

Hilary Benn, Secretary of State for International Development, World AIDS Day speech at the London School of Economics, 30th November 2006

Thanks. I'm very pleased to be speaking here at the LSE, and to be doing so on the eve of World AIDS day. You have a long and distinguished career helping in the fight against AIDS and at the LSE. We are very pleased to support your work, including supporting this series of lectures.

AIDS involves the most intimate of human behaviour. It is bound up with poverty and economics, with health care, social attitudes and culture, and it is research like yours that helps us better understand the disease and deal with it in a more effective way.

It has been over twenty five years since AIDS was first discovered. Since that time, twenty five million people have lost their lives to this disease, most of them in Africa. Communities have been ripped apart. A generation of hard working people has been wiped out, leaving a growing number of old people and children dependent on a shrinking labour force.

Fifteen million children have lost a parent to AIDS. What does that mean? It means they lost the person they depended on more than anyone else in the world. It means they lost the squeeze of a hand, the whisper of encouragement, the words of experience that our parents give us.

And, as the UNAIDS report made clear last week - almost forty million people are living with HIV. And while the numbers of children infected and dying as a result are declining, the numbers of infections are still growing, with young people making up 40% of those.

And although, the majority of people with AIDS live in Africa, the epidemic is actually growing fastest in eastern Europe and central Asia – above all in Ukraine and Russia, where the majority of infections are due to drug users sharing needles.

Now, we are making some progress.

We worked very hard last year at Gleneagles and got agreement from the G8 to support universal access to treatment by 2010. Under our EU Presidency, we agreed, what is I think fair to describe as, a progressive approach to HIV prevention, and published the “EU statement on HIV prevention for an AIDS free generation” which commits the EU to take action. We also agreed measures to prevent drug users here in the UK being infected through our policy on harm reduction.

And then at the UN general assembly special session on AIDS in June this year, all governments agreed to work towards trying to achieve comprehensive HIV prevention, treatment, care and support by 2010. And as donors, we agreed to ensure that for all poor countries, no credible and costed national plan to tackle AIDS should go unfunded.

Now those are the commitments.

Is this enough? No it's not. It is progress? Yes, it is. And we have to do more.

I think this requires two things.

One – we need to increase our efforts to achieve the 2010 target.

Two – we need to end the stigma and prejudice, because if we don't do that, we will not achieve it.

And, how will we achieve the 2010 target? Well, there are ten times more people on anti-retroviral treatment in sub-Saharan Africa than there were three years ago. That is one million people benefiting. I was in Malawi 4 years ago. I met Justin Malawezi. He was trying to work out how to make treatment available and it was the very first country to provide ART. But that's only a quarter of those who need it. And in Asia, an even smaller proportion of those who require treatment are at present getting it.

So we have a lot, a lot to do. What needs to be done?

First, countries in the front line must set out how they intend to defeat AIDS. These plans for tackling AIDS – which must include costs – are about building the clinics and the hospitals, getting rid of the user fees so that people can seek help. It's about employing the doctors and the nurses. It's about doing the tests. It's about buying the anti-retroviral drugs, and offering the treatment.

Secondly, these plans have got to have targets so we can measure progress, country by country. That is why, we agreed at UNGASS in June that countries would set ambitious interim targets for 2008 so that we can see how far we have got – and how far we have yet to go – to reach our goal by 2010. And the great merit of openness about progress on these targets means that people are better able to hold their governments to account for the promises that they have made.

Now, according to UNAIDS, 44 countries have now set clear targets against which the success of prevention, treatment and care programmes can be measured. And over 20 countries have produced full AIDS plans showing costs.

Thirdly, universal access to prevention and care and treatment will be impossible unless decent healthcare is available in every community, every village, every town and every city; unless every child who has lost a parent to AIDS is properly cared for, and unless all girls are in school.

Fourthly, donors need to back these AIDS plans and also provide long-term, predictable funding for health plans and education plans. And that's why the promises made at Gleneagles to increase aid by an extra \$50 billion a year, with half to Africa, by 2010 are so important. It's why replenishing the Global Fund matters.

And it's why debt relief matters. A quarter of a million people marched in Gleneagles to call for debt relief. And we worked hard to get an agreement to cancel up to \$55 billion of debts owed by poor countries. Already, the debt of 20 countries has been cancelled. What does it mean? It means that every penny they owed to the World Bank, the IMF and others is gone. It means that, in Zambia they have been able to provide free health care for the first time.

That is why the UK is playing its part as the second largest donor on AIDS in the world, spending £1.5 billion over three years. It's why we are giving £100 million to the Global Fund.

And it's no doubt the Global Fund has played a major part in getting people onto treatment. By the middle of this year, it had helped half a million people to do so, and had reached nearly six million people with counselling and testing.

Take an example – Malawi, where nearly a million people are infected out of a population of twelve million. With government leadership and help from the Global Fund and donors like the UK, the number of people getting treatment has risen from 4,000 in 2003 – it was hardly anyone when I was there in 2001 – to 70,000 in September this year. And because a strong leadership has helped keep the adult prevalence rate down to 14% and it's falling.

And in addition to our support for AIDS programmes, the UK is directly helping the government of Malawi to improve health services through a £100 million programme over six years. Malawi has a very high loss of health workers, partly because they are dying of AIDS. The support helped double the number of nurses, triple the number of doctors, and to retain them through better pay and conditions. The programme started in April this year and already 700 nurses, who had left the health sector in Malawi, have now returned.

As well as funding treatment programmes directly we are also taking steps to help others to lower the price of drugs and increase the range of drugs and tests available.

We are supporting, for example, the development of drugs in easy-to-use forms for children, through joining a partnership with the US, the UN, pharmaceutical companies and the generic drug manufacturers.

Desperately needed. Why? Because AIDS did not emerge in the west as a disease affecting children. So, surprise, surprise, no paediatric treatment became available.

And in September this year we agreed to be a founding member of UNITAID, the new international drug purchasing facility. By providing predictable and long-term funding to buy drugs it will help lower drug prices, and so help get more people on treatment, improve access and increase coverage.

And predictable finance is really important, because as finance minister you need reliable funding to pay the doctors and nurses, run the clinics, buy the medicines. That is why we bust our gut over debt relief so governments don't have debt repayments each year and can pay for doctors and nurses.

UNITAID's first board meeting in October was quick to agree \$70 million of support to expand second line therapy – where first line ARVs do not work - to 100,000 patients, and approved \$36m to fund ARV treatment for up to 100,000 children in 2007.

And today we got the news that the Clinton Foundation got the prices down for paediatric treatment. They reached an agreement with CIPLA and Ranbaxy to lower prices by 45%. Well done to them.

And, the UK has made a long-term financial commitment to UNITAID over a 20 year period. We will contribute £15 million in 2007 and – depending on UNITAID's performance – will gradually increase our contribution to £40 million a year by 2010.

But this is not the only way in which we aim to reduce the costs of drugs. As our recent white paper – we published this summer – pointed out, we also need to look at how we can make the pricing of antiretroviral and other drugs more transparent so that the costs of production and the tariffs imposed by countries are clear to everyone.

Because if you have more transparency it means we will be able to track the costs and value added to the drugs from the production line to the people who use them. And this is really important to ensure that lower production prices mean lower prices for the end-user.

The other advantage of increasing public scrutiny in this way should reduce corruption and also help to bring down the cost of drugs to the people who need them so desperately.

Now, while treatment is the key to keeping alive people living with AIDS today, prevention is the key to achieving an AIDS-free generation tomorrow. And that, frankly, is what we all want.

And the truth is, prevention will not be successful unless it is directed at those most at risk of infection – young people, women and girls, men who have sex with men, injecting drug users, sex workers. The very people most often discriminated against – whose rights need to be protected.

Women make up two thirds of the people living with HIV in sub-Saharan Africa. Clare Short used to say 'the face of AIDS in Africa, is the face of a

young woman' and she is absolutely right. In some African countries, young women are almost 3 times more likely to be HIV-infected than men of the same age. Why? Discrimination against women – social restrictions, violence or fear of violence, lack of financial security – that's what makes women more vulnerable to HIV.

Sex between men accounts for up to 10% of global HIV infections. Yet UNAIDS reports that fewer than one in twenty men who have sex with other men have access to HIV prevention and care services that they require.

In Ethiopia, up to three quarters of female sex workers are infected with HIV. Yet some donors debate whether it's right to provide condoms to them. Some donors even place restrictions on working with them. This simply isn't right and it simply isn't sensible.

Injecting drug use accounts for about a third of new infections outside sub-Saharan Africa. But less than 5% of drug users have access to harm reduction services – like needle exchanges. So that's the nature of the problem.

So what are we doing about all of this? Well, we're making the case about the importance of meeting these needs of these vulnerable groups, and making the case on the importance of sexual health and rights. And we are doing our part to ensure that these groups get the services and support they need.

In Swaziland, two thirds of girls who are in school are free of HIV compared to two thirds of girls who are out of school who have HIV. In other words, education is in effect a social vaccine against AIDS. So one of the best ways to help girls avoid HIV is to get them where they should be – in schools with a desk, a classroom and a teacher. It's one reason why we are helping countries get all children into school is putting our aid money into a £8.5 billion programme to support ten year education plans in poor countries.

Secondly, condoms save lives. This shouldn't now need saying or repeating, but not everyone has got the message. But they are in short supply. Since 2001, the UK has paid for over a billion condoms. Every second, fifteen UK supplied condoms are used, every hour, over 50,000 condoms, and yet in Africa there are still only enough to provide around eight condoms for each man, each year. Not enough! Over 200 million couples have an unmet need for contraception.

There's a lot of evidence that harm reduction programmes – needle and syringe exchanges included – work in preventing HIV infection among injecting drug users. That is one of the reasons we have lower rate in the UK. We are working with a number of governments to help ensure that drug users have the right to medical, social and economic care. DFID funded programmes in China helped convince the government to build up and expand their own harm reduction programmes. The Chinese government has seen it works and they are making a real difference.

Now, improving services will be crucial for achieving universal access, but it is only part of the story. Because we also have to ensure that people can and will use the services. So not only supply but also about demand.

And the truth is – and I am a great believer in telling the truth – if we do not end stigma and discrimination and do something about gender inequality we will fail to achieve universal access

Why? Because we know stigma, prejudice and discrimination against men who have sex with other men, against sex workers and injecting drug users is actually stopping people from getting the essential information they need, services they need, condoms they need and needles they need. And more services won't help if people are unable or afraid to use them.

Many studies show the problem:

Human Rights Watch, for example, found in Ukraine and Russia that injecting drug users often avoid needle exchange points. Do you know why? Because police officers patrol these sites and they randomly abuse or arrest those that come to exchange their dirty needles.

A woman in Ukraine, as part of this study, described how fear of such abuse not only forces her to share needles, but also denies her access to care at the needle exchange point. It is not a very sensible thing to do, is it?

Some women don't seek out HIV testing. Why? Because they are too afraid of what their husband or family will do to them if they turn out to be positive. I learnt of a Somali woman called Idil, who was widowed at sixteen and inherited by her husband's brother, who was then beaten by him and then abandoned once he discovered she had HIV. We know about it, because she is now receiving treatment through a DFID funded programme.

And people living with HIV too often face discrimination by health care workers. Research done by the Asia Pacific Network of People Living With HIV and AIDS shows that one in four people said they were discriminated against. What does that mean? They were forced to wait longer, made to pay more, or in some cases just turned away because they're HIV positive.

What these and other studies show is that around the globe, fear of stigma and discrimination is keeping people from accessing the information, is stopping people from coming forward for counselling, testing, treatment and care.

In Southern Africa, as we know, TB is the largest cause of death for people with HIV and AIDS. And yet, in Zambia now, many people diagnosed with TB – who may only have TB - avoid treatment. You know why? Fear that people will think they also have HIV. Another example of stigma and discrimination.

Here in the UK – where our approach to stigma still lags behind our ability to treat – stigma leads to vulnerable groups such as gay men and such as

African communities living here avoiding testing. And there are disturbing reports about people in prison being discriminated against.

Again and again discrimination means that those who are most vulnerable to the disease can't or don't get access to the information and services needed to prevent and treat it. And thus the virus continues to spread and we continue to have this major pandemic on our hands.

Truth is, we also need to recognise that it's also about the lack of power that marginalised groups have in their lives. And it isn't just an issue for injecting drug users, men who have sex with men or sex workers. This is also an issue for women and girls. Across the globe, women have always been the shared face of poverty; but now in Africa they are also the face of AIDS.

And that's way, in South Africa young women are four times as likely to be infected as young men – 30% of pregnant women in their early 20s infected. In Lesotho, less than 10% of young women in their late teens are infected but by the time they get to their early 20s, that rises to 40%.

Now why are there are many women and girls living with AIDS? The answer is because they don't have a lot of control over what happens to them. They sell themselves for money and food. What they need is to be able to say – “you are going to use a condom if we're going to have sex”. Men and boys need to respect these decisions and understand that “no” means “no”.

Now these changes are going to take time, but we need to act now to help women have more control. And that is one of the reasons why we are investing more in research into microbicides. They're being trialled in Africa at the moment. If, and it's a big if, they work they will provide a means that would enable women and girls to protect themselves from HIV.

Education is crucial for girls and so is economic empowerment. We partly funded a study, called the IMAGE study, that found that providing women with microfinance as well as education about HIV can transform their relationships with men and reduce domestic violence by a half.

This study in South Africa - and I'm sure some of you are familiar with it - is an excellent example of a really practical way of dealing with a very, very complex issue. Its approach helps give women more choices about what happens to them and more power, and it is that which is helping change the lives of those most at risk.

And we all – not just governments – need to work with women and men to challenge the imbalance of power, and to talk about sexuality and sexual relations, and to emphasise safe, pleasurable, respectful, and consensual sexual behaviour.

Sounds at one level pretty easy, eh? But not always a comfortable thing to do.

Truth is some people get embarrassed when talking about sex. Others have a problem with it. The truth is that human beings have sex – we wouldn't be here tonight if that wasn't the case. I always say people should not die because they do have sex. That is really what we are talking about here – people should not die because they do something that is so natural to us.

Abstinence is fine for those who are able or can abstain, but condoms prevent infection for those who can't.

It means we have to be honest about what the problem is and tell the truth about what works. And it means giving people the information and services they need to protect themselves.

Some people inject themselves with drugs. We have to face up to the fact that they do, whether we like it or not. So having harm reduction programmes, having needle exchange, will minimise the risk of HIV transmission. It is the right and sensible thing to do.

Some people are sex workers. Some men have sex with other men. These activities can be risky. But they not need to be if you act in the right way.

That is why we have to end the silence and the denial that there is around sex, including male-to-male sex, drugs and AIDS. Because it makes it harder to get accurate information across and services available. And it makes it harder to ensure that all of the people who need to be reached, are reached.

And the truth is, we can see that in countries where there is much greater openness and honesty about the nature of the threat that HIV presents, progress is being made – Brazil, Thailand, as well as parts of India, Kenya, Malawi – in fact prevalence amongst young people has fallen in five high prevalence countries in Africa.

And I think, one of the best ways of overcoming this denial, stigma and silence is by people living with HIV and AIDS speaking out. Around the world they have led the way in speaking out and breaking the silence. They have led the global movement to increase access to treatment. They have been responsible for innovations such as treatment literacy, positive prevention and home based care. They have held those not taking sufficient action to account – whether it's governments or whether it is development agencies.

And more than anything else, people living with HIV and AIDS and their organisations have demonstrated their ability to challenge the abuse of the rights of those living with HIV and AIDS and of groups vulnerable to HIV.

And that's why this year we, as DFID, have supported such groups – the Global Network of people living with HIV and AIDS, the International Community of Women Living with HIV and AIDS, the International Treatment Preparedness Coalition – to help them to have a louder voice and to help them have it heard by others.

But other people need to speak out too. Tackling stigma cannot be done by those living with HIV alone. Attitudes will not change unless leaders do the right thing too.

And I say that because above all, tackling stigma and discrimination is about political and moral leadership – politicians, religious figures, communities, the media, campaigning organisations, and each of us as individuals on how we behave - we too can lead in our own lives by our own actions.

Because we should have learned by now that we can't let discomfort or prejudice or embarrassment get in the way of saving lives.

We should have learnt by now that we can beat this epidemic if we put our minds to it. And that the doing so is one of the ways in which we can best express our common humanity as together we seek to build a better world.