

Keynote Speech at Global Partners Forum by Gareth Thomas, UK

Minister for International Development

At Lancaster House, 9 February 2006

Ladies, Gentleman, distinguished guests. I am delighted to welcome you to the Global Partners' Forum on Children affected by HIV and AIDS. The UK is pleased to be co-chairing this meeting with UNICEF. We know this will be a productive conference.

This is a crucial time in our efforts to tackle AIDS. 2005 saw real progress – through the Gleneagles and World Summit commitments on universal access to AIDS treatment; through a strong commitment from the EU to HIV prevention based on what works; and through pledging \$3.7 billion for the Global Fund. In 2006 our challenge is to build on this progress, and to turn these commitments into concrete actions.

Our work today and tomorrow will be central to ensure that the Global Steering Committee on Scaling Up Towards Universal Access, the UN high level meeting in June, and the International AIDS Conference in August focus on the needs of children, and prioritise action for children affected by AIDS.

For the first time, this Global Partners Forum has been preceded by a technical meeting, including civil society representatives. Recommendations from this meeting should inform the conclusions we reach here.

So what are the blockages to achieving Universal Access? There are 6 priority areas that we will focus on.

First, **national planning and monitoring**. We must implement the Three Ones – One agreed AIDS action framework, one national AIDS coordinating authority and one agreed country-level monitoring and evaluation system.

We must support governments to develop their own responses, and to strengthen their child strategies, integrating them into their national AIDS strategies and into Poverty Reduction Strategies.

We must seek to use the momentum around Universal Access to deliver ambitious country plans to reach more children affected by AIDS.

Second, children must have adequate **legal protection**. Stigma and discrimination are damaging the lives of children affected by AIDS, and limiting effective responses to address children's needs. We know that children affected by AIDS are vulnerable through poverty, loss of parents, exclusion from education, exploitation, violence. The social stigma and discrimination associated with AIDS deepens vulnerability, preventing children from accessing basic services.

How can we ensure care for children whose rights are denied through unequal inheritance laws? How can we protect children who are not registered at birth?

The UN Convention on the Rights of the Child – enshrined since 1990 - recognises the right of children to birth registration; but, still, 48 million children around the world are not registered at birth. Third, **community organisations** play a vital role in supporting vulnerable children – holding governments and donors to account, providing basic services and challenging stigma.

Community organisations can often reach and communicate with people that governments can't. We know about the excellent work of the Kenyan Network of Women with AIDS (who support more than 1,000 AIDS orphans), of the Matthew Rusike Home in Kenya (which provides care and support to more than 6,000 orphans) and volunteers on the “Young People We Care” programme in Zimbabwe (which supports over 5000 young people to care for the sick, and provide support to bereaved families). But their brilliant work is often compromised through intermittent and unreliable funding.

Getting the money to those in most need is crucial. We must ensure, as donors that we support organisations in ways that recognise their limitations - in a predictable and flexible way. DFID is working to address these issues in a number of countries, including by funding umbrella organisations, setting up flexible pooled funding for community organisations and investing in their capacity. But more needs to be done to help community organisations fulfil their potential.

Fourth, **Education** has been identified as the 'social vaccine'. Experience in Uganda has shown that girls who complete secondary school are least likely to acquire HIV. And education has the potential to underpin and reinforce community efforts. Education can tackle social stigma, provide knowledge and skills, and empower girls and boys to protect themselves from infection.

We must dismantle the barriers preventing children affected by AIDS from attending school. Experience shows that the removal of school fees is one of the most significant ways of making a difference. In Zambia, since the Government removed user fees in 2002, girls' enrolment at primary level increased from 65% in 2000 to 81.5% in 2004.

Fifth, on **health care**. We have cheap, simple and effective programmes to prevent mothers transmitting HIV to their babies during pregnancy and childbirth. In rich countries programmes have proved to be resoundingly successful. We must replicate these results in poor countries, breaking the inheritance of HIV infection across generations.

The price of first line antiretroviral (ARV) drugs has reduced dramatically in recent years, but ARVs for children can cost more than six times as much as drugs meant for adults.

Where child-friendly drugs exist, but are too expensive, the price must come down. Pharmaceutical companies can help, including through differential

pricing. Voluntary licensing and bulk procurement are also central to improving the situation.

We also need new and better drugs for children. Drugs in syrup form are expensive, have to be kept cold and taste awful; carers often have to break and crush adult tablets to give to children, which risks under or overdosing.

We need appropriate drugs, including fixed dose combinations, if we're going to really scale up access for children. In time, this will also be an issue for second-line drugs, which for adults can currently cost more than 10 times as much as first line treatments.

But drugs are of no use if national health services cannot distribute them and get them to the right people, with the right advice and oversight. Support to health services is important, as is support to national regulatory authorities.

When we have new products it is important that they are approved as quickly as possible.

The cheap antibiotic cotrimoxazole, which DFID-supported research showed reduced mortality in children with HIV by as much as 43%, remains unavailable to the majority of children in desperate need. Health ministries and health workers need to look urgently at their practices and step up access to cotrimoxazole.

Diagnostics are also a major problem. Diagnosing HIV in children is complex and expensive. Improved testing techniques are needed to enable rapid diagnosis in newborn babies and children in developing countries.

And the final issue for debate is **social welfare** - to ensure a minimum standard of living and the ability to access essential services. We know that social security is affordable in even the poorest countries. So, how can we ensure social transfers such as child benefits and social pensions are possible in developing countries?

Experience in rich countries has proved that social welfare is central to proper support for the most vulnerable of children. We need to help make it a reality for the millions of children affected by AIDS across the globe.

These 6 key issues – of national planning, legal protection, community mobilisation, education, healthcare and social welfare – will structure our debates today and provide the basis for the recommendations you will form tomorrow.

We are at a critical moment.

The world is focused on achieving Universal Access to comprehensive AIDS programmes. We must ensure that children are an integral part of that ambitious goal. To build on the momentum generated in 2005, we must go beyond 'business as usual'.

Tackling AIDS in children is not simply a political choice, it is an obligation.