Global Future

Number 1, **2006**

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THIS ISSUE

Prioritising children in the global response to HIV and AIDS

FEATURING

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United Nations Special Envoy for HIV/AIDS in Africa

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Heather Elliott

WELCOME

Dear Reader,

Welcome to the first 2006 edition of Global Future. If you're thinking that this edition is coming to you much later than usual, you're correct. We are now producing only three editions per year; these should be in subscribers' hands each May, September and December.

You'll also notice our new look! Feedback from our reader surveys in 2004 and 2005 have led us to enhance our layout and design, to make the magazine more reader-friendly. You'll see that we have a bit more colour, and some new features – one of them is this space you're looking at now, which will be devoted to letters from readers.

We hope that you'll find this edition worth the wait!

Heather

what next?

in number 2, 2006

'Humanitarianism revisited: key issues for relief work in the 21st century'

Relief workers and agencies grapple with enormous pressures. Not only with the 'everyday' dramas of protection, governance and civil (or uncivil) society, but with unfair distribution of resources, and with emergencies that fail to receive media attention or funding, or quickly become forgotten when not deemed politically or economically strategic.

Since the end of the Cold War and '9/11', humanitarian action has become even more politicised and insecure. The humanitarian landscape has also become increasingly crowded with the engagement of many thousands of NGOs and private companies.

This edition of Global Future will examine what a humanitarian agency should seek to achieve and to what extent it is possible to uphold the principles of accountability, neutrality and impartiality in today's world – highlighting the impacts of these critical issues upon the people, communities and states who are faced with conflicts and emergencies.

front cover image: Street children in Cambodia, potentially quite vulnerable to the pandemic, get a night-time comic book lesson on HIV and AIDS.

photographer: Jon Warren / World Vision

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World Vision

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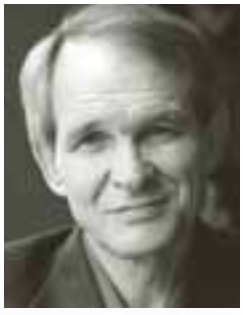
by DAVE TOYCEN

DELIVERING... FOR CHILDREN



The world has now been living with HIV and AIDS for more than a quarter of a century.

When the first handful of cases was reported in June 1981, who could have predicted the devastating global impact of the virus and the dramatic effect it would have on international development work?

It has been 25 years of learning, and of trying to catch up as the virus hurtled across the globe at a terrifying pace. In the global response to the pandemic over the past two-and-a-half decades, however, something has been clearly absent. Children – the most vulnerable members of society – remain on the periphery of the world's response. In the areas of prevention, care and treatment, children and youth are still at the bottom of the priority list or off the agenda entirely. That marginalisation places at risk not only millions of young lives, but the future of many societies as well. And, given the suffering of orphans and vulnerable children, it is unconscionable.

This August, as decision-makers, scientists, practitioners and leaders convene in Toronto for the sixteenth International AIDS Conference, it is morally and strategically imperative that children and young people move to the core of the global response to HIV and AIDS. The conference theme, "Time to Deliver", is a good reminder that it is indeed time to reassess global priorities and increase our vigilance to ensure that what, and how, we "deliver" reaches the youngest and most vulnerable members of society.

In this edition of *Global Future*, our contributing writers bring into focus some critical aspects of "prioritising children". Stephen Lewis compellingly links the widespread neglect of children with the gross inequality in our world. Benn, Toole and other contributors highlight the lack of diagnostic tests and anti-retroviral drugs for children; Kean and Bacon point to the glaring gap between the sweet rhetoric of pledged support and the bitter reality that it has failed to materialise for children. More aid? yes, but it must translate into real interventions for children.

I believe three key priorities are necessary as we broaden global response to include children and young people:

- Design prevention and treatment programmes and services specifically to address the needs of children and youth, with attention to gender-based vulnerabilities. If children have limited access to prevention, treatment, care and support, the epidemic will continue to flourish and more children will die.
- Ensure that the unique needs of children who have been orphaned or otherwise made vulnerable by HIV and AIDS receive adequate attention and resources.
- Listen to the young, creating opportunities for them to have a voice and to shape the programmes and policies that impact their lives.

In many World Vision programmes in high-prevalence areas, children and young people are actively involved in response to the AIDS crisis – as peer educators promoting HIV prevention; as volunteer care-givers for ill, orphaned, and other vulnerable children; and as active contributors in the decision-making of community care coalitions, which are responding to the impacts of AIDS in World Vision programme areas.

Prioritising children in HIV and AIDS response at every level from the local to the global will reduce the vulnerability of children, help arrest the spread of HIV, and help guarantee a more stable and secure future for entire societies. Our children and young people deserve nothing less. ■

Mr Dave Toycen is President and CEO of World Vision Canada.

by Stephen Lewis

The ugly truth of the HIV pandemic

Stephen Lewis argues passionately that the impacts of HIV and AIDS on children expose the gross inequality in our world and the ugly truth that children are at the bottom of the ladder of social and economic priorities.

Two weeks ago, I was visiting a small community centre on the outskirts of Mbabane, the capital of Swaziland. Outside the centre, greeting the visitor with vibrant singing, were all the students of the local primary school, 350 of them, row on row. The principal, a young woman, addressing the crowd, said that of the 350, some 250 were orphans!

I had encountered high orphan ratios before, but never 70%. I looked at those children, most of them clearly malnourished, wearing frayed and tattered uniforms, and thought of the tragic tenor of their young lives.

What distinguishes orphans whose parents have died of AIDS is the sheer torment of their childhood experience: they don't become orphans when the parents die, they become orphans while the parents are dying. They administer to sick mothers and fathers, over long periods of time – months, sometimes years – and then they stand in the huts and watch their parents die. How do they ever get over the trauma? How do they ever regain their emotional equanimity? It is estimated that there are now 14 million children in sub-Saharan Africa orphaned by AIDS, expected to rise to 18 million by 2010.

Quite simply, it's a nightmare with which no country can begin to cope.

Neglect, inequity

I think of the orphans every time I'm asked to write articles like this. They illustrate one of the ugliest truths in the modern world, a truth which seems to remain immutable: children are always on the bottom rung of the ladder of social and economic priorities. It's as though the world has no conscience when it comes to kids. There's money galore for wars in Afghanistan and Iraq, there's money in every Western budget for the terrorist threat, but when it comes to children, the cupboard is bare.

Alas, it is ever thus. It's as though the *Convention on the Rights of the Child*, ratified by 189 out of 191 countries (only Somalia and the United States have failed to ratify), is but a hoax for children. When it comes to orphans, many factors conspire to make life wretched. We now know that fewer than 3% of all the orphans receive some kind of helpful intervention from the state; when you think of it, that's an astonishing piece of political delinquency. Community-based and faith-based organisations – surrogate families, foster families, orphanages – desperately try in every possible way to absorb the orphan kids, but everyone is so poor, it's almost impossible to establish an ongoing relationship. Increasingly, between 40% and 60% of the orphans and vulnerable children in several southern African countries are being looked after by the grandmothers.

Now there's a phenomenon to conjure with! The grandmothers have emerged as the unsung heroes of Africa. They go through the agony of burying their own adult children, and then, at the age of 50, 60, 70, they return to parenting again, often looking after five or ten or more orphan grandchildren.

There's money galore for wars and the terrorist threat, but when it comes to children, the cupboard is bare

They have nothing: no food, no money for school fees or uniforms or textbooks, no guarantee of shelter. The school fees situation is a particular abomination. The orphan children want nothing more than to go to school, for a sense of self-worth, for peer activity, for a school feeding lunch programme so that they'll have at least one meal a day. It's all denied them thanks to the twisted legacy of the World Bank and the IMF who exacted user fees as a condition of loans during the maliciously destructive period of so-called Structural Adjustment Programmes. The world has a lot to answer for.

And then, when the grandmothers die, the children are often left to survive in child-headed households, where the age of the child heading the household, and looking after the siblings, can be as young as eight. HIV/AIDS has profoundly damaged the wholesome pattern of normal family relationships.

But that's only a part of the life of the child in the world of AIDS. There are also, of course, the children who are infected... some two million, three hundred thousand of them around the world – 700,000 new cases last year alone, with 570,000 deaths. The numbers are abstractions. Without treatment, 50% die before the age of two; 80% die

before the age of five. It gives new meaning to the word "carnage".

It's a further commentary on the human condition that although we've had treatment for adults since 1996, it's literally only now, this very moment in time, that we're beginning to develop anti-retroviral drugs for children... drugs that can save and prolong their little lives. It's terribly painful to meet infected children, everywhere on the continent, who will surely die as they wait for pediatric drug formulations as yet unavailable.

And then there's perhaps the most repugnant reality of all: the absence of facilities to prevent transmission of the virus from mother to child; it's known as "pMTCT". Believe it or not, fewer than 10% of all the pregnant women in Africa have access to pMTCT. Yet, by administering the wonder drug Nevirapine to the mother during the birthing process, and providing the liquid equivalent to the newborn baby within 72 hours of birth, transmission of HIV can be cut in half.

We've lost hundreds of thousands of children, probably millions of children during the last decade, simply for lack of facilities for the prevention of mother-to-child transmission. How can it possibly be explained or justified?

Thousands, millions of children are lost due to a lack of facilities; how can it possibly be explained or justified?

But it gets worse. In the Western world, pregnant mothers who are HIV-positive routinely receive, instead of Nevirapine, full anti-retroviral therapy for the last several months of pregnancy. The transmission to the child is then reduced to roughly 1%! How's that for one of the more grotesque examples of the inequity between the developed and the developing worlds?

Particular vulnerability for girls

This overall situation for children in the world of HIV/AIDS is particularly pronounced when it comes to girls.

It's the girls who are pulled out of school to look after sick and dying parents. It's the girls who are forced into early marriage with older men, putting the girls at even greater risk of infection. It's the girls who, when orphaned, and struggling for survival, engage in what we call "transactional sex"... sex for a few pennies to keep body and soul together. We'll never know how many young girls have been infected in the process. And above all, it's the girls who are the targets of so much sexual violence.

Four of the eight Millennium Development Goals, scheduled to be reached by 2015, speak directly to the situation of young women and girls: cutting poverty in half, achieving parity between the sexes in primary school enrolment, approximating gender equality and subduing the pandemic of AIDS. Not one of them will be achieved in the high-prevalence countries of southern Africa. It's not just a travesty; it could be said to call for the laying of charges before the International Criminal Court.

And that's how I want to end this piece. There's something unconscionable about the way we've ignored the needs and rights and lives of children during the pandemic. Late last year, UNICEF announced a campaign to remedy the wanton neglect of the past.

They will address treatment and prevention and care; they'll tackle the seething predicament of orphans; they'll attempt to roll out pMTCT across the continent. It's all totally admirable.

But it's late. We're all late. The entire international community is late. Who atones for the countless lives lost, and the excruciating pain and suffering felt by the children of Africa and beyond, as the world dithered?

Historians will write the epitaph. It will be short: "Here lie crimes against humanity." ■

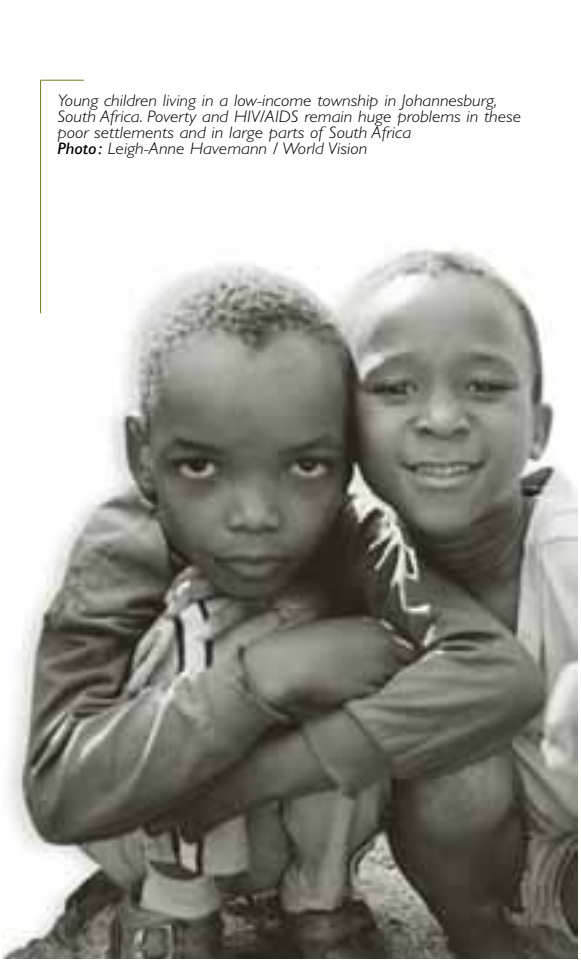
Mr Stephen Lewis is the United Nations Special Envoy for HIV/AIDS in Africa.

Josephine, 5, undergoes a check-up. She is cared for by her grandparents, along with another 29 children. The traditional family safety net is on the verge of breaking in Africa, due to the impact of HIV and AIDS.
***Photo:** Alison Low / World Vision*

by Stuart Kean and Clive Bacon

More than words? Transforming rhetoric into reality

Orphans and vulnerable children are still the most likely to be missing out on basic needs. Governments and the international community are failing to fulfil their commitments, argue Stuart Kean and Clive Bacon.



Young children living in a low-income township in Johannesburg, South Africa. Poverty and HIV/AIDS remain huge problems in these poor settlements and in large parts of South Africa
Photo: *Leigh-Anne Havemann / World Vision*

The mention of your name
scares me out of my skin
Out of the darkness you crept in
Swept our continent,
home is but full of graves
Thousands and thousands
you have killed
Causing no meaning to life.[1]

There are high expectations when governments and international organisations make policy commitments with the potential to transform the lives of millions of children and adults who languish in poverty. Sadly, those expectations are too often dashed. This is not to say that policy commitments are not necessary, indeed they are, but it is far more important that policy rhetoric is translated into practice.

Civil society is increasingly playing a central role in holding governments to account – monitoring progress made by governments in fulfilling their policy commitments and tracking resource flows; checking whether policy is becoming reality. To improve the prospects of policy rhetoric being translated into practice, the capacity of civil society must be strengthened and its role as advocate must not be compromised.

Policy commitments for children

In June 2001, world leaders made a global commitment to action by signing the *Declaration of Commitment* at the UN General Assembly Special Session (UNGASS) on HIV/AIDS, which included policy commitments for governments and the international community to respond to the needs of orphans and vulnerable children (Articles 65–67). This Declaration is a powerful tool for ensuring international action for orphans and vulnerable children. It also provides a means by which world leaders can be held accountable to a clear timetable of action.

In July 2004, an internationally agreed Framework was published by UNICEF, UNAIDS and others, which provides operational guidance to all stakeholders involved in responding to the needs of children made vulnerable by HIV and AIDS, including a core set of indicators.[2] The Framework has been used as the focus of advocacy efforts to ensure that as many governments as possible endorse it and commit resources to implementing its recommendations.

Monitoring policy commitments

World Vision is a vocal advocate for children affected by HIV and AIDS and is working hard to keep them high on the global agenda. A key part of our work, therefore, is to inform and challenge leaders, holding them to account for the promises they have made. To this end, a monitoring exercise was conducted in four of the worst-affected countries in sub-Saharan Africa to provide a qualitative assessment of how far commitments are actually being realised in the lives of Africa's orphans and vulnerable children.

This UNGASS monitoring exercise was part of a joint advocacy project between the World Vision offices in Ethiopia, Mozambique, Uganda and Zambia, in conjunction with colleagues in the UK. The staff devised a common methodology using nine indicators by adapting the set of core national-level indicators contained within the Framework.[3] Research was then carried out in four communities within each country (two World Vision programme areas and two adjacent communities not receiving World Vision support). Surveys and focus group discussions were conducted with children, parents, care-givers and officials.

Governments and the international community are not fulfilling their commitments

The study found that across all four countries, orphans and vulnerable children are still the most likely to be missing out in terms of education, health, nutrition and other basic needs. Furthermore, very few are receiving appropriate psycho-social support, few are likely to have their births registered and many find themselves the victims of property grabbing. The overriding conclusion is that governments and the international community are failing to fulfill the commitments they signed up to in the UNGASS *Declaration of Commitment*.

At the conclusion of the research, the community members and World Vision staff produced community and national action plans. The World Vision report, *More than Words?*,[4] was launched simultaneously in eight countries and was used to provoke deeper

Findings of *More than Words?*

Education. School attendance rates for orphans and vulnerable children (OVC) were found to be falling behind those of non-OVC. Even in Uganda, where a successful campaign for Universal Primary Education has resulted in high overall enrolment rates, orphans and vulnerable children are still more likely to be out of school.

Health. In Mozambique and Ethiopia, the difference in access to health care was particularly pronounced, with a far smaller percentage of orphans and vulnerable children receiving medical treatment, compared to non-OVC.

Nutrition. Worryingly, the results from this monitoring exercise show a stark difference between the number and quality of meals received by orphans and vulnerable children, compared to non-OVC. The most notable difference was observed in Mozambique, where only 9% of orphans and vulnerable children had received normal meals (as defined by the community) in the week prior to the survey.

Psycho-social support. Despite widespread recognition of the need to provide psycho-social support, in the four countries monitored only a very small proportion of orphans and vulnerable children reported having received any form of psycho-social support.

External support. Most of the households caring for orphans and vulnerable children were not receiving external support.

Protection. The figures for birth registration of orphans and vulnerable children were generally low, and varied between the four countries, from 0% in Ethiopia (where there is no mandatory system) to 37% in Uganda. Likewise, despite promising to protect orphans and vulnerable children from "loss of inheritance", all four countries are struggling to deal with the surge in property grabbing since the HIV and AIDS epidemic took hold.

and more urgent commitments at a high-level ministerial UNGASS review meeting in New York in June 2005.

Success of global advocacy

In 2005, such lobbying and campaigning by civil society organisations produced significant achievements globally. At the G8 summit in 2005, leaders made the unprecedented commitment in their communiqué to work with African partners to "ensure that all children left orphaned or vulnerable by AIDS or other pandemics are given proper support". Likewise, world leaders at the UN Summit in September 2005 committed themselves, as part of reaching the goal of universal access to treatment by 2010, to "the reduction of vulnerability of persons affected by HIV/AIDS... in particular orphaned and vulnerable children and older persons". The European Commission, Canadian International Development Agency (CIDA), and Netherlands Ministry of Foreign Affairs endorsed the Framework, and the Irish Government not only endorsed the Framework but agreed to spend 20% of its HIV and AIDS expenditure on children. UNAIDS agreed that the global resources required to respond to the needs of children is $6.4 billion between 2006 and 2008 – a massive increase over previous estimates.

What needs to be done?

These indications of increased commitment still remain to be transformed into action and actually be delivered to children affected. The breadth of the response required is ever-widening, as indicated by the outcomes of the recent Global Partners Forum for Children Affected by AIDS,[5] which identified six areas requiring action, including community mobilisation, school fee elimination, legal rights (especially birth registration), child health, as well as including the needs of children affected by AIDS in national planning instruments such as PRSPs (poverty reduction strategy papers) and National AIDS strategies.[6]

There are several important opportunities in 2006, including the UNGASS Review, G8 Summit and the international AIDS conference, where civil society must pressure the international community to fulfil its commitments.

There is little to suggest that the gap between policy rhetoric and practice will be closed unless there is sustained advocacy from all sections of civil society: community, national and international.

Two challenges face civil society. First, at a time when it increasingly works in partnership with governments to deliver services to children affected by AIDS, civil society's role as advocate must not be compromised. The second challenge is to strengthen the capacity of civil society to undertake more systematic and coordinated tracking of policy commitments. If successful, the prospects for translating policy rhetoric into practice look promising. ■

Dr Stuart Kean is Senior HIV and AIDS Policy Adviser and Mr Clive Bacon is HIV and AIDS Programme Adviser for World Vision UK.

[1] Extract from a poem by Judy Wangui, an orphan from Kenya who lives with her grandmother

[2] UNICEF, *The Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV/AIDS*, 2004, http://www.unicef.org/aids/files/Framework_English.pdf

[3] UNICEF, *Guide to Monitoring and Evaluation of the National Response for Children Orphaned and made Vulnerable by HIV/AIDS*, 2005, http://data.unaids.org/Topics/ME/ME_NationalResponseOVC_guide_en.pdf

[4] This report can be found online at http://www.worldvision.org.uk/resources/more+than+words+-+ungass.pdf.

[5] The outcomes and background documents can be found on the AIDS Portal: http://www.aidsportal.org/ckw2/overlay/V2/subjectStartPage.aspx?ctx=ovl&source=ovnav&ohid=3&ovid=2.

[6] Refer keynote speech at Global Partners Forum by Gareth Thomas, UK Minister for International Development, at Lancaster House, 9 February 2006, http://www.unicef.org/uniteforchildren/makeadifference/files/GPF_DFID_Gareth_Thomas_keynote_speech.pdf

by Mike Toole

Focusing the HIV response spotlight on children

What are the medical and social issues around scaling up prevention of HIV infection in infancy, and some of the barriers to effective treatment, care and support for infected children? Mike Toole explains.

Anastasia, 17, is HIV-positive and needs to take her medication every day, at fixed hours. Seven pills a day is a must.
Photo: *Laura Runcanu / World Vision*

There are three major challenges in reducing the impact of HIV and AIDS on children. First, the prevention of parent-to-child HIV transmission; second, access to adequate treatment, care and support for children infected by HIV; and third, attention to the needs of orphaned and other children affected by HIV and AIDS. This article looks specifically at the first two areas: at the issues around scaling up prevention of HIV infection in infancy, and treatment, care and support for infected children.

In the year 2004, more than half a million children globally died of HIV-related illness – surpassing deaths caused by measles and making HIV the pathogen causing the third highest number of deaths among children under five (after malaria and pneumococcus).[1] As the HIV pandemic worsens, 2.2 million children under the age of 15, of whom approximately 90% reside in sub-Saharan Africa, are living with HIV. About 700,000 of them are in need of anti-retroviral (ARV) treatment if they are to survive. About 1,800 children become infected with HIV every day.

Among children under five, most have become infected through their mothers, during pregnancy and childbirth or through breastfeeding.[2] In the absence of an inexpensive ARV treatment to prevent infection, 25–45% of infants born to infected mothers will become infected with HIV, yet less than 10% of women in need have access to this treatment. Despite the risk of contracting HIV through breast milk, children in low-resource settings without access to safe water and sanitation are often at even greater risk of death from causes other than HIV if they are not breastfed.

Prevention

The most effective way of reducing the number of children infected with HIV would be to scale up prevention efforts. Much attention has focused on the use of ARV prophylaxis during pregnancy to prevent mother-to-child transmission (MTCT); however, there are numerous constraints to this exclusively medical approach. First, ante-natal care coverage may be low in some areas where HIV is highly prevalent. Even if women do attend ante-natal clinics and agree to a screening test, fear of stigma and violence often prevents women returning for results or disclosing their status.[3] Moreover, most MTCT programmes advise women not to breastfeed their infants. If a woman does not breastfeed, her community is more likely to suspect her HIV status and this may lead to stigma and discrimination against her and her family. Recent policy developments suggest that the approach to parent-to-child HIV transmission should be much broader than a focus on women in pregnancy, and should aim to prevent primary HIV transmission in both parents.

Preventing parent-to-child transmission needs to focus on HIV prevention in both parents

Much of the world's population lives in regions where HIV is currently spreading fast among vulnerable groups. In these settings, the prevention of new infections is paramount.[4] A high proportion of pediatric HIV infection results from maternal infections late in pregnancy, or during breastfeeding. These infants would not be protected even with universal access to ante-natal testing and prophylaxis. When labour or early breastfeeding coincide with the high peak in viral load that accompanies primary infection, the risk to the baby is very high. Specific programme guidance is needed to prevent new maternal infections.

When a woman is tested alone in the ante-natal clinic it means that her partner often learns his status without the right to decline to know. Men need to be invited to attend ante-natal clinics and receive appropriate counselling – both with their partner and separately – about the risk of HIV infection during pregnancy. Experience shows that, when invited, many are willing to do so. Health workers need to tell men that sex during pregnancy does not harm the fetus, and men must be encouraged to be faithful to their wives during her pregnancy and post-partum abstinence; unprotected extra-marital sex during these times might cause the death of their child.

Treatment, care and support

Anti-retroviral therapy is not reaching children in resource-limited settings. The World Health Organization (WHO) estimates that about 15% of the total number of those on AIDS treatment should be children. But only a fraction of the children with HIV who need treatment are

receiving life-prolonging ARV treatment today. As a result, half of all children infected with HIV die before their second birthday.

Half of all HIV-infected children die before their second birthday

Despite the increased emphasis on rolling out ARV treatment in the developing world, as evidenced by the "3x5 Initiative" and other projects, treatment of pediatric HIV has not received high priority in most settings. Many national treatment programmes have omitted children from their plans, while others have had trouble implementing targets. Even the most progressive and successful programmes, such as those launched by Médecins Sans Frontières (MSF), have found it difficult to include children. As of late 2005, only 6% of the 40,000 patients on HAART (highly active anti-retroviral therapy) in MSF projects were children below 15 years old. Nevertheless, MSF has demonstrated that ARV treatment can be highly effective in children.

MSF FINDINGS

MSF presented data at an international conference in 2005 from a cohort of 1,840 children under 13 years of age from Africa, Asia and Latin America.[5] All patients received ARV treatment regimens recommended by WHO. To reach a larger number of children, MSF teams started treatment based on clinical or immunological criteria defined by WHO.

As of March 2005, 83.9% of the children were alive and on treatment. The probability of survival after six months was 94% and still as high as 91% after 24 months.

Why are so few children receiving life-saving ARV treatment?

One reason is the lack of diagnostic resources in most developing countries. Children infected with HIV often present with common childhood illnesses, such as diarrhea, skin infections and pneumonia, and are not tested for HIV by health workers. More than 90% of adults infected with HIV in developing countries do not know their HIV status. Therefore, when they bring their sick children to clinics, there is no reason for the health worker to suspect that the children are infected with HIV. Moreover, the diagnostic tests available in developing countries often do not detect HIV antibody in children under 18 months of age. To help remove obstacles in caring for children with HIV, the development of new diagnostic tests needs to be accelerated.

Efforts to treat children who have HIV are further hampered by lack of appropriate drug formulations. Simplified ways to treat HIV in adults have become available to patients in developing countries within the past year. Most adult patients in developing countries now take either a triple fixed-dose combination treatment – one pill twice a day – or one double combination plus a third drug. But neither the triple nor double combinations are available in dosages for children.

When childhood doses are available, they come at a premium. It can cost over six times more to treat a child than to treat an adult – US$1,300 (for a 14-kilogram patient taking three different syrups) versus US$200 per year. There is only a weak global market in pediatric AIDS drug formulations: in wealthy countries relatively few children are being born with HIV, while developing countries are often simply too poor. Consequently, drug companies have little interest in developing or marketing pediatric formulations adapted to poor countries, such as fixed-dose combinations or breakable or chewable tablets.

It can cost over six times more to treat a child than an adult

While children are often the focus of advocacy and targeted programmes in primary health care and education, they have fared less well when it comes to HIV. Perhaps the stigma associated with HIV infection in adults that has dogged the epidemic since the beginning has cast its shadow across children as well. There needs to be heightened advocacy world-wide to promote better prevention and treatment efforts that benefit children. Several organisations, such as the Clinton Foundation, the Elizabeth Glaser Pediatric AIDS Foundation, MSF, UNICEF and World Vision have made children their focus. However, much more is needed if children are to be spared early death from this viral killer. ■

Dr Michael J Toole is Head of the Centre for International Health, Burnet Institute, Australia, and is a medical epidemiologist and public health physician. He is also Associate Professor in the Department of Epidemiology and Preventive Medicine at Melbourne's Monash University, Technical Director of the Papua New Guinea National HIV/AIDS Support Project, and director of the Burnet Institute's HIV programme in the Lao PDR, which focuses on young people.

[1] Global Health Council, 2006, http://www.globalhealth.org; World Health Organization, 2005, http://www.who.int/immunization_monitoring/data/GlobalImmunizationData

[2] T Smart, "Children with HIV are being left behind in the rollout of antiretroviral therapy" in *HIV & AIDS Treatment in Practice #40*, 28 January, 2005

[3] P Nieburg, T Cannell & J S Morrison, *Expanded HIV Testing: Critical gateway to HIV treatment and prevention requires major resources, effective protections*. Center for Strategic and International Studies, 2005, http://www.csis.org/hivaids/expandedhivtesting.pdf (accessed 12 November 2005)

[4] W R Holmes, "Seeking rational policy settings for PMTCT", *The Lancet*, 366:1836, 2005

[5] Presented at the Third International AIDS Society conference in Rio de Janeiro, July 2005

by Carol Kidu

Protecting Pacific children from HIV/AIDS and its impact

Papua New Guinea has led the Pacific region in developing legislation relevant to HIV and AIDS, but legislation alone will not change the reality on the ground, reports Dame Carol Kidu.

Dame Carol Kidu with a group of school children; community ownership and empowerment are needed to protect children
Photo: *World Vision*

"There is no trust more sacred than the one the world holds with children."[1] This statement by Kofi Annan, Secretary General of the United Nations, challenges the global social conscience, knowing that the sacred trust is betrayed on a daily basis for millions of children.

For too long, Pacific nations lived with an image of children in happy, carefree, loving Pacific extended families – a myth that had shattered in reality long before we were willing to admit it. While Pacific nations have been picking up the broken pieces trying to focus on creating child-friendly communities, the rising tide of the global HIV epidemic has reached our shores.

For Papua New Guinea (PNG), the silent tide has spread into our communities. Like a wave, it is hard to confine the spread and to define the nature of HIV – leading to a deep-seated fear and rejection of reality.

The first diagnosed case of HIV infection in Papua New Guinea was in 1987. The Department of Health responded with low-level awareness and with the passage of the safe blood legislation in 1988, but political denial resulted in valuable time being lost.

Now in 2006, we are faced with a generalised epidemic, and HIV has been recognised as a critical emerging issue in the nation's Medium-Term Development Strategy 2005–2010. The National AIDS Council has been moved from the Health Department to the Prime Minister's Department with a Minister assisting the Prime Minister specifically on HIV/AIDS, and there is a Special Parliamentary Committee on HIV/AIDS.

PNG has led the Pacific region in terms of legislation relevant to HIV/AIDS, but legislation alone will not change the reality on the ground. Strong political commitment to community empowerment and ownership of the issue are fundamental to protecting our children from the impact of the reality.

The reality

In late 2005, UNICEF in partnership with the Government launched the "Unite for Children, Unite against AIDS" global campaign in PNG. Before this, most public awareness had focused on the adolescent and adult population.

The UNICEF booklet *Children and HIV/AIDS in Papua New Guinea* (2005) estimates that 11,000 children in PNG are currently infected with HIV. And about 800,000 children are affected by HIV and AIDS; that's about 37% of all children in PNG!

The numbers are frightening, but the human realities are heart-breaking

It is estimated that 9,400 children are currently orphaned and that the number will increase rapidly because of the continued high HIV infection rate. These quantitative academic facts are frightening, but the qualitative human realities are heart-breaking.

The extended family is often not able nor willing to cope, and grandmothers or young aunties are taking the burden alone, or some children fend for themselves. Government systems are unable to cope with the social and medical impact of HIV and increasingly the burden of prevention and care is being taken by NGOs and churches supported by international agencies and donors. This community-based approach to protecting our children is essential for sustainability.

Jeanette Southwell, of Anglicare STOPAIDS PNG, describes in detail the situation at family level:

> "Given the level of general unemployment and the reality that most wage earners support an extensive extended family, the added burden of 'full care' for three or four additional children places unrealistic expectations on an already over-extended family.
>
> Grandmothers play a key role as carers; initially caring for the dying son/daughter, they then find themselves supporting the orphan family. Often these women live in poverty... and they in turn rely on the children for support. These children are particularly vulnerable and will possibly be coerced into selling sex, drugs, gambling or dabbling in petty crime. ...It is vital that we look to establish positive support for orphans, especially through education and life skill training."

Protecting children

The National Strategic Plan (NSP) for HIV/AIDS 2004–2008 offers a broad strategic framework for

supporting orphans and vulnerable children. However, implementation of such strategies is largely in the hands of NGOs and churches because they have the networks on the ground.

The "Campaign for Children" initiative supports strategies for country-level programmes to protect vulnerable children around the "Four Ps":

- **P**revent mother-to-child-transmission ("pMTCT plus")
- **P**rovide pediatric treatment
- **P**revent infection among adolescents and young people
- **P**rotect and support children affected by HIV/AIDS

The primary prevention focus will be driven through intensified public advocacy, expansion of community mapping, and theatre against AIDS.

The major strategy for accelerating the prevention of mother-to-child HIV transmission (commonly known as "pMTCT plus") is integrating pMTCT into the existing health care system through the maternal and child health services. At the grassroots level of health sub-centres, 63% of health services are provided by missions, so the role of faith-based organisations in protecting our children is fundamental.

We cannot simply stand by and watch the disaster unfolding

Access to improved pediatric care, including access to anti-retroviral (ARV) treatment for HIV-infected children, will be facilitated in close collaboration with the World Health Organization's initiative for expanded access to ARV treatment. Theoretically it sounds good, but in reality over 80% of our population is rural-based, with limited access to even the most basic health services.

Noting that in the capital, Port Moresby, HIV/AIDS is now the third-highest cause of death in children, and causes prolonged ill health and misery, two leading PNG medical specialists have argued that the answer is "[putting] primary prevention of HIV in adults at the top of any prevention agenda. [Programmes to prevent parent-to-child-transmission...], implemented in many health facilities in the country, depend on knowing the pregnant mother's HIV status prior to delivery, [availability of] supervised anti-retroviral treatment for both mother and newborn baby, and infected mothers [being able] to make informed decisions about feeding options. Such programmes have significant implications for human resource planning and training."[2]

Violence is another contributing factor to vulnerability. A situational analysis of child sexual abuse and the commercial sexual exploitation of children in PNG was published in 2005 by an indigenous NGO, HELP Resources Inc., with the help of UNICEF. This confronting research revealed many child sexual abuse issues that had previously remained hidden. One positive trend is an increase in reporting, possibly reflecting an increased awareness of the rights of women and children.

Father Jude Ronayne-Forde is the HIV/AIDS Secretary in the Archdiocese of Port Moresby. He runs a day care centre, a hospice for HIV-positive mothers and school programmes for orphans and for children whose parents are HIV-positive, and sees the daily reality:

> "The parents get the HIV virus and die from AIDS related illnesses – but the children suffer for the rest of their lives! Protecting children means protecting mothers first (pMTCT)! A programme of care for children must begin when parents are firstly diagnosed as HIV-positive. A very bad time for children is in the weeks after their mother has died – often these children drift into malnutrition.
>
> Schooling, social life, security, love, a future – go out the window when parents die. We need to emphasise again and again the fundamental rights of children!"

A HOLISTIC RIGHTS-BASED APPROACH

For sustainability, a holistic rights-based approach to protection and programming is fundamental. This includes the right to education, the right to freedom from poverty, and the right to a life free from violence.

Building resilience in vulnerable children and helping them develop coping strategies requires an innovative approach to child care in PNG society. The National Catholic HIV/AIDS Secretariat has published a practical handbook, *Building Resilience Among Children Affected by HIV/AIDS*. The author of the book, Sister Silke-Andrea Mallmann CPS, states:

> "The dimension of the HIV/AIDS pandemic and its consquences... often make us feel powerless. As care-givers we are faced with an increasing number of children who have lost or are going to lose their parents. The impact challenges us to approach child care and education differently but we have experienced teachers and trainers on our side – the children themselves! ... Children need strong advocates to make their voices heard and to fight for their future."

HIV/AIDS is ravaging our country leaving many children orphaned without hope for a bright future. We cannot simply stand by and watch the disaster unfolding. We must plan now for psycho-social support for vulnerable children. They do not deserve their fate. There is nothing they did to justify their distress, their hardship and their loss. ■

Dame (Dr) Carol Kidu, MP, DBE is Papua New Guinea's Minister for Community Development.

[1] UNICEF, *The State of the World's Children 2000*, http://www.unicef.org/sowc00/foreword.htm

[2] Prof J Vince of the School of Medicine and Health Sciences, University of Papua New Guinea, and Dr Mobumo Kiromat of the Department of Pediatrics, Port Moresby General Hospital.

by Josée Verner

Children and AIDS: CIDA moves towards a comprehensive approach

The Minister of International Cooperation of the Government of Canada, host of the sixteenth International AIDS Conference, describes Canada's approach to supporting children affected by the HIV and AIDS pandemic.

In its recent call to arms, UNICEF rightly calls children "the missing face of AIDS". Every day, nearly 1,800 more children under 15 are newly infected with HIV, mostly from mother-to-child transmission, and another 1,400 die of AIDS-related causes. By 2010, AIDS is expected to orphan 25 million children.

Like many donors, the Canadian International Development Agency (CIDA) has supported projects and programmes that address the rights and needs of children living with or affected by HIV/AIDS. But too often, the sheer scope of the pandemic – and the inability of health, welfare, and educational systems, as well as families and communities, to cope – has overshadowed even the most successful programmes, thereby denying children their rights.

Funding for health systems

Since 2000, Canada has committed over US$800 million to the global fight against HIV/AIDS. These funds have addressed all aspects of the pandemic, including the needs of children who are affected, and infected, by HIV/AIDS. In Nigeria, for example, CIDA has provided $10 million to UNICEF to reduce mother-to-child transmission, improve care and support, and strengthen the abilities of families to care for affected children. The Canada Fund for Africa, the centre-piece of Canada's G8 commitments to Africa, has contributed $12 million to the Canadian Coalition for Youth and HIV/AIDS to strengthen local health systems and social institutions that can help protect infected and affected children in Burkina Faso, Mozambique, Kenya and Ethiopia. This has been complemented by a significant $50 million investment in AIDS vaccine research and development in Africa through both the International AIDS Vaccine Initiative and the African AIDS Vaccine Programme.

Overwhelmed hospitals and clinics cannot provide basic services to children

The pandemic's impact on health systems has been particularly detrimental to children. Overwhelmed with caring for AIDS-affected patients, hospitals and clinics cannot provide basic services to children with life-threatening illnesses such as pneumonia, diarrhea and malaria. In September 2005, CIDA launched a new "Agenda for Action on Health", which aims to strengthen national health systems with a focus on increasing the quantity and quality of human resources for health. Following this, furthermore, CIDA pledged $5 million to the World Health Organization to specifically help address the dire shortage of health workers in Africa.

Research for change

While these programmes continue, CIDA's Child Protection Research Fund (CPRF) has also funded research that, with children's participation, can inform policy and improve aid effectiveness.

In South Africa, for example, the high rates of HIV infection add to the problems of a country grappling with high incidences of child abuse and exploitation, increased numbers of street children, and children in conflict with the law. In 2002, CIDA's Children's Rights and Protection Unit, through the CPRF, enabled the International Institute for Child Rights at the University of Victoria to undertake "Circles of Care". This participatory research project harnesses the resilience of children and the capacity of families and communities to mobilise for action in the face of AIDS.

In northern Uganda, horrendous conditions in camps for displaced persons have led to a breakdown in traditional family structures and values. Women and children, and girls in particular, are vulnerable to sexual attack, communicable disease, systematic rape, forced prostitution and poverty. In 2002, CIDA enabled the Liu Institute for Global Issues at the University of British Columbia to look at how reviving traditional values could strengthen protection and psycho-social support for sexually exploited children in conflict situations.

These two HIV/AIDS research projects will be presented with 11 others at the Children's Rights and International Development Conference on 12–14 June 2006 in Ottawa. Sponsored by CIDA and the University of Ottawa, the conference will draw on experiences from the 13 CPRF Projects to explore issues of children's rights, protection and participation, children and armed conflict, child labour, violence and sexual exploitation, children and institutional care, and alternative approaches to children's rights and protection.

In late 2005, on a parallel track, CIDA commissioned UNICEF to produce "Child Protection and HIV/AIDS", a paper that will look at how bi-lateral and multi-lateral donors, international NGOs and governments can best implement the *Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS.*

Millions of children, adolescents and young people are at risk from HIV/AIDS; the pandemic threatens their own futures. It also under-mines global efforts to reach the Millennium Development Goals. By taking an increasingly comprehensive approach to the diverse challenges of children and HIV/AIDS, CIDA hopes to make a difference on both counts. ■

The Honourable Josée Verner, PC, MP is Canada's Minister of International Cooperation and Minister for La Francophonie and Official Languages.

living with HIV and AIDS

Kunthata Chimoto: "I am now strong, and I am back at school."
Photo: World Vision

Kunthata Chimoto, 16

GRADE SIX, NTHONDO, MALAWI

"My parents died of AIDS. I cannot remember how they looked, what they liked or how they would want me to live. I miss them. I don't know what it would be like to have biological parents.

My grandmother knew that I was HIV-positive before I did. The doctor and my grandmother thought I was too young, at 14, to know my HIV status.

My peers already suspected. I had lost weight, had skin rashes and frequent coughs. It was distressing because I did not know the truth. My grandmother underestimated my ability to understand. After a year of uncertainty she finally told me my status because she knew it was the only way I might get anti-retroviral drugs and counselling. I was not surprised, but it was as if my death sentence was confirmed. I was distressed for three months. I saw no reason to live. I could not go out and chat with even my closest friend and if she came to visit me I refused to talk.

Our community Medical Assistant counselled me on how to live positively with HIV, and from that I became a transformed person. I decided to live on with HIV. I came out and joined the community. I played with my friends.

About a year later, I started talking about my status openly among friends, family members and villagers. I needed to speak out so people could understand and support me, but also to let them know that HIV is real, painful and should be avoided.

It was not easy. Many of my friends did not want to be seen with me. They believed I would infect them and their parents told them to avoid me. But the church slowly understood and people started praying for me. They supported me. Toward the end of last year I became very sick, bed-ridden, and I was discharged from the hospital to die. World Vision took me to a private Catholic hospital where nuns provided me with loving care.

I was still struggling with skin cancer. At this time World Vision and Ntchisi District Hospital referred me to a government institution that provides anti-retrovirals. The first two weeks were difficult, but after three weeks the drugs helped me to gain weight. I am now strong. I'm a member of a village youth group that works on HIV and AIDS, and I am back at school.

Malawian children who cannot access anti-retrovirals are in as hopeless a situation as I was. Their future is finished. They are in pain. Many are living far away from the hospitals that can provide the drugs. They cannot walk, they can't afford transport.

My cousin Kelvin had AIDS. He was staying with an old grandmother who could not help him to get anti-retrovirals, and he died. That is an awful thing, and now that we can stop it from happening, we must. Adults often have ways to afford anti-retrovirals, but children depend on the consideration of others. Anti-retrovirals must be provided for children in their village. We need food to support the treatments. We need clothes. We need love. Government, NGOs and people with power and money should not forget to share with the poor in need." ■

[see Kelvin's story next page]

Global life
VOICES OF LIFE FROM AROUND THE GLOBE

Liweleya Situmbeko, 17

MONGU, ZAMBIA

Photos

Left - Liweleya is protective towards his younger sister Memory.
Photo: *Corey Wright / World Vision*

Centre - Mirabela works to bring children with HIV and AIDS and perfectly healthy children together, in order to break stigma.
Photo: *Corina Iordanescu / World Vision*

Far Right - Brahmaramba Allure taking tuition for children in the community.
Photo: *Reena Samuel / World Vision*

"I started secondary school in 2001 and soon realised that the general attitude toward girls is negative – they are considered second-class and inferior.

Males believe that females have less capacity in everything. A boy wants a lot of girlfriends, meaning sexual partners. This is acceptable and even encouraged. His friends will praise him for that. You get status, you become popular.

But the attitude of these same people towards girls is something else; if a girl has several boyfriends she will be called bad names.

This encourages male youth to bad behaviour. They think it's something a man has to do. Boys always want to control the relationship. They feel they should have the power to do anything. They are acting out what they observe at home. They are brought up to believe a man must control a woman.

If a boy proposes sex to a girl and she refuses, he will plead with her and then threaten to ruin her reputation. The girl loses her dignity and her friends; she is being tortured emotionally.

I think these attitudes are wrong. Mostly I disagree silently. It's very difficult to oppose these attitudes by myself, one male against ten.

I believe you should treat other people just as you want them to treat you. If you want to live a good life, behave well toward others who are weaker than you.

I was brought up by my mother. My father left us when we were still young. My mother took care of me and my sister Memory. Mother was facing problems while my father was doing well by himself. She suffered because of the bad attitudes of men around her.

My sister is 13 and now I fear for her. That's why I am speaking out. Often I am thinking about something else, and when she passes by I start to worry – what is going to happen to her?

Let's say a male proposes sex. She may agree because she is afraid the guy will bring problems for her. She might become pregnant, she might get sexually transmitted infections and even HIV. Instead of her concentrating on school, she will worry about AIDS and lose everything.

We need to see this discussed on TV and radio and in magazines. It would be helpful to start peer education programmes on gender. With peer education, a male can stand and speak to other males. He can be given an official role and a chance to express all his feelings.

If a male, who is well-known among his peers, is the one to say that it's bad to have such negative attitudes towards females, it will be effective. With male youth speaking against these attitudes, there can be a change."

Stories compiled by Mr Nigel Marsh, World Vision.

Kunthata Chimoto's cousin, Kelvin Mkuntha (pictured aged 14), told his story some months before he died, during a regular visit by community-based care workers. He believed he had contracted HIV while nursing his mother as she died of AIDS.

"I was doing well in class, and I liked mathematics best, so I'm sorry not to be there," he said. "I've just been too unwell this year, with the sores in my mouth and pain in the throat. I'm also coughing a lot, and I've got bad diarrhea.

"I believe people don't die forever – there is life after death, and my mother is still alive in heaven. Heaven is up there, a joyful place, where there is God, and Jesus, and life forever. I'd like to see that. If I want to get there, I have to die first, haven't I?"

Kelvin's story appeared in *Global Future* in 2004.

Global

VOICES OF LIFE FROM ARO

"Mirabela", 17

FROM ROMANIA'S NETWORK OF YOUNG FIGHTERS AGAINST HIV AND AIDS

"Since I was a little girl, I have carried an immense sorrow in my heart. Now, I am 17 years old, and I'm just starting to realise how serious it is.

I am infected with a cruel and unforgiving virus that wants to have my life.

The HIV virus appeared in my country in 1988, the year I was born. As I was growing up I felt such anger, thinking of the heartlessness of those who made thousands of children like me suffer for their irresponsible actions. I used to wonder what I had done wrong to be punished this way. I realise now that many people have spread and contracted the virus through ignorance and misinformation.

There is still a huge need for accurate information in our education system, and the media has a responsibility to raise awareness about HIV and AIDS throughout Romania.

Many avoid people they know to have HIV. They hide from the issue and have no comprehension of the devastating impact this has on a person's life. Too often, people have to become infected to understand the suffering that comes with HIV and how they could have protected themselves.

This is why none of my friends or even my loved ones knows I have HIV. I hear my friends saying "I'm glad I don't have AIDS," or "Would you have the courage to touch somebody who has AIDS?". So how can I tell them I have HIV?

At the moment, I look like a perfectly healthy, typical teenager and an optimistic one at that. It is hard to explain what I feel when I think that I may develop AIDS, and how it feels to live with the uncertainty of not knowing if that will actually happen. I would be lying if I said that what is yet to come doesn't frighten me, but I tell myself that I will never give up my life.

I will fight together with other children and we will be healed because we believe in God. We have HIV or AIDS and that gives us a strong motivation to live every moment of our lives as if they were our last. Late in the evening, when we go to bed, we don't know if next morning we'll wake up to see the beauty of nature and the beloved people in our lives.

I haven't lost the strength to fight the pain and isolation that living with HIV brings. I laugh with my friends and enjoy every moment of time spent with them, knowing that one day I will win this battle."

Brahmaramba Allure, 16

OLD SINGARAYAKONDA, SOUTHERN INDIA

"I live with my brother Subarao, who is 13, and my grandfather who is 80. I lost both my parents to AIDS last year.

My father was a carpenter and my mother a daily labourer. They looked after us with a lot of love. I wanted to become a teacher and my father assured me that I could study as long as I wanted to.

Last February, my father fell ill with fevers and was unable to go to work. He became thin and weak. He was tested and found he had HIV. He did not share the results with me, but I saw the report and wept bitterly.

Two weeks after my father's test my mother was also asked to do the same test and was found HIV-positive. I took care of my father. I was very disturbed and could not focus on my studies.

My father died the day before my exams began. My mother fell ill within a week and never recovered. There was no food as no-one was earning. We spent days without food. For a week before her death, Mother was bed-ridden. We could not afford to admit her to hospital so we looked after her at home. I never expected my mother to die so fast, within two months of my father.

I was depressed. All day I thought about my brother, my studies, and whether my relatives would look after us. People who were affectionate before would not come close to us. Neighbours stopped visiting our house.

I stopped my studies to earn so my brother could go to school. I was only able to get a job in a tobacco grading unit, working every day and earning 810 rupees (US$18) a month. I hated the job; I had always expected to be a teacher.

I am now working as a tutor in a school run by World Vision. I am the bread-winner. I will take care of my brother and grandfather and will help my brother complete his studies. I wish I had my parents. I did not want to do this, but I am forced into it.

In our society, it is impossible to insist on an AIDS test before marriage. I know I am vulnerable. I feel threatened by this disease. If we start talking then other children will not have to go through what I suffered. I have started discussing it in my coaching class and with the friends in Karunamaya Children's Club, a group of 12 of us who meet every month.

Now I am ready to talk to others about AIDS and spread awareness of HIV. Men from the village go to the city and come back to their wives once a year. Some women enter into prostitution, while landlords force others into sex. Some of the young boys in the village have already been with women. It's important that young people are educated about HIV and how it spreads like this – especially girls."

life

UND THE GLOBE

"Pedrito", 10

Chiquimula, Guatemala

Pedrito's community now has more understanding about HIV and AIDS.
Photo: Cecilio Martinez / World Vision

"I attend third grade in a local primary school. I like to play ball, go fishing and climb trees. My town is a small village in the east of the country, very far from Guatemala City. My grandpa and other farmers grow beans, corn and fruit for us to eat. Some of their crops are sold. It's very hot here.

At home we live with my two grandparents, my sister Carla and my mum Teresa, who is sick. I'm afraid of my mum's disease; they say I can become infected. Some children and other people from town told me: "Your mother has AIDS!"

I didn't know that until my dad died a short time ago. I miss him a lot, because we used to play and go out to the fields. They took blood from my sister and me... luckily, nothing bad was in it.

My mum was very sick and no-one wanted to take her to the hospital because they said that she was going to die. At school and in the streets they used to say bad things to us about my mother. I didn't like that; I used to get really angry.

Teachers and nurses from the health centre told the people that my mum was not going to die and that they were going to give her medication. Also, the pastor at church talked to everyone and asked them to help my mum; they even marched with balloons and banners to teach people.

After that, people stopped saying bad things to us in the streets. Now, they come from church to pray and other children play with us.

I remind mum when it's time to take her medicines if she forgets. I like to do it, because she takes the medicines and feels happy. She's even going to get a job at the drugstore. I want my mummy to live. That's why I think the best medicine she can get is our love and joy."

"Heartprints"

World Vision gave disposable cameras to children in AIDS-affected parts of Zimbabwe, Uganda, Kenya and Tanzania and asked them to illustrate aspects of their lives. The photographs have been used in exhibitions and on an interactive CD. They show that children are not just passive victims of the pandemic, but display a full range of emotional and practical involvement.

Photos by (L to R) - Dorothy Nakayima (Uganda), Wilson Olwenyo (Kenya), Everton Masiiwe (Zimbabwe), Millicent Akinyi (Kenya)

Global life

VOICES OF LIFE FROM AROUND THE GLOBE

Re-thinking our HIV and AIDS approach: where are the gaps?

Much more is needed to prevent mother-to-child transmission, to diagnose and treat infected infants and children, and to address the field of sexually transmitted diseases, argues Luisa Morgantini.

Every day, as many as 1,300 children die from HIV/AIDS-related illnesses across the world. UNICEF recently highlighted the plight of children in the face of this crisis, reminding us that children affected by the disease are often the "missing face" of AIDS. Children are missing not only from policy discussions, but they also lack access to the most basic care and prevention services.[1]

Since 1987 the European Commission has worked to reduce the spread of HIV/AIDS in the developing world, but statistics show us that it's not enough. The European Union HIV/AIDS Programme in Developing Countries has co-operated with governments and non-governmental organisations, international agencies and the United Nations. Since its inception, the programme has implemented HIV/AIDS interventions in at least 90 developing countries, embracing and incorporating the links between HIV/AIDS, poverty, and sexual and reproductive health and rights.

But our strategy was not adequate, as the dramatic actual situation demonstrates.

More can be done

We must increase the prevention of mother-to-child transmission. The majority of the half-million children under the age of 15 who die from AIDS-related illnesses every year contract HIV through mother-to-child transmission.

We have to support activities that include the fields of sexually transmitted diseases. We need to fight against dogmatic propaganda that promotes abstinence as the entire solution to the spread of HIV/AIDS, even in situations where it is highly unlikely to be practised, and that blocks people's access to condoms, which can be the most effective preventive tool in many situations.

We also have to strengthen education for young people in and out of school through media information campaigns. The vast majority of adolescents and young people aged 15–24, in fact, have no access to the information needed to protect themselves from HIV. Communication is the first step on the way to prevention.

But it is still not enough...

UNAIDS data show that pediatric treatments must be strongly implemented.[2] Less than 5% of HIV-positive children in need of AIDS treatment are receiving it, and only 1% of children born to HIV-infected mothers have access to the low-cost antibiotics.[3] Children with HIV/AIDS are missing out on treatment because of a shortage of specially-designed drugs; commercial pharmaceutical companies have not developed pediatric formulations of AIDS medicines because children are not an attractive market. It is not a coincidence that the AIDS crisis has exploded most dramatically in highly indebted countries. Africa is without doubt the region most affected by the virus. Inhabited by just 10% of the world's population, Africa is estimated to have more than 60% of the HIV-infected population.

Pharmaceutical companies maintain control over who can manufacture their patented drugs and how much they cost. Generic drug manufacturers have not been allowed to create cheap versions of AIDS drugs, with which developing nations would drive down costs and make the drugs more widely available.

Corporations need to put human security before profit

The international community and European Union have to pressure the big pharmaceutical corporations to put human security before profit.

For a long time, civil society, movements, associations and NGOs have been fighting against the spread of the pandemic and working with infected people, especially in the poorest areas of the world. Our role is also to support their efforts.

Finally, more efficient preventive measures need to be strongly supported; promoting abstinence alone or refusing condoms even in situations where they can be the most effective solution will only fuel the spread of the epidemic. Access to medicines for everybody has to be achieved. Freedom from diseases has to become a right for all. ■

Ms Luisa Morgantini is an Italian Member of the European Parliament and Chair of the European Parliament's Development Committee. She is a leading member of the Italian peace movement and was one of the founders of the Women in Black anti-war organisation.

[1] UNICEF, *Unite for children, Unite against AIDS*, http://www.unicef.org/uniteforchildren/press/press_29373.htm

[2] UNICEF, *A Call to Action: Children – the missing face of AIDS*, 2005, http://data.unaids.org/Publications/ExternalDocuments/UNICEF_Unitedforchildren_25Oct05_en.pdf

[3] UNICEF, *op. cit.*

by Christoph Benn

Acting on what we know about children and HIV and AIDS: the role of the Global Fund

Increased funding for HIV/AIDS over the past decade has not halted the growth of the pandemic, says Christoph Benn. More resources and greater commitment are needed.

Increased funding for HIV/AIDS over the past decade has not translated into the scale-up of critical child- and adolescent-targeted interventions that are necessary to halt the growth of the pandemic and mitigate its impact.

The Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria was created in 2002 to bring about a massive increase in the financing available to fight these three diseases, the world's top infectious disease killers. Established and given its mandate by governments (North and South), by the UN and by a broad swathe of groups representing civil society, the Global Fund is an effective and flexible mechanism that complements national, bi-lateral and multi-lateral funds and programmes, and allows eligible countries to determine how best to apply funding.

In the fight against HIV/AIDS, the Global Fund has rapidly become an important source of funding, filling gaps in the national plans of low- and middle-income countries. It is therefore a critical piece in the financing puzzle for neglected interventions such as those that target children and adolescents.

What we know: key areas of neglect

The growing number of new infections in children and young people around the world is proof that key interventions are globally under-funded and under-prioritised. In late 2005, UNICEF launched a campaign, "Unite for children, unite against AIDS", to get children and young people onto the HIV/AIDS agenda. UNICEF has set important and ambitious goals for pediatric treatment of HIV/AIDS, prevention of mother-to-child transmission of HIV/AIDS, prevention of HIV infections among adolescents and young people, and care and support for children affected by HIV/AIDS. Global commitment, priorities and funding must be greatly increased in order to scale up the programmes that will lead to these dramatic results.

Prevention of mother-to-child transmission. We know that more than two million children are living with HIV right now; most of them contracted HIV from their mothers during pregnancy, childbirth or breastfeeding. And we know that prevention of mother-to-child transmission, the most effective way to avert HIV infection in children, is woefully insufficient almost everywhere except in the wealthiest nations. While only 1–2% of babies born to North American and European women living with HIV contract HIV from their mothers, the global average is 35%.

Accessible pediatric treatment. We know that treatment for children living with HIV/AIDS is inadequate. Very few of the drugs available come in pediatric formulations, and those that do are priced well out of the reach of most families (and taste terrible, which matters when you are administering treatment to a child every day).

Orphans and vulnerable children. We know that approximately 15 million children have been orphaned by HIV/AIDS in the last 25 years and that over the next ten years, this number will increase by millions more. While many of these children have been taken in by extended family members, communities are now stretched to the limits of their capacity to care for orphaned children. Many of these children are not receiving adequate care, nutrition or education. Many live in child-headed households where they are vulnerable to neighbours and extended family members who may take the little they do have, including their homes and crops.

New infections are increasing for children and young people, key interventions are under-funded

HIV prevention for children, adolescents and young people. Finally, we know that most adolescents and young people do not have adequate information to protect themselves from HIV. In the rapidly growing epidemic in Eastern Europe and Central Asia, 75% of new infections are being diagnosed in young people. Despite 25 years of experience in responding to the HIV/AIDS pandemic, each new generation remains largely ignorant of the means of transmission and prevention of HIV infection or lacks the tools to do anything about it.

What we know is needed

These areas of neglect have been well documented. Governments know the scope of the problem. Resources to fight HIV/AIDS have grown in the past five to ten years, thanks to increasing domestic dollars

being earmarked for HIV/AIDS, and large, newly dedicated sources of funding such as the Global Fund and also the World Bank and the US President's Emergency Plan for AIDS Relief. Yet this has not been enough to translate what we know into global action to decrease the number of new HIV infections and address neglected interventions for children and adolescents.

Without child- and adolescent-targeted interventions, the Millennium Development Goals don't have a chance

Greatly increased resources. Despite recent funding increases, the global resource gap in the fight against HIV/AIDS remains enormous. In 2005, an estimated US$8.3 billion was available to fight HIV/AIDS globally from all sources, compared to $300 million in 1996. These funds are financing critically important interventions, the most prominent – and expensive – being anti-retroviral treatment for people living with HIV/AIDS. Yet urgently needed child- and adolescent-targeted interventions – without which the Millennium Development Goals do not have a chance – have remained desperately under-funded. Governments must live up to their commitments to increase funding in terms of domestic health budgets and international health development financing.

UNAIDS has estimated the cost of reaching the UNICEF goals to be approximately $6 billion per year from 2006 through 2010. As an important and growing source of additional funding to fight HIV/AIDS globally, the Global Fund will be a significant financier of the programmes to be scaled up to meet these goals. Donor nations can complement their bi-lateral programmes to fight HIV/AIDS by channelling additional financing through the Global Fund.

Increased commitment. The UNICEF campaign is a call to governmental and non-governmental partners alike to get children and young people onto the HIV/AIDS agenda. The national HIV/AIDS control plans of all affected countries must include strategies for meeting these goals. The African Union has pledged its support to the UNICEF campaign and has included orphans and vulnerable children in its HIV/AIDS Strategic Plan.

There is an important role particularly for faith-based organisations and other non-governmental partners to implement programmes targeting children affected by HIV/AIDS. Several studies have shown that it is particularly the religious communities and congregations who care for these most vulnerable children. The heroic efforts of communities, families and individuals at the frontline of the fight against HIV/AIDS need to be strongly supported by the international community. Organisations that wish to submit proposals to the Global Fund do so through a Country Coordinating Mechanism (CCM), which represents all stakeholders, public and private. In most cases a representative of the faith-based community is a member of the CCM.

Children do not have a strong lobby. Adults affected by HIV/AIDS can organise themselves and become advocates. That is why ministries and decision makers will normally give priority to grants promising to reduce adult HIV prevalence rates. But funding organisations can and must indicate their strong support for OVC programmes.

Maximising the Global Fund as a source of financing

Data is starting to show the impact of Global Fund financing. By December 2005, when the average age of Global Fund grants was only 18 months, financed programmes had already supported anti-retroviral treatment for 384,000 people and community outreach for HIV prevention education for 7.9 million people.

As with much of the data currently collected around the world, these totals mask the numbers of children and adolescents reached. In terms of some of the available child- and adolescent-specific data, however, Global Fund grants financed programmes that served 116,000 women for the prevention of mother-to-child transmission of HIV and provided care and support for 496,800 orphans and vulnerable children.

These latter programmes ranged from nutritional support for child-headed households, to school fees, to health insurance for orphans. In Swaziland, for example, 28,546 children have received educational scholarships and in Cameroon 3,344 children are benefiting from medical and nutritional support.

The Global AIDS Alliance has put out a call to make the next round of Global Fund financing the "orphans' and vulnerable children's round". The Global Fund plans to make another call for proposals in 2006. In response to that call, eligible countries must be supported in submitting high-quality proposals that include neglected interventions to ensure that approved proposals are filling these critical gaps. ■

Dr Christoph Benn is Director of External Relations with The Global Fund to Fight AIDS, Tuberculosis and Malaria.

References used:
UNAIDS, *Pediatric HIV Infection and AIDS*, 2002; *AIDS Epidemic Update 2005*; *Resource Needs for an Expanded Response to AIDS in Low- and Middle-Income Countries*, 2005
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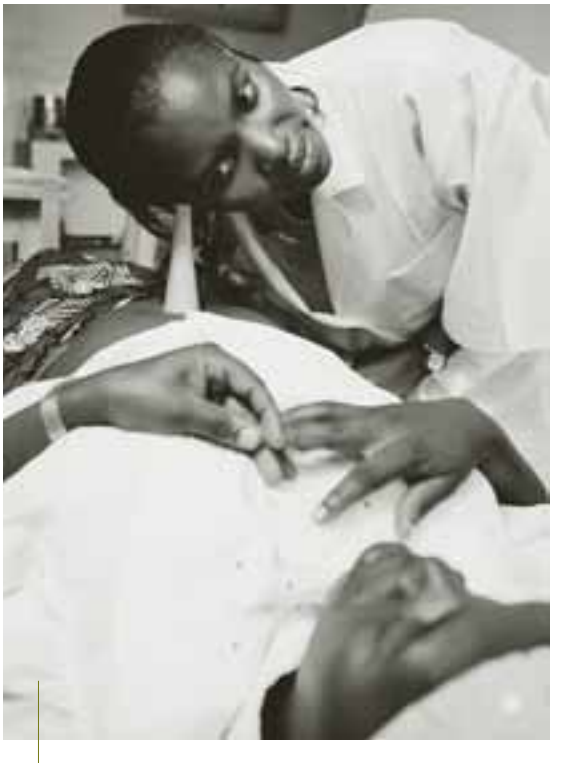

In the Shyorongi Health Center, Rwanda, community health workers provide counselling and diagnostic services to pregnant women. Plural grants worth over US$90 million provide support to such programmes. ***Photo:*** *John Rae / The Global Fund*

by Mark Lorey and Martha Newsome

World Vision's child-focused response to the AIDS pandemic

World Vision's child-focused response to the pandemic is based not only on the agency's core commitment to children, but also on an assessment of the most strategic ways to invest resources in the fight against AIDS. Mark Lorey and Martha Newsome explain.

As part of the Hope Initiative, some schools in Thailand teach their students about ARV treatment, caring for people affected with AIDS, and protecting themselves against HIV.
Photo: *Somluck Khamsaen / World Vision*

Since the advent of AIDS, care and prevention for children has been at the bottom of the world's list of priorities for HIV response – or off the list entirely.

In this era of global interdependence, no country is immune from the effects of crises in other parts of the world. If the global community fails to prevent new infections among children at risk of HIV and fails to facilitate care for the millions of children already made severely vulnerable by AIDS, the consequences will be dire – for the children themselves, for their families, communities and countries, and for all of us in the human family.

For more than 50 years, World Vision has partnered with communities working for the well-being of children. In many parts of the world, the AIDS pandemic threatens to reverse all the progress to date in improving health and nutrition, expanding educational opportunities, and strengthening household livelihoods.

The AIDS pandemic is a crisis of unparalleled scope and scale, with devastating impacts on children. In light of the enormity and severity of the pandemic in Africa and the increasing potential for catastrophic prevalence rates in Asia/Pacific, Latin America/Caribbean, and Eastern Europe, World Vision has developed an organisation-wide initiative focusing human, technical, and financial resources on maximising our contributions toward addressing the pandemic.

The Hope Initiative is World Vision's effort to enhance and expand responses to HIV and AIDS in all of the more than 90 countries where World Vision operates. The initiative's overall goal is to reduce the global impact of HIV and AIDS on children, their families and communities.

World Vision's core response to the pandemic is strongly child-focused. This reflects not only our organisational commitment to children, but also our assessment of the most strategic ways to invest resources in the fight against AIDS.

Care for orphans and vulnerable children essential

The AIDS pandemic is leaving an unprecedented number of children orphaned and rendering many more children vulnerable. Children made vulnerable by AIDS include children who are living with HIV and AIDS, children whose parents are living with HIV and AIDS, and children in households that have absorbed orphans.

A recent World Vision study in four countries in sub-Saharan Africa showed that, compared to children in the general population, orphans are less likely to have access to basic needs. Many orphans face property grabbing and other forms of discrimination, abuse and exploitation. Deprived of parental guidance and protection, orphans often become highly vulnerable to HIV infection.[1]

In many communities, the extended family system and other traditional safety nets providing care for orphans and vulnerable children (OVC) are being severely strained by the multiple, mutually exacerbating impacts of HIV and AIDS. The challenge is to find ways to help communities care for the unprecedented number of children and families made vulnerable by the HIV pandemic.

Care for OVC is the highest priority in World Vision's global HIV response because:

- as a child-focused Christian organisation, World Vision is called to respond to AIDS as the greatest humanitarian crisis facing the world's children;
- OVC are among those most severely affected by AIDS and most neglected in AIDS programming to date;
- investing in OVC is a critical investment in the future strength and security of their communities and countries;
- care for OVC is a powerful common ground for initiating broader response to HIV and AIDS in communities; and
- strengthening support for OVC can reduce their long-term risk of contracting and transmitting HIV.

World Vision utilises OVC programming strategies that have been developed through more than ten years of experience in AIDS-affected communities, and that are aligned with globally-agreed best practices in promoting OVC care. Our focus is on strengthening family and community care for OVC, primarily through support of community-led care coalitions that bring together churches

and other faith communities, government, local business, community-based organisations and other NGOs. At the end of 2005, more than 340,000 OVC in Africa had been reached through this community-led care approach, involving more than 16,000 volunteer care-givers.

Building on efforts already underway in the community, these coalitions identify the most vulnerable local children, then take responsibility for supporting volunteer care-givers who monitor, assist and protect OVC through regular visits to the children and their households. World Vision's roles are to:

- mobilise these coalitions where necessary;
- strengthen their technical and general organisational capacities;
- help them train and support volunteer care-givers;
- provide modest amounts of financial and material support;
- link them to other sources of support; and
- advocate for more resources to be made available for their work.

The window of hope

HIV prevention among children is World Vision's top priority in our overall prevention programming. Girls and boys between the ages of five and 15 constitute a "window of hope" for HIV prevention. Because these children are generally not yet sexually active and have among the lowest HIV prevalence rates in the overall population, prevention efforts focusing on them have the potential to make a large and lasting impact. We employ two main approaches to this end.

Prioritising children in HIV response is a moral imperative and a strategic necessity

The first approach focuses on ensuring that children acquire the knowledge, attitudes and skills they need to protect themselves before they enter the high-risk period of later adolescence and young adulthood. To reach all children in a community, we provide age-appropriate, values-based life skills materials and training to a range of community volunteers – including teachers and community, church, and other faith leaders – who then train children. As well as providing children with the basic facts about how they can protect themselves from HIV infection, the training builds self-esteem, helps children form and maintain healthy relationships with family and friends, and develops skills in communication, negotiation, and decision-making. By the end of 2005, over 300,000 primary school students in Africa had received this training. World Vision has also equipped more than 17,500 children to serve as peer educators, helping other children to sustain healthy behaviours.

The second approach helps communities to protect their children from neglect, exploitation and abuse and to change local practices that increase children's gender-based vulnerability to HIV. In relief and development programming, World Vision works with community care coalitions, churches and faith communities, and other community groups to support community-led child protection with a special focus on HIV risk reduction. A particularly promising approach is a "community conversations" model that brings together key opinion-leaders in communities (including traditional authorities, faith leaders, government officials and others) to identify the attitudes and practices that lead to girls' and boys' vulnerability to HIV and to develop a plan for modifying these to reduce risk.

Prioritisation, partnerships, learning

It is both a moral imperative and a strategic necessity to make children a top priority on the global HIV and AIDS agenda.

In the face of the pandemic's enormity, no single organisation can make an adequate difference alone. The Hope Initiative is World Vision's commitment to do our part to address the AIDS crisis in all the countries where we work, in respectful partnerships with governments, churches and other faith communities, other agencies, communities, families, and children. We welcome the opportunity to learn from others engaged in HIV response and to share our learnings with those seeking to serve children affected by HIV and AIDS.[2] ■

Mr Mark Lorey is Director of Research, Development and Learning for World Vision's HIV and AIDS Hope Initiative. Ms Martha Newsome is Regional HIV and AIDS Director for World Vision in Africa.

[1] World Vision UK, *More Than Words? Actions for Orphans and Vulnerable Children in Africa. Monitoring progress towards the UN Declaration of Commitment on HIV/AIDS*, 2005. The countries in the study were Ethiopia, Mozambique, Uganda and Zambia.

[2] A wide range of World Vision resource materials for organisations interested in OVC care, HIV prevention for children, and other child-focused HIV programming is available through the World Vision HIV and AIDS Library: http://www.worldvision.org/help/aids-lib.nsf.

Do you know?

- *In 2005, the world counted 40.3 million HIV-infected people, including 2.3 million children.*[1]
- *The HIV rate increased between 2003 and 2005 in all regions except the Caribbean, where it remained about the same. The largest percentage gains were in East Asia (26%) and Eastern Europe and Central Asia (33.3%).*[2]
- *Over half a million children under 15 died in 2005 due to AIDS-related causes. This translates to a child dying every minute of every day.*[3]
- *ARV or other drug treatments are available to less than 2% of HIV-infected children.*[4]
- *World-wide, at least 15 million children have lost one or both parents to AIDS, and the number of children orphaned by AIDS is expected to grow to 25 million by 2015.*[5]
- *Because of the 10-year time lag between infection and death, the number of orphans will continue to rise for at least the next decade.*[6]
- *2006 pledges of US$1.9 billion for the Global Fund for AIDS, Tuberculosis, and Malaria (GFATM) from wealthy countries falls far short of the US$3 billion requested by UNAIDS.*[7]
- *In 2005, World Vision committed more than US$57 million to HIV and AIDS programmes.*[8]
- *Young people offer the greatest hope for defeating HIV and AIDS. In some countries where treating young people is a priority, prevalence rates have dropped by a third!*[9]

Sources: [1]UNAIDS, *AIDS Epidemic Update: 2005*, December 2005. [2]*ibid.* [3]*ibid.* [4]*ibid.* [5]*ibid.* [6]UNICEF, http://www.unicef.org/media/media_9473.html [7]Global Fund, *Monthly Progress Update*, 27 January 2006 [8]World Vision Hope Initiative [9]UNICEF, *op. cit.*

by Jim Yong Kim

Providing hope for children affected by AIDS

Social policy frameworks must integrate HIV and AIDS response with health, education and economic policies, says Jim Yong Kim.

This book loan shop in Myanmar helps people affected by HIV and AIDS, raising extra income for those who fall sick or need drugs or hospital treatment. Such support is vital where there is no social security system to help in times of crisis.
Photo: *James East / World Vision*

Only a few years ago, most of the world thought it was an impossible challenge to treat HIV/AIDS in developing countries. Today, that has changed. Countries both rich and poor are committed to universal access to treatment, billions in funding are available, and treatment programmes are being scaled up at a rate never before imagined.

In 2003, when the World Health Organization launched the "3x5 Initiative" to put three million patients in poor countries on anti-retroviral (ARV) therapy, only a few developing countries had treatment programmes. Today, over 50 countries have more than doubled the number of people receiving ARV therapy.

This is progress to be celebrated, although admittedly we have taken just the first steps in the long journey to control the AIDS pandemic. As one critical next step in that journey, we must immediately turn our attention to the millions of children around the world affected by AIDS.

We must commit to an all-out effort to rapidly scale up anti-retroviral treatment programmes for children. Currently, the number of HIV-positive children receiving treatment is woefully small.

Treating children brings a new set of challenges that must be met. Dramatically increasing the availability of medications specifically formulated for children is critical. Treatment with adult medications, using what is essentially guesswork, greatly increases the likelihood that children will receive improper doses and develop resistance to otherwise life-saving medications.

The ripple effect of HIV/AIDS threatens the fabric and future of whole societies

Diagnostics must also be more widely available for babies under 18 months. Tests that work well are available, but they are extremely expensive. Advocacy efforts to bring the cost down are key. Effective treatment facilities must be available, for both adults and children, and clinics that offer HIV/AIDS services integrated with primary care are widely proving to be the best approach.

Finally, the number of physicians, nurses and other health workers with experience treating HIV/AIDS is very small, not just in the developing world, but everywhere. Training must be scaled up along with treatment.

The need for social support

All of these steps are critically important, but they are not sufficient. Children are especially vulnerable to the social impacts of the HIV/AIDS pandemic, and effective treatment efforts must be paired with equally robust efforts to offer social support for all affected children. These efforts must reach not only children living with HIV, but the millions more at risk due to the impact of AIDS on their parents, families and communities. This comprehensive definition of treatment is mandated not simply by humanitarianism, but because the ripple effect of HIV/AIDS on children threatens the fabric and future of whole societies.

Family and community structures are being stretched to breaking point, as poor households that take in orphans struggle to meet the costs of a larger family. The impacts are immediate, but also have serious long-term repercussions. For example, many vulnerable children are forced to forego educational opportunities that are their very hope for the future. Young girls are at particular risk.

What do these millions of vulnerable children need?

Food. Children in the developing world are already vulnerable to hunger, which is the direct or indirect cause of as many as 60% of all childhood deaths in the developing world. The link between proper nutrition and good health, early childhood development, maternal survival and the ability to learn is irrefutable. The impact of the AIDS epidemic on the availability of food runs the gamut from the overall disintegration of food production systems to the unbearable pressure on individual families to feed themselves. Vulnerable children must have access to supplemental feeding programmes.

Financial support. In addition, providing even minimal levels of financial support to poor families can make the difference between hunger and proper nutrition. Direct cash transfers to poor families are not being provided in adequate amounts, even though evidence shows that where they are available, the impact on helping families

support children in their care is significant. Micro-credit and other income-generation approaches also have a role to play.

Basic health. Children impacted by HIV/AIDS must also have access to a solid set of basic health services. For children living with HIV, treatment must be given in the context of overall health care. But children who are free of the virus are also increasingly vulnerable to disease as economic and social conditions deteriorate. The risks of tuberculosis, malaria and malnutrition are high. For example, over 750,000 African children die each year of malaria. Every 10 seconds a child dies of a disease that could have been prevented by a vaccine. We can not allow a generation of children to be at even greater risk of poor health than has been true in the past. Ensuring that these children have good access to health services also creates an opportunity to bolster fragile health infrastructures to the benefit of poor people of all ages.

Every 10 seconds a child dies of a disease that vaccine could prevent

Education. Making sure that vulnerable children stay in school is also key, for a broad array of reasons. Unfortunately, this goal is routinely undermined when paying school fees proves an insurmountable barrier for poor families. The experience in Kenya provides striking evidence of the impact of AIDS on children's education, as well as of the benefit of eliminating school fees. A survey in Kenya found that 52% of AIDS orphans were no longer in school, as compared to only 2% of non-orphans. When Kenya eliminated schools fees in 2003, 1.3 million children entered the school system. Elimination of school fees in Uganda and Tanzania had similar results.

Simply put, eliminating school fees is central to the future of millions of children in the developing world, as schooling is intricately interwoven with a host of other key indicators. For example, one study of 63 countries linked education to a 43% decline of malnutrition among girls and young women between 1970 and 1995. Education is also a powerful tool in fighting the spread of HIV/AIDS, with experts estimating that hundreds of thousands of cases per year could be prevented if all children received a primary education. Schools not only provide education, they are often the one place that a child gets everything from training in basic life skills to a much-needed meal. On many fronts, staying in school represents a child's best chance to thrive in the future.

Towards effective social policy

If the prescription for the welfare of a generation of children in the developing world is to scale up social support along with treatment for HIV/AIDS, what approaches are necessary? Currently, social services are most often provided by non-governmental organisations and are therefore, by definition, a patchwork. The results are fragmented, geographically and otherwise. Even if this delivery mechanism had been sufficient in the past, it is surely not adequate to meet the enormous challenges of the AIDS pandemic and its effect on children. Similarly, community and district-level responses can contribute, but are not enough.

At the other end of the spectrum, long-term, macro-level government development programmes are not meeting the crushing immediate needs of vulnerable children and their families. That must change, and national institutions must be strengthened to fill the gap. Effective social policy frameworks must be developed that integrate HIV/AIDS response with health, education and economic policies.

Just as the global community has stepped forward to provide treatment for the 40 million people around the world living with HIV/AIDS, so too must we support the social safety net that is needed to protect millions of children who are vulnerable – directly and indirectly – to the AIDS pandemic.

The deck is already stacked against children living in poverty around the world; HIV/AIDS threatens to increase the burden immeasurably. Our response must be immediate, comprehensive and formulated to give vulnerable children not only a fighting chance against AIDS, but also the best possible chance for a healthy start and a step out of poverty. ■

Dr Jim Yong Kim is Chief of the Division of Social Medicine and Health Inequalities at Brigham and Women's Hospital, Boston, USA, and former director of HIV/AIDS Programs for the World Health Organization.

Further reference

- ***AIDS Epidemic Update 2005* (UNAIDS)** Provides a wealth of statistics on HIV and AIDS, as well as detailed reports on the state of the pandemic in each region, and on methods for intensifying HIV prevention efforts. http://www.unaids.org/epi/2005/doc/report_pdf.asp
- ***Learning to Survive: How education for all would save millions of young people from HIV/AIDS* (Global Campaign for Education, 2004)** Sets out why universal primary education is crucial to halting the spread of HIV and AIDS, and outlines what both rich and poor countries need to do now to enable millions of children to learn to survive. http://www.campaignforeducation.org/resources/Apr2004/Learning%20to%20Survive%20final%202604.pdf
- ***Lessons for Life* (World Vision, 2005)** This video presents the current situation and struggles of HIV- and AIDS-infected children and adolescents in Ecuador, as well as actions being taken by the national Lessons for Life Committee. It is available by e-mail from: comunicaciones_ecuador@wvi.org
- ***HIV-Positive Lives in Latin America & the Caribbean: Myths, realities and responses* (World Vision, 2005)** Focuses on 14 common myths about HIV and AIDS in 14 countries of Latin America and the Caribbean; includes 28 testimonies of people living with or affected by HIV and AIDS or engaged in prevention and treatment. http://www.childrights.org/PolicyAdvocacy/pahome2.5.nsf/cractionnews/1B92B42B641AF38688256F62001D3C9E?OpenDocument
- ***Reaching Out to Africa's Orphans: A framework for public action* (World Bank, 2004)** Aims at addressing the needs of young children affected by the loss of one or both parents as a consequence of HIV, AIDS and conflicts; examines the many risks and vulnerabilities faced by orphans and the ameliorating role played by governments and donors. http://siteresources.worldbank.org/INTHIVAIDS/Resources/375798110303715339 2/ReachingOuttoAfricasOrphans.pdf
- ***State of the World's Children 2006: Excluded and invisible* (UNICEF)** A sweeping assessment of the world's most vulnerable children, whose rights to a safe and healthy childhood are exceptionally difficult to protect. http://www.unicef.org/publications/index_30398.html
- ***The Macroeconomics of AIDS* (International Monetary Fund, 2005)** The social, economic, and fiscal effects of HIV and AIDS, as explained by authors with diverse backgrounds and from different organisations and institutions. http://www.imf.org/external/pubs/ft/AIDS/eng/
- ***Violence against children affected by HIV/AIDS: A case study of Uganda*, World Vision, 2005)** Examines the nature of violence, including psychological abuse, against orphans in parts of Uganda devastated by the HIV and AIDS pandemic. http://www.globalempowerment.org/policyAdvocacy/pahome2.5.nsf/allreports/88D92CF19F341A7A8825704500251541/$file/VAC%20Uganda_web.pdf
- ***What should we know about the AIDS law?* (World Vision)** This illustrated pamphlet explains national AIDS legislation in the Dominican Republic. http://www.visionmundial.org.do/descargas/ley_sida.pdf

by Mirriam Cepe

HIV and AIDS prevention and care for children in emergency settings

After the Asia tsunami, World Vision recognised the need to incorporate HIV/AIDS interventions into its relief response, reports Mirriam Cepe.

UNFPA and World Vision provide health care for people in Thailand
Photo: *Pamela Sitko / World Vision*

On 26 December 2004, the tsunami that hit Indonesia, India, Sri Lanka and Thailand killed thousands and displaced more than a million people. According to UNAIDS, populations destabilised by emergencies and natural disasters, particularly women and children, are at increased risk of exposure to HIV infection.[1]

Understandably, most humanitarian emergency responses address basic needs and immediate health provision. The relevance of HIV at the planning and initial stages of the emergency response is less recognised.

World Vision's one-year anniversary report on the tsunami response details its programme, encompassing emergency relief, community rehabilitation and integrated recovery.[2] Gender, HIV and AIDS, and advocacy are cross-cutting programme components. In coordination with governments, other agencies and the affected communities, the goal is to help people return to their normal lives.

Challenges, learning opportunities

Within the first month after the tsunami, World Vision conducted an HIV/AIDS Rapid Assessment that strongly recommended incorporating HIV and AIDS early on in the emergency response.[3] Our *HIV/AIDS Programming Toolkit for Relief Emergencies* guides staff to deliver a multi-sectoral response to HIV and AIDS.

Advocating for the vulnerable. Food insecurity, displacement and economic vulnerability of women and children, increased frequency of commercial sex work, and the influx of military and other personnel may all contribute to the epidemic of HIV transmission. World Vision has prioritised the integration of child protection across all sectors and is currently supporting 189 "Child Friendly Spaces" in four countries. Displaced persons and vulnerable groups benefit from programmes advocating for land to be inherited by widows and women's livelihood.[4]

Rehabilitating livelihood. Ensuring food security will reduce the vulnerability of women, young boys and girls forced or trafficked into sexual exploitation. World Vision has responded by providing food assistance. Emergency school-feeding programmes reached more than 38,000 children in Sri Lanka alone. "Cash-For-Work" initiatives for clean-up and reconstruction provide much-needed income to affected families. Boats, farming equipment, sewing machines, seeds, micro-credit and income-generating activities help communities start small businesses. Livelihood training, such as mechanical repairs and vegetable cultivation, are vital economic recovery activities.

Reconstruction. Due to the massive destruction caused by the tsunami, World Vision is building houses, clinics, schools, roads, water-supply systems, and community meeting places. Reducing the walking distances to water sources, as well as ensuring well-lighted locations to protect women and children (who usually collect water), and ensuring safety for women and children in public toilets and temporary housing, lessen the occurrence of sexual abuse.

Restoring the health system. Destruction of health infrastructure and inadequate supplies may impede HIV and AIDS prevention efforts through lack of universal precautions, unavailability of condoms or through transfusion of contaminated blood. Individual HIV voluntary testing requires the availability of counselling. Voluntary counselling and testing (VCT) are rarely available in emergency settings and it is often difficult to ensure confidentiality of counselling in temporary housing or confined camps. Reconstructing clinics, providing basic medical equipment, providing condoms and restoring the health systems are necessary for preventing transmission of HIV and other diseases. Water, hygiene kits and soap distributed to communities in temporary shelters encourage the practice of universal precaution and curb disease transmission, availability of family planning services, infant feeding counselling and prevention of mother-to-child transmission.

Recognising community capacity

With the influx of agencies that assisted in the relief, reconstruction and rehabilitation of communities after the tsunami, most of the effort was limited to taking care of immediate needs. Yet the effectiveness of external help depends on identifying and building on social and cultural systems, in affirming that communities hold the key to their present and their future. Involvement of people living with HIV in the design, implementation

PARENTS' AWARENESS OF HIV/AIDS[6]

PROVINCE:		Ranong	Phang Nga	Krabi	Phuket	Trang	All
Talk to children about HIV/AIDS	YES	54.9%	57.4%	67.5%	57.3%	58.9%	59.0%
	NO	45.1%	42.6%	32.5%	42.7%	41.1%	41.0%
Should children know about safe sex?	YES	83.2%	85.3%	92.9%	89.1%	91.1%	88.2%
	NO	14.7%	12.1%	4.7%	9.1%	6.1%	9.4%
	Do not know	2.2%	2.6%	2.4%	1.8%	2.8%	2.3%

and evaluation strategies is essential. Through committed collaboration and partnership, efforts should be geared towards supporting family and community action. The communities themselves do a major part of the rehabilitation through reclaiming normality in their family and community life.

In Thailand, World Vision's UNFPA[5]-funded project demonstrates this community capacity. One community health committee recognised, "We have been affected by the tsunami and two members of our community died of AIDS. We want to rebuild our lives, but we also want to protect our children from HIV. We will educate our youth about HIV/AIDS and teach them how to use condoms." The project encouraged the community health committee to include young people in the planning.

Communities hold the key to their present and to their future

The results of the baseline survey conducted by the World Vision Thailand Tsunami Response Team (shown in the table above), confirm that conversations are happening at the family level and point to the fact that parents are concerned about HIV and AIDS affecting their children.

The role of gender. Men and women are influenced by traditional gender norms. These need to be challenged so that men are encouraged to play a more responsible role in HIV prevention. It is important to engage men and boys in HIV prevention efforts because they often control women's and girl's vulnerability to HIV. Societal norms about masculinity and gender may heighten men's vulnerability to HIV. For example, in some Asian countries, male family members hire a sex worker to "initiate" the first sexual experience to introduce young boys to "manhood". It is acceptable for men to have multiple sex partners; the "macho" image is that the more women a man has, the more masculine or manly he is.

The value of children's participation. It is World Vision's core belief that every child has the right to reach his or her full potential. All programmes should ensure that children's participation is both recognised and practised.

Youth and children should therefore be involved in planning and implementing activities to mitigate the impact of HIV and AIDS. Involving them in decision-making will increase the likelihood that they will choose behaviours to help them avoid HIV infection. They can be agents of change and channels of hope among their peers and the wider community.

MAINSTREAMING HIV AND AIDS IN EMERGENCY RESPONSE

The need to improve the documentation and understanding of HIV and AIDS issues brought about by large-scale emergencies is well recognised. Monitoring and evaluating HIV and AIDS programmes helps to measure performance and raise effectiveness. As well as ensuring that lessons learned will be part of the ongoing capacity building, HIV mainstreaming should be part of every disaster preparedness plan.

Mainstreaming of HIV starts with educating staff. The presence, or absence, of staff with HIV and AIDS expertise significantly influences the ability to mainstream HIV and AIDS into the acute phase of the relief response. Policies and practices need to improve service delivery and capacity building of both staff and community. One way to understand the implications of this epidemic is for staff to learn directly from the affected women, men and children.[7]

Much has been done in responding to massive disasters and yet there is an enormous gap in mainstreaming HIV and AIDS in emergency and relief activities. The silent nature of the epidemic and the stigma associated with it have hampered HIV prevention. There is lack of data estimating the number of children made vulnerable by large-scale disasters. Methods of assessing HIV prevalence and risk in emergency settings need improvement.

There is a need for donors and implementing partners to better understand HIV prevention and the value of responding early on in the emergency response. HIV mainstreaming in emergencies requires policies and practices that are co-dependent at all levels.

Effective community participation can lead to active engagement and action of communities affected. Children are our hope for the future. Through their participation and involvement, we are ensuring that the emergency relief efforts we have achieved will not be undermined by HIV and AIDS. ■

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[1] UNAIDS, *HIV/AIDS and Conflict*, http://www.unaids.org

[2] World Vision Asia Tsunami Response Team, *World Vision Tsunami Anniversary Report*, 2005, http://www.wvtsunami.org

[3] World Vision, *Rapid HIV/AIDS Assessment Report*, 2005

[4] World Vision International, *Annual Review 2004*, http://www.wvi.org

[5] United Nations Population Fund

[6] World Vision Thailand Tsunami Response Team, *January 2006 Baseline Survey Report*, p 48

[7] S Holden, *AIDS on the Agenda: Adapting Development and Humanitarian Programmes to Meet the Challenge of HIV/AIDS*, Oxfam, UK, 2003


Canon Gideon Byamugisha
Photo: Nigel Marsh / World Vision

ANOTHER WORLD IS POSSIBLE

Never again will there be in [the world] an infant who lives but a few days… My [people] will long enjoy the works of their hands… They will not toil in vain or bear children doomed to misfortune.[1]
Isaiah 65:20–23

Although many Bible scholars and theologians in different places and at different times have offered varying interpretations of this ancient text, many are agreed that it describes God's desire, intention and purpose to give children long life (v. 20), health and prosperity (v. 21) and justice (v. 23).

Today, both social injustice and economic disparity are increasing, with disastrous consequences for the lives of children caught in this quagmire. Added to this, the HIV and AIDS crisis has created unprecedented numbers of orphans and vulnerable children, who already have the burden of social and economic inequity. The pandemic has left millions of children highly vulnerable and predictions are that the situation for children will only get worse.[2]

Yet the more I read of the Millennium Development Goals, and the numerous other commitments made by our world leaders on behalf of the world's children, the more I am convinced that another, transformed world is possible – a world with transformed leaders and partnerships that put children's health and well-being at the centre of all policy formulation, strategic planning and programming.

This conviction is not baseless. It comes from my strong belief that God is present among people and at work in the world to bring to completion the "Isaiah" vision and agenda, as revealed by God and written down in Isaiah 65:17–25.

Building that world

Contrary to this vision, dream and purpose, the current crisis of orphaned and vulnerable children is without parallel in history in many parts of our globalised world. Unquestionably, this has profound implications for our future in terms of long-term human survival, well-being and development; the survival of future generations relies on a transfer of human capital (knowledge, skills, values, character formation, modelling, etc.) from the preceding generation. A generation of disadvantaged children born to disadvantaged children repeats the cycle of deprivation, poor health and early death. And the intensity and impact of this cycle increases as the number of children, families, whole communities and nations in desperate circumstances continues to soar.

But is this situation inevitable? The answer is "No". Policy changes and resource allocation decisions must be acted upon with the same zeal we put into other concerns. We must take real steps towards achieving and surpassing the Millennium Development Goals and other promises. This will help bring about a transformed world as desired, willed and purposed by God and recorded for both our attention and action in Isaiah.

Building another world from the current one – a world that puts children's health and well-being at the centre of all our leadership and development goals – can be made possible by transforming the way resources and power are currently distributed across gender, race, age and national boundaries.

More than cosmetic changes

Comprehensive and exemplary policy principles for bringing about this transformation have been agreed to so far, in various paper commitments. Unfortunately, many of the organisations and governments that participate in putting these good intentions on paper are the very same ones whose policies and actions create a socio-economic and spiritual environment that multiplies the pauperisation, suffering and early death of the world's children.

A few adjustments and cosmetic changes in our global systems and relationships will not be enough. We need a transformed global humanity that looks closely at the current disease epidemics, wars, widespread hunger and violence against children. Are these not symptoms of things that have gone wrong in the way we relate, train, trade and live with one another as individuals, families, communities and nations of the world?

Our world is in need of many "Davids" to transform our "Goliath-sized" structures, systems and thinking processes that continue to keep 80% of the world's children from enjoying a safer, healthier and fairer world as envisioned by Isaiah many centuries ago.

There are those among us who are saying that there are no alternatives in the way we currently relate with one another as members of the one world. They say this is the world with victors and the vanquished, with the prosperous and the deprived, with those who are obese and pay dearly to lose weight and those who cannot keep body and soul together, due to hunger, malnourishment and illness – and you have to accept it as it is.

However, there are those, like me, who think and know that another world – more humane, more loving and more considerate to all her children – is possible.

A way forward

No country has ever achieved long-term growth that addresses children's vulnerability without massive investments in education, health and practical support through social assistance and welfare transfers. We need to ensure that macro-economic policy is coordinated with well-conceived and well-implemented social policy, to address both short- and long-term needs for survival

and development. People must be lifted out of poverty through adopting socio-economic policies, programmes and partnerships that are multi-sectoral, multi-level and multi-dimensional. We cannot accept broken and half-achieved commitments to human rights, health and development for children – we must monitor and evaluate promises by state, non-state and inter-state actors.

The challenge before us is to maintain our vision of a transformed world that is safer, healthier and fairer to children. We should not be seduced by the forces of those who would wish to subvert that vision by encouraging and popularising cosmetic responses.

Several things will help us to keep focused. The first is to be grounded firmly in the life experiences of those children most oppressed, marginalised and abandoned by the current systems. The second is to consider (as individuals, families, local communities, institutions, businesses and nations) laying down those aspects of our policies and actions which continue to inhibit many children. Children discriminated against by gender, age and location cannot experience the abundant life willed by God in the Scriptures and in various conventions, declarations and proclamations.

Finally, we must be prepared, like Jesus, to be ridiculed, branded and maligned by those who would want to maintain the status quo of the current world order which is largely unsafe, unhealthy and unfair to 80% of the world's children.

Children must not die young!

The Isaiah agenda and mission shows clearly that our socio-economic and political systems, processes and relationships have fallen short. But let us delight in the conviction that God is present and active in our efforts aimed at transformation. Even though in many parts of our two-thirds world we are still faced with the horrors of millions of children either losing their lives or losing their parents at an age they need them most; although many of our working men and women find it increasingly hard to make ends meet; and although our old folks are dying long before their bodies wither away... we still know that so many "Davids" can defeat so many "Goliaths". And if God is the initiator of this mission of a transformed world, who can be against those state, inter-state and non-state actors working together, committed to that divine purpose?

Let us work toward a global partnership and solidarity movement around the Isaiah agenda, beginning with its first conviction that children should not die young. Let all our places and countries of worship, education, work and residence mobilise in partnership with each other and with all people of good will. For I can see a global partnership unfolding which believes that another world is possible as a working base for the programmes of thought and action – a world that is safer, healthier and fairer to all its children. ■

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[1] Bible references can be read in full at http://www.ibs.org/niv.

[2] UNICEF, *Fighting HIV/AIDS: Strategies for success 2002–2005*, June 2004

World Vision is a Christian relief, development and advocacy partnership that serves 100 million people in nearly 100 countries. World Vision seeks to follow Christ's example by working with the poor and oppressed in the pursuit of justice and human transformation.

Children are often most vulnerable to the effects of poverty. World Vision works with each partner community to ensure that children are able to enjoy improved nutrition, health and education. Where children live in especially difficult circumstances, surviving on the streets, suffering in exploitative labour, or exposed to the abuse and trauma of conflict, World Vision works to restore hope and to bring justice.

World Vision recognises that poverty is not inevitable. Our Mission Statement calls us to challenge those unjust structures that constrain the poor in a world of false priorities, gross inequalities and distorted values. World Vision desires that all people be able to reach their God-given potential, and thus works for a world that no longer tolerates poverty.

back cover image:
Children taking part in a balloon activity in the National Fair of HIV/AIDS in Lima, Peru.

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