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OFFICE OF NATIONAL AIDS POLICY

EXECUTIVE OFFICE OF THE PRESIDENT

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TO:

Patti Solis Doyle

FAX NUMBER:

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FROM:

Paul Yandura

DATE:

November 13, 1997

PAGES:

(including cover sheet) 3

COMMENTS:

SCHEDULING REQUEST PROPOSAL

Date: 11/05/97

☐ ACCEPT☒ REJECT☐ PENDING

TO: Patti Solis Doyle, Director of Scheduling for the First Lady

FROM: Sandra L. Thurman, Director, Office of National AIDS Policy

REQUEST: Attendance at World AIDS Day Interfaith Service of Celebration and Healing.

PURPOSE: Commemoration of World AIDS Day.

BACKGROUND: This Interfaith Service will be held for persons living with and affected by HIV and AIDS in commemoration of World AIDS Day. World AIDS Day is an annual event sponsored by the World Health Organization designed to increase awareness of the many challenges presented by the global AIDS pandemic. More than 1 million children worldwide are living with HIV/AIDS; every day 1,000 more become infected. By the year 2000, 10 to 15 million children will be orphaned by AIDS. For this reason, the 1997 theme is "Give Children Hope in a World with AIDS". The First Lady's involvement in this event will underscore this Administration's commitment to the fight against AIDS and to the health and well-being of the world's children.

PREVIOUS PARTICIPATION: The First Lady has had no previous participation in World AIDS Day events. However, she has spoken at several Pediatric AIDS events, most recently in Los Angeles to the Pediatric AIDS Foundation Elizabeth Glaser Scientist Awards Reception. In January 1997 she spoke at the Gay Mens Health Crisis Award Banquet honoring David Geffen. In September 1995 she spoke at the World Health Organization Colloquium on Women in Health Service in Beijing.

DATE & TIME: Sunday, November 30, 1997
7:00p.m.

DURATION: 60 minutes

LOCATION: Church of the Epiphany
1317 G Street, NW

PARTICIPANTS: Sandra Thurman, Director, Office of National AIDS Policy (confirmed)
Marian Wright-Edelman, Childrens Defense Fund (confirmed)
Maya Angelou (invited)

OUTLINE OF EVENTS: Interfaith Service:
Opening: Gay Mens Choir of Washington D.C.
Greeting: The Rev. Randolph Charles
Inspirational
Message: First Lady
Litany: Sandra Thurman
Guest Speaker: Youth Speaker (unnamed)
Music: St. Augustine's Youth Choir

REMARKS: Brief remarks. Inspirational message or prayer.

MEDIA: White House Photo.

FIRST LADY: Yes.

VICE PRESIDENT: No.

RECOMMENDED BY: Sandra Thurman

CONTACT: Sandra Thurman or Paul Yandura (202) 632-1090

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*Give Children Hope
in a World with AIDS*

WORLD AIDS DAY • 1 DECEMBER 1997

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RESOURCE BOOKLET

American Association for World Health
1825 K Street, NW, Suite 1208 • Washington, DC 20006
www.aawhworldhealth.org • Telephone (202) 466-5883





World AIDS Campaign

Children Living in a World with AIDS

Dear Friends,

Secretariat

UNAIDS

Steering Committee

• UNAIDS
and co-sponsors:

UNICEF

UNDP

UNFPA

UNESCO

WHO

WORLD BANK

• Others:

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

Children and AIDS
International NGO Network

NGO Group for the Convention
on the Rights of the Child

PANOS

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20, avenue Appia

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<http://www.unaids.org>

e-mail: desantis@unaids.org

UNAIDS has developed the World AIDS Campaign to signal a shift of emphasis from World AIDS Day initiatives of the past. This is being done in order to achieve more tangible results both in the advocacy and the programmatic areas over a longer period of time, to maximize the use of available resources and to increase the reach and impact of mobilisation efforts around the world.

The theme for the 1997 World AIDS Campaign is *Children Living in a World with AIDS*. The focus is on every human being under the age of 18 years, in line with the definition of children set out in the United Nations Convention on the Rights of the Child. The 1997 campaign theme will overlap with that of the 1998 campaign which will focus on the concerns of young people (15-24 years).

In preparing this campaign, UNAIDS has been advised by a Steering Committee composed of its cosponsors (UNICEF, UNDP, UNFPA, UNESCO, WHO and the World Bank), as well as the François-Xavier Bagnoud Center for Health and Human Rights of the Harvard School of Public Health, the Children and AIDS International NGO Network, the NGO Group for the Convention on the Rights of the Child, and PANOS.

We look forward to hearing about any activities that you may be undertaking in the context of this campaign.

With best regards,

Anne Winter
Manager, Communication and
Public Information



World AIDS Campaign

Children Living in a World with AIDS

1997 WORLD AIDS CAMPAIGN

Secretariat

UNAIDS

Steering Committee

• UNAIDS
and co-sponsors:

UNICEF

UNDP

UNFPA

UNESCO

WHO

WORLD BANK

• Others:

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Center for Health and Human
Rights, Harvard University

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The Joint United Nations Programme on HIV/AIDS (UNAIDS) has developed the 1997 World AIDS Campaign in order to signal a shift of emphasis from World AIDS Day initiatives of the past. This is being done in order to achieve more tangible results both in the advocacy and the programmatic areas, maximize use of available resources, ensure cost-effectiveness, and increase the reach and impact of mobilisation efforts around the world.

The theme of the 1997 World AIDS Campaign is *Children Living in a World with AIDS*. The focus is on every human being under the age of 18 years, in line with the definition of children set out in the United Nations Convention on the Rights of the Child. The 1997 campaign theme will overlap with that of the 1998 campaign which will focus on the concerns of young people (15-24 years).

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The purpose of this note is to set out the overall aim and core objectives of the campaign. Each objective is further developed into messages and expected outcomes. The latter are meant to function as general performance indicators of the campaign. At the international level they have been established in general terms in order to reflect the role of the campaign as a global blue-print for action, the idea being that this can then be adapted to the needs of people and organizations at the implementation level in countries.

1997 World AIDS Campaign

Children Living in a World with AIDS

Secretariat of the campaign:

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

Steering Committee:

UNAIDS

UNAIDS cosponsors:

United Nations Children's Fund (UNICEF)

United Nations Development Programme (UNDP)

United Nations Population Fund (UNFPA)

United Nations Educational, Scientific and Cultural Organization (UNESCO)

World Health Organization (WHO)

The World Bank

Others:

François-Xavier Bagnoud Center for Health and Human Rights of the Harvard School of Public Health

Children and AIDS International NGO Network

NGO Group for the Convention on the Rights of the Child

PANOS

Vision statement

The ultimate vision of UNAIDS and its partners is towards a world in which HIV transmission is substantially reduced, adequate treatment, care and support are provided, and where the vulnerability to the impact of HIV/AIDS on children, their families and their communities is significantly reduced.

Mission Statement

Fewer children infected, fewer children affected, fewer children who are vulnerable to the impact of HIV/AIDS, and an increasing number of girls and boys who are protected in a world that upholds their rights.

Guiding Principles

The guiding principles for the 1997 World AIDS Campaign are in line with those set forth in the United Nations Convention on the Rights of the Child and in the 1996-2000 UNAIDS Strategic Plan. These include the definition of a child as a human being under 18 years of age.

Overall aim of the campaign

Increased understanding of the magnitude of the HIV/AIDS epidemic and its global dimensions, with an emphasis on promoting action and sound policies to prevent HIV transmission and to minimize the epidemic's impact on children, their families and their communities.

Expected Outcome:

By the end of 1997, the following outcome is expected:

- Mobilisation of governmental organizations, international organizations, NGOs, the media, the corporate sector and communities to promote the aim and objectives of the campaign, and to develop actions and responses to meet them.

Campaign Objectives

Objective 1

Better understanding of the magnitude and diversity of the impact of HIV/AIDS on children, their families and their communities.

Messages :

- All children in the world face a lifetime of risk from HIV infection.
- Every day, 1,000 children become infected with HIV. Every day, these children compromise their future to a preventable disease.
- If the spread of HIV is not contained, AIDS may increase infant mortality by as much as 75% and under-5 child mortality by more than 100% in the regions most affected by the disease.
- Understanding the concerns and aspirations of children is critical in influencing the future course of the HIV/AIDS epidemic.
- 90% of HIV-positive children under the age of 15 are infected through mother-to-child transmission. Reducing HIV infection in infants means reducing transmission of the virus to women.
- Over 9 million children are estimated to have lost their mothers to AIDS. Many millions more are living with an HIV-positive parent and face deprivation and orphanhood in the years ahead.
- Reducing children's vulnerability to HIV means promoting their educational and income-generating opportunities and those of their families, as well as strengthening social safety nets.

- Young girls, children who live in poor neighbourhoods or slum areas, refugee and displaced children, institutionalized children, children facing hardship and neglect, and sexually exploited children are especially vulnerable to the impact of HIV/AIDS.
- In a world with AIDS, children are everyone's responsibility.

Expected Outcomes:

By the end of 1997, the following outcomes are expected for Objective 1:

- Increased opportunities for children, their families and their communities to communicate their concerns and aspirations in relation to the impact of HIV/AIDS on their lives.
- Stated commitment by governmental organizations, international organizations, NGOs, the corporate sector and communities to minimize the impact of HIV/AIDS on the lives of children, their families and their communities.
- Promotion of the campaign's aim and objectives by key media organizations, media networks and professionals throughout its duration.
- Increased awareness of the issues relating to prevention and care of HIV/AIDS in general terms.

Objective 2:

Stronger commitment, improved policies and increased action for preventing HIV infection and minimizing the epidemic's impact on children, their families and their communities.

Messages :

- Nearly 1 million children are living with HIV and suffer the physical and psychological consequences of infection. In line with the United Nations Convention on the Rights of the Child, all children living with HIV/AIDS must have access to treatment, counselling, education, recreation and social support, and be protected against any form of discrimination.
- Greater efforts must be made worldwide to reduce mother-to-child transmission of HIV during pregnancy, child-birth and breastfeeding. This includes efforts to prevent primary HIV infection among girls and women.
- Because of HIV/AIDS, millions of children are already experiencing the loss of their parents, educators, health workers, community leaders and role models. To increase opportunities for children, greater encouragement and support must be given to their families and communities in their prevention and care efforts.

- **Children in a world with AIDS are vulnerable but they are not helpless. They are our best resource for change. Governments, NGOs, religious and children's organizations need to listen to the voices of boys and girls and to work together with them towards a safer world.**
- **Reducing children's vulnerability to HIV/AIDS means giving girls and boys access to timely and relevant information; ensuring their access to adequate and friendly services; strengthening social safety nets; formulating policies which will enhance prevention efforts; and developing programmes for prevention, care and impact reduction.**

Expected Outcomes:

By the end of 1997, the following outcomes are expected for Objective 2:

- Increased opportunities for boys and girls, their families and their communities to have their concerns and aspirations heard and reflected in decisions affecting their lives.
- Improved practices for data collection, research, and documentation of best practice initiatives to strengthen planning, policy and programme development and implementation.
- Increased inter-sectoral collaboration to maximize resources for prevention of HIV infection and to minimize the epidemic's impact on girls and boys, their families and their communities.
- Increased availability of resources for the prevention of HIV infection and minimization of the epidemic's impact on especially vulnerable girls and boys.
- Development of adequate policies to help minimize the mother-to-child transmission of HIV in varied settings.

Objective 3:

Increased and improved access to quality education and relevant information on the prevention and care of HIV/AIDS for children, their families, and their communities.

Messages:

- **Children, their families and their communities will be better protected from HIV if their rights are respected, they are informed about what they can do to prevent infection, and they are enabled to take appropriate action.**
- **Children, their families and their communities can and do save their own lives when they are informed and empowered to make the right decisions.**

Expected Outcomes:

By the end of 1997, the following outcomes are expected for Objective 3:

- Increased access to accurate and up-to-date information and quality education on the prevention and care of HIV/AIDS for children, their families and their communities.
- Broadening of prevention initiatives to include "life skills" education programmes for children.
- Increased access to education and availability of information on the prevention and care of HIV/AIDS for especially vulnerable children, in both formal and informal settings.

Objective 4:

Greater understanding of the interaction between children's rights, human rights, and HIV/AIDS.

Messages :

- **The protection and promotion of children's rights enhance HIV prevention and impact reduction:**

Children have a right to survival, protection and development and thus must be protected from the impact of HIV/AIDS.

Children have a right to be heard and to have their aspirations and needs reflected in decisions affecting their future.

Children have a right to be protected from discrimination and exploitation, irrespective of their HIV/AIDS status or that of members of their families.

Children have a right to access health and social services on an equitable basis, irrespective of their HIV/AIDS status or that of members of their families.

- **Sound and effective HIV prevention and impact reduction concerning children will help illuminate the significance of their rights.**
- **Children's rights are human rights. By affirming their rights, we help promote human rights for all.**

Expected Outcomes:

By the end of 1997, the following outcomes are expected for Objective 4:

- Increased promotion of the rights of the child by media organizations, networks, and professionals.

- Increased opportunities for girls and boys and their communities to communicate their concerns and aspirations in regard to their rights.
- Increased opportunities for girls and boys to have their concerns and aspirations reflected in decisions affecting their rights.
- Increased action to ensure legal protection of the rights of the child in the context of HIV/AIDS.
- Increased inclusion of human and children's rights issues in programmes/initiatives for HIV prevention and in those aimed at reducing the epidemic's impact on children, their families and their communities.
- Increased understanding of human and children's rights issues in HIV/AIDS programming and equivalent understanding of HIV/AIDS issues in human and children's rights programming.



World AIDS Campaign

Children Living in a World with AIDS

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

Secretariat

UNAIDS

Steering Committee

• UNAIDS
and co-sponsors:

UNICEF

UNDP

UNFPA

UNESCO

WHO

WORLD BANK

• Others:

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

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Children Living in a World with AIDS

World AIDS Campaign Media Briefing

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Facts and Figures

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Children living in a world with AIDS

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

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

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

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

Unfortunately, the magnitude of the problem remains to be documented with any precision. There is a glaring gap in data on the incidence of infection among children as they grow into adolescence. One of

the shortcomings of HIV epidemiological surveillance to date has been to use the cut-off point of 14 years for younger children for the collection and aggregation of data - the older 15-49 year age group being considered as adults. A first step therefore for governments in fulfilling their obligations to children in the context of HIV/AIDS is to collect comprehensive data on HIV transmission among older children and adolescents, so that they can design effective prevention and care programmes in the light of these data.

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

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

expects to rise to 1 million by the end of 1997. Well over 90% of these children live in developing countries.

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

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

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

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

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

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

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

girls and especially vulnerable children, both boys and girls, such as refugees, street kids, and children exposed to drug use.

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

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

The industrialized world has unmet needs as well. In a survey conducted in 1992 in the United

States, government lobbyists on children's issues admitted that while they were generally successful in promoting other causes such as education and anti-poverty programmes, they were much less so with childhood AIDS issues such as prevention, orphan care and education around sexual health.

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

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

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

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

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

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

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

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

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

Children with HIV: A future compromised

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

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

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

Children with HIV/AIDS in developing countries

HIV infection in children typically runs a faster course to AIDS and then death than in adults. And paediatric AIDS kills especially fast in developing countries. Sick children in developing countries are gener-

ally at greater risk of death than children in industrialized countries and this is no less true of children with HIV. In Europe, 80% of HIV-positive children survive at least until their third birthday, and more than 20% reach the age of 10. In Zambia, however, nearly half of HIV-positive children in one study had died by the age of two. In another study in Uganda, 66% were dead by the age of three.

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

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

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

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

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

Women and children - a dual vulnerability

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

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

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

In Kenya, for example, an AIDSCAP report found that the vulnerability of women is exacerbated by historical trends which have removed men from their families for lengthy peri-

ods of time, increased the acceptability of male sexual activity outside of marital relations, and sanctioned the behaviour of older men to use their wealth and prestige to seek sex with girls and young women.

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

But for prevention strategies to be equitable and effective, AIDS programmes must avoid falling into the ancient trap of seeing women only as mothers. And it would be tragic if, once again, as for contraception, women alone were left

with the responsibility for HIV prevention within sexual relationships, and men were absolved of this responsibility. HIV prevention must also move beyond measures that primarily focus on reducing the transmission of HIV between sexual partners. As stressed by UNFPA and other leading agencies, the respective status and roles of men and women in society must be considered in order to understand and act on the constraints imposed by the gender gap on behaviours relevant to HIV.

Why babies born in poor countries are at greater risk

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

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

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

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

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

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

because clean water for making up the formula is not available.

The policy of UNAIDS and its cosponsors is to encourage HIV-positive mothers to be given as much information as possible on the relative risks of breast-feeding 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 breast-feeding period or use artificial feeding - and will become increasingly important as new drug regimens are developed to reduce the risk of vertical transmission.

Anti-HIV drugs to keep babies from getting infected

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

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

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

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

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

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

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

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

It is not just mother-to-child

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

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

In Western Europe and the United States, a large number of

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

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

Children orphaned by AIDS

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

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

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

Extrapolating these findings from Brazil to other countries is difficult because fertility rates and HIV infection rates among women differ from one country to the next. However, the results make it clear that, in any given country, the number of children with an HIV-positive parent is far greater than the number of children who have already lost a parent to AIDS.

Children orphaned by AIDS are just the more visible part, the tip of the iceberg, of the larger looming problem of children with parents living with HIV/AIDS.

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

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

A uniquely painful experience

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

For one thing, the psychological impact can be even more intense than for children whose parents die from more sudden causes, such as in armed conflict or as a result of an accident. HIV ultimately

makes people ill but it runs an unpredictable course. There are typically months or years of stress, suffering or depression before a parent dies. And in developing countries, where the epidemic is concentrated, effective pain or symptom relief is often unavailable to alleviate a parent's suffering.

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

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

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

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

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

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

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

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

Taking care of these children is difficult", she says.

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

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

A vicious circle of poverty and discrimination

The relation between HIV/AIDS, impoverishment and denial of human rights is apparent

in the impact of the epidemic on children who have been orphaned by AIDS.

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

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

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

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

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

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

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

"This lady likes mistreating me because my mother is dead", says one Ugandan girl

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

What is being done to help?

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

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

basic support to those who most need it.

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

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

Reaching children before their parents die

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

In 1994, representatives from NGOs throughout southern

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

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

Orphanages - a last resort

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

Orphanages may be more successful in countries where they have been more commonly used in the past, such as in Thailand and India. **But even in countries where orphanages are the norm, they can act as a magnet for stigmatization.**

In 1995 in Romania, a group of citizens led by a town mayor stormed an orphanage because it housed children who were known to be HIV-positive. "The local population argued that these children can infect the other children in the town, as well as those in the orphanage", reported Romanian journalist Dan Stoica for Panos.

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

Children in the shadow of HIV risk

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

HIV and child sexual abuse

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

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

Children in the sex trade

No one knows how many child sex workers there are in the world. Because of the clan-

destine nature of the trade, precise figures are not known, and there is a chronic lack of accurate research in this area. Figures reported to the first World Congress Against Commercial Sexual Exploitation of Children, which took place in Stockholm in August 1996, suggested that:

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

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

Girls are at greater risk than boys because of systematic

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

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

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

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

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

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

Abuse closer to home

Awareness all over the world is growing of the scale of child abuse which takes place

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

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

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

Girls employed as domestics are vulnerable to another type of sexual abuser - the male head of household, or his sons. Occupational exposure to sexual

coercion is, of course, not restricted to household employees, but live-in domestics run a particularly great risk because they are accessible around the clock.

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

HIV and consensual sex with peers

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

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

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

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

HIV and drug use

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

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

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

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

Refugee and displaced children

As civil conflict, political persecution, and natural disasters continue to plague many countries, millions of people are forced to live outside of their countries of origin. The majority of the world's refugees are children and women. In conditions ranging from large

rural encampments with very limited infrastructure to intensely crowded urban shanty towns, young refugees are particularly vulnerable to nonconsensual sex. Even if there is consent the availability of condoms is often quite limited.

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

Children in detention and HIV

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

The window of hope

Strengthening development to strengthen coping

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

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

However, it is still difficult to make reliable estimates of the impact of AIDS on economies, because AIDS impacts differently on different socioeconomic systems and even on different sectors within the same economy.

For example, the loss of a single income earner in a family may have a different impact in rural and urban areas due to the types of family structures. In urban areas, the loss of a single wage earner can affect a large group of extended family members. Labour-intensive farming systems are also more vulnerable to the loss of able-bodied adults than others.

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

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

A shift of emphasis is needed away from relief towards longer-term intersectoral approaches to meeting the needs of AIDS-affected children. A relief approach of providing directly for children's needs is generally not sustainable where the number of affected children is large. Wherever possible, resources should be directed to enabling families and communities to

establish and maintain a sufficient economic base to provide for children's needs. And children themselves need to have their educational and employment opportunities bolstered if they are to break out of the pernicious cycle of poverty and AIDS.

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

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

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

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

School education on HIV/AIDS

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

The review showed that responsible and safe behaviour can be learned. Education on sexuality and/or HIV does not encourage increased sexual activity. Quality programmes in fact help delay first intercourse, and protect sexually active young people from sexually transmitted disease, including

HIV, and from pregnancy. Among other things, quality programmes feature a clear explanation of the risks of unprotected sex and methods - including abstinence - for avoiding them, and help young people practise communication and negotiation skills.

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

According to one AIDS worker in Zimbabwe, "we start in schools from about 8 years or 9 years old. It sounds too early but in our country there is a lot of child sex abuse, even rape, which makes it very important for us to introduce the subject during that period or even earlier. We want to have this child know that this is my body, nobody has a right to my body, if anybody fidgets around with my body I should report it to my

mum and dad so that I am protected. We start talking about the information that helps this child to know who they are and how they can best protect themselves", she says.

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

Reaching children outside the school setting

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

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

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

Injecting drug use and HIV prevention

As with the prevention of sexual transmission, HIV prevention related to drug use must encompass far more than the simple provision of information. There must be an emphasis on the acquisition of skills for negotiation, building self-confi-

dence, making the right decisions and resisting peer pressure. And the disempowering context within which these children live must be recognized and remedied - for example, the interface between drug use, with its stigma especially for females, and the commercial sexual exploitation of girls.

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

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

Involving children

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

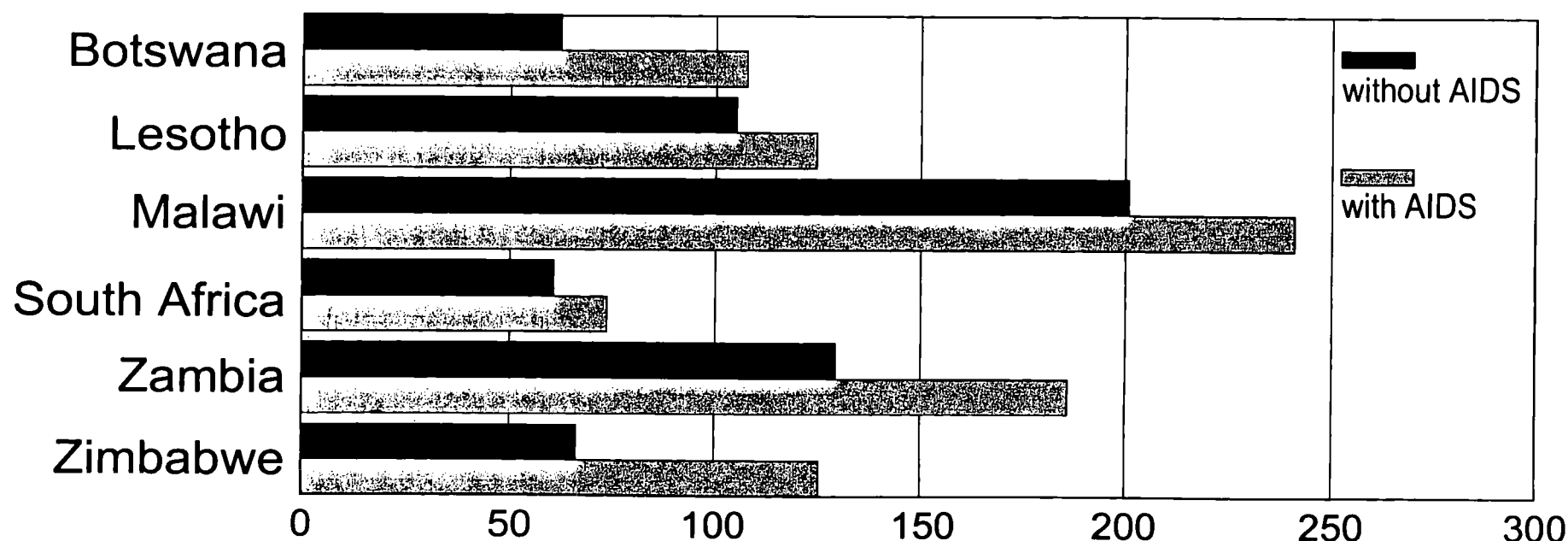
At an international conference on AIDS in Kampala in 1995, a "delegation" of young Africans from 11 countries ranging in age from 14 to 24 issued a declaration of their needs and priorities. "We strongly believe that our energy, idealism and commitment can be used to stop the further spread of the AIDS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

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

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

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

Child Mortality Rate* with and without AIDS, Southern Africa: 1996



* Child mortality rate is the number of children dying before age 5 per 1,000 live births

Source: International Programs Center - Population Division US Bureau of the Census, Washington, DC



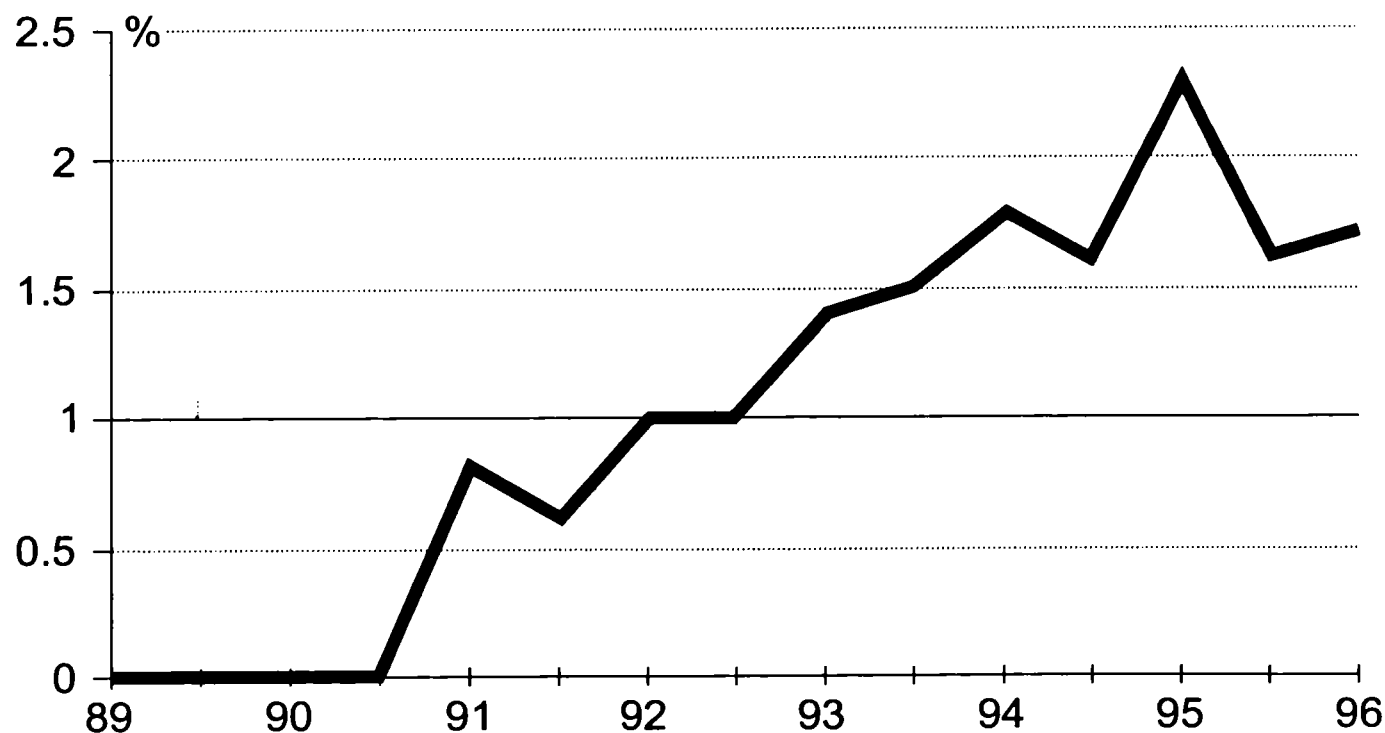
End 1996 Global Estimates on Children* and HIV/AIDS

Cumulative number of HIV infections	2.6 million
New HIV infections in 1996	400,000
Children living with HIV/AIDS in 1996	830,000
Number of deaths due to HIV/AIDS in 1996	350,000
Number of children who lost mothers to AIDS by mid-1996	9 million

** HIV epidemiological surveillance uses age 14 as the cut-off point for children for the collection and aggregation of data*



The Median of HIV Seroprevalence in Pregnant Women in Thailand

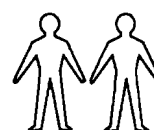


Source: Ministry of Health, Thailand



Impact of the Epidemic on Children in Brazil

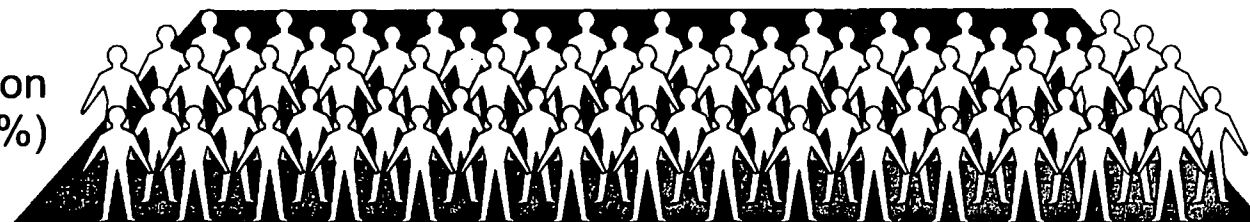
Mother died of AIDS
10,600 (6%)



Mother living with AIDS
34,600 (19%)



Mother living with HIV infection
137,800 (75%)



Source: the Global Orphan Project, Boston & Brasilia



World AIDS Campaign — a new logo

Un nouveau logotype pour la Campagne mondiale contre le SIDA

Para la Campaña mundial contra el SIDA: un nuevo logotipo

ENGLISH			
	World AIDS Campaign	World AIDS Campaign	
FRANÇAIS			
	Campagne mondiale contre le SIDA	Campagne mondiale contre le SIDA	
ESPAÑOL			
	Campaña mundial contra el SIDA	Campaña mundial contra el SIDA	

World AIDS Campaign — a new logo

What is the World AIDS Campaign?

The World AIDS Campaign is an annual campaign that culminates on World AIDS Day – 1 December – each year. Its aim is to promote increased advocacy and programmatic activities and initiatives around HIV/AIDS-related issues. Each year a different theme will be selected.

How to reproduce the World AIDS Campaign logo?

The World AIDS Campaign logo can be reproduced either using a scanner or a camera.

How to use the World AIDS Campaign logo?

Use it to produce your own World AIDS Campaign material, such as posters, stickers, T-shirts, leaflets, brochures, newsletters.

The colours for the World AIDS Campaign logo are black and red. The red for the ribbon is PMS 186 U for uncoated paper and PMS 186 C for coated paper (and M 90, Y 78, K 6).

Un nouveau logotype pour la Campagne mondiale contre le SIDA

Qu'est-ce que la Campagne mondiale contre le SIDA?

La Campagne mondiale contre le SIDA se déroule sur toute l'année, avec pour point d'orgue la Journée mondiale SIDA, chaque 1er décembre. Le but de cette campagne est d'intensifier l'action de sensibilisation et de promouvoir les activités programmatiques ainsi que les initiatives portant sur des questions en rapport avec le VIH/SIDA. Un thème différent sera sélectionné chaque année.

Comment reproduire le logotype de la Campagne mondiale contre le SIDA?

La reproduction du logotype de la Campagne mondiale contre le SIDA peut se faire avec l'aide d'un scanner ou d'une caméra.

Comment utiliser le logotype de la Campagne mondiale contre le SIDA?

Utilisez-le pour préparer votre propre matériel en vue de la Campagne mondiale contre le SIDA, par exemple affiches, autocollants, T-shirts, circulaires, brochures, lettres d'information.

Les couleurs du logotype de la Campagne mondiale contre le SIDA sont le noir et le rouge. Le rouge pour le ruban est PMS 186 U pour le papier non couché et PMS 186 C pour le papier couché (et M 90, J 78, N 6).

Para la Campaña mundial contra el SIDA: un nuevo logotipo

¿Qué es la Campaña mundial contra el SIDA?

La Campaña mundial contra el SIDA es una campaña anual que culmina con el Día mundial del SIDA que se celebra el 1 de diciembre de cada año. El propósito de dicha Campaña es sensibilizar al público acerca del VIH/SIDA y promover acciones programáticas y nuevas iniciativas en relación a la epidemia. Cada año se elige un nuevo tema para la Campaña.

¿Como reproducir el logotipo de la Campaña mundial contra el SIDA?

El logotipo de la Campaña mundial contra el SIDA se puede reproducir utilizando un 'scanner' o una cámara apropiada.

¿Como servirse del logotipo de la Campaña mundial contra el SIDA?

Utilícelo para elaborar su propio material destinado a la Campaña mundial contra el SIDA, por ejemplo: carteles, pegatinas o etiquetas adhesivas, camisetas, prospectos y folletos, boletines informativos.

Los colores elegidos para el logotipo de la Campaña mundial contra el SIDA son el negro y el rojo. El rojo de la cinta es PMS 186 U para papel ordinario y PMS 186 C para papel cuché (y M 90, A 78, N 6).

THE WHITE HOUSE
WASHINGTON

**THE SIGNIFICANCE OF THE NEW UNAIDS INFORMATION:
A COMPARISON OF PREVIOUS AND CURRENT ESTIMATES**

<i>Previous Estimate[†] – 1996</i>	<i>Revised Estimate – 1997</i>
22.6 million persons currently living with the HIV virus	30.6 million persons currently living with the HIV virus
3 million new infections (equivalent to 8500 per day)	5.8 million new infections (equivalent to 16,000 per day)
1.5 million new infections among persons aged 15-24	2.9 million new infections among persons aged 15-24
1.5 million deaths due to AIDS	2.3 million deaths due to AIDS
6.4 million cumulative deaths due to AIDS	11.7 million cumulative deaths due to AIDS
1000 children die each day of AIDS	1200 children die each day of AIDS
1000 children are infected with HIV each day	1600 children are infected with HIV each day

[†] based on UNAIDS Press Releases of February and June, 1997

Other Facts to Note:

- Cumulative number of child deaths due to HIV/AIDS: 2.7 million
- Child deaths due to HIV/AIDS in 1997: 460,000
- Cumulative number of AIDS orphans: 8.2 million

The UNAIDS estimates also highlight regional disparities in the epidemic and the dramatic impact of HIV/AIDS on child mortality and overall life expectancy in Sub-Saharan Africa.

PRESIDENT WILLIAM J. CLINTON
VIDEOTAPED REMARKS ON YOUTH AND AIDS
NOVEMBER 18, 1997

I am pleased to take part in this commemoration of World AIDS Day. AIDS is not somebody else's problem. We are all living with AIDS and we must all be a part of the fight. Our nation salutes individuals and families living with AIDS, care givers and researchers, activists and policy makers, for working together to provide hope in a world with AIDS.

And we have good reason to be hopeful. Powerful new treatments are helping those living with AIDS to live longer and healthier lives. But the epidemic continues, and more and more HIV is affecting young people. So today, I would like to reach out to young Americans just like you. Today I call on each of you to help us save lives -- starting with your own.

Only you have the power to keep yourself safe. Get the facts about HIV and AIDS and use them. This deadly virus does not discriminate. HIV doesn't care if you are male or female, gay or straight, rich or poor, black, white, yellow, brown or red. The virus takes advantage of any one who puts him or herself at risk.

As you face the challenges of growing up and the pressures of keeping up, I urge you not to let HIV keep you from reaching your dreams. You are important -- to your family, to your friends, to us all. You have the capacity and the potential to make a difference in your own life and in America's future. But you have to take responsibility for your health, your education and your safety. Reach out to the adults in your lives -- your parents, teachers and others you trust -- for advice and for support. It could save your life.

One last thing. Talk to each other. I urge you to share the facts about HIV and AIDS with your friends and your peers, in education and prevention programs, or in every day conversation. In neighborhoods, schools, youth centers, churches, clubs, recreation centers, shelters, and in the streets -- spread the word about how to stop HIV. Take responsibility and become part of the solution. We need to fight ignorance with education. We need to fight fear with facts. We need to fight indifference with compassion. And most importantly, we need to fight AIDS, not people with AIDS.

Always remember to respect yourself, protect yourself, and keep believing in your future. This nation's future depends on you.

THE WHITE HOUSE
Office of the Press Secretary

For Immediate Release

December 1, 1997

WORLD AIDS DAY, 1997

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BY THE PRESIDENT OF THE UNITED STATES OF AMERICA

A PROCLAMATION

For more than 15 years, America and the world have faced the challenges posed by HIV and AIDS. This devastating disease respects no borders and does not discriminate. In every city, town, and community, we have lost sons and daughters, brothers and sisters, mothers and fathers, life partners and friends. HIV and AIDS have affected us all, regardless of income, region, gender, race, religion, sexual orientation, or age. Sadly, both the number of people living with AIDS and the number of new HIV infections is rising worldwide. This year, as we observe the tenth World AIDS Day, we recognize with particular concern the toll HIV and AIDS continue to take on our children and youth.

The statistics are heartbreaking. In America alone, more than 7,500 children under the age of 13 have been diagnosed with AIDS. Every hour of every day, two more Americans under the age of 21 become infected with HIV. Around the world, more than 1 million children are living with HIV and AIDS. Twelve hundred children die of AIDS each day, even as 1,600 more become infected with the HIV virus. Compounding this tragedy is the terrible reality that many of the world's young people who are living with HIV and AIDS do not have access to the life-extending drugs and medical protocols that our scientists and doctors have developed. There is also a critical shortage of prescription drugs suitable for children suffering from pediatric HIV and AIDS. Of the 14 approved drugs for adults and adolescents, only five are approved for children.

From the earliest days of my Administration, we have sought to meet the challenges posed by AIDS with increased resources and action. I am proud of our success, with the cooperation of the Congress, in dramatically increasing funding for AIDS prevention measures and research. Such programs and research have helped to slow the spread of HIV and AIDS and have made possible the production of new drugs that are extending the lives of people with HIV and AIDS here at home and around the world.

But our progress against the scourge of AIDS has not been the result of government action alone. We have been able to make these great strides in understanding and treating HIV and AIDS thanks in large part to the hard work and commitment of thousands of researchers, health care providers, and clinical trial participants. I am proud as well of the resounding response of courage, compassion, responsibility, and love that the AIDS crisis has brought forth from our people. The lesbian and gay community, particularly in the early years of this epidemic, energized existing organizations and created new institutions to respond to the unmet needs of those living with HIV and AIDS. Educators and activists, members of religious and civic groups, business and labor organizations,

more

(OVER)

and tens of thousands of other men and women of goodwill have joined together to comfort the afflicted and bring an end to this disease.

We can rejoice in our progress, but we cannot rest. In May, I announced a new HIV vaccine initiative, and I am pleased that the global community has joined together in making the development of this vaccine a top international priority. Within 10 years, we hope to have the means to stop this deadly virus. But until we reach that day, I call on every American to remain with us on our crusade to eradicate this terrible epidemic and care for those living with AIDS along the way. As we mark World AIDS Day this year, we must continue to provide care for the sick and ensure that all have access to the treatment they need. And one of our most important tasks now is to strengthen our efforts to educate young people about HIV and AIDS and to make available to them and others at high risk effective prevention programs. By giving our children real hope for a future free from the shadows of HIV and AIDS, we can best commemorate the many loved ones we have already lost to the disease during its long and tragic course. May their enduring memory light our journey toward a vaccine for HIV and a final cure for AIDS.

NOW, THEREFORE, I, WILLIAM J. CLINTON, President of the United States of America, by virtue of the authority vested in me by the Constitution and laws of the United States, do hereby proclaim December 1, 1997, as World AIDS Day. I invite the Governors of the States, the Commonwealth of Puerto Rico, officials of the other territories subject to the jurisdiction of the United States, and the American people to join me in reaffirming our commitment to defeating HIV and AIDS and to helping those who live with the disease. I encourage every American to participate in appropriate commemorative programs and ceremonies in workplaces, houses of worship, and other community centers and to reach out to protect our children and to help all people who are living with AIDS.

IN WITNESS WHEREOF, I have hereunto set my hand this first day of December, in the year of our Lord nineteen hundred and ninety-seven, and of the Independence of the United States of America the two hundred and twenty-second.

WILLIAM J. CLINTON

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