

DROUGHT, DISEASE AND HIV: A DEADLY THREAT TO CHILDREN

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On 6 June 2007, Swaziland declared a drought emergency. The announcement came after studies conducted by the Government and UN agencies documented massive crop failure hailed as the worst in recent history. The newspaper headlines carried the stark prediction: **More than 400,000 people will need food assistance.**

This season's drought has been called the worst in 15 years as it has impacted all regions of the country. Prolonged dry spells and high temperatures at critical stages of maize development decimated Swaziland's crops, resulting in the lowest annual harvest on record 60% below last year's level.

A drought is not a rare event. In fact, Swaziland has experienced some form of drought for the past six years. Because of this, every society has developed coping mechanisms; behaviours that are engaged to reduce or minimize the impact of an emergency. But when these mechanisms are pushed to the limit, people take desperate measures. In Swaziland, a recent report cited that some households might soon fall back on such measures selling assets for food, skipping meals or simply not eating at all.

A drought also has myriad effects social, economic, and psychological. The literature on drought is replete with stunning examples: peasants harvesting wild plants to eat during a famine; farmers eating their stock of seeds in desperation; and families pulling children out of schools to save costs or to help out with the household chores such as fetching water. In arid, north-eastern Kenya, which experienced a severe drought in 2006, people abandoned settlements in remote areas and flocked to villages, towns and road-sides, hoping they would be noticed and receive help. Nouachott, the capital of Mauritania, doubled its population in 1977 after a severe drought drove people off the land and into the urban area.

Last year, I met a mother in Kenya living in a make-shift road-side camp with her handicapped 11-year-old daughter. Because of drought, she had lost everything but her most reliable camel. Her husband had gone away, seeking greener pastures for his surviving heads of livestock. But soon, even her camel became expendable. "I sold the last camel to feed my child," she said, lamenting the loss of the only means of transport for her handicapped daughter. Selling a transport camel is a desperate measure for a nomadic family.

While the story of nomads in Kenya doesn't seem to apply in Swaziland, it teaches us that there are universal experiences in almost all drought situations. The vulnerability of women and children is greatly exacerbated in a drought. Threats to child survival increase and children fall prey to malnutrition, measles, diarrheal diseases, and respiratory and skin infections much more easily.

The most deadly of these ailments is measles. It is a primary cause of death in children during emergencies in Africa. Malaria is another.

But there is some good news. Malaria is not a major public health problem in Swaziland. Secondly, 92% of infants are vaccinated against measles, and 80% of children under five years old have received the appropriate doses of vitamin A, which markedly improves the survival of children with diarrhea, respiratory infections and measles. These are impressive achievements.

If Swaziland's coverage rates for measles vaccinations and vitamin A supplementation were lower, these would have been vital priorities during this emergency period. Instead, the country can use its resources in other areas of impact mitigation. Swaziland places child immunization high on its list of priorities for children; it remains one of only 10 countries in all of Africa that pays for the full cost of children's vaccines from its national budget. That is one of the lesser known achievements of the Kingdom.

Diarrhea is another ailment that can severely impact children during times of drought. Water scarcity may force families to use water from contaminated sources, such as those shared with livestock. Simple measures like boiling or treating water before using it for drinking or cooking can reduce the chances of diarrhea. If a child does suffer from diarrhea, oral rehydration salts or ORS can help replace necessary fluids lost due to diarrhea. ORS is available at nearly every hospital or health facility in the country.

Simple and effective interventions like measles vaccinations and vitamin A supplementation reaffirm the value of the saying that prevention is better than cure. More than 80% of Swazi children ages 12-23 years old are fully immunized against killer diseases like measles, diphtheria, whooping cough, and polio. This dedication to immunization is paying off. Measles is a rare disease in Swaziland. Recently, I asked the nurses at a clinic in Mahlangatsha in the Manzini region when they had last seen a case of measles. Neither nurse could remember a case of this very common childhood illness.

Immunization and vitamin A are just two of the 13 high impact interventions recommended by the World Health Organisation (WHO) and an international panel of experts on child survival. Swaziland is on course in promoting a number of these interventions, such as oral rehydration therapy, antibiotics for pneumonia and zinc.

I commend the Government for its investment in children and salute all of those who contributed to these small, but significant achievements. Yet the fight for children is not won. We are reminded of the nation's continued struggles by the preliminary findings of the recent Demographic and Health Survey (DHS). This population-based survey sampled more than 5,000 households around the country. Data showed continued increases in the mortality rate of infants and children since 1997. The HIV prevalence rate among persons 15 to 49 years old 26% is the highest among all countries which have comparable data. Nearly 50% of females between 25 and 29 years old were infected with HIV. Men of the same age also have unacceptably high infections rates. The cycle of HIV infection is tragically shared; first among men and women, and then on to their newborn children.

While the combined threats of drought, poverty and abuse take an extreme toll on children, especially those who are orphaned or vulnerable, the greatest enemy of children in Swaziland is HIV. The disease accounts for nearly 50% of the deaths of children under five years old, undercutting all benefits of immunization and child survival interventions. HIV also takes the lives of thousands of parents each year, leaving their children without caretakers to feed and protect them. It is not an overstatement to say that the HIV epidemic is a threat to children in all segments of Swazi society.

Now, the issue is not whether to reduce our investment in immunization and other high impact interventions in order to double up our efforts to combat HIV; rather, the question is how to do these two things simultaneously. As a country, we must sustain child survival gains *and* combat the HIV epidemic. I agree with Derek Von Wissell, the director of NERCHA, who wrote a thought provoking article two weeks ago entitled, "What Happens to Society When Abnormal Becomes Normal?" Not only during this time of drought, but at all times, we must work together to do extraordinary things to respond to this extraordinary situation and combat this epidemic.