

# In or Out?

## Asia-Pacific Review of Young Key Populations in National AIDS Strategic Plans



GOAL



METRICS



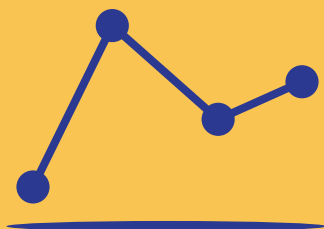
SOURCE



PARTNERSHIPS



RESULTS



DATA



TARGET



LINKS



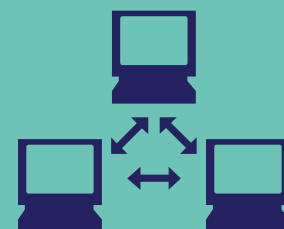
TRENDS



TIMELINE



PROGRAMMES



SYNERGIES

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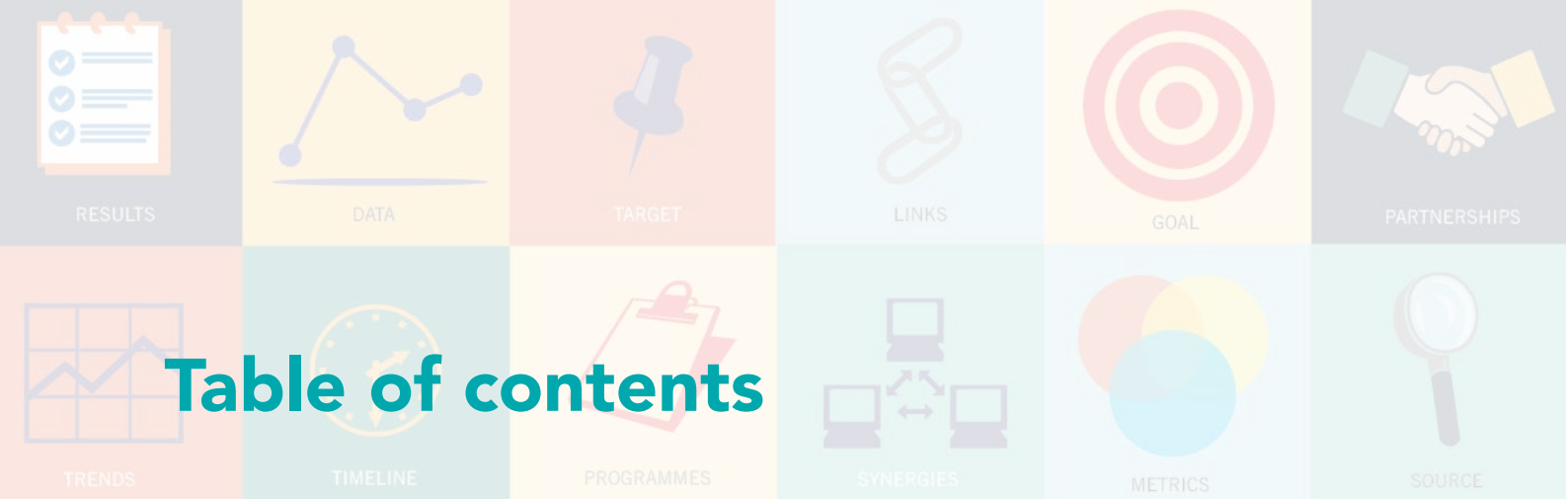
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in National AIDS Strategic Plans**



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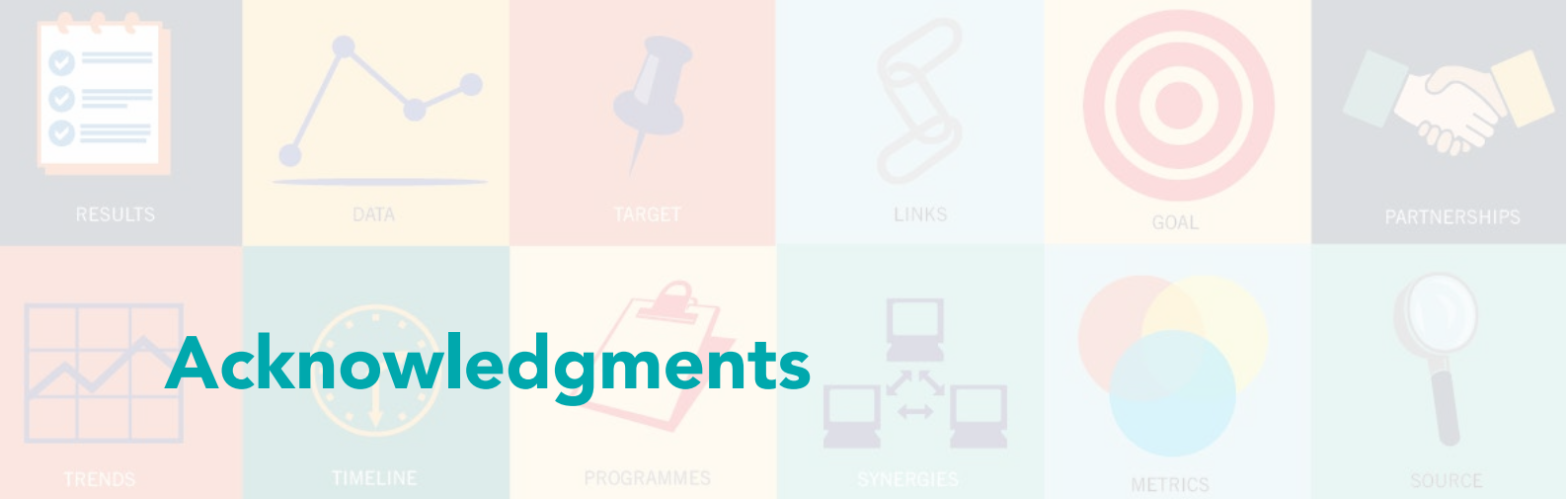
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This review is the product of collaboration between the following agencies: the United Nations Educational, Scientific and Cultural Organization (UNESCO), the United Nations Population Fund (UNFPA), the United Nations Children’s Fund (UNICEF), the United Nations Development Programme (UNDP), the Joint United Nations Programme on HIV/AIDS (UNAIDS), Save the Children and the Global Network of People living with HIV/AIDS (GNP+).

The overall co-ordination, conceptualisation and implementation of this review was managed by Justine Sass, the Regional HIV & AIDS Advisor for Asia and the Pacific, UNESCO. The primary author was the consultant Karen Humphries-Waa.

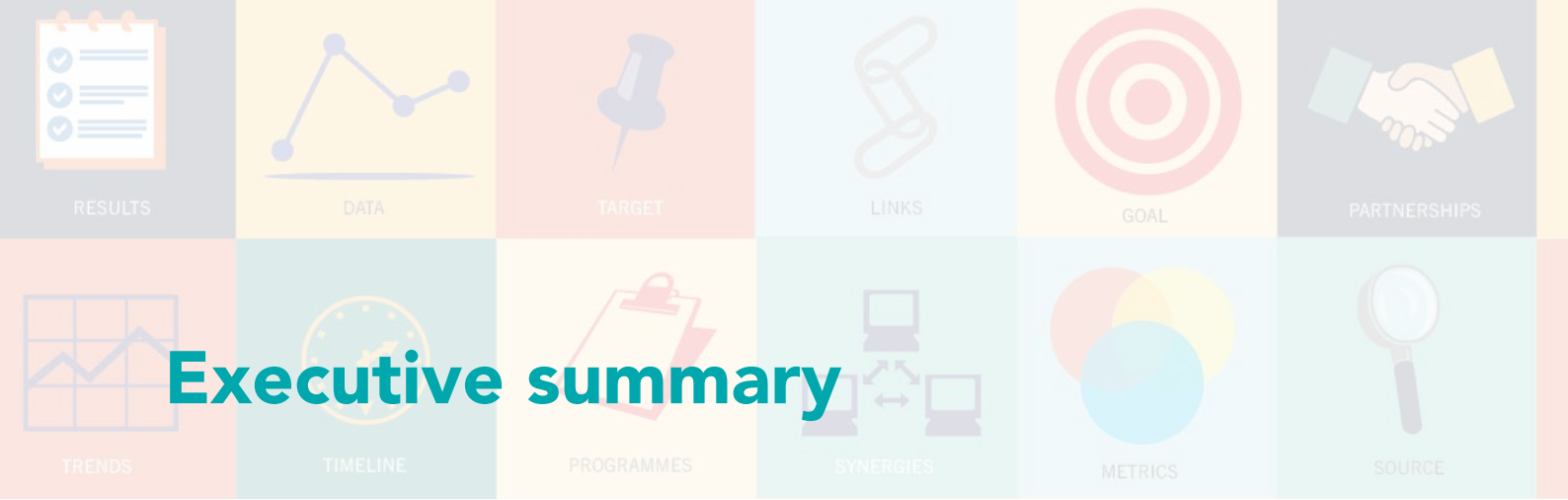
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The working group liaised closely with Amala Reddy from UNAIDS Asia-Pacific Regional Support Team and Khin Cho Win Htin and Ye Yu Shwe from the HIV and AIDS Data Hub for Asia and the Pacific. Rachel Baggaley and Alice Armstrong of the World Health Organization (WHO) also reviewed this report, and agreed to the use of the WHO logo. Additional support was also provided by Min Kyung Yi, Jessica Watts and Nicola Paviglianiti, interns at UNESCO’s Asia-Pacific Regional Bureau for Education.



AIDS	Acquired Immune Deficiency Syndrome	OST	Opioid substitution therapy
ANC	Antenatal care	OI	Opportunistic infection
ART	Antiretroviral therapy	OVC	Orphans and vulnerable children
ARV	Antiretroviral	PDR	People’s Democratic Republic
ASAP	AIDS strategy and action plan	PLHIV	People living with HIV
CABA	Children affected by AIDS	PMTCT	Prevention of mother-to-child transmission
CBO	Community-based organization	PPTCT	Prevention of parent-to-child transmission
FP	Family planning	PNG	Papua New Guinea
FSW	Female sex worker	PWID	Person/People who inject(s) drugs
FWID	Females who inject drugs	PWUD	Person/People who use(s) drugs
IDU/DU	Injecting drug user/Drug user	SRH	Sexual and reproductive health
GBV	Gender-based violence	STI	Sexually transmitted infection
GNP+	Global Network of People living with HIV	TB	Tuberculosis
HIV	Human Immunodeficiency Virus	TG	Transgender people
HTC	HIV testing and counselling	TGSW	Transgender sex worker
IEC	Information, education and communication	UNAIDS	Joint United Nations Programme on HIV/AIDS
KP	Key populations	UNDP	United Nations Development Programme
M&E	Monitoring and evaluation	UNESCO	United Nations Educational, Scientific and Cultural Organization
MARP	Most-at-risk population	UNFPA	United Nations Population Fund
MARYP	Most-at-risk young person/people	UNICEF	United Nations Children’s Fund
MCH	Maternal and child health	VCT	Voluntary counselling and testing
MSM	‘Men who have sex with men’ or ‘Males who have sex with males’*	WHO	World Health Organization
MSW	Male sex worker	YKP	Young key population(s)
MWID	Males who inject drugs	YP	Young person/people
NGO	Non-governmental organization	YPLHIV	Young person/people living with HIV
NSP	National strategic plan		

\* Both definitions include younger cohorts.



National strategic frameworks or plans (NSPs) determine a country’s national response to HIV and AIDS, guiding allocation of funding, resources and human capacity. They provide a vision of the results a country wants to achieve and the approach for reaching these results over a period of time. Previous reviews of NSPs have found they often lack clear goals and priorities, cost estimates, plans for resource mobilisation, and interventions that are efficient, reliable and feasible. Many plans are not strategic, include limited situational analysis and do not identify the key drivers of the epidemic and the programmes necessary to reverse its course.

The Global Fund to Fight AIDS, Tuberculosis and Malaria has called on development partners to help countries improve NSPs and annual action plans so they are: selective and carefully prioritised; evidence-driven; have clear implementation arrangements and accountability; and include operational monitoring and evaluation. In order to prioritise effectively, analysis of the epidemic should include identification of those subpopulations where most new infections are occurring. This means paying attention to key populations at higher risk of HIV exposure including men who have sex with men, transgender people, sex workers and their clients, people who inject drugs, and people living with HIV.

In Asia, it has been estimated that more than 95 per cent of all new infections among young people are occurring among young key populations at higher risk of HIV exposure. Behaviours which place young people at a higher risk for HIV infection such as unprotected paid sex, unprotected sex between males, and the sharing of contaminated injection equipment, often start at an early age (see Figure 1). It can be difficult for young people, including those from key populations, to access HIV-related information and services. Barriers to access may hinge upon social, cultural, religious, financial, logistical, or legislative issues. These mean young key populations are more likely to have a poor understanding of HIV, inadequate access to health and support services as well as greater engagement in high-risk behaviours. In many countries this is translating into early HIV infection and the potential for escalated growth of the epidemic.

To better understand how countries are tackling the HIV epidemic among young key populations, a number of agencies agreed to partner to investigate how these groups were being addressed in national AIDS strategic plans in the Asia-Pacific region. This report is the outcome of this effort, and aims to inform country-based reviews and progress reports of current NSPs, and the development of future plans with greater attention to these populations.

## Methods

This review analyses the inclusion of young key populations in the NSPs for HIV and AIDS of 19 countries in the Asia-Pacific region namely Afghanistan, Bangladesh, Bhutan, Cambodia, China, Fiji, Indonesia, Lao PDR, Malaysia, Mongolia, Myanmar, Nepal, Papua New Guinea, Philippines, Samoa, Sri Lanka, Thailand, Timor-Leste and Viet Nam. The primary document examined for the review of each country’s strategy was the NSP. However, where operational, implementation or monitoring and evaluation (M&E) plans were available these were also assessed. These documents were reviewed using an analytical framework developed following consideration of: seven existing NSP reviews; guidance documents on comprehensive packages for key populations; and the HIV and AIDS Investment Framework.



This tool enabled a content analysis of the plans under the three broad headings: development and review of the NSP; content including core elements, basic programmes, critical enablers and synergistic development activities; and operationalisation of the plan. For each of these categories the NSPs were assessed for interventions which address young and adult key populations, specifically men who have sex with men, transgender people, people who sell sex, people who inject drugs and people living with HIV. The review also included an analysis of interventions for young people, more generally, as broader interventions for youth may also reach those at higher risk of HIV exposure.

## Results and recommendations

Despite the importance of young key populations to the trajectory of HIV epidemics there is inadequate inclusion of these groups in the NSPs reviewed. In particular:

- There is very limited analysis of young key populations within the section of the document addressing strategic information;
- They are not involved in plan development; and
- There are virtually no plans for future research, nor goals, targets or basic programmes for these populations.
- Generally the only young key populations which receive targeting tend to be young people living with HIV, particularly children. Even those countries which have been identified as having concentrated epidemics among particular key populations often neglect to include sufficient attention to these groups.

The majority of NSPs reviewed would benefit from additional strategic information regarding young people and key populations, including behavioural as well as prevalence data. It is important to understand the drivers of the epidemic and the factors, whether cultural, social, economic or political that may make young people vulnerable or likely to adopt high-risk behaviours. Specific research regarding young key populations should be undertaken in order to address these groups. Data regarding all key populations should be captured with disaggregation by age and inclusion of those under age 15. Involvement of representatives of all key populations, including younger members, as stakeholders in the development of NSPs would assist in improving the relevance of plans and ensure a stronger sense of ownership of interventions. Their engagement in the development, implementation, and monitoring and evaluation of HIV programmes is likely to be critical to programme success

Attention to young key populations in HIV programming and within broader ‘synergistic development activities’ is very uncommon. Very little consideration is given to interventions which provide an enabling environment for young people or young key populations with virtually no inclusion of human rights initiatives for these cohorts. With the exception of children and young people living with HIV, younger cohorts are largely neglected. ‘Vulnerable young people’, such as children affected by AIDS, especially vulnerable adolescents, orphans and vulnerable children, are more likely to be included within the NSPs than young key populations themselves, whether it is as targets of future research, programming, activities which are critical to providing an enabling environment, development synergies or monitoring and evaluation.

The report recommends that:

- Goals and overarching targets be included for young people and the relevant key populations.
- Basic programmes be developed which are friendly and accessible to young people and, where relevant, tailored to young key populations.
- Interventions to create an enabling environment and synergistic development activities not only address adult key populations with comprehensive interventions but also include efforts to reach young key populations as they are particularly at risk of acquiring HIV.
- Support groups and organisations for key populations be encouraged to have representation and chapters for young people.

- Governments adopt a human rights approach that recognises the rights of young people and offers protection from discrimination and abuse. This should include review and reform of the laws, policies and regulations that impede young people and young key populations from accessing services, education and information.
- Legal literacy and support services for key populations be inclusive of young people, so that they may understand their rights and address any violations.
- Education programmes in and out of school address homophobic bullying and other forms of GBV, sexual orientation and gender identity issues.
- Health care providers be trained with respect to the needs and rights of young people as well as those of adult key populations.
- Interventions include efforts to assist young key populations in accessing education, child and social protection.
- Monitoring and evaluation frameworks be strengthened for countries across the region, including greater attention to young key populations. Indicators and targets should be developed for key populations with specific inclusion of younger cohorts.
- Data gathered to track the progress of the strategic plan against targets and milestones be disaggregated by age, sex, diversity and the use of services.
- Costing and budget allocation be included for young people and key populations within operational plans.

NSPs provide a vision of the results a country wants to achieve, and approaches for doing so. At present, there is insufficient attention and inadequate strategies outlined in most Asia-Pacific NSPs to address the HIV epidemic among young key populations. To resolve this, countries need to take steps to connect the policy, political and financial processes to on-the-ground realities when revising or developing new NSPs.



National strategic frameworks or plans (NSPs) determine a country's national response to HIV and AIDS, guiding allocation of funding, resources and human capacity. They provide a vision of the results a country wants to achieve, and the approach for reaching these results over a period of years. Previous analyses of national strategic plans have found that many are often *'political, policy and financial processes disconnected from on-the-ground realities...and that they are not strategic'* [1]. NSPs often lack clear goals and priorities, cost estimates and plans for resource mobilization, and interventions that are efficient, relevant and feasible [1]. These reviews found that many plans typically *'insufficiently identify the key drivers of the epidemic and programmes to reverse the course of the epidemic, and that when the situation analysis is done it is rarely used to inform the formulation of programmes'* [1].

Numerous resources exist to improve the national strategic planning process and the importance of these frameworks has been emphasized in recent Global Fund application guidelines which require costed NSPs [1-3]. The Global Fund has identified key populations as being central to the fight against HIV and has increased levels of funding for programmes targeted to these populations [2]. To be successful, development partners have been called on to help countries develop improved national strategic plans and annual action plans that are: selective and carefully prioritised; evidence-driven; feasible, with clear implementation arrangements that draw on the diverse resources available, accountability and costing; and linked to functioning and sustainable systems for monitoring and evaluation [4].

This prioritisation exercise should include an analysis of the epidemic and subpopulations where most new infections are occurring, as well as the identification of groups for targeted interventions. This means attention to key populations at higher risk of HIV exposure which include men who have sex with men, transgender people, sex workers and their clients, people who inject drugs (PWID), and people living with HIV (PLHIV) [5]. NSPs should include tailored HIV prevention, care, treatment and support interventions that address their structural, social and individual vulnerabilities.

In 2010, young people aged 15-24 years accounted for 42 per cent of new HIV infections worldwide in people aged 15 years and older [6]. In the Asia-Pacific region over 1.12 billion young people are aged 10-24 years, and in 2012, an estimated 690,000 or 15 per cent, of young people aged 15-24 years were living with HIV [7,8]. In 2008, the Commission on AIDS in Asia [9] estimated that more than 95 per cent of all new infections among young people in Asia were occurring among young key populations at higher risk of HIV exposure. Behaviours which place young people at a higher risk for HIV such as unprotected paid sex, unprotected sex between males, and the sharing of contaminated injection equipment, often start at an early age (see Figure 1).

While there are limited data on age of initiation of risk behaviours in the Asia-Pacific region, as Figure 1 demonstrates, most sex workers in Bangladesh report initiating selling sex before the age of 12 years, while those in Papua New Guinea (PNG) reported a mean age of initiation of 17-19 years [10,11]. Reported age of sexual debut varies among key populations and between countries. For example, 61 per cent of men who have sex with men in Afghanistan reported sexual debut by the age of 15 years, while among *hijras* (transgender people) and male sex workers in Pakistan this was 16 years of age [10,12]. In India, 23-34 per cent of people injecting drugs reported initiating injection at 22-25 years of age [10].

Where accurate surveillance data for young key populations is available, the HIV prevalence among these groups is often found to be significantly higher than that of the general youth population. For example, HIV prevalence for young people aged 15–24 years who inject drugs in Afghanistan and the Philippines has been reported at 7.6 per cent and 9.5 per cent, respectively compared to the prevalence in general youth of 0.1 per cent for both countries [10, 12–15]. Similarly, the HIV prevalence for young people (15–24 years) selling sex in Papua New Guinea is reported as 12.1 per cent for females and 14.6 per cent for males compared to general prevalence of 0.3 per cent for youth [16,17]. Thailand also has an HIV prevalence of 0.3 per cent for youth and a prevalence of 12.1 per cent for young men who have sex with men (<25 years) [18]. However, for many countries strategic information for young key populations regarding HIV prevalence, knowledge, access to services and risk behaviour is limited or unavailable [10].

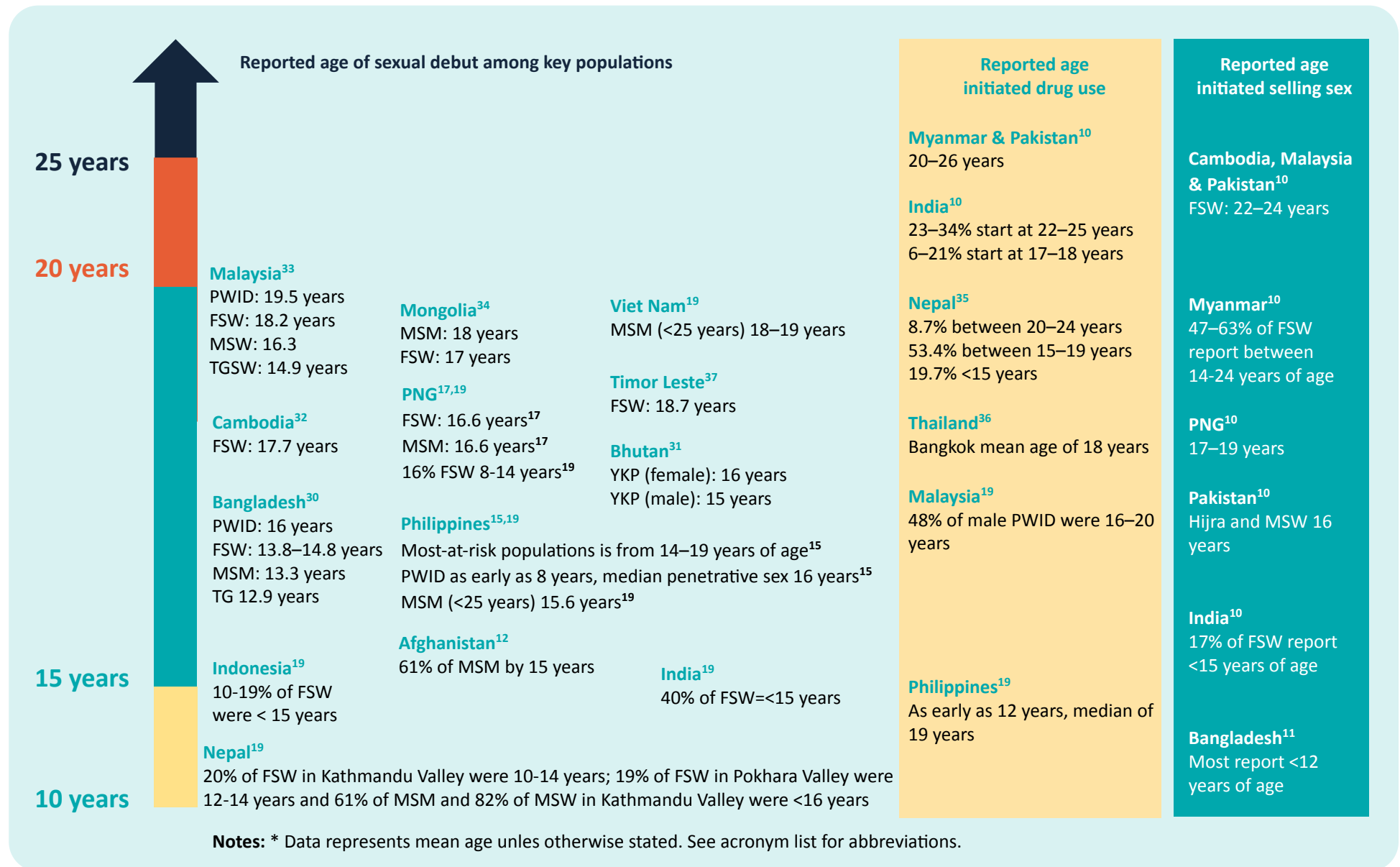
Barriers to young people, including those from key populations, accessing HIV-related information and services, may hinge upon cultural, religious, financial, logistical, or legislative issues [20]. Laws regarding the legal age of majority often deny young people basic health care and social protection services without parental consent [21]. Young people are over-represented with respect to poverty and unemployment [22,23]. Adolescence is a time of great peer influence, often associated with desire to demonstrate maturity that can herald experimentation with sex and drugs [22]. Young people are still developing physically and mentally and may not have negotiating skills or decision-making power in their relationships with adults [20]. They are less likely to be aware of services and may face greater barriers to access due to waiting lists, geography or perceptions of services being 'unfriendly' [20]. Young key populations are more likely to lack adequate adult protection in their community and assistance in accessing education, services and support [20]. Fears regarding lack of privacy, stigmatisation and possible imprisonment may provide further barriers to access [20]. Sex work, same-sex sexual relationships and injecting drug use are often illegal, driving these populations underground, making them less visible and impeding access for those prevention programmes targeting them [21,24–27].

The social and legal marginalisation suffered by many young people from key populations also makes them more vulnerable to exploitation, violence, crime and abuse [20]. This can include police abuses, as reported during focus group discussions with young people in Myanmar. "When we were younger and selling ourselves on the street, the police would bully us and force us to sleep with them. We were so frightened that we slept with them. Sometimes, we were beaten by the police" [21]. Others reported forced sex, which was typically unprotected. Not only is forced sex unlikely to be protected sex, but victims of such abuse are more likely to later engage in further high-risk behaviours that place them at even greater risk [28].

In summary, these legal, social and cultural barriers mean young key populations are more likely to have a poor understanding of HIV, inadequate access to health and support services as well as greater engagement in high-risk behaviours [29]. In many countries this is translating into early HIV infection and the potential for escalated growth of the epidemic [21].

To better understand how countries are prioritising tackling the HIV epidemic among young key populations, a number of agencies agreed to partner to investigate how these groups were being addressed in the national AIDS strategic plans (NSPs). This report is the outcome of this effort, and examines the attention to young key populations within the NSPs in the Asia-Pacific region, with a view to informing the country-based reviews and progress reports of current plans, and the development of future plans with greater attention to these populations.

**Figure 1: Data on different ages of initiation of sexual and drug-taking behaviours\* [10–12,15,19,30–38].**





This review analyses the inclusion of young key populations in the national strategic plan (NSP) for HIV and AIDS of 19 countries in the Asia-Pacific region. The primary document examined for the review of each country's strategy was the NSP. However, where operational, implementation or monitoring and evaluation (M&E) plans were available these were also assessed.

## Objectives

The objectives of this review were to:

- Identify strengths, weaknesses and gaps in how NSPs address young people from key populations in identified areas:
  - Strategic information/HIV epidemiology;
  - Legal and policy framework/enabling environment;
  - Advocacy/meaningful engagement and leadership of key populations;
  - Programming including interventions for HIV prevention, treatment, care and support;
  - Monitoring and evaluation; and
  - Resources including budget and implementing agencies.
- Make recommendations on further integration of young people from key populations in NSPs for countries in the Asia-Pacific region.

## Methodology

### *Country selection*

This review was a desk based study of current national strategic plans on HIV & AIDS including, where available, the associated implementation/operational and M&E plans. Inclusion criteria for the review were that the country must:

- Be part of the Asia-Pacific region;
- Be a low or middle-income country. High income countries (Australia, Japan, New Zealand, the Republic of Korea, and the Republic of Singapore) were excluded on this basis. There was no search for separate strategic plans for Hong Kong SAR, China and Taiwan of China, which are special administrative regions of the People's Republic of China; and
- Have a current NSP or action plan, i.e. the term of the plan continued beyond 2013.

The 19 countries in the Asia-Pacific region that met these criteria included:

- nine countries from South-East Asia, namely: Cambodia, Indonesia, Lao People's Democratic Republic (PDR), Malaysia, Myanmar, Philippines, Thailand, Timor-Leste, and Viet Nam;
- five countries from South Asia, namely: Afghanistan, Bangladesh, Bhutan, Nepal and Sri Lanka;
- three countries from Oceania, namely: Fiji, Papua New Guinea and Samoa; and
- two countries from Eastern Asia, China (action plan only, no NSP could be obtained) and Mongolia.

A complete list of the documents examined including M&E and operational plans are detailed in Table 1. The implementation periods for the NSPs varied. However, the majority were initiated between 2010 and 2011 (the exceptions being Fiji and Thailand (2012), and Sri Lanka, 2013). The majority of plans (10 NSPs) have an endpoint of 2015, which coincides with the United Nations Millennium Development Goal 'To halt and begin to reverse the spread of HIV by 2015', with the next common end of term being 2016 (six NSPs). Alternative timelines were in place for Indonesia (2014), Sri Lanka (2017) and Viet Nam (2020).

**Table 1: Planning documents for countries in the Asia-Pacific Region reviewed in this analysis**

Country	National Strategic Plan	Inclusive years	Monitoring & Evaluation Plans and other documents
Afghanistan	National HIV/AIDS Strategic Framework	2011–2015	Monitoring & Evaluation Plan 2011–15
Bangladesh	3 <sup>rd</sup> National Strategic Plan for HIV & AIDS Response	2011–2015	National AIDS Monitoring & Evaluation Plan 2011–15 Implementation Plan of NSP 2011–15
Bhutan	National Strategic Plan for the Prevention and Control of STIs & HIV/AIDS	2012–2016	Monitoring & Evaluation Plan included in NSP pages 36–39
Cambodia	National Strategic Plan for Comprehensive & Multi-Sectoral Response to HIV/AIDS III	2011–2015	Monitoring & Evaluation Plan included in NSP pages 52–63
China	Only Action Plan available		Action Plan to Prevent & Control HIV/AIDS 2011–2015
Fiji	National Strategic Plan on HIV & STIs	2012–2015	Monitoring & Evaluation Plan included in NSP pages 44 onwards, a more comprehensive M&E plan was under development during the time of this analysis
Indonesia	National Strategic Plan	2010–2014	Monitoring & Evaluation Plan included in NSP pages 49–53
Lao PDR	National Strategic & Action Plan on HIV/AIDS/STI Control and Prevention	2011–2015	Monitoring & Evaluation Plan included in NSP page 39, a more comprehensive M&E plan is to be finalised.
Malaysia	National Strategy on / HIV & AIDS	2011–2015	Monitoring & Evaluation Plan and the National Action Plan on HIV and AIDS are both included in the NSP (pages 38 and 51)
Mongolia	National Strategic Plan on HIV, AIDS & STIs	2010–2015	Monitoring & Evaluation and Work plans are included in NSP pages 91–105
Myanmar	National Strategic Plan & Operational Plan on HIV & AIDS	2011–2015	Monitoring & Evaluation Plan included in NSP pages 49–53
Nepal	National HIV/AIDS Strategy	2011–2016	
Papua New Guinea	National HIV & AIDS Strategy	2011–2015	National HIV & AIDS Strategy Implementation Framework 2011–15 and the National HIV and AIDS Strategy Monitoring & Evaluation Framework
Philippines	The 5 <sup>th</sup> AIDS Medium Term Plan	2011–2016	Monitoring & Evaluation Plan 2011–2016
Samoa	National HIV/AIDS Policy & Plan of Action	2011–2016	
Sri Lanka	National HIV/AIDS Strategic Plan	2013–2017	National HIV Monitoring & Evaluation Plan 2013–2017 and the Strategic Information Management Operational Plan for NSACP
Thailand	National AIDS Strategy (abbreviated English version)	2012–2016	
Timor-Leste	National HIV & STI Strategy	2011–2016	Monitoring & Evaluation framework included in NSP
Viet Nam	National Strategy on HIV/AIDS Prevention & Control	2010 with a vision to 2020	

## *Analytical framework*

The analytical framework for the review was developed by a small working group of the Asia-Pacific Interagency Task Team on Young Key Populations which included representation from UNESCO (lead agency), UNAIDS, UNICEF, UNFPA, UNDP, Save the Children and GNP+. The framework draws upon:

- An analysis of existing reviews of NSPs for attention to other issues including those on:
  - Young people [39];
  - Integration of human rights into NSPs in the Asia-Pacific region [40];
  - Gender-based violence [41];
  - Disability [42];
  - Sexual and reproductive health and rights [43]; and
  - Key populations in South Africa [44].
- A recent review of NSPs from 10 countries in the Asia-Pacific region (including analysis of attention to human rights; young people; and other intervention packages [45].
- Guidance documents on comprehensive packages for key populations [46–50].
- The HIV and AIDS Investment Framework approaches to identify core interventions [49]. The strategic investment framework developed by UNAIDS is a tool designed to guide investment priorities that are cost effective, efficient and produce maximum impact. Figure 2 demonstrates the principles and components of the HIV and AIDS investment framework. The components of this investment framework shaped the content analysis of this review.

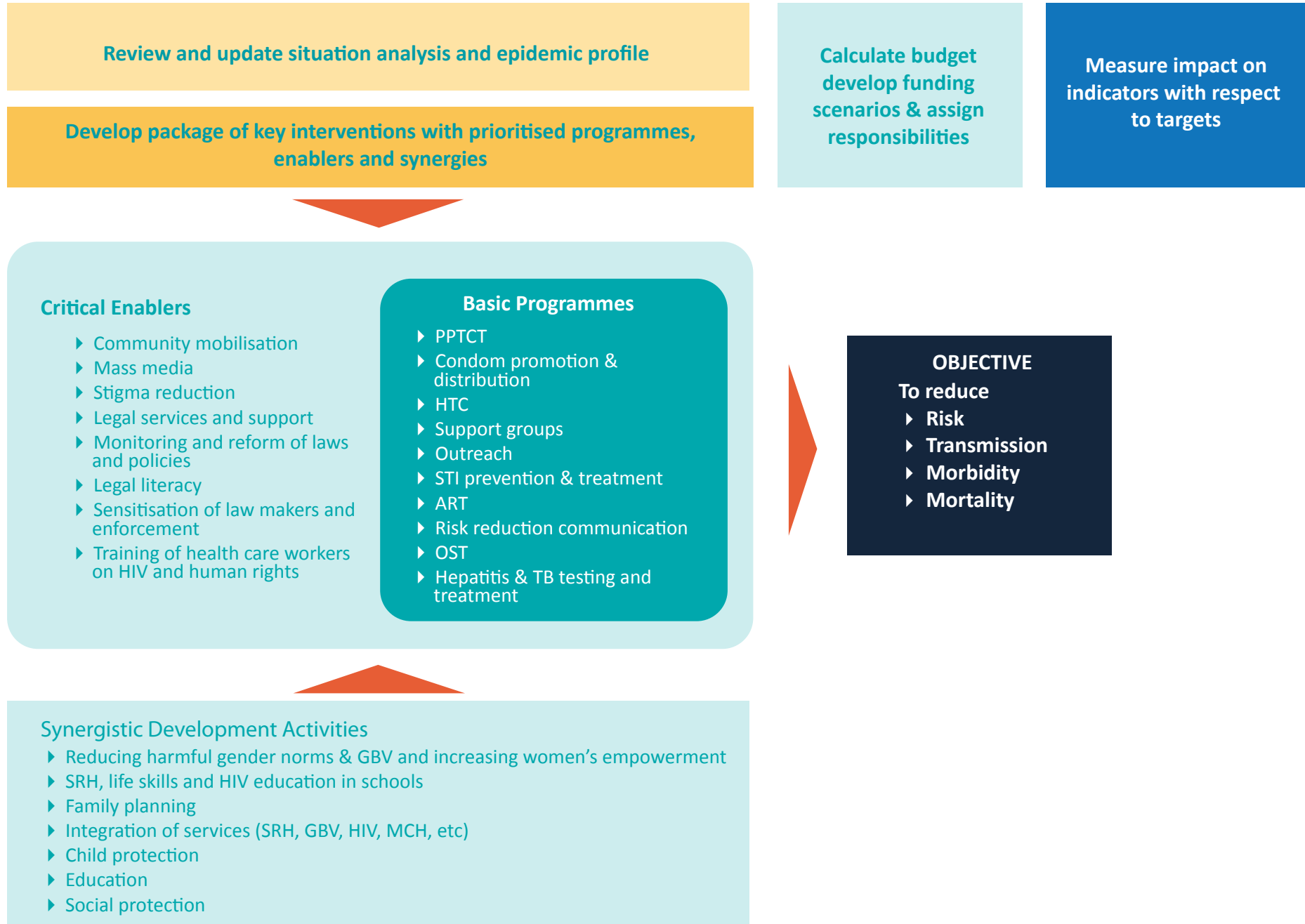
Drawing from the above analysis, a tool was developed to analyse NSPs for their attention to young key populations. This tool, using Microsoft Excel, enabled a content analysis of the plans under the three broad headings development and review, content and operationalisation (please refer to Appendix I for further detail regarding definitions and details included in these parameters). For each of these categories the NSPs are assessed for interventions which address young and adult key populations, specifically men who have sex with men, transgender people, sex workers, people who inject drugs and people living with HIV, as well as young people in general.

Development and review, including consideration of:

- Strategic information (HIV epidemiology),
- Future research,
- Stakeholder involvement,
- Peer review,
- Use of a previous NSP to inform the current plan, and
- Establishment of a review process.



**Figure 2. Adapted HIV Investment Framework [49]**



### Content, including:

- Core elements: goals, overarching targets and geographic prioritisation,
- Basic programmes: prevention of parent-to-child transmission (PPTCT) of HIV; condom promotion and distribution; HIV testing and counselling (HTC); support groups; outreach; sexually transmitted infections (STI) prevention, testing and treatment; antiretroviral therapy (ART); risk reduction communications; needle and syringe programmes (NSPs); opioid substitution therapy (OST); and hepatitis and tuberculosis (TB) testing and treatment. Basic programming, as defined by the comprehensive packages of care, varies depending on the key population in question. Further detail regarding the nature of these packages may be found within the discussion of basic programmes for each key population.
- Critical enablers: community mobilisation; mass media; HIV-related legal services; legal audits, monitoring and/or reform of laws, regulations or policies; legal literacy or 'know your rights/laws' programmes; training of health care workers on HIV and HIV related human rights issues; training and sensitisation of law makers and law enforcement agents; and stigma and discrimination reduction.
- Synergistic development activities: sexual and reproductive health (SRH), life skills and HIV education in schools; family planning; integration of services such as SRH/HIV/maternal and child health (MCH)/gender-based violence (GBV); reducing harmful gender norms, and increasing women and girls' empowerment; child protection; social protection; education; and interventions for vulnerable young people such as orphans and vulnerable children (OVC), children affected by AIDS (CABA), and street children.

### Operationalisation, including:

- M&E framework with indicators,
- M&E framework with targets,
- Costed operational plan, and
- Implementing agencies.

## Limitations

### The limitations of this review include:

- This review only captured those documents published in English. The difficulties in obtaining some documents may hinge upon the lack of an English translation. The absence of certain documents within this review does not necessarily indicate that they have not been developed. There may be plans and reports available in the native language of the country in question. For example, at the time of the analysis only an abbreviated English version of the Thai NSP was available.
- There is no standard format for NSPs so direct comparison of plans between countries can be somewhat problematic.
- There were difficulties in obtaining current NSPs for all countries in the Asia-Pacific region. For some countries a strategic plan for HIV and AIDS was simply not available, including those for Brunei Darussalam and the Democratic People's Republic of Korea. For other countries, the NSP was out-of-date and newer versions were unable to be accessed. This included (in chronological order of expiry) the Marshall Islands (2009), the Solomon Islands (2010), Kiribati and the Maldives (2011), India and Vanuatu (2012), the Federated States of Micronesia, Tonga and Tuvalu, Nauru and Palau (2013). Pakistan lacks a current national plan. However, it has developed a series of provincial strategic plans, which were not included in the review as sub-national plans were not considered in this analysis. The Pacific Regional Strategy (2013) was also in the process of being reviewed at the time of writing. For China, only the China Action Plan to Prevent and Control HIV/AIDS could be obtained and this was included in the review.

- For those countries with a current NSP, not all of the associated documents including monitoring and evaluation (M&E) frameworks, operational plans and budgets were available. Some NSPs include M&E frameworks and operational/implementation plans within the NSP itself such as Bhutan, Fiji and Indonesia (see Table 1 for a complete list of documents).
- Since the time of NSP development there may have been progress reports which recommend remedial actions or alternative strategies and which may include young key populations. Since progress reports have not been included within the scope of this review, any such strategy amendments have not been captured.
- Some of the plans reviewed were in draft format such as those for Bhutan and Timor-Leste. There may have been amendments made to plans which have not been captured in this analysis.
- Inclusion of young people from key populations within the NSP does not necessarily translate into effective programming in the community. It was not possible within the scope of this review to determine the quality of the interventions specified within the NSPs. As a result, the strategic plans reviewed may not provide an accurate picture of the activities implemented which may be limited in terms of coverage or appropriate targeting.
- The NSPs may address adult key populations but not specify targets and interventions for younger cohorts. Undoubtedly some programmes addressing key populations in general will reach younger cohorts however since young key populations face additional barriers to accessing programmes the degree of reach is difficult to determine. Additional attention to younger members may be required to ensure they are targeted effectively.
- Significant gaps exist in the available strategic information for young key populations. Most countries include key populations in national HIV or behavioural surveillance surveys; however, few disaggregate the analysis by age and sex. As discussed within the body of the review, an accurate situation analysis which includes data disaggregated by age (and sex) is pivotal to the development of any NSP. The ability to critique NSPs and make appropriate recommendations is also limited by the lack of such data.
- Even when a country does have access to comprehensive strategic information for a population, this may not all be included in the NSP. For example some data reported as M&E indicator baselines may not be specifically included in situation analysis within the NSP or other documents. For example, China and Thailand are reported to have good HIV surveillance systems but do not include a comprehensive situation analysis in the plans reviewed [51].



# Assessment of the inclusion of young key populations within national strategic plans

This assessment of the inclusion of young key populations in NSPs takes into account not only direct references to these groups, but also consideration of key populations generally (with no age specification) and of young people generally (10–24 years). The key populations considered in this analysis include: men who have sex with men; male, female and transgender people selling sex; transgender people; people who inject drugs; and people living with HIV. In order to differentiate broad references to key populations from those targeted at the younger cohorts, the former will be referred to as key populations or adult key populations and the latter as young key populations.

Countries that include comprehensive strategic information and programming for adult key populations and young people in an NSP, may capture a significant number of young people from key populations. However, as discussed previously, young key populations face a combination of barriers to accessing education, health care and other services, which make them particularly vulnerable and difficult to reach. In this way, while strategies which include activities for young people and adult key populations may form a good base, they do not replace specific interventions for young key populations, which in all likelihood, will require additional targeted consideration.

This analysis considers NSPs with respect to:

- their strategy development and review;
- content including core elements, basic programming, critical enablers and synergistic development activities; and
- operationalisation with respect to M&E indicators and targets, budgets and implementing agencies.

It evaluates each of these components with respect to the inclusion of adult and young key populations and young people in general.

## National strategic plan development and review

A methodical strategic planning process is pivotal to the development of an effective, evidence-based National Strategic Plan. This process must seek to answer three questions:

- What is the HIV situation in the country?
- What has been done about it so far?
- What should be done about it in the future [52]?

In order to answer these questions, accurate strategic information and situation analyses are required, preferably with the inclusion of all relevant populations. Topics to be considered within the situation analysis should include:

- population issues such as demography, geography, migration and mobility;
- health indicators, including sexually transmitted infections (STIs) such as HIV;

- social issues such as ethnic and cultural differences, religion, sexual behaviour, drug-taking behaviour, gender differences, women’s status and family patterns;
- political, legal and economic issues; social services including education, communications and health services; and
- partnerships with civil society and the private sector [52].

In addition it is important that the planning process includes key stakeholders in order to achieve a strong sense of ownership of the NSP. This should include participation of stakeholders representing young people and relevant key populations, including younger members.

All of the national strategic plans reviewed utilized available strategic information and a review of a previous NSP, where available, in the development of the current plan. Over half of the reviewed NSPs noted significant gaps in the available data or the quality of the research methods utilized (including Afghanistan, Bangladesh, Bhutan, Lao PDR, Malaysia, Mongolia, Philippines, Papua New Guinea, Sri Lanka and Timor-Leste). This appears to be confirmed by an independent assessment of the quality of surveillance systems in 2009, which found that:

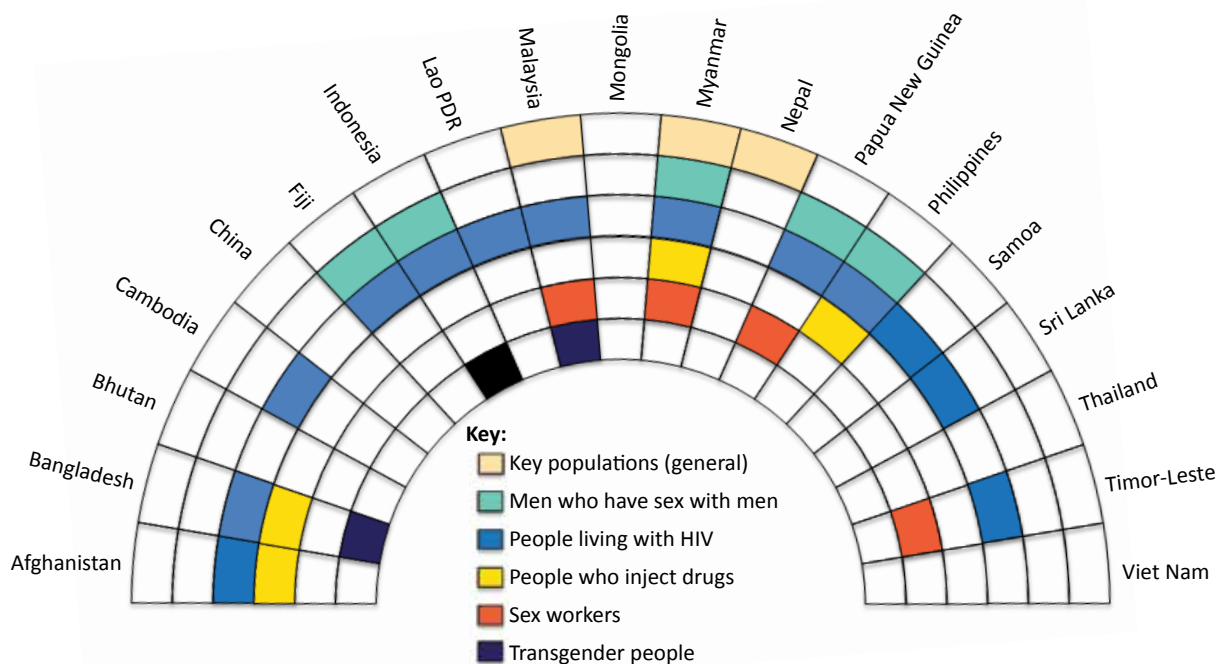
- at least three of the countries included in this review (Afghanistan, Bhutan and Fiji) had poorly functioning surveillance systems providing insufficient information;
- seven countries had partially functional surveillance systems (Indonesia, Lao PDR, Malaysia, Mongolia, Papua New Guinea (PNG), Philippines and Sri Lanka); and
- seven countries had fully functional surveillance systems (Bangladesh, Cambodia, China, Myanmar, Nepal, Thailand, and Viet Nam) [51].

**Significant gaps in strategic information exist in many NSPs: PNG [17]**

*‘Although the 2010 estimates have benefited from a significantly greater availability of data, the quality of the data is still variable and not consistent. Although surveillance systems are improving and more people are being tested, there is much that is still unknown about the scale and impact of the epidemic. The need to rapidly continue to strengthen surveillance is clear’.*

Stakeholders representing the interests of select adult key populations were reportedly included in the development process by many countries. The most common key populations reported to participate in the development process were people living with HIV (12 countries, 63 per cent), followed by men who have sex with men (7 countries, 37 per cent), and people who inject drugs (6 countries, 32 per cent). Four countries (21 per cent) reported the inclusion of transgender people and sex workers while three included key populations (without specification of groups).

**Figure 3: NSP indicates inclusion of key populations, as stakeholders, in NSP development**



Young people or organisations representing young people were reportedly involved in the development of eight NSPs (42 per cent, namely: Afghanistan, Bangladesh, Bhutan, Fiji, Lao PDR, Nepal, Papua New Guinea and Timor-Leste). However, there were no reports of specific representation of young key populations. Whilst the vast majority of countries have an established review process for NSPs, only Indonesia reported receiving input by way of an international peer review.

### **Situation analysis of adult and young key populations**

All of the NSPs reviewed contain attention to adult key populations within the situation analyses. However, there is very limited inclusion of young key populations. The key populations considered and the quality of the strategic information provided, both qualitative and quantitative, vary considerably.

**The quality of strategic information regarding key populations varies considerably: Mongolia [34]**

*‘Some critically important information for prevention programmes is lacking, particularly, reliable information on men who have sex with men, SWs and IDUs, including behaviour patterns and the social structures and norms of their communities. Even adequate size estimations of MARP groups are not available, which hampers effective planning of services and programmes, and standard reporting’.*

For some countries legal and social factors contribute to barriers in accessing key populations for research purposes. Such barriers will be even greater for younger cohorts for whom the consent of a parent or guardian is typically required prior to survey participation [10].

**Legal and social factors may act as barriers to accessing key populations for research: Afghanistan [12]**

*'The criminalization of sex work and its largely hidden nature, sexual contacts between men, coupled with pervasive social stigma and rejection, have resulted in limited understanding of the networks, sexual and risk behaviours of these populations as well as of the magnitude of the HIV epidemic among them'.*

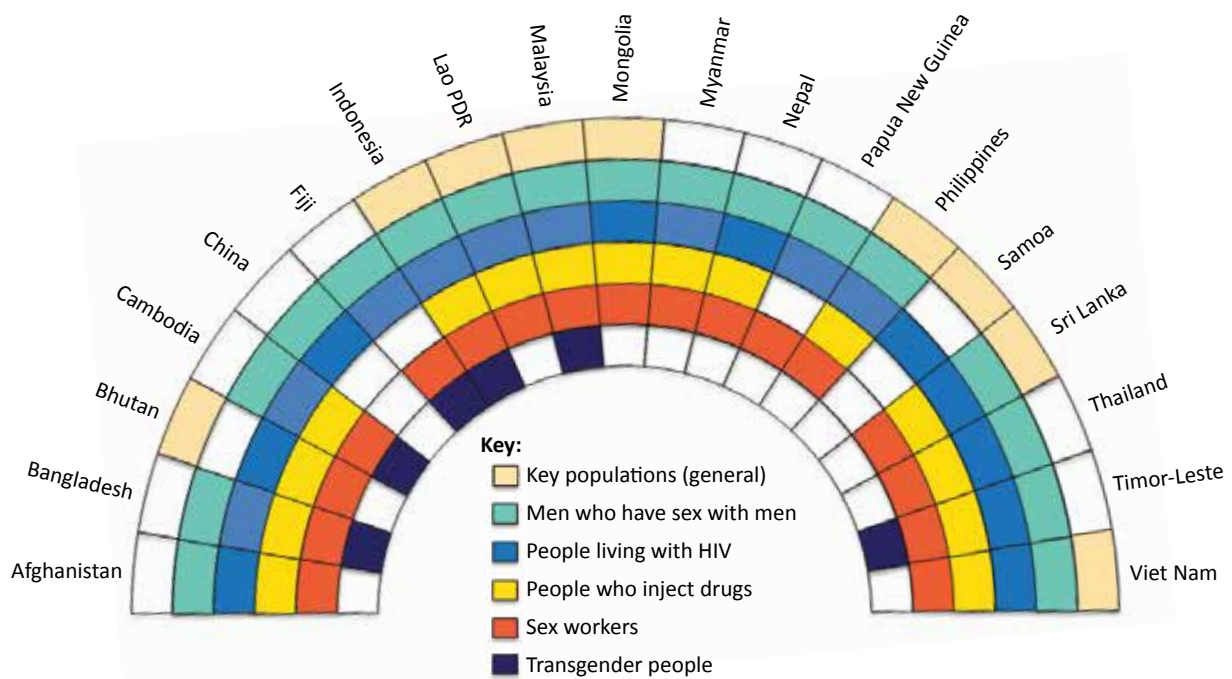
Previous classifications of the HIV epidemic, as for example a low prevalence or concentrated epidemic in certain populations, may have guided the collection of strategic information and limited the subsequent situation analysis. For example, the HIV epidemic in Oceania is relatively small and stable with the main means of transmission being unprotected heterosexual intercourse [53]. Injecting drug use is believed to play a minor role in epidemics in this sub-region [53]. By comparison, many countries in Asia demonstrate low-level or concentrated epidemics where prevalence is higher in defined subpopulations or those individuals with high-risk behaviours [51,53]. Behaviours such as injecting drug use, unprotected sex between men and sex work are central to these epidemics with the latter being particularly prominent in countries with maturing epidemics such as Papua New Guinea.

In Asia, HIV epidemics in key populations have tended to follow a similar course, varying in magnitude and progress depending on the risk behaviours prevalent in the country. Initial outbreaks were mostly detected in men who have sex with men or people who inject drugs. However, concurrent risk behaviours in some populations, particularly sex workers who inject drugs and people who inject drugs who also buy or sell sex, may lead to a more widespread epidemic among sex workers and their clients [53]. Over time, research has shown male clients of sex workers pass the infection to their wives, girlfriends and other sexual and/or drug using partners [53]. More recently there has been a resurgence of the epidemic among men who have sex with men which is suggested as being related to social factors such as mobility and increased use of technology for communication e.g. internet dating and short message service (SMS) mobile communications [53]. Low perceived risk of HIV infection, not knowing where to take a test, fear of a positive result and the associated stigma, have been identified as barriers to HIV testing in this population [54,55].

To further complicate matters, national epidemics can hide heterogeneity across districts or other sub-national variations, such as urban versus rural patterns of infection. For example, Indonesia has a concentrated epidemic nationally. However, the provinces of Papua and West Papua have prevalence rates of between 1.36 per cent and 2.41 per cent in the general population [17]. Due to the fluid nature of HIV epidemics, thorough and regular monitoring of all key populations is essential to provide a current and accurate situation analysis.

All of the NSPs reviewed include some information regarding key adult populations, particularly people living with HIV. Sex workers and men who have sex with men are discussed in the situation analyses of 18 NSPs, people who inject drugs by 16 NSPs but transgender people are only addressed in six plans.

**Figure 4: NSP includes strategic information for key populations**



When young key populations are included in the situation analysis, this typically refers to children or young people living with HIV (as was the case for seven plans, representing 37 per cent of all reviewed). Attention to young people selling sex (see definition in Appendix), young men having sex with men, young transgender people and young people who inject drugs in situation analyses is rare. Those countries which do include specific reference to young key populations include:

- Afghanistan (young men and boys who have sex with men including transactional sex for money or drugs, and young people who inject drugs);
- Bangladesh (young people who inject drugs, children living with HIV);
- Bhutan, Cambodia, Indonesia, Myanmar and Papua New Guinea (children and/or young people living with HIV);
- Mongolia (most at risk young people);
- the Philippines (young people living with HIV, young men who have sex with men, young female sex workers, young people who inject drugs, most at risk youth);
- Samoa and Sri Lanka (young men who have sex with men).

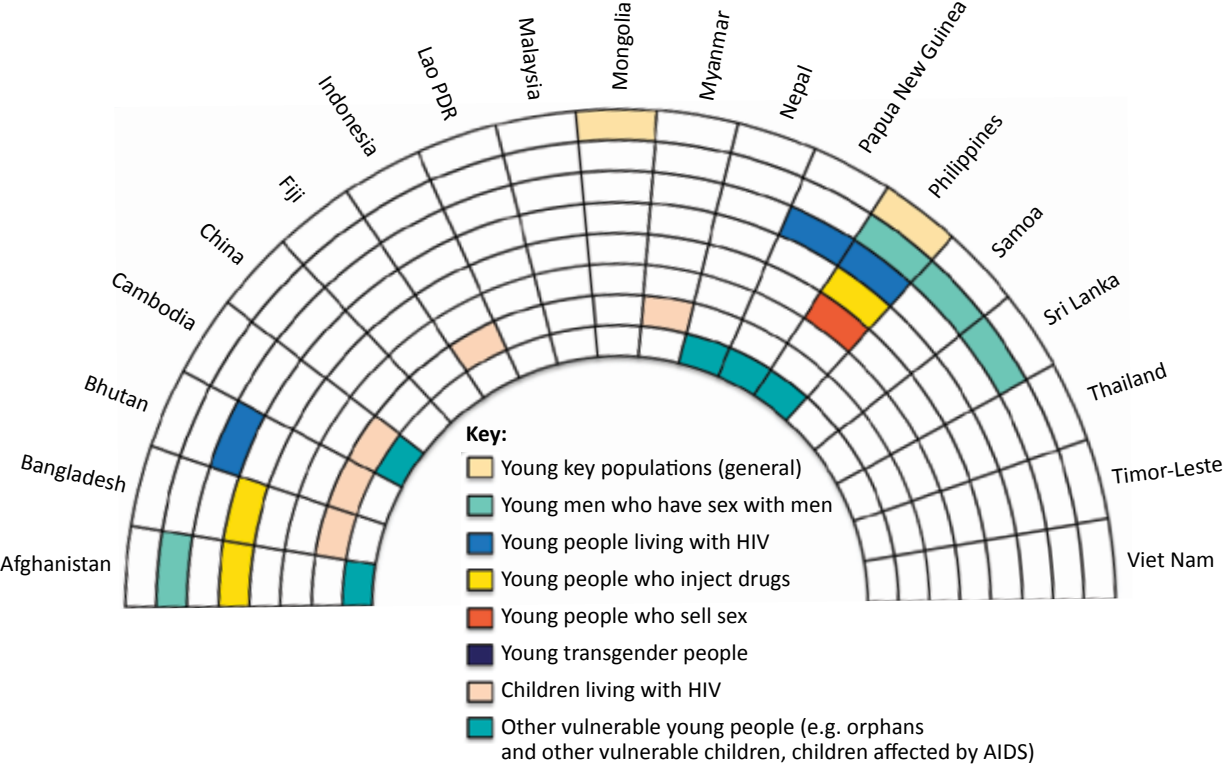
**Examples of strategic information for young key populations included in the NSP: Philippines [15]**

*‘Adolescents engaging in commercial sex, male-to-male sex, or injection drug use may cause up to 95 per cent of the infection in their age group, but receive less than 10 per cent of the HIV funding allocated for their age cohort....The results revealed that most-at-risk populations are predominantly young: 65% of men who have sex with men, 62% of FSW and 55% of IDU were 15–24 years of age. Age-disaggregation showed that young people most-at-risk below the age of 18 had equal levels of risk behaviors (e.g., anal sex without condoms, and number of sex partners among men who have sex with men) as adult MARPs. However, young people had lower knowledge than the adult MARP population (18–24% compared with 31–46% among adult MARP) and they have limited access to services (e.g., only 5% of FSW and 0.5% of men who have sex with men under 18 accessed HIV testing, compared with 24% and 10% in the adult population)’.*



Even when information is provided for these groups the data are generally very limited. This lack of data for these younger cohorts has been noted previously, as Reddy [10] reported that less than half the countries in the Asia-Pacific region have a reasonable proportion of young key affected populations represented within country surveillance systems. Of those countries which do provide strategic information for young key populations, the Philippines provides perhaps the most comprehensive analysis.

**Figure 5: NSP includes strategic information for young key populations**



The analysis also considered reference to the need for future research to fill data or other evidence gaps. Our review found that little attention is given to future research for young key populations with only six NSPs (32 per cent of the total reviewed) indicating such. The majority of plans suggesting the need for further research made general references to surveillance among young key populations or children/young people living with HIV. Only Sri Lanka specified further research regarding another young key population, ‘beach boys’, identified in the plan to be a young male sex worker sub-population.

The following section examines attention to specific key populations within the strategic information of the NSPs, with reference to the nature of the epidemic and particular attention to young key populations.

**Men who have sex with men**

Nearly all countries included in this analysis (89 per cent), with the exception of Bhutan and Samoa, include strategic information regarding men who have sex with men within the situation analysis of the NSP. Approximately half of the NSPs namely Afghanistan, Bhutan, Cambodia, Fiji, Lao PDR, Mongolia, Myanmar, Papua New Guinea and Sri Lanka, discuss the need for future research on men who have sex with men. The lack of consideration of adult men who have sex with men in the situation analysis for Samoa is puzzling since the NSP does state that 14.7 per cent of young men reported sex with men. Apart from Samoa only three other countries (a total of four countries, 21 per cent) include discussion

## Examples of strategic information for men who have sex with men

### Afghanistan [12]

'A 2009 study on male vulnerabilities to HIV and sexual exploitation in Afghanistan highlighted the evidence of sexual exploitation of male adolescents by older males. As the study revealed, almost 61 per cent of the interviewed adult males (a purposive sample of 100 persons) had sex with other males, reporting sexual debut by 15, and almost 89 per cent of them had been involved in transactional sex'.

### Mongolia [34]

'...fear of being identified as gay keeps many MSM from seeking STI treatment, thus further exacerbating their HIV risk and the risk of bridging to other groups. Many MSM, especially young men, are exploring their sexuality in semi-hidden MSM settings, such as public MSM cruising areas, MSM-friendly hotels or MSM websites, that are often not conducive to safer sex. As a result of societal pressure and family expectations, many MSM eventually marry and live "double" lives – engaging in sex with multiple male sexual partners, while at the same time having sexual relationships with women. MSM thus also constitute a potential bridge population for spreading HIV into the general population'.

### Only the Cambodia [32] NSP discusses particular issues facing transgender people

*'Sometimes referred to as "long hair men who have sex with men," transgenders are at higher risk for HIV than other (short hair) men who have sex with men due to higher risk sexual behaviours, greater gender-related stigma, discrimination and violence and less access to services'.*

regarding young men who have sex with men within the situation analysis. The additional countries are Afghanistan, the Philippines and Sri Lanka. Sri Lanka provides information about 'beach boys' or young male sex workers who have sex with men, and is the only country to specify young men who have sex with men for future research [56].

When provided, the strategic information for men who have sex with men is generally simple prevalence data with none of the NSPs including what could be described as a comprehensive situation analysis. The limitations in the strategic information for men who have sex with men is surprising since 42 per cent of the countries in the analysis have concentrated epidemics among this population (see Table 3), with reported HIV prevalence among them as follows: China (6.7 per cent), Indonesia (6.1 per cent), Lao PDR (5.6 per cent), Malaysia (12.6 per cent), Mongolia (10.7 per cent), Myanmar (8.9 per cent), Thailand (7.1 per cent) and Viet Nam (16.7 per cent). Indeed, very few countries provide an in-depth analysis of men who have sex with men despite their strategic importance in many epidemics. For example, Afghanistan includes no strategic information for men who have sex with men even though 61 per cent of males interviewed in one survey reported having had sex with other males [12]. Those countries that do provide a more thorough analysis, including for example information regarding indicators such as number of sexual partners, condom use, and HIV knowledge and testing, are Bangladesh, Mongolia and Sri Lanka. Of these only Mongolia has a concentrated epidemic in this population (HIV prevalence 10.7 per cent) whilst the others have prevalence of <1 per cent for men who have sex with men [32,36,56]. The NSP for Mongolia makes some particularly insightful observations regarding the social barriers and behaviours of this population.

### Transgender people

Very few NSPs include strategic information for transgender people. Only five countries (Bangladesh, Cambodia, Fiji, Indonesia and Malaysia) include information regarding adult transgender people. Six countries discuss the need for further research (Bangladesh, Bhutan, Cambodia, Myanmar, Philippines and Sri Lanka). There is no specific inclusion of young transgender people in situation analyses or as targets for research. For some countries HIV prevalence rates among transgender people are alarmingly high, as indicated in Table 3, (see for example Cambodia 24.4 per cent, Indonesia 21.9 per cent, and Malaysia 9.7 per cent). Only Bangladesh and Cambodia provide information for transgender people beyond HIV prevalence. Bangladesh provides data regarding condom use, service reach and HIV knowledge while Cambodia includes a general discussion of higher risk sexual behaviours, greater stigma and discrimination and less access to services [32,34]. There is a notable absence of data from countries such as Samoa and Thailand, where transgender people have a history of integration into the community [57,58]. Transgender people,

along with male sex workers, are sometimes grouped with men who have sex with men, for example in the NSP for Fiji [59]. Of the NSPs analysed, only Cambodia and Fiji mention the additional discrimination and harassment faced by transgender people, although Fiji does so only for transgender sex workers [34,59].

### Female, male, transgender and young people who sell sex

Strategic information regarding people who sell sex is included in most plans with the exception of the NSP for Samoa and the action plan for China, both of which provide only limited situation analyses. For the majority of plans the focus is predominantly on female sex workers (FSW) with only four countries (Afghanistan, Bangladesh, Nepal and Sri Lanka) providing information regarding male sex workers (MSW). Of these countries, only Bangladesh and Nepal report HIV prevalence data (0.3 per cent and 5.2 per cent respectively) [32,60]. The Fiji NSP is the only one in our analysis to include discussion regarding transgender sex workers, noting that this population are often targeted for harassment, violence and abuse from heterosexual men, street children and the police [59]. Only Mongolia and the Philippines include strategic information regarding young people who sell sex (under the age of 25 years) within the situation analysis [15,36].

Those countries for which reported HIV prevalence data indicate a concentrated epidemic among sex workers (SW) include Cambodia (HIV prevalence for FSW 13.9 per cent), Indonesia (SW 9 per cent, FSW 7 per cent, MSW 18.3 per cent), Myanmar (SW 7.1 per cent, FSW 9.4 per cent), Nepal (MSW 5.2 per cent), Papua New Guinea (SW 17.8 per cent, FSW 19 per cent, MSW 14.1 per cent) and Thailand (MSW 12.2 per cent) see Table 3. Those countries with concentrated epidemics do not generally provide more comprehensive data or situation analyses for these populations.

The strategic information provided for female sex workers is generally more detailed than that provided for other key populations. Discussions include information relating to differences between those working in establishments or brothels compared to those working independently or freelance; those with sex work as an occupation or main source of income as versus those who utilise sex work to supplement their income; legal restrictions; geographic location, migration and trafficking; concurrent injecting drug use; as well as access to services, HIV knowledge and condom use. The clients and partners of sex workers are regularly included as vulnerable populations. Strategic information is often provided for these groups, particularly the clients of sex workers.

None of the plans reviewed specify future research for young people who sell sex. Seventeen countries (89 per cent) specify sex workers and/or female sex workers as populations for future research and/or monitoring and evaluation whilst only six include male sex workers as target populations for surveillance (namely Bangladesh, Lao PDR, Malaysia, Nepal, Papua New Guinea and the Philippines).

## Examples of strategic information on people who sell sex

### Fiji [59]

'Sex workers working from the streets, especially transgender sex workers were more likely to experience harassment and abuse from men, street kids and the police. Transgender sex workers experienced violence and sexual abuse from heterosexual men'.

### Mongolia [34]

'An assessment in 2005 on HIV and STIs in three border areas with Russia and China revealed that SWs (aged 18-23 years) had good HIV knowledge, although misconceptions were still common. While most tried to use condoms if possible, occasionally they had sex without condoms because these were not sold at border posts and clients (especially Chinese) often refused to use them. They mainly catered to Chinese and Russian clients, and occasionally to Mongolian traders and truck drivers, although they preferred foreign clients because they paid more. In addition to limited control over consistent condom use with clients, sex workers often have limited access to sexual and reproductive health care services (especially in border areas), due to high fees, the lack of information on where to go, lack of registration documents, and inconvenient opening hours'.

### Sri Lanka [56]

'The term "beach boys" refers to young men who work near or on the beaches, typically tourist beaches, and who offer sexual services in exchange for some form of payment. They also include those working in restaurants, hotels, guesthouses and boat-related tourism. They are at risk of HIV infection due to low levels of condom use and having unprotected sex with male and female sexual partners including tourists from high HIV prevalence countries'.

## Examples of strategic information regarding young people who inject drugs

### Bangladesh [30]

'Bangladesh has an estimated 20,000 to 40,000 people who inject drugs, 23% of the total populations are young people. These young people have limited knowledge about HIV/AIDS because of societal barrier'.

### Afghanistan [12]

'Information on abuse and adolescent dependence on substances indicates that children and adolescents are often involved at a very young age and become familiar with opiate drugs because of drug use at home'.

## Examples of strategic information for people with overlapping vulnerabilities

### Viet Nam [67]

'Many evidences show that the growing per centage of drug injecting female sex workers and men who have sex with men have increased the risk of sexual transmission from these groups to their sexual partners, therefore the people infected with HIV through sexual transmission made up a higher percentage than previous years'.

### Timor-Leste [37]

'Injecting drug use is known to occur in Timor-Leste. In a recent IBBS study, 6.4% of female sex workers and 11.5% of men who have sex with men reported ever injecting. However frequency of injecting among these groups was low, perhaps indicating that injecting drug use is a relatively recent phenomenon. The population size estimation of 400 is less than 0.1% of the adult population and may be an underestimation and not indicate the possible rapid growth in this behaviour in the near future'.

## People who inject drugs

There are an estimated 3–4 million people who inject drugs living in Asia. High HIV prevalence rates have been reported in a number of countries in the region including Cambodia (24.4 per cent), Indonesia (36.4 per cent), Pakistan (27.2 per cent), Thailand (25.2 per cent), Myanmar (18 per cent) and Viet Nam (11.6 per cent) [61,62]. People who inject drugs are widely included in situation analyses of NSPs for countries in Asia. In the plans examined, only the China Action Plan and the NSPs for countries in Oceania (Fiji, Papua New Guinea and Samoa), did not include people who inject drugs in the situation analysis. The Oceanic countries report low levels of injecting drug use i.e. the Fiji NSP indicates there are very few reports of injecting drug use amongst the people of Fiji. Samoa reports no known cases of transmission by needles due to drug use; and Papua New Guinea states that injecting drug use is not yet recognised as an important factor in the transmission of HIV although it does state that cases have been reported [17,59,63]. The lack of strategic information for countries in Oceania is interesting since studies in other countries in the region (Federated States of Micronesia, Marshall Islands and Vanuatu) have found that more than 10 per cent of young men report injecting drugs [64]. For Asia the prevalence of injecting drug use (amongst 15–64 year olds) varies from 0.015 to 0.53 per cent with rates being highest in Myanmar (0.23 per cent) and Viet Nam (0.53 per cent) [31,65]. Other countries such as Afghanistan, report a high prevalence of illicit drug use which can be a significant risk factor for injection initiation (particularly transition from opioids such as heroin) as well as increasing the likelihood of unprotected sexual behaviour [66].

### The NSP for Afghanistan [12] provides a more comprehensive discussion of drug use, including among adolescents and children

*'Unsafe Injecting drug use is considered the key mode of the HIV transmission in Afghanistan as IDUs report the highest HIV prevalence rates in the country largely due to injecting practices such as sharing of needles and syringes (47 per cent) and unprotected sexual contacts. Afghanistan is the world's largest producer of opium and a host to almost 1 million drug users or 8 per cent of the adult population (15–64 years old), including 740,000 males, 120,000 females and 60,000 children estimated in 2005. The 2009 UNODC, MoCN and MoPH Drug Survey estimated the number of IDUs ranging from 19,000 to 25,000 persons, similar to the 2005 UNODC data that included 7,000 of those who inject heroin and 12,000 of those who inject pharmaceutical drugs. While systematic information is presently unavailable, data suggest a considerable number of adolescents and children among IDUs and drug users at large'.*

Concentrated epidemics among people who inject drugs are relatively common in Asia (see Table 3) with nine countries reporting HIV prevalence rates of greater than 5 per cent, including Cambodia (24.4 per cent), China (6.4 per cent),

Indonesia (36.4 per cent), Malaysia (18.9 per cent), Myanmar (18.0 per cent), Nepal (6.3 per cent), the Philippines (13.6 per cent), Thailand (25.2 per cent) and Viet Nam (11.6 per cent). Despite the alarmingly high prevalence rates in many countries, the quality of the strategic information is surprisingly limited with a minority of countries providing fragmented data regarding risk behaviours, HIV knowledge or intervention reach. Approximately half (10 of the 19) countries specify people who inject drugs for future research. Only three countries (Afghanistan, Bangladesh and the Philippines) include strategic information regarding young people who inject drugs within their NSPs but there is no discussion of additional research for this group.

Some countries (namely Bhutan, Cambodia and Viet Nam) provide sex-disaggregated data for people who inject drugs. Timor-Leste and Viet Nam make reference to overlapping vulnerabilities, i.e. drug-injecting men who have sex with men and female sex workers, whilst Nepal and the Philippines also discuss the overlap between injecting drug use and sex work.

### People living with HIV

The prevalence of HIV in the general population for countries in the Asia-Pacific is generally low at less than 0.5 per cent, the exceptions being Cambodia (0.8 per cent), Myanmar (0.6 per cent), Papua New Guinea (0.5 per cent), Thailand (1.1 per cent), Timor-Leste (0.58 per cent) and Viet Nam (0.5 per cent) (see Table 3). Some countries, such as Fiji, Mongolia and Samoa, have a low prevalence of HIV but high prevalence of STIs indicating unsafe sexual practices and potential risk for escalation of the HIV epidemic.

Strategic information regarding people living with HIV is, as would be expected, included in all NSPs. The omission of three plans (China Action Plan and NSPs for Bhutan and Samoa) to specify those infected with HIV for future research is likely simply an oversight since surveillance of this population should be inherent in any HIV and AIDS strategy. Children living with HIV are more commonly discussed within situation analyses (five countries, Bangladesh, Bhutan, Cambodia, Indonesia and Myanmar) as compared to other references to young people living with HIV, which are mentioned in three plans, namely those of Bhutan (youth), Papua New Guinea (adolescents), and the Philippines (youth).

For people living with HIV, the strategic information most commonly provided generally relates to: the history of the epidemic within the country; prevalence rates including general prevalence with disaggregation by sex and key populations; treatment with antiretroviral therapy (ART); mode of transmission; AIDS-related deaths; and geographic distribution of HIV infections. Prevalence data is rarely disaggregated by age in a comprehensive manner. A few countries provide information regarding: contraception use; PPTCT uptake and children born to females living with HIV; partners of people living with HIV; TB infection; access to support groups and services; knowledge of rights and treatment options; experience of stigma and discrimination; and disclosure of status to friends and family.

The provision of more comprehensive strategic information is not necessarily associated with countries with a higher prevalence of HIV although Cambodia does provide baseline data within the M&E framework for several of the indicators discussed. Data for children and young people is, however, generally limited to prevalence. Few countries specify the treatment rates related to CD4 count. Those that do include Thailand and Viet Nam [18,67].

### Examples of strategic information for people living with HIV

#### Philippines [15]

'The age groups with the most number of cases were 20-24 years (18%), 25-29 years (25%) and 30-34 years (19%). A deeper analysis of the data shows that since 2006, overall HIV infection increased five-fold among the total reported cases from 309 in 2006 to 1,591 in 2010. During the same period, HIV infection among 15-24 year olds increased ten-fold from 44 in 2006 to 489 in 2010'.

#### Thailand [18]

'...in 2008 and 2009, 52.6% and 51.9% newly registered ART clients already had symptoms of AIDS or CD4 counts under 100 cell/cu.mm'.

#### Viet Nam [67]

'The number of PLHIV who are being treated with ARV drugs currently meet only 49.4% if starting ARV treatment at CD4  $\leq$  250 and 37.5 if starting at CD4  $\leq$  350 cells/mm<sup>3</sup>. Most of PLHIV accessed to treatment services in late stages. 77% of PLHIV started the treatment at CD4 counts below 100 cells/mm<sup>3</sup>'.

## Examples of strategic information for young people

### Afghanistan [12]

“The situation of Afghan girls is of particular concern - under traditional pressures, they enter early marriage and early pregnancy which increase their odds of contracting STIs and HIV from their spouses who are often of older age and thus have longer sexual experience than their wives”.

### Mongolia [14]

“SGS data show considerable rates of unsafe sexual practices among youth: only 39% of sexually active youth had used a condom the first time they had sex. The same proportion (39%) had multiple sex partners in the previous year (49% of young men, 27% of young women), while 84% had casual sex with a non-regular, non-commercial partner. Furthermore, 5% of young women and 2% of young men reported having sex for money or gifts; while 6% of young men had sex with a SW in the last year (up from 3% in 2005).

Condom use at last sex with a SW was 78%, but consistent condom use with SWs was only 55%. Thus, many young people are at risk of STIs, as well as HIV, especially given the high STI prevalence among the general population”.

### Myanmar [70]

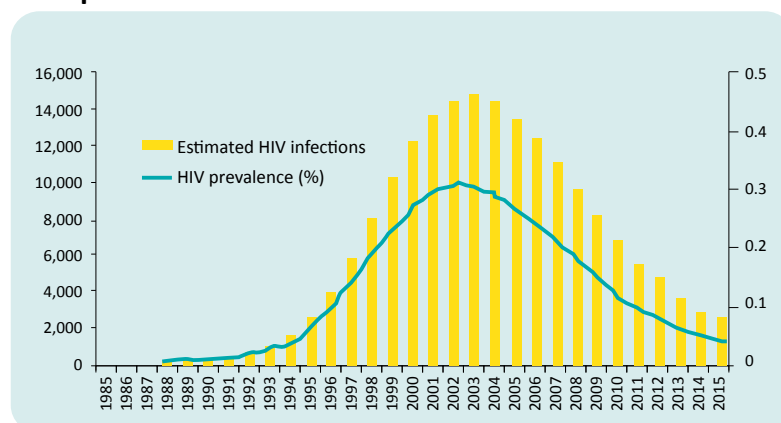
“Street children and out of school young people have a degree of mobility, may live in communities with higher HIV prevalence and incidence and higher concentration of high risk behaviours. Such street children and young people may also be sex workers, drug users and men who have sex with men.... A 2008 survey of Out-of-school youth found only 48% could correctly identify ways of preventing sexual transmission; only 52% reported using a condom at last casual sex. Stigma and discrimination still existed among out of school youth towards people living with HIV; 11.7% male and 12.6% female respondents reported having taken an HIV test in the last 12 months and receiving their results, whereas 70% intended to get an HIV test. In the 2008 BSS among of out-of-school youth, 2.3% of male youth reported ever having sex with another man with 1.6% having had sex with another man in the last 12 months”.

## Situation analysis of young people

Young people in Asia-Pacific generally have a very low risk of contracting HIV, with prevalence rates for those 15–24 years between <0.1–0.5 per cent. Whilst these figures represent estimates, survey data has revealed higher prevalence in some areas such as Tanah Papua, Indonesia which has a prevalence of 3 per cent in this age group (see Table 3). As discussed previously, young people can face significant barriers to accessing services. Laws regarding the legal age of majority often deny young people independent access to basic health care and social protection services [21]. Young people are still developing physically and psychosocially and may not have negotiating skills or decision-making powers in their relationships with adults [20]. They are also less likely to be aware of services and more likely to be fearful of approaching them. Programming for young people may not only assist in addressing risk behaviours and HIV prevention for those in the general population but also those from young key populations.

Approximately two-thirds of the NSPs reviewed include discussion of young people within the situation analysis of the epidemic. Almost a third consider the risk behaviours particular to this segment of the population. However, only a few mention barriers related to access to services. Only eight (42 per cent of the countries reviewed) specify that future research should be undertaken on young people. Some countries such as Nepal and the Philippines acknowledge that the HIV epidemic is demonstrating considerable growth among younger populations. The Philippines notes a decrease in the age of people becoming infected with HIV and a ten-fold increase in prevalence for 15–24 year olds between 2006 and 2010, twice the national rate [15]. A few countries, such as Nepal (see Figure 6), report having demonstrated some success in reducing the prevalence of HIV among young people [60].

**Figure 6: HIV prevalence among young (15-24) population in Nepal: 1985-2015**



Source: Reproduced from the Nepal NSP, NCASC, 2011 [60]

For the majority of NSPs reviewed in this analysis, however, the strategic information regarding young people is limited. Data are generally not disaggregated by age or sex, and legal restrictions may prevent the gathering of data from those younger than the

legal age of majority. When young people are discussed, this generally refers to those aged 15–24 years, with those under the age of 15 rarely considered or alternatively, discussed under the broad category of children for which age groups are generally not specified. As discussed previously risk behaviours for HIV often start at an early age and lack of information regarding these younger cohorts represents a significant gap in strategic information.

**Barriers to reaching young people identified in NSPs**

*‘Currently age data for those under age 18 cannot be collected due to legal restrictions’.*  
Bangladesh [30]

*‘In the case of younger participants, some said that although aware of condoms, sometimes they feel ashamed of looking for condoms or do not know where to get them’.*  
Timor-Leste [37]

Those countries which do provide more comprehensive situation analysis for young people include Bhutan, Mongolia, Samoa, Myanmar, the Philippines, Timor-Leste, and Viet Nam although some of this information pertains to more vulnerable populations such as out-of-school youth, or street and mobile/migrant children rather than young people from the general population. A few countries, such as Afghanistan and Timor-Leste, whilst not including specific data, provide discussion regarding social factors which increase the HIV risk of young people. Timor-Leste includes a particularly insightful discussion of the impact of social change upon the HIV/STI risk behaviours of youth, drawn from a report from the World Bank (see Table 2) [38]. This report identified a number of factors which have resulted in significant social alienation amongst the youth of Timor-Leste including unemployment, lack of social cohesion, political marginalization and dissatisfaction and social/cultural factors. It is suggested that these factors have not only contributed to civil unrest but also to a general increase in risk taking including sexual behaviour.

**Table 2: The impact of social change in Timor-Leste on HIV/STI risk behaviour of youth [38]**

Social Change	HIV/STI related risk
Decline in influence of church and family	- Undermining of traditional norms of sexual abstinence.
Established understandings of traditional marriage as precursor to church marriage may be breaking down	- Reduced commitment to on-going responsibility to sexual partners.
Mobility	- Separation from strong support structures; and - Greater exposure to wider range of individuals, social contexts and cultural influences.
Exposure to popular culture	- Modelling of sexual behaviour in conflict with established norms.
Increased materialism	- Status associated with material rewards for engaging in sex; and - Young people susceptible to engaging in sex with older partners for material reward and status.

Any comprehensive situation analysis of HIV and AIDS should include strategic information for young people, including data regarding prevalence and risk behaviours, disaggregated by age and sex; consideration of any social or economic factors particular to that country which may place the young person at higher risk; and discussion of any barriers whether legal or cultural which may impede access to services.

**Table 3: Epidemic classification, surveillance quality and HIV prevalence for the general and key populations [8,10,12,15,17,18,30–33,38,51,53,57,60,62,66,68–71]**

Country	Surveillance quality [51]	State of epidemic [51,53]	HIV prevalence	Key population HIV prevalence		Young key population HIV prevalence	
<b>Afghanistan</b>	1	Low	<0.1% [12] 15–24 yrs 0.1% [10]	SW MSM PWID	0.3% [62] 0.5% [62] 4.4% [62]	SW (<25 yrs) PWID (<25 yrs)	0.3% [62] 2.7% [62]
<b>Bangladesh</b>	3	Low	<0.1% [30] 15–24 yrs <0.1% [53]	SW FSW MSW MSM Hijra (transgender) Male PWID Female PWID	0.2% [62] 0.3% [62] 0.3% [62] 0.1% [30] 0.3% [30] 1.6% [30] 1% [30]	SW (<25yrs) PWID (<25 yrs)	0.2% [62] 0.7% [62]
<b>Bhutan</b>	1	Low	<0.1% [31]–0.3% [53] 15–24 yrs 0.2% [53]				
<b>Cambodia</b>	3	Concentrated	0.8% [8] 15–24 yrs 0.2% [8]	Brothel based SW Non-brothel based SW FSW MSM Transgender PWID	14.7% [32] 11.7% [32] 13.9% [62] 2.1% [8] 24.4% [32] 24.4% [71]	MSM (<25 yrs)	1.1% [62]
<b>China</b>	3	Concentrated	15–49 yrs <0.1% [8]	SW/FSW MSM PWID	0.3%[62] 6.7%[62] 6.4%[62]	SW (<25 yrs) MSM (<25 yrs) PWID (<25 yrs)	0.2%[62] 5.6%[62] 3.7%[62]
<b>Fiji</b>	1	Low	0.1% [57] 15–24 yrs 0.1% [53]	SW	1%[62]		
<b>Indonesia</b>	2	Concentrated	0.3% [53] 15–24 yrs 0.4–0.5% [8] Papua 15–49 yrs 2.4% [68] 15–24 yrs 0.2% [66]	Direct/Indirect SW SW FSW/MSW MSM TGPWID	10.4%/4.6%[68] 9% [62] 7/18.3% [62] 6.1% [62] 21.9% [68] 36.4% [68]	FSW (15–19 yrs) FSW (20–24 yrs) MSM (15–19yrs) MSM (20–24 yrs) MSM (<25 yrs) TG (15–19 yrs) TG (20–24 yrs) PWID (15–19 yrs) PWID (20–24 yrs) PWID (<25 yrs)	5.4% [68] 8.2% [68] 2.0% [68] 4.9% [68] 6.1% [68] 5.4% [68] 14.2%[68] 6.4% [68] 29.8% [68] 11.6% [62]
<b>Lao PDR</b>	2	Low	0.2% [69] 15–24 yrs 0.2% [8]	SW MSM PWID	0.98%[62] 5.6% <sup>a</sup> [69] 0.09% [71]–1.5% <sup>b</sup> [69]	SW (<25 yrs) MSM (<25 yrs)	0.81% [62] 5.2% [62]
<b>Malaysia</b>	2	Concentrated	0.4% [53] 15–24 yrs 0.1% [53]	SW MSM TG PWID	4.2% [62] 12.6% [62] 9.7% [33] 18.9% [62]	SW (<25 yrs) MSM (<25 yrs) PWID (<25 yrs)	1.1% [62] 6.2% [62] 4.8% [62]



<b>Mongolia</b>	2	Low	<0.1% [53] 15–24 yrs <0.1% [53]	MSM	10.7% [62]	MSM (<25yrs)	10% [62]
<b>Myanmar</b>	3	Concentrated	0.6% [53] 15–24 yrs 0.1% [8]	SW FSW MSM PWID	7.1% [62] 9.4% [62] 8.9% [62] 18% [70]	FSW (15–19 yrs) FSW (20–24 yrs) MSM (15–19 yrs) MSM (20–24 yrs) MSM (<25 yrs) PWID (15–19 yrs) PWID (20–24 yrs) PWID (<25 yrs)	3.4% [70] 7.1% [70] 0.6% [70] 7.1% [70] 4.5% [62] 7.4% [70] 14.8% [70] 13.3% [62]
<b>Nepal</b>	3	Concentrated	0.3% [60] 15–24 yrs 0.1% [53]	FSW MSW MSM PWID	1.7% [60] 5.2% [60] 3.8% [60] 6.3% [71]	PWID (<25 yrs) MSM (<25 yrs)	1.1% [62] 1.3% [62]
<b>Papua New Guinea</b>	2	Concentrated/ Generalised (2009/2011)	0.5% [8] 15–24 years 0.3% [53]	SW FSW/MSW MSM	17.8% [62] 19/14.1% <sup>c</sup> [17] 4.4% [62]	SW (<25yrs) FSW (15–24 yrs) MSW/TGSW (15–24) MSM (15–24 years)	12.7% [62] 12.1% <sup>c</sup> [17] 14.6% <sup>c</sup> [17] 1.9% [62]
<b>Philippines</b>	2	Concentrated	0.036% [15] 15–24 yrs <0.1% [53]	Key populations SW FSW MSM PWID	0.47% [15] 0.26% [62] 0.24% [15] 1.68% [62] 13.6% [62]	SW (15–24 years) MSM (15–24 years) MSM (<25 yrs) PWID (<25 yrs)	0.23% [15] 1.5% [15] 1.46% [62] 9.5% [62]
<b>Samoa</b>	0*		<0.02% [62] 15–24 yrs 0.3% [62]	Key populations	0% [62]		
<b>Sri Lanka</b>	2	Low	<0.1% [54] 15–24 yrs <0.1 [53]	Key populations SW MSM	<1% [54] 0.2% [62] 0.86% [62]		
<b>Thailand</b>	3	Concentrated	1.1% [8] 15–24 yrs 0.3% [8]	SW FSW MSW MSM PWID	3.2% [62] 2.2% [62] 12.2% [62] 7.1% [62] 25.2% [62]	FSW (15–24 yrs) MSM (<25 yrs) PWID (<25 yrs)	2.6% [18] 12.1% [18] 5.3% [62] 25.2% [62]
<b>Timor-Leste</b>	3*	Low	0.58% [37]	SW MSM	1.5% [62] 1.3% [62]		
<b>Viet Nam</b>	3	Concentrated	0.5% [53] 15–24 yrs 0.2% [53]	SW/FSW MSM PWID	2.7% [62] 16.7% [65] 11.6% [62]	MSM (<25 yrs)	3.0% [62]

**Notes:** Surveillance quality assessment was based upon the assessment of Calleja et al (2010): 1 not enough information; 2 partial implementation of surveillance; 3 good surveillance data [51].

\*As a classification was not available for this country an estimate was, derived by the author, based on specifications from the relevant publication.

<sup>a</sup>Based on a survey from Vientiane; <sup>b</sup>Based on a survey of two northern provinces; <sup>c</sup>Port Moresby.

**Epidemic classification: Low level epidemics:** are those in which HIV transmission occurs mostly among most-at-risk populations. The prevalence of HIV infection has not consistently exceeded 1 per cent in the general population nationally or 5 per cent in any subpopulation. **Concentrated epidemics:** HIV has spread rapidly in one or more defined subpopulation but is not well established in the general population. Numerical proxy: HIV prevalence is consistently over 5 per cent in at least one defined subpopulation but is less than 1 per cent among pregnant women in urban areas. **Generalised epidemics:** HIV is firmly established in the general population. Numerical proxy: HIV prevalence consistently exceeding 1 per cent among pregnant women. Most generalized HIV epidemics are mixed in nature, in which certain (key) subpopulations are disproportionately affected [51,72].

## National strategic plan content

The content of the NSPs was reviewed under the categories of core elements, basic programming, critical enablers and synergistic development activities (see Appendix I for definitions and details of the criteria reviewed). The emphasis of the content will vary depending on the nature of the epidemic within the country in question and the populations identified to be at highest risk of HIV exposure. The following analysis will review the content of the NSPs within this context, with particular attention to interventions for adult and young key populations, and young people generally.

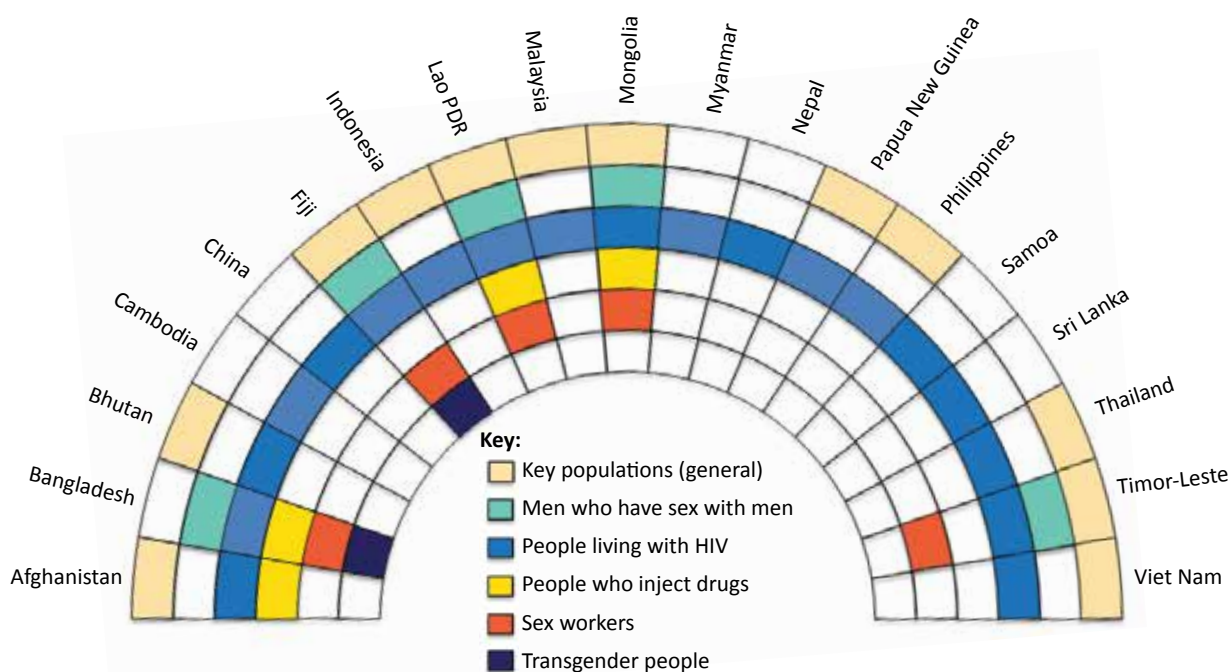
### Core elements and basic programming

The analysis of NSPs began first with consideration of goals, targets and objectives (see Figure 7 and Figure 8). All of the NSPs reviewed included goals for key populations. However, there was considerable variation in the groups targeted.

- All NSPs stated goals for people living with HIV, with three also including goals for females living with HIV;
- Two thirds of NSPs (12 countries) included reference to key populations generally;
- Approximately a quarter (five countries) included goals for men who have sex with men and sex workers;
- 21 per cent of NSPs (four countries) specified goals for people who inject drugs; and
- Only two countries mentioned transgender people within their goals.

Generally these goals refer to reducing transmission, increasing HIV testing and treatment, and programme/service coverage levels for these populations. Perhaps the most inclusive goal for key populations was stated by Bangladesh, which included the ‘strategy’ to minimise HIV transmission among female sex workers, men who have sex with men, hijra (transgender people) and people who inject drugs through comprehensive targeted interventions.[32]

**Figure 7: NSPs which specify goals for key populations**

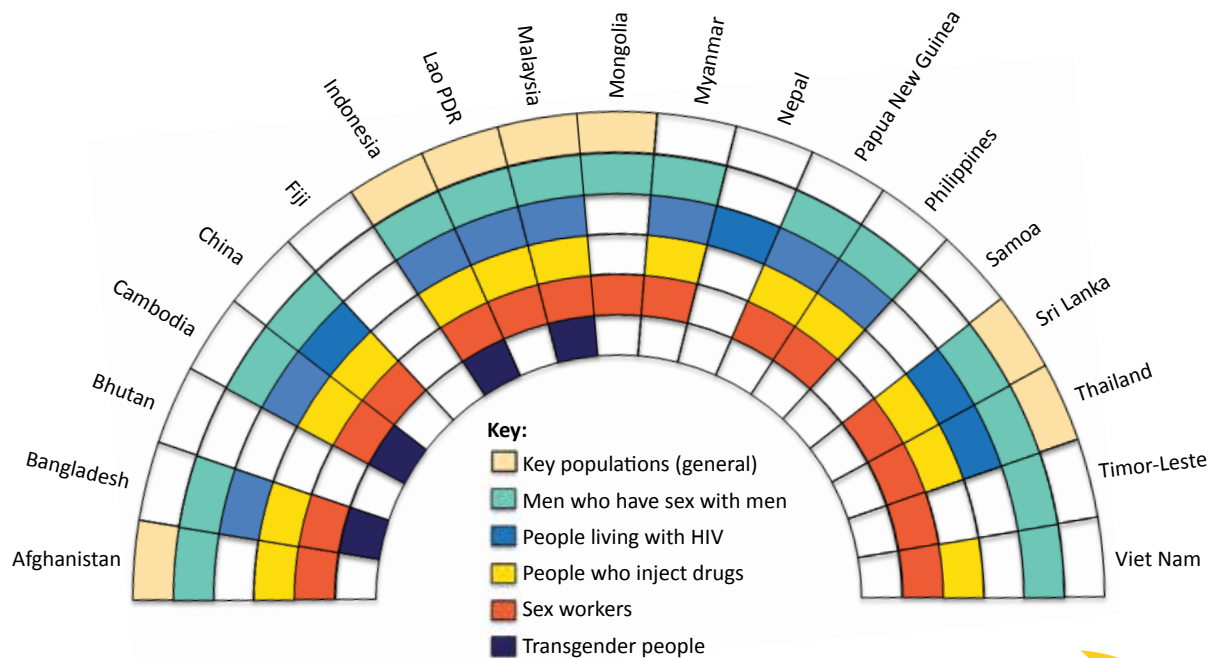


Overarching targets tend to be more inclusive with all but four countries stating targets for key populations other than people living with HIV. The plans for Bhutan and Samoa include no discussion of targets. Four NSPs (21 per cent) include targets for all key populations (Bangladesh, Cambodia, Indonesia and Malaysia) whilst seven (37 per cent) state targets for all key populations with the exception of

transgender people (see Figure 7). For men who have sex with men, sex workers, transgender people and people who inject drugs, targets usually relate to prevalence, HIV knowledge and behavioural objectives such as condom use and HIV testing. For people living with HIV, targets generally refer to access to ART, vertical transmission, reducing deaths from TB and AIDS-related illnesses, and stigma and discrimination. Geographic prioritisation is discussed generally in eight NSPs (42 per cent), with only Indonesia providing detailed analysis and targeting for all key populations across cities and districts.

Goals for younger cohorts are rarely included and when they are, typically refer to young key populations in general (Lao PDR and the Philippines) or children/young people living with HIV (the Philippines, Sri Lanka, and Viet Nam). Approximately half of the plans (nine countries) reviewed included overarching targets for children living with HIV with only Sri Lanka including specific targets for another young key population, namely ‘beach boys’ (young men who offer sexual services in exchange for some form of payment). The targets included for the latter group included HIV prevalence, condom use and that they are contacted by services.

**Figure 8: NSPs which specify overarching targets for key populations**



**Examples of targets for young key populations in NSPs**

*‘Target only at-risk youth (i.e. young MARPs), as most Lao youth are categorised as low risk’.*  
Lao PDR [69]

*‘To reach at least 60 per cent to 80 per cent of the most-at-risk adolescents’.*  
Philippines [15]

Key populations are generally well-targeted for basic programming within NSPs with the exception of activities related to harm reduction interventions for injecting drug use, needle and syringe programmes and opioid substitution, which are appropriately targeted for people who inject drugs. Hepatitis and TB testing and treatment also tend to be focused on people who inject drugs and people living with HIV.

As the comprehensive packages for different key populations vary significantly, reference to basic programming within NSPs will be discussed in more detail for each key population (including younger cohorts) along with an analysis of young people more generally with the goals and targets.

## Men who have sex with men and transgender people

### Core elements

Of the countries which have identified a concentrated epidemic amongst men who have sex with men, including China (6.7 per cent), Indonesia (6.1 per cent), Laos PDR (5.6 per cent), Malaysia (12.6 per cent), Mongolia (10.7 per cent), Myanmar (8.9 per cent), Thailand (7.1 per cent) and Viet Nam (16.7 per cent), only the NSP for Mongolia includes goals for this population. Goals are included for men who have sex with men in the NSPs of only five countries, namely Bangladesh, Fiji, Lao PDR, Mongolia and Timor-Leste; however most plans include overarching targets for this population.

As mentioned previously, transgender people are less likely to be included in the core elements of the NSP. Only Bangladesh and Fiji include this group for goals and only four countries specify overarching targets for them (Bangladesh, Cambodia, Indonesia and Malaysia). Those countries with concentrated epidemics among transgender people, Cambodia (HIV prevalence 17 per cent), Indonesia (21.9 per cent) and Malaysia (9.7 per cent), all include targets for this population.

### Basic programmes

The key elements of a comprehensive package of services and programmes to support HIV prevention, treatment and care among men who have sex with men and transgender people include [47]:

- Peer outreach, peer education and drop-in services;
- Risk reduction communications;
- Promotion of and access to means of HIV prevention, such as condoms and lubricants;
- HIV testing and counselling (HTC);
- Access to ART;
- Support groups; and
- STI prevention, testing and treatment services.

Providing specific services that are friendly and sensitive towards these key populations is important particularly for transgender people who have experienced rejection, humiliation and discrimination in health services [47].

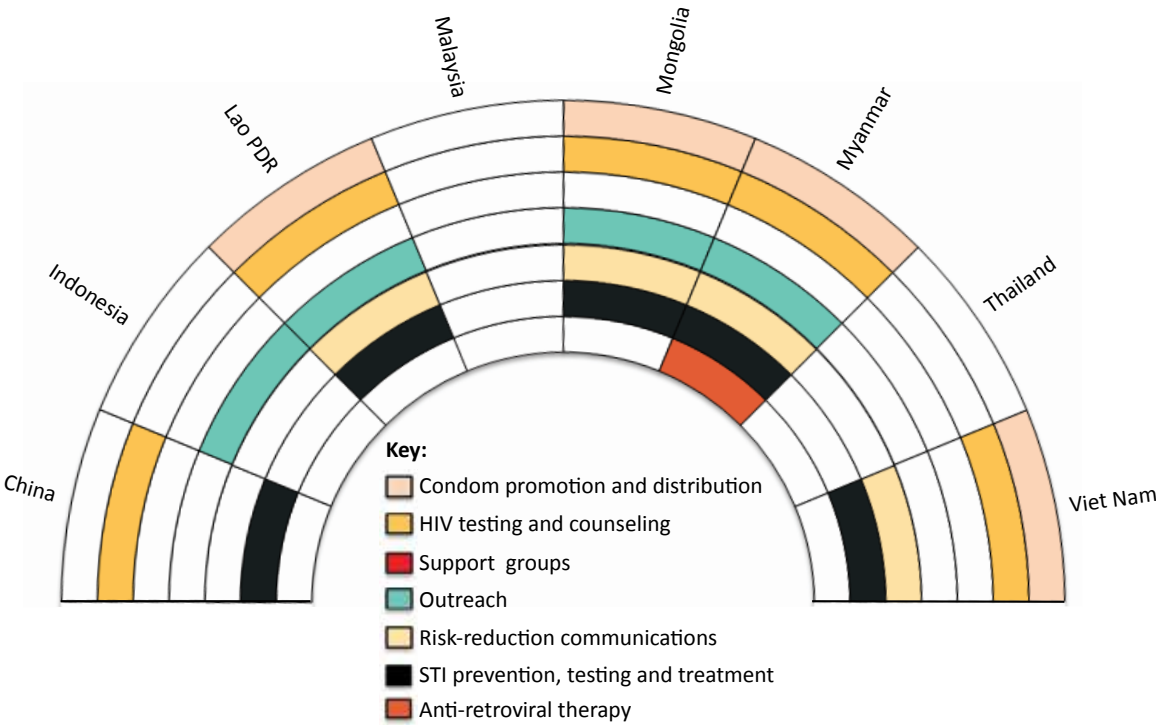
Inclusion of men who have sex with men for basic programmes varies considerably from 16 per cent of NSPs including support groups, risk-reduction communications and ART, to 68 per cent specifying men who have sex with men for condom promotion and distribution (see Figure 9 and Table 4). No country specifies men who have sex with men for all of the recommended programmes.

The following NSPs include six out of the seven specified interventions: Afghanistan and Myanmar include all but support groups; the Philippines does not include risk-reduction communications; and Timor-Leste does not refer to ART for HIV-positive men who have sex with men. Of those countries with a concentrated epidemic among men who have sex with men, Myanmar provides the most comprehensive range of programmes. Young men who have sex with men are largely neglected for basic programming within the NSPs reviewed; the exception being Malaysia which includes reference to a risk reduction programme for young men who have sex with men and transgender people [35].

**Young men who have sex with men and young transgender people are largely neglected within NSP programming: One exception is Malaysia [33]**

*'Develop a series of workshops for young men who have sex with men and TG (18 – 24 years old), which integrate living skills, gender and sexuality with safer sex knowledge/ skills to reinforce safer sex behaviour'.*

**Figure 9: Basic programmes for men who have sex with men in countries with concentrated epidemics among men who have sex with men**



Transgender people are referred to in only a minority of programmes within the NSPs (see Table 4). Only the Philippines, targets transgender people for six of the seven basic programmes, with the exception of risk reduction communications. Nepal includes transgender people for four interventions and Cambodia specifies this group for three interventions. Of the two other countries for which concentrated epidemics exist among this population, Indonesia includes no basic programming for transgender people whilst Malaysia includes risk reduction communications for both young transgender people and young men who have sex with men [35].

**Table 4: Countries which refer to basic programmes for men who have sex with men and transgender people, # countries (% total)**

	Outreach	Risk-reduction communications	Condoms	HTC	ART	Support groups	STI services
MSM	11 (58%)	11 (58%)	13 (68%)	11 (58%)	3 (16%)	3 (16%)	12 (63%)
Transgender	2 (11%)	2 (11%)	3 (16%)	2 (11%)	1 (5%)	1 (5%)	4 (21%)

## Males, females, and transgender people who sell sex

### Core elements

Three countries (Fiji, Lao PDR, and Timor-Leste) include goals for sex workers generally, whilst two others (Bangladesh and Mongolia) specify goals for female sex workers. None of the NSPs include goals for male sex workers. Fifteen NSPs include overarching targets for sex workers, the majority of these being female sex workers, with three countries (Lao PDR, Papua New Guinea and the Philippines) specifically referring to targets for male sex workers. The targets for these latter two countries are stated in the M&E frameworks. Only Sri Lanka includes targets for younger (male) sex workers, described as ‘beach boys’ [56].

#### Example of target for sex workers: Lao PDR [69]

*‘80% high-frequency sex workers and male sex workers have accessed to quality-assured STI services as needed’.*

Of those countries which report a concentrated epidemic among female sex workers, Cambodia (13.9 per cent), Indonesia (7 per cent), Myanmar (9.4 per cent) and Papua New Guinea (19 per cent), none specify goals in their NSPs for this population. However, all but Cambodia include overarching targets. The latter does state targets for sex workers in general, without disaggregation by sex. For those countries with concentrated epidemics amongst male sex workers, Indonesia (18.3 per cent), Nepal (5.2 per cent), Papua New Guinea (14.1 per cent) and Thailand (12.2 per cent) no goals are specified in any NSPs and only Papua New Guinea and Nepal include targets for this population.

### Basic programmes

Essential programmes for comprehensive HIV prevention, treatment, care and support of sex workers include [50]:

- Peer outreach;
- Risk-reduction communications;
- Reliable and affordable access to condoms;
- Access to voluntary HTC;
- Care and support of those who test positive for HIV;
- Access to STI and PPTCT services; and
- Support groups [73].

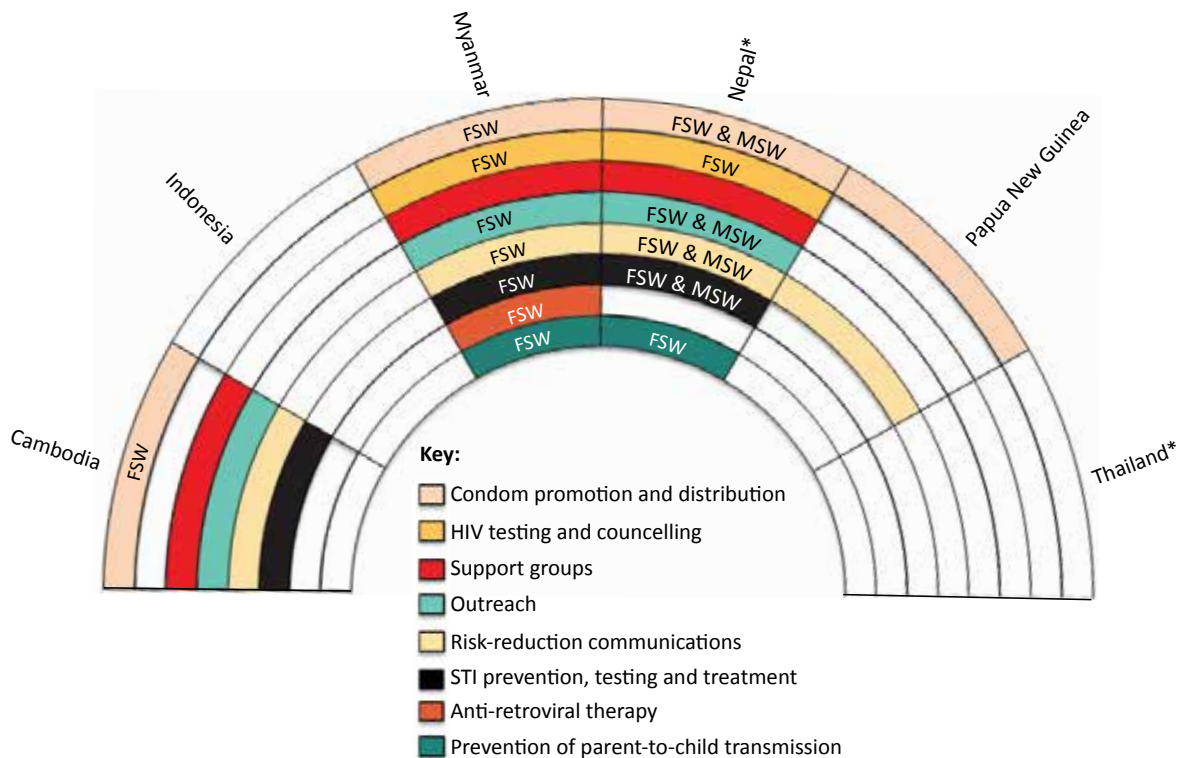
The majority of NSPs include basic programmes for sex workers (see Tables 5 and Figure 10). Those which don’t include specific programmes for sex workers include Fiji, Indonesia, Malaysia and Thailand. China, Papua New Guinea and Samoa include only a limited range of programmes for this population. The complete lack of programmes specifically targeting sex workers for Indonesia, Malaysia and Thailand is surprising considering the concentrated epidemics in these countries. The NSP that includes the largest variety of programming approaches for sex workers is Myanmar, although with a heavy emphasis towards female sex workers. Other countries with a variety of specified interventions for sex workers include Nepal (seven out of eight interventions, excluding ART, four of which are specified for both male and female sex workers) and the Philippines and Timor-Leste which both include reference to six interventions for sex workers [38,60,74].

**Table 5: Countries which refer to basic programmes for sex workers, # countries (% total)**

	Outreach	Risk-reduction	Condoms	HTC	ART	Support groups	STI services	PPTCT services
Sex workers*	11 (58%)	13 (68%)	12 (63%)	9 (47%)	3 (16%)	4 (21%)	13 (68%)	5 (26%)
Female sex workers	6 (32%)	6 (32%)	7 (37%)	6 (32%)	2 (11%)	1 (5%)	7 (37%)	5 (26%)
Male sex workers	1 (5%)	1 (5%)	1 (5%)	0	0	0	1 (5%)	0

**Notes:** \*Gender unspecified. No plans specified for transgender sex workers.

**Figure 10: Basic programmes for sex workers in countries with concentrated epidemics**



**Notes:**

FSW = Specifies for female sex workers; FSW & MSW = Specifies for female and male sex workers  
 No plans specified for transgender sex workers  
 \*Nepal and Thailand have concentrated epidemics among male sex workers

There is a notable lack of programmes targeting young people selling sex or children in commercial sexual exploitation within NSPs with the exceptions of those for Nepal and Sri Lanka. Nepal specifies under age and new entrant female sex workers for outreach, risk reduction communications, STI and PPTCT services [60,58]. Sri Lanka includes targeting ‘beach boys’ (young men who work on or near beaches and offer sexual services for payment) for prevention services [56]. Basic programmes planned for this population include condom promotion and distribution, HIV testing, outreach, STI prevention testing and treatment, and risk-reduction communications.

**Example of NSP that refers to ‘under-aged’ sex workers : Nepal [60]**

*‘Provide comprehensive priority interventions (condom promotion, and communication through peer and community outreach, STI diagnosis and treatment, counselling and testing) for female sex workers and their partners; these services will be made available along with Sexual and Reproductive Health (SRH) including family planning (FP), and PMTCT, focused in every targeted geographical area either as an integrated or linked service. Emphasize on reaching under aged and new entrants FSWs and those with overlapping risks (FSW who are also IDU) with prevention package and referral to other services.*

**People who inject drugs**

**Core elements**

As discussed previously, concentrated epidemics among people who inject drugs are relatively common in Asia with nine countries reporting HIV prevalence rates greater than 5 per cent, namely: Cambodia (24.4 per cent), China (6.4 per cent), Indonesia (36.4 per cent), Malaysia (18.9 per cent), Myanmar (18.0 per cent), Nepal (6.3 per cent), the Philippines (13.6 per cent), Thailand (25.2 per cent), and Viet Nam (11.6 per cent). Four NSPs state goals for people who inject drugs, namely: Afghanistan,

Bangladesh, Lao PDR and Mongolia, whilst 13 include overarching targets for this population. Two countries, Bangladesh and Cambodia, set targets for both males and females who inject drugs within their M&E frameworks [32,34]. There are no references to young people who inject drugs in the core elements of any of the NSPs.

### Basic programmes

A comprehensive package of interventions for the prevention, treatment and care of HIV for people who inject drugs includes:

- Needle and syringe programmes;
- Opioid substitution therapy (OST) and other evidence based drug dependence treatment;
- HIV testing and counselling (HTC);
- Antiretroviral therapy (ART);
- Prevention and treatment of sexually transmitted infections (STIs);
- Condom programmes;
- Risk-reduction communications;
- Prevention, vaccination, diagnosis and treatment for viral hepatitis; and
- Prevention, diagnosis and treatment of tuberculosis [75].

The majority of NSPs include reference to essential programmes for people who inject drugs (see Table 6). Indonesia and Nepal are the only two countries with concentrated epidemics which include reference to all the recommended programmes for people who inject drugs (see Figure 11). Thailand is notable for the absence of programmes included within the NSP for this population. Afghanistan specifies females who inject drugs as well as people who inject drugs, for five of the seven services it has within the plan; whilst Nepal includes coverage of both males and females who inject drugs for risk reduction communications [14,60].

#### Example of an NSP that addresses young people at risk of injecting drug use: Nepal NSP [60]

*‘Continue outreach activities in sites already covered and expand outreach activities to reach more injecting drug users through peer education approach on harm reduction with targeted information, education and communication for IDUs linking them to Drop in centres. Special attention will be given to adolescent girls, boys and women in risk of injecting drug use’.*

Young people who inject drugs are targeted for programmes by three countries, Afghanistan and Nepal (OST and risk reduction communications) and the Philippines (needle and syringe programmes). Afghanistan provides the most comprehensive coverage of this younger cohort, described as juvenile injecting drug users, including them for five of the seven interventions discussed, needle & syringe programmes, OST, risk-reduction communications, condom programming, HTC and ART [14]. There is no discussion regarding how these younger drug users will be targeted or how the programmes will differ from those for adults who inject drugs.

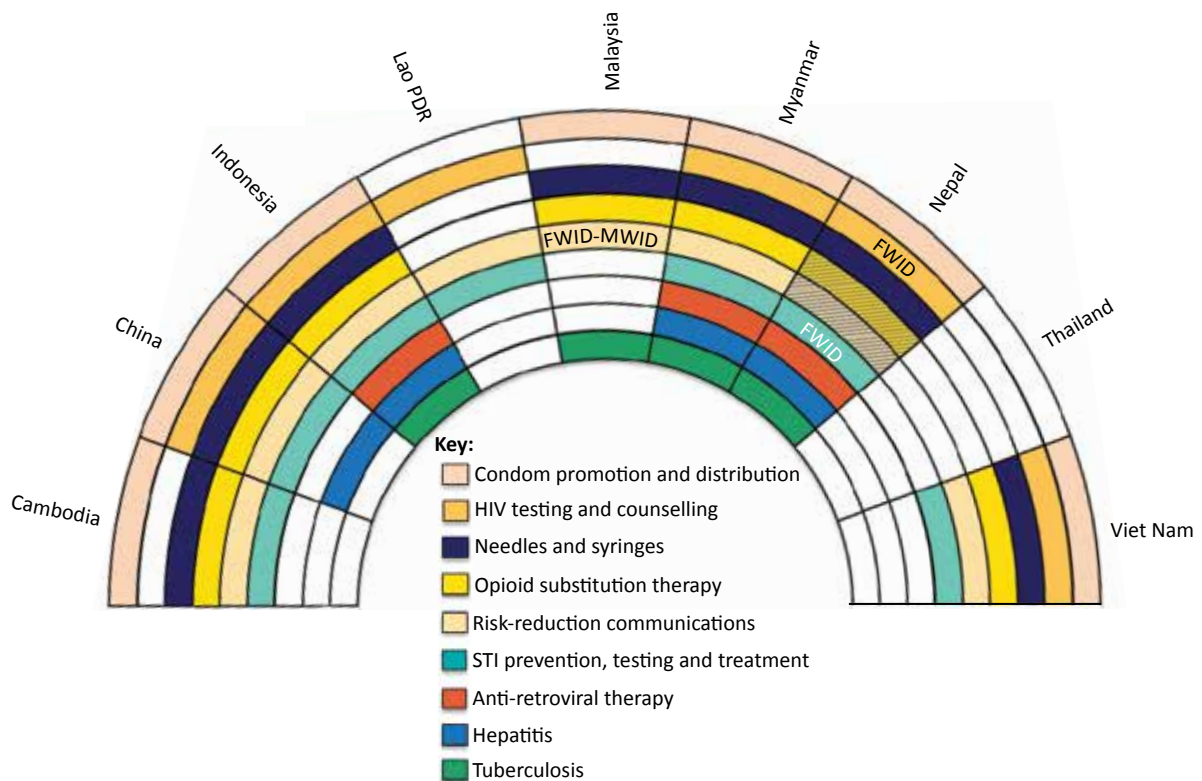
**Table 6: Countries which refer to basic programmes for people who inject drugs, # countries (% total)**

	Needle & syringe	OST	Risk-reduction	Condoms	HTC	ART	STI services	Hepatitis	TB
<b>PWID*</b>	13 (68%)	12 (63%)	13 (68%)	13 (68%)	11 (58%)	5 (26%)	11 (58%)	4 (21%)	4 (21%)
<b>Female PWID</b>	1 (5%)	2 (11%)	2 (11%)	1 (5%)	1 (5%)	1 (5%)	1 (5%)	0	0
<b>Male PWID</b>	0	0	1 (5%)	0	0	0	0	0	0

\*Gender unspecified



**Figure 11: Basic programmes for people who inject drugs in countries with concentrated epidemics**



### People living with HIV

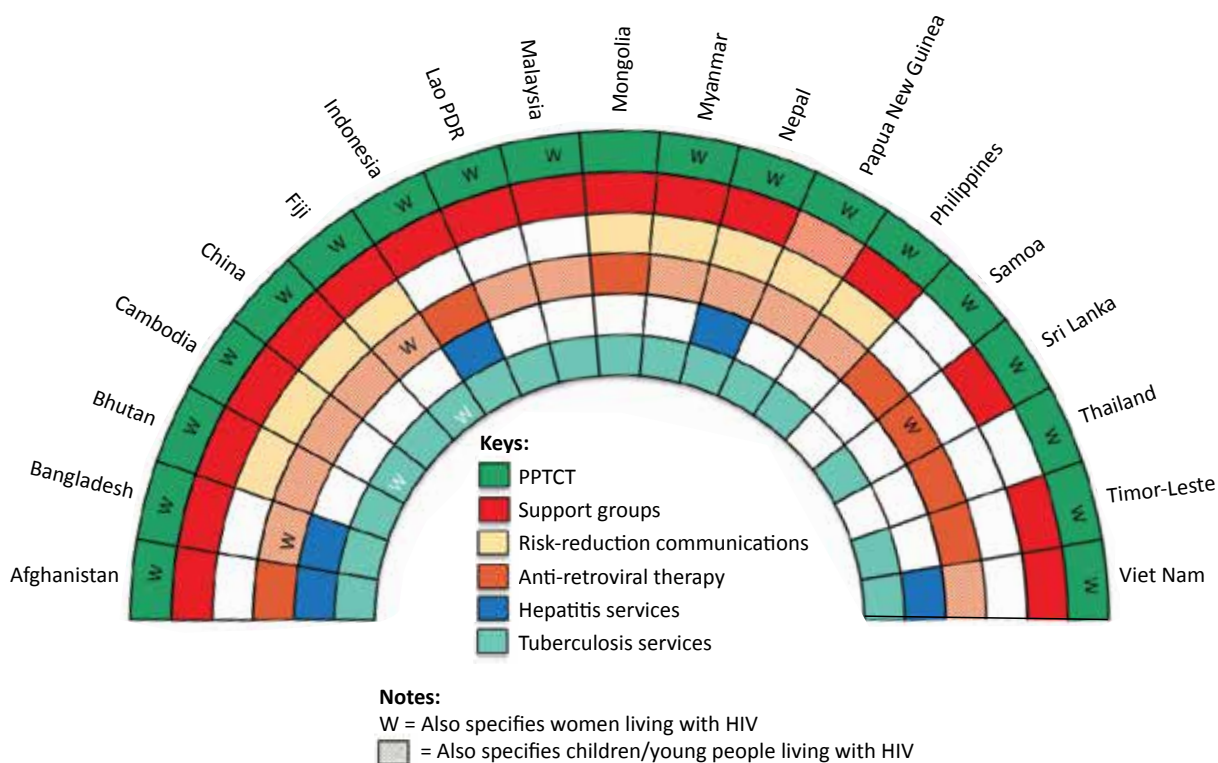
As discussed previously, the prevalence of HIV in the general population for countries in the Asia-Pacific is generally low at less than 0.5 per cent, the exceptions being Cambodia (0.8 per cent), Myanmar (0.6 per cent) Papua New Guinea (0.5 per cent), Thailand (1.1 per cent), Timor-Leste (0.58 per cent) and Viet Nam (0.5 per cent), see Table 3. However, regardless of prevalence the inclusion of a full range of basic programmes for people living with HIV is important for any NSP.

### Basic programmes

A general care package for people living with HIV will vary according to the type of epidemic, the populations affected, the prevalence of opportunistic infections and other health conditions. The key elements include [72]:

- PPTCT services;
- ART;
- Information and education, including positive living (good nutrition and healthy lifestyle), the progression of the disease, treatment and care options and risk reduction, how to prevent transmission to others including parent to child transmission [22];
- Hepatitis testing and treatment;
- TB testing and treatment; and
- Support groups.

**Figure 12: Basic programmes for people living with HIV**



With the exception of hepatitis services and risk reduction communications, basic programming for people living with HIV is well covered across the region. ART is discussed in all NSPs with some countries including specific mention of females living with HIV (see Figure 12). Children and/or young people living with HIV are targeted for ART by 11 countries. Few countries specify CD4 levels for which ART should be initiated. PPTCT is also widely discussed within the NSPs, generally being referred to as PMTCT and specified for females. Some countries such as Fiji, Indonesia, Papua New Guinea, Samoa, and Thailand also include discussion of the male partners of females living with HIV as being included for this programme. The majority of countries, with the exception of Thailand and Timor-Leste specify TB services and support groups for people living with HIV. However, only about half of the NSPs analysed discuss risk-reduction communications. Hepatitis testing and treatment for people living with HIV is included in a minority of NSPs (Afghanistan, Bangladesh, Indonesia, Nepal and Viet Nam). A few countries include children in discussions of TB testing and treatment and Papua New Guinea specifies young people as among the populations of people living with HIV who should be targeted for support groups (See Figure 12).

**Attention to young people living with HIV in NSPs: PNG [17]**

*'Identify the requirements of PLHIV support groups for specific populations such as women, young people, men who have sex with men, sex workers, men and sero-discordant partners, and establish groups as needed'.*

## Young people

### Core elements

The United Nations issued a target that 95 per cent of youth, aged 15–24, should have information, education, services and life skills that enable them to reduce their vulnerability to HIV infection by 2010 [22]. Despite this, the inclusion of goals and targets for young people is not universal. Goals for young people are only included in approximately a third of the NSPs reviewed, namely those for Bangladesh, Fiji, Papua New Guinea, the Philippines, Samoa and Timor-Leste. Overarching targets for younger cohorts are specified by about two-thirds of countries. No discussion of geographic prioritisation for young people could be found.

### Basic programmes

In order to provide effective interventions to prevent HIV in young people, the core areas of action targeting both risk and vulnerability reduction should include [22,76]:

- Information to acquire knowledge regarding sexual and reproductive health and HIV;
- Opportunities to develop life skills;
- Appropriate health services for young people;
- Condoms for sexually active young people;
- Diagnosis and treatment of STIs;
- Voluntary and confidential HTC; and
- Creation of a safe and supportive environment, including psychosocial support and care.

With respect to basic programming, this should include risk-reduction communications, access to HTC and STI services and condom promotion and distribution. Young people need skills to be able to refuse or negotiate sex; to use condoms correctly and consistently; to communicate with their partners and other adults about sex, condoms and contraception; and to know how to avoid situations and places that may expose them to risk behaviours [22]. Health services should deliver an evidence-informed package of interventions in a manner receptive and responsive to young people. This should include those programmes related to condom promotion and distribution, risk reduction communication, HTC and STI services and referral for young pregnant women to PPTCT services.

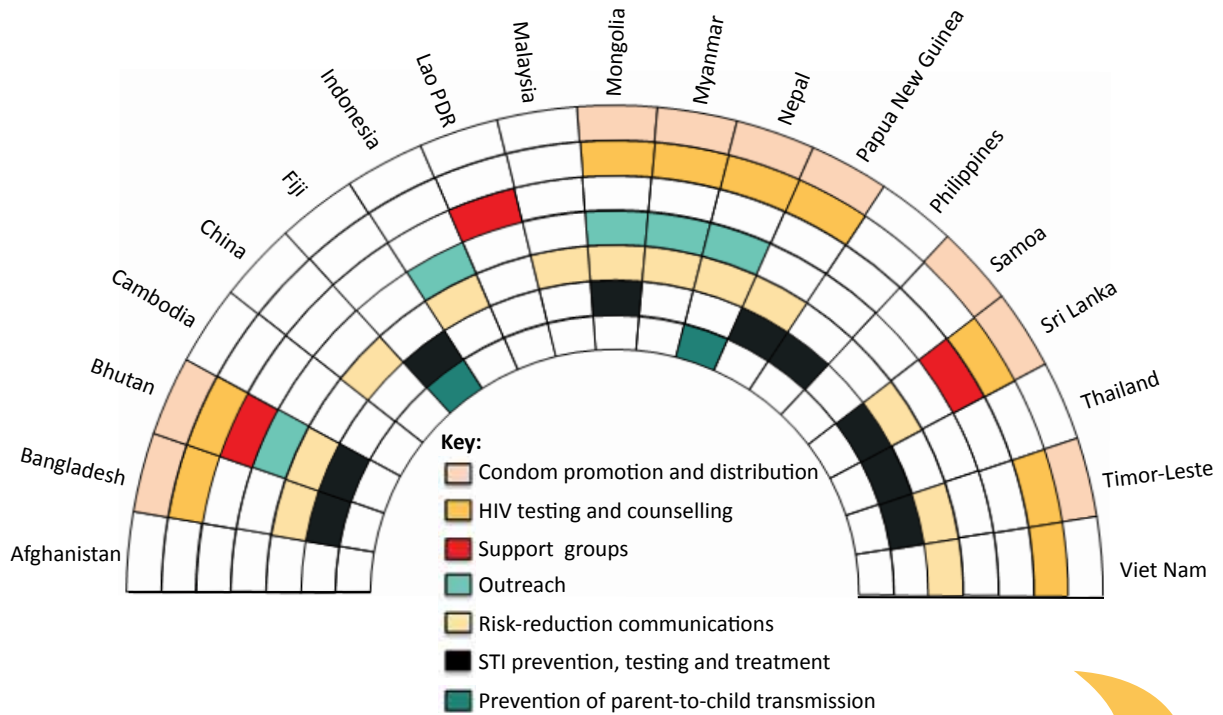
Young people receive mixed attention in the NSPs for basic programmes depending on the country in question (see Figure 13). The programmes most discussed include: condom promotion and distribution; HTC; STI prevention, testing and treatment; and risk reduction communications. Five countries (Bhutan, Fiji, Mongolia, Myanmar and Nepal) also include reference to peer educator-based outreach for young people.

#### **Some caveats regarding services for young people in NSPs: Timor-Leste [37]**

*‘High coverage HIV testing is not recommended as an intervention to promote safe sex behaviour among youth at this point in time. HIV prevalence among young people in Timor-Leste is almost certainly currently very low. A HIV negative test result may reinforce assumptions of low risk and unsafe behaviour’.*

Some countries such as Nepal and the Philippines include a more comprehensive approach to young people. Details regarding the programming plans for young people in the Philippines are provided in the good practice example. Nepal proposes an accessible and affordable HIV prevention package for young people with the emphasis on those most at risk and out-of-school [60]. Key actions include: ensuring-adolescent friendly services including HTC, ART and PMTCT; and condom programming and HIV related information. The package is not only planned to be age-appropriate but also gender-sensitive and developed in consultation with young people.

**Figure 13: Basic programmes for young people**



**Promotion of accessible and affordable prevention packages for young people: Nepal [60]**

*‘Ensure accessible and affordable prevention HIV package for young people with emphasis to most at risk young and out of school young people into the existing prevention intervention approaches with linkages to SRH condom services as well as non-health services such as protection, HIV related information and skills and legal service’.*

**Good Practice Example: The Philippines NSP [15]**

The Philippines NSP includes the strategy developed in the 2010 National Strategy Framework on the Country HIV Response on Children and Young People. This details a rights-based, age appropriate, gender-sensitive and gender-responsive design and implementation of HIV interventions and programmes, which ethically and meaningfully engage and empower children and young people, and includes:

1. A strong focus on those most-at-risk for, and vulnerable to, HIV infection;
2. Children and young people, particularly those living with and affected by HIV are ensured access to an agreed minimum set of appropriate services;
3. The development and implementation of policies that promote effective HIV responses that protect children and young people from all forms of abuse, exploitation and violence and increase access to essential HIV-related health and other services at all levels; and,
4. improve coordination mechanisms, capacity of child caring institutions, and strategic information based on jointly agreed standards of quality for HIV prevention programming for children and young people, particularly the ones most-at-risk for HIV infection.

**Figure 14: Pyramid of risk and vulnerability**



Pyramid of risk and vulnerability. Source: Responding to HIV prevention needs of adolescent and young people in Asia: Towards cost effective policies and programmes, UNFPA Policy paper 2007.

Even those countries which have made efforts to address the needs of young people, may still face challenges to programme implementation. For example the Filipino Government, after consultation with groups representing young people, recently proposed an Act to improve access of people of all ages to family planning services. However, a political campaign to block the Act has led to legal proceedings and delays [77,78]. Critical enablers, explored further in the next section, seek to address such barriers and are often essential for programming to be effective.

**Table 7: Proposed minimum set of interventions for children in the Philippines [15]**

Target population		Minimum set of interventions
<p><b>Children and young people living with HIV Infection</b></p> <p>Those who were exposed to HIV either through mother-to-child or engagement in behaviours that put them at risk for HIV</p>		<ul style="list-style-type: none"> <li>• Access to HIV information, age-appropriate and gender-responsive psychosocial counseling of the child and the family;</li> <li>• Access to comprehensive pediatric HIV management, including access to pediatric formulated medicine;</li> <li>• Provision of services across a continuum of care (from prevention to TCS, from primary to tertiary level, from home and community base, clinic to hospital, and vice versa) and through a structured referral mechanism.</li> </ul>
<p><b>Children and young people affected by HIV</b></p> <p>Still under the care of loved ones (with both parents living or a close relative living with HIV);</p> <p>Have experienced loss of one or both parents or a loved one due to HIV; and/or</p> <p>Living in child-caring institutions or agencies.</p>		<ul style="list-style-type: none"> <li>• HIV prevention education;</li> <li>• Strengthening coping skills and child’s emotional resources; and</li> <li>• Ensuring safe and stable living conditions, ideally in the family environment.</li> </ul>
<p><b>Children and young people most-at-risk for HIV-infection</b></p> <p>Those who currently engage in behaviour that puts them at immediate risk of acquiring HIV</p>	<p>Children and young people in prostitution (male and female)</p> <p>Males having sex with males (men who have sex with men)</p> <p>Injecting drug users (IDU)</p> <p>Sexually active children and young people</p>	<p>All most-at-risk children have the right to be provided the following:</p> <ul style="list-style-type: none"> <li>• Access to HIV and STI prevention information, services and commodities, including where to access HIV-related services;</li> <li>• Behaviour-specific life skills which empower young people to adapt safe behaviours, and motivation to translate skills into practice;</li> <li>• Access to HIV testing and counselling, and STI screening and management;</li> <li>• Referral to vocational training, in-school or out-of-school education opportunities, rehabilitation, shelters, and psycho-social counselling; and</li> <li>• For drug users, principles of harm reduction apply, similar to those that apply in adults</li> </ul>
<p><b>Children and young people vulnerable to HIV-infection</b></p> <p>Those more likely to start the high risk behaviours</p>	<p>Street children and young people;</p> <p>Out-of-school children and young people;</p> <p>Urban and rural workers; and</p> <p>Children of people most at risk of HIV</p>	<p>The following should complement the broader, less HIV-specific prevention approaches, namely:</p> <ul style="list-style-type: none"> <li>• Key HIV and STI prevention information, including messages on where to access HIV-related services;</li> <li>• Strengthening life skills directed towards building the psycho-social and emotional resources of the child or young person;</li> <li>• Integration of HIV prevention and healthcare-seeking behaviours into intervention programmes that are already in place to respond to their broad needs; and,</li> <li>• Making health and essential HIV-related services and facilities accessible alongside the training of service providers, improving facilities, and implementing linking activities in the community.</li> </ul>
<p><b>Children and young people at low risk and vulnerability</b></p> <p>comprise the majority of children and young people population in the Philippines</p>	<p>Living in a fairly stable family environment;</p> <p>Enrolled in school, or regularly participating in alternative forms of education and learning; and,</p> <p>Living in communities with organized support mechanisms in place.</p>	<ul style="list-style-type: none"> <li>• Integration of age-appropriate and gender-sensitive HIV prevention education in the general school curriculum (formal and non-formal);</li> <li>• HIV prevention education linked to other learning objectives related to: sexuality, reproductive health, relationships, personality-development, life-skills, substance abuse education, and prevention of STIs;</li> <li>• Inclusion of issues of drug use, sex work, and male-to-male sex in skill-based sexuality education;</li> <li>• Provision of access of children and young people to HIV-related information, programmes and services; and,</li> <li>• Integration of age-appropriate and gender-sensitive HIV prevention education in the Parents’ and Teachers’ regular assembly program.</li> </ul>

## Critical enablers and synergistic development activities

Critical enablers and synergistic development activities are those programmes necessary to enable an efficacious and equitable implementation of basic programme activities [79]. They improve the sustainability of AIDS responses by integrating activities into broader health and non-health sectors and supporting the human rights and empowerment of those affected by HIV [79].

The analysis of NSPs found that the predominant focus of interventions to promote an enabling environment focused on people living with HIV, although some references were made to key populations (see Table 8). The enabling interventions most commonly referred to for key populations included community mobilisation, legal audits, monitoring and reform of laws and policies, training of health workers and the sensitisation of lawmakers and law enforcement.

### Consideration of the impact of criminalization on key populations: Bhutan [31]

*‘Review of criminalisation of both female sex work and sodomy (unnatural sex acts); access to sexual and/or reproductive health services for adolescents, women, and men who have sex with men’.*

Young key populations are rarely included for critically enabling activities. When they are it is generally as young people most at risk or children/young people living with HIV (see Table 8). Since barriers to an enabling environment vary for each key population more detail will be provided for each population in turn.

**Table 8: Countries which refer to critically enabling interventions for key populations, # countries (% total)**

	Community mobilisation	Stigma reduction	Legal services & support	Monitoring & reform of laws	Legal literacy	Training of health workers	Sensitisation of lawmakers & enforcement
Key populations	6 (32%)	11 (58%)	6 (32%)	11 (58%)	6 (32%)	9 (47%)	7 (37%)
Men who have sex with men	4 (21%)	2 (11%)	2 (11%)	3 (16%)	1 (5%)	5 (26%)	3 (16%)
Transgender people	2 (11%)	1 (5%)	2 (11%)	1 (5%)	1 (5%)	3 (16%)	2 (11%)
Sex workers	7 (37%)	2 (11%)	2 (11%)	7 (37%)	2 (11%)	4 (21%)	10 (53%)
People who inject drugs	2 (11%)	2 (11%)	0	9 (47%)	0	3 (16%)	0
People living with HIV	13 (68%)	17 (89%)	12 (63%)	19 (100%)	6 (32%)	16(84%)	9 (47%)
Young key populations	1 (5%) c 1 (5%)k	1 (5%)c	1 (5%)k	1 (5%)c 1 (5%)s	0	3(16%)c 1 (5%)h	1 (5%)k

**Key:** k = young key populations; c = children living with HIV; s = young people who sell sex; h = young people living with HIV.

Development synergies represent investment in other sectors that can have a positive impact on HIV outcomes such as social protection, education, gender equality, GBV and poverty reduction [79]. Coverage of key populations for synergistic development activities is not widespread within NSPs. Those most commonly included are people living with HIV, key populations in general and sex workers. Discussion of young key populations is even more rare and when included tends to be regarding children/young people living with HIV or young key populations generally.

The Nepal NSP is the most inclusive of key populations for development synergies. This NSP also includes the most comprehensive programme for reducing harmful gender norms and GBV and increasing women’s and girl’s empowerment [60].

The next section considers attention to critical enablers within NSPs for each key population (including younger cohorts) along with the goals and targets. This is followed by a similar analysis for young people generally.

### Men who have sex with men and transgender people

Men who have sex with men and transgender people often face both legal and social barriers to accessing HIV information and services. In 2010, criminal sanctions for consensual male-to-male sex were in place for 19 countries in the Asia-Pacific region [25]. Of those reviewed this includes Afghanistan, Bangladesh, Bhutan, Malaysia, Myanmar, Papua New Guinea and Sri Lanka [25]. Other countries are reported to selectively apply other criminal provisions such as indecency offenses to target men who have sex with men and transgender people including Cambodia, China, Indonesia, Mongolia, the Philippines, Thailand and Viet Nam [25].

Cross-dressing is criminalised in some countries in the Asia-Pacific region, such as Malaysia and Tonga, although prosecution is not always actively enforced [25]. However, stigma and discrimination against these populations are reportedly widespread and in some countries they face harassment and violence from law enforcement [25]. Despite these issues only a minority of NSPs include men who have sex with men and transgender people for activities which serve as critical enablers.

#### Recognition of stigma and discrimination: Mongolia [34]

*‘Very high levels of stigma and discrimination, including violence, and very low societal acceptance of men who have sex with men – even within their own families – drive most men who have sex with men underground, which makes it particularly difficult to reach them with specific HIV prevention interventions. There are also reports of arbitrary detentions, interrogations and even violence against the men who have sex with men community by police and intelligence, and of involuntary testing without pre- and post-test counselling’.*

None of the NSPs reviewed included critical enablers for young men who have sex with men or young transgender people. Only three countries include mention of monitoring and/or reform of laws and policies related to adult men who have sex with men (Bhutan, Myanmar and the Philippines) with only the latter including reference to addressing legal issues facing transgender people [15].

#### Consideration of men who have sex with men for critically enabling interventions

*‘Bhutan should consider revising the Penal Code and removing the paragraphs that criminalize male-to-male sex’.*

*Bhutan [32]*

*‘The ability to change one’s name and gender identity in official documents, and the legal right to live as another gender, free from stigma and discrimination’.*

*Philippines [15]*

Nepal’s NSP probably provides the most significant attention to men who have sex with men and transgender people with regard to critical enablers [60]. Both Cambodia and Nepal refer to legal services and support for both men who have sex with men and transgender people, with Nepal also including these populations for legal literacy. Three countries plan to sensitise lawmakers and law enforcement to the issues surrounding men who have sex with men, Bangladesh, Nepal and Papua New Guinea, with the first two countries also referring to interventions for transgender people.

Interventions to reduce stigma and discrimination against men who have sex with men are included in the NSPs for Lao PDR and the Philippines. However, only the Philippines makes reference to interventions for transgender people. Five countries include training for health workers regarding men who have sex with men (Cambodia, Fiji, Nepal, Papua New Guinea and Sri Lanka) and three specify community mobilisation for this population (Lao PDR, Myanmar and Nepal). For transgender people, community mobilisation is discussed in the NSPs for Malaysia and Nepal. Nepal also makes reference to health worker training to address the particular needs of transgender people, as do the NSPs for Cambodia and Fiji.

**Critical enabling interventions for men who have sex with men and transgender people :  
Nepal [60]**

*'Sensitize men who have sex with men/MSW and TG on the importance of legal services and lawyers providing these services. Advocate MSMs' right and needs with local law enforcement, health service providers, and other stakeholders to encourage them to respect, protect, and fulfil the rights of men who have sex with men/TG and meet the needs of men who have sex with men and TG and their female partners for services'.*

**Synergistic development activities**

Consideration of men who have sex with men and transgender people for synergistic development activities is rare. Three NSPs (China, Mongolia and Nepal) specify men who have sex with men for family planning or SRH services, with Nepal also including transgender people.

**Males, females, transgender people who sell sex**

All of the countries in the Asia-Pacific region, with the exception of New Zealand and parts of Australia, criminalise sex work [24]. These legal restrictions limit access to HIV and sexual health services, condoms and harm reduction services, fuel stigma and discrimination and impact the ability of sex workers to make informed choices regarding their health. Criminalisation legitimises violence, discrimination and exploitation and means sex workers are reluctant to report offenses. Indeed abuse of sex workers by law enforcement is reported throughout the region including harassment, extortion, unauthorised detention and assault [24]. In some countries harassment extends to those working to provide HIV prevention services to sex workers, such as peer educators and outreach workers. Sexual assaults by police or the military have been reported against sex workers in many countries in the region, including in Bangladesh, Cambodia, China, Fiji, Myanmar, Nepal, Papua New Guinea and Sri Lanka [24].

**Critical enabling interventions for sex workers are needed throughout the region**

*'Freelance sex workers (FSWs), on the other hand, are not affiliated with licensed establishments and thus are technically breaking the law. They are not easy to reach for health interventions because they are not based in places that are under the regulation of local governments. While Social Hygiene Clinics (SHCs) may try to reach out to them by offering the same services as those given to establishment-based workers, there is no compelling reason for the SHCs to do so because freelance sex work is illegal to begin with'.*

*Philippines [15]*

*'A qualitative study in 2007 in the Chinese border town of Erenhot revealed a close link between sex work, and the trafficking of Mongolian girls and women. Debt bondage, i.e. being "sold" to an entertainment establishment and then being required to work to pay off the "debt", is the typical mode of operation. There are no reliable estimates of the size of the problem. Some sex workers had been lured into China under false promises of well-paid work as models, waitresses, masseuses or hairdressers, and subsequently forced into sex work'.*

*Mongolia [34]*



NSPs include minimal attention to critical enablers for sex workers. Less than half (37 per cent) include plans to reform laws regarding sex workers and only one country, Nepal, mentions this group for legal support or services. Ten countries, however, do include the sensitisation of lawmakers and law enforcement to issues regarding sex workers perhaps to build a foundation for changes in legislation. Approximately one-third of countries specify community mobilisation for sex workers and four specify training and sensitisation of health workers regarding sex workers (namely Cambodia, Nepal, Papua New Guinea and Sri Lanka). Only Lao PDR and Myanmar include plans to reduce general stigma and discrimination among sex workers in the NSP.

As mentioned previously, the majority of emphasis for interventions is directed towards female sex workers, with only Nepal addressing male sex workers in the area of legal literacy and services. Papua New Guinea is the only NSP which refers to the need to legal and justice programmes for young people who have been sexually exploited and abused.

**Attention to legal and justice programmes for young people who sell sex: PNG [17]**

*'Strengthen law and justice programs at national, provincial and community levels to address the sexual exploitation and abuse of young people, including young people in sex work'.*

A concentrated epidemic among sex workers provides no prediction of whether NSPs include interventions to facilitate an enabling environment. For example, of the eight interventions that were considered for sex workers, Cambodia includes three and Indonesia has none. Myanmar makes the best effort with plans for community mobilisation, stigma reduction, monitoring and reform of laws and sensitisation of lawmakers and enforcement regarding sex workers.

**Comprehensive consideration of critical enablers for sex workers: Myanmar [70]**

*'Build understanding of communities about issues affecting sex workers. Reform of Suppression of Prostitution Act, 1949. National policies in place to indicate need for programmes for SW which respect consent and confidentiality. Enforcement of policy in which condom possession is not used as liability of sex work'.*

**Synergistic development activities**

Sex workers are rarely specified for synergistic development activities. When they are, those most commonly included are:

- family planning/SRH services (six countries);
- reducing harmful gender norms and GBV and increasing women and girls' empowerment (four countries); and
- social protection (four countries).

No references to synergistic development activities for male sex workers were identified.

Myanmar provides perhaps the best selection of development synergies for sex workers, including being the only country to mention young people selling sex, including:

- Build understanding of communities about issues affecting sex workers, including a focus to address partners and GBV;
- Sex workers friendly reproductive health services in the public sector;
- Recovery, re-integration and social services for women who want to leave sex work services tailored to the needs of under-age sex workers; and
- Drop in centres providing primary health care and social services [70].

## People who inject drugs

Legal barriers impeding HIV prevention for people who inject drugs have been reported to exist in 61 per cent of countries in the Asia-Pacific, compared to 36 per cent elsewhere in the world [26]. International treaties and conventions as well as national laws combine to prohibit drug use and create harsh penalties for drug-related offenses. Numerous countries in the region retain the death penalty for drug offenses including Bangladesh, China, Indonesia, Lao PDR, Malaysia, Thailand and Viet Nam [26].

### Consideration of legal reform to address the needs of people who inject drugs: Myanmar [70]

*'Enforcement of Directive 2001 from Myanmar Police Force Headquarters regarding not making arrests for possession of hypodermic needles. Revision of Narcotic Law of 1974 regarding one month hospitalisation of drug users identified'.*

While the WHO guidelines state that OST is the most promising method of reducing drug dependence, in 2009 methadone was only legally available in five countries in Asia, of which China, Indonesia, Lao PDR and Myanmar are included in this review. At the time of publication buprenorphine was legally available in three countries, of which only the NSP for Nepal has been reviewed [26]. Some countries within the region also have laws that are prohibitive of needle and syringe programmes, with penalties for the provision of clean needles for the purpose of injecting illicit drugs (in 2009 this included Bangladesh, Bhutan, Lao PDR, Malaysia, Myanmar, the Philippines, Sri Lanka and Thailand) or for the possession of injection equipment, such as in Sri Lanka [26,27].

It is perhaps unsurprising that the attention given to critical enablers for people who inject drugs within the NSPs, is on the reform of laws and the sensitisation of lawmakers and law enforcement. Nearly half of the NSPs reviewed include activities to address these issues. Three countries also specify training of health workers for people who inject drugs and interventions to reduce stigma and discrimination; whilst two seek community mobilisation efforts for this population. The two countries which were found to have the greatest number of categories of interventions for a more enabling environment are Myanmar and Nepal which include four and three interventions, respectively. Nepal makes particular reference to harm reduction for females who inject drugs including reducing harassment, stigma and discrimination. There are no references to activities to provide an enabling environment specifically for young people who inject drugs in any of the NSPs reviewed.

### Synergistic development activities

There are very limited references to people who inject drugs within discussions of synergistic development activities:

- five countries consider them for social protection (Afghanistan, Myanmar, Nepal, the Philippines and Viet Nam);
- three discuss education (Indonesia, Myanmar and Viet Nam);
- two refer to integration of services (Afghanistan and Malaysia); and
- one country (Mongolia) mentions family planning.

Once again there are no specific references to activities for young people who inject drugs although Myanmar does mention youth vulnerable to drug use.

### Identified need for tailored services for young people who use drugs: Myanmar [70]

*'Tailored services for young drug users and youth vulnerable to drug use established and improved health as well as other social and support services. Alternative vocational training for drug users especially PLW (reinsertion and socio economical reintegration), promoted through community programmes. Local support groups and networks of drug users and ex-drug users are established to support sustained behaviour change and empower participation with a focus on economic and income generating activities'.*

## People living with HIV

### Critical enablers

As mentioned earlier, people living with HIV are generally well-covered in activities which promote an enabling environment:

- all of the NSPs reviewed included discussion of monitoring and reform of laws and policies;
- 89 per cent of plans discuss interventions to reduce stigma and discrimination;
- 84 per cent specify training for health workers and sensitisation of law makers and law enforcement;
- thirteen countries (68 per cent) plan community mobilisation for people living with HIV; and
- twelve specify legal services and support but only six discuss legal literacy.

Few mentions are made of enabling activities for young people living with HIV and those that are generally refer to children living with HIV such as training of health workers in paediatric care (three countries, Bangladesh, Bhutan and Papua New Guinea).

### Synergistic development activities

The inclusion of development synergies for people living with HIV ranges across NSPs:

- all of the NSPs reviewed included reference to social protection,
- eight countries discuss family planning,
- six refer to the integration of services, and
- four include reference to harmful gender norms and increasing women's empowerment.

Very few activities are included for young people living with HIV; and where they are it is generally children living with HIV who are discussed, and the interventions related to social or child protection. Seven NSPs include children or young people living with HIV for child protection whilst eight specify them for social protection. Children affected by HIV, orphans and vulnerable children are also commonly discussed for these interventions.

#### **Children affected by HIV are commonly discussed in NSPs: Viet Nam [67]**

*'To ensure incentive policies for children infected with HIV and affected by AIDS so that they are provided with all healthcare, educational and social services'*

## Young people

The creation of a safe and supportive environment is a key action for the development of effective HIV interventions for young people [22]. Barriers to the provision of an enabling environment may hinge upon cultural, religious, financial, logistical, or legislative issues. A recent review highlighted the variety of laws and policies which may impede young people's access to HIV services including those which:

- restrict access to SRH services to married persons;
- require parental consent for minors to access HTC, medical treatment or other SRH services;
- lack of safe access to legal safe abortion;
- lack of birth registration or access to other forms of civil registration, particularly for orphans, refugees and internally displaced people, necessary to access health services [21].

Despite these challenges little attention is given to interventions which provide an enabling environment for young people. Few NSPs address the legal or policy restrictions which may impact on the human rights of young people.

## Examples of critical enablers for young people

### Bhutan [31]

'Review access to sexual and/or reproductive health services for adolescents...'

### Mongolia [34]

'The laws to be revised include... the Family Law and the Childhood Rights Law, with regard to protection of children and young people; and laws that restrict the provision of HIV and STI information and education to young people, and/or their access to basic HIV, STI, and sexual and reproductive health-care services'.

### Myanmar [70]

'High quality mass-media campaign and behavioural change communications for HIV prevention among young people, particularly those at risk including out-of-school young people and street children'.

### Nepal [60]

'Advocate and support functional collaboration among relevant ministries, departments and other stakeholders to bring comprehensive impact, to build support and to raise issues related to vulnerability of adolescents and young people'.

### Papua New Guinea [17]

'Inform parents, teachers and other people in positions of authority and trust about the legal and human rights of young people, especially laws that protect young people from sexual exploitation and abuse'.

Four countries (Bhutan, Mongolia, Papua New Guinea and the Philippines) specify plans for the monitoring and reform of laws and policies regarding young people, with the latter two countries also referring to legal services and support for young people. The laws to be reviewed are generally related to the protection of children from exploitation and abuse and improving access for young people to sexual and reproductive health services. Nepal is the only country to include sensitisation of lawmakers for young people. Legal literacy for young people is not discussed in any of the NSPs reviewed.

Young people are included for community mobilization interventions in a number of countries such as Bhutan, Fiji, Indonesia, Lao PDR and Myanmar. The NSPs for Bhutan and Bangladesh also include training of health workers regarding HIV case management for young people, particularly children. Mass media communications targeted at young people are included in the NSPs for Myanmar and Timor-Leste. However there is no discussion of training regarding HIV human rights issues for young people.

### Synergistic development activities

In order to reduce the vulnerability of young people to HIV, long-term developmental interventions are required to address cultural, economic, political and social change, including changes in gender and power relations [22]. Within the synergistic development activities, those related to reducing harmful gender norms and GBV and increasing women's and girls' empowerment, education and social and child protection, seek to address these issues. Additionally the creation of a safe and supportive environment and opportunities to acquire information and life skills are considered pivotal to successful programming. Schools, health services including SRH services, youth centres, workplaces, peers and outreach all provide channels to provide young people with opportunities to develop life skills and gain information regarding how to protect themselves from HIV transmission.

The majority of NSPs give scant attention to synergistic development activities for young people apart from life skills/SRH or HIV education in schools, which is included in all but one NSP (Malaysia). A number of countries also include similar education in youth services and informal settings for out-of-school or street children and adolescents including Afghanistan, Bangladesh, and Bhutan. However, the coverage and quality of these programmes may vary significantly. For example, whilst Bangladesh includes such programmes the number of schools providing such education is extremely limited (0.14 per cent) and there are no targets specified for the current period [32].

Approximately one-third of countries (namely Fiji, Indonesia, Samoa, Myanmar, Nepal and Papua New Guinea) make reference to the need for family planning services for young people. Myanmar, Nepal and Papua New Guinea also refer to the integration of SRH with other services such as HIV, STI, mother and child health, antenatal care and health services for youth. Five countries (Bhutan, Cambodia, Fiji, Mongolia and Papua New Guinea) include reference to young people in the context of programmes to reduce harmful gender norms and

increase women and girls' empowerment. These programmes typically specify that they seek to address gender inequality and improve women's rights, although rarely address gender-based violence or specify interventions.

### **Integrating disadvantaged women and girls into communities: Bhutan [31]**

*'To empower disadvantaged girls and women in Bhutan and integrate them back into their own communities as independent, socially and economically productive members of the society. The main beneficiaries of RENEW are out of school adolescent girls, disadvantaged women are those women who are victims of domestic violence, women and adolescent girls who are victims of rape or sexual abuse, commercial sex workers, and women and adolescent girls who are HIV-positive or victims of drug abuse'.*

Papua New Guinea also discusses social protection and education programmes for young people. Child protection is discussed broadly in two NSPs. However, the main focus of these programmes tends to be toward vulnerable young people such as children affected by HIV, orphans and vulnerable children, especially vulnerable adolescents, out-of-school children and street children. These vulnerable young populations generally gain more attention across the synergistic development activities including for social protection and education, than their key population peers.

### **Inclusion of orphans and vulnerable children in NSP for Cambodia [32]**

- Provision of a comprehensive package of services, as described by the National Plan of Action for orphans and vulnerable children (OVC), to all OVC and their households;
- Specifically address, through community-level programs, the needs of subgroups of OVC, including the reproductive health needs of older OVC, especially those living in institutions and orphanages, and female OVC who maybe at increased risk for early marriage, sexual violence, trafficking and sexual exploitation.
- Linkage of OVC and their caregivers to existing social protection interventions, particularly community-based health insurance, public works programmes, cash or in-kind transfers, subsidies and complimentary social welfare services. Inclusion of social assistance programmes to households with vulnerable children in commune investment plans.

## National strategic plan operationalisation

The availability of action or operational plans and monitoring and evaluation (M&E) frameworks differed between countries. For some countries such as Bangladesh, Papua New Guinea and Sri Lanka, separate NSP, M&E framework and implementation/operational plans were available, whilst for others (Bhutan, Fiji, Indonesia, Malaysia, Mongolia, Myanmar, Timor-Leste), the M&E and/or implementation plans were incorporated into the NSP itself (see Table 1). For China, only the Action Plan on HIV and AIDS was obtained for review. Some detail regarding indicators and/or targets is provided for the majority of countries, with these only being completely unavailable within the plans of Samoa and Thailand.

Young people are generally included within these indicators and targets although there is little disaggregation of this data across age groups, the populations studied mostly being youth or children (see Table 8). Children and young people living with HIV are included within the M&E frameworks of most NSPs (15 countries). However, other young key populations are generally not specified, the exception being the Papua New Guinea NSP which includes indicators but no targets for young male and females who sell sex, young men who have sex with men and young transgender people. Vulnerable children and young people, (orphans and vulnerable children, children affected by AIDs and especially vulnerable young people), are more likely to be specified for indicators and/or targets, and are included by approximately a third of the NSPs reviewed namely Cambodia, Indonesia, Lao PDR, Malaysia, Nepal and Papua New Guinea. There is also relatively extensive inclusion of indicators and targets for adult key populations. For example, the majority of plans (with the exception of Samoa and Thailand for which M&E frameworks were not available) specify indicators and/or targets for people living with HIV, men who have sex with men, sex workers and people who inject drugs. Approximately one-third of plans, namely Bangladesh, Cambodia, Fiji, Indonesia, Malaysia and Papua New Guinea, include indicators for transgender people.

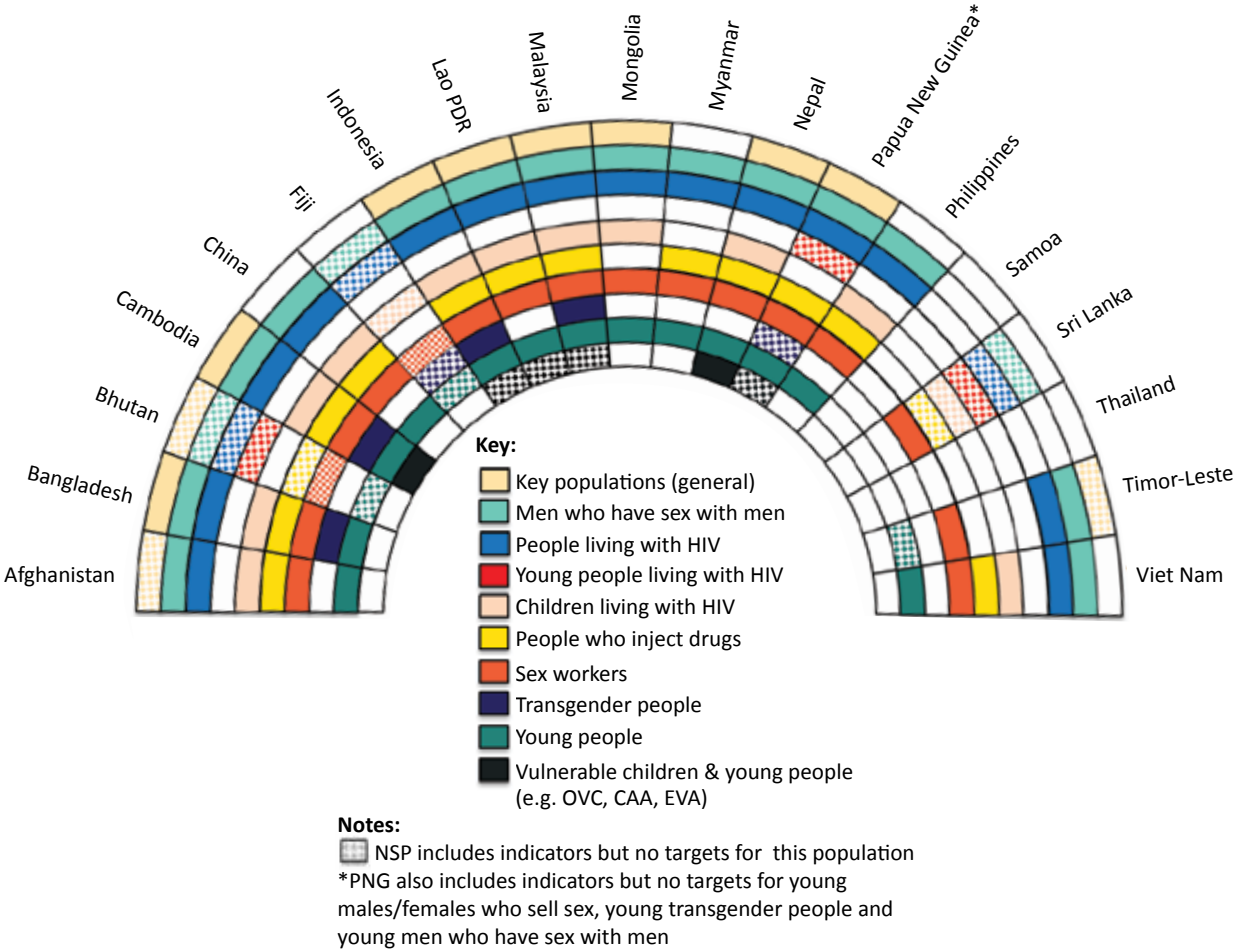
Some plans specify gender-disaggregated indicators and targets for particular key populations. Most often these are for male and female sex workers (Bangladesh, Indonesia, Malaysia, Nepal, Papua New Guinea, the Philippines, and Viet Nam) or females living with HIV (Afghanistan, Fiji, Lao PDR, Malaysia and Nepal). Bangladesh includes male and female people who inject drugs as well as sex workers and Bhutan also includes men living with HIV.

In the recent Global AIDS Response Progress Reports provided by countries in the Asia-Pacific region, less than half reported key indicators for young people from key populations, including prevalence of HIV, condom use at last sex, safe injecting practice, receiving an HIV test and getting the result, and access to prevention programmes [80]. This is not surprising since this NSP review reveals that young key populations are rarely included for indicators and targets. For those that do, the plans tend to focus on children or young people living with HIV or the vulnerable young people (orphans and those vulnerable to or affected by HIV). Indicators and targets are generally not specified for other young key populations, such as young people selling sex, young men who have sex with men, young transgender people and young people who inject drugs. Papua New Guinea is the only country which reports planning the collection of age and sex disaggregated data for key populations generally, men who have sex with men, transgender people (male-to-female transgender and female-to-male transgender), and female and male sex workers. Even then, age-groups for young people tend to be 15–19 and 20–24 years, with no inclusion of those under age 15. The lack of surveillance for these younger cohorts does not bode well for their inclusion in future situation analyses, goal and target development and programme planning.

The costing of the operational plans varies considerably. Many include budgets for key populations, although none included allowance for specific programmes for young key populations. Two plans, those for the Philippines and Afghanistan do note that the proportion of the HIV budget spent on younger cohorts is disproportionately low. The NSP for Afghanistan comments that whilst almost 70 per cent of the population is below the age of 25 years, and there is *'an urgent need to equip young*

people with the information skills and services to prevent HIV', only 5 per cent of the prevention funding is spent on youth [12]. The Philippines NSP goes one step further, making the observation that whilst adolescents engaging in commercial sex, male-to-male sex, or injection drug use may cause up to 95 per cent of infections, they are allocated less than 10 per cent of the HIV funding for their age cohort [15]. Finally, with respect to implementation of the NSP, eight (42 per cent) of the operational plans include discussion regarding the agencies responsible for the required activities. These are predominantly government departments and ministries although there are often general references to civil society or non-government organisations. Few specify those organisations delegated to work with specific key populations and no agencies were assigned for implementation of programmes for young key populations.

**Figure 15: Inclusion of indicators and targets in the M&E framework for key populations, young people and young key populations**





# Conclusions and recommendations

National strategic plans determine a country's response to HIV and AIDS, guiding allocation of funding, resources and human capacity. Comprehensive analysis of the country epidemic, including subpopulations where most new infections occur, is pivotal to the development of a pertinent plan. Targeted programming to address those at higher risk of HIV exposure, provide an enabling environment and appropriate development synergies is essential to an effective strategy.

Data regarding the age of sexual debut and initiation of risk behaviours, as well as the limited HIV prevalence data available for young key populations, supports the assertion that these groups are important to the trajectory of epidemics throughout the Asia-Pacific region. Yet analysis has revealed the inclusion of these groups within the NSPs to be limited at best, and there are virtually no plans for future research. Even those countries which have been identified as having concentrated epidemics among particular key populations often neglect to provide sufficient strategic information and interventions for these groups. For young people from the general population, those below the age of 15 years are generally not addressed, nor are the legal barriers to the access of services for those below the age of majority well explored. This is despite most countries having ratified the United Nations Convention Rights of the Child, which states that all children have a right to practical and appropriate information, skills and services and protection from all forms of harmful behaviours and practices [81].

The majority of NSPs reviewed would benefit from additional strategic information regarding young people and key populations, particularly behavioural data. It is important to understand the drivers of the epidemic and the factors, whether cultural, social, economic or political that may make young people vulnerable or likely to adopt high risk behaviours. Specific research regarding young key populations should be undertaken in order to address these groups, since they are not generally captured in current surveillance systems. Over and above national surveillance, additional data collection methods such as location-led assessments and qualitative approaches such as key-informant interviews and focus groups should be utilised. Data should be disaggregated by age (e.g. 10–14, 15–19, 20–24 years) and sex or gender identity (male, female and transgender).

Whilst it may be obvious to focus on those groups already identified with concentrated epidemics, a broader approach will ensure that growth or shifts in infected populations are identified promptly. This is particularly important for those low prevalence countries where there are significant populations engaging in high-risk behaviours. There is considerable guidance available regarding the collection of strategic information for key populations and young people including a recent publication from UNICEF [19,82,83].

Young people, including those from key populations, do not appear to be included in the development process for most NSPs. Involvement of representatives of all key populations, including younger members, as stakeholders in the development of NSPs will not only assist in improving the relevance of the plan but also ensure a stronger sense of ownership of interventions. Their engagement in the development, implementation, and monitoring and evaluation of HIV programmes is likely to be critical to programme success.

Young people often feature within goals and overarching targets in NSPs. However, where young people are included, age groups are often limited to youth 15 years or older, or to children where the age group is often not defined. Key populations are not always included in the goals of the NSP, even



though prevalence rates may be high. Inclusion for these groups for overarching targets is also mixed. Attention to young key populations for goals and overarching targets is negligible. Generally the only young key populations, which receive targeting, tend to be young people living with HIV, particularly children. Geographic prioritisation is generally overlooked in most NSPs.

The goals for the NSP should be inclusive of both key and younger populations. Overarching targets should seek to address those populations at highest risk of HIV exposure. Efforts should be made to include geographic prioritisation across programmes for the general and for key populations. Improvements in strategic information will undoubtedly assist in this process.

The basic programmes identified as most important for young people are those related to the development of life skills and knowledge regarding HIV transmission and access to appropriate health services. These, particularly if initiated early, are also important for key populations. However, additional programming is also required to more comprehensively address the risk behaviours of young key populations. Young people receive mixed attention for basic HIV programming and attention to young key populations is very uncommon. Indeed, with the exception of children and young people living with HIV, younger cohorts are largely neglected. Basic programming should not only address the relevant adult key populations with comprehensive interventions but also include efforts to reach young key populations since they are at particularly at risk of acquiring HIV.

Very little attention is given to interventions which provide an enabling environment for young people or young key populations with virtually no inclusion of human rights initiatives for these cohorts. Whilst a number of countries include legal reform and lawmaker and law enforcement sensitisation to provide a more enabling environment for key populations, legal and policy restrictions for young people, including age of consent, are generally not mentioned. Stigma reduction and community mobilisation predominantly focus on people living with HIV.

Variable attention is given to synergistic development activities which impact on young people and those for young key populations focus on children and young people living with, vulnerable to or affected by HIV. Indeed it would appear that vulnerable young people are more likely to be included within the NSPs than young key populations themselves, whether it is as targets of future research, programming, activities which are critical to providing an enabling environment, development synergies or monitoring and evaluation.

Reform of laws which are punitive to young key populations, support discrimination or harassment and/or impede access to services will be pivotal to providing an enabling environment for these groups. Where law reform is not achievable, governments may adopt a pragmatic approach by not requiring harmful laws be enforced against young key populations and make steps to enable rather than restrict access to services. Consideration must be given as to how to provide interventions for those young people who fall under the age of consent or majority. Sensitisation of law makers and law enforcement will be important to improving the legal and policy environment, as well as implementation of these changes. Reducing stigma and discrimination of key populations generally, including the training of health workers in human rights issues related to treating younger members, will be vital to improve the reach of services and reduce barriers to access. Communities will need to be mobilised to better protect and support young people at greater risk of HIV exposure. The availability of SRH, education, child protection and social support services which are receptive and responsive to young key populations will also be central for effective programming for these populations.

Considerable improvements could be made to the monitoring and evaluation frameworks for countries across the region. Attention to young key populations is currently insufficient. Data gathered to track the progress of the strategic plan against targets and milestones, should be disaggregated by age, sex, diversity and the use of services [22]. Guidance is available to assist countries with developing the relevant indicators, which include not only young people and key populations but also capture young key populations [82,84,85]. It is important that these indicators disaggregate key populations by age so that younger cohorts may be specifically assessed and targeted.

Few NSPs include operational plans with budgets and agencies responsible for interventions for young people and none were provided for young key populations. As noted previously, budgets for younger cohorts are often disproportionately small considering their role or potential contribution to HIV epidemics. In order to provide effective strategy implementation suitable organisations must be assigned responsibility and budgets specifically allocated. Cost assessment and agency delegation for HIV prevention interventions for young people and key populations, including their younger cohorts should be included within operational plans.

NSPs provide a vision of the results a country wants to achieve, and approaches for doing so. At present, there is insufficient attention and inadequate strategies outlined in most Asia-Pacific NSPs to address the HIV epidemic among young key populations. To resolve this, countries need to take steps to connect the policy, political and financial processes to on-the-ground realities when revising or developing new NSPs.

### Key Recommendations:

#### Development and review of the NSP

1. Comprehensive strategic information which includes:
  - behavioural and prevalence data,
  - disaggregation by age including those less than 15 years, and
  - all key populations, with particular emphasis on those with prevalence rates indicating concentrated epidemics.
2. Involvement of representatives of young key populations as stakeholders in the development of NSPs will not only contribute to the relevance of the plan but also ensure a stronger sense of ownership.
3. Efforts should be made to include geographic prioritisation across programmes, for the general and key populations.

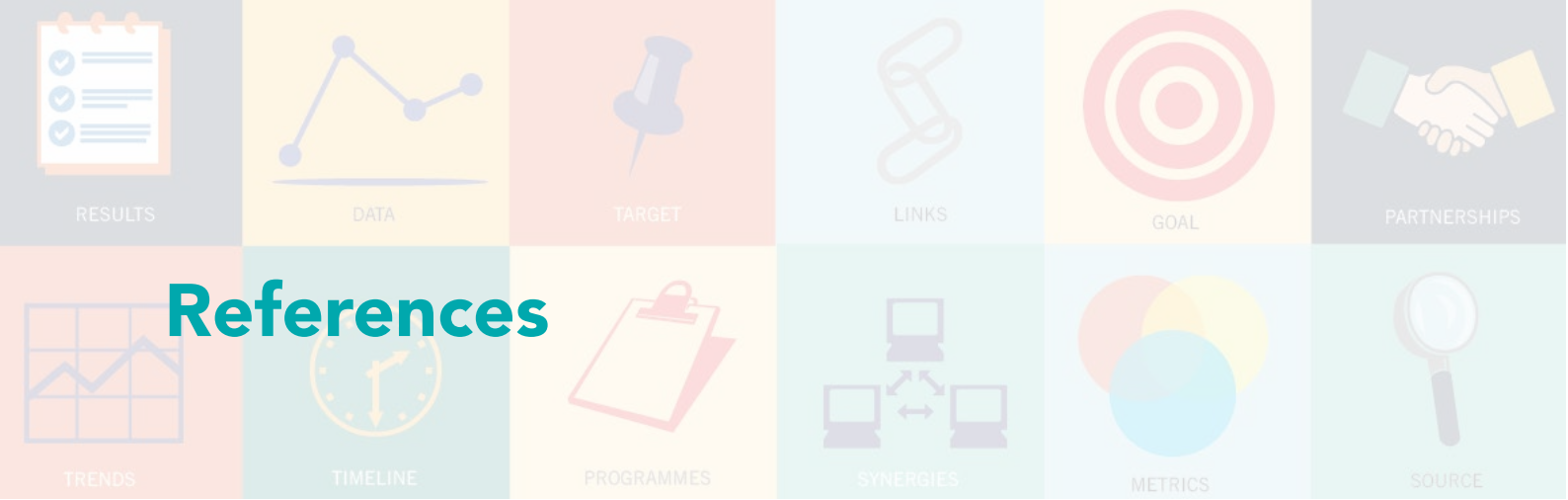
#### NSP content

4. Goals and overarching targets should be included for young people and the relevant key populations.
5. Development of basic programmes which are friendly and accessible to young people and where relevant tailored to young key populations.
6. Support groups and networks and organisations for key populations should be encouraged to have representation and chapters for young people. Representatives of these younger cohorts should participate in:
  - Consultations regarding policy and programme development, implementation and evaluation; and
  - Advocacy to law and policy makers, so that they may be sensitised to the vulnerabilities and human rights issues of these populations.
7. Interventions for specific key populations should include plans to reach younger cohorts.
8. Capacity building of health services, including family planning/SRH, HTC, STI and PPTCT services, that are receptive and responsive to young key populations.
9. Governments need to adopt a human rights approach that recognises the rights of young people. This should include review and reform of the laws, policies and regulations that impede young people and young key populations from:
  - Accessing HIV services, education and information about HIV; and
  - Protection from discrimination, harassment, exploitation and abuse, including from law enforcement.
10. The provision of legal literacy, legal support and services to key populations should be inclusive of young people, so that they may understand their rights and address any abuse, discrimination or rights violations.
11. Inclusion of programmes to reduce stigma against key populations, including addressing homophobic bullying and other forms of GBV, and incorporating sexual orientation and gender identity issues into education programmes in and out of school.

12. Communities should be mobilised to better protect and support young people at higher risk of HIV exposure.
13. Interventions to assist young key populations in accessing education, child and social protection.
14. Health care providers must be trained not only with respect to the needs of people living with HIV and other key populations but also to the needs and rights of young people to access services.

**Operationalisation**

15. Indicators and targets should be developed for key populations with specific inclusion of younger cohorts.
16. Cost assessment for HIV prevention interventions for young key populations should be included within programme budgeting.



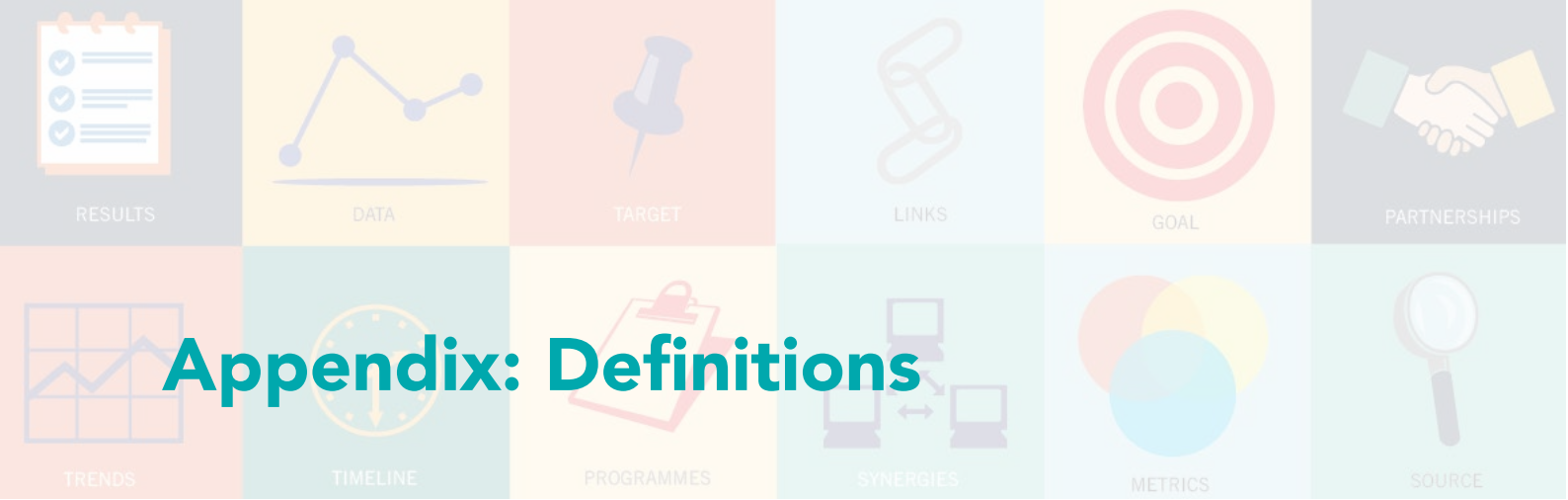
# References

1. The Southern Africa Technical Support Facility. [n.d.] *Strategic Planning for HIV/AIDS: HIV/AIDS Strategic Self-Assessment Tool (SAT): Guidelines for Evaluating HIV/AIDS Strategies and Action Plans*. The Southern Africa Technical Support Facility. [http://www.tsfsouthernafrica.com/guides/strat\\_op\\_plan/folder1.htm](http://www.tsfsouthernafrica.com/guides/strat_op_plan/folder1.htm)
2. The Global Fund to Fight AIDS, Tuberculosis and Malaria. [n.d.] *Key Populations Action Plan: 2014–2017 DRAFT*. Geneva, Global Fund.
3. The Global Fund to Fight AIDS, Tuberculosis and Malaria. 2012. *The Global Fund Strategy 2012–2016*. Geneva, Global Fund. <http://www.theglobalfund.org/en/about/strategy>
4. Hester, V., McGreevey, B., Hecht, R., Avila, C. and Gaillard E. [n.d.] *Assessing Costing and Prioritization in National AIDS Strategic Plans*. Washington D.C., Results for Development Institute & AIDS 2031. [http://www.resultsfordevelopment.org/sites/resultsfordevelopment.org/files/resources/Assessing%20Costing%20and%20Prioritization%20in%20National%20AIDS%20Strategic%20Plans\\_0.pdf](http://www.resultsfordevelopment.org/sites/resultsfordevelopment.org/files/resources/Assessing%20Costing%20and%20Prioritization%20in%20National%20AIDS%20Strategic%20Plans_0.pdf)
5. UNAIDS. *UNAIDS Terminology Guidelines*. 2011. Geneva, UNAIDS. [http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/JC2118\\_terminology-guidelines\\_en.pdf](http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/JC2118_terminology-guidelines_en.pdf)
6. UNAIDS. [n.d.] *UNAIDS Fact Sheet Adolescents, young people and HIV*. Geneva, UNAIDS. [http://www.unaids.org/en/media/unaids/contentassets/documents/factsheet/2012/20120417\\_FS\\_adolescentsyoungpeoplehiv\\_en.pdf](http://www.unaids.org/en/media/unaids/contentassets/documents/factsheet/2012/20120417_FS_adolescentsyoungpeoplehiv_en.pdf)
7. United Nations, Department of Economic and Social Affairs. 2012. *World Population Prospects: The 2012 Revision*. New York: United Nations, Department of Economic and Social Affairs. <http://esa.un.org/wpp/Excel-Data/population.htm>
8. UNAIDS. *Global Report: UNAIDS report on the global AIDS epidemic 2013*. 2013. Geneva, UNAIDS. [http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/UNAIDS\\_Global\\_Report\\_2013\\_en.pdf](http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/UNAIDS_Global_Report_2013_en.pdf)
9. UNAIDS. *Redefining AIDS in Asia: Crafting an Effective Response*. 2008. New Delhi, Oxford University Press. [https://www.unaids.org/en/media/unaids/contentassets/dataimport/pub/report/2008/20080326\\_report\\_commission\\_aids\\_en.pdf](https://www.unaids.org/en/media/unaids/contentassets/dataimport/pub/report/2008/20080326_report_commission_aids_en.pdf)
10. Reddy A. *Regional Review of Strategic Information on Young Key Populations at Higher Risk of HIV Exposure*. 2012. Bangkok, UNAIDS. <http://www.aidsdatahub.org/en/regional-profiles/key-presentations/item/24335-regional-review-of-strategic-information-on-young-key-populations-at-higher-risk-of-hiv-reddy-a-unaids-rst-2012>
11. Asian Human Rights Commission. *Bangladesh's Child Sex Workers: NO PLACE TO GO*. 2002. Asia Child Rights AHRC. <http://acr.hrschool.org/mainfile.php/0103/20>
12. Ministry of Public Health, Islamic Republic of Afghanistan. 2011. *National Strategic Framework on HIV/AIDS for Afghanistan - II 2011–2015*. Kabul, Ministry of Health. <http://moph.gov.af/Content/Media/Documents/HIVAIDSStrategicFramework2011-2015299201221169620553325325.pdf>
13. Philippine National AIDS Council. *Philippines Global AIDS Response Progress Report 2012*. (2012). Manila, Ministry of Health. <http://www.aidsdatahub.org/en/component/k2/item/24189-ungass-country-progress-report-philippines-philippine-national-aids-council-2012>
14. Ministry of Public Health, Islamic Republic of Afghanistan. 2012. *Afghanistan Global AIDS Response Progress Report*. Kabul, Ministry of Health. <http://www.aidsdatahub.org/en/component/k2/item/24184-afghanistan-global-aids-response-progress-report-2012-ministry-of-public-health-2012>
15. Philippine National AIDS Council. 2011. *The 5th AIDS Medium Term Plan: 2011–2016 Philippine Strategic Plan on HIV and AIDS*. Manila, Ministry of Health. [http://issuu.com/chrio\\_one/docs/5th\\_amtp\\_final\\_version](http://issuu.com/chrio_one/docs/5th_amtp_final_version)
16. Kelly, A., Kumpul, M., Man, W., Nosi, S., Lote, N., Rawstorne, P. et al. 2011. *Askim Na Save [Ask and Understand]: People Who Sell and Exchange Sex in Port Moresby*. Sydney, Papua New Guinea Institute of Medical Research & the University of New South Wales. <http://www.aidsdatahub.org/en/papua-new-guinea-reference-library/item/15350-askim-na-save-ask-and-understand-people-who-sell-and-exchange-sex-in-port-moresby-kelly-a-kumpul-m-man-wyn-et-al-2011>
17. National AIDS Council of Papua New Guinea. 2010. *Papua New Guinea National HIV and AIDS Strategy 2011–2015*. Port Moresby, Ministry of Health. <http://www.aidsdatahub.org/en/whats-new/309-papua-new-guinea/721-papua-new-guinea-national-hiv-and-aids-strategy-2011-2015-national-aids-council-of-papua-new-guinea-2010>
18. National AIDS Committee, Thailand. 2011. *Thailand National AIDS Strategy 2012–2016*. Bangkok, Ministry of Health.

19. UNICEF. 2013. *Young Key Populations and HIV in Asia and the Pacific (DRAFT)*. Bangkok, UNICEF.
20. UNICEF, UNFPA, UNESCO, UNODC, WHO, FHI. 2010. *HIV prevention among most at risk and especially vulnerable adolescents and young people in South Asia*. Kathmandu, UNICEF Regional Office South Asia. [http://www.unicef.org/rosa/MARA\\_Programme\\_Guidance\\_Notes.pdf](http://www.unicef.org/rosa/MARA_Programme_Guidance_Notes.pdf)
21. Godwin, J. 2013. *Young people and the law in Asia and the Pacific: A review of laws and policies affecting young people's access to sexual and reproductive health and HIV services*. Bangkok, UNESCO.
22. UNFPA. 2008. *Inter-Agency Task Team on HIV and Young People Guidance Brief: Overview of HIV Interventions for Young People*. New York, UNFPA. <http://www.unfpa.org/hiv/iatt/docs/overview.pdf>
23. ILO. 2013. *Youth employment in Asia-Pacific*. Bangkok, ILO. [http://www.ilo.org/asia/areas/WCMS\\_117542/lang-en/index.htm](http://www.ilo.org/asia/areas/WCMS_117542/lang-en/index.htm)
24. Godwin, J. 2012. *Sex Work and the Law in Asia and the Pacific*. Bangkok, UNDP. <http://www.snap-undp.org/elibrary/Publications/HIV-2012-SexWorkAndLaw.pdf>
25. \_\_\_\_\_. 2010. *Legal environments, human rights and HIV responses, among men who have sex with men and transgender people in Asia and the Pacific: An agenda for action*. Bangkok, UNDP. [http://regionalcentrebangkok.undp.or.th/practices/hiv/ids/documents/874\\_UNDP\\_final.pdf](http://regionalcentrebangkok.undp.or.th/practices/hiv/ids/documents/874_UNDP_final.pdf)
26. UNAIDS. 2009. *Law, Policy & HIV in Asia and the Pacific: Implications on the vulnerability of men who have sex with men, female sex workers and injecting drug users*. Bangkok, UNAIDS. [http://www.aidsdatahub.org/dmdocuments/Law\\_Policy\\_HIV\\_2009\\_HADH.pdf](http://www.aidsdatahub.org/dmdocuments/Law_Policy_HIV_2009_HADH.pdf)
27. Lawyers Collective HIV/AIDS Unit. 2010. *A Preview of Law and Policy in South and South East Asia: Drugs, Treatment and Harm Reduction*. New Delhi, Lawyers Collective. [http://www.aidsdatahub.org/dmdocuments/Legal\\_Review\\_Tripti.pdf](http://www.aidsdatahub.org/dmdocuments/Legal_Review_Tripti.pdf)
28. Stockman, J.K., Lucea, M.B. and Campbell, J.C. 2013. Forced sexual initiation, sexual intimate partner violence and HIV risk in women: A global review of the literature. *AIDS and Behavior*. Vol. 17, No. 3, pp. 832–847.
29. UNICEF. 2011. *Adolescence an Age of Opportunity*. New York, UNICEF. [http://www.unicef.org/sowc2011/pdfs/SOWC-2011-Main-Report\\_EN\\_02092011.pdf](http://www.unicef.org/sowc2011/pdfs/SOWC-2011-Main-Report_EN_02092011.pdf)
30. Government of the People's Republic of Bangladesh. 2010. *3rd National Strategic Plan for HIV and AIDS Response 2011–2015*. Dhaka, Ministry of Health. [http://www.aidsdatahub.org/dmdocuments/3rd\\_national\\_strategic\\_plan\\_for\\_hiv\\_and\\_aids\\_response\\_%28NSP%29\\_2011\\_2015.pdf](http://www.aidsdatahub.org/dmdocuments/3rd_national_strategic_plan_for_hiv_and_aids_response_%28NSP%29_2011_2015.pdf)
31. National STIs and HIV/AIDS Prevention and Control Programme, Bhutan. 2011. *Bhutan National Strategic Plan for the Prevention and Control of STIs and HIV/AIDS: 2012-2016*. Thimpu, Ministry of Health.
32. National AIDS Authority Cambodia. 2010. *The National Strategic Plan for Comprehensive and Multi-sectoral Response to HIV/AIDS III 2011-2015*. Phnom Penh, Ministry of Health. <http://www.aidsdatahub.org/en/reference-librarycols2/national-responses/item/14481-the-national-strategic-plan-for-comprehensive-and-multi-sectoral-response-to-hiv/aids-iii-2011-2015-national-aids-authority-cambodia-2010>
33. Ministry of Health, Malaysia. 2010. *Malaysia National Strategic Plan on HIV and AIDS 2011–2015*. Kuala Lumpur, Ministry of Health. [http://www.moh.gov.my/images/gallery/Report/NSP\\_AIDS\\_2011\\_2015.pdf](http://www.moh.gov.my/images/gallery/Report/NSP_AIDS_2011_2015.pdf)
34. National Committee on HIV/AIDS, Mongolia. 2009. *Mongolian National Strategic Plan on HIV, AIDS and STIs 2010–2015*. Ulan Batur, Ministry of Health. [http://www.aidsstar-one.com/sites/default/files/prevention/resources/national\\_strategic\\_plans/Mongolia\\_2010-2015.pdf](http://www.aidsstar-one.com/sites/default/files/prevention/resources/national_strategic_plans/Mongolia_2010-2015.pdf)
35. Bergenstrom, A., Andreeva, V. and Reddy, A. [n.d.] *Overview of epidemiology of injection drug use and HIV in Asia*. Bangkok, UNODC.
36. Wattana, W., van Griensven, F., Rhucharoenpornpanich, O., Manopai boon, C., Thienkrua, W., Bannatham, R. et al. (2007). Respondent-driven sampling to assess characteristics and estimate the number of injection drug users in Bangkok, Thailand. *Drug and Alcohol Dependence* Vol. 90, No. 2, pp. 228–33.
37. Ministry of Health, Timor-Leste. 2010. *Timor-Leste National HIV and STI Strategy 2011-2016*. Dili, Ministry of Health.
38. USAID, FHI. 2011. *Behaviors, Knowledge, and Exposure to Interventions: Report from a Behavioral Surveillance Survey Port Moresby, Papua New Guinea*. Bangkok, United States Agency for International Development. <http://www.aidsdatahub.org/en/reference-librarycols2/item/24313-behaviors-knowledge-and-exposure-to-interventions-report-from-a-behavioral-surveillance-survey-port-moresby-papua-new-guinea-usaid-and-fhi-may-2011>
39. UNAIDS. 2010. *Analysis from the national AIDS strategic plans on HIV and young people*. Geneva, UNAIDS. <http://yahanet.org/sites/default/files/National-AIDS-Strategic-Plans-on-HIV-and-Young-People.pdf>
40. UNAIDS, International HIV/AIDS Alliance. 2012. *Integration of Human Rights in National Strategic Plans for HIV in the Asia-Pacific: Review of the National Strategic Plans of China, India, Kiribati, Nepal, Philippines, Sri Lanka, Thailand, Vanuatu*. Geneva, UNAIDS.
41. Gibbs, A., Mushinga, M., Crone, E.T., Willan, S. and Mannell, J. 2012. How do national strategic plans for HIV and AIDS in southern and eastern Africa address gender-based violence? A women's rights perspective. *Health and Human Rights* Vol. 14, No. 2, pp. 10–20.
42. Hanss-Hancock, J. and Grant, K. 2010. *National Response to Disability and HIV in Eastern and Southern Africa*. Durban, South Africa, HEARD.
43. Crone, E., Gibbs, A. and Wilan, S. 2011. *From Talk to Action: Review of Women and Girls and Gender Equality in National Strategic Plans in Southern and Eastern Africa*. Durban: HEARD & ATHENA Network. <http://www.heard.org.za/downloads/heard-and-athena-gender-report.pdf>

44. Desmond Tutu HIV Foundation, UNAIDS. 2011. *Key Populations, Key Solutions: A Cap Analysis and Recommendations for Key Populations in South Africa, and Recommendations for the National Strategic Plan for HIV/AIDS, STIs and TB (2012–2016)*. Cape Town, South Africa, Desmond Tutu Foundation. <http://www.migration.org.za/publication/report/2011/key-populations-key-solutions-gap-analysis-and-recommendations-key-population>
45. UNAIDS. 2012. *Review of New NSPs in Asia-Pacific Region*. Bangkok, UNAIDS. [http://www.aidsdatahub.org/dmdocuments/NSP\\_Review\\_10\\_Countries\\_Aug\\_2012.pdf](http://www.aidsdatahub.org/dmdocuments/NSP_Review_10_Countries_Aug_2012.pdf)
46. WHO, UNODC, UNAIDS. 2012. *Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users*. Geneva, WHO. [http://apps.who.int/iris/bitstream/10665/77969/1/9789241504379\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/77969/1/9789241504379_eng.pdf)
47. UNDP. 2009. *Developing a Comprehensive Package of Services to Reduce HIV among Men who Have Sex with Men and Transgender Populations in Asia and the Pacific*. Colombo, UNDP. <http://www.snap-undp.org/elibrary/Publication.aspx?ID=655> (Accessed 15 August 2013)
48. UNAIDS. 2011. *Key Programmes to Reduce Stigma and Discrimination and Increase Access to Justice in National HIV Responses*. Geneva, UNAIDS. <http://www.aidsdatahub.org/en/reference-librarycols2/human-rights/item/24153-key-programmes-to-reduce-stigma-and-discrimination-and-increase-access-to-justice-in-national-hiv-responses-unaids-2011>
49. UNAIDS. 2012. *Investing for Results. Results for people: A people-centred investment tool towards ending AIDS*. Geneva, UNAIDS. [http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2012/JC2359\\_investing-for-results\\_en.pdf](http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2012/JC2359_investing-for-results_en.pdf)
50. WHO, UNFPA, UNAIDS, Global Network of Sex Work Projects, The World Bank. 2013. *Implementing Comprehensive HIV/STI Programmes with Sex Workers: practical approaches from collaborative interventions*. Geneva, World Health Organisation. [http://www.nswp.org/sites/nswp.org/files/9789241506182\\_eng.pdf](http://www.nswp.org/sites/nswp.org/files/9789241506182_eng.pdf)
51. Calleja, J., Jacobson, J., Thuy, N., Stengaard, A., Alonso, M., Ziady, H. et al. 2010. Has the quality of serosurveillance in low- and middle-income countries improved since the last HIV estimates round in 2007? Status and trends through 2009. *Sexually Transmitted Infections* Vol. 86, Suppl 2, pp. ii35–ii42.
52. UNAIDS. 1998. *Guide to the Strategic Planning Process for a National Response to HIV/AIDS*. Geneva, UNAIDS. [http://data.unaids.org/publications/IRC-pub05/jc441-stratplan-intro\\_en.pdf](http://data.unaids.org/publications/IRC-pub05/jc441-stratplan-intro_en.pdf)
53. WHO, UNAIDS, UNICEF. 2011. *Global HIV/AIDS Response: Epidemic update and health sector progress towards Universal Access*. Geneva. [http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/20111130\\_ua\\_report\\_en.pdf](http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/20111130_ua_report_en.pdf)
54. Song, Y., Li, X., Zhang, L., Fang, X., Lin, X., Liu, Y. et al. 2011. HIV-testing behavior among young migrant men who have sex with men (MSM) in Beijing, China. *AIDS Care*, Vol. 23. No. 2, pp. 179–86.
55. Zhang, L., Xiao, Y., Lu, R., Wu, G., Ding, X., Qian, H. et al. 2013. Predictors of HIV testing among men who have sex with men in a large Chinese city. *Journal of Sexually Transmitted Diseases* Vol. 40, No. 3, pp. 235–240.
56. National STD/AIDS Control Programme, Sri Lanka. 2012. *National HIV Strategic Plan Sri Lanka 2013–2017*. Colombo, Ministry of Health. <http://www.aidscontrol.gov.lk/web/Web%20uploads/Guidelines.Reports.Publications/Sri%20Lankan%20National%20HIV%20Strategic%20Plan%20-%202013-2017.pdf>
57. Winter, S. 2009. Lost in transition: transpeople, transprejudice and pathology in Asia. *International Journal of Human Rights* Vol. 13, No. 2, pp. 365–90.
58. Schmidt J. 2012. Gender diversity: Fa’afafine. *Te Ara Encyclopedia New Zealand*. <http://www.teara.govt.nz/en/gender-diversity/page-3>
59. Ministry of Health, Fiji. 2012. *Republic of Fiji National Strategic Plan on HIV and STIs, 2012–2015*. <http://www.aidsdatahub.org/en/reference-librarycols2/stigma-and-discrimination/item/24434-republic-of-fiji-national-strategic-plan-on-hiv-and-stis-2012-2015-ministry-of-health-shaping-fijis-health-2012>
60. National Centre for AIDS and STD Control, Nepal. 2011. *National HIV/AIDS Strategy 2011-2016*. Kathmandu, Ministry of Health. [http://www.ilo.org/wcmsp5/groups/public/---ed\\_protect/---protrav/---ilo\\_aids/documents/legaldocument/wcms\\_190733.pdf](http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/legaldocument/wcms_190733.pdf)
61. Bergenstrom, A. 2012. *The Road to Zero New Infections Among People Who Inject Drugs in Asia*. Bangkok, UN Regional Interagency Team on AIDS. [http://www.aidsdatahub.org/dmdocuments/PPT\\_by\\_UNODC\\_for\\_UNRITA\\_14\\_June\\_2012\\_DH4thJuly2012.pdf](http://www.aidsdatahub.org/dmdocuments/PPT_by_UNODC_for_UNRITA_14_June_2012_DH4thJuly2012.pdf)
62. UNAIDS. *AIDSinfo Online Database*. <http://www.aidsinfoonline.org/devinfo/libraries.aspx/Home.aspx>
63. Ministry of Health, Samoa. 2010. *Samoa National HIV & AIDS Policy 2011-2016*. Apia, Ministry of Health.
64. Ali, H. and Howard, J. 2011. Prevalence of Injecting Drug Use Among Youth in the Pacific Island Countries and Territories: What Is the Evidence? *Asia Pacific Journal of Public Health* Vol. 23, No. 1, pp. 112–4.
65. Mathers, B.M., Degenhardt, L., Phillips, B., Wiessing, L., Hickman, M., Strathdee, S.A. et al. 2008. Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review. *The Lancet*. Vol. 372, No. 9651, pp. 1733–45.

66. Cheng, Y., Sherman, S.G., Srirat, N., Vongchak, T., Kawichai, S., Jittiwutikarn, J. et al. 2006. Risk factors associated with injection initiation among drug users in Northern Thailand. *Harm Reduct Journal*. Vol. 3, No. 1, pp. 10.
67. National Committee for AIDS, Drugs and Prostitution Prevention and Control, Vietnam. 2010. *National Strategy on HIV/AIDS Prevention and Control 2010-2020 (Fifth Draft)*. Hanoi, Ministry of Health.
68. National AIDS Commission, Republic of Indonesia. 2010. *Indonesia National HIV and AIDS Strategy and Action Plan 2010-2014*. Jakarta, Ministry of Health. [http://www.ilo.org/wcmsp5/groups/public/---ed\\_protect/---protrav/---ilo\\_aids/documents/legaldocument/wcms\\_173075.pdf](http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/legaldocument/wcms_173075.pdf)
69. National Committee for the Control of AIDS, Lao PDR. 2011. *National Strategic and Action Plan on HIV/AIDS/STI 2011–2015*. Vientiane, Ministry of Health. <http://www.aidsdatahub.org/en/reference-librarycols2/surveillance-situational-analysis-assessments/item/24437-national-strategic-and-action-plan-on-hiv-aids-sti-2011-2015-national-committee-for-the-control-of-aids-lao-pdr-2010>
70. Ministry of Health, Myanmar. 2011. *Myanmar National Strategic Plan on HIV and AIDS 2011–2015*. Naypyidaw, Ministry of Health. <http://www.aidsdatahub.org/en/whats-new/291-bangladesh/813-3rd-national-strategic-plan-for-hiv-and-aids-response-nasp-2011-2015>
71. WHO. 2010. *A strategy to halt and reverse the HIV epidemic among people who inject drugs in Asia and the Pacific 2010–2015*. Geneva, WHO. [http://www.aidsdatahub.org/dmdocuments/Publications\\_Harm\\_Reduction\\_Strategy2010-2015.pdf](http://www.aidsdatahub.org/dmdocuments/Publications_Harm_Reduction_Strategy2010-2015.pdf)
72. \_\_\_\_\_. 2013. *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach*. Geneva, WHO. [http://apps.who.int/iris/bitstream/10665/85321/1/9789241505727\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/85321/1/9789241505727_eng.pdf)
73. UNAIDS. 2012. *UNAIDS Guidance Note on HIV and Sex Work*. Geneva, UNAIDS. [http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2009/JC2306\\_UNAIDS-guidance-note-HIV-sex-work\\_en.pdf](http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2009/JC2306_UNAIDS-guidance-note-HIV-sex-work_en.pdf)
74. Philippine National AIDS Council. 2010. *Fifth AIDS Medium-term Plan National Monitoring and Evaluation Plan*. Manila, Ministry of Health.
75. WHO. 2012. *WHO UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users – 2012 revision*. Geneva, WHO. [http://apps.who.int/iris/bitstream/10665/77969/1/9789241504379\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/77969/1/9789241504379_eng.pdf)
76. Mavedzenge, S., Luecke, E. and Ross, D. 2013. *Effectiveness of HIV Prevention, Treatment and Care Interventions Among Adolescents: A Systematic Review of Systematic Reviews*. New York, UNICEF.
77. The Philippine Star. 2013. Nursing group advances youth, healthcare issues. Manila: *The Philippine Star* Feb 14 2013. <http://www.philstar.com/science-and-technology/2013/02/14/908486/nursing-group-advances-youth-healthcare-issues>
78. Ford, L. 2013. Philippines: where Catholics, condoms and conservatism collide over health. *The Guardian*. <http://www.theguardian.com/global-development/2013/may/30/philippines-catholics-condoms-conservatism>
79. United Nations Development Programme. 2012. *HIV/AIDS Understanding and Acting on Critical Enablers and Development Synergies for Strategic Investments*. New York, UNDP. <http://www.undp.org/content/undp/en/home/librarypage/hiv-aids/understanding-and-acting-on-critical-enablers-and-development-sy/>
80. UNAIDS. 2012. *UNAIDS Report on the Global AIDS Epidemic*. Geneva, UNAIDS. [http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2012/gr2012/20121120\\_UNAIDS\\_Global\\_Report\\_2012\\_en.pdf](http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2012/gr2012/20121120_UNAIDS_Global_Report_2012_en.pdf)
81. United Nations General Assembly. 1989. *Convention on the Rights of the Child 1989, United Nations Treaty Series, vol. 1577*. <http://www.refworld.org/cgi-bin/texis/vtx/rwmain?docid=3ae6b38f0>
82. UNAIDS. 2007. *A Framework for Monitoring and Evaluating HIV Prevention Programmes for Most-At-Risk Populations*. Geneva, UNAIDS. [http://www.aidsdatahub.org/dmdocuments/Framework\\_for\\_M&E\\_of\\_prevention\\_in\\_most\\_at\\_risk\\_populations\\_2007.pdf.pdf](http://www.aidsdatahub.org/dmdocuments/Framework_for_M&E_of_prevention_in_most_at_risk_populations_2007.pdf.pdf)
83. WHO. 2004. *National AIDS programmes: a guide to monitoring and evaluating HIV/AIDS care and support*. Geneva, WHO. [http://www.aidsdatahub.org/dmdocuments/Guide\\_to\\_monitoring\\_and\\_evaluating\\_HIV\\_AIDS\\_care\\_and\\_support.pdf.pdf](http://www.aidsdatahub.org/dmdocuments/Guide_to_monitoring_and_evaluating_HIV_AIDS_care_and_support.pdf.pdf)
84. WHO. 2009. *Monitoring the declaration of commitment on HIV/AIDS: guidelines on construction of core indicators: 2010 reporting*. Geneva, WHO. [http://data.unaids.org/pub/manual/2009/jc1676\\_core\\_indicators\\_2009\\_en.pdf](http://data.unaids.org/pub/manual/2009/jc1676_core_indicators_2009_en.pdf)
85. UNAIDS. 2013. *Global AIDS response progress reporting 2013: construction of core indicators for monitoring the 2011 UN political declaration on HIV/AIDS*. Geneva, UNAIDS. [http://www.unaids.org/en/media/unaids/contentassets/documents/document/2013/GARPR\\_2013\\_guidelines\\_en.pdf](http://www.unaids.org/en/media/unaids/contentassets/documents/document/2013/GARPR_2013_guidelines_en.pdf)



**Document definitions:**

<b>National Strategic Plans</b>	Provide a vision of the results that the country wants in the prevention and management of HIV and AIDS, and the approach for trying to achieve identified goals.
<b>Operational/Work/Action Plans</b>	Accompanying documents that define actions/activities that will contribute to strategy results, as well as who is responsible for undertaking them, the cost, and the timetable. Could be called national action framework/plan; implementation plan/framework; operational plan; work plan.
<b>Monitoring &amp; Evaluation Plans</b>	Plans which provide for data collection, analysis and review to assess what progress has been made, direct strategic planning and make programme adjustments.

**Age group definitions:**

Definitions of ‘young people’, ‘children’, ‘youth’, ‘adolescent’ and the age of adulthood differ across countries and cultures. The definitions used in this review are based upon those utilised by the United Nations. The following provides these definitions and examples of countries in the Asia-Pacific region that utilise this language within the NSP.

<b>Adolescent</b>	Person aged 10 to 19 years e.g. Philippines, Thailand
<b>Child</b>	Person under 18 years, unless under domestic law the child reaches majority at an earlier age e.g. Papua New Guinea, Philippines
<b>Young person</b>	Person aged 10 to 24 years e.g. China, Fiji
<b>Youth</b>	Person aged 15 to 24 years e.g. Thailand, Myanmar

**Key population terms and definitions:**

**Key populations/Key populations at higher risk of HIV exposure**

The term ‘key populations at higher risk of HIV exposure’ or ‘key populations’ refers to those who are most likely to be exposed to HIV or to transmit it, and whose engagement is critical to a successful response. In all countries, key populations include people living with HIV. In most settings, men who have sex with men, transgender persons, people who inject drugs, sex workers and their clients, and sero-negative partners in sero-discordant couples are at higher risk of exposure to HIV than other people. These populations are not mutually exclusive. Many young people have multiple factors that may contribute to HIV risk and vulnerability, e.g. a young person may be living with HIV, transgender, sell sex and inject drugs.[5]

**Young people who sell sex:** While young females, males and transgender persons 18 years and older who receive money or goods in exchange for sexual services may be sex workers, adolescents under the age of 18 involved in selling sex are considered by the UN and most governments to be ‘commercially sexually exploited’ as defined by the Convention on the Rights of the Child and other instruments. This report has used the term ‘young people who sell sex’ as most NSPs do not make the distinction by age when referring to sex workers, or do not refer to commercially sexually exploited children. Where this distinction is made in the NSP, it has been captured in this analysis.

There is a considerable diversity of language used across countries in the region to describe the populations discussed within this review. Definitions or language utilised within the NSPs which differs from that utilised by UNAIDS has been captured in the table below, with examples of countries which use different terms.



Population	Country/Region example	Other Possible Terms
Key Populations	Afghanistan Sri Lanka Afghanistan  Bangladesh, Samoa, Philippines	At-risk populations Groups at high risk Key affected populations Risk groups Vulnerable groups Most at risk populations (MARP)
Young people from key populations	Bangladesh, Mongolia  Lao PDR	At-risk or most at-risk young people (MARYP) At-risk or most at-risk adolescents (MARA) Youth key population
Transgender	Indonesia South Asia, including Bangladesh Thailand	Waria Hijra  Kathoey
Person/People who use/s drugs (PWUD)	Myanmar Lao PDR, Malaysia, Mongolia Sri Lanka, Afghanistan  Sri Lanka	Person/People who inject drugs (PWID) Injecting drug user (IDU) Intravenous/injecting drug user (IDU) Addict Heroin smokers/users
Young people who use drugs	Afghanistan	Juveniles who inject drugs/juvenile IDUs
Men who have sex with men	Lao PDR Mongolia, Philippines	Gay Homosexual
Sex workers (SW)	Viet Nam  Bhutan  Bhutan  Bhutan, Cambodia Cambodia, Indonesia	Prostitutes Beer girls Hotel workers Bar girls Karaoke girls Drayang girls/workers Service workers Entertainment workers May be further broken down by brothel-based, hotel-based, street-based, home-based, direct and indirect or other location/activity based specification
People living with HIV (PLHIV)	Timor-Leste, Viet Nam Papua New Guinea, Timor-Leste China Fiji, Thailand, Nepal	HIV-positive PLHIV People living with AIDS (PLWA) People living with HIV/AIDS (PLWH) Children living with HIV/AIDS
Vulnerable young people	Cambodia, Myanmar Bangladesh Myanmar  Malaysia, Philippines  Malaysia Malaysia Viet Nam, Afghanistan	OVC – Orphans & vulnerable children EVA – Especially vulnerable adolescents Youth or young people who are vulnerable to drugs Street – based children or adolescents; children living in slums Children of PWID Children of sex workers Children affected by AIDS (CABA or CHABA)

## Definitions of programmes, critical enablers and synergistic development activities

Development Review Section	
Strategic information	An assessment as to whether an epidemic response situation analysis was included during the initial development process. This may include HIV infection and AIDS cases (based on HIV testing and AIDS case reporting as well as on informed estimations); other conditions that share the same methods of transmission as HIV, such as hepatitis B, syphilis, chancroid, gonorrhoea, and other STDs (an indicator that people are engaging in behaviours that put them at risk of HIV infection); behaviour that may put people at risk of infection or protect them, including information about sexual behaviour, condoms use, drug use, needle-sharing; knowledge about HIV, how it is spread, and how to avoid it, which might give indications of people's capacity to adopt safer behaviours; and attitudes to sex, condoms, drug use, personal perception of risk and personal control over their health and behaviour that might explain people's willingness or reluctance to engage in risk activities. Seeks to determine whether there is strategic information specific to key populations, young people and young key populations. Captures inclusion of any data or discussion regarding specific key populations, young people or young key populations whether prevalence or behavioural information. A comprehensive epidemic response analysis of each subgrouping is not required.
Future research	Inclusion of plans for future research, particularly regarding key populations/young people/young key populations.
Stakeholder involvement	Multi-sector involvement of directly and indirectly affected and interested individuals, groups, or entities, using an inclusive process that will allow for informed and engaged participation, of diverse interests and perspectives which characterise the HIV epidemic for the country in question. Were key populations, young people and young key populations' interest groups included in the development of the NSP. The following terms may be used to describe stakeholder involvement 'participation', 'contribution', 'included', 'involvement' and 'consultation' in the NSP development process.
Peer review	Review of the NSP by organisations external to the development process, whether national and international organisations /consultants, civil society, PLHIV networks. The NSP must specifically state that the plan was sent outside of the development group, for external review, by those who would be considered peers.
Old NSP informs NSP	Was the most recent NSP informed by consideration of the content of the old NSPs, including review of the achievements, strengths, weaknesses and gaps under the old NSPs? Were the documents utilised in the development of the new NSP specifically named (with inclusive term) and the review process of said document described?
Review process established	Are there plans for mid-term, end of term or annual review of the NSP? Capture the time frame of the review within supporting data.
Content: Core elements	
Goals	A broad objective set by the plan. For example, in the context of this review it may be to 'Reduce mortality from HIV/AIDS' or to 'Reduce the number of new infections with HIV'. Attention should then be paid to whether goals are set regarding specific key populations, young people and young key populations. May also be described within the vision, strategies, aim/s or objective/s.
Overarching targets	A target should be specific, measurable, achievable, realistic and time limited. For example a target might be to 'Reduce the incidence of HIV among female sex workers by 20 per cent by 2014.' Attention should be paid to whether targets include specific key populations, young people and young key populations. Targets may also be found in the monitoring and evaluation plan.
Geographic prioritisation	Resources for HIV prevention and treatment should be focused to achieve the maximum impact including focusing on geographic HIV 'hot-spots'. Plans should identify those localities with high disease burdens prioritise them.

Basic programmes	
PPTCT, may be called PMTCT	<p>Prevention of parent to child transmission (PPTCT) or prevention of mother to child transmission (PMTCT). This is strategy includes family planning, provision of ART prophylaxis to prevent HIV transmission during pregnancy, labour, delivery and breastfeeding, and providing care for mothers and their families i.e. maternal, antenatal, postnatal testing and treatment. Attention should be paid to whether PPTCT interventions include specific key populations, young people and young key populations. Notes should include reference to the type of ART regimens where they are specified (in NSPs or operational plans). In particular:</p> <p>Option A: Treatment or prophylaxis dependent on CD4 count, CD4 <math>\leq</math>350 or WHO stage 3 or 4 regardless of CD4 count receives life-long ART; CD4 &gt;350, and WHO stages 1 and 2 receives antenatal and intra-partum prophylaxis (AZT, sdNVP, TDF/FTC) and Extended infant NVP syrup for breastfed (BF) infants.</p> <p>Option B: All HIV-infected pregnant women initiated on ART regardless of CD4 count, CD4 <math>\leq</math>350, or WHO stage 3 or 4, life-long ART; CD4 &gt;350 and WHO stages 1 and 2, stop ART after delivery if formula fed, or after cessation of BF.</p> <p>Option B+: Life-long ART for all HIV infected pregnant women regardless of CD4 count.</p>
Condom promotion/distribution	<p>The promotion and distribution of condoms. Where reference is made to lubricants and the provision of commodities to sexual partners (i.e. partners of people who inject drugs, clients of sex workers) this should be included within the supporting data.</p>
HTC	<p>HIV testing and counselling (HTC). To include PITC (provider initiated counselling and testing), VCT (voluntary counselling and testing), VCCT (voluntary confidential counselling and testing) and ANC (antenatal Care) testing. Attention to be paid to language around community-based testing/referrals (in the context of task shifting) to remove service bottlenecks and improve efficiency in the health care system.</p>
Support groups	<p>A group of people with similar interests or concerns, support groups may provide emotional and moral support for one another; information and education; social network of people with similar problems; empowerment; and reduction in isolation and discrimination. Support groups may be fully organised and managed by their members (self-help support groups) or professionally operated.</p>
Outreach	<p>Outreach is an activity of providing services to populations who might not otherwise have access to those services. A key component of outreach is that the groups providing it are not stationary, but mobile; in other words they are meeting those in need of outreach services at the locations close to those in need. Outreach not only provides services but has an educational role, raising the awareness of existing services. Outreach may include for example: peer outreach; provision of information; distribution of commodities; delivery of referral, wound dressing and HTC services; and web based or virtual communications. Specific note should be made if peer-based, including through younger cohorts. May include reference to outreach services or activities, peer outreach, education and networks.</p>
STI prevention, testing and treatment	<p>Prevention, testing and treatment of sexually transmitted infections. The latter may also be termed venereal diseases (VD) or sexually transmitted diseases (STDs).</p>
ART	<p>Antiretroviral therapy (ART) or HIV treatment. ART typically refers to a triple or more antiretroviral drug combination. Suboptimal regimens are mono-therapy and dual therapy. Capture where available the type of therapy offered within supporting data. In this context ART does not include PPTCT but will note inclusion of PREP (pre-exposure prophylaxis) and PEP (post-exposure prophylaxis) and HIV care packages.</p>
Risk reduction communications	<p>Communications which seek to reduce behaviours associated with a higher risk of HIV exposure/transmission. These communications may include BCC (behaviour change communications), IEC (information, education, communication) and web-based or virtual communications. BCC promotes tailored messages, personal risk assessment, greater dialogue, and an increased sense of ownership. IEC combines strategies, approaches and methods that enable individuals, families, groups, organisations and communities to play active roles in achieving, protecting and sustaining their own health. May include terms such as: the integration of information and support with prevention programmes; behaviour change support or education; negotiation skills; sexual skills or alternative sexual practices; information or education regarding HIV transmission and/or prevention; information about risks or risk reduction; counselling including premarital and couple counselling; partner disclosure.</p>

Needle and syringe programme	Needle and syringe programmes increase the availability of sterile injecting equipment. Includes needle and syringe exchange programmes.
Opioid substitution therapy (OST)	Opioid substitution therapy (OST) is the recommended form of drug dependence treatment for people who are dependent on opioids. References to detoxification programmes, rehabilitation and treatment services for drug users, and drug dependency treatment should be captured. However, grading should rest on specific mention of drug substitution treatment, particularly opioid substitution.
Hepatitis	Hepatitis testing and treatment (including Hepatitis A, Hep B, Hep C).
Tuberculosis (TB)	Tuberculosis testing and treatment, and/or DOTS (directly observed treatment, short-course) should be recorded. Also note where reference is made to MDR-TB (multi-drug resistant TB). Where no mention of TB testing or treatment is made then capture opportunistic infection (OI) programmes.
<b>Critical enablers</b>	
Community mobilization	Community mobilisation may be defined as when a particular group of people becomes aware of a shared concern or common need, and together decides to take action in order to create shared benefits. Community mobilization as a critical enabler can be sub-divided into three parts: outreach and engagement, support and advocacy. However, in this review it will be considered in the context of network support/ community development and advocacy. Community mobilisation includes efforts to develop a strong effective community system that encourages a broad spectrum of community members to participate. Could include reference to community-based groups for advocacy, building political commitment, increasing awareness and improving access to services, promoting coordination and partnership-building of civil society; or capacity-development of civil society (NGOs, CBOs, FBOs). May include reference to: mobilisation of community participation or local resources; advocacy at township level; building community understanding, awareness or empowerment; coordination and multi-sectoral cooperation amongst stakeholders and gatekeepers; collaboration of public and private sector; community capacity or enhanced capacity; improved support from townships; establish and/or strengthen community based organisations, engagement of community organisations.
Mass media	Mass media programmes aimed at the general population through broad efforts including electronic, print and digital media (including social media and other new media) communications related to HIV, HTC and risk reduction. Media programmes to address stigma are captured under 'stigma and discrimination reduction'. Specific risk-reduction activities among key populations will be highlighted above under basic programmes. May be termed mass communication, mass-media campaigns, education to the general public through the media, public media.
<b>Human rights programmes</b>	
HIV-related legal services	Could include reference to: legal aid or support; strategic litigation; dispute resolution; legal action; involvement of lawyers.
Legal audits, monitoring and/ or reform of laws, regulations or policies	Could include reference to: audits of national legislation relating to HIV; reform of national legislation relating to HIV; audit of the nature of enforcement of such laws; audit of access to justice; policy development with regulatory/legal basis relating to HIV, such as HIV/AIDS workplace policies to protect the rights of employees infected with HIV; laws related to key populations e.g. decriminalisation of sex work or reform of a Suppression of Prostitution Act, same-sex sexual relations, drug use; revisions or amendments to laws; changes in or development of national policies.
Legal literacy	Know your rights/ laws' programmes. Could include reference to: awareness-raising on human and legal rights (e.g. gender equality) and/or laws in the context of HIV; demand generation for legal services. Note: Campaigns/awareness raising regarding stigma and discrimination not recorded as 'know your rights/laws', is addressed by 'stigma and discrimination reduction'.
Training of health care workers on HIV and HIV-related human rights issues	Could include reference to: training on HIV-related human rights issues, such as informed consent, confidentiality, partner notification, non-stigma and non-discrimination, tolerance, compassion, understanding, attitudes, communication, counselling skills, risk behaviour, safe-sex, HIV testing, results, care and treatment.

Training and sensitization of law makers and law enforcement agents, police, lawyers and/or judges on HIV-related human rights issues	Could include reference to: training on HIV-related human rights issues, such as non-violence, non-stigma and non-discrimination. May include sensitisation of local, township or community leaders; local or township authorities; local justice staff; as well as law makers and law enforcement.
Stigma and discrimination reduction	Could include reference to: community programmes that actively/explicitly aim to reduce stigma and discrimination based on HIV or other status (e.g. sexual orientation, gender, drug use, sex work); research and documentation of stigma and discrimination; microcredit or income-generating activities when expressly stated that these are intended to reduce stigma and discrimination. May also include terms such as: building understanding of communities about issues; sensitisation and awareness creation on human rights and protection mechanisms. Note: stigma and discrimination reduction training for health care workers, law enforcement agents, politicians, parliamentarians or government officials are not recorded as 'stigma and discrimination reduction programmes' as these are already addressed by previous categories..
<b>Synergistic development activities</b>	
SRH, life skills and HIV education in schools	Sexual and reproductive health (SRH), life skills and HIV education contribute towards the knowledge and personal skills essential for the prevention of HIV, and the mitigation of the impacts caused by AIDS. Education can create the conditions of understanding and tolerance that contribute to reduced stigma and discrimination against people living with HIV. SRH education includes human sexual anatomy, sexual reproduction, sexual intercourse or other sexual activity, reproductive health, emotional relations, reproductive rights and responsibilities, abstinence, and birth control. Life skills-based education (LSBE) is being adopted as a means to empower young people in challenging situations. Note terminology may vary, including use of the terms reproductive health or sexuality education.
Family Planning	Information and services regarding planning when to have children and contraception. May include reproductive or SRH health services for young people, key populations or their partners, prevention of unintended pregnancies in HIV positive mothers.
Integration of SRH/HIV/MCH/GBV etc.	The integration of sexual and reproductive health (SRH); HIV, HTC or PPTCT; mother and child health (MCH) or antenatal care (ANC); youth; and gender based violence (GBV) services, policies and programmes. Bi-directionality is a term used to describe the linking of SRH and HIV-related policies and programmes. Collaboration between anti-trafficking and HIV prevention, care and mitigation should also be captured.
Reducing harmful gender norms, GBV, and increasing women and girls' empowerment	Programmes referencing gender equality and addressing harmful gender and social norms and practices; gender-based violence; and engaging and promoting women and girls' leadership, empowerment and civic engagement; building understanding of communities regarding women's rights; addressing the reproductive health rights of women.
Child Protection	Specifically with reference to young key populations or children of people from key populations. Includes measures, structures and services developed to prevent and respond to abuse, neglect, exploitation and violence affecting children living with or affected by HIV and AIDS or vulnerable to HIV infection. This may include: national poverty-reduction strategies; government policies and resource allocations for expanded social welfare and services to facilitate the access of families and communities to care for CABA; legislation and enforcement: e.g. anti-discrimination laws to ensure equal access to essential services such as health care, including ART and education; services/interventions to protect CABA from violence (including armed conflict), sexual discrimination, sexual abuse and unequal power relations; build all children's (including CABA's) life skills, knowledge and participation; provide essential services, including prevention, recovery and reintegration; interventions to address child trafficking, commercial sexual exploitation of children, child labour and harmful traditional practices, such as female genital mutilation/cutting and child marriage; meeting the needs of vulnerable young people including OVC needs for example community and home-based care, improving access to services, including support services, psychosocial, advice, counselling, health services, HIV counselling, testing, referral, treatment and follow-up; strengthening of family or community based protection systems; protection and care of OVC including formalised kinship care, foster care, day care, social houses; drop in centres or shelters for overnight and longer stay; referral networks to link street children with families of origin or new families; legal action or involvement of lawyers to take action against individuals who commit violence against children.

Vulnerable Young People (including OVC, EVA, CABA, young people vulnerable to drug use)	Inclusion of targets and/or programmes specifically targeted for vulnerable young people, in particular orphans and vulnerable children (OVC), especially vulnerable adolescents (EVA), children affected by AIDS, (CHABA/CABA), young people vulnerable to drug use, street children.
Social Protection	Social protection is defined as the set of public and private policies and programmes aimed at preventing, reducing and eliminating the economic and social vulnerability of children, women and families, in order to ensure their access to a decent standard of living and essential services. Social protection boosts households' capacity to care for their children and removes demand-side barriers to services and complements and supports sector interventions in health and nutrition, education, child protection, and HIV/AIDS. Social protection instruments include: social transfers, long-term predictable transfers and safety net/ humanitarian response e.g. cash transfers (including pensions, child benefits, poverty-targeted, seasonal), food transfers, nutritional monitoring, support or security, food and fuel subsidies, nutritional supplements, public works; programmes to ensure economic and social access to services: e.g. user fee abolition, social health insurance, exemptions, vouchers, subsidies; social support and care services: e.g. psycho-social support, family support services, home-based care; legislation and policies to ensure equity and non-discrimination in children and families' access to services and employment/ livelihoods: e.g. minimum and equal pay legislation, employment guarantee schemes, childcare policy, maternity and paternity leave, removal of discriminatory legislation/ policies affecting service provision/employment; promotion of socio-economic reintegration, economic or income generation activities or economic empowerment, for example recovery and re-integration services for women who want to leave sex work.
Education	Education helps to overcome the conditions that facilitate the spread of HIV, including poverty, ill health, violence and abuse, particularly against girls and women. Reference made broadly to education (not in the context of specific SRH/life skills and HIV education), vocational or livelihood training, non-formal education, linkages for re-entry into schools.
<b>Operationalisation</b>	
M&E framework with indicators	Does the monitoring and evaluation (M&E) framework include quantitative and/ or qualitative variables that provide a valid and reliable way to measure strategic achievement, assess performance or reflect changes connected to an intervention.
M&E framework with targets	Does the M&E framework include the objectives the NSP is working towards, expressed specifically, as measurable values, with the desired value for an indicator at a particular point in time?
Operational plan costed	Does the operational plan include a detailed budget for the activities included?
Implementing agencies	Does the operational plan specify which agencies will be accountable for implementation of the activities detailed?

National strategic frameworks or plans (NSPs) determine a country's national response to HIV and AIDS, guiding allocation of funding, resources and human capacity.

In the Asia-Pacific region, with low/concentrated epidemics, one would expect that NSPs would prioritise key populations at higher risk of HIV exposure, including men who have sex with men, transgender people, sex workers and their clients, people who inject drugs, and people living with HIV.

This review analyses attention to key populations, with a particular focus on younger cohorts (under age 25), in 19 NSPs in the Asia-Pacific region. It considers three broad areas: development and review of the NSP; content including core elements, basic programmes, critical enablers and synergistic development activities (drawing on the UNAIDS Investment Framework); and operationalisation of the plan.

It aims to inform country-based reviews and progress reports of current NSPs, and the development of future plans with greater attention to these populations.

The review is a joint effort between UNESCO, UNFPA, UNICEF, UNDP, UNAIDS, Save the Children and GNP+, with additional support from WHO.

RESULTS

DATA

TARGET

LINKS



TRENDS



TIMELINE



PROGRAMMES



SYNERGIES