Children infected, affected by AIDS around the world: comparative study, an early management of their pandemic ?

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SUMMARY

The aim of this article is to elaborate a better analysis of the consequences of AIDS pandemic on the psychology and well-being of OVC (Orphans and Vulnerable Children AIDS), young adolescents and CIAH (Children Infected or Affected by HIV/AIDS). First of all to understand the difficulties of establishing accurate statistics about the CIAH. On the other hand, to obtain a plethora of reproducible examples on how to support CIAH in their daily development. Finally, this article shall propose potential ways of research to stem the spread of the pandemic of AIDS among the population of children and young adolescents of reproductive age. Our conclusions are based on two years of an exclusive survey, nine months on the ground with the CIAH and the organizations that support them, in twenty nine countries around the world **.

** A detailed illustration of that exclusive enquiry online www.enfant-du-sida.org/blog (English translation online)

INTRODUCTION

Worldwide, there are tens of millions of people living with HIV / AIDS (or PLWHA), of which many are children [1]. These estimations are more or less reliable, because it is always difficult to give a precise figure of the number of the CIAH. These estimations are difficult to ascertain, even in the case of adults, for reasons that we shall develop throughout this article.

Furthermore, it should be noted that many of these children have contracted the HIV / AIDS at birth or during infancy. It is estimated that half of those infected with HIV / AIDS are before their 25th years, many of them will die because of the disease before 35 years old.

It seems evident, unlike some particularly resistant prejudices, that this pandemic has never been confined to Africa alone (where nearly 70% of PLWHA are living [2]). And even if one considers that 95% of PLWHA are living in underdeveloped countries, the fact remains that the HIV / AIDS is a threat to men, women and children of all continents [3].

A pandemic of HIV / AIDS which globally remains a disease of the 21st century, as stated in 2008 the Nobel Prize for medicine and discoverer of the AIDS virus, Professor Luc Montagnier [4]. A health crisis that no country in the world can pretend to ignore anymore, since this phenomenon with dire

consequences to the very gates of Western Europe. Overall, we shall recall that in Europe 30% of PLWHA are unaware of their status [5].

These are facts that we analyzed on the ground from September 2008 to June 2009: an exclusive survey. Firstly to be able to built a better analysis of the reason why statistics are often difficult to establish on the subject. Secondly and mainly, to analyze at least partially, the type of psychosocial consequences that may affect this population of CIAH in the long term.

Finally, we present in the discussion section of this article what could be the collective and interorganizational solutions as we might conceive them from now on, to improve care and quality of life of CIAH. All of which should make us understand the importance of lighting provided by these two years of studies on the field, as described in this article.

STATES SITES

First some numbers, to establish a more accurate representation of the current evolution of the pandemic among the population of CIAH and their parents. We cite examples that could be very useful to shed light on the way these statistics are established, and assume the real magnitude of such a pandemic among children and teenagers of reproductive age. We also emphasize these processes and socio-economic mechanisms that often seem to be at least partly bounded to this unprecedented health crisis (all graphs illustrating this article, *Table 1*).

1 – Ground truth

International bodies estimated in 2007 that less than 10% of children infected by HIV/AIDS in the world have had access to treatment suited to their needs [6] . Next year in 2010 the number of orphans affected by the death of their parents following infection by HIV/AIDS, should rise to over 24 million [7]. Finally in 2010, 35 million shall be living with HIV/AIDS, among which more than 2.5 million children [8].

But do we know exactly what kind of phenomena we are talking about ? Truly, the authorities in many countries still have little incentive to fully inform the public about the plight of these CIAH.

In regions like the Caucasus, Kazakhstan for example, estimates for the CIAH are entirely controlled by the government. AIDS among children seems to be one of the ultimate taboo. The official statistics (provided by our local sister organizations) arranged to highlight the less alarming figures [9]. Official statistics which ignore the plight of children in regions of Kazakhstan, yet very well known to be the epicenter of the AIDS pandemic in this country (high unemployment, drug trafficking, prostitution). Besides, the official estimates seem to be three to four times lower than our local partners daily estimations on the field. A political line which of course does not go in the sense of an accurate census, and therefore effective measures to help the Caucasians CIAH.

Always at the gates of the European Union, we also would like to mention the situation of children of Russia, where again the authorities are doing everything in their power to stifle organizations independent

estimations, which could alert the public opinion about that health catastrophe : namely hundreds of thousands of Russian children living with HIV/AIDS ; children left to themselves, facing all kind of risk that adults might face: drug addiction, prostitution, infectious diseases of all kinds, children dying alone, often abandoned in the street.

Beyond Europe we would like to cite the example of India, where the government tries to minimize the reality of the progression of the pandemic among children and young adolescents, by combining all NGOS fighting against AIDS, under one single banner (using plenty of attractive million subsidies). Thus, the statistics for PLWHA in India have been divided by half in just a few months, miraculously.

Again, how limiting progression of the pandemic among CIAH if the authorities of a country such India (the widest democracy in the world), merely manipulate public opinion, instead of accelerating the opening of Testing Center and encouraging efficient HIVpositive patient support ? Because, in India there are now fewer than 30 ARV (antiretroviral drugs) distribution centers across the country, for more than one billion people living in India [10].

The example of Malaysia is another type of problem that we can not ignore. In Malaysia, the religious taboos and discrimination associated with the HIV/AIDS infection are such that the AIDS orphans of a different community from the majority of Malay people (Malaysia is an Islamic republic), are displaced often hundreds of miles from their home, to be integrated into orphanages for HIV positive children, exclusively reserved for Christian and Hindu HIV positive orphans.

This is a double punishment, an uprootment because of their ethnicity, as well as a discrimination because of their status. Despite the fact that they are innocent children who are not able to assert their basic rights, such as to remain with their communities. And the fact that the solution of sponsorship, successfully practiced by some of our sister organizations for many years (among which *Orphelin Sida International*, Paris), provides a solution to this kind of forced uprooting: the money raised through the generosity patrons and sponsors around the world, allow these children to be fed and follow a normal scholarship, without being forced to leave their community and their parents that still remains alive.

So how extremist countries like Malaysia shall be able somehow to develop a comprehensive policy, united against the spread of the HIV / AIDS among CIAH, under such conditions? Especially since the Muslim majority and yet in power, is the first community in a straight line to the progression of the infection and its spread into the general population. This of course because of religious taboos and extreme positions of a government who refuse simply by pure ideology, to inform, advice and prevent its people about the pandemic among children and teenagers [11].

However, keep in mind that the extreme situation of the countries listed above is the exception. In most countries where we have conducted our investigation, the political and economical situation is stable.

This indeed is a paradox, because the stability of a country should not equate with welfare and health of the population? From our point of view now the answer should

evidently no, not necessarily. This is what makes certain organizations fighting against AIDS, for example in Johannesburg, telling us that "we are missing something".

For South Africa for example, a country rich and politically stable today, as most countries where we conducted investigations, there is no civil war, armed conflict, poverty or social devastation enough to explain alone, the seriousness of the health crisis and the magnitude of the situation faced by CIAH and their families [12].

2 – Underlying mechanisms

We believe that the field survey we conducted is therefore the ideal vehicle to highlight, at least in part, the mechanisms that underlie the increase in the number of CIAH worldwide.

This survey has identified a number of recurring patterns related to the spread of HIV / AIDS among the population of children and young adolescents. These patterns of contamination in positive feedback could sometimes last for several decades and can not wither away by themselves.

Indeed, many countries where we conducted this survey are among the hardest hit by the pandemic. We cited above South Africa, where nearly twenty percent of the population is HIV positive: the most infected country in the world in number of PLWHA, where about 5 million people are infected with HIV / AIDS ! Still in Africa, we can also cite the most infected country in the world (in terms of percentage of the general population). A small kingdom in Southern Africa, this country is Swaziland, where 25% of the population is HIV positive [13].

However, is Africa and Swaziland the situation is not hopeless. South Africa is no longer top the list of countries where the spread of the pandemic is the greatest. In terms of prevention, education, information of the general population, tedious long term work of organizations and local NGOS that we observed in Soweto and elsewhere, seems to bear fruit. The only damper on the attitude of governments in South Africa, is Jacob Zuma's opinions : the South African president elected during our investigation in this country, still calling for "a shower after intercourse" to get rid of the AIDS virus. A remark however maddening a certain number of South African newspapers after the elections (there's a certain progress from a point of view, the former South African health minister called for drinking lemon juice to fight against infection).

In Swaziland, prevention campaigns highly visible in large cities, seem to have had an impact on the behavior of the population, especially the sharp increase of male circumcision (circumcision reduces the risk of transmission of AIDS) and the Continued use of condoms, especially among younger men. Practices that shall contribute to long-term decline in the number of children born infected with HIV / AIDS in Swaziland [14].

Of course, far be it from us to describe Africa as a model in the fight against AIDS among children and young adolescents. How not to talk about the situation of CIAH in Kenya, near the capital Nairobi: Kibera, the largest slum in Africa where over 800,000 thousand people are living (50% are children). Its has been estimated that in Kibera over 25% of the population is either HIV positive or end-stage AIDS [15]. How not to cite these people who build their homes (or what takes place) literally on the rubbish from the nearby capital. Families (often a single mother and

several children from different fathers) live of prostitution and odd jobs. Malnutrition and poverty in Kibera are the blocks of an explosive spread of AIDS among children and young teenagers [16].

We do not want to err on the opposite side, which would be to idealize the experiences of children and teenagers that are facing AIDS in Africa. There should be a full study, exclusively reserved for this specific phenomenon. Yet this is neither the purpose nor the contention of this article. Especially because from our point of view, we have more to learn in a holistic, transcontinental analysis of CIAH daily experiences worldwide (more details on the mechanisms and processes that underlie the progression of the pandemic in South Africa , Swaziland, Kenya, Tanzania, Morocco, Algeria : [17]).

Again, the progression of the pandemic has never been confined only to Africa. Then, what are the mechanisms underlying the spread of the HIV / AIDS among children and teenagers around the world?

In Russia for example, there is one of the largest population of children infected by HIV / AIDS, as well as many other STI (sexually transmitted infections) and opportunistic diseases. In Russia, like most former socialist republics, it is an economic cataclysm that devastated this region at the gates of Europe after the fall of the Berlin Wall in 1989. Number of children and young teenagers have been abandoned and neglected, left to themselves by parents unable to care for them. Thus, tens of thousands of Russian children were found living in the street, drug trafficking and prostituting themselves.

Today, two generations of Russian sacrificed children are organized in bands or communities, living in the streets. The "street families" as our partners in the field qualify them. Since these children have grown up in the street (those who survived), nowadays have to raise their own children in the street, all together staying in squats or basements of buildings in outlying areas of major Russian cities. That is the main reason why the number of Russian children infected by HIV / AIDS reached near 200 thousands. Precise information and estimates, however, is very difficult to ascertain, largely because of an obvious desire of the Russian authorities not to recognize the problematic [18].

One thing is certain: just twenty years after the breakup of the Soviet Union, the children we met in Saint Petersburg are still left to themselves. A cycle of propagation and raise of prevalence of the infection in a positive feedback pattern : young adolescents contaminated, contaminates the second generation of children, which in turn will contaminate other children and teenagers newly arrive in the “street life”, and so on. We have to add that the situation of Russia CIAH remains one of the most intractable in the world, from our point of view. Even local organizations are unable to uproot these children from their ghettos : most of these children are addicts, sick, living on the margins of society and they simply not see any reason to reintegrate the civil society [19].

Besides in Europe, we can mention countries like Poland or even Romania, a country where the recent CIAH health crisis reached unbelievable proportions at the end of last century. Fortunately, the care and prevention now seems optimum, in a country where has emerged a new generation of volunteers and where prevention centers were opened across the entire country.

At the gates of Europe, Kazakhstan, meanwhile, the richest Caucasus state regarding natural resources of that region, has yet experienced one of the most extraordinary increase in the number of PLWHA in the world or the last decade [20]. Again, the unprecedented economic crisis occurred at the end of last century, created massive unemployment in certain regions which have been industrious and hard to reform their lifestyle. That particular situation has caused a strong infatuation, of the younger generation in particular, for the black market and smuggling of all kinds : mainly for drug traffic and migrant prostitution (to and from the big Russian neighbor).

That way, many women of childbearing age have been contaminated by the AIDS virus. An infection that they have passed for years (and still today) to their clients themselves often migrant workers, then to their children. The loop is closed, in accordance to an infectious pattern of positive feedback in Kazakhstan that has grown exponentially in recent years [21].

Thus, in large part because of the drastic policy of censorship that the Kazakh authorities have charged against all information about the numerous cases of children infected in state hospitals. And mainly because of the obsolescence of these hospitals and the poor quality of cares that are provided (lack of syringes and catheters not available for several infants in intensive care services, lack of ARV treatment, etc..). But someday, some organizations founded by parents of those infected children have decided to defy the censors to the peril of their lives. Note also that access to websites as politically neutral as TDMES website is simply impossible from a country like Kazakhstan.

These underlying mechanisms of positive feedback related to migrant prostitution, between Kazakhstan and other countries of the Caucasus, we also observed them in India : one of the hardest hit countries in the world (with the lowest ratio of ARV distribution centers VS. number of PLWHA). India: a country of over one billion people, millions of men, women, children infected by HIV/AIDS and yet less than thirty distribution centers of ARV across the entire country (antiretroviral are the only effective treatment against AIDS).

It is actually India that has been given to see more clearly the positive feedback loop of bimodal contamination: both horizontal (among adults) and vertical (transmission from mother to children, through breastfeeding, or bleeding during delivery if no Caesarean section is done nor medication is administered to the embryo, etc..). In India more than in the Caucasus, the problem for organizations fighting against AIDS among the so-called migrant workers, reached unprecedented proportions. These are workers who move sandstone contract hiring, or just young prostitutes in childbearing age, most often from neighboring Nepal or the poorest states of Southern India [22]. A mix of population that constitutes the ideal breeding ground for the spread of HIV / AIDS among children and young adolescents.

In India, we must add to these processes, a wild lack of education and a lack of information toward the general population. Not to mention the prejudices of certain metropolitan mayor of Rajasthan, though well educated and graduated, that clearly indicated their support to the sustain we try to provide generously for PLWHA. But they also told us why they consider those PLWHA as " persons of easy virtue, which would bring ruin upon their families and their children". While these teenagers are actually minor prostitutes who

are often subjected to this kind of trade against their will, who are infected with HIV / AIDS (sometimes from an early age), without any reliable information about it (India is a countries where HIV screening tests are rare). Young migrant prostitutes who infect on their turn, in a concentric transcontinental proportions, migrant workers also fathers who go spread the pandemic in their families and their villages far from their.

Here in India, we observed one of the best possible illustration of these holistic processes and mechanisms working to the spread of the virus within the population of children and young adolescents, as well as an obvious example of an increasing exponential statistics related to this phenomena. We can cite the example of a young woman, today working for an NGOS to fight against AIDS in India, infected in her youth by her husband during one his mission across the country. Her late husband's family accused her of being responsible for the death of their son, they drove her out from their home. Back to her original village, her parents offered her to sleep in the barn, she had to use the pond nearby to perform her ablutions. When the locals learned that she was HIV positive, they decided to evict her because she would be responsible for contamination of the entire village, simply by using the village pond's water.

Yes, in India the work against the spread of this pandemic is simply enormous, both in terms of prevention, care for the population concerned, and also in terms of fight against superstition and prejudice.

About superstitions and misinformation, we would cite the case of the Islamic Republic of Iran. Since the Iranian government until 2004 claimed that "AIDS does not exist in Iran." Today authorities changed their mind, pressed by the exponential increase of the number of PLWHA ; particularly in the areas of refugees, south of Tehran (mothers prostitutes and drug addicts from Afghanistan or elsewhere). The government of the mullahs finally allow civil associations and NGOS to exercise their prevention work and information (program against the transmission of HIV from prostitute mothers to their newborn child, methadone for drug addicts, "rainbow group" devoted to the gay community, etc. [23]). All these actions in Iran caused quite a stir, just as it allows us to appreciate the urgency of a situation which health authorities have had to resign to leave the professionals take care of the prevention against it.

Yet again, it is regrettable that it is not possible to estimate more precisely the magnitude of the progression of the pandemic in Iran (statistics misleading or nonexistent, threats of closure of the organization if it does not keep the most hermetic silence). A situation that condemns to itself a whole population, which is reduced to organize herself against censorship into groups of civil initiatives (associations and international NGOS are not allowed to practice in many countries). Groups of civil initiatives that can benefit from using already scarce international bodies, that consider the views of statistics manipulated by those in power (not to mention the political situation for the least sensitive), that such and such country is not considered a priority.

The archetypal example of such a scenario is that of Uzbekistan, where such civil initiative groups after an extraordinary work of several years in the field (particularly among young drug users), just begin to receive the necessary funds to support these families infected by HIV/ AIDS, like the family we

visited in the southern neighborhood of Samarkand.

Anyway, as we said earlier in this subchapter, it is clear that the wild majority of countries where we conducted investigation, have a relative stability, both politically and economically. Except countries like Venezuela or Peru, politically centralized or on the opposite extremely libertarian, led by their respective governments. Economical and political orientations that have no doubt have direct impact on the progression of the HIV / AIDS among children and young adolescents in these countries [24].

3 – Long term perspectives

Nevertheless, inertia nor rulers greed could not reasonably alone explain the magnitude of the consequences of the pandemic among the CIAH. So what could be the mechanisms underlying this quasi steady progression of the pandemic in children over 25 years, especially during this last decade?

It is possible that this statistical increase in the number of children with AIDS is due partly to the fact that international surveys are better each and every year. We were concerned however that this increase is also connected directly with a real propagation of the virus in the population of children and young adolescents. It would be a relatively new phenomenon in the history of the AIDS pandemic, which is based in part (ironically) on the efficiency of ART of last generation.

On one hand and we must rejoice, because adults live better and better and longer and longer with the HIV / AIDS, and this is attributable to a victory over two decades spent to fight against this pandemic, for the rights of PLWHA.

Moreover, the desire to have children more frequently expressed by those adults infected. But the pregnant mother, then the newborn child, still often receive only basic cares. As a result, that horizontal transmission of the virus (from mother to child) reaches in some regions of the world unprecedented proportions, as it is already the case today in countries like India, South Africa or Russia [25].

But, far be it from us to believe that the situation is hopeless. Quite the contrary, when the intellectual, logistical and financial resources are invested properly, the well-being of CIAH is clearly improved. Recall for example that in 2008, approximately 45% - against 35% in 2007 - HIV-positive pregnant women received antiretroviral treatment to prevent HIV transmission to their child. In countries with low and middle incomes, 21% of pregnant women - against 15% in 2007 - have benefited from HIV free screening test [26]. Moreover, again thanks to an efficient and coordinated action, more children benefit from programs of pediatric ARV treatment: the number of children under 15 years old who received such treatment was around 198.000 in 2007 , and 275.700 in 2008 : so 38% of HIV positive children receiving treatment [27].

Globally, AIDS remains the leading cause of death among women of childbearing age. Women who in many countries are sexually active when they are still very young girls. They die from the virus infection of HIV / AIDS, often taking with them their infant. AIDS is the sixth leading cause of infant mortality in the world: yet a disease for which we have

appropriate treatment adapted the needs of these children (and the death of a child on two is due to a disease preventable and treatable [28])

Thus according to the director of UNICEF, Ann M. Veneman : "the disease (HIV/AIDS) still has a devastating impact on their health, their livelihoods and their survival" [29]. This is why organizations such as TDMES and its sister organizations [30], try to build up an international and coordinated surveillance network, to support CIAH and sustain the wonderful work of our partners worldwide.

CONCLUSION

We therefore conclude this study by highlighting the fact that after nearly thirty years of struggle against AIDS, in terms of management of the pandemic among the population of children and young adolescents, we are still at the beginning of an efficient support to this particular issue that yet concern the future of our humanity.

During these two years of study, including nearly nine months on the ground alongside with children from twenty nine countries around the world, we have attempted to develop with the highest scrutiny a better representation of the progression of the HIV/AIDS pandemic among CIAH. We also briefly described socioeconomically and politically the mechanisms and underlying processes, that from our point of view could contribute to the explanation of such a health crisis.

According to several examples that we have observed on the ground, we described how statistics on the pandemic concerning CIAH are often manipulated to minimize the seriousness of the situation of HIV positive children for in Russia, Kazakhstan or India. We have also seen how dogmatic, religious taboos and stigmatizations, could add to the counterproductive actions of governments like in Malaysia for example, to produce a very worrisome situation regarding the plight of children facing the progression of the HIV/AIDS pandemic.

We have tried to detail as clearly as possible how the progression of the pandemic among children and young adults of reproductive age, based on bimodal positive feedback mechanisms, could lead to an exponential both vertical and horizontal transmission of the HIV/AIDS. In other words, the progression of the pandemic among children shall not reach any natural limit, neither today nor tomorrow. Even though for twenty five years, many politicians have explained that the AIDS pandemic would reach someday by itself a statistical boundary, and it would be confined to Africa alone.

All this is wrong of course. We now know that the phenomenon of an exponential infection among children and young adolescents, is also a problem to manage at the gates of Western Europe (in Eastern Europe, Poland, Russia, Caucasus, etc..) .

Finally, we noted that the countries hardest hit by the worldwide growth of the AIDS pandemic among young children or teenagers, do not know any economical nor political major crisis that could alone explain this fact. The children are not victims of armed conflicts, the socio-economical conditions are stable (or has returned to stable for several years). Russia for instance has step out of the dark years after the fall of the Berlin wall; India the greatest democracy in the world and

is considered as a WHO student model; or even South Africa is simply the richest country on the richest continent in the world (at least by the energy standards of the 20th century [31])

These data confirmed on the field by our sister organizations [32] [33], make the situation experienced by the children even more unfair. Since in these countries only a few or no programs at all are undertaken for CIAH. However, it became clear that the potential for appropriate care and sustain is already in place. Civil associations and NGOS empowering them, carry out actions that improve the fate of CIAH (monitored through individualized files, socio-psychological support, training for adults and even for children, etc. : [34])

An unfortunate situation, because if no major policy is undertaken quickly, a policy that is less erratic in space and time, the general population in many other countries may know the fate known by these countries now wasted by the HIV / AIDS pandemic. Again, when positive feedback processes such as bimodal transmission mechanisms (both vertical and horizontal) appear in the general population of a given country, nor the passage of time or the death of millions of individuals can break these loops and self-supporting cycles, except with a coordinated, long term policy in collaboration with NGOSs and grassroots associations.

Joint policies to fight against the spread of the pandemic among children and young adolescents, that shall not have any real efficiency without education and information of the wildest number of citizens of a given country. But how trainings and information to the people, and sometimes even the life of an organization itself, would be possible if the political contexts is prone to censorship ? Like Kazakhstan, Turkmenistan, Iran or Laos and Malaysia: countries where websites of prevention and information about AIDS are sometimes impossible to access, such as that of TDMES. Countries where the CIAH and their families are stigmatized by the authorities themselves: positive mothers excluded from maternity common to other mothers, HIV positive children placed in special centers, infectious diseases hospital head department who are not allowed to simply recognize the existence of children infected by HIV / AIDS, etc.

No need to veil the face. Again if no policy is a large international company, the number of ASIS increase exponentially around the world. From our point of view the answer is yes, we are undoubtedly only at the beginnings of an efficient management of that pandemic among children and young adolescent.

DISCUSSION

The purpose of this study was not to establish accurate statistics of the spread of the pandemic among the population of CIAH. It was clear that our organization (or our sister associations in France or elsewhere), had not the means to establish such statistics in 29 countries on 5 continents.

Our motivation clearly was to study in the field the daily life of the CIAH and the difficulties encountered by those of our sister organizations who support them everyday. Thus, we believe we have been able to develop a precise representation, alive, according to a highest scrutiny, in a way to put into perspective the magnitude of this

exponential increase of the HIV / AIDS pandemic among CIAH.

Here below are some suggestions that from our point of view, could improve the long-term quality of life for these children.

1 – Common long term strategy

Generally, actions to fight against the AIDS pandemic can be regrouped under three categories: prevention, information, training - communication, international collaboration - fight for the spread of ARV treatment worldwide.

These are also where the main axes financed by the major international bodies (such as UNAIDS). However, several conditions should be implemented to allow the establishment of more efficient actions, according to a triptychs strategy to fight against the HIV/AIDS pandemic (cited above) :

As for the prevention section, actions must be undertaken with young people: in schools, colleges and even elementary schools, to educate teenagers about AIDS. For example, as TDMES did it in France in year 2008-2009 [35]. Or, as the Indian authorities have begun with the SALSEP (school adolescent life skills education program). However, it is regrettable that so few teenagers benefit from such programs, either through lack of means or because of reluctance to talk about AIDS with these children.

Information regarding the disease and its transmission should be better known to the younger generation, sexually active earlier today in some countries, and more and more harshly confronted with AIDS and other sexually transmitted infections [36]. As a result, CIAH and their families shall be less stigmatized: ignorance is indeed the best breeding grounds for prejudice, discrimination and violence against them. One example is Poland, a member of the European Union since 2004, where some children were seen recently denied schooling because of their HIV positive status [37].

Finally, we wish to emphasize here that the free information concerning the HIV / AIDS, is a mainstay of prevention and education. That, contrary to this policy of censorship that has been given to observe in some countries such as the Caucasus, for example: one of the region that has known in recent years one of the strongest increase of people infected with HIV / AIDS. Yet international authorities describe the Caucasian epidemic as being at its very beginning : it could be easily stopped if appropriate means are invested and prejudices, taboos set aside [38].

2 – Five steps of CIAH support

As we saw earlier, an increased flow of information between the various associations and NGOSs involved in this field is essential. Brainstorming ideas and programs that work : "The local associations are forced to find themselves the solutions that work because they have no choice!", dixit Myriam Mercy (*SolEnSi* former president, current president of *Orphelin Sida International* in an interview for the documentary "Enfant du Sida" [39].

About screening and identification of CIAH, we must initially encourage voluntary testing. It is also necessary that the tests are available to the general population. We must especially urge those most at risk: children of

drug addict mothers, prostitutes, street children engaged themselves in prostitution and / or addiction, offer a AIDS screening test to all pregnant women and couples about to get married, etc. [40].

Regarding access to treatment, it is difficult to imagine that in 2007 only 10% of HIV positive children around the world have had access to treatment suited to their needs [41]. UNAIDS and UNICEF had set a goal of raising that figure to 80% by 2010. Today, there are indications that this goal, however partial, is unlikely to be reached next year [42]. No wonder when one sees the inertia and the venality of some democratic government.

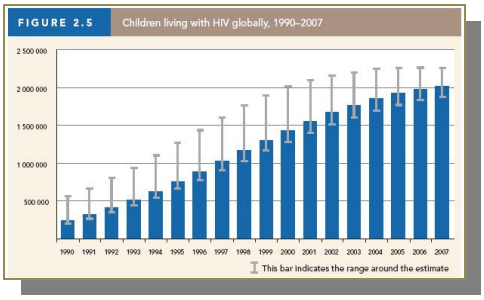
For example, in 2001 in Doha the Agreement on aspects of intellectual property rights related to trade, grants permission to countries experiencing a health emergency (including South Africa and India) to produce generic ARVs, without fear of sanction from the WHO (World Health Organization). Two Indian laboratories are now producing this type of ARV (Cipla and Ranbaxy laboratories), but 99% of that production is ultimately sold abroad for money, rather than to serve Indian populations. Not to mention that in 2007 there were only 25 distribution centers of ARVs in 13 states of India: a country five times the size of a country like France, with over one billion people of which nearly three million (probably more) living with the HIV / AIDS [43]. Again from our point of view, only a coordinated action among an international network of NGOs could be effective in the long term response to such a problematic.

Finally, the training of employees and volunteers of our sister organizations is mandatory : how to tell a young child his or her HIV status or the parents' status, how to make him of her understand the importance of medication, what are their rights and how to defend them, etc. As well as trainings to teach our sister organizations what shall be the best way to establish a long term strategy to fight efficiently against that pandemic : how to define its organization main goal, bound for what type of audience specifically, in conjunction with what type of structure, etc.

It should be noted also that without substantial financial assistance, appropriate to the magnitude of the plight faced by CIAH, nothing shall be possible. These are the reasons that lead us to believe that information and trainings are the cornerstones of our fight for these children.

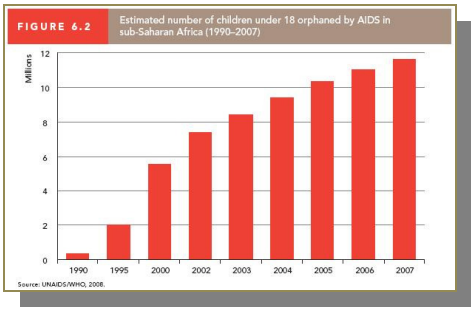
Table 1

Fig. 1 | Number of HIV positive children



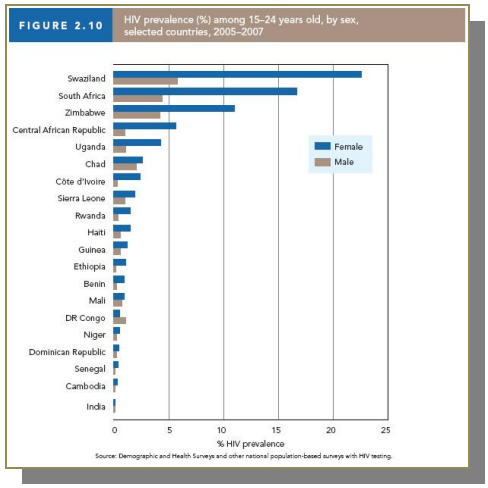
A constant increase in the number of children infected in the world since 1990 (source: UNAIDS, UNICEF, WHO - 2007).

Fig. 2 | Number of AIDS orphans



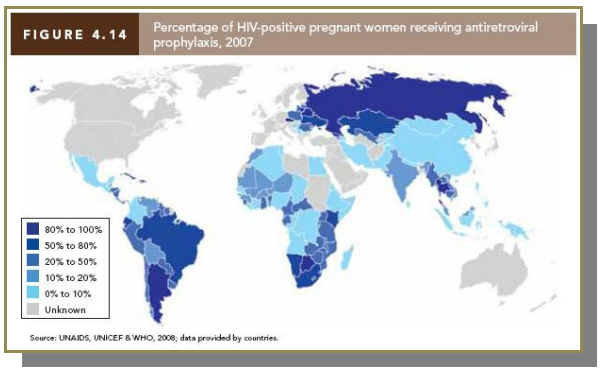
Again, a constant increase in the number of AIDS orphans since 1990 (source: UNAIDS, UNICEF, WHO - 2007).

Fig. 3 | Number of HIV positive teenagers



Prevalence (%) of young adults living with HIV, by sex and country.

Fig. 4 | Pregnant women and ARV



Prevalence (%) of HIV positive pregnant women receiving worldwide standard ARV prophylaxis (antiretroviral).

Table 2

A C W T
Report | 2009

SERVING AIDS CHILDREN

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Sevran, France
93270

2 years of study on children infected or affected by HIV, 9 month on the field: side by side with our sister organizations.

For the good of hundreds of children and families we are supporting

This questionnaire was elaborated according to studies of S. Dekens about multifactor vulnerability of CIAH (children infected or affected by HIV / AIDS).

A General information

1 – Name of the organization

2 – Name of the executive manager

3 – Eventually, the name of the person in charge of the programs dedicated to children or teenagers infected or affected by HIV

(Notice: children are under 14 years old; teenagers are between 14 and 18 years old)

4 – Address of the organization

5 – Telephone

6 - Website

7 – Email contact

8 - Can you give us a very short historic of the creation of your organization?

9 – How many people are working for your organization?

(Thank you to clearly distinguish between employees and volunteers)

B Vulnerability & Statistics

10 – How many people are infected by HIV/AIDS in your country?

11 - Do they have free access to appropriate ARVs treatments?

12 – How many children are infected in your country?

13 – How many of them are orphans?

14 - Do they also have access to ARVs treatments, appropriate for children?

15 – What kind of help do those children receive from the government of your country?

16 –How many *infected* children is your organization taking care of?

(Thank you to clearly distinguish between those you are taking care directly, and those you are taking care of indirectly; for example, if you help parents infected that have children also infected, you are helping the children indirectly and this is a good point we want to report)

17 - How many *affected* children (e.g. with one or both parents infected or dead because of HIV)?

(Thank you to clearly distinguish between those you are taking care *directly*, and those you are taking care of *indirectly)*

18 – Does your organization have a program dedicated to children infected or affected by HIV/AIDS, that you would like to highlight particularly (in a few words, thank you)?

(Do you have psychological support for those children? Support groups? Holiday's meetings? Any artistic expression group? Etc.)

C Multifactor Vulnerability

19 – How do you evaluate the familial background of the children you are taking care of?

(Do you make home visits? Have you any contact with their school? Etc.)

20 – How do you evaluate the children's nutrition and health?

(Is starving a problem in your country? Do you have nutrition support programs? Do you have contact with doctors or hospitals? Etc.)

21 – Do children infected or affected by HIV have problems at school, because of their serological status?

(Do you help them with advocacy support if needed? Do you offer trainings and information to teachers of that school? Etc.)

22 – Is drug addiction a problem for those children?

(Thank you to distinguish clearly between children or teenagers users, and children that have one or both parents addicted to any kind of drug)

23 – Is prostitution a problem for those children?

(Thank you to distinguish clearly between prostitute children or teenagers, and children that have prostituted mothers)

24 – Is War, gangs or guns a problem for the children in your country?

25 – Did you create a personalized and confidential files database concerning each and every child you are in contact with?

Thank you for your cooperation

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