

Prevention of Mother-to-Child HIV Transmission and Management of Paediatric HIV Infection in Jamaica

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The acquired immunodeficiency syndrome (AIDS) was first recognized in children in 1982 in the United States of America and documented clearly in 1986 in Jamaica (1). Neither nation responded aggressively to the crisis of the human immunodeficiency virus (HIV) in its earliest years and many infections occurred that could have been prevented. Nonetheless, by 1994, the AIDS Clinical Trials Group 076 study had documented the benefits of antiretroviral therapy to a pregnant woman and her newborn infant for the prevention of mother-to-child transmission of HIV (PMTCT). We then knew that to reduce the risk of HIV transmission from mother to infant, outreach, counselling and testing of pregnant women were essential. This was of special urgency in the Caribbean, a region with the highest seroprevalence rates for HIV outside sub-Saharan Africa. By 2004, Jamaica had overcome obstacles of financing, logistics and improved on stigma offering HIV testing to all willing pregnant women (2). Coverage was high and the paediatric epidemic began to decline as women availed themselves of the opportunity to take antiretroviral medications. Much damage had already been done, however, and Jamaica's response to paediatric HIV/AIDS, described in these pages, was an imperative for the health of the nation's children and their families. We also believe that it holds promising lessons for other developing nations on how to tackle aggressively PMTCT and paediatric care challenges.

In this special issue of the West Indian Medical Journal (WIMJ), Professor Celia Christie has recruited authors of scientific articles, clinical observations and editorial commentaries on nearly every facet of paediatric HIV/AIDS and related topics in Jamaica. Drawing from academia, the Ministry of Health, healthcare providers and others, Professor Christie and her colleagues have provided a broad variety of studies and clinical observations that stem from work supported by the Elizabeth Glaser Paediatric AIDS Foundation, the Jamaican Ministry of Health, the National Institutes of Health, the University of the West Indies, the Centers for

Disease Control and Prevention, and from Jamaican philanthropic sources. This amazing array of supporters is a testament to the competitiveness of Jamaican clinical scientists and programme developers in securing research support and clinical service funds. While the products of the investments must be seen to be fully appreciated, with new paediatric HIV/AIDS services and nearly universal HIV testing for pregnant women islandwide, the manuscripts in this WIMJ issue do provide insight into the substantial programmatic impact of the work.

This special WIMJ issue does not shy away from topics that remain bedeviling for Jamaica, as for other nations. Disease manifestations in infants and children are protean, as in adults, and the WIMJ authors report disseminated BCG infection, isoniazid-resistant tuberculosis and renal complications of HIV disease in children. HIV orphans are a new challenge for Jamaica, including both HIV-infected and uninfected children. Stigma inhibits full coverage with HIV counselling and testing. Adherence rates both to PMTCT measures and to paediatric HIV antiretroviral therapies are suboptimal. Treatment options remain limited by fiscal limitations, and emergence of resistance to antiretroviral agents is certain to threaten this region, as it has elsewhere. Yet the successes highlighted and the lessons learnt are indigenous ones; Jamaicans confronted the epidemic and are winning the fight against paediatric HIV/AIDS.

It is rare for a clinician like Professor Christie (and the guest editors) to have lived through the advent of a new disease, its inexorable expansion in the 1980s, its peaking in the 1990s and its rapid reduction in the 2000s. Child health providers have seen this exact phenomenon *vis-à-vis* the HIV/AIDS epidemic in the Western Hemisphere (with the exception of Haiti where the paediatric epidemic continues). Jamaica's 2008 population is 2.8 million persons on an island smaller than the US state of Connecticut. Jamaica has the fourth highest public debt per capita in the world and ranks only 101st of 177 nations in the health expenditure per capita as estimated in 2007–2008 (3, 4). That Jamaica should have made such progress in the fight against paediatric HIV is a testament to the authors who have contributed to this issue, to their mentors and to the Jamaican health leaders and activists who have confronted this plague. Clinicians, scientists and policy activists elsewhere will learn from you. And the mothers, fathers and children of Jamaica thank you.

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