



Children and AIDS

A stocktaking report

UNITE FOR CHILDREN
UNITE AGAINST AIDS 

Children and AIDS

A stocktaking report

Actions and progress during the first year of *Unite for Children, Unite against AIDS*

The quotations used throughout this report represent the views of the individuals quoted and not necessarily the views of UNICEF.

UNAIDS, the Joint United Nations Programme on HIV/AIDS, brings together the efforts and resources of ten UN system organizations to the global AIDS response. Cosponsors include UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODC, ILO, UNESCO, WHO and the World Bank. Based in Geneva, the UNAIDS secretariat works on the ground in more than 75 countries worldwide.



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INTRODUCTION

AIDS is redefining the very meaning of childhood for millions, depriving children of many of their human rights – of the care, love and affection of their parents; of their teachers and other role models; of education and options for the future; of protection against exploitation and abuse. The world must act now, urgently and decisively, to ensure that the next generation of children is AIDS-free.

– UNICEF, *A Call to Action: Children, the missing face of AIDS*

Twenty-five years into the AIDS epidemic, the children in its path remain at grave risk. It is estimated that 2.3 million children under 15 years old are infected with HIV, 15.2 million children under 18 have lost one or both parents to AIDS, and millions more have been made vulnerable. The risks inherent in these statistics are many, as children affected by AIDS may experience poverty, homelessness, school drop-out, discrimination, loss of life opportunity and early death.

Unite for Children, Unite against AIDS was launched in October 2005 with the goal of putting the 'missing face' of children at the centre of the global HIV/AIDS agenda. In the year since, the world's response to protect and support AIDS-affected children remains tragically insufficient. But in important and positive ways, that is beginning to change.

This report takes stock of some of the most important actions and changes for children affected by HIV/AIDS that have taken place in the first year of *Unite for Children, Unite against AIDS*. Among other developments, the report finds that children and AIDS had by 2006 become more clearly integrated into national policy frameworks, including national plans of action (NPAs) and poverty reduction strategy papers (PRSPs) in at least 20 countries in sub-Saharan Africa. It finds increasing numbers of children now receiving treatment as a result of improved testing, lower drug prices and simpler formulations. It reports that in several countries, behaviour change has translated into declining HIV prevalence among young people. And the disparity between orphans and non-orphans in access to education has been reduced in several countries.

Over the past year, there has been a broad, growing recognition of the need to intensify and accelerate actions towards universal access to comprehensive prevention, treatment, care and support. Commitment to this goal by 2010 was affirmed by Heads of State and Government and their representatives participating in the 2006 High-Level Meeting on AIDS held at the United Nations in New York, 31 May–2 June 2006.

There is also a better understanding of how crucial it will be to achieve the targets established during the UN General Assembly Special Session on HIV/AIDS (2001) – and the targets for children articulated in the four programme areas of *Unite for Children, Unite against AIDS* – in order to achieve the goal of coming as close to universal access as possible.

It is acknowledged that the Millennium Development Goals (MDGs) – especially MDG 6, which is to halt and reverse the spread of HIV/AIDS by 2015 – will not be reached without integrating approaches to children and AIDS with approaches to child health and survival.

There are, however, huge gaps in progress:

- Only 1 in 10 pregnant women with HIV in low- and middle-income countries is receiving antiretroviral (ARV) prophylaxis for preventing mother-to-child transmission of HIV.
- Only 1 in 10 children needing antiretroviral treatment (ART) receives it – the others face a bleak and short-lived future.
- At most, 1 in 25 children born to HIV-infected mothers receives cotrimoxazole prophylaxis to prevent opportunistic infections that can be fatal.
- Children who have lost both parents – to AIDS or any other cause – are generally less likely than non-orphans to attend school.
- Fewer than one in three young people in sub-Saharan Africa has the comprehensive knowledge about HIV that will help protect them against the virus.

This report seeks to identify discernible trends through the measurement of new and existing data against a baseline used here for the first time in the areas of preventing mother-to-child transmission of HIV, providing paediatric treatment, preventing infection among adolescents and young people, and protecting and supporting children affected by HIV/AIDS – the ‘Four Ps’.

Monitoring progress on the ‘Four Ps’

One of the key objectives of *Unite for Children, Unite against AIDS* is to more accurately reflect the situation of children and AIDS and to set a baseline for measuring progress for children and identifying the gaps in the response. UNICEF and UNAIDS have been working together with national governments and partners to develop a core set of indicators that can be used to track progress on the ‘Four Ps’ at the country level. The agreed indicators and estimates on children and AIDS are compiled in a set of statistical tables in this report beginning on page 28.



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Further, this report reviews progress towards support strategies identified as critical elements of a child-focused response. It seeks to illuminate some of the ways in which *Unite for Children, Unite against AIDS* has shown relevance and promise, as well as some of the ways it has failed to spur the global, regional and country mobilization required to address the problems facing children affected by AIDS. It will explore how *Unite for Children, Unite against AIDS* needs to move forward in the next year to achieve its ambitious goals.

UNAIDS provides a dynamic and flexible structure for broad participation in *Unite for Children, Unite against AIDS* based on the mandates, accountabilities and comparative advantages of each member of the UN family. Their contributions to the ‘Four Ps’ and the contributions of many other partners are acknowledged in the following pages.

GETTING RESULTS FOR CHILDREN

“There was a recognition that the situation was desperate, that we were way behind on all of the critical areas around children, and it was time to do something about it on a really urgent basis.”

— Stephen Lewis, Former UN Secretary-General’s Special Envoy for HIV/AIDS in Africa, on the XVI International AIDS Conference

A year has come and gone since *Unite for Children, Unite against AIDS* was launched. The initial responses can be seen and heard in many ways and in many contexts. The call to action for an AIDS-free generation has been echoed by voices throughout the world and by organizations large and small, speaking on behalf of children as the ‘missing face’ of AIDS. Children affected by AIDS are now more visible and are taken more seriously in global, regional and national forums where they had received little consideration before.

The Political Declaration on HIV/AIDS adopted at the High-Level Meeting on AIDS held at the UN in June 2006 made particular reference to the needs of children and women coping with the epidemic. More than two dozen sessions of the XVI International AIDS Conference, held in Toronto in August 2006, were devoted to children and young people.

The challenges of creating an AIDS-free generation remain huge. Have countries heeded the many calls to action? This review finds that in some important ways, the answer is yes.

Civil society advocacy

In the past year, advocacy organizations have come together to help place children more centrally on the international AIDS agenda. To name just a few, the Global Movement for Children in 2006 issued a report titled *Saving Lives: Children’s right to HIV and AIDS treatment* urging the international community to do more to treat HIV-positive children. The Global AIDS Alliance played a strategic leadership role in shaping the AIDS policy debate and organizing coalition-based campaigns. The Ecumenical Advocacy Alliance’s campaign, ‘Keep the Promise’, holds religious leaders, faith-based organizations, governments and intergovernmental organizations accountable for their commitments and advocates for further efforts and resources to fight HIV and AIDS. A campaign by the Organization of African First Ladies Against HIV/AIDS targets adults in their role as protectors and guardians of children.

PROGRAMMES FOR CHILDREN: THE 'FOUR Ps'

"The campaign should now deliver on the 'Four Ps'. There is a very clear programme, and we have to translate that into action in countries."

— **Peter Piot,**
Executive Director,
UNAIDS

Unite for Children, Unite against AIDS provides a framework for nationally owned AIDS programmes around the 'Four Ps' – the urgent imperatives of preventing mother-to-child transmission of HIV, providing paediatric treatment, preventing infection among adolescents and young people, and protecting and supporting children affected by HIV/AIDS. Progress in these areas will make a real difference in the lives and life opportunities of children affected by AIDS. It will contribute towards MDG 6 – to halt and begin to reverse the spread of HIV/AIDS by 2015 – as well as towards the other MDGs.

Goals of *Unite for Children, Unite against AIDS*: The 'Four Ps'

- **Prevent mother-to-child transmission of HIV**
By 2010, offer appropriate services to 80 per cent of women in need
- **Provide paediatric treatment**
By 2010, provide either antiretroviral treatment or cotrimoxazole, or both, to 80 per cent of children in need
- **Prevent infection among adolescents and young people**
By 2010, reduce the percentage of young people living with HIV by 25 per cent globally
- **Protect and support children affected by HIV/AIDS**
By 2010, reach 80 per cent of children most in need



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PREVENTING MOTHER-TO-CHILD TRANSMISSION OF HIV

“We believe that universal access for PMTCT is a necessity, and must happen now.”

– **Leslie Ramsammy,**
Minister of Health,
Guyana

Target: By 2010, offer appropriate services to 80 per cent of women in need

Progress in the prevention of mother-to-child transmission (PMTCT) of HIV reflects a desire on the part of governments and partners to act decisively to accelerate action at country level.

The urgency is clear. An estimated 530,000 children were newly infected with HIV in 2006, mainly through mother-to-child transmission.² Without treatment, one out of two infected infants will die before age 2.³

Knowledge applied in high-income countries has already resulted in a steep drop in the rate of transmission – down to about 2 per cent.⁴ Reductions occur through such essential actions as identifying HIV-infected pregnant women through the routine offer of testing, enrolling them in PMTCT programmes, ensuring that health systems are fully able to deliver effective antiretroviral (ARV) regimens, and supporting women in providing optimal, safe infant feeding.

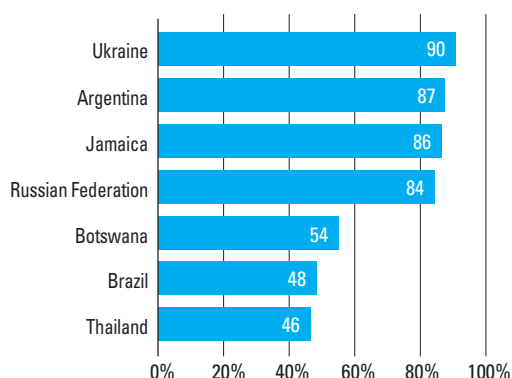
Situation and trends

One of ten young pregnant women living in the capital cities of sub-Saharan Africa is HIV-infected, and about one of three children born to HIV-infected pregnant women will contract the virus.⁵ Of countries reporting these data, infection rates are highest in Botswana (Gaborone) and Swaziland (Mbabane), where one in three young pregnant women is infected, and in Lesotho (Maseru) and South Africa (Pretoria), where one in four is infected.⁶

Taking PMTCT programmes to scale remains a challenge. It is estimated that only 9 per cent of pregnant women with HIV in low- and middle-income countries were receiving ARV prophylaxis for preventing transmission to their children in 2005, an increase from 3 per cent in 2003.⁷

Only seven countries for which these data are available for 2005 provide ARV prophylaxis to more than 40 per cent of HIV-infected pregnant women (see *Figure 1 on page 7*). Except for Botswana, all of these countries lie outside sub-Saharan Africa, the most affected region.

Figure 1: Countries where at least 40 per cent of HIV-infected pregnant women received ARVs for PMTCT, 2005



Note: Two countries reported that at least 40 per cent of HIV-infected pregnant women received ARVs for PMTCT prior to 2005: Belarus (more than 60 per cent) and Suriname (44 per cent).

Source: UNICEF and WHO on behalf of the expanded Inter-Agency Task Team on PMTCT, 'A Report Card on the Prevention of Mother-to-Child Transmission of HIV and Paediatric HIV Care, 2006' (forthcoming).

Yet in some high-prevalence countries in Eastern and Southern Africa (Namibia, Rwanda, South Africa and Swaziland), trends in ARV access for PMTCT are starting to show remarkable increases (see Figure 2).

Progress can be attributed partly to a decentralized approach in which structures – such as district, regional and provincial health management teams – are responsible for the planning, implementation and monitoring of PMTCT services, including the training of service providers.

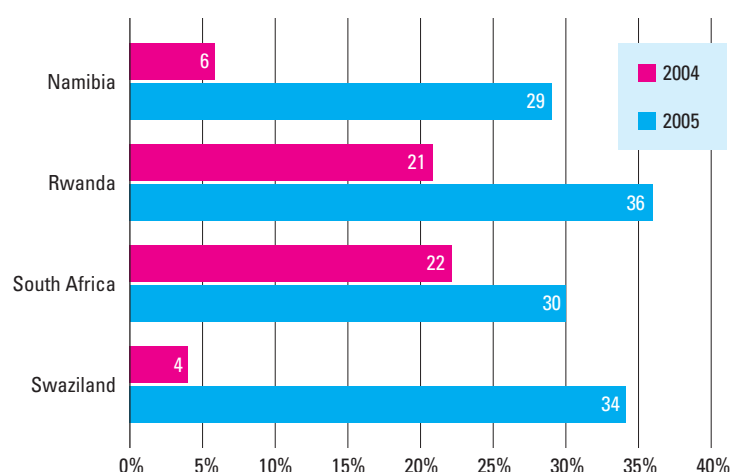
Demonstrated political commitment is a factor as well. To date, more than 100 countries surveyed by UNICEF on behalf of the expanded Inter-Agency Task Team on the Prevention of Mother-to-Child Transmission of HIV have established national PMTCT programmes.

In some countries, programmes are moving from care for the infected individual to care for the whole family. The MTCT-Plus Model of Care – a package of HIV prevention, care, support and treatment for mothers, children and their families, using PMTCT as an entry point – has been adopted in several countries, including nine countries supported by the Columbia University Mailman School of Public Health, which pioneered this approach.⁸

Mothers 2 Mothers (m2m) is an innovative, facility-based programme at 73 sites in Botswana, Ethiopia and South Africa using education and empowerment to prevent mother-to-child transmission of HIV, combat stigma within families and communities, and keep mothers alive through treatment adherence. m2m trains and employs HIV-infected mothers as peer educators – 'mentor mothers' – and is working with local non-governmental organizations (NGOs) to create a model that can be integrated with national PMTCT efforts in sub-Saharan Africa.

In August 2006, the World Health Organization (WHO) issued revised guidelines on preventing HIV infection in children that include more efficacious ARV regimens and maternal HIV care and treatment.⁹ In November 2006, WHO and UNAIDS released draft guidelines on provider-initiated routine offer of HIV testing and counselling that derived from an ongoing consultative process.¹⁰

Figure 2: Percentage of HIV-infected pregnant women who received ARVs for PMTCT, 2004–2005 (selected countries)



Source: UNICEF and WHO on behalf of the expanded Inter-Agency Task Team on PMTCT, 'A Report Card on the Prevention of Mother-to-Child Transmission of HIV and Paediatric HIV Care, 2006' (forthcoming), and 'PMTCT Report Card 2005: Monitoring Progress on the Implementation of Programmes to Prevent Mother-to-Child Transmission of HIV', December 2005.

By supporting national programmes and as part of the international partnership against AIDS, the US **President's Emergency Plan for AIDS Relief (PEPFAR)** reports that as of September 2006 it prevented HIV infections in about 101,500 infants through its assistance to PMTCT services for women during more than 6 million pregnancies and provision of ARV prophylaxis for women during 533,300 pregnancies.

Towards eliminating HIV in children

A Global Partners Forum on preventing mother-to-child transmission of HIV took place in Abuja (Nigeria) in December 2005. Emanating from the forum was a call to action for national governments and partners to support measures needed to eliminate HIV in infants and young children.

The Abuja call has been a real catalyst, and regional follow-up meetings on PMTCT held in Kampala (Uganda) in April 2006 and in Nairobi (Kenya) in June 2006 reflected a new momentum in partnership-building around the issue. The Kampala meeting was a follow-up to a resolution by health ministers of the East, Central and South African Health Community Secretariat on strengthening PMTCT programmes in the region. It identified key programme areas and technical support needs for accelerating scale-up. The Nairobi meeting sought to build the capacity of a core group of regional experts to support countries in adapting and implementing a standard PMTCT training package.



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The **Elizabeth Glaser Pediatric AIDS Foundation** in 2005 provided counselling and testing to more than 658,500 women and ARV prophylaxis to more than 52,200 women in 17 countries. As of September 2006, nearly 9 per cent of the people the Foundation supports with treatment are children. The goal is to increase that to 15 per cent by optimizing the identification of sick children, integrating paediatric treatment into existing ARV treatment centres, and strengthening monitoring and evaluation.

PROVIDING PAEDIATRIC TREATMENT

Target: By 2010, provide either antiretroviral treatment or cotrimoxazole, or both, to 80 per cent of children in need

An estimated 2.3 million children under 15 are living with HIV.¹¹ The virus progresses rapidly in children, with an estimated one third of infants dying by the time they reach their first birthday and half dying by their second birthday.¹² In 2006 alone, an estimated 380,000 children died of AIDS-related causes.¹³ The vast majority of these deaths were preventable, either through treating opportunistic infections with antibiotics or through antiretroviral treatment (ART).

WHO recommends that cotrimoxazole be given to children infected with HIV as well as to children born to HIV-infected mothers when early diagnosis of HIV infection is unavailable. Estimates put the number of HIV-exposed and infected children in 2005 at about 4 million. This figure could be cut nearly in half if all countries diagnosed HIV infection in infancy and if cotrimoxazole was given exclusively to infected children.¹⁴ Of the 2.3 million children infected with HIV, 780,000 were estimated to be in need of ART in 2005.¹⁵

“We have the tools. We have the know-how. We just have to find a way to deliver for the hundreds of thousands of children in immediate need of treatment.”

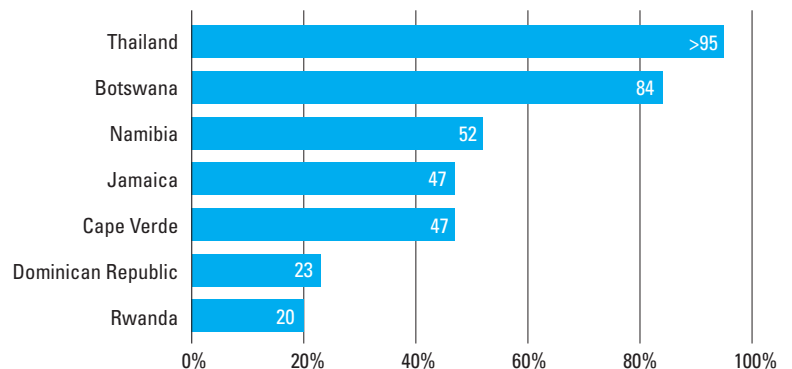
**— Mark Kline, President,
Baylor International Pediatric
AIDS Initiative**

Situation and trends

At the global level, UNICEF, WHO and partners estimate that in 2005 only 4 per cent of children needing cotrimoxazole prophylaxis received it,¹⁶ and only about 75,000 children – 10 per cent of children in need – had access to ART.¹⁷

Only seven countries for which data are available for 2005 provide ART to at least 20 per cent of children in need (see *Figure 3*). But four of these countries – Botswana, Cape Verde, Namibia and Rwanda – are in sub-Saharan Africa, where the HIV burden is highest (see *Figure 4 on page 10*).

Figure 3: Countries where at least 20 per cent of children under 15 in need received ART, 2005



Source: UNICEF and WHO on behalf of the expanded Inter-Agency Task Team on PMTCT, 'A Report Card on the Prevention of Mother-to-Child Transmission of HIV and Paediatric HIV Care, 2006' (forthcoming).

National data on paediatric care and treatment are limited because most countries have not yet incorporated specific key indicators into national monitoring systems, or they are just doing so now. Nonetheless, there appears to be momentum, albeit from a very low base. And with the significant additional focus on paediatric treatment during the past 12 months, 2006 data are expected to show a significant increase in the number of children being placed on treatment.

Scaling up

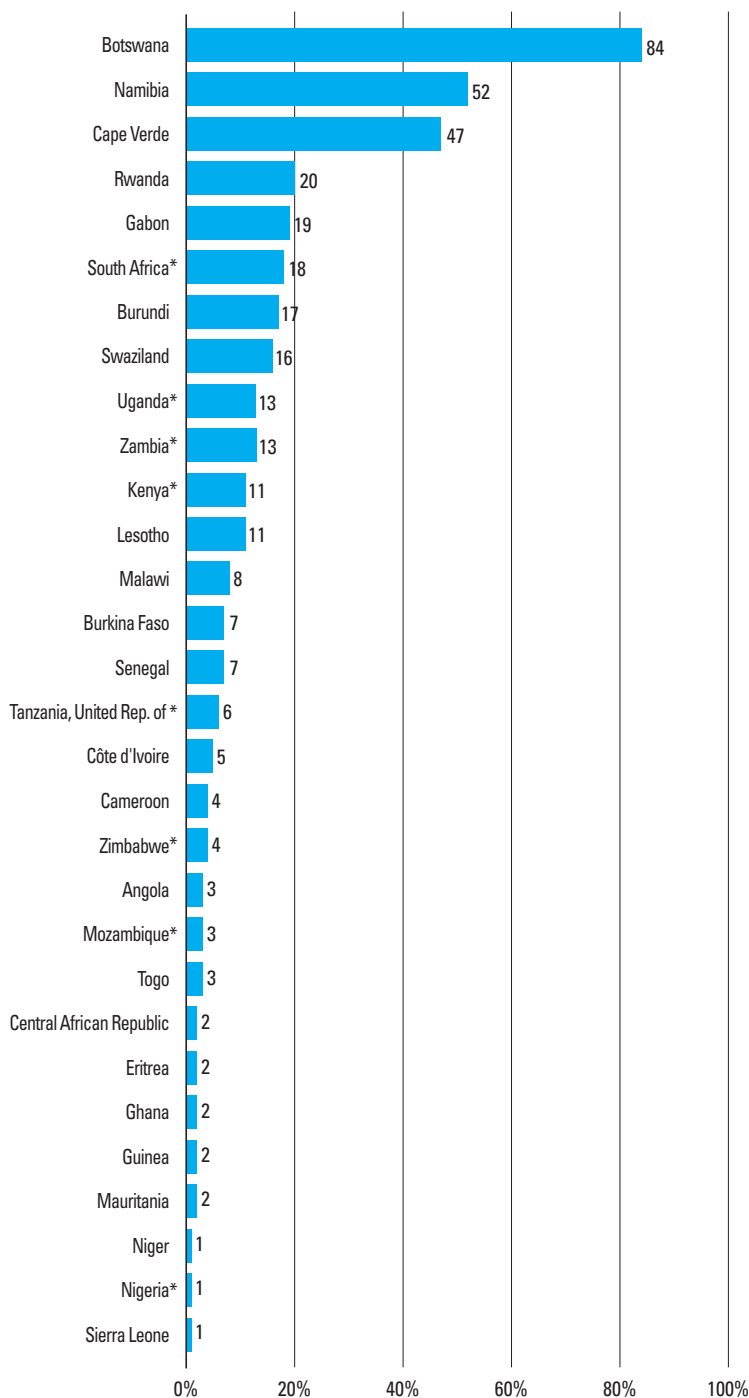
Several countries – including Botswana, India, Rwanda, South Africa, Thailand, Uganda, Tanzania and Zambia – have been able to scale up HIV treatment for children by integrating it into treatment sites for adults. Some countries – Uganda, Tanzania and Zambia – have become better at identifying HIV-infected infants for treatment before the onset of severe illness through routine testing of sick children for HIV infection.

Several countries have adopted innovative testing methods for early detection of HIV in children. In Botswana, for example, the use of filter paper to collect dried blood spots to facilitate HIV virological testing of exposed children was introduced in 2005; the spots are collected at clinics and hospitals and sent to a centralized laboratory for analysis.¹⁸ Clinicians and nurses have begun training in preparation for the rollout of this approach across the country.

“With the dried blood spot, we’ve now been able to diagnose children much earlier than we used to do at 18 months. So what we are now doing is rolling it out to all the districts.”

– **Sheila Tlou, Minister of Health, Botswana**

Figure 4: Percentage of children under 15 in need receiving ART in sub-Saharan Africa, 2005



Note: Percentages in Chad, Comoros, Congo, the Democratic Republic of the Congo*, Gambia and Madagascar are less than 1. Countries marked with an asterisk (*) and India accounted for approximately two thirds of all HIV infections transmitted from mother to child in 2005.

Source: UNICEF and WHO on behalf of the expanded Inter-Agency Task Team on PMTCT, 'A Report Card on the Prevention of Mother-to-Child Transmission of HIV and Paediatric HIV Care, 2006' (forthcoming).



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India and Rwanda have developed paediatric care and treatment scale-up plans, which have formed the basis for strategic planning, fund applications and resource allocation. Zimbabwe has revised its child health card to more effectively capture HIV-related information, with other countries following suit.

In **Rwanda**, national conferences in 2005 and 2006 on paediatric treatment, care and the support of children infected and affected by HIV/AIDS have resulted in commitments to fully integrate children into the national AIDS response and a set of key recommendations on children and AIDS for the 2007 national plan of action. The conferences were convened by the National AIDS Control Commission with President Paul Kagame as patron. Rwanda is the first country to hold annual national reviews on children and AIDS.

Increasing commitment

The urgency of issues surrounding paediatric HIV treatment has increased amid advocacy by such organizations as the Global Fund to Fight AIDS, Tuberculosis and Malaria, PEPFAR, the World Bank and civil society groups.

The levels of commitment from a variety of actors have increased as well. In September 2006, the Governments of Brazil, Chile, France, Norway and the United Kingdom launched UNITAID, a drug-purchasing facility financed through levies on international air travel and similar mechanisms. Funds generated through UNITAID have been allocated to supply paediatric ARV drugs and diagnostics to governments committed to scaling up treatment. About \$35 million have been raised so far. The Clinton Foundation will take the lead in disseminating the commodities related to paediatric HIV.

Prices of ARV drugs for children have come down dramatically over the past 12–18 months. For example, the Clinton Foundation HIV/AIDS Initiative negotiated a reduction in the cost of paediatric ARVs to less than \$0.16 per day, or \$60 per year, helping to spur competition in the development of paediatric formulations.¹⁹

Since April 2005, the Paediatric Initiative of the **Clinton Foundation HIV/AIDS Initiative (CHAI)** has assisted 16 countries in putting 10,000 children into treatment, doubling the number of children on treatment outside Brazil and Thailand. It seeks to reach an additional 100,000 children in 35 countries with ART by the end of 2007. CHAI works with governments to strengthen diagnosis and delivery of ART for children through human resources training and improved laboratory infrastructure.

Several drugs are now available in single-dose paediatric formulations, and Cipla has developed Pedimune[®], a fixed-dose combination formulation for young children. Abbot, Bristol-Myers Squibb and other pharmaceutical companies have also provided significant financial support to such organizations as the Baylor International Pediatric AIDS Initiative, as well as for the new Paediatric AIDS Corps being deployed to help scale up national responses to paediatric treatment.

The **Baylor International Pediatric AIDS Initiative** was launched in 1996 to improve testing, care, support, prevention and research for children affected by HIV/AIDS and their families. As of October 2006, it provided care for 12,196 children infected with HIV and supplied highly active ART for 4,924 children through its health clinics – Centers of Excellence – throughout Africa and Eastern Europe.

Research is ongoing in several areas, including the impact of the routine offer of testing to identify HIV-infected infants, treatment adherence, strategic treatment interruption for younger children, impact of specific ARV regimens, and clinical outcomes for children in low-resource settings.

In August 2006, WHO issued new guidelines for the care and treatment of HIV-infected children and for cotrimoxazole prophylaxis in HIV-exposed and infected children, which will help standardize care within national programmes.²⁰

With various partners, the **World Health Organization** promotes universal access to HIV prevention, care and treatment for children and works nationally and internationally to build the health sector's response to HIV. WHO and UNICEF co-convene the Inter-Agency Task Team on the prevention of HIV infection in pregnant women, mothers and their children and paediatric HIV care, treatment and support (expanded Inter-Agency Task Team on PMTCT). WHO's comprehensive guidelines on PMTCT, on diagnosing and treating HIV infection in children and on the use of cotrimoxazole in adults and children, as well as the operational tools it has developed to support programme implementation, training and evaluation, have been instrumental in facilitating country responses for children. WHO also supports efforts to define needs for ARV products and to address obstacles hindering drug reformulation and development.



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PREVENTING INFECTION AMONG ADOLESCENTS AND YOUNG PEOPLE

“We must advocate and promote a comprehensive approach to HIV prevention: one that is rights-based, evidence-informed and comprehensive in nature. That’s the only honest approach, reflecting international best practice.”

– **Steve Kraus, Chief,
HIV/AIDS Branch,
UNFPA**

Target: By 2010, reduce the percentage of young people living with HIV by 25 per cent globally

Primary prevention is key to an effective response to the AIDS epidemic. The chain of new infections will not be broken without comprehensive prevention strategies for keeping adolescents and young people free of infection by building their capacities to avoid behaviours that put them at risk.

New evidence suggests that declining HIV prevalence in Kenya, in urban areas of Côte d’Ivoire, Malawi and Zimbabwe, and in rural areas of Botswana has resulted from the adoption of safer sexual behaviours by young people.²¹

It is estimated that more than 10 million young people between ages 15 and 24 are infected with HIV.²² Prevalence rates are highest in sub-Saharan Africa and higher among young women than young men in the region.²³ In Côte d’Ivoire and Kenya, for example, there are five infected young women for every infected young man; corresponding ratios are 4 to 1 in Uganda and 3 to 1 in several countries, including Namibia, Nigeria, South Africa, Zambia and Zimbabwe.²⁴

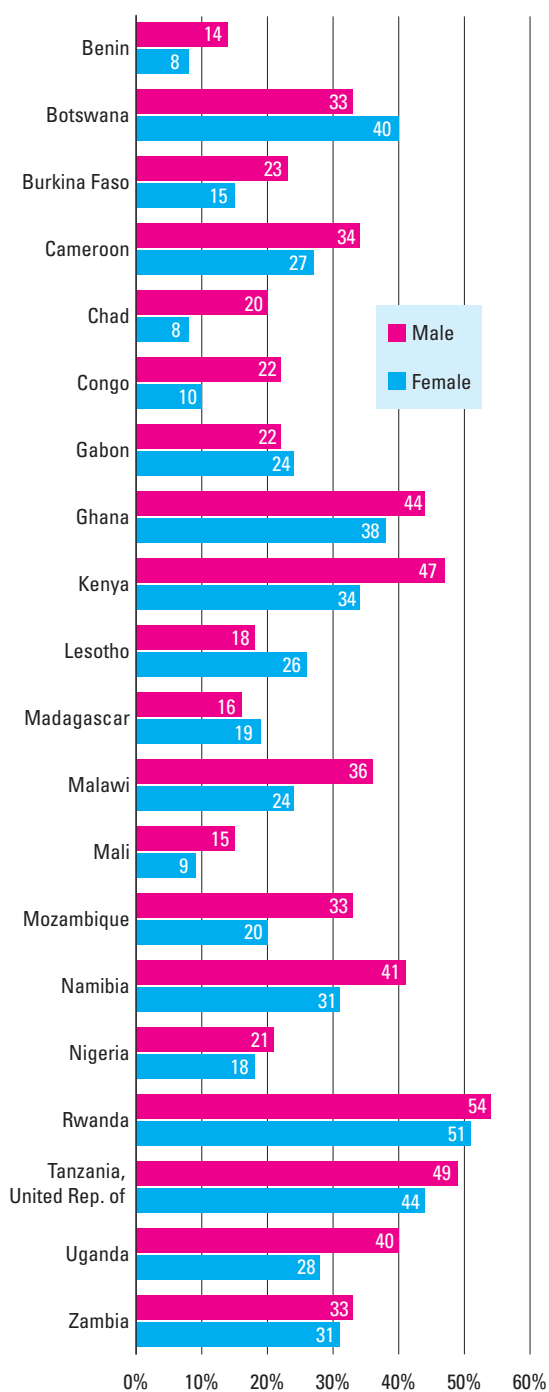
Prevention trends and comprehensive knowledge

It appears that prevention efforts have intensified in some countries. In its *2006 Report on the Global AIDS Epidemic*, UNAIDS provides a snapshot: an increase in comprehensive prevention interventions such as voluntary counselling and testing and HIV education in schools.²⁵

In more than 70 countries surveyed, testing and use of counselling services increased from roughly 4 million people in 2001 to 16.5 million in 2005. In 58 surveyed countries that reported these data for 2005, AIDS education was provided in 74 per cent of primary schools and 81 per cent of secondary schools.²⁶

Progress towards the *Unite for Children, Unite against AIDS* target of reducing HIV prevalence among young people is assessed using two MDG indicators: HIV prevalence in pregnant women 15–24 years old, and the percentage of the population with ‘comprehensive correct knowledge’ of HIV/AIDS. Such knowledge includes correctly identifying two major ways to prevent the sexual transmission of HIV (using condoms and limiting sex to one faithful, uninfected partner), rejecting common misconceptions about HIV transmission and knowing that a healthy-looking person can have HIV.

Figure 5: Percentage of young people (15–24 years old) in sub-Saharan Africa who have comprehensive knowledge of HIV



Source: UNICEF, *The State of the World's Children 2007*.

On average, only 23 per cent of young women and 31 per cent of young men surveyed in sub-Saharan Africa have this life-saving knowledge, although individual country averages may be higher or lower (see Figure 5).²⁷

On the other hand, there is some good news coming out of the Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS) undertaken between 1995 and 2003–2004 with regard to young people’s basic AIDS knowledge and sexual behaviours (see box, below). Although most of these survey results pre-date *Unite for Children, Unite against AIDS*, they underline the need for a statistical baseline, and they show that results can be achieved.

Young people’s knowledge and behaviours: What the surveys say²⁸

- Young people appear to be having first sex at a later age.** Young women aged 15–24 were surveyed in 24 countries, 11 of which showed a significant decrease in the proportion of young women reporting sexual experience before age 15, and 11 showing no significant change. Only Haiti and Nigeria showed an increase in the proportion of women reporting sexual experience before age 15. The results for young men mirrored these findings: Of the 12 countries surveyed, only Haiti had an increase.
- Condom use appears to be increasing during ‘high-risk’ sex, or sex with non-marital, non-cohabiting partners.** In 11 countries in which young women and men were surveyed twice, 9 showed significant increases in the use of a condom at last high-risk sex as reported by women and 5 showed significant increases as reported by men. No change between surveys was seen in the other countries.
- More young women appear to be having high-risk sex, and condom use during high-risk sex remains low.** Young women aged 15–24 were surveyed in 10 countries of sub-Saharan Africa. In seven of these countries, there were significant increases in the percentage of young women having sex with non-marital, non-cohabiting partners in the past year, and there were decreases in only two: Malawi and Zambia. Young women surveyed reported using a condom with a non-marital, non-cohabiting partner only 26 per cent of the time, while young men surveyed reported using a condom during high-risk sex only 40 per cent of the time.

Reaching adolescents and young people most at risk

The emphasis of prevention responses is shifting, as major players in the AIDS field – including UNAIDS, UNFPA, UNICEF, WHO and the World Bank – have come together with renewed attention on the need to focus strategies on adolescents and young people most at risk. The consensus is that risk-avoidance interventions targeted to at-risk and vulnerable groups in countries with low HIV prevalence and concentrated epidemics are more effective than behavioural-change interventions among the general population.

Prevention strategies include not only information and voluntary counselling and testing for HIV, but also services for harm reduction and prevention of sexually transmitted infections, as well as life-skills-based education.

Family Health International (FHI) works in more than 60 countries to impart the knowledge and skills young people need to sustain good health and prevent HIV. FHI developed YouthNet, a programme of reproductive health and HIV prevention activities for young people. YouthNet has conducted research on key issues and disseminated information on best practices throughout the world. It has provided technical assistance in more than 20 countries.

One good example of a prevention programme for at-risk children is taking place in Punjab (Pakistan), where provincial government departments and NGOs in 2006 agreed to work together to promote HIV/AIDS awareness among service providers, supply information and tools for young people at risk, and ensure that referral mechanisms are in place for them. In Syria, the 'SHOUT' programme, begun in May 2005, trains young volunteers as

peer educators in HIV prevention and addresses service gaps for at-risk adolescents in three governorates. In Ukraine, the response strategy includes youth-friendly health care at 10 government clinics throughout the country.

The **United Nations Population Fund (UNFPA)** works to better link AIDS, sexual and reproductive health, and broader issues of public health, development, gender and human rights. UNFPA focuses on HIV prevention and works with partners in three priority areas: preventing HIV in young people and adolescents, comprehensive condom programming, and preventing HIV in women and girls, with activities to reduce gender-based violence, strengthen male involvement and protect and promote women's rights. UNFPA leads the Inter-Agency Task Team on Young People and HIV/AIDS.



PROTECTING AND SUPPORTING CHILDREN AFFECTED BY HIV/AIDS

“There has been much better partnership between children and AIDS groups and the broader development issues that are related – around social welfare or around justice. And I think those types of alliances are so crucial.”

– Clare Shakya, Social Development and Livelihoods Adviser, UK Department for International Development

Target: By 2010, reach 80 per cent of children most in need

Globally, as of 2005, an estimated 15.2 million children had lost one or both parents to AIDS. Some 80 per cent of these children – about 12 million – live in sub-Saharan Africa.²⁹ It is estimated that by 2010 more than 20 million children will have been orphaned by AIDS.³⁰

Orphans due to AIDS are not the only children affected by the epidemic. Many more children live with parents who are chronically ill, live in households that have taken in orphans due to AIDS or have lost teachers and other adult members of the community to AIDS.

Orphans and vulnerable children face grave risks to their education, health and well-being. They may have to forgo schooling; there may be less food or clothing for them in the household; they may suffer from anxiety, depression and abuse. Alarmingly, new evidence finds that orphans and vulnerable children have a higher risk of exposure to HIV than non-affected children.³¹

Unite for Children, Unite against AIDS calls for national strategic planning to make communities and families the primary beneficiaries of an increased global response for orphans and vulnerable children.

Orphans considered in national planning instruments

To date, at least 20 countries in sub-Saharan Africa have completed national plans of action (NPAs) on orphans and vulnerable children (*see box, below*), and several other countries have nearly completed and launched their NPAs.

Sub-Saharan African countries with NPAs on orphans and vulnerable children

Benin	Namibia
Burkina Faso	Nigeria
Central African Republic	Rwanda
Côte d'Ivoire	Senegal
Ethiopia	South Africa
Kenya	Swaziland
Lesotho	Tanzania, United Rep. of
Malawi	Uganda
Mali	Zambia
Mozambique	Zimbabwe

NPAs are a useful first step, but their success depends on their implementation. On average, only 35 per cent of total budgets

had been pledged by May 2006 in 14 countries where NPA funding data were available.³²

Social protection is being considered in poverty reduction strategy papers (PRSPs) in a number of countries. Mozambique's PRSP for 2006–2009 includes targets for school attendance and underweight prevalence, external support for caregivers and a monitoring mechanism. Tanzania's PRSP for 2005–2010, cooperatively developed by civil society, NGOs and local government, addresses vulnerability within an overall social protection framework.³³

A package of essential services

Among the recommendations of the third Global Partners Forum on children affected by HIV/AIDS, held in London in February 2006, were several in the area of protection and support, including the promotion of civil registration and access to social services, support for social protection measures, and the abolition of school fees and indirect costs of education.

A minimum package for orphans and vulnerable children includes access to such services as education, health care, social welfare and protection. Functioning civil registration systems are important because orphans and vulnerable children are often required to produce birth and death certificates in order to claim benefits or go to school.

Several countries in southern Africa, including Botswana, Namibia and South Africa, have provided child grants and other benefits on a national scale, reaching many children affected by AIDS. In South Africa, for example, the country with the largest number of orphans due to AIDS, more than 7.1 million children under 14 living in poverty – 79 per cent of those eligible – were benefiting from the child support grant by April 2006. This represents a two-thirds increase since 2004 and a 20-fold increase since 2000. More than 325,000 children were benefiting from foster care grants in 2006.³⁴

An increasing number of other countries in sub-Saharan Africa have begun to provide social protection for children affected by AIDS. The highest levels of support are seen in the following countries: Botswana, where 95 per cent of households receive some form of external support for the care of orphans and vulnerable children; Namibia (33 per cent); Lesotho (25 per cent); Uganda (23 per cent); Zambia (13 per cent); and Kenya and Togo (both 10 per cent). Kenya, Malawi and Mozambique, for example, have piloted cash-transfer programmes in some of the poorest areas, where children are especially vulnerable to leaving home or dropping out of school.

The UK **Department for International Development** (DFID) supports the development of social protection measures, including cash-transfer programmes, in several African countries. It is working with the Government of Zambia to develop a programme that will provide approximately \$6 a month to the poorest 10 per cent of households, around 1 million people.

NGOs are also increasing their response by providing essential protection to thousands of children affected by AIDS. A 2006 survey of NGO actions in 28 sub-Saharan African countries found that between 3.3 million and 5 million orphans and vulnerable children were receiving services in the form of education, routine health care, food, economic support or psychosocial support.³⁵

The care of orphans and vulnerable children is a top priority for **World Vision**. It assists communities in providing care and support to more than 600,000 children affected by AIDS in 20 countries in Africa.

Education for all children

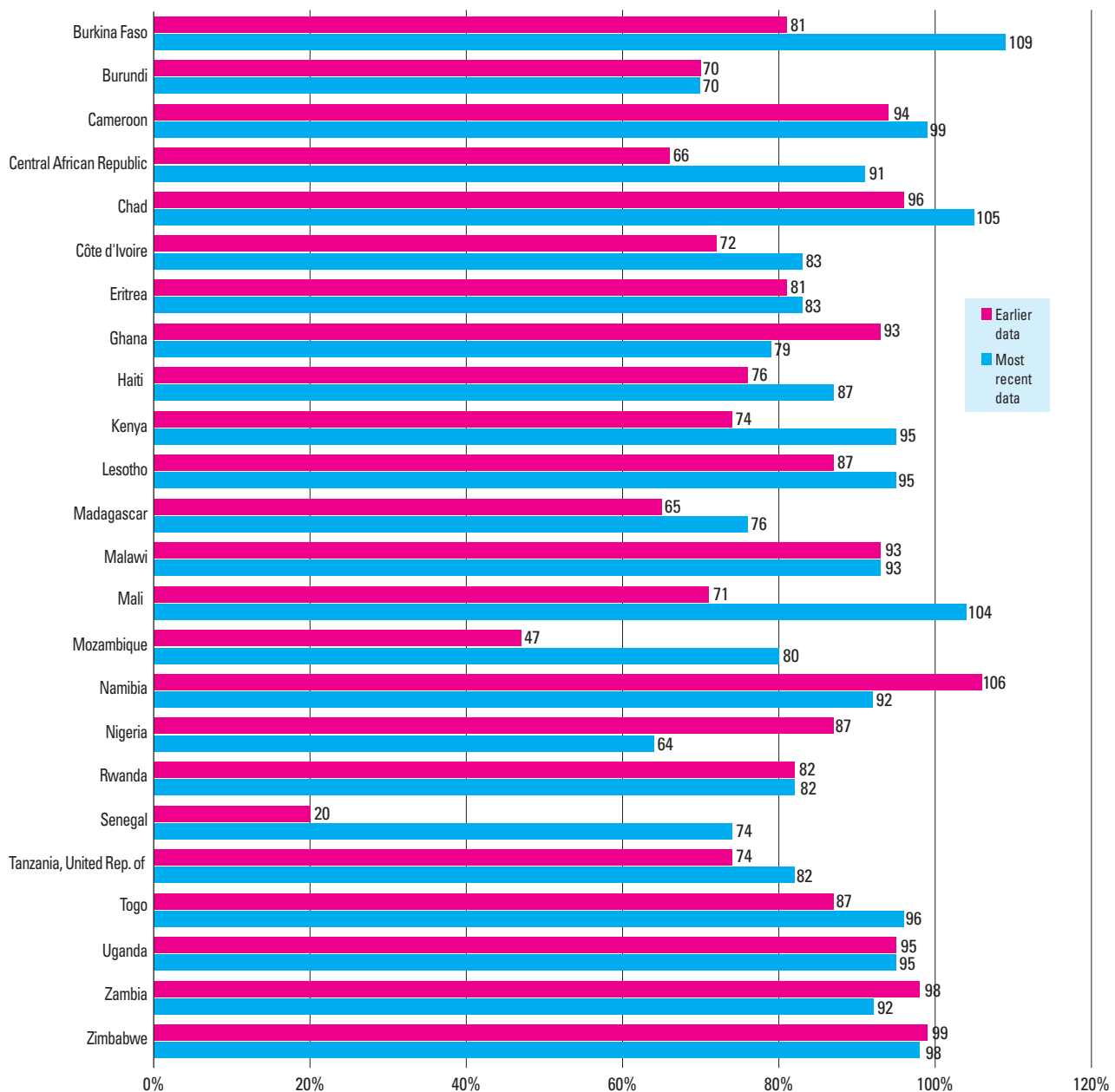
In several countries, there appears to be progress in improving access by orphaned and vulnerable children to education, as seen in ratios of orphaned children to non-orphaned children aged 10–14 currently attending school, a core indicator. Currently, in sub-Saharan Africa, for every 100 per cent of children living with one parent who attend school, 79 per cent of orphaned children attend school.³⁶

Twenty-four countries have measured the school attendance ratio of orphans to non-orphans at least twice. The ratios have increased in 15 countries, and orphans are more likely to attend school than non-orphans in several countries with ratios greater than 100 per cent (see *Figure 6, page 18*).

Part of this progress is due to the abolition of school fees, as in Kenya and Uganda. *Unite for Children, Unite against AIDS* calls on partners to assist governments in their efforts to eliminate user fees and other barriers to primary education.

The first **East Asia–Pacific Regional Consultation on Children and AIDS**, held in Vietnam in March 2006, drew the attention of decision makers from governments and civil society to the ‘Four Ps’ and highlighted the need to scale up programmes for children towards the goal of universal access. It culminated in the Hanoi Call to Action, a consensus statement on children and AIDS. Consultations throughout the region are expected to result in the integration of children and AIDS into national plans and policies and generate important momentum.³⁷

Figure 6: Ratio of the proportion of orphans attending school to the proportion of non-orphans attending school



Note: ‘Orphans’ refers to children 10–14 years old whose parents have both died from any cause. ‘Non-orphans’ refers to children 10–14 years old living with one or both parents.
Source: UNICEF analysis (2006) of DHS and MICS data.

RESOURCES FOR CHILDREN

“How much money is spent for children? I think all the donor agencies and national governments should be able to answer that question by this day next year.”

– **Gopakumar Nair, HIV and AIDS Policy and Programme Adviser, Save the Children UK**

Donor countries have taken steps over the past few years to ensure that children get a fair share of AIDS funding through the use of earmarks and set-asides of resources for purposes specifically related to children, including the ‘Four Ps’.

Already, several donor governments have earmarked at least 10 per cent of their HIV/AIDS funding to go towards services for children. The US Leadership against HIV/AIDS, Tuberculosis, and Malaria Act (2003) allocates 10 per cent of total spending on AIDS in fiscal years 2006–2008 to children, specifically to orphans and children made vulnerable by the epidemic. The UK Government has earmarked 10 per cent of its international AIDS assistance, committing £150 million (about US\$293 million) between 2005 and 2008 to children affected by AIDS.³⁸ The Government of Ireland has earmarked up to 20 per cent of its additional resources for children and AIDS in 2006.³⁹

Other countries have put protection and care for children directly into their AIDS and development policies, including Austria, Denmark, Finland, Germany, the Netherlands, Norway and Sweden.⁴⁰ And Brazil, Chile, France, Norway and the United Kingdom have committed to paediatric treatment through UNITAID (see page 11).

Based on a UNAIDS assessment in 2005, *Unite for Children, Unite against AIDS* estimated that nearly \$30 billion would be needed between 2006 and 2010 to dramatically scale up the global response for children. UNICEF plans to raise and contribute \$1 billion to the ‘Four Ps’ by 2010, and its budgetary allocations to HIV/AIDS programmes have been increasing significantly.

Tracking resources is a critical area being addressed by countries implementing National AIDS Spending Assessments and other systems for the regular collection, analysis and reporting of data on HIV-related expenditures in all sectors, not just the health sector. These efforts are promoted by UNAIDS. Partners in *Unite for Children, Unite against AIDS* will work with UNAIDS to ensure that within these assessments, methods are established to track which funds are benefiting children.

Unite for Children, Unite against AIDS was originally suggested by **National Committees for UNICEF** in response to the growing orphan crisis in sub-Saharan Africa, and the Committees continue to play a critical role in the development and management of the campaign. In 2006, UNICEF National Committees in 37 countries organized conferences on children and HIV/AIDS, lobbied for important legislation, called on governments to change policies, and formed partnerships with media, corporations, the sporting and music industries and the general public to promote issues of children and AIDS. They provide strategic financial contributions in support of national programmes, and in their own countries constitute a powerful voice for children.

AN INTEGRATED APPROACH

“It’s quite complicated, this issue of AIDS for children. It’s quite complex. Because it’s not only the disease – it’s children’s well-being, and their education.”

**– Jeanette Kagame,
First Lady of Rwanda**

Integration of actions and resources is an essential component of *Unite for Children, Unite against AIDS*. Accomplishing this requires making a commitment to forge links across diseases and sectors, to bridge gaps between partners working towards HIV/AIDS goals and partners working towards child health goals, and to ensure that the considerable resources committed for HIV/AIDS benefit children, the families who look after them and the systems that support them.

Integration means ensuring that children and families have access to health systems and services that provide quality care and support, and that girls and orphans stay in school and learn how to protect themselves. It means providing good nutrition for children affected by AIDS and securing safe water and basic sanitation for AIDS-affected households. It means empowering women to make decisions with their own health and the best interests of their children and families in mind.

The integration of these and other actions provides the world’s best hope of reaching the Millennium Development Goals. Among the encouraging developments: Global Partners Forums on paediatric treatment and PMTCT are increasingly working with child health groups. Evidence from countries including Kenya, Tanzania and Zambia indicates that HIV/AIDS funding that is strategically invested in the health sector, particularly in staffing health systems, can have a positive impact on such non-AIDS services as immunization and antenatal care.

Bringing together the global HIV/AIDS response and the global health response will yield better results for children. A major challenge to reaching all children – with health services in general and with HIV/AIDS services, treatment



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and care in particular – lies in moving beyond small-scale projects to national programmes. This requires health systems to function effectively, skilled personnel to be available, and essential supplies and equipment to be in place. It also requires communities to demand these services and to utilize them.

In the specific areas of the 'Four Ps':

- **Preventing mother-to-child transmission:** Antenatal care is the main entry point for PMTCT, and its coverage needs to be high if PMTCT targets are to be reached. But antenatal care with a full package of services is not reaching all women, and as PMTCT programmes expand, both coverage and quality of antenatal care services will need to improve. Making testing routine, expanding PMTCT services, ensuring a family-centred approach and providing additional HIV care and treatment are prerequisites for a scaled-up response and an increase in access to services.
- **Providing paediatric treatment:** A great deal of work remains to adequately address the disparity faced by children in access to care and treatment. In many situations, the next steps are to scale up and better harmonize efforts and support national governments with the tools and capacity to make a significant difference in children's lives. This will also require ensuring that children are healthy and able to respond to treatment. In that regard, immunization, good nutrition, safe water and basic sanitation are essential.
- **Preventing infection among adolescents and young people:** Getting better prevention results means gathering better data and answering such question as: Who are the adolescents and young people most at risk of HIV infection? Where are they? What is the best way to reach them with information and services? Key challenges are to strengthen national planning, resource allocation and the capacity of national programmes to distribute and monitor



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the utilization of funds. Comprehensive responses are required because many high-risk populations engage in multiple risk behaviours.

- **Protecting and supporting children affected by HIV/AIDS:** Effective national responses provide orphans and vulnerable children with a package of essential services that includes education, health care, social welfare and protection. The need for a decentralized approach is fundamental because much of the response will be made at the community level by non-governmental, local and faith-based organizations. Monitoring and evaluation of service coverage also need to be improved, in order to quantify the extent to which governments, NGOs and others are responding to the protection and support needs of children and to evaluate the quality of such support.

A CALL TO ACTION

Every minute that passes, another child under 15 dies of an AIDS-related illness and another four young people aged 15–24 become infected with HIV. This simply does not have to be.

– **UNICEF, A Call to Action: Children, the missing face of AIDS**⁴¹

Ensuring that the next generation of children is AIDS-free will require bolder advocacy efforts from the platform of *Unite for Children, Unite against AIDS* in 2007. This is consistent with the overall goal of coming as close as possible to universal access to prevention, treatment, care and support. The focus will continue to be on making sure that priorities for children lie at the centre of the global response to HIV/AIDS.

Unite for Children, Unite against AIDS calls on the international community to ensure that scale-up in programmes for the 'Four Ps' is supported by progress on overarching issues that affect results. Since it was launched in October 2005, child-focused advocacy by partners has led to some significant gains, allowing for new calls to action.

1. Mobilize resources and put the care and protection of children first

The cost of implementing programmes on a scale large enough to reach 2010 targets was originally estimated at \$30 billion, assuming that costs in 2009 and 2010 would be at least as much as in 2008. Rapid and important gains in the pricing and availability of drugs and the production of generic medications continually change the basis for estimates, but these are unlikely to significantly reduce the scale of overall financial requirements.

Several donors, including PEPFAR (the US President's Emergency Plan for AIDS Relief) and the Governments of Ireland and the United Kingdom, have decided to earmark at least 10 per cent of their AIDS funding for children and adolescents. *Unite for Children, Unite against AIDS* advocates for other governments to follow suit in 2007 and make larger, more predictable contributions to national AIDS-control programmes, to such innovative financing mechanisms as UNITAID and the International Finance Facility, and to such channels as the Global Fund to Fight AIDS, Tuberculosis and Malaria, which are becoming increasingly important.

In 2007, advocacy is still needed for donor countries to consider negotiating debt relief for high-HIV/AIDS-prevalence countries, to do more to promote the reallocation of resources to the 'Four Ps', and to devote their contributions to the strengthening of health care and education systems – especially through self-sufficiency of teachers and health workers in highly affected countries. Support also needs to be given to efforts by African countries to meet their 2001 Abuja commitment to allocate at least 15 per cent of national budgets to improving health care.

The collection and disaggregation of AIDS-related data by age group and by sex is one of the most vital, simple and effective ways of making children more central to the global response.

2. Come as close as possible to universal access to treatment

In spite of significant progress in the areas of paediatric treatment and PMTCT over the past year, there is a need for strengthened public-private partnerships in the development of appropriate, effective and affordable medications and diagnostics. Significantly larger investments in procurement and supply management are urgently needed to ensure life-saving access for all children in need.

Companies, especially those working in AIDS-affected countries, have a responsibility towards their employees and communities to adopt and implement policies and programmes on HIV/AIDS.

Priority action is also needed to strengthen the capacity of highly affected countries to find flexible ways of removing obstacles in pricing, tariffs and regulatory policies, as well as to employ the flexibilities of the World Trade Organization Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS).

3. Strengthen education and health services

In spite of important progress in mobilizing joint action for rapid scale-up of programmes during the past year, more is required to provide sufficient resources, institute policies and build the capacity needed to make routine testing available to all women, adolescents and young children. Due emphasis should be placed on providing resources for training and supporting nurses, community health workers and other appropriate personnel at the primary level of health-care delivery services. More urgent action should be expected from the governments of highly affected countries to provide access to quality health care for children and adolescents affected by HIV and AIDS.



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Urgent action should also be expected from governments to eliminate school fees and other indirect costs of education for orphans and other children made vulnerable by HIV and AIDS.

Rapid scale-up of budgetary allocations and expenditures is needed, as is innovation in channelling increased resources and appropriate services to affected families and communities, including direct financial assistance and support measures for all those caring for vulnerable children.

Countries are also encouraged to incorporate HIV/AIDS and children into such national policy frameworks as poverty reduction strategies, medium-term expenditure frameworks, sector-wide approaches and national AIDS strategies.

Unite for Children, Unite against AIDS is an ideal platform for implementing the call issued at the XVI International AIDS Conference for a rapid return to prevention as a priority alongside treatment, care, support and protection. And no excuse should be allowed for the continued lack of priority given to the prevention needs of girls and young women.

Greater effort must be made by governments and civil society to reach the most at-risk and marginalized adolescents, both within and outside the education system. Countries should be expected to ensure that all young people have access to the comprehensive knowledge, information, life skills and services they need to protect themselves from infection.



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4. The challenge can be met through partnership

No single country, donor or development agency on its own can provide everything that children need, and countries will not reach MDG 6 and the other Millennium Development Goals without greater collaboration and cooperation among the large number of actors involved.

Partnerships can allow different agencies to tackle different tasks, pursue complementary goals and achieve bigger and better results than they would by working alone. They can succeed only if they foster shared ownership and objectives.

‘Delivering as One’ through UN Reform and implementing the principles of the ‘Three Ones’ – one agreed-upon national AIDS action framework, one national AIDS coordinating authority that has broad-based multisectoral support and one country-level system for monitoring and evaluation – will require all involved to shift their attitudes and approaches to partnerships.

In 2007, *Unite for Children, Unite against AIDS* will make a greater effort to pursue a partnership strategy based on these considerations. The best way for agencies and other actors to support *Unite for Children, Unite against AIDS* is to continue working in programmes more strategically than before to strengthen the coherence, sharpen the focus and galvanize accelerated action behind the ‘Four Ps’.

TOWARDS UNIVERSAL ACCESS

“The fact that we’ve made progress on the treatment agenda is fantastic, but it gives us some new challenges on the care agenda, and it must not be allowed to detract from the prevention agenda... The ‘Four Ps’ are inseparably interlocked and we need to look at them as a whole.”

*– David Bull,
Executive Director,
UK National Committee
for UNICEF*

Has the international community heeded the call to action of *Unite for Children, Unite against AIDS*? This review finds that in some discernible ways, the answer is yes. But much more remains to be done. Many children and their families are still being denied the treatment, care, support and information needed to survive and live healthy lives.

The world is moving towards a most ambitious goal – that of coming as close as possible to universal access to comprehensive prevention, treatment, care and support – which will reverse the spread of HIV/AIDS.

For the four target areas of *Unite for Children, Unite against AIDS*, results are mixed. Paediatric treatment appears to have much of the gains and momentum, yet relatively few children in the world have been able to avail themselves of life-saving ART. The PMTCT target is being met in some countries where services are mainstreamed into existing maternal and child health programmes, but this needs to happen in many more countries. Likewise, preventive interventions to promote behavioural change need to be delivered as a priority to groups most at risk in order for that target to be met.

In the area of protecting and supporting orphans and vulnerable children, this report finds an overall sense of progress, especially at the country and community levels and in moves towards a more holistic approach. But the true extent of such progress will probably not be known until agreed-on reporting standards are established.

Advocacy efforts have undoubtedly increased during the past year or so. Nonetheless, those working on AIDS advocacy should conduct frequent reality checks. Are efforts translating into real results for children?

The magnitude of what is needed to save and improve the lives of children caught in the maelstrom of HIV/AIDS underlines the relevance of *Unite for Children, Unite against AIDS*. And some success in raising awareness of children’s needs within the scope of the wider epidemic shows the promise of such a campaign. But it is clear that relevance and promise are not enough. What matters in the end are tangible results that are good for children: for their health, for their families, in their communities and throughout their lives.

ENDNOTES

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STATISTICAL TABLES

Detailed information by country is available in the accompanying tables:

Table 1: Preventing mother-to-child transmission of HIV, page 29.

Table 2: Providing paediatric treatment, page 32.

Table 3: Preventing infection among adolescents and young people, page 35.

Table 4: Protecting and supporting children affected by HIV and AIDS, page 38.

Progress against targets and commitments on children and AIDS is monitored by using 21 estimates and indicators derived from a larger set of agreed indicators. These have been developed through a process of discussion and negotiation with national governments and various international organizations, led by UNAIDS.

The indicators constitute the core set that will be used to track progress at the country level. They have also been selected to capture a number of international and agency-specific initiatives, such as Universal Access; the national estimation process for HIV and AIDS estimates, led by UNAIDS; the PMTCT Report Card issued jointly by UNICEF and WHO; UNICEF's Country Reports on Indicators for the Goals (CRING); and *Unite for Children, Unite against AIDS*.

Statistics are compiled through country fact sheets that were developed in line with 'Three Ones' principles in collaboration with the Multi-Agency Monitoring and Evaluation Reference Group (MERG) on HIV/AIDS and are derived from pre-existing data.

Over the past year, there have been significant achievements in forging consensus on key indicators, compiling baselines and producing country fact sheets. The baseline data show the enormity and urgency of the challenges ahead.

Note on the data

The data presented in the following statistical tables are accompanied by definitions, sources and explanations of symbols. Data are derived from the accountable United Nations organizations whenever possible. When such internationally standardized estimates do not exist, data are drawn from other sources that are known to be comprehensive and nationally representative, including the population-based Demographic and Health Surveys, Multiple Indicator Cluster Surveys, Reproductive Health Surveys and Futures Group Coverage Surveys. Detailed information about these surveys is available at <www.measuredhs.com> and <www.childinfo.org>.

Additional programme coverage data for measuring country progress were collected using the Report Card on the Prevention of Mother-to-Child Transmission and Paediatric HIV Care questionnaire, developed with input from members of the expanded Inter-Agency Task Team on PMTCT. These include national-level programme indicators developed through collaborative processes that are led by UNAIDS and have been adopted by most countries.

TABLE 1. Preventing mother-to-child transmission of HIV

	Estimated adult HIV prevalence rate (15+ years old), end-2005	Antenatal care coverage (%), 1997–2005*	Annual number of births, 2005 (thousands)	Number of pregnant women counselled on PMTCT services, 2005	Estimated number of HIV-infected pregnant women, 2005	Number of HIV-infected pregnant women who received ARVs for PMTCT, 2005	% of HIV-infected pregnant women who received ARVs for PMTCT, 2005**
Afghanistan	<0.1	16	1,441	–	<100	–	–
Albania	–	91	53	–	–	–	–
Algeria	0.1	81	684	–	<500	–	–
Angola	3.7	66	767	11,366	33,000	367	1
Antigua and Barbuda	–	100	2	–	–	–	–
Argentina	0.6	98	687	570,000	2,400	2,088	87
Armenia	0.1	93	34	21,720	<100	–	–
Azerbaijan	0.1	70	134	–	<100	–	–
Bahamas	3.3	–	6	–	<500	–	–
Bahrain	–	97x	13	–	<100	–	–
Bangladesh	<0.1	49	3,747	–	<200	–	–
Barbados	1.5	100	3	–	<100	–	–
Belarus	0.3	100	91	87,548	<200	119x	>60x
Belize	2.5	96	7	7,025	<100	38	>38
Benin	1.8	81	348	69,921	7,300	1,214	17
Bhutan	<0.1	51	64	–	<100	–	–
Bolivia	0.1	79	265	–	<500	–	–
Bosnia and Herzegovina	<0.1	99	36	163	–	–	–
Botswana	24.1	97	45	48,014	14,000	7,543	54
Brazil	0.5	97	3,726	1,911,875	14,000	6,771	48
Brunei Darussalam	<0.1	100x	8	–	<100	–	–
Bulgaria	<0.1	–	67	–	–	–	–
Burkina Faso	2.0	73	617	33,376	15,000	937	6
Burundi	3.3	78	347	9,993	16,000	524	3
Cambodia	1.6	38	429	17,729	6,500	228	4
Cameroon	5.4	83	563	636,202	35,000	3,592	10
Cape Verde	–	99	15	–	–	12	–
Central African Republic	10.7	62	150	8,982	19,000	803	4
Chad	3.5	39	471	1,856	19,000	193	1
Chile	0.3	95x	249	–	<500	–	–
China	0.1	90	17,310	144,934	7,500	135	2
Colombia	0.6	94	968	–	3,100	–	–
Comoros	<0.1	74	28	70	<100	–	–
Congo	5.3	88	177	19,943	11,000	1,093	10
Congo, Democratic Republic of the	3.2	68	2,873	91,274	99,000	1,725	2
Cook Islands	–	–	–	–	–	–	–
Costa Rica	0.3	92	79	–	<200	–	–
Côte d'Ivoire	7.1	88	665	108,699	57,000	2,543	4
Croatia	<0.1	–	41	–	–	–	–
Cuba	0.1	100	134	–	<200	–	–
Djibouti	3.1	67	27	3,593	1,200	16	1
Dominica	–	100	2	–	–	–	–
Dominican Republic	1.1	99	211	69,278	2,500	676	27
Ecuador	0.3	84	295	61,810	1,000	223	22
Egypt	<0.1	70	1,909	–	–	–	–
El Salvador	0.9	86	166	105,595	800	144	24
Equatorial Guinea	3.2	86	22	–	800	–	–
Eritrea	2.4	70	170	8,128	5,100	88	2
Ethiopia	–	28	3,104	85,690	–	2,341	–
Fiji	0.1	–	19	–	<100	–	–
Gabon	7.9	94	42	24,739	3,600	90	3
Gambia	2.4	91	52	10,724	1,400	87	6
Georgia	0.2	95	49	15,000	<100	15	20
Ghana	2.3	92	683	28,013	19,000	1,078	6
Grenada	–	99	2	–	–	–	–
Guatemala	0.9	84	437	–	2,100	200	10
Guinea	1.5	82	387	6,105	6,800	77	1
Guinea-Bissau	3.8	62	79	–	3,600	–	–

TABLE 1. Preventing mother-to-child transmission of HIV

	Estimated adult HIV prevalence rate (15+ years old), end-2005	Antenatal care coverage (%), 1997–2005*	Annual number of births, 2005 (thousands)	Number of pregnant women counselled on PMTCT services, 2005	Estimated number of HIV-infected pregnant women, 2005	Number of HIV-infected pregnant women who received ARVs for PMTCT, 2005	% of HIV-infected pregnant women who received ARVs for PMTCT, 2005**
Guyana	2.4	81	15	12,788	<500	112	32
Haiti	3.8	79	255	66,937	12,000	800	7
Honduras	1.5	83	206	55,201	1,700	198	12
India	0.9	60	25,926	891,912	130,000	2,279	2
Indonesia	0.1	92	4,495	921	2,000	4	<1
Iran (Islamic Republic of)	0.2	77	1,348	–	700	–	–
Iraq	–	77	978	2	–	–	–
Jamaica	1.5	98	52	28,914	<500	300	86
Jordan	–	99	150	–	<100	–	–
Kazakhstan	0.1	91	237	129,706	<500	47	9
Kenya	6.1	88	1,361	429,123	99,000	19,403	20
Kiribati	–	88x	2	–	–	–	–
Korea, Democratic People's Republic of	–	–	342	–	–	–	–
Korea, Republic of	<0.1	–	457	–	<500	–	–
Kuwait	–	95x	51	–	–	–	–
Kyrgyzstan	0.1	97	116	–	<100	–	–
Lao People's Democratic Republic	0.1	27	205	600	<100	11	15
Lebanon	0.1	96	66	–	<100	–	–
Lesotho	23.2	90	50	11,804	15,000	1,811	12
Liberia	–	85	167	–	–	130	2
Libyan Arab Jamahiriya	–	81x	136	–	–	–	–
Madagascar	0.5	80	712	8,911	2,000	8	<1
Malawi	14.1	92	555	63,632	89,000	5,076	6
Malaysia	0.5	74	547	374,386	1,400	141	10
Maldives	–	81	10	–	–	–	–
Mali	1.7	57	661	40,402	13,000	415	3
Marshall Islands	–	–	2	–	–	–	–
Mauritania	0.7	64	126	14	1,000	10	1
Mauritius	0.6	–	20	–	<100	–	–
Mexico	0.3	86x	2,172	–	2,400	–	–
Micronesia (Federated States of)	–	–	3	–	–	–	–
Moldova, Republic of	1.1	98	43	35,375	<500	32	6
Mongolia	<0.1	94	58	–	<100	–	–
Montenegro†	–	–	–	10,800	33	6	18
Morocco	0.1	68	717	–	<500	–	–
Mozambique	16.1	85	773	102,116	150,000	8,490	6
Myanmar	1.3	76	976	133,859	7,700	629	8
Namibia	19.6	91	56	31,907	14,000	4,055	29
Nauru	–	–	–	–	–	–	–
Nepal	0.5	28	787	–	–	–	–
Nicaragua	0.2	86	154	3,545	<200	29	19
Niger	1.1	41	750	18,477	9,200	57	1
Nigeria	3.9	58	5,377	30,428	250,000	532	<1
Niue	–	–	–	–	–	–	–
Occupied Palestinian Territory	–	96	138	–	–	–	–
Oman	–	100	64	–	–	–	–
Pakistan	0.1	36	4,773	–	–	–	–
Palau	–	–	–	–	–	–	–
Panama	0.9	72	70	–	<500	–	–
Papua New Guinea	1.8	78x	174	10,000	3,700	46	1
Paraguay	0.4	94	177	24,100	<500	47	13
Peru	0.6	92	628	304,601	2,100	188	1
Philippines	<0.1	88	2,018	–	<500	–	–
Qatar	–	–	14	–	–	–	–
Romania	<0.1	94	211	72,802	–	21	–
Russian Federation	1.1	–	1,540	1,335,768	6,800	5,709	84
Rwanda	3.1	94	375	190,969	16,000	5,782	36
Saint Kitts and Nevis	–	100	1	–	–	–	–

TABLE 1. Preventing mother-to-child transmission of HIV

	Estimated adult HIV prevalence rate (15+ years old), end-2005	Antenatal care coverage (%), 1997–2005*	Annual number of births, 2005 (thousands)	Number of pregnant women counselled on PMTCT services, 2005	Estimated number of HIV-infected pregnant women, 2005	Number of HIV-infected pregnant women who received ARVs for PMTCT, 2005	% of HIV-infected pregnant women who received ARVs for PMTCT, 2005**
Saint Lucia	–	48	3	–	–	–	–
Saint Vincent and the Grenadines	–	99	2	–	–	–	–
Samoa	–	–	5	–	–	–	–
Sao Tome and Principe	–	91	5	8	–	8	–
Saudi Arabia	–	90x	671	–	–	–	–
Senegal	0.9	79	423	16,114	4,600	57	1
Serbia†	–	–	–	10,800	33	6	18
Seychelles	–	–	3	–	–	–	–
Sierra Leone	1.6	68	252	–	4,800	57	1
Singapore	0.3	–	39	–	<100	–	–
Solomon Islands	–	–	15	–	–	–	–
Somalia	0.9	32	366	–	4,400	–	–
South Africa	18.8	92	1,082	513,401	250,000	75,077	30
Sri Lanka	<0.1	100	329	–	<100	–	–
Sudan	1.6	60	1,166	8,492	23,000	41	<1
Suriname	1.9	91	9	5,127	<100	33x	44x
Swaziland	33.4	90	29	17,062	14,000	4,780	34
Syrian Arab Republic	–	71	532	–	–	–	–
Tajikistan	0.1	71	185	9,203	<100	4	5
Tanzania, United Republic of	6.5	78	1,408	241,399	110,000	6,202	6
Thailand	1.4	92	1,009	636,901	11,000	5,081	46
The former Yugoslav Republic of Macedonia	<0.1	81	23	–	–	–	–
Timor-Leste	–	61	49	–	–	–	–
Togo	3.2	85	236	17,516	9,200	720	8
Tonga	–	–	2	–	–	–	–
Trinidad and Tobago	2.6	92	19	–	600	–	–
Tunisia	0.1	92	166	–	<200	–	–
Turkey	–	81	1,500	–	–	–	–
Turkmenistan	<0.1	98	108	–	<100	–	–
Tuvalu	–	–	–	–	–	–	–
Uganda	6.7	92	1,468	343,213	110,000	12,073	11
Ukraine	1.4	–	392	417,610	2,400	2,168	90
United Arab Emirates	–	–	69	–	–	–	–
Uruguay	0.5	94	57	–	<500	–	–
Uzbekistan	0.2	97	615	–	<500	–	–
Vanuatu	–	–	6	–	–	–	–
Venezuela, Bolivarian Republic of	0.7	94	593	–	2,300	–	–
Viet Nam	0.5	86	1,648	39,837	5,500	368	7
Yemen	–	41	845	–	–	–	–
Zambia	17.0	93	472	88,879	97,000	14,071	15
Zimbabwe	20.1	93	384	159,829	98,000	8,461	9

DEFINITIONS OF THE INDICATORS

Estimated adult HIV prevalence rate: Percentage of adults (15–49 years old) living with HIV as of end-2005.

Antenatal care coverage: Percentage of women (15–49 years old) attended at least once during pregnancy by skilled health personnel (doctors, nurses or midwives).

Annual number of births: Estimated number of live births in 2005.

Number of pregnant women counselled on PMTCT services: Number of pregnant women who received HIV counselling when they attended an antenatal clinic.

Estimated number of HIV-infected pregnant women: Estimated number of pregnant women (15–49 years old) living with HIV as of 2005.

Number of HIV-infected pregnant women who received ARVs for PMTCT: Number of women testing HIV positive during visits to antenatal clinics who were provided with antiretroviral therapy (ARVs) to prevent mother-to-child transmission.

Percentage of HIV-infected pregnant women who received ARVs for PMTCT: Calculated by dividing the number of HIV-infected pregnant women who received ARVs for PMTCT by the estimated number of HIV-infected pregnant women.

MAIN DATA SOURCES

Estimated adult HIV prevalence rate: UNICEF, *The State of the World's Children 2007*.

Antenatal care coverage: UNICEF, *The State of the World's Children 2007*.

Annual number of births: UNICEF, *The State of the World's Children 2007*.

Number of pregnant women counselled on PMTCT services: UNICEF and WHO, 'Report Card on the Prevention of Mother-to-Child Transmission of HIV and Paediatric Care, 2006' (forthcoming).

Estimated number of HIV-infected pregnant women: UNAIDS/WHO unpublished estimates, 2006.

Number of HIV-infected pregnant women who received ARVs for PMTCT: UNICEF and WHO, 'Report Card on the Prevention of Mother-to-Child Transmission of HIV and Paediatric Care, 2006' (forthcoming).

Percentage of HIV-infected pregnant women who received ARVs for PMTCT: UNICEF and WHO, 'Report Card on the Prevention of Mother-to-Child Transmission of HIV and Paediatric Care, 2006' (forthcoming); UNAIDS/WHO unpublished estimates, 2006.

NOTES

– Data not available.

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

** United Nations General Assembly Special Session on HIV/AIDS (2001) indicator.

x Data refer to years or periods other than those specified in the column heading, differ from the standard definition or refer to only part of a country.

† Due to the cession in June 2006 of Montenegro from the State Union of Serbia and Montenegro, and its subsequent admission to the UN on 28 June 2006, disaggregated data for Montenegro and Serbia as separate States are not yet available. Aggregated data presented are for Serbia and Montenegro pre-cession.

TABLE 2. Providing paediatric treatment

	Estimated number of children (0–14 years old) living with HIV, 2005	Estimated number of HIV-infected pregnant women, 2005	Number of infants born to HIV-infected pregnant women started on cotrimoxazole prophylaxis, 2005	% of infants born to HIV-infected pregnant women started on cotrimoxazole prophylaxis, 2005	Estimated number of children (0–14 years old) living with HIV in need of ART, 2005	Number of children (0–14 years old) receiving ART, 2005**	% of children in need receiving ART, 2005
Afghanistan	–	<100	–	–	–	–	–
Albania	–	–	5	–	–	5	–
Algeria	–	<500	–	–	–	–	–
Angola	35,000	33,000	–	–	13,000	438	3
Antigua and Barbuda	–	–	–	–	–	–	–
Argentina	–	2,400	–	–	–	1,827	–
Armenia	–	<100	3	6	–	3	–
Azerbaijan	–	<100	–	–	–	–	–
Bahamas	<500	<500	–	–	<500	–	–
Bahrain	–	<100	–	–	–	–	–
Bangladesh	–	<200	–	–	–	–	–
Barbados	<100	<100	–	–	<100	–	–
Belarus	–	<200	–	–	–	–	–
Belize	<100	<100	–	–	<100	6	8
Benin	9,800	7,300	719	10	3,000	–	–
Bhutan	–	<100	–	–	–	–	–
Bolivia	–	<500	–	–	–	–	–
Bosnia and Herzegovina	–	–	–	–	–	–	–
Botswana	14,000	14,000	8,116	58	6,400	5,400	84
Brazil	–	14,000	–	–	–	7,500	–
Brunei Darussalam	–	<100	–	–	–	–	–
Bulgaria	–	–	–	–	–	–	–
Burkina Faso	17,000	15,000	–	–	5,700	420	7
Burundi	20,000	16,000	197	1	6,700	1,137	17
Cambodia	–	6,500	–	–	–	1,071	–
Cameroon	43,000	35,000	–	–	14,000	550	4
Cape Verde	–	–	12	–	32	15	47
Central African Republic	24,000	19,000	–	–	7,900	160	2
Chad	16,000	19,000	–	–	6,700	7	<1
Chile	–	<500	–	–	–	–	–
China	–	7,500	–	–	–	566 [†]	–
Colombia	–	3,100	–	–	–	–	–
Comoros	<100	<100	–	–	<100	1	<1
Congo	15,000	11,000	–	–	4,700	13	<1
Congo, Democratic Republic of the	120,000	99,000	77	<1	43,000	179	<1
Cook Islands	–	–	–	–	–	–	–
Costa Rica	–	<200	–	–	–	–	–
Côte d'Ivoire	74,000	57,000	–	–	24,000	1,184 [†]	5 [†]
Croatia	–	–	–	–	–	–	–
Cuba	–	<200	–	–	–	–	–
Djibouti	1,200	1,200	12	1	<500	8	2
Dominica	–	–	–	–	–	–	–
Dominican Republic	3,600	2,500	–	–	1,000	234	23
Ecuador	–	1,000	–	–	–	–	–
Egypt	–	–	–	–	–	–	–
El Salvador	–	800	12	2	–	188	–
Equatorial Guinea	<1,000	800	–	–	<500	–	–
Eritrea	6,600	5,100	160	3	2,200	54	2
Ethiopia	–	–	–	–	–	1,260	–
Fiji	–	<100	–	–	–	–	–
Gabon	3,900	3,600	125	3	1,400	268	19
Gambia	1,200	1,400	–	–	500	2	<1
Georgia	–	<100	15	20	–	4	–
Ghana	25,000	19,000	–	–	8,200	146	2
Grenada	–	–	–	–	–	–	–
Guatemala	–	2,100	66	3	–	356	–
Guinea	7,000	6,800	42	1	2,500	50	2
Guinea-Bissau	3,200	3,600	–	–	1,300	–	–

TABLE 2. Providing paediatric treatment

	Estimated number of children (0–14 years old) living with HIV, 2005	Estimated number of HIV-infected pregnant women, 2005	Number of infants born to HIV-infected pregnant women started on cotrimoxazole prophylaxis, 2005	% of infants born to HIV-infected pregnant women started on cotrimoxazole prophylaxis, 2005	Estimated number of children (0–14 years old) living with HIV in need of ART, 2005	Number of children (0–14 years old) receiving ART, 2005**	% of children in need receiving ART, 2005
Guyana	<1,000	<500	92	37	<500	35	14
Haiti	17,000	12,000	–	–	4,900	46	1
Honduras	2,400	1,700	–	–	1,400	1	<1
India	–	130,000	–	–	–	1,300	–
Indonesia	–	2,000	1	<1	–	1	–
Iran (Islamic Republic of)	–	700	–	–	–	20	–
Iraq	–	–	3	–	–	–	–
Jamaica	<500	<500	–	–	<500	165	47
Jordan	–	<100	–	–	–	3	–
Kazakhstan	–	<500	52	15	–	52	–
Kenya	150,000	99,000	8,600	9	44,000	5,000	11
Kiribati	–	–	–	–	–	–	–
Korea, Democratic People's Republic of	–	–	–	–	–	–	–
Korea, Republic of	–	<500	–	–	–	–	–
Kuwait	–	–	–	–	–	–	–
Kyrgyzstan	–	<100	–	–	–	–	–
Lao People's Democratic Republic	–	<100	14	28	–	3	–
Lebanon	–	<100	–	–	–	–	–
Lesotho	18,000	15,000	–	–	5,700	623	11
Liberia	–	–	–	–	–	–	–
Libyan Arab Jamahiriya	–	–	–	–	–	–	–
Madagascar	1,600	2,000	3	<1	700	1	<1
Malawi	91,000	89,000	–	–	24,000	1,999	8
Malaysia	–	1,400	–	–	–	–	–
Maldives	–	–	–	–	–	–	–
Mali	16,000	13,000	322	2	5,400	–	–
Marshall Islands	–	–	–	–	–	–	–
Mauritania	1,100	1,000	8	1	<500	6	2
Mauritius	–	<100	–	–	–	–	–
Mexico	–	2,400	–	–	–	–	–
Micronesia (Federated States of)	–	–	–	–	–	–	–
Moldova, Republic of	–	<500	5	1	–	11	–
Mongolia	–	<100	–	–	–	–	–
Montenegro†	–	33	–	–	–	–	–
Morocco	–	<500	–	–	–	–	–
Mozambique	140,000	150,000	–	–	57,000	1,686	3
Myanmar	–	7,700	63	1	–	136	–
Namibia	17,000	14,000	543	4	5,400	2,824	52
Nauru	–	–	–	–	–	–	–
Nepal	–	–	–	–	–	–	–
Nicaragua	–	<200	6	6	–	11	–
Niger	8,900	9,200	–	–	3,500	22	1
Nigeria	240,000	250,000	–	–	95,000	900	1
Niue	–	–	–	–	–	–	–
Occupied Palestinian Territory	–	–	–	–	–	–	–
Oman	–	–	–	–	–	–	–
Pakistan	–	–	–	–	–	–	–
Palau	–	–	–	–	–	–	–
Panama	–	<500	–	–	–	–	–
Papua New Guinea	–	3,700	20	1	–	–	–
Paraguay	–	<500	20	8	–	102	–
Peru	–	2,100	–	–	–	203	–
Philippines	–	<500	–	–	–	–	–
Qatar	–	–	–	–	–	–	–
Romania	–	–	–	–	–	–	–
Russian Federation	–	6,800	–	–	–	330†	–

TABLE 2. Providing paediatric treatment

	Estimated number of children (0–14 years old) living with HIV, 2005	Estimated number of HIV-infected pregnant women, 2005	Number of infants born to HIV-infected pregnant women started on cotrimoxazole prophylaxis, 2005	% of infants born to HIV-infected pregnant women started on cotrimoxazole prophylaxis, 2005	Estimated number of children (0–14 years old) living with HIV in need of ART, 2005	Number of children (0–14 years old) receiving ART, 2005**	% of children in need receiving ART, 2005
Rwanda	27,000	16,000	–	–	7,400	1,443	20
Saint Kitts and Nevis	–	–	–	–	–	–	–
Saint Lucia	–	–	–	–	–	–	–
Saint Vincent and the Grenadines	–	–	–	–	–	–	–
Samoa	–	–	–	–	–	–	–
Sao Tome and Principe	–	–	2	–	–	2	–
Saudi Arabia	–	–	–	–	–	–	–
Senegal	5,000	4,600	–	–	1,800	126	7
Serbia†	–	33	–	–	–	–	–
Seychelles	–	–	–	–	–	–	–
Sierra Leone	5,200	4,800	23	1	1,900	23	1
Singapore	–	<100	–	–	–	–	–
Solomon Islands	–	–	–	–	–	–	–
Somalia	4,500	4,400	–	–	1,700	–	–
South Africa	240,000	250,000	64,291	26	67,000	12,247	18
Sri Lanka	–	<100	–	–	–	–	–
Sudan	30,000	23,000	–	–	9,700	–	–
Suriname	<100	<100	–	–	<100	–	–
Swaziland	15,000	14,000	764	5	5,200 [†]	851	16
Syrian Arab Republic	–	–	–	–	50	–	–
Tajikistan	–	<100	–	–	–	–	–
Tanzania, United Republic of	110,000	110,000	–	–	41,000	2,318	6
Thailand	16,000	11,000	–	–	4,100	6,495 [†]	>95 [†]
The former Yugoslav Republic of Macedonia	–	–	–	–	–	–	–
Timor-Leste	–	–	–	–	–	–	–
Togo	9,700	9,200	378	4	3,500	101	3
Tonga	–	–	–	–	–	–	–
Trinidad and Tobago	<1,000	600	–	–	<500	–	–
Tunisia	–	<200	–	–	–	–	–
Turkey	–	–	–	–	–	–	–
Turkmenistan	–	<100	–	–	–	–	–
Tuvalu	–	–	–	–	–	–	–
Uganda	110,000	110,000	–	–	39,000	5,000 [†]	13 [†]
Ukraine	–	2,400	2,100	88	–	413	–
United Arab Emirates	–	–	–	–	–	–	–
Uruguay	–	<500	–	–	–	–	–
Uzbekistan	–	<500	1	<1	–	–	–
Vanuatu	–	–	–	–	–	–	–
Venezuela, Bolivarian Republic of	–	2,300	–	–	–	–	–
Viet Nam	–	5,500	–	–	–	252	–
Yemen	–	–	–	–	–	–	–
Zambia	130,000	97,000	–	–	40,000	5,000	13
Zimbabwe	160,000	98,000	5,505	6	44,000	1,700	4

DEFINITIONS OF THE INDICATORS
Estimated number of children living with HIV:

Estimated number of children (0–14 years old) living with HIV as of 2005.

Estimated number of HIV-infected pregnant women: Estimated number of pregnant women (15–49 years old) living with HIV as of 2005.

Number of infants born to HIV-infected pregnant women started on cotrimoxazole prophylaxis: Number of HIV-exposed infants seen by a medical professional within two months of birth and started on cotrimoxazole prophylaxis.

Percentage of infants born to HIV-infected pregnant women started on cotrimoxazole prophylaxis: Calculated by dividing the number of HIV-exposed infants started on cotrimoxazole prophylaxis by the estimated number of children born to HIV-infected pregnant women, assuming a ratio of one child to one HIV-infected mother. The denominator is the estimated number of HIV-infected pregnant women.

Estimated number of children living with HIV in need of ART: Estimated number of children (0–14 years old) living with HIV in need of antiretroviral treatment (ART) as of 2005.

Number of children receiving ART: Number of children (0–14 years old) living with HIV receiving ART as of 2005.

Percentage of children in need receiving ART: Calculated by dividing the number of children receiving ART by the estimated number of children in need of ART.

MAIN DATA SOURCES

Estimated number of children living with HIV: UNAIDS, *2006 Report on the Global AIDS Epidemic*.

Estimated number of HIV-infected pregnant women: UNAIDS/WHO unpublished estimates, 2006.

Number of infants born to HIV-infected pregnant women started on cotrimoxazole prophylaxis: UNICEF and WHO, 'Report Card on the Prevention of Mother-to-Child Transmission of HIV and Paediatric Care, 2006' (forthcoming).

Percentage of infants born to HIV-infected women started on cotrimoxazole prophylaxis: UNICEF and WHO, 'Report Card on the Prevention of Mother-to-Child Transmission of HIV and Paediatric Care, 2006' (forthcoming).

Estimated number of children living with HIV in need of ART: UNAIDS/WHO unpublished estimates, 2006.

Number of children receiving ART: UNICEF and WHO, 'Report Card on the Prevention of Mother-to-Child Transmission of HIV and Paediatric Care, 2006' (forthcoming).

Percentage of children in need receiving ART: UNICEF and WHO, 'Report Card on the Prevention of Mother-to-Child Transmission of HIV and Paediatric Care, 2006' (forthcoming).

NOTES

– Data not available.

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

** United Nations General Assembly Special Session on HIV/AIDS (2001) indicator, as part of men and women with advanced HIV infection receiving antiretroviral combination therapy.

† Due to the cession in June 2006 of Montenegro from the State Union of Serbia and Montenegro, and its subsequent admission to the UN on 28 June 2006, disaggregated data for Montenegro and Serbia as separate States are not yet available. Aggregated data presented are for Serbia and Montenegro pre-cession.

‡ Data source is WHO, unpublished data, 2006.

TABLE 3. Preventing infection among adolescents and young people

	HIV prevalence among young people (15–24 years old)			Knowledge and behaviours					
				% of young people (15–24 years old) who have comprehensive knowledge of HIV (1999–2005*) **		% of young people (15–24 years old) who used a condom at last high-risk sex (1999–2005*) **		% of young people (15–19 years old) who had sex before age 15 (1999–2005*) **	
	Male (2005)	Female (2005)	Pregnant women in capital city (2001–2005*) **	Male	Female	Male	Female	Male	Female
Afghanistan	–	–	–	–	–	–	–	–	–
Albania	–	–	–	–	0	–	–	–	–
Algeria	–	–	–	–	–	–	–	–	–
Angola	1	3	3	–	–	–	–	–	–
Antigua and Barbuda	–	–	–	–	–	–	–	–	–
Argentina	–	–	–	–	–	–	–	–	–
Armenia	–	–	–	8	7	44	–	1	1
Azerbaijan	–	–	–	–	2	–	–	–	1
Bahamas	–	–	–	–	–	–	–	–	–
Bahrain	–	–	–	–	–	–	–	–	–
Bangladesh	–	–	–	–	–	–	–	–	–
Barbados	–	–	–	–	–	–	–	–	–
Belarus	–	–	–	–	–	–	–	–	–
Belize	–	–	–	–	–	–	–	–	–
Benin	0	1	2	14	8	34	19	24	16
Bhutan	–	–	–	–	–	–	–	–	–
Bolivia	–	–	–	18	–	37	20	15	6
Bosnia and Herzegovina	–	–	–	–	–	–	–	–	–
Botswana	6	15	34	33	40	88	75	–	–
Brazil	–	–	–	–	–	–	–	–	–
Brunei Darussalam	–	–	–	–	–	–	–	–	–
Bulgaria	–	–	–	–	–	–	–	–	–
Burkina Faso	1	1	2	23	15	67	54	5	7
Burundi	1	2	9	–	24	–	–	–	3
Cambodia	–	–	3	–	37	–	–	–	1
Cameroon	1	5	7	34	27	57	46	12	18
Cape Verde	–	–	–	–	–	–	–	40	21
Central African Republic	3	7	14	–	5	–	–	–	–
Chad	1	2	4	20	8	25	17	11	19
Chile	–	–	–	–	–	–	–	–	–
China	–	–	–	–	–	–	–	–	–
Colombia	–	–	–	–	–	–	30	–	10
Comoros	<0.1	<0.1	–	–	10	–	–	–	–
Congo	1	4	3	22	10	38	20	–	–
Congo, Democratic Republic of the	1	2	3	–	–	–	–	24	12
Cook Islands	–	–	–	–	–	–	–	–	–
Costa Rica	–	–	5	–	–	–	–	–	–
Côte d'Ivoire	2	5	5	–	16	–	–	15	19
Croatia	–	–	–	–	–	–	–	–	–
Cuba	–	–	–	–	52	–	–	–	–
Djibouti	1	2	–	–	–	–	–	–	–
Dominica	–	–	–	–	–	–	–	–	–
Dominican Republic	–	–	–	–	–	52	29	18	13
Ecuador	–	–	–	–	–	–	–	–	7
Egypt	–	–	–	–	–	–	–	–	–
El Salvador	–	–	–	–	–	–	–	–	–
Equatorial Guinea	1	2	–	–	4	–	–	–	–
Eritrea	1	2	–	–	37	–	–	–	9
Ethiopia	–	–	12	–	–	30	17	5	14
Fiji	–	–	–	–	–	–	–	–	–
Gabon	2	5	–	22	24	48	33	48	24
Gambia	1	2	–	–	15	–	–	40	69
Georgia	–	–	–	–	–	–	–	–	3
Ghana	0	1	4	44	38	52	33	4	7
Grenada	–	–	–	–	–	–	–	–	–
Guatemala	–	–	–	–	–	–	–	15	7
Guinea	1	1	4	–	–	32	17	17	22

TABLE 3. Preventing infection among adolescents and young people

	HIV prevalence among young people (15–24 years old)			Knowledge and behaviours					
				% of young people (15–24 years old) who have comprehensive knowledge of HIV (1999–2005*) **		% of young people (15–24 years old) who used a condom at last high-risk sex (1999–2005*) **		% of young people (15–19 years old) who had sex before age 15 (1999–2005*) **	
	Male (2005)	Female (2005)	Pregnant women in capital city (2001–2005*) **	Male	Female	Male	Female	Male	Female
Guinea-Bissau	1	3	–	–	8	–	–	–	–
Guyana	–	–	–	–	36	–	–	–	–
Haiti	–	–	4	28	15	30	19	28	12
Honduras	–	–	–	–	–	–	–	19	13
India	–	–	–	17	21	59	51	–	–
Indonesia	–	–	–	–	7	–	–	–	–
Iran (Islamic Republic of)	–	–	–	–	–	–	–	–	–
Iraq	–	–	–	–	–	–	–	–	–
Jamaica	–	–	–	–	–	–	–	–	–
Jordan	–	–	–	–	–	–	–	–	–
Kazakhstan	–	–	–	–	–	65	32	6	1
Kenya	1	5	–	47	34	47	25	31	15
Kiribati	–	–	–	–	–	–	–	–	–
Korea, Democratic People's Republic of	–	–	–	–	–	–	–	–	–
Korea, Republic of	–	–	–	–	–	–	–	–	–
Kuwait	–	–	–	–	–	–	–	–	–
Kyrgyzstan	–	–	–	–	–	–	–	–	–
Lao People's Democratic Republic	–	–	–	–	–	–	–	–	–
Lebanon	–	–	–	–	–	–	–	–	–
Lesotho	6	14	27	18	26	48	50	30	16
Liberia	–	–	–	–	–	–	–	12	32
Libyan Arab Jamahiriya	–	–	–	–	–	–	–	–	–
Madagascar	1	0	–	16	19	12	5	8	16
Malawi	3	10	15	36	24	47	35	18	14
Malaysia	–	–	–	–	–	–	–	–	–
Maldives	–	–	–	–	–	–	–	–	–
Mali	0	1	3	15	9	30	14	11	26
Marshall Islands	–	–	–	–	–	–	–	–	–
Mauritania	0	1	–	–	–	–	–	2	13
Mauritius	–	–	–	–	–	–	–	–	–
Mexico	–	–	–	–	–	–	–	–	–
Micronesia (Federated States of)	–	–	–	–	–	–	–	–	–
Moldova, Republic of	–	–	–	–	19	63	44	–	–
Mongolia	–	–	–	–	32	–	–	–	–
Montenegro†	–	–	–	–	–	–	–	–	–
Morocco	–	–	–	–	12	–	–	–	–
Mozambique	4	11	15	33	20	33	29	–	28
Myanmar	–	–	–	–	–	–	–	–	–
Namibia	4	13	8	41	31	69	48	31	10
Nauru	–	–	–	–	–	–	–	–	–
Nepal	–	–	–	–	–	–	–	20	9
Nicaragua	–	–	–	–	–	–	17	–	11
Niger	0	1	–	–	5	–	–	–	–
Nigeria	1	3	–	21	18	46	24	8	20
Niue	–	–	–	–	–	–	–	–	–
Occupied Palestinian Territory	–	–	–	–	–	–	–	–	–
Oman	–	–	–	–	–	–	–	–	–
Pakistan	–	–	–	–	–	–	–	–	–
Palau	–	–	–	–	–	–	–	–	–
Panama	–	–	–	–	–	–	–	–	–
Papua New Guinea	–	–	–	–	–	–	–	–	–
Paraguay	–	–	–	–	–	–	–	–	–
Peru	–	–	–	–	–	–	19	–	5
Philippines	–	–	–	–	–	–	–	–	–
Qatar	–	–	–	–	–	–	–	–	–
Romania	–	–	–	–	–	–	–	12	3

TABLE 3. Preventing infection among adolescents and young people

	HIV prevalence among young people (15–24 years old)			Knowledge and behaviours					
				% of young people (15–24 years old) who have comprehensive knowledge of HIV (1999–2005*) **		% of young people (15–24 years old) who used a condom at last high-risk sex (1999–2005*) **		% of young people (15–19 years old) who had sex before age 15 (1999–2005*) **	
	Male (2005)	Female (2005)	Pregnant women in capital city (2001–2005*) **	Male	Female	Male	Female	Male	Female
Russian Federation	–	–	–	–	–	–	–	–	–
Rwanda	0	2	10	54	51	40	26	15	5
Saint Kitts and Nevis	–	–	–	–	–	–	–	–	–
Saint Lucia	–	–	–	–	–	–	–	–	–
Saint Vincent and the Grenadines	–	–	–	–	–	–	–	–	–
Samoa	–	–	–	–	–	–	–	–	–
Sao Tome and Principe	–	–	–	–	11	–	–	–	–
Saudi Arabia	–	–	–	–	–	–	–	–	–
Senegal	0	1	1	–	13	52	36	31	29
Serbia†	–	–	–	–	–	–	–	–	–
Seychelles	–	–	–	–	–	–	–	–	–
Sierra Leone	0	1	3	–	16	–	–	–	25
Singapore	–	–	–	–	–	–	–	–	–
Solomon Islands	–	–	–	–	–	–	–	–	–
Somalia	0	1	–	–	0	–	–	–	–
South Africa	5	15	25	–	–	–	–	–	9
Sri Lanka	–	–	–	–	–	–	–	–	–
Sudan	–	–	–	–	–	–	–	–	–
Suriname	–	–	–	–	27	–	–	–	–
Swaziland	8	23	37	–	27	–	–	–	–
Syrian Arab Republic	–	–	–	–	–	–	–	–	–
Tajikistan	–	–	–	–	1	–	–	–	–
Tanzania, United Republic of	3	4	8	49	44	47	42	13	11
Thailand	–	–	–	–	–	–	–	–	–
The former Yugoslav Republic of Macedonia	–	–	–	–	–	–	–	–	–
Timor-Leste	–	–	–	–	–	–	–	–	–
Togo	1	2	9	–	20	–	–	15	11
Tonga	–	–	–	–	–	–	–	–	–
Trinidad and Tobago	–	–	–	–	33	–	–	–	–
Tunisia	–	–	–	–	–	–	–	–	–
Turkey	–	–	–	–	–	–	–	–	–
Turkmenistan	–	–	–	–	3	–	–	–	<1
Tuvalu	–	–	–	–	–	–	–	–	–
Uganda	2	5	5	40	28	55	53	16	12
Ukraine	–	–	–	–	–	–	–	–	–
United Arab Emirates	–	–	–	–	–	–	–	–	–
Uruguay	–	–	–	–	–	–	–	–	–
Uzbekistan	–	–	–	7	8	50	–	–	–
Vanuatu	–	–	–	–	–	–	–	–	–
Venezuela, Bolivarian Republic of	–	–	–	–	–	–	–	–	–
Viet Nam	–	–	–	50	42	68	–	0.3	1
Yemen	–	–	–	–	–	–	–	–	–
Zambia	4	13	21	33	31	40	35	27	18
Zimbabwe	4	15	19	–	–	69	42	6	3

DEFINITIONS OF THE INDICATORS

HIV prevalence among young people: Percentage of young men and women (15–24 years old) living with HIV as of end-2005.

HIV prevalence among young pregnant women in capital city: Percentage of blood samples taken from pregnant women (15–24 years old) who test positive for HIV during 'unlinked anonymous' sentinel surveillance at selected antenatal clinics.

Comprehensive knowledge of HIV: Percentage of young men and women (15–24 years old) who correctly identify 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 transmission, and who know that a healthy-looking person can transmit HIV.

Condom use at last high-risk sex: Percentage of young men and women (15–24 years old) who say they used a condom the last time they had sex with a non-marital, non-cohabitating partner, of those who have had sex with such a partner in the past 12 months.

Sex before age 15: Percentage of young people (15–19 years old) who say they had sex before age 15.

MAIN DATA SOURCES

HIV prevalence among young people: UNICEF, *The State of the World's Children 2007*.

HIV prevalence among young pregnant women in capital city: UNICEF, *The State of the World's Children 2007*.

Comprehensive knowledge of HIV: UNICEF, *The State of the World's Children 2007*.

Condom use at last high-risk sex: UNICEF, *The State of the World's Children 2007*.

Sex before age 15: DHS, MICS and RHS (1999–2005); www.statcompiler.com.

NOTES

– Data not available.

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

** United Nations General Assembly Special Session on HIV/AIDS (2001) indicator.

† Due to the cession in June 2006 of Montenegro from the State Union of Serbia and Montenegro, and its subsequent admission to the UN on 28 June 2006, disaggregated data for Montenegro and Serbia as separate States are not yet available. Aggregated data presented are for Serbia and Montenegro pre-cession.

TABLE 4. Protecting and supporting children affected by HIV/AIDS

	Orphaned and vulnerable children						% of children whose households received external support (2004–2006*) **
	Children who have lost one or both parents due to all causes, 2005	Children who have lost one or both parents due to AIDS, 2005	Children whose mother has died due to any cause, 2005	Children whose father has died due to any cause, 2005	Children both of whose parents have died due to any cause, 2005	Orphan school attendance ratio (1999–2005*) **	
Afghanistan	1,600,000	–	700,000	1,100,000	170,000	–	–
Albania	–	–	–	–	–	–	–
Algeria	–	–	–	–	–	–	–
Angola	1,200,000	160,000	590,000	820,000	230,000	90	–
Antigua and Barbuda	–	–	–	–	–	–	–
Argentina	690,000	–	120,000	590,000	23,000	–	–
Armenia	–	–	–	–	–	–	–
Azerbaijan	–	–	–	–	–	–	–
Bahamas	8,000	–	3,000	6,000	600	–	–
Bahrain	–	–	–	–	–	–	–
Bangladesh	4,400,000	–	1,800,000	2,900,000	350,000	–	–
Barbados	3,000	–	600	3,000	<100	–	–
Belarus	–	–	–	–	–	–	–
Belize	5,000	–	2,000	4,000	200	–	–
Benin	370,000	62,000	160,000	250,000	44,000	–	–
Bhutan	78,000	–	30,000	53,000	6,000	–	–
Bolivia	310,000	–	110,000	230,000	22,000	–	–
Bosnia and Herzegovina	–	–	–	–	–	–	–
Botswana	150,000	120,000	110,000	100,000	56,000	99	95
Brazil	3,700,000	–	850,000	3,000,000	150,000	–	–
Brunei Darussalam	4,000	–	900	3,000	<100	–	–
Bulgaria	–	–	–	–	–	–	–
Burkina Faso	710,000	120,000	320,000	470,000	79,000	109	–
Burundi	600,000	120,000	310,000	400,000	110,000	70	–
Cambodia	470,000	–	170,000	340,000	110,000	71	–
Cameroon	1,000,000	240,000	540,000	660,000	180,000	99	–
Cape Verde	–	–	–	–	–	–	–
Central African Republic	330,000	140,000	180,000	220,000	76,000	91	–
Chad	600,000	57,000	280,000	410,000	84,000	105	–
Chile	200,000	–	33,000	170,000	4,000	–	–
China	20,600,000	–	5,400,000	16,000,000	880,000	–	–
Colombia	870,000	–	210,000	680,000	25,000	–	–
Comoros	33,000	–	14,000	22,000	3,000	59	–
Congo	270,000	110,000	140,000	180,000	48,000	–	–
Congo, Democratic Republic of the	4,200,000	680,000	2,100,000	2,800,000	800,000	72	2
Cook Islands	–	–	–	–	–	–	–
Costa Rica	44,000	–	9,000	36,000	800	–	–
Côte d'Ivoire	1,400,000	450,000	790,000	940,000	350,000	83	–
Croatia	–	–	–	–	–	–	–
Cuba	120,000	–	25,000	94,000	3,000	–	–
Djibouti	48,000	6,000	22,000	32,000	6,000	–	–
Dominica	–	–	–	–	–	–	–
Dominican Republic	220,000	–	74,000	160,000	14,000	96	–
Ecuador	230,000	–	59,000	180,000	8,000	–	–
Egypt	–	–	–	–	–	–	–
El Salvador	150,000	–	40,000	120,000	6,000	–	–
Equatorial Guinea	29,000	5,000	14,000	20,000	5,000	95	–
Eritrea	280,000	36,000	120,000	190,000	34,000	83	–
Ethiopia	4,800,000	–	2,300,000	3,200,000	660,000	60	4
Fiji	25,000	–	9,000	18,000	2,000	–	–
Gabon	65,000	20,000	32,000	41,000	8,000	98	–
Gambia	64,000	4,000	26,000	43,000	6,000	85	–
Georgia	–	–	–	–	–	–	–
Ghana	1,000,000	170,000	490,000	640,000	110,000	79x	–
Grenada	–	–	–	–	–	–	–
Guatemala	370,000	–	100,000	290,000	19,000	98	–
Guinea	370,000	28,000	160,000	250,000	38,000	113	–
Guinea-Bissau	100,000	11,000	48,000	72,000	16,000	103	–

TABLE 4. Protecting and supporting children affected by HIV/AIDS

	Orphaned and vulnerable children						
	Children who have lost one or both parents due to all causes, 2005	Children who have lost one or both parents due to AIDS, 2005	Children whose mother has died due to any cause, 2005	Children whose father has died due to any cause, 2005	Children both of whose parents have died due to any cause, 2005	Orphan school attendance ratio (1999–2005*) **	% of children whose households received external support (2004–2006*) **
Guyana	26,000	–	11,000	19,000	3,000	–	–
Haiti	490,000	–	250,000	340,000	100,000	87	–
Honduras	180,000	–	52,000	140,000	8,000	–	–
India	25,700,000	–	7,800,000	19,200,000	1,400,000	–	–
Indonesia	5,300,000	–	1,800,000	3,800,000	340,000	82	–
Iran (Islamic Republic of)	1,500,000	–	480,000	1,100,000	71,000	–	–
Iraq	–	–	94,000	377,000	23,000	–	–
Jamaica	55,000	–	17,000	40,000	3,000	–	–
Jordan	–	–	–	–	–	–	–
Kazakhstan	–	–	–	–	–	–	–
Kenya	2,300,000	1,100,000	1,400,000	1,300,000	410,000	95	10
Kiribati	–	–	–	–	–	–	–
Korea, Democratic People's Republic of	–	–	–	–	–	–	–
Korea, Republic of	450,000	–	61,000	400,000	8,000	–	–
Kuwait	–	–	–	–	–	–	–
Kyrgyzstan	–	–	–	–	–	–	–
Lao People's Democratic Republic	290,000	–	120,000	200,000	30,000	–	–
Lebanon	–	–	–	–	–	–	–
Lesotho	150,000	97,000	100,000	95,000	47,000	95	25
Liberia	250,000	–	130,000	170,000	60,000	–	–
Libyan Arab Jamahiriya	–	–	–	–	–	–	–
Madagascar	900,000	13,000	370,000	590,000	65,000	76	7
Malawi	950,000	550,000	540,000	650,000	240,000	93	–
Malaysia	480,000	–	130,000	370,000	17,000	–	–
Maldives	–	–	–	–	–	–	–
Mali	710,000	94,000	320,000	470,000	85,000	104	2
Marshall Islands	–	–	–	–	–	–	–
Mauritania	170,000	7,000	75,000	120,000	17,000	–	–
Mauritius	23,000	–	5,000	19,000	900	–	–
Mexico	1,600,000	–	390,000	1,200,000	46,000	–	–
Micronesia (Federated States of)	–	–	–	–	–	–	–
Moldova, Republic of	–	–	–	–	–	–	–
Mongolia	79,000	–	28,000	57,000	6,000	–	–
Montenegro†	–	–	–	–	–	–	–
Morocco	–	–	–	–	–	–	–
Mozambique	1,500,000	510,000	860,000	980,000	310,000	80	–
Myanmar	1,700,000	–	600,000	1,200,000	140,000	–	–
Namibia	140,000	85,000	86,000	83,000	31,000	92	33
Nauru	–	–	–	–	–	–	–
Nepal	970,000	–	410,000	650,000	84,000	–	–
Nicaragua	130,000	–	39,000	93,000	6,000	–	–
Niger	800,000	46,000	370,000	520,000	87,000	–	–
Nigeria	8,600,000	930,000	4,400,000	5,800,000	1,500,000	64x	–
Niue	–	–	–	–	–	–	–
Occupied Palestinian Territory	–	–	–	–	–	–	–
Oman	–	–	–	–	–	–	–
Pakistan	4,400,000	–	1,500,000	3,100,000	240,000	–	–
Palau	–	–	–	–	–	–	–
Panama	53,000	–	12,000	43,000	2,000	–	–
Papua New Guinea	350,000	–	160,000	240,000	48,000	–	–
Paraguay	150,000	–	44,000	110,000	6,000	–	–
Peru	660,000	–	190,000	500,000	32,000	85x	–
Philippines	2,000,000	–	650,000	1,400,000	100,000	–	–
Qatar	–	–	–	–	–	–	–
Romania	–	–	–	–	–	–	–
Russian Federation	–	–	–	–	–	–	–
Rwanda	820,000	210,000	490,000	620,000	290,000	82	13
Saint Kitts and Nevis	–	–	–	–	–	–	–

TABLE 4. Protecting and supporting children affected by HIV/AIDS

	Orphaned and vulnerable children						
	Children who have lost one or both parents due to all causes, 2005	Children who have lost one or both parents due to AIDS, 2005	Children whose mother has died due to any cause, 2005	Children whose father has died due to any cause, 2005	Children both of whose parents have died due to any cause, 2005	Orphan school attendance ratio (1999–2005*) **	% of children whose households received external support (2004–2006*) **
Saint Lucia	–	–	–	–	–	–	–
Saint Vincent and the Grenadines	–	–	–	–	–	–	–
Samoa	–	–	–	–	–	–	–
Sao Tome and Principe	–	–	–	–	–	–	–
Saudi Arabia	–	–	–	–	–	–	–
Senegal	560,000	25,000	250,000	370,000	67,000	74x	1
Serbia†	–	–	–	–	–	–	–
Seychelles	–	–	–	–	–	–	–
Sierra Leone	340,000	31,000	150,000	240,000	52,000	71	–
Singapore	26,000	–	5,000	21,000	600	–	–
Solomon Islands	–	–	–	–	–	–	–
Somalia	630,000	23,000	310,000	440,000	110,000	65	–
South Africa	2,500,000	1,200,000	1,300,000	1,600,000	450,000	–	–
Sri Lanka	310,000	–	68,000	250,000	10,000	–	–
Sudan	1,700,000	–	740,000	1,100,000	180,000	96	–
Suriname	10,000	–	3,000	7,000	500	89	–
Swaziland	95,000	63,000	67,000	56,000	28,000	91	–
Syrian Arab Republic	–	–	–	–	–	–	–
Tajikistan	–	–	–	–	–	–	–
Tanzania, United Republic of	2,400,000	1,100,000	1,300,000	1,500,000	410,000	82	–
Thailand	1,200,000	–	290,000	990,000	50,000	–	–
The former Yugoslav Republic of Macedonia	–	–	–	–	–	–	–
Timor-Leste	–	–	–	–	–	–	–
Togo	280,000	88,000	130,000	190,000	38,000	96	10
Tonga	–	–	–	–	–	–	–
Trinidad and Tobago	28,000	–	9,000	20,000	1,000	–	–
Tunisia	–	–	–	–	–	–	–
Turkey	–	–	–	–	–	–	–
Turkmenistan	–	–	–	–	–	–	–
Tuvalu	–	–	–	–	–	–	–
Uganda	2,300,000	1,000,000	1,300,000	1,500,000	540,000	95	23
Ukraine	–	–	–	–	97,959	–	–
United Arab Emirates	–	–	–	–	–	–	–
Uruguay	55,000	–	8,000	48,000	1,000	–	–
Uzbekistan	–	–	–	–	–	–	–
Vanuatu	–	–	–	–	–	–	–
Venezuela, Bolivarian Republic of	480,000	–	120,000	380,000	16,000	–	–
Viet Nam	1,800,000	–	600,000	1,300,000	88,000	–	–
Yemen	–	–	–	–	–	–	–
Zambia	1,200,000	710,000	860,000	800,000	420,000	92	13
Zimbabwe	1,400,000	1,100,000	1,100,000	920,000	700,000	98	8

DEFINITIONS OF THE INDICATORS

Children who have lost one or both parents due to all causes: Estimated number of children (0–17 years old) as of end-2005 who have lost one or both parents to any cause.

Children who have lost one or both parents due to AIDS: Estimated number of children (0–17 years old) as of end-2005 who have lost one or both parents to AIDS.

Children whose mother/father has died due to any cause: Estimated number of children (0–17 years old) as of end-2005 who have lost their biological mother/father to any cause.

Children both of whose parents have died due to any cause: Estimated number of children (0–17 years old) as of end-2005 who have lost both parents to any cause.

Orphan school attendance ratio: Percentage of children (10–14 years old) 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: 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: UNICEF, *The State of the World's Children 2007*.

Children who have lost one or both parents due to AIDS: UNICEF, *The State of the World's Children 2007*.

Children whose mother/father has died due to any cause: UNICEF, UNAIDS and PEPFAR, *Africa's Orphaned and Vulnerable Generations: Children Affected by AIDS*, 2006.

Children both of whose parents have died due to any cause: UNICEF, UNAIDS and PEPFAR, *Africa's Orphaned and Vulnerable Generations: Children Affected by AIDS*, 2006.

Orphan school attendance ratio: UNICEF, *The State of the World's Children 2007*.

Percentage of children whose households received external support: Household surveys; Futures Group Coverage Survey 2006.

NOTES

– Data not available.

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

** United Nations General Assembly Special Session on HIV/AIDS (2001) indicator.

x Data refer to years or periods other than those specified in the column heading, differ from the standard definition or refer to only part of a country.

† Due to the cession in June 2006 of Montenegro from the State Union of Serbia and Montenegro, and its subsequent admission to the UN on 28 June 2006, disaggregated data for Montenegro and Serbia as separate States are not yet available. Aggregated data presented are for Serbia and Montenegro pre-cession.

KEY PARTNERS FOR CHILDREN AND AIDS

Advocates for Youth • AWEPA (Association of European Parliamentarians for Africa) • African Network for Care of Children Affected by HIV/AIDS (ANECCA) • AusAID (Government of Australia) • Department for International Development (DFID; UK Government) • Baylor International Pediatric AIDS Initiative (BIPAI) • Better Care Network • Brazil + 7 • Catholic Medical Mission Board (CMMB) • Clinton Foundation and Clinton Foundation HIV/AIDS Initiative • Columbia University (ICAP) • Development Cooperation Ireland (DCI) • Ecumenical Advocacy Alliance • Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) • Family Health International (FHI) • Global Business Coalition (GBC) • Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) • Global Movement for Children • HelpAge International • International Save the Children Alliance • Irish Aid (Government of Ireland Department of Foreign Affairs) • Medecins sans Frontieres (MSF) • Mothers 2 Mothers (m2m) • Government of the Netherlands • Organization of African First Ladies Against HIV/AIDS • Paediatric AIDS Treatment for Africa (PATA) • Plan International • Population Council • Population Services International (PSI) • US President's Emergency Plan for AIDS Relief (PEPFAR) • Save the Children International • Staying Alive • The AIDS Support Organization (TASO) • UNAIDS, the Joint United Nations Programme on HIV/AIDS • UNITAID • United Nations Children's Fund (UNICEF) • United Nations Educational, Scientific and Cultural Organization (UNESCO) • United Nations Office on Drugs and Crime (UNODC) • United Nations Population Fund (UNFPA) • US Centers for Disease Control and Prevention (CDC) • The World Bank • World Health Organization (WHO) • World Vision • national governments, national civil society organizations and many others throughout the world •

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