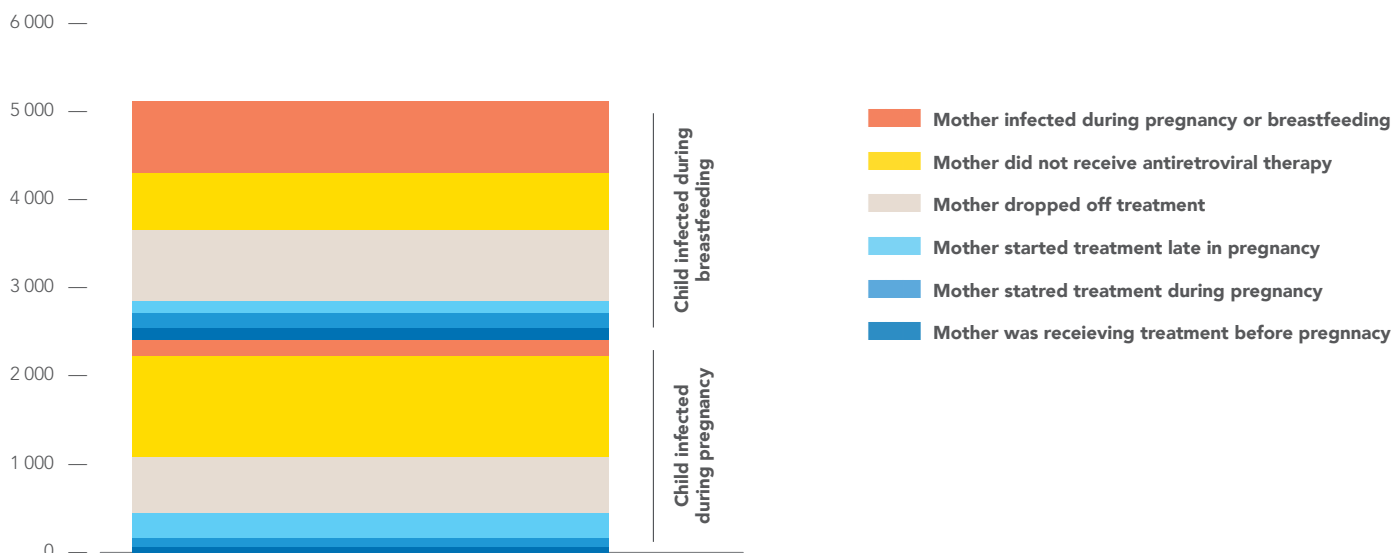
Percentage of HIV-exposed infants who received a virological test for HIV within two months of birth, 2015 and 2020



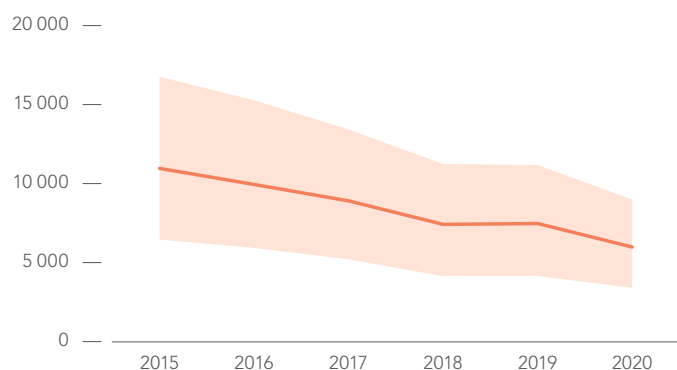
2015
45% [53-68%]

2020
76% [65-97%]

Children acquiring HIV by missed prevention opportunity, 2020



Young women aged 15-24 years acquiring HIV, 2015-2019



Condom use with most recent non-regular partner, young women and young men, most recent survey (%)

Men
81



Women
54

Knowledge of HIV prevention among young women and young men, most recent survey (%)

Men
47



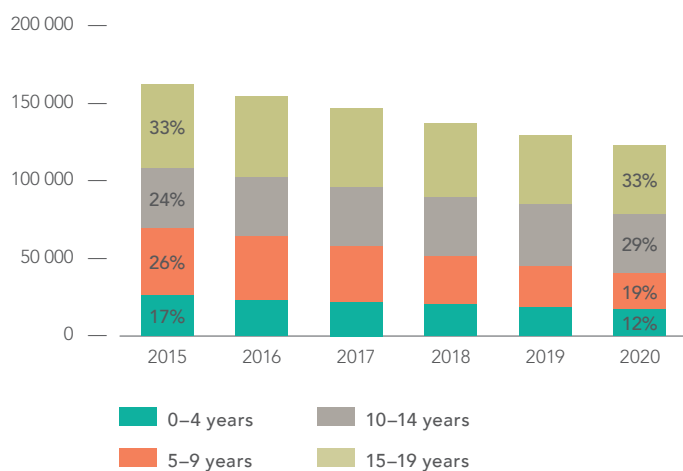
Women
46

Number of voluntary medical male circumcisions, all ages

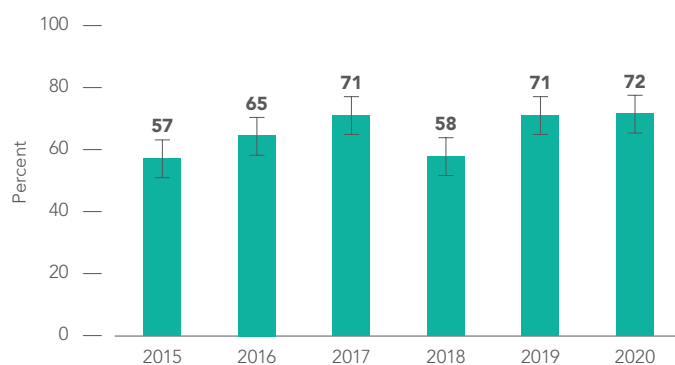
2015
188 732

2020
82 060

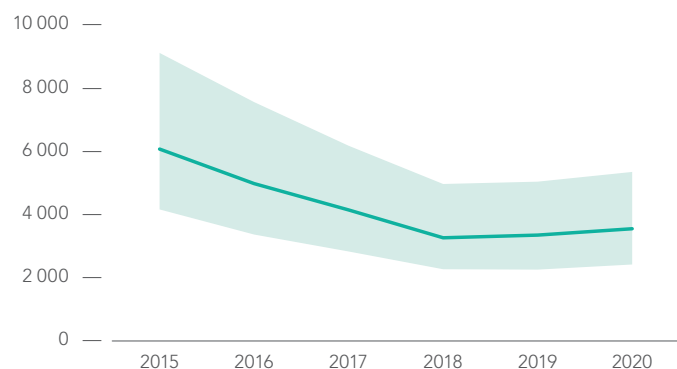
Children and adolescents living with HIV by age, 2015-2020



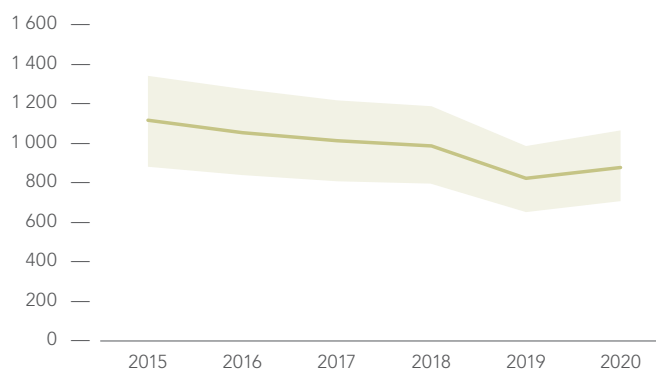
Antiretroviral therapy coverage among children aged 0-14 years, 2015-2020



Children aged 0-14 years dying from AIDS-related causes annually, 2015-2020



Adolescents aged 15-19 years dying from AIDS-related causes annually, 2015-2020



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