The Role of Public Policy in Eradicating Pediatric AIDS: A Comparative Analysis of the United States and Sub-Saharan Africa

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I. Abstract

Pediatric AIDS killed 280,000 children in 2008, nearly all of them in sub-Saharan Africa.\(^1\) Ninety percent\(^2\) of those children contracted HIV from their mothers, despite the fact that there is a simple, proven, cost-effective method to prevent mother-to-child transmission of the virus. The number of children living with HIV has increased to over two million\(^3\) and without treatment, half of them will not live beyond their second birthdays.\(^4\)

Meanwhile, in the United States, the number of children infected with HIV has dropped from more than 2,000 per year at the height of the epidemic (between 1989-1994) to less than 200 per year today.\(^5\)

HIV/AIDS policy in both the US and sub-Saharan Africa are presented, trends and best practices are identified, and conclusions are discussed.

II. Purpose

This paper explores variations between HIV/AIDS policy in the United States and sub-Saharan Africa, the historical context and common components of those policies, and the trends in sub-Saharan policies that may explain the gap in results managing the pediatric AIDS epidemic. It also examines the recommendations of global leaders on addressing pediatric AIDS, and briefly discusses the way forward.

\(^1\) “2009 AIDS Epidemic Update.” UNAIDS, November 2009.


III. Introduction & Background

Since the HIV/AIDS epidemic began in 1981, 25 million people worldwide have died as a result of contracting the virus.\(^6\) Two million died in 2008 alone.\(^7\) Of those two million, 280,000 were children under the age of fifteen.\(^8\)

Of the approximately 370,000 children under fifteen who were newly infected with HIV in 2007, ninety percent contracted the virus from their mothers.\(^9\) In 2008, an additional 430,000 children were born HIV-positive, resulting in a total of 2.1 million children (under 15) living with HIV worldwide.\(^10\) In the majority of cases, pediatric HIV/AIDS is preventable through a simple medical intervention which interrupts the transmission of the virus from an HIV-positive mother to her baby.\(^11\) Often a single pill taken by the mother when labor begins, followed by a dose given to the newborn, is enough to prevent a baby from contracting HIV both during labor (when transmission is most likely) and during breastfeeding, proving that prevention of mother-to-child


\(^7\) “2009 AIDS Epidemic Update.” UNAIDS, November 2009.

\(^8\) Ibid.


transmission of HIV is possible even in resource-constrained settings.\textsuperscript{12} When possible, more complex regimens of drugs can be administered and are even more effective.\textsuperscript{13}

Given that the medical advances necessary to virtually eradicate pediatric AIDS have been achieved, the fact that children continue to suffer and die from this disease must be attributable to other factors, including poor public policy or poor implementation of good public policy.

\textit{History and Scope of the Pediatric AIDS Epidemic}

\textbf{FIGURE 2.5} Children living with HIV globally, 1990–2007

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure2.5.png}
\caption{Children living with HIV globally, 1990–2007}
\end{figure}


\begin{thebibliography}{10}
\end{thebibliography}
United States

Cumulatively, the number of people diagnosed with AIDS in the US through 2007 was 1,051,875 and 9,209 of them were children. An estimated 1,106,400 people were living with HIV in the United States at the end of 2006, and 56,300 people were newly infected in the same year. 562,793 people have died from AIDS-related illnesses in the US since 1981. 14 4,891 of those deaths were children under the age of 13.15 Of the 159 reported cases of pediatric HIV/AIDS cases in the US in 2007, 139 were the result of mother-to-child transmission.16 The number of children infected with HIV has dropped from more than 2,000 per year at the height of the epidemic (between 1989-1994) to less than 200 per year today.17

The most significant factor contributing to the risk of children contracting HIV in the United States is ethnicity. 59% of all pediatric AIDS cases in the United States (through 2007) have been in African American children, even though African Americans make up only 12% of the total US population.18 African Americans are more likely than any other ethnic group to contract HIV, and therefore more likely to pass the virus to their children perinatally. Some reasons for higher HIV prevalence in the African American community include poverty, higher rate of sexually transmitted diseases, and stigma.

14 Ibid.
15 Ibid.
16 Ibid.
Poverty is a particularly important factor to consider because of its implications on access to healthcare, housing, nutrition, and education.\textsuperscript{19}

\textit{Sub-Saharan Africa}

Sub-Saharan Africa is the epicenter of the HIV/AIDS epidemic. The Joint United Nations Programme on HIV/AIDS reports that, “HIV has reduced life expectancy by more than 20 years, slowed economic growth, and deepened household poverty.”\textsuperscript{20} Currently, 67\% of all people living with AIDS reside there (22.4 million). In 2008, 1.9 million new infections occurred in the region and 1.4 million people died from AIDS-related illnesses. The adult HIV prevalence is 5.2\% in sub-Saharan Africa, by far the highest in the world (the next highest prevalence rate is 1\% in the Caribbean). As a result, perinatal transmission of HIV in sub-Saharan Africa is also the highest in the world. 91\% of all new infections among children in 2008 occurred there.\textsuperscript{21} Half of those children will not survive until their second birthday without treatment.\textsuperscript{22}

Because the characteristics of the epidemic vary among countries in sub-Saharan Africa, so does the level of risk of perinatal infection due to specific factors. Some common variables that contribute to a pregnant mother’s level of vulnerability include lack of education, poor quality or inaccessible health care, human rights violations, and cultural norms.\textsuperscript{23} In addition, sub-Saharan Africa’s health systems are relatively weak


and services are provided at multiple locations, sometimes long distances apart from each other. When pregnant mothers do access health care, often HIV-testing services are not offered at a local facility, test results are not delivered, or the necessary drugs are not available for prevention of mother-to-child transmission.\textsuperscript{24}

\textbf{IV. Methodology}

\textit{Sources Used}

Timely and accurate reporting on the global HIV/AIDS epidemic is available from myriad sources, largely due to the demanding reporting requirements organizations and government ministries receiving HIV/AIDS funding from international donors must follow. International data collection and reporting has improved drastically since 2003, when the United States President’s Emergency Plan for AIDS Relief (PEPFAR) was enacted.\textsuperscript{25} UNAIDS has issued annual reports on the global epidemic since 2002, and UNICEF, with its partners (UNAIDS, World Health Organization, United Nations Population Fund) has issued a stocktaking report on HIV/AIDS in children since 2006.\textsuperscript{26} Both of those sources, and the reports they have issued over the past several years, were utilized in this analysis. In addition, publications issued by Office of the Global AIDS Coordinator (the implementing agency for PEPFAR) were consulted and referenced.

The Center for Disease Control and Prevention, under the auspices of the US Department of Health and Human Services, has performed extensive surveillance of the


epidemic since the first known cases of AIDS appeared in the United States. CDC tracks AIDS cases, new HIV infections, as well as “the behavior and characteristics” of people at high risk for contracting the virus. Through their national surveillance system, CDC is able to track trends in HIV and AIDS across the United States.\(^{27}\) CDC’s National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) was established in 1994 and is responsible for collecting, interpreting, and publishing data from the community to the national level.\(^{28}\) The NCHHSTP is also involved in international HIV/AIDS research and surveillance through it’s Global AIDS Program (GAP).\(^{29}\) The extensive information (data, reports, presentations, factsheets) provided by the CDC and its various HIV/AIDS programs were reviewed and many were selected for use in this analysis.

In order to gain a functional understanding of the clinical components of pediatric HIV/AIDS prevention, care, and treatment, a number of academic journals and books were reviewed. *The Journal of the National Medical Association, AIDS Care, Current Opinion in Obstetrics and Gynecology,* and *The Journal of the American Medical Association* were particularly useful. *AIDS in Africa, Second Edition, Histories of Sexually Transmitted Diseases and HIV/AIDS in Sub-Saharan Africa,* and *AIDS in Africa: The Social and Policy Impact* were instrumental in the construction of a


\(^{28}\) Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, “About NCHHSTP.” [http://www.cdc.gov/nchhstp/About.htm](http://www.cdc.gov/nchhstp/About.htm)

framework to understand and assess the history and public policy associated with HIV/AIDS in Africa.

Several online resources were consulted, including websites of various organizations associated with pediatric HIV/AIDS. Online content from advocacy groups, international organizations such as UN member organizations, and US domestic government agencies were reviewed and, when relevant, referred to in the course of this analysis. When selecting online resources, the most important criterion was credibility, which was judged subjectively.

Definitions

There are several important indicators to consider when describing the scope and impact of the pediatric HIV/AIDS epidemic. For the purposes of this analysis, we are especially concerned with HIV incidence, HIV prevalence, AIDS cases, and deaths of persons with AIDS. In addition, the terms “perinatal transmission,” “mother-to-child transmission,” and “vertical transmission” are used interchangeably in this report. Defining these important terms will aid in the understanding of the analysis overall.

- HIV incidence: the number of new HIV infections in a specific population during a specific period of time
- HIV prevalence: the number of people living with HIV/AIDS at the end of a given year
- AIDS cases: the number of persons diagnosed with AIDS
- deaths of persons with AIDS: deaths among persons with AIDS attributable to any cause of death
perinatal/vertical/mother-to-child transmission of HIV: HIV transmission from mother to child during pregnancy, labor and delivery, or breastfeeding

V. Findings from the Research

Policy Responses to HIV/AIDS in the United States

The Ryan White CARE (Comprehensive AIDS Resources Emergency) Act, passed by Congress and signed into law by President George H.W. Bush in 1990 provides federal funds to health providers who serve people living with HIV/AIDS, to subsidize the care and treatment of those patients. The legislation has been reauthorized a number of times (1996, 2000, 2006, 2009) and continues to be the largest US domestic Federal program supporting people living with HIV/AIDS. When HIV/AIDS patients in the US are unable to afford health services, they can draw upon funds provided by the CARE Act to states, cities, and local organizations. Money is distributed first to the areas most affected by HIV/AIDS, based on the epidemiological data from the previous five years. Subsequent funding is available to all 50 states, based on the number of estimated AIDS cases in their population. Additional money is available to public and private organizations to serve those newly infected with HIV and to increase the capacity of those organizations to provide quality health care in the future. Funds are also available for education, training, and the Minority AIDS Initiative, which is focused specifically on the disproportionate burden of HIV/AIDS on the minority population of the United States. The CARE Act specifically addresses pediatric HIV/AIDS in Part D (Title IV), which “funds public and private organizations directly to provide family-centered and

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community-based services to children, youth, and women living with HIV and their families...also supports activities to improve access to clinical trials and research for these populations.” Since 1990, the Ryan White CARE Act has supported more than 500,000 HIV-positive Americans per year and has contributed significantly to the reduction in mother-to-child transmission of the virus through providing access to testing, counseling, and prevention services.

In addition to legislative policy, the United States Congress has delegated technical policy-making power to the Department of Health and Human Services (HHS). HHS exercises this power through the issuance of clinical guidelines, which are to be taken as the official US position on HIV/AIDS prevention, care, and treatment strategies. Guidance from HHS (universal HIV testing for pregnant mothers, introduction of drugs to prevent vertical transmission, scheduled cesareans, and not breastfeeding) has resulted in a drop in pediatric HIV infections in the US to less than 2%. HHS develops its guidance through task forces, and in April 2009 the public health task force issued new recommendations for the use of antiretroviral (ARV) drugs in pregnant women, both for the treatment of their own disease and for the prevention of mother-to-child transmission. The task force recommended the use of more complex ARV regimens, earlier introduction of ARVs during pregnancy, intravenous ARVs given during labor and


delivery, the administration of ARVs to the newborn and refraining from breast feeding. The guidance emphasized the applicability of its recommendations in resource-rich countries only and carefully warned against the implementation of its guidelines in more constrained settings.  

US public policy regarding HIV/AIDS is further facilitated through the White House Office of National AIDS Policy (ONAP). Its mission is to “coordinate the continuing efforts of the government to reduce the number of HIV infections across the United States.” President Obama has committed to creating a National HIV/AIDS Strategy, which ONAP is responsible for coordinating. The stated vision of the National HIV/AIDS Strategy includes “reducing HIV incidence, increasing access to care and optimizing health outcomes, and reducing HIV-related health disparities.” The Strategy is intended to be a comprehensive statement of the United States’ priorities, policies, and broad plans for implementation through strategic partnerships and integration with the global AIDS response.

Policy Responses to HIV/AIDS Across Sub-Saharan Africa

As one would expect, the public policy responses to HIV/AIDS have varied across the countries of sub-Saharan Africa. Despite the fact that National AIDS Plans

34 Ibid.


37 Ibid.
were developed in every country in sub-Saharan Africa by 1990\textsuperscript{38}, UNAIDS reports that, “[p]oliticians in some countries have ignored the threat of AIDS, perhaps for fear that the discussion about safer sex, reducing harm to injecting drug users or other sensitive subjects would alienate one or another segment of their supporters.”\textsuperscript{39} It is also true that HIV prevention strategies have been most successful in countries where political leaders have faced the epidemic head-on and supported good public health policies.\textsuperscript{40} Though sub-Saharan Africa has not responded to its HIV/AIDS crisis uniformly, there are some important trends as well as some notable distinctions among policies found in the literature.

\textit{Trends}

Education was among the first HIV/AIDS public policy initiatives embarked upon in sub-Saharan Africa. The first government-supported programs were undertaken in Uganda and Rwanda in 1985. They included the distribution of leaflets, radio programs, theater groups, and word-of-mouth campaigns.\textsuperscript{41} Educational efforts have been expanded over time, and all signatories to the \textit{Declaration of Commitment on HIV/AIDS} have committed to including HIV education programs in their public schools.\textsuperscript{42} However, UNAIDS finds that insufficient investment has been made in the education of girls,


\textsuperscript{40} Ibid.


which would “substantially reduce HIV risk and vulnerability for women and girls.” As a result, many girls of child-bearing age have not received the information necessary to protect themselves or their children from HIV infection.

The link between human rights and HIV/AIDS has been explored and documented, particularly as it applies to the epidemic in women and children. Though all the countries of sub-Saharan Africa have ratified the African Charter, which specifically prohibits discrimination on the basis of race, color, sex, language, political, or other opinion, national or social origin, property, birth, and other status, the rules of that charter are enforced with varying rigor. Sofia Gruskin, of the Harvard School of Public Health, and Miriam Maluwa, of the Joint United Programme on HIV/AIDS reported that, “[t]here is a contradiction between many international and national commitments to human rights and HIV/AIDS and actual legal and policy implementation and practice.” The uniform protection of human rights under the Charter, or any of the other treaties addressing human rights such as the Convention on the Rights of the Child and The Convention on the Elimination of All Forms of Discrimination Against Women, would dismantle barriers to prevention of mother-to-child transmission services. Because of discrimination based on sex or HIV status (“other status”), women are routinely denied access to medical services. This results in increased vulnerability to HIV/AIDS for women, and subsequently for HIV-positive pregnant women.

43 Ibid, p. 64.
46 Ibid.
The recognition of the serious negative impact that HIV/AIDS has on economic development has also emerged as a trend in sub-Saharan Africa’s policies addressing the epidemic. As early as 1985, government officials were being called on to change their HIV/AIDS policy in response to economic concerns, specifically relating to the tourism industry. That year, a Swedish television company reported that 20% of all Kenyans had AIDS and went on to warn viewers against traveling there. Though the information was incorrect (only 15 AIDS cases had been documented in Kenya at the time), the potentially devastating effects of such a report on the Kenyan tourism industry were immediately clear. The Kenyan government responded by becoming the first country in the region to provide its national AIDS data to the World Health Organization.47 As the epidemic has progressed, more linkages have been established between economic development and HIV/AIDS in sub-Saharan Africa, including the impact of premature deaths as a result of pediatric AIDS. In Lesotho, for example, children are the population most affected by HIV/AIDS (along with those 30-50 years of age). Stunted population growth is a contributor to economic instability in the region, especially in the agricultural sector.48

The countries of sub-Saharan Africa have responded to the economic effects of the HIV/AIDS epidemic in various ways, but all have adopted the *Action to Combat HIV/AIDS in View of Its Devastating Human, Economic, and Social Impact*. The resolution (adopted in 1998) “urges parliamentarians to evaluate properly the growing impact of the HIV/AIDS epidemic on world economic development,” and “urges governments and NGOs to

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adopt a long-term, timely, coherent and integrated AIDS prevention policy” to address this and other negative outcomes of the epidemic.\textsuperscript{49} Because economic instability is one important indicator used to measure vulnerability to HIV infection, it is reasonable to assume that depressed economic conditions in sub-Saharan Africa contribute to the continuing pediatric AIDS epidemic there.

One of the most disturbing deviations from the sub-Saharan African public policy trends in HIV/AIDS has been “AIDS denialism.” There are those government leaders, namely the former President of South Africa, Thabo Mbeki and his Minster of Health, Manto Tshabalala-Msimang, who publicly deny that HIV is the cause of AIDS.\textsuperscript{50} President Mbeki created a Presidential AIDS Advisory Panel on which a number of scientists participated at the World AIDS Conference in 2000, including prominent AIDS denialists Peter Duesberg and David Rasnick.\textsuperscript{51} Minister Msimang has advocated for the use of non-medical interventions (beetroot, garlic, etc.) for AIDS patients and has referred to anti-retroviral drugs as “poison.”\textsuperscript{52} Public policy that is subject to the influence of AIDS denialists is extraordinarily dangerous and impedes any progress that may otherwise be made in the prevention of mother-to-child transmission of HIV.\textsuperscript{53}


Why Pediatric AIDS Persists in Sub-Saharan Africa

As the statistics clearly demonstrate, pediatric HIV/AIDS has been virtually eradicated in the United States. The barriers to accomplishing the same level of success in sub-Saharan Africa are many and complex. Though there is evidence to suggest that effective public policy response in sub-Saharan Africa has been constrained by an overarching and persistent perception of AIDS as a “social disease,” there are several other important factors that contribute to the continuing pediatric AIDS epidemic in the region.54

One critical component necessary to accomplish the significant reduction of pediatric AIDS cases is health system capacity. Currently, sub-Saharan Africa suffers a massive shortage of human resources capable of administering prevention of perinatal transmission services. The table below shows the extent of the shortage in seven countries which are the results of a study published in 2010.

Table 4. Human resource needs.

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</table>

Ratio of human resources (full-time equivalents) available/needed. MTCT, mother-to-child transmission.

Source: AIDS 200955


In addition to human capacity, appropriately resourced medical settings are also lacking in many parts of sub-Saharan Africa. In 2007, only 38% of clinics providing prenatal services also had the resources to give pregnant mothers an HIV test and counsel her about protecting her baby from HIV.56

Because HIV in sub-Saharan Africa is most often sexually transmitted, changing behavior is another important component in the fight against pediatric AIDS. Fewer HIV-positive women overall means fewer HIV-positive pregnant women, and subsequently fewer cases of perinatal transmission of the virus. There are myriad reasons for resistance to behavior change, ranging from educational to psychosocial. As Dr. Jeffrey Kelly puts it in his article, *Advances in HIV/AIDS Education and Prevention,* “the behavior changes needed to avoid or reduce risk for sexually contracting HIV involve either not having sex or having safer sex. These are not necessarily easy, gratifying, or naturally-reinforced behavioral choices.”57 Add to that the unique cultural landscape of sub-Saharan Africa, and the challenges of reaching the women of child-bearing age with effective prevention messages are apparent.58 However, many of those barriers do not exist within the context of the prevention of mother-to-child transmission of HIV itself. While it is true that appropriate education and sensitivity to cultural norms and stigma are still very important considerations in a PMTCT setting, the difficulties of dealing with changing sexual behavior are no longer relevant. The prevention of mother-to-child


transmission is comparatively straightforward and it is extremely effective. Dr. Nicholas Hellmann, an HIV/AIDS expert and Vice President for Medical and Scientific Affairs at the Elizabeth Glaser Pediatric AIDS Foundation has said, “PMTCT is the drug equivalent of a vaccine. Inexpensive, relatively simple to administer, it can reliably prevent most transmissions of HIV from a mother to her infant.”59 By the time an HIV-positive pregnant woman requires medical intervention to prevent the transmission of the virus to her baby, changing sexual behavior is a secondary consideration. Cultural norms and behavior affecting her ability to access prevention services become primary.

According to a 2009 report issued by the Office of the Global AIDS Coordinator, many HIV-prevention programs have special activities directed at addressing gender issues.60 Despite the inclusion of gender equity training in many sub-Saharan African countries’ National AIDS Plans, UNAIDS reports that “the epidemic continues to expand, largely due to the failure to tackle societal conditions that increase HIV risk and vulnerability.”61 Violence against women, lack of educational opportunities for women and girls, high rates of poverty among women resulting from scarce economic opportunities, and discrimination against women all present significant barriers to access

59 “This Pandemic is Entirely Preventable” Barnes, Pamela; Hellmann, Nicholas. The Globe and Mail, February 9, 2009, p A13.


for women seeking prevention of mother-to-child transmission services in sub-Saharan Africa.\textsuperscript{62}

\textbf{VI. Conclusions}

\textit{Common Components of Policy Responses: US/Sub-Saharan Africa}

Though the characteristics and scale of the pediatric AIDS epidemics in the United States and sub-Saharan Africa are different, there are two common elements of their public policies that are the building blocks for prevention of mother-to-child transmission of HIV. The emphasis on education as a continuous policy response, with varying implementation strategies across countries, emerged as a common component. For example, the first national AIDS plan in Ghana was produced in 1989 by the National Technical Committee on AIDS. In addition to the creation of an epidemic surveillance structure and blood screening facilities, AIDS workshops were developed to educate target populations about HIV/AIDS. These workshops were aimed at traditional healers, churches, and those in the tourism industry.\textsuperscript{63} In the United States, a national education effort was led by the Office of the Surgeon General. In 1988, “Understanding AIDS,” a brochure outlining general facts about HIV and specifically addressing pediatric AIDS, was mailed to every household in the country.\textsuperscript{64}

Emphasis on the prevention of mother-to-child transmission is also found in many national policies, including the United States and numerous sub-Saharan African countries. In the United States, the CDC monitors and evaluates the pediatric AIDS epidemic and issues

\textsuperscript{62} Ibid.


guidance for policymakers and clinicians regarding the resources and strategies necessary to reduce perinatal transmission. The Institutes of Medicine also publish reports relevant to the pediatric AIDS epidemic, including the 1999 report, *Reducing the Odds: Preventing Perinatal Transmission of HIV in the United States.*

Many sub-Saharan African national plans also prioritize technical guidance and provision of PMTCT services. For example, the Tanzanian Ministry of Health’s National AIDS Control Program issues a report called *National Guidelines for the Management of HIV and AIDS.* The 2009 edition notes that the prevention of mother-to-child transmission should be included in the minimum package of services provided by an effective HIV/AIDS response. The report goes on to enumerate the essential components of perinatal transmission prevention practices.

**Recommendations from Global Leaders**

There is broad consensus in the global medical community on what needs to be done to reduce the incidence of pediatric AIDS cases worldwide. Leaders in the HIV/AIDS field have converged on the opinion that prevention of vertical transmission of HIV is possible on a massive scale, and must be undertaken in order to effectively combat the HIV/AIDS epidemic as a whole. In its *Third Stocktaking Report,* UNICEF concludes that the immediate increase of women’s access to PMTCT services, particularly antiretroviral drugs, is “achievable and...can bear fruit in the next one to three years.”

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those leaders are: universal adoption of opt-out HIV testing, a family-centered approach (integration of services), strengthening health systems, and a focus on human rights.

Opt-Out Testing

The World Health Organization recommends the implementation of “opt-out” or “provider-initiated” HIV testing in high-prevalence countries. As a result of this global guidance, 54% of sub-Saharan African countries have adopted this strategy and between 2007 and 2008 the number of pregnant women receiving an HIV test increased by 11% (from 17% to 28%). In Malawi alone, 68% of pregnant women were tested for HIV during the course of their regular antenatal care in 2008. In 2004, before the adoption of opt-out testing, that number was just 8%.

Family-Centered Approach

“Family-centered care” describes a model of HIV/AIDS prevention, care, and treatment that focuses not on the individual, but on providing high-quality, integrated health services to whole families. Global leaders have endorsed the family-centered care model because it has proven more effective than other programs at lowering rates of mother-to-child transmission of HIV. Additionally, family-centered care results in reduced infant AIDS mortality and increases the number of pregnant women who receive HIV tests and treatment for their own disease. Family-centered care is fully integrated into the existing healthcare system and UNAIDS reports


69 Ibid, p 98.


that “integration of HIV initiatives with programmes addressing sexual and reproductive health is helping to ensure that women have access to the information and services they need to make informed reproductive decisions.”

**Health System Strengthening**

One of the most important recommendations to emerge from global leaders is an increased focus on strengthening health systems in sub-Saharan Africa, including building the capacity of healthcare providers. Physicians for Human Rights (PHR) has called for a substantial investment in capacity building in an article titled, *Strengthening Africa’s Health Systems*. They note the “shortage of people, shortage of places, and shortage of things,” that need to be addressed in order to make HIV/AIDS programs sustainable. According to PHR, “a mere 3% percent of the world’s healthworkers combat 24% of the global disease burden.”

Specifically addressing the needs of mothers and children, UNAIDS has said, “Scaling up antiretroviral therapy for women, especially pregnant women, in the context of PMTCT requires investment in facility improvement, laboratory equipment and human capacity building within maternal, newborn and child health services.” Global leaders have responded to these concerns by outlining specific priorities for human capacity development, which include assisting in the development of management skills and retention strategies; supporting coordinated training; and providing feedback and best-practices documentation to country programs.

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Human Rights

The leading global health organizations agree that the most effective prevention programs are based on a human-rights approach to patient care and treatment. Often, this requires collaboration between health providers and community groups. When these partnerships are successful, a framework is introduced that is “supported by protective laws to ensure non-discrimination, reduce stigma, change harmful gender norms, and enable people living with HIV to protect themselves and others through empowerment and with dignity.”\textsuperscript{76} HIV prevention programs designed using this framework, by virtue of their specific focus on vulnerable groups, prioritize women and children’s rights to access services that prevent perinatal transmission of HIV.\textsuperscript{77}

The Way Forward

While pediatric AIDS has been virtually eliminated in the United States, in the developing world three out of four children requiring services to prevent mother-to-child transmission of HIV do not receive them.\textsuperscript{78} As we have seen, the medical technology to stop perinatal transmission exists and has been proven effective in resource-limited settings. Though there is still work to be done in the United States to combat HIV and AIDS, policymakers have successfully blended politics with science to create good public policy addressing the pediatric AIDS epidemic. Despite the adoption of national plans, many of which include the best


practices offered by global leaders in the field of HIV/AIDS, the children of sub-Saharan Africa continue to contract HIV from their mothers at astonishing rates.

Some assert that “national governments’ lack of political will and reluctance to commit financial resources are the principal reasons for the failure to successfully combat pediatric AIDS [in Africa].”\textsuperscript{79} It is my belief that a new global framework for addressing the epidemic has been erected, and that national governments that are unable or unwilling to address the pediatric HIV/AIDS crisis will be supported by international institutions (including various agencies of the United Nations: UNAIDS, the World Health Organization, and UNICEF), non-governmental organizations, and private corporations to achieve their stated public policy goals. Working in partnership with national governments, these institutions and organizations will provide the capacity - policymaking, financial support, technical assistance - necessary to help sub-Saharan Africa end pediatric AIDS.

\textbf{VII. Bibliography}


\begin{footnotesize}
\textsuperscript{79} Ibid.
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Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, “About NCHHSTP.” http://www.cdc.gov/nchhstp/About.htm


