

Speech

Check against Delivery

JOINT LEARNING INITIATIVE ON CHILDREN AND HIV/AIDS

International Symposium

Harvard Medical School

24 September 2007

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I first want to thank Jim Kim, Peter Bell, Agnes Binagwaho for inviting me here today, and to pay tribute to the tremendous work they – and all of you – are doing. It is a privilege to be here today with so many experts and activists. The issue of children and AIDS was overlooked for far too long. UNAIDS was one of the first to welcome the creation of the Joint Learning Initiative on Children and AIDS, and I look forward to hearing about the progress you've made.

Let's start by looking at progress on AIDS in general. It's a mixed picture, but there definitely is progress.

Today, 2.5 million people in developing countries are taking anti-retroviral treatment – up from 100,000 in 2001.

And in some populations in East Africa, the Caribbean, and Asia, HIV infections are falling.

But if HIV is declining in some populations, it is rising in others. In some Asian countries there's an upsurge in HIV infections among men who have sex with men, but infections are declining in other groups. The most striking overall increases have taken place in East Asia, Eastern Europe, and Central Asia: the number of people living with HIV went up by one fifth here between 2004 and 2006.

Globally, young people (15-24) accounted for 40% of new HIV infections last year. One in seven new HIV infections last year occurred among under-fifteens. By the end of 2006, 2.3 million (1.7-3.5 million) children (under 15) were living with HIV.

Let's just remind ourselves that the United Nations Convention on the Rights of the Child defines children as people up to the age of 18. But AIDS epidemiologists

compile information for under fifteens and for 15-24-year-olds. Lack of disaggregated data for children makes it even harder to take effective action on their behalf.

One reason for this is the feminization of the epidemic: almost half of all adults living with HIV are women. Only one in ten pregnant women with HIV in low and middle-income countries receives anti-retroviral prophylaxis to prevent transmission of HIV to their children. Every year, more than 500,000 children are infected via transmission from their mothers.

But this is just one way children become infected with HIV. Sexual abuse is another. The second (and main) way is through sex – whether it's between young girls and older men, sex between adolescents, or sex between trafficked girls or boys and clients, sexual violence and rape, or incest.

A third cause of infection is injecting drug use, which often starts in adolescence. In Russia, 76% of all people living with HIV are or have been injecting drug users.

This is all fuelled by ignorance about HIV transmission. It's amazing how prevalent this still is in 2007. I've just come back from China where most young people have barely a clue about how HIV is transmitted.

At the same time, only one in ten children needing HIV treatment can get it – even though paediatric drug formulations are much more widely available, and the price of antiretroviral drugs for children has dropped – in some cases to less than 16 US cents per day. Just 4% of children born to HIV-positive mothers receive cotrimoxazole, which WHO recommends providing to children when early diagnosis of HIV infection is unavailable. In Botswana and Zimbabwe, child mortality rates have nearly doubled since 1990.

Last week UNICEF reported some remarkable declines in child mortality throughout the world, for the first time fewer than 10 million children under five died – except in countries with high HIV prevalence and those in conflict.

More than 15 million children worldwide have now been orphaned by AIDS – over 12 million in Southern and East Africa. Orphan populations are increasing in some populations in Asia, Latin America and the Caribbean, and Eastern Europe too.

This much we know. Now let me turn to what we don't know.

We are constantly striving to know more about the AIDS epidemic, through better and more accurate data collection. But there's still a long way to go.

Today's surveillance categories are too broad and too blurred. Collecting data for children up to the age of 15 and then for young people between the ages of 15 and 24 doesn't give us the sort of information we need: there's a huge difference in terms of action between HIV infection at 15 and acquiring HIV at 24. We need much more refined data about different age groups. We also need to distinguish between the different categories of orphan – “double”, “one parent”, maternal and paternal. And we need to become much more systematic in pinpointing the differences between epidemics within countries.

We also need to re-evaluate the way we perceive the issue of children and AIDS. As so often happens, we have tended to only do this through the medical lens, with a primary focus on mother to child transmission. But this is to over-simplify, and to ignore critical social and rights-related issues.

One problem is that we don't know enough about what these issues are. We sense that AIDS is breaking up families and communities and challenging traditional safety nets. We know that the impact on household welfare is greater on the poor than on the better off, and that gender inequities make girls more vulnerable than boys. We are aware that it is threatening children's rights - civil, political, economic, social and cultural.

And then there's the new reality: older children living with HIV. In recent years, I've been meeting increasing numbers of HIV positive adolescents and young adults.

But we often still lack hard, empirical data: the impact of AIDS on children remains under-researched and poorly understood. We simply don't know enough about what is happening. That's why the Joint Learning Initiative is so badly needed.

Now let's look at what action is being taken today.

It's nearly 20 years since world leaders decided that people under 18 needed their own convention. That convention - the 1989 United Nations Convention on the Rights of the Child, famously ratified by all UN Member States except the US and Somalia – stresses the importance of making the “best interests of the child” a primary consideration and lists a series of rights. These include such basics as information, education, non-discrimination, health, social security, an appropriate standard of living, to be protected from violence and different forms of exploitation, and the right not to be separated from their parents. All are critical if children are to grow up to live safe and healthy lives in a world with AIDS.

Since then, a series of international meetings and declarations have highlighted the urgent need to address the issue of children and AIDS. But to what extent are these declarations being acted on?

A few countries have substantially increased access to services to prevent transmission of HIV from parents to children. For example, in Argentina, Botswana, Jamaica, and Ukraine, more than 85% of HIV-positive pregnant women received antiretroviral drugs to prevent transmission of HIV to their children.

Some countries - including Botswana, Rwanda, and Thailand - have scaled up HIV treatment for children by integrating it into treatment sites for adults. Thailand is getting antiretrovirals to more than 95% of the under-15s in need.

Several countries in southern Africa have provided child grants and other benefits on a national scale. Kenya, Malawi and Mozambique have piloted cash-transfer programmes in poor areas.

In 58 countries surveyed last year, 74% of primary schools and 81% of secondary schools said they were providing AIDS education. This is critical if adolescents are to protect themselves from infection. To be effective, AIDS education must fulfil the right to information (as required in the Convention on the Rights of the Child). It must provide information about all risks, and offer a broad palette of prevention options – including abstinence, condoms, and measures to address inequalities between girls and boys.

More efforts are being made to see that children get a fair share of AIDS funding. A number of donors including the US and UK have earmarked at least 10% of their AIDS money to go towards services for children.

And lastly, more is being done to integrate services – to forge links across diseases and sectors and bring partners closer together. In Kenya, Rwanda, Tanzania and Zambia, strategic investment of AIDS funding is improving services such as immunization and antenatal care. And Norway's Women and Children First Initiative sets out to provide a continuum of care for mothers, newborns, and children.

Many organizations are providing support to help countries look after their children better. UNAIDS co-sponsor UNICEF, for example, has made tackling children and AIDS one of its top priorities. In 2005, UNAIDS joined UNICEF to launch "Unite For Children, Unite Against AIDS", which sets targets for scaling up "The Four Ps": prevention of HIV transmission from mother to child, paediatric treatment for HIV, prevention of HIV among adolescents and young people, and protection and support for children affected by HIV.

And as Peter mentioned earlier, civil society groups –the Elizabeth Glaser Paediatric Foundation, the Ecumenical Advocacy Alliance and, of course, the Francois-Xavier Bagnoud Association – are doing tremendous work.

But most importantly of all, communities are responding and adapting to the new realities around children and AIDS – often with tremendous resilience.

So how do we build on this progress and intensify its impact?

We're here today because there are no simple answers to these questions.

AIDS, as many of you have heard me say before, is an exceptional issue – in terms of its threat to humanity and its complexity. The Joint Learning Initiative was itself born out of recognition that the issue of children and AIDS is immensely complex – and that it requires a complex response.

I would like to suggest seven elements that I regard as key to making that response effective.

First, it must be firmly grounded in human rights principles – in line with the 2003 Comment on the Convention on the Rights of the Child that “the child should be placed at the centre of the response to the pandemic, and strategies should be adapted to children’s rights and needs”. To be effective, those strategies have to work equally well for seven-year-olds as seventeen-year-olds.

Second, it must involve a wide range of actors – not least the children concerned, their parents, grandparents, and members of the communities they live in. This means bringing children and family members – including those living with HIV - to the table when programmes are designed.

Third, it must prevent new HIV infections – for example by scaling up access to services to prevent mother to child transmission and by making HIV prevention more available and accessible to adolescents. By addressing vulnerability and – though I know this is controversial – by preventing sexual transmission. Universal Access to HIV prevention, treatment, care and support is not only for adults!

Fourth, it must provide treatment for children. This will mean scaling up testing and counseling, and making antiretroviral drugs and cotrimoxazole more easily available.

Fifth, it must provide adequate levels of social welfare to children infected and affected by HIV, and to their families and communities – for example through cash transfers.

Sixth, it must be fully funded at international and national level. This means more money for children and AIDS from international donors and a higher priority for children in national development plans. At UNAIDS, we estimate that \$2.7 billion will be needed for programmes for orphans and vulnerable children in 2008.

And finally, as I mentioned earlier, it must be based on more accurate information. This means not just improving surveillance but also clarifying how children become vulnerable, looking more closely at socio-economic contexts, and intensifying research into psychosocial impacts and responses. It means looking at children in the contexts of their families and communities, improving monitoring and evaluation systems, studying how households cope and what local care-giving practices involve.

To turn this wish-list into reality, high levels of political will and commitment will be required. To inform and drive the process forward, we will need a growing body of knowledge about children and AIDS. We will need evidence from successful

interventions to show what can be done. And we will need sustained activism to make sure the right action is taken – now and in the years to come.

This brings me to my conclusion: it is time now to bite the bullet and start thinking and acting in the context of the longer term – something we have repeatedly failed to do up to now. Here, children clearly have a major role to play.

We need to be confident that what we are doing now works on two levels – both now and in the years to come. We must take steps now so a girl born today doesn't grow up to produce an HIV positive baby and so children born with HIV get anti-retroviral treatment and live longer, healthier lives.

This means doing what you are doing in the Joint Initiative: taking a long, hard look at what we are doing, identifying what works and coming up with new approaches and new research to address new trends.

It means working together in a coherent fashion, on long-term, integrated programmes: the day of the short-term, ad-hoc project is over.

And it means ensuring that our response is comprehensive, flexible and anticipatory - tailored to different epidemics and ready to change as epidemics evolve: AIDS doesn't stand still, and the world around it is not standing still - nor can we.

Thank you.