Delivering on Commitments

on HIV/AIDS, Children and Young People in South Asia

SAARC

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Background report for the SAARC-UNICEF ROSA Meeting

Delivering on Child Rights in South Asia:
Our Commitment on HIV/AIDS, Children and Young People

September 20th, 2004
New Delhi, India
in observance of
"The SAARC Decade of the Rights of the Child: 2001-2010"
and
'The SAARC Awareness Year on TB and HIV/AIDS: 2004"

Contents

Foreword

South Asia stands out as the region with the second largest number of HIV infections in the world. HIV is now found in every country in South Asia. No longer can any society in the region consider itself immune to the virus.

The newest global HIV/AIDS estimates indicate there are more than 5.2 million people living with HIV and AIDS in South Asia. With almost one-quarter of the world's population, the region is now home to some of the world's fastest growing AIDS epidemics.

Both SAARC and UNICEF are particularly concerned by the rise in new infections and the impact of the epidemic among people who, up to now, have not been considered highly vulnerable, in particular children and young people. Whilst the health and development of children and young people was one of the five original areas of cooperation identified by Member States when they initiated consultations on the establishment of SAARC in early 1981, and has continued to receive high priority ever since the formal launching of SAARC in December 1985, it is only in the last few years that the impact of HIV/AIDS on children and young people has been given the due attention is requires.

Member States of SAARC have made strong commitments to reduce both the spread of the HIV/AIDS and its impact upon individuals, families and communities. Yet the challenges posed in curbing the threat of HIV/AIDS remain daunting.

A number of countries in our region stand at the crossroads, where decisions made now will determine whether they successfully control and reduce the spread of HIV/AIDS or instead move into generalised epidemics which will ultimately impact on the social and economic progress of nations and the future well-being of hundreds of millions of children and young people in South Asia.

The movement of HIV from high-risk populations to low-risk groups including children and young people reveals where prevention efforts seem to be failing. In South Asia, levels of injecting drug use and unprotected commercial sex are beginning to lead to rising infection rates among people normally not considered at risk of infection, including married women.

As the pandemic moves into the more general populations, without the correct knowledge, skills and access to services, young people become extremely vulnerable to infection. Global experience has shown that where HIV transmission has been reduced, in addition to targeted interventions, there has been a strong and widespread focus upon preventing the growth of the epidemic among and through young people.

We can be proud that there are success stories in South Asia. Significant reductions in risk behaviours have been documented in areas where high profile and large-scale HIV prevention campaigns have focused on providing information and essential prevention services to those most at risk.

As the pandemic matures in South Asia, an emerging trend that demands our full attention is that of children living in families who are affected by HIV/AIDS or are orphaned by AIDS. The impact on a child of losing one or both parents to AIDS has been well documented around the world. These children are more likely to be impoverished, to miss out on educational opportunities, and are at greater risk of abuse, neglect, exploitation and discrimination. Though more research is required in South Asia, studies and experience suggest that children orphaned by AIDS in this region also have their basic rights violated or unfulfilled.

The reality today is that whilst we have made many commitments to accelerate action, there is still a culture of silence and denial in too many countries. Leaders - whether in government, faith-based organisations, civil society, or academia -- and those individuals, whose stature and influence shape cultural attitudes and norms, must continue to be fully engaged in efforts to stop the spread of the pandemic.

As we observe and commemorate the "SAARC Decade on the Rights of the Child" and the "SAARC Awareness Year on TB and HIV/AIDS" it is time that Governments and all leaders in South Asia act resolutely to transform the well-articulated multiple commitments into accelerated actions to arrest the spread and change the course of the HIV/AIDS epidemic, and reduce its impact on children, young people, their families and communities. SAARC and UNICEF are committed to continue to work to support governments and other leaders in South Asia in this effort.

Mr. Q.A.M.A. Rahim
Secretary-General
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1. HIV/AIDS in South Asia

Across the region of South Asia, the HIV/AIDS epidemic is threatening to reverse the hard-won child survival gains of the past decades. Over 5.2 million people in South Asia are estimated to be infected with HIV/AIDS as of end 2003[i], of whom up to one-quarter are aged under 25 years. The data is dominated by the epidemic in India where some 5.1 million people were estimated to be living with HIV/AIDS by the end of 2003.[ii] (UNAIDS/WHO 2004).

All of the basic factors that can fuel the HIV epidemic are evident in South Asia: widespread poverty, low levels of literacy and educational attainment, large economic disparities, endemic gender inequalities and gender-based discrimination, huge mobile populations, added to by a wall of silence and denial which cuts across all levels of society.

What makes HIV/AIDS in South Asia an enormous challenge to overcome is the fact that there is no single epidemic in the region, but a diversity of epidemics. The two interlinked generalisations that can be made are that across South Asia the epidemics have all followed a similar pattern, and that virus has spread mostly through identifiable risky behaviours that the majority of the population do not engage in.[iii]

HIV/AIDS in South Asia: end 2003 estimates

	Adult prevalence rate	Number of adults & children living with HIV	Number of women living with HIV	Number of children 0-14yrs living with HIV
Bangladesh	<0.2 %	2,500-15,500	400-2,500	—
Bhutan	<0.1 %	<100	<100	—
India	0.8 %	5.1M (2.2M-7.6M)	630,000-2.1M	54,000-270,000
Maldives	0.1 %	< 100	< 100	—
Nepal	0.5%	61,000 (29,000-110,000)	16,000 (7,200-24,000)	—
Pakistan	0.1 (0.0-0.2)	74,000 (24,000-150,000)	8,900 (3,000-18,000)	—
Sri Lanka	<0.1	3,500 (1,200-6,900)	200 – 1,200	-
South Asia		5.238 M (2.256 M – 7.88M)	1.517 M (640,000-2.15M)	54,000-270,000

Data source: UNAIDS (2004), 2004 Report on the Global AIDS Epidemic.

These major behaviours driving the epidemics in South Asia are injecting drug use, sex between men, commercial sex work* and use of commercial sex workers - and added to this is the major vulnerability factor of large numbers of mobile populations.

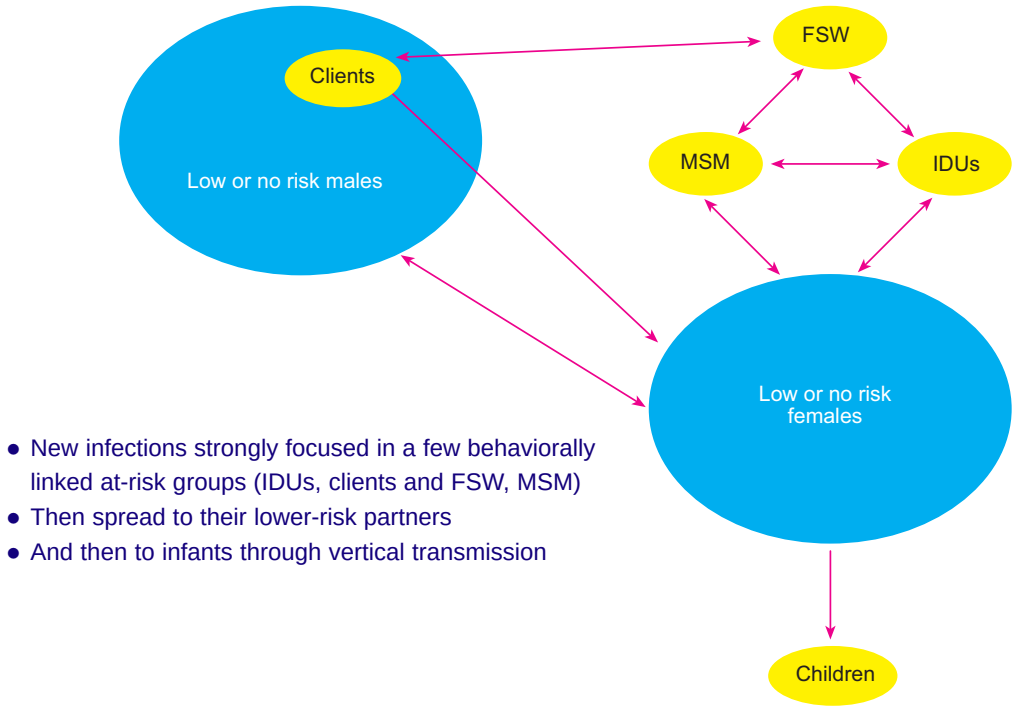
In most Asian countries, including those of South Asia, the general pattern of the epidemic is that the earliest HIV spread occurs among injecting drug users and men who have sex with men. Two or three years after the injecting epidemic takes off, there is an increase in HIV prevalence amongst sex workers and their clients. Then a few years later, HIV levels start to grow more gradually among women (usually partners of clients of sex workers or of injecting drug users) and through them, to children through mother-to-child transmission.[iv]

However, despite these similarities, the epidemics of South Asia show great diversity, both in levels of HIV infection and in the timing of the start of epidemic spread. These can be characterised in three distinct phases[v] :

Firstly, there are several States of India which saw early and rapidly growing epidemics in the late 1980s. In these States, HIV levels have exceeded 1% of the adult population. In India, six States have an estimated prevalence of over 1% among adults[vi], and very alarming rates amongst high risk populations. For example:

- In 2002 in Mumbai (Maharastha State), 39% of injecting drug users and 55% of female sex workers were tested as HIV-positive in routine surveillance;[vii]
- In Chennai (Tamil Nadu State) 63% of injecting drug users were found to be HIV infected in sentinel site surveillance, up from 26% three years earlier.[viii]

South Asian epidemics tend to follow similar patterns



- New infections strongly focused in a few behaviorally linked at-risk groups (IDUs, clients and FSW, MSM)
- Then spread to their lower-risk partners
- And then to infants through vertical transmission

** female sex workers do not infect each other through sex - they might through sharing needles - but it is the clients who introduce and spread HIV.*

Second are those which have seen delayed epidemics, with HIV among drug injectors growing rapidly in the mid-1990s and steadily increasing in sex workers and STD patients a few years later. This includes much of Nepal and parts of India. The HIV levels have grown more gradually in Nepal and these states, but do not yet exceeding more than 0.5 percent.

Finally, there is a group of countries in South Asia which have yet to see extensive HIV spread, including Bangladesh, Pakistan, Bhutan and Sri Lanka. In these countries the national HIV prevalence is below 0.1%.

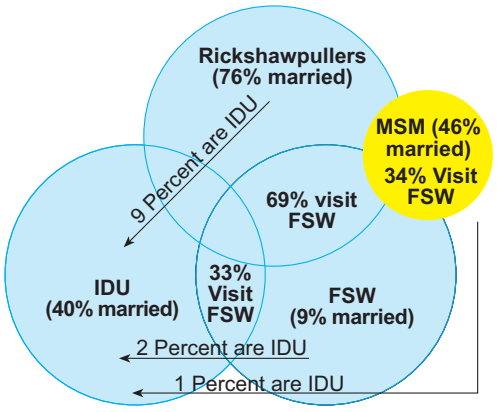
However, despite the fact that the national adult HIV prevalence is below 1% in all the countries of the region, this is not a cause for complacency. Low prevalence can - and does - seriously distort understanding of the epidemic. All countries are experiencing growth in prevalence rates; and the national figures mask serious epidemics in some provinces and states where infection rates are high and still rising among high-risk behaviour groups.

Even in the South Asian countries where there is low HIV prevalence there are relatively high levels of risk behaviours including injecting drug use and sex work.

As such, the epidemic is not only a threat in India. In parts of Bangladesh, Nepal, and Pakistan, where high-risk behaviours among segments of the population have been driving the epidemic, alarming increases in their HIV prevalence rates in recent years point to a situation where a crossover into a more generalized epidemic must almost certainly be occurring.

Underlying this proposition is the fact that populations with high risk behaviours overlap with other sub-populations. In many parts of Asia there are multiple links among all of the higher risk behavioural groups. Individuals are not isolated - many sex workers also inject drugs, many injecting drug users frequent sex workers, many sell blood, many move between cities, between rural and urban areas and many have regular partners and children. As the illustration from Bangladesh shows, there are no clear boundaries between those with high risk behaviours and the general population. Behavioural surveillance studies showed relatively high levels of injecting or sexual links among injecting drug users (IDUs), female sex workers (FSW), men who have sex with men (MSM) and male rickshaw pullers. Of particular note in showing the linkage to the spread of HIV amongst the wider population is the fact that a large proportion of each group (except sex workers) were married, potentially putting their wives and at risk of infection.[ix]

Potential spread of HIV among vulnerable populations in Central Bangladesh



(MAP/Monitoring the AIDS Pandemic, 2001, The Status and Trends of HIV/AIDS/STI epidemics in Asia and the Pacific)

2. Children, Young People and HIV/AIDS in South Asia

In South Asia young people are moving more to the centre of the AIDS challenge. Upto 1.25 million young people are already living with the disease, and the number of new infections among this age group is increasing rapidly.[x] In India, it is estimated that around half of all new infections occur among people under 25 years of age.[xi] To prevent the growth of the epidemic among and through young people, it is therefore important that they have full and accurate knowledge and necessary skills on how to protect themselves from infection, have access to health and information services that are oriented to their needs, and have a supportive environment around them.

Only a minority of young people in South Asia engage in risk behaviours. But very large proportions of those people at risk of HIV infection in South Asian countries - drug injectors, sex workers and their clients, and men who have sex with men, are in their teens or early twenties.[xii]

Throughout Asia, the high risk behaviour most heavily concentrated among the young is drug injection, and not just in areas where drug use is a relatively new phenomena. In Manipur state of India, over 40% of the males who injected drugs included in the surveillance systems in 2002 were under the age of 25.[xiii] In Kathmandu valley (Nepal), where injecting drugs is a long established practice, some 44% of new injectors were under 25 years.[xiv]

As the epidemic starts to diffuse into the general population, young people - particularly girls - become more vulnerable for many interlinked reasons.

Why are young people in South Asia vulnerable ? :

They lack knowledge and information:

- Of full and accurate information. Nearly all young people have heard of HIV/AIDS, but there are serious misconceptions and misunderstandings;
- About the choices available to them; including abstinence before marriage;
- About their rights and responsibilities in the context of HIV/AIDS.

They lack skills and confidence:

- To negotiate difficult situations (whether it is refusing unsafe or unwanted sex or resisting peer pressure to use alcohol or drugs);
- To feel that they have the power to protect themselves and influence others to practise responsible behaviour and avoid infection.

They lack access to youth-oriented services:

- That are affordable, convenient and sensitive to their needs;
- That provide psychological counselling and support for managing grief, stress and discrimination;

- That offer "peer to peer" counselling: often the most effective way to provide education and support for young people.

They do not have a safe and supportive environment:

- That gives young people a place to talk openly and without criticism of their feelings;
- That gives them a voice and a meaningful role in community decision-making, especially relating to HIV prevention strategies for young people;
- That provides unconditional love and support from a caring adult (parent, family member, trusted teacher or religions leader or community leader);
- That provides role models for responsible behaviours.

Many young people are having sex:

- In many countries, many girls and boys are sexually active before the age of 18;
- In many countries of South Asia child marriage or early marriage is the norm;
- Adolescents who start sex early are at higher risk (esp. girls for biological reasons).

Currently, the rate of infection between boys and girls in South Asia is about equal, although globally the rate of girls' infection is rising more rapidly. Adolescent girls suffer a double disadvantage of being both females and children, and are susceptible to all kinds of abuses and exploitation, given the pervasive gender biases in South Asia.

The impact of the epidemic on the lives of children is yet to be felt.

One of the most devastating consequences of the HIV/AIDS epidemic is the growing number of orphaned children and those left vulnerable by disease and death of caregivers and family members. Not only are the social consequences of the HIV epidemic high, they are also long term. With HIV prevalence still rising in South Asian countries and the stage of high rates of AIDS-related deaths yet to come, the real impact on children will only be felt deeply in the coming decades.

South Asia Orphan Estimates

	All children (0-17 years)	Total orphans as % of all children	Total number of orphans 2003	Maternal orphans 2003	Paternal orphans 2003	Double orphans 2003	Children orphaned in 2003	2010 estimate total orphans
Bangladesh	59,000,000	9%	5,300,000	2,500,000	3,400,000	650,000	540,000	4,900,000
Bhutan	Reliable data not available							
India	400,000,000	9%	35,000,000	15,700,000	23,300,000	4,000,000	3,700,000	32,300,000
Nepal	11,000,000	9%	1,000,000	480,000	700,000	140,000	110,000	1,000,000
Pakistan	77,000	6%	4,800,000	1,700,000	3,400,000	300,000	540,000	4,800,000
Sri Lanka	6,000,000	5%	340,000	86,000	270,000	15,000	39,000	310,000

Data source: UNAIDS/UNICEF/USAID -Children on the Brink 2004

Families and communities in South Asia are already doing their best to cope with relatively large numbers of orphans, due not only to HIV/AIDS but through other factors including high levels of maternal mortality. The future increase in numbers of maternal, paternal and double orphans due to AIDS-related deaths will continue to place enormous stress on already weak and overburdened family and community safety nets, unless systems to strengthen capacities over the long term are rapidly developed. With the impact of HIV/AIDS limiting the expected reduction in adult mortality over the next decade, the anticipated major decreases in orphaned children may only be reduced slightly.

Data and experiences from elsewhere around the world have shown that the majority of orphans and children made vulnerable by the pandemic are living with their extended families and communities. The percentage of children being pushed out onto the street or into institutional care is small. Hence, the fundamental pre-emptive strategy in South Asia - before the real scale of the impact arrives - must be to strengthen the ability of families and communities to protect and support children in their care.

The impact of HIV and AIDS on a child starts well before the death of a parent or caregiver. Children living in households where a member is HIV-positive will be exposed to other infectious diseases. He or she may have to care for ill and dying family members and face the trauma of seeing someone they love slowly die. Their distress will be magnified by the stigma often associated with HIV/AIDS.

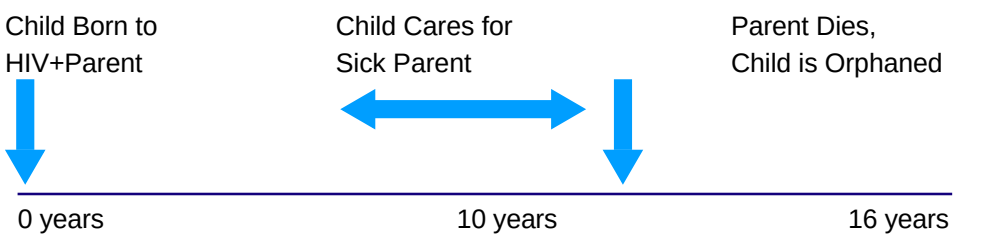
Discrimination against people living with HIV/AIDS hits children in schools, in medical facilities, in orphanages, in their neighborhoods, and in their own homes. Doctors, both government and private, have refused to treat and sometimes even touch HIV-positive children.

Discrimination, combined with corruption and a failing public health system, leaves many children living with HIV/AIDS without even the rudiments of health care. There is a direct connection between children not being treated for HIV and being discriminated against in schools and the community: in addition to suffering pain and disfigurement, untreated children are more likely to be identifiably ill, and teachers, classmates, and parents of other students are more likely to suspect them of being HIV-positive. Schools have expelled or segregated children because they or their parents are HIV-positive. Fear of discrimination discourages people from doing anything that might identify them as HIV-positive, such as getting tested for HIV, seeking treatment and support, and taking other measures to protect themselves and others.

In addition to the association of HIV/AIDS with people already deeply stigmatized by society, discrimination against people living with the disease, including children, is connected in large part to the widespread public misperception that HIV can be transmitted by casual contact. A critical element of addressing discrimination against people living with HIV/AIDS, as well as preventing the spread of HIV, is accurate and comprehensive information about how the disease is and is not transmitted. Children as well as adults have a right to age-appropriate information to protect themselves against transmission.

Human Rights Watch 2004 - "Future Forsaken - Abuses Against Children Affected by HIV/AIDS in India"

HIV/AIDS-Affected Children and their Families



Higher risk of infection, abuse, malnutrition loss of schooling, health care, higher work load

As preparedness before approaching orphaning crisis occurs, Governments in South Asia can benefit from a body of global experience developed over recent years, and in particular to use of five overarching strategies as the framework for the development of their response:[xv]

- Strengthen the **capacity of families** to protect and care for orphans and other children;
- Strengthen and support **community-based responses**;
- Ensure **access to essential services** for orphans and other children made vulnerable by HIV/AIDS;
- Ensure that **governments have the mechanisms and systems to protect** the most vulnerable children;
- Raise awareness to create a **supportive environment** for children affected by HIV/AIDS.

Of paramount importance in South Asia is that the present first-line response of placing children in orphanages or other forms of institution must be revisited and revised. Increasing institutional care will not help to solve the problem of an increasing number of children orphaned through AIDS and other causes. This is not only economically unviable, but violates the basic rights and needs of children.

Governments in South Asia need urgently to recognise that institutional care should be only the last resort and kept to a minimum. Institutional care rarely meets the key developmental needs of children, and is in conflict with the right of every child to live and develop in a family environment. Existing institutions do have a role to play in caring for children for whom no better alternative exists. However, where residential care is necessary, guidelines and standards should be put in place to ensure that children receive sufficient care and monitoring mechanisms put into place through government systems.

How HIV and AIDS Impacts on Children[xvi]

Economic hardship - with no working parent to support them and savings spent on care, household capacity to provide for children's basic needs declines. An increasing number of children are forced to take on an adult responsibility of supporting the family.

Loss of family, identity, attention and affection - siblings whose parents have died may be separated to live with relatives of foster parents. They often need to move to faraway places or even from an urban setting to a village to live with relatives. Orphans may not receive the same day-to-day care, supervision and attention from other adults as they did from their parents.

Psychological distress - children's psychosocial distress begins with a parent's illness. They suffer lingering emotional problems from looking after dying parents, living in households stressed by the drain on their resources, and the stigmatisation of AIDS.

Increased demands for labour - the demands increase for children's labour for domestic chores, income generating work or caring for an ailing parent. The need for a child's additional labour starts when a parent falls ill and may continue semi-permanently as their labour is often exploited in households they join as orphans.

Reduced opportunity for schooling - economic pressure and the time involved in caring for ill parents along with siblings can force children to withdraw from school. In South Asia, girls are especially vulnerable because of cultural and gender biases and are more likely to be forced to leave school and take on adult tasks.

Increase malnutrition and illness - orphans and vulnerable children tend to experience decreased nutrition and reduced access to regular medical care due or because of declining family incomes as a result of parents' illness or to discrimination in their foster homes.

Increased abuse and risk of HIV infection - with little income and reduced protection at household levels, orphans and vulnerable children face increased risk of abuse and of HIV infection. Girl orphans are at particular risk of sexual abuse and also pressured into early marriage to reduce the financial burden of their guardian's family.

Loss of their inheritance - orphans and widows are often disenfranchised within their extended family and lose other legal entitlements upon the death of a husband and father. The death of the parents may be seen as an opportunity for property grabbing by relatives.

Preventing newborns from HIV Infection

As the epidemic unfolds across South Asia, transmission of HIV from mother to child is increasingly becoming an important issue due to the growing number of new infections among young women. There is strong evidence that in several Indian States, HIV prevalence among pregnant women has already crossed the 1% threshold.[xvii] According to the National AIDS Control Organisation of India (NACO) data, there are already large numbers of infants infected through vertical transmission of HIV.[xviii]

This information is based on the 2001 Census, taking into account information of male-female distribution and tabulation of data of 2003 HIV estimates. This indicates that there will be 1.78 million women who are HIV positive. Considering the GFR (General Fertility Rate) among women as 103.2 per thousand, there will therefore be 184,000 pregnant women who are HIV positive. If the transmission rate of HIV infection from infected mothers to children is taken as 30% in worst case scenario, there will be 55,145 HIV infected children in the country.[xix]

Only India has developed a comprehensive strategy and mechanism to prevent vertical transmission of HIV and is presently finalising approaches for scaling up at large scale in higher prevalence States. Sri Lanka, Bangladesh and Nepal have all undertaken feasibility assessments and are at different stages of finalising protocols and guidelines and commencing pilot PPTCT programmes.

Just like prevention amongst young people, a failure at this stage of the epidemic to develop guidelines and protocols and commence comprehensive PPTCT - even at a limited scale targeting high risk populations - will impact heavily in years to come.

An oft-cited constraint of lack of resources (financial, technical, system) has been shown not to be a constraint to operationalising PPTCT: it has been shown that it is feasible to successfully integrate interventions to prevent parent-to-child transmission of HIV into maternal and child health services even in low resource settings.[xx]

Four-pronged approach to Prevention of Parent to Child Transmission of HIV

1. Primary prevention of HIV infection;
2. Prevention of unintended pregnancies among HIV-infected women;
3. Prevention of HIV transmission from HIV-infected women to their infants (comprehensive package includes HIV counselling and testing, antiretroviral drug use, safer delivery practices, and infant feeding counselling and support);
4. Provision of care and support to HIV-infected women, their infants and their family.

3. The Cost of Waiting

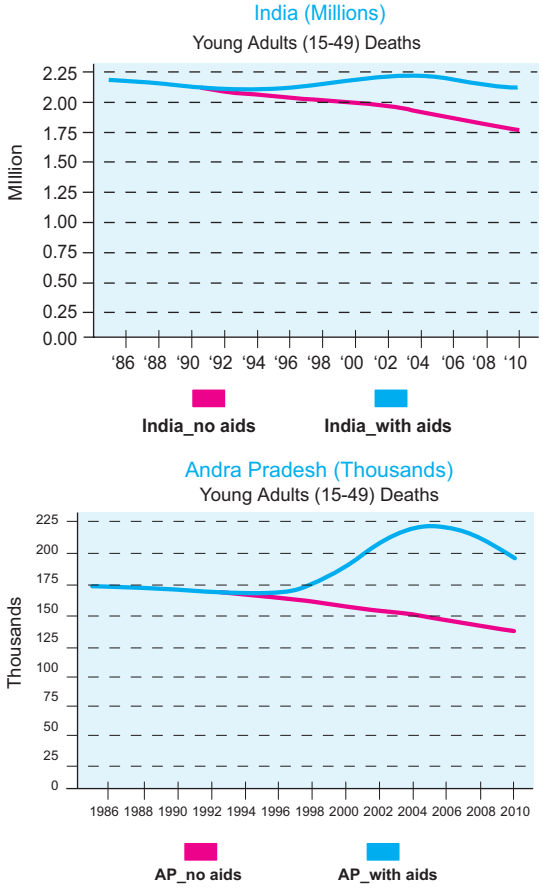
HIV/AIDS is already taking a far greater toll in Asia than is commonly realised, and the human, social and economic losses caused by the epidemic will reverse hard-earned gains in poverty reduction if governments and donors do accelerate actions now.[xxi]

In the worst hit areas of Asia, including parts of India and Nepal, HIV/AIDS has already killed large numbers of young adults, taken years off life expectancy, orphaned large numbers of children, and filled hospitals with sick and dying people. For example, in the Indian State of Andra Pradesh, ADB/UNAIDS estimates that 1 in 8 hospital beds are being used for people sick with HIV/AIDS, nearly five times the national average.[xxii]

Failure to immediately establish comprehensive and effective prevention, care and treatment programmes will result not only in large numbers of people becoming infected and increased death tolls, but also an erosion of poverty reduction efforts.

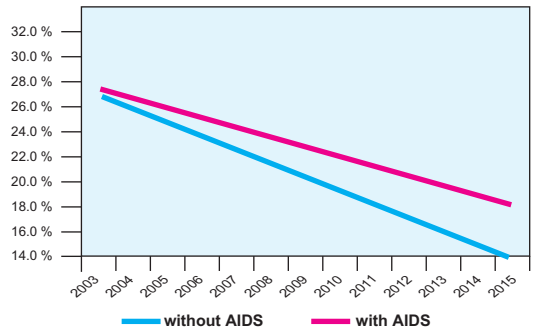
Even if the HIV epidemic could be halted and reversed today in South Asia, the impact on families and communities will not be fully felt for the next decade. The time lag between HIV infection and progression to AIDS-related death means that communities having to deal with large numbers of very ill people, and of AIDS-related deaths (and orphans) would not plateau until early in the next decade.

Young Adult Deaths with and without AIDS for India and Andra Pradesh, 1985-2010



Source: ADB/UNAIDS 2004. Asia-Pacific's Opportunity: Investing to Avert an HIV/AIDS Crisis.

Projected Poverty Reduction achievements with and without AIDS in India (2003-2015)



Source: ADB/UNAIDS (2004). Asia-Pacific's Opportunity: Investing to Avert an HIV/AIDS Crisis.

4. The Convention on the Rights of the Child: the framework for guaranteeing children's rights in the face of the HIV/AIDS pandemic

HIV/AIDS impacts so heavily on the lives of all children and young people that it affects all their rights — civil, political, economic, social and cultural. The Convention on the Rights of the Child which has been ratified by all countries in South Asia - along with other human rights instruments - recognises children as rights-holders, not merely as passive beneficiaries of protective measures.

The Convention on the Rights of the Child recognizes that a child is any person up to the age of 18 years; and is based on four overarching principles that should guide responses to HIV/AIDS prevention, care and support of children and young people[xxiii]:

(i) **Best interests of the child (article 3):** In decisions affecting children with HIV/AIDS, orphans and other children made vulnerable by HIV/AIDS, the children's best interests are a primary consideration.

(ii) **Right to non-discrimination (article 2):** Children living with HIV/AIDS, orphans and other children affected by HIV/AIDS are at great risk of discrimination, abandonment or denial of care. Special measures are required for especially vulnerable children such as those who are homeless, subjected to abuse, or in detention to ensure that they have access to services and information.

(iii) **Right to life, survival, and development (article 6):** The Convention recognises every child's inherent right to survival and development including in spiritual, moral, psychological and social aspects of life.

(iv) **Right to have views respected:** Children are entitled to express their views in matters affecting them, and their views should be given due weight in accordance with the child's age and maturity. Children can enrich decision-making and participate in HIV/AIDS policy making and program delivery. The views of children in families affected and orphans regarding their future care should be heard when decisions about their lives are being made.

Adequate measures to address HIV/AIDS can be provided to children and young people only if their rights are fully respected, protected and fulfilled. Some of the key rights in this regard are the following:

- the right to access information and material aimed at the promotion of their social, spiritual and moral well-being, physical and mental health (art. 17);
- their right to preventive health care, sex education and family planning education and services (art 24(f);
- their right to an appropriate standard of living (art 27);
- their rights to privacy (art 16);
- the right not to be separated from parents (art. 9);
- the right to be protected from violence (art. 19);
- the rights to special protection and assistance by the state (art. 20);
- the rights of children with disabilities (art. 23);
- the right to health (art. 24);
- the right to social security, including social insurance (art. 26);
- the right to education and leisure (arts. 28 and 31);
- the right to be protected from economic and sexual exploitation and abuse, from illicit use of narcotic drugs (arts 32, 33, 34 and 36);
- the right to be protected from abduction, sale and trafficking as well as torture or other cruel inhuman or degrading treatment or punishment (arts 35 and 37) and
- the right to physical and psychological recovery and social reintegration (art 39).

Children and young people are confronted with serious challenges to their rights as a result of HIV/AIDS. The Convention on the Rights of the Child provides a powerful framework for efforts to reduce the negative impact of the pandemic on the lives of children.

5. Key Leadership Commitments on HIV/AIDS, Children and Young People in South Asia

September 2000

United Nations Millenium Summit. Heads of State and Government adopted the United Nations Millenium Declaration, committing action to halt and begin to reverse the spread of HIV/AIDS by 2015.

April 2001

United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP) 57th Session. Resolution 57/1 adopted at the UNESCAP session called for accelerated action to fight HIV/AIDS in Asia and the Pacific.

June 2001

United Nations Special Session on HIV/AIDS. The heads of State and Government and representatives of States and Governments, including all South Asian countries, committed themselves to take action to address the HIV/AIDS crisis in the outcome document, the "Declaration of Commitment on HIV/AIDS", which was adopted by the UN General Assembly on 2nd August 2001.

October 2001

First Asia Pacific Ministerial Meeting on HIV/AIDS, Melbourne, Australia. In addition to reaffirming commitment to the Declaration of Commitment from the UN Special Session on HIV/AIDS, the Ministerial Statement recognised the severity of the HIV/AIDS crisis in the region, outlined a set of sound key principles for HIV/AIDS and made a number concrete commitments including to address the HIV/AIDS pandemic through comprehensive and multi-sectoral responses which form part of broader economic and social development goals; greater coordination among all partners, including people living with HIV/AIDS and vulnerable groups including young people, and the formation of the Asia Pacific Leadership Forum on HIV/AIDS.

January 2002

11th Summit Meeting of the South Asian Association for Regional Cooperation (SAARC), Kathmandu, Nepal. In the "Kathmandu Declaration" the leaders stressed the importance and priority to be given to HIV/AIDS care and support, including prevention of mother to child transmission.

"The Leaders recognized the debilitating and widespread impact of the HIV/AIDS, TB and other deadly communicable diseases on the population of South Asia and stressed the need for evolving a regional strategy to combat these diseases. The strategy should include, inter alia, culturally appropriate preventive measures, an affordable treatment regime and should specially target the vulnerable groups……"

"The Heads of State or Government agreed to mobilize the necessary resources and intensify broad based actions to achieve a set of priority goals related to improving the status of children, such as polio eradication by 2005, protection of children from mother-to-child transmission of HIV/AIDS, and quality basic education to the children within a time-bound period."

May 2002

The UN General Assembly's Special Session on Children. The special session attracted 69 summit-level participants and 190 high-level national delegations. The political leaders committed their governments to a time-bound set of specific goals for children and young people, and to a basic framework for getting there. Among these were solemn commitments to combat HIV/AIDS, with an articulation of the strategies and actions to achieve this objective. The more than 400 children who were there as delegates and active participants delivered a statement - "A World Fit for Us" - in which they envisioned, *inter-alia;* the eradication of HIV/AIDS."

December 2002

1st South Asia Forum of Young People on HIV/AIDS. Young people from all 8 countries in South Asia participated in the Forum coordinated by UNICEF; in addition to developing action plan for region, made specific calls for leaders at the High Level Conference.

February 2003

South Asia High Level Conference on HIV/AIDS. 8 official country delegations represented in this high visibility event coordinated by UNICEF with UNAIDS support. Participants also included Ms Carol Bellamy (UNICEF Executive Director), Dr Peter Piot (UNAIDS Executive Director), Dr Nafis Sadik (Special Envoy of the UN Secretary-General on HIV/AIDS in Asia-Pacific), and Mr QAMA Rahim, (SAARC Secretary General). The outcome document "The Kathmandu Call against HIV/AIDS in South Asia" was adopted by all South Asian countries.

December 2003

2nd South Asia Forum of Young People on HIV/AIDS. Follow-up to 1st Forum and served also as input into Interfaith Consultation. Young people from all 8 countries in South Asia participated.

December 2003

South Asia Inter-Faith Consultation on Children, Young People and HIV/AIDS. 120 participants from 8 countries including senior faith-based leaders and government partners in consultation coordinated by UNICEF. Outcome document - "The South Asian Inter-Faith Pledge on Children, Young People and HIV/AIDS" includes commitment for formation of Inter-Religious Council for South Asia.

January 2004

12th Summit Meeting of the South Asian Association for Regional Cooperation (SAARC), Islamabad, Pakistan. The "Islamabad Declaration" reiterated the priority to be afforded to HIV/AIDS in South Asia and the role of SAARC.

> *"Easy and affordable health care, and prevention and treatment of HIV/AIDS, Tuberculosis and other serious communicable diseases are priorities. The year 2004 is declared as the "SAARC Awareness Year for TB and HIV/AIDS". The SAARC Secretariat should effectively implement the proposed programmes on the observance of the SAARC Awareness Year and develop a regional strategy through a consultative process and collaborate closely with the Joint UN Programme on HIV/AIDS (UNAIDS) and other international organizations and civil society."*

July 2004

Second Asia Pacific Ministerial Meeting on HIV/AIDS, Bangkok, Thailand. Under the theme of "Access for All: Political Accountability" with a focus on multi-sectoral action and the important role of political leadership, the Ministerial Meeting produced a statement which, amongst others, expressed deep concern that, despite progress in political commitment and leadership, the pandemic in the region has continued unabated. Special attention was drawn to a number of areas related to children and young people, including the following:

> *"We pledge to take the necessary actions required to address the special prevention, treatment and care needs of women, young people, orphans, people living in extreme poverty and other socially vulnerable groups in the region."*

> *"We commit to strengthen the overall capacity of health, education, social services and other social protection systems, emphasizing human resource development, and of communities and civil societies, to ensure effective and sustainable services essential to HIV/AIDS prevention, treatment and care."*

> *"We commit to support and strengthen the role and participation of young people in HIV/AIDS programmes at regional, national and community levels."*

6. What Needs to be Done: delivering on commitments on HIV/AIDS, children and young people in South Asia

An HIV/AIDS epidemic of potentially devastasting proportions is looming in much of South Asia. Only decisive action to rapidly accelerate and expand the HIV/AIDS response at national and sub-national levels can prevent a huge increase in HIV infection and deaths, and overcome a reversal of many social and economic gains made in the last decade. Experience has shown that scaled up and focussed prevention programmes can change the shape and course of the epidemic.

Acting decisively means that South Asian countries must rapidly move from commitments to action to ensure an expanded multi-sectoral prevention, care and treatment response which targets populations most at risk.

- Rapidly expand and support comprehensive prevention programmes with widespread coverage that target and reach the right populations, including people with high risk behaviours and their spouses/partners, and young people;
- Simultaneously strengthen systems and accelerate actions to provide care and support, including antiretroviral treatment;
- Ensure that those at risk are able to adopt safer behaviours through supportive social, legal, political and security environment;
- Develop a (genuine) multisectoral response at national and sub-national levels that involves a broad range of ministries with their own resources and programmes for prevention, care and support, along with the private sector, media, civil society, faith-based organizations, people living with HIV/AIDS, and young people;
- Ensure the collection not only of national, but also sub-national epidemiological and behavioural data and use this information to identify and respond to localized epidemics.

In addition, specific actions need to be taken to fulfil the many commitments and pledges made to ensure the rights of children and young people to be protected from infection and from the impact of HIV/AIDS. These include[xxvi]:

- Ensure the right to primary education for all young people;
- Ensure the right of all children to birth registration;
- Protect the inheritance rights of orphans and widows;
- Ensure that children and young people who are old enough to understand the nature and consequences of an HIV test have the right to provide informed consent to confidential HIV testing;
- Prohibit HIV testing as a pre-condition for entry into educational programmes, and develop laws to protect students and staff who have HIV from being excluded from schools and educational institutions on the grounds of their HIV status;
- Provide age appropriate HIV/AIDS and sexual health and development education in schools, educational institutions and in non-formal settings;
- Promote the involvement of people living with HIV/AIDS in providing HIV/AIDS education;
- Review school curricula to ensure that the content of educational programmes does not add to the stigma experienced by people living with HIV/AIDS and vulnerable populations;
- Ensure that all young people have access to HIV prevention tools and services;
- Eliminate harmful traditional practices such as early or forced marriage which increases vulnerability of female children to HIV infection, not only for biological reasons, but through reducing access to education, knowledge and life skills needed by female adolescents and women to make informed choices and protect their sexual and reproductive health within marriage;
- Protect children and young people against trafficking, abuse, neglect and sexual contact with adults;
- Promote responsible, objective and accurate reporting and provision of information by media;
- Ensure that the best interests of children and young people are a primary consideration in HIV/AIDS policies and programmes, and that the views of children and young people are heard and respected in HIV/AIDS policy making, programme delivery and decision-making processes affecting their rights;
- Take specific additional actions to protect the rights of children and young people living with and affected by HIV/AIDS particularly:
  - Ensure that children and young people infected with HIV have sustained and equal access to comprehensive HIV/AIDS treatment and care, including antiretroviral therapies.
  - Prohibit discrimination against children and young people living with or affected by HIV/AIDS in health care, schools, employment and social services.
  - Prevent the segregation of children and young people living with HIV from other children.
  - Eliminate barriers that keep the poorest children and young people from accessing health care and education.
  - Develop and implement policies that provide children without adult caregivers with placement in family environments, including strengthening community systems of care.
  - Develop standards, guidelines, screening criteria and monitoring mechanisms for residential placements to ensure that children are only placed in institutional care when no better options are available and only until family or community placement can be made.

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