BACKGROUND PAPER
East Asia and Pacific Regional Partnership Forum on CHILDREN AND HIV & AIDS

31 March – 2 April 2008
Bangkok, Thailand

Scaling Up the Response for Children
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Acknowledgements

The background paper for the Regional Partnership Forum on Children and HIV & AIDS acknowledges the achievements since the East Asia and Pacific Regional Consultation on Children and HIV & AIDS held in Hanoi, Viet Nam, in March 2006. While there have been many achievements since the Hanoi Consultation, many challenges remain. Challenges and opportunities towards bringing effective outcomes for children and their families in the Asia-Pacific region are highlighted in this paper.

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<td>Acquired immunodeficiency syndrome</td>
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<tr>
<td>ART</td>
<td>Antiretroviral treatment</td>
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<td>ARV</td>
<td>Antiretroviral</td>
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<tr>
<td>ASEAN</td>
<td>Association of South East Asian Nations</td>
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<td>AusAID</td>
<td>Australian Agency for International Development</td>
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<td>BLI</td>
<td>Buddhist Leadership Initiative</td>
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<td>BSS</td>
<td>Behavioural sentinel surveillance</td>
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<td>CBOs</td>
<td>Community-based organisations</td>
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<td>CDC</td>
<td>Center for Disease Control</td>
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<td>CDHS</td>
<td>Cambodia Demographic and Health Survey</td>
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<td>CHAI</td>
<td>Clinton Foundation HIV &amp; AIDS Initiative</td>
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<td>CHBC</td>
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<td>CoC</td>
<td>Continuum of care</td>
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<td>DBS</td>
<td>Dried-blood spot</td>
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<td>DfID</td>
<td>Department for International Development (UK)</td>
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<td>DHS</td>
<td>Demographic Health Survey</td>
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<td>EAP</td>
<td>East Asia and Pacific</td>
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<td>EVA</td>
<td>Especially vulnerable adolescent</td>
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<td>FBO</td>
<td>Faith-based organisation</td>
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<td>FHI</td>
<td>Family Health International</td>
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<td>FP</td>
<td>Family planning</td>
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<td>FSW</td>
<td>Female sex worker</td>
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<td>GFATM</td>
<td>Global Fund to Fight AIDS, Tuberculosis and Malaria</td>
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<td>GO</td>
<td>Government organization</td>
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<tr>
<td>HIV</td>
<td>Human immunodeficiency virus</td>
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<td>IDU</td>
<td>Injecting drug user</td>
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<td>LTFU</td>
<td>Long-term follow up</td>
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<tr>
<td>M &amp; E</td>
<td>Monitoring and evaluation</td>
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<td>MARA</td>
<td>Most-at-risk adolescent</td>
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<td>MARPs</td>
<td>Most-at-risk populations</td>
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<td>MCH</td>
<td>Maternal and child health</td>
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<td>MICS</td>
<td>Multiple Indicator Cluster Surveys</td>
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<td>MoH</td>
<td>Ministry of Health</td>
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<td>MoSVY</td>
<td>Ministry of Social Affairs, Veterans and Youth Rehabilitation</td>
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<td>MSM</td>
<td>Men who have sex with men</td>
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<td>MTCT</td>
<td>Mother-to-child HIV transmission</td>
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NAP National AIDS Programme
NCHADS National Center for HIV & AIDS, Dermatology and Sexually Transmitted Diseases
NMCHC National mother and child health centre
NGO Non-government organisation
NPA National Plan of Action
OFW Overseas Filipino workers
OIs Opportunistic infections
OPCs Out-patient clinics
OVC Orphans and vulnerable children
PCR Polymerase chain reaction
PEPFAR Presidential Emergency Plan for AIDS Relief
PITC Provider-initiated testing and counseling
PLHIV People living with HIV
PLWHA People living with HIV & AIDS
PMTCT Prevention of mother-to-child HIV transmission
RH Reproductive health
RST Regional Support Team
S & D Stigma and discrimination
SEARO Southeast Asia Regional Office
SRH Sexual and reproductive health
STI Sexually transmitted infections
T & C Testing and counselling
UNAIDS Joint United Nations Programme on HIV & AIDS
UNDP United Nations Development Programme
UNESCO United Nations Educational Scientific and Cultural Organization
UNFPA United Nations Population Fund
UNGASS UN General Assembly Special Session
UNICEF United Nations Children’s Fund
USAID United States Agency for International Development
VAAC Viet Nam Administration of AIDS Control
VCT Voluntary counselling and testing
VCCT Voluntary confidential counseling and testing
WCRP World Conference on Religion and Peace
WHO World Health Organization
WPRO Western Pacific Regional Office
Executive Summary

The Regional Partnership Forum, held in Bangkok, Thailand, from 31 March to 2 April 2008, brought together 133 participants from 17 countries, representing governments, regional and national non-government organizations of East Asia and the Pacific region, international organizations and United Nations agencies. The Forum reviewed the progress within the East Asia and the Pacific region on the commitment to children infected and affected by HIV and AIDS and to those made vulnerable to HIV since the Hanoi Consultation. It offered a vital opportunity to share experiences in promoting change and reaffirmed and strengthened the commitment made along with new milestones in enhancing coverage of services and improved policy measures.

This background paper acknowledges the achievements that have been made since the Hanoi Consultation while pointing to challenges and opportunities ahead towards bringing effective outcomes for children and their families in East Asia and the Pacific.

Since the Hanoi Consultation, there have been actions initiated within many countries in the East Asia and the Pacific region to address better the needs and rights of children in relation to HIV. It is important to acknowledge the progress being made.

Both country and regional levels of analyses regarding the situation of children and HIV and AIDS have become more available based on improved methods and tools (qualitative and quantitative) to guide efforts to plan, strengthen and scale up responses to children. Many countries in the region have refined legislation and developed policies and guidelines to reduce mother-to-child HIV transmission and paediatric HIV treatment. A number of countries have set up nationally recognized coordination bodies tasked with PMTCT and have developed a national PMTCT training curriculum and national scale-up plans.

Furthermore, many of the countries have initiated a range of prevention, treatment and care actions for children and young people in the context of HIV. Some have developed national strategies while some have set up national taskforces to strengthen social protection of orphans and vulnerable children, including children affected by AIDS. Several countries are also increasingly pursuing a family-centred and child-sensitive approach to AIDS, and introducing monitoring and reporting systems for HIV-infected mothers and children. It is to be recognized that regional and international cooperation on networking, information sharing, knowledge diffusion, and research to scale up responses has been enhanced through active partnership, including the convening of the Regional Partnership Forum on Children and AIDS and the subsequent adoption of the Hanoi Call to Action in the 12th ASEAN Summit Declaration.

Although there have been many achievements since the Hanoi Consultation in 2006, many challenges remain. The HIV and AIDS epidemic and the situations of children vulnerable to HIV and affected by HIV and AIDS vary greatly across the region and within countries. There is a need for continued vigilance to ensure that HIV prevention and treatment are reaching young people and adolescents who are most at risk or affected by HIV. Continued efforts are necessary to scale-up prevention of mother-to-child transmission services and paediatric treatment including ensuring linking of services with reproductive, maternal, newborn and child health services; appropriate targeting of services based on epidemiological characteristics of each country; ensuring access to quality treatment and ARV; counselling education on infant feeding and minimizing loss to follow up.
Future response requires a sharply defined multi-sectoral government response in collaboration with civil society organizations to confront legal and socio-cultural barriers that hinder access to HIV prevention and treatment. It is important to link the “4 Ps” (preventing mother-to-child transmission; providing paediatric treatment; preventing infection among adolescents and young people; and protecting and supporting children affected by HIV & AIDS) around local epidemics in the approach at regional, national and sub-national levels in order to bring about the most effective outcomes for children.

Strengthening of research information collection, and monitoring, evaluation and critical analysis of programme quality to improve the delivery and effectiveness of programmes is necessary. In addition, enhancement of close coordination and collaboration between the relevant ministries as well as identification and implementation of concrete plans to mainstream HIV into the relevant sectors to ensure maximum use of resources, greater impact and sustainability are key to strategic approaches for accelerating HIV prevention in the region.

Stigma and discrimination remain prevalent, and continue to restrict access by people living with HIV (PLHIV) and those at risk to essential services. Therefore, national action plans must enact and enforce laws that prohibit discrimination. Also, it is important to provide health workers and the public with the correct information about HIV transmission through training and public campaigns.

There is a need to better link HIV-related health services with other health, education and social service programmes. Operational linkage of services in a prevention, treatment and care continuum is especially important within the health sector and between health and other sectors to bring about a holistic response.

It is our hope that the commitment made at the East Asia and the Pacific Regional Partnership Forum will strengthen partnerships to address better the needs and rights of children in relation to HIV.
1 Introduction

The HIV epidemic has had a staggering impact around the world. Virtually no country has remained untouched. While there has been much progress towards addressing the consequences of AIDS to children and their families, there also have been large, unmet gaps in national responses to the pandemic, both socially and economically. One of the ongoing challenges is ensuring that the needs and rights of affected children are addressed. Children have often been described as the ‘missing face of AIDS’. It is time to place children at the forefront of a comprehensive HIV and AIDS agenda and ensure that their voices are heard.

There is much debate and discussion over the terminology for children who are affected by HIV and AIDS and how various terms should be defined to provide a common understanding and response. Box 1 presents some of the working definitions.

Box 1

Children vulnerable to, infected and affected by HIV & AIDS are those:

• who live in a household with chronically ill parents/caregivers or live in a high HIV-risk setting;
• who have lost one or more parent to AIDS;
• who are infected with HIV or who have been exposed to HIV;
• who are experiencing worsening economic burdens as a result of extra costs and/or diminishing income due to AIDS-related illness in the household, the death of family members, or the addition of orphaned children to be cared for;
• who suffer from stigma and discrimination and have had their rights violated because of their HIV status or by association with a family member living with HIV and AIDS; and
• who are missing opportunities for education, health care and other access to essential services because of HIV or AIDS status of at least one member of their household.

HIV has a profound influence in the lives of children. Their survival, development and care are severely compromised: they experience losses at an early age: loss of parents, loss of security and loss of the overall well-being of their family. Many are left to fend for themselves, disadvantaged from a young age by the stigma and discrimination associated with AIDS, and they are sometimes denied access to education and other basic rights. Some are growing up with risk by repeating the perilous journey of their parents, adopting risky behaviours out of pressing needs for survival or for want of care-givers’ guidance or for want of hope because they are denied equal opportunities for growth.

Provision of access to essential services, such as basic education and health services, shelter, clothing and food, is not only necessary for children but it is also an obligation by nations toward the fulfilment of children’s basic rights. As of 2008, all nations in the world except one have ratified the Convention on the Rights of the Child, including all countries in East Asia and the Pacific. It is therefore crucial for governments and civil society organizations to respond with policy and programmatic measures that are inclusive of the needs and rights of these children, many of whom are marginalized by their parents’ or their own HIV status, and suffer multiple discriminations.

There has been increased recognition of the importance of prioritising children in the response to HIV & AIDS. The First Global Partners Forum was co-convened by the Joint United Nations
Programme on HIV & AIDS (UNAIDS) and the United Nations Children’s Fund (UNICEF) in 2003 to mobilize action and monitor progress towards fulfilling the global commitments for children affected by HIV and AIDS laid out in the United Nations General Assembly 2001 Declaration of Commitment on HIV & AIDS and the Millennium Development Goals. The first meeting resulted in the endorsement of the Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS by nearly 30 organizations. This framework provides direction for mounting an effective response. It identifies five key strategies required to respond effectively to the needs of orphans and vulnerable children:

- strengthen the capacity of families;
- mobilize and support community-based responses;
- ensure access to essential services;
- ensure protection of vulnerable children; and
- create a supportive environment.

Although this framework is developed based on evidence collected mainly from high-prevalence countries in Africa, it has been adapted in various ways to guide the work of partners within the East Asia and Pacific region. It recognizes that no government or organization alone is able to address all the issues identified. Partnership among governments, international, bilateral, non-government, faith-based and civil society organizations is emphasized. In 2007, a companion paper was developed to assist governments in translating the framework into action.

A major response to addressing the multifaceted issue of HIV and AIDS and children was the launch in 2005 by UNICEF and UNAIDS of the Unite for Children, Unite Against AIDS campaign. The goal of the campaign is to put the face of children at the centre of the global, regional and national HIV and AIDS agenda. The campaign focuses on what is commonly known as the ‘4 Ps’.

- preventing mother-to-child transmission;
- providing paediatric treatment;
- preventing infection among adolescents and young people; and
- protecting and supporting children affected by HIV & AIDS.

Since the launch of the campaign, children and AIDS have become increasingly integrated into national policy frameworks in many countries. Access to treatments has improved, and, in some countries, behaviour change for preventive behaviours has been translated into declining HIV prevalence among young people. Yet there remain huge gaps between targets and results.

The 2005 call for accelerating actions toward universal access of HIV prevention, treatment and care led to the East Asia and Pacific Regional Consultation on Children and HIV & AIDS, 22-25 March 2006, in Hanoi, Viet Nam. The consultation was co-organized by UNICEF East Asia and Pacific Regional Office in collaboration with UNAIDS, WHO, the United States President’s Emergency Plan for AIDS Relief (PEPFAR) through United States Agency for International Development (USAID), Family Health International, Save the Children, and the Viet Nam National Committee for Population and Family Planning.

This meeting was critical in raising the profile of children and AIDS in the region. More than 300 delegates from countries throughout East Asia and the Pacific, civil society representatives, under-18 delegates and international partners met in Hanoi. At the consultation, delegates...
adopted the Hanoi Call to Action for Children and HIV & AIDS in the East Asia and Pacific Region.\textsuperscript{6} The Call to Action outlined nine key areas for urgent action (listed in section four).

As it has been nearly two years since the Hanoi Consultation, a follow-up Regional Partnership Forum was reconvened in Bangkok on 31 March – 2 April 2008. The East Asia and the Pacific Regional Partnership Forum reviewed progress within the region on commitment to children infected and affected by HIV & AIDS and those made vulnerable by HIV since the Hanoi Consultation and discussed future actions required. The Regional Partnership Forum reaffirmed and strengthened the commitment made along with new milestones in enhancing coverage of services and improved policy measures.

The specific objectives of the Regional Partnership Forum were to:

1. Identify achievements and progress since the Hanoi Consultation in March 2006;

2. Share effective initiatives to meet the needs of children who are vulnerable to, infected and affected by HIV & AIDS; and

3. Strengthen partnerships and action to address the key issues identified within the Call to Action.
2 East Asia and the Pacific Region – An Overview

In 2007, the number of people living with HIV globally was estimated to be 33.2 million. The reduction from 39.5 million in 2006 is largely attributed to improved surveillance in several countries, particularly India. Of these, the estimated number of children under 15 years who are living with HIV is 2.5 million, with some 330,000 new infections among children in 2007.

Within East Asia-Pacific there are approximately 50,000 children below the age of 14 who are living with HIV. They form part of the estimated 4.9 million people living with HIV, including 440,000 people who were newly infected in 2007. East Asia is also witnessing one of the fastest growing epidemics in the world, with 20 per cent more new infections in 2007 compared to 2001, higher than most other regions.

The growth trajectory of HIV in the East Asia and Pacific region merits attention, especially regarding HIV’s potential impact on children. About half a million children, or an estimated 450,000, in East Asia and the Pacific lost one or both parents to AIDS by 2005.

HIV prevalence and its epidemiological patterns vary between countries in the region and showed various changes in HIV prevalence patterns and development. In 2007 Myanmar, Thailand and Cambodia all showed declines in HIV prevalence. In Cambodia, for example, HIV prevalence fell to an estimated 0.9 per cent among the adult population (15 – 49 years) in 2006, down from a peak of 2 per cent in 1998. Despite the overall achievements in reversing the HIV epidemic in Thailand, prevalence among injecting drug users has remained high. Similarly, recent studies show increasing prevalence among men who have sex with men (e.g. in Bangkok from 17 per cent in 2003 to 28 per cent).

In China, while HIV infections have been reported in all provinces, most people living with HIV seem to be in Henan, Guangdong, Guangxi, Xinjiang and Yunnan provinces. It is estimated that just under half of all people living with HIV in China in 2006 were infected from injecting drugs with contaminated equipment, while a similar proportion acquired the virus during unprotected sex. Although the epidemic is still dominated by injecting drug use, recent data indicate an emerging epidemic among men who have sex with men in major cities, and it is estimated that as many as 7 per cent of HIV infections could be attributed to unsafe sex between men.

In Indonesia and Viet Nam the epidemic is growing at particularly high rates. The estimated number of people living with HIV in Viet Nam has more than doubled between 2000 and 2005, from 120,000 to 260,000. The main risk factors associated with HIV infection are the use of contaminated injecting equipment and unprotected sex with non-regular partners or sex workers. The HIV epidemic in Indonesia is among the fastest growing in Asia. The majority of HIV infections are estimated to occur mainly through contaminated needles, unprotected paid sex and, to a lesser extent, unprotected sex between men. In Indonesia’s Papua province (bordering Papua New Guinea), the epidemic is particularly serious, with unprotected sex being the main mode of transmission. In a province-wide population-based survey in Papua in 2006, adult HIV prevalence was estimated at 2.4 per cent and reached 3.2 per cent in the remote highlands and 2.9 per cent in less-accessible lowland areas. Among 15 – 24 year olds, HIV prevalence was 3 per cent.

In Papua New Guinea the majority of reported HIV infections to date have been in rural areas, where more than 80 per cent of the population lives. Unsafe heterosexual intercourse is estimated to be the main mode of HIV transmission. Papua New Guinea faces a unique challenge, especially in prevention because of violence and youth unemployment problems.
3 Global Commitments

There has been a steady development of the focus on children in the context of HIV at both the global and regional levels in the past several years. National leaders have committed to the protection and care of orphans and vulnerable children through goals set at the United Nations General Assembly Special Session (UNGASS) on HIV & AIDS in 2001 and on Children in 2002. In 2003, the global partners’ forum on orphans and vulnerable children was established and consensus was reached on a response framework. In 2005, UNICEF and its partners launched a global campaign for children vulnerable to, infected and affected by HIV and AIDS.

As resolved at the October 2005 United Nations General Assembly, the Universal Access Initiative includes a focus on orphans and vulnerable children:

We commit ourselves to: Developing and implementing a package for HIV prevention, treatment and care with the aim of coming as close as possible to the goals of universal access by 2010 for all those who need it, including through increased resources and working towards the elimination of stigma and discrimination, enhanced access to affordable medicines and the reduction of vulnerability of persons affected by HIV & AIDS and other health issues, in particular orphaned and vulnerable children and older persons.  

The global focus on children and HIV and AIDS generated regional momentum for building partnerships to respond to the issue and led to the organization of the East Asia and Pacific Regional Consultation in 2006.
4 The Hanoi Call to Action

More than 300 delegates from 24 countries who attended the East Asia and Pacific Regional Consultation on Children and HIV & AIDS, held in Hanoi, Viet Nam, on 22-24 March 2006, adopted the Hanoi Call to Action for Children and HIV & AIDS.16

The Call to Action specified that as HIV spreads in East Asia and the Pacific, there is a growing recognition of the need to include children in national responses. The meeting commended countries that have undertaken assessments to look at the circumstances of children affected by HIV and AIDS; that are expanding access to paediatric antiretroviral treatment and care; that are pursuing prevention strategies for children, young people and women at risk; and that are strengthening care and support for orphans and vulnerable children.

During the consultation, the delegates also undertook a critical review of the status of children under 18 years of age who are vulnerable to, infected and affected by HIV and AIDS and agreed to scale up prevention, treatment, care and support throughout the region. As part of this plan the meeting called on all governments, civil society members and international partners to adopt the following action agenda.

The Hanoi Consultation urgently called for action in nine key areas:

1. Country level analysis of the situation of children and HIV & AIDS supported by improved methods and guidelines - with quantitative estimates of children vulnerable to, infected and affected by HIV & AIDS and qualitative assessment of their circumstances - to guide efforts to plan, strengthen and scale up the response

2. Assessment of existing legislation, policies and guidelines for the protection, support and care of children vulnerable to, infected and affected by HIV & AIDS and to update and/or develop additional policies and guidelines as required

3. Based on these assessments and with accelerated efforts targeted specifically for children, the development of country-specific targets and locally defined action plans for scaling up the responses for: primary HIV prevention; the prevention of maternal to child transmission; HIV testing and counselling; paediatric and adult antiretroviral treatment; family-oriented clinical care; psychosocial support and child and family protection services

4. Increased resource mobilization and improved resource allocation and utilization to close the gap between what is currently available and what is needed for an adequate response to children vulnerable to, infected and affected by HIV & AIDS

5. Establishment of national-level multi-sectoral mechanisms that focus on child welfare and development, help to coordinate the scaled up response and promote an inclusive approach at all levels that involves the public sector, civil society, religious leaders, and children and young people

6. The reduction of HIV & AIDS-related stigma and discrimination, financial barriers and other obstacles to enable access for all children to essential services, including an uninterrupted basic education, health care and other social welfare services
7. Expanded efforts to protect children and provide them with the most family-like care environment and ensure that institutional care is used for children without caregivers only as a temporary measure or as the last resort.


9. Strengthened and enhanced coordination in regional and international cooperation on networking, information sharing and research to scale up the response.

Since the Regional Consultation, the Association of Southeast Asian Nations (ASEAN) at its twelfth Summit on HIV & AIDS held in Cebu, the Philippines, in January 2007, adopted the Hanoi Call to Action. The ASEAN Heads of State noted the nine urgent areas for action to scale up the response to children vulnerable and affected by HIV & AIDS and incorporated the Call in the ASEAN Summit Declaration on HIV & AIDS, affirming commitment to prioritize, lead and strengthen national AIDS programmes ensuring policies and programmes respond to the people most at risk and most in need within the region.

The Declaration on HIV & AIDS drew attention to the commitment on integration of HIV with development priorities to reduce both the impact of development on HIV transmission and the impact of the HIV epidemic on development, consistent with ASEAN’s commitments to the Millennium Development Goals and the 2006 UN General Assembly decision.

In addition, the United Nations Partnership was created in response to the Hanoi Call to Action, and the terms of reference was endorsed by the UNAIDS Regional Directors’ meeting in March 2007.
5  Children and HIV: Responses from East Asia and the Pacific

Since the Hanoi Consultation, there have been actions initiated within many countries in East Asia and the Pacific region to better address the needs and rights of children in relation to HIV. This is a positive step forward. While much more needs to be done, it is important to acknowledge the progress being made.

The ‘4 Ps’ – prevention of mother-to-child transmission, paediatric AIDS treatment, primary prevention and the protection of children affected by AIDS – are the cornerstones of national responses to children. Even prior to Unite for Children, Unite Against AIDS campaign and the Hanoi Call to Action many countries in the region had identified the importance of ensuring that ‘4 Ps’ were reflected in national HIV targets. It is also recognized that for countries in the region to succeed in delivering better care and support services to these children and their families, there is a need to better link HIV-related health services with other health, education and social service programmes. Prevention and protection cannot function effectively unless they come together to form part of a strong health, education and social welfare systems.

Orphans and vulnerable children as well as young male and female drug users and sex workers need not only detailed information on HIV prevention but also access to education, health and social services, and entrepreneurial and vocational training to help them envision a more positive future for themselves. Operational linkage of services in a prevention, treatment and care continuum is especially important within the health sector and between health and other sectors to bring about a holistic response.

The response to children is often hindered by a lack of information on children infected and affected by HIV in most countries. This includes information on the number of children who have been orphaned by AIDS, along with what constitute vulnerable children.

Obtaining information on children and HIV can assist governments and their partners in developing policy responses and programmes that reflect country situations and needs. While conducting one-off situation assessments is important, it is equally important to ensure there are ongoing processes to keep track of risk and vulnerability factors among children and young people.

Over the last few years, there have been concerted efforts by a number of countries to address gaps in knowledge on the emerging concerns of children affected by AIDS. For example, a range of countries are currently planning, conducting or have conducted situational assessments. These include Cambodia, China (Yunnan province), Indonesia, Lao PDR, Malaysia, Myanmar, Papua New Guinea and Viet Nam (see Protection and Care section below).

The following sections provide updates of key actions that have been taken around the 4 Ps in partnership with a host of organizations across East Asia and the Pacific region since the Regional Consultation in Hanoi.
5.1 Prevent mother-to-child transmission of HIV

A growing trend that calls for vigilant monitoring is the feminization of AIDS in East Asia-Pacific. Prevention efforts ought to focus proactively on girls and women whose partners are at high risk. Already, around 70 per cent of the young people now living with HIV in Thailand are girls and women between the ages of 15-24. A decade ago, 90 percent of HIV transmissions occurred between sex workers and their clients.

More recent estimates suggest that 50 percent of the new infections in the country are occurring between spouses, as men pick up HIV through multi-partner or commercial sex and pass it on to their wives. Likewise, Ministry of Health (MoH) data in China shows that the proportion of women infected with HIV has grown from 15 per cent in 1998 to 42 per cent in 2005. The cumulative number of new infections in Fiji, according to its MoH, showed that the proportion of women living with HIV had since 2003 risen to 47 per cent by 2005. A large number of men who have sex with men (MSM) in Asia also have sex with women. A 2006 STI survey in Cambodia showed, for instance, more than 50 per cent of MSM had two to five female sexual partners in the past year, and about 8 per cent had more than 11 female sexual partners.

In 2005, around 40,000 women in East Asia and the Pacific were HIV positive according to estimates by UNAIDS and UNICEF. It is likely that many more women are unaware of their HIV status because of limited awareness, fear and limited access to testing and counselling services. Coverage of voluntary counselling and testing (VCT) services in the region is very low – only 0.1 per cent of adult populations in South-East Asia.16

Moreover the region is still not meeting the needs of even the small numbers of pregnant women known to be HIV positive. Without any intervention, 15 to 30 per cent of HIV-infected pregnant women will transmit the virus to their children during pregnancy and delivery, while up to 20 per cent will pass it on during breastfeeding. Yet when properly administered, PMTCT service can reduce the risk to less than 2 per cent.17

A comprehensive programme to prevent HIV transmission from pregnant women, mothers and their children covers four components:

1. Prevention of HIV, especially among pregnant women and young people
2. Prevention of unintended pregnancies among HIV-infected women
3. Prevention of HIV transmission from HIV-infected pregnant women to their infants
4. Provision of treatment, care and support to HIV-infected women and their newborn and families

**Strategies**

Countries throughout the region have already devoted resources to ensure prevention of mother-to-child HIV transmission. Ensuring that all four components of PMTCT are scaled up is critical, although the extent to which they should be scaled up will need to be determined by local epidemiology to ensure the convergence of services in the prevention, treatment and care continuum.18 The efficacious results of strengthening the linkage of services to improve HIV/STI prevention, treatment and care require a commitment by different departments to work together. A vertical system is not always amenable to horizontal linkages, and the overarching question of leadership – who takes the lead – calls for a strong political will to work together. It also necessitates common ownership of the goal to ensure parents and children live healthier without HIV and live longer when they are HIV positive.
Many women in the region are susceptible to infections from the risky behaviour of their partners, whether before or during pregnancy. The engagement of men as another parent through couples’ counselling and testing, HIV-risk and pregnancy education, and a better coordinated health system to track those potentially at risk from sexually transmitted infections (STIs), reproductive health, outpatient or even private care services will be the most viable, long-term strategy to prevent HIV in children.19

Achievements

There has been progress in most countries in addressing PMTCT services. Nearly three fourths of East-Asia and Pacific Countries have existing national PMTCT policy/programme guidelines: Cambodia, China, Indonesia, Lao PDR, Malaysia, Mongolia, Pacific Islands, Papua New Guinea, Thailand and Viet Nam. A number of countries reported preparation of a PMTCT scale-up plan in 2007: Cambodia, Indonesia, Lao PDR, Papua New Guinea, Thailand, Viet Nam; setting up of a nationally recognized coordination body tasked with PMTCT: Cambodia, Indonesia, Lao PDR, Papua New Guinea, Thailand, Viet Nam, Malaysia and Myanmar; and a national PMTCT training curriculum: Cambodia, Myanmar, Papua New Guinea, Pacific Islands and Viet Nam.

Only a few countries have undertaken a national assessment of PMTCT: Cambodia, Myanmar and Indonesia. Malaysia has conducted a national review of its PMTCT programme. Four countries – Cambodia, Indonesia, Malaysia and Mongolia - have introduced a provider-initiated routine offer of HIV testing (opt-out) in PMTCT sites/antenatal care settings.

The number of sites offering PMTCT services and the number of pregnant women who benefited from the service have reportedly increased in some countries including Cambodia, China, Myanmar, Pacific Islands, Papua New Guinea, Philippines, Thailand and Viet Nam.

Box 2

In Cambodia, while the overall service coverage is still low, reaching only 12 per cent of all pregnant women, there has been clear progress in 2007, with an overall increase in service accessibility and uptake. As of September 2007, there were 73 health centres and 40 referral hospitals in 43 districts in 24 provinces providing PMTCT services. During the first half of 2007, a total of 32,457 pregnant women attended antenatal care services for the first time at public health facilities offering PMTCT services. Of these, 24,080 (74 per cent) were tested for HIV and 21,469 (89 per cent) received their test results. When compared to data from the same period in 2006, the absolute number of pregnant women who tested for HIV more than doubled, increasing from 11,721 cases in 2006 to 24,080 cases in 2007. The HIV prevalence among women who were tested was 1 per cent.20

Challenges

The UNGASS Declaration sets the target of delivering PMTCT services to 80 per cent of all pregnant women in need by 2010. For a region with largely concentrated epidemics, it is important to utilize local epidemiological data to ascertain comprehensive scale-up in the most cost-effective ways. Some of the challenges and constraints include:

- Ensuring greater programme impact through a more targeted PMTCT services, such as through prioritizing services in high prevalence areas and/or targeted at populations at higher risk;
• Loss to follow up between antenatal care attendance and after delivery to detect the newborn’s HIV status;
• Vertical programming which hinders linkages between antenatal care services, that usually provide voluntary counselling, HIV education and testing to pregnant women, as well as referral to PMTCT treatment during birth, with other services such as STI, reproductive health and antiretroviral therapy services, (given that most women are infected through their spouse or sexual partners);
• Need to encourage linkages between disease prevention services and maternal and child health services and ownership;
• Limited number of appropriately skilled health care professionals and limited access to HIV-related services, which are particularly important in high prevalence pockets of a country;
• Ensuring a focus on the provision of prevention messages, rather than solely the offer of HIV test and ARV treatment;
• Ensuring ongoing provision of HIV information for pregnant women and their partners through referral to VCT/STI services, counselling and father’s involvement in antenatal care and PMTC programmes in hospital settings;
• Ensuring that unregistered migrants and mobile populations gain access to pre- and post-test counselling in antenatal care clinics, PMTCT and post-natal services;
• Enhancing community awareness of the availability of PMTCT services and more generally paediatric care services; and finally,
• Encouraging government ownership of PMTCT services.

Box 3

China has developed an implementation plan for the prevention of mother-to-child transmission. The plan adheres to the principle of integration of PMTCT with routine MCH health care. China is supported in its endeavours to scale-up PMTCT by the Joint Technical Missions to Support PMTCT Scale up and Paediatric Care Implementation in Selected High HIV Burden Countries. Such support has been offered because the global PMTCT IATT reviewed the status of global implementation of PMTCT programmes and recommended that joint technical missions be organized to help high-burden countries accelerate PMTCT scale up.

China has been successful in scaling up its PMTCT programme. China has expanded PMTCT services from a single UNICEF-supported county pilot programme in 2006 to over 271 counties, reaching over 2.65 million pregnant women in 2006. From January to September 2007, 1,309,625 pregnant women were tested for HIV. Of these 1,332 women tested HIV positive (<0.1 per cent of total women tested).
5.2 Provide paediatric treatment

Issue

With increased sexual transmission to women, the number of children born HIV positive or orphaned by AIDS is certain to rise. In 2005, the number of children below the age of 15 living with HIV was estimated to be 50,000 in East Asia and the Pacific. Though low, that figure was around four times greater than the estimated 13,000 in industrialized countries. To put it into further context, the number has gone up by 61 per cent since 2003. Paediatric HIV treatment has only emerged as a global issue in recent years, and all countries in the region have a great opportunity to scale up such services toward universal access.

So far, several countries with concentrated and generalized epidemics – Cambodia, China, Fiji, Malaysia, Myanmar, Papua New Guinea, Thailand and Viet Nam – have begun preparations for paediatric HIV treatment and care. Two countries in the region, Cambodia and Thailand, have achieved significant coverage, exceeding 90 per cent, in delivering ARV to children in need of treatment. However, of the 64,000 children living with HIV in Asia-Pacific, only one in five are receiving ARV, and nearly all of those receiving paediatric ARV are in three countries – Cambodia, India and Thailand.

Governments in East Asia-Pacific have a golden opportunity to push for 100 per cent access for cotrimoxazole and ARV given that the population of children living with HIV is relatively small.

There are, however, several major obstacles to expanding paediatric HIV treatment. These include the lack of affordable, simple, diagnostic testing technologies for young children; the lack of knowledge of ARV efficacies and side-effects in children; the limited variety and availability of second line drugs, which are also costly; and the complexity of monitoring the viral load. Challenges also include issues such as the lack of human resources and the difficulty in improving lab facilities and logistics in low resource settings. In addition, paediatric HIV treatment is hindered by very limited public awareness of and access to HIV-treating services, a situation made worse by the region’s severe stigma and discrimination.

Strategies

Inefficient health care systems, fear of testing, severe stigma and discrimination and denial on the part of parents are barriers to any efforts to identify HIV-positive children and result in many missed opportunities.

Most children are detected either through PMTCT or when children with opportunistic infections are brought to clinics. Linking PMTCT and AIDS treatment programmes is therefore an obvious way to identify more children in need of treatment, as is offering HIV testing to all sick children in health centres in high-prevalence areas. Specifically, it requires the health system to strengthen follow up to pregnant women who test HIV positive and those who have undergone PMTCT treatment after delivery, which will help detect the newborn’s HIV status and lead to treatment referral.

To ensure paediatric AIDS services will reach 100 per cent coverage, governments will have to prioritize investment in human, financial and logistical capacities, and scale up VCT and treatment services. The overall effort to scale up antiretroviral treatment (ART) for adults living
with HIV also requires active inclusion of ARV for children. The hope of survival through ART will in turn encourage testing and care-seeking for those at risk or children who are exposed to HIV.27

New guidelines and improved integration of nutrition and HIV into maternal and child health programmes will also help revive exclusive breastfeeding practices. Despite evidence of breast milk's efficacy in reducing infant mortality, exclusive breastfeeding has been sidetracked by the aggressive promotion of infant formula, uncertainty around HIV transmission risks and mixed feeding practices due to parental ignorance about dual risks of infant infections.

Finally, governments need to strengthen policy to improve long-term access to ARV for HIV-positive mothers, their partners and children to increase rates of surviving HIV.

**Achievements**

There has been progress in providing antiretroviral treatment to HIV-infected children. In 2006, 9 out of 14 East Asia and Pacific countries reported providing treatment to HIV-infected children in need of treatment (Cambodia, China, Indonesia, Myanmar, Pacific Islands, Papua New Guinea, Philippines, Thailand and Viet Nam).30

Eight countries (Cambodia, China, Malaysia, Myanmar, Papua New Guinea, Philippines, Thailand and Viet Nam) have existing national paediatric care and treatment guidelines. In Lao PDR, there exists antiretroviral treatment guidelines for both adults and children. In 2006, the Philippines established a comprehensive paediatric management of HIV and AIDS with the provision of antiretrovirals for the first time in the country.

In Cambodia a lot of activity has occurred in the area of paediatric care as it developed an HIV paediatric care clinical management training curriculum, integrated HIV paediatric care into the ‘Continuum of Care’ framework, and provided support to refurbish some paediatric wards and procure basic medical equipment for 10 referral hospitals, not only for the treatment of children living with HIV but also for the strengthening of medical care for all children. It also trained physicians and paediatricians on HIV paediatric clinical management and care.31 By the end of June 2007, paediatric HIV care was available at 22 public health facilities throughout the country. Antiretroviral treatment was provided for 2,155 children aged below 15 years, up from a few hundred in mid-2005. This represents about 70 per cent of the children estimated to require antiretroviral treatment. In addition, 1,858 infected children were receiving treatment or prophylaxis for opportunistic infections.32

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**Box 4**

With newer evidence of the reduced risk of HIV transmission through exclusive breastfeeding, there is also a need to revise the infant feeding guidelines. Recent studies conducted by Columbia University researchers and their collaborators in Africa show that exclusive breastfeeding is associated with only a 1 per cent risk of HIV transmission per month and sharply reduces the risk of other diseases.28 Whatever women decide to do, they must stick to that decision. Mixed feeding is extremely dangerous because it exposes the infant to gastrointestinal infections that enhance both the risk of HIV transmission as well as diarrhoea and pneumonia. However, mixed feeding is still the norm in many communities, and programmes that promote exclusive breastfeeding and discourage mixed feeding - through counselling as well as public education - must continue.29
In China the ‘4 Frees and One Care’ policy has provided free drugs to thousands of people living with HIV and assisted affected children and families since its implementation in 2003. An estimated 7,000 children younger than 15 who are living today with HIV were infected through vertical transmission: 766, or nearly 80 per cent, of reported paediatric cases are currently in treatment, and 44 have died.33

Table 1: Children receiving antiretroviral treatment

<table>
<thead>
<tr>
<th>Country</th>
<th>% of people receiving ART are children</th>
<th>Number of children on treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cambodia</td>
<td>11%</td>
<td>1,500</td>
</tr>
<tr>
<td>China</td>
<td>4%</td>
<td></td>
</tr>
<tr>
<td>Indonesia</td>
<td>1%</td>
<td>3,500</td>
</tr>
<tr>
<td>Lao PDR</td>
<td>36 children</td>
<td></td>
</tr>
<tr>
<td>Myanmar</td>
<td>4%</td>
<td>11,000</td>
</tr>
<tr>
<td>Pacific Islands</td>
<td>2%</td>
<td></td>
</tr>
<tr>
<td>Papua New Guinea</td>
<td>40 children</td>
<td></td>
</tr>
<tr>
<td>Thailand</td>
<td>8%</td>
<td>80,000</td>
</tr>
<tr>
<td>Viet Nam</td>
<td>4%</td>
<td>252</td>
</tr>
</tbody>
</table>

* Government Data from UNICEF PMTCT Report Card

**Challenges**

There are a number of factors that prevent further progress in providing paediatric HIV treatment. In many countries there are a limited number of clinicians trained in paediatric HIV care and a limited number of sites with the capacity to provide paediatric HIV care. In fact, more generally, countries in the region confront inadequate human resources working in paediatric care, let alone providing ARV treatment. There is a need to ensure greater knowledge among paediatricians in antiretroviral efficacies and side-effects in children.

Another often neglected area in paediatric treatment is nutrition. AIDS wrecks the immune system of children more quickly than adults. Widespread malnutrition further accelerates the course of the disease in children of developing countries, and conversely, HIV infection exacerbates malnutrition by causing malabsorption, diarrhoea and other disorders of the digestive system.24,25
There remains an ongoing need to ensure that targets for paediatric treatments are identified within national strategic plans. This ensures that greater attention is focused on the needs of children and helps educate government and community leaders about the effective options available to treat children with HIV. Developing more effective, less expensive paediatric formulations and determining their efficacy for children will have to be addressed.36

Strengthening human, financial and logistical capacities and addressing the lack of VCT services and facilities to help identify children with HIV in the region are necessary. HIV-related stigmas must be addressed so that families with children in need of treatment are able to seek it freely.

5.3 Prevent infection among adolescents and young people

Issue

The goal of ensuring healthy outcomes for mothers and children, i.e. free of HIV and reduced death and disease burden from AIDS, requires that governments more closely examine the key drivers of the HIV epidemic within their countries. For East Asia and the Pacific, the primary behavioural drivers that have the largest impact on children and women are men who buy sex and men who have multiple sex partners. The higher the proportion of men who frequent sex workers, the higher the multiplication of risk of HIV transmission. This includes men who have sex with men (MSM) and men who buy sex from male sex workers. Among these, a high proportion are also married with female spouses.37

While sex workers remain most at risk and are the key HIV-prevention target, the male clients of sex workers are bridges of HIV transmission to women and children. Commercial sex work and its large clientele in the general population thus constitute the dominant mode of HIV’s spread in all Asian countries, despite the historical trend of intravenous drug use (IDU) being the cause of explosive HIV epidemics at the onset. The historical trend in Thailand shows that the HIV epidemic trajectory began with IDU and was later propelled by sex work into the general population. The pattern was repeated in other Asian countries with the combination of IDU and sex work-driven epidemics.38

It remains important to keep young people free of HIV infection. Yet examples abound of young people who are ignorant of how to protect themselves. Many young people in the region still cannot name a correct way to prevent HIV. Some 69 per cent of young people in Indonesia’s high-prevalence province of Papua said you can detect HIV by appearance.39 A survey of young people aged 15 to 24 years in Timor-Leste found that 50 per cent of young people thought that bites from mosquitoes or other insects could spread HIV and 40 per cent thought that HIV could be spread by sharing clothes with people who have the diseases.40 In a 2004 survey in China, 56 per cent of young people surveyed thought they could prevent HIV through regular exercise, and 26 per cent cited improved nutrition.41 And it is not just young people who are in the dark about HIV. A large proportion of people who live with HIV in the region also have reported not knowing what HIV or AIDS were until they were infected. This group included migrant labourers, businessmen who frequented sex workers and housewives.
China’s former Vice Minister of Health, Dr. Wang Longde, once said, “AIDS is the most well-publicized disease. But it is also overwhelmingly misunderstood, a disease rife with confusion and misconceptions.” His statement is well substantiated in the statistics above. Poor knowledge creates fear, giving rise to dangerous myths and worsening stigma and discrimination. Such attitudes are pronounced even among health care workers. In a recent study conducted by the Asia-Pacific Network of People Living with HIV (APN+), up to 80 per cent of people living with HIV experience discrimination – 54 per cent in health care facilities.

**Strategies**

Adolescents and young people have the right to know how HIV is transmitted and the means to protect themselves. They also must be equipped with skills in negotiation, management of negative emotions and responsible decision-making. And they must have easy access to information, youth-friendly reproductive health and HIV prevention services, and condoms.

However, on the policy level, most countries in the region – Indonesia, Malaysia, the Pacific Island countries, the Philippines, Timor-Leste, Thailand and Viet Nam – have not set targets in their National Strategic Plans (NSPs) for prevention among adolescents and young people. China, Cambodia and Lao PDR are the only countries with specific prevention targets, aiming to raise skills-based knowledge among adolescents and young people and change behaviours of those at higher risk.

In the absence of national targets, a number of campaign partners are focused on raising awareness and knowledge in partnership with children and young people themselves. Across East Asia and the Pacific, a variety of approaches have been introduced to prevent HIV infection among young people.

Peer-based education has often been a strategy used. This approach is often adopted because young people may place greater value or trust information that comes from their peers rather than authority figures who may not understand the current situation facing young people. Peer education can also often be an effective strategy for reaching multitudes of young people nationwide. The development of information and education campaign materials is another strategy that is widely used. Printed resources, radio and television have often been used to communicate health messages. These strategies are often complementary.

Life skills-based education (LSE) has been another approach. It aims to provide young people with a set of skills that can help them lead healthy and balanced lives. It is a powerful approach to opening up discussions about sexuality, relationships and substance use. LSE has been introduced as an optional school subject in most countries. Close to four fifths of East Asia and Pacific countries (Cambodia, China, Indonesia, Lao PDR, Malaysia, Myanmar, Pacific Islands, Philippines, Thailand, Timor-Leste and Viet Nam) have facilitated the development and implementation of a national education curriculum on HIV and AIDS.

LSE programmes – especially those run by peer educators – are also effective in reaching children and young people who are not in school and thus, commonly assumed as vulnerable to risk behaviours and HIV. Throughout the region, peer-led LSE programmes have taken root and thrived.
Achievements

Based on assessments of HIV awareness and advocacy campaigns, it was found that the levels of knowledge of children and youth on HIV and AIDS in some countries had improved.

Some examples of recent activity include:

- Indonesia: Implementation of HIV education in schools in Papua and West Papua, as well as Islamic schools in East Java and Aceh, reached nearly 83,000 students in lower secondary schools in 2007.42
- Lao PDR: All high schools in seven targeted provinces now have an integrated curriculum on reproductive health, HIV & AIDS/STI and drug use education that uses a life skills approach reaching around 40,000 students in 2007.43
- Philippines: Relevant structures (local AIDS Councils and Task Forces for AIDS and children) were formed, which led to the issuance of local AIDS legislations and the formation of an AIDS coordinating mechanism.44
- China: Over 2,800 young people have been integrated into existing Ministry of Education peer education networks, including 231 campaign youth ambassadors reaching 27,000 peers with interpersonal communication, 394,000 to 464,000 young people through participatory and civil engagement activities and over 3 million youth via the internet.45
- Cambodia: The Ministry of Education developed and costed a National HIV Strategy and plan for reducing HIV vulnerability among adolescents and young people.
- Malaysia: A life skills-based education on HIV was pilot tested in 16 secondary and 4 primary schools in the state of Kedah. Based on lessons learned, the module was critically assessed and reviewed as a prerequisite for nationwide application.46
- Mongolia: More than 600 peer educators from all provinces were trained and conducted 80-minute HIV & AIDS prevention information sessions to their peers reaching an estimated 60,000 to 80,000 young people nationwide.47
- Myanmar: The country’s long-standing life skills-based programme has already been implemented as a core curriculum in primary and secondary schools.
- Pacific Islands: 16,000 young people were reached by community-based life skills training.48
- Timor-Leste: 40,000 young people (15–24 years old) in 13 districts were reached through the national HIV & AIDS campaign conducted from May to November 2007.49
- Papua New Guinea: UNICEF is working with 10 communities in the four regions towards AIDS competence. Twenty leaders in communities were trained and gained skills to facilitate AIDS competence.

Knowledge of HIV and life skills is crucial, but it is not enough. Adolescents and young people also need confidential, youth-friendly VCT services. A number of countries have introduced such services that provide a safe space for young people to seek counselling and testing and learn about safe sex as well as other life skills.

More attention also needs to be paid to child sexual abuse and children who are orphaned by AIDS, as those without parental care are especially vulnerable. All abuse heightens a child’s vulnerability to HIV but sexual abuse the most. Studies have indicated that children who suffer sexual abuse often later turn to alcohol or drugs to alleviate their traumatic memories. Many also feel that they have less control over their sexuality or sex in general, making them highly vulnerable to unprotected sex. Countries in the region need to confront sexual abuse, while helping victims come forward and cope with their experiences.
Challenges

Improved coverage of prevention programmes that target the most-at-risk adolescents remains critical. To achieve improved coverage of prevention programmes there is a need to enhance government and non-government organizations’ capacity for HIV prevention among most-at-risk and vulnerable children. Also, there is a need to incorporate national targets that address children, young people and HIV prevention. Again, in order to affect meaningful change and action, governments at all levels must confront HIV and its predominant relation to sex work and drug use behaviours head-on and non-judgmentally.

Scaling up HIV education in recognition of children and young people’s right to know is important. The concentration of HIV among sub-groups in many countries in the region also requires a greater convergence of prevention, treatment and care services around children and young people affected by HIV and those most at risk.

Figure 1: Pattern of new HIV infections in East Asia and the Pacific

In addition, it is important to make available services such as improved supplies of prevention commodities, tracking of STI prevalence, scaling up STI diagnostic and treatment, youth-friendly HIV testing and counselling, organizing peer support among sex workers, widely reaching the male population who frequent sex workers, reviving public education on HIV, safe sex and sexuality, whether in-school or out-of-school, and supporting social mobilization and multi-channel communication to fight stigma and change social attitudes. Above all, it requires the highest political commitment, underpinned by policy, programme and domestic resources to sustain such prevention efforts.56

Mainstreaming HIV education into national education systems ensures the ongoing sustainability of the programme. Yet this is a significant challenge to achieve in most countries. In countries with decentralized education systems, this is even more of a challenge as it often requires the development of partnerships and resources at the regional/district/local level. In all countries, integrating HIV education into the national education system can only succeed by developing an effective partnership with the education sector. In addition to targeting children in schools, there remains a need to ensure HIV education reaches and is relevant to out-of-school children, particularly those who may be marginalized within society or are at greater risk. Many countries in the region report this to be a significant challenge.
5.4 Protect and support children affected by HIV and AIDS

Issue

It is estimated that around 450,000 children in East Asia and the Pacific have lost one or both parents to AIDS.\textsuperscript{51} But, as with all numbers associated with HIV and children in the region, this figure does not capture the whole picture. Firstly, current estimation and projection techniques do not provide accurate projections of the number of children born infected and/or growing up in HIV affected households in countries where the national adult prevalence is below 5 per cent. Modelling techniques are further impeded by the lack of size estimates of the sub-population at high risk and their fertility rates.

Secondly, stigma and discrimination – again – prevents us from knowing exactly how many children are affected by HIV and what their situation is. The data can be hard to obtain because people are generally afraid of being associated with HIV and fear stigma and discrimination. Children affected by HIV often live in places others ignore or avoid because of fear and prejudice. They are frequently found in poor neighbourhoods, where drug users and sex workers also reside. They live in houses isolated from the rest of the community because their mother or father may be dying of AIDS. They may be part of ethnic minorities living in remote areas of a country. They may be bundled off to orphanages.\textsuperscript{52}

Official data are so far only available in Cambodia, Thailand and Viet Nam, and, unofficially, in China and Indonesia. A study supported by UNAIDS, USAID and the Policy Project put the number of children affected by HIV in Cambodia at 60,000. Viet Nam, according to a UNICEF-supported exercise, has around 283,000 affected children. And in Thailand, the Ministry of Public Health has estimated that more than 300,000 children have lost at least one parent to AIDS.

While the situation of these children orphaned by AIDS remains hidden from view, most of them are likely taken in by relatives, often elderly grandparents. Although extended family traditions are generally strong throughout East Asia and the Pacific, the quality of care varies from situation to situation. Many children are well looked after, but anecdotal reports from NGOs also reveal some cases of sexual abuse, sexual exploitation and trafficking of these children to brothels. Some are ostracized in their schools and communities. Some are abandoned, while others run away after their last surviving parent dies. And whether these children have been entered in any official records is unclear.

But the plight of these children begins long before their parents die. Huge medical expenses and loss of jobs bring catastrophic changes to the family. Children reportedly drop out of school to make ends meet. Later, they become malnourished and are deprived of basic necessities as the family sinks deeper into poverty. All too often, children whose parents are still alive are even more overlooked, despite the glaring fact that their survival and well-being are clearly threatened by HIV.\textsuperscript{53}

Proactive response is the best way forward, and it means engaging governments early to address multiple vulnerabilities surrounding children who are vulnerable, those affected by AIDS, and orphaned by AIDS and other causes. There are increased signs and evidence, albeit on small-scale studies, that these children, along with children of the most-at-risk populations, are exposed to factors that lead them into the same perilous journey as their parents. They are also more susceptible, in the absence of parental care and bonding, to sexual abuse, exploitation and neglect. This calls for increased monitoring of conditions of these children and intensified measures for social protection, including access to education.
It is assumed that prevention efforts ought to be an integral part of the protection of children affected by AIDS and those made vulnerable by parental risk behaviours and poverty. In low-HIV-prevalence settings and given relative ignorance of AIDS’ impact on children, there is a pressing need for governments and civil society organizations to galvanize political and community support to this other “vulnerable group” – the children and partners of the most-at-risk populations. Protective factors need to be reinforced including parenting education, the prevention of teen pregnancy, substance abuse, adolescents’ healthy development and sense of self, equal access to education, food security, health care and social services, community engagement in care and open talk as well as efforts to fight stigma. While these may not have an immediate effect on slowing the growth of HIV, they are a vital part of forestalling those risks.

Table 2: Number of children living with HIV and AIDS and orphans by region, 2005

<table>
<thead>
<tr>
<th>Regions</th>
<th>Estimated adult HIV prevalence rate (15+years), end-2005</th>
<th>Estimated number of people (all ages) living with HIV, 2005 (1,000s)</th>
<th>Mother-to-child transmission</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Estimate</td>
<td>Low estimate</td>
<td>High estimate</td>
</tr>
<tr>
<td>Sub-Saharan Africa</td>
<td>6.1</td>
<td>24500</td>
<td>21600</td>
</tr>
<tr>
<td>Eastern and Southern Africa</td>
<td>8.6</td>
<td>17500</td>
<td>15800</td>
</tr>
<tr>
<td>West and Central Africa</td>
<td>3.5</td>
<td>6900</td>
<td>5300</td>
</tr>
<tr>
<td>Middle East and North Africa</td>
<td>0.2</td>
<td>510</td>
<td>320</td>
</tr>
<tr>
<td>South Asia</td>
<td>0.7</td>
<td>5900</td>
<td>3600</td>
</tr>
<tr>
<td>East Asia and Pacific</td>
<td>0.2</td>
<td>2300</td>
<td>1800</td>
</tr>
<tr>
<td>Latin America and Caribbean</td>
<td>0.6</td>
<td>1900</td>
<td>1500</td>
</tr>
<tr>
<td>CEE/CIS</td>
<td>0.6</td>
<td>1500</td>
<td>1000</td>
</tr>
<tr>
<td>Industrialized countriesb</td>
<td>0.4</td>
<td>2000</td>
<td>1400</td>
</tr>
<tr>
<td>Developing countriesb</td>
<td>1.1</td>
<td>35100</td>
<td>30300</td>
</tr>
<tr>
<td>Least developed countriesb</td>
<td>2.7</td>
<td>11700</td>
<td>10100</td>
</tr>
<tr>
<td>World</td>
<td>1.0</td>
<td>38600</td>
<td>33400</td>
</tr>
</tbody>
</table>

* Data refers to the most recent year available during the period specified in the column heading.  
b Also includes territories within each country category or regional group.


**Strategies**

As mentioned above, the Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS provides direction for mounting an effective response. It identifies five key strategies required to respond to the needs of orphans and vulnerable children broadly as follows:
• strengthen the capacity of families;
• mobilize and support community-based responses;
• ensure access to essential services;
• ensure protection of vulnerable children; and
• create a supportive environment.

Further actions were identified in the Enhanced Protection for Children Affected by AIDS (the companion paper to Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS) to mobilize resources to finance policy and programmes benefiting children affected by AIDS.

Because East Asia and the Pacific is largely a low-HIV-prevalence region, the emphases and approaches to impact mitigation issues will be distinct from those implemented in high-prevalence countries. The formulation of policies and programmes will need to take into consideration limited financial resources as well as the capacity of social welfare systems. An important distinction must be drawn between the scenarios in Sub-Saharan Africa and Asia.

Teokul and Tangcharoensathien discuss the crucial difference between high-prevalence African countries and the East Asian region, where a smaller number of children are infected and affected by HIV and AIDS. This difference in magnitude requires policy considerations that take into account four issues as follows:

1. The concentrated nature of the epidemic;
2. Severe stigma and discrimination where social exclusion and ostracism hurts more than help if and when one's identity is exposed;
3. Multiple vulnerabilities of children whose parental risk behaviours – as sex workers, clients of sex workers, injecting drug users and men with multiple sex partners (whether with other men and/or with women) – will have predetermined the need for special protection; and
4. The larger poverty alleviation measures – through universal benefits, conditional or unconditional cash transfers – that are already in place in some countries to bridge widening socio-economic disparities amid rapid economic growths.

Therefore, the policy consideration for children affected by AIDS in East Asia and the Pacific needs to factor in the drivers of HIV and the unique situations of the region as well as the current levels of social protection systems. Social protection responses will need to be inclusive of all orphans and vulnerable children, not only those affected by AIDS. This will not only minimize biases or exclusions but also enable governments, which are State Parties to the Convention on the Rights of the Child, to respond to the situation appropriately. Equitable distribution is a primary principle to be considered and upheld.54

While the further development of strategies is required and each country has to adopt strategies based on specific country situations, it is suggested that the region focuses particularly on the following areas:

1. Social transfer focusing on cash transfer to improve well being

Social transfer programmes can mitigate the economic impacts of HIV and AIDS on children and their families. For example, providing cash transfers, either conditional or unconditional, can improve the well being of vulnerable children, including orphans in poverty and children affected by AIDS (CABAs). The scheme should engage trusted institutions, for example community-based organizations, NGOs or local governments, in identifying and delivering benefits to recipients, i.e. children, families or their care givers, while ensuring that they are
informed of their entitlements and creating strong oversight mechanisms. While providing cash transfers to OVC or their families has induced demand for basic social services, it is important that the countries also have policies that promote universal coverage of essential social services for all children, for example free health services, immunizations and educational services.

II Engaging and institutionalizing capacity of community-based settings, i.e. CBOs, NGOs and local government/authorities, to care for and be responsive to the needs of OVC or of destitute families, whereby OVC and families are treated as part of the solution by:

1. Strengthening and building community mechanisms to analyse the situation in these communities and prioritizing target groups, their needs and necessary actions. These include arranging for substitute families to either adopt or provide foster care to children with clear identification and management of who will be the guardian or have custody of OVC, e.g. immediate kin, distant relatives or other families in the community, especially in the case of double orphans (both parents dead). (Note that marginal cash transfers or ensuring the availability of basic services have positive effects of finding substitute family for orphans, especially when communities are involved in identifying beneficiaries and delivering cash transfers, as mentioned in the core policy. This will generate a sense of ownership and induce contributions from community resources).

2. Establishing community referral systems for coordinating assistance to OVCs through various local mechanisms, such as through monitoring school enrolment and attendance, and access to basic health and nutrition services in a continuum. The focal points in the community (e.g. a public health nurse, a community health worker, a volunteer, or a teacher) play a crucial role in ensuring that support from the various sources are distributed to all OVCs. As this is a delicate issue, it requires long-term engagement and commitment by all partners, especially the community focal points. In addition, close monitoring and follow-up is needed to ensure OVCs adequately access social services and cash assistance. Effective implementation calls for a strong, structured coordination mechanism between health, education and social welfare systems.

3. Promoting networking and knowledge-sharing among public agencies, NGOs, international organizations and community-based organizations, as well as the media, to scale up assistance to OVCs.

III Creating awareness at the national level to enhance social responsibility for the care of OVCs by:

1. Devising a set of strategies regarding psychosocial support that will enable OVCs to be successful in their passage to adulthood, such as through role modelling in place of absent parental inspirations, skill building in arts, music and sports, or engaging OVCs in community activities

2. Promulgating and enforcing legislation to ensure access to justice and judicial protection for OVCs and prohibiting discrimination against them

3. Developing national plans of action for incorporating OVCs, then all children, into the existing social welfare and social protection systems or reforming the systems

The above policy recommendations were further discussed at the Regional Partnership Forum as well as in continuous dialogue with the partners. In addition, ideas for gaining more information and studies offering insights for targeting and resource utilization were explored.
Achievements

Cambodia has established a National Multi-sectoral Orphans and Vulnerable Children Task Force for developing a situation analysis of orphans, children affected by HIV and other vulnerable children. It has also adopted an Alternative Care Policy. In Papua New Guinea, an Orphans and Other Vulnerable Children Task Force was established and co-chaired by the Department for Community Development and the National AIDS Council. The Task Force is comprised of key government and non-government organizations. A Four-Year National Strategy on Protection, Care and Support of Children Vulnerable to Violence, Abuse, Exploitation and Neglect in the Context of the HIV Epidemic in Papua New Guinea has been developed. Papua New Guinea has also developed a training manual to strengthen the capacity of faith-based organizations to identify and respond to issues facing orphans and vulnerable children affected by HIV and AIDS in the communities. China has developed a national policy for the care of children orphaned by AIDS. Myanmar has developed a family and community-based care manual for women, children and families affected by AIDS. Thailand has developed community-based care and support models for children with HIV but implemented these only in two provinces.

Table 3: Achievements in legislation and policy

<table>
<thead>
<tr>
<th>Country</th>
<th>Legislation/Policy</th>
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| Cambodia           | • National Plan of Action for Orphans and Vulnerable Children (with costing)  
                     • Alternative care policies                                    |
| China              | • National Policy for the care of children orphaned by AIDS  
                     • Henan Provincial Policy for the care of children orphaned by AIDS       |
| Indonesia          | • Development of National Strategic Plan 2007–2010       
| Lao PDR            | • National Assembly passed a law on children, which includes a provision for children affected and infected by AIDS |
| Papua New Guinea   | • Community-based care and support policy on orphans and other vulnerable children  
                     • The Lukautim Pikinini Act (Child Protection), passed in April 2007, prohibits institutional care and identifies orphans and other vulnerable children as requiring rights-based care and support. The first national child-protection policy is being developed and will provide the policy framework for improving the protection and care of orphans and other vulnerable children. |
| Viet Nam           | • Developed an outline for a National Plan of Action on Children and HIV & AIDS (with costing) |

As mentioned above, there have been concerted efforts by a number of countries to address gaps in knowledge on the emerging concerns of children affected by AIDS in the last several years. For example, several countries have already conducted, are currently planning or are conducting situational assessments of children affected by HIV and AIDS. These include
Cambodia, China (Yunnan province), Indonesia, Lao PDR, Malaysia, Myanmar, Papua New Guinea and Viet Nam (see Protection and Care section below). Among those, China, Indonesia and Malaysia are sharing similar research tools for both quantitative and qualitative assessments to measure the socio-economic and psychological impact of AIDS on households caring for children affected by HIV and AIDS. The findings reveal important policy implications for the future programming and policy recommendations (see Box 5).

Box 5

With both financial and technical support of UNICEF Indonesia and the UNICEF East Asia and Pacific Regional Office, the Centre for Health Research, University of Indonesia, recently undertook research to investigate the socio-economic impact of HIV and AIDS on families with children and adolescents aged 6-18 years old in 7 provinces in Indonesia by using both quantitative and qualitative methodologies as well as policy reviews. The quantitative study examined families where at least one adult member had HIV and where one or more children were living in the household. It also included households where children may be cared for by a person other than their parent by reason of their parental HIV status or where the household may be child-headed.

The study found that such households had a lower socio-economic status, less financial support and less educational support than a reference group consisting of families who had no adult members who are known to be HIV positive.

Other findings about the impact on children of HIV and AIDS cases in their household included:

- financial problems and/or taking care of an ill person in the household pushed children to drop out from school or led to increased absences from school;
- discrimination in school by classmates, with the reason being poverty and discrimination because of their living with HIV-infected persons;
- they played with friends less in out-of-school activities;
- they were more anxious and had a weaker self images (than the study reference group);
- they tended to engage in behaviour that may place their health at greater risk such as smoking, drinking alcohol, drug use and premarital sex; and
- discrimination by health personnel was higher among children affected by HIV and AIDS (than experienced by the study reference group).

Over the past two years, there has been substantive progress in legislation and policies that relate to the rights, protection, care and support of children in most countries. Effective structures for the implementation and enforcement of such legislation and policies are important, however, and will require sustained effort and political will. As shown previously in Table 3, an increasing number of countries are integrating issues of children affected by HIV and AIDS into overall policies for vulnerable children.

Another key area where there has been progress in East Asia and the Pacific is in working with faith-based groups. Faith-based response to the protection and care of AIDS infected and affected children and their families has been a distinct part of national responses and is growing. In Lao PDR, UNICEF assisted monks, volunteers and hospitals to initiate comprehensive care for children infected, ensuring that 147 needy, hard-to-reach mothers and children had access to treatment and community-based care, and 125 children received school supplies or small education grants. In Malaysia, pools of trainers involving religious leaders, marginalized
Scaling Up the Response for Children

Communities and people living with HIV from Kedah were established and trained with a particular focus on care, stigma and discrimination. Cambodia has reported that there has been a 16 per cent increase (against a target of 5 per cent) in the number of people living with HIV who received psychosocial support in the 12 provinces where the Buddhist Leadership Initiative (BLI) programme was implemented.

Challenges

Meeting the challenge of children affected by AIDS is complex, particularly in low-prevalence countries because of targeting and resource allocation issues. Models of care and support that are developed need to be effective, sustainable and appropriate for particular country situations. In countries with under-resourced social welfare systems or without a tradition of providing social safety nets, a scale-up response to children affected by AIDS can be very challenging. There needs to be a focus on ensuring the strengthening of families and communities to provide alternate care, as well as community-based and home-based care strategies. Institutional care should be adopted only as a last resort or a temporary measure.

There also remains a need in many countries to continue strengthening social protection systems and child-protection support for children. Providing social transfer systems such as cash transfer has been explored. In addition, there remains an ongoing debate in low-prevalence countries about how to provide services to children orphaned by AIDS without further stigmatization and how to allocate limited financial resources most efficiently without neglecting other vulnerable children.

Educating communities about HIV can increase acceptance of children and families affected by HIV and AIDS. This can facilitate extended families being involved in meeting the care and support needs of children orphaned by AIDS.

Although an increasing number of countries have reviewed legislation and polices to improve legal and social protection of children affected by AIDS, there is a need for all countries in the region to ensure that adequate legal and social protection legislation are in place and that mechanisms are in effect to guarantee compliance.

5.5 Develop partnerships

Issue

Partnerships have often been described as the fifth ‘P’ in the global campaign Unite for Children, Unite Against AIDS. Partnerships have become a defining characteristic of the response to HIV. The challenges posed by HIV mean that to be effective a multi-sectoral response is needed.

Partners include government, non-government organizations, faith-based organizations, civil society, UN agencies, donors, private sector, researchers, affected communities and health care professionals. It is important to include as partners children and young people living with or affected by HIV and their families.

The Hanoi Consultation represented a significant step towards deepening existing partnerships while underscoring the need for expanded and strengthened alliances.
**Strategies**

Internationally and regionally, there have been a range of initiatives to facilitate partnerships in the response to children and HIV. The Inter-Agency Task Team (IATT) on Children HIV and AIDS created in 2001 brings together a range of representatives from donor organizations, UN agencies and non-government organizations as well as representatives from regional partners to discuss and coordinate mechanisms for children affected by AIDS.

Regionally, the Consultation on Children and HIV & AIDS that was held in Hanoi in 2006 represented a significant step towards strengthening partnerships and ensuring that the issue of children and AIDS was clearly placed on the agenda of all partners. The Call to Action recognized the importance of establishing national multi-sectoral mechanisms to help coordinate the scaled-up response and promote an inclusive approach. Many of the commitments outlined in the Call to Action can only be achieved through coordination and cooperation.

**Achievements**

Partnerships in 2007 notably helped strengthen referral systems, advocacy, service delivery and resource leveraging. At the national level, the global campaign has enriched already strong partnerships with governments in the region. UN agencies report that they are involved in their country-based UN Theme Group on HIV & AIDS, which ensures improved coordination of activities and better support to governments. Partnerships between UN agencies, NGOs, faith-based organizations and business sector stakeholders have been strengthened.

Efforts are ongoing to build and fortify alliances in order to improve coordination, reinforce programmes and scale up HIV and AIDS interventions.

In Cambodia, UNICEF has been contributing to national technical and coordination efforts in HIV through its participation in key fora such as the Joint Government-Donor Technical Working Group on HIV, as well as the Country Coordinating Committee that coordinates proposal submissions and acts as the supreme authority in-country on Global Fund matters. Other key technical bodies are the PMTCT Technical Working Group, as well as the Sub-Committee on the National Multi-sectoral Task Force on OVC.

Faith-based initiatives, particularly in the protection and care of AIDS infected and affected children and their families, such as BLI in Cambodia, southern China, Lao PDR, Mongolia, Myanmar and Viet Nam, and similar initiatives for predominantly Muslim countries (Indonesia, Malaysia and southern Thailand) were initiated. In Malaysia, a training programme involving religious leaders, marginalized communities and people living with HIV from Kedah state was set up to mobilize community support for care, and reduce stigma and discrimination.

In Indonesia, close partnerships continued with the government and NGO partners. In addition, there was a close collaboration with UN partners in the development of a draft strategic framework for a joint UN response to HIV in Papua and West Papua. In the Philippines, UNICEF is part of the UN Theme Group on HIV & AIDS and is involved in multi-sectoral collaboration in various technical forms, including the UN Technical Working Group on HIV & AIDS and Country Coordinating Mechanism (CCM).

In Thailand, key partners include the Bureau of AIDS, TB and STIs and Health Promotion, under the Ministry of Public Health; the National Network of People Living with HIV & AIDS (TNP+) and regional branch networks; Thailand NGOs Coalition on AIDS (TNCA) and member organizations;
Thailand Youth Network on HIV & AIDS (YouthNet). Key civil society partners included the Young Muslim Association of Thailand (YMAT), AIDS Access Foundation, Pattanarak Foundation and Centre for AIDS Rights. UN Theme group participation included joint activities with UNAIDS and ILO and strategic cooperation with UNESCO and UNFPA.

**Challenges**

Throughout East Asia and the Pacific region there are good partnerships that have developed at the national and regional level. The ongoing involvement of a variety of partners is critical. Faith-based organizations, non-government organizations and civil society continue to have an important role to play in working collaboratively with governments and health care providers. The major challenge is that partners need to ensure that they coordinate their activities towards building a unified effective coalition to address children and HIV.

Addressing stigma and discrimination remains very important. Fear of stigmatization and discrimination can result in those most at risk and those people living with HIV not accessing the prevention, care, support and treatment services they may require. Stigma and discrimination is an issue that needs to be addressed across all programme and service areas to ensure greater community support and understanding for people living with and affected by AIDS. There are clear roles for many partners in addressing stigma and discrimination: governments can enact laws that prohibit discrimination; health services can ensure their staff are well educated in universal precautions and in providing services that maintain patient confidentiality; and faith-based organizations can promote understanding and compassion towards people with HIV and AIDS. Targeting education and health sectors are key priorities, but so too will be ensuring greater understanding within the community.
6 The Way Forward

6.1 Urge for continued decisive leadership

Considerable progress has been made since the Hanoi Consultation in 2006. Yet many challenges remain.

New infections are still rising in a number of countries such as Papua New Guinea, Viet Nam and Indonesia. There is a need for continued vigilance to ensure that HIV prevention and treatment are reaching people who are most at risk and most in need. Future response demands a sharply defined multi-sectoral government response along with a revitalized civil society effort to confront legal and social barriers that hinder access to HIV prevention and treatment.

The Regional Partnership Forum provided an opportunity for governments across the region to discuss the nine areas for Action as stated in the Hanoi Call to Action and consider how some of the barriers and challenges can be overcome to achieve the regional target of Universal Access to HIV Prevention, Treatment, Care and Support.

Key areas of national responsibility include assessment and monitoring, planning, coordination, legislation and financing.

6.2 Establishing assessment and monitoring system

Lack of data continues to be a major constraint to accurately determining progress in the region. Inadequate scientific and social research particularly on risk behaviours among young people in East Asia and the Pacific; the lack of consensus building on annual data for evidence-informed actions among multiple stakeholders; bureaucratic bottlenecks and logistical issues; and other factors continue to impede national/local governance and local service delivery. Therefore, there is an urgent need for better estimates of the number of children vulnerable to, infected with and affected by HIV and AIDS and for qualitative information on the circumstances of these children.

There is an explicit need for more effective communication and coordination of national bodies and departments on HIV data reporting to include high-quality social, economic and health indicators and to capture the current trends on children and HIV and AIDS. The design and use of standard monitoring tools and capacity building to enhance technical knowledge and management skills to ensure the quality of interventions are also necessary.

Ongoing monitoring of progress for children vulnerable to infection and affected by HIV and AIDS requires further strengthening. Also, efforts to systematically monitor and evaluate programme effectiveness and quality have been identified as key internal constraints and must be intensified and expanded.
6.3 Action planning and policy development

Over the past two years, many countries have developed national HIV & AIDS plans and policies for the 4 Ps. Exploring issues surrounding children and HIV, and especially linkage with other orphans and vulnerable children, still needs to gain prominence in national plans and policies.

HIV is a cross-cutting issue – its impact is multifaceted, and it requires economic and social responses, as well as health, legislative and educational. It requires coordination and a convergence of efforts by various ministries within governments. Thus, greater collaboration between relevant ministries and concrete plans to mainstream HIV into the relevant sectors will be crucial to ensure the maximum use of resources, greater impact and sustainability. Stigma and discrimination remain prevalent, which continue to restrict access by PLHIV and those at risk to essential services. Therefore, national action plans must enact and enforce laws that prohibit discrimination.

One of the key steps would be the establishment of clearly identified focal points on children and HIV in core ministries. Given the key role of health systems in achieving priority goals, specific attention to strengthen the health care force is required. In order to achieve the 4 Ps, governments are encouraged to grant necessary authority to national HIV and AIDS coordinating bodies.

For programming and policy formulation, it is extremely important that data are collected and analysed to inform decisions, including locations where services are needed. Epidemic patterns need to be well analysed not only at the national level but also sub-national levels because actions matter most at levels closest to those most-at-risk and affected by HIV. It is also essential to perform cost-effective analysis as well as expenditure tracking systems to suggest appropriate budget allocations as well as management of funding to ensure effective ways of spending limited financial resources.

6.4 Coordination of a multi-sectoral response

Building leadership and fostering close coordination and partnership between concerned agencies is a key factor for addressing the complex challenges posed by HIV. Governments must continue to play an important role in encouraging and enabling the participation of the different sectors and organizations working for children and people living with HIV and affected by HIV and AIDS (e.g. social welfare, education, health care, community, business sector and faith-based organizations). The multi-sector coordination at the sub-national level is challenging, and it requires institutional capacity building as well as system building.
6.5 Financing to ensure an adequate and sustained response

Although there is a high level of commitment from the governments, resources for national AIDS programmes continue to be insufficient for a durable response to AIDS and to achieve the 4P (PMTCT, Paediatric AIDS care, primary prevention, and protection and care) goals from 2006-2010. The main source of funding for HIV and AIDS prevention often is from the development agencies. In order to assure sustainable programme and ownership, national governments’ budgets for AIDS programmes need to be increased, and the allocation of resources should be adequate to the needs of not only adults but also children and young people. In addition, stronger and more creative ways are required to leverage and mobilize resources from existing and new donors.
7 Recommendations to Scale up the 4 Ps

Linking of the 4 Ps around local epidemics

The HIV and AIDS epidemic and the circumstances of children vary greatly across the region and within countries. Available resources do not permit countries to take on all aspects of the response with equal force nor does the epidemiology warrant such an approach. National delegations and their partners will need to consider how they will link the 4 Ps around local epidemics.

Increasing access to prevention, care, treatment and support

The Scaling Up Towards Universal Access initiative offers a process for setting targets and designing action plans that take children into consideration. In keeping with the current progress, country delegations need to consider how to best achieve a scaled-up response for children vulnerable to, infected and affected by HIV and AIDS.

Improving evidence-based approaches

The East Asia and the Pacific regional response continues to be constrained by a lack of high-quality, consistent data on children vulnerable to, infected and affected by HIV and AIDS. The design and use of standard monitoring tools are needed to improve programme effectiveness and to understand and respond better to the needs of children. These tools are also needed to decide on adequate financial allocations and programme formulations. Effective evidence-based solutions require joint programming and joint actions by the government. The scaling up of the 4 Ps in the region calls for much greater efforts in resource leveraging, evidence-based policy and political advocacy, as well as better data gathering, data analysis and results-based monitoring and evaluation.

Resource Mobilization

Clear strategies are needed to increase the resources for national AIDS programmes in East Asia and the Pacific. Unless resources are quickly mobilized and allocated, funding gaps will continue to hold back HIV interventions. Also, investment in the low-prevalence countries should not be decreased.
Endnotes

2 UNAIDS, UNICEF. The framework for the care, protection and support of vulnerable children living in a world with HIV and AIDS. 2004.
41 UNFPA, Baseline Survey Report for Youth Sub-Project by Divisions of Statistical Demography, Institute of Population and Labor Economics, Chinese Academy of Social Sciences, Beijing, China, March 2004
Appendix: Overview of Country Achievements

**Cambodia**

Cambodia remains one of the success stories in reversing the spread of HIV. HIV prevalence has fallen to an estimated 0.9 per cent of the general population in 2006. Cambodia provides evidence that well-focused and sustained prevention efforts can have an impact on reversing the spread of HIV.

In Cambodia many of the elements that are critical to a sustained response are in place. This includes political leadership and ensuring a multi-sectoral response. There has also been a significant scaling-up of programmes such as PMTCT and paediatric treatment services. Cambodia has also shown leadership in ensuring that policies and coordinating mechanisms that are necessary are in place to ensure an effective and coordinated response to children orphaned and made vulnerable by AIDS.

| HIV and AIDS | HIV prevalence has fallen to an estimated 0.9 per cent among the adult population in 2006, down from a peak of 2 per cent in 1998. |
| National response | • Review of National HIV Strategic Plan 2006-2010 (NSP II)  
• National Multi-sectoral Taskforce on Orphans and Vulnerable Children established  
• Alternative Care Policy adopted  
• National Plan of Action for Orphans, Children Affected by HIV and other Vulnerable Children 2008-2010 developed and costed  
• Successful fundraising through Global Fund Round 7 (US$42 millions, with US$6 millions for OVC)  
• National PMTCT training curriculum  
• National paediatric care and treatment guidelines  
• Setting up of a nationally recognized coordination body tasked with PMTCT |
| Assessments | • Conducted a participatory situation analysis of orphans, children affected by HIV and other vulnerable children in Cambodia  
• Conducted a national review of PMTCT services  
• A secondary analysis of 2005 CDHS as part of the orphans and vulnerable situation analysis found that 8.8 per cent of all children in Cambodia are orphans. Other key findings include the fact that children in HIV-affected households are more likely to eat fewer meals and experience hunger more often than their peers in non-HIV affected households. Maternal orphans are significantly more likely to be severely stunted than other children. HIV-affected households have significantly lower income than non-affected households. From 13 to 17 years old, orphans fare considerably worse in school attendance than non-orphans, and children who have lost their mothers are less likely to have birth registration or birth certificate available. |
### PMTCT
- In 2007, only 33% per cent of referral hospitals, 22% per cent of national hospitals and 6.2% per cent of health centres provide PMTCT services, but there was a 57% per cent increase in the number of pregnant women reached with PMTCT services compared to the first half of 2006.
- First national review of PMTCT services
- Drafting of a national expansion strategy and plan with population-based benchmarks and targets
- In 2007 overall service coverage was still estimated as quite low, reaching about 12% per cent of all pregnant women. However overall service accessibility and uptake increased: PMTCT is now available at 113 health facilities (73 health centres and 40 referral hospitals) countrywide.
- During the first half of 2007, a total of 32,457 pregnant women attended antenatal care services for the first time at a public health facility offering PMTCT services. Of these first ANC attendees, 24,080 (74 per cent) were tested for HIV and 21,469 (89 per cent) received their test results. Compared to the same period in 2006, the absolute number of pregnant women who tested for HIV more than doubled from 11,721 in 2006 to 24,080 in 2007. The percentage of ANC mothers accepting HIV testing increased from 69 per cent in 2006 to 74 per cent in the first semester of 2007.
- Implementation of the newly introduced provider-initiated routine offer of HIV testing (opt – out) in PMTC sites/antenatal care settings

### Paediatric treatment
- By the end of September 2007, paediatric HIV care was available at 22 public health facilities throughout the country. ART was provided for 2,372 children younger than 15 years, up from a few hundred in mid-2005.
- The introduction of HIV paediatric care services has also had a positive impact on the overall utilization of paediatric services at the referral hospitals.

### Prevention
- The Ministry of Education developed and costed a National HIV Strategy and plan for reducing HIV vulnerability among adolescents and young people.
- Ministry of Education, Youth and Sports implemented the Life skills programme in schools in 14 provinces.
- Numerous NGOs are also providing HIV information and life skills training to in and out-of-school children. Some also facilitate access to reproductive health services for young people.
- Several NGOs support HIV prevention and care for work place programmes in garment factories.
- The HIV Hotline Inthanou continues to service the general public, adolescents and young people. From January to September 2007, the hotline answered 43,812 calls from Cambodia's 24 provinces. A majority (61 per cent) of the calls were from young people aged 15 to 24.
## Protection and care

- Establishment of the National Multi-sectoral Orphans and Vulnerable Children Task Force led by the Ministry of Social Affairs, Veterans and Youth Rehabilitation
- Participatory situation analysis and National Plan of Action for OVC developed and costed
- Alternative Care Policy adopted
- Minimum standards on residential and community-based care developed
- Alternative care database functional
- Mapping of service providers for community-based care
- Numerous NGOs providing direct services to HIV-affected families and their children

### Data sources

* Consolidated 2007 COARS.
* PMTCT and Paediatric HIV Care Report Card 2007 Regional Analysis Report: HIV and AIDS and Children

## China

China’s rapid economic development continues to lift millions out of poverty, which has improved the situation for children. However, it has also brought new threats that could influence the country’s HIV epidemic. The HIV virus is transmitted primarily through injecting drug use and unprotected sex. One of the ongoing challenges is that the epidemic is spreading from high-risk groups to the general population, and the percentage of women infected is on the rise.

The Chinese Government has shown great leadership in responding to the HIV epidemic. The “4 Frees and One Care policy” has resulted in thousands of people, including children, who live with HIV receiving free antiretroviral therapy. Likewise, it ensures that children orphaned by AIDS have access to free education. As a result of “4 Frees and One Care Policy,” China has made progress across a range of priority areas.

### HIV and AIDS

- It is estimated that just under half of all people living with HIV in China in 2006 were infected while injecting drugs with contaminated equipment.
- In 2006 it was estimated that as many as 7 per cent of HIV infections could be attributed to unsafe sex between men.
- Most of the people living with HIV in China are believed to be in Henan, Guangdong, Guangxi, Xinjiang and Yunnan provinces.

### National response

- Development of a national policy for the care of children orphaned by AIDS
- Continued implementation of the government’s ‘4 Frees and One Care’: free antiretroviral drugs, free prevention of mother-to-child transmission, free voluntary counselling and testing, free schooling for children orphaned by AIDS and care to people living with HIV and AIDS
- National paediatric care and treatment guidelines
- Life-skills training guidelines for children in and out of school
### Assessments
- Household assessment of children affected by AIDS
- National advocacy and assessments on children orphaned and affected by AIDS

### PMTCT
- Expansion of PMTCT to over 271 government-supported counties.
- From January to September 2007, 1,309,625 pregnant women were tested for HIV. Of these 1,332 women tested HIV positive (<0.1% of total women tested).

### Paediatric treatment
- From January to September 2007, 683 infants born to HIV-infected women were receiving antiretrovirals for PMTCT.
- An estimated 7,000 children younger than 15 who are living today with HIV were infected through vertical transmission, 761, or nearly 80 per cent, of reported paediatric cases are currently in treatment, and 44 have died.
- Development of a National paediatric care and treatment and scale-up plan
- Ongoing paediatric care-related activities include training of physicians, paediatricians and other caregivers on HIV paediatric care
- Support for supply chain assessments

### Prevention
- Implemented various national campaigns on HIV and AIDS prevention, focused on increasing awareness of children affected by HIV and AIDS.
- Over 2,800 young people have been integrated into existing MOE peer-education networks, including 231 campaign youth ambassadors reaching 27,000 peers with interpersonal communication, 394,000 to 464,000 young people with participatory and civil engagement activities and over 3 million youth via the Internet.
- Assessment of life-skills education conducted

### Protection and care
- An international meeting on children affected by AIDS in Henan Province and national summer camps for children affected by AIDS were held. These resulted in several publications, including Ethical Guide for the Reporting of Children affected by AIDS, Working with the Media: A Guide for Children Affected by AIDS and other child rights-focused publications to address increased coverage of children affected by AIDS in the media.
- 277 institutions (‘sunshine homes’ and orphanages) were established, and 3,167 double orphans (93 per cent of the total school-aged reported) received government support.
- Achieved country target for care and support

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Data sources
- Consolidated 2007 COARS.
- PMTCT and Paediatric HIV Care Report Card.
- 2007 Regional Analysis Report: HIV and AIDS and Children
The Democratic People’s Republic of Korea has not reported any cases of HIV. There is awareness of the potential threat posed by HIV among government and other agencies. Early HIV-prevention activities are required if an HIV epidemic is to be avoided.

| HIV and AIDS | • DPR Korea claims to have achieved Goal 6 of the UN Millennium Development Goals (“Goal 6: Halt and begin to reverse the spread of HIV & AIDS”). This claim is based on the official government position that there is no reported incidence of HIV in the country. |
| National response | NA |
| Assessments | NA |
| PMTCT | NA |
| Paediatric treatment | NA |
| Prevention | • Developed an information package for newlywed couples on a range of subjects including HIV and AIDS awareness  
• First inter-sectoral workshop on HIV and AIDS |
| Protection and care | NA |

Data source
Consolidated 2007 COARS.
Indonesia has one of the fastest growing epidemics in Asia. In the eastern province of Papua, HIV has spread beyond initial risk groups. In Jakarta, HIV prevalence among injecting drug users has been estimated to be as high as 40 per cent.

Despite constraints, there has been much progress. There has been a focus on combating the epidemic among the most-at-risk groups and in regions that are most affected. There has been engagement and efforts towards scaling up the “4 Ps.”

There has also been good work undertaken to assess the situation of children and families affected by HIV and AIDS using both quantitative and qualitative methodologies. This information can assist in the development of effective policies, services and programmes for children affected by HIV.

| HIV and AIDS | • The HIV epidemic in Indonesia is among the fastest growing in Asia.  
• The majority of HIV infections are estimated to occur through the use of contaminated injecting equipment, unprotected paid sex, and, to a lesser extent, unprotected sex between men. 
• In 2005, more than 40 per cent of injecting drug users in Jakarta tested HIV positive and about 13 per cent in West Java. Disaggregated analysis reveals 52 per cent of injecting drug users, 45 per cent of sex workers and 31 per cent of men having sex with men are young people below the age of 24. 
• In Papua the epidemic is more serious, with unprotected sex being the main mode of transmission. In 2006, adult HIV prevalence was estimated at 2.4 per cent and reached 3.2 per cent in the remote highlands and 2.9 per cent in less-accessible lowland areas. Among 15-24 year olds, HIV prevalence was 3 per cent. |
| National response | • Development of National Strategic Plan 2007-2010 and a National Strategy for Children and Young People 2008-2010 |
| Assessments | • A national assessment of children and family affected by HIV and AIDS was carried out, which showed that families below the poverty line are disproportionately higher in the sample of families affected by HIV and AIDS. 
• Ministry of Health and National AIDS Commission collected and analysed secondary data on young people’s risk behaviour and their vulnerability to HIV, which highlighted that young people under twenty are almost twice as likely to share needles as adults. Young sex workers are less likely to negotiate and use condoms during sex. They also know less about HIV transmission and are far more likely to contract sexually transmitted infections. 
• An assessment on HIV skills-based prevention education in Papua, when compared to the assessment in 2003, showed a decrease in the proportion of young people who have ever had sexual intercourse and an increase in awareness of HIV. Accurate knowledge, however, was very low, with 69 per cent of young people saying you can detect HIV and AIDS by the appearance of an individual. |
| PMTCT | • A national PMTCT taskforce was established to provide overall policy and programmatic guidance towards a systematic introduction and implementation of comprehensive PMTCT and paediatric AIDS services. Similar task forces were established in the provinces of East Java, North |
Sumatra, Papua, West Papua and NAD.

- A national level PMTCT communication strategy and PMTCT IEC materials were developed to strengthen PMTCT services at the field level.
- In 2005, 798 pregnant women were tested for HIV (4 pregnant women tested HIV positive); by 2007 this had increased to 4,830, and 1,315 pregnant women tested HIV positive.
- 89 HIV-infected pregnant women received antiretrovirals to reduce the risk of mother-to-child transmission in 2007.
- Preparation of a PMTCT scale-up plan was undertaken.
- The newly introduced provider-initiated routine offer of HIV testing (opt – out) in PMTC sites/antenatal care settings was carried out.

<table>
<thead>
<tr>
<th>Paediatric treatment</th>
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<tbody>
<tr>
<td>• 25 infants born to HIV-infected women were receiving antiretrovirals for PMTCT in 2007.</td>
</tr>
<tr>
<td>• In 2007, 19 HIV-infected children were receiving ART (in 2005 one HIV-infected child was receiving antiretroviral treatment).</td>
</tr>
<tr>
<td>• Ongoing paediatric care-related activities which include training of physicians, paediatricians and other caregivers on HIV paediatric care</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Prevention</th>
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</thead>
<tbody>
<tr>
<td>• In 2007, implementation of HIV education in schools in Papua and West Papua, as well as in Islamic schools in East Java and Aceh, reached nearly 83,000 students in lower secondary schools in 2007. Additionally, 1,567 teachers and school principals were trained and involved in the teaching of HIV to the students.</td>
</tr>
<tr>
<td>• Approximately 35,000 young people in Papua and West Papua were reached through radio programmes that were conducted by young broadcasters.</td>
</tr>
<tr>
<td>• Assessment of life skills education conducted in 2007 has been used to refine programme implementation at the national and provincial levels.</td>
</tr>
<tr>
<td>• The provincial department of education in Papua, with the support of the Indonesia’s Ministry of National Education, has initiated the process to make HIV education an integral part of the school system, particularly the school curriculum.</td>
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<tr>
<th>Protection and care</th>
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</thead>
<tbody>
<tr>
<td>• A national assessment of care and protection was carried out in seven provinces to assess socio-economic impact on households affected by HIV and AIDS as well as to assess the psycho-social impact on children affected by HIV and AIDS. For the survey, about 1,400 households were sampled, including both index and reference groups. Findings revealed an increase in the dropout rate among children affected and among families with high funeral costs, high levels of discrimination and low access to government insurance schemes. Consultation meetings were held at the provincial level to discuss future strategies.</td>
</tr>
<tr>
<td>• Guided by the assessment, the Ministry of Social Affairs will be initiating community- and centre-based pilot projects for the care and support of families affected in seven provinces.</td>
</tr>
</tbody>
</table>

Data sources

- Consolidated 2007 COARS.
- PMTCT and Paediatric HIV Care Report Card.
- 2007 Regional Analysis Report: HIV and AIDS and Children
Lao PDR

Lao PDR is classified as a low-prevalence country. Economic and social change has led to increased mobility and migration, both within the country as well as to neighbouring countries, several of which already have generalized epidemics.

There has been a focus on strengthening capacities in preventing mother-to-child transmission and paediatric treatment as well as a scaling-up of prevention programmes using a life-skills-based approach in high schools in seven provinces.

At the national level, there have also been impressive legislative efforts to strengthen the protection of children infected and affected by AIDS.

| HIV and AIDS | • HIV prevalence estimated at 0.1 per cent  
|             | • 3,700 estimated number of people living with HIV |
| National response | • National assembly passed a law about children that includes a provision for children infected and affected by AIDS  
|                  | • National PMTCT and voluntary counselling and testing guidelines |
| Assessments | • National needs assessment on children and adolescents affected by HIV and AIDS  
|             | • Quantitative research into knowledge and practice (KAP) among lower-secondary pupils in relation to HIV and AIDS/STIs, reproductive health and drug use in eight provinces was carried out with 1,207 eighth grade pupils. |
| PMTCT | • In 2007, three facilities nationally providing ANC were also providing HIV testing and antiretrovirals to PMTCT.  
|       | • In 2007, 1,860 pregnant women were tested for HIV. There were 26 pregnant women who tested HIV positive. In 2005, 550 pregnant women were tested for HIV, and 14 pregnant women tested HIV positive.  
|       | • In 2007, 24 HIV-infected pregnant women received antiretrovirals to reduce the risk of mother-to-child transmission.  
|       | • 17 infants born to HIV-infected women were receiving antiretrovirals to PMTCT in 2007.  
|       | • Initiation of the integration of PMTCT into existing clinical and community maternal and child health services in four areas: policy development; service delivery; health communication; and research.  
|       | • PMTCT guidelines advocating counselling and testing for women at risk have been developed, approved and disseminated.  
|       | • In 2007, HIV-prevention education was provided to 43 per cent of women attending ANC in four central, five provincial and 12 district hospitals in six provinces.  
|       | • In 2007, pregnant women in 309 villages in Laungnamtha, Luanprabang, Savannakhet and Vientiane provinces received information on HIV and AIDS and PMTCT during MCH outreach services.  
|       | • A PMTCT pilot, offering VCT to women in ANC in three major hospitals in Vientiane  
|       | • Preparation of a PMTCT scale-up plan was undertaken. |
### Paediatric treatment
- In 2007, 36 HIV-infected children were receiving antiretrovirals (compared to 3 HIV-infected children receiving antiretrovirals in 2005).
- Support for paediatric AIDS and the preparation of a proposal that includes a children’s treatment plan
- Ongoing paediatric care-related activities, which includes training of physicians, paediatricians and other caregivers on HIV paediatric care and clinical management

### Prevention
- 100 per cent of high schools in the targeted seven provinces now have an integrated curriculum on reproductive health, HIV and AIDS/STI and drug-use education using a life-skills approach that reached about 40,000 students in 2007.
- Implementation of discrimination-prevention activities in 200 communities and cases of discrimination in school were followed up.
- Telephone hotline counselling service in Vientiane
- Developed an integrated curriculum on reproductive health, HIV and AIDS/STI and drug-use education using a life-skills approach
- 24 per cent of factory workers nationally were reached in three ‘most-at-risk’ provinces, with an eight module evidence-based curricula to promote condom use, communication, negotiation and refusal skills.

### Protection and care
- Supporting Buddhist monks to mobilize community support for affected families
- In 2007, monks, volunteers and hospitals provided comprehensive care for children infected, ensuring that 147 needy hard-to-reach mothers and children had access to treatment and community-based care and 125 children received school supplies or small education grants. Discrimination-prevention activities were also carried out in 200 communities, and cases of discrimination by schools were followed up.
- Achieved country target for care and support.
- Law on the Protection of Rights and Interests of Children was passed. Article 17 is about the care of children affected by HIV and AIDS, and Article 31 is on Education for Children Affected by HIV and AIDS.

**Data sources**
- Consolidated 2007 COARS.
- PMTCT and Paediatric HIV Care Report Card.
- 2007 Regional Analysis Report: HIV and AIDS and Children
Malaysia

Malaysia is experiencing a concentrated epidemic, with HIV prevalence estimated at 0.5 per cent among the general population. The main mode of transmission is through the use of contaminated injecting equipment. Given the prominence injecting drug use plays in the country’s epidemic, Malaysia launched a pilot harm-reduction programme in 2005, which includes a needle and syringe exchange programme (NSEP) and methadone maintenance therapy (MMT). In 2007, the programme was scaled up.

As indicated by the data outlined below, PMTCT services and paediatric treatment are well developed in Malaysia. Data on children and young people and HIV remains limited; however, efforts are currently underway to address this deficiency.

| HIV and AIDS | • HIV prevalence estimated at 0.5 per cent  
  • As of December 2006, 76,389 estimated to be living with HIV |
|-------------|-------------|
| National response | • National Strategic Plan 2006-2010 with a focus on Strategy 4: Reducing HIV vulnerability among women, young people and children  
  • First National AIDS Conference, December 2007  
  • National paediatric care and treatment guidelines |
| Assessments | • A pilot household situation survey of children affected by AIDS is currently being carried out  
  • Conducted a national review of the PMTCT programme |
| PMTCT | • In 2005, 27 facilities were providing both PMTCT and antiretroviral treatment; by 2007 there were 171 facilities.  
  • In 2007, 380,346 pregnant women were tested for HIV, and 190 pregnant women tested HIV positive (<.05). In 2005, 349,922 pregnant women were tested for HIV, and 107 women tested positive.  
  • Evaluation of the PMTCT programme was undertaken. This resulted in improved guidelines on engagement with the private health sector.  
  • Carrying out the newly introduced provider-initiated routine offer of HIV testing (opt – out) in PMTCT sites/antenatal care settings |
| Paediatric treatment | • In 2007, 60 facilities were providing paediatric antiretroviral treatment.  
  • In 2007, 177 infants born to HIV-infected women were receiving anti-retrovirals for PMTCT.  
  • In 2007, 500 HIV-infected children were receiving antiretroviral treatment. |
| Prevention | • The states of Kedah and Perlis successfully expanded the ProStar Youth Centres, a prevention programme for youth in a total of seven districts. The programmes under these centres included peer-to-peer education on HIV and AIDS, which targeted both in-school and out-of-school children and young people; sports tournament awareness raising; mobilization of religious leaders; and peer counselling.  
  • The ProStar model is currently expanding towards national coverage. |
• A Life Skills Based Education on HIV has been pilot tested in 16 secondary and 4 primary schools in the state of Kedah. Based on lessons learned, the module was critically assessed and reviewed in 2007 as a prerequisite for nationwide application.

• In 2007, two workshops were conducted to refine LSBE Module, namely Psychosocial Competencies in HIV Prevention (PCHPE) Module. This module has just completed its final round of being piloted and additional revisions have been approved. The printed module will then be distributed to all schools.

• The National Service Training curriculum has adopted the HIV and AIDS education module developed by the AIDS/STD Section of the Ministry of Health. The HIV and AIDS education module will reach about 10,000 youth in the first phase, a further 30,000 in the second phase, and a total of 100,000 by the end of 2008.

• First National AIDS Conference was held in 2007. This included a youth forum (120 youth); symposium on HIV Among Women and Infants; HIV and Children symposium; and HIV and Young people symposium.

• Production of a new video report “Treating mothers, saving children from HIV,” highlighting the government’s PMTCT programme, was aired on local television.

• Broadcast messages on children and HIV on television and radio in 2007 reached at least one million listeners.

• Training involving religious leaders, marginalized communities and people living with HIV from Kedah was initiated to mobilize community support for care, and reduction of stigma and discrimination.

• Harm-reduction-related activities that are linked to HIV and AIDS were implemented.

Protection and care

• Child Protection Act 2001 has been enforced, whereby the provisions under this act encompass all children, including children affected by AIDS.

Data sources

Consolidated 2007 COARS.
PMTCT and Paediatric HIV Care Report Card.
2007 Regional Analysis Report: HIV and AIDS and Children
## Mongolia

Mongolia has low national HIV prevalence, yet the country is vulnerable to a growing epidemic. In particular, high levels of migration within the country and into China and Russia, where prevalence is higher, render Mongolia vulnerable to an expanding epidemic.

There have been efforts towards scaling up PMTCT services nationwide. There has also been a significant focus on HIV-prevention programmes in the non-formal education system.

<table>
<thead>
<tr>
<th>HIV and AIDS</th>
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<tbody>
<tr>
<td>- HIV prevalence estimated at &lt;0.1 per cent.</td>
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<tr>
<td>- Estimated number of people living with HIV &lt;500.</td>
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<tr>
<th>National response</th>
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<tr>
<td>- As the result of the extensive advocacy among the high- and middle-level government officials by the UN agencies, including UNICEF, the Government of Mongolia has adopted the ‘Three Ones’ principle. In this regard, the National AIDS Committee, chaired by the Deputy Prime-Minister of Mongolia was re-established; national AIDS programme monitoring and evaluation indicators were set; and the National AIDS strategy was revised in 2006.</td>
<td></td>
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<tr>
<td>- National PMTCT and voluntary counselling and testing guidelines were established.</td>
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<tr>
<th>Assessments</th>
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<tr>
<td>- Antenatal care (ANC) and STIs epidemiology survey among 2,000 pregnant women is currently being conducted by the Ministry of Health and UNICEF.</td>
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<tr>
<th>PMTCT</th>
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<tr>
<td>- National PMTCT working group was established by the Ministry of Health.</td>
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<tr>
<td>- National PMTCT guidelines were developed.</td>
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<tr>
<td>- The first training of trainers on PMTCT is planned for the second quarter of 2008.</td>
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<tr>
<td>- VCT and PMTCT service centres nationwide were established through the use of existing health structures at the national and sub-national levels.</td>
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<tr>
<td>- Carrying out the newly introduced provider-initiated routine offer of HIV testing (opt – out) in PMTC sites/antenatal care settings</td>
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| Paediatric treatment | Cases of paediatric AIDS are not registered yet. |

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<tr>
<th>Prevention</th>
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<tbody>
<tr>
<td>- Setting up of life-skills-based HIV and AIDS prevention programmes within the non-formal education system</td>
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<tr>
<td>- As part of the Unite For Children, Unite Against AIDS, the Lesson for Life campaign was conducted nationwide in November and December 2007. More than 600 peer educators from all provinces were trained and conducted 80 minute HIV and AIDS prevention information sessions for their peers, reaching an estimated 60-80,000 young people.</td>
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<tr>
<td>- Second National Peer Education Forum in which key aspects of peer education among young people were discussed</td>
<td></td>
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<tr>
<td>- Three pilot peer-education projects were implemented in three provinces, and 390 herder children from rural and remote areas were reached by trained peer educators.</td>
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Myanmar

The HIV epidemic in Myanmar is showing signs of a decline in HIV prevalence among the general population, although HIV prevalence among injecting drug users and commercial sex workers is still high.

There has been, during recent years, a significant scaling up of PMTCT services, prevention programmes, and care and support programmes.

There has been increased attention given to the impact of HIV on orphans and vulnerable children through the establishment of an inter-agency technical group and analyses of the situation of children affected by AIDS.

HIV and AIDS

- Epidemic is showing signs of a decline, with HIV prevalence among pregnant women at antenatal clinics having dropped from 2.78 per cent in 2000 to 1.29 per cent in 2006.

National response

- The First Technical Strategy Group on AIDS sub-working group on orphans and vulnerable children affected by AIDS is contributing to higher-level advocacy for common strategies and appropriate responses.
- National PMTCT training curriculum
- National paediatric care and treatment guidelines
- Family and community-based care manual for women, children and families affected by AIDS

Assessments

- Conducted a qualitative study on the situation and needs of children affected by AIDS
- Conducted a Joint PMTCT review assessment

PMTCT

- After six years of implementation, the PMTCT Programme was jointly reviewed by UNICEF, UNFPA and WHO. The review recognized the general success but also emphasized the need to focus more on primary prevention, as well as care and support.
- PMTCT coverage increased significantly from 30 townships to 106 townships and 37 hospitals. At the end of 2006, the number of pregnant women reached was 182,688, out of which 993 were HIV positive.
Pacific Island Countries

**Paediatric treatment**
- National paediatric care and treatment and scale-up plan

**Prevention**
- The life-skills-based training and peer education for out-of-school youth was also evaluated, which resulted in the revision of training contents and increased targeting of higher risk youths.
- Overall, 137,854 out-of-school youths were trained for HIV prevention and life skills in 2006.
- In 2007 the Life Skills and HIV and AIDS Prevention Education programme in primary schools covered 15,170 primary schools in 94 townships, comprising 1.8 million children. More than 44,000 primary teachers were trained in using the new life-skills curriculum, which promotes children’s active participation and critical thinking.
- The upgrading and revision of the secondary school life skills continued, and a framework for the revised curriculum was drafted, reflecting the findings of the baseline assessment and learning needs of students.
- Assessment of life-skills education

**Protection and care**
- In 2007, over 15,000 orphans and vulnerable children including children affected by AIDS and their families received protection, care and support services in collaboration with NGOs and INGOs.
- Faith-based organizations have been working on support of children and families affected by HIV AIDS.

Data sources
COARS (UNICEF Myanmar).
2007 Regional Analysis Report: HIV and AIDS and Children

**Pacific Island Countries**

The Pacific Island Countries have low HIV prevalence. There have been significant efforts to improve the capacity of prevention of mother-to-child transmission (PMTCT) services. There has also been a focus on HIV prevention using a life-skills-based approach. There is little or no data on children orphaned by AIDS, although there has been a comprehensive assessment undertaken of the vulnerability of youth to HIV in the Pacific.

**HIV and AIDS**
- Pacific Island countries have low HIV prevalence. Cumulative HIV cases (2005): 21 cases in Micronesia, 13 cases in Tonga, 2 cases in Vanuatu, 10 cases in Marshall Islands, 5 cases in Solomon Islands, 8 cases in Palau, 9 cumulative HIV cases in Tuvalu (2004)
- There were 236 cumulative HIV cases in Fiji by early 2007 (22 per cent increase over early 2006 annual reporting).

**National response**
- National PMTCT training curriculum
## Assessments

- There are no reliable data on children orphaned by AIDS.
- An assessment of youth vulnerability to HIV in the Pacific was produced in 2006.

## PMTCT

- In Fiji there have been eight confirmed cases of mother-to-child HIV transmission. In Tuvalu and Vanuatu there has been one documented case in each country of mother-to-child HIV transmission. In the Marshall Islands there was one documented pregnancy involving an HIV-positive woman, but the outcome for the child is unknown. In Palau, Solomon Islands, Tonga and Micronesia, there are no documented cases.‘
- Regional PMTCT policy and national actions plans were drafted by seven countries.
- HIV core clinical teams from Solomon Islands and Vanuatu went to Papua New Guinea for PMTCT/ART clinical placement.
- PMTCT adoption and pilot training conducted for 25 MoH country representatives from Fiji, Vanuatu, Solomon Islands, and Kiribati, plus 20 observers.
- A national PMTCT training package was developed for four Pacific Island countries.
- A PMTCT documentary highlighting the importance of a whole-family approach and the critical role of primary prevention was produced and aired on the ‘Pacific Way’ television programme.
- In Fiji, four national facilities that provide ANC also provided HIV testing and antiretrovirals for PMTCT in 2007. Services are available in the three main hospitals ANC facilities, but they refer children to Colonial War Memorial Hospital.
- In 2007, 7,000 pregnant women were tested for HIV in Fiji. Five pregnant women tested HIV positive in 2007 (approx <.07% of pregnant women tested). All five HIV-infected pregnant women received antiretrovirals to reduce the risk of mother-to-child transmission.

## Paediatric treatment

- In Fiji, the Colonial War Memorial Hospital was the only facility providing paediatric antiretroviral treatment in 2007.
- In 2007, there were no HIV-infected children receiving antiretrovirals in Fiji.

## Prevention

- 16,000 young people were reached by community-based life-skills training in 2007. All of the 14 Pacific Island countries have had at least one Training of Trainers/Refresher Training workshop, totalling 550 youth trainers across all countries. 60 young people were trained on how to develop education material and youth radio programmes, and 50 teachers were trained on life-skills-based education approaches.
- In Tuvalu, a HIV and AIDS Resource Manual for Teachers as well as IEC materials for children and adults have been developed both in English and in Tuvaluan.‘

## Protection and care

NA

Data sources

Papua New Guinea is experiencing an epidemic that is still expanding. HIV prevalence is estimated to be among the highest in the region. The spread of HIV is driven by early initiation of sex, multiple sex partners, low condom-use rates, and high levels of STIs. The epidemic is also fuelled by endemic violence against girls and women.

While there have been efforts to strengthen PMTCT services and paediatric treatment, a significant challenge in delivering an effective response to HIV and AIDS is a severely degraded and declining public health infrastructure. There is a need for improved coverage of PMTCT services and paediatric treatment.

Despite this bleak picture, there are success stories, including expanded prevention programmes and the implementation of community-based care models.

<table>
<thead>
<tr>
<th>HIV and AIDS*</th>
<th>• Majority of reported HIV infections to date have been in rural areas, where more than 80 per cent of the population lives. Unsafe heterosexual intercourse is estimated to be the main mode of HIV transmission.</th>
</tr>
</thead>
</table>
| National response | • National OVC Strategy  
• National PMTCT training curriculum  
• National Paediatric care and treatment guidelines  
• Community-based care and support policy based on the results of the 2006 situation assessment of orphans and vulnerable children |
| Assessments | • National assessment, conducted in 2005, was ready to be translated into a national OVC programme under the leadership of the Community Development Ministry. |
| PMTCT | • In 2006, 18,494 pregnant women were tested for HIV, and 214 of these tested HIV positive.  
• In 2006, 31 HIV-infected women received antiretrovirals to reduce the risk of mother-to-child transmission.  
• In 2006, 25 infants born to HIV-infected women received antiretrovirals for PMTCT.  
• Following the development of minimum standards for delivery of PMTCT services, children and women are now more likely to receive standardized, quality PMTCT services.  
• A PMTCT scale-up plan has been prepared. |
| Paediatric treatment | • In 2006, 23 HIV-infected children were receiving antiretrovirals.  
• Children and infants serviced by provincial hospitals in Lae and Mt Hagen are now being treated by paediatricians who have received on-site training and mentoring regarding the best practices for treatment and care of infected infants and children.  
• Development of a national paediatric care, treatment and scale-up plan  
• Establishment of paediatric AIDS clinic at PNG’s largest hospital  
• Ongoing paediatric care-related activities, which include training of physicians, paediatricians and other caregivers on HIV paediatric care and clinical management |
<table>
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<tr>
<th>Prevention</th>
<th>Protection and care</th>
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<tr>
<td>● Twenty-six adolescents and youth from seven provinces have been trained as National Training of Trainers, and these trainers have subsequently trained a further 157 facilitators from six provinces. In one district, 450 adolescents and youth have been trained in life-skills facilitation.</td>
<td>● Orphans and Other Vulnerable Children Task Force established and co-chaired by the Department for Community Development and the National AIDS Council, comprising a mix of key government and non-government organizations</td>
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<tr>
<td>● Adolescents in two communities in Lae and five communities in Mt Hagen live in communities that are now better equipped to address stigma and discrimination and provide home care, through the engagement of their communities in the AIDS competence process.</td>
<td>● Provincial committees established in three of the six focal provinces and a capacity assessment of faith-based organizations in four provinces undertaken</td>
</tr>
<tr>
<td>● Children in 150 villages in two districts live in communities that have developed village-level responses to HIV and AIDS, including the training of 57 facilitators who worked within these communities.</td>
<td>● Development of a Four-Year National Strategy for the Protection, Care and Support of Children Vulnerable to Violence, Abuse and Exploitation</td>
</tr>
<tr>
<td>● UNICEF is working with 10 communities in the 4 regions to achieve AIDS Competence and 20 leaders were trained and are skilled to facilitate AIDS Competence.</td>
<td>● The Lukautim Pikinini Act (Child Protection) was passed in April 2007, which prohibits institutional care and identifies orphans and other vulnerable children as requiring rights-based care and support.</td>
</tr>
</tbody>
</table>

Data sources:
Consolidated 2007 COARS.
PMTCT and Paediatric HIV Care Report Card.
2007 Regional Analysis Report: HIV and AIDS and Children
Into the third decade of the HIV pandemic, the Philippines managed to keep HIV prevalence way below 1 per cent in all sectors of society. Still, there is reason for concern. The Philippine National AIDS Council now speaks of a “hidden and growing” HIV and AIDS epidemic in the Philippines, having been alarmed by the increasing number of HIV-infection cases each month, as well as other danger signs such as a high prevalence of sexually transmitted infections, low condom use, a relatively young sexually active population, and prevalence of misconceptions on HIV and AIDS.

| HIV and AIDS | • By the end of 2007, the Philippines had an estimated 7,490 adults living with HIV, with a national overall prevalence of 0.02 per cent.  
  • All modes of transmission have been reported, but unsafe sexual transmission remains the most common (88 per cent).  
  • Of the reported HIV cases, 13 per cent were young people aged 15-24, and 1.5 per cent were children below 15 years old. |
| National response | • Development of the 4th AIDS Medium Term Plan 2005-2010 and Operational Plan 2007-2008  
  • Development of a national monitoring and evaluation system  
  • Expanded the number of AIDS treatment hubs providing management and treatment for HIV and AIDS to 11 to increase access to care and treatment for people living with HIV |
| Assessments | • No recent major studies, because major studies conducted in 2005 have provided enough information for advocacy and programme implementation |
| PMTCT | • Pilot initiative launched in Davao Medical Center (DMC) is one of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)-supported AIDS treatment hubs. PMTCT protocol and operational guidelines were developed in DMC and the pilot commenced 16 July 2007.  
  • In 2007, there are seven facilities providing ANC, which also provide HIV testing and antiretrovirals for PMTCT. Overall, there are 11 AIDS treatment facilities providing antiretroviral treatment. There is one facility providing both antiretrovirals to PMTCT and ART.  
  • From the pilot PMTCT trial: 798 pregnant women were tested for HIV in 2007.  
  • One pregnant woman who was known to be HIV positive received MTCT intervention in 2007. |
| Paediatric treatment | • In 2007, there were two facilities providing paediatric antiretroviral treatment.  
  • In 2007, three HIV-infected children were receiving antiretroviral treatment.  
  • In 2007, development of the ‘Interim Guidelines on the Integrated Management of Paediatric HIV and AIDS’  
  • Training workshop on the use of the guidelines was conducted and attended by 25 health care providers from three specialized hospitals, which served as treatment hubs for HIV and AIDS in the country. |
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<th>Prevention</th>
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<tr>
<td>• Implementation of the CPC6 programme has seen the general decline of STI referrals among children and youth in focal sites. There has been success at improving the level of knowledge of children and youth. In a comparative assessment, it was found that children and youth who both correctly identify ways of preventing sexual transmission of HIV and reject major misconceptions about the virus were significantly higher in focus areas (54 per cent) than in non-focus areas (14 per cent).</td>
<td>• The capacity of local governments was strengthened to respond to HIV and AIDS with a particular focus on most-at-risk children. The formation of local AIDS Councils and Task Forces for AIDS and children was facilitated.</td>
</tr>
<tr>
<td>• Information and education activities, with a special focus on young people, were conducted in focus areas. More than 30,000 young people participated in these activities, and in total more than 400,000 individuals benefited from HIV and AIDS education.</td>
<td>• Forty-two Barangay Councils for the Protection of Children have been reactivated, and another 30 structures are in the process of reactivation with HIV prevention mainstreamed into the structure.</td>
</tr>
<tr>
<td>• In addition, over 5 million individuals were reached by HIV and STI information through broadcast and print media.</td>
<td>• Life-skills training module was developed. A total of 84 social workers and NGO staff who are working with at-risk and vulnerable children in CPC6 areas were trained on the use of the life-skills module.</td>
</tr>
<tr>
<td>• Over 20,000 most-at-risk and vulnerable children and youth were enrolled in behavioural change, life-skills education and peer-education programmes. Prevention services, including the treatment of STIs, counselling and testing services, were made available through referral net works.</td>
<td>• The capacity of local governments was strengthened to respond to HIV and AIDS with a particular focus on most-at-risk children. The formation of local AIDS Councils and Task Forces for AIDS and children was facilitated.</td>
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<td>• Life-skills training module was developed. A total of 84 social workers and NGO staff who are working with at-risk and vulnerable children in CPC6 areas were trained on the use of the life-skills module.</td>
<td>• Forty-two Barangay Councils for the Protection of Children have been reactivated, and another 30 structures are in the process of reactivation with HIV prevention mainstreamed into the structure.</td>
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Thailand is one of the world’s success stories in containing HIV. Its strong focus on prevention programmes, such as the 100 per cent Condom Programme, resulted in a rapid decline in HIV transmission. The latest UNAIDS AIDS Epidemic Update indicates that the number of new annual HIV infections in Thailand continues to decline, although there is concern that HIV prevalence remains high among injecting drug users and is increasing among men who have sex with men.

Thailand remains a leader in the region in providing PMTCT, paediatric AIDS treatment, and protection and care services. Yet, there is concern that PMTCT services are not accessed by vulnerable groups including mobile populations, migrants and minorities.

Despite a good overall national response, there is a need to ensure greater attention is given to children and young people in national programming.

| HIV and AIDS* | • Number of annual new HIV infections continues to decline, although the decline in HIV prevalence has been slowing in recent years as more people are receiving antiretroviral therapy.  
• More than 43 per cent of new infections in 2005 were among women, the majority of whom probably acquired HIV from their husband or partners who had been infected either during unsafe paid sex or through injecting drug use.  
• Prevalence among injecting drug users has remained high over the past 15 years, ranging between 30 per cent and 50 per cent.  
• Recent studies show increasing HIV prevalence among men who have sex with men (from 17 per cent in 2003 to 28 per cent in 2005). |
| National response | • National Paediatric care and treatment guidelines |
| Assessments | • Contributions to the database on children, young people and HIV and AIDS include dissemination of the results of MICS (including data on PMTCT coverage and KAP on HIV and AIDS) and support for the completion of the National Sexual Behaviour Survey of Thailand 2006 in collaboration with UNAIDS.  
• A study was initiated on HIV vulnerability among foreign migrant children in three provinces.  
• Children affected by HIV and AIDS were also included in a review of institutional care for children supported by child protection. |
| PMTCT | • In 2007, there were 939 facilities providing ANC that also included HIV testing and counselling for pregnant women and antiretrovirals for PMTCT.  
• From October 2006 to September 2007, 794,406 pregnant women were tested for HIV. 6,196 pregnant women tested HIV positive, and 5,942 HIV-infected pregnant women received antiretrovirals to reduce the risk of mother-to-child transmission. By way of comparison, in 2006, 543,411 pregnant women were tested for HIV and 4,651 tested HIV positive.  
• 6,196 infants born to HIV-infected women received antiretrovirals for PMTCT (October 2006 to September 2007).  
• Improved monitoring and reporting system for programme planning, through development and implementation of the ‘Child Plus’ programme used for monitoring care for HIV-infected mothers and children after delivery  
• Preparation of a PMTCT scale-up plan |
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<tr>
<th>Paediatric treatment</th>
<th>Prevention</th>
<th>Protection and care</th>
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<td>• From October 2006 to September 2007, 6,687 HIV-infected children received antiretroviral treatment.</td>
<td>• Active participation of children with HIV in a national awareness campaign</td>
<td>• Development of effective community-based care and support models for children with HIV in two regions (Chiang Rai and Khon Kaen).</td>
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<td>• Comprehensive paediatric HIV care model started in Khon Kaen province was further developed and expanded to 10 community hospitals in Chiangrai Province in the north and Songkhla Province in the south in 2007. Over 2,400 children with HIV, 5,460 children affected by HIV and AIDS and 3,060 people living with HIV benefited from activities. Skills and capacities of hospital staff, NGOs and people living with HIV were strengthened to enable them to work effectively with HIV and families in the community.</td>
<td>• Peer-based and life skills-based education for HIV prevention among young people through activities in south and north Thailand was strengthened in 2007. Sex education and life-skills-based education for HIV and AIDS prevention was implemented in a total of 165 schools in 15 provinces, including 11 provinces in the south with 136 government schools as part of the regular curriculum and 68 Muslim schools. Over 74,150 children and young people participated in HIV and AIDS prevention activities, which included 61,346 students in schools, 7,817 children and young people in communities and 5,082 vulnerable children and young people. More than 1,669 youth leaders from schools, communities and vulnerable groups were trained to be effective HIV and AIDS facilitators/educators and served as resource persons for HIV and AIDS training or workshops at provincial offices, hospitals, schools, juvenile detention centres and communities.</td>
<td>• Over 7,400 community leaders and 1,550 government officials from more than 20 provinces were involved in activities strengthening the capacity of local governments in HIV and AIDS planning for children and families affected by HIV and AIDS.</td>
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<td>• Paediatric care and treatment and a scale-up plan has been prepared.</td>
<td>• Two books were published presenting findings of the Right to Know project on HIV risk behaviour of vulnerable young people, techniques for HIV prevention work and lessons learned.</td>
<td>• National advocacy for children and HIV and AIDS was scaled up significantly, with distribution among the general public and HIV and AIDS organizations of 32,500 copies of six books dealing with children and HIV, 11,000 copies of a book on children’s artwork, 24,000 copies of a planner/diary featuring children’s art and 8,300 copies of the VCD/DVD “The Sea has a Secret”/”Who am I?”</td>
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<td>• Ongoing paediatric care-related activities, which includes the training of physicians, paediatricians and other caregivers on HIV paediatric care and clinical management</td>
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<td>• Expansion of a comprehensive paediatric HIV care model</td>
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Data sources
Consolidated 2007 COARS.
PMTCT and Paediatric HIV Care Report Card.
2007 Regional Analysis Report: HIV and AIDS and Children
Timor-Leste has a low-prevalence epidemic. There are many factors, however, that could feed into an expanding epidemic. There exists a low level of HIV knowledge among young people and evidence that young people are engaging in sexually risky behaviour. In response, HIV-prevention programmes in Timor-Leste have expanded their reach with strong support from the government. A national HIV and AIDS campaign was conducted in 2007, and there have been significant efforts to ensure life-skills-based education is made available for young people, both in and out of school.

Access to treatments – supported by the Brazilian government – is also available to people with HIV.

| HIV and AIDS* | • HIV prevalence estimated at <0.2 per cent |
| National response • | • National Youth Policy and formulation of seven optional strategies for its implementation |
| Assessments | • Conducted nationwide HIV campaign baseline and post-campaign surveys to assess the impact of the campaign |
| PMTCT | • There was one facility providing both antiretrovirals for PMTCT and antiretroviral treatment in 2007 (nationally, there were two facilities providing antiretroviral treatment in 2007).  
• In 2007, two HIV-infected pregnant women received antiretrovirals to reduce the risk of mother-to-child transmission. |
| Paediatric treatment | NA |
| Prevention | • The Adolescent and Participation Project works in collaboration with seven NGOs across the country to implement life-skills-based education and the Adolescent/Youth Literacy Project. Over 30 NGOs around the country collaborate to implement peer education and prevention-education activities on HIV and AIDS/STI in the Nationwide HIV and AIDS Campaign.  
• Life-skills-based education for young people in and out of school was being implemented in six districts in 2007, 131 life-skills facilitators have been trained, while 7,595 students and out-of-school young people received life-skills-based education.  
• Life-skills-based education is being incorporated into the new primary school curriculum and will be integrated into the pre-secondary school curriculum.  
• 40,000 young people – 15-24 year olds – in 13 districts were reached through the national HIV and AIDS campaign conducted from May to November 2007.  
• 630 young people, in and out of school, across six districts and six internally displaced persons camps in Dili were trained as HIV and AIDS/STI Peer Educators in 2007. They provided HIV information to 17,931 young people. |
Viet Nam

Viet Nam appears to be experiencing a rapid increase in its epidemic, mainly driven by injecting drug use and unprotected sex among sex workers and clients. There is also a more general concern that Viet Nam is witnessing a growing number of orphans, street children, child labourers, child sex workers and trafficked children who are highly vulnerable not only to HIV but also to various forms of neglect and abuse.

There has been a strong political commitment to confront HIV, and the Government has shown a strong commitment to addressing the needs of children and HIV. In cooperation with UNICEF and other partners, it hosted the East Asia and Pacific Regional Consultation on Children and HIV and AIDS. Following the consultation, Viet Nam developed its own national plan of action on children and HIV and AIDS. It has also taken other actions such as a study of vulnerability of young people to HIV and AIDS and conducted a legal review on children affected by HIV and AIDS in Viet Nam.

HIV and AIDS

- Cumulative reported data as of 31 August 2007 are 132,628 cases of HIV infection; 26,828 cases of AIDS; and 15,007 deaths due to AIDS (UNGASS, Feb 08).
- Prevalence in the general population is estimated at 0.53 per cent. According to the 2005 Estimation and Projection Report, there were an estimated 293,000 people living with HIV in 2007 (UNGASS, Feb 08).
- Of all reported HIV cases, 78.9 per cent are in the age group 20–39, with males accounting for 85.2 per cent of total reported HIV cases (UNGASS, Feb 08). In 2006, however, it was estimated that one third of new HIV infections occurred among women.
- Main risk factors associated with HIV infection are the use of contaminated injecting equipment and unprotected sex with non-regular partners or sex workers.
- The average prevalence nationwide among IDU is 28.6 per cent and female sex workers is 4.4 per cent, but the rate differs between cities/provinces (UNGASS, Feb 08).
- Increasing numbers of women are acquiring HIV from men who were infected during unsafe paid sex and injecting drug use.

National response

- National Plan of Action (NPA) on Children and HIV and AIDS near completion
- NPA on Care and Treatment (2007), which includes specific targets on children
- NPA on PMTCT (2007)
- NPA on IEC and BCC (2007)
- NPA on Harm Reduction (2007) for MARP including youth
- Master plan for Adolescent Reproductive Health (2006)
### Viet Nam

- **NPA for Reproductive Health and HIV and AIDS prevention education in secondary schools (2007)**
- **Approved M&E framework for HIV and AIDS (2007)**
- **Law on Prevention and Control of HIV (2007)**
- **National ART, palliative care, PMTCT and OST guidelines**

### Assessments
- **Study on vulnerability of young people to HIV and AIDS focusing on children in institutions (2006)**
- **Legal review on children affected by HIV and AIDS in Viet Nam (2007)**
- **Estimation and Projection Package (EPP) and Spectrum that generated estimates on children infected and affected by HIV and AIDS (2007)**
- **Assessment on Orphans and Vulnerable Children (2006/07)**
- **Child Fora with HIV affected children (2007)**
- **Situation Analysis on Children and HIV and AIDS in preparation for the drafting of the NPA (2007)**
- **National Assessment on PMTCT that informed the drafting of the guidelines (2006)**
- **End project assessment of the UNICEF supported PMTCT pilot (2007)**
- **Preparations for Survey Assessment of Vietnamese Youth 2 in progress**
- **Research on street children and HIV in progress**
- **Preparation for Survey on Assessment of Viet Nam Youth (SAVY) II**
- **Preparation for study of vulnerable children, including children affected by HIV and AIDS**
- **Community Home-Based Care assessment in progress**

### PMTCT
- **In 2006, there were 948 facilities providing ANC which also provided HIV testing and counselling for pregnant women.**
- **By September 2007, there were 26 facilities providing ANC which also provided HIV testing and antiretrovirals for PMTCT.**
- **In 2007, 138,682 pregnant women tested for HIV. 479 pregnant women tested HIV positive (<0.4). By way of comparison, in 2005, 25,657 pregnant women were tested for HIV and 659 pregnant women tested HIV positive.**
- **From October 2006 to September 2007 (information available only for PEPFAR supported sites), 744 HIV-infected pregnant women received antiretrovirals to reduce the risk of mother-to-child transmission.**
- **Review of PMTCT pilot project was conducted at each district site. Primary prevention activities were carried out at the community level, while HIV testing and counselling were integrated into ANC services. Pregnant women found to be HIV-positive were referred to appropriate sites for treatment for themselves and for PMTCT for their newborn.**
- **Final PMTCT pilot project assessment is being carried out.**

### Paediatric treatment
- **In September 2007, 789 HIV-infected children were receiving antiretroviral treatment. By way of comparison, in 2005 there were 252 HIV-infected children receiving antiretroviral treatment.**
- **In 2007, 30 facilities were providing paediatric ART.**
| Prevention | • National Programme of Action for HIV and RH Education in Secondary Schools was developed and approved by Ministry of Education and Training (2007).
• Peer education life-skills-based programme for primary HIV prevention was established in 2007 in vocational schools under Ministry of Labour, reaching over 30,000 youth and in universities reaching over 40,000 youth.
• UNICEF-supported Healthy Living and Life Skills pilot project being evaluated to inform national policy and scaling up
• ADB-funded project “prevention among young people” started and on-going, addressing most-at-risk adolescents’ issues as well |
| Protection and care | • Pilots and small-scale implementation of alternative care and comprehensive care for OVCs
• Pilots on family-centred care
• National child protection strategy under development
• Guidance document on re-integration, community-based alternative care and increased social grants for vulnerable children |