ORPHANS

107TH STORY of Level 1 printed in FULL format.

South China Morning Post

February 22, 1998

SECTION: News; Pg. 6

LENGTH: 383 words

HEADLINE: Little victims of AIDS epidemic

BYLINE: From HUW WATKIN in Phnom Penh

BODY:

RASMEY was just a few days old when he was found by Nuth Dara abandoned on the steps of the post office in central Phnom Penh.

Mr Nuth Dara could have left the small, bawling bundle where he found it, but instead he took Rasmey home.

He quickly grew into an energetic and mischievous toddler. He learned to walk and speak, but then fell ill with chronic diarrhoea.

"I try to feed him up, but he just keeps getting weaker and the doctors can't cure him," Mr Nuth Dara said. "He's a lovely child and I wish more than anything he could live to become a man. But I know he will soon die."

Rasmey is one of thousands of Cambodian children who have fallen victim to the country's HIV/AIDS epidemic, one the Ministry of Health estimates will kill 4,000 children and leave a further 6,000 orphaned within two years.

But Pawana Wienrawee, of the United Nations aids programme UNAIDS, said that figure was conservative.

"We have a fairly good idea of the situation in Phnom Penh, but out in the provinces we just don't really know how many people are HIV-positive. Nor do we know how many people are dying from AIDS because illness is often misdiagnosed and the cause of death is usually unrecorded," she said.

The limited knowledge health professionals do have has prompted warnings the epidemic shows all the signs of spinning out of control.

Limited Ministry of Health testing has revealed at least 100,000 Cambodians are already HIV-positive, and the disease's spread is startling. The United Nations Development Programme forecasts 500,000 people - close to one in 20 of the population - will be infected by 2006.

Extra-marital sex with prostitutes is a popular form of recreation for Cambodian men, and almost half of the nation's 60,000 commercial sex workers are infected.

Testing has found that between five and 10 per cent of police and soldiers are HIV-positive.

The Ministry of Health's national AIDS programme manager, Dr Tia Phalla, said infection rates in most vulnerable groups appeared to have peaked, but authorities were bracing for a surge of infections among married women.

"In our culture women do not have the power to insist on condoms. Men will go to brothels (and have unprotected sex), then sleep with their wives," Dr Phalla said.

LANGUAGE: ENGLISH

LOAD-DATE: February 22, 1998

Children Living in a World with AIDS

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 mother, or both mother and father, 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-infected 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 AIDS orphans 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 Navalaka 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 a real burden, " 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 grand-parent 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 Ugan-dan. "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 AIDS orphans 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 AIDS orphans, 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 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

programs, 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 programs 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 programs 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 arrange 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.

Reproduced from the UNAIDS web site: Children living in a world with AIDS

Enabling AIDS Ministries: Opportunities for Giving

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An Editorial from

The Journal of the American Medical Association

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The 'Silent' Legacy of AIDS Children Who Survive Their Parents and Siblings

Stephen W. Nicholas, MD
Elaine J. Abrams, MD

Over the past decade, efforts to improve the organization and provision of health care for families affected by the human immunodeficiency virus (HIV) have focused primarily on infected individuals. However, from the start it has been clear that children who were or would be orphaned as a result of the epidemic would add unique complexities to the equation.

How many children have been or will be orphaned by the acquired immunodeficiency syndrome (AIDS) epidemic? In this issue of JAMA, Michaels and Levine (1) estimate that 18,500 children and adolescents have already been orphaned. By 1996, this number will increase to 45 600 and by the year 2000 to 82000 orphans. Additionally, tens of thousands of young adults will become motherless.

These estimates, which are similar to recent Centers for Disease Control and Prevention (CDC)(2) estimated are based on a set of reasonable assumptions that, if anything, appear to be deliberately conservative. As discussed by the authors, the fertility rates of intravenous drug users may very well be higher than the age- and race-adjusted cumulative fertility rate.

The authors also assumed that the rate of AIDS deaths among women will plateau after 1993. Unfortunately, this is likely to be overly optimistic, not only because of a lack of treatment options, but more pointedly because there is every reason to believe that the majority of the estimated 80,000 HIV-infected women (3) in the United States are unaware of their diagnosis (4,5) Therefore, even if a therapeutic break-through occurred tomorrow, most HIV-infected women would not receive potentially life-prolonging or saving treatment of appropriate health care.

The study by Michaels and Levine did not address those HIV-affected children who are effectively orphaned prior to their parents' deaths. This phenomenon is best reflected by the living arrangements of HIV-positive children (which we believe parallel those of uninfected siblings: only 45% of all HIV- positive children who received health care in New York during 1990 lived with a 33% lived with unrelated foster or adoptive parents (6). In 1989, 39% of the HIV-positive children born at Harlem Hospital went into foster care directly from the newborn nursery because of an inability by the mother to provide adequate care (S.W. Nicholas, MD, unpublished data, 1989.

The sobering estimates by Michaels and Levine, which probably underestimate the true extent of the problem, are noteworthy because of the tragic aura that surrounds these young survivors. Most of them, living in that complex place called poverty, have a whole range of unmet social, educational, and health needs. Many have already experienced a variety of personal losses unrelated to AIDS. Ironically, AIDS orphans are themselves at high risk of HIV infection because of early sexual activity, unsafe sexual practices, and experimentation with drugs. Finally, many of these children will not only experience the loss of a parent from AIDS, but will also witness the illness and death of one or more infected siblings. The ultimate legacy of the AIDS epidemic is a deafening silence.

What is to be done Axiomatically, to prevent children from becoming motherless, the debilitation and death of HIV-infected mothers must be prevented. This cannot be accomplished unless HIV-infected women are diagnosed and given appropriate treatment and health care.

Children orphaned by the AIDS epidemic need improved health, social, and, in particular, psychosocial support services. They often need help from a variety of sources within the community, such as schools, churches, YMCAs or the juvenile justice system. Because of the secrecy that results from the stigma of AIDS, from the fear that someone will discover the "family secret," many potential sources of help are not sought. How best to disclose HIV-related information, while still protecting confidentiality, is a dilemma that must be addressed immediately on behalf of these children. Some pilot programs have begun working on ways to facilitate the disclosure of AIDS- related information to schools, day-care, and other community programs. More programs like these are desperately needed.

While some ill HIV-infected women establish future custody plans for their children, most do not. Lack of planning results from denial, fear of disclosure, lack of a potential guardian, lack of any formal counseling or legal advice, and inflexible laws. Not infrequently, elderly grandmothers in ill health become guardians by default when the mothers die. The health care team, with the assistance of legal counsel, should discuss future custody plans with every HIV-infected parent. Every state should review its existing guardianship laws, many of which leave children in legal limbo at the time of a parent's death, even when a guardian has been named in the parent's will. One solution to prevent such limbo is the "stand-by guardian ship law," enacted in New York in 1992, which allows an ill or dying woman to name a guardian for her children prior to mental incapacitation, physical debilitation, or death.

Ultimately, the majority of HIV-affected children will end up in formal or informal foster care or adoptive care. A variety of innovative foster care programs to meet the complex needs of HIV-positive children have been created throughout the country. Few programs, however, have focused adequately on the needs of uninfected siblings. Special HIV units designed to track and oversee the care of HIV-infected foster children should expand their programs to include all HIV-affected children. Model programs designed to augment early permanency planning are urgently needed. Such programs would train, certify, and supervise a future guardian (typically identified by an ill HIV-infected mother) to provide respite care, home assistance, and other help in caring for HIV-affected children. As the mother becomes more ill, the role of this individual would expand as necessary. Ultimately, at the time of maternal debilitation, mental incapacitation, or death, the individual would become either a foster parent or an adoptive parent. As with many of the successful AIDS programs established to date, such model programs very likely will need to cross traditional boundaries, improve interagency conununications, and establish new collaborative relationships.

Michaels and Levine have taken the silence that surrounds AIDS orphans and have transformed it into an audible sound. But this sound must now be amplified into a voice that can clearly articulate the federal, state, and local actions that are needed to meet the needs of every person in this nation affected by the AIDS epidemic.

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3478 JAMA, December 23M. 1992-Vol. 268. No. 24

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1. Michaels D, Levine C. Estimates of the number of motherless youth orphaned by AIDS in the United Stater. JAMA. 1992;268:3461.

2. Caldwell MB, Fleming PL, Oxtoby MJ. Esimated number of AIDS orphans in the United States. Pediatrics. 1992;90:482.

3. Gwinn M. Pappaioanou M. George JR, et al. Prevalence of HIV infection in childbearing women in the United States: surveillance using newborn blood samples. JAMA 1991;265:1704-1708

4. Krainski K, Borkowsky W, Bebenroth B. Failure of voluntary testing for human immunodeficiency virus to identify infected parturient women in a high-risk population. N. Engl. J. Med. 1988;818:185.

5. Landesman S, Minkoff H, Holman S, McCalla S,Sijin O. Serosurvey of human immunodeficiency virus infection in parturients: implications for human immunodeficiency virus testing programs of pregnant women. JAMA 1987;258:2701-2703.

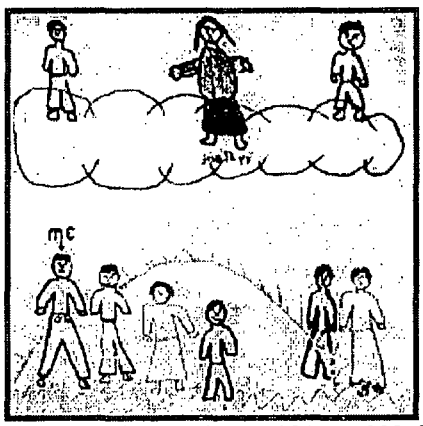
6. Pediatric HIV Continuum of Care Study Final Report Albany, NY: AIDS Institute, New York State Department of Health; July 10, 1992.

When AIDS Strikes Parents

Who will care for a new generation of orphans - and the youngsters soon to become orphans?

TIME, November 1, 1993 - *By CHRISTINE GORMAN*

TWELVE-YEAR-OLD NICOLE KNOWS more about AIDS than most children her age. She doesn't have the disease or carry the virus, but she has felt its deadly sting just the same. AIDS has taken both her parents. "I was nine years old when my mother died." Nicole (not her real name) calmly begins her story. "She told me that my father did drugs and died Of AIDS, and that she got it from him." Nicole's grownup demeanor disappears, however, when she starts to read aloud a letter she wrote in the year after her mother died: "Dear Mom ... I miss you so much. That day at the funeral I just looked at you, and I saw someone else in the coffin. I was saying to myself, 'That cant be my mother.' She is still in the hospital ... I knew people had to die. But I never thought about you dying."



A nine-year-old boy lost both parents to AIDS drew his mother in heaven, hovering over his new family on earth.

Nicole's story is becoming an all too common one in the age Of AIDS. At least 30,000 children in the U.S. have lost one or both parents to the scourge, and over the next seven years that number is expected to at least triple. Within this group, Nicole is relatively lucky. She lives with her aunt on Manhatta's Lower East Side, does well in school and dreams of becoming a pediatrician. But perhaps half the AIDS orphans could wind up living in the streets or falling into an overloaded foster-care system. "We're seeing some 3,000 children in the Chicago area who will need placement very soon." says Cathy Blanford of the Lutheran Social Services of Illinois. "I expect the numbers will grow way beyond what anyone can imagine."

No one thought much about this dilemma back when AIDS was considered a disease of unmarried homosexual men. Now women are the fastest-growing segment of the AIDS population. From 1991 to 1992 the number of new cases among women jumped 10%, compared with 2.5% for men. Some of these women have husbands or boy-friends who are bisexual; others pick up the virus because they or their lovers are drug addicts who use contaminated needles. The majority have children.

Although the toll is highest in drug-ridden ghettos, this is not just a big-city phenomenon. Rural Lancaster County, Pennsylvania, best known for Amish festivals and shoofly pie, has seen its drug problems increase as people have moved in from poor neighborhoods in New Yohave either lost or are about to lose a parent to the disease. Often, infected mothers leave large cities and return to places where they grew up, where aunts and grandmothers can take in the children. "Perhaps half the women we see have come home to die." says Jacquelyn Clymore of the AIDS Service Agency in Raleigh, North Carolina.

In the Bronx, Michael, 11, and Jose, 9, learned from their mother that is is infected with the deadly virus

It is hard enough for a child to lose a parent. But when AIDS is the killer, the pain is all the more profound. Since most of the infected mothers are single parents, no father is around to fill the void. If the mother's drug use had caused her family to spurn her, relatives may be unwilling to care for her kids. Moreover, the stigma of AIDS causes many families to keep the cause of death quiet. The surviving children are isolated in their shame. "If they know, they usually dont tell anybody," Clymore notes. "Not their best friend, not their teachers, not anybody."

The silence takes its toll. With no acceptable outlet for their rage or grief, children often cause trouble in school. Boys especially, may run afoul of the police.

Some teenagers turn to indiscriminate sex or shooting drugs-as though they are daring the AIDS virus to do to them what it did to their parents.

But the cycle does not have to repeat itself A growing number of community organizations are trying to prevent further tragedy by starting support groups for children orphaned or about to be orphaned by AIDS. Over the past three years, counselors at the St. Francis Center in Washington have helped the kids cope with depression, fear of abandonment, and the

lifelike visions some have of their dead parents. "The teenagers, in particular, are caught in a squeeze," says Dottie Ward-Wimmer, a nurse at St. Francis who specializes in grief counseling. "They're older. They're smarter. They know that if their mother had cancer, people would feel sorry for them rather than shun them." Professionals at the Henry Street Settlement in New York City have found that if youngsters talk with one another about what they are going through, they are less likely to fall into self-destructive behavior. They also have an easier time adjusting to their new family.

Social and health agencies are trying to reach more AIDS sufferers before they pass away so that their children can be better prepared. That's not easy. Denial and shame are sometimes so strong that some parents never admit, to officials or anyone else, that they have AIDS. Marina Alvarez is not one of them. She founded a support group in the Bronx, New York, for mothers like herself who are HIV Positive. "Information dispels fear," she says. "I can't say that my sons are absolutely O.K. with my illness. I dont think anybody's ever O.K. with a life-threatening illness. But they don't live in shame."

About half the ailing parents die before they designate anyone to take custody of their children. To improve that statistic, both Illinois and New York have enacted laws in the past year that allow parents to name a standby guardian to care for their children on a temporary basis. That way parents with AIDS do not have to give up permanent custody every time they go into the hospital, and they can know who will take in their children after death comes. "We try to match people up while the birth parents are still healthy enough to make good decisions." says Blanford of her Chicago program. "It helps the children make the transition because they have a sense from their parents that this is O.K."

After the guardians take over comes the hard part. The orphans need counseling, and their new families, which may have doubled in size, often require temporary financial and housing support. "For many families a little help at a critical time can make a big difference." says Carol Levine of the AIDS Orphans Project in New York. Otherwise, the newly blended families can break apart under the strain, and the orphans end up in foster care.

Some social workers believe communities may have to open orphanages. But they envision institutions that are smaller and more homelike than the cheerless warehouses of old. Whatever the strategy, society will need to pay more attention to AIDS orphans.

"In the next 10 years a lot of the families who are presently coping will not be able to do it any longer," Levine predicts. *"There are not enough grandmothers to raise these children."*

Monday
December 1, 1997

PORT-AU-PRINCE, Haiti

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AIDS orphans

Thousands lose parents in HIV-ravaged Haiti

Michelle Faul/Associated Press

They jump rope, beat out a hypnotic Haitian rhythm on a plastic beach bucket and sing, lustily, out of tune.

The children at Rainbow House don't know they were born to the poorest of the poor in Haiti, and are heirs to the AIDS disease that killed their mothers.

``Welcome, Baby Jesus,'' Sherlene Telusma, 7, lisps through a broken tooth, practicing a Christmas carol.

Haitian accountant Robert Penette and his Canadian wife, Danielle Reid Penette, have taken in as many HIV-infected orphans as they can afford. At the moment that's 17, with Sherlene the oldest and the youngest 14 months old.

Prior to World AIDS Day, recognized today, Haiti's Ministry of Public Health announced that nearly every second child among an estimated 6,000 to 8,000 living on the streets of Port-au-Prince -- seven out of 15 -- was infected with the AIDS virus.

Four thousand newborns were HIV-positive in 1995, according to a new study from the National Strategic Plan for the Prevention and Control of AIDS. In all, more than 25,000 children under the age of 15 will be orphaned within two years because of the AIDS epidemic in Haiti.

Rainbow House is a light, airy home, with the alphabet adorning the wall of a classroom and rag dolls in the girls' bedroom, in the Boutillier hilltop suburb where breezes cool the tropical heat.

Still, Sherlene was worried. ``She kept asking who was going to take care of her mother. And, 'What's maman going to do for food?'" said Danielle Penette, who is from Montreal.

For nearly a year before she came here, Sherlene, then 5, was the sole provider for her mother and an older brother, begging all day on the streets of Port-au-Prince for pennies to buy some rice and beans to take home in the evening.

A neighbor brought her to Rainbow House when her mother became terminally ill.

At first, ``she was like a caged bird. Angry that she couldn't go out on the street when she wanted, unused to the discipline we impose,'' said Danielle Penette.

Sherlene is happier since she started school in October. ``I'm learning to write in a notebook, and we draw a lot and sing. I love singing,'' she says, the braids on her head bobbing as she broke into song.

``Sherlene knows that an illness killed her mother. But she doesn't know that she is infected with the same virus. And she doesn't know that it will kill her,'' said Penette.

Some of the children have already died since the Penettes opened the home two years ago, and several others suffering full-blown AIDS are very listless.

Advances in AIDS treatment that have helped contain the disease in the West are only available to the rich in Haiti.

``We don't have the money to give any AIDS treatment to the children. All we can do is treat the opportunistic ailments that attack them because their immune systems are weak. They suffer a lot of diarrhea and skin infections,'' Penette said. A doctor friend treats the children free of charge.

Sherlene has scars on her stomach from shingles, a skin disease, and scratches often at sores on her arms.

Most Haitian children infected like Sherlene probably will die on the streets where they live, Penette said.

According to the National Strategic Plan study, nearly 101,400 new AIDS cases were reported this year -- for a total of nearly 324,700 cases in all. Just three years ago, there were only 5,000 cases of full-blown AIDS reported in Haiti.

In a country with abominable health care, most cases go unreported, he said. And many Haitians still believe that people who die of AIDS are the victims of black magic.

Overall, the Caribbean has the second highest HIV-infection rates in the world, surpassed only by sub-Saharan Africa.

Nearly two in every 100 Caribbean residents aged 15 to 50 are infected with the virus, according to a new study by the Trinidad-based Caribbean Epidemiological Center.

It found that Caribbean females between 15 and 19 have a five times higher rate of infection than males, said Dr. Uli Wagner, a German epidemiologist working for the research center.

Wagner said Caribbean nations should copy the success of Uganda, where countrywide campaigns urging condom use have dramatically reduced the infection rate.

What are your thoughts on *AIDS orphans ?*

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ELECTRONIC MAIL&GUARDIAN

July 17, 1997

Malawi's AIDS orphans turn to begging or drugs

Seven people die of AIDS every hour in Malawi, leaving behind tens of thousands of orphans. The lucky children are taken in by extended families; the unlucky majority are left to fend for themselves on the streets.

ANTHONY LIVUZA in Blantyre

CHIKONDI and Leonard Sichali, 11 year-old twins, are considered to be extremely fortunate.

They were taken in by their extended family when their mother, a teacher, died of AIDS in April 1995 followed by their father eight months later. The couple left no savings or articles of value to help their children.

The children were taken in by their maternal grandmother, a registered nurse. On her lowly salary she takes care of the children's needs including education, clothing and food.

However her resources are stretched to the limit as she also has to care for two of her own daughters at secondary school and three other grandchildren, whose single mother is attending a teachers' training school 80 kilometres away.

"I have no option but to use my meager resources to care for everyone. Fortunately, next year the twins will move in with their uncle who has just secured a job in town," says Kachulu, who was widowed some 16 years ago.

There is no doubt that the twins are lucky. Tens of thousands of AIDS orphans have no-one to turn to and according to government statistics at least a quarter of the children orphaned by AIDS and adopted by the extended family system are eventually left to fend for themselves. These children are usually abandoned when the extended family finds the burden too great.

Their future is bleak, as they usually end up begging, drug peddling or working as casual labourers. But social workers and donors maintain the extended family system is still the best option.

"Putting children in a home will not solve the situation. The country cannot cope," says Rick Olson, Head of an AIDS Initiative run by the United Nations International Children's Fund.

Olson says orphanages would stretch Malawi's financial resources because "very, very few donors" would be willing to fund such institutions indefinitely when the number of orphans is rising every day. There are between 60,000 to 80,000 orphans in community and organised care but estimates indicate the figure will shoot to nearly 100,000 by 2000.

"The resources required to keep homes running for such a large number of orphans would be enormous...running into millions of dollars. I don't see anyone managing that," says Olson who strongly favours community-based orphan care.

Some non-governmental organisations have orphan care programmes but these are almost all limited to helping the victimised children within their extended family rather than on their own. A few take in small babies but these are usually put up for adoption later on.

One such home is the Open Arms Infant Home set up by the Davona Church. The home "admits" some 25 babies diagnosed as carrying the HIV virus who are given 24 hour volunteer care at any one time. But this is really a temporary measure which cannot be sustained.

Many social workers feel children can only grow up normally when they are brought up in natural surroundings with which they can identify for life. "Orphans should not feel neglected or treated as community outcasts. They need to identify with communities," says Stan Phiri who runs one of the country's largest community-based orphanages in Mangochi, 200 kilometres north of Blantyre.

The programme -- Community-based Options for Protection and Empowerment, -- tackles social, psychological and economic needs of orphans and helps families to cope with loss or separation. It also tries to provide home-based care to terminally-ill patients and improve access to health centres for children under five years-old.

Stan Phiri says the project sponsored by Save the Children (USA) Federation has filled a vital need through the provision of basic needs including food, beddings, clothes and shelter.

The project also provides start-up capital to women saddled with children whose fathers die of AIDS. A life skills component integrates orphans with other children by keeping them in school or apprenticeships.

Phiri says communities in the project area are responding well and feels orphans homes are a waste of resources. "If such an attitude prevailed throughout the country, we would have no cause to worry about orphans."

A survey by the project in 1995 found that in one sample area 500 families -- representing 25 percent of the population -- needed assistance "reflecting the serious nature of the AIDS crisis."

The National AIDS Control Programme estimates that

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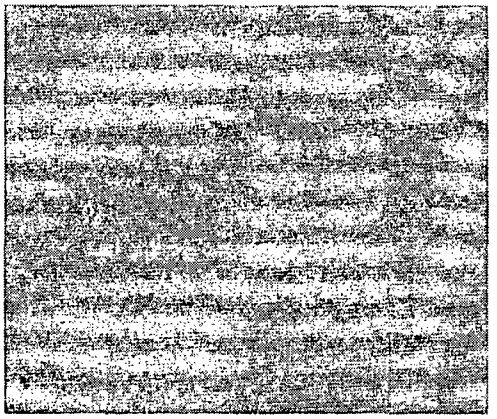
about one million of the 11 million Malawians are HIV positive while another 200,000 have died since the first case was officially diagnosed in 1985.

Most of those who die are in the active 24-40 age group, usually leaving very young children, most of whom are cared for by relatives although some, if they are lucky, are adopted. According to official figures seven people are dying of AIDS in Malawi every hour.

"The situation is deteriorating so much that by 1998 at least 12 AIDS sufferers will be dying every hour," says AIDS worker Dr. George Liomba.

(--Africa Information Afrique/Misanet July 17, 1997)



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(MH) A Home on Her Own: Ex-Model Cares for AIDS Orphans

The Miami Herald, Inc.; a Knight Ridder publication. One Herald Plaza, Miami, FL 33132-1693 - Miami Herald (MH) - Monday, May 26, 1997 Edition: Final Section: Front Page: 1A Word Count: 1,457

by Katherine Ellison; Herald Staff Writer

SAO PAULO, Brazil - Tucked away in a closet in the mansion Sonia Boguzinskas shares with 20 HIV-infected infants and children is a fossil from her former life: a pair of gold, leopard-print spike-heel shoes.

The six-foot former model once strode runways in them, in her heady years of French champagne and serial marriages.

Now she changes 80 diapers a day.

Her hands are chapped from giving baths, her long blond hair is brittle, and her blouse, lacking a button, falls open.

"I'm happy," she says. "I've never been so happy."

At the age of 50, Boguzinskas has surrendered to the masochistic passion of devout motherhood, but there's a catch. Judges keep sending her babies, yet she can't find people to help care for them.

The government hasn't responded. Private groups give funds and food, but no people. Boguzinskas is alone for long stretches in the seven-bedroom house, filled with her crying, biting, scrambling brood, ages four months to seven years, and her happiness, increasingly, is mixed with desperation.

"She has told me 100 times that she will kill herself," says Natasha Smit de Barros, a Dutch volunteer who comes Tuesdays and Thursdays. "She says she'll go jump off a building in New York to show everyone what's happening in Brazil."

Growing problem

Part of what's happening is an alarming expansion of the number of AIDS orphans.

As of last year, 13,000 Brazilian babies and children were known to have lost their mothers to AIDS: a 23 percent increase over 1995, according to a new study by the Brazilian chapter of the Boston-based Global Orphan Project. Eight percent, or 1,040, of them are believed to be HIV-positive.

Miguel Fontes, the study's author, said Brazil's proportion of AIDS orphans is lower than Africa's but higher than anywhere else in this hemisphere, including the United States.

That's true, he said -- despite the higher U.S. incidence of AIDS in general -- because Brazilian mothers with AIDS tend to live fewer years, due to the relatively poor health care available. (Brazil's number of AIDS orphans is probably also higher than Fontes' study shows, because of greater problems here in keeping track of the poor, who account for most of the AIDS cases.)

Many of Brazil's AIDS orphans, especially those who themselves are infected, end up abandoned in hospitals or in the street. Government orphanages don't accept children with AIDS, and established private agencies are becoming overbooked.

Boguzinskas' living room looks and sounds like the center of this storm.

Two-year-old Mariana, whose crack-addicted mother threw her out a hospital window -- to be caught by a nurse -- is banging a pink plastic guitar against the side of her playpen.

Nine-month-old Alzira, whose mother tried to strangle her, is giggling in Smit's lap; she still can't sit up by herself.

Chubby, 1-year-old Paloma is dashing to and fro in her walker. Her mother dropped her off six months ago, promising to return. Paloma is fed through a catheter plugged into her stomach. Boguzinskas frets that she isn't trained to change it, but the plug is becoming infected.

The other side of life

Boguzinskas' life changed after she almost lost it. In 1978, while working as a fashion-show producer, she was diagnosed with cancer of the uterus. First her hair went, then her husband. Then she met Little Bean.

She was visiting a friend at a hospital, she says, when the elevator stopped at the wrong floor. There, she spotted a newborn in an incubator. Doctors called him Feijaozinho, Little Bean. He had been found in a box under a bridge, HIV-positive and nearly dead.

Boguzinskas went to a judge the next day and took him home the same week.

She had, by then, already quit her job and was volunteering several hours each week to help children with cancer and AIDS. "The children gave me the strength to get through the chemotherapy," she said. "I had been a very vain woman, with gorgeous hair, before then, but then I saw the other side of life."

And so, as she took Little Bean home, Boguzinskas had an inspiration.

"What do you say we take all the AIDS kids off the street?" she whispered in the baby's ear.

`All of us were rejects'

She approached an old acquaintance, the owner of a large electronics company, and won his patronage, although he insisted on anonymity. In 1992, she moved into the mansion, her sponsor paying for the rent plus a nurse and other assistants. Her cancer went into remission, but her sponsor, in 1994, died in a helicopter crash, leaving her on her own.

She has, since then, sold jewels and a car to pay for some expenses. But she lost the assistants, and eventually ran up a $50,000 debt to her landlord. Finally, early this year, after heavy rains flooded the mansion and Boguzinskas called TV reporters to plead for help, representatives from a national charity, the Good Will League, stepped in to take over the rent payments, assume her debts and help repair the roof and walls.

"It's as if this woman came from another world," says Naaman do Valle, a Good Will League official who has been working with her. "She has fantastic strength."

Boguzinskas was once very wealthy, but before that she was poor. She never knew her father, and her Ukrainian immigrant mother "drank, and never liked me anyway." As a child, she was left with her grandmother, and as a teenager, she started working for a beauty salon, where she was soon discovered by a top Brazilian designer of the 1960s.

"Deep down, I identify with these children, since all of us were rejects," she said. But that has made it all the harder to watch them die -- 10 have gone in just the past five years.

Gifts, but no helping hands

Supplies are no problem. The American School provides diapers; the Carrefours chain delivers groceries. The mansion is flooded with gifts of brand new strollers, car seats, cribs, mattresses and stuffed animals.

Nor does Boguzinskas want money. "AIDS is a big industry," she says. "I don't want to get my hands dirty."

Her problem is people, or rather the lack of them. Since the death of her sponsor,

Boguzinskas has struggled to find trained assistants, who won't run away for fear of contamination. A team of state hospital doctors sees the children once a week, but Smit, a part-time English teacher, is her only regular volunteer.

The result is that Boguzinskas, who hasn't spent a night away from the children in five years -- and who wakes regularly, twice, before dawn, to give bottles and check foreheads for fevers -- frequently breaks down in tears.

Eighteen of her 20 wards, even the five-year-olds, are still in diapers, for convenience.

Three infants rock in their car seats for long periods upstairs, attended only by a black-and-white TV.

"No one can blame her, because no one, on their own, could do a better job," said Smit, who seems just as serene as Boguzinskas is agitated.

Prayers from the Vatican

Boguzinskas grew hopeful four months ago after Emerson Kapaz, the Sao Paulo state secretary of Science, Technology and Economic Development, watched her TV plea and promised help.

But even though she calls him now, almost every day, Kapaz has not come through. In an interview, he said one of his assistants was trying to register Boguzinskas as a legal institution, making her eligible for government aid.

"We still don't know if it will work," he said.

Boguzinskas is trying to hold on, but she has grown skeptical, and very, very tense.

Another baby arrived at the mansion recently, a one-month-old girl without a name, whose mother, a maid, already has two other children with AIDS.

A couple of weeks ago, after being on her own for more than 48 hours, Boguzinskas called Smit at home.

"Call the pope!" she said.

After only a little hesitation, Smit put the call through, reaching a Vatican secretary.

"She told me: We can just pray for her," Smit said.

CAPTION: photo: Sonia Boguzinskas cares for AIDS orphans in Brazil (a), Sonia Boguzinskas feeds one of her adopted AIDS orphan in Brazil (a)

KATHERINE ELLISON / Herald staff GIVING HOPE: Sonia Boguzinskas cares for 20 AIDS orphans in Brazil. `The children gave me the strength to get through the chemotherapy,' says the former model whose cancer is in remission. The increasing number of her charges has left her begging for help.

KATHERINE ELLISON / Herald staff A HELPING HAND: Her first adoptee inspired Sonia Boguzinskas to ask `What do you say we take all the AIDS kids off the street?'

Keywords: HEALTH; AIDS; CHILD; BRAZIL; JUVENILE

DT 970526
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40 Million Children May Lose Parents to AIDS

WASHINGTON (Reuters) - Nearly 40 million children in developing countries stand to lose one or both parents to AIDS over the next 13 years, with catastrophic results, U.S. experts said Wednesday.

A survey by the U.S. Agency for International Development (USAID) and the Census Bureau predicted the AIDS epidemic would create a ``lost generation'' of children at risk of exploitation and disease.

``More than 40 million children in 23 developing nations will likely have lost one or both their parents by 2010. Most of these deaths will be the result of the HIV/AIDS pandemic and complicated illnesses,'' Brian Atwood, administrator of USAID, told a news conference called to release the results of the survey.

``In countries across Africa, Asia and Latin America, HIV/AIDS is unraveling years of progress in economic and social development,'' he added.

``Life expectancy -- which has been steadily on the rise for the last three decades -- will drop to 40 years or less in nine sub-Saharan countries by the year 2010.''

Atwood said serious work to help stop infants from dying in developing countries was being wiped out.

``In all 23 countries included in this study, AIDS-related mortality will eliminate the gains made in child survival over the past 20 years. In Zambia and Zimbabwe, infant mortality rates will likely nearly double, and child mortality rates will triple,'' Atwood said.

Those children who survived would be left without protection, love and care. ``Many of these children will increasingly be forced into child labor, and will suffer higher rates of disease and death,'' USAID said in a statement.

Atwood said laws should be changed to protect such children and to allow surviving mothers to own land and to work, so they could care for their children when fathers died of AIDS. He also called for funds to help local agencies care for AIDS orphans.

``This report is a call to arms for developing and developed nations alike,'' Atwood said. ``The human and social costs of these numbers are staggering. We cannot begin the 21st century with a generation of children lost to abandonment, despair and hopelessness.''

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Associated Press
23 March 1997

Teens Give Hillary a Lesson on African 'Baby Dumping'

First lady sees how U.S. foreign aid
helps clinics fight AIDS in Zimbabwe

Harare, Zimbabwe -- Evicted by her mother, spurned by her boyfriend, desperately afraid, the girl crouches in the bush, gives birth in silence, then walks away from her baby.

A village "auntie" finds the baby, confronts the girl and helps smooth things over with her mother to let her return home.

"Baby dumping," demonstrated for first lady Hillary Rodham Clinton in a skit Saturday by teenage girls at a family-planning clinic, causes great anxiety in Zimbabwe.

Clinics like Kuwadzana Polyclinic, where the first lady watched the teens' presentation, are trying to combat unwanted pregnancies that lead young mothers to leave babies to die. They have lowered Zimbabwe's birth rate but still confront daunting challenges of "AIDS orphans" and the spread of sexually transmitted diseases.

With the help of U.S. aid money, the Kuwadzana is trying to reduce the transmission of HIV by dispensing condoms, is treating sexually transmitted diseases and is counseling both men and women on ways to avoid pregnancy.

It is the type of foreign aid that deserves to remain intact, Hillary Clinton said -- especially since such efforts cost so little. U.S. aid to all countries comprises about 1 percent of the total federal budget, she said.

"There are a lot of misconceptions in our country about foreign aid," the first lady said. "One of my hopes is through visits like this, where you can see people on the front lines working to use the money which the United States has provided . . . more Americans would be proud."

Hillary Clinton and daughter Chelsea are halfway through a two-week visit to Africa designed to display to Americans how far African countries have come economically and politically. The first lady previously visited Senegal and South Africa and will stop in Tanzania, Uganda and Eritrea before heading home on Easter.

The first lady said 30 African countries have seen their economies grow by 3 to 4 percent. In Zimbabwe, growth is 7 percent. But the United States hardly contributes to the economic expansion, she said, noting that American business holds only 7 percent of the African market.

"Even that small percentage translated into 100,000 American jobs," Hillary Clinton said. "Just think what that means for the United States."

Just as minuscule amounts of government aid have helped trigger social progress in Africa, small contributions by big corporations are making a difference too, she said.

At the Dorothy Duncan Center for the Blind, where most young patients were blinded by measles, children compile books of poetry in Braille, using 22 computers donated by IBM.

"Enjoy these, children of Africa, and pass them on to 10 children of your own. Go well," Aiden Gamble, 7, read for the first lady, his small hands gliding lightly along the book's first page.

"Very good job, Aiden," Hillary Clinton said.

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Children Living in a World with AIDS

Facts & 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-infected.
- 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-infected children under the age of 15 have been born to HIV-infected mothers, and hundreds of thousands of chil-dren 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 socio-economic 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.
- An unknown number 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

Reproduced from the UNAIDS web site: Children living in a world with AIDS

Enabling AIDS Ministries: Opportunities for Giving

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Children Living in a World with AIDS

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 injec-tion 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 obliga-tions 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 programs 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-infected 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 grand-parents 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 life-time 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 programs 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 programs, 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 Con-vention 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 pretest 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 programs, 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.

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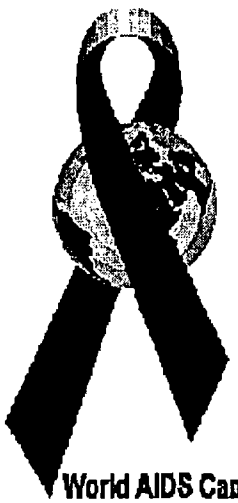

Children with HIV: A Future Compromised

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-infected 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 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-infected children survive at least until their third birthday, and more than 20% reach the age of 10. In Zambia, however, nearly half of HIV-infected 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, antifungal drugs for thrush and cryptococcal meningitis (a severe infection of the nervous system), 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-infected infants have acquired the virus from their HIV-positive mothers during pregnancy or delivery, or acquired it through breastfeeding.**

And women of childbearing age make up an ever-increasing proportion of people with HIV worldwide - a trend that reflects their own biological and social vulnerability to 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, 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 con-straints 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 breastfeeding 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 diarrhea and respiratory infections. And breastfeeding is a natural, costfree 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 i 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. Condom use is vital.

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.

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Children Living in a World with AIDS

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. **An unknown number 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 push-ing 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 neighbors 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.

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Children Living in a World with AIDS

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 re-sponsible and safe behavior 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 communi-cation 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, organizations such as UNICEF and WHO argue 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 ex-ploitation 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 confer-ence on AIDS in Marrakech 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.

Reproduced from the UNAIDS web site: Children living in a world with AIDS

Enabling AIDS Ministries: Opportunities for Giving

Top | Covenant to Care | Last | First

International AIDS/Orphans File

UNITED PRESS INTERNATIONAL

Jump to other years

(UPI) By the end of 1998 33M HIV/AIDS cases

United Press International - Tuesday, November 24, 1998

UNITED NATIONS, Nov. 24 (UPI) -- The World Health Organization estimates by the end of this year more than 33.4 million adults and children will be living with HIV/AIDS, up 10 percent from last year.

UNAIDS estimates today that has claimed nearly 14 million lives worldwide, 11.5 million in sub-Saharan Africa alone.

Secretary-General Kofi Annan says AIDS "is still an emerging epidemic with 95 percent of all infections and deaths occurring in the developing world."

In a message for World AIDS Day Dec. 1, Annan says: "Because the victims are mostly young adults, who would otherwise be raising families and supporting the economy, the repercussions are reaching crisis level.

"This tidal wave risks wiping out the hard-won gains of poor nations."

The Secretary-General points out that in Botswana, a child born early in the next decade can expect to live just past 40 -- instead of to age 70 in the absence of AIDS. By the year 2005 Zimbabwe estimates it will have more than 900,000 orphans under age 15.

Nearly half of all HIV infections occur in people aged 15-24 years and 75,000 people in Western Europe and North America were infected last year.

In his message, Annan also remembered Jonathan Mann, first director of the WHO's Global Program on AIDS, and his wife Mary Lou, AIDS researchers who died with several United Nations colleagues in a Swissair plane crash.

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CDC NCHSTP Daily News Update Database

Accession Number:	N26483
Title:	Myanmar, Cambodia Face Huge AIDS Problem
Source:	Fox Market Wire Online (11/12/98)
Abstract:	Speaking at a conference in Bangkok on child development, Kul Gautam, UNICEF's director for East Asia and the Pacific, said that Myanmar and Cambodia could face AIDS epidemics comparable in proportion to the problem in Africa. Gautam said that Thailand, Cambodia, and Myanmar have the largest number of cases in Southeast Asia, but that Thailand is addressing its problem, while the other two countries are not. He argues that the two countries have "serious problems but do not yet have serious programs." According to UN statistics presented at the conference, by 1997 there were almost 50,000 AIDS orphans in Thailand, with nearly 15,000 in Myanmar and 8,000 in Cambodia. The data also indicates a high level of HIV infection in the countries, ranging from 1.01 percent to 2.4 percent of the adult population. Gautam noted that it is difficult to determine the extent of the disease in the countries, but that anecdotal evidence suggests it is very high. He also said that in some areas intravenous drug use causes more infections than sexual contact.
Major Descriptors:	Developing nations. Epidemics. Persons with AIDS.

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kaiser family foundation
Daily HIV/AIDS report

Thursday, October 29, 1998

GLOBAL CHALLENGES

KENYA: Second National HIV/AIDS Conference Held This Week

At the opening of Kenya's second national HIV/AIDS conference in Nairobi Wednesday, Health Minister Jackson Kalewo said the government will establish "a broad-based national HIV/AIDS council to address AIDS-related problems and [coordinate] with international agencies working to combat AIDS." He also urged Kenyans to "shed their traditional inhibitions and discuss AIDS openly in order to stop the spread of the disease." He said, "We are hypocrites; we do not discuss [these] things openly. That's why we are here cursing sex. Let us be ourselves; we must know the causes of contacting the HIV/AIDS virus." The *AP Worldstream* reports that many Africans do not discuss sex in public or at mixed-sex gatherings. In his speech commencing the three-day conference, Kalewo also "urged Kenyans to avoid sexual promiscuity and drunkenness." According to a report by the Health Ministry's National AIDS/STDs Control Program, 9% of the Kenyan population, or 1.5 million people, have been infected with HIV since the first case was reported in 1980. About 256,750 have died over the 18-year-period. Kalweo said that "the devastating effects of AIDS over the past two decades have assumed such proportions that many households in Kenya are not able to cope with the impact." With regard to the 440,000 AIDS orphans in the country, Kalweo said "the ministry is restructuring its programs to emphasize the involvement of support systems and traditional approaches." In addition, he said community foster care homes and day care centers will be established to care for children orphaned by AIDS (*AP Worldstream* , 10/28). The *BBC News* reports that the number of Kenyans infected with HIV has doubled to 10% since the country's first HIV/AIDS conference was held five years ago. It also reports that "[p]art of the work of the meeting, which is being attended by about 600 delegates, will be to review the impact of anti-AIDS campaigns" (*BBC News* , 10/28).

Kaiser Daily HIV/AIDS Report

CDC NCHSTP Daily News Update Database

Accession Number:	N26369
Title:	Uganda Has 1.5 million Orphans
Source:	Africa News Service (10/27/98)
Abstract:	Dr. Robert Limlim, a program officer with UNICEF, announced Monday that there are over 1.5 million orphans in Uganda, two-thirds of whom lost their parents to AIDS. He noted that the number of orphans has risen by 300,000 since 1990 due to the disease. Limlim made the announcement at an international conference on orphans in Kampala, adding that AIDS is the primary cause of death among adults in Uganda.
Major Descriptors:	Developing nations. Orphans. Persons with AIDS.

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CDC NCHSTP Daily News Update Database

Accession Number:	N26250
Title:	Two Million Zambians Expected to Die of AIDS in 2010
Source:	African National Congress Daily News Briefing Online (10/08/98)
Abstract:	Peter Chintala, deputy minister for religious affairs in Zambia, warned Wednesday that about 20 percent of people in the country will die from AIDS in the next 10 years, with at least 2 million dead by the year 2010. He said that the deaths would leave 1 million orphans. Furthermore, over 25,000 children contract HIV from their mothers in the country annually. Speaking at a meeting on HIV/AIDS sponsored by Zambian churches, Chintala called on Zambian youths that to try and prevent the sexual transmission of HIV and to use the "God-given gift" of sex appropriately.
Major Descriptors:	Developing nations. Mortality rates. Persons with AIDS.

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CDC NCHSTP Daily News Update Database

Accession Number:	N26238
Title:	UNAIDS Leader Says HIV Epidemic Poses Increasing Threat
Source:	Reuters Health Information Services (10/07/98)
Abstract:	Dr. Peter Piot, executive director of the Joint UN Program on HIV/AIDS, said Tuesday that the HIV epidemic is increasingly threatening children worldwide. Piot, speaking at a convention in Geneva organized by the Committee on the Rights of the Child, asserted that governments must be responsible and accountable for improving the conditions of HIV-infected children and those whose family members are affected by the virus. He also called for increased measures to prevent the spread of HIV and spoke out against restricting access to sexual health education for children. Over 500,000 children were infected through mother-to-child transmission in 1997, with over 1.5 million orphaned due to the disease.
Major Descriptors:	Children. Children with HIV/AIDS. Epidemics. Government roles. Health education needs. HIV prevention.

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CDC NCHSTP Daily News Update Database

Accession Number:	N26109
Title:	In Zambia, the Abandoned Generation
Authors:	Daley, Suzanne
Source:	New York Times (09/18/98) P. A1
Abstract:	The AIDS epidemic has resulted in a dramatic increase in orphans in Zambia and many other African nations. According to the United Nations, 40 percent of children in rural parts of East Africa who have lost a parent by age 15, lost their parent due to AIDS. Last year, AIDS orphaned 1.7 million children, the overwhelming majority of whom were in sub-Saharan Africa. Zambia has the highest proportion of orphaned children in the world, the United Nations reports, with 23 percent of children under 15 missing one or both parents. Furthermore, the number of parental deaths is expected to increase. Many of the children are taken in by extended families, with about three-quarters of households taking care of one or more orphans. However, high poverty levels have resulted in the abandonment of many of the children; there are more than 90,000 children now living on the streets of Lusaka, as compared to 35,000 in 1991. Officials believe that HIV levels in the adult population will not begin to fall before 2010 and that orphan levels will not peak until a decade after that. The HIV rate in urban areas of Zambia is expected to plateau at 28 percent and at 22 percent in rural areas.
Major Descriptors:	Developing nations. Epidemics. Orphans. Poverty.

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CDC NCHSTP Daily News Update Database

Accession Number:	N25894
Title:	Condition Critical for Mother and Child
Authors:	Wainberg, Mark A.
Source:	Washington Post (09/08/98) P. A15
Abstract:	UNAIDS recently announced that HIV-infected mothers in developing countries should consider alternatives to breast-feeding, even though many feel that there are no other viable options in many of these areas. The announcement by the UN agency indicates that there is concern about the transmission of HIV from mother to child through breast milk, notes Mark A. Wainberg, head of the International AIDS Society, in a Washington Post commentary. Other data show that the use of AZT during pregnancy can aid in the reduction of the transmission of HIV, but scientists are worried that the use of monotherapy will result in the development of AZT-resistant HIV in developing nations. Nations also face the problem of orphaned children whose mothers have died as a result of HIV. The World Health Organization estimates that 18,000 people are infected with the virus daily, with 1,600 infants born infected every day. In many developed nations, such as the United States, the number of children born with HIV has been reduced due to the use of anti-HIV drugs; but, in many developing countries--where access to these drugs is severely limited--many more children are born HIV-positive. Many of these areas also lack proper AIDS education campaigns, which further contributes to the HIV problem, Wainberg concludes.
Major Descriptors:	Breastfeeding. Developing nations. HIV/AIDS education needs. Perinatal transmission. Treatment barriers.

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CDC NCHSTP Daily News Update Database

Accession Number:	N25692
Title:	Governors Urged to Help AIDS Orphans
Authors:	Manyandure, Daniel
Source:	Africa News Service (08/23/98)
Abstract:	Participants in a one-day forum in Harare, Zimbabwe, urged governors to support a community-based orphan care package. They asked that the governors back the programs by granting them part of the $50 million allocated to each province for developmental projects. One participant said, "The orphan problem is our national responsibility, and we challenge governors to remember these children and give them a share when they distribute this money." According to the National AIDS Coordination Program, over one-quarter of the adult population in Zimbabwe carries HIV. The group estimates that there will be 1.5 million AIDS orphans in the country by 2001. One pilot study of the community-based AIDS orphan projects indicated that the programs were successful.
Major Descriptors:	Developing nations. Fundraising. Government roles. Orphans.

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CDC NCHSTP Daily News Update Database

Accession Number:	N25643
Title:	Breast-Feeding and HIV: Weighing Health Risks
Authors:	Specter, Michael
Source:	New York Times (08/19/98) P. A1
Abstract:	The United Nations took initial steps to reverse its position on the use of breast-feeding to nurse infants recently, stating that HIV-infected women should consider feeding their children with formula to reduce the risk of mother-to-child transmission of the virus. In many parts of Africa, however, water sources are contaminated and can lead to serious diseases that can be passed on through formula prepared with the water. With a reported 3 million deaths due to AIDS in children since the beginning of the epidemic and over 600,000 new HIV infections among infants, health officials have been forced to examine their position on the merits of breast-feeding. The use of uncontaminated formula or short-course AZT administration during pregnancy may have been able to prevent over one-third of the infections. Since anti-HIV drugs are expensive, prevention remains the best hope for controlling HIV in Africa. However, formula is also expensive; in Uganda, the cost of formula for one child is about 1.5 times the amount a village family earns annually. According to Dr. Francis Miro at Makerere University in Uganda, 85 percent of children who are formula-fed will die from water contamination in rural areas, while 27 percent of infants born to HIV-positive mothers contract the virus through breast-feeding. Even if HIV-positive mothers manage to prevent their children from contracting the virus, another problem looms on the horizon; with many HIV-infected people succumbing to the disease quickly due to a lack of medication, the number of AIDS orphans in Africa will continue to rise.
Major Descriptors:	Breastfeeding. Developing nations. Financial issues. Health risk appraisal.

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CDC NCHSTP Daily News Update Database

Accession Number:	N25510
Title:	Project Launched to Reduce Transmission of AIDS to [Children]
Authors:	Ballenger, Josey
Source:	Africa News Service (07/30/98)
Abstract:	Three South African provinces--Gauteng, the Western Cape, and KwaZulu-Natal--are set to initiate an anti-AIDS program designed to reduce mother-to-child transmission of HIV through the use of AZT. The initiative will involve the administration of the drug, which is being offered at reduced prices by its manufacturer Glaxo Wellcome, from the 36th week of pregnancy through delivery. Studies show that AZT can help reduce vertical transmission of HIV by up to two-thirds. According to South African health authorities, there are at least 200 infants born with HIV daily and as many as 3 million children could be orphaned in the next 10 years as a result of AIDS. Dr. Liz Floyd, director of AIDS and communicable diseases in Gauteng, said that the program was partly to test the sustainability of the treatment in the developing world. She also noted that, while the cost of AZT has been reduced, there are other costs involved, such as counseling.
Major Descriptors:	AZT. Financial issues. Perinatal transmission.

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THE HENRY J. KAISER FAMILY FOUNDATION
Daily kaiser family foundation
HIV/AIDS report

Tuesday, July 28, 1998

GLOBAL CHALLENGES

HAITI: HIV Infection Rate 'Disastrous'

A surge of HIV infection in Haiti has propelled the disease to become one of the "main cause[s] of death in adults," said Jean-William Pape, director of the Haitian research group GHESKIO and medical professor at Cornell University. Pape addressed the annual convention of the Association of Haitian Physicians on July 23, and announced that approximately "26,000 Haitians were infected with the HIV virus in 1997," a statistic that compares unfavorably with the 40,000 people who contracted HIV in the U.S. and the 30,000 Western Europeans who became infected during the same period. Pape blamed the high incidence of sexually transmitted diseases, which he said are "preparing the bed for HIV," and noted that "57% of pregnant women seeking prenatal care had a sexually transmitted disease, including HIV." Illinois Department of Employment Security research economist Harry Fouche noted that under the current Haitian economic situation, patients cannot afford AIDS treatments that cost "$12,000 to $18,000." As a result, Pape said that the disease "has killed many mothers leaving behind orphans in Haiti," and that the AIDS epidemic has taken "10 years off the life expectancy of Haitians, which is 54 years." Fouche noted that "a heavy condom promotional campaign" was initiated in 1991, and as a result the number of condoms sold in the country has increased from a "few thousand" to 7 million (Agence France Press, 7/24). Click here to read *Daily Report* coverage of the AIDS epidemic in Haiti.

Kaiser Daily HIV/AIDS Report

THE HENRY J. KAISER FAMILY FOUNDATION
Daily kaiser family foundation
HIV/AIDS report

Tuesday, June 30, 1998

12TH WORLD AIDS CONFERENCE

MOTHER-TO-INFANT TRANSMISSION: UN Launches AZT Treatment Program

Hoping to slow the spread of HIV from mothers to their children, United Nations officials announced yesterday a pilot program that will treat 30,000 pregnant women in 11 developing nations with the HIV-fighting drug AZT for as little as $50 each. The announcement comes on the heels of findings presented this week at the 12th World AIDS Conference in Geneva that AZT can dramatically reduce mother-to-infant transmission, one of the "AIDS epidemic's most devastating problems" (Perlman, *San Francisco Chronicle*, 6/30). Aimed at women in developing nations where expensive AIDS therapies are virtually out of reach, the $3.6 million program will provide a short course of AZT to woman in their 36th week of pregnancy. While pregnant American women with HIV often undergo a three-month course of AZT for about $800, the UNAIDS program will provide the shorter-term treatment for about $50, the *Los Angeles Times* reports (Maugh, 6/30). AZT manufacturer Glaxo Wellcome is making the cheaper therapy possible by providing AZT for the program at "a discounted rate of up to 75% on prices in the industrial world" (Pilling, *Financial Times*, 6/30). U.S. Surgeon General David Satcher said the United States will back the program financially, but he would not disclose how much funding the federal government will offer, the *Boston Globe* reports (Knox, 6/30).

Alternatives To Breastfeeding

In addition, the program will offer alternatives to breastfeeding, "thought to be the route of infection for a third of children," in developing countries, *BBC News* reports. UN officials have been looking for substitutes for breast milk but are wary of asking women to give up breastfeeding, which is "cheap and convenient" for women in poorer countries. According to one UN spokesperson, however, "We have now a new equation. ... We cannot just sit back and maintain our position. We are not happy to ask women not to breastfeed, but we have to do it" (Doole, 6/29). Breast milk substitute and testing will cost $70 per patient, the *Financial Times* reports (6/30). HIV-infected women in Botswana, Burkina Faso, Cambodia, Honduras, Cote d'Ivoire, Rwanda, Tanzania, Thailand, Uganda, Zambia and Zimbabwe will be targeted by the UN program (*BBC News*, 6/30).

Just The Beginning

Each year, two million HIV-positive women become pregnant worldwide, and about 540,000 of their babies -- more than one quarter -- are born with HIV in Third World nations in Asia and Africa. Though the new UN program "will prevent only a tiny fraction" of the cases of mother-to-infant transmission, health officials "see the program as an opening wedge in an effort to bring the benefits of AIDS research to the nations hardest hit by the" AIDS epidemic (*Boston Globe* , 6/30). UN officials and health officials worldwide praised the new effort, calling it a good first step in stamping out transmission to children. "All our efforts at providing safe water and other protections for children have been undermined, undone, by the AIDS epidemic," said Dr. David Alnwick, head of UNICEF's health program. "But we are now committed to supporting every possible practical action that will prevent the transmission of HIV from mother to their infants" (*San Francisco Chronicle* , 6/30). "We've made dramatic advances in the last four years in reducing mother-to-child transmission of HIV in developed countries," said Dr. Lynne Mofenson of the National Institute of Child Health and Human Development. "With the now-proven efficacy of the short course of AZT ... I hope we may see a similar impact in the developing world in the next four years" (*Los Angeles Times* , 6/30).

Detractors

Some AIDS activists were not as enthusiastic, the *New York Times* reports. Members of the French advocacy group ACTUP-Paris called the program "unethical" and argued it was "far too limited" because it treats HIV-infected women only during pregnancy, not after they have given birth. The detractors further criticized UN officials for their inattention to the fate of children whose mothers die of AIDS. "The UN will be an orphan factory soon," said ACTUP-Paris' Marie de Cenival. She said the new program is a "wrong and cheap" strategy, and that it will do little to improve the health system in African nations, home to 21 million of the world's 30 million HIV-infected people. "We want to limit spread of the epidemic, but we think it is a political strategy and we want people to understand that," she said.

In Defense

The *New York Times* reports that UN officials strongly defended the program, arguing that "the United Nations did not have enough money to treat all HIV-infected pregnant women and had to act now, even if the program created some orphans" (Altman, 6/30). The *San Francisco Chronicle* reports that Bernard Kouchner, France's secretary of state for health, "shrugged" off ACTUP's challenge. "This epidemic has gotten ahead of us completely," he said. "We cannot have a perfect strategy against it. But we must move as swiftly as we can wherever we can, and of course that means we must move into the battle of providing access to real and continuing care for the mothers" (6/30).

Kaiser Daily HIV/AIDS Report

CDC NCHSTP Daily News Update Database

Accession Number:	N25843
Title:	Zimbabwe Gets $64 Million Loan From World Bank
Authors:	Magombo, Nelson
Source:	PANA Wire Service (05/15/98)
Abstract:	The World Bank approved on Friday a $64 million loan to Zimbabwe for the procurement of medications against sexually transmitted diseases, including HIV, over the next five years. Dr. David Parienyatwa, Zimbabwe's Deputy Minister of Health and Child Welfare, also said that a bill to be presented in the country's parliament would promote AIDS education in the workplace. In Zimbabwe, which has 12.5 million residents, an estimated 1.5 million people in Zimbabwe are infected with HIV. It is estimated that 500,000 children have been orphaned in the country due AIDS.
Major Descriptors:	Developing nations. Funding sources. Sexually transmitted diseases (STDs).

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THE HENRY J. KAISER FAMILY FOUNDATION
Daily kaiser family foundation
HIV/AIDS report

Friday, April 17, 1998

GLOBAL CHALLENGES

THAILAND: Number Of HIV-Infected Newborns Expected To Increase

The head of Thailand's Foundation for a Better Life for Children this week said "government agencies and non-governmental organizations working for children had estimated that" a number of child-related problems, including the number of "orphans born to HIV-positive mothers," would be "more serious this year," the *Bangkok Post* reports. According to Sen. Vallop Tangkananurak, "the number of orphans born to AIDS mothers has reached 70,000, while about 20% of one million newborn infants per year are found to be HIV-infected." Other problems cited by the senator are an expected increase in the number of drug-addicted children and a rise in child prostitution (Santimetanedol, 4/16).

Kaiser Daily HIV/AIDS Report

CDC NCHSTP Daily News Update Database

Accession Number:	N24224
Title:	AIDS Will Orphan 40 Million
Authors:	Marshall, Toni
Source:	Washington Times (12/02/97) P. A11
Abstract:	During a news conference for World AIDS Day Monday, Peter Piot, executive director of UNAIDS, estimated that more than 40 million people will die of AIDS by 2010. He added that while new drugs are helping control the virus in some populations, these treatments are largely unavailable in developing countries and do not cure the virus. Children are now being affected most by the virus, added Brian Atwood, director of the U.S. Agency for International Development, which last month reported that more than 40 million children in the 23 countries which have been hit hardest by the virus will be orphaned by 2000. In fact, said Sally Shelton-Colby of U.S. AID's Global Programs, Fields Support and Research Bureau, the group with the fastest-growing rate of increase of HIV infection is individuals between the ages of 15 and 24. Atwood also noted that deaths from AIDS "eliminate the gains made in child survival over the past two decades."
Major Descriptors:	Developing nations. Orphans.

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CDC NCHSTP Daily News Update Database

Accession Number:	N24163
Title:	U.S. Agency Says AIDS Will Orphan Millions
Source:	New York Times (11/20/97) P. A7
Abstract:	At a news conference Wednesday, the United States Agency for International Development said that 40 million children in developing nations will lose one or both parents to AIDS by 2010. Combined with a population explosion among young people, said Dr. Nils Daulaire, senior adviser on children and women's health issues, "it is a crisis of staggering proportion." The U.S. AID report predicted that AIDS, which is already widespread in Africa, will boom across Asia and Latin America within the next decade. Daulaire added that this outlook will affect the future of the world's entire network of development, trade, and diplomacy.
Major Descriptors:	Children. Orphans. Developing nations. Families of Persons with HIV/AIDS.

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CDC NCHSTP Daily News Update Database

Accession Number:	N23338
Title:	United Nations: AIDS to Hit 1 Million Children
Source:	IPS Wire (07/14/97)
Abstract:	According to a new United Nations report, the number of children with AIDS in the world is expected to rise from 830,000 in 1996 to more than 1 million this year. UNAIDS head Dr. Peter Piot said that "the disastrous impact of AIDS on children has not been given enough attention," and warned of a reversal in current trends of reducing child mortality if the disease is not contained. According to the UN report, over 90 percent of the world's children with HIV are located in Africa. It is projected that by 2010, if the spread of HIV has not been contained, AIDS will increase infant mortality by 25 percent and under-five mortality by over 100 percent in the regions most affected by the disease. According to a U.N. Children's Fund (UNICEF) study, the largest and fastest growing group "in difficult circumstances" in Zimbabwe are children orphaned by AIDS; about 8 percent of children under the age of 15 years have lost their mothers to AIDS. One in five babies born to infected mothers are infected during delivery, and one in seven are infected during breastfeeding.
Major Descriptors:	Children. Epidemiology. HIV transmission. Perinatal transmission. Breastfeeding. Developing nations. Orphans.

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CDC NCHSTP Daily News Update Database

Accession Number:	N22614
Title:	Mrs. Clinton in Africa
Source:	Washington Times (04/01/97) P. A14
Abstract:	First lady Hillary Rodham Clinton and daughter Chelsea visited six African countries on their recent trip, and focused attention on progress in economic growth, political stability, and health and human rights. The editors of the Washington Times applaud the trip, but say that it cannot replace critical policy decisions that have not been made by the Clinton administration. The authors point out that Mrs. Clinton announced a new $8 million grant for education in Uganda, and that she visited HIV clinics in Zimbabwe, where children are often orphaned when their mothers die of AIDS or abandon them. According to the editors, although Mrs. Clinton should be praised for her work in showing some of the challenges facing Africa, they note that many of the serious issues, such as unrest in Zaire and Sudan, went unaddressed.
Major Descriptors:	Developing nations. Clinics. Funding sources.

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JAMA HIV Document

Record 1 from database: **AIDSLINE**


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Title

A comparison of definitions of AIDS orphans and implications for policy development.

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Source

Int Conf AIDS, 1996 Jul 7-12, 11:2, 391 (abstract no. Th.D.4889)

Abstract

Issue: National and international definitions for the term "orphan" vary. The underlying assumptions and data sources are often seen as solely technical matters, and the implications for policy and program development and comparative studies have not been addressed. Project: Epidemiologic, ordinary language, programmatic, and legal definitions of the term "orphan" were charted for five countries [US, UK, Tanzania, Uganda, and Thailand], three international organizations, and three software systems used for demographic projections. Results: (1) Ordinary language definitions sometimes differ from those used in epidemiologic modeling and projections because the latter depend on the available data bases. (2) Definitions vary in terms of whether the death of both parents, either parent, or only the father or mother determines whether a child is counted as an "orphan." (3) Definitions that use "death of mother" fail to consider children whose fathers have died and do not distinguish between those who have lost mothers and those who have lost both parents. (4) Definitions do not generally distinguish between HIV-infected and non-infected orphans, leading to imprecise assessments of children with special needs. (5) The upper age limit for including a child as an orphan varies, leaving significant numbers of youth over the specified age ineligible for services. (6) Legal definitions and entitlements may offer special protections not reflected in customary practice in regard to inheritance, placement, or services. Lessons Learned: In communicating the extent of the problem and assessment of need, epidemiologists should make explicit their definitions, data sources, and underlying assumptions. Beyond the technical justifications for certain choices, the selected parameters should be examined for their implications for including or excluding populations eligible for services.

Language of Publication

English

Unique Identifier

96925185; ICA11/96925185


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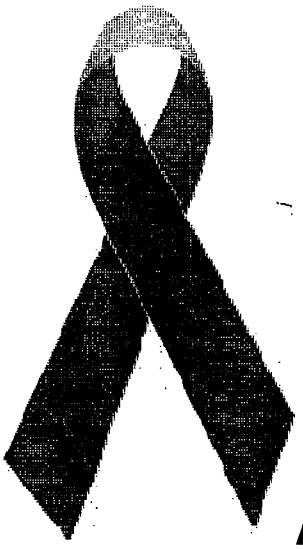
MeSH Heading (Major)

Acquired Immunodeficiency Syndrome|*; Child, Abandoned|*; Public Policy|*

MeSH Heading

Child; Comparative Study; Human

UNAIDS JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS



Orphan issues mentioned on pages #3, 7, 8.

AIDS epidemic update:
December 1998

UNAIDS

World Health Organization

Global summary of the HIV/AIDS epidemic, December 1998

People newly infected with HIV in 1998	**Total**	**5.8 million**
	Adults	5.2 million
	Women	*2.1 million*
	Children <15 years	590 000
No. of people living with HIV/AIDS	**Total**	**33.4 million**
	Adults	32.2 million
	Women	*13.8 million*
	Children <15 years	1.2 million
AIDS deaths in 1998	**Total**	**2.5 million**
	Adults	2.0 million
	Women	*900 000*
	Children <15 years	510 000
Total no. of AIDS deaths since the beginning of the epidemic	**Total**	**13.9 million**
	Adults	10.7 million
	Women	*4.7 million*
	Children <15 years	3.2 million

Anatomy of the epidemic

❒ Global summary

By the end of 1998, according to new estimates from the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO), the number of people living with HIV (the virus that causes AIDS) will have grown to 33.4 million, 10% more than just one year ago. The epidemic has not been overcome anywhere. Virtually every country in the world has seen new infections in 1998 and the epidemic is frankly out of control in many places.

More than 95% of all HIV-infected people now live in the developing world, which has likewise experienced 95% of all deaths to date from AIDS, largely among young adults who would normally be in their peak productive and reproductive years. The multiple repercussions of these deaths are reaching crisis level in some parts of the world. Whether measured against the yardstick of deteriorating child survival, crumbling life expectancy, overburdened health care systems, increasing orphanhood, or bottom-line losses to business, AIDS has never posed a bigger threat to development.

According to new UNAIDS/WHO estimates, 11 men, women and children around the world were infected per minute during 1998—close to 6 million people in all. One-tenth of newly-infected people were under age 15, which brings the number of children now alive with HIV to 1.2 million. Most of them are thought to have acquired their infection from their mother before or at birth, or through breastfeeding.

While mother-to-child transmission can be reduced by providing pregnant HIV-positive women with antiretroviral drugs and alternatives to breastmilk, the ultimate aim must be effective prevention for young women so that they can avoid becoming infected in the first place. Unfortunately, when it comes to HIV infection, women appear to be heading for an unwelcome equality with men. While they accounted for 41% of infected adults worldwide in 1997, women now represent 43% of all people over 15 living with HIV and AIDS. There are no indications that this equalizing trend will reverse.

Altogether, since the start of the epidemic around two decades ago, HIV has infected more than 47 million people. And though it is a slow-acting virus that can take a decade or more to cause severe illness and death, HIV has already cost the lives of nearly 14 million adults and children.

An estimated 2.5 million of these deaths occurred during 1998, more than ever before in a single year.

❒ AIDS and the infectious disease picture

According to recent WHO estimates, malaria causes over 1 million deaths a year. In 1998, AIDS deaths totalled some 2.5 million. Both diseases are among the five top killers worldwide. However, it is important not to overlook the dynamics in this picture. Already in 1954, millions of people were dying annually of malaria. AIDS is a still-emerging epidemic whose death toll rises every year, while the ranks of the newly infected swell by some 16 000 a day.

Tuberculosis, the second biggest infectious killer, is also on the rise, driven in large part by the HIV epidemic. People whose immune defences are weakened by HIV infection become an easy prey for other microbes, including the bacillus that causes tuberculosis. The resulting infections

(along with some cancers) are responsible for the recurring illnesses which in their late stages are called "AIDS", and which ultimately lead to death. Around 30% of all AIDS deaths result directly from tuberculosis.

While people undermined by HIV infection are more easily infected with the TB bacillus, many already harbour it from childhood. In either case, individuals with dual HIV/TB infection run a far greater risk than TB carriers who are HIV-negative that their tuberculosis will become active and potentially lethal. Worldwide, millions of people are already infected with both HIV and the tuberculosis bacillus, and the potential for further growth of co-infection in the developing countries is vast, given the crushing prevalence of TB carriers in the general population (some 30%) and the almost 6 million new HIV infections a year. Tackling the dual epidemics calls for stronger TB casefinding and treatment—tuberculosis can be cured with antibiotics regardless of whether the person is HIV-infected or not—in parallel with stronger AIDS prevention programmes to avert new HIV infections.

❐ Regional roundup

Sub-Saharan Africa is home to 70% of the people who became infected with HIV this year. It is also the region in which four-fifths of all AIDS deaths occurred in 1998.

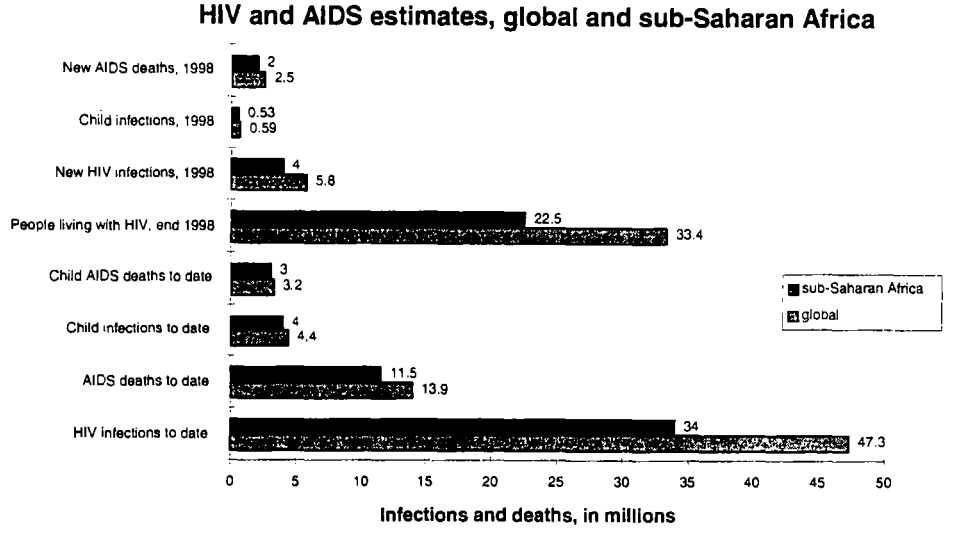
Africa, the global epicentre, continues to dwarf the rest of the world on the AIDS balance sheet. Since the start of the epidemic, 83% of all AIDS deaths so far have been in the region. Among children under 15, Africa's share of new 1998 infections was 9 out of 10. At least 95% of all AIDS orphans have been African.[1] Yet only a tenth of the world's population lives in Africa south of the Sahara.

The sheer number of Africans affected by the epidemic is overwhelming. Since HIV began spreading, an estimated 34 million people living in sub-Saharan Africa have been infected with the virus. Some 11.5 million of those people have already died, a quarter of them children. In the course of 1998, AIDS will have been responsible for an estimated 2 million African deaths—5500 funerals a day. And despite the scale of death, today there are more Africans living with HIV than ever before: 21.5 million adults and a further 1 million children.

While no country in Africa has escaped the virus, some are far more severely affected than others. The bulk of new infections continue to be concentrated in East and especially in Southern Africa.

The southern part of the African continent holds the majority of the world's hard-hit countries. In Botswana, Namibia, Swaziland and Zimbabwe, current estimates show that between 20% and 26% of people aged 15–49 are living with HIV or AIDS. South Africa, which trailed behind some of its neighbours in HIV infection levels at the start of the 1990s, is unfortunately catching up fast: one in seven new infections on the continent this year are believed to be in this one country. Zimbabwe is especially hard-hit. There are 25 surveillance sites in the country where blood taken from pregnant women is tested anonymously as a way of tracking HIV infection. The most recent data, from 1997, show that in only 2 of these sites did HIV prevalence remain below 10%. In the remaining 23 sites, some 20–50% of all pregnant women were found to be infected. At least one-third of these women are likely to pass the infection on to their baby.

[1] UNAIDS defines AIDS orphans as people who lost their mother or both their parents to AIDS when they were under the age of 15.



Other areas of the continent are far from immune. One in ten adults or more are HIV-infected in Central African Republic, Côte d'Ivoire, Djibouti and Kenya. In general, however, West Africa is less affected by HIV than Southern or East Africa, and some countries in Central Africa have also seen HIV remain relatively stable. Early and sustained prevention efforts can be credited with these lower rates in some cases—Senegal provides a good example. But elsewhere, where far less has been done to encourage safer sex, the reasons for the relative stability remain obscure. Research is under way to explain the differences between epidemics in various countries. These studies are looking into factors that may play some role, such as patterns of sexual networking, levels of condom use with different partners, and treatment of other sexually transmitted diseases (STDs), which if left untreated make it easier for HIV to pass through sexual intercourse.

Increasingly, the spotlight is on the spread of HIV through the **Asian continent,** especially in South Asia and East Asia. While rates remain low relative to some other regions, well over 7 million Asians are already infected and HIV is clearly beginning to spread in earnest through the vast populations of India and China.

India provides an interesting example of the shifting patterns of HIV.

- Until recently, it was commonly assumed that HIV infection in the world's second most populous nation was concentrated in urban sex workers and their clients and in drug injectors living in a few states. The last round of sentinel surveillance in antenatal clinics shows that in at least in five states, more than 1% of pregnant women in urban areas are now infected.

- India's rural areas—home to 73% of the country's 930 million people—were thought to be relatively spared by the epidemic. Again, new studies show that at least in some areas, HIV has become worryingly common in villages as well as cities. A recent survey of randomly selected households in Tamil Nadu found that 2.1% of the adult population living in the countryside had HIV, as compared with 0.7% of the urban population. For this small state, with its population of 25 million, the study findings suggest that there are close to half a million people already infected with HIV in Tamil Nadu. Considering that nearly 10% of the people surveyed had gonorrhoea, syphilis or another sexually transmitted disease, HIV clearly has fertile ground for further spread.

Regional HIV/AIDS statistics and features, December 1998

Region	Epidemic started	Adults & children living with HIV/AIDS	Adults & children newly infected with HIV	Adult prevalence rate[2]	Percent of HIV-positive adults who are women	Main mode(s) of transmission[3] for adults living with HIV/AIDS
Sub-Saharan Africa	late '70s - early '80s	22.5 million	4.0 million	8.0%	50%	Hetero
North Africa & Middle East	late '80s	210 000	19 000	0.13%	20%	IDU, Hetero
South & South-East Asia	late '80s	6.7 million	1.2 million	0.69%	25%	Hetero
East Asia & Pacific	late '80s	560 000	200 000	0.068%	15%	IDU, Hetero, MSM
Latin America	late '70s - early '80s	1.4 million	160 000	0.57%	20%	MSM, IDU, Hetero
Caribbean	late '70s - early '80s	330 000	45 000	1.96%	35%	Hetero, MSM
Eastern Europe & Central Asia	early '90s	270 000	80 000	0.14%	20%	IDU, MSM
Western Europe	late '70s - early '80s	500 000	30 000	0.25%	20%	MSM, IDU
North America	late '70s - early '80s	890 000	44 000	0.56%	20%	MSM, IDU, Hetero
Australia & New Zealand	late '70s - early '80s	12 000	600	0.1%	5%	MSM, IDU
TOTAL		**33.4 million**	**5.8 million**	**1.1%**	**43%**	

- The virus is firmly embedded in the general population, among women whose only risk behaviour is having sex with their own husbands. In a study of nearly 400 women attending STD clinics in Pune, 93% were married and 91% had never had sex with anyone but their husband. All of these women were infected with a sexually transmitted disease, and a shocking 13.6% of them tested positive for HIV.

In **Eastern Europe** and in **Latin America and the Caribbean**, infections are concentrated in marginalized groups though clearly not limited to them.

In Latin America the pattern of HIV spread is much the same as in industrialized countries. Men who have unprotected sex with other men and drug injectors who share needles are the focal points of infection. In Mexico studies suggest that up to 30% of men who have sex with men may be infected; among drug injectors in Argentina and Brazil the proportion may be close to half. While transmission through sex between men and women is on the rise, especially in Brazil, heterosexual HIV spread is especially prominent in the Caribbean. Prevalence rates of 8% among pregnant women have been reported from Haiti and one surveillance site in the Dominican Republic.

HIV continues to gallop through drug-injecting communities in **Eastern Europe** and **Central Asia.** A region which until the mid-1990s appeared to have been spared the worst of the epidemic, it now holds an estimated 270 000 people living with HIV. For the moment Ukraine remains the worst-affected country, though the Russian Federation, Belarus and Moldova have all registered enormous increases in the past few years. With HIV gaining new footholds as it penetrates new

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2 The proportion of adults (15 to 49 years of age) living with HIV/AIDS in 1998, using 1997 population numbers.

3 MSM (sexual transmission among men who have sex with men), IDU (transmission through injecting drug use), Hetero (heterosexual transmission).

drug-user communities, the potential for continued spread through drugs and sex is undeniable given the known overlap between drug-injecting and sex-worker populations and the dramatic rises in other STDs. In the Russian Federation, for example, syphilis rates have shot up from around 10 cases per 100 000 people in the late 1980s to over 260 cases per 100 000 a decade later.

In **North America** and **Western Europe**, new combinations of anti-HIV drugs continue to reduce AIDS deaths significantly. For example, recently-published figures show that in 1997 the death rate for AIDS in the United States was the lowest in a decade—almost two-thirds below rates recorded just two years earlier, before combination therapy came into widespread use. However, because new infections continue to occur while antiretroviral drug cocktails keep already-infected people alive, the proportion of the population living with HIV has actually grown. This obviously increases the demands for care. In a number of less obvious ways, it adds to countries' prevention challenges.

During 1998, North America and Western Europe recorded no progress in reducing the number of new infections. The early dramatic rises in HIV were successfully reversed by the mid-to-late 1980s thanks to prevention campaigns that raised condom use among gay men from virtually zero to well over 50%. But over the last decade, the rate of new infections has remained stable instead of continuing to decrease. During 1998 alone, nearly 75 000 people became infected with HIV, bringing the total number of North Americans and Western Europeans living with HIV to almost 1.4 million.

Clearly, the epidemic is no longer out of control in these countries. Just as clearly, it has not been stopped. And at this stage the prevention challenges are greater than ever. One reason is that prevention efforts have already reached the easier-to-reach groups, such as the largely well-educated and well-organized white gay communities. Another reason is that HIV infections are increasingly concentrated in the poorer sectors of the population. In the USA, to take one example, HIV has become a disproportionate threat to US citizens of African origin. Although African-Americans represent only 13% of the total US population, they bear an undue share of American poverty, underemployment and inadequate health care access. African-Americans are now more than 8 times as likely as whites to have HIV. According to the Centers for Disease Control and Prevention (CDC), among black males national HIV prevalence is estimated to have reached 2% and AIDS has become the leading killer in the 25–44 age group. For black women in the same age group, AIDS takes second place as cause of death. The US administration has just announced a new $156 million federal effort for minority communities to help curb HIV spread through drug injecting and sex, and to help ensure access to antiretroviral drug therapy for those already living with HIV.

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Further details about regional patterns of HIV infection, together with end-1997 estimates of HIV infection and AIDS deaths for 170 individual countries, can be found in the UNAIDS/WHO publication *Report on the global HIV/AIDS epidemic—June 1998.*[4] These country-specific estimates are the most recent ones available.

[4] The report is available on the Internet at http://www.unaids.org/unaids/document/epidemio/june98/global%5Freport/index.html

A health crisis and beyond

❒ Invisible no longer

For many years, AIDS was referred to as "the invisible epidemic". HIV makes its silent way through a population for many years before infections develop into symptomatic AIDS and become a cause of recurring illness and, finally, death. The virus thus spread stealthily for years before AIDS deaths were registered in any significant numbers.

In industrialized countries AIDS activists succeeded in raising the profile of the epidemic early on. But in the developing world where most men and women with HIV live, it is only now, two decades after the virus first started spreading, that the repercussions of AIDS are stripping off its cloak of invisibility.

In countries with mature epidemics—Uganda in East Africa, Zambia and Zimbabwe in Southern Africa, for example—AIDS is leaving highly-visible damage in its wake. Some doctors report that three-quarters of beds on hospital paediatric wards are occupied by children ill from HIV. Millions of adults have died. Most have left behind orphaned children. Many have left surviving partners who are infected and in need of care. Their families struggle to find money to pay for their funerals, and their employers must now train other staff to replace them.

❒ Wiping out the gains of development

Together, the epidemic's visible and less-visible consequences constitute an urgent and massive threat to development.

Life expectancy crumbles

Life expectancy at birth is one of the key measures that policy-makers look at to assess human development. Because of the extra deaths from AIDS in children and young adults, this indicator is giving off alarm signals. According to a just-released report prepared by the United Nations Population Division in collaboration with UNAIDS and WHO, the epidemic will wipe out precious development gains by slashing life expectancy.

The impact on life expectancy is proportional to the severity of the local epidemic. In Botswana, for example, where more than 25% of adults are infected, children born early next decade can expect to live just past their 40th birthday. Had AIDS not been in the picture, they could have expected to live to the age of 70. Not surprisingly, between 1996 and 1997 Botswana dropped 26 places down the Human Development Index, a ranking of countries that takes into account wealth, literacy and life expectancy.

Taking the nine countries with an adult HIV prevalence of 10% or more (Botswana, Kenya, Malawi, Mozambique, Namibia, Rwanda, South Africa, Zambia and Zimbabwe), calculations show that AIDS will on average cost them 17 years of life expectancy. Instead of rising and reaching 64 years by 2010–2015, a gain which would be expected in the absence of AIDS, life expectancy will regress on average to 47 years.

Deteriorating child survival

The dismal decline in life expectancy is due not only to deaths of adults—most of them young or in early middle age—but also to child deaths. HIV is contributing substantially to rising child mortality rates in many areas of sub-Saharan Africa, reversing years of hard-won gains in child survival.

By 2005–2010, for example, 61 of every 1000 infants born in South Africa are expected to die before the age of one year. In the absence of AIDS, infant mortality would have been as low as 38 per 1000. With AIDS in the picture, the infant mortality rate in Namibia is projected to be 72 per 1000; without the epidemic the country could have expected a far lower rate of 45 per 1000.

Children on the brink

Zimbabwe offers a frightening window onto orphanhood, another aspect of the epidemic's development impact. In this nation, where over a quarter of the 5.5 million adults are HIV-infected, AIDS is already pushing hundreds of thousands of children to the brink.

The government estimates that in two years' time 2400 Zimbabweans a week will be dying of AIDS. Most of those deaths will be in adults, and they will be concentrated in the young adult ages when people are building up their families. What is more, they may be disproportionately concentrated among single women whose death would leave a child with no parent at all: one recent study in a farming area showed that single mothers, many of them widowed by AIDS, were twice as likely to be HIV-infected as married women.

As early as 1992, a study in Zimbabwe's third largest city, Mutare, recorded that over 10% of children in the study area were orphaned, and that nearly one household in five had taken in orphans. By 1995, an enumeration in the same area showed that the proportion of children who were orphaned had grown to nearly 15%.

The number of children in need of care is rising just as AIDS is cutting into the number of intact families able to provide such care. Some 45% of those caring for orphans are grandparents; often they have no income of their own, and there is a limit to how many children they can take on without outside help. One orphan-support programme reports helping an 80-year-old grandmother who lives with 12 children in a single room. Another has received a request for help from a widower with 9 dependants who has just inherited another 3 grandchildren to care for. A study of households headed by adolescents and children (some as young as 11) showed that while the overwhelming majority had lost both parents, most did have surviving relatives. However, in 88% of those cases, the relatives reported that they did not want to care for the orphans.

Children themselves are beginning to worry about orphanhood and to recognize the importance of supporting needy children. A majority of children interviewed in one study said that if orphans' needs were not met they would become delinquent. Many said the children would drift into prostitution and onto the streets. They also worried about abuse and exploitation of orphans by relatives. With reason. Reports of sexual abuse of girls have risen rapidly in recent years in Zimbabwe, prompting the establishment of a special clinic at a major Harare hospital and an initiative to promote child-friendly courts. In a single rural district of Zimbabwe one study recorded nearly 400 cases of child sexual abuse, at least a quarter of them girls under the age of 12, and at least 10% of them orphans.

AIDS and business: the bottom line suffers

The onslaught of AIDS is denting the prospects for economic development too. In the hard-hit countries of Africa, the epidemic is decimating a limited pool of skilled workers and managers and eating away at the economy. With many economies in the region in flux, it is hard to determine exactly what the impact of HIV is on national economies as a whole. However, it is clear that businesses are already beginning to suffer.

In Zimbabwe, for instance, life insurance premiums quadrupled in just two years because of AIDS deaths. Some companies say that their health bills have doubled. Several report that AIDS costs absorb as much as one-fifth of company earnings. In Tanzania and Zambia, large companies have reported that AIDS illness and death cost more than their total profits for the year. In Botswana, companies estimate that AIDS-related costs will soar from under 1% of the wage bill now to 5% in six years' time, because of the rapid rise in infection in the last few years.

HIV—a threat to the world's young people

This year's World AIDS Campaign—"Young people: Force for change"—was prompted in part by the epidemic's threat to those under 25 years old. Young people are disproportionately affected by HIV and AIDS. Around half of new HIV infections are in people aged 15–24, the range in which most people start their sexual lives. In 1998, nearly 3 million young people became infected with the virus, equivalent to more than five young men and women every minute of the day, every day of the year. And as HIV rates rise in the general population, new infections are increasingly concentrated in the younger age groups. A recent study in Malawi, for instance, found the annual rate of new HIV infections to be as high as 6% in teenage women, compared with under 1% in women over 35.

But the Campaign also highlights the power of young people. The future of the HIV epidemic lies in their hands. The behaviours they adopt now and those they maintain throughout their sexual lives will determine the course of the epidemic for decades to come. Young people will continue to learn from one another, but their behaviour will depend largely on the information, skills and services that the current generation of adults choose to equip their children with.

Research shows that young people adopt safer sexual behaviour provided they have the information, skills and means to do so. In Senegal, 40% of women under 25 and 65% of men used condoms with non-regular partners in 1997, compared with less than 5% for both sexes at the start of the decade. In fact, given the chance, young people are more likely to protect themselves than adults. In Chile, a 1996 study showed that condom use is highest among 15–18-year-olds, and similar patterns have been found in Brazil and Mexico.

Safer sexual behaviour is becoming the norm among young people in developed countries, too. In several studies in Western Europe, some 60% of young people are now using condoms the very first time they ever have sex—a six-fold increase since the early 1990s. Among young people in the United States, abstinence is becoming more common and condom use is rising significantly. Among high school students in 1997, 63% of boys reported that they had used a condom the last time they had sex, up from 55% six years earlier. For girls, condom use rose to 51% from 38% over the same period.

Young escapees on Brazil's streets

Brazil is a country of contrasts, of great wealth and of crushing poverty from which young people find it hard to escape. Around a third of the 31 million Brazilians aged between 15 and 24 come from families living below the poverty line. Only one adolescent in 12 completes high school, and many of the rest—half of the boys and as many as three-quarters of the girls—remain jobless. Across the country, some two million people aged 15–19 neither work nor go to school.

Undereducated and underemployed, these young people are easy targets for adults selling drugs or buying sex. In fact, they are easy targets for adults wanting sex but unwilling to pay for it. Research in São Paulo, Brazil's largest city, indicates that one girl in five has been sexually abused in her own home or in the surrounding community.

Girls who have lived through sexual abuse are more likely than others to drift onto the streets, into prostitution, and onto the waiting list for HIV infection. In Brazil's impoverished northeast, communities are trying to head off this danger by identifying girls who are at risk of violence or abuse in the home. These girls are invited to join support groups that teach them skills that will help them make a living as well as defend themselves against violence and unwanted sex. Of 850 girls who have been helped by one such programme, so far there are no reports of any of them ending up in prostitution or in a street gang. With HIV rates running as high as 17% among poorer sex workers in some cities, supporting young women with alternatives to a life on the streets is an important way of protecting them from HIV infection.

However, much remains to be done. In the USA, for example, 3 million adolescents a year contract a sexually transmitted disease, a clear indicator of unsafe sex. In developing countries, where the likelihood of encountering a partner infected with a sexually transmitted disease is high, STD infection rates in young people are often much higher.

Young people are vulnerable to HIV for many reasons—they do not know about HIV or STDs, or they know about them but do not know how to avoid infection. Those with the information may be unable to get hold of condoms, or may feel unable to discuss condom use with their partner. Young people, and especially girls, may be unable to defend themselves against unwanted sex. In the Democratic Republic of Congo, nearly a third of young women in a large study reported that they had been forced by their partners into first sex. Similar statistics on coerced sex are reported from many parts of the world.

What is more, adolescence is a time when many people experiment—not only with different forms of sex but with drugs. Apart from the HIV risk connected with needle-sharing, it is known that alcohol and other drugs can affect sexual behaviour and increase young people's risk of becoming infected with HIV or the other STDs. Excessive drinking, for example, diminishes inhibitions, increases aggression, diminishes the ability to use important information learnt about AIDS prevention, and impairs the capacity to make decisions about protection.

Whether or not young people's drug-using habits change over time, the consequences of risk behaviour at this age can be irrevocable, as can be seen in data from places as far apart as Asia and Europe. In Myanmar over 60% of teenage drug injectors are infected with HIV—indeed teenagers are the *only* group of drug users in which HIV prevalence has continued to climb steadily since the early 1990s. In Belarus, over four-fifths of registered HIV infections are in drug users in their teens and twenties. In Lithuania, over half of HIV infections registered in injecting drug users are in people under 25. Regardless of whether these young people continue their drug use or abstain, they will carry HIV with them till their premature death.

What drives the epidemic?

The AIDS epidemic has unfolded very differently in different parts of the world, and among different populations. It is not always clear why HIV infection takes off in some places while rates in neighbouring countries remain stable over many years. However, there are several factors which clearly influence the shape of the epidemic. People on the move—escaping from abuse, or even just leaving their families in search of work—are especially likely to be exposed to infection. People whose daily existence is stressful and dangerous may not care about the long-term risks posed by HIV. People in conflict and refugee situations may have little control over their exposure to HIV, indeed even to sex. And the stigma that still attaches to HIV hinders people from protecting themselves and others from infection, or from seeking out care and support.

The different faces of AIDS can be seen in the following country situations, which illustrate some of the factors driving the epidemic.

❒ Driven by loneliness: Migrant labourers in South Africa

The world's population is becoming more and more mobile. People are on the move for all sorts of reasons, but probably the most common reason for people to leave their homes (and often their families) is to seek work.

Nowhere is this more true than in South Africa. Thriving mining industries attract workers not just from rural areas of the nation, but from neighbouring economies where job opportunities are limited and wages are lower. It is hard to know how many people move into and around South Africa in search of work. More than a decade ago 2.5 million South Africans were registered as migrant workers, and that number is likely to have increased. This year, over half a million people will join the country's growing urban population.

Carltonville, at the heart of South Africa's gold mining industry, is home to 88 000 mine workers, 60% of them migrants from other parts of South Africa or from nearby countries: Lesotho, Malawi and Mozambique. With the miners come wages. Some US$ 18 million is paid out to workers every month in Carltonville. With the wages come all manner of goods and services, including, of course, drugs and sex. Some 400–500 sex workers service the Carltonville mines. And with drugs and sex comes HIV.

The city has become the HIV hot spot of Gauteng Province. Around 22% of adults in Carltonville are infected with HIV, a rate over two-thirds higher than the national average. A small survey of sex workers found HIV in three-quarters of them, while one mineworker in five is thought to be infected. That count is probably an underestimate because it does not include the men who have dropped out of the mines because they are too sick to work.

Why are infection levels so high in miners? Most men live lonely lives in single-sex dormitories, often hundreds of miles from their families. They also have a dangerous job. A gold-miner in South Africa has a one in forty chance of being killed by a rock-fall underground and a one in three chance of serious injury. Compared with that, the dangers associated with a long, slow infection like HIV might seem remote.

Of course, the HIV dangers are not just to the mineworkers themselves, or to their sex partners around the mining sites. Most migrant workers return home periodically. Increasingly, they are

carrying infection back to their wives and their home communities. In Hlabisa, a rural district of KwaZulu/Natal, some 60% of households are estimated to have one or more male migrants. One study here found that sex outside the primary relationship is accepted as almost inevitable in separated families, for both men and women. In this community, HIV rates are rising dramatically, with the prevalence among pregnant women shooting up to 26% in 1997 from 4% just five years earlier. A study in 1995 found that of women whose partners were at home less than a third of the time, 13% were infected. No infections were recorded among women who spent more than two-thirds of the time with their husbands or regular partners.

❒ Driven by conflict: Survivors in Rwanda

Before the political turmoil of the mid-1990s, more studies had been done to understand the HIV epidemic in Rwanda than in most developing countries. The pattern of infection recorded there was a familiar one: high rates in urban areas (more than 10% of pregnant women infected) but far lower rates in the rural areas that were home to the bulk of the population (just over 1%).

The political difficulties of recent years not only interrupted HIV surveillance; they changed the shape of the epidemic. By 1997, when a well-designed survey of HIV was carried out in the general population, little difference remained between urban and rural rates. Both were just over 11%. Among teenagers, infection was actually higher in rural areas than in cities. And it was appallingly high at the youngest ages: among 12, 13 and 14 year olds, a full 4% were already HIV-infected.

Many of the changes can be ascribed to the huge population movements during and after the years of ethnic conflict. Nearly three-quarters of the 4700 people surveyed in 1997 had lived elsewhere in the preceding three years—an astonishingly high turnover for this largely rural country. Migrants who had spent the years of conflict outside Rwanda had lower rates of HIV infection than those who endured the troubles inside the country. Most of these people are recently returned from Uganda and Tanzania, countries where HIV prevention campaigns are relatively strong.

HIV prevalence among people who said they had spent the conflict years in refugee camps was 8.5%. Most of these people had fled from rural areas where pre-conflict HIV prevalence was just 1.3%. That suggests a six-fold increase in HIV infection among refugees in the camps. Overcrowding, violence, rape, despair and the need to sell or give away sex to survive are all likely to have contributed to this huge leap in infection.

Wars and armed conflicts generate fertile conditions for the spread of HIV. Rape—inside or outside refugee camps—has doubtless played a part in spreading the virus in Rwanda. Some 3.2% of women surveyed reported being raped, over half of them during the conflict itself. Two-fifths of them were teenagers. Among women who had been raped 17% were HIV-positive, compared with 11% of those who had not. Women who reported rape were three times as likely as those who were not raped to have suffered from genital sores, another STD.

❒ Driven by danger: Soldiers in Cambodia

Decades of political turmoil and civil war have left much of Cambodia's infrastructure in tatters. Education, health care, the transport network—all are being rebuilt more or less from scratch as peace gradually returns to the country. In the meantime Cambodian soldiers, many of them teenagers with no schooling, continue to battle Khmer Rouge rebels in the northwest of the country. For them, risk is a way of life, whether from combat, malaria or land mines.

It is understandable that many of these young men view sex as a source of comfort, not of special danger. The risk of HIV infection, which will not in any case kill them for at least a decade, can seem negligible. "The regular troops are there at the front because they have no education and nothing to eat at home," says a military doctor. "They have no idea of the future. They first think day by day."

But the HIV risks are not negligible at all. Behavioural research shows that over a third of Cambodian soldiers have visited a brothel just in the last month, including many of the married men in the army and the police force who are separated for long periods from their wives and children. Some 43% of sex workers tested positive in Cambodia's brothels in 1998, while HIV prevalence in the military was around 7%.

One in five soldiers say that besides visiting prostitutes, they also have girlfriends—often waitresses or "beer girls" who promote various brands of the beverage in restaurants or nightclubs. Both the beer girls and their soldier partners make a distinction between their relationship and an act of commercial sex in a brothel, for condom use with these girlfriends is abysmally low—just 8%. Yet over 20% of beer girls tested positive for HIV in 1998.

To decrease risky behaviour and new infections, Cambodia's military has trained a number of soldiers about HIV and other STDs and given them support in spreading the prevention message to other soldiers. This system, known as peer education, works well in the military because, as one officer said, "Soldiers live and fight and die together. They have the same problems and the same habits. They are not intellectuals but are very pragmatic and can follow others' example".

While it is still early days in the peer education programme, there is already evidence that Cambodian soldiers are reducing their risk of HIV infection. Condom use by soldiers in brothels is now 63%—16% more than in 1997—and visits to brothels in the month preceding the survey fell by 40%, a remarkable change in a single year.

❒ Driven by stigma: Shame, silence and denial

It is hard to measure stigma—people with HIV see it in a scornful look in the marketplace, in the refusal of family and friends to visit, care for or even touch them, in the maltreatment of their children or the loss of their job on a flimsy pretext. But stigma is a very real obstacle to both prevention and care. In many of the hardest-hit countries, government officials and ordinary citizens—including those most affected by the epidemic—often continue to look the other way because of the rejection, discrimination and shame attached to AIDS.

Stigma and the fear it engenders both fuel the spread of HIV, since those with risky behaviour in the past may be reluctant to change that behaviour in case the change is interpreted as an admission of infection. Fear of acknowledging HIV infection can stop a married man from raising the subject of condom use with his wife. Fear of advertising her HIV status may prevent an infected woman from giving her baby replacement feeding to avoid transmitting the virus through breastmilk.

The stigma attached to HIV affects both sexes. However, the consequences may be more severe for women, who risk being beaten and even thrown out of the house by their husband if their status is revealed. This is true even when the husband was the source of the woman's infection. An HIV-infected woman may be blamed for the death of her children, and deprived of care.

In places where shame and stigma are the rule, many people simply do not want to know if they are HIV-infected, even when counselling and testing are offered. And the small minority of people who know their HIV status rarely share it with others, even in confidential support groups. In Zimbabwe's city of Mutare, for example, surveillance data show that close to 40% of pregnant women are HIV-infected, and infection levels in men are likely to be similarly high. There are probably 30 000 adults living with HIV in Mutare. Yet there is just one HIV support group in the city, and it has just 70 members. Many more people know or fear they are HIV infected: some will find support in their partners or families but many will struggle alone with the implications of their infection.

"HIV/AIDS is among us"

South Africa, which in 1998 accounted for nearly 1 in 10 of the new HIV infections estimated to have occurred worldwide, is the latest country in the ranks of those seeking to break through the shroud of stigma and shine a light on the human disaster of AIDS.

"For too long we have closed our eyes as a nation, hoping the truth was not so real," South African Deputy President Thabo Mbeki told South Africans in October 1998. "For many years, we have allowed the human immunodeficiency virus to spread... At times we did not know that we were burying people who had died from AIDS. At other times we knew, but chose to remain silent.

"[Now] we face the danger that half of our youth will not reach adulthood. Their education will be wasted," Mbeki said. "The economy will shrink. There will be a large number of sick people whom the healthy will not be able to maintain. Our dreams as a people will be shattered."

Appealing to South Africans to change "the way we live and how we love", Mbeki called for abstinence, fidelity and condom use, and urged a caring, non-discriminatory attitude to those already infected with or affected by HIV. The speech was nationally televised, and the whole nation was urged to stop work to listen to it. Many private companies gave workers a day off. Flags flew at half mast on government buildings and religious leaders, youth, trade unionists, women's organizations and business leaders committed themselves to the President's Partnership Against AIDS.

Silence can continue to reign even when people with HIV are ill and dying. Because AIDS is just the name for a cluster of diseases that immunodeficient people develop, patients and their carers can choose to view the illness as just tuberculosis, or diarrhoea, or pneumonia. An example from southern Africa is telling. In one study of home-based care schemes, fewer than 1 in 10 people who were caring for HIV-infected patients at home acknowledged that their charges were suffering from AIDS. Patients themselves were only slightly more likely to acknowledge their status, and several told researchers that they had not disclosed their HIV-positivity to anyone, including the person caring for them. This self-imposed silence is hard on the patient. It can also be hard on the carers, particularly when they are children or adolescents. If they do not know that their parent or loved one is suffering from a fatal disease, they cannot prepare themselves for the death or acknowledge that it will inevitably come no matter how much effort they put into care. So carers risk compounding their feelings of grief and loss with feelings of failure.

In some countries, leaders have spoken out loudly, clearly and repeatedly about AIDS, have sought to demystify it, and have encouraged discussion about safe sex everywhere from the classroom to the boardroom. It is in such countries—of which Uganda is probably the best-known example in the developing world—that most progress has been made not just in putting a brake on new infections but in ensuring the well-being of those people who are already living with the virus.

Note about UNAIDS/WHO estimates

The estimates concerning HIV and AIDS in this document are based on the information available to UNAIDS and WHO at the current time. They are provisional. WHO and UNAIDS, together with experts from national AIDS programmes and research institutions, keep these estimates under constant review with a view to updating them as improved knowledge about the epidemic becomes available and as advances are made in the methods used for deriving estimates.

For example, knowledge about the epidemic improves not only as better information becomes available about HIV spread (for example, through more representative sentinel surveillance), but also as more is learnt about the factors that help or hinder the spread of the virus (for example, the natural history of HIV infection in different parts of the world, the impact of HIV infection on fertility, and the effects of improved treatment). This improved knowledge together with methodological advances together provide the basis for updated estimates of HIV incidence, prevalence and mortality.

Because of these factors, the 1998 estimates cannot be directly compared with those for 1997 or earlier years, nor with those that may be published subsequently. While they are largely based on the country-specific models prepared for last year's estimates and published in the joint UNAIDS/WHO publication *Report on the global HIV/AIDS epidemic—June 1998*, the December 1998 estimates reflect upward or downward adjustments that were made for a number of countries in the light of updated information.

The purpose of publishing these estimates is to help governments, nongovernmental organizations and others who have a stake in bringing AIDS under control to gauge the status of the epidemic in their country and to monitor the effectiveness of the considerable efforts at prevention and care being made by all partners.

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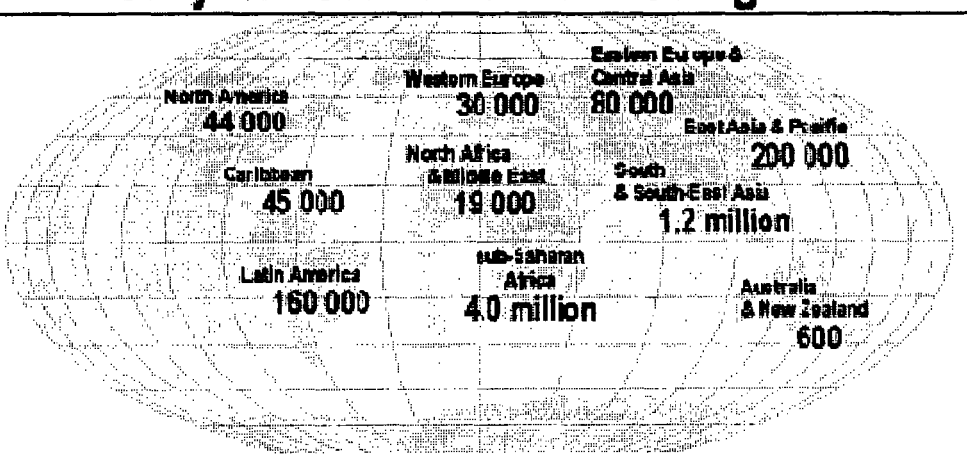
End–1998 global estimates
Adults and children

- People living with HIV/AIDS ..... 33.4 million
- New HIV infections in 1998 ..... 5.8 million
- Deaths due to HIV/AIDS in 1998 2.5 million
- Cumulative number of deaths due to HIV/AIDS ..... 13.9 million

UNAIDS

World Health Organization

Estimated number of adults and children newly infected with HIV during 1998

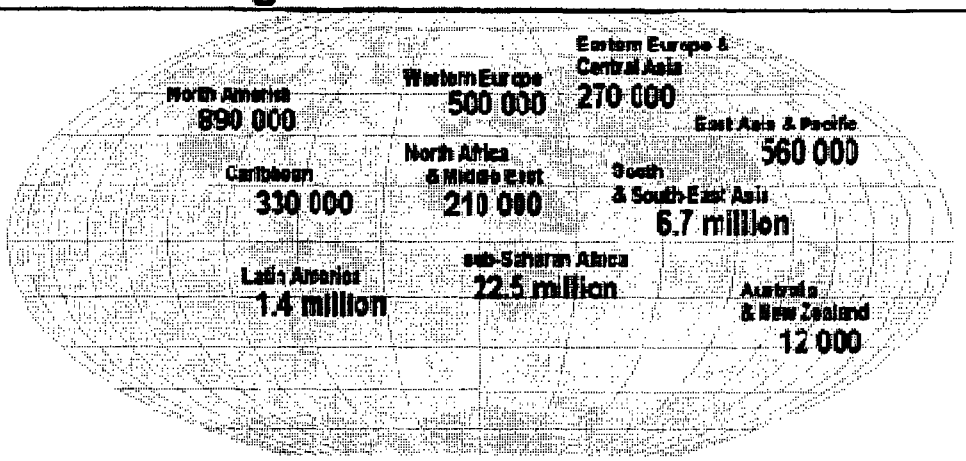


Total: 5.8 million

UNAIDS

World Health Organization

Adults and children estimated to be living with HIV/AIDS as of end 1998



Total: 33.4 million

UNAIDS

World Health Organization

Estimated number of new HIV infections in young people

- About 7 000 young people aged 10–24 get infected with HIV every day, that is five young persons every minute
- About 1.7 million young people in Africa get infected with HIV every year
- Close to 700 000 young people get infected with HIV every year in Asia and the Pacific

UNAIDS

World Health Organization

Children Living in a World with AIDS

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 mother, or both mother and father, 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-infected 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 AIDS orphans 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 Navalaka 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 a real burden, " 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 grand-parent 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 Ugan-dan. "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 AIDS orphans 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 AIDS orphans, 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 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 programs, 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

programs 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 programs 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 arrange 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.

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Enabling AIDS Ministries: Opportunities for Giving

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Children Living in a World with AIDS

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 re-sponsible and safe behavior 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 communi-cation 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, organizations such as UNICEF and WHO argue 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 ex-ploitation 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 confer-ence on AIDS in Marrakech 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.

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Enabling AIDS Ministries: Opportunities for Giving

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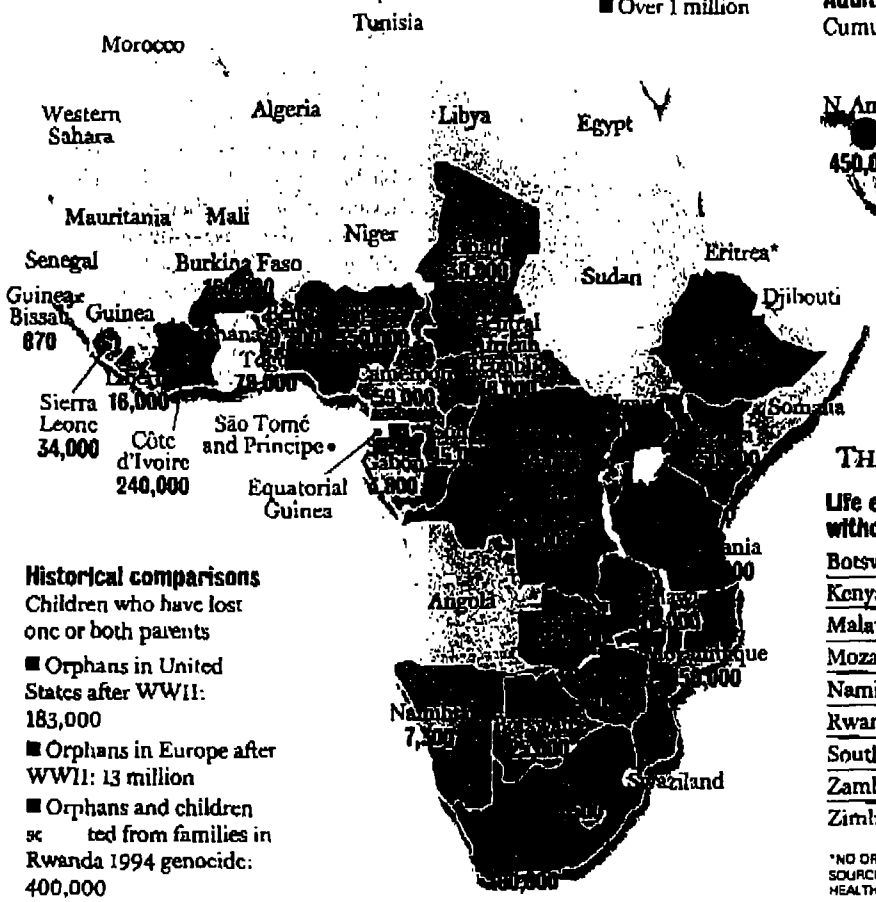
Mapping the AIDS Epidemic's Hot Zone

The HIV plague is at its most devastating in 29 nations of sub-Saharan Africa, according to the United Nations. Across the AIDS hot zone, women are infected as frequently as men—often at the very beginning of their sexual maturity—and when they die, they often leave orphans behind.

THE ORPHANS OF AIDS

Children who have lost one or both parents, 1997–98

- Under 100,000
- 100,000–499,000
- 500,000–1 million
- Over 1 million



Historical comparisons
Children who have lost one or both parents

- Orphans in United States after WWII: 183,000
- Orphans in Europe after WWII: 13 million
- Orphans and children separated from families in Rwanda 1994 genocide: 400,000

A PLAGUE ON MANY COUNTRIES

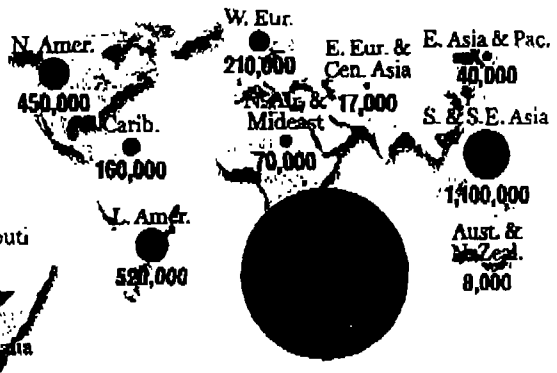
Percent of adults (15–49) living with HIV/AIDS

Africa		Other countries	
Botswana	25%	Brazil	0.43%
Kenya	12	Cambodia	2.40
Malawi	15	China	0.06
Mozambique	14	France	0.37
Namibia	20	Haiti	5.17
Rwanda	13	India	0.82
South Africa	13	Mexico	0.35
Zambia	19	Thailand	2.23
Zimbabwe	26	United States	0.18†

THE PATTERN OF DEATH

Adults and children
Cumulative AIDS deaths through 1999

Total: 16.3 million



THE COST OF AIDS

Life expectancy with/without AIDS, 2000–2005		Money available to treat each case, 1996	
Botswana	41/70 yrs.	Botswana	$14.27
Kenya	48/66	Kenya	13.43
Malawi	40/53	Malawi	8.94
Mozambique	38/53	Mozambique	2.40
Namibia	41/64	Namibia	8.00
Rwanda	41/51	Rwanda	27.63
South Africa	47/64	South Africa	n.a.
Zambia	42/60	Zambia	8.07
Zimbabwe	41/66	Zimbabwe	9.32

*NO ORPHAN DATA AVAILABLE †AGES 15 AND ABOVE. ALL NUMBERS ARE ESTIMATES. SOURCES: INTERNATIONAL RED CROSS; UNICEF; UNAIDS; UNITED NATIONS WORLD HEALTH ORGANIZATION. GRAPHIC BY BONNIE SCRANTON—NEWSWEEK

South Africa on World AIDS Day last year, a woman who admitted on television that she was HIV-infected was beaten to death by neighbors in her township.

Some African leaders are finally getting religion themselves. Others have long had it. Nelson Mandela has been very outspoken on the AIDS threat; his successor, Thabo Mbeki, plans to announce this week a new Five Year Plan to combat the epidemic. Ugandan President Yoweri Museveni [illegible] a global pioneer on the issue: early on in the pandemic, he waged a prolonged campaign of public education, condom distribution, voluntary testing, counseling and support services. The policy has paid off: HIV infection has dropped from 15 percent of the population to 9.7 percent.

Yet Uganda also has the highest number of AIDS orphans in the world—1.1 million in all. The danger now is that with so many desperate kids, the good that has been done might actually be undone. Destitute girls may turn to prostitution to survive, unconnected young boys could turn violent. In the Rakai district—where the cycle of death and destruction all began—32 percent of children 15 and under are orphaned: 75,000 kids in all. The signs, of course, were there a decade ago. But now, more than ever, nobody has an excuse for apathy.

With MICHAEL HIRSH *and* GREGORY VISTICA *in Washington,* TOM MASLAND *in Cape Town,* CHRISTOPHER DICKEY *in Paris,* ROD NORDLAND *in London,* CLAUDIA KALB *and* GREGORY BEALS *in New York and* MICHAEL CADMAN *in Johannesburg*