and funding and international commitment for access to antiretroviral has increased (e.g. the 3Gs Initiative and the Global Fund to Fight 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 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 psychosocial care for children with HIV/AIDS; and
- Difficulties in instituting a comprehensive and successful follow-up system to monitor the health of HIV-positive infants.

Prevention and early action are key

The evolution of the course of the epidemic among children and West Asia and the Pacific will be determined by the pace at which evidence-based interventions3, known to be effective in averting or reversing the spread of 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 rates 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 male-controlled methods, as such microbicides;
- Improve access to diagnosis and treatment of sexually transmitted infections;
- 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
- 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 psychosocial care management for children living with HIV/AIDS.

The success of Thailand in reducing MTCT is a good example of holistic approaches. Figure 3 shows that much of the success in reducing the number of AIDS cases among children between the ages of 0 and 1 already started before the introduction of antiretrovirals in the late 1990s. By the mid-nineties, the basic framework for successful PMTCT had been established through the reduction of HIV prevalence among pregnant women.
Figure 1 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.

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 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 (STIs), a known risk factor for HIV. Unprotected sex represents the principal route of transmission, and the majority of new infections occur among young adults. Figure 2 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 increased from 800 to 1,000 between 2001 and 2004, and New Zealand has reported close to 200 cases of women reported HIV/AIDS.

For the Pacific Islands and other countries such as Timor-Leste, Mongolia and the Philippines with a prevalence below 0.1 per cent (considered low prevalence) there is currently a remarkable sensitivity of opportunity to halt the impending scourge of AIDS. Proactive responses including: regular cross-sectional surveys; sentinel and behaviour surveillance; the screening of STIs; public education and focus; targeted outreach will substantially reduce disease burdens over the coming years. Public awareness of HIV/AIDS can be an early 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 adults 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 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 that the sharing of food does not transmit HIV/AIDS.

Figure 1: HIV prevalence among pregnant women in selected countries

<table>
<thead>
<tr>
<th>Year</th>
<th>Papua New Guinea</th>
<th>Moresby</th>
<th>Lae</th>
<th>Average</th>
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<tr>
<td>2003</td>
<td>2.5 per cent</td>
<td>2.5 per cent</td>
<td>2.5 per cent</td>
<td>2.5 per cent</td>
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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 highest levels of HIV among pregnant women show an increase of 16 per cent per annum. In late 2003, 1.4 per cent of pregnant women were HIV positive. Morality 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, 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 fueling the epidemic.

Figure 2: Reported HIV/AIDS cases in 15 Pacific Island countries, 2001-2003

Even though there is a compelling need to prevent infection among young children who acquire HIV from their mothers, preventing women or mothers from becoming infected in the first place is still the most effective way of reducing the number of children infected. UNICEF estimates that about one quarter of new infections are among children. To curb the number of new infections among children it is necessary to implement an effective prevention of mother-to-child transmission (PMTCT) programme. By 2002 there were 72 countries and territories in the region including Papua New Guinea and the east Indonesian province of Papua that have included PMTCT interventions in their national HIV/AIDS strategies. UNAIDS and UNICEF have called on all countries to ensure that every mother who is HIV-positive is offered an intervention to prevent HIV transmission from mother to child.

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