

July 2008

*Jesus said... whoever
welcomes a little child in
my name welcomes me.
Matthew 18:3*

HIV&AIDS and WORKING WITH CHILDREN

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I recently read “Ana’s Story: a journey of hope” (2007) by Jenna Bush - yes, the US President’s daughter, based on her work with UNICEF. It is an easy read but thought provoking book capturing the complex issues that a teenager living with HIV in Lima, Peru, faces at home, in school, receiving treatment, and revealing her secret. For many of you however the stories of children and adolescents grappling with HIV is a daily reality. Given the evolving nature of responding to HIV&AIDS, let’s keep on learning good practice from each other.

Stay tuned for the next AIDSLink with new information from the UNAIDS 2008 Report on the global AIDS epidemic released on the eve of the International AIDS Conference in Mexico City.

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1. BIBLICAL FOUNDATIONS: CHILDREN & VULNERABILITY (part 1)

The teaching of Jesus concerning children stands in stark contrast to the world of his time. Exposing unwanted children to die was still a common practice in the Roman Empire, and children had no or minimal rights. Indeed the very presence (Mt 19:13) and words (Mt 21:15-16a) of children could result in annoyance in society’s male leadership. In contrast, Jesus delights in children (Mt 19:14; 21:16b) and sees them as signs in/to his coming kingdom (Mt 18:1-3).

Read Matthew 18:1-6.

1. What according to Jesus can we learn from children (18:3-4)? How do people in your world see children?
2. What does Jesus mean by verse 5? How do you express this in your setting?
3. How could verse 6 be said in words appropriate in your setting?

“Cause to sin” in verse 6 is literally “cause to stumble,” so we could say, “whoever causes one of these little ones who trust in me to lose their faith.” Where do children learn the vital lessons of love and trust – positive and negative? In the home, the church, and the community! They experience it from the adults in their lives. Where love and trust are absent, and especially where these are violated, children grow up hurt and angry, feeling betrayed. Those who are abused may, out of their feelings of being wounded, grow up to hurt others.

Children also experience stages of grief through loss including the loss of love and trust:

- Denial: "I feel fine. "This can't be happening."
- Anger: "Why me? It's not fair!" "NO! NO! How can you accept this!"
- Bargaining: "I'll do anything."
- Depression: "I'm so sad, why bother with anything?"; "I'm going to die . . . What's the point?"
- Acceptance: "It's going to be OK."

1. Describe a case in which a child has suffered significant loss. How is grief being expressed?
2. What are appropriate ways to address this loss and the resulting expressions of grief?

2. DISCUSSIONS IN SCHOOLS — SEX BEFORE MARRIAGE

Zebene Shewaakena, from the Ethiopia Kale Heywot Church shares the following experience working in schools. For further details contact: zebene_shewakena@yahoo.com

“The issue of sexual behavior among young people connected with HIV&AIDS, like other African countries, is of big concern in Ethiopia.

A series of discussions, debates, and exchanges of ideas have been done on the issues among young people for the past couple of years. One issue which makes for lively debate is ‘sex before marriage’.

The thought of sex before marriage becomes a big deal among youth in our setting. The argument is made on the fact that firstly if someone practises sex before marriage with a lover, he/she can make a right decision to choose the right future marriage partner. Secondly they said that since abstinence is becoming impossible for many people, having sex with only one lover may keep them away from practicing sex with many partners. Though the idea received great opposition from the public in the beginning, however, this thought nowadays is widely accepted among youth and it is now eroding the long standing culture of abstinence until marriage that is the beautiful culture of Ethiopia when we talk about marriage.

In order to fight against such a unhealthy attitude and maintain the value of the existing positive thinking of the society towards preventing the spread of HIV&AIDS, our project attempted to reach youth in small discussion groups through trained facilitators in school and out of school in our project area. Some of the discussion points in the groups are practicing sex before marriage and its consequences, sex and HIV&AIDS, sex and its social acceptance, the condom and its limitations, what the scripture says about sex and marriage, and its relation with the existing society value.

In effect, a significant numbers of youth, both in schools and out of school, have been convinced about abstinence until marriage and to keep on teaching their peers. But still we face challenges from those who have say that abstinence is practically impossible for youth in this modern day.”

3. MEMORY WORK WITH CHILDREN

Changing children's lives (2007.p6) shares learning from the memory work that Healthlink Worldwide, along with six other non-governmental organizations across sub-Saharan Africa, have developed in response to the HIV epidemic. The focus is on learning and analysis in the theory and practice of memory work as well as demonstrating its effectiveness as an HIV response. It is aimed at international and national level policy makers who design or support HIV initiatives as well as practitioners who implement responses to the HIV epidemic directly at a local and national level.

“Memory work is a practical approach that encourages families to communicate openly about HIV, in order to strengthen children’s resilience to the pandemic. By nurturing a safe environment, memory work creates conditions where disclosing one’s HIV status and open communication is possible. Involving children, parents and guardians as well as the wider community ensures a holistic and sustainable response to the impact of HIV” (p6).

Available for download (8.4MB) at:
www.healthlink.org.uk/PDFs/changingchildrenslives.pdf

Did you know?

- The number of children living with HIV globally continues to increase steadily. 90% acquired the virus during pregnancy, birth or breastfeeding—forms of HIV transmission that can be prevented.
- Approximately 2 million children were living with HIV globally in 2007, up from 1.6 million in 2001.
- Nearly 90% of all HIV positive children live in sub-Saharan Africa
- In sub-Saharan Africa the epidemic has orphaned nearly 12 million children aged under 18 years.

2008 UNAIDS Report on the Global AIDS Epidemic

4. CONDUCTING A SITUATION ANALYSIS OF OVCS

Conducting a Participatory Situation Analysis of Orphans and Vulnerable Children Affected by HIV/AIDS: Guidelines and Tools by Renee DeMarco is a powerful tool that builds on experiences from Family Health International's work in the developing world. It was funded by the U.S. President's Emergency Plan for AIDS Relief, USAID.

Conducting a situation analysis is a complex and delicate process. It gathers and analyzes information to guide planning and action. Done properly, it can help build consensus among key stakeholders and produce sound recommendations to promote shared understanding among relevant parties. As this resource is focused on children, it features a special emphasis on ethical considerations for information-gathering. The six-chapter, 210-page guide offers sample consent forms, baseline surveys and interview guides, which can be adapted for local use and is available at:

www.fhi.org/NR/rdonlyres/ebkv627kkethzv7u6geatgcd3m6v5ilur6smufou63ey7kociufxxajkcsvfs4nvgug44zqvnvrh/ConductOVCSitAnalysisHV.pdf

5. OPPORTUNISTIC INFECTIONS & ARVs in PEDIATRIC HIV INFECTION

“In the pre-antiretroviral era and prior to the development of potent combination highly active antiretroviral treatment regimens (HAART), opportunistic infections (OIs) were the primary cause of death in HIV-infected children. Current HAART regimens suppress viral replication, provide significant immune reconstitution, and have resulted in a substantial and dramatic decrease in AIDS-related OIs and deaths in adults and also in children. Despite this progress, prevention and management of OIs remain critical components of care for HIV infected children. OIs continue to be the presenting symptom of HIV infection among children whose HIV-exposure status is not known, for example, due to lack of maternal antenatal HIV testing.”

The *Guidelines for the use of antiretroviral agents in pediatric HIV infection*, Working Group on Antiretroviral Therapy and Medical Management of HIV-Infected Children (Feb 2008), report addresses the paediatric-specific issues associated with antiretroviral treatment, and provides guidelines to health care providers caring for infected infants, children, and adolescents. The appendix has been extensively modified to include up-to-date drug information, including updated information about paediatric dosing and new drug formulations. Available (2.4MB) at:

<http://aidsinfo.nih.gov/Guidelines/Default.aspx?MenuItem=Guidelines>

These guidelines note (p1.) that “although the pathogenesis of HIV infection and the general virologic and immunologic principles underlying the use of antiretroviral therapy are similar for all HIV-infected people, there are unique considerations for HIV-infected infants, children, and adolescents, including:

- Acquisition of infection through perinatal exposure for many infected children
- In utero, intrapartum, and/or postpartum neonatal exposure to zidovudine and other antiretroviral medications in most perinatally infected children
- Requirement for use of HIV virologic tests to diagnose perinatal HIV infection in infants under age 18 months
- Age-specific differences in CD4 cell counts;
- Changes in pharmacokinetic parameters with age caused by the continuing development and maturation of organ systems involved in drug metabolism and clearance
- Differences in the clinical and virologic manifestations of perinatal HIV infection secondary to the occurrence of primary infection in growing, immunologically immature persons
- Special considerations associated with adherence to antiretroviral treatment for infants, children, and adolescents

Also available is *Guidelines for the use of antiretroviral agents in pediatric HIV infection* (Feb 2008) (3.6MB) at: www.aidsinfo.nih.gov/ContentFiles/pediatricGuidelines.pdf

These guidelines from the Centers for Disease Control and Prevention, the National Institutes of Health, the HIV Medicine Association of the Infectious Diseases Society of America, and the Pediatric Infectious Diseases Society are updated regularly to provide current information. The most recent information is available at <http://AIDSinfo.nih.gov>

6. PARTNERING and the LOCAL CHURCH

Partnering with the Local Church (2008) produced by TEARfund as part of its ROOTS series highlights the role of the local church in integral mission. It examines the various relationships between Christian organizations and local churches and provides models for working, including church mobilization. This is a practical and useful tool for Christian organizations that work with local churches, including NGOs and church denominations. It is available (700KB) at: <http://tilz.tearfund.org/Publications/ROOTS/Partnering+with+the+local+church.htm>

6. MAKING IT KNOWN – A CREED FOR THE AIDS PANDEMIC

The theme for World AIDS Day 2008 is “Leadership”, so take the lead and make sure your program, organization and partners are marking World AIDS Day 1 December 2008. Share with AIDSLink any recommended resources and creative ideas that you have to mark this day.

The Christian HIV/AIDS Alliance (CHAA), a UK based network of Christian agencies, churches and individuals praying and working together to serve and empower those affected by HIV&AIDS, has initiated a *Creed for the AIDS pandemic* - a statement of belief and commitment to action on HIV & AIDS for churches and individuals. It is suitable to be read in church services for World AIDS Day or any occasion when the pandemic is remembered. See: www.chaa.info/index.php?option=com_content&view=article&id=87&Itemid=55

7. TIP of the MONTH – HOT SEATING

Hot seating is particularly effective for getting people to put themselves in the shoes of others and think through the implications and pressures faced in different situations. This tool provides a lively way to explore sensitive and complex issues, identify what people already do and don't do, explore feelings, address myths and misunderstandings, and explore strategies to address the issue.

1. Prepare case studies for people to explore. These should be real-life dilemmas, written in the first person. For example, if you are exploring HIV and children, a case study could read, 'I am a nine year old boy who is having difficulty sleeping. I am worried about my big sister working hard to get money for my mother to go to the hospital to get her medicine.' Alternatively, ask participants to think of dilemmas
2. Ask for a volunteer to sit in the 'hot seat'. This means to sit on a selected chair or place on the floor in front of the group
3. Ask the volunteer to read out the case study as if they were the person in the case study
4. Invite the rest of the participants to ask questions addressing the person in the case study as if they are that person's friend – for example, What else are you worried about?
5. Where questions require information that is not provided in the case study, encourage the volunteer in the hot seat to fill in the details
6. Repeat the activity with other volunteers and other case studies
7. When the activity is complete, encourage the participants to discuss what they have learned. For example, why was it easy or difficult to respond to the questions? What choices did the boy have? What did the responses show? Clarify any misunderstandings that people may have?

Tips for facilitators: Encourage a relaxed atmosphere. It can be less threatening if two people take the hot seat at once. Don't pressure people to take the hot seat if they don't want to.

This tool has been adapted from *Tools Together Now, 2006*, p126 by AIDS Alliance and is available for downloading (2.9MB, 250 pages) at: www.aidsalliance.org/sw36326.asp



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