

Speech

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**4th Global Partners Forum
on Children affected by HIV**

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“The AIDS Response: Putting Children and Families First?”

Speech by

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I am pleased to be here and wish to thank the organizers for possessing the foresight and commitment to move this critical agenda forward. I want to thank Agnes Binagwaho, the Honorable Minister of State for Overseas Development, Peter Power, Ann Veneman, the Executive Director of UNICEF, Methusela Nyabuchweza from Tanzania and Aloyce Fungafunga (Tanzania Youth representative) for their comments.

This is an important meeting at an important time – as Peter Piot, the Executive Director of UNAIDS, has highlighted, we are at the beginning of a new phase in the AIDS response. A point where it has become clear that AIDS is becoming a complex, long-wave event, requiring a long term, forward looking response. A point where we can recognize that this response will only have real impact if it puts children and their families at the very heart of the response.

The good news is that we have reached a stage where we can see that more than 25 years of work on AIDS is finally beginning to deliver results. Today, on a global basis, fewer people are becoming infected with HIV than there were 5 years ago, primarily due the scaling up of prevention efforts and fewer are dying of AIDS, partly as a result of increased access to treatment. While the number of new HIV infections has fallen in many countries and regions, the AIDS epidemic is not over in any part of the world

Global new infections among children dropped 10%, from 410,000 in 2005 to 370,000 at the end of 2007. One reason for this is that one third of all women in developing countries who require drugs to prevent transmission of HIV to their newborns can now access them (up from 14% in 2005). In some countries, such as Argentina, Belarus, Botswana, Bahamas, Moldova and Thailand, greater than 75% of pregnant women with HIV infection are being provided interventions to prevent mother to child transmission. And access to ARV treatment for children has improved, though at a slower pace than for adults.

For young people engaging in risk behavior, we are also seeing some positive trends. They are waiting longer to become sexually active – for example in Cameroon, the percentage of children having sex before age 15 has gone down from 35% to 14%. In other countries in the world, condom use is going up and there is a reduction in the number of sexual partners.

By and large, however, AIDS responses have tended to shortchange children. Not enough attention has been paid to preventing new infections, or to diagnosing and treating children. At the end of 2007, fewer than 200,000 children worldwide received AIDS treatment – 60% more than the year before but only a third of the treatment access of adults. Not enough research has been carried out. And not enough has been done for children whose families and communities are affected by AIDS.

As a result, only 40% of young people worldwide have comprehensive HIV knowledge – less than half-way to the 2005 target set at the AIDS UN General Assembly Session in 2001. Just 8% of children at risk in low- to middle-income countries were tested for HIV within the first two months of life. And a paltry 4% of infants born to HIV+ women were put on cotrimoxazole, an affordable, widely available, effective and well tolerated antibiotic treatment recommended for all HIV-exposed children.

I'm with you here in Dublin today to reaffirm UNAIDS commitment to end this trend – to work with UNICEF to rally a UN-wide effort for children and AIDS, and to do all we can to support effective implementation of the recommendations of the Joint Learning Initiative on Children and AIDS

I want to commend all the JLICA partners for the exceptional way they are using the learning process. Their careful analysis of the data, open consultations, and methodological rigor, present an important model that other learning initiatives can benefit from.

One of the most important aspects of this work is the spotlight it has thrown on the need to focus on combined approaches. If we've learnt anything in the past 27 years it is that there is no single way to tackle AIDS, and that no single organization or sector can do the job on its own. This after all is why UNAIDS was created in the first place-to rally the strengths and comparative advantages of the UN family!

We all know it's not enough to just hand out condoms and pills. We have to come up with packages of interventions, responding to the continuum of needs, adopting a life-cycle approach. This means starting from pre-conception stage through PMTCT to meeting the

needs of children, education for young people, adults, and now, the needs of the elderly. We need, in short, to get better at joining up the dots!

We also – and this is the really tricky part – have to break down the structural barriers that prevent so many people from accessing services – the low status of women and girls, homophobia, discrimination against migrants and ethnic minorities. One other major obstacle here that has particular relevance to today's discussions is our collective failure to overcome taboos about adolescent sexuality and the critical problem of intergenerational sex.

We've also learned that we can't just target individuals in isolation – that to be effective we have to work with groups, communities, families and provide a comprehensive menu of interventions. This has been a major shortcoming in responses in the past. There's no point in counseling women if you don't talk to men too. It doesn't make sense to provide PMTCT to prevent babies getting infected and not follow up with treatment and care for mothers.

And it's clear, as this meeting will emphasize, that we need to do much more in terms of social protection. In an increasing number of countries, social transfers in the form of free education, affordable health care, food support, and other child development services are becoming standards of care. These enable families to have choices and empower them to provide better care for their children.

Another thing we've learnt over the past decade is the importance of locally specific responses. It's become a cliché but it's also very true that there are more AIDS epidemics than countries in the world. Every context has its differences – and we must do more to tailor our responses to settings. The vast majority of children infected and affected by HIV live in sub-Saharan Africa. But by no means all. It's our job to find ways not just to meet their needs – but those of children in “concentrated” epidemics in Asia, Latin America, Eastern Europe etc. Different challenges will need different solutions.

In hyper-endemic scenarios, where more than 15% of all adults are infected, AIDS is likely to affect every single child in some way or another. It is actually much harder to ensure that support for AIDS affected children is taking place in low and concentrated epidemics – for example, by making special efforts to ensure that sex workers, injecting drug users and their

partners have ready access to HIV programmes including support for their children, or that gay adolescent boys are prepared and equipped to protect themselves from HIV.

We know that AIDS is breaking up families, fragmenting communities and challenging traditional safety nets. Yet we do very little of our prevention work with families, and only limited work around structural and long-term development.

We know that the impact on household welfare is greater on the poor than on the better off. And that the issue of protecting children provides a lever to promote broader development oriented responses to HIV: rolling out social protection to poor families supporting children in highly impacted areas is one such example.

We know 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.

We also know that we must better measure the scale of the epidemic among children. Presently country-estimates of HIV in children are primarily based on data from adults, and that much more direct data collection is needed to get more robust information about the epidemic among children and how it is changing.

So if we know all this, why aren't we doing more about it?

One reason is politics. We need strong political leadership – at both government and civil society level – to mobilize a shift in focus so AIDS strategies meet the real needs of families and children. Too often in the past politics has stood in the way, hobbled by taboos around sexuality and HIV: Another reason is finances – the fear for example that social protection approaches would cost too much yet the evidence has shown that they don't.

The 4th Global Partners Forum on Children and AIDS presents a crucial platform for mapping out what we need to do to take concerted and coordinated action to implement the solutions JLICA and others have pointed us to.

On behalf of UNAIDS, I pledge our support in working with governments, the UN family and civil society to take forward the communiqué agreed to at this meeting to our efforts at regional and at country level. We will work to get recommendations integrated into national plans, and encourage bilateral and multilateral funding streams – including the Global Fund –to direct resources where they will have most impact.

At its best, the AIDS movement has succeeded in putting people at the centre of development. That is the approach we need: putting children and families at the heart of the AIDS response. That is what we do when we support inclusive social protection across the most AIDS affected countries, or when we make sure that sex workers in Calcutta or Guatemala City can school their children free of stigma, or when education ministries the world over embrace their responsibility to educate children frankly and accurately about sex and AIDS.

And that commitment to put children at the heart of the response is why we are here today.

Thank you.