

**A progress report on the Global Plan
towards the elimination of new HIV infections
among children by 2015 and keeping their mothers alive**



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Ebube Sylvia Taylor of Nigeria, aged 11, speaking at the launch of the Global Plan in June 2011 on behalf of all children born free of HIV.

FOREWORD

One year ago, at the United Nations General Assembly High Level Meeting on AIDS, global leaders made a historic commitment before the world: to end HIV infections among children by 2015 and to keep their mothers alive.

Every year, almost 330 000 babies become infected with HIV because they are born to mothers living with HIV. Preventing this is not just a moral imperative but one of the best investments that the world can make to address HIV.

We know that the virtual elimination of mother-to-child transmission of HIV is possible because it has been achieved in the developed world. This is due to HIV testing in pregnancy, widespread access to antiretroviral medication for mothers (including simple, inexpensive antiretroviral regimens delivered before and after childbirth) and lifelong treatment given for the mother's own health. In contrast, in the developing world, women too often go untested for HIV, with devastating consequences for themselves and their newborns.

Without treatment, up to 40% of babies born to HIV-positive mothers will start life infected, and almost half of them will die before they are two years old.

When we prevent mother-to-child transmission, we also keep mothers alive and families healthy – not only by diagnosing HIV infection and treating the mother, but also by creating a gateway to essential reproductive and health services that benefit everyone she loves.

The Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive is a powerful tool for countries. It extends beyond scaling up programmes for preventing mother-to-child transmission to include testing for HIV-exposed infants and ensuring those that are living with HIV have access to life-saving treatment. It also emphasizes the importance of keeping mothers alive by linking them with treatment – and we know that suppressing viral

load with treatment is an effective means of preventing onward sexual transmission of HIV.

We know that the Global Plan is working because we are already seeing results in countries that have implemented the Global Plan in the past year. Further, it is working because it puts women at the centre of the response.

The Global Plan focuses on strengthening links between and integrating AIDS, maternal and child health and women's health programming to achieve the greatest possible impact on health outcomes for women, children and families. It also emphasizes human rights and gender equity for all women, including the most vulnerable. Sex workers, people who use drugs and migrants are mothers too and should not see their children get sick and die because of stigma and discrimination.

The Global Plan also clearly recognizes that men care about their families and their communities. We know that men can significantly influence their partner's health decisions and use of health resources. Including men in these programmes opens an avenue for fathers to be more involved in the welfare of their partners and their children.

Our efforts to achieve virtual elimination of new HIV infections among children by 2015 and to keep mothers alive will not succeed without sufficient investment in HIV as well as in maternal and child health programmes. To maintain our momentum, we all must embrace the shared responsibility to invest in HIV programmes, including those that focus on women and children.

We can all commit to accelerate progress, to put women at the centre and to win this fight. Together, we can end AIDS among children and mothers – working in concert with governments, civil society and the private sector, in partnership with communities and families.

We can get to zero new HIV infections, zero discrimination and zero AIDS-related deaths. It begins with women and their children.



Michel Sidibé
Executive Director, UNAIDS



Eric Goosby
Ambassador, United States
Global AIDS Coordinator

Progress has been made in eliminating new HIV infections among children and keeping mothers alive

One year ago, the Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive (1) was launched at the United Nations General Assembly High Level Meeting on AIDS. This plan, launched by UNAIDS and the United States Office of the Global AIDS Coordinator, includes two ambitious targets for 2015: reduce the number of children newly infected with HIV by 90%; and reduce the number of pregnancy-related deaths among women living with HIV by 50%. Although the Global Plan involves all countries, 22 countries (including 21 in sub-Saharan Africa) have been given priority, since they account for nearly 90% of pregnant women living with HIV.¹

Progress has been made towards reaching the targets of the Global Plan. The number of children acquiring HIV infection continues to decline as services to protect them and their mothers against HIV expand.

About 330 000 [280 000–380 000] children were newly infected with HIV in 2011, almost half the number in 2003, when the number of children acquiring HIV infection peaked at (570 000 [520 000–650 000]) (2), and 24% lower than the number of children newly infected in 2009 (the baseline year for the Global Plan). Among the 21 Global Plan priority countries in sub-Saharan Africa,

the number of children newly infected decreased from 360 000 [320 000–420 000] in 2009 to 270 000 [230 000–320 000] in 2011, a 25% decrease. With accelerated efforts, the number of children acquiring HIV infection can be reduced by 90% by 2015 from the baseline year of 2009. The estimated number of women living with HIV dying from pregnancy-related causes has declined by 20% since 2005.

Focusing on children

The accelerated pace of the improvements is impressive. The cumulative number of new HIV infections averted among children more than doubled between 2009 and 2011 in low- and middle-income countries, as services to eliminate new HIV infections among children expanded (3). Almost 600 000 new HIV infections among children have been averted since 1995 because of antiretroviral prophylaxis being provided to pregnant women living with HIV and their infants. Most of the children who averted infections live in sub-Saharan Africa, where the number of children who acquired HIV infection in 2011 (300 000 [250 000–350 000]) was 26% lower than in 2009.

Drastically reducing the numbers of children newly infected with HIV will depend especially on progress being made in the priority countries identified in the Global Plan.

DECLINE IN NEW HIV INFECTIONS AMONG CHILDREN, 2009–2011

The Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive identified 22 priority countries. Many of them need urgent action to achieve the Global Plan target. Greater progress is possible.

Rapid decline	Moderate decline	Slow or no decline
Will reach the target if the 2009–2011 decline of 30% or more continues through 2015.	Can reach the target if the decline in 2009–2011 of 20–30% is accelerated.	In danger of not reaching the target, with a decline in 2009–2011 of less than 20%.
31% Ethiopia 31% Ghana 43% Kenya 60% Namibia 49% South Africa 39% Swaziland 55% Zambia 45% Zimbabwe	22% Botswana 30% Burundi 24% Cameroon 20% Côte d'Ivoire 21% Lesotho 26% Malawi 24% Uganda	0% Angola 4% Chad – Democratic Republic of the Congo 5% Mozambique 2% Nigeria 19% United Republic of Tanzania – India

Note: The baseline year for the Global Plan is 2009. Some countries had already made important progress in reducing the number of new HIV infections among children in the years before 2009, notably Botswana which by 2009 already had 92% coverage of antiretroviral regimens among pregnant women and a transmission rate of 5% (see table pp18–19). In countries with high coverage, further declines are much harder to achieve.

Lucy Ghati

National Empowerment Network of People Living with HIV/AIDS in Kenya

ENDING NEW HIV INFECTIONS AMONG CHILDREN AND KEEPING THEIR MOTHERS ALIVE WILL HELP END AIDS

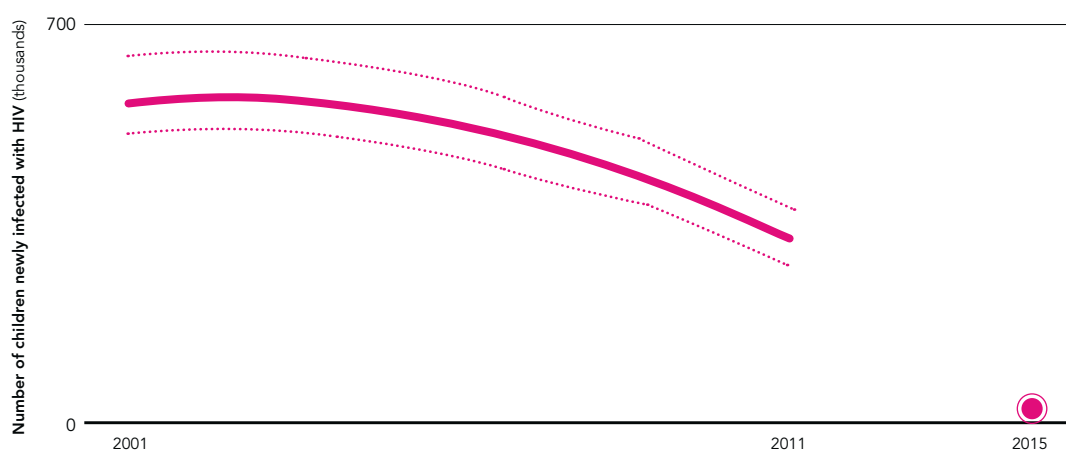
As a mother living with HIV, I would do everything in my capacity to stop passing the virus to my baby and I know that other women sharing my status would do the same. I believe we can end new HIV infections among children and keep their mothers alive: we have the scientific knowledge and tools to make this a reality and proof that it can be done. But in Kenya, one of every five children born to a woman living with HIV still gets infected with HIV.

Results from many locations show that providing antiretroviral therapy to pregnant women living with HIV will prevent the transmission of HIV to infants. But science will only work when programmes are well designed and address the unique challenges facing women. Only 60% of pregnant women living with HIV in Africa received the medicine needed to prevent their children from becoming infected with HIV in 2011.

Many programmes still focus on health facilities, even though half the relevant women do not access these facilities. This calls for better programme design, necessary investment and the meaningful and sustainable involvement of communities at all levels of the response. We need women and men to become agents of change, to build knowledge and demand and to advocate for resources, stronger community systems and the scaling up of services. ■



New HIV infections among children (0–14 years old), 2001–2011 and the target for 2015



Focusing on mothers

In low- and middle-income countries, an estimated 1.5 million [1.3 million–1.6 million] women living with HIV were pregnant in 2011. Reaching the target of halving the number of mothers dying among these women requires that all the estimated 620 000 [600 000–700 000] pregnant women living with HIV who are eligible for treatment receive it. This is especially crucial in sub-Saharan Africa, where AIDS is the leading cause of mothers dying (4).

Globally, the number of women dying from AIDS-related causes during pregnancy or within 42 days after pregnancy ends (referred to as pregnancy-related deaths) was estimated to be 37 000 (18 000–76 000) in 2010, down from an estimated 46 000

(23 000–93 000) deaths in 2005. Among the 22 high-priority countries, the number of pregnancy-related deaths among mothers living with HIV decreased from 41 500 (21 000–84 000) in 2005 to 33 000 (16 000–68 000) in 2010 (5).

If HIV infection in children is to be eliminated and mothers kept alive, a comprehensive package of interventions must be implemented. This package involves a series of steps that starts with preventing women from becoming infected with HIV. Expanding community engagement in creating demand and expanding community support services linked to health facilities at the primary level of care are essential for successfully delivering the package.

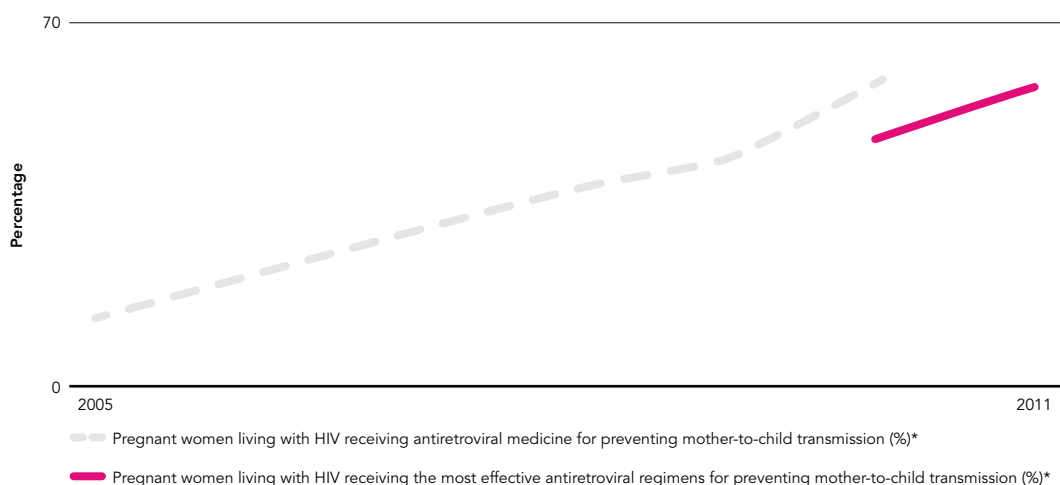
Preventing reproductive-age women from acquiring HIV infection

In several countries with high levels of HIV prevalence, steep drops in the number of adults acquiring HIV infection since 2001 have helped to reduce the number of pregnant women living with HIV and, in turn, reduced the number of children newly infected. Further reducing the number of people acquiring HIV infection in the general population will help to reduce the number of children infected even more. Recent recommendations by WHO to provide HIV testing and counselling to couples and to offer antiretroviral therapy for

HIV prevention in serodiscordant couples could reduce the number of people newly infected further. When couples are counselled and tested for HIV infection together they can make informed decisions about HIV prevention and reproductive health, including contraception and conception.

If a woman becomes infected with HIV during pregnancy or when breastfeeding, the probability of transmission to the child is higher than among women who are already living with HIV (6). It is therefore vital that pregnant women and women who are breastfeeding take extra precautions to avoid HIV infection.

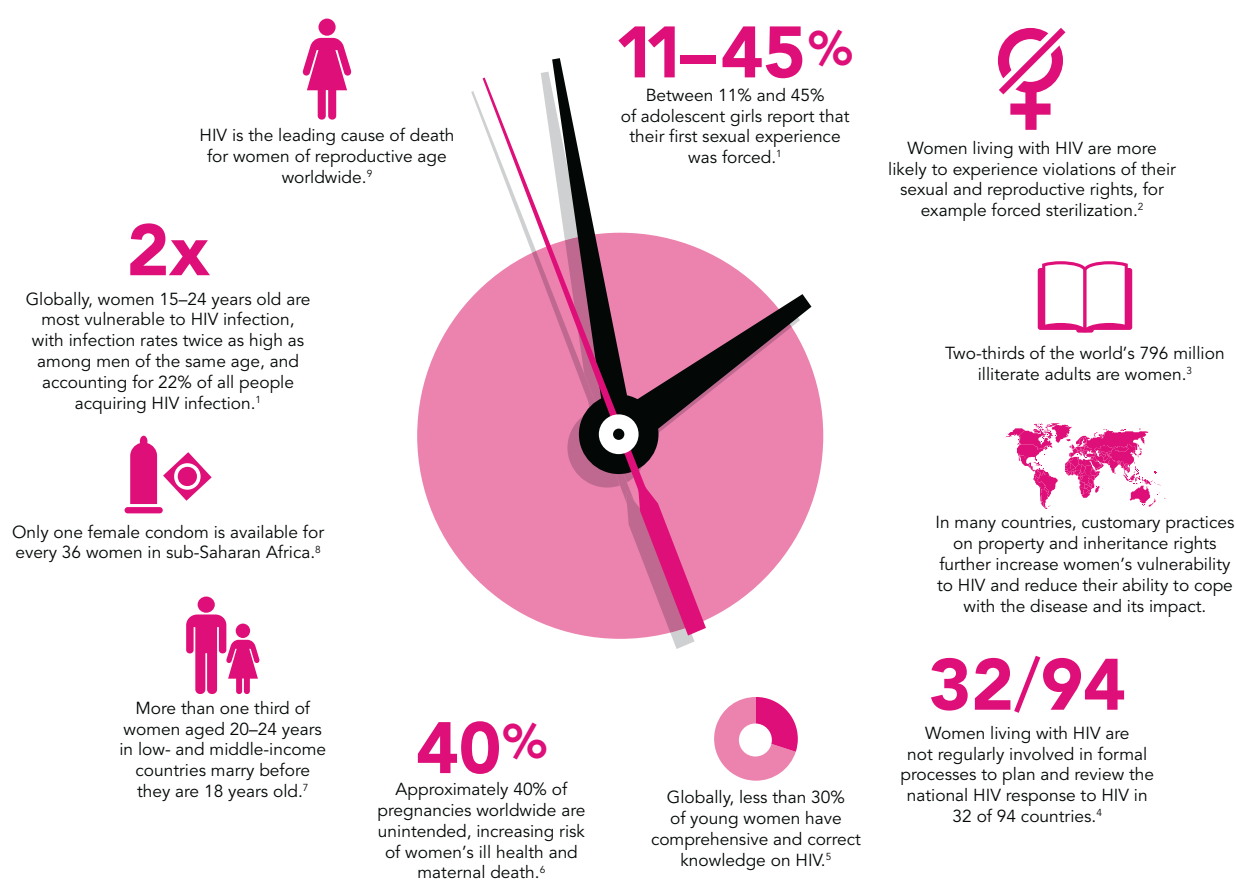
Coverage with antiretroviral regimens among pregnant women living with HIV, low-and middle-income countries, 2005-2011



*Coverage in 2010 and onwards cannot be compared with previous years as it does not include single-dose nevirapine, which WHO no longer recommends.

EVERY MINUTE, A YOUNG WOMAN ACQUIRES HIV INFECTION

Because of their lower economic and sociocultural status in many countries, women and girls are disadvantaged in negotiating safer sex and accessing HIV prevention information and services.



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Reducing the number of reproductive-age women acquiring HIV infection will also have long-range benefits to maternal health and reduce the number of all women dying from pregnancy-related causes, especially in countries with a high prevalence of HIV infection.

Avoiding unintended pregnancies

Preventing unintended pregnancies is the second intervention that is critical for reducing the number of children acquiring HIV infection. In 17 of the 22 priority countries, more than 20% of married women report wanting to limit or space their next birth but lack access to contraception. A recent analysis of 6 of the 22 priority countries found that 13–21% of women living with HIV who knew their HIV status had an unmet need for family planning. Family planning services need to be made available to both women living with HIV and women who are HIV-negative. Reducing the unmet need for family planning will improve the prospects of mothers surviving. Globally, an estimated 20% of pregnancy-related deaths could be prevented if unmet need for contraception were to be eliminated (7).

A recent study (8) suggested that using hormonal contraception potentially increases a woman's chances of becoming infected with HIV. After reviewing existing evidence, a group of experts convened by WHO determined that there is not enough evidence to suggest that women at higher risk of HIV infection should stop using

hormonal contraception but highlighted the importance of using condoms for preventing HIV infection among women using hormonal contraceptives.

Reducing transmission of HIV from mothers living with HIV to their babies

The third intervention is to counsel and test pregnant women for HIV, and if they are living with HIV, to provide the services and medication necessary to ensure their health and reduce the risk of transmission to the child. In 2011, 57% of the estimated 1.5 million [1.3 million–1.6 million] pregnant women living with HIV in low- and middle-income countries received effective antiretroviral drugs to avoid transmission to the child. This is considerably short of the Global Plan's coverage target of 90% by 2015.

Among the 22 priority countries, Botswana, South Africa and Swaziland have achieved 90% coverage for preventing mother-to-child transmission with dual- and triple-therapy regimens. Ghana, Namibia, Zambia and Zimbabwe appear to be on track to achieving this.

In the other priority countries, however, less than 75% of the estimated number of pregnant women living with HIV received antiretroviral therapy during pregnancy in 2011 (2). Elsewhere, coverage was especially low in western and central Africa (27% [23–30%]), North Africa and the Middle East (6% [4–9%]) and Asia (19% [14–25%]), where single-dose nevirapine is still in wide use (2).



Annah Sango

International Community of Women
Living with HIV/AIDS

SEX EDUCATION WILL HELP END AIDS

"Mom, where did I come from?" My mother told me that I fell from heaven. A simple question made my parents uncomfortable; looking for creative ways to avoid answering.

Confused, I was reluctant to ask further because I did not want to be disrespectful. Besides, in our community, a child who asks uncomfortable questions can be called all sorts of names like 'nzenza', a person of loose morals, or 'jeti', going ahead of her time. I grew up with a strong belief that a good girl should not think about sex, let alone talk about it.

This experience is quite common among young girls in Africa as they grow up with so many unanswered questions about their bodies and relationships with boys. Having proper sex education will help girls to answer all these questions. Sex education will help us understand our bodies, sexuality and health needs. It will build our self-confidence and show us how to develop healthy relationships with the opposite sex, avoid unwanted pregnancies and protect ourselves and our future children from HIV. Sex education will tell girls where to go if they need help and how to help others to better understand themselves and build their future.

If we want to decrease new HIV infections in Africa, let's start talking about sex and sexuality with our children in our homes, schools and communities. ■

Counselling and testing pregnant women and providing them with the necessary medication and services are only part of the intervention. The most effective antiretroviral regimens (excluding single-dose nevirapine, which is no longer recommended for pregnant women living with HIV except for emergency use among pregnant women who first present to the health facility during labour) must be provided to the mother and the child to prevent the children from acquiring HIV infection. Antiretroviral prophylaxis must be continued throughout breastfeeding. Among the 21 priority countries in sub-Saharan Africa, coverage of prophylaxis during pregnancy and delivery is estimated at 61%, but the estimated coverage drops to 29% during breastfeeding. Several of the priority countries have documented low rates of HIV transmission at six weeks of age because of increased access to high-quality services to prevent infants from acquiring HIV infection. However, the infection rates among children up to 18 months (and sometimes older) are still high because of transmission during breastfeeding.

Two options are currently recommended. Programmes that use option A need to distinguish whether or not pregnant women require antiretroviral therapy for their own health (CD4 count less than 350 cells per mm³) before starting antiretroviral medicine. Women who do not need antiretroviral therapy for their own health should receive antiretroviral medicine through 7 days after delivery, and their babies receive

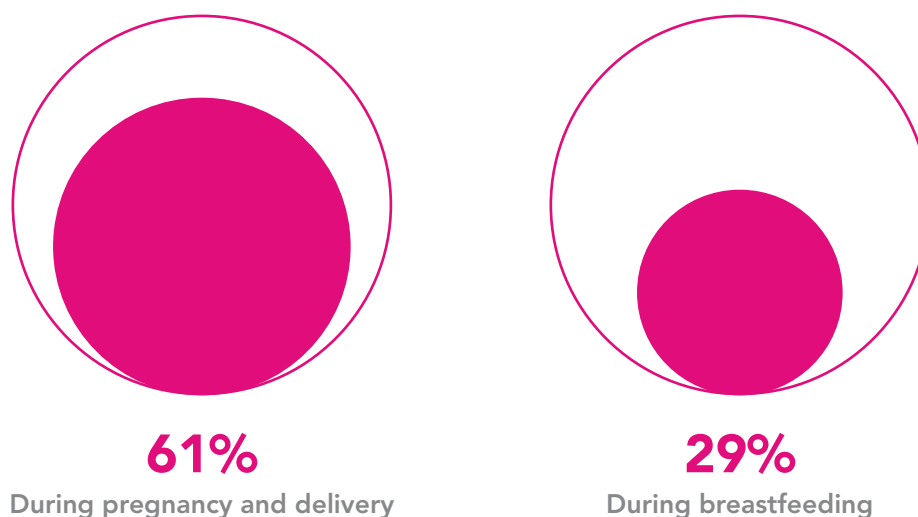
antiretroviral medicine through the end of the breastfeeding period. The additional step of CD4 testing before starting treatment is important for programmes that use option A. Not only will option A not protect the health of the women with lower CD4 counts but it is also less effective than option B in stopping transmission from mother to child when mothers are at advanced stages of HIV disease. Programmes that use option B can immediately start the regimen of three antiretroviral drugs, which will be administered until one week after breastfeeding has ended, while their infants receive a short course of 4–6 weeks of antiretroviral medicine. Some countries are considering switching protocols from option A to option B or to option B+, in which pregnant women start lifelong antiretroviral therapy immediately. Option B+ would bring further advantages, since it probably improves women's health and ensures that women and babies are protected from day one of future pregnancies, further reducing the chances of HIV transmission. In particular, in countries with high fertility, this may have a considerable effect on the number of children acquiring HIV infection. The increased resources needed for continued treatment may be offset by simplified procedures, improved health outcomes for mothers and children and additional benefits, such as preventing HIV transmission in discordant couples and reducing the risk of developing resistant HIV strains as a consequence of treatment interruptions among women with multiple pregnancies (9).

High coverage and the most effective regimens will allow countries to reach the low mother-to-child transmission rates targeted by the Global Plan of 5% in breastfeeding populations and 2% in non-breastfeeding populations. Between 2000 and 2005, despite widespread knowledge of how to reduce mother-to-child transmission, the transmission rate remained flat.ⁱⁱ Initially, the coverage of vertical transmission interventions was too low to have any effect; once coverage started to increase, the regimens were not strong enough to reduce the transmission rate substantially.

Since 2010, when more effective prophylaxis regimens were introduced, the transmission rate has declined.

Lower rates of HIV transmission from mothers to children confirm the increasing success of countries' efforts to provide effective prophylaxis throughout pregnancy, delivery and breastfeeding. Between 2010 and 2011, much of the progress in reducing the transmission rate resulted from moving towards more effective regimens, whereas the number of women reached with any prophylactic regimen increased slowly.

Percentage of eligible mother-child pairs receiving effective prophylaxis to prevent new HIV infections among children, low- and middle-income countries, 2011



Challenges remain. One of five children born to women living with HIV was infected with HIV during pregnancy or through breastfeeding in 2011. More effective regimens and higher coverage can reduce this rate to less than 5%.

Providing treatment, care and support to mothers living with HIV and their families

As a result of the slow progress earlier in the decade, about 3.4 million [3.1 million–3.9 million] children younger than 15 years were living with HIV globally in 2011, 91% of them in sub-Saharan Africa. An estimated 230 000 [200 000–270 000] children died from AIDS-related illnesses in the same year.

The fourth intervention is to provide support, care and treatment to mothers living with HIV and to their families. Children who become infected when their mother is pregnant or while breastfeeding require early HIV diagnosis and timely treatment. Providing appropriate HIV treatment and care for mothers and children, including screening and managing TB, improves overall survival prospects for children. Failing that, disease progression and death is usually rapid: almost 50% of the children infected during pregnancy or delivery die within one year, and about 50% of children infected during breastfeeding die within nine years of infection (10).

The use of dried blood spots has increased access to early infant diagnosis. However, too many regimens for children are being used, complicating service provision, and efforts to simplify must continue to be made.

As programmes to eliminate new HIV infections among children in antenatal care settings at the primary level of care continue to expand, more attention must be paid to ensure that children are diagnosed and treated in these settings.

There is still a major gap between children and adults in coverage of antiretroviral therapy. Globally, about 562 000 children received antiretroviral therapy in 2011 (up from 456 000 in 2010), but coverage was only 28% [25–32%]: higher than the 22% [20–25%] in 2010 but much lower than the 57% [53–60%] coverage of antiretroviral therapy among adults. Even though antiretroviral therapy services still reach only a small fraction of eligible children, substantially fewer children are dying from AIDS-related causes: 230 000 [200 000–270 000] in 2011 versus 320 000 [290 000–370 000] in 2005.

In 2011, an estimated 620 000 [600 000–700 000] pregnant women were eligible for antiretroviral therapy for their own health, but only 190 000 pregnant women living with HIV with a CD4 count less than or equal to 350 cells per ml received it. Fewer than half (45%) of pregnant women known to be living with HIV in low- and middle-income countries were even assessed for their eligibility to receive antiretroviral therapy in 2010ⁱⁱⁱ (2).

Providing timely antiretroviral therapy to mothers living with HIV greatly reduces the indirect maternal mortality among them. In addition to reducing pregnancy-related deaths, treatment allows mothers to live longer and more healthy lives.



Agnes Binagwaho

Minister of Health, Republic of Rwanda

INTEGRATION WILL HELP END AIDS

HIV is a general health menace that cannot be tackled in isolation. Integration with other health programmes is the only way to make the HIV response efficient, effective, equitable and sustainable.

Rwanda's experience proves that reinforcing the health system and tackling the HIV epidemic go hand in hand. Rwanda's performance-based financing approach has shifted the focus of health care financing from input to results and contributed to improving access and the quality of care. Rwanda's national health insurance has also helped streamline health financing. This has increased efficiency and community ownership and participation in health care.

Programmes to eliminate HIV infection among children and keep their mothers alive are integrated into routine maternal and child health services in 80% of facilities. Health workers are trained to provide both services, and clients save time and effort.

Integration is the way to attain universal access: more than 95% of the people in Rwanda who need antiretroviral therapy are receiving it.

Rwanda therefore not only benefits from the declining global prices of essential HIV medicines. We also implement HIV and other health programmes efficiently, maximizing the benefit from every dollar spent.

Continued, sustainable funding is paramount to the HIV response, but visionary leadership, innovation and ownership are also crucial to help end AIDS. ■

Improving the retention of women and children in programmes for preventing mother-to-child transmission and in antiretroviral therapy is critical to reducing vertical transmission and keeping mothers and babies living with HIV alive and healthy. Enhancing community support and using mobile health technologies, such as text messaging for appointment and adherence reminders, as well as reducing the number of steps in the cascade of care are crucial to optimizing results.

Engaging communities

Meeting Global Plan targets requires programs to go well beyond doing “more of the same”. Only by working with communities in the response can we identify and address the real challenges to providing quality services that work for women, mothers and children. Engaging communities in the planning, designing, development and delivery of programs, and ensuring that they are funded to play that role, ensures relevance, impact, ownership and sustainability that contribute to a reduction of HIV-related discrimination throughout the health sector.

Community-based organizations (CBOs), especially networks of women and mothers living with HIV, have many strengths that can advance rapid expansion of services for women, mothers and children and reduce HIV transmission and promote health and survival. Communities can improve the supply and quality of services by serving as extension workers to expand and support front-line health care workers. CBOs have

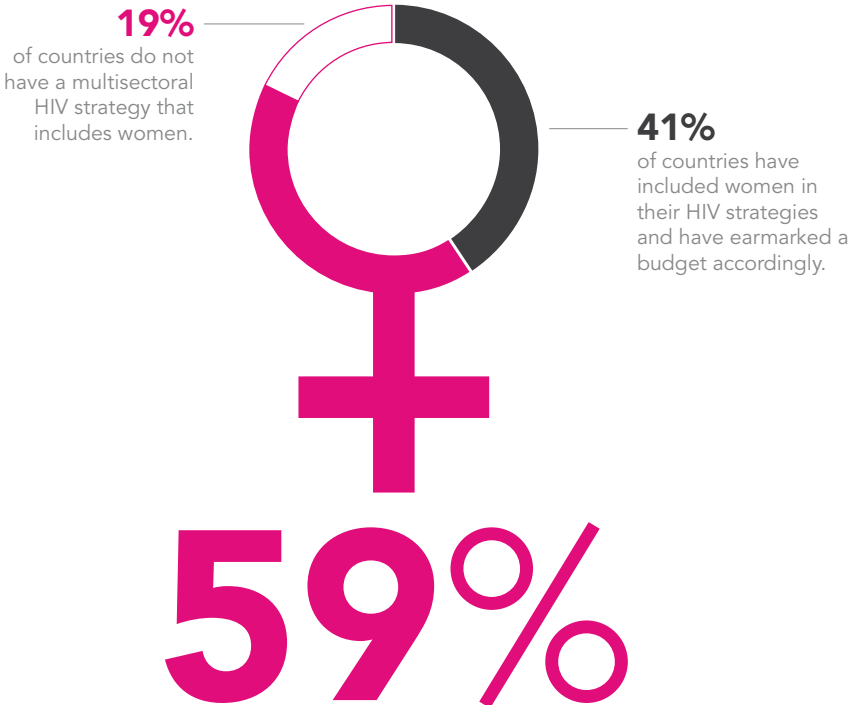
the trust and endorsement of communities, easily creating links between community, faith-based organizations and facility-based services and providing women with direct peer support that many need. Community based experts demand health services that are fit for purpose, for example by advocating for the right services and the right medicines and monitoring progress.

Community-based experts bring women and their families into contact with health care, increasing the demand for and uptake of services, including ARV adherence and facility delivery. Communities are also the driving force behind campaigns for behavior change and reduction of discrimination, providing peer support, and maximizing the use of community assets and resources. Communities can create an enabling environment by advocating for scale-up and the right to sexual and reproductive health and promoting community engagement in policies and strategies. Given that community is made up of people accessing and linking women and mothers to formal health care they are also appropriately positioned to deliver dynamic accountability mechanisms, at the community and national level.

Effective community engagement must be well resourced and sustained to enable community members to participate in program design, implementation and monitoring. This requires financial and technical support and investment, particularly for women and mothers living with HIV, who are the most committed to having healthy, HIV-free babies.

WOMEN NEED FUNDED HIV STRATEGIES

Globally, women represent 49% of all adults living with HIV. Young women have a much higher risk of acquiring HIV than young men. HIV strategies therefore need to account for the specific needs of women and girls, and they need budgets to get implemented.



Of 170 countries reporting in 2012, 59% did not have a multisectoral HIV strategy, including women, with an earmarked budget. Some 40% had included women as a sector in their HIV strategies but had not earmarked a budget. The other 19% had neither an HIV strategy nor an earmarked budget.

Source: NCPI (National Commitments and Policy Instrument) data, government reporting, from 2012 country reports. Geneva, UNAIDS, 2012

Progress indicators

COUNTRIES	Number of women living with HIV delivering ^a		OVERALL TARGET		OVERALL TARGET		PRONG 1 TARGET		PRONG 2 TARGET	
	2009	2011	2009	2011	2005	2010	2009	2011	Latest available data	Year
Angola	15 700	16 000	5 300	5 300	480	380	0.26	0.24	..	
Botswana	14 500	13 500	700	500	220	80	1.35	1.18	..	
Burundi	8 100	7 000	2 700	1 900	380	300	0.09	0.08	29%	2002
Cameroon	30 300	28 600	8 900	6 800	1 100	980	0.46	0.42	21%	2004
Chad	14 500	14 500	5 000	4 800	460	380	0.35	0.33	21%	2004
Côte d'Ivoire	18 500	16 100	5 400	4 400	1 400	940	0.19	0.17	..	
Democratic Republic of the Congo	..	..	..	..	1 140	1 100	..	..	27%	2007
Ethiopia	54 100	42 900	18 900	13 000	1 740	760	0.04	0.04	25%	2011
Ghana	11 900	10 800	3 900	2 700	520	400	0.11	0.09	36%	2008
India					2 000	1 700	..	..	14%	2006
Kenya	89 300	86 700	23 200	13 200	3 400	2 200	0.58	0.52	26%	2009
Lesotho	16 400	16 100	4 700	3 700	420	320	3.12	2.88	23%	2009
Malawi	68 500	63 500	21 300	15 700	2 600	1 780	0.74	0.58	26%	2010
Mozambique	96 800	98 300	28 400	27 100	2 200	2 400	NA	NA	19%	2004
Namibia	9 700	9 200	1 900	800	220	140	0.98	0.90	21%	2007
Nigeria	219 200	228 600	70 900	69 300	7 400	6 600	0.47	0.42	20%	2008
South Africa	250 000	241 300	56 500	29 100	3 600	3 800	1.81	1.67	14%	2004
Swaziland	11 100	10 900	2 000	1 200	220	150	3.39	3.04	25%	2007
Uganda	88 300	96 700	27 300	20 600	3 000	2 400	1.05	0.98	38%	2006
United Republic of Tanzania	92 500	96 000	26 900	21 900	4 000	3 000	0.69	0.69	25%	2010
Zambia	86 000	83 400	21 000	9 500	2 200	1 620	1.13	0.94	27%	2007
Zimbabwe	57 900	52 700	17 700	9 700	2 800	1 680	1.68	1.25	13%	2011
TOTAL	1 287 000	1 265 000	365 000	273 000	42 000	33 000				

.. Data not available or not applicable. NA: not available.

Sources:

a. Spectrum software 2012 country files.

b. WHO, UNICEF, UNFPA and World Bank. *Trends in maternal mortality: 1990 to 2010* (<http://www.who.int/reproductivehealth/publications/monitoring/9789241503631/en>, accessed 15 June 2012).

c. MDG database updated [online database]. New York, United Nations, 2012 (<http://mdgs.un.org/unsd/mdg/News.aspx?ArticleId=49>, accessed 15 June 2012).

COUNTRIES	PRONG 3 TARGET 3.1		PRONG 3 TARGET 3.2		PRONG 3 TARGET 3.3		PRONG 4 TARGET		CHILD TARGET			
	Mother-to-child transmission rate (%) ^a		Percentage of women receiving antiretroviral drugs, excluding single dose nevirapine, to reduce transmission during pregnancy ^b		Percentage of mother–infant pairs receiving antiretroviral drugs to reduce transmission during breastfeeding ^a		Percentage of eligible pregnant women receiving antiretroviral therapy ^b		Percentage of under-five deaths caused by HIV ^c		Coverage of antiretroviral therapy among children younger than 15 years old (%) ^b	
	2009	2011	2009	2011	2009	2011	2009	2011	2008	2010	2009	2010
Angola	34%	33%	19%	16%	1%	0%	0%	0%	2%	2%	10%	11%
Botswana	5%	4%	92%	93%	31%	44%	62%	77%	17%	15%	91%	89%
Burundi	34%	27%	19%	38%	19%	39%	0%	0%	6%	6%	13%	14%
Cameroon	29%	24%	20%	54%	12%	20%	28%	42%	5%	5%	11%	13%
Chad	34%	33%	7%	13%	7%	13%	19%	0%	3%	3%	5%	8%
Côte d'Ivoire	29%	27%	50%	68%	0%	0%	0%	0%	4%	3%	15%	15%
Democratic Republic of the Congo	..	..	..	..	..	..	..	..	1%	1%	..	..
Ethiopia	35%	30%	8%	24%	2%	11%	4%	24%	2%	2%	11%	19%
Ghana	33%	25%	31%	75%	0%	0%	0%	0%	4%	3%	11%	14%
India	..	..	..	..	..	..	..	..	..	..	..	..
Kenya	26%	15%	34%	67%	16%	67%	42%	61%	9%	7%	19%	31%
Lesotho	28%	23%	38%	63%	10%	19%	28%	45%	31%	18%	16%	25%
Malawi	31%	25%	24%	53%	4%	22%	12%	51%	13%	13%	22%	29%
Mozambique	29%	28%	38%	51%	8%	14%	22%	25%	11%	10%	0%	20%
Namibia	20%	8%	60%	85%	13%	79%	36%	84%	20%	14%	75%	77%
Nigeria	32%	30%	12%	18%	3%	11%	9%	27%	4%	4%	9%	13%
South Africa	23%	12%	60%	>95%	0%	38%	0%	69%	35%	28%	39%	58%
Swaziland	18%	11%	57%	95%	17%	34%	40%	71%	30%	23%	53%	60%
Uganda	31%	21%	27%	50%	0%	50%	0%	15%	6%	7%	14%	21%
United Republic of Tanzania	29%	23%	34%	74%	7%	17%	18%	40%	6%	5%	12%	14%
Zambia	24%	11%	58%	86%	21%	67%	51%	88%	12%	10%	24%	31%
Zimbabwe	31%	18%	11%	78%	2%	19%	4%	51%	25%	20%	22%	37%
TOTAL	28%	22%	34%	61%	6%	29%	16%	48%			19%	26%

Sources:

a. Spectrum software 2012 country files.

b. 2012 progress reports submitted by countries. Geneva, UNAIDS, 2012 (<http://www.unaids.org/en/dataanalysis/monitoringcountryprogress/progressreports/2012countries>, accessed 15 June 2012) and Spectrum software 2012 country files.

c. *World health statistics 2011*. Geneva, World Health Organization, 2011 (<http://www.who.int/whosis/whostat/2011/en/index.html>, accessed 15 June 2012).

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Notes and references

NOTES

i. The 22 priority countries are Angola, Botswana, Burundi, Cameroon, Chad, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Ghana, India, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, South Africa, Swaziland, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.

ii. The mother-to-child transmission rate is the number of children newly infected in a year divided by the number of women living with HIV who delivered in that same year. The transmission rate applies to the full population and not just those in programmes for preventing mother-to-child transmission and includes both perinatal and breastfeeding transmission.

iii. This was in the 99 low- and middle-income countries reporting data, representing 81% of the estimated number of pregnant women living with HIV.

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