

TOWARDS AN AIDS-FREE GENERATION

Children and AIDS
Sixth Stocktaking Report, **2013**

UNITE FOR CHILDREN UNITE AGAINST AIDS

Stocktaking reports on children and AIDS are the flagship publications of the Unite for Children, Unite against AIDS campaign. The United Nations Children’s Fund (UNICEF) leads the development of these publications as part of its commitment to the Joint United Nations Programme on HIV/AIDS (UNAIDS), in collaboration with the 10 other UNAIDS co-sponsors.

UNAIDS brings together the resources of the UNAIDS Secretariat and 11 United Nations system organizations for coordinated and accountable efforts to unite the world against AIDS. The division of labour is as follows:

Convening agencies and partners	Division of labour
WHO, UNICEF , ILO, UNDP, UNESCO, UNFPA, UNHCR, WFP, World Bank.	Prevent mothers from dying and babies from becoming infected with HIV.
WHO , ILO, UNDP, UNHCR, UNICEF, WFP.	Ensure that people living with HIV receive treatment.
WHO , ILO, UNICEF, WFP.	Prevent people living with HIV from dying of tuberculosis.
UNODC , UNDP, UNESCO, UNFPA, UNICEF, WHO, World Bank.	Protect drug users from becoming infected with HIV and ensure access to comprehensive HIV services in prisons and closed settings.
UNDP, UNFPA , UNESCO, WHO, World Bank.	Empower men who have sex with men, sex workers and transgender people to protect themselves and to fully access antiretroviral therapy.
UNDP , ILO, UNESCO, UNFPA, UNHCR, UNICEF, UNODC, UN Women, WHO.	Remove punitive laws, policies, practices, stigma and discrimination that block effective responses to AIDS.
UNDP, UNFPA, UN Women , ILO, UNESCO, UNHCR, UNICEF, UNODC, WFP, WHO.	Meet the HIV needs of women and girls, and stop sexual and gender-based violence.
UNICEF, UNFPA , ILO, UNESCO, UNHCR, WFP, WHO.	Empower young people to protect themselves from HIV.
UNICEF, World Bank , ILO, UNDP, UNHCR, WFP.	Enhance social protection for people affected by HIV.
UNHCR, WFP , UNDP, UNFPA, UNICEF, UNODC, WHO.	Address HIV in humanitarian emergencies.
WFP , UNHCR, UNICEF, WHO.	Integrate food and nutrition within the HIV response.
UNESCO , ILO, UNFPA, UNICEF, WHO.	Ensure high-quality education for a more effective HIV response.
World Bank , ILO, UNDP, UNESCO, UNFPA, UNHCR, UNICEF, UNODC, WHO, WFP.	Support strategic, prioritized and costed multi-sectoral AIDS plans.

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Because HIV-related stigma persists, UNICEF takes steps to safeguard the identities of children and their mothers in accordance with their wishes and with global standards of child rights and protection. UNICEF obtains written consent from people living with the virus before identifying them as such in photographs and other media. Unless otherwise stated, people depicted in this publication, and in the accompanying materials online, should not be assumed to be living with HIV.

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Cover photo: In northern Rwanda, children run home after school. Students took part in a discussion group that was organized to raise awareness of important social issues such as health, hygiene, sanitation and HIV. © UNICEF/RWAA2011-00631/Noorani

TOWARDS AN AIDS-FREE GENERATION

Children and AIDS: Sixth Stocktaking Report, 2013

CONTENTS

ii	About this report	
1	Executive summary: Towards an AIDS-free generation	
4	Chapter 1 Responding to HIV in the first decade of life	6 The first decade: Progress and challenges 15 New paradigms, opportunities and innovations 17 Strategies to accelerate progress in the first decade of life
24	Chapter 2 Responding to HIV in the second decade of life	26 The second decade: Transition and vulnerability 29 Inequities and barriers to services 32 Strategies to accelerate progress in the second decade of life 39 Sustaining the gains achieved in the first decade of life
40	Chapter 3 Partnerships for an AIDS-free generation	42 Two decades, many sectors 44 Addressing HIV among children in emergency situations: A case for enhanced partnership 45 Towards an AIDS-free generation: Addressing gaps, sustaining gains
46	References	
53	Annex: Statistical tables	53 Notes on the data 54 Statistical table 1: Elimination of new HIV infections among children by 2015 and keeping their mothers alive 58 Statistical table 2: Providing paediatric HIV care and treatment 66 Statistical table 3: Demography and epidemiology of HIV among adolescents 70 Statistical table 4: Knowledge, HIV testing and sexual behaviour among adolescents 74 Statistical table 5: Epidemiology, knowledge, HIV testing and sexual behaviour among key affected populations aged below 25 years 78 Statistical table 6: Protection, care and support for children affected by HIV and AIDS
82	Photo captions and credits	
83	Acronyms	

ABOUT THIS REPORT

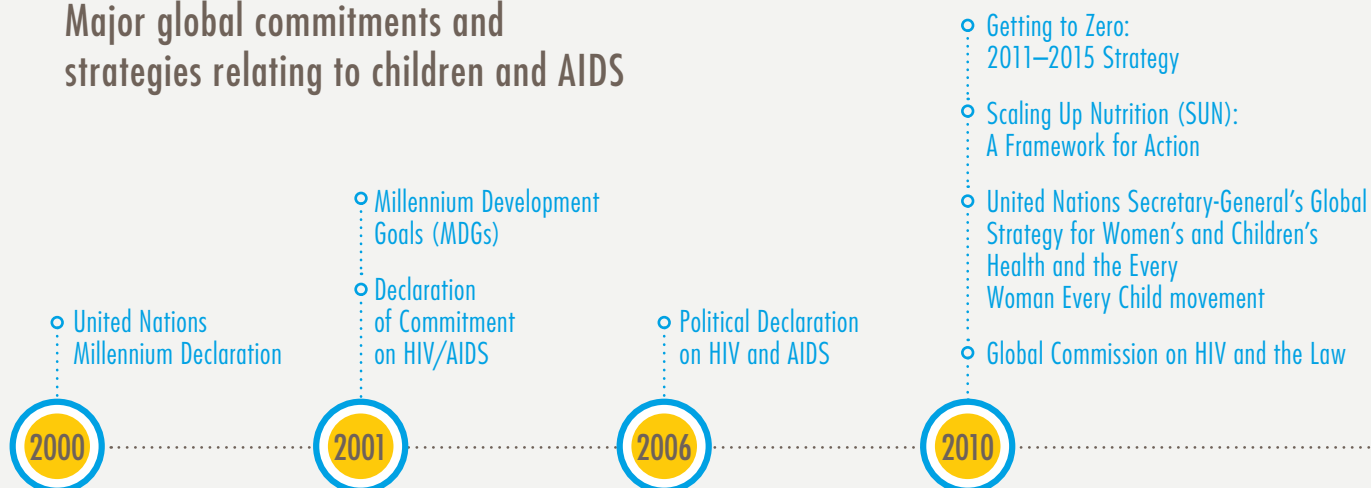
This *Sixth Stocktaking Report* focuses on the response to HIV and AIDS among children in low- and middle-income countries.¹ It is structured around the first and second decades of a child's life, and has the following objectives:

- to review the HIV burden among children and adolescents and the progress being made in addressing it
- to identify key strategies to accelerate access to HIV prevention, treatment, protection, care and support for children and adolescents
- to summarize opportunities arising from recent scientific advances, new technology and emerging practice innovations
- to mobilize national and international efforts to keep children HIV-free and ensure that those living with HIV remain AIDS-free.

While national governments are ultimately accountable for their international and domestic commitments, this report is intended to inform the coordinated efforts of all stakeholders striving to achieve the goal of an AIDS-free generation, including donors, technical experts, United Nations organizations, implementing partners, civil society and communities in diverse settings worldwide. The involvement of adults and adolescents living with HIV is essential for the success of the strategies described in this report. Responding to HIV is a shared responsibility, and achieving an AIDS-free generation will be a shared triumph.

Throughout this report, the term 'children' applies to all children below the age of 18 years, including adolescents, as defined in the Convention on the Rights of the Child. The United Nations defines adolescents as persons aged 10–19 years, and young people as persons aged 15–24 years.

Major global commitments and strategies relating to children and AIDS



TOWARDS AN AIDS-FREE GENERATION

An AIDS-free generation means a generation in which all children are born free of HIV and remain so for the first two decades of life, from birth through adolescence. It also means that children living with and affected by HIV have access to the treatment, care and support they need to remain alive and well. For the first time in the history of the HIV epidemic, the global community has accumulated the knowledge, experience and tools to achieve an AIDS-free generation.

An AIDS-free generation begins in the first decade of life

The major components of the HIV response for young children – elimination of mother-to-child transmission (EMTCT) of HIV, treatment of children living with HIV and mitigation of the social and economic

“Children should be the first to benefit from our successes in defeating HIV, and the last to suffer from our failures.”

Anthony Lake, Executive Director, UNICEF

impact of HIV and AIDS on children – are well established. The challenge today is to apply existing knowledge and pursue new opportunities and innovations – while using finite resources as efficiently and effectively as possible – to ensure that children survive and thrive in their first decade of life.

- Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS
- Global Plan Towards the Elimination of New HIV Infections Among Children by 2015 and Keeping Their Mothers Alive
- Investment Approach for an Effective Response to HIV/AIDS

- Committing to Child Survival: A Promise Renewed
- Family Planning 2020

- Global Plan target year
- MDG deadline

2011

2012

2015



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More progress has been made between 2009 and 2012 than during the previous decade, according to 2012 data, which show a 35 per cent decline in new HIV infections among children under the age of 15 years, compared with 2009.² In 2012, coverage of antiretroviral drugs (ARVs) for pregnant women living with HIV reached 62 per cent in the 22 priority countries in the Global Plan Towards the Elimination of New HIV Infections Among Children by 2015 and Keeping Their Mothers Alive (the 'Global Plan').³ Yet, approximately 230,000 (180,000–300,000) children – or 630 (540–760) per day – were newly infected with HIV in these countries during 2012.⁴ While the world is currently reducing new HIV infections among children faster than at any other time in history, the pace will have to be accelerated even more to achieve the Global Plan 2015 target.

Ensuring the health of pregnant and breastfeeding women living with HIV is central to achieving an AIDS-free generation

In the past three years, countries have begun moving towards early initiation of triple-drug regimens and simplified programming for eliminating mother-to-child transmission of HIV. This approach emphasizes the long-term health of pregnant and breastfeeding women living with HIV as well as the prevention of HIV infection among their children. The World Health Organization's 2013 Consolidated Guidelines on

the Use of Antiretroviral Drugs for Treating and Preventing HIV Infection recommend initiating antiretroviral therapy (ART), either lifelong or during the mother-to-child transmission risk period, for all pregnant and breastfeeding women living with HIV. All children under 5 years of age diagnosed with HIV should also be provided with lifelong ART, regardless of their CD4 count.⁵ The move to providing ART for all pregnant and breastfeeding women represents an important paradigm shift that places women's health and well-being at the centre of preventing HIV in children. Keeping mothers alive and healthy is one of the most important factors for early child survival.

Preventing HIV infection among women and girls of childbearing age and helping women and girls who are living with HIV to avoid unwanted pregnancies remain priorities towards preventing HIV infections among children.

More children are accessing ART, but progress for children lags behind progress for adults

Overall, ART coverage for children under 15 years old living with HIV in low- and middle-income countries has consistently been around half that for adults – 34 per cent of children in 2012 compared with 64 per cent of adults in 2012.⁶ Children under 15 years old who need ART to survive are significantly less likely than adults to receive it. In the

absence of HIV testing and timely ART initiation, one third of infants living with HIV die before their first birthday, and more than half die before the age of 2 years.⁷ A huge effort will therefore be needed to reach the global goal of providing ART to all eligible children by 2015.

Much more attention is needed to prevent and treat HIV during adolescence, so that children remain AIDS-free in the second decade of life

As the international community reflects on the gains made in the first decade of a child's life, it cannot continue to neglect the crucial second decade of childhood. Approximately 2.1 million (1.7 million–2.8 million) adolescents were living with HIV globally at the end of 2012,⁸ and approximately two thirds of new HIV infections in adolescents aged 15–19 years were among girls.⁹ Adolescents experience a second wave of vulnerability to HIV that is driven by many factors, and they encounter numerous barriers to accessing services. As children living with HIV grow older, their treatment, care and support needs also change, and they face new challenges in adhering to medications, taking greater responsibility for their own health and accessing the services and information they need to lead healthy and productive lives. Worldwide, disproportionately high HIV prevalence is reported among key adolescent populations – males who have sex with males, adolescents who inject drugs and sexually exploited adolescents.¹⁰ A comprehensive strategy is needed to address these diverse needs.

Social protection and child protection, care and support must underpin efforts to scale up high-impact interventions through the first two decades of life

Creating an AIDS-free generation is more than a biomedical endeavour. Economic and social drivers of HIV – such as poverty, food insecurity, drug and alcohol use, social marginalization, gender inequality, violence and sexual exploitation, and

lack of access to education, including comprehensive sexuality education – need to be addressed concurrently as part of a multi-sectoral approach to HIV among children.

Efforts to address the needs of children living with HIV, or in households affected by HIV, through comprehensive protection, care and support interventions have not achieved broad coverage.¹¹ Much greater collaboration across sectors is required. Economic and psychosocial support is particularly important for the estimated 17.8 million (16.1 million–21.6 million) children who have lost one or both parents to AIDS.¹² These measures not only alleviate hardship but can help reduce the risk of HIV infection and support long-term adherence to medication and continuity of care for children and their families.¹³

Two decades, many sectors

This report highlights both gains and gaps in the response to HIV among children in the first and second decades of life and stresses the urgency of achieving results more quickly with the resources available. While it emphasizes high-prevalence settings, there is no less concern for lower-prevalence settings and the clear challenge to maintain and expand upon progress made. To this end, innovations and new paradigms are presented along with key strategies designed to accelerate the pace of progress.

An AIDS-free generation will only be achieved through strong leadership from government, with partners aligning their support to common objectives. The wholehearted participation of civil society and affected communities will also be required, not only as implementing partners but also in planning, decision-making, awareness raising, advocacy and strengthening accountability.

The path to an AIDS-free generation is clear. The world must now strongly commit to sustaining the hard-won gains and to addressing the remaining inequities and gaps in the response to HIV among children.

CHAPTER 1

RESPONDING TO HIV IN THE **FIRST DECADE** OF LIFE

“Eliminating new HIV infections among children is an ambitious but achievable goal. With the support of the Every Woman Every Child movement, an AIDS-free generation can be ours. There is no better investment than the health of women and children.”

Ban Ki-moon,
Secretary-General of the United Nations





THE FIRST DECADE: PROGRESS AND CHALLENGES

Since the first effective ARV regimen for the prevention of mother-to-child transmission (PMTCT) of HIV was reported in 1994, the outlook for children born to mothers living with HIV has improved dramatically. In high-income countries, mother-to-child transmission of HIV has been virtually eliminated.¹⁴ Today, steadily expanding coverage of the most effective ARVs, together with new approaches to providing them, offer hope that mother-to-child HIV transmission can also be virtually eliminated in low- and middle-income countries.

The Global Plan Towards the Elimination of New HIV Infections Among Children by 2015 and Keeping Their Mothers Alive ('the Global Plan') identifies 22 priority countries where almost 90 per cent of all new HIV infections among children occur. Of these countries, 21 are in sub-Saharan Africa; the other country is India.¹⁵ Reducing mother-to-child transmission to less than 5 per cent of breastfeeding infants and to less than 2 per cent of non-breastfeeding infants is an important target of the Global

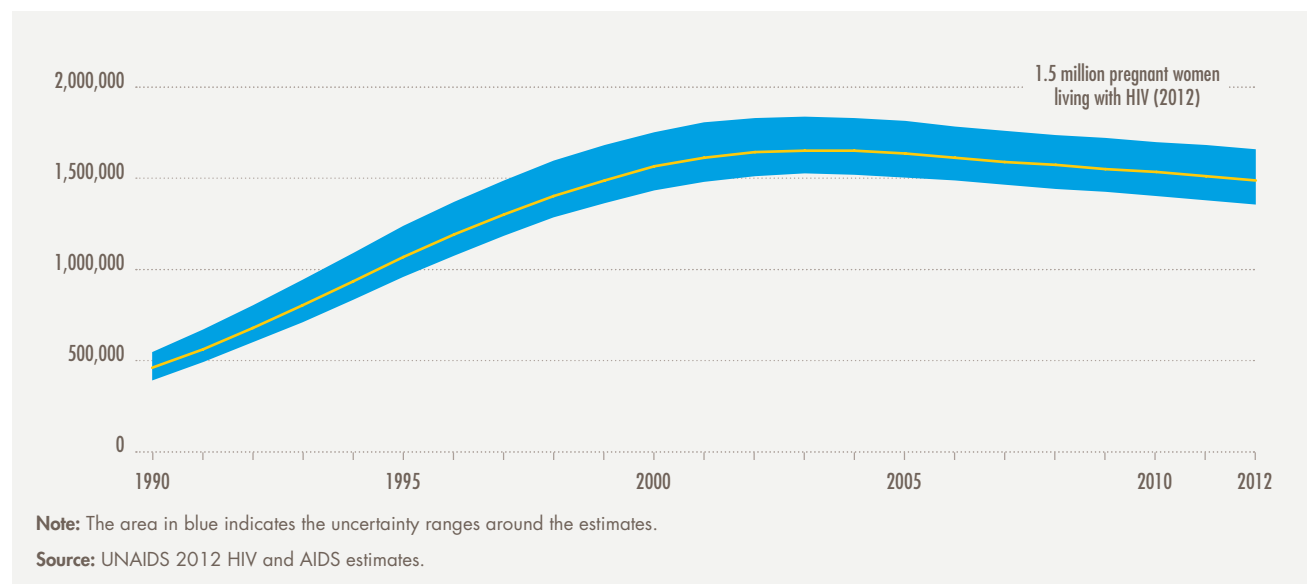
Plan.¹⁶ This means reaching an estimated 1.5 million (1.4 million–1.7 million) pregnant women living with HIV annually, based on 2012 estimates (see *Figure 1.1*).¹⁷ Without any interventions, between 15 per cent and 45 per cent of infants born to these women will acquire HIV: 5–10 per cent during pregnancy, 10–20 per cent during labour and delivery, and 5–20 per cent through breastfeeding.¹⁸

Significant progress is being made in expanding access to ARVs for PMTCT

Encouraging progress has been made in scaling up and improving the quality of programmes. In 2012, approximately 900,000 pregnant women living with HIV in low- and middle-income countries received ARVs to prevent mother-to-child transmission – either ART primarily for their own health or the most efficacious antiretroviral prophylaxis.¹⁹ This represents one third more than the number who received it in 2009. While the world is currently reducing new HIV infections among children faster than at any other time in history, the pace will have to be accelerated even more to achieve the 2015 target of 90 per cent reduction (see *Figure 1.2*).

FIGURE 1.1

Estimated number of pregnant women living with HIV in low- and middle-income countries, 1990–2012



The Global Plan Towards the Elimination of New HIV Infections Among Children by 2015 and Keeping their Mothers Alive

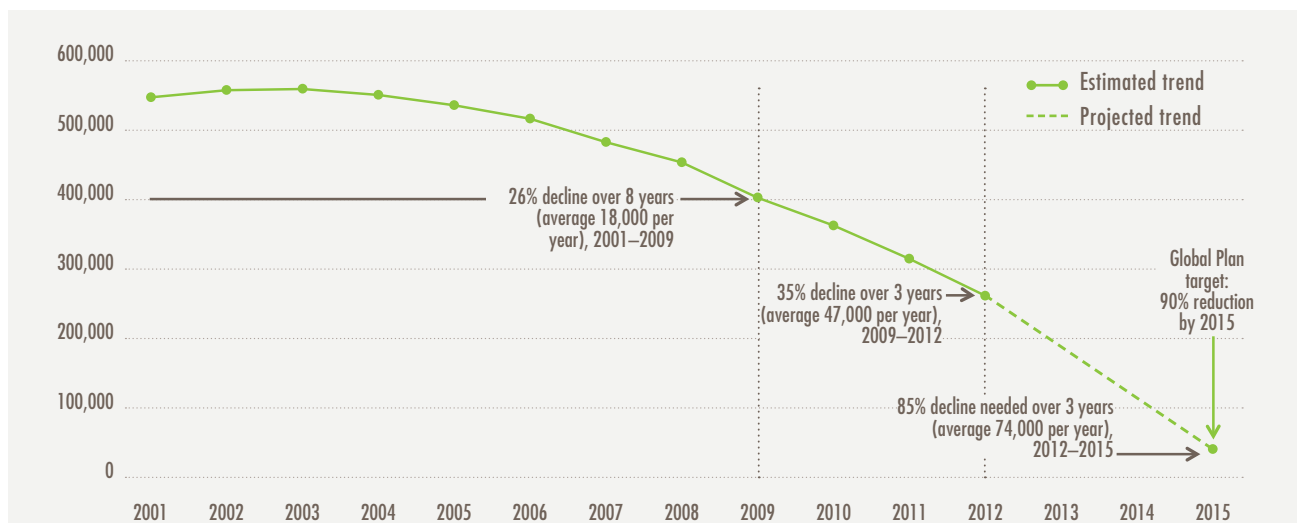
Since its launch in 2011, the Global Plan has helped to catalyse efforts to tackle HIV in children and their mothers across Millennium Development Goals 4 (reduce child mortality), 5 (improve maternal health) and 6 (combat HIV, tuberculosis and malaria). While covering all low- to middle-income countries, it focuses on the 22 priority countries that account for almost 90 per cent of the world's pregnant women living with HIV as well as almost 90 per cent of new infections among children. The Global Plan focuses on achieving two global targets:

- **Target 1:** Reduce the number of new HIV infections among children by 90 per cent
- **Target 2:** Reduce the number of AIDS-related maternal deaths by 50 per cent.

In 2011, the cost of achieving the Global Plan targets for 17 of the 22 priority countries was estimated at around US\$1 billion per year over five years, 43 per cent of which is for providing PMTCT services to pregnant women living with HIV and treatment for their own health, 37 per cent for the prevention of primary HIV infection, 12 per cent for paediatric ART and 8 per cent for family planning.²⁰ Several countries – including Botswana, Namibia and South Africa – are making substantial domestic investments towards achieving the goals of the Global Plan. Major international donors to this effort include the Global Fund to Fight AIDS, Tuberculosis and Malaria and the United States President's Emergency Plan for AIDS Relief (PEPFAR).

FIGURE 1.2

Estimated number of new HIV infections in children (aged 0–14): Global trend and projections, 2001–2015



Source: UNICEF analysis of UNAIDS 2012 HIV and AIDS estimates.

While the overall coverage of ARVs for PMTCT for low- and middle-income countries reached 62 per cent in 2012, there was considerable variation across regions (see *Figure 1.3*). In Eastern and Southern Africa, where the HIV burden is greatest, three quarters of pregnant women have access (66–85 per cent). In Central and Eastern Europe and the Commonwealth of Independent States (CEE/CIS), coverage is reported as very high (greater than 95 per cent), as it is in Latin America and the Caribbean (88 per cent; 58–95 per cent). All other regions have estimated coverage below half.²¹

One of the core targets of the Global Plan is to provide ARVs to 90 per cent of the world's pregnant women living with HIV by the end of 2015. This is now within reach. In the 22 Global Plan priority countries, 62 per cent of pregnant women living with HIV received ARV prophylaxis in 2012, compared with 57 per cent in 2011 and 49 per cent in 2010.²²

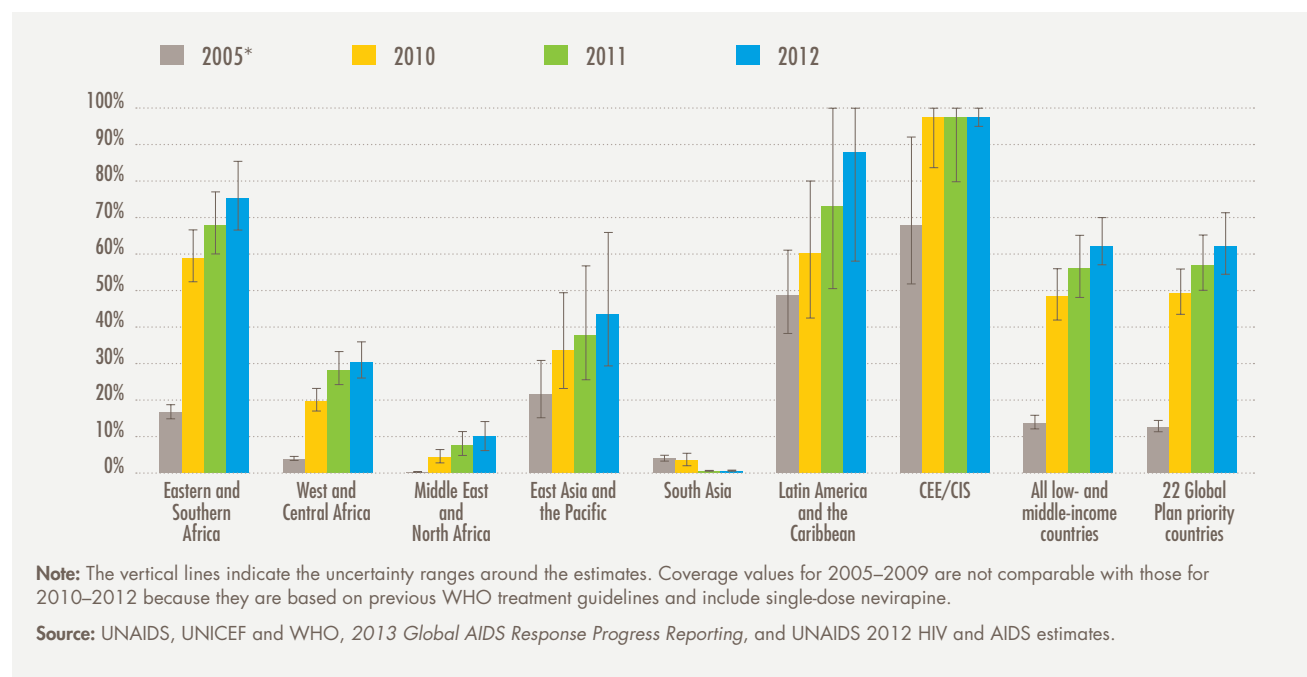
Since 2009, most countries have shifted their policies away from the use of single-dose nevirapine to more effective regimens for PMTCT.

Four priority countries of the Global Plan – Botswana, Ghana, Namibia and Zambia – have already met the 90 per cent target, while Mozambique, South Africa, Swaziland and Zimbabwe are close to it. However, five countries – Kenya, Lesotho, Nigeria, South Africa and Swaziland – have experienced declines in PMTCT coverage in the last year, and four countries – Angola, Chad, the Democratic Republic of the Congo and Nigeria – had national ARV coverage for PMTCT of less than 20 per cent in 2012.²³

The 2013 World Health Organization (WHO) guidelines on ART recommend universal HIV testing for all pregnant women as part of the basic package of services for antenatal care in all settings. In some countries with concentrated or low-prevalence

FIGURE 1.3

Estimated percentage of pregnant women living with HIV receiving the most effective antiretroviral medicines for PMTCT, in UNICEF regions, all low- and middle-income countries and the 22 Global Plan priority countries, 2005–2012





epidemics, the offer of routine HIV testing for all pregnant women may be considered prohibitive when assessed against the number of cases detected.²⁴ In Viet Nam and other countries with concentrated epidemics, HIV testing is being incorporated into a standard list of tests during pregnancy.²⁵ Adequate referral and linkage to follow-up services is critical.

In India, where overall numbers are large but the population of women living with HIV is spread out across the country, the initiation and maintenance of ARVs in women and children living with HIV in maternal and child health settings is recommended as part of antenatal care.²⁶ Cambodia has also demonstrated that this approach can not only increase access to treatment at the level of primary care but also lead to reductions in loss to follow-up of women and children diagnosed with HIV.

Access to ART for pregnant women for their own health is increasing, but is still lower than for other adults

The percentage of pregnant women living with HIV (with CD4 levels less than 350 cells per cubic millimetre) who received ART for their own health in 2012 in low- and middle-income countries was only 58 per cent, compared with 64 per cent for all adults (with CD4 levels less than 350 cells/mm³) estimated to have received ART that year.²⁷

By 2012, several priority countries of the Global Plan – including Botswana, Ghana, Malawi, Namibia, South Africa, Swaziland and Zambia – reported that more than 75 per cent of pregnant women eligible for ART under WHO's 2010 criteria received it, while more than 50 per cent were receiving it in Kenya, Lesotho, the United Republic of Tanzania and Zimbabwe.²⁸ As more countries adopt the use of ART for all pregnant and breastfeeding women living with HIV, in line with WHO's 2013 guidelines on ARVs,²⁹ this upward trend for ART coverage is expected to continue.

Increasing impact: New infections among children are falling

As a result of recent progress in EMTCT, fewer infants are acquiring HIV. In low- and middle-income countries, about 260,000 new infections among children occurred in 2012,³⁰ but between 2005 and 2012, more than 850,000 HIV infections in children were prevented in low- and middle-income countries.³¹

The vast majority of new HIV infections among children aged 0–14 years were in Eastern and Southern Africa (130,000) and West and Central Africa (98,000), followed a long way behind by South Asia (15,000) and East Asia and the Pacific (7,900), and then by all other regions, which reported fewer than 3,000 new infections each in 2012.³²

FIGURE 1.4

Country progress in reducing new HIV infections among children aged 0–14 in the 21 Global Plan priority countries in Africa, 2009–2012

RAPID DECLINE (50 PER CENT OR MORE)	MODERATE DECLINE (30–49 PER CENT)	SLOW DECLINE (LESS THAN 30 PER CENT)
Ghana (76%)	United Republic of Tanzania (49%)	Cameroon (29%)
Namibia (58%)	South Africa (46%)	Côte d'Ivoire (27%)
Zimbabwe (55%)	Mozambique (45%)	Lesotho (17%)
Malawi (52%)	Uganda (45%)	Democratic Republic of the Congo (15%)
Botswana (52%)	Kenya (44%)	Nigeria (10%)
Zambia (50%)	Swaziland (38%)	Chad (9%)
Ethiopia (50%)	Burundi (31%)	Angola (9% increase)

Source: UNICEF update to a table published in the Joint United Nations Programme on HIV/AIDS, *Global Report: UNAIDS report on the global AIDS epidemic 2013*, UNAIDS, Geneva, 2013, p. 9.

In the 22 priority countries of the Global Plan, overall mother-to-child transmission rates have declined, from an estimated 26 per cent in 2009 to 17 per cent in 2012. The number of children under 15 who were newly infected in these countries fell by 36 per cent, from 360,000 in 2009 to 230,000 in 2012. In this period, seven countries halved new HIV infections among children (see *Figure 1.4*).³³

The rate of HIV transmission from mother to child has been steadily improving in most regions.

However, much remains to be done. The CEE/CIS region reports the most favourable transmission rate (6 per cent), followed by Latin America and the Caribbean (10 per cent) and Eastern and Southern Africa (13 per cent). All other regions report worrying transmission rates higher than 20 per cent (East Asia and the Pacific, 22 per cent; West and Central Africa, 28 per cent; Middle East and North Africa, 34 per cent; South Asia, 38 per cent).³⁴

BOX

Validation of countries achieving elimination of mother-to-child transmission

Countries beyond the scope of the Global Plan are also making progress towards EMTCT. For example, Cuba and Panama,³⁵ Thailand³⁶ and several countries in Eastern Europe, including Armenia, Belarus, Georgia, Kazakhstan and the Republic of Moldova,³⁷ report that they are approaching transmission rates of 2 per cent. Regional initiatives are building momentum – for example, the European Action Plan for HIV/AIDS 2012–2015 was established in 2011,³⁸ and elimination initiatives on paediatric HIV infections and congenital syphilis exist in East Asia and the Pacific and in Latin America and the Caribbean.³⁹ In recognition of this trend, WHO has established criteria and processes for validating country reports of the elimination of new HIV infections among children. Countries will apply to WHO, and the process of validation will be supported by regional and country-level bodies set up for this purpose. These criteria and processes were established for validating the elimination of both HIV and congenital syphilis.⁴⁰

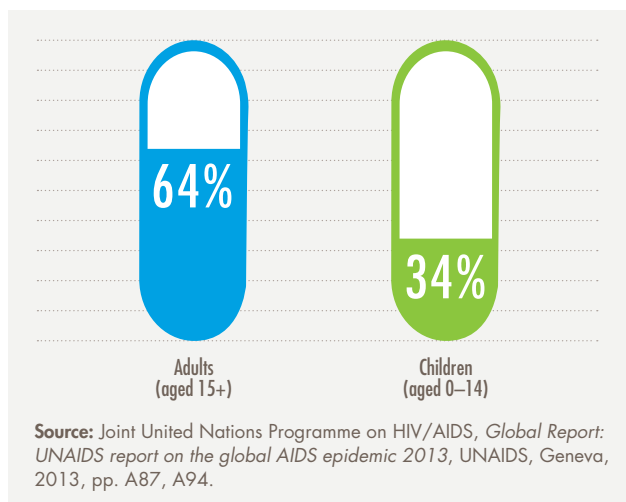
More children are accessing ART, but progress for children lags behind progress for adults

In the absence of HIV testing and timely ART initiation, one third of infants living with HIV die before their first birthday, and half die before the age of 2 years.⁴¹ Globally, the pace of scale-up of ART for children under 15 years is only half that of adults. For children, an increase in ART access of 14 per cent was registered from 2011 to 2012, compared to an increase of 20 per cent for adults over the same period.⁴² In low- and middle-income countries, overall ART coverage for children under the age of 15 years has consistently been around half that for adults – 34 per cent compared to 64 per cent for adults in 2012 (see Figure 1.5).⁴³

The CEE/CIS region reports the highest ART coverage for children younger than 15 years: at 85 per cent (80–89 per cent), followed by Latin America and the Caribbean at 67 per cent (50–83 per cent). East Asia and the Pacific reported 53 per cent (41–72 per cent) coverage, whereas South Asia reported 39 per cent (30–49 per cent) coverage. The region with the

FIGURE 1.5

Percentage of adults (aged 15+) and children (aged 0–14) living with HIV receiving antiretroviral therapy in low- and middle-income countries, 2012



greatest need, Eastern and Southern Africa, reported 40 per cent (35–46 per cent) coverage. The lowest coverage was registered in West and Central Africa, 15 per cent (13–18 per cent), and in the Middle East and North Africa, 7 per cent (4–10 per cent).⁴⁴

ART coverage for children younger than 15 years in the 22 Global Plan priority countries increased from 29 per cent (500,000 children) in 2011 to 34 per cent (560,000 children) in 2012, but the pace of scale-up across low- and middle-income countries lags behind that of adults.⁴⁵ Four of the Global Plan priority countries had greater than 50 per cent ART coverage among eligible children – Botswana (>95 per cent), Namibia (88 per cent), South Africa (63 per cent) and Swaziland (54 per cent) – and coverage has doubled in nine other countries in the last three years.⁴⁶ Other priority countries have very low coverage, and on average, only one in three eligible children have access to ART in the 22 priority countries (see Figure 1.6). A huge effort therefore will be needed to reach the global goal of providing ART to all eligible children by 2015.

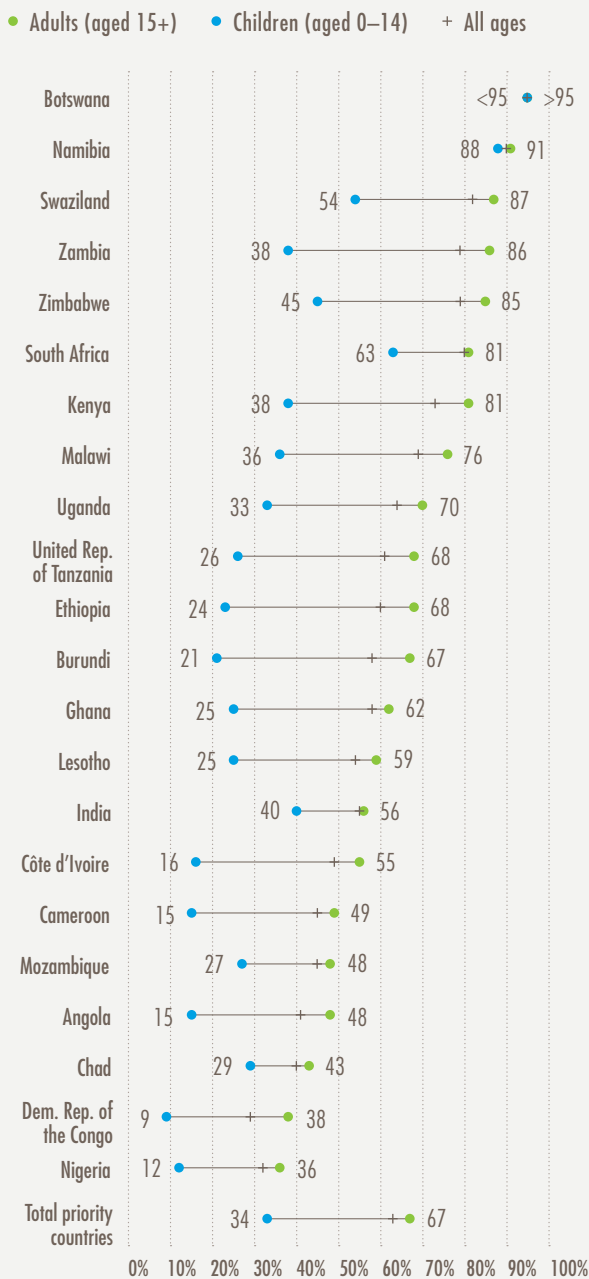
Providing paediatric ART presents a number of unique and complex challenges. Among them are the limited availability of fixed-dose combinations, poor palatability of currently recommended paediatric drug formulations for infants, and the need to use virological testing to determine HIV infection in children under the age of 18 months. However, new drugs such as granular ‘sprinkles’ and new technologies for performing virological testing at the point of care are expected to help overcome the challenges and may facilitate improved uptake and adherence.

Timely diagnosis of HIV in pregnant women and children is crucial, but coverage of testing varies widely and linkages to treatment and care are still inadequate

Significant proportions of pregnant women and children living with HIV remain undiagnosed or, if diagnosed, are not adequately enrolled into care.

FIGURE 1.6

Percentage of ART coverage among eligible adults (aged 15+), children (aged 0–14) and all ages in the 22 Global Plan priority countries, 2012



Note: Some numbers do not add up due to rounding. The coverage estimate is based on the estimated unrounded number of children receiving and eligible for ART.

Source: UNAIDS, UNICEF and WHO, 2013 *Global AIDS Response Progress Reporting*.

An estimated 40 per cent of pregnant women in low- and middle-income countries received HIV testing and counselling in 2012, up from 26 per cent in 2009.⁴⁷ Coverage varies widely by country and region.

Four of the 22 Global Plan priority countries (Botswana, Mozambique, South Africa and Zambia) exceeded 95 per cent coverage for testing pregnant women in 2012, but coverage was less than 25 per cent in three others (Chad, the Democratic Republic of the Congo and Nigeria).⁴⁸

Early infant diagnosis remains low

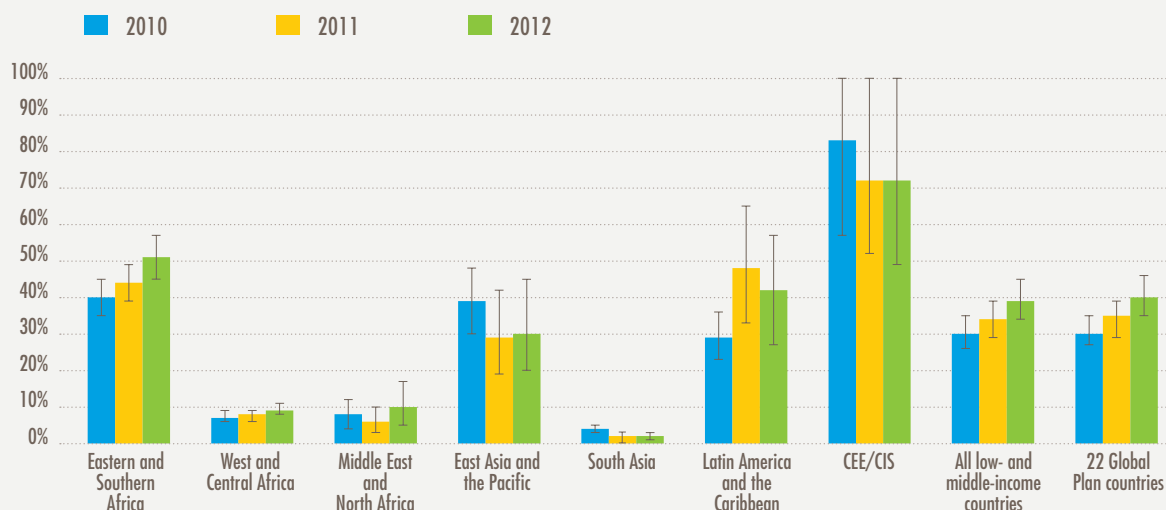
WHO recommends that infants exposed to HIV be tested at 4 to 6 weeks of age, using a virological test.⁴⁹ ART should be started as soon as an infant is diagnosed with HIV, regardless of clinical and immune system status. Some countries are considering even earlier testing, at birth, especially for children born to mothers who have not received PMTCT services.

While early infant diagnosis (EID) is expanding in many countries, overall testing rates for infants remain low. Only 39 per cent of children in low- and middle-income countries were estimated to have access to HIV testing within the recommended 2 months of birth in 2012 (see Figure 1.7).⁵⁰

The CEE/CIS region had the highest coverage of EID of all regions reported, at 72 per cent (although the uncertainty range around the estimates is very wide: from 49 per cent to greater than 95 per cent), followed by Eastern and Southern Africa at 51 per cent (45–57 per cent), Latin America and the Caribbean at 42 per cent (27–57 per cent) and East Asia and the Pacific at 30 per cent (20–45 per cent). In West and Central Africa, EID is at 9 per cent (8–11 per cent). South Asia stands at only 2 per cent (1–3 per cent) coverage.⁵¹

FIGURE 1.7

Estimated percentage of infants born to women living with HIV receiving a virological test by 2 months of age, by UNICEF region, all low- and middle-income countries and the 22 Global Plan priority countries, 2010–2012



Note: The vertical lines indicate the uncertainty ranges around the estimates.

Source: UNAIDS, UNICEF, WHO, 2013 *Global AIDS Response Progress Reporting*, and UNAIDS 2012 HIV and AIDS estimates.

INITIATIVES

Presumptive diagnosis in Lesotho



Where early infant diagnosis is weak, severe illness can progress quickly in children with HIV. Presumptive diagnosis allows health workers to offer immediate ART to infants showing signs of HIV-related disease. In some areas of Lesotho, for example, difficult terrain leads to long waits for the return of HIV test results, and also makes it difficult to keep test kits in stock. Delivery of infant HIV test results can take 6 to 12 weeks, delaying the start of life-saving treatment for infants who need it. Presumptive diagnosis eliminates this wait by relying on immediate assessment rather than laboratory test outcomes as the basis for ART initiation.

In 2010, the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) supported Lesotho’s Ministry of Health in training maternal and child health nurses at three hospitals in presumptive diagnosis. Between January 2010 and December 2011, the specially trained nurses diagnosed 48 infants with severe HIV disease and started ART promptly. Of these 48 children, 43 received a test for HIV. When their test results arrived, 42 of them proved to be living with HIV and 1 was HIV-negative.

EGPAF intends to train more health-care workers in the WHO presumptive diagnosis criteria. A recommendation for scale-up in Lesotho has been made, while efforts to improve routine systems for EID are also intensifying.

Among the 22 Global Plan priority countries, only two were providing EID for more than 80 per cent of infants in need in 2012: South Africa (85 per cent) and Swaziland (81 per cent). They were followed by Namibia (74 per cent), Lesotho (69 per cent⁵²) and Zambia (61 per cent). Coverage of EID is less than 10 per cent in five of the priority countries: Angola, Chad, the Democratic Republic of the Congo, Malawi and Nigeria.⁵³

In low- and middle-income countries, the vast majority of children diagnosed with HIV do not begin ART in a timely manner; in 2012, only 34 per cent of children under 15 years diagnosed with HIV received treatment. As a result, an estimated 210,000 (190,000–250,000) children died from AIDS-related illnesses that year.⁵⁴

Current service delivery models rely heavily on the provision of paediatric HIV treatment at specialized paediatric HIV clinics or adult HIV clinics, whereas task shifting or task sharing with health-care workers other than medical doctors – to facilitate care to decentralized levels, including through community-based services – should be a priority to improve access.⁵⁵

Special attention is needed to ensure that women have access to ARVs and are retained in care during the breastfeeding period

Breastfeeding is critical for child survival and growth. WHO recommends that mothers living with HIV who are taking ART and breastfeeding should exclusively

breastfeed their infants for the first six months of life, introducing appropriate complementary foods thereafter, while continuing to breastfeed until the child is 12 months old. Breastfeeding should then stop only when a nutritionally adequate and safe diet without breast milk can be provided. Infants of mothers who are receiving ART and breastfeeding should receive 6 to 12 weeks of infant prophylaxis with daily nevirapine. Alternatives exist for women living with HIV who do not breastfeed.⁵⁶

While global data on ARV coverage during the breastfeeding period are limited, it is estimated that, in 2012, nearly half of mothers in the 21 Global Plan priority countries in Africa did not receive ARVs during the breastfeeding period. Up to about half of all new infections in children in sub-Saharan Africa are estimated to have occurred as a result.⁵⁷ Special attention is therefore needed in all countries to ensure access to, and retention on, ART for breastfeeding mothers.

Primary prevention needs for women and family planning services for women living with HIV remain inadequate

Provision of ARVs to pregnant women and mothers living with HIV to prevent mother-to-child transmission (identified as Prong 3 of PMTCT in the Global Plan) and of treatment of mothers and children living with HIV for their own health (Prong 4) has been substantial. However, progress in primary

BOX

Progress on reducing new HIV infections among children has been faster than ever before. But to meet the 2015 target, the pace of progress will have to accelerate.

850,000 new HIV infections among children (0–14 years) in low- and middle-income countries were prevented between 2005 and 2012.

Only **39%** of children in low- and middle-income countries were estimated to have access to HIV testing within the recommended 2 months of birth in 2012.

prevention among women and girls of childbearing age (Prong 1) and in reducing unmet need for family planning by women living with HIV (Prong 2) has not been as impressive. In the Global Plan priority countries in Africa, the number of women becoming newly infected declined 10 per cent between 2009 and 2012. Ghana reported the greatest decline, at 44 per cent, during the same period, and South Africa reported a 21 per cent decline.⁵⁸ This trend highlights the need for innovation in following up with pregnant women who test HIV-negative at their first antenatal visit and the importance of broader primary prevention (outside of antenatal settings) among women and girls to achieving the goal of an AIDS-free generation.

Unmet need for family planning services among women living with HIV continues to undermine efforts to eliminate new infections among children.⁵⁹ For women in low- and middle-income countries, unmet need for family planning declined only slightly, from 15 per cent in 1990 to 12 per cent in 2010.⁶⁰ UNAIDS reports that in East Africa and West Africa, the unmet need for family planning services for more than 20 per cent of women did not change between 1990 and 2010.⁶¹ This means that more than one in five women in stable relationships expressing the desire to delay or stop childbearing were not using contraception.

Renewed commitment and resources for family planning from the global community, including through the Family Planning 2020 initiative, are

welcome.⁶² Family planning services for women living with HIV must be voluntary and non-coercive. Reports of forced sterilization and other coercive attempts to prevent women living with HIV from having children underscore the importance of a human rights-based approach, including for family planning services.⁶³

NEW PARADIGMS, OPPORTUNITIES AND INNOVATIONS

The WHO guidelines on ARVs released in 2013⁶⁴ provide important opportunities to simplify and further scale up interventions among children and their mothers. They include recommendations in the following six areas:

- **Offering ART to all pregnant and breastfeeding women living with HIV, regardless of CD4 count,** to protect their health, protect their babies from HIV and protect their sexual partners from HIV. This approach emphasizes the importance of pregnant and breastfeeding women living with HIV beginning treatment without delay. It also reduces the risk of HIV transmission during breastfeeding as long as mothers continue to take ART. Simplifying ART for pregnant and breastfeeding women through the use of a standardized one-pill-daily, fixed-dose combination of three ARVs should also facilitate further decentralization and integration of HIV services to the primary-care level, including maternal and child health services.

260,000 new HIV infections occurred among children (0–14 years) in low- and middle-income countries in 2012.

62% of pregnant women living with HIV in 22 Global Plan priority countries received ARVs to prevent mother-to-child transmission in 2012.

34% of children (0–14 years) received the life-saving ART they needed in 2012 versus

64% of adults.

Without treatment, **one third** of infants living with HIV will die before their first birthday, and half will die before their second birthday.

Lifelong ART for pregnant women: Malawi blazes the trail



In 2011, the Government of Malawi pioneered offering lifelong simplified treatment for all pregnant and breastfeeding women (previously known as Option B+) using a provider-initiated (not mandatory) 'test and treat approach', regardless of CD4 count or any other preconditions. Children under 5 years of age are also prioritized in this way, without preconditions. For pregnant women living with HIV, simplified treatment, which consists of a fixed-dose, single-pill, triple-drug regimen taken once per day, was made widely available, including through lower-level health-care facilities. The number of pregnant and breastfeeding women living with HIV started on ART had increased from 1,257 in the second quarter of 2011, to 10,663 in the third quarter of 2012.⁶⁵ By June 2013, 13 of the 22 Global Plan priority countries had adopted the same policy of offering lifelong ART for all pregnant and breastfeeding women living with HIV, and Lesotho and Uganda (besides Malawi) had already started to implement the approach.

Further country progress details are available from the website of the Inter-Agency Task Team on the Prevention and Treatment of HIV Infection in Pregnant Women, Mothers and Children: www.emtct-iatt.org.

- **Harmonizing ARV drug regimens for pregnant and breastfeeding women, and other adults and adolescents, living with HIV:** Previous WHO guidelines recommended different adult ARV regimens for PMTCT and for treatment. The 2013 WHO guidelines on ARVs recommend the same, fixed-dose, single-pill, triple-drug regimen for all adults and adolescents as first-line therapy. This approach will simplify the delivery of ART for both treatment and prevention and enable pregnant women living with HIV to continue on the same drug regimen for their own health. The experience of Malawi suggests that the simplified regimen is easier to take and that it improves adherence, while also aligning PMTCT and ART services and promoting access to these services in primary-care facilities.⁶⁶
- **Expanding ART delivery in antenatal, maternal and child health settings:** The 2013 WHO guidelines on ARVs⁶⁷ include a specific recommendation that, in generalized epidemics, ART should be initiated and maintained in eligible pregnant and post-partum women and infants in maternal and child health-care settings, with linkage and referral to ongoing HIV care and ART where appropriate. Governments are responding by implementing task-shifting measures to enable midwives and other cadres to initiate and follow up on ART.⁶⁸
- **Making use of new technologies for infant testing:** Diagnostic technologies are now advancing rapidly. In the coming years, point-of-care virological tests for early infant diagnosis should become available, which will allow nurses and other non-physician health workers to test infants at lower-level health facilities, without the need to send samples to central laboratories for processing. This important advance should enable more timely identification of HIV-infected infants and promote more rapid linkage to treatment and care.
- **Recommending lifelong ART for all children under 5 years of age, regardless of CD4:** Infants and children are vulnerable to rapid progression of HIV-related disease. Left untreated, half of children born with HIV will die before their second birthday. In order to facilitate rapid

access to treatment for children diagnosed with HIV infection, the 2013 WHO ARV guidelines have recommended immediate treatment without the need for CD4 testing for children up to 5 years of age.⁶⁹

- **Addressing the needs of HIV-exposed but uninfected infants:** An increasing amount of evidence suggests that all children born to women living with HIV – whether the children are HIV-infected or not – have poorer health outcomes than children born to HIV-free mothers.⁷⁰ This evidence underscores the importance of early identification and linkage to care and treatment for pregnant women living with HIV. It also highlights the need for increased emphasis on early identification of all HIV-exposed children and linking these mothers and their children to care and support through a wide range of settings.

STRATEGIES TO ACCELERATE PROGRESS IN THE FIRST DECADE OF LIFE

To build upon the progress made in recent years and take advantage of new opportunities to address HIV among children in the first decade of childhood, the following 11 strategies need to be pursued:

1. Put the health of women at the centre of the response to HIV among children

The shift to provide ART to all pregnant and breastfeeding women living with HIV, regardless of CD4 count (previously known as Options B and B+), means that the past distinction between ARVs as prophylaxis to prevent HIV transmission to children and ART for the health of pregnant women is becoming obsolete. The 2013 WHO guidelines on ARVs⁷¹ and emerging practice in countries now

INITIATIVES

Innovation

Combined technology, treatment and programming innovations are expanding access to HIV services and increasing the speed of service delivery – and such improvements are often more cost-effective than before. They include:

- SMS technology, delivering test results and reminders to patients in Malawi and Zambia 📍
- Point-of-care machines and communication technology in decentralized settings, speeding up diagnoses in Eastern and Southern Africa (supported by UNITAID, the Clinton Health Access Initiative and UNICEF) 📍
- ‘Telemedicine’, a decentralized approach to HIV testing, treatment and care in India (supported by the MAC AIDS Fund and UNICEF). 📍



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strongly support the integration of PMTCT and ART programmes by emphasizing that HIV outcomes in children are inextricably linked to the health of their mothers. Furthermore, increasing evidence of poorer health outcomes for infants born to mothers living with HIV, regardless of the HIV status of the infants, points to the importance of early treatment for women living with HIV to protect their own health and that of their babies. The provision of ARV prophylaxis only during pregnancy and breastfeeding for women living with HIV with higher CD4 counts (the approach previously known as Option A) is no longer recommended by WHO and should be phased out as soon as possible.

2. Prevent mother-to-child transmission among women from key populations

Outside sub-Saharan Africa, the majority of cases of mother-to-child transmission are occurring among key populations, including women who inject drugs and female partners of men who inject drugs, sex workers, female partners of men who also have sex with men, and other marginalized groups such as women in prisons. For example, in Ukraine, where the epidemic is driven by injecting drug use, a study in 2010 showed mother-to-child transmission rates of 11 per cent in women who injected drugs versus 6 per cent in women who did not.⁷² Scaling up harm reduction programmes and integration with sexual and reproductive health and maternal and child health services has led to substantial increases in coverage of HIV testing and ART for pregnant women injecting drugs. To achieve elimination of mother-to-child transmission in this population wherever they may live, further action is needed to ensure early access to services that can address both

drug dependency and HIV-related issues, including provision of medication-assisted substitution treatment for women with opioid drug dependence.⁷³

Women represent 5–10 per cent of the over 30 million people in prisons each year, but this proportion is increasing and women in prisons are at higher risk for HIV than their male counterparts.⁷⁴ Women can be pregnant, give birth and breastfeed while in prison and other closed settings. The isolation of prison health services from general health services and the substandard conditions and services, including HIV and reproductive health services, means access to PMTCT can be limited. It should be a priority for countries to include populations in closed settings in their efforts to prevent transmission of HIV through comprehensive services equivalent to those in the community.

3. Integrate TB prevention, diagnosis and treatment as a core component of the PMTCT package of care in high TB prevalence settings

Active tuberculosis (TB) has been diagnosed at rates up to 10 times higher in pregnant women living with HIV than in women without HIV infection.⁷⁵ There is also increasing evidence to show that untreated TB in pregnant women living with HIV is associated with a higher risk of poor obstetric and perinatal outcomes, including the death of both the infant and mother. TB in pregnant women living with HIV is also associated with more than double the risk of transmission of HIV to the unborn child.⁷⁶ It is therefore vital that collaborative TB/HIV activities be incorporated as part of the package of care at all stages of pregnancy and neonatal, post-partum and post-natal care, particularly in high HIV and TB burden settings. The inclusion of regular TB symptom screening, as recommended by WHO, will help ensure early diagnosis and treatment of TB and also identify women who do not have active TB and are eligible for isoniazid preventive TB therapy.⁷⁷ Should full integration of TB diagnostic, prevention and treatment services in maternal, newborn and child health services not be possible, effective patient-centred referral mechanisms with TB services need to be established.

4. Accelerate the introduction of new technologies for diagnostics and medicines

Implementing the 2013 WHO guidelines on ARVs⁷⁸ should be a priority for countries in order to streamline PMTCT and ART programming and simplify the provision and procurement of ARVs.

Improved ARV formulations for children under the age of 3 years, such as 'sprinkles', are likely to be available in the near future and will need to be scaled up to help overcome the current limitations of paediatric HIV treatment. More effort is also needed to develop ART regimens that could be harmonized for use by infants and older children as well as adolescents and adults, such as scored dispersible fixed-dose combinations.

Introducing new technologies that enable point-of-care virological testing for early infant diagnosis should also be a high priority. Innovations in the use of mobile phone technology are increasing efficiency by providing appointment reminders and health information and reducing turnaround time for laboratory results.

5. Decentralize and integrate family-centred HIV services, including task shifting

In many countries ART services are provided at locations separate from those where maternal and

child health, family planning and other sexual and reproductive health services are provided. Improved integration of these services, including by decentralizing HIV testing, treatment and care to the primary-care level, is essential to strengthen the continuum of HIV care for women and children.

WHO recommends task shifting as a critical tool to allow decentralization of treatment and care, and comparable clinical outcomes can be achieved when appropriate training and supervision are provided to non-physician health-care providers. Task shifting and task sharing are important strategies to optimize human resource capacity in settings with weak health systems.⁷⁹

In particular, the initiation and maintenance of ARVs in women and children living with HIV in maternal and child health settings should contribute to increased access to treatment at the level of primary care and reduce loss to follow-up of women and children diagnosed with HIV in these settings.⁸⁰

Integration through non-traditional channels such as the employment sector increasingly offers opportunities to reach more women through their participation in the workforce. With the wider backing of the International Labour Organization's Convention No. 183 on maternity protection, 57 countries have national HIV workplace policies providing a potential platform to facilitate PMTCT and other HIV-related services.⁸¹

INITIATIVES

Integrating PMTCT with maternal and child health services



In Rwanda, the integration of the national PMTCT programme into the country's existing maternal and child health services has helped ensure that virtually all women receive their test results and doubled the proportion of HIV-exposed infants receiving ARV prophylaxis. Studies in some areas show that this figure increased from 47 per cent in 2007 to 96 per cent in 2011. Male involvement increased as well.⁸²

In South Africa, where HIV testing was linked to an immunization programme, mothers involved in the programme reported feeling comfortable with having their infants tested at immunization clinics, and most would recommend it to others.⁸³



6. Align programming for all HIV-exposed children with broader efforts to promote child survival, growth and development

Major progress in reducing maternal and child mortality has been made in the past 20 years: Between 1990 and 2010, maternal mortality in sub-Saharan Africa dropped by 41 per cent,⁸⁴ and between 1990 and 2012, the under-five mortality rate declined by 47 per cent.⁸⁵ The *Countdown to 2015: Accountability for Maternal, Newborn and Child Survival* report launched in 2013 recognized that HIV cannot be ignored in making progress on maternal mortality.⁸⁶ The continuing global drive for accelerated and improved maternal and child survival – through routine child immunization programmes and initiatives such as *Committing to Child Survival: A Promise Renewed* – provides opportunities to create new entry points to HIV testing and enhanced care for both HIV-infected and uninfected children born to women living with HIV, especially in high HIV burden settings.

Weaknesses in systems and services can mean that even where the effective course of action is clear, the intervention may not reach the child in time. Research has shown that mortality in children diagnosed with HIV can be reduced by 67 per cent with cotrimoxazole – an antibiotic – as prophylaxis, yet

coverage in low- and middle-income countries is low (44 per cent).⁸⁷ Eastern and Southern Africa reported coverage of 56 per cent, and CEE/CIS reported 69 per cent in 2012; however, all other regions report very low coverage (3–43 per cent).⁸⁸ Better integration and decentralization of such simple interventions as part of the broader management of childhood illness can significantly improve child health outcomes.⁸⁹

Provider-initiated HIV testing also needs to be more widely available in other services for children, such as routine immunization and early child health or nutrition programmes, as well as community-based and health facility-based services for infants. These services can play an especially important role in identifying children whose mothers did not access antenatal and PMTCT services during pregnancy.

7. Strengthen linkages between HIV programming and national social welfare and community-based support systems

HIV has broad social and economic consequences for children and their families, but orphans and vulnerable children, including those living in families affected by HIV, frequently do not receive any type of support.⁹⁰ Mitigating the impact of HIV on the estimated 17.8 million (16.1 million–21.6 million) of the world's children who have lost one or both parents to AIDS⁹¹ – 85 per cent of whom live in sub-Saharan Africa⁹² – is a particularly formidable task.

While comprehensive social support for children and families affected by HIV is an essential element of the response to HIV, it is frequently an afterthought in many HIV-specific programmes. Stronger linkages between HIV programming and broader national social protection efforts and community-based services are needed to ensure that more children and families receive the support they need. Such social protection programmes, particularly cash transfers, appear to be rapidly expanding, with some estimates suggesting they have doubled in Africa – from

120 programmes implemented between 2000 and 2009 to about 245 programmes in 2012 – with an estimated US\$10 billion supporting cash transfer programmes in 2012 alone.⁹³

Social protection has already proven to have an impact not only in support for children and families already affected by HIV, but also in preventing HIV and improving treatment and care outcomes.⁹⁴ The opportunity exists now to tailor these programmes to include HIV-affected populations, extending the support they offer to include transportation to clinics, nutrition support, cash transfers for poor households, psychosocial support and palliative care services.

In Zambia, the inclusion of early childhood development in the Education Sector Plan (2012–2015) seeks to expand access to schooling and improve educational quality and equity, especially for orphans and vulnerable children and children affected by HIV and AIDS.⁹⁵

In India, mechanisms are being put in place to reduce out-of-pocket expenses for people affected by HIV and support access to primary health care, including through call centres coordinating free and low-cost transport.⁹⁶

Community- and faith-based services have a long tradition of providing HIV-related (health, social and economic) services in rural and remote areas. In Malawi, for example, case management performed by community health workers has resulted in improved retention in care and higher utilization of antenatal and post-natal services for mother-baby pairs. While these approaches have not been brought to scale in many settings,⁹⁷ their value is increasingly recognized, especially in rural areas. However, over-reliance on volunteers cannot adequately compensate for a lack of government infrastructure and services. Building effective and sustainable community systems requires human and financial resources, and partnerships between community members and the health, social welfare, child protection, legal and political systems.

8. Reinforce safer breastfeeding efforts and messaging

The 2013 WHO guidelines on ARVs emphasize that the risk of post-natal HIV transmission through breastfeeding will be minimized as countries transition towards offering ART to all pregnant women living with HIV, as long as they continue on treatment without any lapses. Women who are breastfeeding should do so exclusively – giving their infants only breast milk, without any other kind of food or liquid, up to 6 months of age.⁹⁸ Women need to be supported in doing this, and these messages should be reinforced in all breastfeeding programming.

9. Strengthen primary HIV prevention and family planning services

Every new HIV infection in a child also represents a failure of primary HIV prevention for women and girls. Pregnant women may be at increased risk of HIV acquisition and transmission, and rates of sero-conversion (the development of antibodies) during pregnancy can be significant, particularly in high HIV prevalence settings. Comprehensive HIV prevention programming for women and girls, including pregnant women in antenatal care, needs to be reinforced.



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The target of halving new HIV infections among women of reproductive age is integral to the overall goal of eliminating new HIV infections among children by 2015 and keeping their mothers alive.

It is estimated that if the unmet need for family planning among women living with HIV was addressed in the 22 countries with the highest burden of HIV, there would be 61,000 fewer children with HIV in 2015 alone.⁹⁹ Rights-based, non-coercive family planning for women living with HIV needs to become more widely available, particularly through

under-utilized entry points, such as maternal and child health and sexual and reproductive health services, in addition to primary health-care services.

10. Address stigma and discrimination, including through strong community engagement

Women living with HIV may face a complex mix of stigma and gender-based inequities, including judgemental attitudes among health-care providers. The challenges may be even greater for young

BOX

Comprehensive HIV prevention and family planning for women and girls

It has been estimated that deploying comprehensive PMTCT could avert nearly 80 per cent of child HIV infections by 2015 in 25 high HIV burden countries.¹⁰⁰ Effective delivery of ARVs to pregnant women living with HIV would account for 60 per cent of averted infections among their infants. Reducing new HIV infections in women of reproductive age and responding to unmet need for family planning would account for 13 per cent, while another 6 per cent would be attributable to limiting the duration of breastfeeding to 12 months.¹⁰¹

Couples testing and counselling is also an important intervention for strengthening HIV prevention, including by making ART available to sero-discordant couples (in which one partner is HIV-positive and the other is not). In 2013, WHO recommended offering ART to all people living with HIV in sero-discordant relationships. Studies suggest that providing HIV testing and counselling for both partners together can result in reduced new infections among such couples.¹⁰² In some locations in Rwanda, rates of HIV testing of male partners during antenatal care are now over 80 per cent.¹⁰³

women, women living with disabilities, mothers or pregnant women who inject drugs, and women and their accompanying children in prisons. In addition to the challenge of discrimination from service providers, these women may have fears regarding child custody. Fear of disclosing their own status may inhibit mothers from enrolling children in HIV treatment programmes, especially when there is an obligation to consult other family members about health-care decisions.¹⁰⁴

Community engagement is a key approach to tackling HIV-related stigma and discrimination while providing support to children and families living with HIV. An eight-country analysis found that in nearly all settings, community-driven advocacy helps identify and publicize obstacles to HIV treatment access, addresses stigma and discrimination, and promotes human rights and changes to obstructive and discriminatory laws and practices.¹⁰⁵ Leadership at all levels is essential to promote law reform and put in place supportive policies that contribute to an enabling environment for the response to HIV among women and children.

11. Expand the knowledge base through research, monitoring and evaluation

As the new approaches described in this section are scaled up, operational research is essential to guide implementation, especially to identify best practices for the delivery of HIV interventions for women and children in primary-care and community-based settings, and to optimize synergies between HIV programming and child and social protection efforts. Answering questions regarding overall transmission rates and the impact of HIV-related programming on maternal and infant morbidity and mortality should be high priorities, along with continuing research on the safety of lifelong ART for pregnant and breastfeeding women. Clinical research can also lead to expanding the range of available interventions for women and children, including improved paediatric treatment options, microbicides and vaccines.

Strengthening monitoring and evaluation will require more focused data-driven planning and analysis of results with equity in mind. Multi-partner support will be not only desirable, but a prerequisite for achieving results that combine to serve the most disadvantaged and excluded. More effective monitoring and evaluation of programmes at the primary health-care level will also help local decision makers improve programme performance. For example, bottleneck analyses were conducted in each of the 22 Global Plan priority countries to identify specific entry points for improvements and to inform costed EMTCT plans for each country. This is a good example of how partnerships and tailored tools can add value and accelerate the pace of progress.



CHAPTER 2

RESPONDING TO HIV IN THE **SECOND** **DECADE** OF LIFE

New infections among adolescents could be halved by 2020 by scaling up high-impact interventions and working across sectors.





THE SECOND DECADE: TRANSITION AND VULNERABILITY

A good start in life has a clear influence on later development. And adolescence provides an opportunity to reinforce health, nutrition and education bases, and the social and economic drivers that contribute to a healthy and productive adult life.

Numbering an estimated 1.2 billion globally, adolescents (aged 10–19 years) comprise almost one fifth of the world’s population.¹⁰⁶ Almost a quarter of all adolescents live in sub-Saharan Africa, and the number of adolescents in that region is expected to double by 2050.¹⁰⁷

Adolescence is recognized as a period of life involving significant physical, physiological and psychological changes that mark the transition to

adulthood. This is also the period of life when social and gender roles are reinforced, and adolescents face increasing pressure to assume adult roles and responsibilities, often before they are physically and psychologically mature. Healthy passage through the second decade of life is profoundly dependent on effective education, health care, support, protection and nurturing from family, peers and communities.

As adolescents experience the many social and economic pressures that come with transitioning to adulthood, they can become especially vulnerable to HIV. They may become sexually active or begin to experiment with drugs and alcohol, which puts them at risk. But very often adolescents do not perceive themselves as vulnerable to HIV.

Approximately 2.1 million (1.7 million–2.8 million) adolescents were estimated to be living with HIV

FIGURE 2.1

Estimated number of adolescents aged 10–19 living with HIV, by country, and male/female percentages, by UNICEF region, 2012
Total adolescents: 2.1 million (1.7 million–2.8 million). Females: 1.2 million; males: 930,000

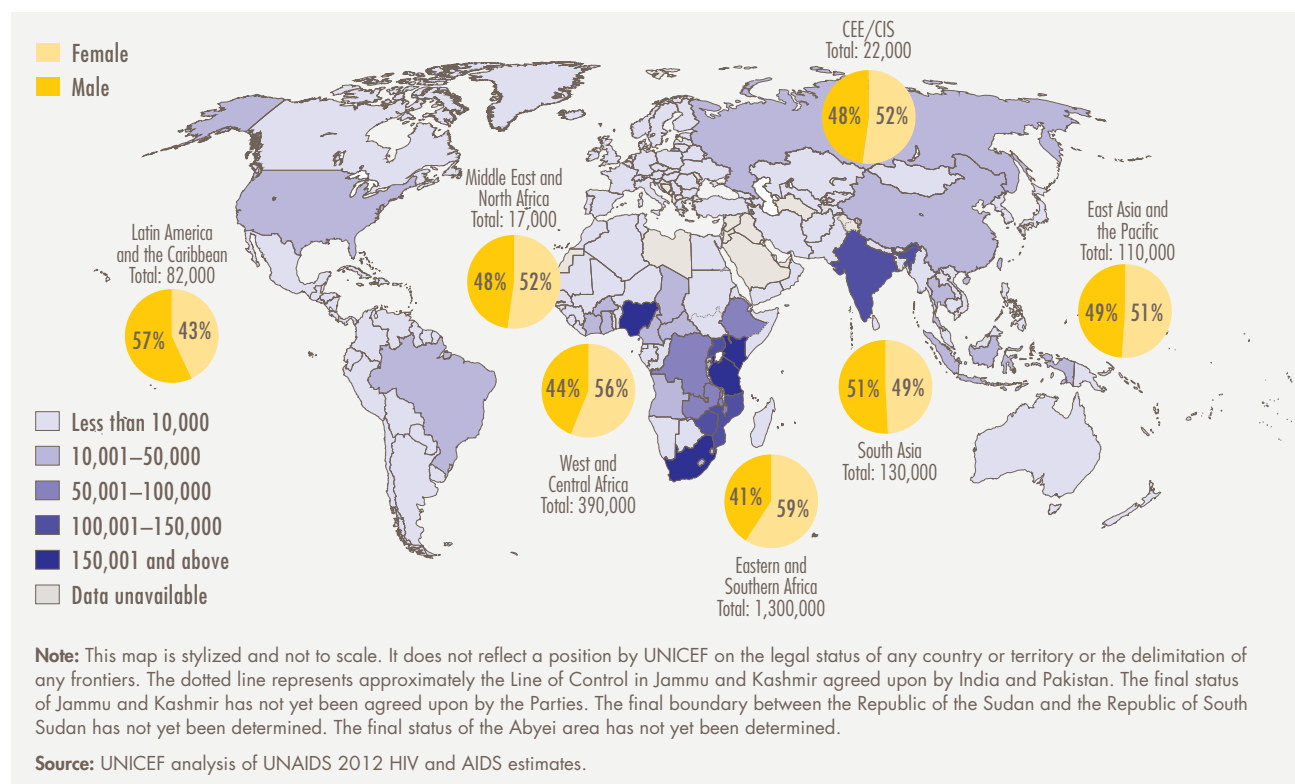
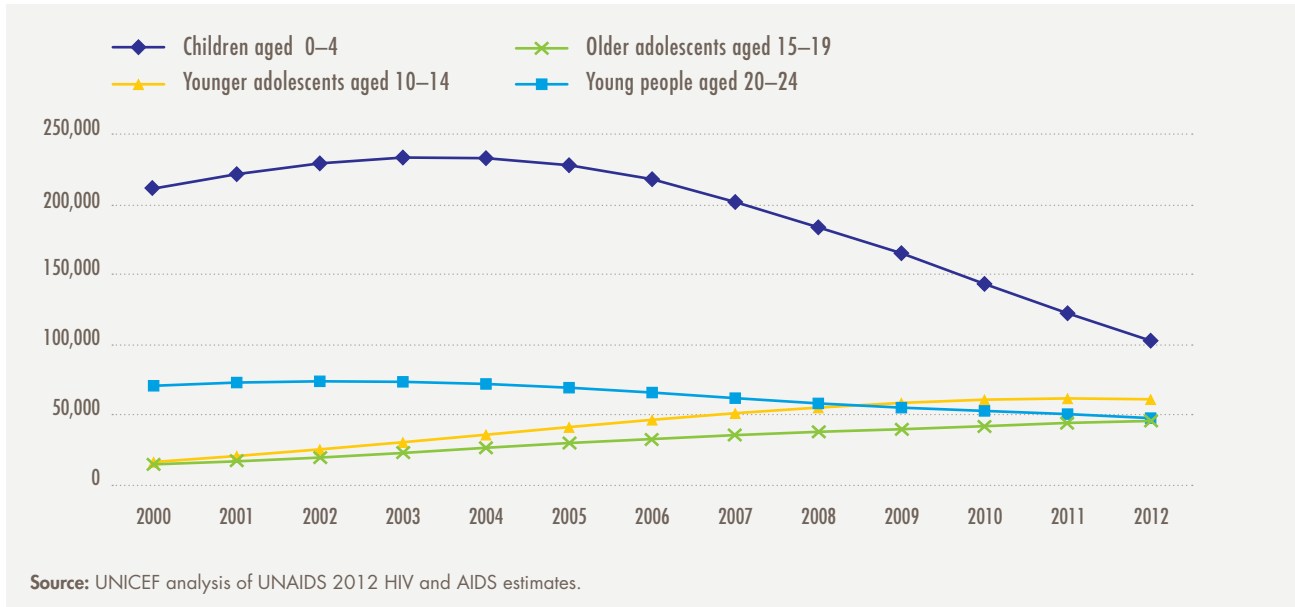


FIGURE 2.2

Estimated number of AIDS-related deaths among children aged 0–4, younger adolescents aged 10–14, older adolescents aged 15–19 and young people aged 20–24, 2000–2012



globally in 2012, more than 80 per cent of them in sub-Saharan Africa (see Figure 2.1). While the number of global AIDS-related deaths for all ages fell by 30 per cent between 2005 and 2012, among adolescents they increased by 50 per cent in that period (see Figure 2.2).¹⁰⁸

While declines in new infections among infants have been marked, due to progress in preventing mother-to-child HIV transmission, the decline in new infections among adolescents has been much more modest. In 2012, about one third of all new infections occurred among young people aged 15–24 years (780,000; (670,000–960,000). Of these, about 300,000 (250,000–390,000) were among adolescents aged 15–19 years (see Figure 2.3).¹⁰⁹

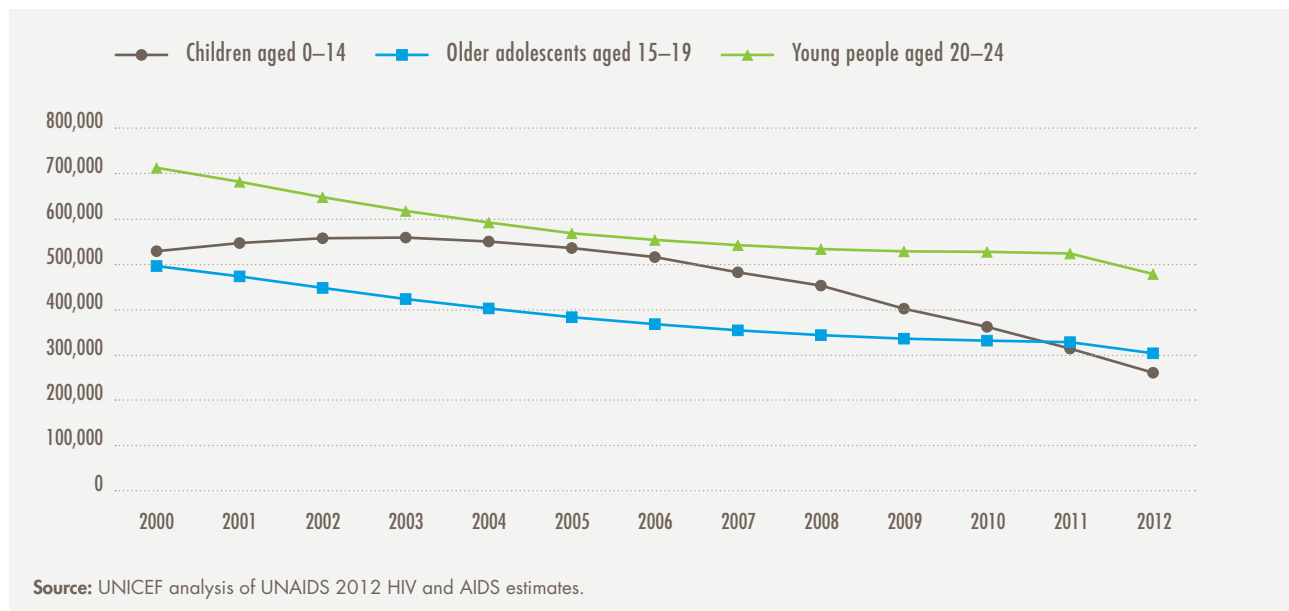
Recent data suggest that behaviour change among these age groups is making a difference, although not as quickly as is needed. Globally, boys tend to report higher condom use than girls. In sub-Saharan Africa, only about one in three adolescent girls (15–19 years) who reported multiple partners in

the last 12 months reported using a condom at last sex.¹¹⁰ Although still at low levels, condom usage has increased in most regions, while the number of sexual partners among adolescents aged 15–19 years has decreased and adolescents have been initiating sexual activity at a later age than in the past.¹¹¹ CEE/CIS appears to depart from this trend. Recent studies in several countries of this region suggest that the age of initiation of sexual activity is decreasing, with the median age of first sex being 15–17 years or below among adolescents.¹¹²

Voluntary medical male circumcision (VMMC) is supported by compelling evidence from three separate clinical trials that demonstrated a 60 per cent reduction in the risk of female-to-male sexual transmission of HIV.¹¹³ WHO and UNAIDS recommendations emphasize that male circumcision should be considered an effective intervention for HIV prevention in countries with high HIV burden and low male circumcision prevalence.¹¹⁴ Some of the 14 priority countries in Africa meeting these criteria are beginning to show results.¹¹⁵ There is evidence in Kenya that

FIGURE 2.3

Estimated number of new HIV infections among children aged 0–14, adolescents aged 15–19 and young people aged 20–24, 2000–2012



programmes have had much greater success in reaching males younger than 25 years.¹¹⁶ Shifting social norms will be key to accelerating progress in cultures that do not practice male circumcision.

According to UNAIDS, 3.2 million African men had been circumcised through specific services for

VMMC. Although the cumulative number of men circumcised in 2012 was nearly double what it was in 2011 (1.5 million), the target of 20 million men circumcised by 2015 is unlikely to be met.¹¹⁷

Countries in sub-Saharan Africa are now considering expanding early infant male circumcision as a

BOX**Adolescent girls and HIV¹¹⁸**

40% of women who sell sex in North America, East Asia and South Asia began to do so before the age of 18.ⁱ

In 3 countries in Africa, more than **80%** of the adolescents aged 15–19 years who were newly infected with HIV in 2012 were girls: South Africa (82%), Sierra Leone (85%), Gabon (89%).

In South Asia, comprehensive knowledge of HIV is low – **17%** only for girls and **34%** for boys aged 15–19 years.ⁱⁱ

In 35 countries, more than **one third** of women aged 20–24 were married or in union by the age of 18.ⁱⁱⁱ

More than **15 million** adolescent girls between the ages of 15 and 19 give birth every year.^{iv}

strategy for HIV prevention in the long term. UNICEF and partners are assessing early experiences of delivering early infant medical male circumcision using maternal, newborn and child health platforms that may lead to an expansion of this intervention in high HIV prevalence countries.

Adolescents face many barriers to accessing health and support services, and they are routinely neglected in national and global AIDS strategies. This must change. Without increased attention to the needs of adolescents, an AIDS-free generation cannot be achieved.

INEQUITIES AND BARRIERS TO SERVICES

Three broad groups of adolescents face major barriers accessing prevention, treatment and care interventions: adolescent girls, adolescent key populations and adolescents living with HIV. The core vulnerability of these groups lies in structural, socio-economic and gender inequality, including failures in child protection and social protection. This can be exacerbated where providers lack skills or are unwilling to work with at-risk and vulnerable adolescents, which too often results in limiting their access to accurate information and the services they need.

Social and economic inequities drive HIV in adolescent girls

In 2012, approximately two thirds of new HIV infections in adolescents aged 15–19 years were among girls, mainly in sub-Saharan Africa.¹¹⁹ In three countries in this region more than 80 per cent of the adolescents aged 15–19 years who were newly infected with HIV in 2012 were adolescent girls – South Africa (82 per cent female), Sierra Leone (85 per cent female) and Gabon (89 per cent female).¹²⁰

Social and economic inequalities play a marked role in the vulnerability of adolescent girls and the disproportionate levels of HIV among them. Low social status, household poverty and food insecurity, poor-quality education and violence all limit opportunities for girls. The death of caregivers and the caregiving role that is so often assumed by women and girls can be limiting. The promise of gifts and other financial and social benefits, including the potential for upward social mobility, can affect early sexual debut and motivate girls to engage in age-disparate sexual relationships, transactional sex or marriage at a young age. Where HIV prevalence is high, these factors combine with increased biological vulnerability, limited knowledge about HIV and low risk perception to enhance the risks and limit the choices girls and their families make.¹²¹

1 in 5 women globally has had a child by the age of 18.^v

In UNICEF's Eastern and Southern Africa region, **29%** of females and **20%** of males aged 15–19 years have ever tested for HIV and received their results.^{vi}

An estimated **210,000** children under 15 died from AIDS-related illnesses in 2012.

150 million girls and **73 million** boys under the age of 18 have experienced sexual violence.^{vii}

In sub-Saharan Africa, where HIV prevalence is high, **13%** of girls and **9%** of boys aged 15–19 years reported sexual debut before the age of 15. Slightly higher rates are reported for adolescent girls in West and Central Africa (16%).^{viii}



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Key populations: Excluded, stigmatized and criminalized

Worldwide, disproportionately high HIV prevalence is reported among adolescent males who have sex with males, adolescents who inject drugs and sexually exploited adolescents.¹²² In one of the few reports on the subject, more than 95 per cent of new HIV infections in adolescents in Asia and the Pacific were reported to occur in adolescents belonging to 'key populations' – people whose behaviours put them at considerable risk of HIV infection and whose young age renders them particularly vulnerable.¹²³ In selected countries in Asia, the limited data available suggest that over 60 per cent of young key populations initiate sexual activity early in life (by 15–19 years old) and that HIV testing is low.¹²⁴

Prevention programmes in Asia have been credited with containing HIV transmission resulting from sexual exploitation and commercial sex, although hot spots of concern persist.¹²⁵ However, HIV transmission during unprotected sex between males appears to be an increasingly powerful driver of the epidemics in several countries. Where HIV incidence among men who have sex with men has been measured, it has been found to be very high. HIV prevalence exceeding 10 per cent has been found in cities in China,¹²⁶ India,¹²⁷ Thailand¹²⁸ and Viet Nam.¹²⁹ Epidemics driven by unprotected sex between males also predominate in the smaller Pacific nations, but HIV prevalence there is still low. Studies tend to be limited in scope and may include, but are not limited to, young men.

Sharing contaminated injection equipment is an extremely efficient mode of HIV transmission, and the risk of infection increases dramatically the longer injecting continues. In a 2012 survey in

Myanmar, HIV prevalence was 7 per cent among 15–19-year-olds injected drugs, and more than double that (15 per cent) among 20–24-year-olds.¹³⁰ Studies suggest that injecting drug use accounts for more than two thirds of all new infections in Iran, 40 per cent of new infections in Eastern Europe and more than one third in the Philippines.¹³¹ In Pakistan, where injecting drug use is a key driver of the epidemic, studies indicate HIV prevalence more than tripled, from 11 per cent in 2005 to 38 per cent in 2011.¹³² Emerging evidence from Eastern Europe suggests that a small but important proportion of injecting drug use begins during adolescence.¹³³

In addition to the factors that increase vulnerability for all adolescents, the vulnerability of adolescents in these key populations is profoundly compounded by severe social stigma, as well as harsh legal and policy settings and law enforcement practices that criminalize their behaviours and foster discrimination and violence, thereby hindering access to the few health services and other HIV prevention, treatment, protection, care and support interventions that target the needs of these populations.

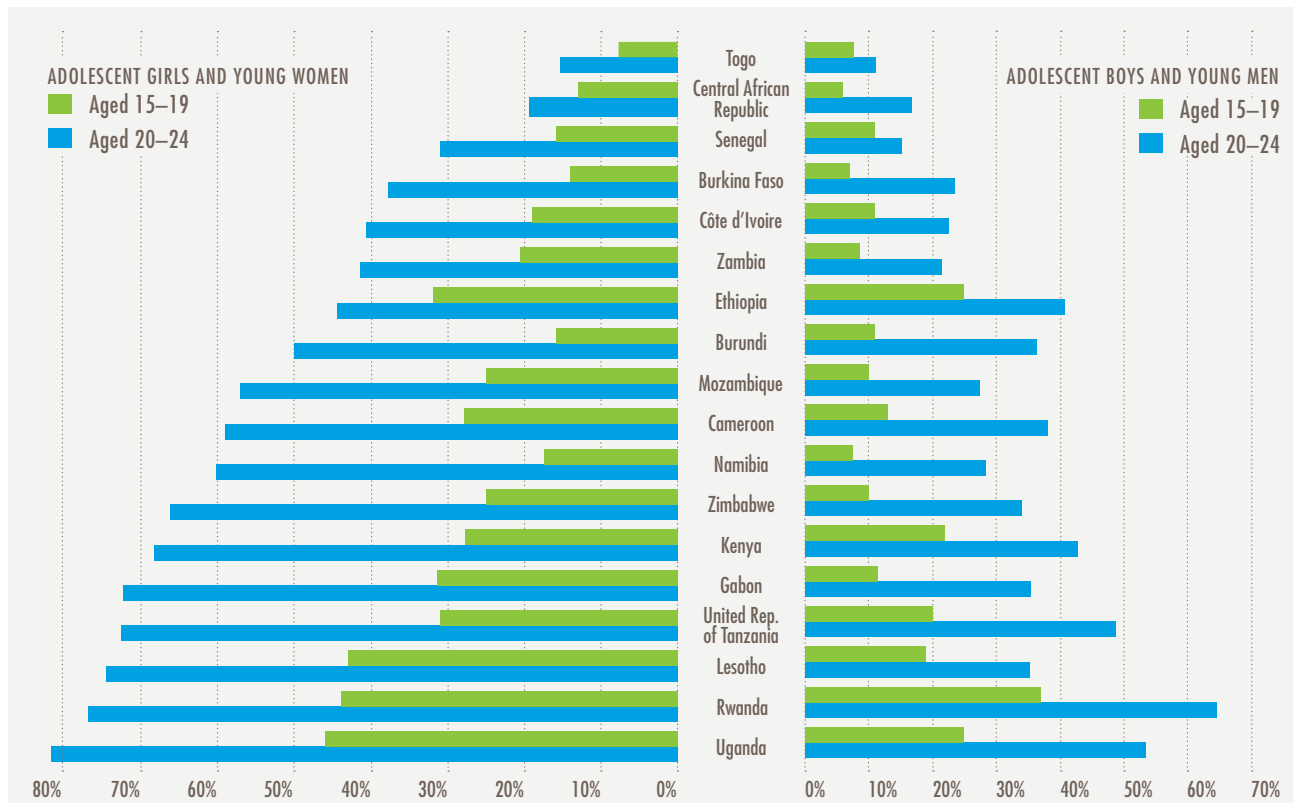
Adolescents living with HIV: Shut out from testing, treatment and care

Coverage of HIV testing and counselling is low among adolescents and especially low among key populations in most parts of the world. While access and coverage vary greatly by country, survey data from 2008 to 2012 in sub-Saharan Africa indicated that fewer than one in five adolescent girls aged 15–19 years were aware of their HIV status (see *Figure 2.4*).¹³⁴ Guidance that testing should be strictly voluntary is clear. However, there are reports that testing of key populations in some settings is mandatory or coerced, and this is of great concern.¹³⁵

Only a small proportion of adolescents who are long-term survivors born with HIV have access to ART, and most receive it through limited numbers of specialized centres in urban and peri-urban settings.¹³⁶ Retention rates are also poor.

FIGURE 2.4

Percentage of adolescent girls and boys aged 15–19 and young women and men aged 20–24 who have ever been tested for HIV and received results, in selected sub-Saharan African countries



Note: Countries were selected on the basis of data availability.

Source: UNICEF global databases, 2013, based on Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS) and other national surveys, 2006–2012.



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In general, HIV programmes struggle to reach and retain adolescents, and incentives to attract adolescents to services are rare. On the contrary, age-of-consent laws frequently limit access to testing and other interventions, leading to delayed diagnosis of HIV in adolescents and late entry to care in many countries.¹³⁷ A lack of adolescent-friendly services plays an important role in the poorer ART treatment outcomes for adolescents than for adults receiving ART.¹³⁸

Providing lifelong treatment to adolescents, who may not be adequately served by either paediatric or adult HIV treatment programmes, presents unique challenges. Whether they acquired HIV as infants, due to mother-to-child transmission, or later, through sexual transmission or injecting drug use, poor adherence to ART and questions surrounding disclosure of their HIV status are key issues for this age group.¹³⁹ In some cases, adolescents may not know that they are living with HIV, although they may have been diagnosed and may even be on treatment. For

adolescents who were infected through mother-to-child transmission, a parent's concerns about revealing her or his own HIV status can affect the decision to tell the adolescent. Navigating sexuality as it unfolds is challenging for most adolescents, but to also be living with HIV adds additional complexity and potential consequences. Aggravating all of these scenarios is stigma.

STRATEGIES TO ACCELERATE PROGRESS IN THE SECOND DECADE OF LIFE

Opportunities for greater success in reducing the impact of HIV on adolescents lie in increasing demand for, access to and uptake of key interventions, while also addressing the social and economic factors that heighten adolescents' vulnerability to HIV and limit their access to the services they need. The following five strategies present opportunities for greater impact among adolescents:

INITIATIVES

Finding persuasive ways to engage adolescents



When UNICEF, MTV and the United States President's Emergency Plan for AIDS Relief (PEPFAR) joined forces to find persuasive ways to engage adolescents and young people on how to protect themselves from HIV and AIDS, they chose one of the world's oldest delivery systems: a compelling story. *Shuga*, a video and radio drama series that follows young people in both urban and rural settings in Africa as they go about their daily lives navigating the challenge of HIV risk, soon became the basis for a multimedia HIV-prevention campaign.

Launched on TV in Kenya in 2009, by 2012 *Shuga* had been joined by *Shuga: Love, Sex, Money*, a radio series heard in six countries – Cameroon, the Democratic Republic of the Congo, Kenya, Lesotho, South Africa and the United Republic of Tanzania – with a collective audience of young people estimated at 45 million.

The *Shuga* radio series has already had an impact on health-seeking behaviours among the young. While it was being broadcast in the Democratic Republic of the Congo, for instance, eight selected government and NGO-funded HIV testing and counselling sites in Kinshasa, the largest urban area, were monitored. Data collected over 12 months showed that the number of adolescents and young people aged 10–24 receiving voluntary HIV testing and counselling increased 50 per cent following the launch of the *Shuga* radio series and its related magazines.



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1. Scale up HIV testing and counselling for adolescents and strengthen linkages to prevention, treatment, care and support

Scaling up HIV testing and counselling services for adolescents through a variety of testing modalities – such as mobile HIV testing and other forms of outreach, community-based approaches and provider-initiated testing and counselling – is essential to addressing late diagnosis and late entry to care. There are encouraging signs that countries are reviewing laws related to age of consent for HIV testing to enable adolescents to come forward. In Ukraine in 2010, a parental consent law governing age of consent for HIV testing was lowered from 18 to 14 years, and in Bosnia and Herzegovina, the age when adolescents can independently provide consent to HIV testing or seek HIV prevention and care services

has been lowered from 18 to 15. Belarus has lowered the age to 16 years, with further consideration being given to lowering it to 14 years. Simultaneously, existing care and treatment services must be strengthened to ensure that adolescents manage the transition from paediatric to adult services, adhere to medications and are retained in lifelong care.

The 2013 WHO guidelines on HIV testing and counselling and care for adolescents living with HIV propose a comprehensive range of strategies for scaling up HIV testing and counselling for adolescents and strengthening linkages to care.¹⁴⁰ They include the recommendation that HIV testing and counselling with linkages to prevention, treatment and care be offered to adolescents from key populations in concentrated or low epidemic settings, and to all adolescents in generalized epidemic settings.



Tailoring high-impact interventions to adolescents most in need

The health sector has a particular responsibility to make services more adolescent-friendly. Paediatric and adult HIV treatment providers need to work together more closely to help adolescents transition between these services and to link them to long-term treatment, care and support in appropriate settings, such as primary-care and community-based services.

Many adolescent girls learn their HIV status through testing linked to a pregnancy. Integrating PMTCT into maternal and child health services is therefore essential to the well-being of adolescent girls living with HIV, particularly as countries move towards offering lifelong treatment for all pregnant women living with HIV. Sexual and reproductive health services are important to help prevent unplanned pregnancies among adolescent girls, and they are also an important platform for the integration of PMTCT programming. However, more attention is needed to address the quality and acceptability of HIV-related care for adolescent clients in these settings.

Initiatives such as the introduction of vaccination for the human papillomavirus (HPV) targeting adolescent girls aged 9–13 in schools and community settings provide an opportunity for integration with other sexual and reproductive health interventions for adolescents.

Key populations face discrimination, violence and a wide range of barriers to accessing health services. Efforts are needed to address low levels of awareness and negative attitudes about these groups among service providers in health facilities. Community outreach and localized interventions, including targeted approaches to raise awareness and demand for services, are likely to be more effective and more acceptable to these groups. For instance, Child Helpline International, a phone-in counselling and referral service operational in more than 140 countries, supports children and adolescents from a wide range of backgrounds and situations, including key populations, on a range of health and social issues.¹⁴¹ While the information and referral it provides are critical, the non-judgemental contact is a service in itself.

2. Scale up high-impact interventions based on an investment approach and tailor them to the needs of adolescents at highest risk

The UNAIDS Investment Approach proposes focusing HIV investments on six high-impact interventions: condoms, medical male circumcision, targeted prevention for key populations, PMTCT, ART and behaviour change communications.¹⁴² Investments in these high-impact interventions should be balanced with investments in social and programmatic ‘critical enablers’ to enhance outcomes and in synergistic development activities that can have an effect on

the structural drivers of HIV vulnerability. Innovative approaches that increase demand for interventions and allow for tailoring them effectively to the unique needs and cultural contexts of adolescents are needed.

National AIDS Spending Assessment reports compiled by UNAIDS in high-burden countries suggest that overall investment in HIV prevention for adolescents should be more systematic and sustained over time.¹⁴³ New modelling by UNICEF and Futures Institute to assess the impact of the UNAIDS Investment Approach on adolescents shows that substantial gains can be achieved by increasing spending for this age group in a targeted manner.¹⁴⁴

Four scenarios were modelled (see Figure 2.5). Scenario 1 is the base scenario and assumes constant coverage for prevention and treatment through 2020; Scenario 2 is the ideal investment approach and assumes scale-up of services through 2015; Scenario 3 is the delayed investment approach and assumes that coverage targets will be achieved – but with a five-year delay (i.e., not until 2020); and Scenario 4 is the poor implementation scenario, or low investment approach, and assumes lower-than-ideal coverage targets, achievement of targets delayed until 2020 and low intervention impact.

The modelling shows that Scenario 2 (the ideal investment approach) could avert 2 million new adolescent infections by 2020, half the number of new infections that would occur in adolescents if country investment and programme focus remained unchanged between 2011 and 2020. In addition, it would reduce the population of adolescents living with HIV from approximately 2.1 million in 2011 to about 1.6 million in 2020. The majority of infections averted would be among females.¹⁴⁵

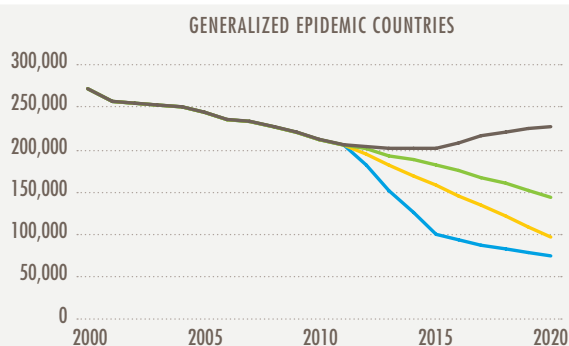
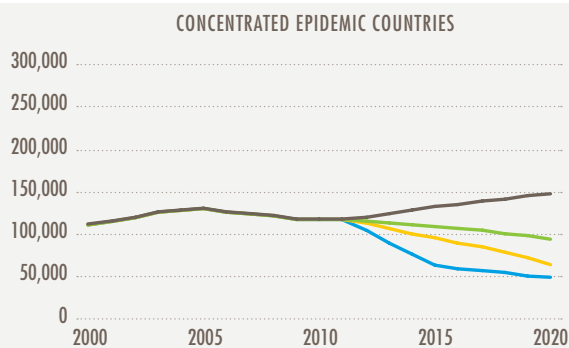
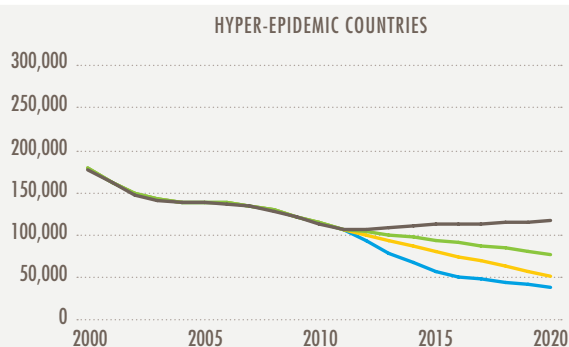
An effective, adolescent-specific HIV response based on the investment approach would account for approximately one quarter of any total global AIDS resource need. Achieving this optimal investment level would involve increasing adolescent HIV funding in low- and middle-income countries from slightly more than US\$3.8 billion in 2010 to almost US\$5.5 billion by 2014. After 2015, reductions in new infections would somewhat reduce the overall funding need.

In addition to the urgent need to scale up high-impact interventions, the modelling suggests that programming for adolescents requires a stronger emphasis on critical enablers and development synergies than programming for adults. Key development synergies for adolescents would come from the education, child protection, social protection, justice and health sectors. Following Scenario 2, it is estimated that 25 per cent of the resources would need to be allocated for high-impact interventions, 50 per cent for critical enablers and 25 per cent for development synergies.

FIGURE 2.5

Projected number of new HIV infections among adolescents aged 10–19 by epidemic type, 2000–2020

- Scenario 1 (base): Base projection with constant coverage of all interventions
- Scenario 2 (ideal): All countries scale up services to reach target levels by 2015
- Scenario 3 (delayed): Countries do not achieve coverage targets until 2020
- Scenario 4 (low): Countries do not invest adequately in adolescent interventions



Source: UNICEF and Futures Institute, 'The Impact and Cost of the HIV/AIDS Investment Framework for Adolescents' (unpublished document).

As progress is made, the allocation would shift to 33 per cent, 25 per cent and 40 per cent, respectively, by 2020.

Scenario 3 of the modelling, the delayed investment approach, suggests that a five-year delay in implementation would reduce impact by one third. Poor implementation, Scenario 4, would result in little decline in the annual number of new infections. Striving for the ideal outcomes of Scenario 2 will require strong leadership and sustained political commitment to more effective and efficient responses for adolescents as a priority.

3. Address root causes of HIV vulnerability through critical enablers of high-impact HIV services and synergies with development sectors

The UNAIDS Investment Approach emphasizes the importance of addressing critical enablers and engaging and investing strategically across the development sectors in order to support and sustain HIV-specific investments. These activities can help to reduce the legal, social and economic drivers of adolescent vulnerability to HIV, and they need to be included in national plans and other strategies alongside the high-impact interventions.

Critical enablers are activities that optimize the delivery of high-impact, HIV-specific, basic programme activities.¹⁴⁶ They include implementing laws and policies to protect human rights and engaging communities in service delivery and demand creation. Key critical enablers for adolescents include activities that enhance child rights consistent with the Convention on the Rights of the Child and its Optional Protocols, that promote equality and strengthen laws and law enforcement practices to reduce stigma and discrimination and that enhance access to services for key populations. The interests of other marginalized groups, such as indigenous, minority or immigrant communities, or children and adolescents living with disabilities or

in institutions or criminal justice settings, can also be served by attention to critical programme enablers. Strategies to promote gender equality are essential to the fight against HIV in adolescents.

Social norms can promote educational advancement, social engagement and employment, but they can also limit opportunities for adolescents to thrive and reach their full potential. Sexual violence, often a manifestation of gender-related power imbalances, is directly linked with HIV risk. Research also shows a correlation between childhood experiences of violence and later risk behaviours associated with the acquisition of HIV.¹⁴⁷ Intimate partner violence is also associated with HIV risk.¹⁴⁸ A recent global review found that women who had experienced intimate partner violence were 50 per cent more likely to have acquired HIV than women who had not experienced such violence.¹⁴⁹ Social norms also shape the strategies that girls choose – or that families impose – for coping with poverty, early marriage and transactional sex.

Human rights-based approaches are essential to preventing HIV among adolescents from key population groups. These include decriminalization of homosexuality and emphasizing a public health – rather than criminal justice – approach to illicit drug use, including through harm reduction programmes. Collaboration between the criminal justice and public health sectors is crucial to supporting the rights of adolescents who are sexually exploited.

Development synergies are defined as investments across sectors that can have a positive effect on HIV outcomes.¹⁵⁰ For adolescents, the child protection, social protection and education sectors present specific, key opportunities to leverage HIV results more effectively.

Economic vulnerability and food insecurity are both causes and consequences of negative outcomes related to HIV and sexual and reproductive health for adolescents. Social protection programmes provide

opportunities to address some of the economic drivers of vulnerability to HIV for children, including adolescents. Cash transfers, food, transport allowances and other microcredit and savings programmes have been effective in mitigating the impact of HIV on children and families affected by HIV, and in reducing HIV-related risk.¹⁵¹ Impacts include better negotiation skills, increased condom use, a reduction in the number of sexual partners, delayed sexual debut in girls and increased uptake of testing, as well as improved school attendance.¹⁵² Rather than concentrating efforts in one sector or another, an integrated

approach is needed to improve health and social outcomes for adolescents.

Education has sometimes been described as a 'social vaccine', particularly for girls, and there are associations between increased educational access and reductions in early marriage and pregnancy.¹⁵³ While schools offer a key platform for the HIV response in many countries,¹⁵⁴ education systems have not fulfilled their potential to equip adolescents with the knowledge and skills or the linkages to services that could help them reduce their risk of acquiring HIV.

INITIATIVES

Education: A critical part of the enabling environment



The Global School-based Student Health Surveys conducted by WHO with school-aged children in more than 51 countries to date show that initiation of sexual behaviour commonly happens during adolescence.¹⁵⁵ While school-based programmes alone are not sufficient to prevent new HIV infections and related risks, they can be a cost-effective way to influence vulnerability.¹⁵⁶

Research suggests that HIV education programmes delivered through schools have the potential to influence determinants of behaviour, children and young peoples' social networks and, over time, their socio-economic status.¹⁵⁷ Attending school is also related to increased self-confidence that can enhance children's ability to protect themselves, as seen in programmes in South Africa and Uganda. Furthermore, increasing access to and retention in schooling helps prevent HIV infection; this is especially evident for girls, orphans and other vulnerable children.¹⁵⁸

The United Nations Educational, Scientific and Cultural Organization (UNESCO) and other UNAIDS co-sponsors conducted a review of more than 87 studies globally on the impact of sexuality education programmes.¹⁵⁹ More than a third of the programmes reviewed resulted in delayed initiation of sexual intercourse; about a third decreased the frequency of sexual intercourse; and more than a third decreased the number of sexual partners, either among the entire sample or in important sub-samples. While some programmes had little or no effect, notably, none of the programmes hastened the initiation of sexual intercourse.

The UNAIDS Inter-Agency Task Team on Education's Accelerate Initiative, led by the World Bank and technical partners such as the Partnership for Child Development, has supported national government efforts in 37 sub-Saharan African countries,¹⁶⁰ and after more than a decade, in 2010, reached an important benchmark: all of its countries had national school health policies, with 76 per cent of them working from education-specific HIV strategies and plans.¹⁶¹

By 2012, an in-depth analysis of 39 countries around the world showed that 74 per cent of them had included a response to HIV in both education management and planning processes at the national level.¹⁶²

Advocacy tools and further information on this initiative are available at: www.schoolsandhealth.org.

In addition, schools, already faced with the challenges of keeping adolescents from dropping out, have typically lacked the policies, trained staff and necessary engagement with parents and communities to provide sexual and reproductive health education that is of high quality, age-appropriate and gender-sensitive. UNESCO, UNICEF, UNAIDS, WHO and other partners have called for stronger, practical linkages across sectors to provide sexual and reproductive health education that addresses a number of related issues, including harmful social and gender norms, HIV prevention and prevention of adolescent pregnancy.

4. Increase demand for sexual and reproductive health and HIV-related services by engaging and empowering adolescents

The Convention on the Rights of the Child recognizes the evolving capacities of children in the first and second decades of life and endorses the principle that children should participate in decisions affecting them, in accordance with their evolving capacities. These sentiments are echoed in a number of forums and are repeated in Health in the Post-2015 Agenda: Report of the Global Thematic Consultation on Health, which states that “adolescents are the next generation of adults and will have a major influence on the achievement of the post-2015 agenda. Empowering adolescents in their health development, including healthy sexual and reproductive health practices ... will enable them to enter adulthood with stronger overall capabilities, better equipped to make informed choices for themselves and their communities.”¹⁶³

From both a rights and a public health perspective, programmes are more effective when the intended beneficiaries participate in their design, implementation and evaluation. All adolescent programming, as well as activities to support critical enablers and development synergies, needs to more actively engage and empower adolescents as

BOX

Political Declaration on HIV and AIDS: United Nations General Assembly, 2011

The United Nations General Assembly’s 2011 Political Declaration on HIV and AIDS calls on countries to “reaffirm the central role of the family, bearing in mind that in different cultural, social and political systems various forms of the family exist, in reducing vulnerability to HIV, inter alia in educating and guiding children, and take account of cultural, religious and ethical factors to reduce the vulnerability of children and young people by ensuring access of both girls and boys to primary and secondary education, including HIV and AIDS in curricula for adolescents, ensuring safe and secure environments, especially for young girls, expanding good quality youth-friendly information and sexual health education and counselling services, strengthening reproductive and sexual health programmes, and involving families and young people in planning, implementing and evaluating HIV and AIDS prevention and care programmes.”¹⁶⁴

full participants in the response to HIV. In 2012, the Bali Global Youth Forum Declaration placed special emphasis on marginalized and vulnerable groups and on creating an enabling environment for their meaningful participation, in addition to a call for stronger partnership.¹⁶⁵

All over the world, various forms of media are having a huge impact on social norms, particularly for adolescents. Across health and development sectors, new linkages and partnerships are needed to capitalize on the appeal of media to adolescents, particularly social media platforms. Technology and social media offer great potential for engaging adolescents and empowering them in ways that will support HIV prevention and treatment objectives.

5. Improve data and strategic information to inform programming, including disaggregation by age, sex and risk behaviours

Because of ethical issues concerning research with children, most countries do not capture comparable data for the 10–14 year age group, and data on key populations of adolescents are even more difficult to obtain. Similarly, even where they exist, data from service delivery sites are not always disaggregated by adolescent age groups, data collection methods and indicators vary, and the standardization needed to compare data across countries is lacking.

Age-, sex- and risk-disaggregated strategic information is urgently needed in order to capitalize on the approaches described in this chapter and respond more effectively to the needs of adolescents. Planning for the scale-up of adolescent ART, for example, requires an accurate, disaggregated estimate of the number of adolescents eligible for treatment, based on the latest WHO guidelines, as well as actual coverage data from services and accurate estimates of the costs of services and commodities. Similar estimates need to be generated

for the numbers of adolescent key populations and other core interventions. This requires epidemiological, programmatic and operational research to make service delivery as effective and acceptable for as many adolescent communities as possible.

SUSTAINING THE GAINS ACHIEVED IN THE FIRST DECADE OF LIFE

As the international community reflects on the gains made in the first decade of life – increasing coverage of interventions to address HIV among infants and their mothers, and significant results from broader investments in child survival, growth and development – it cannot continue to neglect the crucial second decade of life. As adolescents navigate the transition to adulthood, they face unique challenges that are profoundly linked to their social and economic vulnerability, unwelcoming health services and the risks associated with HIV that can only be met through effective inter-sectoral approaches. A new commitment to addressing the challenges of the second decade of life is needed, so that all children – infants, young children and adolescents alike – have the opportunity to become healthy, secure and productive adults.



CHAPTER 3

PARTNERSHIPS FOR AN AIDS-FREE GENERATION

An AIDS-free generation will be achieved only with strong leadership from government and strong participation from civil society.





TWO DECADES, MANY SECTORS

Shaping and driving the HIV response for children is not the responsibility of any one actor. Working across the first two decades of life with strong partnerships within and between sectors has never been more critical.

An AIDS-free generation will be achieved only with strong leadership from government, particularly national AIDS commissions and ministries of health, as well as parliamentarians, law enforcement authorities and child protection agencies. It requires the active involvement of other ministries (such as finance, social welfare, education and youth) and local government, and strong participation from civil society, including non-governmental,

faith-based and community-based organizations. Working with affected communities, including people living with HIV, women, young people and their advocates, these partnerships will be central not only to implementation but also to advocacy, awareness raising and shared accountability. At the local level, community compacts and charters are useful mechanisms.

Regional bodies have been very active in most parts of the world, and regional initiatives have introduced new ways of doing business. For instance, the Laços Sul-Sul (South-South Ties) initiative has a strong human rights focus, uniting eight participant countries (Bolivia, Brazil, Cabo Verde, Guinea-Bissau, Nicaragua, Paraguay, Sao Tome and Principe, and Timor-Leste) towards the goal of halting the



This report reminds us that an AIDS-free generation is one in which all children are born free of HIV and remain so – from birth and throughout their lives – and it means access to treatment for all children living with HIV. It also reminds us that women’s health and well-being should be at the centre of the AIDS response. I have no doubt that we will achieve these goals. The well-being of children does not end with stopping AIDS, but includes protecting children from the factors that make them vulnerable, such as poverty, discrimination and social marginalization, and violations of their human rights, including sexual violations. HIV is fuelled by a variety of factors that are acute during childhood and adolescence, and children need information and opportunities to allow them the best possible start in life.”

Michel Sidibé, Executive Director, UNAIDS

AIDS epidemic by sharing information, strategies and action plans, and fostering solidarity. In Africa a new Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria in Africa was endorsed at the 19th Summit of the African Union in 2012. Developed by the African Union Commission and the New Partnership for Africa's Development (NEPAD) Planning and Coordinating Agency, the roadmap is structured around three strategic pillars – health governance, diversified financing and access to medicines. It offers a set of practical and African-owned solutions to enhance sustainable responses to AIDS, TB and Malaria, with goals, expected results, roles and responsibilities to hold stakeholders accountable over a three-year time frame, through 2015; and it emphasizes finding new partnerships, new financing arrangements and new ways to strengthen sustainable African institutions.

At the international level, reporting requirements often provide the most powerful advocacy material. At all levels, transparency around data and financing can help to create and sustain commitments and shared responsibility. Ongoing commitment from key partners such as the Global Fund and PEPFAR, and

strengthened domestic allocations for programming, will be central to future success, as will expanded partnership with health-care providers, researchers and the private sector, all of whom have critical roles to play.

All UNAIDS co-sponsoring agencies, spanning multiple sectors, have significant responsibilities across the first and second decades, both in directly supporting the implementation of high-impact interventions and in helping to create enabling legal, social and economic environments for children and their families.

Several interagency task teams (IATTs) are operational to support progress in countries.¹⁶⁶ These task teams consist of UNAIDS co-sponsor organizations as well as policy and technical partner organizations.

The Interagency Task Team on the Prevention and Treatment of HIV Infection in Pregnant Women, Mothers and Children¹⁶⁷ plays a leading role in supporting country-led implementation of the Global Plan. The core mandate of the group is to coordinate technical assistance, develop and disseminate

BOX

Global Commission on HIV and the Law

In its *Risks, Rights and Health* report, the Global Commission on HIV and the Law, facilitated by the United Nations Development Programme (UNDP), calls for the removal of discriminatory laws, policies and practices affecting people living with HIV and for the promotion of laws grounded in human rights and backed by evidence. The report, released in 2012, outlines how laws that protect human rights save lives, save money and lead to effective HIV responses. The report includes specific recommendations for children and adolescents. Responding to this call entails helping countries implement laws that prohibit discrimination against children affected by AIDS at school, at home and in their communities; promote appropriate family-centred care models for children orphaned by AIDS; promote access to comprehensive sexuality health education for children in and out of school; and ensure that sexually active young people have confidential and independent access to health services. Working with a range of partners, UNICEF helps countries align this work with their reporting obligations as States Parties to the Convention on the Rights of the Child.¹⁶⁸

[Risks, Rights and Health, Global Commission on HIV and the Law, July 2012, <www.hivlawcommission.org> and <www.undp.org>.](#)



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guidance and tools, and track progress towards the targets of the Global Plan. While the Global Plan is chaired by UNAIDS and PEPFAR, the IATT is co-convened by UNICEF and WHO. Established in 1998, it comprises 32 multilateral, government and non-governmental organizations working towards strengthening global, regional and national partnerships and programmes that address the survival of pregnant women, mothers and children living with HIV.

ADDRESSING HIV AMONG CHILDREN IN EMERGENCY SITUATIONS: A CASE FOR ENHANCED PARTNERSHIP

In 2012, children younger than 18 years constituted 46 per cent of the 45.2 million people who were forcibly displaced worldwide as a result of persecution, conflict, generalized violence and human rights violations. Over the past decade, this proportion has ranged from a low of 41 per cent in 2009 to a high of 50 per cent in 2004.¹⁶⁹

As social structures break down in emergency and humanitarian situations, food insecurity, violence, sexual assault, poverty and issues related to protection exacerbate existing risks and vulnerabilities to

HIV, particularly for adolescent girls and women. In many emergency settings, substantial challenges also exist in sustaining access to information – such as health records – and health services, including ART, PMTCT and maternal and child health services. Ensuring continuity of ARVs and other commodities in unstable situations is of peak concern, as are efforts to sustain HIV prevention, including access to condoms and post-exposure prophylaxis. Given the uncertainty of the duration of most emergencies and the propensity for protracted humanitarian situations, HIV prevention, treatment and care for both younger children and adolescents should be included in emergency risk assessment, preparedness and training from the very beginning.

Disruptions in HIV treatment are a clear risk in emergency situations. In Mozambique, for example, flooding in Gaza Province in early 2013 left more than 12,000 people at risk of losing access to treatment.¹⁷⁰ As a result of the flooding, health centres closed and stocks of medication were ruined; transportation routes became inaccessible, initially resulting in a temporary shortage of commodities such as ARVs, post-exposure prophylaxis kits and condoms. Through partnerships between government ministries – including the National Institute of Disaster Management, the Ministry of Health, the National AIDS Commission, NGOs and United Nations agencies – routine services were restored. Looking to the future, specific training sessions are being carried out in the two provinces with the highest risk of natural disasters and a high HIV burden (Gaza and Zambezia), and contingency plans are being developed to prepare the government and partners for an adequate HIV response in future emergencies.

The recent escalation of conflict in the Central African Republic, resulting in insecurity, violence, looting and robberies, is the latest in a series of crises that have affected the country since the mid-1990s. Since early 2013, tens of thousands of people have fled into the bush or been further displaced. Several hospitals and health posts have been looted and many have been abandoned. Displacement and disruption of health

Adolescents and HIV in emergencies

Emergency situations can both increase the factors that make young people vulnerable to HIV and disrupt vital HIV prevention, treatment and care services.

Although Haiti and Côte d'Ivoire are thousands of miles apart and faced emergencies with very different causes – one geological, the other political – a retrospective analysis of these two emergencies found that the outcomes for adolescents and young people were virtually the same. Among the lessons learned were the necessity of:

- ensuring a focus on adolescents when directing interventions, and including younger adolescent girls
- involving adolescents and youth as participants in interventions, to ensure that their ideas and perspectives are given adequate consideration
- understanding the ways in which emergencies increase the factors that make young people vulnerable to HIV.

The analysis underscores the urgency of putting interventions for adolescents in place long before actual emergencies occur. Preparation is crucial; without it, countries risk rushing to catch up to the needs of adolescents and young people amid the challenges of an emergency setting.

services has left many people living with HIV without access to ARVs. Before the recent crisis, up to 15,000 people living with HIV were on ART and an estimated further 50,000 eligible for treatment could not be covered. The number of patients whose antiretroviral therapy was interrupted by the crisis has been estimated in the thousands by the Comité national de lutte contre le SIDA. A well-coordinated response

by humanitarian and health actors is under way to retrace patients lost to ART and ensure the provision of the minimum package for HIV as outlined by the Inter-Agency Standing Committee's (IASC) *Guidelines for HIV Interventions in Humanitarian Settings*.¹⁷¹

TOWARDS AN AIDS-FREE GENERATION: ADDRESSING GAPS, SUSTAINING GAINS

Children did not feature prominently on the global AIDS agenda in 2001 when the MDGs were established and the first United Nations General Assembly Special Session on HIV/AIDS was held. Both of those events have since served as a major driver of change, leading to the creation of the Global Fund and PEPFAR and an extraordinary global effort to mount a more effective response to the HIV pandemic. Significant gains have been made in reducing new infections among infants and keeping their mothers alive and healthy. However, similar dynamism must be applied to narrow the persistent gaps in programmes for orphans and vulnerable children, in care and treatment for children and adolescents, and in wider adolescent programming.

This report describes the substantial challenges that persist in addressing HIV among children, as well as important new opportunities to tackle them. As the international community begins to coalesce around a new development agenda beyond 2015, an enhanced response to HIV among children can help to serve as a driver of further gains and more effective collaborations in child rights, health, survival and development.

The path to an AIDS-free generation is clear. If it is to be successfully travelled, the world must now strongly commit to sustaining the hard-won gains and to addressing the remaining inequities and gaps in the response to HIV for children.

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ANNEX: STATISTICAL TABLES

NOTES ON THE DATA

Data sources and compilation

The data and analyses presented in this *Sixth Stocktaking Report* are derived from information in UNICEF global databases that are compiled from various sources. These include nationally representative data collected from household surveys – e.g., Demographic and Health Surveys, Multiple Indicator Cluster Surveys and Reproductive Health Surveys; national programme service statistics collected annually by UNAIDS, UNICEF and WHO through the Global AIDS Response Progress Reporting (GARPR) process: country estimates of HIV care and treatment needs modelled by UNAIDS and WHO in collaboration with countries; and the United Nations Population Division country estimates of the number of annual births.

In 2013, UNAIDS, UNICEF and WHO collected HIV coverage data from national programmes worldwide, through the 2013 GARPR process, a reporting tool used to monitor and report on their national progress towards HIV and AIDS goals and targets. The tool typically comprises indicators to track progress towards universal access to HIV prevention, treatment and care, including HIV interventions for women and children such as preventing mother-to-child transmission and paediatric HIV care. The tool also collated updated household survey data on HIV knowledge and sexual behaviour. The GARPR replaces the Joint Reporting Tool on the health-sector response to HIV and AIDS and collected HIV programme data for the 12-month period of January–December 2013.

Estimates on HIV care and treatment needs of children and pregnant women

In 2013, UNAIDS and WHO refined the HIV and AIDS estimation methodology to reflect more reliable data available from population-based surveys, expanded national sentinel surveillance systems and programme service statistics in a number of countries. As a result, UNAIDS has retrospectively generated new estimates for HIV prevalence, numbers of people living with HIV, paediatric HIV treatment needs and children

whose parents have died due to all causes or AIDS for past years based on the refined methodology.

To achieve consistency and establish a comparative measurement of progress, trend analyses must be recalculated using only the newly generated estimates.

Similarly, global estimates of the number of children in need of antiretroviral therapy and the number of pregnant women living with HIV have been refined, and the coverage rates for 2005–2011 have thus been recalculated using the newly generated estimates. These estimates included the most recent country-reported data from 2012. The methods and assumptions of the UNAIDS and WHO estimation model continue to evolve and are regularly updated as new data become available.

As a result, the estimated proportion of children (aged 0–14) who received antiretroviral therapy in 2012 is 34 per cent. It is not very different from the estimated coverage published in previous stocktaking reports. Any change in estimated coverage is not related to an increase or a decrease in the number of children in need of antiretroviral therapy receiving treatment, but to changes in the estimation methodology and in coverage of key HIV and AIDS programme interventions, particularly PMTCT. In light of these changes, 2012 coverage rates should not be compared with coverage figures published in previous versions of progress reports including the same data. For this reason, all estimates of paediatric antiretroviral therapy and antiretrovirals for PMTCT for previous years have been back-calculated for this year's report.

Overall, the differences between the newly generated estimates and previously published estimates are not related to trends over time, and are therefore not comparable. Nor are other revised estimates comparable to estimates published in previous years. Trends over time may be assessed, however, using new UNAIDS methodological revisions applied retrospectively to earlier HIV and AIDS data.

More details about the data, reporting by specific countries and the methodology for HIV estimates can be found at www.unaids.org.

TABLE 1

Elimination of new HIV infections among children by 2015 and keeping their mothers alive

Countries and areas	Estimated HIV prevalence (%) among adults (aged 15–49), 2012	Antenatal care coverage – at least one visit (%), 2008–2012*	Annual number of births (thousands), 2012	Estimated number of pregnant women living with HIV, 2012			Reported number of pregnant women living with HIV who received ARVs for PMTCT, 2012	Estimated percentage of pregnant women living with HIV who received ARVs for PMTCT, 2012		
				Estimate	Low estimate	High estimate		Estimate	Low estimate	High estimate
Afghanistan	<0.1	48	1,053	–	<100	<1,000	7	–	1	10
Albania	–	97	40	–	–	–	1	–	–	–
Algeria	–	89 x	946	–	–	–	–	–	–	–
Andorra	–	–	–	–	–	–	–	–	–	–
Angola	2.3	80 x	934	15,000	12,000	19,000	2,656	17	14	22
Antigua and Barbuda	–	100	1	–	–	–	–	–	–	–
Argentina	0.4	99 x	695	–	1,400	2,400	1,612	–	63	>95
Armenia	0.2	99	41	–	<100	<100	13	–	22	>95
Australia	–	98	305	–	<100	<200	–	–	–	–
Austria	–	–	80	–	<100	<200	–	–	–	–
Azerbaijan	0.2	77 x	168	–	<100	<100	35	–	37	75
Bahamas	–	98 x	6	–	–	–	–	–	–	–
Bahrain	–	100 x	20	–	–	–	–	–	–	–
Bangladesh	<0.1	55	3,150	–	<100	1,400	16	–	4	>95
Barbados	–	100 x	4	–	<100	<100	–	–	–	–
Belarus	0.4	100	103	–	<200	<500	203	–	83	>95
Belgium	–	–	129	–	<200	<500	–	–	–	–
Belize	1.4	96	8	–	<100	<100	40	–	44	60
Benin	1.1	86	371	3,400	2,900	4,000	1,349	40	34	47
Bhutan	0.2	97	15	–	<100	<100	9	–	32	>95
Bolivia (Plurinational State of)	0.3	86	273	–	<200	<1,000	163	–	21	72
Bosnia and Herzegovina	–	87	34	–	–	–	1	–	–	–
Botswana	23.0	94 x	48	13,000	11,000	14,000	12,207	>95	86	>95
Brazil	–	98	3,009	–	3,900	5,300	7,641	–	>95	>95
Brunei Darussalam	–	99	7	–	–	–	–	–	–	–
Bulgaria	–	–	70	–	<100	<100	–	–	–	–
Burkina Faso	1.0	94	683	5,400	4,400	6,700	3,582	66	53	81
Burundi	1.3	99	443	5,100	3,900	6,500	2,742	54	41	69
Cabo Verde	0.2	98 x	10	–	<100	<100	244	–	>95	>95
Cambodia	0.8	89	386	–	<1,000	2,300	1,058	–	61	>95
Cameroon	4.5	85	820	27,000	23,000	31,000	17,362	64	56	73
Canada	–	100 x	391	–	<200	<500	–	–	–	–
Central African Republic	–	68	156	–	–	–	–	–	–	–
Chad	2.7	53	579	12,000	10,000	16,000	1,680	14	11	18
Chile	0.4	–	246	–	<100	<500	–	–	–	–
China	–	94	18,455	–	–	–	–	–	–	–
Colombia	0.5	97	912	–	1,400	2,800	854	–	30	59
Comoros	2.1	92	26	–	<200	<500	–	–	1	2
Congo	2.8	93	165	3,100	2,700	3,500	579	19	17	22
Cook Islands	–	100	–	–	–	–	–	–	–	–
Costa Rica	0.3	90	74	–	–	–	37	–	–	–
Côte d'Ivoire	3.2	91	731	20,000	16,000	24,000	13,294	68	55	84
Croatia	–	–	41	–	<100	<100	–	–	–	–
Cuba	<0.1	100	108	–	<100	<100	106	–	>95	>95
Cyprus	–	99 x	13	–	–	–	–	–	–	–
Czech Republic	–	–	118	–	<100	<100	–	–	–	–
Democratic People's Republic of Korea	–	100	356	–	–	–	–	–	–	–
Democratic Republic of the Congo	1.1	89	2,839	32,000	28,000	37,000	4,176	13	11	15
Denmark	–	–	64	–	<100	<100	–	–	–	–
Djibouti	1.2	92 x	24	<500	<500	<500	63	20	15	26
Dominica	–	100	–	–	–	–	–	–	–	–
Dominican Republic	0.7	99 x	218	–	<1,000	1,200	1,300	–	>95	>95
Ecuador	0.6	84 x	328	–	<500	1,200	550	–	60	>95
Egypt	<0.1	74	1,898	–	<100	<200	9	–	6	15
El Salvador	0.6	94	128	–	<500	<1,000	166	–	23	81
Equatorial Guinea	–	86 x	26	–	<1,000	2,600	–	–	–	–
Eritrea	0.7	70 x	230	<1,000	<500	<1,000	291	46	34	69
Estonia	–	–	14	–	<100	<200	–	–	–	–
Ethiopia	1.3	43	3,084	38,000	32,000	46,000	15,828	41	35	49
Fiji	0.2	100	18	–	<100	<100	14	–	71	>95

Elimination of new HIV infections among children by 2015 and keeping their mothers alive

Countries and areas	Estimated HIV prevalence (%) among adults (aged 15–49), 2012	Antenatal care coverage – at least one visit (%), 2008–2012*	Annual number of births (thousands), 2012	Estimated number of pregnant women living with HIV, 2012			Reported number of pregnant women living with HIV who received ARVs for PMTCT, 2012	Estimated percentage of pregnant women living with HIV who received ARVs for PMTCT, 2012		
				Estimate	Low estimate	High estimate		Estimate	Low estimate	High estimate
Finland	–	100 x	61	–	<100	<100	–	–	–	–
France	–	100 x	792	–	<1,000	1,700	–	–	–	–
Gabon	4.0	95	53	1,500	1,300	1,900	1,064	70	57	87
Gambia	1.3	98	77	–	<1,000	1,300	1,068	–	80	>95
Georgia	0.3	98	59	–	<100	<100	24	–	36	79
Germany	–	100 x	699	–	<500	<500	–	–	–	–
Ghana	1.4	96	794	9,500	7,800	11,000	8,957	95	77	>95
Greece	–	–	110	–	<100	<100	–	–	–	–
Grenada	–	100 x	2	–	–	–	13	–	–	–
Guatemala	0.7	93	474	–	1,000	4,600	252	–	8	36
Guinea	1.7	85	428	6,300	5,000	8,000	2,755	44	34	55
Guinea-Bissau	3.9	93	63	2,200	1,600	3,100	738	33	25	46
Guyana	1.3	92	16	–	<100	<500	152	–	48	>95
Haiti	2.1	90	265	5,000	4,200	5,700	4,889	>95	85	>95
Holy See	–	–	–	–	–	–	–	–	–	–
Honduras	0.5	97	208	–	<500	<1000	238	–	37	60
Hungary	–	–	98	–	<100	<100	–	–	–	–
Iceland	–	–	5	–	<100	<100	–	–	–	–
India	0.3	74 x	25,642	–	27,000	49,000	–	–	–	–
Indonesia	0.4	96	4,736	–	8,100	20,000	1,048	–	5	13
Iran (Islamic Republic of)	0.2	97	1,454	–	<500	1,100	115	–	11	27
Iraq	–	78	1,037	–	–	–	–	–	–	–
Ireland	–	100 x	71	–	<100	<200	–	–	–	–
Israel	–	–	156	–	<100	<500	–	–	–	–
Italy	–	99 x	563	–	<200	<500	–	–	–	–
Jamaica	1.7	99	50	–	<500	<500	295	–	61	>95
Japan	–	–	1,071	–	<100	<100	–	–	–	–
Jordan	–	99	192	–	–	–	–	–	–	–
Kazakhstan	–	99	340	–	–	–	302	–	–	–
Kenya	6.1	92	1,535	86,000	76,000	97,000	45,397	53	47	60
Kiribati	–	88	2	–	–	–	–	–	–	–
Kuwait	–	100 x	67	–	–	–	–	–	–	–
Kyrgyzstan	0.3	97	148	–	<100	<200	111	–	64	>95
Lao People's Democratic Republic	0.3	54	181	–	<500	<500	49	–	13	19
Latvia	–	92 x	23	–	<100	<200	–	–	–	–
Lebanon	–	96 x	62	–	–	–	5	–	–	–
Lesotho	23.1	92	57	16,000	14,000	17,000	9,153	58	52	64
Liberia	0.9	79 x	150	<1,000	<1,000	1,300	850	87	69	>95
Libya	–	93 x	130	–	–	–	34	–	–	–
Liechtenstein	–	–	–	–	–	–	–	–	–	–
Lithuania	–	100 x	34	–	<100	<100	–	–	–	–
Luxembourg	–	–	6	–	<100	<100	–	–	–	–
Madagascar	0.5	86	781	–	2,100	3,100	77	–	2	4
Malawi	10.8	95	639	68,000	61,000	75,000	40,770	60	54	67
Malaysia	0.4	97	516	–	<500	<1,000	342	–	48	>95
Maldives	<0.1	99	8	–	<100	<100	–	–	–	–
Mali	0.9	75	705	–	4,200	7,200	3,339	–	44	77
Malta	–	100 x	4	–	<100	<100	–	–	–	–
Marshall Islands	–	81 x	–	–	–	–	–	–	–	–
Mauritania	0.4	84	131	–	<500	<1,000	554	–	72	>95
Mauritius	1.2	–	14	–	<100	<100	95	–	>95	>95
Mexico	0.2	96	2,269	–	1,100	1,900	773	–	41	67
Micronesia (Federated States of)	–	80	2	–	–	–	–	–	–	–
Monaco	–	–	–	–	–	–	–	–	–	–
Mongolia	<0.1	99	64	–	<100	<100	5	–	15	18
Montenegro	–	97 x	7	–	–	–	–	–	–	–
Morocco	0.1	77	739	–	<500	<1,000	195	–	35	65
Mozambique	11.1	91	995	94,000	81,000	110,000	80,779	86	74	>95
Myanmar	0.6	83	922	–	2,800	4,000	2,890	–	69	>95
Namibia	13.3	95 x	60	8,100	6,700	9,700	7,619	94	78	>95

TABLE 1

◀ Elimination of new HIV infections among children by 2015 and keeping their mothers alive

Countries and areas	Estimated HIV prevalence (%) among adults (aged 15–49), 2012	Antenatal care coverage – at least one visit (%), 2008–2012*	Annual number of births (thousands), 2012	Estimated number of pregnant women living with HIV, 2012			Reported number of pregnant women living with HIV who received ARVs for PMTCT, 2012	Estimated percentage of pregnant women living with HIV who received ARVs for PMTCT, 2012		
				Estimate	Low estimate	High estimate		Estimate	Low estimate	High estimate
Nauru	–	95 x	–	–	–	–	–	–	–	
Nepal	0.3	58	593	–	<1,000	1,200	110	–	9	18
Netherlands	–	–	180	–	<100	<200	–	–	–	–
New Zealand	–	–	63	–	<100	<100	–	–	–	–
Nicaragua	0.3	90 x	139	–	<200	<500	141	–	48	>95
Niger	0.5	83	858	–	2,500	3,900	707	–	18	30
Nigeria	3.1	66	7,028	200,000	170,000	230,000	33,323	17	15	19
Niue	–	100	–	–	–	–	–	–	–	–
Norway	–	–	62	–	<100	<100	–	–	–	–
Oman	–	99	72	–	<100	<100	–	–	–	–
Pakistan	<0.1	61 x	4,604	–	1,000	3,200	55	–	2	6
Palau	–	90	–	–	–	–	–	–	–	–
Panama	0.7	96	75	–	<200	<500	187	–	59	>95
Papua New Guinea	0.5	79 x	210	<1,000	<1,000	1,100	328	39	29	51
Paraguay	0.3	96	160	–	<500	<1,000	215	–	29	>95
Peru	0.4	96	600	–	<1,000	4,000	696	–	25	>95
Philippines	<0.1	91	2,383	–	<200	<500	19	–	9	18
Poland	–	–	411	–	<200	<500	–	–	–	–
Portugal	–	100 x	94	–	<200	<500	–	–	–	–
Qatar	–	100	22	–	–	–	–	–	–	–
Republic of Korea	–	–	470	–	<100	<200	–	–	–	–
Republic of Moldova	0.7	98 x	43	–	<200	<500	141	–	64	>95
Romania	–	94 x	224	–	<100	<200	–	–	–	–
Russian Federation	–	–	1,690	–	–	–	–	–	–	–
Rwanda	2.9	98	410	10,000	9,000	12,000	9,057	87	75	>95
Saint Kitts and Nevis	–	100 x	–	–	–	–	–	–	–	–
Saint Lucia	–	99 x	3	–	–	–	12	–	–	–
Saint Vincent and the Grenadines	–	100	2	–	–	–	17	–	–	–
Samoa	–	93	5	–	–	–	1	–	–	–
San Marino	–	–	–	–	–	–	–	–	–	–
Sao Tome and Principe	1.0	98	7	–	<100	<100	36	–	42	86
Saudi Arabia	–	97	565	–	–	–	–	–	–	–
Senegal	0.5	93	524	–	2,000	3,300	1,000	–	30	48
Serbia	–	99	94	–	<100	<100	–	–	–	–
Seychelles	–	–	2	–	–	–	4	–	–	–
Sierra Leone	1.5	93	222	3,200	2,300	4,800	3,018	93	67	>95
Singapore	–	–	53	–	<100	<100	–	–	–	–
Slovakia	–	97 x	58	–	<100	<100	–	–	–	–
Slovenia	–	100 x	21	–	<100	<100	–	–	–	–
Solomon Islands	–	74 x	17	–	–	–	–	–	–	–
Somalia	0.5	26 x	452	–	1,100	2,700	57	–	2	5
South Africa	17.9	97	1,102	280,000	260,000	310,000	234,952	83	75	90
South Sudan	2.7	40	396	7,500	4,600	12,000	1,002	13	8	21
Spain	–	–	493	–	<500	<1,000	–	–	–	–
Sri Lanka	<0.1	99 x	383	–	<100	<100	5	–	6	16
State of Palestine	–	98	130	–	–	–	–	–	–	–
Sudan	–	74	1,263	–	–	–	191	–	–	–
Suriname	1.1	91	10	–	<100	<200	107	–	>95	>95
Swaziland	26.5	97	37	12,000	11,000	13,000	10,167	83	75	92
Sweden	–	100 x	114	–	<100	<200	–	–	–	–
Switzerland	–	–	82	–	<100	<200	–	–	–	–
Syrian Arab Republic	–	88	529	–	–	–	–	–	–	–
Tajikistan	0.3	79	265	–	<200	<1,000	62	–	11	44
Thailand	1.1	99	702	–	4,400	6,200	4,918	–	78	>95
The former Yugoslav Republic of Macedonia	–	99	23	–	–	–	–	–	–	–
Timor-Leste	–	84	40	–	–	–	–	–	–	–
Togo	2.9	72	245	5,100	4,200	6,300	4,411	86	70	>95
Tonga	–	98	3	–	–	–	–	–	–	–
Trinidad and Tobago	–	96 x	20	–	<500	<500	–	–	–	–
Tunisia	<0.1	98	189	–	<100	<100	9	–	17	52

Elimination of new HIV infections among children by 2015 and keeping their mothers alive

Countries and areas	Estimated HIV prevalence (%) among adults (aged 15–49), 2012	Antenatal care coverage – at least one visit (%), 2008–2012*	Annual number of births (thousands), 2012	Estimated number of pregnant women living with HIV, 2012			Reported number of pregnant women living with HIV who received ARVs for PMTCT, 2012	Estimated percentage of pregnant women living with HIV who received ARVs for PMTCT, 2012		
				Estimate	Low estimate	High estimate		Estimate	Low estimate	High estimate
Turkey	–	92	1,268	–	<100	<200	–	–	–	
Turkmenistan	–	99 x	111	–	–	–	–	–	–	
Tuvalu	–	97 x	–	–	–	–	–	–	–	
Uganda	7.2	93	1,591	100,000	88,000	120,000	73,870	72	62	86
Ukraine	0.9	99 x	495	–	2,000	3,900	5,220	–	>95	>95
United Arab Emirates	–	100 x	131	–	–	–	–	–	–	–
United Kingdom	–	–	771	–	<1000	1100	–	–	–	–
United Republic of Tanzania	5.1	88	1,898	97,000	83,000	110,000	73,955	77	66	89
United States	–	–	4,226	–	3,200	11,000	–	–	–	–
Uruguay	0.7	96 x	49	–	<100	<200	–	–	–	–
Uzbekistan	0.1	99 x	623	–	<500	<1,000	508	–	62	>95
Vanuatu	–	84 x	7	–	–	–	–	–	–	–
Venezuela (Bolivarian Republic of)	0.6	94 x	601	–	1,000	2,700	690	–	25	67
Viet Nam	0.4	94	1,440	–	<1,000	6,200	1,294	–	11	86
Yemen	0.1	47 x	752	–	<500	2,400	20	–	1	6
Zambia	12.7	94 x	608	79,000	71,000	88,000	76,963	>95	87	>95
Zimbabwe	14.7	90	439	68,000	60,000	76,000	55,849	82	72	91

SUMMARY INDICATORS

Sub-Saharan Africa ^{a/}	4.5	78 †	34,734	1,400,000	1,200,000	1,500,000	857,830	63	55	73
Eastern and Southern Africa	6.9	79 †	15,780	1,000,000	940,000	1,100,000	753,490	75	66	85
West and Central Africa	2.3	78 †	17,667	350,000	300,000	400,000	104,086	30	26	36
Middle East and North Africa	0.1	83 †	10,223	6,700	4,600	10,000	641	10	6	14
South Asia	<0.1	71 †	35,448	39,000	32,000	57,000	202	1	<1	1
East Asia and the Pacific	0.2	89 **†	30,975	36,000	24,000	53,000	11,966	43	29	66
Latin America and the Caribbean	0.5	96 †	10,951	24,000	19,000	33,000	21,449	88	58	>95
CEE/CIS	0.5	– †	5,889	13,000	9,000	17,000	6,621	>95	>95	>95
Least developed countries	1.7	74 †	29,287	640,000	580,000	730,000	348,803	63	52	74
Low- and middle-income countries	0.9	–	–	1,500,000	1,300,000	1,600,000	898,455	62	57	70
World	0.8	83 **†	138,314	1,500,000	1,400,000	1,700,000	–	–	–	–

DEFINITIONS OF THE INDICATORS

Estimated HIV prevalence (%) among adults (aged 15–49), 2012: Percentage of adults (aged 15–49) living with HIV as of 2012.

Antenatal care coverage – at least one visit (%), 2008–2012: Percentage of women (aged 15–49) attended at least once during pregnancy by skilled health personnel (doctor, nurse, midwife).

Annual number of births (thousands), 2012: Estimated number of live births in 2012 (in thousands).

Estimated number of pregnant women living with HIV, 2012: Estimated number of pregnant women living with HIV as of 2012.

Reported number of pregnant women living with HIV who received ARVs for PMTCT, 2012: Number of women testing HIV-positive during visits to antenatal clinics who were provided with most effective antiretrovirals (ARVs) to prevent mother-to-child transmission of HIV. Excludes single-dose nevirapine.

Estimated percentage of pregnant women living with HIV who received ARVs for PMTCT, 2012: Calculated by dividing the reported number of HIV-positive pregnant women who received most effective ARVs (excluding single-dose nevirapine) for prevention of mother-to-child transmission (PMTCT) of HIV by the estimated unrounded number of pregnant women living with HIV in 2012. The point estimates and ranges are given for countries with a generalized epidemic whereas only ranges are given for countries with a low or concentrated epidemic. Ranges in coverage estimates are based on plausibility (uncertainty) bounds in the denominator (i.e., low and high estimated number of pregnant women living with HIV).

MAIN DATA SOURCES

Estimated HIV prevalence (%) among adults (aged 15–49), 2012: UNAIDS, *Report on the Global AIDS Epidemic, 2013*.

Antenatal care coverage – at least one visit (%), 2008–2012: Statistical data provided by UNICEF Data and Analytics Section, September 2013.

Annual number of births (thousands), 2012: United Nations Population Division.

Estimated number of pregnant women living with HIV, 2012: UNAIDS, *Report on the Global AIDS Epidemic, 2013*.

Reported number of pregnant women living with HIV who received ARVs for PMTCT, 2012: UNAIDS, UNICEF, WHO, *2013 Global AIDS Response Progress Reporting*.

Estimated percentage of pregnant women living with HIV who received ARVs for PMTCT, 2012: UNAIDS, UNICEF, WHO, *2013 Global AIDS Response Progress Reporting*, and UNAIDS, *Report on the Global AIDS Epidemic, 2013*.

NOTES

– Data not available.

* Data refer to the most recent year available during the period specified in the column heading.

** Excludes China.

† Regional averages are calculated only when the population represents 50 per cent or more of the region's total population of interest.

x Data refer to years or periods other than those specified in the column heading. Such data are not included in the calculation of regional and global averages, with the exception of 2005–2006 India. Estimates from years prior to 2005 are not displayed.

y Data differ from the standard definition or refer to only part of a country. If they fall within the reference period, such data are included in the calculation of regional and global averages.

p Based on small denominators (typically 25–29 unweighted cases). No data based on fewer than 25 unweighted cases are displayed.

a/ Sub-Saharan Africa includes the Sudan and Djibouti.

Some estimates do not add up to the totals because of rounding. Low- and middle-income countries are classified as such by the World Bank as of July 2013; these countries form the basis for the data analysis in UNAIDS, UNICEF and WHO.

TABLE 2

Providing paediatric HIV care and treatment

Countries and areas	Estimated number of children (aged 0–14) living with HIV, 2012			Estimated number of pregnant women living with HIV, 2012			Number of infants born to pregnant women living with HIV started on cotrimoxazole prophylaxis, 2012	% of infants born to pregnant women living with HIV started on cotrimoxazole prophylaxis, 2012			Number of infants born to pregnant women living with HIV started on antiretroviral prophylaxis to prevent mother-to-child transmission, 2012
	Estimate	Low	High	Estimate	Low	High					
Afghanistan	–	–	–	–	<100	<1,000	–	–	–	–	–
Albania	–	–	–	–	–	–	–	–	–	–	–
Algeria	–	–	–	–	–	–	9	–	–	–	–
Andorra	–	–	–	–	–	–	–	–	–	–	–
Angola	30,000	24,000	39,000	15,000	12,000	19,000	2,061	13	11	17	2,061
Antigua and Barbuda	–	–	–	–	–	–	–	–	–	–	–
Argentina	–	–	–	–	1,400	2,400	2,525	–	>95	>95	2,525
Armenia	–	–	–	–	<100	<100	10	–	29	>95	12
Australia	–	–	–	–	<100	<200	–	–	–	–	–
Austria	–	–	–	–	<100	<200	–	–	–	–	–
Azerbaijan	–	–	–	–	<100	<100	35	–	38	76	31
Bahamas	–	–	–	–	–	–	–	–	–	–	–
Bahrain	–	–	–	–	–	–	–	–	–	–	–
Bangladesh	–	–	–	–	<100	1,400	9	–	1	15	11
Barbados	–	–	–	–	<100	<100	–	–	–	–	–
Belarus	–	–	–	–	<200	<500	195	–	87	>95	204
Belgium	–	–	–	–	<200	<500	–	–	–	–	–
Belize	–	–	–	–	<100	<100	–	–	–	–	44
Benin	9,100	7,700	11,000	3,400	2,900	4,000	–	–	–	–	432
Bhutan	–	–	–	–	<100	<100	–	–	–	–	–
Bolivia (Plurinational State of)	–	–	–	–	<200	<1,000	–	–	–	–	15
Bosnia and Herzegovina	–	–	–	–	–	–	0	–	–	–	–
Botswana	11,000	10,000	12,000	13,000	11,000	14,000	8,688	68	62	76	11,818
Brazil	–	–	–	–	3,900	5,300	–	–	–	–	7,436
Brunei Darussalam	–	–	–	–	–	–	–	–	–	–	–
Bulgaria	–	–	–	–	<100	<100	–	–	–	–	–
Burkina Faso	21,000	17,000	25,000	5,400	4,400	6,700	1,907	35	29	43	1,732
Burundi	17,000	14,000	21,000	5,100	3,900	6,500	2,149	42	33	55	2,149
Cabo Verde	–	–	–	–	<100	<100	62	–	>95	>95	62
Cambodia	–	–	–	–	<1,000	2,300	470	–	20	71	960
Cameroon	59,000	51,000	67,000	27,000	23,000	31,000	5,277	19	17	22	10,564
Canada	–	–	–	–	<200	<500	–	–	–	–	–
Central African Republic	–	–	–	–	–	–	–	–	–	–	–
Chad	34,000	28,000	43,000	12,000	10,000	16,000	558	4	3	6	1,650
Chile	–	–	–	–	<100	<500	–	–	–	–	–
China	–	–	–	–	–	–	197	–	–	–	3,305
Colombia	–	–	–	–	1,400	2,800	–	–	–	–	–
Comoros	–	–	–	–	<200	<500	0	–	<1	<1	1
Congo	13,000	12,000	15,000	3,100	2,700	3,500	–	–	–	–	–
Cook Islands	–	–	–	–	–	–	–	–	–	–	–
Costa Rica	–	–	–	–	–	–	50	–	–	–	50
Côte d'Ivoire	63,000	53,000	74,000	20,000	16,000	24,000	4,951	25	21	31	7,641
Croatia	–	–	–	–	<100	<100	–	–	–	–	–
Cuba	–	–	–	–	<100	<100	1	–	3	8	108
Cyprus	–	–	–	–	–	–	–	–	–	–	–
Czech Republic	–	–	–	–	<100	<100	–	–	–	–	–
Democratic People's Republic of Korea	–	–	–	–	–	–	–	–	–	–	–
Democratic Republic of the Congo	88,000	77,000	100,000	32,000	28,000	37,000	–	–	–	–	–
Denmark	–	–	–	–	<100	<100	–	–	–	–	–
Djibouti	1,200	<1,000	1,500	<500	<500	<500	–	–	–	–	22
Dominica	–	–	–	–	–	–	–	–	–	–	–
Dominican Republic	–	–	–	–	<1,000	1,200	225	–	19	32	706
Ecuador	–	–	–	–	<500	1,200	–	–	–	–	550
Egypt	–	–	–	–	<100	<200	–	–	–	–	9
El Salvador	–	–	–	–	<500	<1,000	–	–	–	–	–
Equatorial Guinea	–	1,700	6,100	–	<1,000	2,600	–	–	–	–	–
Eritrea	3,100	2,300	4,400	<1,000	<500	<1,000	166	26	18	36	280
Estonia	–	–	–	–	<100	<200	–	–	–	–	–

Providing paediatric HIV care and treatment

Countries and areas	% of infants born to pregnant women living with HIV started on antiretroviral prophylaxis to prevent mother-to-child transmission, 2012			Number of infants born to pregnant women living with HIV receiving virological test for HIV within two months of birth, 2012	% of infants born to pregnant women living with HIV receiving virological test for HIV within two months of birth, 2012			Estimated number of children needing antiretroviral therapy based on UNAIDS/WHO guidelines, 2012			Number of children (aged 0–14) receiving antiretroviral therapy, 2012	Estimated antiretroviral therapy coverage among children (aged 0–14), % 2012		
	Estimate	Low	High		Estimate	Low	High	Estimate	Low estimate	High estimate				
Afghanistan	–	–	–	–	–	–	–	–	–	–	8	–	–	–
Albania	–	–	–	0	–	–	–	–	–	–	15	–	–	–
Algeria	–	–	–	63	–	–	–	–	–	–	262	–	–	–
Andorra	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Angola	13	11	17	1,010	7	5	8	19,000	15,000	24,000	2,903	15	12	19
Antigua and Barbuda	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Argentina	–	>95	>95	190	–	8	14	–	–	–	3,000	–	–	–
Armenia	–	35	>95	7	–	21	>95	–	–	–	13	–	–	–
Australia	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Austria	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Azerbaijan	–	33	67	38	–	41	83	–	–	–	22	–	–	–
Bahamas	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Bahrain	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Bangladesh	–	1	19	–	–	–	–	–	–	–	48	–	–	–
Barbados	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Belarus	–	91	>95	162	–	72	>95	–	–	–	154	–	–	–
Belgium	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Belize	–	48	66	44	–	48	66	–	–	–	95	–	–	–
Benin	13	11	15	432	13	11	15	5,300	4,500	6,200	2,635	49	42	58
Bhutan	–	–	–	–	–	–	–	–	–	–	5	–	–	–
Bolivia (Plurinational State of)	–	3	9	–	–	–	–	–	–	–	86	–	–	–
Bosnia and Herzegovina	–	–	–	1	–	–	–	–	–	–	1	–	–	–
Botswana	93	85	>95	4,827	38	35	42	10,000	9900	10,000	10,261	>95	>95	>95
Brazil	–	>95	>95	2,241	–	42	57	–	–	–	–	–	–	–
Brunei Darussalam	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Bulgaria	–	–	–	14	–	–	–	–	–	–	6	–	–	–
Burkina Faso	32	26	39	1,101	20	17	25	12,000	9700	14,000	6,863	59	49	72
Burundi	42	33	55	547	11	8	14	9700	7800	12,000	2,023	21	17	26
Cabo Verde	–	>95	>95	42	–	>95	>95	–	–	–	66	–	–	–
Cambodia	–	42	>95	439	–	19	66	–	–	–	4,595	–	–	–
Cameroon	39	34	45	9,563	35	31	41	33,000	29,000	38,000	4,992	15	13	17
Canada	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Central African Republic	–	–	–	–	–	–	–	–	–	–	825	–	–	–
Chad	13	10	16	443	4	3	4	20,000	17,000	25,000	5,812	29	24	37
Chile	–	–	–	–	–	–	–	–	–	–	–	–	–	–
China	–	–	–	1,119	–	–	–	–	–	–	–	–	–	–
Colombia	–	–	–	332	–	12	23	–	–	–	6,249	–	–	–
Comoros	–	<1	1	0	–	<1	<1	–	–	–	1	–	–	–
Congo	–	–	–	316	10	9	12	7,500	6,600	8,500	1,148	15	13	17
Cook Islands	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Costa Rica	–	–	–	50	–	–	–	–	–	–	61	–	–	–
Côte d'Ivoire	39	32	48	5,346	27	22	34	35,000	29,000	41,000	5,620	16	14	19
Croatia	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Cuba	–	>95	>95	108	–	>95	>95	–	–	–	24	–	–	–
Cyprus	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Czech Republic	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Democratic People's Republic of Korea	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Democratic Republic of the Congo	–	–	–	1,916	6	5	7	53,000	47,000	61,000	4,751	9	8	10
Denmark	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Djibouti	7	5	9	22	7	5	9	<1,000	<1,000	<1,000	40	6	5	8
Dominica	–	–	–	0	–	–	–	–	–	–	0	–	–	–
Dominican Republic	–	61	>95	522	–	45	73	–	–	–	1,083	–	–	–
Ecuador	–	45	>95	550	–	45	>95	–	–	–	550	–	–	–
Egypt	–	6	14	9	–	6	14	–	–	–	42	–	–	–
El Salvador	–	–	–	8	–	1	3	–	–	–	335	–	–	–
Equatorial Guinea	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Eritrea	44	30	60	–	–	–	–	1,900	1,400	2,600	632	34	26	46
Estonia	–	–	–	–	–	–	–	–	–	–	–	–	–	–

TABLE 2

◀ Providing paediatric HIV care and treatment

Countries and areas	Estimated number of children (aged 0–14) living with HIV, 2012			Estimated number of pregnant women living with HIV, 2012			Number of infants born to pregnant women living with HIV started on cotrimoxazole prophylaxis, 2012	% of infants born to pregnant women living with HIV started on cotrimoxazole prophylaxis, 2012			Number of infants born to pregnant women living with HIV started on antiretroviral prophylaxis to prevent mother-to-child transmission, 2012
	Estimate	Low	High	Estimate	Low	High					
Ethiopia	170,000	140,000	200,000	38,000	32,000	46,000	7,001	18	15	22	7,072
Fiji	–	–	–	–	<100	<100	8	–	40	62	15
Finland	–	–	–	–	<100	<100	–	–	–	–	–
France	–	–	–	–	<1,000	1,700	–	–	–	–	–
Gabon	3,600	3,000	4,200	1,500	1,300	1,900	371	24	19	29	474
Gambia	–	–	–	–	<1,000	1,300	1,070	–	81	>95	337
Georgia	–	–	–	–	<100	<100	24	–	32	69	24
Germany	–	–	–	–	<500	<500	–	–	–	–	–
Ghana	28,000	23,000	33,000	9,500	7,800	11,000	2,236	24	20	29	2,723
Greece	–	–	–	–	<100	<100	–	–	–	–	–
Grenada	–	–	–	–	–	–	11	–	–	–	11
Guatemala	–	–	–	–	1,000	4,600	121	–	3	12	168
Guinea	14,000	11,000	17,000	6,300	5,000	8,000	2,275	36	29	46	1,658
Guinea-Bissau	5,900	4,500	7,700	2,200	1,600	3,100	–	–	–	–	707
Guyana	–	–	–	–	<100	<500	127	–	42	>95	174
Haiti	12,000	10,000	14,000	5,000	4,200	5,700	1,168	24	20	28	2,663
Holy See	–	–	–	–	–	–	–	–	–	–	–
Honduras	–	–	–	–	<500	<1,000	–	–	–	–	119
Hungary	–	–	–	–	<100	<100	–	–	–	–	–
Iceland	–	–	–	–	<100	<100	–	–	–	–	–
India	–	–	–	–	27,000	49,000	–	–	–	–	13,432
Indonesia	–	–	–	–	8,100	20,000	–	–	–	–	–
Iran (Islamic Republic of)	–	–	–	–	<500	1,100	74	–	7	16	77
Iraq	–	–	–	–	–	–	–	–	–	–	–
Ireland	–	–	–	–	<100	<200	–	–	–	–	–
Israel	–	–	–	–	<100	<500	–	–	–	–	–
Italy	–	–	–	–	<200	<500	–	–	–	–	–
Jamaica	–	–	–	–	<500	<500	–	–	–	–	338
Japan	–	–	–	–	<100	<100	–	–	–	–	–
Jordan	–	–	–	–	–	–	–	–	–	–	–
Kazakhstan	–	–	–	–	–	–	306	–	–	–	309
Kenya	200,000	180,000	240,000	86,000	76,000	97,000	–	–	–	–	48,602
Kiribati	–	–	–	–	–	–	–	–	–	–	–
Kuwait	–	–	–	–	–	–	–	–	–	–	–
Kyrgyzstan	–	–	–	–	<100	<200	76	–	44	>95	84
Lao People's Democratic Republic	–	–	–	–	<500	<500	14	–	4	5	32
Latvia	–	–	–	–	<100	<200	–	–	–	–	–
Lebanon	–	–	–	–	–	–	5	–	–	–	5
Lesotho	38,000	34,000	42,000	16,000	14,000	17,000	–	–	–	–	–
Liberia	3,700	3,100	4,400	<1,000	<1,000	1,300	–	–	–	–	604
Libya	–	–	–	–	–	–	–	–	–	–	–
Liechtenstein	–	–	–	–	–	–	–	–	–	–	–
Lithuania	–	–	–	–	<100	<100	–	–	–	–	–
Luxembourg	–	–	–	–	<100	<100	–	–	–	–	–
Madagascar	–	–	–	–	2,100	3,100	8	–	<1	<1	8
Malawi	180,000	160,000	200,000	68,000	61,000	75,000	17,588	26	23	29	36,667
Malaysia	–	–	–	–	<500	<1,000	258	–	36	74	258
Maldives	–	–	–	–	<100	<100	–	–	–	–	–
Mali	–	–	–	–	4,200	7,200	–	–	–	–	–
Malta	–	–	–	–	<100	<100	–	–	–	–	–
Marshall Islands	–	–	–	–	–	–	–	–	–	–	–
Mauritania	–	–	–	–	<500	<1,000	–	–	–	–	45
Mauritius	–	–	–	–	<100	<100	69	–	81	>95	72
Mexico	–	–	–	–	1,100	1,900	–	–	–	–	–
Micronesia (Federated States of)	–	–	–	–	–	–	0	–	–	–	0
Monaco	–	–	–	–	–	–	–	–	–	–	–
Mongolia	–	–	–	–	<100	<100	2	–	6	7	2
Montenegro	–	–	–	–	–	–	–	–	–	–	–

Providing paediatric HIV care and treatment

Countries and areas	% of infants born to pregnant women living with HIV started on antiretroviral prophylaxis to prevent mother-to-child transmission, 2012			Number of infants born to pregnant women living with HIV receiving virological test for HIV within two months of birth, 2012	% of infants born to pregnant women living with HIV receiving virological test for HIV within two months of birth, 2012			Estimated number of children needing antiretroviral therapy based on UNAIDS/WHO guidelines, 2012			Number of children (aged 0–14) receiving antiretroviral therapy, 2012	Estimated antiretroviral therapy coverage among children (aged 0–14), %, 2012		
	Estimate	Low	High		Estimate	Low	High	Estimate	Low estimate	High estimate				
Ethiopia	18	16	22	7,260	19	16	22	73,000	63,000	84,000	17,677	24	22	29
Fiji	–	75	>95	5	–	25	38	–	–	–	7	–	–	–
Finland	–	–	–	–	–	–	–	–	–	–	–	–	–	–
France	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Gabon	31	25	38	681	45	35	54	2,000	1,700	2,400	494	24	20	29
Gambia	–	26	48	–	–	–	–	–	–	–	271	–	–	–
Georgia	–	32	69	24	–	32	69	–	–	–	42	–	–	–
Germany	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Ghana	29	24	35	1,702	18	15	22	14,000	12,000	17,000	3,504	25	20	30
Greece	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Grenada	–	–	–	4	–	–	–	–	–	–	1	–	–	–
Guatemala	–	4	17	206	–	5	21	–	–	–	1,024	–	–	–
Guinea	26	21	33	8	<1	<1	<1	8,300	6,800	10,000	1,114	13	11	17
Guinea-Bissau	32	23	43	–	–	–	–	3,300	2,500	4,400	335	11	8	14
Guyana	–	58	>95	71	–	24	76	–	–	–	201	–	–	–
Haiti	54	47	63	3,901	79	68	92	6,700	5,700	7,800	2,265	34	29	40
Holy See	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Honduras	–	18	29	176	–	26	43	–	–	–	783	–	–	–
Hungary	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Iceland	–	–	–	–	–	–	–	–	–	–	–	–	–	–
India	–	27	49	–	–	–	–	–	–	–	34,367	–	–	–
Indonesia	–	–	–	–	–	–	–	–	–	–	1,695	–	–	–
Iran (Islamic Republic of)	–	7	17	40	–	4	9	–	–	–	141	–	–	–
Iraq	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Ireland	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Israel	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Italy	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Jamaica	–	70	>95	–	–	–	–	–	–	–	454	–	–	–
Japan	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Jordan	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Kazakhstan	–	–	–	306	–	–	–	–	–	–	–	–	–	–
Kenya	57	50	64	33,777	39	35	44	150,000	130,000	170,000	55,439	38	34	45
Kiribati	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Kuwait	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Kyrgyzstan	–	49	>95	14	–	8	18	–	–	–	70	–	–	–
Lao People's Democratic Republic	–	9	13	22	–	6	9	–	–	–	163	–	–	–
Latvia	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Lebanon	–	–	–	5	–	–	–	–	–	–	4	–	–	–
Lesotho	–	–	–	–	–	–	–	22,000	19,000	24,000	5,395	25	22	27
Liberia	62	48	78	564	–	–	–	2,100	1,800	2,500	430	20	17	24
Libya	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Liechtenstein	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Lithuania	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Luxembourg	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Madagascar	–	<1	<1	4	–	<1	<1	–	–	–	14	–	–	–
Malawi	54	49	61	2,830	4	4	5	100,000	90,000	110,000	36,441	36	33	41
Malaysia	–	36	74	258	–	36	74	–	–	–	490	–	–	–
Maldives	–	–	–	–	–	–	–	–	–	–	0	–	–	–
Mali	–	–	–	777	–	11	19	–	–	–	1,912	–	–	–
Malta	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Marshall Islands	–	–	–	–	–	–	–	–	–	–	0	–	–	–
Mauritania	–	6	13	–	–	–	–	–	–	–	51	–	–	–
Mauritius	–	85	>95	14	–	16	21	–	–	–	10	–	–	–
Mexico	–	–	–	–	–	–	–	–	–	–	1,800	–	–	–
Micronesia (Federated States of)	–	–	–	0	–	–	–	–	–	–	0	–	–	–
Monaco	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Mongolia	–	6	7	2	–	6	7	–	–	–	–	–	–	–
Montenegro	–	–	–	–	–	–	–	–	–	–	0	–	–	–

TABLE 2

◀ Providing paediatric HIV care and treatment

Countries and areas	Estimated number of children (aged 0–14) living with HIV, 2012			Estimated number of pregnant women living with HIV, 2012			Number of infants born to pregnant women living with HIV started on cotrimoxazole prophylaxis, 2012	% of infants born to pregnant women living with HIV started on cotrimoxazole prophylaxis, 2012			Number of infants born to pregnant women living with HIV started on antiretroviral prophylaxis to prevent mother-to-child transmission, 2012
	Estimate	Low	High	Estimate	Low	High					
Morocco	–	–	–	–	<500	<1,000	190	–	34	63	190
Mozambique	180,000	150,000	220,000	94,000	81,000	110,000	60,571	64	54	74	51,299
Myanmar	–	–	–	–	2,800	4,000	1,288	–	32	45	3,134
Namibia	18,000	16,000	22,000	8,100	6,700	9,700	–	–	–	–	7,871
Nauru	–	–	–	–	–	–	–	–	–	–	–
Nepal	–	–	–	–	<1,000	1,200	72	–	6	11	108
Netherlands	–	–	–	–	<100	<200	–	–	–	–	–
New Zealand	–	–	–	–	<100	<100	–	–	–	–	–
Nicaragua	–	–	–	–	<200	<500	100	–	32	76	120
Niger	–	–	–	–	2,500	3,900	239	–	6	10	278
Nigeria	430,000	370,000	500,000	200,000	170,000	230,000	8,562	4	4	5	12,455
Niue	–	–	–	–	–	–	–	–	–	–	–
Norway	–	–	–	–	<100	<100	–	–	–	–	–
Oman	–	–	–	–	<100	<100	–	–	–	–	–
Pakistan	–	–	–	–	1,000	3,200	0	–	<1	<1	32
Palau	–	–	–	–	–	–	–	–	–	–	–
Panama	–	–	–	–	<200	<500	168	–	56	>95	192
Papua New Guinea	3,100	2,300	4,100	<1,000	<1,000	1,100	–	–	–	–	302
Paraguay	–	–	–	–	<500	<1,000	113	–	15	55	170
Peru	–	–	–	–	<1,000	4,000	–	–	–	–	496
Philippines	–	–	–	–	<200	<500	–	–	–	–	–
Poland	–	–	–	–	<200	<500	–	–	–	–	–
Portugal	–	–	–	–	<200	<500	–	–	–	–	–
Qatar	–	–	–	–	–	–	–	–	–	–	–
Republic of Korea	–	–	–	–	<100	<200	–	–	–	–	–
Republic of Moldova	–	–	–	–	<200	<500	60	–	27	44	149
Romania	–	–	–	–	<100	<200	–	–	–	–	196
Russian Federation	–	–	–	–	–	–	–	–	–	–	–
Rwanda	27,000	23,000	33,000	10,000	9,000	12,000	7,576	72	62	84	–
Saint Kitts and Nevis	–	–	–	–	–	–	–	–	–	–	–
Saint Lucia	–	–	–	–	–	–	7	–	–	–	10
Saint Vincent and the Grenadines	–	–	–	–	–	–	14	–	–	–	19
Samoa	–	–	–	–	–	–	–	–	–	–	–
San Marino	–	–	–	–	–	–	–	–	–	–	–
Sao Tome and Principe	–	–	–	–	<100	<100	20	–	24	49	30
Saudi Arabia	–	–	–	–	–	–	–	–	–	–	–
Senegal	–	–	–	–	2,000	3,300	–	–	–	–	444
Serbia	–	–	–	–	<100	<100	–	–	–	–	–
Seychelles	–	–	–	–	–	–	11	–	–	–	10
Sierra Leone	5,800	4,300	8,600	3,200	2,300	4,800	435	13	9	19	151
Singapore	–	–	–	–	<100	<100	–	–	–	–	–
Slovakia	–	–	–	–	<100	<100	–	–	–	–	–
Slovenia	–	–	–	–	<100	<100	–	–	–	–	–
Solomon Islands	–	–	–	–	–	–	–	–	–	–	–
Somalia	–	–	–	–	1,000	2,700	–	–	–	–	50
South Africa	410,000	370,000	450,000	280,000	260,000	310,000	205,885	73	67	80	239,434
South Sudan	19,000	12,000	28,000	7,500	4,600	12,000	259	3	2	6	240
Spain	–	–	–	–	<500	<1,000	–	–	–	–	–
Sri Lanka	–	–	–	–	<100	<100	5	–	5	14	5
State of Palestine	–	–	–	–	–	–	–	–	–	–	–
Sudan	–	–	–	–	–	–	–	–	–	–	–
Suriname	–	–	–	–	<100	<200	–	–	–	–	–
Swaziland	22,000	20,000	25,000	12,000	11,000	13,000	9,092	74	67	83	8,459
Sweden	–	–	–	–	<100	<200	–	–	–	–	–
Switzerland	–	–	–	–	<100	<200	–	–	–	–	–
Syrian Arab Republic	–	–	–	–	–	–	–	–	–	–	–
Tajikistan	–	–	–	–	<200	<1,000	68	–	10	41	67
Thailand	–	–	–	–	4,400	6,200	2,560	–	42	58	4,822

Providing paediatric HIV care and treatment

Countries and areas	% of infants born to pregnant women living with HIV started on antiretroviral prophylaxis to prevent mother-to-child transmission, 2012			Number of infants born to pregnant women living with HIV receiving virological test for HIV within two months of birth, 2012	% of infants born to pregnant women living with HIV receiving virological test for HIV within two months of birth, 2012			Estimated number of children needing antiretroviral therapy based on UNAIDS/WHO guidelines, 2012			Number of children (aged 0–14) receiving antiretroviral therapy, 2012	Estimated antiretroviral therapy coverage among children (aged 0–14), %, 2012		
	Estimate	Low	High		Estimate	Low	High	Estimate	Low estimate	High estimate				
Morocco	–	34	63	190	–	34	63	–	–	–	244	–	–	–
Mozambique	55	46	63	34,553	37	31	42	100,000	88,000	120,000	27,164	27	23	32
Myanmar	–	78	>95	243	–	6	9	–	–	–	4,033	–	–	–
Namibia	>95	82	>95	5,989	74	62	89	13,000	12,000	15,000	11,340	88	80	>95
Nauru	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Nepal	–	9	17	40	–	3	6	–	–	–	699	–	–	–
Netherlands	–	–	–	–	–	–	–	–	–	–	–	–	–	–
New Zealand	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Nicaragua	–	39	92	66	–	21	50	–	–	–	104	–	–	–
Niger	–	7	11	33	–	1	1	–	–	–	673	–	–	–
Nigeria	6	6	7	8,276	4	4	5	260,000	220,000	290,000	31,556	12	11	14
Niue	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Norway	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Oman	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Pakistan	–	1	3	7	–	<1	1	–	–	–	139	–	–	–
Palau	–	–	–	–	–	–	–	–	–	–	0	–	–	–
Panama	–	64	>95	65	–	22	48	–	–	–	256	–	–	–
Papua New Guinea	36	27	47	270	32	24	42	1,800	1,400	2,300	722	39	30	51
Paraguay	–	23	82	160	–	21	77	–	–	–	181	–	–	–
Peru	–	13	>95	248	–	6	50	–	–	–	495	–	–	–
Philippines	–	–	–	8	–	3	7	–	–	–	33	–	–	–
Poland	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Portugal	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Qatar	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Republic of Korea	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Republic of Moldova	–	66	>95	144	–	64	>95	–	–	–	63	–	–	–
Romania	–	–	–	190	–	–	–	–	–	–	207	–	–	–
Russian Federation	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Rwanda	–	–	–	7,760	74	63	86	18,000	15,000	21,000	7,597	43	36	52
Saint Kitts and Nevis	–	–	–	–	–	–	–	–	–	–	1	–	–	–
Saint Lucia	–	–	–	7	–	–	–	–	–	–	2	–	–	–
Saint Vincent and the Grenadines	–	–	–	14	–	–	–	–	–	–	2	–	–	–
Samoa	–	–	–	1	–	–	–	–	–	–	3	–	–	–
San Marino	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Sao Tome and Principe	–	36	73	0	–	<1	<1	–	–	–	11	–	–	–
Saudi Arabia	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Senegal	–	13	22	296	–	9	15	–	–	–	1,207	–	–	–
Serbia	–	–	–	1	–	–	–	–	–	–	10	–	–	–
Seychelles	–	–	–	11	–	–	–	–	–	–	2	–	–	–
Sierra Leone	5	3	6	88	3	2	4	3,000	2,200	4,700	457	15	11	24
Singapore	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Slovakia	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Slovenia	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Solomon Islands	–	–	–	–	–	–	–	–	–	–	0	–	–	–
Somalia	–	2	5	–	–	–	–	–	–	–	43	–	–	–
South Africa	84	78	93	240,546	85	78	94	220,000	210,000	250,000	140,541	63	57	69
South Sudan	3	2	5	–	–	–	–	11,000	7,200	17,000	553	5	3	8
Spain	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Sri Lanka	–	5	14	2	–	2	5	–	–	–	24	–	–	–
State of Palestine	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Sudan	–	–	–	–	–	–	–	–	–	–	170	–	–	–
Suriname	–	–	–	–	–	–	–	–	–	–	84	–	–	–
Swaziland	69	63	77	9,898	81	73	90	14,000	12,000	15,000	7,431	54	49	59
Sweden	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Switzerland	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Syrian Arab Republic	–	–	–	–	–	–	–	–	–	–	1	–	–	–
Tajikistan	–	10	41	–	–	–	–	–	–	–	149	–	–	–
Thailand	–	78	>95	3,802	–	62	87	–	–	–	6,274	–	–	–

TABLE 2

◀ Providing paediatric HIV care and treatment

Countries and areas	Estimated number of children (aged 0–14) living with HIV, 2012			Estimated number of pregnant women living with HIV, 2012			Number of infants born to pregnant women living with HIV started on cotrimoxazole prophylaxis, 2012	% of infants born to pregnant women living with HIV started on cotrimoxazole prophylaxis, 2012			Number of infants born to pregnant women living with HIV started on antiretroviral prophylaxis to prevent mother-to-child transmission, 2012
	Estimate	Low	High	Estimate	Low	High					
The former Yugoslav Republic of Macedonia	–	–	–	–	–	–	0	–	–	–	–
Timor-Leste	–	–	–	–	–	–	–	–	–	–	–
Togo	17,000	14,000	21,000	5,100	4,200	6,300	2,476	48	39	59	2,982
Tonga	–	–	–	–	–	–	–	–	–	–	–
Trinidad and Tobago	–	–	–	–	<500	<500	–	–	–	–	–
Tunisia	–	–	–	–	<100	<100	0	–	<1	<1	5
Turkey	–	–	–	–	<100	<200	–	–	–	–	2
Turkmenistan	–	–	–	–	–	–	–	–	–	–	–
Tuvalu	–	–	–	–	–	–	–	–	–	–	–
Uganda	190,000	160,000	230,000	100,000	88,000	120,000	–	–	–	–	–
Ukraine	–	–	–	–	2,000	3,900	–	–	–	–	–
United Arab Emirates	–	–	–	–	–	–	–	–	–	–	–
United Kingdom	–	–	–	–	<1,000	1,100	–	–	–	–	–
United Republic of Tanzania	230,000	200,000	270,000	97,000	83,000	110,000	48,858	51	44	59	71,571
United States	–	–	–	–	3,200	11,000	–	–	–	–	–
Uruguay	–	–	–	–	<100	<200	–	–	–	–	–
Uzbekistan	–	–	–	–	<500	<1,000	–	–	–	–	521
Vanuatu	–	–	–	–	–	–	1	–	–	–	1
Venezuela (Bolivarian Republic of)	–	–	–	–	1,000	2,700	–	–	–	–	–
Viet Nam	–	–	–	–	<1,000	6,200	1,342	–	21	>95	1,822
Yemen	–	–	–	–	<500	2,400	7	–	<1	2	17
Zambia	160,000	140,000	170,000	79,000	71,000	88,000	41,095	52	46	58	34,062
Zimbabwe	180,000	160,000	200,000	68,000	60,000	76,000	36,711	54	48	61	51,566

SUMMARY INDICATORS

Sub-Saharan Africa ^{a/}	3,000,000	2,700,000	3,300,000	1,400,000	1,200,000	1,500,000	478,432	44	39	50	618,518
Eastern and Southern Africa	2,100,000	2,000,000	2,400,000	1,000,000	940,000	1,100,000	447,788	56	50	64	573,292
West and Central Africa	860,000	730,000	990,000	350,000	300,000	400,000	30,644	10	9	12	45,204
Middle East and North Africa	14,000	9,800	23,000	6,700	4,600	10,000	285	9	5	17	347
South Asia	150,000	140,000	210,000	39,000	32,000	57,000	86	3	1	5	13,588
East Asia and the Pacific	63,000	41,000	94,000	36,000	24,000	53,000	6,140	27	18	41	14,653
Latin America and the Caribbean	56,000	46,000	70,000	24,000	19,000	33,000	4,947	43	30	58	16,458
CEE/CIS	19,000	17,000	24,000	13,000	9,000	17,000	774	69	42	>95	1,599
Least developed countries	1,500,000	1,400,000	1,800,000	640,000	580,000	730,000	159,451	41	34	48	189,631
Low- and middle-income countries	3,200,000	3,000,000	3,700,000	1,500,000	1,300,000	1,600,000	490,664	44	38	50	665,304
World	3,300,000	3,000,000	3,700,000	1,500,000	1,400,000	1,700,000	–	–	–	–	–

DEFINITIONS OF THE INDICATORS

Estimated number of children (aged 0–14) living with HIV, 2012: Estimated number of children (aged 0–14) living with HIV as of 2012.

Estimated number of pregnant women living with HIV, 2012: Estimated number of pregnant women living with HIV as of 2012.

Number of infants born to pregnant women living with HIV started on cotrimoxazole prophylaxis, 2012: Reported number of HIV-exposed infants (those born to HIV-positive mothers) started on cotrimoxazole prophylaxis within two months of birth.

Percentage of infants born to pregnant women living with HIV started on cotrimoxazole prophylaxis, 2012: Calculated by dividing the number of HIV-exposed infants started on cotrimoxazole prophylaxis by the estimated number of children born to pregnant women living with HIV. The denominator is the estimated unrounded number of pregnant women living with HIV as of 2012.

Number of infants born to pregnant women living with HIV started on antiretroviral prophylaxis to prevent mother-to-child transmission, 2012: Reported number of HIV-exposed

infants given antiretroviral prophylaxis for the prevention of mother-to-child transmission of HIV as of 2012.

Percentage of infants born to pregnant women living with HIV started on antiretroviral prophylaxis to prevent mother-to-child transmission, 2012: Calculated by dividing the number of HIV-exposed infants given antiretroviral prophylaxis by the estimated number of children born to pregnant women living with HIV. The denominator is the estimated unrounded number of pregnant women living with HIV as of 2012.

Number of infants born to pregnant women living with HIV receiving virological test for HIV within two months of birth, 2012: Reported number of HIV-exposed infants receiving a virological HIV test within two months of birth.

Percentage of infants born to pregnant women living with HIV receiving virological test for HIV within two months of birth, 2012: Calculated by dividing the number of HIV-exposed infants receiving a virological HIV test by the estimated number of children born to pregnant women living with HIV. The denominator is the estimated unrounded number of pregnant women living with HIV as of 2012.

Estimated number of children needing antiretroviral therapy based on UNAIDS/WHO guidelines, 2012:

Estimated number of children (aged 0–14) living with HIV in need of antiretroviral treatment (ART) as of 2012.

Number of children (aged 0–14) receiving antiretroviral therapy, 2012: Reported number of children (aged 0–14) living with HIV receiving ART as of 2012.

Estimated antiretroviral therapy coverage among children (aged 0–14), %, 2012: Calculated by dividing the reported number of children (aged 0–14) receiving ART by the estimated number of children (aged 0–14) in need of ART as 2012.

MAIN DATA SOURCES

Estimated number of children (aged 0–14) living with HIV, 2012: Joint United Nations Programme on HIV/AIDS, *Global Report: UNAIDS report on the global AIDS epidemic 2013*, UNAIDS, Geneva, 2013.

Estimated number of pregnant women living with HIV, 2012: Joint United Nations Programme on HIV/AIDS, *Global Report: UNAIDS report on the global AIDS epidemic 2013*, UNAIDS, Geneva, 2013.

Number of infants born to pregnant women living with HIV started on cotrimoxazole prophylaxis, 2012: UNAIDS, UNICEF, WHO, *2013 Global AIDS Response Progress Reporting*.

Providing paediatric HIV care and treatment

Countries and areas	% of infants born to pregnant women living with HIV started on antiretroviral prophylaxis to prevent mother-to-child transmission, 2012			Number of infants born to pregnant women living with HIV receiving virological test for HIV within two months of birth, 2012	% of infants born to pregnant women living with HIV receiving virological test for HIV within two months of birth, 2012			Estimated number of children needing antiretroviral therapy based on UNAIDS/WHO guidelines, 2012			Number of children (aged 0–14) receiving antiretroviral therapy, 2012	Estimated antiretroviral therapy coverage among children (aged 0–14), %, 2012		
	Estimate	Low	High		Estimate	Low	High	Estimate	Low estimate	High estimate				
The former Yugoslav Republic of Macedonia	–	–	–	–	–	–	–	–	–	–	1	–	–	–
Timor-Leste	–	–	–	–	–	–	–	–	–	–	3	–	–	–
Togo	58	47	71	837	16	13	20	8,800	7,200	11,000	2,098	24	19	30
Tonga	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Trinidad and Tobago	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Tunisia	–	10	29	5	–	10	29	–	–	–	12	–	–	–
Turkey	–	–	–	3	–	–	–	–	–	–	0	–	–	–
Turkmenistan	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Tuvalu	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Uganda	–	–	–	–	–	–	–	110,000	88,000	130,000	35,453	33	28	41
Ukraine	–	–	–	–	–	–	–	–	–	–	2,268	–	–	–
United Arab Emirates	–	–	–	–	–	–	–	–	–	–	–	–	–	–
United Kingdom	–	–	–	–	–	–	–	–	–	–	–	–	–	–
United Republic of Tanzania	74	64	86	26,608	28	24	32	130,000	110,000	150,000	32,407	26	22	30
United States	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Uruguay	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Uzbekistan	–	62	>95	239	–	28	63	–	–	–	2,530	–	–	–
Vanuatu	–	–	–	–	–	–	–	–	–	–	2	–	–	–
Venezuela (Bolivarian Republic of)	–	–	–	90	–	3	9	–	–	–	972	–	–	–
Viet Nam	–	29	>95	955	–	15	>95	–	–	–	3,828	–	–	–
Yemen	–	1	4	2	–	<1	<1	–	–	–	53	–	–	–
Zambia	43	39	48	48,188	61	54	68	89,000	80,000	99,000	34,084	38	35	43
Zimbabwe	75	68	85	23,192	34	30	38	100,000	94,000	120,000	46,874	45	40	49
Sub-Saharan Africa ^{a/}	52	46	60	479,457	39	34	45	1,700,000	1,600,000	1,500,000	550,791	33	28	38
Eastern and Southern Africa	65	58	74	447,014	51	45	57	1,200,000	1,100,000	1,300,000	473,732	40	35	46
West and Central Africa	15	13	17	32,421	9	8	11	500,000	430,000	570,000	76,825	15	13	18
Middle East and North Africa	13	7	21	350	10	5	17	9,600	6,400	16,000	993	7	4	10
South Asia	35	25	47	49	2	1	3	91,000	82,000	130,000	35,266	39	30	49
East Asia and the Pacific	63	42	94	7,124	30	20	45	45,000	32,000	64,000	23,933	53	41	72
Latin America and the Caribbean	86	57	>95	9,438	42	27	57	39,000	33,000	49,000	26,499	67	50	83
CEE/CIS	87	55	>95	1,143	72	49	>95	12,000	12,000	13,000	9,024	85	80	89
Least developed countries	49	41	58	91,737	22	18	25	860,000	770,000	970,000	209,136	28	23	32
Low- and middle-income countries	52	45	61	497,748	39	34	45	1,900,000	1,700,000	2,100,000	646,852	34	31	39
World	–	–	–	–	–	–	–	1,900,000	1,700,000	2,100,000	–	–	–	–

Percentage of infants born to pregnant women living with HIV started on cotrimoxazole prophylaxis, 2012: UNAIDS, UNICEF, WHO, *2013 Global AIDS Response Progress Reporting* and UNAIDS 2012 HIV and AIDS estimates.

Number of infants born to pregnant women living with HIV started on antiretroviral prophylaxis to prevent mother-to-child transmission, 2012: UNAIDS, UNICEF, WHO, *2013 Global AIDS Response Progress Reporting*.

Percentage of infants born to pregnant women living with HIV started on antiretroviral prophylaxis to prevent mother-to-child transmission, 2012: UNAIDS, UNICEF, WHO, *2013 Global AIDS Response Progress Reporting* and UNAIDS 2012 HIV and AIDS estimates.

Number of infants born to pregnant women living with HIV receiving virological test for HIV within 2 months of birth, 2012: UNAIDS, UNICEF, WHO, *2013 Global AIDS Response Progress Reporting*.

Percentage of infants born to pregnant women living with HIV receiving virological test for HIV within 2 months of birth, 2012: UNAIDS, UNICEF, WHO, *2013 Global AIDS Response Progress Reporting*, and UNAIDS 2012 HIV and AIDS estimates.

Estimated number of children needing antiretroviral therapy based on UNAIDS/WHO guidelines, 2012: Joint United Nations Programme on HIV/AIDS, *Global Report: UNAIDS report on the global AIDS epidemic 2013*, UNAIDS, Geneva, 2013.

Number of children (aged 0–14) receiving antiretroviral therapy, 2012: Joint United Nations Programme on HIV/AIDS, *Global Report: UNAIDS report on the global AIDS epidemic 2013*, UNAIDS, Geneva, 2013.

Estimated antiretroviral therapy coverage among children (aged 0–14), 2012: Joint United Nations Programme on HIV/AIDS, *Global Report: UNAIDS report on the global AIDS epidemic 2013*, UNAIDS, Geneva, 2013.

NOTES

– Data not available.

* Data refer to the most recent year available during the period specified in the column heading.

** Excludes China.

‡ Regional averages are calculated only when the population represents 50 per cent or more of the region's total population of interest.

x Data refer to years or periods other than those specified in the column heading. Such data are not included in the calculation of regional and global averages, with the exception of 2005–2006 India. Estimates from years prior to 2005 are not displayed.

y Data differ from the standard definition or refer to only part of a country. If they fall within the reference period, such data are included in the calculation of regional and global averages.

p Based on small denominators (typically 25–29 unweighted cases). No data based on fewer than 25 unweighted cases are displayed.

a/ Sub-Saharan Africa includes the Sudan and Djibouti.

Some estimates do not add up to the totals because of rounding. Low- and middle-income countries are classified as such by the World Bank as of July 2013; these countries form the basis for the data analysis in UNAIDS, UNICEF and WHO.

TABLE 3

Demography and epidemiology of HIV among adolescents

Countries and areas	Demographics			Epidemiology			Adolescents (aged 10–19) living with HIV as a % of people (all ages) living with HIV, 2012	Number of new HIV infections among adolescents ² (aged 15–19), 2012	Number of AIDS deaths among adolescents (aged 10–19), 2012
	Population (thousands), 2012		Adolescents aged 10–19 as a % of total population	Estimated number of adolescents living with HIV, 2012					
	Total	Aged 10–19		Total aged 10–19	Female aged 10–19	Male aged 10–19			
Afghanistan	29,825	7,753	26.0	–	–	–	–	–	–
Albania	3,162	572	18.1	–	–	–	–	–	–
Algeria	38,482	6,391	16.6	–	–	–	–	–	–
Andorra	78	–	–	–	–	–	–	–	–
Angola	20,821	4,879	23.4	13,000	7,900	5,400	5	2,500	<1,000
Antigua and Barbuda	89	16	17.7	–	–	–	–	–	–
Argentina	41,087	6,733	16.4	–	–	–	–	–	–
Armenia	2,969	415	14.0	–	–	–	–	–	–
Australia	23,050	2,929	12.7	–	–	–	–	–	–
Austria	8,464	922	10.9	–	–	–	–	–	–
Azerbaijan	9,309	1,513	16.3	–	–	–	–	–	–
Bahamas	372	60	16.2	–	–	–	–	–	–
Bahrain	1,318	159	12.1	–	–	–	–	–	–
Bangladesh	154,695	32,280	20.9	–	–	–	–	–	–
Barbados	283	38	13.4	–	–	–	–	–	–
Belarus	9,405	971	10.3	–	–	–	–	–	–
Belgium	11,060	1,236	11.2	–	–	–	–	–	–
Belize	324	70	21.6	–	–	–	–	–	–
Benin	10,051	2,330	23.2	4,500	2,400	2,100	6	<500	<500
Bhutan	742	147	19.9	–	–	–	–	–	–
Bolivia (Plurinational State of)	10,496	2,308	22.0	–	–	–	–	–	–
Bosnia and Herzegovina	3,834	539	14.1	–	–	–	–	–	–
Botswana	2,004	444	22.1	7,800	4,600	3,200	2	1,300	<100
Brazil	198,656	34,205	17.2	–	–	–	–	–	–
Brunei Darussalam	412	70	17.1	–	–	–	–	–	–
Bulgaria	7,278	664	9.1	–	–	–	–	–	–
Burkina Faso	16,460	3,907	23.7	16,000	8,100	7,700	14	<1,000	1,200
Burundi	9,850	2,184	22.2	11,000	5,600	5,200	12	<500	<1,000
Cabo Verde	494	109	22.0	–	–	–	–	–	–
Cambodia	14,865	3,055	20.6	–	–	–	–	–	–
Cameroon	21,700	5,045	23.2	29,000	17,000	13,000	5	4,000	1,900
Canada	34,838	4,078	11.7	–	–	–	–	–	–
Central African Republic	4,525	1,042	23.0	–	–	–	–	–	–
Chad	12,448	3,026	24.3	15,000	8,400	7,100	7	1,300	1,300
Chile	17,465	2,724	15.6	–	–	–	–	–	–
China	1,377,065	174,700	12.7	–	–	–	–	–	–
Colombia	47,704	8,797	18.4	–	–	–	–	–	–
Comoros	718	155	21.6	–	–	–	–	–	–
Congo	4,337	947	21.8	7,200	3,800	3,400	10	<500	<1,000
Cook Islands	21	–	–	–	–	–	–	–	–
Costa Rica	4,805	830	17.3	–	–	–	–	–	–
Côte d'Ivoire	19,840	4,591	23.1	35,000	19,000	16,000	8	2,600	2,900
Croatia	4,307	471	10.9	–	–	–	–	–	–
Cuba	11,271	1,430	12.7	–	–	–	–	–	–
Cyprus	1,129	151	13.4	–	–	–	–	–	–
Czech Republic	10,660	995	9.3	–	–	–	–	–	–
Democratic People's Republic of Korea	24,763	3,940	15.9	–	–	–	–	–	–
Democratic Republic of the Congo	65,705	15,400	23.4	53,000	32,000	22,000	11	7,700	3,300
Denmark	5,598	696	12.4	–	–	–	–	–	–
Djibouti	860	179	20.9	<500	<500	<200	5	<100	<100
Dominica	72	–	–	–	–	–	–	–	–
Dominican Republic	10,277	1,997	19.4	–	–	–	–	–	–
Ecuador	15,492	2,966	19.1	–	–	–	–	–	–
Egypt	80,722	15,236	18.9	–	–	–	–	–	–
El Salvador	6,297	1,425	22.6	–	–	–	–	–	–
Equatorial Guinea	736	156	21.2	–	–	–	–	–	–
Eritrea	6,131	1,344	21.9	2,000	1,000	<1,000	11	<100	<200
Estonia	1,291	129	10.0	–	–	–	–	–	–
Ethiopia	91,729	22,993	25.1	91,000	47,000	44,000	12	2,300	7,900
Fiji	875	158	18.1	–	–	–	–	–	–

Demography and epidemiology of HIV among adolescents

Countries and areas	Demographics			Epidemiology					
	Population (thousands), 2012		Adolescents aged 10–19 as a % of total population	Estimated number of adolescents living with HIV, 2012			Adolescents (aged 10–19) living with HIV as a % of people (all ages) living with HIV, 2012	Number of new HIV infections among adolescents ^a (aged 15–19), 2012	Number of AIDS deaths among adolescents (aged 10–19), 2012
	Total	Aged 10–19		Total aged 10–19	Female aged 10–19	Male aged 10–19			
Finland	5,408	620	11.5	–	–	–	–	–	–
France	63,937	7,753	12.1	–	–	–	–	–	–
Gabon	1,633	351	21.5	1,700	1,000	<1,000	4	<200	<200
Gambia	1,791	416	23.2	–	–	–	–	–	–
Georgia	4,358	507	11.6	–	–	–	–	–	–
Germany	82,800	8,075	9.8	–	–	–	–	–	–
Ghana	25,366	5,576	22.0	14,000	7,600	6,900	6	<1,000	1,100
Greece	11,125	1,061	9.5	–	–	–	–	–	–
Grenada	105	20	18.8	–	–	–	–	–	–
Guatemala	15,083	3,537	23.5	–	–	–	–	–	–
Guinea	11,451	2,633	23.0	5,500	–	–	5	–	<500
Guinea-Bissau	1,664	376	22.6	2,000	1,200	<1,000	5	<500	<200
Guyana	795	173	21.7	–	–	–	–	–	–
Haiti	10,174	2,243	22.0	9,400	5,100	4,300	6	<1,000	<1,000
Holy See	1	–	–	–	–	–	–	–	–
Honduras	7,936	1,793	22.6	–	–	–	–	–	–
Hungary	9,976	1,046	10.5	–	–	–	–	–	–
Iceland	326	45	13.7	–	–	–	–	–	–
India	1,236,687	238,563	19.3	–	–	–	–	–	–
Indonesia	246,864	44,619	18.1	–	–	–	–	–	–
Iran (Islamic Republic of)	76,424	11,790	15.4	–	–	–	–	–	–
Iraq	32,778	7,492	22.9	–	–	–	–	–	–
Ireland	4,576	584	12.8	–	–	–	–	–	–
Israel	7,644	1,224	16.0	–	–	–	–	–	–
Italy	60,885	5,788	9.5	–	–	–	–	–	–
Jamaica	2,769	560	20.2	–	–	–	–	–	–
Japan	127,250	11,822	9.3	–	–	–	–	–	–
Jordan	7,009	1,399	20.0	–	–	–	–	–	–
Kazakhstan	16,271	2,420	14.9	–	–	–	–	–	–
Kenya	43,178	9,622	22.3	150,000	89,000	64,000	9	18,000	7,800
Kiribati	101	22	22.2	–	–	–	–	–	–
Kuwait	3,250	466	14.3	–	–	–	–	–	–
Kyrgyzstan	5,474	1,047	19.1	–	–	–	–	–	–
Lao People's Democratic Republic	6,646	1,554	23.4	–	–	–	–	–	–
Latvia	2,060	198	9.6	–	–	–	–	–	–
Lebanon	4,647	861	18.5	–	–	–	–	–	–
Lesotho	2,052	498	24.3	21,000	12,000	8,900	6	2,900	1,200
Liberia	4,190	949	22.6	1,400	<1,000	<1,000	7	<100	<200
Libya	6,155	1,097	17.8	–	–	–	–	–	–
Liechtenstein	37	–	–	–	–	–	–	–	–
Lithuania	3,028	343	11.3	–	–	–	–	–	–
Luxembourg	524	64	12.3	–	–	–	–	–	–
Madagascar	22,294	5,319	23.9	–	–	–	–	–	–
Malawi	15,906	3,796	23.9	91,000	49,000	42,000	8	6,700	5,600
Malaysia	29,240	5,558	19.0	–	–	–	–	–	–
Maldives	338	68	20.1	–	–	–	–	–	–
Mali	14,854	3,412	23.0	–	–	–	–	–	–
Malta	428	51	11.8	–	–	–	–	–	–
Marshall Islands	53	–	–	–	–	–	–	–	–
Mauritania	3,796	841	22.2	–	–	–	–	–	–
Mauritius	1,240	192	15.5	–	–	–	–	–	–
Mexico	120,847	23,529	19.5	–	–	–	–	–	–
Micronesia (Federated States of)	103	26	25.2	–	–	–	–	–	–
Monaco	38	–	–	–	–	–	–	–	–
Mongolia	2,796	473	16.9	–	–	–	–	–	–
Montenegro	621	85	13.6	–	–	–	–	–	–
Morocco	32,521	6,063	18.6	–	–	–	–	–	–
Mozambique	25,203	5,835	23.2	100,000	68,000	34,000	7	17,000	3,900
Myanmar	52,797	9,299	17.6	–	–	–	–	–	–
Namibia	2,259	530	23.5	9,300	5,200	4,100	4	1,000	<500

TABLE 3

Demography and epidemiology of HIV among adolescents

Countries and areas	Demographics			Epidemiology			Adolescents (aged 10–19) living with HIV as a % of people (all ages) living with HIV, 2012	Number of new HIV infections among adolescents ² (aged 15–19), 2012	Number of AIDS deaths among adolescents (aged 10–19), 2012
	Population (thousands), 2012	Adolescents aged 10–19 as a % of total population	Estimated number of adolescents living with HIV, 2012	Adolescents (aged 10–19) living with HIV as a % of people (all ages) living with HIV, 2012	Number of new HIV infections among adolescents ² (aged 15–19), 2012	Number of AIDS deaths among adolescents (aged 10–19), 2012			
	Total	Aged 10–19		Total aged 10–19	Female aged 10–19	Male aged 10–19			
Nauru	10	–	–	–	–	–	–	–	–
Nepal	27,474	6,354	23.1	–	–	–	–	–	–
Netherlands	16,714	2,007	12.0	–	–	–	–	–	–
New Zealand	4,460	606	13.6	–	–	–	–	–	–
Nicaragua	5,992	1,319	22.0	–	–	–	–	–	–
Niger	17,157	3,956	23.1	–	–	–	–	–	–
Nigeria	168,834	37,675	22.3	170,000	93,000	74,000	5	21,000	11,000
Niue	1	–	–	–	–	–	–	–	–
Norway	4,994	642	12.9	–	–	–	–	–	–
Oman	3,314	557	16.8	–	–	–	–	–	–
Pakistan	179,160	39,901	22.3	–	–	–	–	–	–
Palau	21	–	–	–	–	–	–	–	–
Panama	3,802	690	18.2	–	–	–	–	–	–
Papua New Guinea	7,167	1,601	22.3	1,300	<1,000	<1,000	5	<100	<100
Paraguay	6,687	1,395	20.9	–	–	–	–	–	–
Peru	29,988	5,804	19.4	–	–	–	–	–	–
Philippines	96,707	20,817	21.5	–	–	–	–	–	–
Poland	38,211	4,132	10.8	–	–	–	–	–	–
Portugal	10,604	1,094	10.3	–	–	–	–	–	–
Qatar	2,051	171	8.3	–	–	–	–	–	–
Republic of Korea	49,003	6,350	13.0	–	–	–	–	–	–
Republic of Moldova	3,514	424	12.1	<200	–	–	–	<100	<100
Romania	21,755	2,230	10.3	–	–	–	–	–	–
Russian Federation	143,170	14,071	9.8	–	–	–	–	–	–
Rwanda	11,458	2,774	24.2	22,000	11,000	11,000	11	<1,000	1,200
Saint Kitts and Nevis	54	–	–	–	–	–	–	–	–
Saint Lucia	181	32	17.8	–	–	–	–	–	–
Saint Vincent and the Grenadines	109	20	18.3	–	–	–	–	–	–
Samoa	189	42	22.2	–	–	–	–	–	–
San Marino	31	–	–	–	–	–	–	–	–
Sao Tome and Principe	188	40	21.5	–	–	–	–	–	–
Saudi Arabia	28,288	4,723	16.7	–	–	–	–	–	–
Senegal	13,726	3,162	23.0	–	–	–	–	–	–
Serbia	9,553	1,180	12.4	–	–	–	–	–	–
Seychelles	92	14	15.1	–	–	–	–	–	–
Sierra Leone	5,979	1,358	22.7	2,800	2,000	<1,000	5	<1,000	<200
Singapore	5,303	702	13.2	–	–	–	–	–	–
Slovakia	5,446	595	10.9	–	–	–	–	–	–
Slovenia	2,068	191	9.2	–	–	–	–	–	–
Solomon Islands	550	124	22.6	–	–	–	–	–	–
Somalia	10,195	2,440	23.9	–	–	–	–	–	–
South Africa	52,386	9,578	18.3	310,000	210,000	100,000	5	56,000	11,000
South Sudan	10,838	2,544	23.5	8,000	–	–	5	–	<1,000
Spain	46,755	4,304	9.2	–	–	–	–	–	–
Sri Lanka	21,098	3,248	15.4	–	–	–	–	–	–
State of Palestine	4,219	1,060	25.1	–	–	–	–	–	–
Sudan	37,195	8,546	23.0	–	–	–	–	–	–
Suriname	535	97	18.2	–	–	–	–	–	–
Swaziland	1,231	299	24.3	20,000	12,000	7,400	9	3,600	<1,000
Sweden	9,511	1,084	11.4	–	–	–	–	–	–
Switzerland	7,997	865	10.8	–	–	–	–	–	–
Syrian Arab Republic	21,890	4,749	21.7	–	–	–	–	–	–
Tajikistan	8,009	1,710	21.3	–	–	–	–	–	–
Thailand	66,785	9,059	13.6	–	–	–	–	–	–
The former Yugoslav Republic of Macedonia	2,106	273	13.0	–	–	–	–	–	–
Timor-Leste	1,114	312	28.0	–	–	–	–	–	–
Togo	6,643	1,498	22.6	8,000	4,200	3,700	6	<500	<1,000
Tonga	105	23	22.3	–	–	–	–	–	–

Demography and epidemiology of HIV among adolescents

Countries and areas	Demographics			Epidemiology					
	Population (thousands), 2012		Adolescents aged 10–19 as a % of total population	Estimated number of adolescents living with HIV, 2012			Adolescents (aged 10–19) living with HIV as a % of people (all ages) living with HIV, 2012	Number of new HIV infections among adolescents [§] (aged 15–19), 2012	Number of AIDS deaths among adolescents (aged 10–19), 2012
	Total	Aged 10–19		Total aged 10–19	Female aged 10–19	Male aged 10–19			
Trinidad and Tobago	1,337	177	13.3	–	–	–	–	–	–
Tunisia	10,875	1,692	15.6	–	–	–	–	–	–
Turkey	73,997	12,846	17.4	–	–	–	–	–	–
Turkmenistan	5,173	994	19.2	–	–	–	–	–	–
Tuvalu	10	–	–	–	–	–	–	–	–
Uganda	36,346	8,890	24.5	110,000	64,000	48,000	7	15,000	6,300
Ukraine	45,530	4,389	9.6	–	–	–	–	–	–
United Arab Emirates	9,206	812	8.8	–	–	–	–	–	–
United Kingdom	62,783	7,264	11.6	–	–	–	–	–	–
United Republic of Tanzania	47,783	10,828	22.7	170,000	97,000	69,000	11	21,000	10,000
United States	317,505	42,958	13.5	–	–	–	–	–	–
Uruguay	3,395	521	15.3	–	–	–	–	–	–
Uzbekistan	28,541	5,696	20.0	–	–	–	–	–	–
Vanuatu	247	52	21.1	–	–	–	–	–	–
Venezuela (Bolivarian Republic of)	29,955	5,537	18.5	–	–	–	–	–	–
Viet Nam	90,796	14,819	16.3	–	–	–	–	–	–
Yemen	23,852	6,010	25.2	–	–	–	–	–	–
Zambia	14,075	3,357	23.8	82,000	43,000	39,000	7	5,500	4,400
Zimbabwe	13,724	3,327	24.2	120,000	63,000	55,000	9	6,900	6,500

SUMMARY INDICATORS

Sub-Saharan Africa ^{a/}	913,135	209,363	23	1,700,000	1,000,000	720,000	7	210,000	97,000
Eastern and Southern Africa	441,512	101,842	23	1,300,000	800,000	550,000	7	160,000	70,000
West and Central Africa	433,568	98,796	23	390,000	220,000	170,000	6	43,000	27,000
Middle East and North Africa	425,055	79,451	19	17,000	9,100	8,300	7	5,300	<1,000
South Asia	1,650,019	328,314	20	130,000	62,000	64,000	6	24,000	5,100
East Asia and the Pacific	2,074,608	297,376	14	110,000	55,000	53,000	4	34,000	1,400
Latin America and the Caribbean	604,436	111,047	18	82,000	35,000	46,000	5	17,000	2,000
CEE/CIS	408,336	53,017	13	22,000	11,000	11,000	2	5,200	<1,000
Least developed countries	878,097	200,309	23	900,000	510,000	390,000	8	96,000	54,000
Low- and middle-income countries	–	–	–	2,100,000	1,200,000	900,000	6	290,000	110,000
World	7,040,823	1,185,392	17	2,100,000	1,200,000	930,000	6	300,000	110,000

DEFINITIONS OF THE INDICATORS

Population (thousands), 2012: Estimated total population as of 2012 (in thousands).

Adolescents aged 10–19 as a % of total population: Percentage of the total population that is adolescents (aged 10–19).

Estimated number of adolescents living with HIV, 2012: Estimated number of children (aged 0–14) living with HIV as of 2012.

Adolescents (aged 10–19) living with HIV as a % of people (all ages) living with HIV, 2012: Percentage of the estimated number of adults (aged 15+) living with HIV who are adolescents (aged 15–19) living with HIV.

Number of new HIV infections among adolescents (aged 15–19), 2012: Estimated number of new HIV infections among adolescents (aged 15–19) as of 2012.

Number of AIDS deaths among adolescents (aged 10–19), 2012: Estimated number of AIDS-attributed deaths among adolescents (aged 10–19) as of 2012.

MAIN DATA SOURCES

Population (thousands), 2012: United Nations Population Division, 2013.

Adolescents aged 10–19 as a % of total population: United Nations Population Division, 2013.

Estimated number of adolescents living with HIV, 2012: UNAIDS 2012 HIV and AIDS estimates.

Adolescents (aged 10–19) living with HIV as a % of people (all ages) living with HIV, 2012: UNICEF analysis of UNAIDS 2012 HIV and AIDS estimates.

Number of new HIV infections among adolescents (aged 15–19), 2012: UNAIDS 2012 HIV and AIDS estimates.

Number of AIDS deaths among adolescents (aged 10–19), 2012: UNAIDS 2012 HIV and AIDS estimates.

NOTES

– Data not available.

* Data refer to the most recent year available during the period specified in the column heading.

** Excludes China.

‡ Regional averages are calculated only when the population represents 50 per cent or more of the region's total population of interest.

x Data refer to years or periods other than those specified in the column heading. Such data are not included in the calculation of regional and global averages, with the exception of 2005–2006 India. Estimates from years prior to 2005 are not displayed.

y Data differ from the standard definition or refer to only part of a country. If they fall within the reference period, such data are included in the calculation of regional and global averages.

p Based on small denominators (typically 25–29 unweighted cases). No data based on fewer than 25 unweighted cases are displayed.

a/ Sub-Saharan Africa includes the Sudan and Djibouti.

§ Current spectrum modelling software used by UNAIDS assumes HIV infections in the adolescent age group 10–14 are due to mother-to-child transmission. No other transmission routes are included in the model for this age group.

Some estimates do not add up to the totals because of rounding. Low- and middle-income countries are classified as such by the World Bank as of July 2013; these countries form the basis for the data analysis in UNAIDS, UNICEF and WHO.

TABLE 4

Knowledge, HIV testing and sexual behaviour among adolescents

Countries and areas	Knowledge		Sexual behaviour							
	% of adolescents (aged 15–19) who have comprehensive knowledge of HIV, 2008–2012*		% of adolescents (aged 15–19) who had sex with more than one partner in the last 12 months, 2008–2012*		% of adolescents (aged 15–19) with multiple partners who used a condom at last sex, 2008–2012*		% of adolescents (aged 15–19) who had sex before age 15, 2008–2012*		% of adolescents (aged 15–19) who were ever tested and received results, 2008–2012*	
	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
Afghanistan	2	–	–	–	–	–	–	–	–	–
Albania	36	21	0	2	–	–	1	1	–	–
Algeria	12 x	–	–	–	–	–	–	–	1 x	–
Andorra	–	–	–	–	–	–	–	–	–	–
Angola	–	–	–	–	–	–	–	–	–	–
Antigua and Barbuda	–	–	–	–	–	–	–	–	–	–
Argentina	–	–	–	–	–	–	–	–	–	–
Armenia	10	4	–	6	–	–	0	0	1	1
Australia	–	–	–	–	–	–	–	–	–	–
Austria	–	–	–	–	–	–	–	–	–	–
Azerbaijan	3 x	2 x	0 x	3 x	–	–	0 x	1 x	–	–
Bahamas	–	–	–	–	–	–	–	–	–	–
Bahrain	–	–	–	–	–	–	–	–	–	–
Bangladesh	11	–	–	–	–	–	–	–	–	–
Barbados	–	–	–	–	–	–	–	–	–	–
Belarus	–	–	–	–	–	–	–	–	–	–
Belgium	–	–	–	–	–	–	–	–	–	–
Belize	39	–	1	–	–	–	4	–	–	–
Benin	17 x	31 x	2	8	33	40	13 x	13 x	8 x	5 x
Bhutan	22	–	0	–	–	–	2	–	10	–
Bolivia (Plurinational State of)	20	24	–	10	–	43	7	10	–	–
Bosnia and Herzegovina	42	41	1	5	–	–	0	2	–	–
Botswana	–	–	2	1	–	–	2	3	–	–
Brazil	–	–	–	–	–	–	33 x	–	–	–
Brunei Darussalam	–	–	–	–	–	–	–	–	–	–
Bulgaria	–	–	–	–	–	–	–	–	–	–
Burkina Faso	29	31	1	2	57 p	76 p	8	2	14	7
Burundi	43	45	0	1	–	–	4	9	16	11
Cabo Verde	–	–	–	–	–	–	–	–	–	–
Cambodia	43	41	0	0	–	–	0	0	7	3
Cameroon	26	30	4	10	52	70	15	11	28	13
Canada	–	–	–	–	–	–	–	–	–	–
Central African Republic	16 x	26 x	6	17	28	50	27	10	13	6
Chad	10	–	0	–	–	–	21	–	–	–
Chile	–	–	–	–	–	–	–	–	–	–
China	–	–	–	–	–	–	–	–	–	–
Colombia	21 y	–	5	–	45	–	14	–	18	–
Comoros	–	–	1	7	–	51 p	–	–	–	–
Congo	8	18	9	9	25	49	23	24	10	4
Cook Islands	–	–	–	–	–	–	–	–	–	–
Costa Rica	–	–	–	–	–	–	–	–	–	–
Côte d'Ivoire	15	21	4	13	32	70	21	14	19	11
Croatia	–	–	–	–	–	–	–	–	–	–
Cuba	54	–	7	–	64	–	12	–	19	–
Cyprus	–	–	–	–	–	–	–	–	–	–
Czech Republic	–	–	–	–	–	–	–	–	–	–
Democratic People's Republic of Korea	7	–	–	–	–	–	–	–	–	–
Democratic Republic of the Congo	13	–	8	–	18	–	21	–	6	–
Denmark	–	–	–	–	–	–	–	–	–	–
Djibouti	16 x	–	–	–	–	–	–	–	–	–
Dominica	–	–	–	–	–	–	–	–	–	–
Dominican Republic	39 x	33 x	4 x	14 x	37 x	72 x	–	–	–	–
Ecuador	–	–	–	–	–	–	–	–	–	–
Egypt	3	16	–	–	–	–	–	–	–	–
El Salvador	–	–	–	–	–	–	–	–	–	–
Equatorial Guinea	–	–	–	–	–	–	–	–	–	–
Eritrea	–	–	–	–	–	–	–	–	–	–
Estonia	–	–	–	–	–	–	–	–	–	–
Ethiopia	24	32	0	1	–	–	7	1	32	25
Fiji	–	–	–	–	–	–	–	–	–	–

Knowledge, HIV testing and sexual behaviour among adolescents

Countries and areas	Knowledge		Sexual behaviour							
	% of adolescents (aged 15–19) who have comprehensive knowledge of HIV, 2008–2012*		% of adolescents (aged 15–19) who had sex with more than one partner in the last 12 months, 2008–2012*		% of adolescents (aged 15–19) with multiple partners who used a condom at last sex, 2008–2012*		% of adolescents (aged 15–19) who had sex before age 15, 2008–2012*		% of adolescents (aged 15–19) who were ever tested and received results, 2008–2012*	
	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
Finland	–	–	–	–	–	–	–	–	–	–
France	–	–	–	–	–	–	–	–	–	–
Gabon	29	35	9	15	58	77	17	35	31	11
Gambia	33	–	1	–	–	–	4 x	–	4	–
Georgia	–	–	–	–	–	–	–	–	–	–
Germany	–	–	–	–	–	–	–	–	–	–
Ghana	35	34	2 p	3	22 p	–	8	4	–	–
Greece	–	–	–	–	–	–	–	–	–	–
Grenada	–	–	–	–	–	–	–	–	–	–
Guatemala	20	24	1	13	–	79	7	14	–	–
Guinea	–	–	–	–	–	–	–	–	–	–
Guinea-Bissau	12	–	5	–	56	–	27	–	12	–
Guyana	53	45	1	8	–	86	10	16	–	–
Haiti	32	25	2	14	42	58	14	36	18	8
Holy See	–	–	–	–	–	–	–	–	–	–
Honduras	29	33	2	16	39	73	12	24	20	4
Hungary	–	–	–	–	–	–	–	–	–	–
Iceland	–	–	–	–	–	–	–	–	–	–
India	19 x	35 x	0 x	1 x	–	39 x	8 x	3 x	1 x	1 x
Indonesia	6 x,y	2 x,y	–	–	–	–	–	–	–	–
Iran (Islamic Republic of)	–	–	–	–	–	–	–	–	–	–
Iraq	3	–	–	–	–	–	–	–	–	–
Ireland	–	–	–	–	–	–	–	–	–	–
Israel	–	–	–	–	–	–	–	–	–	–
Italy	–	–	–	–	–	–	–	–	–	–
Jamaica	39 y	34 y	16	39	56 p	75	16	49	–	–
Japan	–	–	–	–	–	–	–	–	–	–
Jordan	12 x,y	–	–	–	–	–	–	–	–	–
Kazakhstan	30	30	0	8	–	94 p	0	0	14	14
Kenya	42	51	1	4	–	69 p	12	22	28	22
Kiribati	41	46	1	17	–	29	1	16	–	–
Kuwait	–	–	–	–	–	–	–	–	–	–
Kyrgyzstan	19 x	–	–	7	–	–	0 x	–	–	–
Lao People's Democratic Republic	23	25	–	–	–	–	5	3	–	–
Latvia	–	–	–	–	–	–	–	–	–	–
Lebanon	–	–	–	–	–	–	–	–	–	–
Lesotho	35	28	2	13	37 p	60	9	26	43	19
Liberia	18 x	21 x	8 x	7 x	11 x	29 x	19 x	9 x	3 x	1 x
Libya	–	–	–	–	–	–	–	–	–	–
Liechtenstein	–	–	–	–	–	–	–	–	–	–
Lithuania	–	–	–	–	–	–	–	–	–	–
Luxembourg	–	–	–	–	–	–	–	–	–	–
Madagascar	23	26	3	14	7	9	17	8	8	5
Malawi	40	45	1	5	42 p	36	12	26	–	–
Malaysia	–	–	–	–	–	–	–	–	–	–
Maldives	22 y	–	–	–	–	–	0	–	–	–
Mali	14	–	1	2	–	–	17	–	7	–
Malta	–	–	–	–	–	–	–	–	–	–
Marshall Islands	27 x	35 x	5 x	10 x	–	–	15 x	25 x	–	–
Mauritania	5	–	–	–	–	–	–	–	2	–
Mauritius	–	–	–	–	–	–	–	–	–	–
Mexico	–	–	–	–	–	–	4	–	–	–
Micronesia (Federated States of)	–	–	–	–	–	–	–	–	–	–
Monaco	–	–	–	–	–	–	–	–	–	–
Mongolia	28	24	0	5	–	68 p	0	2	–	–
Montenegro	–	–	–	–	–	–	–	–	–	–
Morocco	–	–	–	–	–	–	–	–	–	–
Mozambique	27	49	3	18	43	44	22	17	25	10
Myanmar	31	–	–	–	–	–	–	–	88	–
Namibia	62 x	59 x	1 x	6 x	77 x,p	84 x	7 x	19 x	18 x	8 x

TABLE 4

◀ Knowledge, HIV testing and sexual behaviour among adolescents

Countries and areas	Knowledge		Sexual behaviour							
	% of adolescents (aged 15–19) who have comprehensive knowledge of HIV, 2008–2012*		% of adolescents (aged 15–19) who had sex with more than one partner in the last 12 months, 2008–2012*		% of adolescents (aged 15–19) with multiple partners who used a condom at last sex, 2008–2012*		% of adolescents (aged 15–19) who had sex before age 15, 2008–2012*		% of adolescents (aged 15–19) who were ever tested and received results, 2008–2012*	
	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
Nauru	8 x	8 x	–	–	–	–	15 x	35 x	–	–
Nepal	25	33	–	2	–	–	5	4	2	4
Netherlands	–	–	–	–	–	–	–	–	–	–
New Zealand	–	–	–	–	–	–	–	–	–	–
Nicaragua	–	–	–	–	–	–	13 x	–	–	–
Niger	12 x	14 x	0	0	–	–	26 x	5 x	2 x	1 x
Nigeria	22	–	3	–	44	–	15	6	7	–
Niue	–	–	–	–	–	–	–	–	–	–
Norway	–	–	–	–	–	–	–	–	–	–
Oman	–	–	–	–	–	–	–	–	–	–
Pakistan	2 x	–	–	–	–	–	–	–	–	–
Palau	–	–	–	–	–	–	–	–	–	–
Panama	–	–	–	–	–	–	–	–	–	–
Papua New Guinea	–	–	–	–	–	–	4 x	4 x	–	–
Paraguay	–	–	6	–	50	–	7	–	–	–
Peru	17 x	–	1 x	– x	–	–	6	–	–	–
Philippines	19	–	–	–	–	–	2	–	0	–
Poland	–	–	–	–	–	–	–	–	–	–
Portugal	–	–	–	–	–	–	–	–	–	–
Qatar	–	–	–	–	–	–	–	–	–	–
Republic of Korea	–	–	–	–	–	–	–	–	–	–
Republic of Moldova	–	–	–	–	–	–	–	–	–	–
Romania	–	–	–	–	–	–	–	–	–	–
Russian Federation	–	–	–	–	–	–	–	–	–	–
Rwanda	49	44	0	0	–	–	5	13	44	37
Saint Kitts and Nevis	–	–	–	–	–	–	–	–	–	–
Saint Lucia	–	–	–	–	–	–	–	–	–	–
Saint Vincent and the Grenadines	–	–	–	–	–	–	–	–	–	–
Samoa	2	5	–	–	–	–	–	–	–	–
San Marino	–	–	–	–	–	–	–	–	–	–
Sao Tome and Principe	39	39	1	7	–	62 p	10	12	27	10
Saudi Arabia	–	–	–	–	–	–	–	–	–	–
Senegal	26	28	0	1	–	–	10	6	16	11
Serbia	53	43	3	15	–	63	1	4	3	3
Seychelles	–	–	–	–	–	–	–	–	–	–
Sierra Leone	23	–	8	–	10	–	22	11	10	–
Singapore	–	–	–	–	–	–	–	–	–	–
Slovakia	–	–	–	–	–	–	–	–	–	–
Slovenia	–	–	–	–	–	–	–	–	–	–
Solomon Islands	29 x	26 x	–	–	15 x,p	–	15 x	16 x	–	–
Somalia	3 x	–	–	–	–	–	–	–	–	–
South Africa	–	–	–	–	–	–	–	–	–	–
South Sudan	8	–	4	–	6 p	–	11	–	3	–
Spain	–	–	–	–	–	–	–	–	–	–
Sri Lanka	–	–	–	–	–	–	–	–	–	–
State of Palestine	5	–	–	–	–	–	–	–	–	–
Sudan	4	–	–	–	–	–	–	–	–	–
Suriname	40	–	2	–	–	–	10	–	–	–
Swaziland	56	52	1	3	–	92 p	3	2	–	–
Sweden	–	–	–	–	–	–	–	–	–	–
Switzerland	–	–	–	–	–	–	–	–	–	–
Syrian Arab Republic	6 x	–	–	–	–	–	–	–	–	–
Tajikistan	11	9	–	–	–	–	0	4	–	–
Thailand	46 x	–	–	–	–	–	–	–	–	–
The former Yugoslav Republic of Macedonia	23 x	–	–	–	–	–	–	–	–	–
Timor-Leste	11	15	–	0	–	–	1	1	–	–
Togo	33	36	4	7	47 p	–	12	6	8	8
Tonga	–	–	–	–	–	–	–	–	–	–

Knowledge, HIV testing and sexual behaviour among adolescents

Countries and areas	Knowledge		Sexual behaviour							
	% of adolescents (aged 15–19) who have comprehensive knowledge of HIV, 2008–2012*		% of adolescents (aged 15–19) who had sex with more than one partner in the last 12 months, 2008–2012*		% of adolescents (aged 15–19) with multiple partners who used a condom at last sex, 2008–2012*		% of adolescents (aged 15–19) who had sex before age 15, 2008–2012*		% of adolescents (aged 15–19) who were ever tested and received results, 2008–2012*	
	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
Trinidad and Tobago	49 x	–	2 x	– x	–	–	5 x	–	–	–
Tunisia	15	–	–	–	–	–	–	–	0	–
Turkey	–	–	–	–	–	–	–	–	–	–
Turkmenistan	4 x	–	–	–	–	–	–	–	–	–
Tuvalu	31 x	57 x	–	–	–	–	2 x	19 x	–	–
Uganda	36	35	2	5	–	56	12	18	45	25
Ukraine	39 x	33 x	2 x	8 x	–	66 x,p	1 x	3 x	–	–
United Arab Emirates	–	–	–	–	–	–	–	–	–	–
United Kingdom	–	–	–	–	–	–	–	–	–	–
United Republic of Tanzania	46	41	3	7	38	45	9	12	31	20
United States	–	–	–	–	–	–	–	–	–	–
Uruguay	–	–	–	–	–	–	–	–	–	–
Uzbekistan	27 x	–	0 x	– x	–	–	–	–	–	–
Vanuatu	14 x	–	–	–	–	–	–	–	–	–
Venezuela (Bolivarian Republic of)	–	–	–	–	–	–	–	–	–	–
Viet Nam	51	–	0	–	–	–	0	–	7	–
Yemen	2 x,y	–	–	–	–	–	–	–	–	–
Zambia	36	38	2 x	5 x	47 x,p	50 x	7	9	21 x	9 x
Zimbabwe	46	42	1	3	–	66 p	4	4	25	10

SUMMARY INDICATORS

Sub-Saharan Africa ^{a/}	26 †	36 †	3	5 †	35 †	– †	13 †	9 †	19 †	– †
Eastern and Southern Africa	34 †	39 †	2 †	5 †	– †	– †	10 †	11 †	29 †	20 †
West and Central Africa	21 †	– †	4 †	– †	37 †	– †	16 †	7 †	10 †	– †
Middle East and North Africa	– †	– †	– †	– †	– †	– †	– †	– †	– †	– †
South Asia	17 †	34 †	0 †	1 †	– †	39 †	8 †	3 †	1 †	1 †
East Asia and the Pacific	– **†	– **†	– **†	– **†	– **†	– **†	– **†	– **†	– **†	– **†
Latin America and the Caribbean	– †	– †	– †	– †	– †	– †	– †	– †	– †	– †
CEE/CIS	– †	– †	– †	– †	– †	– †	– †	– †	– †	– †
Least developed countries	22 †	– †	2 †	– †	– †	– †	12 †	– †	27 †	– †
Low- and middle-income countries	– **†	– **†	– **†	– **†	– **†	– **†	– **†	– **†	– **†	– **†
World	21 **†	– **†	– **†	– **†	– **†	– **†	– **†	– **†	– **†	– **†

DEFINITIONS OF THE INDICATORS

Percentage of adolescents (aged 15–19) who have comprehensive knowledge of HIV: Percentage of adolescents (aged 15–19) who correctly identified the two major ways of preventing the sexual transmission of HIV (using condoms and limiting sex to one faithful, uninfected partner), who reject the two most common local misconceptions about HIV and who know that a healthy-looking person can transmit HIV.

Percentage of adolescents (aged 15–19) who had sex with more than one partner in the last 12 months: Percentage of adolescents (aged 15–19) who reported having sexual intercourse with more than one partner in the last 12 months.

Percentage of adolescents (aged 15–19) with multiple partners who used a condom at last sex: Percentage of adolescents (aged 15–19) who reported having sexual intercourse with more than one partner in the last 12 months and who reported the use of a condom during their last sexual intercourse.

Percentage of adolescents (aged 15–19) who had sex before age 15: Percentage of adolescents (aged 15–19) who reported having sex before age 15.

Percentage of adolescents (aged 15–19) who were tested and received results: Percentage of adolescents (aged 15–19) who have ever been tested for HIV and received the result.

MAIN DATA SOURCES

Percentage of adolescents (aged 15–19) who have comprehensive knowledge of HIV: UNICEF global databases, 2013, based on DHS, MICS and other national surveys, 2006–2012.

Percentage of adolescents (aged 15–19) who had sex with more than one partner in the last 12 months: UNICEF global databases, 2013, based on DHS, MICS and other national surveys, 2006–2012.

Percentage of adolescents (aged 15–19) with multiple partners who used a condom at last sex: UNICEF global databases, 2013, based on DHS, MICS and other national surveys, 2006–2012.

Percentage of adolescents (aged 15–19) who had sex before age 15: UNICEF global databases, 2013, based on DHS, MICS and other national surveys, 2006–2012.

Percentage of adolescents (aged 15–19) who were tested and received results: UNICEF global databases, 2013, based on DHS, MICS and other national surveys, 2006–2012.

NOTES

– Data not available.

* Data refer to the most recent year available during the period specified in the column heading.

** Excludes China.

† Regional averages are calculated only when the population represents 50 per cent or more of the region's total population of interest.

x Data refer to years or periods other than those specified in the column heading. Such data are not included in the calculation of regional and global averages, with the exception of 2005–2006 India. Estimates from years prior to 2005 are not displayed.

y Data differ from the standard definition or refer to only part of a country. If they fall within the reference period, such data are included in the calculation of regional and global averages.

p Based on small denominators (typically 25–29 unweighted cases). No data based on fewer than 25 unweighted cases are displayed.

a/ Sub-Saharan Africa includes the Sudan and Djibouti.

Some estimates do not add up to the totals because of rounding. Low- and middle-income countries are classified as such by the World Bank as of July 2013; these countries form the basis for the data analysis in UNAIDS, UNICEF and WHO.

TABLE 5

Epidemiology, knowledge, HIV testing and sexual behavior among key affected populations aged below 25 years

Countries and areas	Epidemiology HIV prevalence (%) among higher-risk populations in capital city (aged below 25), 2007–2012*			Sexual behaviour % of higher-risk populations (aged below 25) using a condom at last sex, 2007–2012*			Access % of persons who inject drugs (aged below 25) reporting use of sterile injecting equipment the last time they injected, 2007–2012*	Testing % of higher-risk populations (aged below 25) who received an HIV test and knew their result, 2007–2012*		
	People who inject drugs	Sex workers	Men who have sex with men	People who inject drugs	Sex workers	Men who have sex with men		People who inject drugs	Sex workers	Men who have sex with men
Afghanistan	2.7	0.3	0.0	43	51	17	64	79	53	73
Albania	–	–	–	–	–	–	–	–	–	–
Algeria	–	4.3	–	–	40	–	–	–	39	–
Andorra	–	–	8.2	–	–	–	–	–	–	–
Angola	–	7.2	–	–	74	25	–	–	35	30
Antigua and Barbuda	–	–	–	–	–	–	–	–	–	–
Argentina	1.4	–	9.4	65	100	91	92	45	–	99
Armenia	0.0	0.0	3.5	54	91	71	66	0	27	32
Australia	1.7	0.0	–	27	–	39	75	49	60	83
Austria	–	–	–	–	–	–	–	–	–	–
Azerbaijan	1.7	1.2	0.0	8	57	23	54	3	13	19
Bahamas	–	–	15.0	–	–	79	–	–	–	50
Bahrain	–	–	–	–	–	–	–	–	–	–
Bangladesh	0.7	0.2	0.0	43	62	34	41	4	8	11
Barbados	–	–	–	–	73	–	–	–	80	–
Belarus	6.8	0.0	0.0	58	80	65	87	40	70	70
Belgium	–	0.4	3.8	–	–	54	–	24	–	39
Belize	–	0.0	10.5	–	90	60	–	–	57	57
Benin	4.8	13.3	–	60	87	59	26	26	92	31
Bhutan	–	–	–	–	–	–	–	–	–	–
Bolivia (Plurinational State of)	–	0.6	–	–	96	67	–	–	63	36
Bosnia and Herzegovina	–	–	–	43	–	–	76	17	–	–
Botswana	–	–	–	–	–	–	–	–	–	–
Brazil	–	–	–	–	–	–	–	–	18	21
Brunei Darussalam	–	–	–	–	–	–	–	–	–	–
Bulgaria	11.9	0.0	0.0	68	85	66	75	61	59	52
Burkina Faso	–	8.6	1.3	–	98	–	–	–	–	100
Burundi	–	24.3	1.1	–	91	68	–	–	62	23
Cabo Verde	–	0.5	–	–	56	–	–	–	28	–
Cambodia	–	–	1.1	–	–	69	58	36	–	33
Cameroon	–	27.5	28.8	–	76	57	–	–	32	54
Canada	2.6	–	2.2	40	–	65	92	74	–	36
Central African Republic	–	–	33.9	–	–	69	–	–	–	84
Chad	–	19.6	–	–	43	–	–	–	38	–
Chile	–	–	7.3	–	74	50	–	–	91	26
China	3.7	0.2	5.6	47	89	76	57	27	30	39
Colombia	–	0.5	9.5	–	99	–	–	–	41	–
Comoros	–	0.0	–	–	68	–	–	–	100	–
Congo	–	3.8	20.2	–	82	59	–	–	46	27
Cook Islands	–	–	–	–	–	–	–	–	–	–
Costa Rica	–	–	–	–	–	–	–	–	–	42
Côte d'Ivoire	–	11.7	13.8	–	92	67	0	–	47	59
Croatia	–	–	–	–	–	–	–	–	–	–
Cuba	–	0.9	6.2	–	71	71	–	–	32	20
Cyprus	0.0	–	–	–	–	–	–	–	–	–
Czech Republic	–	–	1.4	–	–	40	–	–	–	27
Democratic People's Republic of Korea	–	–	–	–	–	–	–	–	–	–
Democratic Republic of the Congo	–	4.5	5.5	–	27	16	–	–	85	81
Denmark	–	–	–	–	–	–	–	–	–	–
Djibouti	–	12.5	–	–	71	–	–	–	100	–
Dominica	–	–	16.0	–	–	70	–	–	–	24
Dominican Republic	–	2.4	3.7	–	84	41	–	–	79	36
Ecuador	–	–	8.8	–	–	54	–	–	–	22
Egypt	–	–	–	–	–	–	–	–	–	–
El Salvador	–	–	–	–	–	83	–	–	95	52
Equatorial Guinea	–	–	–	–	–	–	–	–	–	–
Eritrea	–	1.5	–	–	68	–	–	–	80	–
Estonia	36.4	11.1	0.0	41	100	41	89	35	56	29

Epidemiology, knowledge, HIV testing and sexual behavior among key affected populations aged below 25 years

Countries and areas	Epidemiology HIV prevalence (%) among higher-risk populations in capital city (aged below 25), 2007–2012*			Sexual behaviour % of higher-risk populations (aged below 25) using a condom at last sex, 2007–2012*			Access % of persons who inject drugs (aged below 25) reporting use of sterile injecting equipment the last time they injected, 2007–2012*	Testing % of higher-risk populations (aged below 25) who received an HIV test and knew their result, 2007–2012*		
	People who inject drugs	Sex workers	Men who have sex with men	People who inject drugs	Sex workers	Men who have sex with men		People who inject drugs	Sex workers	Men who have sex with men
Ethiopia	–	–	–	–	98	–	–	–	98	–
Fiji	–	0.0	–	–	91	–	–	–	27	–
Finland	–	–	–	–	–	45	–	–	–	24
France	–	–	1.5	–	–	57	–	–	63	41
Gabon	–	–	–	–	56	–	–	–	40	–
Gambia	–	–	–	–	–	–	–	–	–	–
Georgia	1.1	–	3.0	50	90	76	88	7	44	29
Germany	0.0	–	3.0	48	–	52	93	63	–	32
Ghana	–	–	–	–	–	–	–	–	–	–
Greece	8.8	–	–	–	0	69	–	77	57	28
Grenada	–	–	–	–	–	–	–	–	–	–
Guatemala	–	–	–	–	95	81	–	–	92	63
Guinea	–	14.8	59.7	–	71	25	–	–	83	47
Guinea-Bissau	–	22.2	–	–	91	–	–	–	95	28
Guyana	–	6.6	–	–	92	–	–	–	88	86
Haiti	–	6.7	13.3	–	91	71	–	–	66	47
Holy See	–	–	–	–	–	–	–	–	–	–
Honduras	–	1.4	4.1	–	78	68	–	–	81	25
Hungary	0.0	–	4.0	21	–	25	67	22	–	100
Iceland	–	–	–	–	–	–	–	–	–	–
India	5.3	1.7	3.5	13	88	44	85	21	38	7
Indonesia	11.6	8.0	6.1	56	49	64	82	84	78	92
Iran (Islamic Republic of)	6.6	0.0	0.0	24	62	45	91	17	25	11
Iraq	–	–	–	–	–	–	–	–	–	–
Ireland	–	–	–	–	–	63	–	–	–	30
Israel	–	–	–	–	–	–	–	–	–	–
Italy	–	–	–	–	–	56	–	–	–	30
Jamaica	–	1.3	25.7	–	91	75	–	–	65	72
Japan	–	–	1.2	–	37	50	–	–	72	20
Jordan	–	–	–	–	–	–	–	–	–	–
Kazakhstan	2.6	1.0	0.3	56.2	73	86	55	58	73	56
Kenya	–	–	12.2	–	87	–	–	–	95	–
Kiribati	–	–	–	–	–	–	–	–	–	–
Kuwait	–	–	–	–	–	–	–	–	–	–
Kyrgyzstan	8.1	3.5	2.2	52	83	74	86	54	31	37
Lao People's Democratic Republic	–	0.8	5.2	–	93	24	–	–	21	12
Latvia	5.8	15.0	3.1	62	80	40	85	59	60	24
Lebanon	–	–	–	–	–	–	–	–	–	–
Lesotho	–	–	–	–	–	–	–	–	–	–
Liberia	–	–	–	–	–	–	–	–	–	–
Libya	–	–	–	–	–	–	–	–	–	–
Liechtenstein	–	–	–	–	–	–	–	–	–	–
Lithuania	0.0	0.0	0.0	–	89	40	97	72	25	16
Luxembourg	0.0	–	–	–	–	60	–	–	–	46
Madagascar	–	0.3	–	–	–	–	–	–	–	–
Malawi	–	–	–	–	–	–	–	–	–	–
Malaysia	4.8	1.1	6.2	25	88	72	94	79	71	75
Maldives	0.0	0.0	0.0	–	–	–	71	15	21	12
Mali	–	25.7	–	–	97	–	–	–	–	–
Malta	–	–	–	–	–	–	–	12	–	–
Marshall Islands	–	–	–	–	–	–	–	–	–	–
Mauritania	–	–	4.6	–	–	–	–	–	59	–
Mauritius	–	11.1	8.3	16	86	58	83	32	75	93
Mexico	6.9	0.9	12.4	38	65	72	40	34	54	38
Micronesia (Federated States of)	–	–	–	–	–	–	–	–	–	–
Monaco	–	–	–	–	–	–	–	–	–	–
Mongolia	–	0.0	10.0	–	84	70	–	–	50	56
Montenegro	–	0.0	0.0	–	81	–	95	–	17	11

TABLE 5

◀ Epidemiology, knowledge, HIV testing and sexual behavior among key affected populations aged below 25 years

Countries and areas	Epidemiology HIV prevalence (%) among higher-risk populations in capital city (aged below 25), 2007–2012*			Sexual behaviour % of higher-risk populations (aged below 25) using a condom at last sex, 2007–2012*			Access % of persons who inject drugs (aged below 25) reporting use of sterile injecting equipment the last time they injected, 2007–2012*	Testing % of higher-risk populations (aged below 25) who received an HIV test and knew their result, 2007–2012*		
	People who inject drugs	Sex workers	Men who have sex with men	People who inject drugs	Sex workers	Men who have sex with men		People who inject drugs	Sex workers	Men who have sex with men
Morocco	1.7	1.0	3.3	28	47	50	58	7	15	25
Mozambique	–	–	–	–	–	–	–	–	–	–
Myanmar	13.3	5.9	4.5	79	96	84	83	26	68	45
Namibia	–	–	–	–	–	–	–	–	–	–
Nauru	–	–	–	–	–	–	–	–	–	–
Nepal	1.1	–	1.3	40	–	75	97	19	–	36
Netherlands	–	–	–	–	–	–	–	–	–	–
New Zealand	–	–	0.0	–	–	–	–	–	–	–
Nicaragua	–	1.2	3.0	–	97	52	–	–	42	28
Niger	–	17.2	–	–	96	–	–	–	70	–
Nigeria	3.7	19.0	15.1	55	87	48	75	18	37	21
Niue	–	–	–	–	–	–	–	–	–	–
Norway	–	–	–	–	–	–	–	–	–	–
Oman	–	–	–	–	–	–	–	–	–	–
Pakistan	33.9	2.2	–	22	–	24	63	8	6	–
Palau	–	–	–	–	–	–	–	–	–	–
Panama	–	–	–	–	27	35	–	–	27	35
Papua New Guinea	–	12.7	1.9	–	75	60	–	–	43	63
Paraguay	4.0	3.0	13.1	48	94	72	93	70	72	54
Peru	–	–	10.5	–	70	52	–	–	–	–
Philippines	9.5	0.3	1.5	16	65	34	22	2	14	4
Poland	–	–	–	–	–	–	–	–	–	–
Portugal	4.9	9.1	2.8	36	93	71	59	41	71	76
Qatar	–	–	–	–	–	–	–	–	–	–
Republic of Korea	–	–	4.3	–	–	57	–	–	–	23
Republic of Moldova	1.4	1.7	0.2	26	96	60	100	36	19	7
Romania	1.2	–	–	22	99	42	87	14	25	42
Russian Federation	12.0	4.1	10.8	54	68	58	86	34	36	31
Rwanda	–	42.1	–	–	78	–	–	–	86	–
Saint Kitts and Nevis	–	–	–	–	–	–	–	–	–	–
Saint Lucia	12.5	–	–	–	–	95	–	22	–	100
Saint Vincent and the Grenadines	–	–	12.9	–	–	–	–	–	–	–
Samoa	–	–	–	–	–	–	–	–	–	–
San Marino	–	–	–	–	–	–	–	–	–	–
Sao Tome and Principe	–	–	–	–	22	–	–	–	68	–
Saudi Arabia	–	–	–	–	–	–	–	–	–	–
Senegal	–	15.0	12.7	–	89	72	–	–	48	31
Serbia	4.8	2.0	1.4	46	91	65	88	17	68	34
Seychelles	–	–	–	–	–	–	–	–	–	–
Sierra Leone	–	–	5.7	–	–	–	–	–	–	–
Singapore	–	–	–	–	–	–	–	–	–	–
Slovakia	–	–	–	–	–	–	–	–	–	–
Slovenia	0.0	–	–	–	–	25	–	–	–	–
Solomon Islands	–	–	–	–	–	–	–	–	–	–
Somalia	–	–	–	–	–	–	–	–	–	–
South Africa	–	–	–	–	–	–	–	–	–	–
South Sudan ⁶	–	–	–	–	–	–	–	–	–	–
Spain	0.0	1.2	10.9	–	–	59	–	–	–	37
Sri Lanka	–	0.0	0.0	–	88	61	–	–	–	7
State of Palestine	–	–	–	–	–	–	–	–	–	–
Sudan ⁶	–	–	–	–	46	–	–	–	6	–
Suriname	–	4.6	–	–	–	75	–	–	93	98
Swaziland	–	64.1	–	–	87	–	–	–	92	–
Sweden	0.0	0.0	0.7	6	0	41	44	47	56	31
Switzerland	6.3	–	2.1	49	–	37	95	65	–	39
Syrian Arab Republic	–	–	–	–	–	–	–	–	–	–
Tajikistan	9.5	3.7	1.4	72	75	70	91	31	41	39
Thailand	25.0	–	5.3	49	94	86	73	54	40	17

Epidemiology, knowledge, HIV testing and sexual behavior among key affected populations aged below 25 years

Countries and areas	Epidemiology HIV prevalence (%) among higher-risk populations in capital city (aged below 25), 2007–2012*			Sexual behaviour % of higher-risk populations (aged below 25) using a condom at last sex, 2007–2012*			Access % of persons who inject drugs (aged below 25) reporting use of sterile injecting equipment the last time they injected, 2007–2012*	Testing % of higher-risk populations (aged below 25) who received an HIV test and knew their result, 2007–2012*		
	People who inject drugs	Sex workers	Men who have sex with men	People who inject drugs	Sex workers	Men who have sex with men		People who inject drugs	Sex workers	Men who have sex with men
The former Yugoslav Republic of Macedonia	0.0	0.0	0.0	53	86	51	89	92	32	32
Timor-Leste	–	–	–	–	–	–	–	–	–	–
Togo	0.0	8.1	19.8	0	90	43	–	0	53	47
Tonga	–	–	–	–	–	27	–	–	–	–
Trinidad and Tobago	–	–	5.8	–	–	–	–	–	–	–
Tunisia	0.6	0.6	9.8	32	59	32	91	17	11	13
Turkey	0.0	1.6	1.7	17	34	27	17	22	–	38
Turkmenistan	–	–	–	–	–	–	–	–	–	–
Tuvalu	–	–	–	–	–	–	–	–	–	–
Uganda	–	–	–	–	–	–	–	–	–	–
Ukraine	7.1	3.0	4.2	58	94	69	95	35	57	36
United Arab Emirates	–	–	–	–	–	–	–	–	–	–
United Kingdom	0.6	–	–	42	–	–	78	–	–	20
United Republic of Tanzania	–	–	–	–	–	–	–	–	–	–
United States	–	–	–	18	–	57	–	51	–	70
Uruguay	–	–	6.9	–	–	44	–	–	–	–
Uzbekistan	5.6	1.7	2.0	55	86	64	78	30	32	27
Vanuatu	–	–	–	–	–	63	–	–	–	–
Venezuela (Bolivarian Republic of)	–	–	–	–	–	–	–	–	–	–
Viet Nam	–	–	3.0	55	82	66	95	26	39	38
Yemen	–	–	3.1	–	–	16	–	–	–	19
Zambia	–	–	–	–	–	–	–	–	–	–
Zimbabwe	–	25.1	–	–	52	–	–	–	53	–

DEFINITIONS OF THE INDICATORS

HIV prevalence (%) among higher-risk populations in capital city (aged below 25 years), 2007–2012: Percentage of higher-risk populations (persons who inject drugs, sex workers and men who have sex with men aged 0–24) living with HIV.

Percentage of higher-risk populations (aged below 25 years) using a condom at last sex, 2007–2012: Percentage of higher-risk populations (persons who inject drugs, sex workers and men who have sex with men aged 0–24) using a condom at last sex.

Percentage of persons who inject drugs (aged below 25 years) reporting use of sterile injecting equipment the last time they injected, 2007–2012: Percentage of people who inject drugs (aged 0–24) reporting the use of sterile injecting equipment the last time they injected.

Percentage of higher-risk populations (aged below 25 years) who received an HIV test and knew their result, 2007–2012: Percentage of higher-risk populations (persons who inject drugs, sex workers and men who have sex with men aged 0–24) who received an HIV test in the past 12 months and knew the result.

MAIN DATA SOURCES

HIV prevalence (%) among higher-risk populations in capital city (aged below 25 years), 2007–2012: UNAIDS online database, <www.aidsinfoonline.org>, accessed on 26 September 2013.

Percentage of higher-risk populations (aged below 25 years) using a condom at last sex, 2007–2012: UNAIDS online database, <www.aidsinfoonline.org>, accessed on 26 September 2013.

Percentage of persons who inject drugs (aged below 25 years) reporting use of sterile injecting equipment the last time they injected, 2007–2012: UNAIDS online database, <www.aidsinfoonline.org>, accessed on 26 September 2013.

Percentage of higher-risk populations (aged below 25 years) who received an HIV test and knew their result, 2007–2012: UNAIDS online database, <www.aidsinfoonline.org>, accessed on 26 September 2013.

NOTES

– Data not available.

* Data refer to the most recent year available during the period specified in the column heading.

** Excludes China.

‡ Regional averages are calculated only when the population represents 50 per cent or more of the region's total population of interest.

x Data refer to years or periods other than those specified in the column heading. Such data are not included in the calculation of regional and global averages, with the exception of 2005–2006 India. Estimates from years prior to 2005 are not displayed.

y Data differ from the standard definition or refer to only part of a country. If they fall within the reference period, such data are included in the calculation of regional and global averages.

p Based on small denominators (typically 25–29 unweighted cases). No data based on fewer than 25 unweighted cases are displayed.

a/ Sub-Saharan Africa includes the Sudan and Djibouti.

δ Due to the cession in July 2011 of the Republic of South Sudan by the Republic of the Sudan, and its subsequent admission to the United Nations on 14 July 2011, disaggregated data for the Sudan and South Sudan as separate States are not yet available for all indicators. In these cases, aggregated data are presented for the Sudan pre-cession.

Some estimates do not add up to the totals because of rounding. Low- and middle-income countries are classified as such by the World Bank as of July 2013; these countries form the basis for the data analysis in UNAIDS, UNICEF and WHO.

TABLE 6

Protection, care and support for children affected by HIV and AIDS

Countries and areas	Children who have lost one or both parents due to all causes, 2012	Children who have lost one or both parents due to AIDS, 2012			Orphaned and vulnerable children			
		Estimate	Low estimate	High estimate	Children both of whose parents have died due to any cause, 2012	Children both of whose parents have died due to AIDS, 2012	Orphan school attendance ratio, 2008–2012*	% of children whose households received external support, 2008–2012*
Afghanistan	–	–	–	–	–	–	–	–
Albania	–	–	–	–	–	–	–	–
Algeria	–	–	–	–	–	–	–	–
Andorra	–	–	–	–	–	–	–	–
Angola	1,100,000	120,000	87,000	170,000	170,000	38,000	85	–
Antigua and Barbuda	–	–	–	–	–	–	–	–
Argentina	–	–	–	–	–	–	–	–
Armenia	–	–	–	–	–	–	–	–
Australia	–	–	–	–	–	–	–	–
Austria	–	–	–	–	–	–	–	–
Azerbaijan	–	–	–	–	–	–	–	–
Bahamas	–	–	–	–	–	–	–	–
Bahrain	–	–	–	–	–	–	–	–
Bangladesh	–	–	–	–	–	–	84 x	–
Barbados	–	–	–	–	–	–	–	–
Belarus	–	–	–	–	–	–	–	–
Belgium	–	–	–	–	–	–	–	–
Belize	–	–	–	–	–	–	–	–
Benin	450,000	43,000	36,000	51,000	60,000	13,000	90 x	–
Bhutan	–	–	–	–	–	–	–	–
Bolivia (Plurinational State of)	–	–	–	–	–	–	–	–
Bosnia and Herzegovina	–	–	–	–	–	–	–	–
Botswana	160,000	120,000	100,000	130,000	46,000	44,000	–	26 y
Brazil	–	–	–	–	–	–	–	–
Brunei Darussalam	–	–	–	–	–	–	–	–
Bulgaria	–	–	–	–	–	–	–	–
Burkina Faso	980,000	130,000	110,000	160,000	160,000	46,000	101	7 x
Burundi	680,000	89,000	73,000	110,000	140,000	40,000	82	–
Cabo Verde	–	–	–	–	–	–	–	–
Cambodia	–	–	–	–	–	–	86	–
Cameroon	1,300,000	330,000	300,000	380,000	250,000	120,000	94	9 x
Canada	–	–	–	–	–	–	–	–
Central African Republic	–	–	–	–	–	–	88	7 x
Chad	960,000	170,000	140,000	200,000	180,000	64,000	117	–
Chile	–	–	–	–	–	–	–	–
China	–	–	–	–	–	–	–	–
Colombia	–	–	–	–	–	–	93	–
Comoros	–	–	–	–	–	–	–	–
Congo	220,000	64,000	58,000	72,000	39,000	21,000	74 p	–
Cook Islands	–	–	–	–	–	–	–	–
Costa Rica	–	–	–	–	–	–	–	–
Côte d'Ivoire	1,300,000	380,000	340,000	440,000	240,000	130,000	66	–
Croatia	–	–	–	–	–	–	–	–
Cuba	–	–	–	–	–	–	–	–
Cyprus	–	–	–	–	–	–	–	–
Czech Republic	–	–	–	–	–	–	–	–
Democratic People's Republic of Korea	–	–	–	–	–	–	–	–
Democratic Republic of the Congo	5,100,000	390,000	350,000	440,000	860,000	140,000	74	9 x
Denmark	–	–	–	–	–	–	–	–
Djibouti	43,000	7,200	5,600	8,700	7,100	2,300	–	–
Dominica	–	–	–	–	–	–	–	–
Dominican Republic	–	–	–	–	–	–	98	–
Ecuador	–	–	–	–	–	–	–	–
Egypt	–	–	–	–	–	–	–	–
El Salvador	–	–	–	–	–	–	–	–
Equatorial Guinea	–	–	5,000	20,000	–	–	–	–
Eritrea	160,000	21,000	14,000	30,000	25,000	7,400	–	–
Estonia	–	–	–	–	–	–	–	–
Ethiopia	4,500,000	900,000	<100	<100	650,000	130,000	90	–
Fiji	–	–	–	–	–	–	–	–

Protection, care and support for children affected by HIV and AIDS

Countries and areas	Orphaned and vulnerable children							
	Children who have lost one or both parents due to all causes, 2012	Children who have lost one or both parents due to AIDS, 2012			Children both of whose parents have died due to any cause, 2012	Children both of whose parents have died due to AIDS, 2012	Orphan school attendance ratio, 2008–2012*	% of children whose households received external support, 2008–2012*
		Estimate	Low estimate	High estimate				
Finland	–	–	–	–	–	–	–	–
France	–	–	–	–	–	–	–	–
Gabon	61,000	19,000	16,000	22,000	9,900	6,000	101	–
Gambia	–	–	–	–	–	–	106	–
Georgia	–	–	–	–	–	–	–	–
Germany	–	–	–	–	–	–	–	–
Ghana	1,000,000	190,000	160,000	230,000	140,000	53,000	76	–
Greece	–	–	–	–	–	–	–	–
Grenada	–	–	–	–	–	–	–	–
Guatemala	–	–	–	–	–	–	–	–
Guinea	670,000	46,000	35,000	58,000	100,000	15,000	73 x	–
Guinea-Bissau	120,000	17,000	13,000	23,000	21,000	6,000	109	8 x
Guyana	–	–	–	–	–	–	–	13 x
Haiti	430,000	100,000	90,000	120,000	61,000	29,000	96	5 x
Holy See	–	–	–	–	–	–	–	–
Honduras	–	–	–	–	–	–	92	–
Hungary	–	–	–	–	–	–	–	–
Iceland	–	–	–	–	–	–	–	–
India	–	–	–	–	–	–	72 x	–
Indonesia	–	–	–	–	–	–	–	–
Iran (Islamic Republic of)	–	–	–	–	–	–	–	–
Iraq	–	–	–	–	–	–	94	–
Ireland	–	–	–	–	–	–	–	–
Israel	–	–	–	–	–	–	–	–
Italy	–	–	–	–	–	–	–	–
Jamaica	–	–	–	–	–	–	–	15 x
Japan	–	–	–	–	–	–	–	–
Jordan	–	–	–	–	–	–	–	–
Kazakhstan	–	–	–	–	–	–	–	–
Kenya	2,600,000	1,000,000	<100	<100	410,000	290,000	95 x	21 x
Kiribati	–	–	–	–	–	–	–	–
Kuwait	–	–	–	–	–	–	–	–
Kyrgyzstan	–	–	–	–	–	–	–	–
Lao People's Democratic Republic	–	–	–	–	–	–	80	–
Latvia	–	–	–	–	–	–	–	–
Lebanon	–	–	–	–	–	–	–	–
Lesotho	220,000	150,000	140,000	170,000	64,000	59,000	98	–
Liberia	190,000	23,000	19,000	27,000	30,000	7,500	85 x	–
Libya	–	–	–	–	–	–	–	–
Liechtenstein	–	–	–	–	–	–	–	–
Lithuania	–	–	–	–	–	–	–	–
Luxembourg	–	–	–	–	–	–	–	–
Madagascar	–	–	–	–	–	–	74	–
Malawi	1,300,000	770,000	700,000	850,000	270,000	240,000	97	17
Malaysia	–	–	–	–	–	–	–	–
Maldives	–	–	–	–	–	–	–	–
Mali	–	–	–	–	–	–	92	–
Malta	–	–	–	–	–	–	–	–
Marshall Islands	–	–	–	–	–	–	–	–
Mauritania	–	–	–	–	–	–	100 p	–
Mauritius	–	–	–	–	–	–	–	–
Mexico	–	–	–	–	–	–	–	–
Micronesia (Federated States of)	–	–	–	–	–	–	–	–
Monaco	–	–	–	–	–	–	–	–
Mongolia	–	–	–	–	–	–	102	–
Montenegro	–	–	–	–	–	–	–	–
Morocco	–	–	–	–	–	–	–	–
Mozambique	2,000,000	740,000	640,000	870,000	420,000	260,000	91	22
Myanmar	–	–	–	–	–	–	–	–
Namibia	130,000	76,000	62,000	95,000	25,000	22,000	100 x	17 x

TABLE 6

◀ Protection, care and support for children affected by HIV and AIDS

Countries and areas	Children who have lost one or both parents due to all causes, 2012	Children who have lost one or both parents due to AIDS, 2012			Orphaned and vulnerable children			
		Estimate	Low estimate	High estimate	Children both of whose parents have died due to any cause, 2012	Children both of whose parents have died due to AIDS, 2012	Orphan school attendance ratio, 2008–2012*	% of children whose households received external support, 2008–2012*
Nauru	–	–	–	–	–	–	–	–
Nepal	–	–	–	–	–	–	72 p	–
Netherlands	–	–	–	–	–	–	–	–
New Zealand	–	–	–	–	–	–	–	–
Nicaragua	–	–	–	–	–	–	–	–
Niger	–	–	–	–	–	–	67 x	–
Nigeria	11,500,000	2,200,000	1,900,000	2,600,000	2,000,000	750,000	100	6
Niue	–	–	–	–	–	–	–	–
Norway	–	–	–	–	–	–	–	–
Oman	–	–	–	–	–	–	–	–
Pakistan	–	–	–	–	–	–	–	–
Palau	–	–	–	–	–	–	–	–
Panama	–	–	–	–	–	–	–	–
Papua New Guinea	320,000	13,000	7600	19,000	43,000	3,900	–	–
Paraguay	–	–	–	–	–	–	–	–
Peru	–	–	–	–	–	–	–	–
Philippines	–	–	–	–	–	–	–	–
Poland	–	–	–	–	–	–	–	–
Portugal	–	–	–	–	–	–	–	–
Qatar	–	–	–	–	–	–	–	–
Republic of Korea	–	–	–	–	–	–	–	–
Republic of Moldova	–	–	–	–	–	–	–	–
Romania	–	–	–	–	–	–	–	–
Russian Federation	–	–	–	–	–	–	–	–
Rwanda	590,000	120,000	110,000	140,000	110,000	47,000	91	13
Saint Kitts and Nevis	–	–	–	–	–	–	–	–
Saint Lucia	–	–	–	–	–	–	–	–
Saint Vincent and the Grenadines	–	–	–	–	–	–	–	–
Samoa	–	–	–	–	–	–	–	–
San Marino	–	–	–	–	–	–	–	–
Sao Tome and Principe	–	–	–	–	–	–	–	4 x
Saudi Arabia	–	–	–	–	–	–	–	–
Senegal	–	–	–	–	–	–	97	–
Serbia	–	–	–	–	–	–	–	–
Seychelles	–	–	–	–	–	–	–	–
Sierra Leone	370,000	26,000	18,000	37,000	56,000	7,800	88	1
Singapore	–	–	–	–	–	–	–	–
Slovakia	–	–	–	–	–	–	–	–
Slovenia	–	–	–	–	–	–	–	–
Solomon Islands	–	–	–	–	–	–	–	–
Somalia	–	–	–	–	–	–	78 x	–
South Africa	4,000,000	2,500,000	2,300,000	2,700,000	1,100,000	940,000	101	–
South Sudan	470,000	110,000	67,000	170,000	75,000	34,000	78	–
Spain	–	–	–	–	–	–	–	–
Sri Lanka	–	–	–	–	–	–	–	–
State of Palestine	–	–	–	–	–	–	–	–
Sudan	–	–	–	–	–	–	–	–
Suriname	–	–	–	–	–	–	–	–
Swaziland	120,000	78,000	69,000	87,000	33,000	30,000	100	41 x
Sweden	–	–	–	–	–	–	–	–
Switzerland	–	–	–	–	–	–	–	–
Syrian Arab Republic	–	–	–	–	–	–	–	–
Tajikistan	–	–	–	–	–	–	–	–
Thailand	–	–	–	–	–	–	93 x	21 x
The former Yugoslav Republic of Macedonia	–	–	–	–	–	–	–	–
Timor-Leste	–	–	–	–	–	–	75	–
Togo	360,000	90,000	75,000	110,000	62,000	30,000	86	6 x
Tonga	–	–	–	–	–	–	–	–

Protection, care and support for children affected by HIV and AIDS

Countries and areas	Children who have lost one or both parents due to all causes, 2012	Children who have lost one or both parents due to AIDS, 2012			Orphaned and vulnerable children		Orphan school attendance ratio, 2008–2012*	% of children whose households received external support, 2008–2012*
		Estimate	Low estimate	High estimate	Children both of whose parents have died due to any cause, 2012	Children both of whose parents have died due to AIDS, 2012		
Trinidad and Tobago	–	–	–	–	–	–	–	–
Tunisia	–	–	–	–	–	–	–	–
Turkey	–	–	–	–	–	–	–	–
Turkmenistan	–	–	–	–	–	–	–	–
Tuvalu	–	–	–	–	–	–	–	–
Uganda	2,700,000	1,000,000	860,000	1,200,000	510,000	330,000	87	11 x
Ukraine	–	–	–	–	–	–	98 x	–
United Arab Emirates	–	–	–	–	–	–	–	–
United Kingdom	–	–	–	–	–	–	–	–
United Republic of Tanzania	3,100,000	1,200,000	1,000,000	1,300,000	570,000	370,000	95	7
United States	–	–	–	–	–	–	–	–
Uruguay	–	–	–	–	–	–	–	–
Uzbekistan	–	–	–	–	–	–	–	–
Vanuatu	–	–	–	–	–	–	–	–
Venezuela (Bolivarian Republic of)	–	–	–	–	–	–	–	–
Viet Nam	–	–	–	–	–	–	–	–
Yemen	–	–	–	–	–	–	–	–
Zambia	1,400,000	670,000	600,000	760,000	370,000	280,000	92	19 y
Zimbabwe	1,200,000	890,000	810,000	980,000	350,000	330,000	92	21

SUMMARY INDICATORS

Sub-Saharan Africa ^{a/}	56,000,000	15,100,000	13,400,000	16,900,000	10,300,000	5,000,000	91 †	– †
Eastern and Southern Africa	27,900,000	10,600,000	9,600,000	11,800,000	5,500,000	3,500,000	90 †	– †
West and Central Africa	28,100,000	4,400,000	3,800,000	5,200,000	4,800,000	1,500,000	91 †	– †
Middle East and North Africa	5,500,000	100,000	71,000	150,000	490,000	21,000	– †	– †
South Asia	40,800,000	610,000	180,000	2,100,000	3,600,000	180,000	72 †	– †
East Asia and the Pacific	26,900,000	780,000	460,000	1,200,000	2,000,000	110,000	– **†	– **†
Latin America and the Caribbean	7,800,000	830,000	650,000	1,000,000	520,000	110,000	– †	– †
CEE/CIS	6,200,000	260,000	200,000	340,000	410,000	57,000	– †	– †
Least developed countries	42,900,000	7,600,000	6,700,000	8,600,000	6,900,000	2,400,000	88 †	– †
Low- and middle-income countries	140,000,000	17,700,000	15,900,000	21,400,000	17,300,000	5,500,000	– **†	– **†
World	150,000,000	17,800,000	16,100,000	21,600,000	17,600,000	5,500,000	– **†	– **†

DEFINITIONS OF THE INDICATORS

Children who have lost one or both parents due to all causes: Estimated number of children (aged 0–17) as of 2012 who have lost one or both parents due to any cause.

Children who have lost one or both parents due to AIDS: Estimated number of children (aged 0–17) as of 2012 who have lost one or both parents due to AIDS.

Children both of whose parents have died due to any cause: Estimated number of children (aged 0–17) as of 2012 who have lost both parents due to any cause.

Children both of whose parents have died due to AIDS: Estimated number of children (aged 0–17) as of 2012 who have lost both parents due to AIDS.

Orphan school attendance ratio: Percentage of children (aged 10–14) who have lost both biological parents and who are currently attending school as a percentage of non-orphaned children of the same age who live with at least one parent and who are attending school.

Percentage of children whose households received external support, 2005–2009: Percentage of orphaned and vulnerable children whose households received free basic external support in caring for the child.

MAIN DATA SOURCES

Children who have lost one or both parents due to all causes: UNAIDS 2012 HIV and AIDS estimates.

Children who have lost one or both parents due to AIDS, 2012: UNAIDS 2012 HIV and AIDS estimates.

Children both of whose parents have died due to any cause, 2012: UNAIDS 2012 HIV and AIDS estimates.

Children both of whose parents have died due to AIDS, 2012: UNAIDS 2012 HIV and AIDS estimates.

Orphan school attendance ratio: UNICEF global databases, 2013, based on DHS, MICS and other national surveys, 2006–2012.

Percentage of children whose households received external support: UNICEF global databases, 2013, based on DHS, MICS and other national surveys, 2006–2012.

NOTES

– Data not available.

* Data refer to the most recent year available during the period specified in the column heading.

** Excludes China.

† Regional averages are calculated only when the population represents 50 per cent or more of the region's total population of interest.

x Data refer to years or periods other than those specified in the column heading. Such data are not included in the calculation of regional and global averages, with the exception of 2005–2006 India. Estimates from years prior to 2005 are not displayed.

y Data differ from the standard definition or refer to only part of a country. If they fall within the reference period, such data are included in the calculation of regional and global averages.

p Based on small denominators (typically 25–29 unweighted cases). No data based on fewer than 25 unweighted cases are displayed.

a/ Sub-Saharan Africa includes the Sudan and Djibouti.

Some estimates do not add up to the totals because of rounding. Low- and middle-income countries are classified as such by the World Bank as of July 2013; these countries form the basis for the data analysis in UNAIDS, UNICEF and WHO.

PHOTO CAPTIONS AND CREDITS

Cover

Children running home after taking part in a discussion group on health, hygiene, sanitation and HIV.
© UNICEF/RWAA2011-00631/Noorani

Page 2

Left: See caption for pages 4–5
Centre: See caption for pages 24–25
Right: See caption for pages 40–41

Pages 4–5

In Lilongwe, Malawi, a mother receiving lifelong treatment with antiretroviral (ARV) medicines holds her infant son.
© UNICEF Malawi/2013/Marinovich

Page 9

At a hospital in Côte d'Ivoire's Worodougou Region, a nurse tells a woman that she has tested negative for HIV.
© UNICEF/NYHQ2011-0238/Asselin

Additional photos in the online version of this report:

A health worker performs an HIV rapid test at the UNICEF-supported Redemption Public Hospital in Monrovia, Liberia. Such tests allow for one-visit diagnosis.
© UNICEF/NYHQ2011-1757/Pirozzi

A health worker checks a pregnant woman in an integrated health centre in the town of Maradi, in southern Niger.
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Page 17

Point-of-care diagnostics can be used without extensive laboratory infrastructure and technical skills.
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Additional photos in the online version of this report:

In Mozambique, viral load tests used to be transported many kilometres for processing. New machines can process the tests locally in one hour.
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An adolescent living with HIV in Tamil Nadu is dressed for school. The MAC AIDS Fund, UNICEF and the Government of India are rolling out a telemedicine initiative to provide services to families like hers.
© UNICEF India/2013

Page 18

A South African woman living with HIV holds the single pill she takes daily for ARV treatment – an innovative approach that ends the need for a daily regimen of several pills.
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Page 20

A woman living with HIV embraces her daughter at a hospital in Moundou, Chad. The mother participated in an elimination of mother-to-child transmission of HIV (EMTCT) programme and the child remains free of HIV.
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Page 21

Two children play at the UNICEF-supported Kaldirgoch Day Care Centre in Tashkent, Uzbekistan. The Centre provides care and medical services to children living with HIV and their families.
© UNICEF/NYHQ2011-1692/Pirozzi

Additional photos in the online version of this report:

An eight-year-old girl living with HIV in Ruili City, China, is embraced by UNICEF Ambassador and international film star Maggie Cheung.
© UNICEF China/2010/Liu

Notes and drawings by children and social workers at the UNICEF-sponsored Happy Kids and Adolescent Centre in Freetown, Sierra Leone.
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Page 22

In rural Zambia, a two-year-old boy, who is living with HIV and on ARV treatment, smiles at his aunt. She took over his care after his mother died of AIDS-related complications.
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Page 23

A registered nurse and midwife stands in the Chelstone Clinic in Lusaka, the Zambian capital. The clinic's services include prevention of mother-to-child transmission of HIV.
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Additional photos in the online version of this report:

A family case manager living with HIV, stands in the Red Ribbon HIV/AIDS awareness campaign's exhibition train at Vijaywada station in India.
© UNICEF/INDA2010-00379/Purushotham

Village health workers in Zimbabwe set out on their bicycles to provide health services to rural communities.
© UNICEF/AUSNC2012-0406/Tattersall

Pages 24–25

A girl who lives and works on the streets of Colombo, Sri Lanka, holds a pocket calendar distributed at an HIV awareness event hosted by the global Think Wise partnership.
© UNICEF/NYHQ2012-1507/Jayasuriya

Page 30

An adolescent boy injects drugs in an abandoned building in Eastern Europe.
© UNICEF Serbia/2010/Maccak

Additional photos in the online version of this report:

Adolescent transgender sex workers on a popular tourist street.
© UNICEF Laos

A young girl, aged 15, lies on a bed in one of the rooms where she meets clients in a brothel in Abidjan, Côte d'Ivoire.
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Page 31

An adolescent boy grimaces as a health worker collects a blood sample for an HIV test at a youth centre that provides free testing in Mondou, Chad.
© UNICEF/NYHQ2011-2154/Estevé

Additional photos in the online version of this report:

In the city of Sfax, Tunisia, a doctor takes blood for an HIV test from a young patient at a UNICEF-supported centre.
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In Odessa, Ukraine, a nurse takes blood for an HIV test in a mobile lab. Hope, Faith and Love, a UNICEF-supported NGO, tests young female sex workers for HIV and syphilis, and counsels them on issues related to HIV and other sexually transmitted infections.
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Page 33

Young people participating in India's Red Ribbon Club programme for HIV prevention walk in Chandrapur District, Maharashtra. The club is a voluntary forum for providing HIV information in villages.
© UNICEF/INDA2011-00068/Crouch

Additional photos in the online version of this report:

At a youth centre in Moundou, Chad, a girl laughs during a skit on HIV prevention. The centre teaches adolescents how to protect themselves against the virus and offers HIV testing.
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Adolescents attend an HIV and AIDS awareness and prevention workshop in the indigenous Shipibo-Conibo community of Nuevo Saposoa in the Ucayali Region in the Peruvian Amazon.
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A girl attends a workshop for HIV and AIDS peer educators at a UNICEF-supported social service centre in the city of Aden, Yemen.
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Page 39

An eleven-year-old boy, whose parents died of AIDS-related causes, at the home of his uncle in Freetown, Sierra Leone. The child was expelled from his aunt's home when she learned he is living with HIV.
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Additional photos in the online version of this report:

A 15-year-old girl, who is living with HIV, writes on the wall of the abandoned house she shares with her family in Zanzibar Island, Tanzania.
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Pages 40–41

A woman who lives with HIV and her granddaughter, aged 14, at home in their village south of Bulawayo, Zimbabwe. They are one of many families benefitting from social support.
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Page 44

Tent for the provision of antiretroviral treatment (ART) in Chiaquelane Camp, Chokwé district, Mozambique.
© UNICEF Mozambique/2013

Additional photos in the online version of this report:

A nurse in Ouham Prefecture, Central African Republic, carries an orphaned child whose mother died of AIDS-related causes. The nurse is now caring for the child.
© UNICEF/NYHQ2011-0814/Grarup

A woman living with HIV speaks to UNICEF staff in the Bouldougou slum on the outskirts of Djibouti City.
© UNICEF/NYHQ2011-1357/Takahashi

A sixteen-year-old girl looks out over the displacement camp where she lives in Port-au-Prince, Haiti. She is pregnant and living with HIV.
© UNICEF/NYHQ2011-1324/Dormino

ACRONYMS


AIDS	acquired immunodeficiency syndrome
ART	antiretroviral therapy
ARV	antiretroviral (drug)
CD4	cluster of differentiation or designation 4: white blood count measure of eligibility for ART treatment
CDC	Centers for Disease Control and Prevention
DHS	Demographic and Health Surveys
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
EID	early infant diagnosis (of HIV)
EMTCT	elimination of mother-to-child transmission (of HIV)
GARPR	Global AIDS Response Progress Reporting
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	human immunodeficiency virus
HPV	human papillomavirus
IATT	Interagency Task Team
ILO	International Labour Organization
MCH	maternal and child health
MDGs	Millennium Development Goals
MICS	Multiple Indicator Cluster Surveys
NEPAD	New Partnership for Africa's Development
NGO	non-governmental organization
PEPFAR	(United States) President's Emergency Plan for AIDS Relief
PMTCT	prevention of mother-to-child transmission (of HIV)
SMS	short message service (text messaging)
TB	tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNHCR	Office of the United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
VMMC	voluntary medical male circumcision
WFP	World Food Programme
WHO	World Health Organization

UNITE FOR CHILDREN  **UNITE AGAINST AIDS**

For the first time in the history of the HIV epidemic, the global community has accumulated the knowledge, experience and tools to achieve an AIDS-free generation. This means a generation in which all children are born free of HIV and remain so for the first two decades of life, from birth through adolescence. It also means that children living with and affected by HIV have access to the treatment, protection, care and support they need to remain alive and well.

Focusing on the first and second decades of life, the *Children and AIDS: Sixth Stocktaking Report, 2013*:

- reviews the HIV burden among children and adolescents and the progress being made
- identifies key strategies to accelerate access to HIV prevention, treatment, protection, care and support for children and adolescents
- summarizes opportunities arising from recent scientific advances, new technology and emerging practice innovations
- seeks to mobilize national and international efforts to keep children HIV-free and ensure that children living with HIV remain AIDS-free.

 For supporting data and materials, please visit: www.childrenandaids.org.

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