TERRAVIVA

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Focusing on Children and AIDS

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UNITE FOR CHILDREN
UNITE AGAINST AIDS

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Children and AIDS

Elhadj As Sy, UNICEF Regional Director for Eastern and Southern Africa.

Eastern and Southern Africa continues to be the epicenter of the HIV and AIDS pandemic. The region with its 20 countries is home to 57 percent of all new HIV infections in the world, and includes seven hyper-endemic countries with an adult HIV prevalence of more than 15 percent. In another five countries prevalence ranges between five and 15 percent.

The impact of HIV/ AIDS on the lives of children in Eastern and Southern Africa remains enormous. Despite a lot of progress over the past years, many children are still at risk of being infected with HIV at birth. Many suffer the scars and trauma of losing their parents to the pandemic, of having to fend for themselves and to raise younger siblings. Young people are often not adequately equipped with the knowledge and skills to protect themselves from the virus.

The region has an estimated population of 188 million children under the age of 18. Approximately nine million of them have lost one or both parents to AIDS.

In 2005, UNICEF and partners launched the 'Unite for Children, Unite against AIDS' campaign to put children at the forefront of the global response to the pandemic. The four main pillars focus on prevention of mother-to-child transmission (PMTCT), a pediatric care and treatment, prevention of new infections among young people as well as protection, care and support for children affected by HIV and AIDS.
Thanks to the campaign, children are no longer the missing face of the pandemic. Programmatic interventions have already achieved a whole series of concrete results for children.

The virtual elimination of mother-to-child transmission is now a realistic goal, creating the possibility of an AIDS-free generation. In the last couple of years, access to PMTCT services has steadily grown. The proportion of pregnant women living with HIV in Eastern and Southern Africa who received antiretroviral prophylaxis for PMTCT stood at 58 percent at the end of 2008. Efforts are underway in many countries to scale up these services to at least 80 percent by the end of 2010 and ensure they reach all women in need.

For infants who are born to mothers living with HIV/AIDS, access to an early HIV-test and pediatric treatment is crucial. Many countries in the region now have scale-up plans and the percentage of children on treatment increased from 30 percent in 2007 to 44 percent in 2008. The sooner the child is on treatment, the more likely he or she can survive and grow up healthy. Without treatment, around half of all infants born with HIV die before reaching their second birthday.

For families affected by HIV, the financial loss of the breadwinner and the emotional loss of caregivers are grave. Families and communities continue to bear approximately 90 per cent of the financial cost of responding to the impact of HIV on children. There is consensus that child-friendly social protection systems and financial support to affected households can be extremely beneficial. The successes of the child cash grant in South Africa and the cash transfer programme in Kenya for instance are demonstrating how vulnerability for the poorest children can be reduced.

This issue of 'Terra Viva' presents the human stories behind the numbers and statistics. It seeks to illustrate the types of innovative approaches and efforts by those working tirelessly in communities to help children affected and infected by HIV and AIDS. UNICEF is pleased to be partnering with Inter Press Service Africa (IPS) to give them a voice and demonstrate that together we can make a real difference in the lives of millions of children in Eastern and Southern Africa.

TERRAVIVA

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Front page picture caption: Mirriam holds her six-week-old son, Peter in a village in Zambia. She and her husband learned they were HIV-positive during an antenatal consultation. She participates in a PMTCT programme, and Peter is now due to be tested for the virus.

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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 Africa 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. Visit the project website for updates.
http://www.ipsnews.net/new_focus/children-frontline/index.asp.

Focus on Infants in HIV Prevention

by Mantoe Phakathi

Nonhlanhla Mabuza with her baby, Thabiso Dlamini, after the circumcision.

Manzini, Swaziland - A proud mother, Nonhlanhla Mabuza cuddles her one-day-old baby boy, at the circumcision clinic of Raleigh Fitkin Memorial (RFM) Hospital.

A day after delivering her second son, Thabiso Dlamini, the 20-year-old mother is not only beaming because she has just successfully delivered her tiny little tot – her bundle of joy has just undergone male circumcision.

"I'm happy that my boy will be less exposed to sexually transmitted infections as he grows up and becomes sexually active," said Mabuza.

Neonatal male circumcision is a new concept in the Kingdom with the highest HIV/AIDS prevalence in the world. About 26 percent of the reproductive age group between 15 and 49 years old is infected with the virus that causes AIDS.

She said she decided to have her baby's penile foreskin removed after attending antenatal care classes at the hospital. Now her boyfriend wants to circumcise together with their six-year-old son.

"The nurses told me that chances of getting sexually transmitted infections are reduced for a circumcised male," said Mabuza. "Even chances of getting HIV are minimised if a man is circumcised."
But the service is not accessible in all public health facilities for now.

According to Faith Dlamini, the head of programmes-coordination at the National Emergency Response Council on HIV/AIDS, to provide safe neonatal male circumcision healthcare providers should be adequately guided and trained.

"That being the case, the programme rollout started in some facilities such as the RFM hospital," said Dlamini.

While in other countries neonatal male circumcision is done for religious and cultural reasons, Dlamini said the main purpose of providing neonatal male circumcision in Swaziland is for HIV prevention.

"In Swaziland we are fortunate that we don't have traditional male circumcision providers," said Dlamini.

Until now, the main target for male circumcision has been men aged 15 and older because, according to United Nations Children Fund (UNICEF) HIV/AIDS specialist Dr Fabian Mwanyumba, this group is already sexually active and needed to be targeted immediately.

"We started by circumcising adult males as an emergency measure because they are already at risk," said Mwanyumba. "Now we want to also focus on infants as a long-term measure of male circumcision as an intervention against HIV/AIDS."

UNICEF donated the male circumcision clinic to RFM in 2009. So far 183 babies have been circumcised at the clinic. Infants aged between 12 hours and eight weeks qualify for neonatal male circumcision.

Chief medical officer at RFM Dr Raymond Bitchong said neonatal male circumcision is more convenient than adult male circumcision because the penis is relatively underdeveloped and the foreskin less vascular - which results in less bleeding.

Bitchong said the healing process usually takes 48 hours for infants unlike in adults where they are supposed to delay any vigorous exercise for two weeks. Adults are also supposed to abstain from sex for six weeks after the procedure to allow the penis to heal properly.

"Circumcising infants is less costly than adults because in neonatal (circumcision) we use a device that is quick and easy to operate," said Bitchong. "Adult male circumcision is done at the theatre and this requires more space and personnel."

Infants aged between zero and eight weeks are given a local anaesthesia to ease the pain, said Bitchong.

"But for those above eight weeks they have energy and they fight during circumcision. Therefore they need to go to theatre for a light general anaesthesia. That requires specialised equipment and more people to work on the circumcision," said Bitchong.

He said it is easy to train nurses to do neonatal male circumcision because the gadget is easy to operate as opposed to adult male circumcision.

Expecting mothers and those attending post-natal care are targeted to be educated about neonatal male circumcision. Male circumcision focal person at RFM, Bethusile Lukhele, said some mothers are approached about the idea of getting their newborn sons circumcised when they bring their babies to the hospital for post-natal care.

"We also target mothers who bring their babies for the six-week vaccination," said Lukhele.

At first, mothers were a bit reluctant about the idea of getting their babies circumcised because they were not informed about the benefits of this programme. When the programme started, Lukhele said, the clinic used to see between 10 and 15 clients a month.

"But now we see an average of 25 neonatal clients every month," said Lukhele.

In the meantime, UNICEF is expanding the number of neonatal male circumcision clinics to other public hospitals and clinics throughout the country.

More mothers, like Mabuza, will be smiling from ear from ear as the programme moves to other public health facilities so that more children can be circumcised.

New Efforts to Address Risky Sexual Behaviour Among Teens

By Aimable Twahirwa

Kigali - Eighteen-year-old David Kimenyi* is sure he infected his girlfriend with HIV. They had unprotected sex many times, even after he discovered he was HIV-positive.

"I am afraid that I would have infected my girlfriend with HIV/AIDS," he said.

"We used to enjoy a good time together and we trusted each other to have unprotected sex," Kimenyi said of the girlfriend he began dating in 2008, not long after he went for an HIV test.

"After several times (of) having unprotected sex, I decided to tell her that I had AIDS," Kimenyi said.

That was six months ago. Kimenyi's girlfriend has left him since then.

Teenagers are the first target of HIV/AIDS because of insufficient sensitisation campaigns, thus (there is) a growing risk (of infection among teenagers) if no appropriate measures to reduce the rate transmission are taken

In Rwanda, the HIV prevalence rate is estimated to be 3.1 percent according to the government's 2008 Demographic and Health Survey.

But health officials are concerned that not enough is being done to contain the pandemic among teenagers.

A country-wide programme involving various stakeholders has been launched to tackle the rate of infection and increasing risky sexual behaviour among teenagers, officials from the National AIDS Control Commission (CNLS) said.

According to the results of a CNLS behavioural survey conducted in 2000, only 10 percent of the country's sexually active youth use condoms. "If teenagers are eager to have sex outside of their marital status, it is also important to educate them about how to reduce the risk of being infected with HIV," Dr. Anitha Asimwe, the executive secretary of CNLS said.

Asimwe told local media that HIV infections in the country currently stand at one percent among youth aged between 15-24 years.

"In most cases, these teenagers don't sometimes feel concerned to go for voluntary testing. The most discouraging issue is that most parents don't want to talk to their children about sex, relationships and other related facts," Asimwe said.

Kimenyi explained he had only gone for testing after contracting STDs.

"I decided to go for the test voluntarily because of certain diseases that I started to suffer from, particularly shingles, skin diseases and pneumonia," Kimenyi said.

At Nakumatt, one of the main supermarkets in the Rwandan capital, Kigali, around 100 young people, mostly teenagers, come to enjoy a light moment. They share drinks, sitting around several plastic tables in the main entrance hall. They sit close together, close enough so that they can touch one another.

This was one of Kimenyi's hangouts. Most of the young boys and girls frequenting public places like the new supermarket in Kigali are interested in having a good time.

And if a girl and boy meet, like each other, and end up going home with each other afterwards, there is a high possibility they will have unprotected sex.

Official figures from government state the lowest prevalence of HIV, at 0.5 percent, is among teenagers aged between 15-19 years. But Bonaventure Ntagengwa, the coordinator of a youth centre for reproductive health based in Kigali, observes that most teenagers appear to have lost their fear of the disease.

Many teenagers, like Kimenyi, also find it difficult to ask their sexual partners if they have been tested for HIV, or to even discuss their own status, health officials say.

Kimenyi admits he never told his girlfriend his status because he was trying to 'ignore' it.

"Raising the issue of (your) HIV status sometimes contribute(s) to (a) breakdown in mutual confidence and friendship," Kimenyi told IPS.

Dr. Agnes Binagwaho, the permanent secretary in the Rwandan ministry of health, said emphasis should also be placed on several other campaigns such as male circumcision - which could contribute to reducing the rate of HIV infection especially among the youth.

"Rwandan youth must be free to make choices to reduce HIV/AIDS and they deserve to be in a community where safety is real," Binagwaho said.

Asimwe said teenagers needed to be sufficiently educated about HIV to reduce their risk of contracting the virus.

"Teenagers are the first target of HIV/AIDS because of insufficient sensitisation campaigns, thus (there is) a growing risk (of infection among teenagers) if no appropriate measures to reduce the rate transmission are taken," Asimwe said.

Name has been changed to protect identity of minor.

Herdboys in Lesotho are at risk to contract HIV.

Herdboys at Risk to Contract HIV

By Letuka Mahe

Maseru - In the scorching heat of the midday summer sun, a teenage boy's sharp voice can be heard vividly as he continuously summons his cattle. Dressed in a shabby-looking rag that was once a blanket and black gumboots, the only thing that occupies his mind is his herd, his everyday companions, nothing else.

Sixteen-year-old Motlalepula Mohapinyane is from Ha Khoabane, Thaba Bosiu, some 40 kilometres east of the capital Maseru. He has been herding his father's cattle since 2007 after he dropped out of Form B (Grade 8) at Letsie High. He knows a little about HIV/AIDS, as well as voluntary counselling and testing (VCT). But he has not had an opportunity to go to the village clinic to get tested.

"I haven't had time to go because of the animals, and my father will not allow me to leave the herd. Maybe I will go when I am a grown-up," he quickly adds. He says he has briefly been to one or two HIV/AIDS awareness campaigns organised by the clinic, and learned a little about condom usage as a means of prevention against HIV infection. "I only use a condom if I am lucky to possess one," he chuckles shyly.

Herdboys in Lesotho are one of a few groups of society that have been marginalised by the speeding wheels of the democratic progress. Their understanding of HIV/AIDS is quite limited, and to them it is like any other virus. Their lack of education about the disease places them at a greater risk of contracting HIV.

According to the United Nations Children's Fund data, over 90 percent of Basotho know about AIDS, yet out of that only 25 percent know comprehensively about the virus. The severity of young people's vulnerability to HIV infection is evidenced by the upsetting data. Sexual activity starts as early as 12 and 14 years for males and females respectively. Only 10 percent of males and six percent of females use condoms when they have sex for the first time.

And it is not easy to find data on herdboys at the clinics regarding their VCT attendance. "From the way our registration books have been designed, it is not easy to categorise our patients by their professions, but only by their gender, age and their villages," says the head clinician at the Thaba Bosiu Red Cross clinic, Lihamang Maebo.

Maebo says they can mostly identify students in their uniforms, otherwise they categorise them as the youth. Another factor that makes it difficult to identify herdboys, she says, is that more female youth go for testing than their male counterparts. However, the nursing sister believes that at the current rate the youth appear to want to know their status, AIDS education seems to have trickled down even to the most marginalised groups like the herdboys.

The National AIDS Commission (NAC) says development of a strategic plan for the empowerment of herdboys is underway. "We are advocating for herdboys' clubs, and a study to collect data on this category of youth, and to find out how many of them are females, is still underway," said NAC officer 'Machale Sepitla.

She said the study is aimed at recognising the vulnerability of the herdboys, establishing the magnitude of the problem as well as to have evidence-based information relating to HIV/AIDS.

Chairperson of the Lesotho Herdboys Association (also known as Monna-ka-khomo), Motlalentoa Hlehlisi, also conforms to NAC's statement: "We have included HIV/AIDS into our working programmes so as to equip herdboys with knowledge on those issues. And at the moment we are in the process of drafting a policy and a strategic plan for herdboys on HIV/AIDS with the help of NAC," he says.

The government of Lesotho is also on the process of addressing such youth problems as this faced by Mohapinyane. According to the Principal Secretary of the ministry of gender, youth, sports and recreation, Makalo Theko, a National Youth Council is due to establish office in March 2010.

It is expected that the council will help facilitate the finalisation of a national youth policy that has seen years of delays in the shelves of the technocrats. The council is expected to bring hope to these marginalised youth as they will also be directly involved in its administration.

All these blueprint developments, however, are a myth to members of most groups of society such as Mohapinyane, who remains oblivious of the risks he is currently facing pertaining HIV/AIDS.

"I just want to be a grown-up, and with these cattle, I will get married and have many children too, like my father."

And with that he throws a rock at a stray from the herd, swears so loud it is ear-shattering, before hastening after his cattle.

Trying to live a no

By Zarina Geloo

Lusaka - Sixteen-year-old Andela Milambo* wants a husband. She is not looking for love, but for someone to share the burden of living with HIV. She wants to be able to take her medicine without having to hide, to discuss the recurring herpes with someone who understands.

Living with HIV since the age of six, she wants someone else to make the decisions, "while I read a magazine."

Milambo says she got infected through a contaminated needle. She describes a life dominated by the fear of dying from AIDS but says the worst times are when she gets herpes flare-ups which make it hard to walk, talk or eat.

" Keeping such a secret is a heavy burden. I suffer tension headaches and have developed a facial tick from the stress."

She skips school often due to "small illnesses" like colds which are usually accompanied by a bad cough that debilitate her body. Her grades are bad and she has little hope of obtaining a full certificate when she completes secondary school next year. "But that's alright, I was not intending to go to college anyway."

She has made no lasting friendships for fear that people will find out her HIV status. While her parents and a few close relatives who know her status try to offer support, they actually make things worse, she says.

"I see them just age in front of me when I am sick, they get so stressed and sad, that I prefer to suffer in silence."

She hears how young people talk about HIV and AIDS and the level of discrimination and ignorance frightens her. "I can never confide in a young person that I am positive, the stigma would kill me faster than AIDS."

Milambo envies other young girls going to movies, laughing, dancing. She has no time for that, she says, because she has to work to stay alive. Instead she does 'boring' things like peer education for her local clinic.

Rather wryly, she says, "Though I say it's boring, the clinic is the one place I feel comfortable at. As a peer educator I have the run of the place with no questions asked. So treatment and information for me is free and easy to get."
It is also the place Milambo is looking for a husband. "Men at the clinic are knowledgeable and because they work around HIV, they are compassionate. When I turn 18 I will choose one. As head of the household, my husband will make the decisions regarding our welfare, while I watch television or read a fashion magazine… being married would make me a 'proper person' because everyone aspires to be married, at least that's the one thing I can achieve."

James Banda also wants a normal life. The eighteen-year-old is openly living with HIV and confines himself to dating HIV-positive girls because he hates having to explain to every new girl why he has to take pills on a regular basis. The girls usually run away from him after that, he says. "The ones that stick around see me as a charity challenge and I am their good Christian deed."

Infected with HIV from his first sexual encounter, his life's mission now is to find a girl with whom he can have a child.

Banda says after his diagnosis he did things 'by the book'.

"I went for rigorous counselling, came out in a big way, telling anyone that would listen about my status, I did the whole nine yards. I was celebrated by NGOs who made me the poster boy of an HIV-positive youth. But after a while, the novelty wore off and I got tired of always talking about HIV as if that's what defines me."
He says there are times when he wishes he had not disclosed his status. Like when he goes to a disco and people come up to him to caution him not to drink, or tell him that he should not be there.

"The books on living positively with HIV says I should continue to live as much of a normal life as possible. The reality is different; there can never be anything normal about my life."

Bouts of opportunistic infections, always being on the lookout for a cure or better therapy, not being able to plan ahead ten or even twenty years are some of the things

The statistics on Zambian youths with HIV

The UNAIDS 2008 report on the global AIDS epidemic estimates that of the one million Zambians infected with HIV, over 20 percent are youth between the ages of 15 and 25. The infection rate in youth has stubbornly remained at 17 percent in spite of many interventions from civil society and government on abstinence and prevention.

rmal life with HIV

that make his life abnormal, Banda says.

Having passed his school-leaving exams with distinction, he is going to college next year to study accounting. He says he has it all; the support of his family, a few good friends and good future prospects. But living with HIV 'is still damn hard.'
Living with HIV in secrecy is what is harder still for Adam Malik*.

Drinking himself 'senseless once in a while' is how Malik copes with his situation. A Zambian of Indian extraction, he lives in a close knit community that refuses to acknowledge HIV in their midst and openly stigmatises people with HIV.

Eighteen-year-old Malik knows this only too well. That is why not even his parents do not know that he contracted HIV at the age of 14 from their house maid, with whom he had a sexual relationship for over a year. He has only recently started treatment.

Malik says because he has always been a quiet solitary person, no one notices when he is depressed or feeling unwell.
But, he adds: "Keeping such a secret is a heavy burden. I suffer tension headaches and have developed a facial tick from the stress."

Malik says he is fortunate Zambia has an efficient ARV programme. He was surprised how easy it was to get onto the programme. And he chose to attend a distant clinic for treatment where no one was likely to recognise him.

He reads up on the latest treatments but does not go for counselling as he is scared of being recognised.

Malik is also frightened that he will be coerced into jumping onto the HIV conference circuit as a young HIV-positive Indian male. "I will be a novelty that the AIDS activists will not be able to resist. They will show me around like a trophy. I have seen it happen to youth who have come out."

His life on the outside has not changed, he says. He is still the good son, taking his mother and sisters shopping, helping his father in the family store, hanging out with the boys on a Friday night.

Soon a wife will be chosen for him and he will be expected to have children, he says. He wonders what will happen then. "It will kill my mother to know that I have HIV. My father will kick me out of his home. My sisters' chances of a good marriage will be ruined. When I think of all this, I hit the bottle to forget."

He knows that this will interfere with the efficacy of his medication, but finds it's the only way he can cope.
"I am frightened," Malik says.

***Names have been changed.**

Pic: Evelyn Matsamura Kiapi/ IPS

Primary school girls at a morning assembly. Assemblies are a good time to talk about sex education.

Lots of Drugs, No Takers

By Vusumuzi Sifile

Harare - Martha* knows that her two young sisters and her need medicine. She also knows where to get it – a clinic a few meters away from her home in Glen Norah, a high-density suburb in the Zimbabwean capital.

But she cannot get the life-prolonging anti-retroviral drugs (ARVs). At 15, the law prevents her from doing so. She can only access the drugs in the company of an adult.

"When my mother died in 2007, my aunt used to collect the drugs for us. She has since relocated to South Africa, and our other relatives say they are too embarrassed to be seen collecting the drugs, people will think they are now sick," said Martha.

Martha is among the estimated 158,798 children who are infected with HIV in Zimbabwe.

According to the National Aids Council (NAC) 39,809 children die every year due to AIDS-related ailments.

The council says children are not dying because there are no drugs. The drugs are there, but youngsters just cannot access them.

"The only challenge is who (will) take the children for anti-retroviral treatment, because they cannot go on their own," said Orirando Manwere, a spokesperson for NAC.

The obstacle to treatment for many children living with HIV in Zimbabwe is that they cannot access ARVs on their own. The law requires them to do so in the company of parents and guardians.

"The main challenge is the laws," said Bekezela Mapanda, the chairperson of a committee that organised the 2009 commemorations for World Aids Day.

"There is need for a review of the policy framework to address issues of HIV and AIDS among children. The state should ensure that these children are able to access treatment and prevention without any prejudice. The law should be clear on how we handle issues of disclosure among children."

The Ministry of Health and Child Welfare estimates for 2009 that 35,190 children are in urgent need of ART. Of these, only less than half, about 16,000 children were receiving ART.

Accessing treatment is a challenge for most of these children, who either live without adults in child-headed households or stay with relatives.

Speaking to IPS on condition of anonymity, a Harare pharmacist said in some cases, drugs meant for children were actually expiring due to low uptake.

"The painful part is that while you have the drugs even expiring, they are not accessible to many children who need them. We should re-look into our legal framework regarding children's access to treatment," he said.

In some cases, activists have resorted to door-to-door campaigns to identify children in need. A home-based care group in Seke, a rural community near Harare, conducted a pilot project and managed to place 83 children on ART.

According to the country director of the Elizabeth Glaser Paediatric AIDS Foundation, an international organisation that seeks to prevent paediatric HIV infection among children, Agnes Mahomva, the inadequate access to treatment is a result of the harsh economic situation that prevailed in Zimbabwe over the last few years.

"The crisis caused a high staff vacancy rate (of such skilled personnel like counsellors)," said Mahomva. "There is a need to address staff retention and motivation issues including strengthening of community-based health care cadres… There is poor identification of HIV-exposed and infected children."

She added there was a need to expand early infant diagnosis and sensitise communities on its importance.

The government has, however, started moving towards improving paediatric ART uptake. A revised Child Health card, which captures HIV status, has been developed. Every child who produces this card at a health service centre will be allowed to access treatment without an adult. The card certifies that the child is positive and should be given treatment.

Social services minister, Paurina Mpariwa, said they were working towards reviewing the policy framework on children's access to social services like ART.

At the moment, Martha and her siblings will continue to hope for an early resolution of the legal impediments to their access to ART

Name has been changed.

Pic: Giacomo Pirozzi / UNICEF

A Zimbabwean boy orphaned by AIDS peers out the broken window of his home in Harare, the capital.

Rural Parents Prevent HIV Transmission to their Children

by Isaiah Esipisu

Nairobi and Kieni, Kenya - 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 been 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 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.

HIV-positive couple Miriam Wanjiru (l) and Samuel Mwangi (r) with their two-year-old HIV-negative son.

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.

Early Diagnosis of HIV Still Elusive

By Evelyn Matsamura Kiapi

Kampala - HIV-positive Justine Kirumira* is a mother torn between doing what is right for her daughters and her own fear of HIV/AIDS. She suspects that her eight and 12-year-old daughters may also have the virus. But she may never know the truth of their status because she refuses have them tested.

Kirumira is terrified to face the test results in case her daughters are HIV-positive. "No, I cannot test my children for HIV. How will I break the news to them?" she asks.

But Kirumira's is not an isolated case. Many parents in Uganda are still reluctant to test their children for HIV because of the fear and stigma that surrounds HIV/AIDS. This reluctance to test for HIV is a trend that is slowing down paediatric AIDS prevention, treatment and care efforts in the East African country, according to health organisations.

"Testing is still eluding us and stigma is still very high. Also, parents do not know yet how to pass this information (that they are HIV-positive) to their children. That's why early diagnosis is still lagging behind," says Dr Zainab Akol, the national programme manager for government's AIDS control programme.

In Uganda, the ministry of health (MOH) estimates that 1,153,000 people are living with HIV as of December 2008, including 88,919 children aged 0-14 years. Of these children, 33,152 have CD4 counts - a measure of how low their white blood cell count has fallen, indicating progress towards full-blown AIDS - that should see them put on antiretroviral treatment under previous guidelines.

Just 40 percent of these severely immune-compromised children were receiving treatment by the end of September 2008, and most of these in urban areas.

The problem in Uganda at least is not a lack of money to pay for drugs: Dr Sabrina Kitaka-Bakeera, from Makerere University Medical School says children's guardians sometimes fail to bring them to hospitals for treatment, or health workers lack the training to prescribe and follow-up treatment with paediatric patients.

Uganda faces an uphill task responding to new guidelines from the World Health Organisation (WHO) that states every child who tests positive for HIV should receive ART regardless of their CD4 count. Each year, more than 20,000 mothers in Uganda pass on HIV to their babies, according to the MOH.

Because Kirumira does not know how to deal with her daughters being HIV-positive every time they fall sick it becomes a traumatising experience for her. Kirumira becomes frantic, praying that they are not HIV-positive. On one occasion, when her daughter was ill with malaria, she locked herself in her bedroom. It was only when a relative stopped by that the relative managed to get Kirumira to take her daughter for treatment.

"Yes, there is a possibility that my daughters may also be HIV-positive. But I rather not know. It's only when they fall sick that I really get worried (that they may be infected after all)," the widow tells IPS at her home in Zana, a suburb east of the capital Kampala.

Many Ugandan parents are still too afraid to test their children for HIV.

Kirumira, who is on ART, says she cannot stand seeing her children on the life-prolonging drugs all their lives because it is very depressing. She also does not want her daughters to be discriminated against in school.

Fear and guilt are the main reasons why parents like Kirumira are reluctant to test their children for HIV, explains psychologist Dr Janet Nambi, the head of the mental health and community psychology department at Makerere University.

"I think it (not testing) has something to do with knowing and accepting the worst because there is always that hope that the child is not HIV-positive. Even when there are signs that the child may be HIV-positive, parents are reluctant to confirm that reality because that reality has consequences," Nambi tells IPS.
She said that many parents also felt guilty for passing on HIV to their children but accepting this was a process parents had to go through.

"I think many parents do not want to deal with that guilt," Nambi says.

The challenges in paediatric treatment lie both in prevention and care, according to Akol.

"In prevention, Uganda is still producing 20,000 to 30,000 HIV-positive children every year. That alone is overwhelming. However good our system is or however hard we work, we cannot manage 20,000 to 30,000 infected children annually," Akol says.

She says because of the stigma surrounding HIV/AIDS, some HIV-positive women cannot even tell their partners about their status for fear of being rejected. "Women who are infected still breast-feed their children even when they know they are infected. That is a concept we are not managing," Akol says.

However, the unavailability of medicines for paediatric ART was also a setback until recently when the WHO developed ART dosages specifically for children. In June 2008, the WHO also set new guidelines indicating that all children confirmed to be HIV-positive and less than one year of age be started on ART to reduce the related morbidity and mortality rates.

"We (the MOH) have introduced 'Early Infant Diagnosis' with the hope that we catch the infection early and treat the children and also try to follow them up," Akol says.

Without care and treatment, over 80 percent of children living with HIV die before they reach their second birthday.

The MOH has also started a strategy called 'positive prevention' which aims for increased prevention and care.

Name has been changed.

Training Teachers to Cope with HIV-positive Students

By Vusumuzi Sifile

Harare- Eleven-year-old Memory's* grandmother wanted her to drop out of school because she is not going to live long enough to complete her studies. And the ridicule and stigma Memory endures at school because of her HIV status does not make her education seem worthwhile. Especially since this ridicule comes from her teacher.

In a country where aids agencies estimate 120,000 children are HIV-positive, school teachers are finding themselves increasingly in the frontline of the epidemic.

The National AIDS Council recently carried out a study that found "teachers had not received enough HIV/ART education to carry out their supportive role in paediatric and adolescent care and support".

And from Memory's situation it is clear that teachers are ill-equipped to cope with the number of HIV-positive children in schools.

"The role of the teacher in the fight against HIV/AIDS among other social development issues cannot be overly emphasised"

Mbuya Tapera*, Memory's grandmother, listens daily as her grandchild relates how she has been ill-treated by her teacher.

"Her teacher believes she is wasting time by coming to school when it is obvious she will die before she completes her studies. I think she is better off at home than at school," says Tapera.

But the situation in the country's schools has not gone unnoticed.

The United Nations Educational, Scientific and Cultural Organisation (UNESCO) Harare Cluster office partnered with the ministry of higher and tertiary education to develop an HIV/AIDS manual for teachers.

The manual will be incorporated into the curriculum at teacher's training colleges at the start of the new academic year.

The manual will also be distributed to teachers who are already practicing. Special courses and workshops will also be held for those teachers already practicing.

"The role of the teacher in the fight against HIV/AIDS among other social development issues cannot be overly emphasised," says higher and tertiary education permanent secretary, Dr Washington Mbizvo.

He says the ministry believes teachers have the ability to develop the intellectual and spiritual capacity of the child. "It is important to enhance teacher education as a means of attaining an HIV/AIDS-free society. We have to ensure that all teachers are grounded in their knowledge of HIV/AIDS," says Mbizvo.

The director and resident representative of UNESCO, Soo Hyang Choi, says the development of the manual was influenced by a realisation that the involvement of teachers would boost the fight against HIV.

"Education can no longer be business as usual, teachers have to acquire adequate skills to be able to address these children in a sensitive and informed manner," said Choi.

Tapera agrees. "These teachers have no understanding whatsoever about HIV. For them whoever has the virus has been sentenced to death. It seems they do not believe that one can live a normal life with it. And it seems they just do not care to listen to some of us," added Tapera.

Memory tested positive in 2005, the year she started primary school. Tapera and other relatives received assistance from community support groups which counselled Memory helped her accept her status and believe that she can still have a good quality of life

"When she went to school, we all believed school was the best place for her," Tapera says. But things have changed. Now everyone at the school knows that Memory is positive, and that her mother died of an AIDS-related illness. "All this is because of her teacher who makes it appear like Memory committed a serious crime," Tapera says.

Other students across the country have also experienced this stigma from their teachers.

Because of the lack of support at their school a group of HIV-positive youngsters in Gwanda, the provincial capital for Matabeleland South, grouped together and formed their own support group. Despite their knowledge about the virus they are not allowed to speak publically to other students at school about issues surrounding HIV.

"If (we) are seen or heard talking about HIV/AIDS or condoms, (we) will be in trouble with our teachers," said Musa Dube*, a member of the group.

But with the introduction of the manual, Musa and others in the group hope their teachers will now support them in their effort to live positively.

But Portia Munyoro, a trainee teacher at the Morgan Teachers' College in Harare believes teachers "are not that inhumane to ill-treat these (HIV-positive) children."

"As teachers, we know that our task is to help these children get a brighter future, whether they are (HIV-) positive or not," Munyoro says.

She says although she has attended a number of counselling workshops at schools and at ward level, she still finds it difficult when it comes to counselling children. "Counselling children is much more difficult than counselling adults because one has to simplify everything, and I hope this manual will equip us with ways of handling this challenge," Munyoro says.

The manual was developed to address this, among other issues.

The manual has sessions on cultivating positive group dynamics, basic and technical information on HIV/AIDS, gender and sexuality.

Rita Mbatha, the founder and executive director of Women's Comfort Corner, a non-governmental organisation that works with women at the grassroots in communities, said the manual will go a long way helping not only teachers and pupils, but also women who do most of the work as care givers.

She says the impact teachers can make on their students would cascade to the rest of the community.

***Names have been changed**.

Government's SMS System for HIV Test Results

By Violet Nakamba Mengo

Lusaka - HIV-positive Bupe Mwamba, 22, lies next to her newborn baby girl at the rural clinic she just gave birth in and wonders if her baby is HIV-positive too.

She has been for counselling throughout her antenatal check-ups and knows there is a chance her baby girl may be HIV-negative. But it still does not eliminate her fears and anxieties.

"It is a moment of reflection about the future of your child and how your child will cope being HIV-positive. It cannot go without (me feeling) some kind of fear as a human being," she said.

Here at the Chipulukuso rural health centre in Ndola, Zambia's Copperbelt province, when an HIV test was done, blood samples were taken and then transported to a central regional hospital for analysis. The results were then sent back to the rural centre in a process that used to sometimes take up to 10 weeks.

And in the lifetime of a newborn baby, it was valuable time wasted during which the HIV-positive infant could have been placed on antiretroviral treatment (ART).

But Mwamba is fortunate. She will not have to wait so long to know her baby's status.

Because of the delays in sending and receiving HIV test results the ministry of health has piloted a short messaging service (SMS) that will now send HIV results of children less than 18 months back to health centres within three to five days.

The blood sample taken from Mwamba's baby, together with other samples from other rural health centres, are couriered to Ndola Arthur Davison Hospital, the central hospital on the Copperbelt region. Here the blood samples are tested for HIV.

The test results of the infants are then sent back to the health centres via a machine that receives information in the form of short messages. The test results will be printed out and the relevant doctor will be able to pass on the diagnosis to the parent.

Director of Public Health in the ministry of health, Victor Munkonka, is optimistic that the programme, once implemented nationally, will reduce the country's infant mortality rate by more that 50 percent. Mukonka explained that the delay in administering ART to children who are less than 18 months old was contributing to the high death rates of babies in the country.

"We realised that we were losing many babies because of the delay in testing them for HIV, this is mostly because of lack of proper diagnostic machines to detect the virus in infants," he said.

Mukonka said the SMS system will save infants' lives through prompt diagnosis and treatment.

Media Network on Child Rights and Development chairperson Felistus Chipako said the decision by the ministry of health to introduce the SMS to address paediatric HIV is a good one.

Zambia has in the recent past struggled to address child mortality, which is among the highest in Sub Saharan Africa. Zambia's 2008 Demographic Health Survey showed the country's under-5 mortality rate was 119 deaths per 1,000 live births.

Chipako said the intervention would help treat HIV-positive children in a more prompt manner than has been the case. "The system also calls for intensive counselling for mothers on how to handle the whole thing when given the results," she added.

Mwamba was discharged the day after her delivery and was scheduled to return to hospital with her baby for a check-up a week later.

When she returned seven days later, she also received the results of her child's HIV test.

Her baby girl is HIV-negative.

"I feel relieved that my baby is HIV negative, I spent the past six days pondering about what life would have been like for the little one living with the virus," Mwamba said.

Mumba said she cannot forget the fear, pain and anxiety in waiting for her baby's test results.

Pic: Giacomo Pirozzi / UNICEF

Newborn Peter Chibeka receives ARVs after his birth at the Samfya Stage 2 Clinic in the rural town of Samfya, Samfya District, Zambia. His parents, Mirriam Chongo and Adrian Chibeka, learned that they were HIV-positive during an antenatal consultation.