Tackling the impact of HIV/AIDS on Children in Africa:

Progress and Challenges

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1. Introduction

HIV/ AIDS impacts and affects children in three ways. It incapacitates and kills their parents. It incapacitates and kills them directly. And, finally, by infecting or orphaning them, it exposes them to stigma, discrimination, abuse and exploitation. It is these three points of reference that I will use as the trajectory for my speech.

Clearly, the issue of HIV/AIDS and its impact on children cannot be dissociated from the general impact on the adult population and society at large. I would therefore naturally go over familiar areas generally well known to you both in the interest of contextualizing the issue and giving coherence to my talk.

My presentation is divided into three parts. I will first deal with the general nature and scale of the problem, and then move on to the efforts being made, progress achieved and the challenges facing Africa. then conclude with some ideas on the way forward.

2. Scale of the epidemic

Words continue to be feeble to describe the scale and depth of the tragedy caused by the HIV/AIDS epidemic. It continues to cause havoc on the lives of nations, communities, families and individuals, thus eroding the progress achieved in human development and posing hitherto unknown threats to childhood. Since its onset, it has claimed the lives of 25 million people in the world. In 2007, about 22.5 million people were living with the virus. In that same year, some 1.7 million people were newly infected with HIV, while 2.1 million people died of AIDS, 76 per cent of them (1.6 million) in sub-Saharan Africa

The impact of the epidemic varies significantly from country to country in both scale and scope. Adult national HIV prevalence is below 2 per cent in several countries of
west and central Africa, as well as in the Horn of Africa, but is far higher in other parts.

- Adult national HIV prevalence was above 5 per cent in seven countries, mostly in Central and East Africa (Cameroon, the Central African Republic, Gabon, Malawi, Mozambique, Uganda, and Tanzania)
- It was 15 per cent in seven southern African countries (Botswana, Lesotho, Namibia, South Africa, Swaziland, Zambia, and Zimbabwe) in 2007.
- And, as can be seen in the figure below, nearly one in four persons in Swaziland, Botswana and Lesotho were living with HIV in 2005/06.

**Figure 1.1: Countries with high HIV/AIDS prevalence, 2005/06**

![Bar chart showing percentages of HIV/AIDS prevalence in various countries](chart)

Source: Based on data from 2007 World Population Data Sheet

Naturally, because of it, life expectancy at birth is estimated to have declined to levels last seen in the 1950s; it is now below 50 years for the sub-region as a whole and below 40 years in Zimbabwe. In Swaziland it has been estimated that life expectancy at birth, which would be 66 without AIDS, is currently just 33.

The epidemic has killed millions of children since its onset. An estimated 2 million children were living with HIV/AIDS at the end of last year alone in Sub-Saharan
Africa. Most of these children acquire HIV from their HIV-infected mothers during pregnancy, birth or breastfeeding. Around 1,900 children are born with HIV every day in Africa, and that 6 per cent of deaths of children in Africa are due to HIV/AIDS.

Perhaps the greatest tragedy wrought by the epidemic has been the staggering population of orphans left behind in the wake of parental death in large numbers. In 2005, an estimated 12 million children in sub-Saharan Africa lost one or both parents to AIDS. Kenya, South Africa, Tanzania and Uganda each counted more than a million children orphaned by AIDS as of 2005.

Table 1.1: Number of orphans (in thousands) in selected African countries, 2005

<table>
<thead>
<tr>
<th>Country</th>
<th>Orphans Due to AIDS</th>
<th>Orphans Due to all causes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cameroon</td>
<td>240</td>
<td>1,000</td>
</tr>
<tr>
<td>Congo (Brazzaville)</td>
<td>680</td>
<td>4,200</td>
</tr>
<tr>
<td>Kenya</td>
<td>1,100</td>
<td>2,300</td>
</tr>
<tr>
<td>Malawi</td>
<td>550</td>
<td>950</td>
</tr>
<tr>
<td>Nigeria</td>
<td>930</td>
<td>8,600</td>
</tr>
<tr>
<td>South Africa</td>
<td>1,200</td>
<td>2,500</td>
</tr>
<tr>
<td>Uganda</td>
<td>1,000</td>
<td>2,300</td>
</tr>
<tr>
<td>Tanzania</td>
<td>1,100</td>
<td>2,400</td>
</tr>
<tr>
<td>Sub-Saharan Africa</td>
<td>12,000</td>
<td>46,600</td>
</tr>
<tr>
<td>World</td>
<td>15,200</td>
<td>132,700</td>
</tr>
</tbody>
</table>

Source: Based on data from UNICEF, 2007

In addition to the grievous emotional scar left by the loss of loving parents that takes years to heal, the lives of orphaned children are affected by a plethora of social and economic woes. Traditionally, it is the extended family - spearheaded by uncles, aunts and more importantly grand parents - that comes to the rescue of these children. In nearly every Sub-Saharan country, extended families have assumed responsibility for more than 90 per cent of orphaned children. A study in seven countries in sub-Saharan Africa revealed that older people, mainly women, were caring for 55 per cent of vulnerable children and each one of them was, on average, responsible for three children. Grandparents – particularly grandmothers – care for:

- around 40 per cent of all orphans in Tanzania,
• 45 per cent in Uganda,
• more than 50 per cent in Kenya, and
• around 60 per cent in Namibia and Zimbabwe.

To make matters worse, because of their age, grandparents may not survive to see their grandchildren reach 18, which might mean that these children will again experience loss and go through the ordeal of yet another transition to new caregivers.

And it is often difficult to get new carers. Children orphaned by AIDS are more likely to be forced out of their homes by relatives or guardians for fear of contagion or unfounded allegations of witchcraft. Where they are found and where customary practice and statutory law dictate that children must make their claims to property and inheritance through adult guardians as is the case in most African countries, the caretakers and guardians may end up being the very predators and poachers of the property that belongs to the children under their care.

Even where there is the will, there may not be the means. In many countries, the extended family is now facing increasing strains for it to be able to provide parental and social protection to orphaned children. The pandemic that creates these orphans and vulnerable children is also playing havoc with other members of the family resulting in an overall decline in communal solidarity. The reality is that absorbing more than one orphaned child may be economically untenable for most households.

Alas, there is no where for such children to turn to but to rely on themselves and for them to constitute themselves into a family of their own. They end up in what are known as “child-headed households”, where children carry the responsibility of playing adult roles and are required to fulfill the material and psychological needs of younger siblings. Africa is home to millions of children growing up in such child-headed households. The effects of the awesome burden of assuming the responsibilities of a childhead of family are hugely devastating. As studies by the African Child Policy Forum (ACPF) have shown, they face tremendous emotional and psychological challenges, live with the constant memory of their deceased parents and their lingering agony and death, and suffer feelings of loneliness, desperation, depression, low self-esteem, fear, and a sense of alienation. This form of family formation is a rapidly growing phenomenon in the continent. The ACPF has carried out a pioneering study of this phenomenon in Ethiopia and estimates that 225,000 households in Ethiopia will be headed by children in 2010.
3. Progress and challenges

3.1. Greater political commitment

Let’s first acknowledge that there has since recently been an unprecedented political commitment in fighting HIV/AIDS and in supporting affected children among the leadership in many African countries.

Thanks to improved leadership, a number of countries have formulated national plans of action and put in place comprehensive policy frameworks to tackle the epidemic and address the needs of affected children. There are a number of good practices: For instance, Cameroon, in its National AIDS Strategic Plan, aims at making ART accessible to 100 per cent of all eligible children. Some have backed their policy and legislative commitments with a substantial allocation of budgetary resources.

3.2 Greater budgetary commitments

In recent years, along with an improved leadership, there has been a surge in resources for the fight against AIDS, with US$ 8.3 billion available in 2005 alone for responding to the epidemic in low- and middle-income countries.

Among 25 countries in sub-Saharan Africa, domestic public sector outlays on AIDS increased by 130 per cent since 2003, reaching a total allocation of $640 million in 2005. Countries with high HIV prevalence like Botswana, Tanzania, Zambia and Zimbabwe are allocating an increasing proportion of their budgetary resources for prevention, care and treatment including ART.

- Botswana has by far the highest per capita domestic spending on HIV among 20 low-and middle-income countries of the world. In 2006, the country covered 91 per cent of its HIV-related spending from its domestic public budget.
- Angola raised its public expenditure on AIDS (domestic and international) by about 60 per cent between 2006 and 2007.
- Cape Verde and Comoros covered the entire HIV-related spending in 2007 from domestic funding sources, while about 93 per cent of Gambia’s AIDS spending came from its domestic sources.

Two points, however.
First, despite this increase, per capita AIDS spending remained low in those countries (roughly US$ 0.65). Secondly, there is too much reliance on international assistance in far too many countries. For example, about 75 per cent of Cameroon’s AIDS spending in 2007 came from international sources, while in 2006, 96 per cent of the AIDS spending of Sierra Leone and about 70 per cent of the AIDS spending of Central African Republic and Guinea-Bissau each came from international sources. This is a worrying scenario because, unlike in other sectors, exclusive reliance on external financing runs the risk of discontinuity in spending, which may have life-threatening implications in the context of HIV/AIDS.

3.3. Expanded access to anti-retroviral treatment

Achieving universal treatment access by 2010 would reduce the number of orphans in 2015 by more than five million. Many governments are making encouraging efforts in allowing people access to these drugs in the continent.

- In 2007, about 88 per cent and 79 per cent of people living with HIV in Namibia and Botswana received ART, respectively.
- Burkina Faso, Burundi, Ethiopia, Mali, Mauritania, Senegal and Zambia were able to provide first-line HIV/AIDS treatment free of charge.
- Rwanda achieved the highest coverage of ART for any low-income country in 2007. The country’s ART coverage jumped dramatically from 10 per cent in 2004 to 71 per cent in 2007.
- Namibia’s coverage jumped four-fold from 2004 to 2007. Countries like Zambia, Benin, Swaziland, Gabon, Senegal and Botswana also achieved a significant increase in coverage between 2004 and 2007.
- Though coverage still stands at only 31 per cent, Equatorial Guinea and Tanzania achieved impressive increases in coverage between 2004 and 2007: from a paltry 1 per cent to 31 per cent.
Africa’s effort in the fight against HIV/AIDS and in availing ART has been hugely boosted by global support that took different forms ranging from financial outlays worth billions of dollars, to technical support, research and awareness creation. Since 2001, the world has mobilized unparalleled resources for the global HIV response. The pace of increase in HIV resources has accelerated, with an average annual increase in resources of US$ 1.7 billion between 2001 and 2004 compared with an average annual increase of US$ 266 million between 1996 and 2001.

In 2005, approximately US$ 8.3 billion was spent on AIDS programmes in low- and middle-income countries. In 2006, there was a total bilateral HIV-related disbursement of US$ 2.9 Billion. Access to HIV/AIDS treatment has remained near the top of the global political agenda of key regional political bodies and a good share of the external funding for HIV-related activities went to care and treatment.

In 2003, the '3 by 5' initiative was launched by UNAIDS and WHO with a target providing three million people living with HIV/AIDS in low- and middle-income countries with antiretroviral treatment by the end of 2005. It was a step towards the goal of making universal access of HIV/AIDS prevention and treatment accessible for all who need them as a human right. In sub-Saharan Africa, the number of people receiving antiretroviral drugs increased eightfold over the two-year period covered by the initiative. A major contributing factor to drug availability, and a telling evidence of global commitment has been the progress achieved in the reduction of prices under the adoption of international trade rules that provide for flexible application of intellectual property provisions with respect to crucial medications.

Praiseworthy as the progress achieved is, the exclusion from vital drugs of even a single person living with HIV remains a tragedy. Much remains to be done. For
instance, only about one in five persons living with HIV and needing medication in Zimbabwe, Gambia, Togo and Central African Republic and one in seven or eight persons in Eritrea and Chad had access to ART. Only one in four persons living with HIV in Democratic Republic of Congo, Mozambique, Angola, Cameroon and Lesotho received ART. In Madagascar, about 96 per cent of those in need of the drugs had no access in 2007.

Figure 3.3: Countries that had low ART service coverage, 2007

Based on data from UNAIDS 2008 Report

3.4 Access to PMTCT services
The other crucial area of intervention in the fight against HIV/AIDS is the availability of services to prevent mother-to-child transmission. Some six countries have succeeded in providing such services. Botswana, Kenya, Swaziland, Namibia, Rwanda and South Africa achieved 60-70 per cent of PMTCT coverage. Mozambique and Zambia achieved the highest increase in PMTCT services from 9 and 19 per cent in 2005 to 47 and 46 per cent 2007, respectively.
But progress has been painfully slow in some countries. In 2007, 90 per cent or more of HIV positive pregnant women in nine countries of the continent had no access to ART to prevent mother to child transmission. A staggering 99 per cent of HIV positive pregnant women in Chad, 93 per cent in Congo (Brazzaville) and 93 per cent in Eritrea, Ethiopia, Liberia and Nigeria had no access to ART in the same year.

3.5 Children’s access to anti-retroviral treatment

Notwithstanding the positive improvements in availing access to drugs for pregnant mothers and people living with HIV in general, children themselves continue to be grossly under-represented in access to ART. In December 2006, only about 115 500 (15%) children of the 780 000 estimated to be in need of HIV treatment had access to it and that figure rose to almost 200,000 in 2007. Many of the 290, 000 children who died in 2007 never received an HIV diagnosis or entered into HIV care.

Several factors threaten treatment and access for HIV-infected children. First, prompt diagnosis of HIV infection in infants, though critical, is often difficult to achieve. Second, available antiretroviral drugs were initially developed for adults and, hence, most standard fixed-dose combinations are inappropriate for children. In the absence of appropriate pediatric formulations, clinicians often have to resort to crushing or dividing adult tablets into smaller doses that children can swallow.
Moreover, the pediatric formulations that are available can be up to four times more expensive than adult equivalents.

According to the United Nations, despite these and other major challenges, there is reason for optimism that the availability and affordability of pediatric formulations and much-needed diagnostics for infants and children will increase in the near future.

3.6 Prevention: The other side of treatment

It is rightly observed that “Prevention makes treatment affordable, and treatment can make prevention more effective.”

Expanding available prevention strategies worldwide, a study argues, would avert more than half of all HIV infections projected to occur between 2005 and 2015 and save US$ 24 billion in associated treatment costs. Observational studies also indicate that, in countries that implemented HIV prevention programmes in the early years of the epidemic, behaviour changes lowered HIV incidence by an average of 50 per cent to 90 per cent.

But progress has been rather slow so far in most countries in implementing HIV prevention strategies. Some 90 per cent of people living with HIV/AIDS across most parts of sub-Saharan Africa do not know that they are HIV-positive, and HIV tests are often expensive and not always available. Only 13 per cent of 15-24 year-olds in Congo (Brazzaville), 11 per cent in Chad and 14 per cent in Niger correctly identified ways of preventing the sexual transmission of HIV and rejected major misconceptions about HIV transmission. In Somalia, only 4 per cent of young women (ages 15–24) report accurate knowledge of HIV, and only 11 per cent of adult females are aware that condoms can prevent HIV transmission. About 75 per cent of young women (ages 15-24) in Burkina Faso and 82 per cent in Nigeria did not have comprehensive correct knowledge about AIDS, while in Mozambique, only 20 per cent of young women and 33 per cent young men did have comprehensive correct knowledge about AIDS in 2003.
Almost a third (30%) of survey respondents in Botswana in 2004 thought that HIV can be acquired by supernatural means and more than half (50.5%) believing the virus can be transmitted by mosquitoes. Only one in five (21%) people knew that having multiple sexual partnerships increased the risk of HIV infection, though three in four knew that condoms could prevent HIV transmission. Furthermore, half of the teenage girls surveyed in some countries did not realize that a healthy-looking person could be infected with HIV/AIDS.

It should be noted however, that there are some encouraging initiatives under way in the continent in the area of prevention. Community-based outreach and education programmes are being implemented to raise awareness on HIV/AIDS and reduce stigma and discrimination, and the media is being used aggressively in many countries.

Messages about HIV prevention are beginning to be integrated into school curricula in many African countries to raise awareness about the disease among the young. In Namibia, life-skills based HIV education is now taught in 79 per cent of secondary schools. Partly due to this, the proportion of those having sex before the age of 15 and sex with more than one partner in the last 12 months has decreased. Adult HIV prevalence appears to have stabilized, and HIV prevalence in young women attending antenatal clinics declined from 18 per cent in 2003 to 14 per cent in 2007.
Thanks to prevention efforts, preliminary data also show favourable changes in risk behaviour among young people in a number of countries such as Botswana, Cameroon, Chad, Kenya, Malawi, Togo, Zambia, and Zimbabwe. Female HIV knowledge also increased in most countries in Sub-Saharan Africa, most notably in Rwanda, where knowledge went from 26 to 48 percent between 1990 and 2004.

3.7 Impact

Thanks to these efforts, there is some heartening news: HIV prevalence is declining or leveling off in some countries.

- Between 2006 and 2007, in five countries, namely Angola, Burundi, Côte d’Ivoire, Uganda and Zimbabwe, there was a decline in the number of people living with HIV.
- In Tanzania, Togo, Rwanda, Mali, Ghana, Equatorial Guinea, Djibouti and Botswana, the number of people living with HIV leveled off.
- In other countries—such as Lesotho, Namibia, South Africa and Swaziland—HIV prevalence is said to have stabilized, although at extraordinarily high levels.

Against this, the situation in a number of countries has deteriorated. A significant increase in the number of infected – by something like 100, 000 in each country – was observed in Kenya, Mozambique, Nigeria, South Africa and Zambia between these two years.

3.8 Efforts at legal and social protection

Legal instruments play an integral role in protecting the rights of people who are discriminated against, marginalized or stigmatized. The law can play two important roles in relation to the HIV/AIDS pandemic. It can either have a protective role or an instrumental role. In its protective role, the law seeks to curb certain kinds of conduct that are perceived to contribute to and accelerate the spread of HIV/AIDS. The law also seeks to protect individuals particularly the vulnerable groups in society from indiscriminate and arbitrary victimization due to their actual or perceived HIV status. It is in this context that the law can act as an invaluable mechanism in the protection of the rights of children infected with and affected by HIV/AIDS. The instrumental role of the law in the context of HIV/AIDS aims to change the underlying values and patterns of social interaction that create vulnerability to HIV/AIDS. In this regard, that law has a far reaching role in that it regulates the relationships between individuals
and tries to find new mechanisms to reduce the vulnerabilities experienced by People Living with HIV/AIDS (PLWHA).

African governments have recognized the need to protect children identifying that the scope of children's rights in the context of HIV/AIDS requires greater attention and action. Despite this, the actual response to HIV/AIDS has been limited in scale, fragmented and short of what is required to halt this preventable tragedy. Existing laws and policies are inadequate and also weakly enforced. Where laws and polices exist, they are constrained by limited financial and human resources, competing demands, low institutional capacity and community awareness.

There is also the important issue of social protection. The legislative and policy frameworks put in place have not, in most cases, been translated into concrete programmatic actions on the ground. As a result:

- In 11 countries with HIV prevalence of 5 per cent or greater, only 15 per cent of households with orphans received any form of assistance in 2007.
- With the exception of Benin, Malawi, Burundi, Mali and South Africa, 83 or more per cent of orphaned and vulnerable children in all other countries for which data is available have not been given any form of free external support in 2006/07.
- Ghana, Ethiopia, Burkina Faso, Guinea-Bissau, Côte d'Ivoire, Democratic Republic of Congo, Central African Republic, Cameroon and Gabon each failed to provide support for about 90 per cent or more of their orphaned and vulnerable child population in 2006/07.
4. What is to be done?

The most important condition for success and for making a beginning to action is the existence of an unambiguous and compassionate leadership committed to the fight against HIV/AIDS, to making adequate legislative and budgetary commitments, and to pursuing a policy of inclusion and non-discrimination. Three clusters of policies could be envisaged.

The first cluster consists of policies to combat orphanhood.

The most effective way of protecting children is to keep their parents alive. Universal and free access to antiretroviral drugs for poor people living with HIV including children and pregnant mothers should be accepted and promoted as an overriding national policy. This will not only save millions of lives but will also significantly reduce the number of affected children. Achieving universal access by 2010 would reduce the number of orphans in 2015 by more than five million. In this regard,
governments should pursue a two pronged strategy:

(i) Increase, to the maximum possible extent, the budget for health especially for the prevention and treatment of HIV and AIDS; and

(ii) adopt a national development policy that puts self-reliance in health, specifically the local production of generic drugs, at the heart of national industrial development. That is the surest way of ensuring self-reliance and sustainability.

The second cluster of policies would revolve around the protection of orphans and child-headed households. Such children suffer from three kinds of deprivation:

(i) Psychological and emotional deprivation - being denied of the love and guidance of an adult figure; the anxiety of assuming adult responsibility at too early an age, and the constant fear of being physically and sexually attacked.

(ii) Material deprivation – food and shelter; and finally

(iii) Lack of legal protection - they live in a legal limbo thus exposing them to property grabbing and other forms of adult invasions of their belongings and their rights.

These various forms of deprivation call for at least three types of interventions: first, community-level action by way of mentoring and psychological, social and economic support; a national policy of income support; and, finally, the legal recognition of the child-headed family as a family unit, and along with it the adoption of legislative protection against any form of discrimination.

The third cluster of policies concerns capacity building. Most of the bottlenecks in policy implementation in sub-Saharan Africa may be attributed to the limitations in the human, financial and institutional capacity of both local, community and grassroot organization, and national governments. Thus enhancing the delivery capacity of both local and national governments is an essential precondition for effective action. Donors can play a major role in this regard. They could work to ensure stability, predictability and sustainability of funding through multi-year financing commitments and by allowing flexibility in how the funds are spent to reflect evolving priorities.

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Finally, some personal remarks, especially to my African brothers and sisters. And these have to do with our own attitude and political position, with our own sense of
purpose and responsibility within the larger world. Many of us tend to confuse world solidarity with the notion that the world owes us something. Some do this out of some philosophical position encapsulated in the words of John Donne that we are one and an integral part of the whole. Others invoke history and the colonial factor as the justification for their insistence on Europe and America helping Africa. Up to a point, I have no problem with either of these intellectual or philosophical perspectives. I too subscribe that we should be united in our humanity and that all human affairs should be the concern of all human beings. I also accept the need and importance of a historical perspective to world development. History explains who we are. But history cannot be a subterfuge for abdication of responsibility. As Shakespeare’s Cassius reminded his Brutus, the fault lies not in our stars but in ourselves. We have to own up to our own share of history and to our own responsibility to claim our destiny in all matters that affect our existence. In the specific case of HIV/AIDS, it is our moral and political duty to assume both individual and collective responsibility to do what it takes – and this means to reiterate once again what I said earlier: first, make sure that our budgets are child and health friendly, and, secondly, build our own industrial capacity to produce locally the drugs we need to put a stop to the death of our fathers, our mothers and our children.