CHILDREN AND HIV/AIDS IN CAMBODIA

BACKGROUND REPORT

Regional Consultation on Children and HIV/AIDS
Hanoi, Vietnam
22 - 24 March 2006
## List of acronyms

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<th>Acronym</th>
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<tr>
<td>ATS</td>
<td>Amphetamine Type Substance</td>
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<tr>
<td>ART</td>
<td>Anti-retroviral Therapy</td>
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<td>ARV</td>
<td>Anti-retroviral Therapy</td>
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<td>CRC</td>
<td>Convention on the Rights of the Children</td>
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<td>HIV</td>
<td>Human Immuno deficiency Virus</td>
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<td>AIDS</td>
<td>Acquired Immuno Deficiency Syndrome</td>
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<td>IDU</td>
<td>Injecting Drug Users</td>
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<td>MDG</td>
<td>Millennium Development Goals</td>
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<td>MoCR</td>
<td>Ministry of Cults and Religions</td>
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<td>MoEYS</td>
<td>Ministry of Education, Youth and Sports</td>
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<td>MoL</td>
<td>Ministry of Labour</td>
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<td>MoSVY</td>
<td>Ministry of Social Affairs, Veterans and Youth Rehabilitation</td>
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<td>MoWA</td>
<td>Ministry of Women Affairs</td>
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<td>MSM</td>
<td>Men Having Sex with Men</td>
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<td>NAA</td>
<td>National AIDS Authority</td>
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<td>NCHADS</td>
<td>National Centre for HIV/AIDS Dermatology and STIs</td>
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<td>NGO</td>
<td>Non Governmental Organisation</td>
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<td>NMCHC</td>
<td>National Maternal and Child Health Centre</td>
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<td>NSP</td>
<td>National Strategic Plan</td>
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<td>OI</td>
<td>Opportunistic Infections</td>
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<td>OVC</td>
<td>Orphans and Vulnerable Children</td>
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<td>PLHA</td>
<td>People Living With AIDS</td>
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<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission</td>
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<td>RGC</td>
<td>Royal Government of Cambodia</td>
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<td>SCA</td>
<td>Save the Children Australia</td>
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1. Situation of children and HIV/AIDS in Cambodia

Cambodia has been heralded worldwide as an HIV/AIDS “success story.” Sentinel surveillance data show a steady decrease in HIV prevalence, from a high of 3.0 percent in 1997 to the current level of 1.9 percent among people in the age group 15-45 years (HSS 2003). This represents about 123,000 adults (57,000 women) living with HIV/AIDS in Cambodia. Moreover, an estimated 12,000 children are infected with HIV. The prevalence among antenatal care attendees declined from 2.5 percent in 1999 to 2.1 percent in 2003. Cambodia is one of the few countries that has been able to reach the 3 by 5 target of having at least 50 percent of people who need anti-retroviral (ARV) treatment receiving it. As of 31 December 2005 a total of 11,284 adults (men 5,861/women 5,423) and 1,071 children (boys 567 / girls 504) received ARV treatment.

![Estimated National HIV Prevalence* among Adults Aged 15-49, 1995-2003, Cambodia](chart)

* From the modeled numbers of PLHA

Behavioural trends indicate that consistent condom use is increasing and risk-taking behaviour among most at-risk populations is declining. Forms of sexual networking however are changing. Men increasingly turn from commercial sex workers to sweethearts for sex, with whom they are less likely to use condoms. However, condom use among married couples is very low indeed and the highest number of new infections now occurs in housewives, from husband to their wife, and from pregnant women to babies.

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1 In Cambodia, the term “sweetheart” is used to refer to a variety of relationships. Sweetheart relationships may involve sexual intercourse between partners, or may be platonic, just as those involving sexual relationships may or may not include the exchange of money or gifts as payment for sex
Orphans represent a significant proportion of children in Cambodia. The 2004 Children on the Brink report estimated that a total of 670,000 children (9 percent of all children) in Cambodia were orphans, with a total of 95,000 of them estimated to be double orphans. There are no reliable estimates regarding the proportion of orphans that can be attributed to HIV and AIDS. Nevertheless, the death toll of people with AIDS suggests that the number as well as proportion of orphans from HIV and AIDS is rising. A 2001 estimate put the figure of HIV/AIDS orphans at 51,000.

Many factors contribute to young people’s vulnerability to HIV and other STIs. A significant sub-sector of Cambodia’s youth population faces difficulties with poverty, lack of employment opportunities, unstable home lives, substance abuse problems, and other factors that lead too many of them to a life literally lived on the streets. Street children can be classified in three main groups; street living children, street working children and children of street living families.

Street living children often cut ties with their families and live alone on the streets. In Phnom Penh, this group is estimated to be 1,200 children, 20 percent of whom are girls mostly aged 12 to 18 years old. Street Working Children are children who spend all or most of their time working on the streets to contribute income for their families or to provide for themselves. These children usually have a home to return to and do not usually sleep on the streets. There are perhaps 10,000 to 20,000 of these children in Phnom Penh, 50 percent of them girls, mostly 6 to 15 years old. Lastly, there are also children of street living families, estimated to be 500 to 1,500 in Phnom Penh.

Street living children, without the safety net of a stable home and a place in the mainstream of Cambodian society and culture, often do not attend school and are forced to eke out a living through any means at their disposal. The economic activities these children engage in range from selling newspapers, shining shoes and working in private businesses such as restaurants and shops, through to those on the margins and excluded who turn to commercial sex work or crime to survive. These activities put them at risk of sexual abuse and trafficking, and thus at risk of HIV infection. For many of these children, the lack of stability in their lives also means they lack access to basic information to keep them healthy and protect themselves from communicable diseases such as HIV and STI.

Women and girls are physically more vulnerable to infection and sexual violence, and entrenched gender-based inequities further compound their risks. The society values attributes such as demureness, submissiveness and lack of knowledge about sex among girls, but tolerates men to have multiple sexual partners. Male dominance makes condom negotiation within marriage challenging the say the least.

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2 Mith Samlanh, 2001
3 A Fair Share for Women, Cambodia Gender Assessment, MOWA, April 2004
2. Cambodia’s progress towards the UNGASS Goals

Article 46 (a)
With coordination from the National AIDS Authority, time-bound national targets to achieve internationally agreed global prevention goals have been developed. Cambodia has a National Strategic Plan for a Comprehensive and Multi-sectoral Response to HIV/AIDS 2006-2010, which has been costed. This plan provides measurable benchmarks for key strategies including strategies for HIV prevention among young people. These benchmarks have been aligned to the Cambodia MDGs. More recently a National Consultation paved the way towards Universal Access by 2010. Issues related to children have been well articulated in the document and include the necessity to scale-up targeted interventions for high-risk populations including IDU/ATS users, and prevention in institutional settings like orphanages.

Cambodia’s way towards Universal Access clearly recognises the necessity to empower women and girls to control their own lives and decide on matters related to their sexuality. One way to achieve this is increasing access to and completion of education for girls. Cambodia has made significant progress over the past five years to increase access to primary education, although completion of the full cycle of primary education remains a challenge. Primary net enrolment increased from 85.5 percent to 91.9 percent, with the gender gap in primary net enrolment ratio also substantially reduced.

Also, in 2004, the Ministry of Women’s Affairs with support from partners, conducted a gender assessment which provides comprehensive analysis and specific recommendations for achieving Gender equity in key sectors.
**Article 46 (b)**

Expanding PMTCT services, particularly in rural areas, is one of the major challenges that Cambodia now faces in preventing HIV transmission. In Cambodia only 46% of women have at least one pre-natal consultation (National Health Statistics, MoH, 2003). Currently, less than 5 percent of Cambodia’s HIV positive pregnant women have accessed short-course antiretroviral prophylaxis to prevent mother-to-child transmission. With coordination and leadership from the National Maternal and Child Health Centre, there are now 30 public health facilities offering PMTCT services in 18 operational districts. In 2005, 14 percent of all pregnant women received education on HIV/AIDS through mother and child care classes. Challenges for expansion of PMTCT include full integration of services, decentralisation of service management, capacity building, strengthening and improving the coverage and quality of antenatal care and delivery services for all pregnant women, reaching high-risk groups, and increasing access to safe motherhood services to the poorest women.

**Article 46 (c)**

Through its Ministry of Social Affairs, Veterans and Youth Rehabilitation, Cambodia has made good progress in developing a regulatory framework for alternative care for children without primary caregivers. A Policy on Alternative Care has been finalised and four sets of minimum standards of alternative care have been developed for residential care, community and family-based care, group home care and pagoda or/and other faith-based care. A national database on alternative care is operational and monitoring forms to collect data for residential care were recently revised. Immediate challenges will include the development of a National Operational Framework for addressing the needs of orphans and vulnerable children (OVCs), taking into account existing policies, legal framework and guidelines and the development of a minimum multi-sectoral package of services for orphans, including children infected and affected by HIV/AIDS. The package of services would ensure access to shelter, adequate nutrition, health, education, and protection.

**Article 47 (2)**

Life skills education has been provided to in-and out-of school youth with support from various (I)NGOs and multi-lateral and bi-lateral agencies. Through the Ministry of Education Youth and Sports, a *Life Skills for HIV/AIDS Education Programme* has been developed in 2005. The programme covers life-skills for both in and out of school children and young people. The Ministry has piloted the programme in two provinces in 2005 and scale-up to a total of six provinces is planned in 2006. A specific programme for Street Children in Phnom Penh is also being implemented since 2005. General and pre-vocational skills that include HIV/AIDS education are also taught as part of the Basic Education curriculum. A pre-service training to equip teachers with skills to teach HIV/AIDS was initiated in 2005 and will cover all of the 18 teacher training colleges in 2006. Other key mainstreaming activities in the education sector include in-service teacher training, development of textbooks and IEC tools on life skills, Reproductive Health, drug use/abuse and HIV/AIDS.

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4 Alternative care is care provided to a child by anyone else than his or her biological parents.
Article 47 (3)
With leadership from its National Center for HIV/AIDS, Dermatology and Sexually Transmitted Diseases (NCHADS), Cambodia has rapidly scaled-up health facility based opportunistic infections (OIs) and ART services in the public sector. As of 31 December 2005, there were 30 health facilities offering treatment for opportunistic infections and antiretroviral therapy in 16 provinces. Cambodia achieved its “3 by 5” target of putting more than 10,000 people on antiretroviral therapy by the end of 2005. As of December 2005, 11,284 adults and 1,071 children (567 boys and 504 girls) were receiving life saving treatment. Gender equity in ARV treatment was achieved in 2005 as female patients accounted for 48% of all patients. There are currently nine functioning pediatric AIDS care sites, where children receive prophylaxis and treatment for opportunistic infections as well as antiretroviral therapy.

The number of home-based care teams providing services for those living with HIV/AIDS has been scaled up from 52 teams in 2001 to 261 teams at the end of 2005. These teams are established in 56 operational health districts located in 17 provinces. Similarly the number of support groups for People Living with HIV (PLWH) has increased from 24 in 2002 to 466 in December 2005.

Recent developments in the area of access to care also include a joint statement between NCHADS and the National Maternal and Child Health Center. The statement formalizes referral systems to increase access to care for pregnant women and mothers who are tested HIV-positive. Increasing a mother’s access to care is crucial to prolonging and improving the quality of her life but will also slow down the increase in the number of orphans, and will increase children’s chances of survival.

3. Country experience in prevention, treatment, care protection and support services

3.1 Progress and lessons learned in the national response 2001-2005

The reversal of the expansion of the epidemic was the greatest achievement during the implementation of the first National Strategic Plan. The Law on Prevention and Control of HIV, enacted in 2002, created a favourable environment for prevention, care and support, and recognises the human rights of vulnerable communities, most-at-risk populations as well as infected and affected individuals. However, enforcement of the law remains a challenge.

Prevention interventions designed for sex workers and their clients like the 100 percent Condom Use Programme and the military and police peer education programme, demonstrated their effectiveness in curbing transmission and reached increasingly more people. Targetted prevention with other vulnerable or most-at-risk populations such as MSM, Injecting Drug Users (IDU), and street children were developed and now need to be scaled-up. Strategies to address spousal transmission need to be developed and implemented nation-wide. However, access to several key services, such as

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5 Excerpt from National Strategic Plan for a Comprehensive & Multisectoral Response to HIV/AIDS, 2006-2010
the PMTCT and management of sexually transmitted infections for the general population remains low.

3.2 Strong national strategic plans and frameworks for action for 2006-2010:

The National Strategic Plan for a Comprehensive and Multi-sectoral Response to HIV/AIDS, 2006-2010 (NSP 2006-2010) is a strategic initiative developed with broad representation from government, civil including organizations representing people living with HIV/AIDS, and development partners. The NSP 2006-2010 draws on the successes and lessons of the years 2001-2005, and broadens and deepens national efforts to prevent and alleviate HIV/AIDS and its impact. Its execution over the next five years will play an important role in the National Strategic Development Plan 2006-2010, into which HIV/AIDS goals have been integrated. This in turn fits with the Royal Government of Cambodia’s Rectangular Strategy, and with Cambodia’s Millennium Development Goals (CMDGs).

The National Strategic Plan for 2006-2010 includes Operational Plans for each strategy, with specific objectives, targets and major activities. Each plan identifies the main government actors and other potential partners. The NSP 2006-2010 puts emphasis on leadership development and project cycle management capacity at both central and local levels to facilitate the integration of HIV/AIDS into the development programs of government and civil society institutions and private sector.

3.3 A strong health response, particularly with respect to family-based HIV care, support and treatment.

Factors that contributed to the success of the health sector response include, government leadership, solid partnerships among medical services, PLHA
groups, the public health system and NGOs at the operational district level; strong referral mechanisms between the home, the community and the institutional care takers; effective involvement of PLHA in all aspects of the continuum of care; partnerships with the international community; and the development of care packages at each level of the health care system.

3.4 Human right-based approaches:

Human rights-based approaches which see children’s needs as rights, have contributed to the success of grassroots programs implemented by non-governmental organizations and other partners. Also crucial have been participatory planning techniques that support communities to reflect, prioritize, make plans, and take action based on their needs and resources.

3.5 National technical working groups and task forces:

National technical working groups and task forces have facilitated collaboration between partners, and helped to develop needed standard operating procedures, policies, and coordinated actions for planning, monitoring and implementation.

3.6 Key lessons learned from programmes:

3.6.1 Working directly through Buddhist pagodas builds upon existing and strong national and local institutions to undertake new types of activity based on the teachings of Buddha.

3.6.2 Youth peer education programmes allow effective information dissemination, build confidence in youth, promote leadership and contribute to the development of good citizens. Moreover, participatory child focussed classroom teaching ensure that appropriate messages are delivered and understood by students.

3.6.3 Community involvement in the project is essential for the long-term sustainability by ensuring that key community leaders, educators and health specialists are motivated to promote access to government services and long-term sustainability.

3.6.4 Supporting the establishment of literacy classes and vocational training at selected Buddhist pagodas and local NGOs provides children unable to participate in the public education system with basic numeracy, literacy and life skills. Reintegration of the child into regular, formal school is the goal but this is not always possible.

3.6.5 Intensive training and planning and community partnerships is another contribution to success. Investing time in building the capacity of youth and partners, mentoring key personnel, monitoring activities and providing space for partners to evaluate and discuss outcomes and constraints leads to a greater confidence, initiative and capacity for action in communities. Many times it has improved the understanding of project issues and a re-thinking of strategies resulting in improved programme quality and innovation.
3.6.6 **Giving children a real voice** in the planning of research activities, program activities and project visioning, consistent with the Child Rights Convention

3.6.7 **Integrating** support and activities for children affected by HIV and those most vulnerable to HIV promotes the effective use of resources and avoids duplication. Coordination amongst all service providers in line with Government planning provides cohesive continuum of care and impact mitigation responses.

4. Integration of children issues into existing national legislation, policies and HIV/AIDS strategic plans

Since the Paris Peace Accords were signed in 1992, and the country began the slow process of recovery from decades of conflict, there have been many positive changes in Cambodia. With 55 percent of today's population under 18 years of age, long-term social and economic improvements will require massive investment in the development and welfare of all children.


The enshrinement of legal instruments is an important step in offering all children in Cambodia opportunities for survival, protection, development and participation in their own development. To this end, the RGC has developed public policies for children in a range of sectors, strengthened its leadership and commitment, and increased resources for various government institutions working with children. Special consideration should be given to those children affected or made vulnerable to HIV which include those who are homeless, exploited, abused, poor, lack access to health and education, affected by violence or incarcerated. Duty bearers (RGC, communities and institutions) have the responsibility to provide opportunities for all rights holders (children) to achieve their full potential.

*The National Strategic Development Plan 2006-2010* addresses issues which must be strengthened if Cambodia is to achieve its Millennium Development Goals. This planning supports RGC policy, legislation and decision-making that impacts directly and indirectly upon all children including those affected by HIV and AIDS. Specifically, this is reflected in but not exclusive to:

*Cambodia’s National Strategic Plan to combat HIV/AIDS:*

Estimates⁶ that there will be nearly 670,000 HIV orphans in the region by 2010 highlight the importance of comprehensive planning to mitigate the

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⁶ UNAIDS, UNICEF and USAID (2002)
impact of HIV on children. The RGC has successfully reduced the new HIV incidence rates. Seven interdependent and mutually reinforcing sub-strategies constitute the core of Cambodia’s National Strategic Plan to respond to HIV/AIDS:1) Increased coverage of effective prevention interventions, 2) Increased coverage of effective interventions for comprehensive care and support, 3) Increased coverage of effective interventions for impact mitigation, 4) Effective leadership by government and non-government sectors for the implementation of the response to HIV/AIDS, at central and local levels, 5) A supportive legal and public policy environment for the HIV/AIDS response, 6) Increased availability of information for policy makers and programme planners through monitoring, evaluation and research, and 7) Increased sustainable and equitable allocated resources for the national response.

Other policies and legislation that support children affected by HIV include:

**Access and Inclusion in Public Education:**
The RGC long-term goals are to provide nine years of **quality basic education for all children** by 2010 and to achieve **Education for All** by 2015. While the abolition of school fees is important to enable children, including those children affected by HIV to attend school, improving the educational status of all children is more complex. While net enrolment in Cambodia has increased to 90.1 percent⁷ there remain about 180,000 geographically “hard to reach” primary school age children (60 percent girls)⁸ who have no access to primary education. Irregular attendance patterns, low (less than 50 percent)⁹ primary school completion rates; and consequent low net enrolment rates for

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⁷ 2005 Household Survey, World Bank  
⁸ Education Management Information System, from NGO Statement to the 2006 Consultative Group Meeting on Cambodia, March 2006  
⁹ NGO Statement to the 2006 Consultative Group Meeting on Cambodia, March 2006
secondary age children mean that vocational and associated literacy programmes become essential. The Education Sector Programme and Education Sector Support Programme, the relatively high disbursement of Priority Action Programme funds, the Public Expenditure Tracking Survey, the new admissions process for mixed merit, need-based scholarships to higher education institutions and wider implementation of Child-Friendly School principles will provide slow improvement. Focusing upon reducing drop out rates after the third grade and improving girl’s attendance rates will also be important.

**Child Friendly Health Systems:**
Recognising its responsibility to provide all communities with increased access and services to public health facilities, the RGC is promoting a healthier population through the development of the Health Sector Strategic Plan, increased health sector budget and expenditure, improved the coordination of services and new healthcare policies, strategies and guidelines. The integration of specific HIV strategies as noted above, improving programme quality, effective community referral systems and the development of health equity funds will better protect the poor thereby directly benefiting all children.

**Abuse and Exploitation:**
The NGO Committee for the Rights of Children\(^\text{10}\) noted an increase in child abuse during recent years, which impacts upon the vulnerability of children to HIV. Recent Save the Children Australia Child Abuse and Exploitation research data\(^\text{11}\) in its preliminary analysis, finds that youth are very concerned about their level of vulnerability in communities. The RGC response has been to establish the Police Department of Human Trafficking and Minor Protection with offices in all the provinces and review The Suppression of Kidnapping, Trafficking and Exploitation of Human Persons Law. However, all stakeholders must increase efforts to protect children from foreign sex tourists, national perpetrators, cyber paedophilia and pornography. The Domestic Violence Law provides a framework to ensure that children are more likely to live without conflict in the home.

**Child Labour:**
The National Institute of Statistics noted that in 2003, 27,950 children were engaged as domestic workers in Phnom Penh\(^\text{12}\). These children are often deprived of their right to education and are vulnerable to exploitation and physical and verbal abuse. Efforts to address the issue of child labour in Cambodia including the establishment of the Sub-Commission for Child Labour and the Department of Child Labour, ratification of the ILO 182 Convention against the worst forms of Child Labour and issuance of Prakas are an important first step.

**Drugs:**
In 2004 Cambodia had 5,002 drug users which increased to 6,876 in 2005\(^\text{13}\); With the estimated real number of drug users being as much as 5 or 10 times higher, the vulnerability to and risk for HIV of children is high, especially those injecting drugs. The RGC has responded by establishing the National

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\(^\text{10}\) NGO Statement to the 2006 Consultative Group Meeting on Cambodia, March 2006

\(^\text{11}\) SCA Research into Sexual Abuse and Sexual Exploitation of Children (funded by AusAID)

\(^\text{12}\) NGO Statement to the 2006 Consultative Group Meeting on Cambodia, March 2006

\(^\text{13}\) of early 9 months of 2005 by the National Authority to Combat Against Drugs, states
Authority to Combat Drugs, the Anti-Drug Departments and the Provincial Anti-Drug Structure throughout Cambodia as well as passing the Law on Drug Control. Children need prevention strategies, information about the potential impact of drug use and access to resources and rehabilitation.

**Juvenile Justice:**
Guidelines have been introduced by the RGC on the implementation of existing national and international law on juvenile justice and the draft law on minors. However, the Law on Aggravating Offence does not state that the arrest, detention or deprivation of the freedom of children should be carried out as a last resort. Children separated from their family and community are often incarcerated with adult prisoners, have few rehabilitation or educational opportunities which may increase vulnerability to and risk for HIV.

**Cambodian National Council for Children:**
This institution was established in 1995 as a coordinating entity to protect the rights of all children. While it has four inter ministerial Sub-Committees and developed the Cambodia Fit for Children Policy and the National Plan of Action Against Trafficking and Sexual Exploitation of Children 2000-2004, this Council needs to be strengthened and fully resourced.

In conclusion, children in Cambodia are benefiting from the strengthening of laws. The RGC, community and institutions should all be working towards providing all children with access to continuum of care programmes and strategies to provide a future full of hope.

5. Future plans towards universal access of prevention, care and impact mitigation for children

5.1 Prevention of HIV in young people

5.1.1 Focus on most-at-risk adolescents and children, in particular street children and out-of school children, including working children under the age of 15. Appropriate departments within the Ministry of Education, Youth and Sports, the Ministry of Social Affairs Veterans and Youth Rehabilitation (MoSVY) and Ministry of Labour and Vocational Training would work as a sub-sectoral team in this service area, with Ministry of Education in the lead role.

5.1.2 Undertake a national assessment (biological/behavioural) of young people and drug use (with special attention on IDU) to inform the expansion of HIV prevention among young drug users/IDU.

5.1.3 The National Authority against Crime and Drugs (NACD) should play an important role within the Technical Working Group on Drugs and HIV/AIDS led by MoSVY.

5.1.4 For the in-school youth population, the Ministry of Education will continue its leadership in implementing existing work-plans, with agreed time-lines and financial resources.
5.2 Prevention of Mother to Child Transmission (PMTCT)

5.2.1 Lessons learned from Continuum of Care should be used for the expansion of the PMTCT programme and the integration of PMTCT services within the Continuum of Care should be further strengthened.

5.2.2 Establish and pilot equity funds in a number of Continuum of Care sites as a strategy to increase demand by HIV+ pregnant women for PMTCT services. Equity funds will subsidise transport costs and service/user fees. UNICEF and the Clinton Foundation will lead efforts to set up pilots, together with the National Maternal and Child Health Center and NCHADS. Lessons learned in 2006 to inform scale-up in 2007.

5.2.3 Build capacity of midwives to support the delivery of PMTCT services, at the commune level. UNICEF and UNFPA to support the Ministry of Health in this work.

5.2.4 Expansion of the roles and responsibilities of the community and home-based care teams and networks of people living with HIV at the commune level to promote access and awareness for PMTCT services in rural communities.

5.3 Paediatric HIV Care

5.3.1 Integrate of paediatric HIV Care within the Continuum of Care.

5.3.2 Rationalise procurement procedures for civil works development through outsourcing to credible private sector enterprises to expedite expansion of new sites. These would be especially supported by UNICEF, UNAIDS and WHO.

5.3.3 Lessons learned in 2006 to inform scale up of paediatric HIV care in 2007.
5.4 **Protection, care and support to orphans and children affected by HIV**

5.4.1 Establish a National OVC Task Force on OVC/Impact Mitigation, with MoSVY as the lead organisation and develop clear ToR and identify membership (Concerned Departments in MoEYS, MoWA, MoH, MoL, MoC&R, MoI and Representative of NAA to be formally appointed to the Task Force) together with a time-frame and designated accountability to move actions forward in the following areas:

- Conduct national assessment for OVC/Impact Mitigation including mapping, review of existing policies, strategies and size estimation.
- Develop a National Operational Framework, taking account of policies, legal framework and guidelines including a minimum package for OVC.
- Create an OVC service network.
- OVC Task Force to organise meetings with key relevant partners to harmonize partner roles and responsibilities (INGOs, NGOs, and Development Partners) of each stakeholder.
- Develop and implement a joint work-plan

Time line for action 3-5 months, from March to July 2006:

The Ministry of Social Affairs will be the lead Ministry with NAA providing facilitation support for this sub-multi-sectoral response for OVC/Impact Mitigation. The role of MoSVY must be formalised and the membership of the National OVC Task Force mandated at the Ministerial level in each Ministry involved. Existing mechanisms should be aligned and drawn into this one National OVC Task Force to avoid duplication.