

SUMMARY



# Children and AIDS

Third Stocktaking  
Report 2008

UNITE FOR CHILDREN  
UNITE AGAINST AIDS



# Children and AIDS: Third Stocktaking Report 2008

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The paintings on the covers of this report are by children at the Maputo Day Hospital, Mozambique, a UNICEF-supported facility providing medicine and psychosocial support, including counselling and antiretroviral therapy, to children living with HIV.

UNAIDS, the Joint United Nations Programme on HIV/AIDS, brings together the efforts and resources of 10 UN system organizations to the global AIDS response. Co-sponsors include UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODC, ILO, UNESCO, WHO and the World Bank. Based in Geneva, the UNAIDS secretariat works on the ground in more than 75 countries worldwide.



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## INTRODUCTION

*The phrase ‘know your epidemic’ has become extremely important in the response to HIV and AIDS. But to better serve children, knowing your epidemic and response must be paired with ‘know your children’.*

This Stocktaking Report, the third since the *Unite for Children, Unite against AIDS* initiative was launched in 2005, examines data on progress, emerging evidence, and current knowledge and practice for children as they relate to four programme areas known as the ‘Four Ps’: preventing mother-to-child transmission of HIV, providing paediatric HIV care and treatment, preventing infection among adolescents and young people, and protecting and supporting children affected by HIV and AIDS.<sup>1</sup>

The phrase ‘know your epidemic’ has become extremely important in the response to HIV and AIDS, with its different levels of epidemic and diverse patterns in a range of geographical, cultural and social settings. Knowing your epidemic and response is about analysing the local situation – who is infected and what factors are driving the risks and behaviours – and understanding and acting on that analysis. Consensus in the scientific community and in civil society is that interventions based on such understanding and tailored to the local situation are needed and, importantly, can work.

But to better serve children, knowing your epidemic and response must be paired with ‘know your children’ – determining which children are vulnerable to HIV and AIDS, which children are affected by the epidemic and what impact it has on them; how to reach children affected by AIDS, how to prevent them from getting infected with HIV and how to treat them; how to care for their mothers and how to support them when their mothers or fathers have died; and how to help all children grow safely and develop into adulthood.

To address these conditions and further improve children’s prospects, countries are drawing on experiences and evidence and doing things differently than they have in the past. In Botswana, Rwanda and Thailand, for example, access to CD4 cell-count testing has been expanded, increasing the numbers of pregnant women living with HIV accessing antiretroviral treatment for their own health. Keeping mothers alive also contributes to the health and well-being of their children, whether they are infected or not.

In South Africa, many infants born to HIV-positive mothers are now tested for HIV at six weeks of age, using dried blood spots for polymerase chain reaction (PCR) testing of DNA, and many of those who test positive receive antiretroviral treatment. A recent study found increased survival rates among infants who were provided with antiretroviral therapy as soon as they were diagnosed with HIV.<sup>2</sup> Without intervention, at least a third of children born with HIV will die from an HIV-related cause by their first birthday and half will die before their second birthday.<sup>3</sup>

In the South Asian countries of Afghanistan, Bhutan, Maldives and Sri Lanka – where the risk of HIV infection in the general population is low – national strategic plans on HIV and AIDS

have been adjusted to focus on prevention for adolescents who are most at risk.

Governments are increasingly investing in social protection in the form of safety nets for families and communities. In Brazil, the number of families affected by HIV and AIDS and vulnerable children receiving social welfare assistance has increased. Cash transfers have shown promise in helping vulnerable children living in Bangladesh, Cambodia, El Salvador, Kenya and several other countries.

Focused responses work. More pregnant women than ever have access to and use services to prevent transmission of HIV to their babies. More children than ever are receiving treatment. HIV prevalence in young people is declining in a number of high-prevalence countries, and greater knowledge of vulnerability in children affected by AIDS is resulting in a better understanding of how to protect and care for all vulnerable children.

Furthermore, assistance for people living with HIV, including children and adolescents, can be sustained during periods of upheaval. Responses have been refined in situations of short-term emergency, humanitarian crisis and protracted conflict in countries with varying levels of epidemic. During recent emergencies in China and Kenya, for example, immediate assistance for people living with HIV was focused on maintaining access to antiretroviral therapy. In the Democratic Republic of the Congo, Somalia and the Sudan, programmes for youth have addressed life skills, HIV and AIDS, and essential services. In Uganda, services for the prevention of mother-to-child transmission and paediatric treatment and care have been dramatically scaled up in the north, a region affected by more than 20 years of conflict.

All the positive signs of progress made to date are not signals to rest, however, but an invitation to acknowledge the stark facts they underscore:

- Pregnant women are not receiving sufficient counselling and related



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services for primary prevention of HIV, prevention of unintended pregnancies and safer infant feeding. Most pregnant women diagnosed with HIV do not have access to essential care and treatment, including antiretroviral therapy: for their own health, to further reduce the likelihood of HIV transmission and to prevent orphaning.

- A critical cohort of the youngest children, those under one year old, is being lost to treatment: They are dying of AIDS-related illnesses without ever being diagnosed.
- Significant numbers of young people continue to be infected with HIV each year, and girls in sub-Saharan Africa, in particular, remain vulnerable. Young people living with HIV are not receiving good-quality counselling and services to support them through adolescence to young adulthood.
- Social systems of protection and care in most countries are not adequate to meet the needs of all children made vulnerable by the AIDS epidemic or from other causes.

To improve the quality of assistance for children and families, and to reach the unreached, much more remains to be done. The funds available for assisting children have increased but are not yet sufficient, and results are not sufficiently tracked. Critical links to overall child survival goals have yet to be forged in many countries. Governments, donors, development partners and communities all have an important role in addressing these issues.

# 1. PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV

*Strengthened maternal, newborn and child health services will enable women to access the array of services to prevent mother-to-child transmission of HIV as part of a continuum of care.*

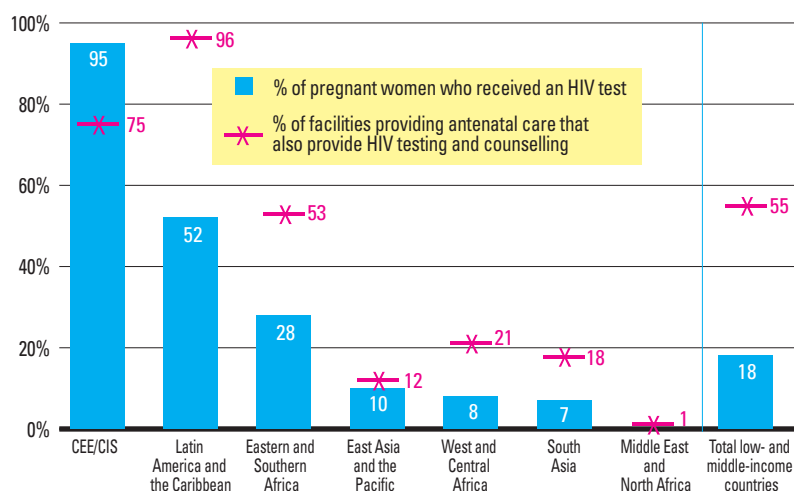
## PROGRESS AND ACHIEVEMENTS

Coverage of services to prevent mother-to-child transmission of HIV (PMTCT) is expanding in low- and middle-income countries. Overall, 33 per cent of pregnant women living with HIV in these countries received antiretroviral regimens, including antiretroviral therapy to prevent transmission of the virus to their infants, in 2007, compared to only 10 per cent in 2004.<sup>4</sup>

Yet far too few pregnant women are aware of their HIV status. In 2007, only 18 per cent of pregnant women in low- and middle-income countries where data were available received an HIV test.<sup>5</sup>

The rates of HIV testing among pregnant women are highest in Central and Eastern Europe and the Commonwealth of Independent States (CEE/CIS) and in Latin America. Accordingly, the proportion of facilities providing antenatal care that includes HIV testing and counselling is highest in these two regions, highlighting that overall access and uptake are strongly related to the expansion and integration of services. In Eastern and Southern Africa – the region with the highest number of pregnant women living with HIV – only 53 per cent of antenatal facilities provided HIV testing and counselling services in 2007. Consequently, only 28 per cent of all pregnant women in this region received an HIV test (Figure 1).

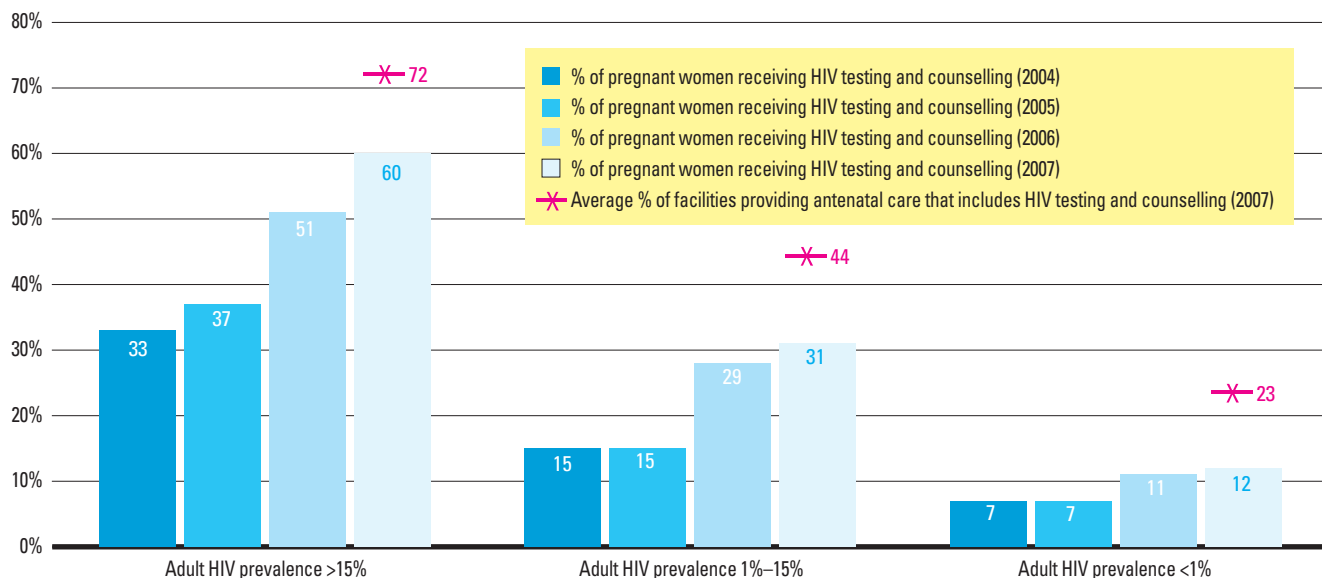
**Figure 1: Percentage of pregnant women tested for HIV and level of facility coverage, by region (2007)**



**Source:** UNICEF calculations based on data collected through the PMTCT and Paediatric HIV Report Card process and reported in *Towards Universal Access: Scaling up HIV services for women and children in the health sector – Progress Report 2008* (UNICEF, UNAIDS, WHO), pp. 34–42.

Data from 2004–2007 show a doubling or near doubling in uptake of HIV testing during antenatal care in three country groupings: seven ‘hyper-endemic’ countries in which adult HIV prevalence rates are more than 15 per cent (Botswana, Lesotho, Namibia, South Africa, Swaziland, Zambia, Zimbabwe); countries with adult HIV prevalence of 1 per

**Figure 2: Percentage of pregnant women tested for HIV, by prevalence level in adult population (2004–2007)**



Source: UNICEF calculations based on data collected through the PMTCT and Paediatric HIV Report Card process and reported in *Towards Universal Access: Scaling up HIV services for women and children in the health sector – Progress Report 2008* (UNICEF, UNAIDS, WHO), pp. 34–42.

cent to 15 per cent; and countries with adult HIV prevalence of less than 1 per cent. The largest increase was seen in the hyper-endemic countries, all of them in southern Africa. In these countries the proportion of pregnant women who received an HIV test and counselling during antenatal care visits and at the time of delivery increased from 33 per cent in 2004 to 60 per cent in 2007 (Figure 2).

In these countries, strong political commitment and leadership, enabling policies and the adoption of innovations in service delivery – namely, the introduction of provider-initiated testing and counselling, combined with rapid testing with same-day results, within antenatal and delivery care settings – have contributed to increasing access and uptake of HIV testing in the context of PMTCT. The seven hyper-endemic countries are also benefiting from important funding opportunities, including considerable financial support from the US President’s Emergency Plan for AIDS (PEPFAR) in 2004–2007, in addition to financing from the Global Fund to Fight AIDS, Tuberculosis and Malaria and other sources. Four of them are PEPFAR focus countries.<sup>6</sup> Overall improvements, however, belie important areas where work must be expanded to reach the international target of 80 per

cent of pregnant women accessing interventions to prevent mother-to-child transmission of HIV.

## MAIN ISSUES

HIV testing and counselling provided as part of the routine package of screening tests during pregnancy and delivery represent the main gateway to HIV prevention, care and treatment for most women. Botswana, in 2004, introduced routine HIV testing and counselling with the option to opt out as part of routine antenatal and delivery care. This policy, combined with the use of rapid testing with same-day results and the involvement of lay counsellors, resulted in an increase in the proportion of pregnant women testing from 27 per cent in 2002 to around 80 per cent in 2007.<sup>7</sup> Botswana focused its initial efforts on expanding PMTCT services to all public health facilities providing maternal and child health services.

The involvement of male partners in PMTCT is also essential to increasing service uptake and can reduce some of the stigma surrounding women’s use of such services. In Rwanda, remarkable efforts have been made to engage male partners of pregnant women in PMTCT interventions, particularly HIV testing. In 2007, nearly two thirds of male partners of pregnant women tested for HIV during antenatal and delivery care visits agreed to be tested themselves.<sup>8</sup>

In countries with concentrated epidemics, provider-initiated HIV testing and counselling should be recommended for women identified as being at high risk of HIV exposure – and linked to prevention, care, support and treatment services, including antiretroviral therapy.





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The ultimate goal of PMTCT is to reduce maternal and child mortality by delivering a comprehensive package of services that includes primary prevention of HIV infection among women of reproductive age, prevention of unintended pregnancies among women living with HIV, counselling and support on infant feeding, as well as antiretroviral therapy for mothers, cotrimoxazole prophylaxis for mothers and infants, and early infant diagnosis and initiation of antiretroviral treatment. Services should link operationally to child survival interventions and to other sexual and reproductive health care. This calls for a strategic shift of perspective from averting HIV infection to improving maternal and child survival.

In most resource-limited settings, women identified as HIV-positive have access to care and treatment, including antiretroviral therapy, only through referral to antiretroviral treatment clinics.

But many of the needed services can and should be delivered within maternal, neonatal and child health-care settings.

HIV-positive pregnant women at an advanced stage of disease are at higher risk of transmitting HIV to their infants than women at an early stage. Initiation of antiretroviral therapy in these women not only addresses the health needs of mothers, but it also significantly reduces the risk of HIV transmission to their infants and can promote the survival of their children, regardless of the child's HIV status. The results of a recent study in Uganda show that among uninfected children under age 10, there was an 81 per cent reduction in mortality and a 93 per cent reduction in orphanhood if their HIV-infected parents were receiving antiretroviral therapy and cotrimoxazole prophylaxis, compared with children whose parents received no intervention.<sup>9</sup>

Supporting HIV-positive mothers to make appropriate infant feeding decisions can improve early child survival. Around one third of overall HIV mother-to-child transmission takes place in breastfed children up to two years of age.<sup>10</sup> A recent study among women who received nevirapine found that the risk of transmission during the first four months of the infant's life is halved when the mother breastfeeds exclusively and avoids mixed feeding.<sup>11</sup>



Women who become infected with HIV during pregnancy and lactation are more likely to pass on the virus to their infants than women who were infected before they became pregnant.<sup>12</sup> Primary prevention services should therefore give special attention to keeping women uninfected throughout pregnancy, childbirth and breastfeeding. Many national programmes offer a package of primary prevention services for all women during antenatal care visits that includes health information and education, HIV counselling, promotion of family planning based on country policies, and couples testing and counselling on safer sex practices such as condom use. Retesting for pregnant women who tested negative, as is the policy in Brazil and Ukraine, should be considered based on epidemic type and available resources.

Data from 32 countries of sub-Saharan Africa reveal that as many as 61 per cent of people living with HIV receiving antiretroviral therapy in this region in 2007 were female. However, access to antiretroviral therapy through PMTCT programmes for pregnant women living with HIV remains poor for various reasons, including limited access to CD4 cell counts. In low- and middle-income countries, only 12 per cent of pregnant women identified as HIV-positive during antenatal care visits were assessed to determine whether they were eligible to receive antiretroviral therapy for their own health.<sup>13</sup>

Scaling up antiretroviral therapy for women, especially pregnant women, in the context of PMTCT requires investment in facility improvement, laboratory equipment and human capacity-building within maternal, newborn and child health services. Timely initiation of antiretroviral therapy requires clinical and immunological assessment of all HIV-infected pregnant women.

In 2008, CD4 testing was expanded to all 28 districts and five referral hospitals throughout Malawi after a study found that CD4 cell counts are a more reliable way to assess women's eligibility for antiretroviral treatment than by observing clinical signs and symptoms. Only 2 per cent of 724

pregnant women assessed clinically at eight antenatal clinics were found to be eligible for antiretroviral treatment for their own health, while in this same group of women, 54 per cent assessed by CD4 cell counts were found to be eligible.<sup>14</sup> Rwanda introduced more efficacious antiretroviral regimens for PMTCT, including antiretroviral therapy for eligible women, in 2005.

PMTCT services can be linked with male circumcision, including neonatal circumcision and circumcision of HIV-negative male partners. These services can be delivered using a family-centred approach as part of an integrated programme of HIV prevention for mothers (both HIV-negative and HIV-positive) and, more broadly, for women of childbearing age, including adolescent girls.

To be successful, PMTCT programmes require functioning health systems that provide quality care for maternal, neonatal and child health (MNCH), as well as sexual and reproductive health care. In Ukraine, for example, the full integration of PMTCT interventions into MNCH programmes, free antenatal and delivery services, and high coverage of antenatal and skilled birth attendance have been central to the success of scaling up PMTCT. In 2000, the Ministry of Health enacted a national policy of universal HIV testing with an opt-out option for all pregnant women upon registration at antenatal clinics and at the time of delivery. Overall, the rate of mother-to-child transmission has been reduced to 7 per cent in 2006, from 25 per cent in 2000, according to the Ministry of Health.<sup>15</sup>

Assessing the impact of PMTCT services requires clear, standardized approaches that take into account both HIV prevalence and the levels of child morbidity and mortality in the country. Data on the coverage of PMTCT services and of paediatric HIV care, support and treatment interventions are collected annually through an inter-agency collaborative process facilitated by UNICEF and the World Health Organization (WHO) in partnership with national governments. Available data are essential in tracking progress towards the scale-up of services, but as yet they do not provide information on the extent to which interventions avert HIV infection in infants or improve child survival.

Prevention of mother-to-child transmission of HIV has received a high level of attention and is an accepted part of many donors' funding portfolios. It is highlighted in the new strategy for HIV and AIDS in the United Kingdom,<sup>16</sup> and the PEPFAR authorization in 2008 has an 80 per cent coverage target. PMTCT is also a priority area for UNITAID, an international commodities financing mechanism that is working to provide long-term funding to lower the costs of drugs and diagnostics for HIV and AIDS. But to meet the 80 per cent access target for PMTCT by 2010, commitment and funding must intensify. New guidance from WHO, UNICEF and partners calls upon the international community to renew its commitment to global PMTCT scale-up and make it a priority.

## 2. PROVIDING PAEDIATRIC TREATMENT AND CARE

*Despite the encouraging increase in the number of children on antiretroviral treatment, the youngest cohort of children exposed to the virus – those under age one – are not getting diagnosed and are missing out on treatment. As a result, large numbers of very young children are dying every year because of AIDS.*

## PROGRESS AND ACHIEVEMENTS

The number of children under 15 in low- and middle-income countries who receive antiretroviral treatment rose dramatically, to almost 200,000 in 2007, up from around 127,000 in 2006 and 75,000 in 2005. The increase is occurring in every region of the world, with the most significant gains in sub-Saharan Africa (*Figure 3*).

Yet, with the most recent global estimates from WHO and UNAIDS reporting 2 million children under 15 years old with HIV infection and 370,000 new infections in 2007,<sup>17</sup> it is evident that those children currently on treatment still represent only a small proportion of those who need it. Coverage will need to be greatly expanded if the *Unite for Children, Unite against AIDS* goal of providing antiretroviral treatment, cotrimoxazole or both to 80 per cent of children in need by 2010 is to be met.

New evidence highlights early HIV diagnosis and antiretroviral treatment as particularly critical for infants and indicates that a significant number of lives can be saved by initiating antiretroviral treatment for HIV-positive infants immediately after diagnosis within the first 12 weeks of life. The Children with HIV Early Antiretroviral Therapy (CHER) study from South Africa demonstrates a 76 per cent reduction in mortality when treatment was initiated within this time period.<sup>18</sup> Other studies have shown that delayed initiation of treatment results in limited immune reconstitution and increased mortality even among children on antiretroviral treatment if it is initiated at more advanced stages of disease.<sup>19</sup>

Clinical guidelines issued by WHO in 2008 recommend the immediate initiation of antiretroviral therapy for infants under one year of age diagnosed as infected with HIV. Numerous partners – including the Baylor International Pediatric AIDS Initiative, the Clinton Foundation HIV/AIDS Initiative, Columbia University International Center for AIDS Care and Treatment, Elizabeth Glaser Pediatric AIDS Foundation, PEPFAR, WHO and UNICEF – have identified early diagnosis as a priority activity in paediatric HIV programming and have contributed towards its implementation.

## MAIN ISSUES

Recent studies find that the median age at which children with HIV begin antiretroviral treatment is between five and nine years old.<sup>20</sup> Most infants with HIV are not treated because access to HIV diagnosis remains limited. In 2007, only 8 per cent of children born to HIV-positive women were tested before they were two months old.<sup>21</sup> There are no clear data on how many of these children tested positive or actually began antiretroviral therapy, an illustration of the critical gap in data covering children's access to HIV and AIDS services.

Some countries have made great strides in providing access to early infant diagnosis of HIV. In 2007, 30 low- and middle-income countries used dried blood spot filter paper to perform DNA PCR testing for HIV in infants, up from 17 countries in 2005.<sup>22</sup> In the sub-Saharan Africa region, Botswana and South Africa – both ‘hyper-endemic’ countries with more than 15 per cent HIV prevalence among adults – offer dried blood spot PCR testing on a wide basis. Early infant diagnosis is being scaled up in several countries with generalized epidemics, including Kenya, Malawi, Mozambique, Rwanda, Swaziland and Zambia.

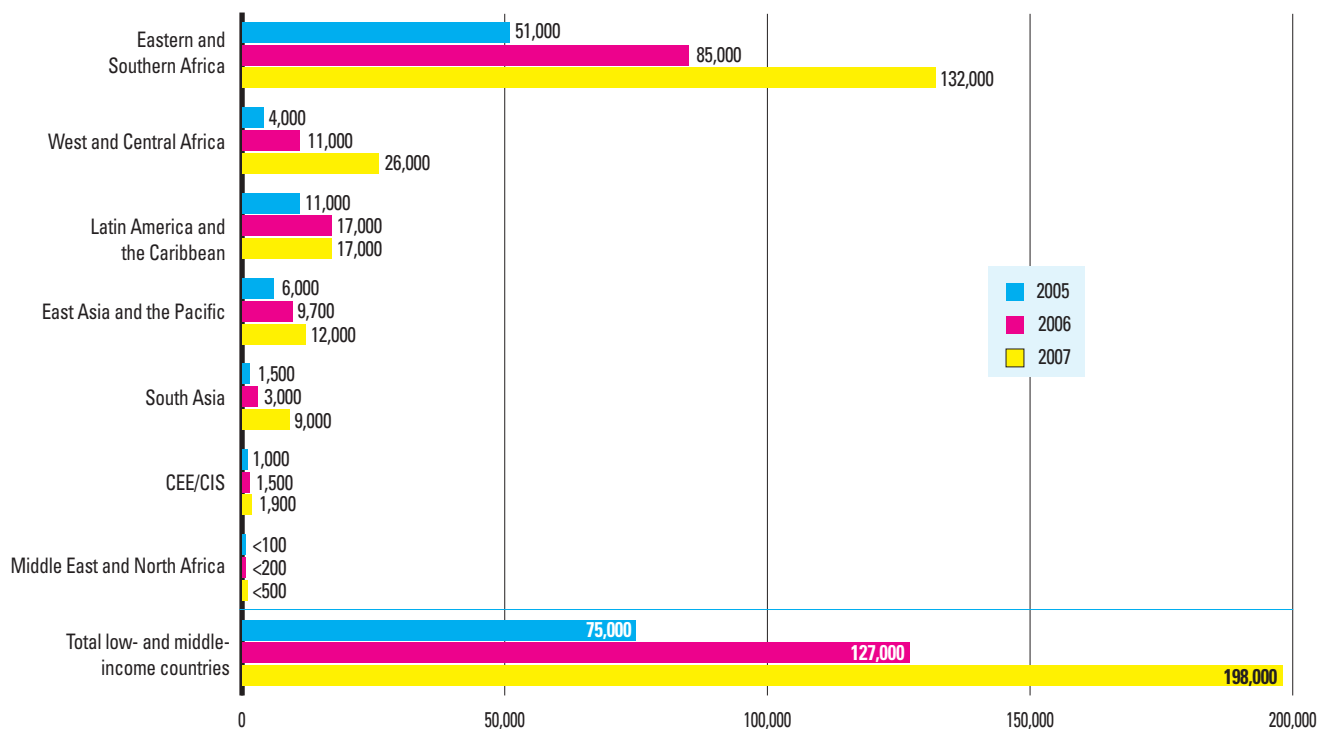
Another reason children do not receive appropriate follow-up is because often it is not known that they were exposed to HIV; frequently, children are identified only when they become very sick. Several countries have revised child health cards to include HIV-related information, making tracking of exposed children easier and

increasing the likelihood that infants known to be exposed to HIV are referred for virological testing, then early treatment if needed. These cards have also helped exposed children receive other critical interventions such as cotrimoxazole preventive therapy and nutritional support.

Another modality for scaling up early diagnosis of young children takes advantage of child health days, organized in many countries to deliver health and nutrition services on a large scale. During child health days in Lesotho in 2007, more than 4,400 children were tested for HIV (including some through dried blood spot PCR testing) and screened for tuberculosis and malnutrition. Nearly 100 per cent of participants (adults and children) were tested. Overall HIV prevalence among children was 3 per cent, and children who tested positive were immediately referred to appropriate care at the nearest antiretroviral treatment clinic.<sup>23</sup>

Early infant diagnosis and early antiretroviral treatment must be part of a broader approach to treating young children based on a comprehensive package of care – including optimal infant feeding, child survival interventions, growth monitoring and immunization – as well as good-quality HIV-specific care that offers drugs (both antiretrovirals and cotrimoxazole), routine monitoring and adherence support. Several countries,

**Figure 3: Number of children under 15 receiving antiretroviral therapy in low- and middle-income countries (2005–2007)**



**Note:** Regional totals do not add up to the total for low- and middle-income countries because of rounding. The seven ‘hyper-endemic’ countries are all in the Eastern and Southern Africa region.

**Source:** UNICEF calculations based on data collected through the PMTCT and Paediatric HIV Report Card process and reported in *Towards Universal Access: Scaling up HIV services for women and children in the health sector – Progress Report 2008* (UNICEF, UNAIDS, WHO), pp. 34–42.





including Botswana, Guyana and Uganda, are in the process of significantly improving their capacity to provide such comprehensive services.

Provision of the common antibiotic cotrimoxazole against opportunistic infection is important for both HIV-exposed and infected children. Effective and integral to the comprehensive approach crucial to saving children's lives, cotrimoxazole prophylaxis was nonetheless initiated in 2007 in only 4 per cent of infants under two months of age born to HIV-positive women – a time when it is critically important, particularly for those infants who will eventually be diagnosed as HIV-infected.<sup>24</sup> UNICEF and WHO, with UNITAID support and in collaboration with the Clinton Foundation in several countries and the US Government in others, is providing donations of cotrimoxazole for use as prophylaxis in HIV-exposed and infected populations in countries of sub-Saharan Africa and South Asia.

Countries are also using a number of simple quality-improvement tools with children that have been utilized successfully with adults, including visual prompts and reminders to clinicians to provide routinely needed services and better documentation.

Children and adolescents living with HIV face particular challenges: accepting their HIV status and disclosing it to family, peers and others; maintaining adherence to treatment and overall medical care; and coping with feelings of isolation and stress. Adolescents face the additional challenge of addressing their emerging sexuality, including having to disclose their HIV status to sexual partners and avoid high-risk behaviours.

In a qualitative study sponsored by WHO and UNICEF examining psychosocial issues facing adolescents and young people living with HIV, 41 per cent of respondent organizations working with young people with HIV identified adherence as a principal concern.<sup>25</sup> Difficulties associated with disclosure to partners were mentioned by 38 per cent of respondents in another study, in Uganda.<sup>26</sup>



Programmes in several countries are now addressing the special challenges faced by these young people. In Uganda, for example, The AIDS Support Organization (TASO) runs peer support groups for adolescents on treatment. HIV- and AIDS-related stigma and peer pressure are among topics addressed through group discussion, recreational activities, music, dance, drama and writing.



### 3. PREVENTING INFECTION AMONG ADOLESCENTS AND YOUNG PEOPLE

*Across the globe, a renewed emphasis on prevention presents an important opportunity to ensure that adolescents and young people benefit from prevention efforts that take local realities into consideration. There is strong consensus that combination prevention – integrating behavioural, structural and biomedical approaches – works.*

## PROGRESS AND ACHIEVEMENTS

HIV prevalence among young people aged 15–24 is declining in many countries, in some of them significantly. HIV prevalence among young women aged 15–24 who are attending antenatal clinics has declined since 2000–2001 in 14 of the 17 countries with sufficient data to determine trends. In seven of these countries, prevalence in this group declined by at least 25 per cent, the global target set for 2010 at the UN General Assembly Special Session on HIV/AIDS (UNGASS) in 2001.<sup>27</sup>

Several countries with high HIV prevalence have experienced declines in risky behaviours, including the initiation of sex before age 15, sex without condoms and sex with multiple partners.<sup>28</sup> Yet a significant number of young people continue to be infected with HIV; in the 15-and-older age group, 45 per cent of all new cases in 2007 were found among those 15–24 years old.<sup>29</sup>

**Table 1: Young people aged 15–24 living with HIV (2007)**

Region	Female	Male	Total
Sub-Saharan Africa	2,550,000	860,000	3,400,000
South Asia	300,000	390,000	690,000
Latin America and the Caribbean	160,000	240,000	400,000
East Asia and the Pacific	210,000	360,000	580,000
CEE/CIS	120,000	220,000	340,000
Middle East and North Africa	55,000	43,000	98,000
<b>Total</b>	<b>3,400,000</b>	<b>2,100,000</b>	<b>5,500,000</b>

**Note:** Some numbers do not add up to totals because of rounding.  
**Source:** UNAIDS/WHO, unpublished estimates, 2008.

On average, about 30 per cent of males and 19 per cent of females aged 15–24 in developing countries have comprehensive and correct knowledge about HIV and how to avoid transmission.<sup>30</sup> These knowledge levels are far below the UNGASS Declaration of Commitment’s goal of comprehensive HIV knowledge in 95 per cent of young people by 2010.

## MAIN ISSUES

There is strong consensus based on evidence that girls and young women remain disproportionately vulnerable to HIV infection in sub-Saharan Africa, particularly in the hyper-endemic countries, where prevalence is greater than 15 per cent. In southern Africa, adolescent women are 2 to 4.5 times more likely to be infected than males of the same age.<sup>31</sup> Addressing the vulnerability of girls is a priority focus of key development partners, including the Global Fund, as well as the UNAIDS secretariat and co-sponsors.

Urgent attention is needed to increase understanding of this vulnerability and to reduce it, taking into account the greater HIV risks to girls of multiple concurrent partnerships,



intergenerational sex, transactional sex and gender-based violence. At a June 2008 technical meeting on young women's vulnerability to HIV infection in Southern Africa, Graça Machel, the international advocate for women's and children's rights, spoke of what she called the lack of empowerment and choice in the region, and called for reflection on and transformation of the cultural practices and attitudes that place girls at risk.<sup>32</sup>

An in-depth analysis of Demographic and Health Survey (DHS) data from five countries – Cameroon, Swaziland, Uganda, the United Republic of Tanzania and Zimbabwe – found a significant association between a young woman's HIV status and the number and age of her partners. Young women aged 15–24 were more likely to be infected with HIV when they had multiple partners and when their partners were older.<sup>33</sup>

Countries are responding to the evidence around girls and HIV. Zimbabwe, for example, has developed a national behaviour change communication strategy with a strong focus on gender issues. A key issue highlighted in the strategy is that sexual relations between younger women and men who are five or more years older is the major factor in the spread of HIV to the younger generation. The strategy recognizes that sexually active young people need support in avoiding multiple partnerships and in obtaining and using condoms, and that young people who are not sexually active need support in delaying sexual initiation.<sup>34</sup>

In the Caribbean, girls and women comprise 50 per cent of people aged 15 and older living with HIV, and in some countries HIV prevalence rates among young women aged 15–24 are two to three times higher than for men of the same age group.<sup>35</sup> In this region, HIV is spread primarily through heterosexual transmission, with commercial sex and sexual exploitation having a significant role in many countries.

Insufficient data is a major constraint in responding appropriately to young people's needs for HIV prevention information and services. Strategic information on the epidemic and its social drivers should inform and support programme and policy decision-making to achieve national goals.

HIV risk among adolescents and young people in countries where prevalence is low and the epidemic is concentrated in specific populations is now well documented. In Central and Eastern Europe, seven countries, in partnership with the London School of Hygiene & Tropical Medicine and UNICEF, have collected disaggregated data on risk behaviour – including injecting drug use, unprotected sex between males and sex in exchange for gifts or money – among those most at risk. In Bosnia and Herzegovina, preliminary survey results show that injecting drug users aged 18–24 were likely to engage in multiple risk behaviours. These results, along with the high levels of hepatitis C virus and low levels of HIV and syphilis in the target population, suggest an opportunity for rapid scale-up of harm-reduction services.<sup>36</sup>

National HIV and AIDS strategic plans need to have a strong focus on prevention, taking into account assessments of young people's risk and vulnerability. In South Asia, four countries with low levels of epidemic – Afghanistan, Bhutan, Maldives and Sri Lanka – finalized or approved national strategic plans in 2007 that readjusted efforts to focus on prevention for people most at risk, especially adolescents engaging in high-risk behaviour.<sup>37</sup> The participation of young people in the planning, design, implementation, monitoring and evaluation of interventions that affect them is crucial.

In generalized epidemic settings where children are in school, the education sector is a crucial avenue for reaching adolescents with gender-sensitive information and skills that are a necessary part of preventing the spread of HIV. There is strong evidence that school-based sex education can be effective in changing the knowledge, attitudes and practices that lead to risky behaviour.

HIV components within life skills-based education are now a part of many education sector responses to the epidemic, and these responses are increasingly being tailored to specific national and local needs, based on evidence. Evaluations are under way to assess the efficacy of such interventions in Lesotho, Namibia and Zambia, and additional work to develop frameworks of life skills-based education that specifically address HIV prevention and local drivers is occurring in Botswana.



An important breakthrough in 2008 was the signing by Ministers of Education and Health from Latin American and Caribbean countries of a historic declaration pledging support to multisectoral strategies to provide comprehensive sex education as part of school curricula, and activities and services to promote sexual health. Most countries in this region offer sex education at all levels of schooling, although there are significant differences in legislation, the scope and appropriateness of what is taught, and the effectiveness of curricula.<sup>38</sup>



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The education sector has a significant role in making sure that schools are safe places for children and adolescents, and policies need to be in place to ensure that students who are infected with HIV can exercise their right to education in an enabling and supportive environment. Notably, Jamaica's National Policy for HIV/AIDS Management in Schools has the goal of promoting effective prevention and care within the educational setting.

Further, the education sector's response needs to be part of a comprehensive approach to prevention that includes access to health and other services and commodities for HIV prevention, treatment, care and support. Measures to address

the societal and cultural factors driving HIV infection at the individual and community levels and in the wider environment are also required.

New evidence on male circumcision provides a basis for focused approaches to preventing HIV. Male circumcision needs to be introduced as an additional strategy in a comprehensive package of prevention measures that include condom use, reduction in number and concurrency of partners, and delaying the onset of sexual activity. In Swaziland, strategies are emerging on how best to reach adolescents through their schools and communities with accurate and relevant information about male circumcision. Activities include awareness-raising among parents, making male circumcision available during school holidays, training staff to be 'youth-friendly' and reducing the cost of the procedure.



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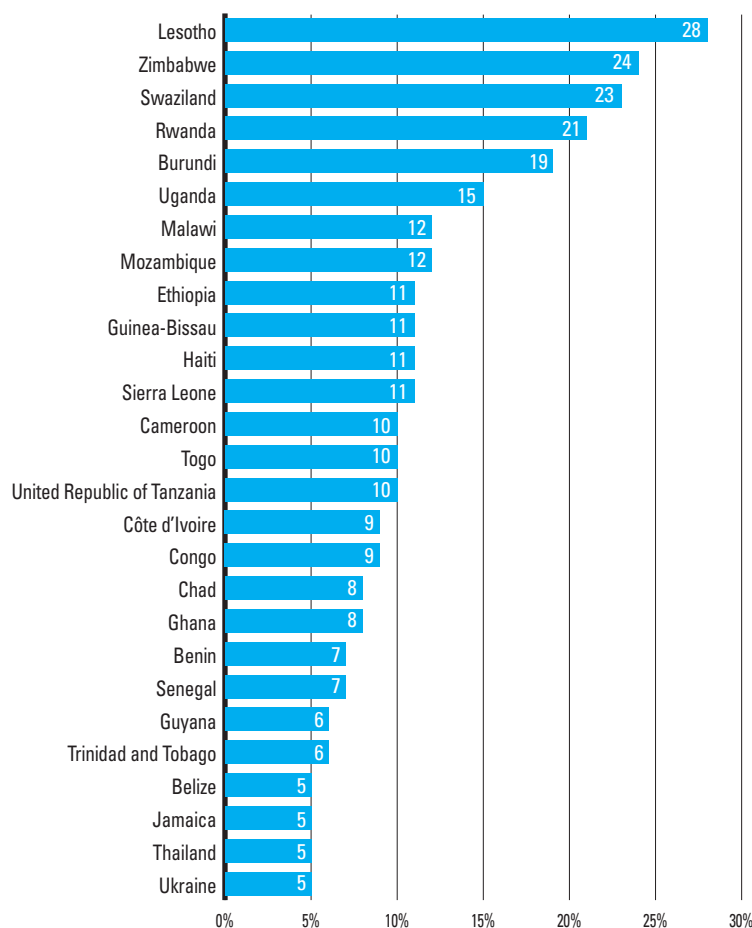
## 4. PROTECTION AND CARE FOR CHILDREN AFFECTED BY AIDS

*There is growing evidence to support programming that is AIDS-driven – but not AIDS-exclusive – and that will assist all vulnerable children, including those affected by AIDS.*

## PROGRESS AND ACHIEVEMENTS

Worldwide in 2007, there were an estimated 15 million children who had lost one or both parents to AIDS, including nearly 12 million children in sub-Saharan Africa.<sup>39</sup> Many millions more were orphaned due to other causes. An analysis of recent household survey data in 47 countries shows that orphanhood from all causes exceeds 5 per cent in many countries (*Figure 4*).

**Figure 4: Percentage of children under 18 who have lost one or both parents, in countries with HIV prevalence greater than 1 per cent (2003–2007)**



Source: UNICEF, *Progress Report for Children Affected by HIV and AIDS*, draft dated June 2008.

AIDS is not the only cause of orphanhood. In Rwanda and Burundi, where the levels of orphanhood from all causes were 21 per cent and 19 per cent, respectively, it is more likely to result from armed conflict than from the epidemic.<sup>40</sup>

National-level responses for orphans and other vulnerable children have been increasing since the 1990s, and nearly 50 countries globally are developing some type of AIDS-sensitive response. It is estimated that 32 countries have developed or finalized national plans of action (NPA) with benefits for

orphans and vulnerable children. But the process of developing NPAs has generally been slow, and implementation at scale is limited.<sup>41</sup>

In 18 countries where household surveys were conducted between 2003 and 2007, the proportion of orphans and vulnerable children whose households received basic external support ranged between 1 per cent in Sierra Leone and 41 per cent in Swaziland, with a median value of 10 per cent (Table 2). Such support included education assistance, medical care, clothing, financial support and psychosocial services. The *Unite for Children, Unite against AIDS* goal is to reach 80 per cent of children most in need with services by 2010.

## MAIN ISSUES

Assistance to orphans and vulnerable children continues to be carried out primarily by families, faith-based groups and other small organizations, and successful programming reinforces the capacity of these support systems. Governments have an important role in coordinating these efforts. In Zimbabwe, in March 2007, the Government began distributing funding pooled from all major donors to a broad network of 26 civil-society organizations, which then managed more than 150 other partners and implementing agencies to provide services to orphans and other vulnerable children. As of March 2008, the programme had reached 165,980 children, surpassing its first-year target, according to a report issued by the Government with UNICEF.<sup>42</sup>



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**Table 2. Percentage of orphans and vulnerable children whose households received basic external support**

Country	Percentage	Survey
Swaziland	41	DHS (2006)
Zimbabwe	31	DHS (2005–2006)
Thailand	21	MICS (2005–2006)
Malawi	19	MICS (2006)
Namibia	17	DHS (2006–2007)
Zambia	16	DHS (2007)
Jamaica	15	MICS (2005)
Guyana	13	MICS (2006–2007)
Rwanda	13	DHS (2005)
Uganda	11	DHS (2006)
Cameroon	9	MICS (2006)
Côte d'Ivoire	9	AI (2005)
Democratic Republic of the Congo	9	DHS (2007)
Guinea-Bissau	8	MICS (2006)
Central African Republic	7	MICS (2006)
Togo	6	MICS (2006)
Haiti	5	DHS (2005)
Sierra Leone	1	MICS (2006)

**Source:** Multiple Indicator Cluster Surveys (MICS), Demographic and Health Surveys (DHS) and AIDS Indicator Surveys (AIS), 2003–2007.

The overall situation of children's vulnerability is complex and needs to be analysed within specific country and local contexts. An analysis of household surveys in 36 countries found, for example, that in many countries children who are orphaned are worse off than other children in relation to certain indicators of child development – nutritional status, school attendance, sexual debut – but in other countries they are better off or equally well off.<sup>43</sup>

The shift towards inclusive programming to help all vulnerable children, including those directly affected by AIDS, is already having an impact. In Zimbabwe, a new programme of support to the National Plan of Action for Orphans and Other Vulnerable Children accepts a wide definition of vulnerability beyond orphanhood and vulnerability due to AIDS.<sup>44</sup>

Cash transfers are increasingly promoted as a cost-effective approach to assist poor and vulnerable households. Cash allows families affected by illness to access the support they need, when they need it, and regular transfers can help keep children in school who would otherwise have to work to assist the family. Linking transfers with social welfare services can increase their reach and effectiveness.

Social welfare sectors are most often responsible for coordinating services for vulnerable children and families, including the management and delivery of cash transfers. Yet, welfare ministries often lack capacity and resources. The growing momentum towards consolidating a social protection agenda,





reaching out to all vulnerable children, including those affected by AIDS, represents a key opportunity to address the capacity and organizational weaknesses of social welfare sectors.

Cross-referral between faith-based and community groups and government social services is seldom undertaken, yet it is one clear way to expand coverage and capacity of both sectors. The Church Alliance for Orphans (CAFO), for example,

with a membership of 380 local congregations and faith- and community-based organizations in Namibia, plays a key advocacy role with government, particularly with the Ministry of Gender Equality and Child Welfare. The ministry leads a permanent task force on orphans and vulnerable children; a subcommittee on care and support is chaired by CAFO's Executive Director.<sup>45</sup>

Schools continue to be vital places where children affected by AIDS – and all children – can find protection and support, and schools often serve as entry points for children in need to receive health services and meals. Gender can frequently be associated with vulnerability, and vulnerable girls, in particular, need protection. School fees represent an obstacle to education for many families, and the abolition of school fees has led to increased school enrolment among vulnerable children, especially girls, in several countries.<sup>46</sup>

In Lesotho, the Ministry of Education and Training has developed a specific plan to provide education opportunities and assistance for orphans and other children considered to be vulnerable. Other ministries, including the Ministry of Health and Social Welfare and the Ministry of Justice and Human Rights and Correctional Services, have also developed policies that incorporate the needs of orphans and vulnerable children.

The evidence base for effective programming in the area of protection and care for children affected by AIDS is also improving. A UNICEF assessment of key indicators of the status of orphans and vulnerable children in 2008 shows the availability of more data in more areas as compared to the previous assessment, in 2006.<sup>47</sup> Nonetheless, more work is needed to ensure that enough data exist to effectively inform programming in this area.



## CONCLUSIONS

*It is hoped that current and future efforts in response to the HIV and AIDS epidemic will be supplemented by endeavours to 'know your children' – and that in knowing children and young people better and how AIDS affects them, and by understanding the implication of evidence and best practices for their care, the second and third generations of children affected by AIDS will not lead to a fourth.*

This *Third Stocktaking Report* calls for several focused, concrete, achievable actions that can bear fruit in the next one to three years, and that can significantly improve prospects for children and women and help nations towards their goals. These initiatives involve changes in thinking, as well as concrete action.

- **Scale up programmes that provide early diagnosis of infants exposed to HIV and treatment of infected children.** Early initiation of treatment can significantly reduce AIDS-related mortality in infants and young children, underscoring the urgent need to expand access to virological testing for infants and start them promptly on treatment. Scaling up in most countries will require the strengthening of laboratory capacity, provision of equipment and ensuring a reliable supply of reagents, the training of service providers and the establishment of networks that effectively link diagnosis with care. National policies will need to be revised to include guidelines for early diagnosis and treatment targets. Infants diagnosed with HIV will require new fixed-dose combination medications appropriate to the youngest populations. There is a need to develop and use innovative mechanisms such as mobile phones to reach families in a timely manner when test results are positive. Time is of particular importance for the youngest children in whom rapid disease progression leads to early death.
- **Expand access to antiretroviral drugs for pregnant women in need of treatment.** Pregnant women infected with HIV need access to the best regimens possible for their own health, for the survival of their children and to prevent transmission of the virus to their infants. Treatment can be effectively provided through a decentralized health systems approach, and ministries of health must provide the necessary policy guidance that takes into consideration the implications for maternal, newborn and child health services, including the effective use of resources. Antiretroviral treatment for women's own health requires repositioning PMTCT as a vital component of both maternal and child survival. Programme assessment should therefore consider not just service uptake but impact in terms of mothers' and children's lives saved.
- **Integrate HIV and AIDS services with primary-health-care programmes.** HIV prevention, diagnosis, care and treatment should be integrated within existing health infrastructure for antiretroviral treatment sites and maternal, neonatal and child health (MNCH) care services. PMTCT should be available in all antenatal care and MNCH services. Integration allows for reaching more children and women with interventions. It also reduces stigma attached to AIDS-only facilities. Infants exposed to HIV can be identified and referred for testing, cotrimoxazole treatment can be initiated for children in need, and adherence to treatment



can be supported during routine well-child visits, scheduled immunization visits and in other settings. Health policies at national and subnational levels may need to be reviewed to improve linkages between HIV and AIDS and child survival interventions, family planning based on national policies, and services to prevent and treat sexually transmitted infections and tuberculosis, as well as to improve programme management and coordination.

- **Accelerate efforts to support mothers on optimal and safe infant and young child feeding practices.** The quality of counselling provided by health-care providers and lay counsellors as it relates to infant feeding and HIV in many countries will need to be improved in line with new evidence on infant feeding and AIDS-related mortality and in light of the global food crisis. Counsellors will need to be retrained to be able to provide clear guidance on infant feeding options, including exclusive breastfeeding and weaning foods. Programmes should engage communities in promoting safe feeding practices and supporting mothers' choices, and policies should facilitate the exercise of infant feeding options depending on individual circumstances.
- **Make prevention programmes more relevant to the needs of adolescents and young people.** Prevention approaches must respond to evidence and understanding of the epidemic in different contexts and be tailored to the specific needs of adolescents and young people. Prevention policies and programmes targeted for adolescents and young people engaging in high-risk behaviours are a critical priority where such behaviours as injecting drug use, men having sex with men, intergenerational sex, and sex work are driving HIV transmission. A supportive policy environment will facilitate the work of the education sector in adapting and updating life skills-based programmes in schools, especially where their content covers potentially



sensitive issues. National strategic plans with a focus on HIV prevention should include clear targets and mechanisms for monitoring progress. Evaluation is needed, as well, to assess the impact of HIV prevention efforts through the mass media, sports and celebrity involvement.

- **Combine prevention strategies for a more effective response.** A broad range of prevention strategies is available and best used in combination to ensure that the specific needs of adolescents and young people at risk are met. To be effective, HIV prevention programmes must combine information, services, life skills and behavioural change activities with actions to address the social issues that make adolescents and young people vulnerable to HIV and lead them to engage in risky behaviours. Although male circumcision has been shown to contribute to reducing HIV risk in men, it should be seen as an additional strategy rather than as a substitute for current prevention measures such as condom use, reduction in number of partners and delay of sexual activity.
- **Understand and address the greater vulnerability of girls.** Along with working to change individual behaviour, national governments and partners must openly address the social and cultural factors driving the particular vulnerability of girls, such as concurrent partnerships, intergenerational sex, transactional sex, and violence against women and girls. Being in school reduces the risk of HIV infection among girls, so efforts to keep girls in school until secondary graduation must be intensified.
- **Prioritize the collection and disaggregation of high-quality data.** Quantitative and qualitative data are essential to identify the populations most at risk, understand trends and evaluate prevention programmes. Data should be disaggregated by such factors as age, sex, marital status,



wealth quintile and geographical location (urban or rural). Improved knowledge about the under-5 and 15–18 age groups and the most at risk among them can inform the development of strong national strategies that are crucial to effective and continued prevention, care and treatment.

- **Invest in the social sector to improve protection of the most vulnerable children.** The global response to the AIDS epidemic can drive efforts for better support and protection not just for children affected by HIV and AIDS but for all of the most vulnerable children. Efforts and investment should be directed towards increasing access to basic services, ensuring appropriate alternative care, and providing social support and protection from abuse and neglect. Social cash transfers in particular can act as a protective mechanism for recipient households in the context of rising food prices. Partnerships with civil society can help support the capacity of families and communities to care for vulnerable children and minimize the need for care in institutional settings.

## Know your children

Finally, this Stocktaking Report acknowledges the efforts by all those working in response to the HIV and AIDS epidemic to ‘know your epidemic’ and respond accordingly. It is hoped that these efforts will be supplemented by endeavours to ‘know your children’ – and that in knowing children and young people better and how AIDS affects them, and by understanding the implication of evidence and best practices for their care, the second and third generations of children affected by AIDS will not lead to a fourth.



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