



HEALTH

Children Hit by AIDS

UNAIDS, the Joint United Nations Programme on HIV/AIDS, estimates that there are already over 23 million people worldwide living with Human Immuno deficiency Virus (HIV), over 40 per cent of whom are women. In some of the worst affected countries, up to 40 per cent of women attending antenatal clinics in urban areas are HIV-positive. Because HIV infection often progresses quickly to AIDS in children, most of the close to 3 million children under 15 who have been infected since the start of the epidemic have developed AIDS, and most of these have died. Of the 1.5 million people who died of AIDS in 1996, 3.50 lakh were children under the age of 15. More children are contracting HIV than ever before, and there is no sign that the infection rate is slowing. There is still no cure or effective vaccine for HIV. By the end of 1997, UNAIDS estimates that 1 million children worldwide will be living with HIV. The US Bureau of the Census estimates that by the year 2010, if the spread of HIV is not contained, AIDS may increase infant mortality by as much as 75 per cent and mortality in children under 5 by more than 100 per cent in those regions most affected by the disease.

HIV infection in children typically runs a faster course to AIDS and then death than in adults. Paediatric AIDS kills especially fast in developing

countries. Sick children in developing countries are generally at greater risk of death than sick children in industrialised countries and this is no less true of children with HIV.

Many of the common and inexpensive antibiotics and other medications used to treat sick children without HIV also work for children with HIV, but often, even these drugs are unavailable.

Children with HIV commonly experience wasting and delayed development and are often killed by typical childhood diseases like diarrhoea, measles, tuberculosis and other respiratory infections. Because these diseases are often the same as those that kill other children, it is sometimes difficult for health workers in poor countries, without access to expensive HIV testing equipment, to distinguish HIV-positive children from others. This may have at least two important consequences. First, children with HIV may not receive the special care they need. Secondly, a general apathy about child health may arise, with consequences for all children. In communities around the world, increases in infant and child deaths due to AIDS may lead to a mistaken belief that immunisation and nutrition programmes for children do not work. Disenchantment with these programmes could increase mortality in uninfected children.

While in poorer countries some babies are still being infected through contaminated blood or medical equipment, virtually all HIV-positive

infants have acquired the virus from their HIV-positive mothers during pregnancy or delivery, or through breastfeeding. While not all children born to HIV-positive mothers become infected, this risk is, again, significantly greater in poorer countries. There are a number of factors that increase a woman's risk of having an infected baby. They include a depressed immune status, poor nutrition and complications in pregnancy.

Children living in hard-hit communities feel the impact as they lose parents, teachers and caregivers to AIDS, as health systems are stretched beyond their limits, and as their families take in other children who have been orphaned by the epidemic. Individual households struck by AIDS often suffer disproportionately from stigma, isolation and impoverishment, and the emotional toll on the children is heavier still. And as the number of children orphaned or otherwise affected by AIDS rises, social security systems, already underfunded and overburdened, where they exist, are at breaking point. The impact is most acute on girls and boys already facing hardship or neglect - children in institutional care, children in poor neighbourhoods or slum areas, refugee children - and even more so for young girls who have unequal opportunities for schooling and employment.

The vulnerability of girls to HIV infection is exacerbated by denial or neglect of their recognised human

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

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

In a world with AIDS, the injection of illicit drugs, always a risky behaviour, carries an additional danger - HIV infection. When people of whatever age share needles and syringes to inject drugs, microtransfusions of blood occur. These are relatively efficient for transmitting HIV and other microbes. Drug injecting is thus a phenomenon



that policy makers, educators and HIV prevention workers concerned with child protection cannot afford to neglect.

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

A full course of such preventive treatment for a pregnant woman and her new born costs about US\$1,000-1,500 in the US. But in many developing countries, the annual per capita health expenditure may be as little as US\$10. The problems faced by AIDS affected families have become a major priority for many national aid programmes as well as for international organisations such as UNICEF and the Save the Children Fund. There are thousands of small community-based schemes around the world that aim to provide care and support to children orphaned by AIDS. But in the world's poorest

countries, children orphaned by AIDS may be seen as only one of many competing urgent priorities.

A shift of emphasis is needed away from relief towards longer-term approaches to meeting the needs of AIDS affected children. Resources should be directed to enable families and communities to establish and maintain a sufficient economic base to provide for children's needs. Education and empowerment combined with the promotion of children's rights are key to HIV/Aids prevention. Much of this needs to be directed not only to the youngsters themselves but to their families - the most important social support for children.

Reducing children's vulnerability to HIV means improving the economic situation of their families. There is a need to create micro-funds, micro-credit schemes, rural employment schemes and other approaches that can raise living standards and ensure sustainable livelihoods for children and their families. □

From *Children Living in a World of AIDS* - by **World AIDS Campaign**