

THE AIDS EMERGENCY

COMMENTARY: THE TOLL ON WOMEN AND CHILDREN



The AIDS emergency

By Janat Mukwaya

The advance of antiretroviral drugs in industrialized countries has left some with the illusion that the worst of the AIDS epidemic has passed. Nothing could be further from reality in the developing world where the silent, voracious epidemic is wiping out the historic gains of the public health and economic development efforts of the last 20 years.

Two decades have passed – a generation for us – since the first rumours drifted out of the remote villages along Lake Victoria, telling of a bewildering illness that sapped its victims to the bone.

Since then, like a vast threshing machine, AIDS has churned through our fertile land with ruthless force, cutting down the young, the educated, so many of our people in the prime of their productive life: 1.8 million Ugandans have died, 1.7 million children have lost their mother or both parents to AIDS over the course of the epidemic. Today, Uganda has the heart-breaking distinction of having the largest population of such orphans in the world.

Our story has been repeated across our continent. Of the 14 million people worldwide who have died of AIDS, more than 11 million have been Africans. A quarter of them have been children. Last year alone, 2 million men, women and children in Africa perished. We mourned our

loved ones at nearly 5,500 funerals a day.

No one among us could have imagined the far-reaching devastation of the human immunodeficiency virus (HIV), but some facts are now clear. Young people – notably women – are the leading victims of this epidemic. More than 7,000 young men and women around the world are infected every day, as are an additional 1,600 children under the age of 15.

A deadly silence

The silence and stigma surrounding this terrible illness are fuelling its spread and stoking a lethal intolerance we must resist with all our might. Last December, Gugu Dlamini, a volunteer for an AIDS organization in South Africa, announced that she was HIV positive at a rally in Johannesburg, hoping to dispel some of the prejudice against people with the virus. Eleven days later Gugu was beaten to death by neighbours who claimed she had brought shame on the community.

The mob violence against this courageous woman was a brutal act of prejudice and intolerance. It was also an ominous reminder of the most vulnerable citizens in our developing countries – the women and children – who are routinely denied their rights to education, economic opportunity and proper health care. They are silenced by ignorance and fear, and doomed by their powerlessness to resist the dangers they face.

Consider our women, for example, who raise our children and produce our food. Their social and economic dependence on their husbands is so complete that they cannot refuse their husbands' demands, even when they fear that the men have contracted HIV from other sexual partners.

Women also avoid seeking vital medical services and counselling, and rarely do they dare to take the test for HIV, so great is their dread that their husbands will beat them and throw them out into a community where they will be even further ostracized.

If grown women are hobbled by their low social status and self-esteem, how can their adolescent daughters resist the sexual advances of older men and the pressures from their communities to marry, despite the potential exposure to HIV? Adolescent girls in sub-Saharan Africa are six times more likely to be infected than boys of the same age. There is a common and appalling myth in several African nations that a man infected with HIV can cure him-

self by having sexual relations with a virgin, thus increasing the toll on young girls.

Childhood lost

Tragically, it is children who shoulder the greatest burden of the epidemic. Worldwide, more than 8 million children have had to grow up without their mothers. Over 90% of those orphaned by AIDS live in sub-Saharan Africa.

To lose one or both parents to AIDS is to face a childhood of pain and peril. The suffering starts with the grief and horror of watching their parent waste away. Soon they suffer prejudice and neglect at the hands of their guardians and community. Every tenet of the Convention on the Rights of the Child is violated, from their right to education, health and development, to protection from exploitation and harm.

Our experience tells us that orphans have alarmingly higher rates of malnutrition, stunting and illiteracy. Often their community shuns them, presuming that they, too, harbour the fatal virus. Relatives who take them in often seize their paltry inheritance, and local laws offer little recourse to these lonely children.

Worse still, as surveys here in Uganda have shown, children whose parents have died often must shoulder heavier workloads and are treated more harshly than the foster family's own children. They are less likely to go to school

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and more likely to be depressed. One of our current district development plans reports that “orphan children [are] being defiled, married, neglected and...subjected to many forms of abuse.”

Throughout the continent, young girls are especially vulnerable, and a reported rapid rise in sexual abuse in Zimbabwe, for example, has prompted the Government to set up a special hospital clinic to deal with the victims of this unconscionable behaviour.

Tens of thousands of orphans are simply abandoned to fend for themselves, like the 90,000 in Zambia living on the streets. Tens of thousands more are struggling in households headed by the eldest child. Newspaper reports chronicled the fate of little girls like Kugu Sengane, in Kwazulu Natal (South Africa), who was only 11 years old when she had to nurse both of her parents through the torment of their dying days. As they languished in pain, Kugu was barely able to keep them washed and fed, while having to care for her toddler brother. This is no life for a child.

Nearly half of those caring for orphans in some regions of Africa are elderly grandparents like Ennie Gambushe, who lives up the road from little Kugu Sengane. At age 64, Ennie aches so badly from her chronic arthritis that she has difficulty merely standing up. Yet after both of her daughters died from AIDS, she was left to look after 15 grandchildren, none of them older than 12.

From South Africa up through central and eastern Africa, such scenes highlight the catastrophic impact AIDS has had on our families and communities, leaving our aging grandparents with an exhausting responsibility. “Young girls – our children, our grandchildren, they are dying before we die,” says 79-year-old Elizabeth Chipepa from Zambia, who inherited three small great-grandchildren when her grand-

daughter succumbed to AIDS. “You can hear others my age saying things like, ‘I’ve lost my three children; the first one has left three children, the second has left six....’”

In my own country, a 60-year-old woman named Honodinta Nakayima is looking after 42 grandchildren, ranging from age 13 down to a few months, after seven of her children died.

The web of generations

For a long time it was typical to describe the AIDS epidemic in Africa as ‘mysterious’ and ‘invisible’, but that could hardly be further from reality. We have all shared the suffering of dying brothers, sisters and childhood schoolmates. There are empty seats at all of our tables, empty desks in our offices. But the loss of a friend or a relative is only the first rupture in the web of family generations that once protected our society.

When AIDS strikes the family breadwinner, his or her income

dries up and the rest of the family slips deeper into poverty as they devote their meagre resources to nurse an ailing kin. Our studies show that when a father dies, his widow and eldest children must work two to four hours longer every day. Girls, in particular, may be forced to leave school to help at home and to work in the fields.

Moreover, the deadly virus rarely stops at one family member. Husbands infect their wives; about a third of newborns in turn acquire the infection from their mothers. Again, trapped by the silence and inhibited by the stigma surrounding the disease, women without symptoms of AIDS often discover their infection only after their infant is diagnosed with HIV.

Consider the wrenching experience of a woman I shall call Assumpta Mboya, who lives across the Great Rift Valley, in Nairobi. One of her 22-month-old twin daughters fell ill, and the doctor found that the baby tested positive for HIV. Soon afterwards,

her baby died, followed by her husband. Then Assumpta had herself tested and confirmed her darkest fear. She still resists testing the surviving twin daughter who is now eight years old, even though she worries constantly about whether this girl is infected, too, and anguishes over what will become of her daughter if she herself dies first. Families like this are disintegrating across our continent, threatening the very foundation of our society.

A call for prevention

Our continent’s human tragedy, caused by HIV/AIDS, is desperately compounded by a social welfare crisis. So many go without treatment for AIDS and its complications because antiretroviral drugs – that have kept patients in industrialized nations alive and healthy – cost thousands of dollars a year, making them only a dream for most in Africa. Massive resources are urgently needed to help us treat those infected, look after those



The popular puppeteer Suyadi entertains children at a UNICEF-sponsored workshop in Indonesia. The workshop explored ways of using puppets to convey messages to children on AIDS as well as on gender issues, peace and sexual exploitation.

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orphaned and prevent further spread of this disease.

Prevention efforts need the world's help also, not only to stave off the torrent that has swept southward into Malawi, Zambia, Zimbabwe, Botswana and South Africa, but also to brake its advance into Asia, where 7 million people are already infected. India is home to 4 million people with HIV, and the patterns of transmission indicate that we have no time to lose.

In the Indian city of Chennai (formerly Madras), the HIV-infection rate among truck drivers quadrupled from 1995 to 1996, a haunting echo of the AIDS explosion among the African lorry drivers who travelled the highways from Nairobi to Lusaka. Also in India, studies of pregnant women in the coastal town of Pondicherry reveal 4 per cent to be infected with HIV. Roughly a third of their infants will acquire the virus.

We have learned that the crucial factor in successful prevention campaigns is the open, unwavering political commitment by each government to confront the epidemic forthrightly, to shatter the silence surrounding the virus and to prohibit discrimination of any kind. Behind the shield of silence, the stigma and shame associated with AIDS only enable this epidemic to further flourish. Nine out of 10 people in Africa with HIV do not know they are infected, and those who do know rarely tell their relatives, let alone their sex partners. Many African newspapers make no mention of AIDS in the bulging death notices.

Here in Uganda, when President Yoweri Museveni took office in 1986 he recognized the seriousness of this disease and its long-term consequences. He quickly established a national committee for AIDS prevention, which launched an intensive public education campaign based on catchy messages to attract our young people. Among other things, it



More than 7 million children in sub-Saharan Africa have been orphaned by AIDS, their mother or both parents having succumbed to the disease. Many of these children, like this boy in Zambia, are cared for by elderly grandparents. But tens of thousands of Zambian children are fending for themselves, many of them living on the streets.

UNICEF/Zambia/Pirozzi

encouraged condom distribution, voluntary HIV testing, counselling and support services. And even more important, it encouraged frank, public debate.

With its slogan 'Faithfulness, abstinence, condoms', our AIDS-prevention campaign has made remarkable progress. Many Ugandans are now postponing their first sexual experiences, taking fewer partners and using condoms more often. We have seen the rate of new infections among our people drop dramatically since the dark year of 1987, when we had 239,000 new cases of HIV/AIDS. By 1997, this figure had declined by more than three quarters, to 57,000. We are especially encouraged by the 40 per cent drop in HIV prevalence among pregnant women in urban areas – an important indicator for tracking the spread of the disease.

But we are not alone. Worlds away in South-East Asia, government officials and community advocates in Thailand have like-

wise been successful with their aggressive campaign to prevent the spread of AIDS. Warned by the catastrophic losses in Africa, Thai officials attacked their HIV epidemic at an earlier stage and particularly targeted their young population with their messages. As a result, in northern Thailand, the number of 21-year-old men who visited commercial sex workers dropped by half during the course of four years. Condom use increased by nearly 50 per cent, and only one third as many HIV infections were reported during that time.

A third country, Senegal, has also managed to stem the spread of the virus through a vigorous education programme aimed at young people. Among women and men under the age of 25, the use of condoms with 'non-regular' partners rose dramatically from only 5 per cent in 1990 to as high as 60 per cent in 1997.

These programmes may be only the first step, but they prove the point made by Dr. Peter Piot,

the Executive Director of the Joint United Nations Programme on HIV/AIDS (UNAIDS), that prevention efforts "[do] not require new breakthroughs in technology, but rather new breakthroughs in political will."

These efforts must be targeted at the most vulnerable – young people, women and children. And they must firmly guarantee people their rights to education, health, economic livelihood – to life itself – so that, armed with knowledge and independence, our people can avoid HIV infection in the first place.

Years from now, when our great-grandchildren look back on the twilight of this century, will they learn that the leaders of the world shirked their duty to fight the leading killer of young people?

We cannot let that happen. Instead, let us show that we boldly reached out to the women and children most threatened by the pandemic and empowered them to defeat this terrible disease. ■

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LEAGUE TABLE: CHILDREN ORPHANED BY AIDS

The devastating impact of the AIDS crisis on children in the developing world has yet to be fully understood. The number of orphans, particularly in Africa, constitutes nothing less than an emergency, requiring an emergency response. As already impoverished societies struggle with this massive blow, their hard-won gains in social development – including improvements in child health, nutrition and education – are being wiped out.

Magnitude of the orphan crisis

Loss is an inevitable corollary of disease and death, but the wrenching toll taken by AIDS is unique: So far the disease has left 8.2 million children without a mother or both parents, the vast majority of them in sub-Saharan Africa. And the total continues to grow, expected to reach 13 million by the year 2000, of whom 10.4 million will still be under the age of 15.

The children's personal tragedies are enormous. So, too, are the social crises occurring as the worst affected communities and nations – among the poorest in the world – struggle to care for the ill as well as a generation of orphans, on a scale unprecedented in human history.

In most parts of the industrialized world, usually no more than 1% of the child population is orphaned. Before the onset of the AIDS epidemic, societies in the developing world absorbed orphans into extended families and communities at a rate just over 2% of the child population. In contrast, a staggering 11% of children in Uganda are now orphans because of AIDS. In Zambia, 9% are orphans; in Zimbabwe, 7%; and in Malawi, 6%. Where prevalence rates among women are high, so are the numbers of children left behind.

Nor are these losses abating: In 35 countries, the rate at which children have been orphaned has doubled, tripled or even quadrupled in just three years, from 1994 to 1997. Fears are that, because of AIDS, Asia will see its orphan population triple by the year 2000. And at this moment, according to UNAIDS, the number of children living with an HIV-positive parent is far greater than the number of children already orphaned, a disturbing prospect for the future.

Children who have lost their mother or both parents are society's most vulnerable members. Socially isolated because of the stigma of AIDS, they are less likely to be immunized, more likely to be malnourished and illiterate, and more vulnerable to abuse and exploitation.

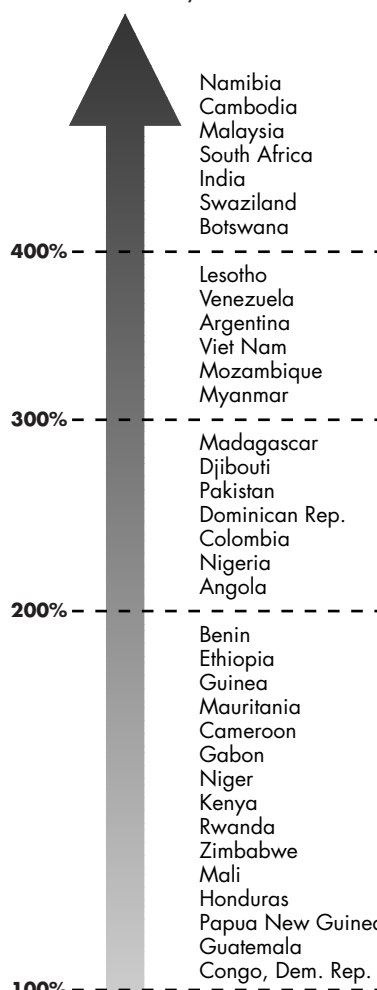
Finding the resources needed to help stabilize the crisis and protect children is a priority that requires urgent action from the international community.



SUB-SAHARAN AFRICA

Mounting toll

Where the number of children orphaned by AIDS has increased sharply over three years*



*Countries are listed in descending order of percentage rate of increase over the three-year period, 1994-97. Here, orphans are defined as children under the age of 15 who have lost their mother or both parents to AIDS.

Source: UNAIDS/WHO.

Uganda	1,100
Zambia	890
Zimbabwe	700
Malawi	580
Togo	400
Botswana	390
Burundi	380
Côte d'Ivoire	380
Congo	360
Tanzania	360
Rwanda	350
Central African Rep.	340
Burkina Faso	290
Kenya	280
Ethiopia	250
Mozambique	180
Sierra Leone	170
Liberia	150
Congo, Dem. Rep.	140
Chad	130
Gambia	120
Ghana	110
Namibia	110
South Africa	110
Cameroon	100
Lesotho	100
Gabon	90
Senegal	90
Nigeria	60
Mali	50
Guinea	40
Angola	30
Benin	30
Niger	30
Guinea-Bissau	20
Mauritania	10
Madagascar	2
Eritrea	No data
Mauritius	No data
Somalia	No data



MIDDLE EAST AND NORTH AFRICA

Egypt	<1
Iran	<1
Iraq	<1
Israel	<1
Jordan	<1
Kuwait	<1
Lebanon	<1
Libya	<1
Oman	<1
Saudi Arabia	<1
Syria	<1
Tunisia	<1
Turkey	<1
Yemen	<1
Algeria	No data
Morocco	No data
Sudan	No data
U. Arab Emirates	No data

Note: < = less than.



CENTRAL ASIA

Afghanistan	<1
Armenia	<1
Azerbaijan	<1
Georgia	<1
Kazakhstan	<1
Kyrgyzstan	<1
Tajikistan	<1
Turkmenistan	<1
Uzbekistan	<1



EAST/SOUTH ASIA AND PACIFIC

Thailand	30
Cambodia	20
Myanmar	8
Papua New Guinea	6
India	3
Malaysia	2
Lao PDR	1
Nepal	1
New Zealand	1
Pakistan	1
Sri Lanka	1
Viet Nam	1
Australia	<1
Bangladesh	<1
Bhutan	<1
China	<1
Indonesia	<1
Japan	<1
Korea, Dem.	<1
Korea, Rep.	<1
Mongolia	<1
Philippines	<1
Singapore	<1



AMERICAS

Haiti	100
Honduras	20
Jamaica	20
Trinidad/Tobago	20
Dominican Rep.	10
United States	10
Panama	9
El Salvador	8
Costa Rica	6
Guatemala	6
Uruguay	4
Argentina	2
Ecuador	2
Mexico	2
Chile	1
Colombia	1
Nicaragua	1
Paraguay	1
Peru	1
Venezuela	1
Bolivia	<1
Canada	<1
Cuba	<1
Brazil	No data

WHAT THE TABLE SHOWS
The number of under-15s per 10,000 who have lost their mother or both parents to AIDS

Note: These estimations do not include those children who have lost only their father. Comparable data on the number of children orphaned by AIDS are not available for many of the developed countries or those in transition, so these countries have been excluded from the league table.

Source: UNAIDS/WHO; data as at end-1997.

Where the numbers are highest*

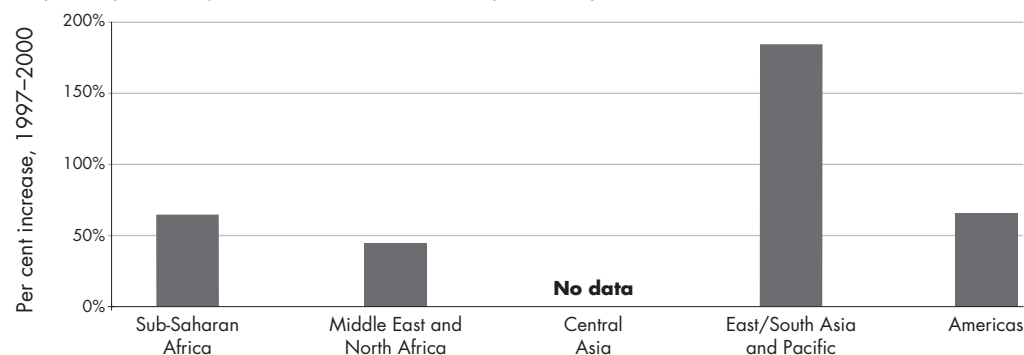
Uganda	1,100,000
Ethiopia	700,000
Tanzania	520,000
Zambia	360,000
Zimbabwe	360,000
Kenya	350,000
Nigeria	350,000
Congo, Dem. Rep.	310,000
Malawi	270,000
Côte d'Ivoire	240,000
South Africa	180,000
Burkina Faso	150,000
Mozambique	150,000
Burundi	110,000
India	110,000

*Children under the age of 15 who have lost their mother or both parents to AIDS, as at end-1997.

Source: UNAIDS/WHO.

Regional view: 2000

Projected percentage increase in number of orphans* by 2000.



Source: UNAIDS/WHO.

*Children under the age of 15 who have lost their mother or both parents to AIDS.

AIDS' impact on children's lives

In one of its most devastating and least visible consequences, HIV/AIDS is eroding precious and hard-won infant and child survival gains in a number of countries in Africa.

In Botswana, for example, AIDS will be responsible for 64% of deaths of children under five by the year 2000, offsetting much of the country's impressive child health progress. In South Africa and Zimbabwe, AIDS is projected to account for a 100% increase in child mortality. Some experts predict even more dramatic increases are to come. The US Census Bureau projects that by the year 2010, the mortality rate among children under five in Zimbabwe will be three-and-a-half times as high as it would have been without AIDS, and infant mortality may double. In some African countries, hospitals report that three out of four paediatric beds are taken up by children with AIDS.

The impact on children extends beyond those infected, as millions in the hardest-hit countries suffer the loss of parents and caregivers, and thus incur much greater risks to their health, nutrition and education. Mounting effects are already being seen on the nutrition of children living in households affected by AIDS. A study in Kagera (Tanzania) found that food consumption in poorer families dropped by 15% at the time of an adult's death from AIDS. Such a decline can have a significant impact on a child's development. Furthermore, children orphaned by AIDS run a higher-than-average risk of stunting; according to the World Bank, stunting among orphans is around 50%.

A fall in literacy rates in many countries is expected since children in AIDS-stricken households are taken out of school when families

can no longer afford fees or when children are needed to help out at home or to earn an income. Orphans living in extended families are also generally the first to be denied an education. A study in Zambia indicated that in urban areas, 32% of orphans were not enrolled in school, compared with 25% of non-orphans. In rural areas, 68% of orphans were not in school, compared with 48% of non-orphans.

Much of the disease's economic impact remains difficult to measure; but there is no question that increased health care expenditures and loss of family income are straining resources, burdening women in particular and putting surviving children at greater risk of malnutrition, illiteracy and disease. AIDS is also decimating the ranks of the skilled and educated during their prime years, with potentially tragic implications for future development. A recent survey in Malawi, for example, found the rate of infection among schoolteachers to be higher than 30%.

The burden is also great on already inadequate health care systems. In Zimbabwe, government projections are that HIV/AIDS will consume 60% of the health budget by the year 2005. In most developing countries, the disease is increasing the price of health care and reducing its availability, which will have the greatest impact on the poor. In many communities, healthy children whose parents have died from AIDS are at greater risk of dying of preventable diseases, because their illnesses tend to be attributed to AIDS and thus to go untreated. Evidence also indicates that orphans are less likely than other children to be immunized and to have their health care needs adequately met.

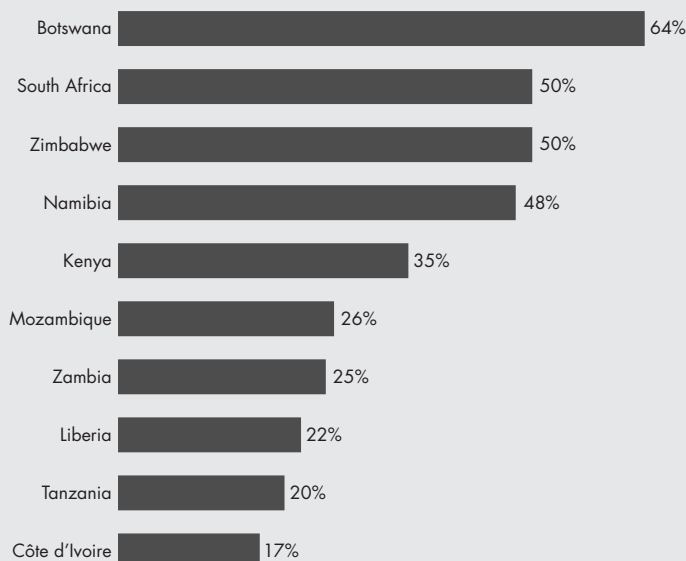


In some African countries hit hard by AIDS, it is no longer unusual to see children under 15 heading households. This Ugandan girl, who lost her parents to AIDS, cares for a blind grandmother and younger siblings.

UNICEF/99-0286/Pirozzi

AIDS and child mortality

The percentage of under-five child mortality due to AIDS, projected for the years 2000–2005



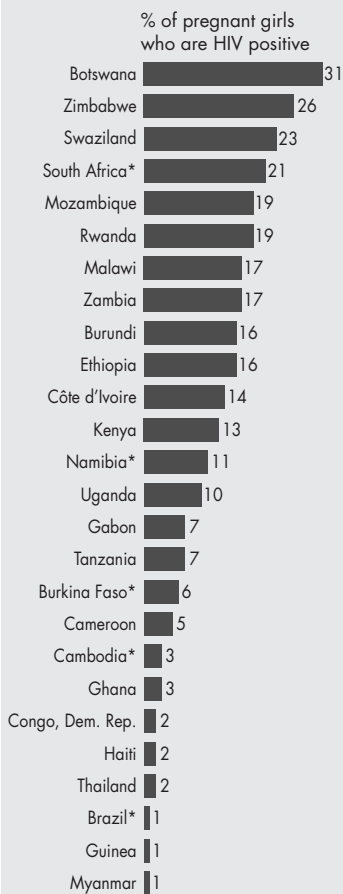
Source: United Nations Population Division, 1999.

At highest risk today: Teenage girls

In many countries, evidence points to a much higher prevalence of HIV among teenage girls than teenage boys.

The most vulnerable

HIV rates among pregnant girls (age 15 to 19) attending antenatal clinics in major urban areas



*Also includes girls outside major urban areas.

Sources: UNAIDS/WHO, US Bureau of Census, national AIDS programmes. Data: 1995-98.

In a recent study in western Kenya, 25% of girls between the ages of 15 and 19 were found to be HIV positive, compared to 4% of boys in the same age group. In Botswana's major urban areas, more than 30% of all pregnant adolescent women are infected, and in South Africa, Swaziland and Zimbabwe the infection rate is over 20% (see chart). Surveys in Zambia showed that the rate among all teenage girls (12%) is nearly three times that of teenage boys.

Higher prevalence rates among girls reflect their biological vulnerability to infection, their social and

physical vulnerability in sexual relations and the impact of gender discrimination. The rates make it clear that much more needs to be done urgently to protect the rights of girls and women. Discrepancies in HIV rates between girls and boys also indicate that girls are more likely to be infected by older men than by boys their own age.

The rate of HIV infection among teenage girls in Asia is low compared to those in Africa, although rates in Asia are on the rise: In India, a Mumbai antenatal clinic is reporting 5% of pregnant teenagers who are HIV positive, twice as many as in 1994. Teenage girls in high-risk groups show alarming prevalence rates: In 19 provinces in Cambodia,

more than 40% of sex workers under the age of 19 are HIV positive. In urban areas in Myanmar, the rate among teenage sex workers is 25%. However, in Thailand, early intervention proved successful in reducing prevalence among all high-risk groups, including teenage sex workers.

Epidemiologists find that, since infections are likely to be relatively recent among young people, a rising rate of infection in this group signals a growth in the spread of the disease. It is also an ominous sign that education and prevention programmes are not in place or not working.

In both industrialized and developing countries, interventions aimed at the young have proven to be the most effective and cost-efficient

method for addressing the crisis in the long term. In the most comprehensive review of sexual health education undertaken to date and involving 68 countries, UNAIDS found that good education *does* help delay first intercourse and protect sexually active young people from HIV, other sexually transmitted diseases and pregnancy. It does not, as some fear, lead to earlier or increased sexual activity.

The benefits of education have been proven most explicitly in Uganda, the first African country with a staggering AIDS burden to respond to the crisis. There, the biggest decrease in prevalence has been among 15- to 19-year-olds, dropping from 38% in 1991 to 7.3% in some areas in 1996.

HIV infections rising among adolescents in North America and Europe

Worldwide, greater and greater numbers of teenagers are being infected with HIV; fully half of 1998's 5.8 million new infections occurred in the 15-to-24 age group.

Teenagers in developing countries are most affected, but the risk is growing for those in industrialized countries and countries in transition, as a new pattern of infection emerges. For example, young people age 13 to 21 now account for one quarter of new infections in the United States; in Canada, too, HIV is spreading at an increasing rate among teenagers. More and more of those infected are young women.

In Eastern Europe and Central Asia, a proliferating use of intravenous drugs has caused an explosion in infections: Some 270,000 people are now living with HIV/AIDS, with a significant number of new infections among adolescents. The epidemic is most advanced in Ukraine, which alone accounts for 18,000 cases of adolescent HIV infection. Until 1995, there were fewer than 30,000 cases of HIV/AIDS in both adults and children in the entire region.

Because intravenous drug use is a major factor in the disease's spread, the Russian Federation – with as many as several million drug users – could see a dramatic rise in infections. Many are likely to be among the young: In St. Petersburg, for example, up to 20% of drug users are teenagers, some as young as 12 years.

The disease is poised for even wider spread. Socio-economic upheavals have been paralleled not only by increasing drug use but also by dramatic changes in sexual behaviour among young people and a sharp increase in the spread of sexually transmitted diseases. In the Russian

Federation, over the last few years the number of under-18 sexually active females has increased four-fold, a pattern also occurring elsewhere in the region. In striking contrast to Western Europe, where 60% of newly sexually active teenagers use condoms, lack of awareness has resulted in extensive high-risk behaviour; in the Republic of Moldova, for example, the rate is about 8%.

To date, HIV/AIDS prevention programmes have been implemented on a small scale in some countries. UNICEF has supported successful needle-exchange programmes including one in Odessa since 1997.

Teens at risk

Adolescents (age 15-19) living with HIV/AIDS

Western Europe		Eastern Europe	
Spain	5,400	Ukraine	18,000
Portugal	3,300	Russian Fed.	2,300
France	2,600	Poland	1,100
Italy	2,200	Subtotal	21,400
Germany	1,000	Total 13 European countries	37,700
United Kingdom	600		
Belgium	400		
Greece	400		
Switzerland	300		
Netherlands	100		
Subtotal	16,300		
		North America	
		United States	17,000

Sources: Hamers and Downs at the European Centre for the Epidemiological Monitoring of AIDS (CESES), 1999; the United States Centers for Disease Control and Prevention. Data as at end-1997.

Born with HIV

HIV/AIDS is cutting a deadly swath through Africa's young: Of the 590,000 children who were infected with HIV globally in 1998 (the highest figure of any year so far), 530,000 were in sub-Saharan Africa. Most of them became infected prior to or during birth or through breastfeeding. In startling contrast, fewer than 1,000 infants were infected that year in the whole of North America and Western Europe.

Poverty and the resulting lack of health services, education and AIDS treatment play a part in this cruel discrepancy. But perhaps the biggest factor is women's lack of control in their sexual relationships and hence over many aspects of their health. Also endangering them is the heavy veil of shame and silence that still hangs over those with the disease in most of Africa. Because of shame or the fear of even appearing to have the

disease, many women are further hindered in protecting themselves and their children. Young women are particularly vulnerable physically and socially to the pressures and forces at play (see *'At highest risk today: Teenage girls'*, page 23).

HIV-positive women in industrialized countries who become pregnant receive the antiretroviral drug zidovudine (ZDV, better known as AZT) from at least the 14th week of pregnancy, and the drug is administered to infants for 6 weeks after birth – an expensive regimen. Access to Caesarean section delivery (see *'Lack of obstetric care: Mothers and babies at risk'*, page 15) and to safe artificial feeding also reduces the risk of mother-to-child transmission. Such regimens account for the 5% or lower transmission rate in both France and the United States. In the developing world, by contrast, between 25% and 35% of children born to HIV-positive mothers acquire the infection during pregnancy, childbirth or through breastfeeding.

Antiretroviral trials

Now there is some hope for reducing mother-to-child transmission in the developing world, as well. Last year, trials in Thailand of a short course of AZT (from the 36th week of pregnancy through labour) given to pregnant women with HIV proved successful in reducing transmission by about 50%. A more recent study found that a much shorter regimen – involving AZT and lamivudine (3TC) given during delivery and for one week after to both mother and child – reduced the chances of transmission by 37%. Following the Thai study, UNAIDS, and its co-sponsors UNICEF and WHO, announced a two-year pilot project aimed at reducing mother-to-child transmission, which will reach 30,000 women in 11 countries. Work is under way to establish facilities and expertise in all 11 countries, while treatment of HIV-



Children at the UNICEF-assisted Vienpeng Home for Babies in Chiang Mai (Thailand). The centre cares for HIV-positive children as well as those who have lost their parents to AIDS.

Ominous leaps from 1994 to 1997

Countries where the number of children living with HIV/AIDS ...

... has quadrupled	Number of children (age 0-14) infected
China	1,400
Namibia	5,000
Viet Nam	1,100

... has tripled	Number of children (age 0-14) infected
Cambodia	5,400
Dominican Rep.	1,400
India	48,000
Malaysia	1,400
Myanmar	7,100
South Africa	80,000
Swaziland	2,800

... has doubled	Number of children (age 0-14) infected
Angola	5,200
Benin	2,400
Botswana	7,300
Djibouti	1,300
Lesotho	3,100
Mozambique	54,000
Nigeria	99,000
Pakistan	1,800

Source: UNAIDS/WHO.

Note: The figures above are end-1997 estimates. In many countries, end-1999 estimates could be considerably higher.

positive mothers in Côte d'Ivoire and Thailand has already begun.

But even more important in halting the virus's spread is access to facilities where women can learn their HIV status in confidential surroundings and be counselled about their fertility options and the feeding of their babies. Most, of course, do not have access to such voluntary and confidential testing and counselling, and many who are seropositive face discrimination or even violence. Also, many of the mothers who know they are HIV positive have no access to appropriate and safe breastmilk substitutes (see *'HIV and infant feeding'*, facing page).

Alarm for Asia

The crisis Africa has faced for over a decade now appears poised to erupt on a wider scale. Higher prevalence among children is one indication of the rapid spread of the virus, and HIV prevalence among children is beginning to increase in a number of

countries that, until recently, have seen a relatively low incidence. In India, for example, 48,000 children were infected with HIV at the end of 1997, triple the number of those infected in 1994. In three countries that had maintained low rates of seroprevalence – China, Namibia and Viet Nam – the rate of infection among children quadrupled between 1994 and 1997.

Counting AIDS' toll on children

Countries with the highest numbers of children living with HIV/AIDS

	Number of children (age 0-14) infected
Ethiopia	140,000
Nigeria	99,000
South Africa	80,000
Tanzania	68,000
Uganda	67,000
Kenya	66,000
Zimbabwe	57,000
Mozambique	54,000
Congo, Dem. Rep.	49,000
India	48,000

Source: UNAIDS/WHO; data as at end-1997.

Despite progress, TB treatment reaches too few

About one third of those ill with AIDS actually die from tuberculosis – their weakened immune systems making them easy prey for this disease. Driven in large part by the AIDS epidemic, TB is on the rise, now killing an estimated 2 million people each year.

But while life-prolonging drugs for AIDS remain a distant reality in the developing world, a highly effective and inexpensive treatment is available for TB. A strategy called DOTS, which stands for Directly Observed Treatment, Short Course, recommended by WHO, can cure up to 95% of TB cases and stem the spread of drug-resistant TB, while at the same time improving the quality of life for those who already have AIDS. As its name conveys, the treatment involves, in particular, the observation of patients swallowing appropriate dosages of anti-TB medicines for the full course of treatment, critical for the prevention of the multi-drug resistant strains of TB which have emerged in recent years.

Yet, only 16% of TB patients are receiving the recommended treatment. In 12 of the 22 countries where 80% of the world's TB cases occur, the DOTS strategy reaches fewer than half of those affected. Only five countries are making good progress:

Cambodia, Kenya, Peru, Tanzania and Viet Nam have implemented DOTS programmes countrywide, with high success rates in detection and treatment.

In Peru, which once had one quarter of South America's TB cases,

DOTS is successful in treating 85% of cases.

Brazil, however, which currently has the highest number of cases in South America, lacks a national DOTS strategy. Nigeria, the Russian Federation and Uganda are reaching less than 10% of cases. India, with an estimated 1.8 million TB cases – 23% of the world's total – has made some progress in recent years, reaching four times as many people in 1998 as in 1997. And China, with more than 1 million cases, has built an effective DOTS-based programme, but it only reaches half the country.



Children await registration for immunizations at one of the many UNICEF-assisted health clinics in China.

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TB treatment scorecard for most-affected countries*

Good progress: Where more than half of TB cases are being treated in the DOTS** programme, with a greater than 70% success rate.

Cambodia
Kenya
Peru
Tanzania
Viet Nam

Some progress: Where between 10% and 50% of TB cases are being treated in the DOTS programme, with a greater than 70% success rate.

Bangladesh
China
Ethiopia
India
Indonesia
Myanmar
Philippines
South Africa
Thailand

Slow progress: Where the DOTS programme is either not used or is used to treat less than 10% of TB cases.

Afghanistan***
Brazil
Congo, Dem. Rep.***
Nigeria
Pakistan***
Russian Fed.
Uganda
Zimbabwe***

* Where 80% of the world's TB cases occur.

** Directly Observed Treatment, Short Course.

*** Implementing DOTS but data not available.

Source: WHO.

HIV and infant feeding

A child whose mother is HIV positive runs a risk, presently estimated to be at least 1 in 7, of acquiring the virus through breastfeeding. About 500 to 700 infants are infected this way every day, but the exact mechanism of transmission is still not fully understood.

Before the terrible spectre of HIV/AIDS emerged, breastfeeding was recognized as the best way to feed infants in virtually all circumstances. Now, given the possibility of transmitting HIV through breastfeeding, joint WHO/UNICEF/UNAIDS guidelines on infant feeding have been issued to assist policy makers and health workers in addressing that risk and helping to safeguard the rights of mothers and their children. Central to these guidelines is the right of mothers to make decisions, on the basis of full and clear information, on what is best for them and their infants and to be supported in carrying out those decisions.

The guidelines warn of the potential harm in mixing breastfeeding and artificial feeding. Indeed, recent findings suggest that this combination may be particularly dangerous to infants. A new study of babies up to three months of age born to infected

mothers suggests that those who are exclusively breastfed may face a significantly lower risk than was previously thought.

The study posits that feeding other solids or fluids in addition to mother's milk in the first months of life may be what injures the baby's gut and allows the deadly HIV virus to enter body tissues. Additional research is urgently needed to further pursue these important early findings.

In the meantime, it remains critical to prevent 'spillover' of artificial feeding to women who can safely breastfeed. This is best done through continued efforts by governments to implement the International Code of Marketing of Breastmilk Substitutes.

The guidelines also call for access to voluntary and confidential HIV counselling and testing for women and men. Women who are aware of their HIV status should be counselled on the risk of HIV transmission to their babies, and on the benefits and risks of all the various infant feeding options.

Women who are HIV negative, or who do not know their status, should be informed of the benefits of breastfeeding and of the particular importance of avoiding infection in the future.