

06



# HIV/AIDS

**ADOLESCENTS  
WOMEN AND CHILDREN  
DATA ISSUES**

For every child  
Health, Education, Equality, Protection  
**ADVANCE HUMANITY**

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## SITUATION REVIEW ON ADOLESCENTS AND HIV/AIDS

**Table 6.1** The number of people living with HIV/AIDS

Region	Year	Adults and children living with HIV/AIDS	Women living with HIV/AIDS	Adult and child deaths due to AIDS
Southeast Asia*	2003	1.5 million	440,400	107,500
	2001	1.3 million ↑	382,300	92,900 ↑
East Asia**	2004	1.1 million	194,900*	51,000
	2002	760,000 ↑	134,000* ↑	37,000 ↑
Oceania**	2004	35,000	7,100	700
	2002	28,000 ↑	5,000 ↑	500 ↑

**Source:** \* 2004 Report on the Global AIDS Epidemic, June 2004  
\*\* UNAIDS/WHO AIDS Epidemic Update, December 2004

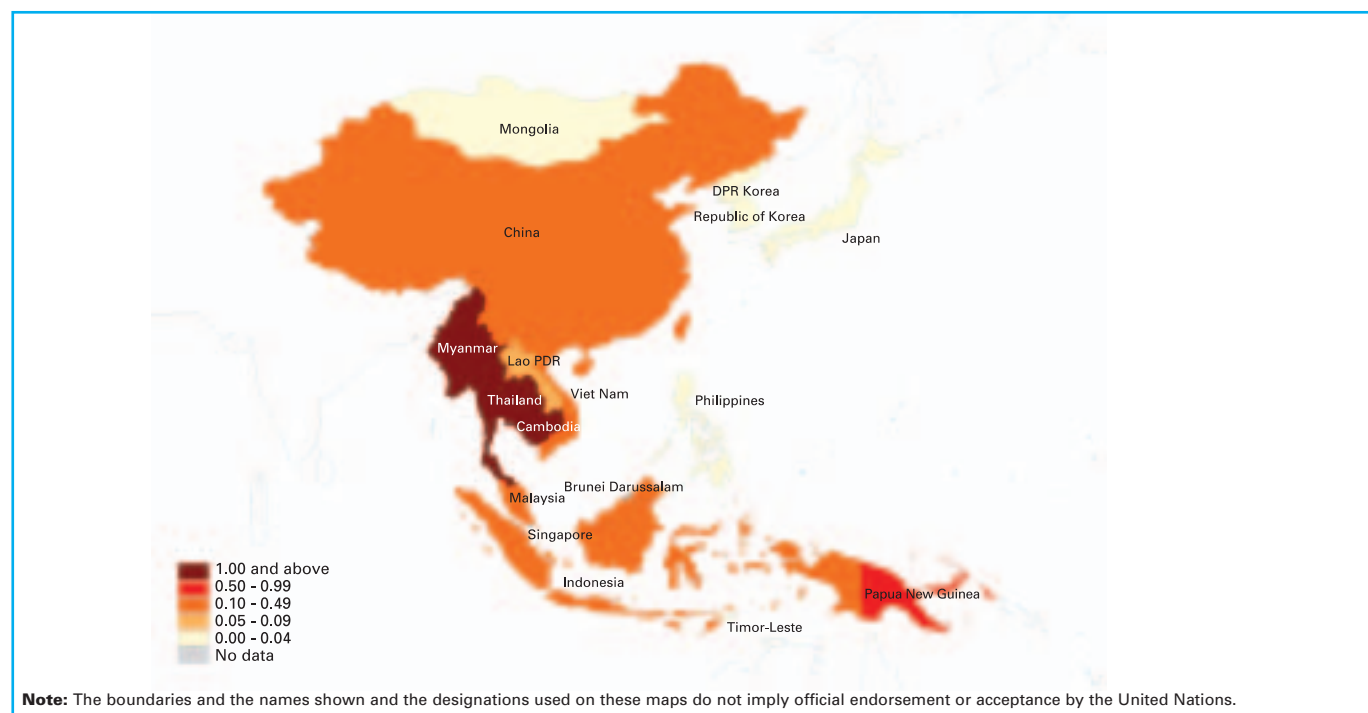
The number of people living with HIV continues to grow in every region, with the steepest increases occurring in East Asia where HIV incidence has increased by 50 per cent between 2002 and 2004.

In some countries in the East Asia and Pacific region the epidemic has progressed from a concentrated to a generalized epidemic.<sup>1</sup> However, the majority of countries are at a relatively early stage where effective actions can result in a quick turnaround in the incidence of HIV infection. Such actions call for

governments, including in those countries that already have wider epidemics, to accelerate responses to thwart the spread of HIV/AIDS, especially among the most vulnerable groups.

New epidemic trends in the region are revealing a gradual encroachment of HIV/AIDS among younger populations, and increasingly among girls. In Thailand, around 70 per cent of the young people now living with HIV/AIDS are girls and young women between ages 15 and 24.<sup>2</sup> In Malaysia, 35 per cent of reported

**Figure 6.1** HIV/AIDS prevalence in Asia at the end of 2003



**Source:** Adapted from 2004 report on the Global AIDS Epidemic, UNAIDS 2004

<sup>1</sup> A concentrated epidemic is where 5 per cent or more of high-risk groups are HIV-infected; a generalized epidemic is where 1 per cent of pregnant women are infected  
<sup>2</sup> Bureau of AIDS, TB and STIs, Department of Disease Control, Ministry of Public Health, Thailand, 2004

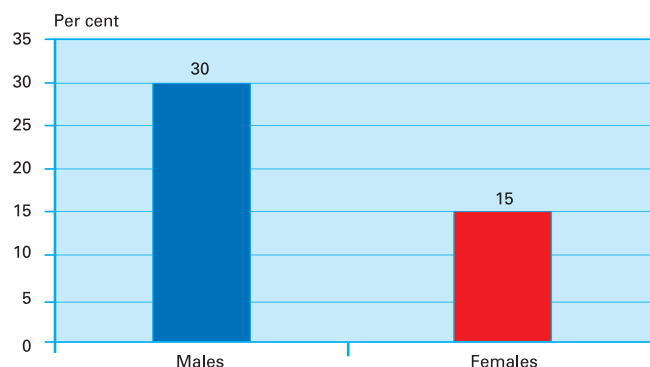
HIV infections occur among those below 29 years old, including 1.6 per cent between the ages 13 and 19.<sup>3</sup> Young people who are especially vulnerable to HIV include: the unemployed; the displaced; those who migrate for work or work in informal sectors; those who hold odd jobs or are engaging in commercial sex work; those who are living in institutions, living on the street or injecting drugs; those in families that use drugs; and young men who have sex with men. In addition many young people, including school students, are increasingly exposing themselves to the risk of HIV by having multiple sex partners.

A recent survey conducted among 6,700 female students across 24 provinces of Thailand showed that 1,448 were already sexually experienced.<sup>4</sup> About 500 were forced by their partners to have sex the first time, mostly with older men, and 80 students admitted to having had more than 20 casual partners. Thailand's laudable tracking of new behavioural patterns among young people demonstrates one of the key, essential steps governments can take towards the design of effective prevention strategies. However, regular monitoring through knowledge and cross-sectional surveys, behavioural surveillance and the analysis of findings for policy and programmatic responses is still not a common practice in most countries within the East Asia and Pacific region. In addition, many young people in East Asia and the Pacific, despite the regions notable economic performance, continue to have scant access to health information, as well as the necessary skills and services to shield themselves from the risks of HIV.

**Young women at even higher risk of infection than young men**

Based on estimates from the end of 2001, young women and girls already constitute more than half

**Figure 6.3 Early sex: 23% of youth in the Philippines have engaged in pre-marital sex**

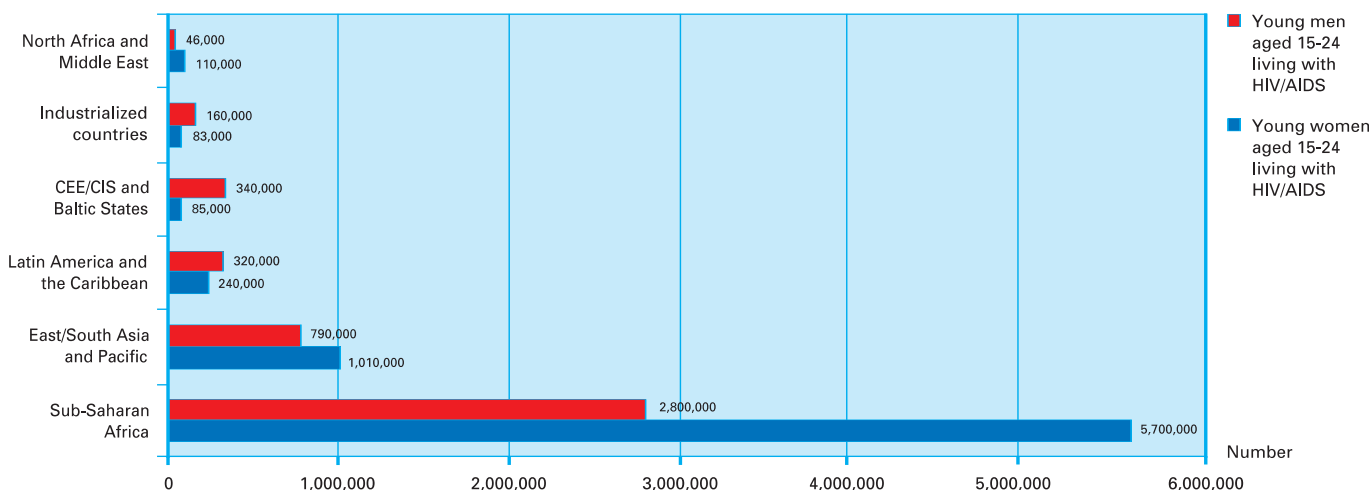


Source: State of the Philippines Population Report 2: PINOY YOUTH; Making Choices, Building Voices, 2002

of young people living with HIV/AIDS in the Asia and Pacific region. A host of social and economic factors are exacerbating the vulnerability of young women and if they are already living with HIV, they often suffer more severe stigma and discrimination than males and are denied equitable access to care and drugs when they fall ill.

Cultural norms about sex, once a protective factor among young people, are changing. Many earlier assumptions about sexual prohibitions among asian adolescents are no longer valid. Although it is often denied, many adolescents – even in the most traditional societies – are becoming sexually active. The State of the Philippine Population Report 2: PINOY YOUTH: Making Choices, Building Voices, 2002<sup>5</sup> found that in a sample of 15 to 25 year olds 30 per cent of males and 15 percent of females reported having had premarital sex.

**Figure 6.2 Young people aged 15-24 living with HIV/AIDS by region and sex, end 2001**



Source: UNAIDS/WHO Epidemiological Fact Sheet - 2004 Update

<sup>3</sup> Department of Disease Control (AIDS/STIs), Ministry of Health, Malaysia, 2004

<sup>4</sup> Bureau of AIDS, TB and STIs, Department of Disease Control, Ministry of Public Health, Thailand, June 2004

<sup>5</sup> State of the Philippine Population Report 2: PINOY YOUTH: Making Choices, Building Voices, UNFPA, 2002

Adolescents across the region may adopt risky behaviours because they are poorly informed about their bodies, sexuality, reproduction, and the consequences of unprotected sex. Many also lack the skills to say no to unwanted sex or to negotiate safer sex. Due to gender-based discrimination, adolescent girls often find it difficult to avoid coercion and are forced into sexual relations. In 2003, less than 50 per cent of sexually active young males in Thailand, India and Indonesia used a condom during sexual initiation with, or regular visits to, sex workers.<sup>6</sup>

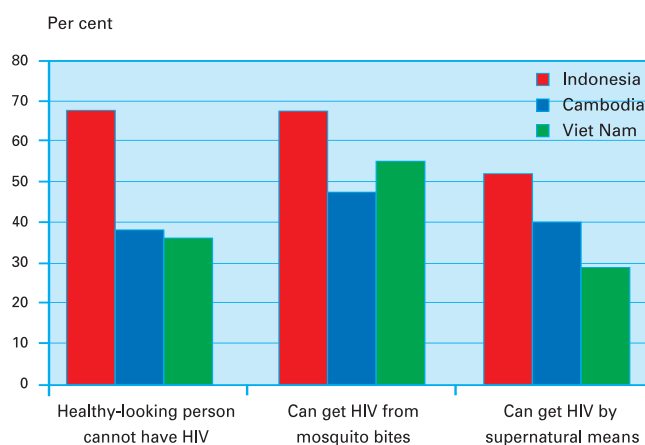
The use of alcohol and drugs is one contributing factor to unsafe sex. Most of the young people attending drug rehabilitation at Yayasan KITA, an NGO in Indonesia, were no strangers to drugs by the age of 15. The youngest reported experimentation with smoking was at four years old, and with alcohol eight years old. By the age of 16 years, many have already begun using heroin, or had their first experience with heroin through injection.<sup>7</sup>

Although knowledge alone is inadequate, the lack of access to correct information and understanding about HIV/AIDS are still obstacles to prevention. In a 2004 survey conducted by the Ministry of Education in China, junior and senior high school students identified the formal school curriculum, extra-curricular activities, and peer education as the desired and most appropriate modes of prevention education. However, almost 80 per cent said they had never participated, while at school, in courses or in special activities related to HIV/AIDS prevention and education.<sup>8</sup>

Although the epidemic in Asia is now more than two decades old, the basic knowledge of HIV/AIDS and how it is transmitted is disturbingly low among young people. Approximately 61 per cent of Indonesian young women aged 15 to 19 know about AIDS, but they do not know how to protect themselves from HIV. In Timor-Leste, 79 per cent of women and 70 per cent of men had never heard of HIV/AIDS.

Clearly, opportunities are being missed to reach young people and to build their capacity to reduce their own HIV risks. Adolescents can be the key to controlling the epidemic but they need to have the knowledge and skills to protect themselves from an early age. We know that early adolescence and puberty, from the ages of 10 to 14, brings physical and emotional changes that strengthen sexual feelings. It is also a time when enduring patterns of healthy behaviour can be established and imparting knowledge and skills should be done in the context of children's and young people's general development. With concerted action, governments can ensure that children enter adolescence equipped to make the choices that will allow them to live free of HIV. It is critical that these efforts be initiated in the vital years before adolescents become sexually active.

**Figure 6.4 Popular misconceptions about HIV/AIDS among young women aged 15-24**



Source: The Global Response to HIV/AIDS Epidemic, 2003

Furthermore, in areas where HIV infection rates are declining or subsiding, it is primarily because supportive environments have enabled young men and women to practise safer behaviours.

However, the sometimes negative attitudes of service providers, issues of non-confidentiality, unfriendly services and inappropriate opening hours or locations are often why adolescents fail to seek sexual and reproductive health services, even when such services are available.

### International commitments

Most governments in Asia and the Pacific adopted, at the United Nations General Assembly Special Session on HIV/AIDS in June 2001, a Declaration of Commitment outlining specific, time-bound goals and targets for overcoming the pandemic. A major goal was targeted at young people:

*By 2005, ensure that at least 90 per cent, and by 2010 at least 95 per cent, of young men and women aged 15 to 24 have access to the information, education, including peer education and youth-specific HIV education, and services necessary to develop the life skills required to reduce their vulnerability to HIV infection; in full partnership with youth, parents, families, educators and health-care providers.*

### National actions

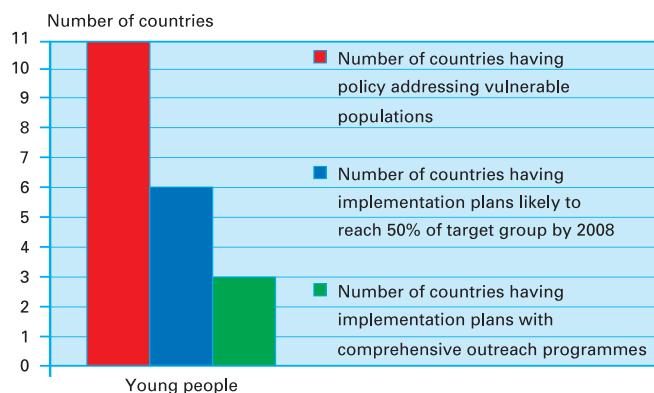
Many countries across the region have developed plans to address HIV/AIDS among young people. Prevention education and provision of youth-friendly health services are already stipulated in national strategies. However, programmes for institutionalized capacity building and sectoral policies in health, education, welfare, labour and social justice that are all vital to implementing and supporting this strategy remain few and far between.

<sup>6</sup> Keiwkamka B, Thephtien B, Wongsawas S (2003), The Behavioural Surveillance Survey of 7 Target Groups in Bangkok, 2003; Behavioural Surveillance Survey in Maharashtra India, 2001, Indonesia Behavioural Surveillance Survey in 13 Provinces 2002-2003.

<sup>7</sup> Summary Document of Young People's Participation at the 14<sup>th</sup> International Conference on the Reduction of Drug Related Harm, Chiangmai, Thailand, UNICEF, April 2003

<sup>8</sup> Baseline Survey on Knowledge and Attitude to HIV/AIDS Prevention and Adolescence of Middle School Students in Rural China, UNFPA - MOE Project Office, 2004.3 Beijing

**Figure 6.5 Many countries plan to address the needs of young people, but few have the programmes in place that are needed to be effective**



Source: ADB-UNAIDS Study Series 2004

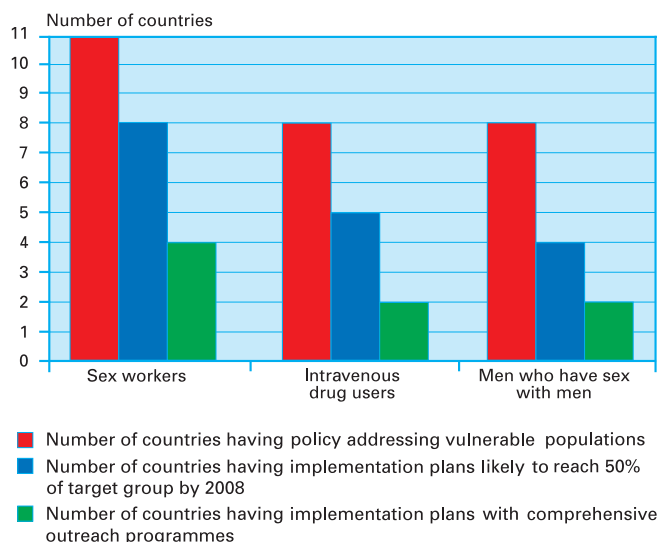
Interventions focused on the most highly vulnerable young people are often said to be the key to slowing or halting the epidemic. However, capacity is clearly inadequate in many countries, and includes an insufficient availability of human and financial resources, as well as a lack of systematic tracking for behavioural trends and risks. Furthermore, social attitudes towards those most at risk, – who are usually already marginalized and discriminated against because of their behaviours, – remain obstacles which hamper effective preventive measures.

### Recommended actions

As a priority, accelerated responses are needed to:

- **Break the silence surrounding HIV/AIDS**, address stigma and discrimination, and engage young people as partners to curtail the pandemic;

**Figure 6.6 Likewise many countries plan to address high risk behaviours, but few have the comprehensive, nationwide outreach programmes needed to be effective**



Source: ADB-UNAIDS Study Series 2004

- **Ensure that all children and young people are thoroughly informed about HIV/AIDS** and have every opportunity to develop the life skills they need to reduce vulnerability and risky behaviours;
- **Reduce the vulnerability of children and young people** at particularly high risk of HIV infection, by identifying who are at risk, by improving the tracking of emerging behaviours that expose them to HIV risks, and by designing focused, targeted interventions such as condom promotion and other means of harm minimization. As a general measure, all prevention efforts need to pay special attention to girls – especially interventions that will increase their capacity to perceive risk, and provide peer support for counselling and protection;
- **Promote and expand access to youth-friendly health care**, including voluntary and confidential HIV counselling and testing, condoms and the treatment of sexually transmitted infections;

A combination of long-term and short-term measures is vital to preventing the further spread of HIV/AIDS. Addressing issues of vulnerability, such as increasing the proportion of girls staying in school and strengthening the capacity of schools to respond to HIV/AIDS, will have to go hand in hand with promoting responsible male partnerships and participation, as well as addressing gender inequity, violence, discrimination and unequal power relations. Even though HIV/AIDS is often an outcome of risk behaviours, large-scale behaviour change will not happen unless structural determinants are concurrently addressed to engender social change.

HIV/AIDS is a disease fuelled by poverty, inequality and the ignorance or denial of risk to oneself. In the few minutes it has taken to read these pages, a dozen young people will be infected with HIV somewhere in the world. HIV has become a disease of the young, with yearly 6,000 infections occurring among 15 to 24 year olds every day.

No single organization can defeat HIV/AIDS and therefore partnerships at all levels are crucial for an effective response. National governments, people living with HIV/AIDS, NGOs, civil society and faith-based organizations, as well as UN agencies, need to work closely together. An alliance of resources and political will are essential to changing prevailing attitudes and social norms and practices through continuous advocacy, communication and social mobilization initiatives. Ingredients for successful prevention include raising HIV/AIDS awareness, promoting the adoption of healthy lifestyles, improving access to condoms and enlisting policymakers' support for the needs and rights of adolescents. Prevention efforts must be aimed at school-age children and young people in general, as well as providing focused interventions for those most at risk. All this will come about only when young people themselves are central actors in the planning, implementation and monitoring of programmes that affect them.

## SITUATION REVIEW ON WOMEN, CHILDREN AND HIV/AIDS

### The issue: more women and children are infected

An estimated 1,700 children under the age of 15 are infected by HIV around the globe every day. Many of these are young children, infected at birth by mothers who are unaware of their HIV status. The number continues to rise as more women are infected by partners who adopt high risk behaviours such as injecting drugs, buying sex, and having multiple sexual partners.

One recognizable pattern of HIV transmission starts with sudden increases among groups that practice high-risk behaviours, following which the epidemic spreads to the general population. This pattern has been seen in parts of East Asia and the Pacific. Commercial sex workers, their clients and/or injecting drug users no longer form the bulk of new infections in countries such as Thailand, Myanmar, Cambodia, and parts of Viet Nam and China. The epidemic profile is shifting towards wives infected by their husbands who are often their only sexual partners.

The growth of HIV prevalence among pregnant women – as the virus infects groups with low risk behaviours – is thus a sign that the epidemic is encroaching on the general population. HIV prevalence among women of reproductive age in East Asia and the Pacific is showing an upward trend (see figure 6.7). The estimated number of HIV positive women has gone up by 24 per cent from 518,900 to 646,000 between December 2001 and 2003. In China, women accounted for 39 per cent of all HIV cases in 2004.<sup>1</sup> Increased infection of wives leads to increased HIV transmission to newborns. Reliable country-level data

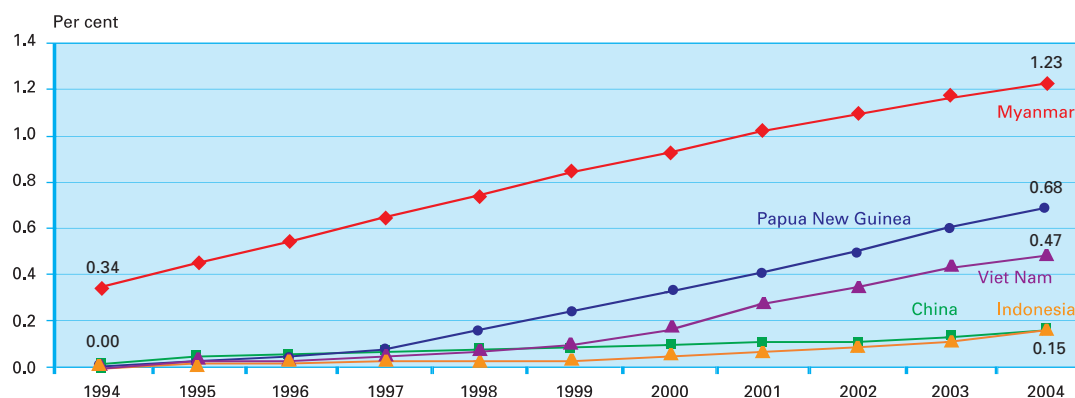
on the numbers of children infected is very limited, but UNAIDS estimates a total of about 168,000 children in the Asia and Pacific region were living with HIV by the end of 2003, up from 136,000 at the end of 2001. Regular assessments are needed to gather information on the numbers of children infected as well as those affected by HIV/AIDS.

Figure 6.7 shows a continuous rise of infections among pregnant women in some countries which will result in more infants being infected at birth. Moreover, many young people have become trapped by drugs and adolescent girls remain vulnerable to sexual abuse, and to being drawn into the sex trade.

Available data for Papua New Guinea and the eastern Indonesian province of Papua, for instance, reflect a rapidly growing epidemic similar to that experienced in sub-Saharan Africa. In Papua New Guinea the high levels of HIV among pregnant women show an increasingly generalized epidemic. In late 2003, 1.1 per cent of pregnant women in Port Moresby and 2.5 per cent in Lae, in the central highlands, were found to be HIV positive. By 2004, Papua New Guinea had reported 10,184 cases, about half of them women, and including 855 children below the age of 18. Behavioural surveillance data indicate that cultural factors (in particular the high level of sexual partner exchange among young people) are fuelling the epidemic.

Even the Pacific Islands are not being spared. Though data are limited, 940 HIV cases have been reported in the Pacific Island countries (excluding Papua New

Figure 6.7 HIV prevalence among pregnant women in selected countries



Source: UNAIDS/UNICEF/WHO Epidemiological Fact Sheets on HIV/AIDS and sexually Transmitted Diseases, 2004

<sup>1</sup> A Joint Assessment of HIV/AIDS Prevention, Treatment and Care in China, State Council AIDS Working Committee Office & UN Theme Group on HIV/AIDS in China, 2004

Guinea). Although the total number is still low compared to other countries in the region, the trend in new infections is a major cause for alarm. These countries also report high rates of sexually transmitted infections, a known risk factor for HIV transmission. Unprotected sex represents the primary risk, and the majority of new infections occur among young adults. **Figure 6.8** shows the number of HIV/AIDS cases reported in 15 Pacific Island countries and territories. In neighbouring Australia, the number of women living with HIV/AIDS has increased from 800 to 1,000 between 2001 and 2004, and New Zealand has reported close to 200 cases of women infected.

For the Pacific Islands and other countries such as Timor-Leste, Mongolia and the Philippines with a national prevalence below 0.1 per cent (considered low prevalence) there is currently a remarkable window of opportunity to halt the impending scourge of AIDS. Proactive responses including: regular cross-sectional surveys; sentinel and behaviour surveillance; the screening of sexually transmitted diseases; public education; and focused, targeted outreach will substantially reduce disease burdens over the coming years. Public knowledge of HIV/AIDS can be an initial indicator in regard to the level of action needed. The latest Demographic and Health Survey (2003) of Timor-Leste, for instance, showed that only two per cent of men and women could identify two or three ways of preventing HIV/AIDS. In the Philippines, a national survey showed that only 53 per cent and 44 per cent of women and men, respectively, are aware that the sharing of food does not transmit HIV/AIDS. Only 19 per cent

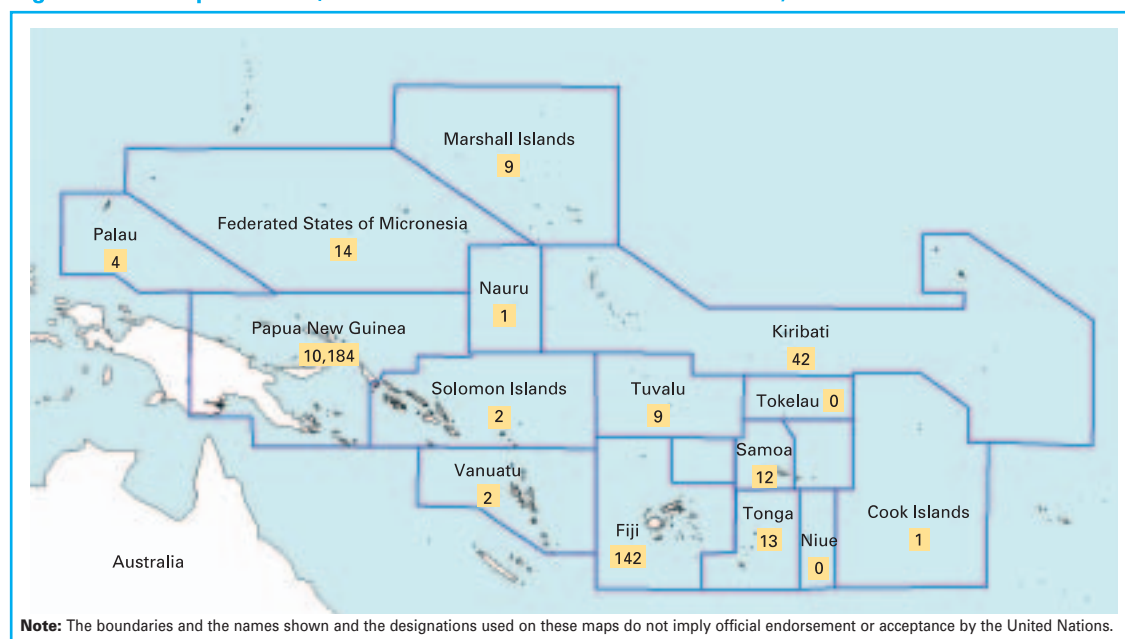
of young adults, in a separate survey in December 2004, could correctly identify ways to prevent HIV transmission, whereas 32 per cent said HIV could be transmitted through saliva. A previous survey in 2002 found that 73 per cent of young people in the Philippines believed they could never get HIV and AIDS, and 28 per cent believed AIDS was curable.

### Children and HIV/AIDS

Children are susceptible to HIV not only from mother-to-child transmission, but also from unsafe blood transfusions and unsafe injections. Surveillance systems established so far have not yet captured the scale of the problem and only a few countries in the region, Cambodia (7,300), Myanmar (7,600) and Thailand (12,000), have reported on the estimated number of children infected.<sup>2</sup>

Although HIV is spreading among the young, a larger number of children are left with the prospect of becoming orphans as AIDS progresses among adults. The collection and reporting of data on children affected or orphaned by AIDS is lacking in most countries due, in part, to the difficulty of arriving at a reliable estimate of numbers of AIDS orphans in concentrated or low-level epidemics – the state of many countries in East Asia and the Pacific. UNICEF, USAID and UNAIDS estimate that over two million children in the region have lost both parents, although it is not known what proportion is a result of AIDS.<sup>3</sup> Recent assessments conducted by UNICEF indicate that the number of children orphaned due to AIDS is approximately 289,000 in Thailand, 265,000 in Viet Nam, 52,000 in

**Figure 6.8** Reported HIV/AIDS cases in 15 Pacific Island countries, 2001-2003



**Source:** Secretariat of the Pacific Community, May 2004

<sup>2</sup> Report on the Global AIDS Epidemic, UNAIDS, 2004

<sup>3</sup> Aggregates of countries in East Asia and the Pacific from "Children on the Brink", USAID, UNAIDS and UNICEF, 2004

Cambodia and 40,000 in Myanmar.<sup>4</sup> Official data from China show about 76,000 children have lost both parents to AIDS, and current estimates project a dramatic escalation of AIDS orphans in China, reaching between 150,000 and 260,000 by 2010. The rapidly expanding epidemic presents the great challenge to policy makers of ensuring high-quality protection and care both for children infected and affected, particularly considering the stigma attached to the disease.

### Strategies to prevent mother-to-child transmission

In June 2001, the United Nations General Assembly Special Session on HIV/AIDS generated an unprecedented level of global leadership, awareness and resource mobilization in response to the HIV/AIDS emergency. A Declaration of Commitment adopted at the Special Session specifies time-bound goals and indicators to measure progress and to ensure accountability. In the Declaration, governments determined that together with partners, they would reduce the proportion of infants infected with HIV by 20 per cent by 2005, and by 50 per cent by 2010, by ensuring that 80 per cent of pregnant women receiving antenatal care have access to:

- information, counselling and other HIV prevention services;
- voluntary and confidential counselling and testing, and effective treatment (antiretroviral therapy and infant feeding support) to reduce mother to child transmission of HIV; and
- access to treatment for opportunistic infections and HIV, especially anti-retroviral therapy and the provision of a continuum of care for HIV-positive women and their families

Approximately two thirds of HIV transmission from mothers to newborns occurs during pregnancy, labour

or delivery, with the remainder occurring as a consequence of breastfeeding. The rate of mother to child HIV infection in developing countries, in the absence of measures to interrupt transmission, can be as high as 45 per cent. There are four components, recommended by UN specialized agencies to facilitate the effective prevention of mother-to-child HIV/AIDS transmission. These are:

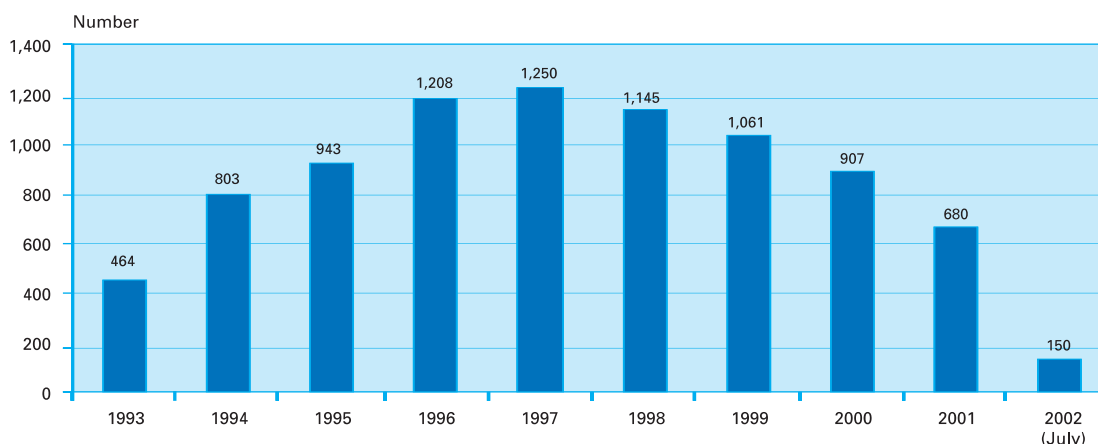
**Component I: Preventing HIV infection in all people, particularly young women.** Even though there is a compelling need to prevent infection among young children who acquire HIV from their mothers, preventing women or mothers from getting infected in the first place should be the top priority. This will involve educating women and men about HIV/AIDS and ways of reducing HIV risks, providing access to condoms, buttressing women's role in society and in the household, and increasing men's responsibility for stemming the spread of HIV.

**Component II: Prevention of unintended pregnancies among HIV-positive women.** Strengthening reproductive health and family planning services so that all women, including those that test HIV positive, are given the means and the support to avoid unintended pregnancy.

**Component III: Reduction of HIV transmission from HIV-infected women to their infants.** Increasing access to voluntary and confidential HIV counselling and testing, antiretroviral therapy, safe delivery practices, and counselling and support on infant-feeding methods.

**Component IV: Provision of a continuum of care and support for infected women, children and families.** Improving access to prevention, anti-retroviral therapy, early diagnosis and treatment of opportunistic infections, psycho-social support and economic and legal support.

Figure 6.9 Number of AIDS cases of children 0-4 years old from mother-to-child transmission, Thailand



Source: Monthly Epidemiological Surveillance Report, December, 2002

<sup>4</sup> HIV/AIDS: A New Development Challenge, Susan Hunter, 2004

Many of the current national-level prevention of mother-to-child transmission (PMTCT) interventions are focusing on the antiretroviral aspects of components three and four. However, while access to antiretrovirals for both PMTCT and the treatment of advanced HIV is essential, a holistic approach encompassing all aspects is needed to have a long range impact that can alter the course of the epidemic.

The success of Thailand in reducing MTCT is a good example of holistic approaches. **Figure 6.9** shows that much of the success in reducing the number of AIDS cases among children between the ages of 0 and 4 already started before the introduction of antiretrovirals in the late 1990's. By the mid nineties, the basis for successful PMTCT had been established through the reduction of HIV prevalence among pregnant women.

### The challenge of treating children with HIV

Most children with HIV need a more intensive course of treatment compared to HIV-positive adults, and therefore require unique care and support measures. Without care and antiretroviral treatment, a significant proportion of children living with HIV in poor countries will die before age five – as many as 30 per cent are dying before their first birthday and 50 per cent before the age of two. However, with sustained care and support these children will have a good chance of growing and developing to their full potential. While the price of antiretroviral drugs has come down steeply in the past few years and funding and international commitment for access to antiretroviral has increased (e.g. the 3x5 Initiative and the Global Fund for AIDS, TB and Malaria), the current challenge is to provide treatment for children living with HIV. Current problems include:

- Limited expertise in terms of the diagnosis of HIV in infants and paediatric HIV treatment, and difficulties in quantifying the disease burden among children;
- Lack of simple and cheap screening methods that would facilitate the identification of infected children early enough to prevent and treat opportunistic infections;
- Lack of simplified paediatric liquid formulations for the youngest children who cannot swallow pills;
- Difficulties of monitoring drug toxicities and resistance levels among young children, whose symptoms may be different from those observed in adults;

- Difficulties with instituting a comprehensive treatment and care approach which, given that HIV/AIDS is a chronic illness, is often not available to children;
- Limited human resources and capacity of the health sector to provide clinical and psycho-social care for children with HIV/AIDS; and
- Difficulties in instituting a systematic and comprehensive follow-up system to monitor the health of HIV-positive infants.

### Prevention and early action are key

The future course of the epidemic among children and women in East Asia and the Pacific will be determined by the pace by which evidence-based interventions<sup>5</sup>, known to be effective in averting or reversing the spread of HIV/AIDS, are scaled up at the national level. The following actions are key to implementing a comprehensive prevention and care strategy aimed at reducing the risks of HIV/AIDS for women and children:

- HIV-prevention efforts that take into account **gender, economic and social disparities**, and that positively influence the extent to which women can exert control over their choices, and subsequently, reduce their vulnerability to HIV;
- Primary prevention of HIV among women of reproductive age expanded through the promotion of research, and increased access to **HIV/AIDS information, life-skills, sexual and reproductive health education** – in and out of schools – as well as access to HIV-prevention methods that include female-controlled methods, such as microbicides;
- Improve access to diagnosis and **treatment of sexually transmitted infections (STIs)**;
- Support ongoing programmes targeting **universal education for girls**;
- Facilitate the timely diagnosis of HIV infection through increased access and use of **voluntary confidential counselling and testing**, followed by access to antiretroviral drug prophylaxis for women and newborns, as well as the treatment of opportunistic infections and STIs;
- Integrate **HIV prevention and care into sexual and reproductive health services** and improve referral systems to increase women's and children's access to treatment and care services;
- Increase efforts aimed at preventing new infections among women and children caused by **unsafe blood transfusions and injections**; and
- Capacity-building to improve **clinical and psycho-social care** management for children living with HIV/AIDS.

<sup>5</sup> For further reading on what constitutes a comprehensive package of evidence-based interventions, please refer to "Costing Guidelines for HIV/AIDS Interventions Strategies", ADB-UNAIDS Study Series: Tool 1, UNAIDS and Asian Development Bank, February 2004

# SITUATION REVIEW ON USING DATA TO GUIDE HIV/AIDS PREVENTION AND CARE

Table 6.2 National and provincial HIV prevalence in selected countries of East Asia and the Pacific\*

Country	National prevalence 2003 %	HIV prevalence in selected provinces/sites and among certain sub-populations							
		Pregnant women (antenatal) %		Injecting drug users %		Female sex workers %		Blood donors %	
Cambodia	1.9	Pailin Province	5.9	-	-	Koh Kong Province	51	-	-
						Siem Reap Province	37		
						Kampong Chhnang Province	37		
China <sup>a</sup>	0.1	8/18 sentinel surveillance sites (2003)	0.3-5.3	Yili, Xinjiang Province (2003)	89	Selected areas of Yunnan, Guangxi, Guangdong & Hunan Provinces	1-6.7	Selected areas, Henan Province	>40
				Yunnan and Guangxi Province (2003)	>20			Shuizhou, Hubei Province	33.7
				Wushi, Qinghai Province (2000)	38			Heze, Shandong Province	8.9
Indonesia	0.1	Papua Province (five villages)	1.0	Bali <sup>b</sup>	53	Sorong, Papua	17	-	-
Lao PDR	0.1	-	-	-	-	Vientiane (2001)	1.1	-	-
						Savannakhet Province (2001)	1		
Malaysia	0.4	All government antenatal clinics <sup>d</sup>	0.05	States in Eastern region <sup>c</sup>	36	Kuala Lumpur <sup>d</sup>	6.9	Peninsular	0.03
				States in Southern region <sup>c</sup>	24			Kelantan <sup>e</sup>	0.12
Mongolia <sup>f</sup>	<0.1	National STI prevalence (Antenatal care survey 2002)	31 (STI)	-	-	Ulaanbaatar (women reporting at least one STI)	67	-	-
Myanmar	1.2	Dawei Province	4	Yangon	54	Yangon (2001)	26	-	-
				Mandalay	56				
				Myitkyina & Bhamo	53				
				Lashio	56				
Papua New Guinea	1.7 <sup>g</sup>	Lae	2.5	-	-	Port Moresby (2000)	16	Port Moresby (2003)	0.38 <sup>g</sup>
		Daru	0.6	-	-				
Philippines <sup>h</sup>	<0.1	-	-	Cebu City	2	9/10 surveillance sites, including Cebu, Davao and Pasay Cities	>=1	-	-
Thailand <sup>i</sup>	1.5	Trat Province	4.5	Bangkok	52	Phrea Province	82	National sample	0.23
						Mae Hong Son	37.5		
						Lamphun	19.7		
Timor-Leste	<0.1	-	-	-	-	Dili <sup>j</sup>	3	Dili <sup>k</sup>	0.56
Viet Nam	0.4	Lang Son Province	1.9	Ho Chi Minh City	84	Thanh Hoa	25.5	-	-

\* Unless otherwise indicated, data are derived from the UNAIDS/UNICEF/WHO Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections

<sup>a</sup> A Joint Assessment of HIV/AIDS Prevention, Treatment and Care in China (2004), by State Council AIDS Working Committee Office & UN Theme Group on HIV/AIDS in China

<sup>b</sup> Monitoring the AIDS Pandemic (MAP): AIDS in Asia: Face the Facts, 2004

<sup>c</sup> Data from Study by Zainuddin et al. 2001, National Strategic Plan of HIV/AIDS, HIV/AIDS Section, Disease Control Division, Ministry of Health, 2004

<sup>d</sup> National Strategic Plan of HIV/AIDS, AIDS STD Section, Disease Control Division, Ministry of Health, 2004

<sup>e</sup> HIV/AIDS Epidemic in Malaysia, 1986-2003, Ministry of Health, 2003

<sup>f</sup> HIV/AIDS Risk and Vulnerability: Young People and Children in Mongolia, a Strategic Framework, 2004

<sup>g</sup> Concesses workshop on HIV/AIDS in Papua New Guinea, 17-18 Nov, 2004

<sup>h</sup> Dept. of Health, National Epidemiology Center. "Status and Trends of HIV/AIDS/STI in the Philippines: 2003 Technical Report of the National HIV/AIDS/STI Surveillance System

<sup>i</sup> Bureau of AIDS, TB and STIs, Dept. of Disease Control, Ministry of Health, Thailand, 2004

<sup>j</sup> Dili STI Survey Team, 2001.

<sup>k</sup> WHO, Timor-Leste, 2004

### The issue: low national prevalence masks localized epidemics

Although overall adult HIV prevalence in Asia is low – 0.4 per cent compared to 7.4 per cent in Africa<sup>1</sup> – national prevalence varies widely. Within countries of the region, there are disturbingly high prevalence rates among some sub-populations and within various geographic areas. These locations and sub-populations are where concentrated epidemics build up, with substantially higher HIV prevalence than national prevalence levels can adequately capture. **Table 6.2** provides a snapshot of national and sub-national HIV prevalence levels in selected countries.

A marked, sudden increase of HIV prevalence has occurred among sub-populations in a number of countries, and those experiencing a generalized epidemic bring lessons about the importance of proactive, early actions. Often countries have acted too late when the prevalence among sub-populations has begun to spread through what is known as “bridge populations” or people closely associated with these sub-groups. These bridge populations include clients of sex workers, their wives and girlfriends as well as sex partners of injecting drug users and men who have sex with men.

Of equal importance is the fact that HIV prevalence increases because more people are entering the sex trade, buying sex and injecting drugs – many of whom are young. Addressing the vulnerability factors that put young people and women at risk of drug use and unsafe sex are just as necessary as tackling their exposure to HIV.

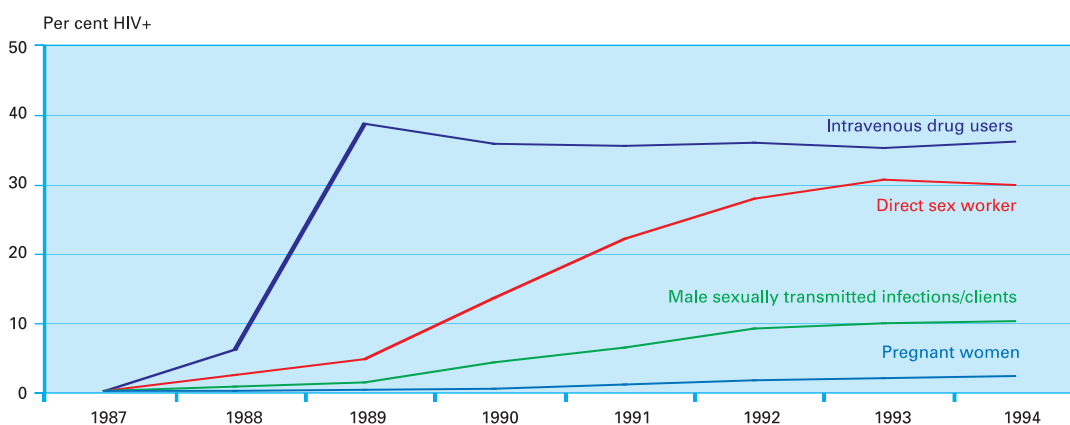
While HIV surveillance is in place in most countries, current data collection does not provide for a full understanding of vulnerability nor does it provide for the regular tracking of new behavioural patterns or for the long-term mitigation of risk. Furthermore, not all countries have instituted a regular reporting mechanism to feed provincial-level data to national authorities for the timely adjustment of policies and programmes, and preventive intervention is neither designed, improved or scaled up by acting upon the most updated sub-national surveillance data. In many countries, severe stigma and discrimination continue to undermine efforts to mount a rapid response.

AIDS is an emergency, and a pressing issue of vast socio-economic consequence. The comparatively low regional and national HIV prevalence in East Asia and the Pacific region hides a potentially explosive condition. Governments and political leaders can achieve a quick turnaround by stepping up systematic tracking and timely prevention measures, and countries that are experiencing low-level and/or concentrated epidemics still have, more than other countries, a remarkable opportunity to avoid the AIDS scourge that is now directly affecting 39.4 million people worldwide, half of whom are women.

### What drives the epidemic

The sub-populations infected with HIV in East Asia in the early stages of the epidemic were injecting drug users, commercial sex workers and men who have sex with men. More recently, young women and men not belonging to any of these sub-populations have become infected and the epidemic is rapidly

**Figure 6.10** Development of the early Thai epidemic



**Source:** Bureau of Epidemiology, Thai Ministry of Public Health; Tim Brown, *The Epidemic in Asia – Dynamics and Projections* Compilation of Presentations East West Centre/UNAIDS/Thai Red Cross AIDS Research Centre

<sup>1</sup> UNAIDS & WHO 2004, *AIDS Epidemic Update*, December 2004

spreading to the general population. Not surprisingly, infection rates among infants are also on the rise.

**Figure 6.10** shows the initial epidemic among intravenous drug users during the late 1980s in Thailand. The rise in prevalence among intravenous drug users is followed by rapid rises in infection rates among sex workers and their clients, and then by increased prevalence among pregnant women. This epidemic pattern is observed in most countries in the region. At the later stage, injecting drug users, commercial sex workers, and men who have sex with men no longer form the bulk of new infections – the epidemic shifts towards children and women who are being infected by their male sexual partners.

### Socio-economic impact of HIV/AIDS on the increase

The number of adults and children living with HIV/AIDS in East Asia and the Pacific is already growing, with 3.3 million currently estimated as infected. The spread of HIV among sub-groups is not an issue that can be overlooked, given the pattern with which the AIDS epidemic is expanding, and, as always, the number of people affected is much higher than those infected. Children, husbands, wives and extended family members bear the brunt of the work and costs of care related to HIV infection. Though the currently low adult prevalence rates in the region do not as yet translate into a discernible impact on death rates, life expectancies or economic growth at the national level, the socio-economic consequences of the epidemic are being increasingly felt. According to UNAIDS and the Asian Development Bank:

- Many households have fallen below the poverty line due to the costs associated with HIV/AIDS;
- In Cambodia, poverty reduction could be slowed by up to 60 per cent, and in Thailand by 38 per cent as a consequence of the HIV/AIDS epidemic; and
- The resources needed for a comprehensive HIV prevention, care and treatment response in 2003 was estimated at USD1.5 billion for countries in the Asia and Pacific. However, for the same year only USD 200 million, in total, was made available by governments, the public sector and donors combined.

Without a rapidly scaled-up response in the region, there may be as many as 10 million new infections by 2010. Even if a comprehensive HIV response reaches all at high risk of HIV, the total cost of the care and treatment for the millions already infected is substantial. Any delay in response to HIV will increase those costs markedly.

### Challenges in collection of HIV/AIDS data

More than twenty years into the AIDS pandemic, the world has learned a lot about how to deal with this communicable disease. But the epidemic's continued escalation is worrisome, and there are increased concerns as to whether current data are adequate to guide interventions targeted at sub-groups and those increasingly at risk, such as young people and women. For early actions to be effective there will need to be ongoing interventions that address vulnerability and prevent more people from adopting drug use and taking up sex work. In addition, there needs to be a strengthening of capacities to convince partners of the effectiveness of condom use.

Though HIV sentinel surveillance has been established in many countries, the limited geographical coverage of sentinel surveillance does not always allow for a complete understanding of the epidemic, particularly in large countries where populations are spread out. Furthermore, while WHO has recommended the introduction of second-generation surveillance systems to examine, over time, epidemiological and behavioural trends many countries are yet to follow this recommendation. Epidemiological and behavioural data for some population groups, such as men having sex with men, and in some areas for female sex workers and intravenous drug users, are not always systematically collected which hampers efforts to understand and respond to epidemics in a timely manner.

Aside from well-identified sub-groups, there are increased concerns in regard to the absence of systematic tracking of HIV vulnerability among young people in general. Such tracking allows a national AIDS programme to design the appropriate targeting of HIV-prevention efforts in order to halt the spread of the virus. There is wide agreement that behaviour change towards the use of condoms among young people (aged 15 to 24) who do not have a regular sexual partner is an effective strategy for reducing HIV risk. However, there are as yet insufficient mechanisms to identify who these young people might be, and how to reach them. In addition, there is little consensus on what constitutes "risk groups" beyond intravenous drug users, commercial sex workers and men who have sex with men, and there are scant data on, or interest in, understanding young people's risk behaviours, nor is there systematic monitoring of knowledge levels, or of life skills-based prevention efforts conducted among particular population groups, such as young men and women between ages 15 to 24.

## Some key concepts

### HIV prevalence

HIV prevalence refers to the overall number of HIV infections in a population at a particular time. National prevalence measures the number of infections against the general population, whereas prevalence among sub-groups measures the number of infections against the estimated population of a particular sub-group. National prevalence may vary or remain constant, for example, depending on the balance between those who die from AIDS, which decreases prevalence, and the number of new infections, which increases prevalence.

### Incidence

Incidence is a measure of new infections at a particular period. A decline in the overall prevalence does not necessarily mean that new infections have been prevented. The overall prevalence can mask the incidence of HIV in different populations: some sub-groups such as female sex workers may show decline while, for others, the number of new infections may be increasing, e.g. wives and girlfriends of clients of sex workers or injecting drug users.

### Low-level epidemic

HIV prevalence does not consistently exceed 5 per cent in any vulnerable groups or sub-groups.

### Concentrated epidemic

HIV prevalence consistently exceeds 5 per cent in vulnerably groups, but below 1 per cent in women attending antenatal clinics.

### Generalized epidemic

HIV prevalence of over 1 per cent in women attending antenatal clinics.

### Second generation surveillance

Second generation surveillance systems are intended to provide a more comprehensive picture of the HIV/AIDS pandemic. WHO has developed guidelines for such surveillance, recommending monitoring of behaviours that are likely to put people at risk of infection (e.g. unprotected sex) and using supplementary sources of information, such as reproductive health surveys and surveillance of other related diseases, such as tuberculosis.

**Source:** Adapted from WHO guidelines, published in "HIV/AIDS in the Mekong Region", Policy Project, Bureau for Asia and the Near East, US Agency for International Development, June 2003

There are countries where data collection efforts are challenged by social, cultural or political sensitivities surrounding unsafe sexual practices by 'low-risk' populations, including unmarried youth and married men, or in regard to the collection of data on women exposed to forced or coerced sex.

For HIV prevention and care interventions to be effective, it is important to obtain an accurate profile of the populations infected, as well as those who are vulnerable, not only to HIV risk, but to drug use, sex work and unsafe sex. To facilitate intensified interventions including voluntary and confidential testing and counselling, age and sex disaggregated data are important, especially at the sub-national level. Focused local outreach must accompany public education, including the education of children

(beginning in primary school) to inculcate a strong sense of what constitutes a healthy lifestyle – before risk behaviours are developed. However, baseline data to guide such outreach are either unavailable, or not regularly collected or used to inform programming in most countries.

### Problems in using HIV/AIDS data for effective interventions

There is still a lack of consensus on definitions about what is being measured and/or who is being targeted for HIV/AIDS prevention or care. For example, definitions of population sub-groups such as 'vulnerable' or 'highly vulnerable youth', 'at-risk youth', 'vulnerable children' or 'children affected by HIV/AIDS' frequently vary from one government and/or agency, to another.

Data on the coverage of interventions that target certain population groups are also rarely available, and even when they are, are often limited to small-scale programmes with no impact at the national level. Age or gender disaggregated data are also rarely available.

Globally, limited data on groups such as young people and children affected by AIDS hampers the effective monitoring and reporting of progress towards the Millennium Development Goals (MDGs). Moreover, there is no regional entity tasked with systematic collection and the continuous updating of a HIV/AIDS database for the East Asia and the Pacific region, nor is there a systematic data reporting mechanism in place to facilitate cooperation between countries and regional bodies for the monitoring and timely assessment of responses. At the national level, epidemiological or behavioural HIV/AIDS surveillance data are not readily available in a 'user-friendly' manner for planning and programming purposes. As a consequence, programmes and interventions continue to be designed without the use of or reference to the latest HIV/AIDS situation.

The decentralization of behavioural surveillance systems, as has been done in many countries, poses another set of problems which includes the sustainability of high-quality data collection and reporting due to limited local capacity and financial resources as well as insufficient implementation guidance.

### Action points

The availability of data is fundamental to the effective control of HIV/AIDS and for the monitoring of progress towards national commitments, including the MDGs. The leadership of national governments and the international community is vital for the strengthening of data collection and improvements in data quality. The following steps are key to controlling the HIV/AIDS epidemic:

- Build consensus on **common definitions** of what constitutes risk groups as marked by their vulnerability to HIV/AIDS and including young people and children at risk of drug use and sex work. Similarly, build consensus on definitions in regard to children affected by AIDS, who may or may not have become orphans, and whose conditions merit special attention.
- Improve national capacity for the **design, collection, analysis and utilization** of sentinel surveillance data. For example, there is also a need to initiate systematic collection of data on the number of orphans and children affected by AIDS.
- Improve the frequency of **screening and surveillance** among sub-groups, particularly considering that the epidemic can progress very quickly within a very short period of time.
- Improve the **age, sex and occupational profiling** of risk groups and those infected in order to facilitate more effective programming and to improve the use of data for strategic planning, including prioritizing and identifying types of interventions for different population groups.
- Improve **epidemiological and survey research**, which has been to date slow in capturing the spread of HIV in new communities and among groups who are at risk as a consequence of new behavioural patterns. This would include survey research on HIV and AIDS related knowledge studies, as well as studies that investigate practices among different segments of the population.
- Improve the **tracking of social attitudes** and use findings to mount a combination of nationwide media and focused community campaigns to tackle stigma and discrimination.
- Improve the use of data for the **costing of financial and human resource** requirements, and for the mid-course adjustment of priorities and/or policies that would lead to an improved quality and coverage of programming.
- **Collaborate closely with UN agencies and international donors** for the timely sharing of national HIV/AIDS data to enable regional and global advocacy for HIV/AIDS response, to increase resources, and to facilitate improved programme design by international partners.
- **Improve evaluation of all HIV and AIDS programmes;** only through scientific research can there be certainty that programmes are yielding beneficial effects. To obtain a better picture, there is a definite need to assess changes in knowledge, attitudes, intentions, practice and HIV status regularly through behaviour surveillance, and linking such monitoring to large-scale, targeted prevention programmes.



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GO GO GIRL  
HOT STUFF  
FOR LOVE

GO GO GIRL  
HOT STUFF  
FOR LOVE

The number of people living with HIV continues to grow in every region. The steepest increase is occurring in East Asia with a 50 per cent jump in HIV incidence between 2002 and 2004.

An estimated 1,700 children under the age of 15 around the globe are infected by HIV every day. Many are young children, infected at birth by mothers who are unaware of their HIV status.

AIDS is an emergency and a pressing issue of vast socio-economic consequence. The comparatively low regional and national HIV prevalence in East Asia and the Pacific region is no cause for complacency, as it hides a potentially explosive condition.



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