TERRAVIVA

World AIDS Day 2010

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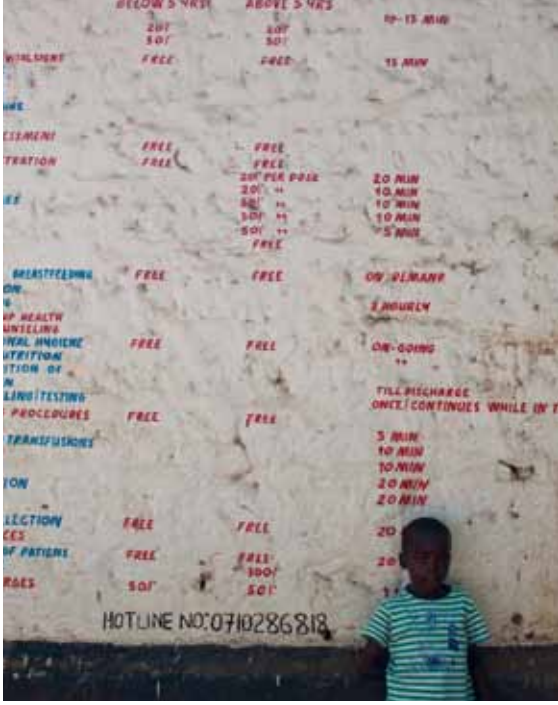
Rewriting the Impact of the AIDS Epidemic on Children



A young boy stands in front of a sign showing prices of care outside the paediatric ward at the Kisumu East District Hospital in Kenya. Credit: UNICEF/NYHQ2010-2260/Christine Nesbitt.

For nearly three decades, HIV and AIDS have devastated individuals and families. Children have been overshadowed by the very scale of the epidemic in the adult population. Thanks to improved evidence and accelerated action, however, the story of how the AIDS epidemic is affecting children is being rewritten.

Children are now central to the HIV response and investments on behalf of children have had an impact. The goal of virtual elimination of mothers – to- child transmission by 2015 appears within reach.

* In 2009, 54 percent of pregnant women living with HIV in sub-Saharan Africa received antiretroviral drugs to prevent transmission of HIV to their children – up from 15 percent in 2005.

* In Botswana, Namibia, South Africa and Swaziland, coverage of antiretrovirals for preventing mother-to-child transmission of HIV reached more than 80 percent.

* In Southern Africa, the number of children under 15 who became newly infected with HIV fell from 190,000 in 2004, to 130,000 – a 32 percent reduction.

* Today, there are an estimated 5 million young people aged between 15-24 living with HIV down from 5.2 million in 2005.

* Before 2005, in many sub-Saharan African countries, children who had lost both parents to AIDS were much less likely to be in school than children whose parents were alive; today, in many places they were almost equally likely to be in school.

Efforts to help children are part of the broader HIV response and contribute towards the Millennium Development Goals. Providing prevention, treatment, care and support for children affected by AIDS has contributed to better approaches – and results - in other areas such as maternal and newborn health testing of adults, outreach to excluded populations; support for social welfare and protection systems; and increased attention to the vulnerability of girls and young women.

Yet, it is clear there is still much to be done, especially to reach the millions of women and children who are falling through the gaps because of inequities rooted in gender, economic status, geographical location, education level and social status.

The welfare of individuals and families affected by HIV depends on their ability to effect change in their health and on their resilience in weathering the economic and social impact of the disease.

The focus must now be on eliminating the disparities in access, coverage and outcomes that exist. HIV does not discriminate, and neither should the AIDS response.

The aim of this newsletter and the partnership between UNICEF and Inter Press Service is to seek out the human stories, to give voice to the people behind the faceless statistics and provide an insight into the complex realities which continue to determine the impact of HIV and AIDS in Southern and Eastern Africa.

We hope it serves as a reminder of the critical importance that continued action and commitment is to finally creating a HIV free generation.

- UNICEF East and Southern Africa, November 2010.

TERRAVIVA

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Front page picture caption: Mentor Mother and mothers2mothers site coordinator Jackline Akinyi Odongo plays with her daughter, Natalie Aki Amor, prior to the launch of the Mother-Baby Pack and the Mother-to-Child Transmission-Free 'Maisha' Zone Initiative, at Kisumu East District Hospital in Kisumu Township in Nyanza Province (Kenya). Jackline completed the PMTCT programme, and Natalie is HIV-negative.

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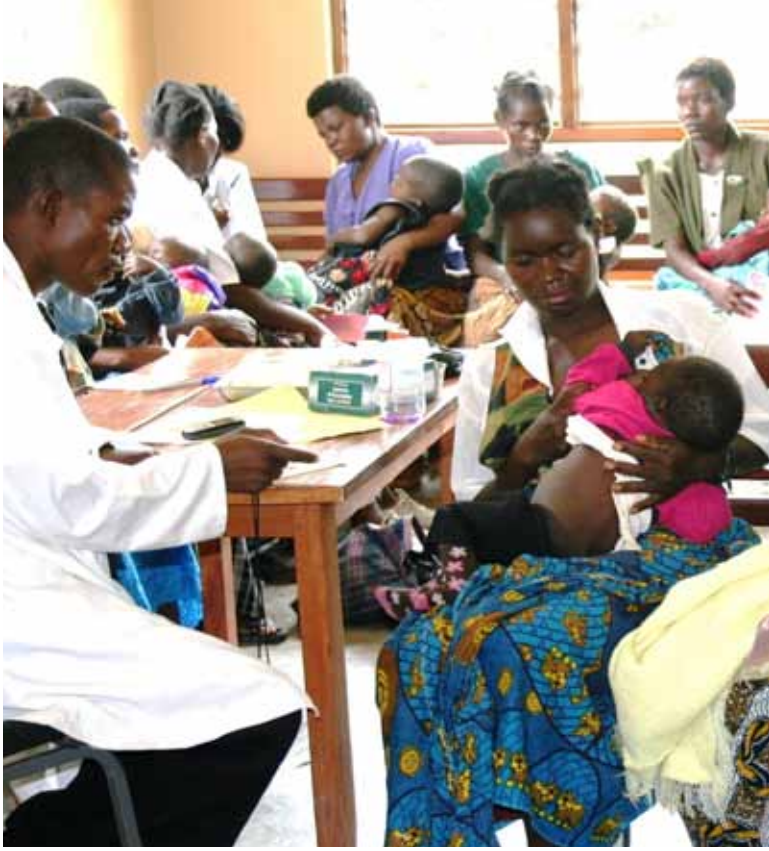
Sub-Saharan Africa continues to register high levels of HIV prevalence. By focusing on the most vulnerable and marginalised children who remain largely invisible in the epidemic, "Children on the Frontline" seeks to ensure that it can help shape policies and inform Africa's leadership on the specific needs and issues facing children effected and affected by HIV/AIDS. With support from UNICEF, IPS reporters in East and Southern Africa seek to humanise the impact of the HIV/AIDS pandemic by demonstrating challenges and highlighting solutions that can contribute to improving children's lives.

Malawi Struggling to Address Paediatric HIV



Women line up to have their children tested for TB at a district hospital in Mchinji, Malawi. Credit: Pilirani Semu-Banda/IPS

By Dingaan Mithi

LILONGWE - There are 91,000 children living with HIV in Malawi. A shortage of resources means that many do not receive proper treatment and care.

The most recent AIDS Epidemic Update, published by UNAIDS and the World Health Organization, estimated that there were 2.1 million children under the age of 15 living with HIV worldwide in 2007; 1.8 million were found in Sub-Saharan Africa. The Campaign to End Pediatric AIDS (CEPA) estimates 370,000 African children were newly infected that year.

In Malawi, UNAIDS estimates that 91,000 children under 15 are living with HIV. Amongst the 27,000 of these children with advanced HIV and low CD4 counts, just under two-thirds are receiving anti-retroviral therapy.

Observers say this care is inadequate.

“There has been no paediatric treatment for children with AIDS in the country, making the administration of drugs difficult. They have had to be given tablets meant for adults, breaking tablets into half,” says George Kayange, executive director of the Child Rights Information and Documentation Centre in Lilongwe.

While this may provide a child with the appropriate dose, young children in particular struggle to swallow such tablets and maintain an effective treatment regimen. Oral ARVs would be one alternative, but Linda Malilo, training coordinator at the Baylor International Pediatric AIDS Initiative (BIPAI), says these are very expensive and in short supply in Malawi.

BIPAI and the Abbott Fund support one of the country’s leading sites for paediatric AIDS care, the Children’s Clinical Centre of Excellence in Lilongwe. The centre’s executive director, Dr Peter Kazembe, says the centre cares for for more than 2,200 children, including 1,535 on ART treatment there.

Among the organisations that refer children to the centre is the Edzi Kumudzi Association. EKAM is a community-based organisation working to assist children living with HIV in rural areas near Malawi’s capital, Lilongwe.

EKAM works with more than 2000 HIV orphans, offering psychosocial support; a lack of resources prevents the community-based organisation from running other programmes, for example supporting good nutrition for HIV-positive children.

EKAM executive director Maxwell Mphoyo told IPS that currently there is poor coordination between organisations like his and the government.

UNAIDS estimates that 91,000 children under 15 are living with HIV in Malawi

“It would be easy for government to improve paediatric HIV care and treatment services if it worked with local NGOs who are always on the ground, helping children living with HIV and AIDS in Malawi,” said Mphoyo.

He argues that coordination between local NGOs and the government would improve care as organisations like EKAM are carrying out HIV and AIDS interventions in rural areas.

This would still leave the government the difficult task of providing enough resources in the national health budget to complement the work of the civil society.

The principal secretary in the office of president and cabinet responsible for HIV and AIDS and Nutrition, Mary Shawa, told local media that the government is serious about achieving universal access to treatment for children and adults alike. One move to make treatment available to more people is a plan to establish a factory to produce anti-retrovirals in Malawi.

“Following United Nations regulations about establishing such an ARV drug company, there were a lot of steps that will have to be taken. We envisage the company being ready in two years time,” says Shawa.

EKAM says the government needs to ensure such a factory also manufactures ARVs specifically for children.

“The factory will be very important for children living with HIV and AIDS, as treatment will no longer be a problem,” says Mphoyo. In addition, he stressed the need to train more health personnel in paediatric HIV and the construction of more health facilities across the country to assist children living with HIV and AIDS.

The Campaign to End Pediatric AIDS (CEPA) is calling on governments across Africa to back their stated commtments to universal access to treatment for adults and children by increasing budget allocations for health. African governments committed to devoting 15 percent of their total budgets to health at an African Union meeting in Abuja, Nigeria in 2001.

Yet Malawi is one of the handful of African governments that achieved this level of spending in 2006, only to fall back: the allocation for health currently stands at just under 13 percent.

Rural Communities Jointly Care for Orphans

Headmen Kamwala (r) and Mphunda (l) ensure the welfare of orphans in their villages. Credit:Claire Ngozo/IPS

By Claire Ngozo

LILONGWE - At the age of 66, village headman Kamwala of Dedza district in central Malawi is starting to feel the effects of ageing. He gets tired easily and needs frequent naps but says he cannot afford this luxury. He and his wife are caregivers to a one-year-old orphan.

Despite having ten children of his own, who are between eight and 34 years old, the village chief has taken in three orphans below the age of eight over the past five years.

"I don't have a choice but to take these children under my wing. They lost both their parents, and I can't leave them to roam around the village, without parental care," Kamwala told IPS.

There are no orphanages in this area, and thus families have resorted to integrating orphans into households. This has become a common practice across Malawi's rural areas, due to a strong sense of community values.

Malawi has almost a million orphans, who have lost either one or both parents, according to 2009 United Nations statistics. The 2008 Malawi Population and Housing Census puts the number of orphans at a little less, 837,300, with almost all of them, 714,741, living in rural areas. More than half a million children have been orphaned by AIDS in Malawi, according to international non-profit organisation ActionAid.

Kamwala confirmed that there are many deaths in his village due to AIDS-related illnesses, which leave large numbers of children without family members, not even relatives.
"It has now become a norm for families around the village to take in orphans. It does not matter whether they are related to them or not. I adopted three children to set an example," he explained.

Villagers take turns looking after the children. Throughout the village, small groups of children gather under trees or sit in grass-thatched shelters where they meet to play games, share meals or listen to folklore stories told by elders of the village.

Unemployed Georgina Kagwa, 28, volunteers in this community initiative. "I teach the children how to read and write as they gather in play groups," she said.

> ***"I don't have a choice but to take these children under my wing."***

Kagwa and fellow volunteers also identify families that can provide homes for orphans and check up on their well-being.

The village's orphan initiative is a welcome development in a country where up to 65 percent of Malawi's 13.1 million people live below the poverty line of less than a dollar per day, according to government statistics.

The people of Kamwala's village see their efforts as a complement to the country's Early Childhood Development (ECD) policy. It was developed in 2003 by the Department of Gender, Child Welfare and Community Services to encourage local communities assist government with the provision of childcare and community-based projects.

Up to 400 community-based childcare centres (CBCCs) have been set up around the country in the last two years, catering for 400,000 orphans, the department's 2010 statistics claim. In addition, the department developed a set of training modules on childcare practices for municipal and provincial government officials, volunteer caregivers and foster parents. The Department of Gender, Child Welfare and Community Services does not disclose how much of its budget goes towards its childcare budget, but social experts believe that more than two thirds are provided by the UN Children's Fund (UNICEF).

Village headman Mphunda, 49, also of Dedza district, has also set up centres in his village where children – both orphans and non-orphans – learn, play and receive health care.

"Every child is treated equally. Before we started this initiative, most orphans were hungry and poor. We have now been trained by government, and we know how best to implement the projects," Mphunda told IPS. "We also know how to make the project sustainable by working as one instead of each family operating in isolation."

Progress in Prevention of Mother-to-Child Transmission of HIV

By Susan Anyangu-Amu

NAIROBI - The number of pregnant women being tested for HIV and accessing treatment in Sub-Saharan Africa has shown significant progress – indicating that virtual elimination of mother-to-child transmission of the virus by 2015 is possible.

According to a new report, Towards Universal Access, the proportion of pregnant women in Sub-Saharan Africa who received an HIV test increased from 43 percent in 2008 to 51 percent in 2009. The report by the World Health Organisation (WHO), the United Nations Children's Fund (UNICEF) and the Joint United Nations Programme on HIV/AIDS assessed HIV/AIDS progress in 144 low- and middle-income countries.

It found an estimated 24 percent of the approximately 125 million pregnant women in these countries received an HIV test in 2009, an increase from 21 percent in 2008 and eight percent in 2005. Fifty-four percent of HIV-positive pregnant women in Sub-Saharan Africa received antiretroviral drugs to prevent transmission to their children in 2009, up from 45 percent in 2008.

Speaking to IPS, UNICEF regional director Elhadj As Sy said the progress made in the prevention of mother-to-child transmission is testimony of the fact that virtual elimination by 2015 is achievable.

"What we need is strong political leadership, funding, good programs and activism. If we build on the progress and with renewed commitment we are well on our way to achieving virtual elimination by 2015," Sy said. However, despite the progress there are still challenges with disparities between regions and within countries.

Four countries in the region report providing HIV testing and counselling to over 80 percent of pregnant women. They are South Africa, Zambia, Namibia and Botswana. These countries have already reached the target set at the United Nations General Assembly Special Session (UNGASS). This is the target of providing 80 percent of pregnant women in need of treatment with antiretroviral drugs to reduce transmission to their children.

Despite the marked progress, countries in Eastern and Southern Africa fared better than their counterparts in West and Central Africa. In Eastern and Southern Africa, 50 percent of pregnant women received HIV testing and counselling, an increase from 43 percent in 2008. In Western and Central Africa, coverage increased from 16 percent to 21 percent between 2008 and 2009.

"While the figures in Western and Central Africa are low, this does not mirror failure on their part. The burden of HIV/AIDS has leaned heavily on Eastern and Southern Africa and this is where most interventions have been directed. Western and Central Africa are just beginning to pick up the problem and their burden of the epidemic is lower," said Dr. David Okello. Okello is director, HIV/AIDS, Tuberculosis and Malaria Cluster at the WHO regional office for Africa.

Seven countries including Nigeria, Angola, Democratic Republic of Congo (DRC) and Ethiopia provided HIV tests to less than one third of pregnant women. "Knowing and accessing treatment is very crucial. Greater investments are needed to increase HIV testing and counselling among pregnant women in order to effectively prevent mother-to-child transmission of HIV," Okello said.

The number of children receiving antiretroviral therapy in Sub-Saharan Africa rose from 224,100 to 296,000. However, the total coverage among children in the region is still low at 26 percent compared to adults at 37 percent. "Too many children are still dying in this time and era when we can test and treat. We need to do more to reach the 10 million who still need treatment," Sy said.

Among infants and children exposed to HIV, access to early testing, care and treatment is still a challenge. More than 90 percent of children living with HIV are infected through mother to child transmission during pregnancy, around the time of birth or through breastfeeding. The challenges facing Sub-Saharan Africa include weak integration of services, persistent drug stock-outs and little follow up of patients started on treatment.

"To address these challenges, countries need to strengthen health systems, improve integration of services and bring facilities closer to the people," Okello said.

Some Successful Mother-to-Child Prevention Strategies

A number of countries have decentralised HIV prevention, care and treatment to primary health centres. South Africa, is doing this with nurses initiating and managing treatment, with a mentoring and referral back-up from the district team. In Zambia mother-to-child transmission services have been integrated in outreach sites and maternal and child health public facilities.

HIV-positive pregnant women are given a colour coded pre-packaged set of antiretroviral medicines, complete with clear directions for when a mother should take the drugs and also when and how to give them to her new born child. The diagrams and colours help the mother understand the changing schedule of the medicines and dosages.

Zambia is also focusing on task-shifting to involve lay providers and people living with HIV in delivery of services.

"The Zambian story is an example of government commitment and involvement of the community. A successful response involves strong initiatives from the community and in Zambia the churches association runs 50 percent of health care. This is clear indication that early responses make a difference," Sy said.

Rural Parents Prevel to their C

By Isaiah Esipisu

NAIROBI and KIENI, Kenya, Jun 23, 2010 (IPS) - When Samuel Mwangi's one-year-old HIV-positive son died five years ago, he thought the death of his child also meant the death of his family's legacy. "I wept. And to the bottom of my heart, I knew that that was the end of my generation," said HIV-positive Mwangi.

The baby's death had been a big blow to Mwangi and his partner, Miriam Wanjiru, because their child had been on an ARV treatment program at a health centre. They had hoped he would survive.

"It had been a trying moment for us as we watched him suffer the painful ordeal of being a HIV-positive infant for his entire one-year lifetime," Mwangi said.

Mwangi and Wanjiru are just one of hundreds of HIV-positive couples in Kieni division, at the foot of Mount Kenya some 210 kilometres east of Nairobi, who thought they could never conceive an HIV-negative child.

Despite the fact that Prevention of Mother-To-Child Transmission (PMTCT) treatment is provided free of charge in Kenya, poor attendance at antenatal clinics, especially in rural areas, keeps women from being educated about the benefits of PMTCT and from accessing treatment.

A study titled 'A Safe Motherhood Project in Kenya: assessment of antenatal attendance, service provision and implications for PMTCT,' reveals that half of all pregnant women in rural Kenya attend antenatal clinics only once in their pregnancy. Many have found the distance to their nearest clinic the biggest barrier to treatment. And this is typical in places like Kieni.

However, three years ago, Wanjiru and Mwangi joined the Kieni Development Initiative Self Help Group (SHG), a group that assists 106 HIV-positive residents from Kieni. Through the group, the couple learned that there was a possibility that Wanjiru could give birth to an HIV-negative child, despite the couple's HIV status.

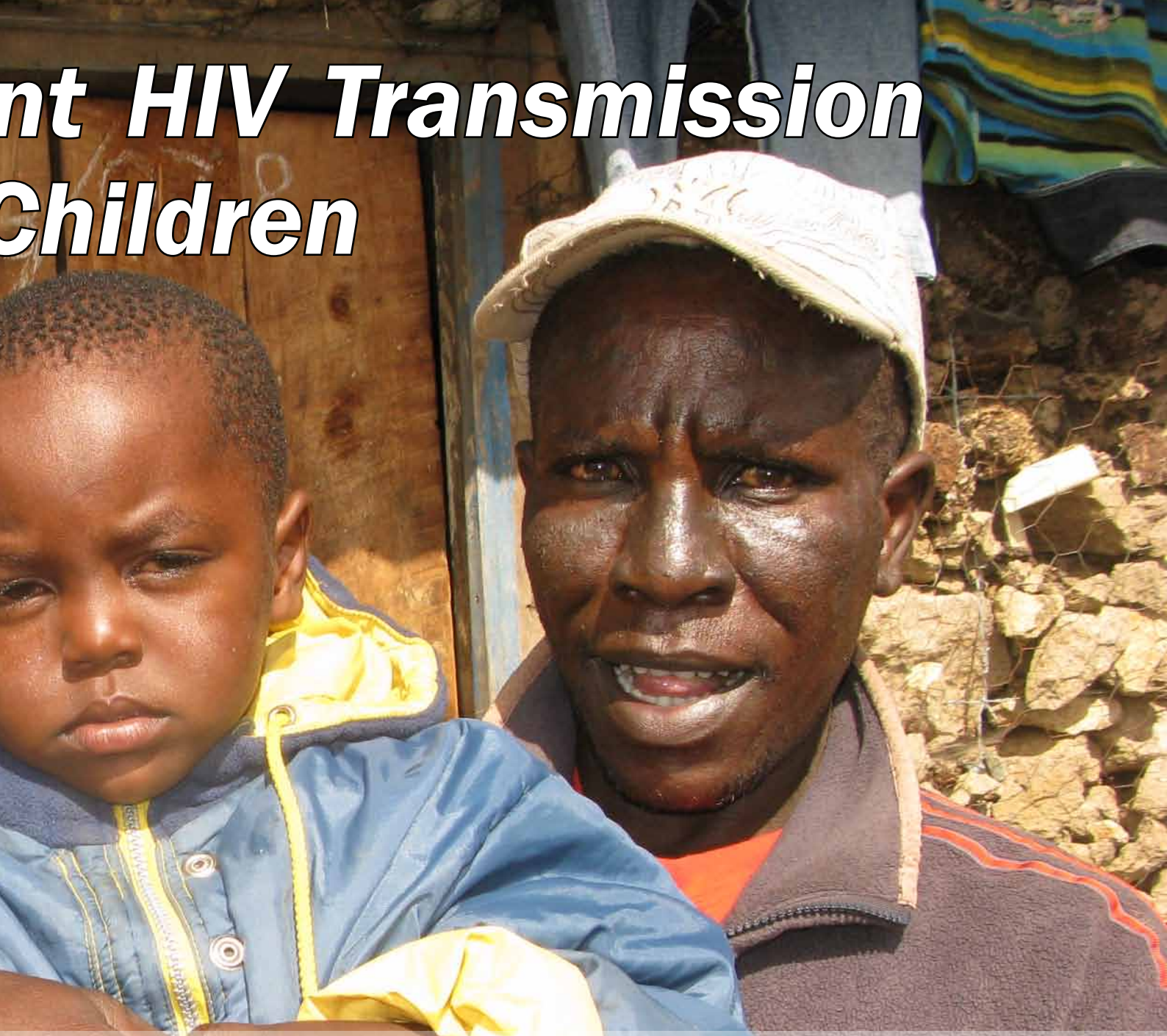
"The prevention of HIV transmission from mother-to-child has worked for thousands of children in Kenya and beyond. All one needs is to follow the medical expert's instructions from the time of conception, throughout the pregnancy, to breastfeeding," explained Professor Joseph Karanja, a consultant gynaecologist and a lecturer at the University of Nairobi.

That's exactly what Wanjiru did with the assistance of the SHG. "We took them for counselling, and later through a program for PMTCT, which was done in collaboration with the Narumoro health centre," said Nancy Mwithigani, the development facilitator of ActionAid-Kenya, one of the NGOs that supports the SHG.

"The doctor prescribed drugs and particular food, which he said was meant to boost my immune system before conception," Wanjiru said.

After three months, her immunity stabilised and she conceived. She immediately began attending the antenatal classes at the Narumoro health centre, situated some 12 kilometres from her home. The classes run for the entire

nt HIV Transmission Children



duration of the pregnancy, and continue for another nine months after birth. Services are free of charge.

Until then, Wanjiru was like many other women in rural Kenya. She thought that PMTCT was a concept geared towards helping the elite, especially those living in urban areas.

"I usually associated it with people who have a lot of money, and not peasant farmers in the villages like me," she said.

PMTCT guidelines were introduced in Kenya in 2005, and to date, PMTCT treatment is available free of charge in about 80 percent of antenatal clinics countrywide. But the distribution of medicines and medical services by government to many marginalised parts of the country has remained a challenge.

After aggressive public awareness campaigns by the humanitarian organisations working in the area, nearly all households in Kieni and other neighbouring villages have been educated about PMTCT. NGOs have also teamed up with government to assist with the distribution of medicines in these and other rural areas.

So when Wanjiru delivered an HIV-negative baby she and her partner were ecstatic. "This boy is the best thing that has happened to us," Wanjiru said of her now two-year-old son, Waweru.

She sits at the doorstep of their informal dwelling peeling potatoes for dinner, occasionally watching on as her son plays 'hide and seek' with his father among the shrubs.

"I'm happy, that even after we tested HIV-positive more than a decade ago, God has given us a reason to smile – a child who is not infected by the HI virus," said Wanjiru.

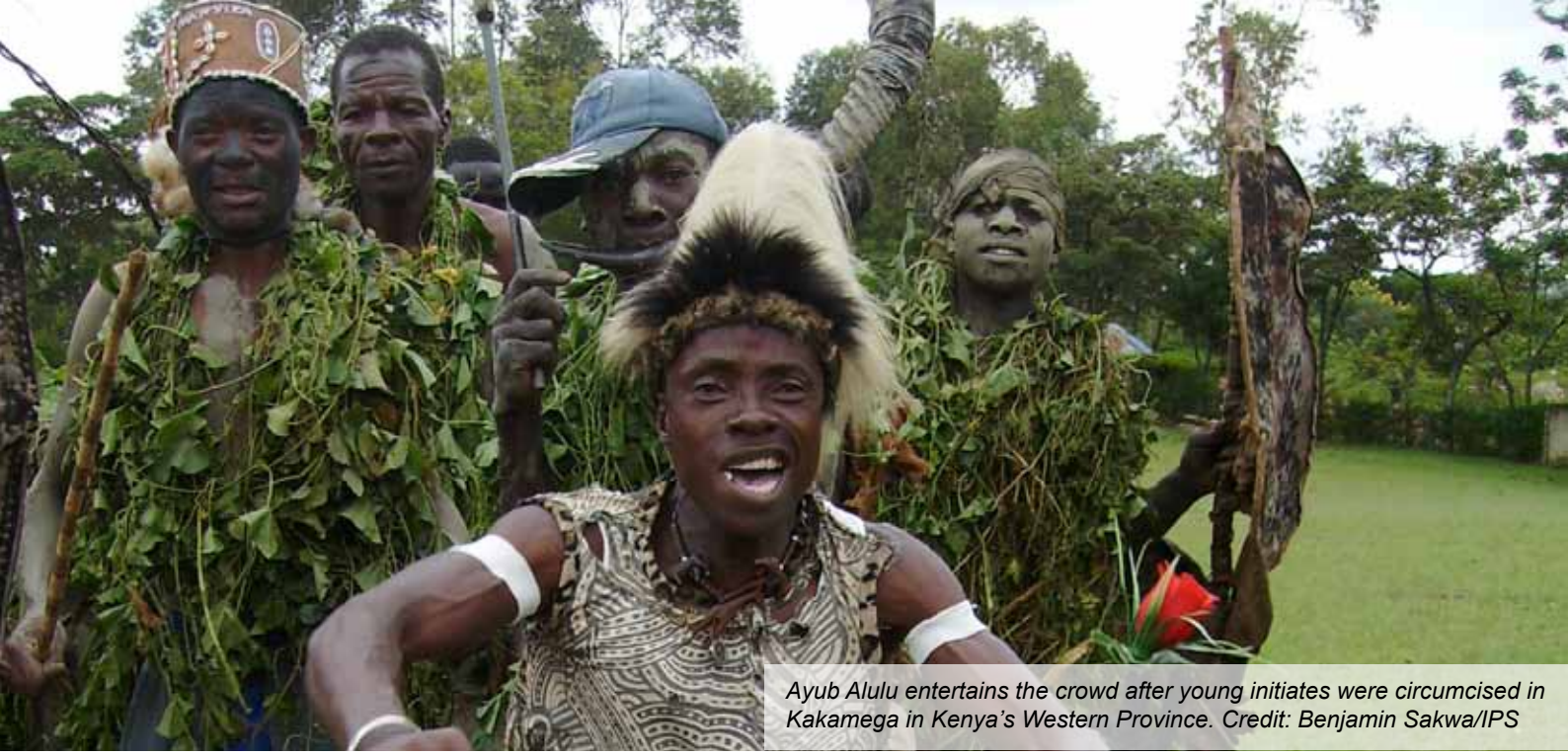
It also gave other couples in the SHG hope.

"Wanjiru's delivery of an HIV-negative child was just the beginning for the group members. Twenty-two other HIV-positive couples immediately expressed similar interests and in the past two years, 13 of them have already given birth to HIV-negative children, justifying the importance and success of the PMTCT treatment," said Mwithigani.

Jane Wandia is another HIV-positive mother in the SHG who has given birth to an HIV-negative baby.

"With free distribution of antiretroviral drugs, my husband and I feel we should go for another baby, because we feel we are strong enough to raise one more," said Wandia. Her husband is HIV negative.

Mwithigani says that PMTCT treatment has now been made available, with the assistance of other NGOs, to other marginalised communities in North Eastern Kenya.



Ayub Alulu entertains the crowd after young initiates were circumcised in Kakamega in Kenya's Western Province. Credit: Benjamin Sakwa/IPS

Attempts to Modernise Traditional Circumcision Rites

By Susan Anyangu-Amu

NAIROBI - During every year that ends in an even number, the month of August is a special occasion for young men in Kenya's Western Province. During this month thousands of boys aged between 10 and 18 undergo male circumcision – something that is seen as an important rite of passage into manhood among their communities. But it is also a time were nearly half the young men circumcised will have to fight for their lives.

For the Bukusu community from Bungoma District, Western Province, male circumcision is a vital stage of initiation for young boys into adulthood and the practice has been part of the community's traditions since the 1800s. But the way it is carried out has made it a deadly practice.

According to Dr. Nicholas Muraguri the head of National AIDS/STD Control Programme in Kenya, in 2010 the Bukusu community plans to circumcise about 20,000 young boys in traditional ceremonies – without the assistance of trained medical staff or even properly sterilised equipment.

Muraguri says out of the total young men to be circumcised, statistics indicate that 40 percent will end up with complications, some of which will be life-threatening and could lead to death.

And the Bukusu are just one of the many communities currently conducting circumcision rites in Kenya's Western Province.

While safe voluntary male circumcision for men is a key strategy of HIV prevention, Muraguri says some of the cultural practices are likely to increase the risk of HIV transmission and may reverse the potential benefits. This includes instances where one knife is used to circumcise several boys or where boys are encouraged to engage in sexual intercourse soon after the procedure.

According to David Alnwick, a senior adviser of HIV/AIDS at the United Nations Children's Fund, the focus has been to encourage male circumcision among communities that previously did not have the practice.

However, parents are encouraged to circumcise their sons shortly after birth. Where neonatal male circumcision is done in medical settings it is rare and unusual that complications will arise.

But adult male circumcision performed by untrained individuals in unhygienic conditions and without proper follow-ups means the complication rate can be high, and severe, potentially life-threatening complications may occur.

Dennis Kuloba is a traditional circumciser from the Bukusu community. For him it is simple: If a man is not circumcised he is not truly a man.

"Men who are not circumcised are not respected in the community and are not allowed to eat on the same table as their circumcised counterparts," Kuloba says.

Kuloba says he uses a special mix of clay soil and ash to sterilise the 'lutembe' (a traditional double-edged knife). The boys are not put under local anaesthesia to numb the area and instead are expected to be courageous and not show any sign of pain while Kuloba removes their foreskin. But Kuloba uses a separate knife for each boy to guard against HIV infection.

Muraguri and his team are trying to find a way to allow young men to hold on to their culture without having to place their lives at risk. It is why government is now offering the service at a drastically reduced price to initiates in the Western Province.

In Kenya, the cost of circumcision in a medical facility ranges between six and 12 dollars. This cost is prohibitive for many rural parents.

"We have reduced the amount to 200 Kenyan shillings ($2.50) in Bungoma and Kakamega districts during this circumcision period.

"For those living in far-flung areas away from medical facilities, we are holding medical camps throughout the circumcision period. Here, the procedure is done at no cost," Muraguri said.

Alnwick hopes that soon traditional circumcision will be widely discouraged: "While we acknowledge it is part of tradition and important to that regard, some of the circumcisers do a very poor job ending up in botched cases that lead to infection and at times death."

Too Young to Know, Yet Too Young to Die

Primary school sex education only teaches content regarded suitable for children aged between six and 12 years. Credit: UNICEF/NYHQ2009-1926/ Giacomo Pirozzi

By Evelyn Matsamura Kiapi

KAMPALA - Thirteen-year-old Jacinta Okello and her fellow primary school classmates call it "doing bad manners". But when you ask her what she knows about sex, she breaks into a shy smile, looks to her feet and giggles.

At 13, Okello should actually be in secondary school but she, just like thousands of other pupils in the system across the country, was a late starter.

And as Okello and other late entrants become young adolescents while in primary school they cannot access teenage sex education because they fall out of the 'age-appropriate' bracket set by the ministry of education and sports national guidelines on HIV/AIDS.

It is a policy that does not meet the sexual and reproductive health needs of the next generation and exposes them to health risks, critics say. Rights activists are now calling for policy changes that will allow adolescents still in primary school to be taught sex education.

Henry Ntale, Behaviour Change Communication and Advocacy Manager of the Naguru Teenage Information and Health Centre is one such activist. From the number of young adolescents visiting the health centre daily, there is a need to disseminate the relevant information based on age - not education - levels, Ntale says.

"The ministry assumes that all kids in primary school are still young and not sexually active. So they give them information based on that assumption. It is our concern that when we use the age-appropriate information, those mature boys and girls in primary school need that information," he says.

The teenage centre is open to young people aged between 10 to 24 years. Approximately 85 adolescents visit for medical checks and 40 for HIV testing on a daily basis. Of these, 60 percent are in school.

Uganda has one of the highest teenage pregnancy rates in Africa at 25 percent with many primary school-going teenage girls leaving school because of this. Dropout rates for girls from the primary school system are as high as 50 percent, according to a 2006 report, 'Unintended Pregnancy and Induced Abortion in Uganda: Causes and Consequences' by the Guttmacher Institute.

Currently primary school sex education only teaches content regarded suitable for children aged between six and 12 years.

"You don't give the same messages to infants as you do those in upper primary. We make the younger children appreciate certain values in society like sharing. But as you get higher up the education chain, you start dealing with complex issues of dealing with stigma and discrimination, of compassion of those infected and affected by HIV/AIDS," says ministry of education and sports spokesman Aggrey Kibenge.

But with the introduction of free primary school education in 1997, many over-age children joined the education system, defying the traditional primary school age bracket.

Today, it is common to find children as old as 17 sitting in a primary school classroom. According to the Uganda Educational Statistics Abstract (2007), a total of 433,632 new entrants joined primary one at seven years, 78,405 joined at nine and there were 516 12-year-olds in primary one.

But according to Kibenge, these figures are negligible compared to the 7.5 million children currently under the free primary school education system. He says policies cannot be created based on minority demand.

"What is the option in terms of the emphasis that we should be giving in our messages at primary school level? Treat the teenagers in primary school as the exception? Are you going to design policies on the basis of the exception?" he asks.

But Ntale says this should be done: "We recommend age-appropriate information regardless of the education level of the child. We rather give them the information and skills to stay safe."

"Young people are too young to know, but again, they are too young to die. You rather let them know than let them die," Ntale says.

But Kibenge insists that the education ministry is giving the appropriate sex information to the right group at the right time. This includes teacher training programmes on sex education and the introduction of story books for pupils on several themes to enhance their awareness on matters concerning HIV/AIDS.

"I am confident that we are reaching all schools," Kibenge says.

For now this means that Okello has to wait till secondary school next year to access appropriate teenage sex education. Her mother, Jovita Okello, says her daughter should know more about the changes in her body than she does now – but Jovita Okello does not know how to educate her daughter about it.

"My daughter started her menses when she was only 12. I did not know how to tell her about the changes in her body. So I just told her she should not let anyone touch her body parts because now, she could get pregnant and also contract HIV," she tells IPS.

She hopes that the primary school system will provide her teenage daughter with the appropriate sex information in a society where parents consider discussion about sex a taboo.

Children Crossing Borders in Search of HIV Treatment

Zimbabwean children labour alongside adults to eke out an existence. Credit: Stanley Kwenda/IPS

By Ignatius Banda

PLUMTREE, Zimbabwe, - A new type of migration is taking place in Zimbabwe. While in the past people crossed the borders into South Africa and Botswana seeking work and fleeing from their repressive circumstances, now a silent migration of HIV-positive children seeking antiretroviral treatment (ART) is taking place.

The deep rural plains of Ndolwane, Plumtree in south-west Zimbabwe share a border with Botswana. And from here, a growing number of families are taking their HIV-positive children into Botswana and South Africa to seek ART.

This, some faith-based organisations report, has been spurred by the long waiting lists for antiretrovirals (ARVs) in Zimbabwe where government programmes to provide free medication for HIV patients are reportedly failing to match demand.

"This is how desperate the people are to provide treatment for their children," said Khumbulani Khaphela, a pastor with an evangelical fellowship church working in rural Plumtree.

"Some families after hearing that others have sent their children across the border have approached us to assist them with going there as well," he said. The churches are expected to finance the medical trips as part of their contribution toward efforts to save the lives of HIV-positive children.

The people of Plumtree are no strangers to migration. Men and women have been forced to leave their poverty-stricken villages as the lack of access to running water, high unemployment, lack of medical care and a litany of woes hit the rural communities hard. Thousands left their homes to work in Botswana and South Africa while sending back a portion of their earnings to their families.

But this migration, HIV/AIDS researchers and local elders say, has contributed to the spread of the virus as husbands living and working away from their wives and families engaged in extramarital sexual relations and returned home HIV-positive. This resulted in the birth of a number of HIV-positive children.

The migration into bordering countries to seek medical attention for children has also been partially been driven by the growing number of HIV-positive urban residents who flock to rural areas for ART. They have sought out treatment in rural hospitals where waiting lists for ARVs are deemed shorter than those in large towns like Bulawayo.

However, faith-based organisations say there have also been reports of parents from urban centres, like Bulawayo, who have also resorted to transporting their children to neighbouring countries for treatment.

"From what we are hearing, it is easy for children with tuberculosis and HIV to be treated in South Africa's government hospitals," said Josphat Dakamela, a village elder in Plumtree. "What can we do? Everybody knows there are no medicines in the country (Zimbabwe) so what is happening here is no surprise."

This is despite assurances by authorities that HIV infections continue to dwindle in this impoverished southern African country. While the Zimbabwean government offers free ARV treatment, this is hard to come by for many living with the virus as patients also have to undergo rigorous vetting before they are placed on long waiting lists for ART.

According to a United Nations report, for the approximately 160,000 children living with HIV in Zimbabwe only one in 16 have access to the life-prolonging drugs.

Local AIDS activists say that Zimbabwean nationals working in neighbouring countries have shunned seeking treatment there because they have no legal status and fear deportation. But for young children the situation is different as the South African and Botswana governments attempt to provide free health care for all children under their own Millennium Development Goal commitments.

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"Many know that children's treatment in the countries they settled is free and have taken advantage of this to send sick children there," said Khaphela.

These parents are helped by the existence of cross-border transport operators who for years have exploited porous border posts to transport Zimbabweans to South Africa as they search for work. Now they also assist HIV-positive children.

"Moving people across the border has never been a problem, but taking children as young as six to South Africa for treatment is something new," says cross-border transporter Mongameli Sibanda.

He says some of the children he transports are visibly in poor health. This has added an urgency to his work as never before. Now his cross-border errands are critical as he races to get children to South Africa. "It is sad when we have children seeking treatment outside the country. These things must be done here (Zimbabwe)," said Sibanda.

In the past, frontline health workers have complained that Zimbabwean parents have left it until too late to seek treatment for children living with HIV.

But this is slowly changing in some rural areas. These dire circumstances are indeed magnified among rural populations like those in Plumtree who are responding to the crisis by crossing the border to seek treatment.

"There is little we can do," said Khaphela. "We cannot fold our hands and watch children die when their families have these rather desperate alternatives. We will keep helping."

Parents' Fears Slowing Uptake of Paediatric AIDS Treatment

A busy clinic in Malawii. Credit: Claire Ngozo/IPS

By Nebert Mulenga

LUSAKA - Diana Banda* is quickly running out of excuses to give her six-year-old son about why he has to take a schedule of drugs every day.

Her son David* is HIV-positive and has been on anti-retroviral treatment (ART) for two years. But he may not learn the truth about his HIV status anytime soon as his mother thinks up one excuse after another as to why he has to religiously take the drugs.

"He asks me almost every day why he has to take these same drugs all the time. At first, I told him that he had a persistent headache but when I went away for a week, he skipped (the medication) for two days and then protested that he had had no headache," said Banda, a housewife in the Zambian capital, Lusaka.

"So as a family, we have now had to convince him that according to the doctor, his head will start enlarging if he ever stops taking the medicine; but he seems to question everything we say and do," she said.

Banda is by no means the only parent shielding her child from knowing his HIV status. There are thousands other Zambian parents and guardians who are too scared to reveal the HIV status of their kids to them – for reasons ranging from the uncertainty of a child's reaction, to the fear of stigma, and even from the fear being judged as promiscuous by their children.

But health experts say families and communities who shield children in their care from knowing their HIV/AIDS status are undermining the country's attempts to promote paediatric anti-retroviral (ARV) uptake and adherence.

"The uptake of paediatric ARV treatment is still very low as compared to the adults and mostly this is because some parents are not very keen on bringing their children for testing. (But then) even those who test and are put on treatment in most cases do not seek the co-operation of the child in the treatment process, which affects adherence," Dr Mutinta Nalubamba, a paediatric ART co-ordinator in the health ministry, said.

She said that at the end of 2009, just over 30,000 children were tested for HIV, though over 70,000 needed the test based on the number of HIV-positive mothers who delivered. "We are asking all families with HIV-positive children to be more open about the problem, because hiding the truth puts a child's life at greater risk," Nalubamba said.

"He asks me almost every day why he has to take these same drugs all the time."

About 40,000 children are born HIV-positive each year in Zambia but only 21,000 are currently receiving ARVs.

Banda says she cannot stand the thought of her son finding out that he is HIV-positive. "It will hurt me so much as an adult because there are days when I feel like I will die any minute – but what about a child?" asks Banda, whose husband died of an AIDS-related illnesses in 2007.

Matildah Mwamba, a traditional birth attendant and marriage counsellor, says most Zambian families fail to talk to their children about their HIV status because of cultural norms that encourage elders to filter the information passed onto children.

"The biggest problem is that HIV/AIDS is still stigmatised as the deadly or incurable pandemic, which is like a death sentence. Before breaking the news to a child, it's like we all have to wonder how the child would take it … and this is why people prefer to tell a child lies or deny the child any possible access to information on the disease," Mwamba said.

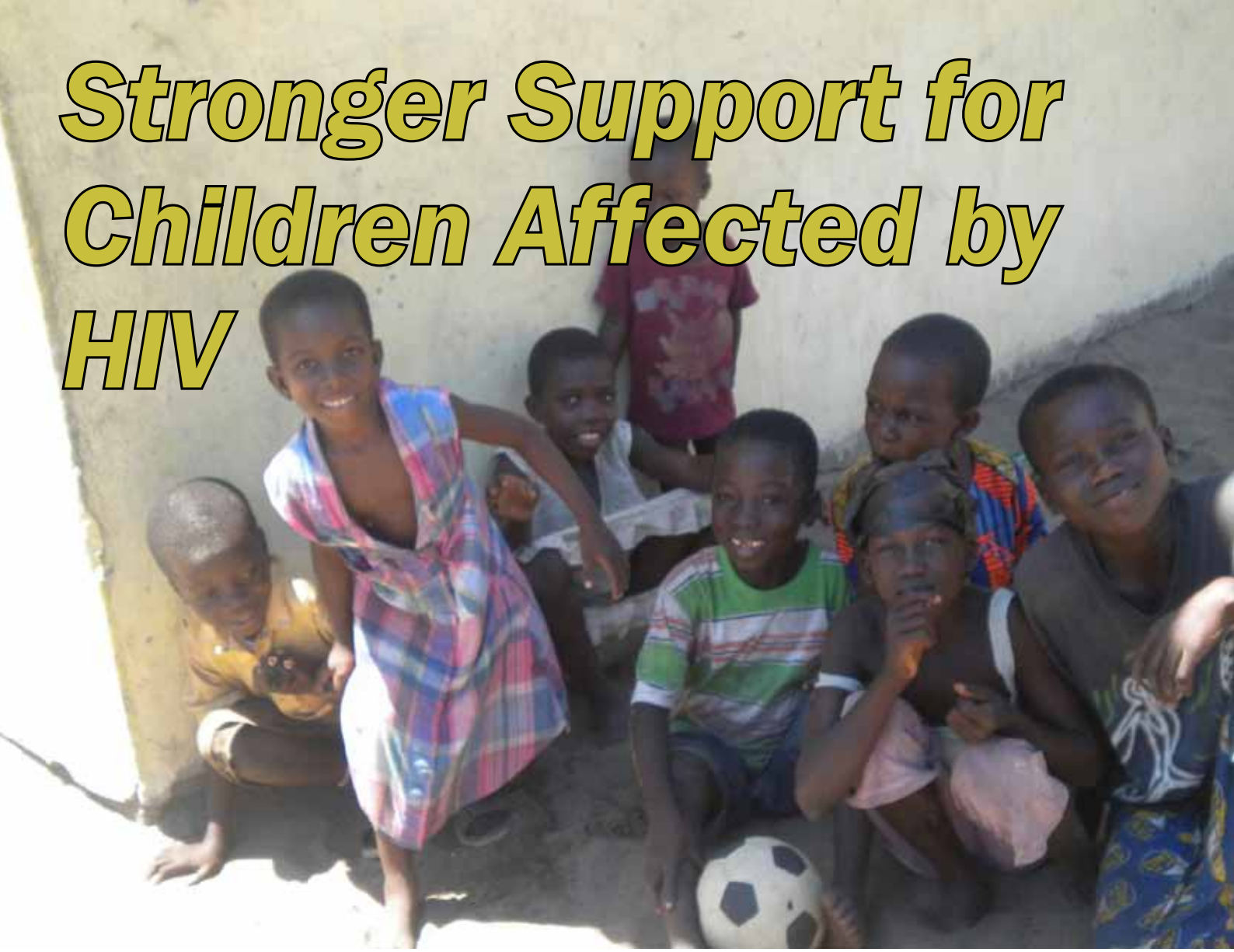
The ministry of health is currently developing guidelines on paediatric counselling. And a number of non-governmental organisations have embarked on intervention programmes to raise HIV/AIDS awareness and combat the non-disclosure approach adopted by many families with HIV-positive children in their care.

Felix Mwanza, a spokesperson for the NGO Treatment and Advocacy Literacy Campaign, tells IPS:

"We want children to develop a keen interest in knowing their HIV status, to be able to relate with their peers, to be able to open up about issues of HIV and AIDS. It's only fair that they (children) know the truth so that they can even help in reminding the parents on the aspect of medication."

**Names have been changed*

Stronger Support for Children Affected by HIV



Rwanda is seeking to expand support available to children affected by HIV, like these orphans in Muhanga village. Credit: Aimable Twahirwa / IPS

By Aimable Twahirwa

KIGALI, Rwanda - At Kigali's Kibagabaga Hospital, 30 young people aged between 12 and 18 years old wait in a crowded holding room, waiting for their turn to see the doctor in charge of prescribing antiretroviral drugs (ARVs). They are among 220,000 children affected by AIDS who are benefiting from social and medical assistance from the Rwandan government and its development partners.

"Sometimes, these children can't even go to a doctor to explain their suffering, because they are likely to have fears, and some feel guilty. Most of these [children are] HIV orphans," said Antoinette Murebwayire, a nurse at the treatment centre. "We are their parents."

Tunga - not his real name - is a 13-year-old young boy from Samuduha, one of the poorest slums of Kigali. His parents, he says, died of AIDS in 2008 when he was in primary six. Tunga had no idea that he was himself HIV positive; his main concern was taking over the care of his two younger brothers.

The paediatric centre at Kibagabaga Hospital sees around 40 patients each day for testing, counseling and treatment. There are 870 children receiving treatment at the centre; 55 of them on anti-retroviral therapy.

"But the fact that most of these infected children are from vulnerable families, makes it hard for them to take drugs due to hunger," Murebwayire told IPS.

Kibagabaga offers voluntary counselling and testing to AIDS orphans and Tunga had no qualms about undergoing a test.

"Taking an HIV test was very easy for me, but when I was told that I was HIV positive... it was another story," he said.

"When I was first informed about my HIV status, I felt it was punishment for something I had done."

But Tunga is fortunate to have support from several sources. He and his two brothers live in a house that was built for them by a local NGO in 2009, after the trio was found homeless.

The little family also receives help in the form of the Family Package, a social and medical assistance package the government has implemented for people living with HIV/AIDS.

The UNICEF-backed programme offers households affected by HIV and AIDS treatment and counselling, family planning and nutritional support, and income-generating projects.

Child-headed households are assisted with paying for school fees and uniforms, as well as a monthly basket of food.

"When my parents died, I lost hope for my life. But with the support I got, I have managed to educate my young brothers and we did not have to drop out of school," Tunga said.

The attention paid by Rwanda's health authorities to the basic needs of children affected by AIDS is welcome, yet more is needed.

An activist with one community-based NGO in Kigali told IPS that many children living in the poorest areas are not aware that free care is available. AIDS orphans and children living with HIV also often lack emotional support, and are isolated from the community around them by a degree of stigma.