2010

Save the Children

Child survival and HIV

Policy brief

HIV-related illnesses are a major cause of children dying, especially in sub-Saharan Africa, and are an obstacle to the international development goal to cut child mortality by two-thirds by 2015. International donors and national governments must make the rights of children to protection from HIV and its impacts a priority, and the response to HIV must be integrated into fair and effective health and protection systems.

What is the problem?

Around 2.1 million children under 15 were living with HIV in 2008 and some 280,000 children died during the year as a result of HIV.[1] At least 8% of deaths of children under five in Africa are directly attributable to HIV.[2] In seven sub-Saharan countries – Kenya, Malawi, Mozambique, South Africa, Zambia, Zimbabwe and Swaziland – this rate is higher (between 15% and 60%). These seven countries account for 47% of all HIV-related under-five deaths.[3]

HIV infection progresses more quickly to AIDS and death in children than adults. African studies suggest that one in three newborns infected with HIV dies before the age of one, over half before their second birthday, and most have died before they are five years old.[4]

A child is also three times more likely to die before the age of five if his or her mother is HIV positive, and ten times more likely to die before five if his or her mother dies.[5] Children orphaned by AIDS are best cared for within the community, but even within the extended family, food, care and other basic needs may be denied.[6]

Children also face the risk of HIV through sexual transmission and injecting drug use. Neglect, discrimination and abuse make children orphaned by AIDS highly vulnerable to HIV infection through early sexual relations.

How can HIV in children be prevented?

More than 90% of HIV infections in children are transmitted from mother to child during pregnancy, childbirth or breastfeeding. Treatment for the prevention of mother-to-child transmission (PMTCT), if implemented correctly, can reduce the risk of transmission from 30–35% to below 2%.[7]

PMTCT strategies include:[8]

- primary prevention of HIV infection, antenatal HIV testing of the mother and her partner, and prevention of unintended pregnancies among HIV-infected women
- antiretroviral treatments (ARVs) for the mother during pregnancy and during breastfeeding, or for life for women in need of treatment for their own health
- ARVs for infants exposed to HIV
- ongoing community and family-based treatment, care and support for HIV-infected parents and their infants
- support for exclusive breastfeeding for HIV-exposed infants for the first six months of life, introducing appropriate complementary foods thereafter, and continued breastfeeding for the first 12 months.[9]

In 2008, an estimated 21% of pregnant women in low- and middle-income countries were tested for HIV and 45% of pregnant women living with HIV in these countries received ARVs, which can cut the risk of mother-to-child transmission as well as protecting the mother's own health. Of those women who do get access to PMTCT services, about half receive only single-dose nevirapine, which is only 40% effective in reducing transmission and provides no lasting benefit to the infected mother.[10]

Most countries with a high HIV prevalence also have very poorly resourced and fragile health systems that do not provide adequate universal maternal and child health services. Distances to facilities, stigma, formal or informal fees and lack of human resources are major barriers.[11] The lack of human resources to staff healthcare facilities in both Africa and Asia is being made worse by HIV, where health workforce staff are ill or dying.

Effective ARV treatment can reduce the death rate from HIV-related illnesses to below 20%.[12] Yet only an estimated 38% of children in need of ARV treatment are receiving it.

HIV interventions and health systems

The global response to HIV has attracted significant new resources and demonstrated numerous successes in poor countries.[13] HIV, seen as a potentially overwhelming threat that needed fast cross-sectoral responses, was able to attract new donor resources through highly-visible, 'vertical' mechanisms such as the Global Fund to Fight AIDS, TB and Malaria, and the US President's Emergency Plan for

AIDS Relief (PEPFAR). In 2008, of the £10.4 billion estimated to have been spent on HIV in low- and middle-income countries, £5.1 bn was from donor assistance.[14]

While funding for HIV remains inadequate, it has been disproportionately large in comparison with funding for other health needs: HIV causes 3.7% of deaths worldwide but it has 25% of healthcare financing.[15] In some countries, such as Mozambique, donor funding for HIV exceeds the total national budget for health.[16]

Much of the donor aid has been deployed outside of national systems, with PEPFAR in particular establishing parallel healthcare delivery systems rather than supporting developing country governments.[17] There is no consensus on the impact of this. Many argue that the massive 'vertical' funding dedicated to HIV has undermined health systems, for example, drawing staff out of the public system to work on HIV alone.[18] Others argue that HIV funding has helped to strengthen health systems by developing infrastructure and systems, improving overall standards, keeping health workers alive, freeing up health service capacity for other needs, and improving access for poor and marginalised groups excluded by traditional health systems.[19] A study by the World Health Organization concluded that both effects can be seen: HIV funding has brought significant benefits to health systems, but has also contributed to weakening health systems in some cases.[20]

Save the Children has called on HIV-specific mechanisms such as the Global Fund to expand their funding to health system strengthening and on donors to work through government systems.[21] We have welcomed the moves towards establishing a Joint Platform for Health System Strengthening between the Global Fund, the GAVI Alliance and the World Bank, but have called on bilateral donors to ensure it works within the International Health Partnership, which should be developed as a mechanism to identify and fill gaps in funding for national health plans.[22]

What actions need to be taken?

Save the Children supports continued investment in HIV prevention, treatment and care for children, and respect for the rights of children to survival, protection, healthcare and non-discrimination. We want to see greatly increased integration with funding for health systems in order to achieve development goals on child and maternal mortality, HIV and malaria.

Governments in developing countries should:

- provide the information, resources and empowerment to enable children to protect themselves from HIV and its effects, and establish social protection systems to mitigate the impact of HIV on families and communities.
- develop credible, budgeted national health plans that include high-quality, equitable PMTCT and paediatric care services. In countries with high HIV prevalence among women of child-bearing age, access to voluntary HIV testing and PMTCT services should be offered to all pregnant women.

- provide ARVs for pregnant women with HIV over the long-term, not just to prevent infection of the newborn. Follow-up and treatment of children with HIV should be strengthened.
- insist that funding from donors strengthens government systems, and advocate for the establishment of harmonised mechanisms of aid delivery such as the Joint Platform for Health System Strengthening.

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Donor governments should:

- meet commitments made to HIV funding, while giving greater priority to integrating that funding within government systems.
- put increased funding and policy focus on children, including support for reduced cost paediatric ARV formulations through UNITAID and increased use of generic competition.
- support the Joint Platform for Health System Strengthening and ensure that their bilateral aid is harmonised through the International Health Partnership.
- double contributions to maternal, newborn and child health delivered through the 'continuum of care' from sexual and reproductive health, antenatal, maternity and newborn, and child health services.

Notes

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