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Joint United Nations Programme on HIV/AIDS (UNAIDS) 1997

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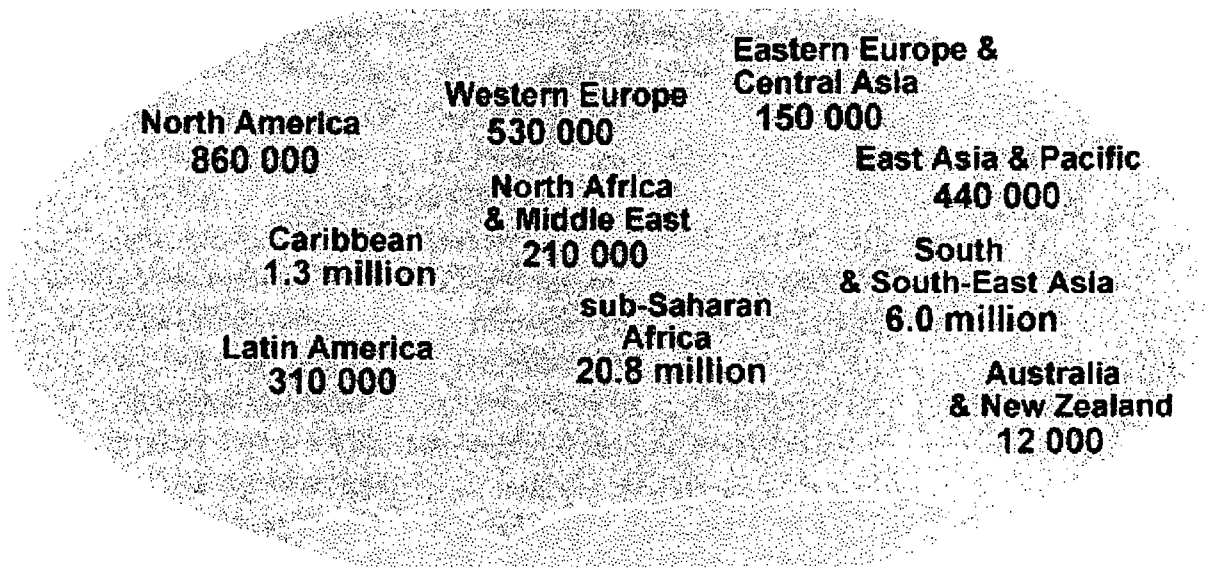
Global HIV/AIDS & STD Surveillance

[ slide 1 of 16 ]

# Adults and children estimated to be living with HIV/AIDS as of end 1997




Total: 30.6 million

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*Last updated on Mon, Jun 22, 1998*

Agency - UN AIDS - 1997

Global HIV/AIDS & STD Surveillance

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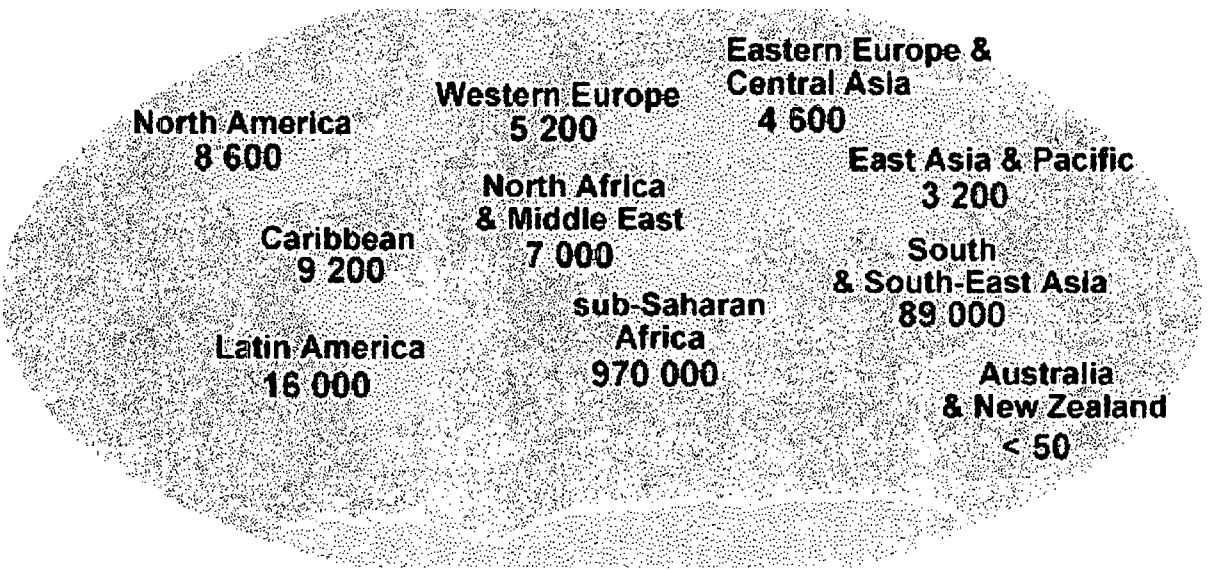
# Children (<15 years) estimated to be living with HIV/AIDS as of end 1997




Total: 1.1 million

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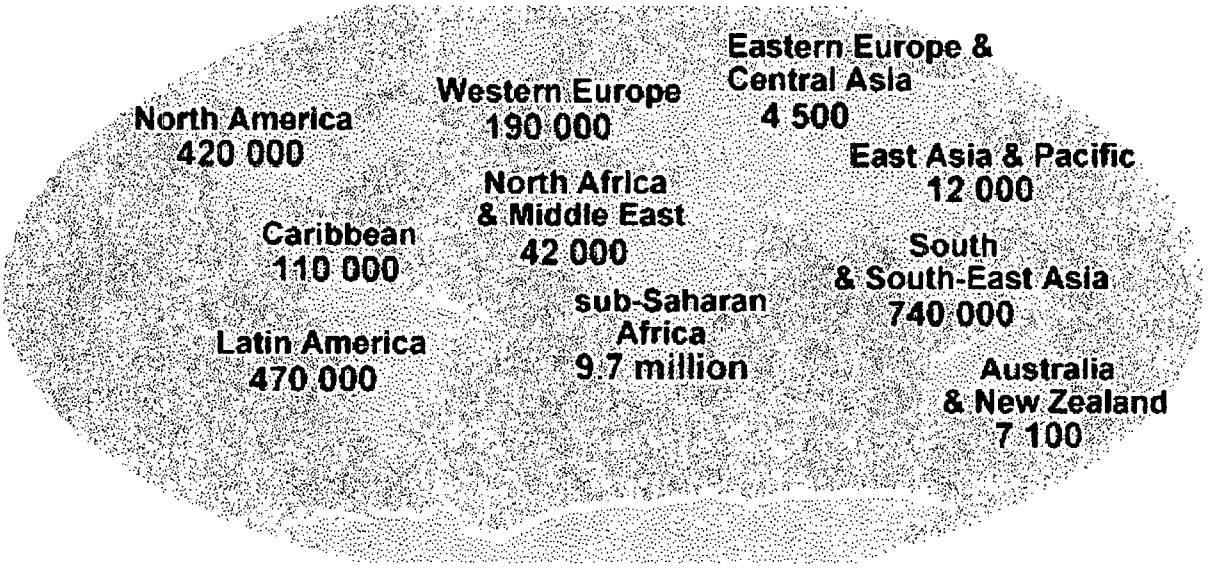
# Estimated adult and child deaths due to HIV/AIDS from the beginning of the epidemic to end 1997




Total: 11.7 million

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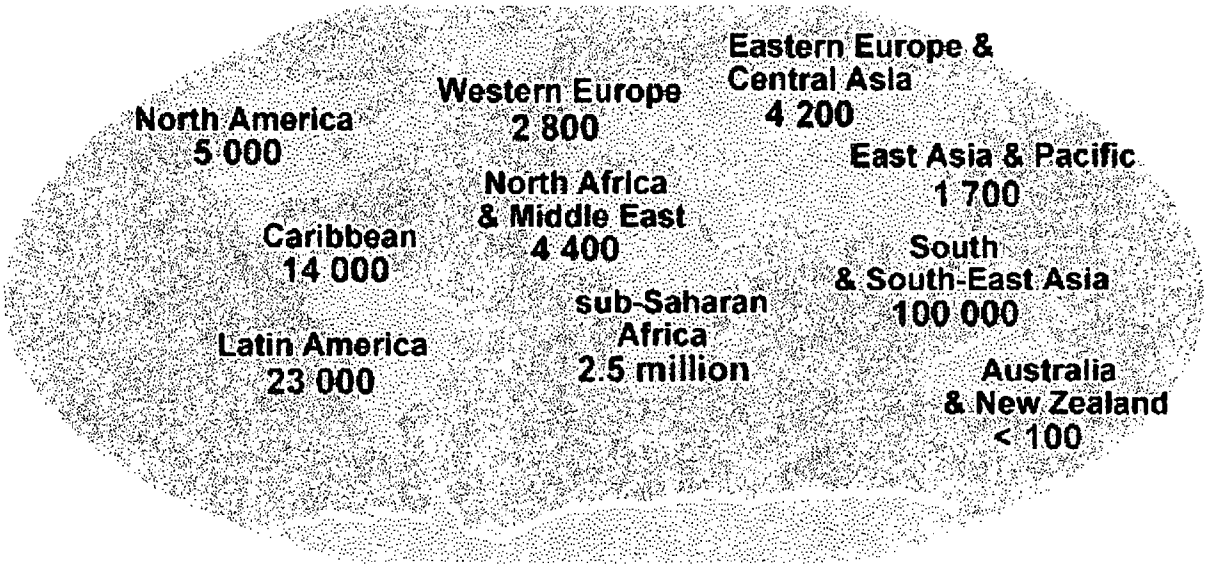
# Estimated child deaths due to HIV/AIDS from the beginning of the epidemic to end 1997




Total: 2.7 million

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Global HIV/AIDS & STD Surveillance

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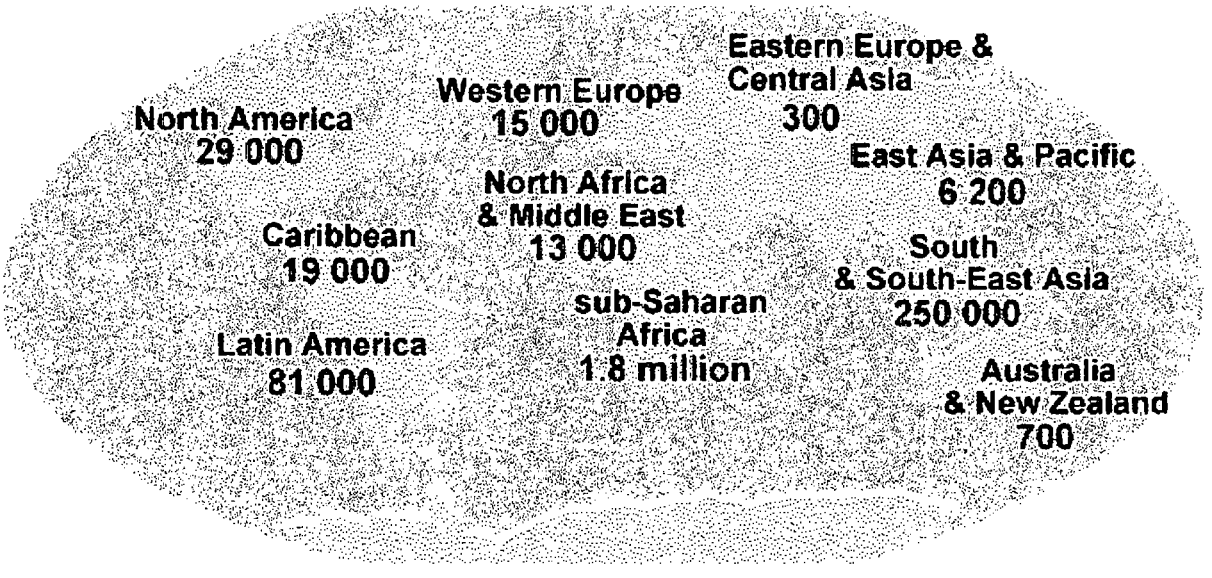
# Adult and child deaths from HIV/AIDS during 1997




Total: 2.3 million

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Global HIV/AIDS & STD Surveillance

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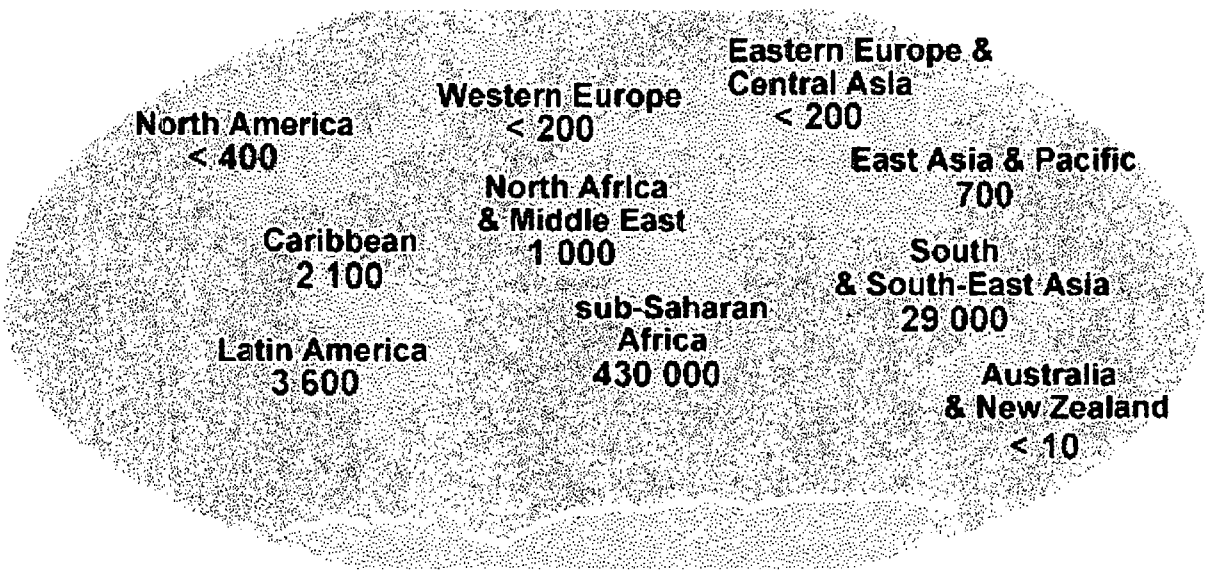
# Child deaths from HIV/AIDS during 1997




Total: 460 000

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Global HIV/AIDS & STD Surveillance

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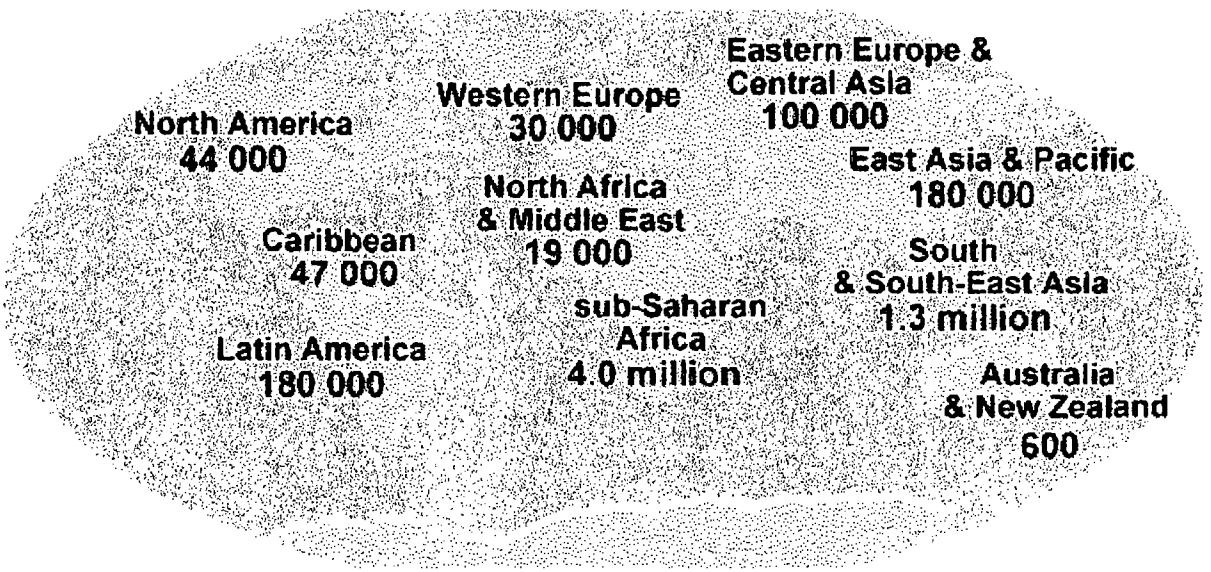
# Estimated number of adults and children newly infected with HIV during 1997




Total: 5.8 million

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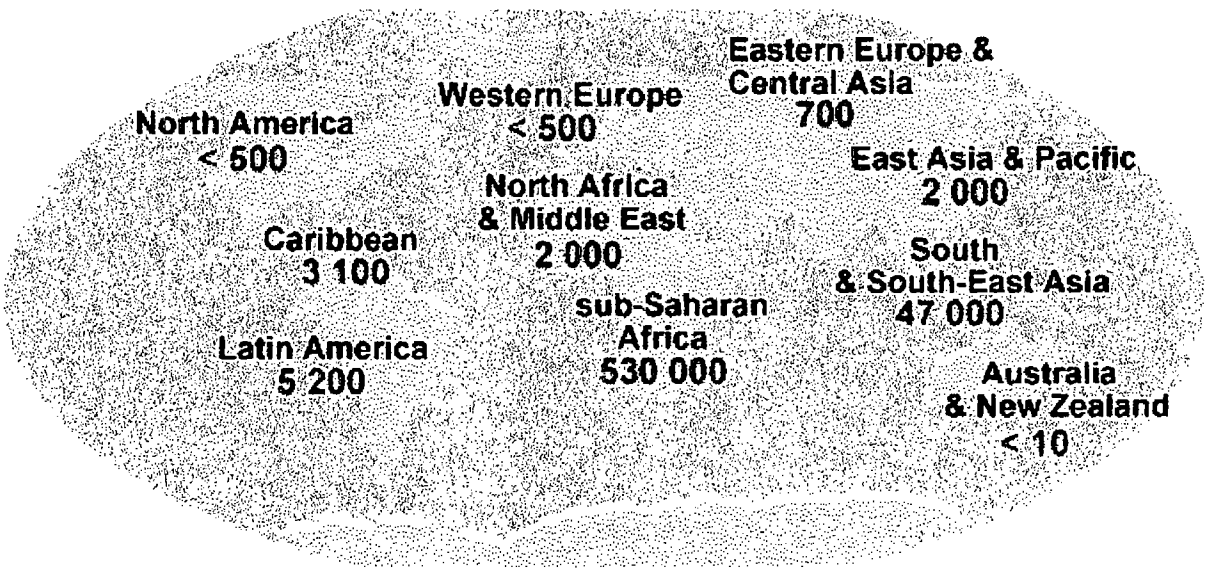
# Estimated number of children (<15 years) newly infected with HIV during 1997




Total: 590 000

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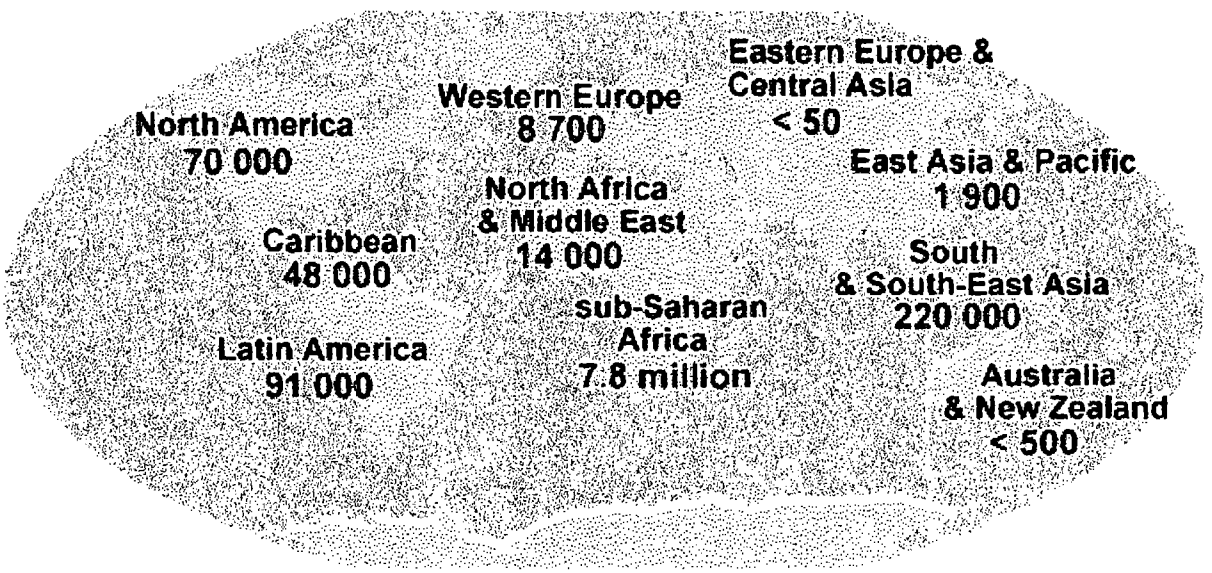
# Cumulative number of children estimated to have been orphaned by AIDS* at age 14 or younger




Total: 8.2 million

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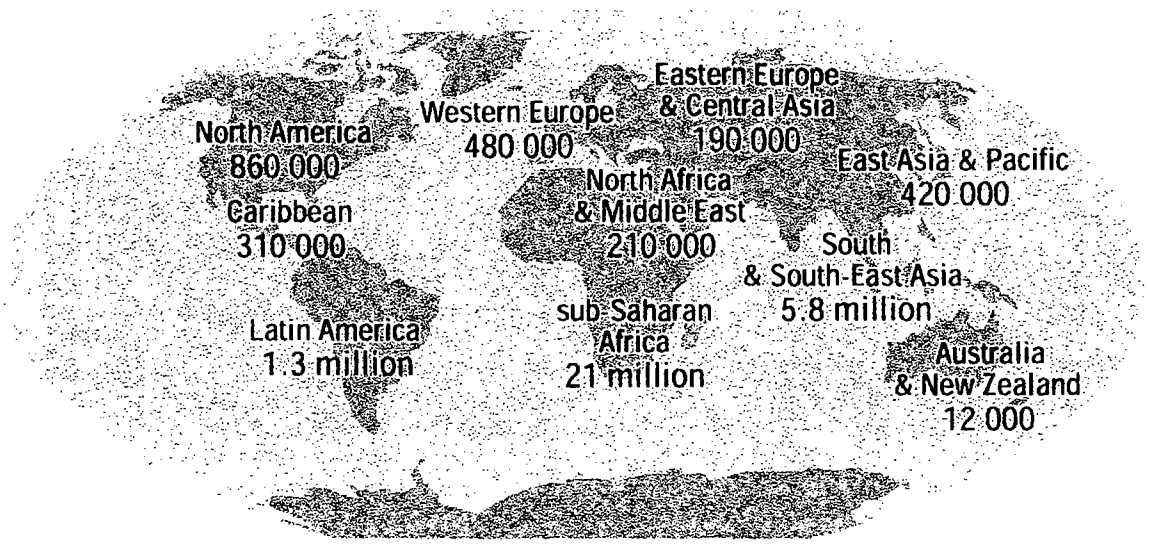
*Last updated on Mon, Jun 22, 1998*

# Global estimates of the HIV/AIDS epidemic as of end 1997

| | | |
|---|---|---|
| People newly infected with HIV in 1997 | Total | 5.8 million |
| | Adults | 5.2 million |
| | *Women* | *2.1 million* |
| | Children <15 years | 590 000 |
| Number of people living with HIV/AIDS | Total | 30.6 million |
| | Adults | 29.4 million |
| | *Women* | *12.2 million* |
| | Children <15 years | 1.1 million |
| AIDS deaths in 1997 | Total | 2.3 million |
| | Adults | 1.8 million |
| | *Women* | *800 000* |
| | Children <15 years | 460 000 |
| Total number of AIDS deaths since the beginning of the epidemic | Total | 11.7 million |
| | Adults | 9.0 million |
| | *Women* | *3.9 million* |
| | Children <15 years | 2.7 million |
| Total number of AIDS orphans* since the beginning of the epidemic | | 8.2 million |

*Defined as children who lost their mother or both parents to AIDS when they were under the age of 15.




Adults and children living with HIV/AIDS – total 30.6 million

# HIV and AIDS: the global situation

The human immunodeficiency virus (HIV) continues to spread around the world, insinuating itself into communities previously little troubled by the epidemic and strengthening its grip on areas where AIDS is already the leading cause of death in adults (defined here as those aged 15-49).

Estimates by the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO), a cosponsor of the Joint Programme, indicate that by the beginning of 1998 over 30 million people were infected with HIV, the virus that causes AIDS, and that 11.7 million people around the world had already lost their lives to the disease.

Unless a cure is found or life-prolonging therapy can be made more widely available, the majority of those now living with HIV will die within a decade.

These deaths will not be the last; there is worse to come. The virus continues to spread, causing nearly 16 000 new infections a day. During 1997 alone, that meant 5.8 million new HIV infections, despite the fact that more is known now than ever before about what works to prevent the spread of the epidemic.

It is possible that momentum for prevention will build up as the epidemic becomes more visible. Today, although one in every 100 adults in the most sexually active age bracket (15-49) is living with HIV, only a tiny fraction know about their infection. Because people can live for many years with HIV before showing any sign of illness, the virus can spread unobserved for a long time. In the face of other pressing concerns, it has been relatively easy in many parts of the world for political, religious and community leaders to overlook the significance of the epidemic. But AIDS cases, and AIDS deaths, are growing the world over, and there are few countries where it is still possible to be ignorant of the scale of the disease. Some 2.3 million people died of AIDS during the course of 1997. In roughly the same number again HIV infection developed into symptomatic AIDS. HIV has more than doubled the adult death rate in some places, and is the single biggest cause of adult death in many others (see page 43). Indeed HIV/AIDS is among the top ten killers world wide, and given current levels of HIV infection, it may soon move into the top five, overtaking such well-established causes of death as diarrhoeal diseases.

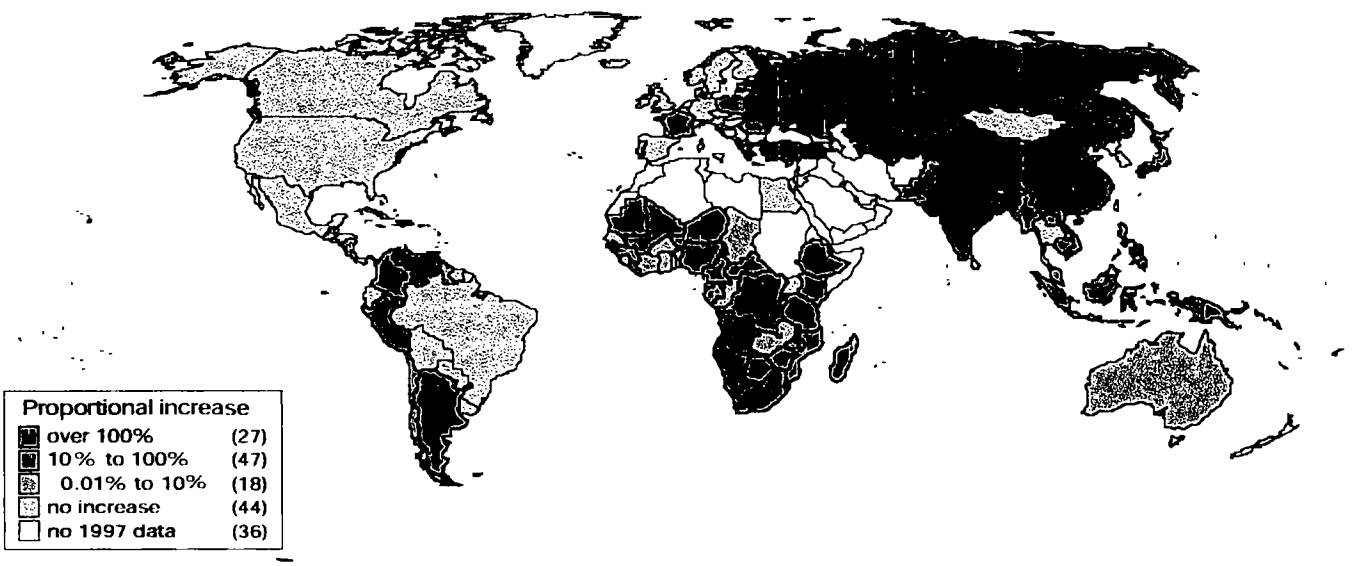
Nearly 600 000 children were infected with HIV in 1997, mostly through their mothers before or during birth or through breastfeeding. The number

of children under 15 who have lived or are living with HIV since the start of the epidemic in the late 1970s has reached around 3.8 million – 2.7 million of them have already died. However, recent developments in the understanding of mother-to-child transmission and in drug research hold out a promise of reducing the number of child infections, at least in populations where pregnant women can choose to be tested for HIV (see page 49).

As the fold-out map at the end of this report shows, HIV infections are concentrated in the developing world, mostly in countries least able to afford to care for infected people. In fact, 89% of people with HIV live in sub-Saharan Africa and the developing countries of Asia, which between them account for less than 10% of global Gross National Product.

The fold-out map reflects the progress of the epidemic so far. But it conceals important changes in patterns of spread. While in some countries HIV has remained at roughly the same low levels for a number of years, others, currently at similar absolute levels of prevalence, are experiencing a rapid spread of the virus. It is these countries that have the greatest potential to avert epidemic spread by acting quickly. Figur e 1 shows the proportional increase in prevalence regardless of the absolute levels of infection.

Figure 1. Proportional increase in country HIV prevalence rates between 1994 and 1997



It is clear that infection rates are rising rapidly in much of Asia, Eastern Europe and southern Africa. The picture in Latin America is mixed, with prevalence in some countries rising rapidly. In other parts of Latin America and many industrialized countries, infection is falling or close to stable. This is also the case in Uganda, one of the earliest countries to record epidemic growth in HIV infection; in Thailand, where the rapid spread of HIV has been checked by active prevention programmes; and in some West African countries. Nevertheless, although the situation is improving among many groups, large numbers of new infections still occur every year in these countries.

## *Orphans*

HIV has often caused huge increases in death rates among younger adults – just the age when people are forming families and having children (see page 44). This inevitably leads to an increase in orphans. In rural areas of East Africa, 4 of every 10 children who have lost one of their parents by age 15 have been orphaned by HIV/AIDS.

As shown in the tables annexed to this report (see page 64), from the beginning of the epidemic until the start of 1998, some 8.2 million children around the world had lost their mother to AIDS. Many of those had lost their fathers as well. In 1997 alone, around 1.6 million children were orphaned by HIV. Over 90% of those orphans live in sub-Saharan Africa.

Extended family structures have in many countries been able to absorb some of the stress of increasing orphanhood. However, urbanization and the migration of labour, often across borders, is eating away at those structures. As the number of orphans grows and the number of potential caregivers shrinks, traditional coping mechanisms stretch to breaking point. That point may be reached much more rapidly in countries such as Thailand, where the nuclear family is increasingly the norm, and in Cambodia, where decades of war and civil strife have already taken a heavy toll on family structures and social coping mechanisms. These two countries already have the highest proportion of AIDS orphans in Asia.

# The evolving picture region by region

## *Sub-Saharan Africa: the epidemic shifts south*

Over two-thirds of all the people now living with HIV in the world – nearly 21 million men, women and children – live in Africa south of the Sahara desert, and fully 83% of the world's AIDS deaths have been in this region. Since the very start of the epidemic, HIV in sub-Saharan Africa has mostly spread through sex between men and women. As shown in the annexed tables, this means that women are more heavily affected in Africa than in other regions, where the virus initially spread most quickly among men by male-to-male sex or drug injecting. Four out of five HIV-positive women in the world live in Africa.

An even higher proportion of the children living with HIV in the world are in Africa – an estimated 87%. There are a number of reasons for this. First, more women of childbearing age are HIV-infected in Africa than elsewhere. Secondly, African women have more children on average than those in other continents, so one infected woman may pass the virus on to a higher than average number of children. Thirdly, nearly all children in Africa are breastfed. Breastfeeding is thought to account for between a third and half of all HIV transmission from mother to child. Finally, new drugs which help reduce transmission from mother to child before and around childbirth are far less readily available in developing countries, including those in Africa, than in the industrialized world.

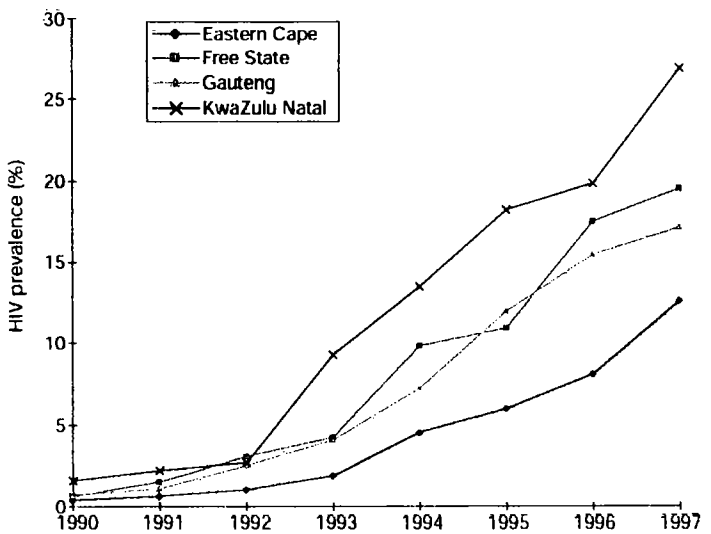
By the early 1980s, HIV was found in a geographic band stretching from West Africa across to the Indian Ocean. The countries north of the Sahara and those in the southern cone of the continent remained apparently untouched. By 1987, the epidemic became more concentrated in the original areas, and began gradually to colonize the south. A decade later, in 1997, HIV had been recorded all over the continent.

In general, West Africa has seen its rates of infection stabilize at much lower levels than East and southern Africa, as the tables in the annex show. However, some of the most populous countries in West Africa are exceptions to this rule. In Côte d'Ivoire, West Africa's third most populous nation, 1 adult in 10 is already believed to be living with HIV. Nigeria has an estimated adult prevalence of 4.1% – relatively low by the standards of the continent, but with 118 million inhabitants (a fifth of the population of sub-Saharan Africa) this translates into 2.2 million infections. And there is no evidence that infection levels have stabilized.

Clearly, if HIV prevalence in Nigeria were to approach the 20% rates all too commonly seen in southern African countries, the burden would be devastating.

Today, the most severe HIV epidemics in the world are to be found in the southern countries of Africa. The virus there is still spreading rapidly, despite already high levels of infection. Figure 2 illustrates the recent growth in infection rates in the general population in South Africa. High-prevalence and relatively low-prevalence areas show the same pattern – a sharp rise in just four years. Some 2.9 million South Africans are thought to be living with HIV at the beginning of 1998, over 700 000 of them infected in 1997 alone.

Figure 2. HIV prevalence among pregnant women, selected provinces, South Africa, 1990-1997




Source: *Department of Health, South Africa*

Other countries in southern Africa face even higher rates of infection. In Botswana, the proportion of the adult population living with HIV has doubled over the last five years, with 43% of pregnant women testing HIV-positive in 1997 in the major urban centre of Francistown. In Zimbabwe, one in four adults in 1997 were thought to be infected. In Harare, 32% of pregnant women were already infected in 1995. In Beit Bridge, a major commercial farming centre, HIV prevalence in pregnant women shot up from 32% in 1995 to 59% in 1996. Although infection levels in Zimbabwe's cities were slightly higher than in rural areas, the difference was not great. In one town near the South African border with a large population of migrant workers, 7 out of 10 women attending antenatal clinics tested HIV-positive in 1995.

The first country in Africa to respond actively to a massive national HIV/AIDS burden was Uganda. The government engaged religious and traditional leaders and other sectors of society in a vigorous debate that helped forge consensus around the need to attack the problem of HIV. Active prevention programmes, focused on delaying sexual relations and negotiating safe behaviour, were brought into schools. Community groups were set up to counsel people and families living with the virus. The efforts of the government and people of Uganda seem to be paying off. At both rural and urban surveillance sites infection rates are falling. The improvement has been particularly marked in the younger age groups. This is in line with behaviour studies showing that young people nowadays are adopting safer sexual behaviour – later sexual initiation, fewer partners, more condom use – than was common a decade ago. First signs of falling infection rates in young people are also being seen in neighbouring Tanzania, in areas with active prevention programmes. In women aged 15-24 in the urban area of Bukoba, prevalence fell from 28% in 1987 to 11% in 1993. In the surrounding rural area, prevalence among women in the same age group fell from almost 10% in 1987 to 3% in 1996.

## Asia: low infection rates but rapid spread

HIV was a latecomer to Asia, but its spread has been swift. Until the late 1980s, no country in Asia experienced a major epidemic – the continent appeared practically immune. By 1992, however, a number of countries, led by Thailand, were facing increasing numbers of infections. These were generally concentrated in groups such as drug injectors and sex workers whose behaviour was known to put them at risk. Although no Asian country has reached anything like the prevalence levels common in sub-Saharan Africa, HIV was by 1997 well established across the continent. The countries of South-East Asia, with the exception of Indonesia, the Philippines and Laos, are comparatively hard hit, as is India. While prevalence remains low in China, that country too has been recording an increasing number of cases.

Only a few countries in the region have developed sophisticated systems for monitoring the spread of the virus, so HIV estimates in Asia often have to be made on the basis of less information than in other regions. Because over half of the world's population lives in the region, small differences in rates can make a huge difference in the absolute numbers of people infected.

The Government of China estimated that at the end of 1996 up to 200 000

people were living with HIV/AIDS. It is now estimated that this figure had doubled by the beginning of 1998. At present, there are two major epidemics under way in China. One is among injecting drug users in the mountainous southwest of the country. The other, newer epidemic is now surfacing among heterosexuals, especially along the prosperous eastern seaboard where prostitution is re-emerging as the gap grows between rich and poor. The warning signs of high-risk behaviour are worryingly clear: sexually transmitted diseases (STDs) have shot up in recent years, and there are no suggestions that the upward trend will be broken.

In India, HIV infection rates, at under 1% of the total adult population, are still low by the standards of many countries, although well over 10 times higher than in neighbouring China. Surveillance is patchy, but it is now estimated that about 4 million people in India are living with HIV. That makes India the country with the largest number of HIV-infected people in the world. Recent testing of pregnant women in Pondicherry shows infection rates of around 4%. Among truck drivers in the southern state of Madras, HIV prevalence quadrupled from 1.5% in 1995 to 6.2% just one year later. In the northeastern state of Manipur, where the epidemic took off quickly among male drug injectors, some drug clinics were registering HIV rates as high as 73% in 1996.

There is limited information about HIV infection in other parts of South Asia, but it is clear that many people are having unprotected sex with non-monogamous partners. A recent study among sex workers in Bangladesh showed that 95% had contracted genital herpes, mostly from their clients, while 60% had syphilis.

Rates of HIV infection remain low in several South and South-East Asian nations. In Bangladesh, Indonesia, Laos, Pakistan, the Philippines and Sri Lanka, infection has not reached 1 adult in 1000 yet. However, other countries in the region – including Cambodia, Myanmar, Thailand and Viet Nam – show much higher levels of HIV. The reasons for these differences are not entirely clear. Nor is there any assurance that prevalence will remain low in those areas that have seen only a modest spread so far, given the widespread occurrence of risk behaviour including commercial sex and, in some places, drug injecting.

Thailand, which has experienced what is probably the best-documented epidemic in the developing world, has shown evidence of a fall in new infections, especially among sex workers and their clients (see page 29). So far, the majority of the almost 800 000 people living with HIV and AIDS in Thailand – some 2.3% of the adult population – fall into these two groups, or are drug injectors. The decrease in new infections is the outcome of sustained prevention efforts aimed at increasing condom use among hetero-

sexuals, discouraging men from visiting sex workers, and offering young women better educational and other prospects to discourage their entry into commercial sex. HIV still appears to be spreading in other groups whose behaviour puts them at risk of infection but who have received less attention in prevention campaigns. HIV rates among Thailand's injecting drug users have stabilized at a relatively high level (around 40%), and a survey among men who have sex with other men in northern Thailand reported low AIDS-awareness and infrequent condom use.

Elsewhere in South-East Asia the picture is mixed. It is bleakest in Cambodia, where 1 in 30 pregnant women, 1 in 16 soldiers and policemen and nearly 1 in 2 sex workers tested positive in sentinel HIV surveillance. While condom use has grown very rapidly (condom sales have risen from virtually nothing to around a million units a month in under three years), commercial sex remains very common: in a recent survey three-quarters of respondents in the military and the police force and two-fifths of male students said they had visited a sex worker in the last year. Viet Nam and Myanmar are also seeing a rapid spread of HIV. In Myanmar, HIV infection among sex workers rose from 4% in 1992 to over 20% in 1996, while close to two-thirds of injecting drug users are infected. Among pregnant women in six urban areas, an estimated 2.2% are infected.

Overall, as shown in the annexed tables, about 6.4 million people are currently believed to be living with HIV in Asia and the Pacific – just over 1 in 5 of the world's total. By the end of the year 2000, that proportion is expected to grow to 1 in 4. Around 94 000 children in Asia now live with HIV.

## *Latin America and the Caribbean: most infections are in marginalized groups*

In Latin America the picture is fragmented, although nearly every country in the continent now reports HIV infections. The pattern of HIV spread in Latin America is much the same as that in industrialized countries. Men who have unprotected sex with other men and drug injectors who share needles are the focal points of HIV infection in many countries in the region. Studies in Mexico suggest that up to 30% of men who have sex with men may be living with HIV. Between 3% and 11% of drug injectors in Mexico are HIV-infected, and in Argentina and Brazil the proportion may be close to half of all injectors.

Rising rates in women nevertheless show that heterosexual transmission is becoming more prominent. In Brazil in 1986, 1 AIDS case in 17

was a woman. Now the figure for AIDS is one in four, and a quarter of the 550 000 adults currently living with HIV in Brazil are women. In the region as a whole the proportion is around one-fifth.

In some places there is clear evidence of increasing infection among poorer and less educated members of the population. For example, in Brazil most of the early AIDS cases were in people with secondary or university education; today 60% of people living with AIDS never studied beyond primary school.

Some 1.3 million people are believed to be living with HIV in Latin America and the Caribbean. HIV prevalence is estimated at under 1 adult in 100 in all but a handful of the region's 44 countries and territories.

Systematic surveillance is limited. Because contraceptive use is far higher in Latin America than in Africa or Asia – and a smaller proportion of sexually active women therefore become pregnant – HIV prevalence among pregnant women is likely to be less representative of rates among all sexually active women than in other parts of the developing world. That said, they are still among the best indicators of HIV in the general population. HIV has reached levels of 1% among pregnant women in Honduras and more than 3% in Porto Alegre, Brazil. Rates are substantially higher in the Caribbean. By 1993, 8% of pregnant women in Haiti were infected with the virus, and the same prevalence was reported from one surveillance site in the Dominican Republic in 1996.

Several countries in Latin America are attempting to ensure care for people living with HIV and AIDS, including providing life-prolonging antiretroviral drugs. Access to care, although better than in other areas of the developing world, remains patchy overall.

## *Eastern Europe: drug injection drives HIV*

Until the mid-1990s, most of the countries of Eastern Europe appeared to have been spared the worst of the HIV epidemic. Mass screening of blood samples from people whose behaviour put them at risk of HIV showed extremely low levels of infection, right up to 1994. The whole of Eastern Europe put together had around 30 000 infections among its 450 million people at the start of 1995. At that time, Western Europe had over 15 times as many cases, while in sub-Saharan Africa over 400 times as many people were living with the virus. But in the last few years, the former socialist economies of Eastern Europe and Central

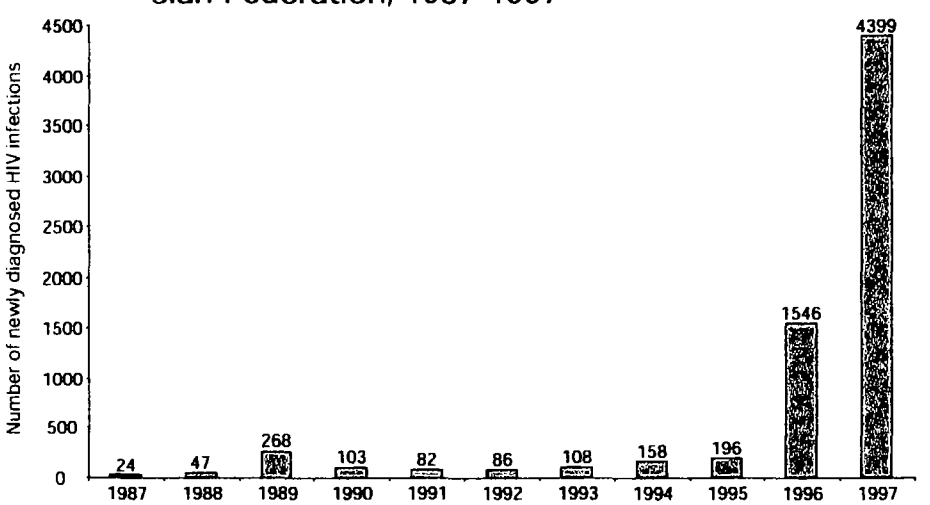
Asia have seen infections increase around six-fold. By the end of 1997, some 190 000 adults in the region were living with HIV infection.

The pattern of consistently low prevalence began to change in 1995 in several of the countries of the former Soviet Union. Belarus, Moldova, the Russian Federation and Ukraine have all registered astronomical growth in HIV infection rates over the last three years, most related to unsafe drug injecting. Now there may be nearly four times as many infections in Ukraine alone as there were in the whole Eastern European region just three years ago.

Ukraine is the worst affected country in the region. Confirmed HIV cases are rising astronomically. Only 44 people tested positive for HIV in Ukraine in 1994, roughly the same number as in 1992 and 1993. But the number of diagnoses shot up over 30-fold in 1995, and in 1996 exploded to over 12 000. In 1997, another 15 000 new infections were identified. These numbers are just the tested cases – the tip of the iceberg. The true number of infections in 1994 was probably around 1500. Now, just four years later, over 70 times that many people – some 110 000 – are estimated to be infected.

A similar pattern appears in the Russian Federation, where 158 people tested positive for HIV in 1994. Many infected men at that time reported contracting the infection from sex with other men, and only two cases were reported among injecting drug users. By the end of last year, the epidemic had taken off in the Russian Federation, as Figure 3 illustrates. Nearly 4400 people tested positive for HIV in 1997, almost three times as many as the previous year.

Figure 3. Number of newly diagnosed HIV infections, Russian Federation, 1987-1997



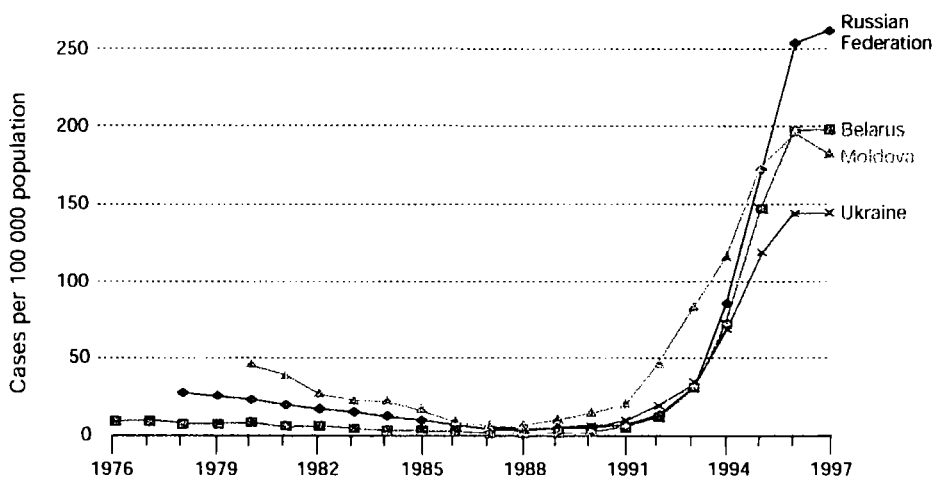

Source: *Russian AIDS Centre*

The bulk of the spread has been in injecting drug users (see page 34-36). Four of every five newly diagnosed infections are in this group. Again, the true number of infections is far higher than these figures suggest. It is estimated that in the Russian Federation there are around six people living with HIV for every one person who has actually tested HIV-positive. That means around 40 000 people may currently be living with HIV.

The sex partners of injecting drug users may provide a conduit for the virus into the general population. In some areas of Eastern Europe, there seems to be a strong overlap between drug injectors and sex workers, who will also have clients from outside the drug-injecting community. Out of a small sample of 103 sex workers arrested on the streets of the Russian city of Kaliningrad, for instance, a third were known to be injecting drug users living with HIV. The city reported that four out of every five women treated for HIV-related illness at the regional AIDS centre make a living out of sex.

There is no doubt that the warning signs for a widespread sexually-transmitted epidemic of HIV exist in many areas of Eastern Europe. Although levels of HIV infection in the general population remain very low, the testing of pregnant women, blood donors and others suggests that the virus is becoming increasingly common in society as a whole. And there has been a dramatic increase in other sexually transmitted diseases, especially syphilis, illustrated in Figure 4. From negligible annual rates of around 10 cases per 100 000 people in the late 1980s, new syphilis infections have shot up into the hundreds. The Russian Federation, which had an annual rate in the single figures in 1987, recorded over 260 cases per 100 000 population a decade later.

Figure 4. Reported annual incidence of syphilis in Belarus, Russia, Moldova and Ukraine, 1976-1997




Source: *WHO Regional Office for Europe*

The rise in new cases of sexually transmitted diseases may reflect a dramatic increase in unprotected sex, a breakdown of STD treatment services, or both. Whatever the reason, it indicates that the risk of HIV spreading rapidly throughout the general population in Eastern Europe is very real.

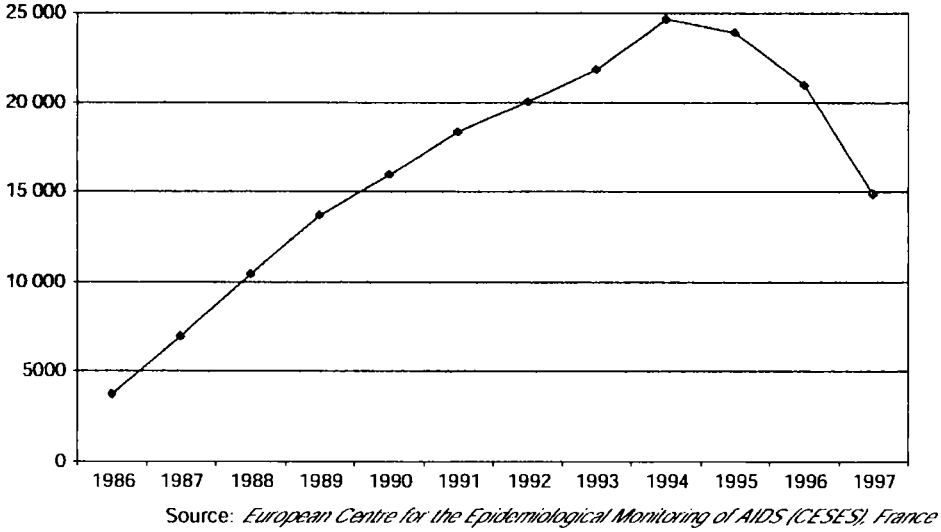
## The industrialized world: AIDS is falling

In general, HIV infection rates appear to be dropping in Western Europe, with new infections concentrated among drug injectors in the southern countries of the continent, particularly Greece and Portugal. It is estimated that 30 000 Western Europeans were newly infected with HIV in 1997. Antiretroviral drugs given to women during pregnancy and the availability of safe alternatives to breastfeeding (see page 49) kept mother-to-child transmission low; it is estimated that fewer than 500 children under the age of 15 were infected with HIV in 1997.

North America estimated it had around 44 000 new HIV infections in 1997, close to half of them among injecting drug users. As in Western Europe, transmission from mother to child was rare, with fewer than 500 new cases.

Generally, industrialized countries concentrate on following AIDS cases rather than tracking HIV. And as HIV infections continue to rise in the developing world, AIDS cases in many industrialized countries are falling, as Figure 5, with data from Western Europe, indicates.

Figure 5. Number of new AIDS cases, Western Europe, 1986-1997




Source: *European Centre for the Epidemiological Monitoring of AIDS (CESES), France*

In Western Europe, new AIDS cases (corrected for delays in reporting) fell from 23 954 in 1995 to 14 874 in 1997 – a 38% drop. The fall in AIDS cases is due in part to prevention measures taken since the late 1980s by gay communities, and to a sustained rise in the proportion of young people using condoms, which led to a drop in the number of people infected with HIV. Because of the long lag time between HIV infection and symptomatic AIDS, the behaviour change of the late 1980s is only now being reflected in fewer new cases of AIDS. But the downturn is probably due most of all to new antiretroviral drug therapies which postpone the development of AIDS and prolong the life of people living with HIV (see page 46).

In the United States, AIDS case reports indicate that the first-ever annual decrease in new cases – 6% – occurred in 1996, and an even larger reduction was expected in 1997. The biggest improvement – a drop of 11% – was in homosexual men. In some disadvantaged sections of society, however, AIDS continues to rise. Among African-Americans, new AIDS cases rose by 19% among heterosexual men and 12% among heterosexual women in 1996. In the Hispanic community, there were 13% more cases among men and 5% more among women than a year earlier. This is partly because these communities may find it hard to access the expensive new drugs that could stave off the onset of AIDS. It is partly, too, because prevention efforts in minority communities, where transmission is often through heterosexual intercourse and drug injecting, have been less successful than in the predominantly well-educated and well-organized gay community.

## *North Africa and the Middle East: the great unknown*

Less is known about HIV infection rates in North Africa or the Middle East than in other parts of the world. Some countries, particularly those with large populations of immigrant workers, carry out mass screening for the virus, but none estimates infections at more than 1 adult in 100. Just over 200 000 people are estimated to be living with HIV in these countries, under 1% of the world total.

Risk behaviour does, however, exist. At least one country in the region has started a programme to reduce risky drug-injecting practices. The generally conservative social and political attitudes in the Middle East and North Africa often make it difficult for governments to address risk behaviour directly. However, in some countries in the region, governments have created elbow room for community and nongovernmental organizations to help sex workers and others whose behaviour puts them at risk to protect themselves from HIV.

## Table 3. AIDS cases by age group, exposure category, and sex, reported July 1995 through June 1996, July 1996 through June 1997; and cumulative totals, by age group and exposure category, through June 1997, United States

| Adult/adolescent exposure category | Males | | | | Females | | | | Totals | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | July 1995–June 1996 | | July 1996–June 1997 | | July 1995–June 1996 | | July 1996–June 1997 | | July 1995–June 1996 | | July 1996–June 1997 | | Cumulative total[1] | |
| | No. | (%) | No. | (%) | No. | (%) | No. | (%) | No. | (%) | No. | (%) | No. | (%) |
| Men who have sex with men | 29,773 | (52) | 24,146 | (48) | – | – | – | – | 29,773 | (42) | 24,146 | (38) | 298,699 | (49) |
| Injecting drug use | 13,701 | (24) | 11,576 | (23) | 5,219 | (37) | 4,574 | (33) | 18,920 | (27) | 16,150 | (25) | 154,664 | (26) |
| Men who have sex with men and inject drugs | 3,528 | ( 6) | 2,684 | ( 5) | – | – | – | – | 3,528 | ( 5) | 2,684 | ( 4) | 38,923 | ( 6) |
| Hemophilia/coagulation disorder | 366 | ( 1) | 250 | ( 0) | 27 | ( 0) | 15 | ( 0) | 393 | ( 1) | 265 | ( 0) | 4,567 | ( 1) |
| Heterosexual contact: | 3,249 | ( 6) | 3,357 | ( 7) | 5,940 | (43) | 5,459 | (40) | 9,189 | (13) | 8,816 | (14) | 54,571 | ( 9) |
| *Sex with injecting drug user* | *969* | | *794* | | *2,078* | | *1,666* | | *3,047* | | *2,460* | | *22,890* | |
| *Sex with bisexual male* | *–* | | *–* | | *400* | | *298* | | *400* | | *298* | | *2,768* | |
| *Sex with person with hemophilia* | *11* | | *5* | | *37* | | *36* | | *48* | | *41* | | *390* | |
| *Sex with transfusion recipient with HIV infection* | *37* | | *33* | | *69* | | *40* | | *106* | | *73* | | *867* | |
| *Sex with HIV-infected person, risk not specified* | *2,232* | | *2,525* | | *3,356* | | *3,419* | | *5,588* | | *5,944* | | *27,656* | |
| Receipt of blood transfusion, blood components, or tissue[2] | 323 | ( 1) | 245 | ( 0) | 274 | ( 2) | 244 | ( 2) | 597 | ( 1) | 489 | ( 1) | 8,075 | ( 1) |
| Other/risk not reported or identified[3] | 6,497 | (11) | 8,385 | (17) | 2,479 | (18) | 3,422 | (25) | 8,976 | (13) | 11,807 | (18) | 44,677 | ( 7) |
| Adult/adolescent subtotal | 57,437 | (100) | 50,643 | (100) | 13,939 | (100) | 13,714 | (100) | 71,376 | (100) | 64,357 | (100) | 604,176 | (100) |
| **Pediatric (<13 years old) exposure category** | | | | | | | | | | | | | | |
| Hemophilia/coagulation disorder | 2 | ( 1) | 3 | ( 1) | – | – | 1 | ( 0) | 2 | ( 0) | 4 | ( 1) | 232 | ( 3) |
| Mother with/at risk for HIV infection[3] | 331 | (93) | 291 | (91) | 335 | (95) | 261 | (90) | 666 | (94) | 552 | (91) | 7,157 | (91) |
| *Injecting drug use* | *96* | | *79* | | *92* | | *61* | | *188* | | *140* | | *2,878* | |
| *Sex with an injecting drug user* | *55* | | *36* | | *44* | | *36* | | *99* | | *72* | | *1,304* | |
| *Sex with a bisexual male* | *4* | | *7* | | *7* | | *4* | | *11* | | *11* | | *161* | |
| *Sex with person with hemophilia* | *–* | | *2* | | *1* | | *–* | | *1* | | *2* | | *27* | |
| *Sex with transfusion recipient with HIV infection* | *–* | | *–* | | *–* | | *–* | | *–* | | *–* | | *26* | |
| *Sex with HIV-infected person, risk not specified* | *60* | | *59* | | *62* | | *58* | | *122* | | *117* | | *982* | |
| *Receipt of blood transfusion, blood components, or tissue* | *2* | | *5* | | *1* | | *5* | | *3* | | *10* | | *150* | |
| *Has HIV infection, risk not specified* | *114* | | *103* | | *128* | | *97* | | *242* | | *200* | | *1,629* | |
| Receipt of blood transfusion, blood components, or tissue[2] | 10 | ( 3) | 2 | ( 1) | 2 | ( 1) | 3 | ( 1) | 12 | ( 2) | 5 | ( 1) | 375 | ( 5) |
| Risk not reported or identified[3] | 13 | ( 4) | 24 | ( 8) | 16 | ( 5) | 24 | ( 8) | 29 | ( 4) | 48 | ( 8) | 138 | ( 2) |
| Pediatric subtotal | 356 | (100) | 320 | (100) | 353 | (100) | 289 | (100) | 709 | (100) | 609 | (100) | 7,902 | (100) |
| **Total** | **57,793** | | **50,963** | | **14,292** | | **14,003** | | **72,085** | | **64,966** | | **612,078** | |

[1]Includes 11 persons known to be infected with human immunodeficiency virus type 2 (HIV-2). See *MMWR* 1995;44:603-06.
[2]Thirty-seven adults/adolescents and 3 children developed AIDS after receiving blood screened negative for HIV antibody. Twelve additional adults developed AIDS after receiving tissue, organs, or artificial insemination from HIV-infected donors. Four of the 12 received tissue, organs, or artificial insemination from a donor who was negative for HIV antibody at the time of donation. See *N Engl J Med* 1992;326:726-32.
[3]See table 11 and figure 7 for a discussion of the "other" exposure category. "Other" also includes 63 persons who acquired HIV infection perinatally but were diagnosed with AIDS after age 13. These 63 persons are tabulated under the adult/adolescent, not pediatric, exposure category.

**Figure 1. Male adult/adolescent AIDS annual rates per 100,000 population, for cases reported in 1995, United States**

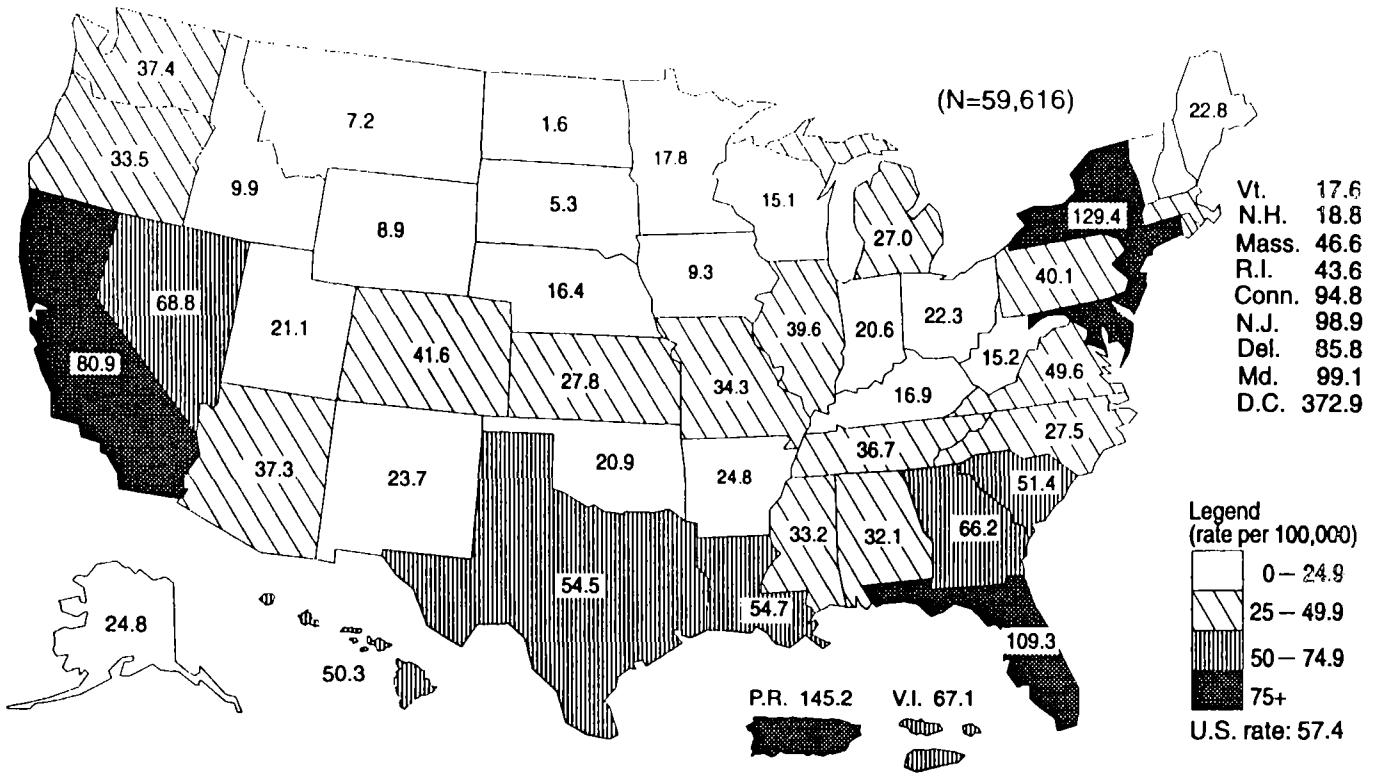
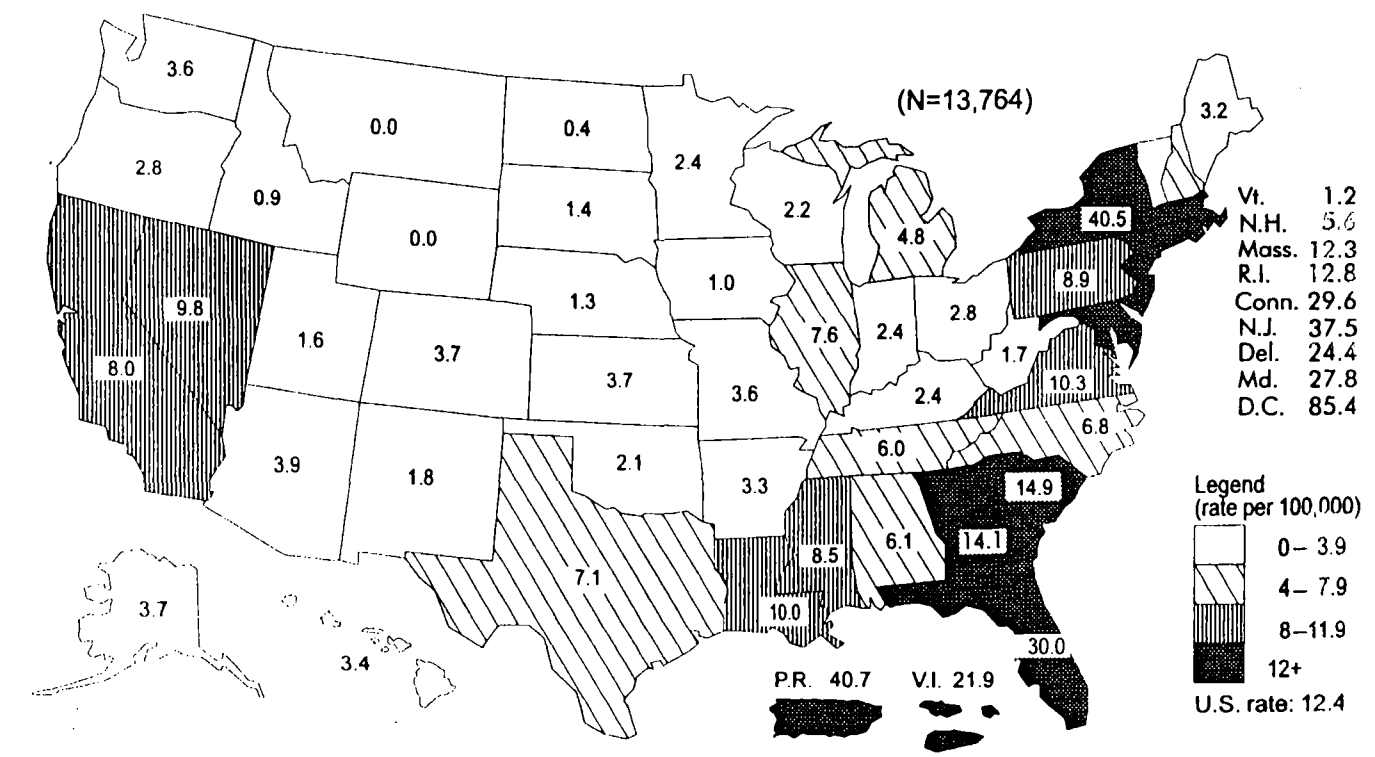



**Figure 2. Female adult/adolescent AIDS annual rates per 100,000 population, for cases reported in 1995, United States**



# STATISTICS ON THE AIDS EPIDEMIC

## National Trends

- Between 650,000 and 900,000 Americans are living with HIV.
- Since the AIDS epidemic began 500,000 Americans have been reported with AIDS -- 300,000 have died.
- An estimated 40,000 to 60,000 Americans are being infected with HIV each year.
- An average of 100 Americans are diagnosed with AIDS each day and 100 to 150 become infected with HIV every 24 hours.
- AIDS is the leading cause of death among Americans aged 25 to 44.
- Women now comprise 14% of people with AIDS. If the current trends continue, an estimated 80,000 children will have been orphaned as a result of this disease by the end of the decade.
- In 1994 alone, 1,000 new pediatric cases of AIDS were reported.
- One in four new HIV infections in the U.S. occur among people under the age of 21.
- People of color have been disproportionately impacted by AIDS. As of October 1995, 38 percent of newly reported AIDS cases were with people of color

## International Trends

- More than 29 million men, women and children around the world have been infected with HIV -- more than 3 million infections occurring within the last year.
- In 1995, 1.1 million adults and 350,000 children in the world died of AIDS.
- 8,500 people become infected with AIDS each day, including nearly 1,000 children.

- It has been estimated in some countries in subsaharan Africa that life expectancy has decreased by up to twenty years because of the AIDS epidemic.

- In 1992, in South Africa 2% of all women who came in for prenatal treatment were HIV positive and that number is up to 14%.

- Without an effective vaccine, AIDS will soon overtake tuberculosis and malaria as the leading cause of death among persons between 25-44 years of age.

**The global HIV/AIDS epidemic as reported by UNAIDS:**

- 16,000 new HIV infections occur each day.
- 1,600 children are infected daily.
- More than 90% of new infections are in developing countries.
- More than 40% of new HIV infections are in women.
- More than 50% of new HIV infections are in 15-24 year-olds.

| | |
|---|---|
| • People currently living with HIV | 30.6 million |
| • New HIV infections in 1997 | 5.8 million |
| • Deaths due to HIV in 1997 | 2.3 million |
| • Cumulative total of deaths from HIV | 11.7 million |
| • Total children orphaned due to HIV | 8.2 million |

**Accelerating the development of an AIDS vaccine represents our only hope for ending this growing devastation.**

World AIDS Campaign

# Children Living in a World with AIDS

**Under embargo until 10:00 GMT,**
**Friday 27 June 1997**

**Secretariat**

UNAIDS

**Steering Committee**

• UNAIDS
*and co-sponsors:*

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WHO

WORLD BANK

• *Others:*

François-Xavier Bagnoud Center for Health and Human Rights, Harvard University

Children and AIDS International NGO Network

NGO Group for the Convention on the Rights of the Child

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## Children Living in a World with AIDS

## World AIDS Campaign
## *Media Briefing*

## *Facts and Figures*

- The United Nations Convention on the Rights of the Child defines a child as every human being below the age of 18 years.

- There is still no cure or effective vaccine for HIV, the virus that causes AIDS.

- UNAIDS, the Joint United Nations Programme on HIV/AIDS, estimates that there are already over 23 million people worldwide living with HIV, over 40% of whom are women. In some of the worst affected countries, up to 40% of women attending antenatal clinics in urban areas are HIV-positive.

- In 1996 alone, 400,000 children under the age of 15 became infected with HIV, bringing the total number of children in this age group living with the virus to 830,000 at the end of 1996.

- By the end of 1997, a million children under the age of 15 are expected to be living with HIV, over 90% of them in developing countries.

- Since the beginning of the epidemic, according to UNAIDS and WHO estimates, well over 2 million HIV-positive children under the age of 15 have been born to HIV-positive mothers, and hundreds of thousands of children have acquired HIV from blood transfusions or through sex.

- Because HIV infection often progresses quickly to AIDS in children, most of the close to 3 million children under 15 who have been infected since the start of the epidemic have developed AIDS, and most of these have died.

- Of the 1.5 million people who died of AIDS in 1996, 350,000 were children under the age of 15.

- The US Bureau of the Census estimates that by the year 2010, if the spread of HIV is not contained, AIDS may increase infant mortality by as much as 75% and mortality in children under 5 by more than 100% in those regions most affected by the disease.

- UNAIDS estimates that, by mid-1996, 9 million children under 15 had lost their mothers to AIDS. More than 90% of these children live in sub-Saharan African countries.

- Most children orphaned by AIDS are concentrated in those countries most affected by the epidemic. For example, data provided by the US Bureau of the Census and the World Bank indicate that there are 1.2 million Ugandan children under the age of 18 who have lost at least one parent to AIDS. This figure is increasing by an estimated 50,000 children each year.

- According to UNICEF, children orphaned by AIDS are the largest and fastest growing group of children in "difficult circumstances" in Zimbabwe. It is estimated that by the end of 1996, approximately 8% of children under 15 years of age in the country had lost their mothers to AIDS.

- Even children who are neither infected with HIV nor orphaned by AIDS are affected by the socioeconomic fallout from the epidemic in hard-hit communities and countries. An AIDSCAP study estimated that, by the year 2005, Kenya's Gross Domestic product (GDP) will be 14.5% smaller than it otherwise would have been had AIDS never occurred. Per capita income is projected to be reduced by 10%.

- The vulnerability of girls to HIV infection is exacerbated by denial or neglect of their recognized human rights - including gender discrimination - resulting in particular in low access to socioeconomic opportunities.

- In many developing countries, some 50% of the population is under the age of 18 years. Directing prevention efforts to children is crucial in minimizing the further spread of the epidemic.

- Adolescents are especially vulnerable to infection through sex or drug injecting.

- Commercial sexual exploitation and domestic sexual abuse of children are contributing risk factors for HIV infection among children.

- Figures reported to the 1996 World Congress Against Commercial Sexual Exploitation of Children indicated that worldwide more than 1 million children enter the sex trade every year.

- Countless numbers of children worldwide are at risk of sexual abuse by relatives, other members of the child's community or strangers.

- Estimates suggest that there are as many as 100 million children and adolescents in the world who are working or living on the street, often in violent and dangerous situations.

- The physical and mental abuse of children may increase the likelihood of their engaging in risk-taking sexual behaviour and thus increase their vulnerability to HIV.

# *Children living in a world with AIDS*

From the sick and neglected infants dying of AIDS in the orphanages of Ceaucescu's Romania to the young people watching over their dying parents in East Africa, images of the children of the AIDS epidemic have been among the most compelling reminders of the reach of this global crisis.

Today's children - defined by the United Nations Convention on the Rights of the Child as people under the age of 18 years old - are growing up in a world with AIDS. They are having to cope not only with issues and problems that have long existed and are now being revealed by the HIV/AIDS epidemic, but also with those that result directly from the epidemic and which, until recently, people only had to face as adults.

**More children are contracting HIV than ever before, and there is no sign that the infection rate is slowing.**

Children below the age of 18 are vulnerable to infection through mother-to-child transmission, unsafe blood and injection practices, sex - including sexual abuse, coercion and commercial exploitation - and injecting drug use. Much of this vulnerability stems from failure to respect their rights, including those guaranteed under the United Nations Convention on the Rights of the Child.

Unfortunately, the magnitude of the problem remains to be documented with any precision. There is a glaring gap in data on the incidence of infection among children as they grow into adolescence. One of the shortcomings of HIV epidemiological surveillance to date has been to use the cut-off point of 14 years for younger children for the collection and aggregation of data - the older 15-49 year age group being considered as adults. A first step therefore for governments in fulfilling their obligations to children in the context of HIV/AIDS is to collect comprehensive data on HIV transmission among older children and adolescents, so that they can design effective prevention and care programmes in the light of these data.

The number of children infected around birth is easier to estimate. Around 90% of children who become infected under the age of 15 years acquire the virus from their HIV-positive mothers, whether before or during birth or through breastfeeding. And as women of childbearing age themselves become infected in ever greater numbers - a trend reflecting their own social vulnerability to HIV - the number of babies infected through mother-to-child transmission rises correspondingly.

Since the beginning of the HIV/AIDS epidemic in the late 1970s and early 1980s, UNAIDS and WHO estimate that close to 3 million children under the age of 15 years have been infected with HIV. In 1996 alone, around 1,000 children died daily of AIDS and even more became newly infected with each passing day. At the end of that year, it was estimated that 830,000 children under 15 were living with the virus, a number that UNAIDS expects to rise to 1 million by the end of 1997. Well over 90% of these children live in developing countries.

In sub-Saharan Africa, the region most severely affected by AIDS so far, the US Bureau of the Census has predicted that AIDS will offset improvements in infant and child mortality achieved in the past decade. **By the year 2010, if the spread of HIV is not contained, AIDS may increase infant mortality by as much as 75% and under-five child mortality by more than 100% in those regions most affected by the disease.**

**Children are not only infected by HIV, they are also affected.** While the number of those infected by HIV continues to grow, the epidemic is also having a direct and devastating effect on millions of other children whose lives have been permanently altered by the intrusion of HIV/AIDS into their households or communities.

Children living in hard-hit communities feel the impact as they lose parents, teachers and caregivers to AIDS, as health systems are stretched beyond their limits, and as their families take in other children who have been orphaned by the epidemic.

Individual households struck by AIDS often suffer disproportionately from stigma, isolation and impoverishment, and the emotional toll on the children is heavier still. And as the number of children orphaned or otherwise affected by AIDS rises, social security systems, already underfunded and overburdened

where they exist, are at breaking point. The impact is most acute on girls and boys already facing hardship or neglect - children in institutional care, children in poor neighbourhoods or slum areas, refugee children - and even more so for young girls who have unequal opportunities for schooling and employment.

In countries such as Uganda, where the epidemic already took hold over a decade ago, the impact of AIDS on the socioeconomic fabric of communities is becoming increasingly visible. As one UNICEF/WHO report puts it, "the effects of the epidemic are starkly obvious from the banana plantations going fallow, the houses closed or abandoned, the funeral processions on the roads and the recent graves near homes where grandparents care for children whose parents have died." AIDS sets back development and changes patterns of life. To a child, this translates into a world turned upside down.

But the shadow of the epidemic extends far beyond even these millions of infected and affected children. **In the final analysis, all children of the world henceforth face a lifetime of risk from HIV. They are exposed to the risk of HIV infection at different life stages as they grow into adulthood, because of circumstances such as sexual exploitation and abuse, or simply due to violation of their rights to information, to education and services.** There is a need for greater recognition of the specific needs of girls and especially vulnerable children, both boys and girls, such as refugees, street kids, and children exposed to drug use.

In short, children and young people in all countries, and those who care for and are responsible for them, are having to adjust and adapt to this new world. The global epidemic is continuing to accelerate. There is, as yet, no vaccine against the virus. Neither is there a cure. For all the welcome recent advances in scientific treatments, there also remains great uncertainty as to whether and how such treatments could ever be made accessible to the vast majority of people living with HIV who are in the developing world.

**AIDS has changed the world for children.** The United Nations Convention on the Rights of the Child provides a framework for promoting and protecting the rights of children which can minimize the impact of the HIV/AIDS epidemic on them. Yet, despite its almost universal ratification, the response to infected, affected and vulnerable children has remained inconsistent. Internationally, AIDS programmes for children have been ad hoc and fragmented and have lagged behind those for adults. In many developing countries, this situation is worsened by poverty and other factors, such as wars and the resulting social breakdown of many communities.

The industrialized world has unmet needs as well. In a survey conducted in 1992 in the United States, government lobbyists on children's issues admitted that while they were generally successful in promoting other causes such as education and anti-poverty programmes, they were much less so with childhood AIDS issues such as prevention, orphan care and education around sexual health.

**In a world with AIDS, children must become everybody's responsibility.**

On World AIDS Day 1994, heads of government from 42 countries attending the Paris AIDS Summit called for a global partnership to reduce the impact of the HIV/AIDS epidemic on children and young people.

Through the 1997 World AIDS Campaign, UNAIDS and its partners aim to bring to the attention of the international community the many facets of the epidemic's impact on the lives of children. The campaign will offer a platform for children and their communities to voice their concerns and aspirations in relation to the epidemic and to support the development of appropriate responses.

This briefing summarizes how the epidemic is having an impact on children who are infected by HIV, those who are directly affected by HIV/AIDS in their families or communities, and the children who are at risk of HIV infection. It outlines the global and national action needed to support children and their families as they face life in a world with AIDS.

## The Rights of the Child in the context of HIV/AIDS

*All children under the age of 18 living in today's world - whether they are themselves infected with HIV, affected by AIDS in their households or communities, or living in the shadow of HIV risk - are recognized by the United Nations Convention on the Rights of the Child.*

*The United Nations Convention on the Rights of the Child in the context of HIV/AIDS has spelled out principles for reducing children's vulnerability to infection and for protecting children from discrimination because of their real or perceived HIV/AIDS status. This human rights framework can be used by governments to ensure that the best interests of children with regard to HIV/AIDS are promoted and addressed:*

- Children's right to life, survival and development should be guaranteed.
- The civil rights and freedoms of children should be respected, with emphasis on removing policies which may result in children being separated from their parents or families.
- Children should have access to HIV/AIDS prevention education, information, and to the means of prevention. Measures should be taken to remove social, cultural, political or religious barriers that block children's access to these.
- Children's right to confidentiality and privacy in regard to their HIV status should be recognized. This includes the recognition that HIV testing should be voluntary and done with the informed consent of the person involved which should be obtained in the context of pre-test counselling. If children's legal guardians are involved, they should pay due regard to the child's view, if the child is of an age or maturity to have such views.
- All children should receive adequate treatment and care for HIV/AIDS, including those children for whom this may require additional costs because of their circumstances, such as orphans.
- States should include HIV/AIDS as a disability, if disability laws exist to strengthen the protection of people living with HIV/AIDS against discrimination.
- Children should have access to health care services and programmes, and barriers to access encountered by especially vulnerable groups should be removed.
- Children should have access to social benefits, including social security and social insurance.
- Children should enjoy adequate standards of living.
- Children should have access to HIV/AIDS prevention education and information both in school and out of school, irrespective of their HIV/AIDS status.
- No discrimination should be suffered by children in leisure, recreational, sport, and cultural activities because of their HIV/AIDS status.
- Special measures should be taken by governments to prevent and minimize the impact of HIV/AIDS caused by trafficking, forced prostitution, sexual exploitation, inability to negotiate safe sex, sexual abuse, use of injecting drugs, and harmful traditional practices.

*Source:* The Role of the Committee on the Rights of the Child and its Impact on HIV/AIDS: Problems and Prospects, presentation by the World Health Organization Global Programme on AIDS at "AIDS and Child Rights: The Impact on the Asia-Pacific Region", Bangkok, Thailand, 21-26 November 1995.

# *Children with HIV: A future compromised*

HIV/AIDS is a disease of the young. Last year altogether 400,000 children under the age of 15 years became infected with HIV worldwide, bringing the total number of children living with the virus at the end of 1996 to 830,000. Hundreds of thousands of HIV-positive babies are born every year to HIV-positive mothers.

**By the end of 1997, UNAIDS estimates that 1 million children worldwide will be living with HIV.**

In 1996 alone, of the 1.5 million people who died of AIDS, 350,000 were children under 15. Analyses indicate that, by the year 2010, if the spread of HIV is not contained, AIDS may increase infant mortality by as much as 75% and under-five child mortality by more than 100% in regions most affected by the disease. Health services, already under strain in many developing countries and in poorer areas of the industrialized world, are likely to have to care for increasing numbers of children with severe HIV-associated illnesses.

## Children with HIV/AIDS in developing countries

HIV infection in children typically runs a faster course to AIDS and then death than in adults. And paediatric AIDS kills especially fast in developing countries. Sick children in developing countries are generally at greater risk of death than children in industrialized countries and this is no less true of children with HIV. In Europe, 80% of HIV-positive children survive at least until their third birthday, and more than 20% reach the age of 10. In Zambia, however, nearly half of HIV-positive children in one study had died by the age of two. In another study in Uganda, 66% were dead by the age of three.

In Africa, in general, the situation for sick HIV-positive children is very grave. **Many of the common, inexpensive antibiotics and other medications used to treat sick children without HIV also work for children with HIV - but often, even these drugs are unavailable.** Poor families are less able to afford health care and basic drugs to tackle opportunistic infections, a problem which is even more acute in countries with low health budgets and where health services are difficult to access. In addition, drugs for rarer HIV-associated illnesses have not been part of essential drug programmes that supply the world's poorest hospitals and clinics and clinical practice guidelines for paediatric AIDS are often less clear than those for adults. Increasing the availability of basic antibiotics for acute respiratory infections, anti-fungal drugs for thrush, and of drugs that can cure tuberculosis, is an urgent priority for developing countries with children and adults affected by AIDS. UNAIDS has made greater access to these drugs one of its primary concerns.

**However, the more rapid course of paediatric AIDS in Africa is explained not only by less developed health care systems, but also by poor nutrition and widespread infectious diseases to which children are particularly vulnerable.**

Poverty is a key reason why children die more quickly of AIDS in developing countries. If children are sleeping three or four to a room, for example, which is more common in poorer households, they are far more likely to transmit and contract tuberculosis or other respiratory diseases if one of them has any of these infections. If children are poorly nourished, their immune systems will weaken. If families do not have access to clean water, they are more vulnerable to waterborne diseases including diarrhoea.

Children with HIV commonly experience wasting and delayed development and are often killed by typical childhood diseases like diarrhoea, measles, tuberculosis and other respiratory infections. Because these diseases are often the same as those that kill other children, it is sometimes difficult for health workers in poor countries, without access to expensive HIV testing equipment, to distinguish HIV-positive children from others. This may have at least two important consequences. First, children with HIV may not receive the special care they need. Secondly, a general apathy about child health may arise, with consequences for all children.

In communities around the world, increases in infant and child deaths due to AIDS may lead to a mistaken belief that immunization and nutrition programmes for children do not work. Disenchantment with these programmes could increase mortality in uninfected children.

## Women and children - a dual vulnerability

The dominant mode of transmission of HIV in newborn babies is so-called vertical transmission from their mothers. While in poorer countries some babies are still being infected through contaminated blood or medical equipment, virtually all HIV-positive infants have acquired the virus from their HIV-positive mothers during pregnancy or delivery, or through breastfeeding.

And women of child-bearing age make up an ever-increasing proportion of people with HIV worldwide - a trend that reflects their own biological and social vulnerability to infection. **Last year, 2.7 million adults became infected with HIV, nearly half of them women, and AIDS now kills more women annually than men in sub-Saharan Africa.**

Long-standing legal, economic and societal manifestations of gender discrimination and inattention to their sexual health influence considerably women's vulnerability to HIV/ AIDS.

In Kenya, for example, an AIDSCAP report found that the vulnerability of women is exacerbated by historical trends which have removed men from their families for lengthy periods of time, increased the acceptability of male sexual activity outside of marital relations, and sanctioned the behaviour of older men to use their wealth and prestige to seek sex with girls and young women.

In the longer term, therefore, reducing the vulnerability of infants to vertical transmission calls for the same kind of action as reducing the magnitude of sexual transmission to women. The human rights of women must be fully promoted and protected, an approach that was reinforced by both the International Conference on Population and Development held in Cairo in 1994 and the United Nations Fourth World Conference on Women, held in Beijing in 1995, which called for a strengthening of preventive programmes and for gender-sensitive initiatives to address HIV/AIDS and to end the social subordination of women and girls. This encompasses the ability of all women, whether or not infected with HIV, to make and effectuate decisions about their reproductive and sexual health, including the avoidance of unplanned and/or unwanted pregnancies. In the immediate term, it is also vital to increase women's access to information about the prevention of HIV transmission in general and, within this, about existing ways of diminishing the risk of mother-to-child transmission both before and during pregnancy, and after birth.

But for prevention strategies to be equitable and effective, AIDS programmes must avoid falling into the ancient trap of seeing women only as mothers. And it would be tragic if, once again, as for contraception, women alone were left with the responsibility for HIV prevention within sexual relationships, and men were absolved of this responsibility. HIV prevention must also move beyond measures that primarily focus on reducing the transmission of HIV between sexual partners. As stressed by UNFPA and other leading agencies, the respective status and roles of men and women in society must be considered in order to understand and act on the constraints imposed by the gender gap on behaviours relevant to HIV.

## Why babies born in poor countries are at greater risk

While not all children born to HIV-positive mothers become infected, **this risk is, again, significantly greater in poorer countries.** Most studies suggest that the probability that an HIV-positive woman's baby will have the virus is between 25% and 44% in a developing country, and between 13% and 25% in an industrialized country.

There are a number of factors that increase a woman's risk of having an infected baby. They include a depressed immune status, poor nutrition, complications in pregnancy, and protracted labour after the waters break.

A further risk factor for the baby is breastfeeding - a practice that by and large is the norm in developing countries. It is estimated that, on average, approximately 1 in 5 babies born to HIV-positive mothers become infected around delivery and 1 in 7 during the breastfeeding period. A recent study of transmission through breast-

feeding to infants over six months of age in Côte d'Ivoire found a rate of 12%. Another South African study found that the mother-to-child transmission of HIV infection was 17% for bottle-fed infants and 38% for breastfed babies. Variations in rates are thought to be dependent on such factors as the level of viral load in the mother and in the breast-milk, the nutrition status of mother and infant, infected and bleeding nipples, and teething problems of the baby.

**But while breastfeeding can kill by transmitting HIV, bottle-feeding can also be dangerous and increases risks to child health.** In recent years, breastfeeding has been heavily promoted and encouraged for good reason. It affords vital protection against deadly childhood diseases, particularly diarrhoea and respiratory infections. And breastfeeding is a natural, cost-free method, whereas the cost of infant formula and even the clean water and fuel needed to prepare it, are often beyond the means of poor families in developing countries.

The HIV-positive mothers of newborns thus face a difficult dilemma in choosing between breastfeeding and bottle-feeding. The context will differ depending on the country and the woman's own socioeconomic status. For example, in Thailand where there is relatively wide access to safe water, HIV-positive mothers are given free infant formula by the government, provided with information on the risk factors, and the mother is encouraged to decide not to breastfeed. In countries in sub-Saharan Africa, however, providing infant formula would not be appropriate in many settings because clean water for making up the formula is not available.

The policy of UNAIDS and its cosponsors is to encourage HIV-positive mothers to be given as much information as possible on the relative risks of breastfeeding and bottle-feeding so that they can decide whether to breastfeed or not. Women must decide for themselves how to handle the delicate balance between the risks and advantages of the two approaches - there can be no universally valid recommendation. But only women in possession of all the information are in a position to make fully informed choices.

To increase women's control over the situation, it is also important for countries to make voluntary HIV testing and counselling more widely available. This is important now - for example, women who know they are HIV-positive may choose to shorten the breastfeeding period or use artificial feeding - and will become increasingly important as new drug regimens are developed to reduce the risk of vertical transmission.

## Anti-HIV drugs to keep babies from getting infected

In 1994, French and American researchers found that the antiviral drug **AZT (zidovudine) administered to HIV-positive women in pregnancy and to their newborns reduced the rate of vertical transmission by 68%.** Without AZT there was a mother-to-child transmission rate of 25.5%. With AZT, it was only 8.3%.

While clearly an important breakthrough, it soon became clear that this discovery would create an enormous ethical dilemma because a preventive regimen like this is difficult if not impossible to apply in many developing country settings. To begin with, AZT is a very expensive drug. **A full course of preventive treatment for a pregnant woman and her newborn costs about US$1,000 - 1,500 in the United States.** An equally important problem is that the AZT regimen as initially developed, calls for the drug to be given for months before delivery, and to be administered as an intravenous infusion during delivery - neither of these being suited to prenatal and delivery care in many developing countries.

As a result, in many industrialized countries including the United Kingdom and the United States, and in countries such as Brazil, the initial AZT regimen is now routinely offered to HIV-positive pregnant women and their newborns. In other countries, such as Thailand, promotion of its use in this context is under consideration by the government. **But in many developing countries, where the annual per capita health expenditure may be as little as US$10,** and where women often attend clinics for prenatal care only late in pregnancy if at all, AZT is only available to the very wealthy or to women participating in clinical trials sponsored by agencies from industrialized countries.

UNAIDS has made improved access to all drugs needed for the treatment of HIV disease in the developing world one of its highest priorities. For this purpose, it is conducting a trial

in five sites in South Africa, Tanzania and Uganda to evaluate the efficacy and tolerance of three simpler, shorter regimens for the prevention of mother-to-child transmission of HIV in a population where breastfeeding is the norm.

The UNAIDS trial has been designed to ensure that it is comparable to the real situation in which the local standard of care applies. The 1,900 HIV-positive participating pregnant women are fully informed about the way the trial is being conducted.

Every year 350,000 children get infected with HIV in developing countries from mother-to-child transmission. Finding shorter and more effective regimens which are adapted to the standards of care of most developing countries increases the chances that women will have access to drugs to protect their newborns.

At the same time, every effort must be made to ensure that women are counselled and supported in refusing unsafe sex during pregnancy - for their own sake, to maximize their chances of staying uninfected, and for the sake of protecting their infants. Equally important is to recognize and promote male responsibility in this respect.

## It is not just mother-to-child

**About 10% of HIV-positive children under age 15 become infected through routes other than mother-to-child transmission.**

**Some children acquire HIV from blood products containing HIV or from contact with unsterile skin-piercing instruments.**

In Western Europe and the United States, a large number of children with haemophilia, a blood-clotting disorder that affects mainly males, were infected through blood products in the early 1980s. Although medical practices and blood supplies have since been revamped in these and many other countries, elsewhere the dangers of transmission through unsafe blood and contaminated injection equipment in hospitals and other medical settings persist. The risk of contracting HIV infection through a blood transfusion is particularly great for children living in countries where the blood supply is not properly screened for HIV.

Adolescents are particularly vulnerable to HIV infection through injecting drug use and, above all, through sex. Issues regarding these children at risk are described in a later section of this report.

# Children orphaned by AIDS

No one knows exactly how many children have been orphaned by AIDS worldwide but UNAIDS estimates that **by mid-1996, 9 million children under 15 years of age had lost their mothers to AIDS, more than 90% of whom were living in sub-Saharan African countries.**

While the global figure of 9 million is appalling, it reflects only a tiny part of a far larger social tragedy. Children whose mothers, or both mothers and fathers, have HIV begin to experience loss and suffering long before their parents' death.

In Brazil, for example, the Global Orphan Project (Boston & Brasilia) has estimated that there are some 183,000 children with living or deceased HIV-positive mothers. Of these, only 6% have already been orphaned. The overwhelming majority - 94% - still have their mothers. But many of these women are already suffering from HIV-related illlnesses and lack the physical strength or family and financial support to take care of their children. All these children face deprivation and orphanhood in the years ahead.

Extrapolating these findings from Brazil to other countries is difficult because fertility rates and HIV infection rates among women differ from one country to the next. However, the results make it clear that, in any given country, the number of children with an HIV-positive parent is far greater than the number of children who have already lost a parent to AIDS. Children orphaned by AIDS are just the more visible part, the tip of the iceberg, of the larger looming problem of children with parents living with HIV/AIDS.

**Most children orphaned by AIDS are concentrated in those countries most severely affected by the epidemic.** Data provided by the US Bureau of the Census and the World Bank indicate that there are 1.2 million Ugandan children under the age of 18 who have lost at least one parent to AIDS and that this figure is increasing by an estimated 50,000 each year.

According to UNICEF, children orphaned by AIDS in Zimbabwe are the largest and fastest growing category of children "in difficult circumstances". AIDS experts in the country estimate that by 1996, approximately 8% of children under 15 had lost their mothers to AIDS.

## A uniquely painful experience

Children who lose a parent to AIDS suffer grief and confusion, like any other children who experience the death of a parent. But there are special differences.

For one thing, the psychological impact can be even more intense than for children whose parents die from more sudden causes, such as in armed conflict or as a result of an accident. HIV ultimately makes people ill but it runs an unpredictable course. There are typically months or years of stress, suffering or depression before a parent dies. And in developing countries, where the epidemic is concentrated, effective pain or symptom relief is often unavailable to alleviate a parent's suffering.

The children's distress is often compounded by the prejudice and social exclusion directed at individuals with HIV and their families. This stigma may translate into denial of access to schooling, health care and of the inheritance rights of orphaned children. In this respect, girls may be at a further disadvantage.

A final cruel difference from other parental diseases is that HIV is likely to have spread sexually between the father and mother. Thus the child's chances of losing a second parent relatively quickly are far higher than, say, those of a child who has lost a parent to a disease that is not communicable to the partner.

These uniquely painful features of parental HIV/AIDS are of course of deep concern to the adults themselves. For HIV-positive mothers and father, making provision for their families is a main priority when they learn that they are infected. "My biggest fear was what was going to happen to the children", says Major Ruranga Rubamira, a major in the Ugandan army and the founder of the Ugandan National Association of People Living with HIV/AIDS. "I didn't know how long I was going to

live and I still felt that within the time left I must try to do something. I tried to start some kind of business for my wife and I tried also to put up a house."

## Extended families soak up the pressure - but for how long?

The extended family is the traditional social security system in many countries. In many developing countries, deep-rooted kinship systems have accordingly provided support to children and families affected by AIDS. It is common, for example, for children orphaned by AIDS to be taken in by aunts and uncles or even grandparents, who may have little income and may have been counting themselves on being supported by the very son or daughter who died of AIDS.

The remarkable generosity of many people in countries most affected by AIDS is also shown by the high incidence of fostering of orphans by unrelated families, often by neighbours. A study in Kagera, Tanzania, indicated that families who had themselves experienced an AIDS death were more likely to take in children orphaned by AIDS from other households. Those households with the most dependents were also the most willing to take on additional orphans.

Financial pressures on those least able to afford them have inevitably increased. "I have 11 orphans living with me", says Leone from Uganda. "My elder sister died and left me with her six children. And the other five belong to my daughter who also passed away. Taking care of these children is difficult", she says.

Even before the AIDS epidemic, many of these communities were already being pushed to breaking point as a result of labour migration, demographic change and other factors. With the advent of AIDS, the constraints have become even greater. One of the symptoms of this is the increasing numbers of households now headed by children - some of which may previously have been headed by grandparents at the death of the parents. "The death of a grandparent may leave the situation where there is nobody else in the extended family willing to care for the children, giving rise to orphan households headed by older siblings", says Geoff Foster of the Family AIDS Caring Trust in Zimbabwe.

It is not only in developing countries that the extended family system is under strain. "Many European countries, particularly in Central and Eastern Europe, are experiencing problems as family systems come under pressure because of changing social structures and demography", argues Naomi Honigsbaum of the European Forum on HIV/AIDS, Children and Families. The same is increasingly true, for example, in metropolitan areas of the United States, such as New Haven and New York.

## A vicious circle of poverty and discrimination

The relation between HIV/AIDS, impoverishment and denial of human rights is apparent in the impact of the epidemic on children who have been orphaned by AIDS.

When an HIV diagnosis in the family becomes known, friends may come to visit less often, and children may be taunted or harassed by schoolmates. In Zimbabwe, focus group discussions with members of AIDS-affected communities indicated that the **social isolation of children orphaned by AIDS was common.** And in the north of Thailand, a 1994 study of 116 households affected by HIV found that stigmatization, due largely to incorrect beliefs about HIV transmission, was widespread in everyday life. It was acknowledged by 20% of HIV-affected families that other children in the area were forbidden to play with their own.

**Family poverty can follow in the footsteps of stigmatization.** The Thai study found that many parents had lost jobs as a result of AIDS and family enterprises had lost customers.

Many extended families that have accepted orphans cannot afford to send all their children to school, and **orphans are often the first to be denied education.** "My foster mother wants to stop me from going to school. She wants me to work as a maid so I can earn money to buy food", says Beatrice, a 16-year-old from Kenya. A study in Zambia indicated that in urban areas, 32% of orphans were not enrolled in school, compared with 25% of non-orphans. In rural areas, 68% of orphans were not enrolled compared with 48% of non-orphans.

For many families, sending their children to school simply becomes an impossible option. "When my father died I was 14 years old", says Maurice Kibuuka, a 14-year-old Ugandan. "There were eight of us and my mother was left in care of us. I became the head of the family and I was responsible for looking for money, food, clothing, and even shelter... I had no choice but to drop out of school."

**Discrimination in accessing health care is a major form of social exclusion faced by orphans.** About two-thirds of children born to HIV-positive mothers do not contract the infection and grow up to be as healthy as any other child in the community. However, this fact is often unknown or ignored. Evidence suggests that children orphaned by AIDS may be at greater risk of dying of preventable diseases and infections because of the mistaken belief that when they become ill it must be due to AIDS and therefore there is no point in seeking medical help.

**Children orphaned by AIDS are also at risk of losing their property rights, and rights to inheritance.** Moreover, as shown before, the realization of children's rights is inextricably linked with their mothers' human rights - hence laws which disenfranchise widows have a devastating effect on the lives of their children.

The resulting poverty and isolation can create a vicious circle, placing children orphaned by AIDS, and particularly orphaned girls, at greater risk of contracting HIV themselves.

"This lady likes mistreating me because my mother is dead", says one Ugandan girl interviewed by Panos. "She wants me to sleep with men because I stay at her house. She brings these men into her house and introduces me to them. She often tells me to be good to them and says this is the only way I can continue to live in her house", she says.

## What is being done to help?

The problems faced by AIDS-affected families have become a major priority for many national aid programmes, as well as for international organizations such as UNICEF, and the Save the Children Fund. There are thousands of small community-based schemes around the world that aim to provide care and support to children orphaned by AIDS. In Uganda, for example, an organization called Uweso provides emergency material support and vocational training for these orphans. In Côte d'Ivoire, the International Catholic Child Bureau is helping to place orphans in foster homes and provides training and assistance. In Kenya and Tanzania, the African Development Foundation has funded farm projects, secondary education and housing for AIDS-affected families.

But **such projects are not being carried out on the scale that is required.** Most orphan programmes can only help fewer than a hundred children at one time. In countries like Thailand, Uganda and Zambia where tens or hundreds of thousands of children are affected, the response desperately needs to be geared up to provide even basic support to those who most need it.

Finance is an important consideration. Many orphan programmes rely on funding from non-governmental organizations based in economically affluent countries and UN agencies, and are seldom self-sustaining. Investment in these orphaned children is necessary for a stable future, both for the children themselves and for their communities. **But in the world's poorest countries, children orphaned by AIDS may be seen as only one of many competing urgent priorities.**

Despite a widespread belief that orphans are well-served by AIDS care organizations, there is a growing realization that such care is inadequate and that children orphaned by AIDS are in reality often a neglected group.

## Reaching children before their parents die

Problems for children affected by AIDS are most acute from the time that HIV is diagnosed in a parent. If organizations wait until children become orphans, it is almost too late. Before the massacres in Rwanda in 1994, Caritas Rwanda, a Christian NGO, tried to help parents plan for the future of their children. They worked with parents to identify solutions and arranged for children to move in with relatives or foster parents. Caritas also advised parents on legal and property matters.

In 1994, representatives from NGOs throughout southern

and east Africa drew up the "Lusaka Declaration on Support to Children and Families affected by AIDS". It urged that wherever possible, **efforts should be made to keep children in AIDS-affected families in their communities.** These efforts, it argued, should begin before the death of the parent. Home-based care schemes, in which visiting health or community support teams attend AIDS patients at home, should also be involved in helping parents plan ahead for their children.

The declaration also recognized that families affected by HIV are vulnerable to exploitation and recommended that NGOs inform people affected by HIV of their legal rights, and that governments revise existing laws to further protect these individuals.

## Orphanages - a last resort

Orphanages should only be considered as a last resort in providing care to those orphaned by AIDS, according to experts. Dr Eric Chevallier of AIDES Médicale Internationale argues: "Orphanages are far more expensive than community-based approaches and they can be culturally inappropriate if they cut children off from their social origins. The link between generations is very important", he emphasizes.

Orphanages may be more successful in countries where they have been more commonly used in the past, such as in Thailand and India. **But even in countries where orphanages are the norm, they can act as a magnet for stigmatization.** In 1995 in Romania, a group of citizens led by a town mayor stormed an orphanage because it housed children who were known to be HIV-positive. "The local population argued that these children can infect the other children in the town, as well as those in the orphanage", reported Romanian journalist Dan Stoica for Panos.

Institutional care has many limitations, as it usually cannot provide children with an ongoing, trusting relationship with a specific adult primary caregiver. Furthermore, institutionalization has proved to have adverse effects on people once they try to reintegrate into their communities, as they tend to lack support networks and the skills to develop them. Institutionalized care has also been found to nurture dependency and to work against self-reliance.

# Children in the shadow of HIV risk

In a world with AIDS, there are children who are infected with HIV and those who are affected by the epidemic's intrusion into their families or communities. But the epidemic casts its biggest shadow by far on the hundreds of millions of children who live in risk of HIV infection because their fundamental rights, including to medical care and to HIV information and education are ignored, or because their personal circumstances make them especially vulnerable.

## HIV and child sexual abuse

Sexual abuse during childhood and adolescence, while not a new phenomenon, has recently emerged as a pervasive problem affecting all societies.

Sexual abuse of children takes two main forms - commercial sexual exploitation, which is now known to be a multi-billion dollar world industry; and sexual abuse in the home or community, whether by relatives, "friends" or associates of the child's family, or others with easy access to the child such as schoolteachers or employers.

## *Children in the sex trade*

**No one knows how many child sex workers there are in the world.** Because of the clandestine nature of the trade, precise figures are not known, and there is a chronic lack of accurate research in this area. Figures reported to the first World Congress Against Commercial Sexual Exploitation of Children, which took place in Stockholm in August 1996, suggested that:

- worldwide, more than a million children enter the sex trade every year;
- children are working as prostitutes in the Netherlands;
- there are between 400,000 and 500,000 child prostitutes in India, according to a survey by *India Today* magazine;
- around 25,400 minors are engaged in prostitution in the Dominican Republic, according to a survey there.

What research has been done suggests that such exploitation is growing, and the age of the children involved is falling. Most children in the sex industry are girls aged between 13 and 18, although there are instances of much younger children being sold. Many such children spend most of their lives on the street, often because they are escaping violence or sexual abuse at home. Other children live in brothels, having been drawn into prostitution by procurers. For example, female children are often purchased from their parents or lured to the city with promises of jobs, education or money, only to be sold to a pimp.

Girls are at greater risk than boys because of systematic gender discrimination resulting in lack of access to educational and employment opportunities. Those who have been abused or forced into prostitution are often stigmatized and marginalized, which further undermines their status, and reduces their opportunities for accessing education, formal employment and, in many societies, marriage.

The HIV/AIDS epidemic has made child sexual abuse and child prostitution more dangerous than ever before. **Studies everywhere indicate that rates of HIV infection among child sex workers and street children are often very high.** Surveys of Kenyan girls living on the street indicated that as many as 30% were HIV-positive.

The belief that children are less likely to be infected has raised the demand for younger sex workers in recent years. The vulnerability of children to sexual exploitation, either through sex work or abuse, may well result in their becoming infected with other sexually transmitted diseases such as gonorrhea, syphilis and chancroid. By damaging the surfaces of the reproductive tract, physical trauma and sexually transmitted disease each increase the child's susceptibility to HIV as well as the HIV/STD risk to their clients. The problem is compounded by the lack of health care services meeting the sexual and reproductive health needs of children.

Only recently has a strong activist movement, driven primarily by non-governmental child action groups, brought the commercial sexual exploitation of children to international attention. The 1996 Stockholm World Congress Against Commercial Sexual Exploitation of Children marked the first concerted international attempt to tackle the problem.

Steps are being taken at national levels to target not only commercial sexual exploitation at home but also abroad. New extraterritorial laws in some countries, including Australia, Germany, Japan, the Netherlands, Sweden, the United States and the United Kingdom, now permit countries to prosecute nationals guilty of sex offences against children overseas. The World Trade Organization recently established a new Task Force to target tour operators and hotels that knowingly cater to sex tourists. Enforcing these new sanctions and laws will require international cooperation from a variety of actors including government entities such as the police and judicial systems, as well as NGOs.

However, several experts at the Stockholm conference also stressed that, while sex tourism is a major problem and was well documented, "commercial sexual exploitation of children is predominantly a local issue, with both clients and agents coming from the local community."

## *Abuse closer to home*

Awareness all over the world is growing of the scale of child abuse which takes place in or near the home. **Countless numbers of children in developing and industrialized countries alike - above all, girls - are at risk of sexual abuse by relatives, other members of the child's community or strangers.** Sexual abuse in the home is also a significant factor in pushing children to leave home, thereby perpetuating a cycle of vulnerability.

A study in Zimbabwe found that most cases of child sexual abuse probably go unreported. Some are detected when the child develops a sexually transmitted disease - proof that abuse took the form of actual sexual intercourse. In 1990, 907 children under 12 were treated for a sexually transmitted disease at the Genito-Urinary Centre in Harare. Most of the offenders responsible for passing these infections to the child were either neighbours or close relatives.

While in some cases sex takes the form of actual rape, in many instances it ranges from enticement to coercion. The growing phenomenon of "sugar daddies" illustrates the grey area surrounding the exchange of sex for goods and cash. These are older men who seek out young girls (often, because they believe they are at less HIV risk from children) and entice them into sex with offers of meals, clothes, luxuries and cash, including money for school fees. The age disparity between the girls and their sugar daddies, who are older and sexually experienced men, creates a particularly great HIV risk for the children.

Girls employed as domestics are vulnerable to another type of sexual abuser - the male head of household, or his sons. Occupational exposure to sexual coercion is, of course, not restricted to household employees, but live-in domestics run a particularly great risk because they are accessible around the clock.

Sanctions and laws are only a first step in stopping child sexual abuse. In the shorter term they may raise awareness of this terrible affliction. Increased attention will in turn help change the culture of silence surrounding abuse and make societies more sensitive to abused and exploited children. But **while laws forbidding sexual exploitation of children exist in nearly every nation on earth, they are notoriously hard to enforce.** Even when cases are brought to court, abused children often make reluctant witnesses.

## HIV and consensual sex with peers

Children are not only at risk of HIV infection when they are sexually exploited or abused, but also when they engage in consenting sex. In many countries, many children have their first sexual relationships when they are under the age of 18. Adolescents also engage in unprotected sex with sex workers.

A major source of vulnerability as far as children is concerned is their lack of knowledge about HIV transmission and their lack of skills in recognizing situations that may turn risky, such as alcohol consumption, standing up to pressure for sex (and drugs), and negotiating condom use and other forms of safer sex.

Love and trust also make children vulnerable. The rate of partner turnover is often greater

during adolescence and the early twenties than in later years. This applies not only to casual partners but to regular relationships which occur one after the other. Although these relationships may not last long, in the minds of young people they are often considered to be "safe" in terms of HIV transmission because they are regular and monogamous. Thus unprotected sex (intercourse without a condom) occurs with a series of partners, but the risk is masked by the apparent monogamy and trust involved in each such relationship. Yet the unwanted pregnancies and high rates of STD infection among young people show that the unintended consequences can be severe and - in a world with AIDS - lethal.

## HIV and drug use

In a world with AIDS, the injection of illicit drugs, always a risky behaviour, carries an additional danger - HIV infection. When people of whatever age share needles and syringes to inject drugs, microtransfusions of blood occur - and these are relatively efficient for transmitting HIV and other microbes. Drug injecting is thus a phenomenon that policy-makers, educators and HIV prevention workers concerned with child protection cannot afford to neglect.

Drugs do not have to be injected to carry an HIV risk. Alcohol, smoking drugs or glue-sniffing are apt to make people forgetful or careless about safe sex, and reduce the likelihood of condom use. While some adolescents inject drugs, many more engage in non-injecting use of substances that can increase their vulnerability to HIV infection.

Many factors, both individual and social, influence drug use. However, the association between drug use and HIV infection appears to be particularly dangerous for females involved in commercial sex and for both girls and boys on the street. The environmental factors involved include poverty, discrimination and lack of access to education and health services. "When surveyed, young people in developed or developing countries often indicate that boredom, curiosity and wanting to feel good are perceived as the main reasons for use. Other functions served by substance abuse are to relieve hunger, to adopt a rebellious stance, to acquire courage to beg or be involved in commercial sex, to keep awake or get to sleep, and to dream", says a WHO report.

Children in difficult circumstances are more likely to maintain and escalate substance abuse. For girls living or working on the street, the risks are particularly great as they often have to cope with violence, HIV and other STDs, unplanned pregnancies and unsafe abortions. If they carry their pregnancies to term, they are often left to their own devices to support themselves and provide for their children.

## Refugee and displaced children

As civil conflict, political persecution, and natural disasters continue to plague many countries, millions of people are forced to live outside of their countries of origin. The majority of the world's refugees are children and women. In conditions ranging from large rural encampments with very limited infrastructure to intensely crowded urban shanty towns, young refugees are particularly vulnerable to nonconsensual sex. Even if there is consent the availability of condoms is often quite limited.

The same is also true for many displaced children who remain within the borders of their country, but not in their homes. They survive in very unstable, often threatening environments where risks are high and rights are rarely protected. To make matters worse, refugee and displaced children are known to be targeted for rape and sexual abuse by adult tormentors from within their own communities, and from external exploiters taking advantage of these environments in which children's rights are often violated.

## Children in detention and HIV

Similar to the saga of their adult counterparts in prisons, children who are in detention or remand centres are often exposed to violence, abuse, and unwanted sex. Drug abuse is also a compounding factor for HIV transmission, along with the prohibition of condoms, and body piercing and unsanitary/unsafe tattooing. Young people in reformatories and other such facilities often have few, if any, options for preventing HIV and other sexually transmitted diseases. Without radical reform in juvenile justice and social welfare institutions, these children will remain with their rights violated - and their risks increased.

# *The window of hope*

## Strengthening development to strengthen coping

The socioeconomic costs of AIDS are affecting the ability of developing economies to sustain their development gains - and this has enormous repercussions on children.

Other diseases have profound effects on the survival and well-being of children. But a distinctive feature of AIDS is that it affects a tremendous number of young people who are also parents - adults in their most sexually active and most productive years. In the worst-hit areas, resources become increasingly stretched as AIDS mortality increases the burden of income-generation and child care and places it on the shoulders of fewer and less able-bodied adults. AIDS stigma can affect the willingness of communities and extended families to care and support those who are most affected. Society's coping capacity is further adversely affected by the fact that the effects of HIV manifest themselves over periods of years and that AIDS deaths tend to be clustered within families, with very often more than one parent and more than one child in a particular household becoming infected.

However, it is still difficult to make reliable estimates of the impact of AIDS on economies, because AIDS impacts differently on different socioeconomic systems and even on different sectors within the same economy. For example, the loss of a single income earner in a family may have a different impact in rural and urban areas due to the types of family structures. In urban areas, the loss of a single wage earner can affect a large group of extended family members. Labour-intensive farming systems are also more vulnerable to the loss of able-bodied adults than others.

Improving understanding of these issues is not just of theoretical interest. It is a practical necessity. Unless knowledge of the socioeconomic effects of AIDS improves and is reflected in planning and policy development, strained economies around the world will tend to consider HIV/AIDS as just one more competing need to respond to, and may find it increasingly difficult to allocate resources for prevention programmes.

Just as important, a deeper understanding of these issues strengthens the argument for building up development as a way of helping families and communities withstand the impact of AIDS.

A shift of emphasis is needed away from relief towards longer-term intersectoral approaches to meeting the needs of AIDS-affected children. A relief approach of providing directly for children's needs is generally not sustainable where the number of affected children is large. Wherever possible, resources should be directed to enabling families and communities to establish and maintain a sufficient economic base to provide for children's needs. And children themselves need to have their educational and employment opportunities bolstered if they are to break out of the pernicious cycle of poverty and AIDS.

While children are an increasing part of the AIDS problem, they are also a critical part of the solution. "We have a window of hope between the ages of 5 and 18 years", says Dr Sam Okware, Uganda's Commissioner for Health. "If that group can be educated, if their behaviour change can be modulated to ensure they do not have risk behaviour, I think we have a future".

Education and empowerment combined with the promotion of children's rights are believed to be key to HIV/AIDS prevention by leading agencies such as UNICEF and UNESCO. However, much of this needs to be directed not only to the youngsters themselves but to their families - the most important social support for children. Reducing children's vulnerability to HIV means improving the economic situation of their families. Development agencies such as UNDP have repeatedly emphasized the need to create micro-funds, micro-credit schemes, rural employment schemes and other instruments that can raise living standards and ensure sustainable livelihoods for children and their families. Reducing children's vulnerability also means keeping the various communities' HIV risks constantly in

mind when, for example, targeting development assistance. In northern Thailand, for example, the Daughters of Education project provides funding for girls who might otherwise be sold into the sex trade to remain in school and develop better employment prospects.

In other words, development not only strengthens society's ability to cope with the impact of HIV/AIDS. Development strengthens society's ability to withstand HIV transmission.

## School education on HIV/AIDS

Provision of AIDS education and education concerning sexual health is an issue fraught with controversy the world over. The objection to providing education on sexual health is most commonly stated as a fear that such education will encourage early sex. UNAIDS recently commissioned an update of an earlier WHO review of studies - mostly in the USA and Europe - on the effect of sexual health education. The aim was to assess the impact of sexual health education on the behaviour of students in terms of rates of teenage pregnancy, abortion, birth, sexually transmitted diseases, and self-reported sexual activity.

The review showed that responsible and safe behaviour can be learned. Education on sexuality and/or HIV does not encourage increased sexual activity. Quality programmes in fact help delay first intercourse, and protect sexually active young people from sexually transmitted disease, including HIV, and from pregnancy. Among other things, quality programmes feature a clear explanation of the risks of unprotected sex and methods - including abstinence - for avoiding them, and help young people practise communication and negotiation skills.

There are also questions as to how early the provision of AIDS and sexual health education should begin. Issues such as the increasing evidence of sexual abuse in particular has persuaded some teachers and AIDS workers that some form of "life-skills" education at primary school is necessary. The UNAIDS-commissioned review also found that sexual health education is best started before the onset of sexual activity. Such early education is believed to be particularly important by AIDS workers in developing countries, where secondary school enrollment is much lower than primary, especially for girls. In many countries, the majority of children have left school by the age of 15. Reaching these children quickly enough, many of whom are poor, unable to read and write and are among the most vulnerable to HIV infection, is arguably the highest AIDS prevention priority.

According to one AIDS worker in Zimbabwe, "we start in schools from about 8 years or 9 years old. It sounds too early but in our country there is a lot of child sex abuse, even rape, which makes it very important for us to introduce the subject during that period or even earlier. We want to have this child know that this is my body, nobody has a right to my body, if anybody fidgets around with my body I should report it to my mum and dad so that I am protected. We start talking about the information that helps this child to know who they are and how they can best protect themselves", she says.

In recognizing the important role children can play in protecting themselves and their communities from HIV, it is equally important to recognize the power that many people and institutional structures may exercise in preventing children from accessing education, information and life-skills training. These "gate-keepers" may be parents, teachers, educators, community and religious leaders, media professionals, policy makers, and government officials. Experience shows, however, that when parents are given the facts, they generally agree on the need for AIDS education. There is an urgent need to bring these gate-keepers on board and gain their cooperation in promoting early life-skills education and prevention for children. This implies the need to provide AIDS and sexual health education also to adults.

## Reaching children outside the school setting

Although some of the most intense arguments around AIDS education have centred on sexual health education in the school setting, UNAIDS and its cosponsors have insisted that education also needs to be targeted as a high priority at those children who are not in school.

In some countries, up to 80% of children do not continue beyond primary level. And it is these groups who are often at much higher risk of HIV infection than those who stay in school. Among these children are those living in rural areas, in urban slums, those employed in factories, refugees, migrants and those engaged in sex work.

Among those at greatest risk are street children. Some estimates suggest that there are as many as 100 million children and adolescents in the world who are working or living on the street, often in violent and dangerous situations. In Brazil alone, there are an estimated 7 million children and adolescents from very poor families living and working on the streets. These groups are some of the most vulnerable to HIV infection and to other dangers. For many, sex may be a means of securing money, food, shelter, protection, comfort or affection.

## Injecting drug use and HIV prevention

As with the prevention of sexual transmission, HIV prevention related to drug use must encompass far more than the simple provision of information. There must be an emphasis on the acquisition of skills for negotiation, building self-confidence, making the right decisions and resisting peer pressure. And the disempowering context within which these children live must be recognized and remedied - for example, the interface between drug use, with its stigma especially for females, and the commercial sexual exploitation of girls.

A key need is to integrate sexual health education and drug education, not conduct them separately, because they are both inextricably intertwined in HIV transmission.

Measures must be designed and carried out in a way that helps build a supportive environment for these children. Information per se is not enough. HIV prevention means tackling their vulnerability at its roots. It means helping the children acquire the skills they need to negotiate safer sex, resist peer pressure for sex and drug use, and establish personal support networks. Counselling is important because it helps children mature and make sound decisions. In short, preventing the HIV risk associated with drug use calls for programmes targeted at the drug users themselves, their sex partners and family members, health care workers and the general community. It also requires advocacy to raise the consciousness of adults not to lure children into drug use.

## Involving children

If children really do offer a "window of hope" for influencing the future course of the AIDS epidemic, understanding their needs and perceptions will be critical.

At an international conference on AIDS in Kampala in 1995, a "delegation" of young Africans from 11 countries ranging in age from 14 to 24 issued a declaration of their needs and priorities. "We strongly believe that our energy, idealism and commitment can be used to stop the further spread of the AIDS epidemic that is devastating the social and economic fabric of our countries", they declared.

At the same time, it must be recognized that children are not in this world alone. Parents, school teachers, religious and community leaders must also be involved in developing programmes for children if they are to be accepted by the community and help build a safe and supportive environment. Securing their involvement requires ensuring that they hear the concerns and aspirations of children. Creative ways can be found of "amplifying" the voice of children.

In Thailand, for example, a Children's Forum has been created in parliament, while a "media page" in newspapers and magazines captures children's voice and channels their experience to the adult world.

**AIDS is the most publicized disease in the world, but its impact on children has received an inadequate response. Adults can and must do their part to ease the suffering of children infected with HIV, help children in AIDS-affected homes and communities, and enable all children living in the shadow of HIV risk to grow up uninfected. But it may be that the epidemic's future course will be shaped by the actions of those it is increasingly affecting: the children who live in a world with AIDS.**