Monday Plenary
Kaiser Family Foundation
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DEBREWORK ZEWDIE: Debrework Zewdie, I'm the Deputy Executive Director of the Global Fund. It's both an honor and privilege for me to introduce our first speaker, you know he is the 42nd President of the United States, the first Democrat to be awarded two terms in six decades and the leader whose administration created more than 22 million jobs and presided over the longest period of economic expansion and prosperity in the U.S. history.

But there are some things you might not know about Bill Clinton, the private citizen. He started one of the fastest growing NGOs in the world. Today the Clinton Foundation has staff and volunteers worldwide. Thanks to his leadership 2 million people living with HIV/AIDS around the world are now receiving the medicine they need to survive [applause].

The Clinton Global Initiative has brought together thousands of world leaders, top business executives novel laureates, and innovative thinkers to take action to solve some of the world's most pressing problems. To date the Clinton Global Foundation members have made 1,700 commitments valued at $57 billion, which have already impacted more than 220 million lives in 170 countries.

Forty cities are working with the Clinton Climate Initiative to reduce their carbon footprint and make a significant impact in the fight against the global climate

change. The Alliance for a Healthier Generation, a partnership between the foundation and the American Heart Association is putting a stop to the rise in childhood obesity in the U.S. Alongside former President George Bush, President Clinton helped raise more than $130 million to help people along the Gulf Coast recover from hurricane Katrina. After the tsunami in Southeast Asia in 2004, he teamed up with President Bush to raise more than $10 million dollars for relief efforts, and served as the UN envoy for tsunami recovery, overseeing the regions efforts to build communities back better than they were before the waves swept them away.

Last year President Clinton was named the United Nations Special Envoy for Haiti to assist the people and the government as they built back better and set out implement their economic vision for the future building on President Clinton's long-standing commitment to Haiti, while in the White House and his work through the Clinton Global Initiative.

Following this year's devastating earthquake, President Clinton continued to work alongside the government and people of Haiti through the Clinton Foundation. In addition President Obama asked President Bill Clinton and President George W. Bush, to raise funds for immediate high-impact relief and long-term recovery efforts. In response the two established the Clinton-Bush Haiti fund. I think we can all agree the world wouldn't be the same today without President Clinton's more

than 35 years of public service. Please join me in giving a warm welcome, President Clinton [applause].

PRESIDENT WILLIAM CLINTON: Thank you. I'm very grateful. Thank you very much, thank you. Thank you very much.

First of all I want to thank Debrework for the introduction. I want to thank Anya and Vuyiseka for speaking earlier. John Mark thank you for representing the EU here. To Nora Volkow and my friend Helene Gayle, I know your part of the program is after I leave but I want to thank you. There are many people in the audience, probably hundreds that I've worked with over the years, but before I begin my remarks I have to say that I will attempt today to speak for the people who work in our NGO CHAI and I'm very grateful to all of them.

To Ira Magaziner and Neil Sony and Ed Wood and all the staff that work all around the world, many of them in countries where they live, to try to help save lives.

Many of our funding partners are here, but the other night at the local AIDS Life event, two of our partners in Cambodia John and Carol Tucker, were there with eight Cambodian children who participated in the event, who are alive today because of people like you. I want you to know, I've been at every meeting since 2002, and it seems now that I've spent a lifetime, which is a long-time for me, going to meetings where

people said wonderful things about whatever it was they came to meet about.

Then what happened afterward never matched their words. Here there's a lot of action to go to with the talk. That's why I came again and I will continue to come as long as you'll have me.

I want to thank you all for persevering through what is a challenging time. When we were in Mexico City we knew then that the economic crisis which was sweeping the globe would challenge our ability to get the needed funding, both public and private, to keep the AIDS movement going. A lot of you have done a remarkable job dealing with that crisis and I thank you for that.

I also think that we know quite well that there is still a lot to be done. This year's conference theme, Rights Here, Right Now, reminds us that healthcare should be a right for everyone, but isn't. Notwithstanding the current economic difficulties, the evidence of the progress that has been made in the last few years is not an excuse to walk away from that right. It's an excuse to run toward it for all of us.

Just think what's happened since 2002; increased investments at the most rapid rate applied to any public health problem in human history, in the last four years going up from six to $16 billion. Donor aide has been the primary source but we also have something relatively new, broad base giving by

private citizens in huge numbers, in large amounts, manifested most clearly for me by UNITAID, which is coming up on its fourth birthday.

It began with a simple, small airline tax on all international travel in and out of France. Now 28 other nations make a contribution to UNITAID every year, some from the airline tax. Norway kicks in a little from the carbon tax. Other people find other ways of doing it, but I want to say to all of you, I am profoundly grateful.

Now the country's who have not found it feasible to contribute, or to pass an airline tax, are being given the opportunity to participate through a voluntary, non-profit arm which has been called Massive Good. It was announced formally as being up and running just a month ago, so we haven't raised much money yet.

But essentially what happened is, three of the biggest airline bookers in the world, online bookers, have given us a box people can check when they book an airplane ticket to make a small, voluntary contribution. One of the things I'd like to ask all of you to do is to do what you can when you go home to get more people to buy their tickets at one of these places and to check the box.

We have a big public relations job to do, but if we did it, I'm convinced hundreds of millions or more dollars a year

could be raised easily from people who knew they had this user friendly option.

Project Red has flourished by allowing people to buy products that give back. They've given $100 million to the Global Fund. All of this is rooted in the simple idea that the best way to raise private money, once you get past Bill Gates [laughter], is to raise a massive amount of money in small amounts from a huge number of people. But to do it you have to make sure they know what the option is and it's reasonably user friendly.

I am really, really excited about the potential of this and profoundly grateful for the work that we've had a chance to do with our foundation CHAI with UNITAID. They asked us to try to negotiate lower prices for second-line drugs in pediatric AIDS medicine, following up on the work we did with first-line drugs earlier.

And look what's happened, second-line medicine has gone down from about $1000, to 425. The children's medicine when I started was $600 a person a year then it dropped to 190 now it's down to 60.

The new first-line combination, even though the least expensive first-line drugs are about $90, the new one, it's just one pill, once a day, has dropped in price 70-percent, so less than $200 per year. So we're doing pretty well. 5.2 million people are on treatment, about half of those under

prices that our foundation negotiated. And that 2.6 million is up 70-percent from the time we met two years ago.

All of you know that the incidents of HIV globally is down 17-percent this decade, but it's worth pointing out that the progress is even greater in places where people have taken a real determined step and I think all of us are thrilled about the new direction in South Africa, but its worth pointing out that women age 15 to 24 saw a reduction in HIV incidents of 60-percent over the last few years. So I'm thrilled about that. I'm thrilled that there are now 300,000 children on treatment and that we are closing the gap that once was a yawning chasm between adults and childhood treatment.

Another interesting thing that I want all of you to know about is that our foundation, which primarily deals with generic drug producers in India, South Africa and a handful of other places, negotiated its first agreement this year with a big American pharmaceutical company Pfizer, which makes a drug that as far as we know, is the only one you can take if you have AIDS and Tuberculosis to treat the TB that doesn't make you so sick you can't function. They gave us a 60-percent reduction in the price right from the beginning and this, for those of you who are familiar with the drug wars in America and elsewhere, this is quite a departure from past practice.

So I ask the new president of Pfizer, Jeff Kindler, I said why are you doing this? And I could tell he didn't expect

to be asked that and he smiled and he said, first of all, it's the morally right thing to do but he said, secondly we don't have a sustainable business model.

We cannot possibly go out 50 years just marketing all our products to 10 to 15-percent of the world. We ought to sell to 100-percent of the world and in order to do that our unit costs have to go down. That was the best news I'd heard in a long time. So I hope we can build on that in the years ahead.

Along the way, a lot of us over the last decade have formed remarkable partnerships. The Global Fund has been instrumental in this, because NGLs get about have the money from the Global Fund and they're represented along with people living with HIV and health care providers and governments, in the deliberations of the Global Fund. So I'm very grateful for that and I think it's been very successful to our success.

I have to say, just by way of personal indulgence because of my experience in Rwanda, Malawi and Haiti, I'm especially grateful for our partnership with Partners in Health and Dr. Paul Farmer and if you want to help Haiti to build its first national health system ever. Number one, don't let anybody tell you it can't be done, don't let anybody tell you that Haitian's don't have the ability to do it. And if you want to help see Paul Farmer before this is over [applause]. I hope I have made a lot of work for him on this.

I also have to tell you as a non-scientist I'm very excited about what we have learned in social science research. The first time I heard about the first circumcision study my instinct was it would work. And I was cautioned not to just go half crazy and advocate it all over the world until we had some proof.

Well we now know things we didn't know two years ago. We know circumcision reduces transmission in excess of 50-percent. We know treatment can reduce transmission by 90-percent. We know we have new tools that just two years ago we didn't have. New drugs and point of care technologies that bring care closer to people who need it.

CHAI helps accelerate how quickly these new technologies get out there in places like Mozambique. And thanks, in no small measure, to Irish Aid. We're working with the government there to use new point of care diagnostics. A simple hand-held machine that can tell someone in any remote rural village, right then and there, what their CD4 count is. If we're going to use the CD4 count for determining when to start treatment early, we need these machines in every rural place in the world that can have it [applause].

I also want to say as most of us in this audience know, before this meeting is over, there will be some very encouraging news on the scientific research front, and I believe there will be more in the next couple of months. I

just want to say that I think the microbials will get better. I think that we'll get closer to a vaccine. I think we'll get closer to easy to take other preventive mechanisms. All this is good.

But to paraphrase what Winston Churchill said when the British finally started winning a battle or two in World War II, this is not the end, it's not even the beginning of the end, it is only the end of the beginning. In other words, we've ramped up, you've done a great job, but we have to transition now from what is essentially been a make it up as you go along, emergency response, to one that we can sustain. Five million people in treatment is a lot compared to where we started but still just a third of those who need treatment today. We cannot get to the end of this epidemic without both more money and real changes in the way we spend it.

I think it is profoundly important that we think about both. Now, for whatever it's worth, this is what I think we should do and I will do my part. First obviously this is a replenishment year for the Global Fund. So the donors need to replenish. Second, in every country we need to fight the temptation to present the choices involved in a way that really creates as false dichotomy.

The current debate in the United States and elsewhere, in the GA, you know between treatment for AIDS and maternal and

child health and building out health systems is a movie we have all seen before. It just had different characters.

First there was the choice we had to make between treatment and prevention. Then people figured out if they couldn't get any treatment why should they practice prevention. Then there was the choice that we were supposed to have to make between kids and adults, because even though there were fewer materials in children's medicine, the numbers were so different, that the cost be higher. Now, it's much lower. Then there was the choice between effective prevention for drug users, and continuing to take a stand against illegal drug use. And now we know that the more provide effective treatment the more drug use goes down, not up [applause].

But there are real choices and hard decisions to make. But if we're going to make hard decisions they ought to be real choices, not false ones. The facts are on our side. Let me just give you an example of why I don't think the choice between putting people on treatment and doing more on maternal and child health, or building stronger health systems, is the real choice.

It's not a coincidence that we have 35-percent fewer children dying every year, now than 20 years ago, or that maternal mortality has dropped by 20-percent in the very same decade in which the Global Fund and PEPFAR channeled more money into global health than ever before.

The fight against AIDS has raised a lot of votes. To fight Tuberculosis and Malaria, to improve health systems, to challenge and motivate governments and NGOs a like, to deliver more and better health care. Fighting AIDS in the right way, clearly improves maternal and child health. And the work that we do at our foundation on PMTCT, our first measure is not an AIDS indicator.

It's whether or not we're increasing attendance of pregnant women and prenatal care, and rates of women delivering with a skilled birth attendant. Seeing those numbers rise will lower the number of children born with HIV and advance maternal health.

And it works the other way around, if you invest in maternal health, you're going to lower HIV transmission, by educating girls on reproductive health, getting them into care when they're pregnant, helping them to deliver at a clinic, or with an attendant.

If you invest in children's health you ensure infants are coming in to get vaccinated. If you have HIV diagnosis available when they do, you can increase coverage for pediatric AIDS treatment. We all know the fight against AIDS is also a fight for improved health systems. When I was in Tanzania last month—

MALE SPEAKER: [Speaking a foreign language].

PRESIDENT WILLIAM CLINTON: —and the child was, as a matter of course, screened for HIV and thank goodness was born HIV negative. We don't have to worry about treating that child but one reason we don't is that the child's mother is part of a health care system that could take care of her and every mother like that in that area that needs the medicine to prevent mother to child transmission can get it. So, I don't think these two things are in conflict.

Now, there is a real choice to be made, but it's not the one we've been told about. For example, if you really want to increase health care systems and to increase treatment, we have to have more qualified health care workers. Africa has 10-percent of the world's population, 25-percent of its health burden and 3-percent of its health care workers. We need more people in the health care workforce. Specifically we need people who can do good work, at lower cost, over a wider geographic range, than doctors can do alone in poor countries, or than doctors or nurses can do alone.

In Zambia we've worked with the government to add a thousand health care workers in less than 18 months. This didn't take very much new money. What it took was different organization and determined local leadership.

We also shouldn't have to choose between treating people in the developing world and the rise of HIV again in countries with higher GDP's. AIDS remains a real challenge in

America. Prevalence among Black men is 3-percent and AIDS is the number three killer of African American women in their prime. And the economic crisis has also hurt domestic care. The Federal AIDS Drug Assistance Program has also not continued to keep up with demand. Even in the United States for time in years and years there are 1600 people on waiting lists in a dozen states.

Recently President Obama announced a new focus on our domestic challenges and I'm encouraged by that. But I would also like to say that the domestic drug manufacturers in America who provide our medicine have been paid for years now at roughly $10,000 a person a year. And they have recovered enormous amount of their cost. They could take care of those 1,700 people tomorrow, fairly allocate the burden, and never miss it [applause] and I think that's what they should do.

Now, let me say, of course we should do the things that I said and of course they will require some more money. But I think there is another false choice that it would be easy for us to avoid. We also have to change the way we do what we do. The world is awash in trouble. It is easy to rail at a government and say why doesn’t the government give us more money, when they're giving somebody else money. But the government gets its money in most of these countries from tax payers who have lower incomes today than they did two years ago. So if we're going to make this case they have to believe

that we're doing our job faster, better, and cheaper. And then we have the moral standing to go ask people to give us more money.

So I want to offer a few observations on that, and I'd like to start with a few comments about the controversy over PEPFAR funding. That's a great thing about not being president anymore, I can say whatever I want [laughter] [applause]. Of course nobody cares what I say anymore but I can say it anyway [laughter]. But I really do want to talk you through this.

A couple of months ago Bill Gates and I were invited to testify together before the Senate Foreign Relations Committee. On President Obama's proposal developed by the State Department, by Hilary and by our new AID Director to invest more money in building health systems around the world. And both of us said, in different ways, that we supported the legislation but we didn't think the AIDS funding should be held now. And we made most of the arguments I just made to you.

But, let me just talk a little bit about what happened and offer some observations on what to do. First of all I completely understand why the advocates for great AIDS funding have loudly protested but I do not think it is either fair or accurate to say the President has gone back on his promises as if this was a callous walking away. When he signed that petition saying he would support greater AIDS funding, it was

before the American economy led the world into the worst financial crisis since the Depression.

Since then he has tried to keep his commitments. Even I read all the right-wing tabloids and blogs at home, even his worst critics will admit that he tries to keep his commitments. That's why they don't like him, because they disagree with what he's doing. But in the last year and a half, we have passed a massive financial stimulus bill, dramatic increases in investment in alternative energy, lowered the cost of a college education by providing direct loans. Just the other day, financial regulation to stop these excesses from occurring again and a sweeping reform of American healthcare. This is a man who tries to keep his commitments.

The budget reflects what they believe was the limit that Congress had put on overall healthcare assistance spending. And the pressure that the United States Government and the G8 got from the governments of the countries where we work to spend more money on health systems and maternal and child health. Now, what we have to do therefore is to deal with that fact.

You have two options here. You can demonstrate and call the President names or we can go get some more votes in Congress to get some more money. My experience is that the second choice is a better one and far better pay off. There is

no way the White House will veto an increase in funding for AIDS.

And so I appreciate how frustrating it is and as I told all the folks that are involved in this, I said the problem with this position and I realize they are in a terrible bind, but sometimes I had to do this, sometimes by prior arrangement, I would meet the House budget ceilings. For example, I would always put more money into early childhood education and believe it or not, it was in the same budget as the National Institute of Health and then Newt Gingrich of all people, would put more money into medical research because even our republicans want to live forever. [Laughter]

Then in the end, because nobody wanted to be seen as cutting education and everybody wanted to be seen as being for medical research, they simply raised the cap. It was a deal. We would work something like this I hope. Maybe it's harder now that I told you what we did. But, I just want to say I think in the end, everybody will have to come around to this.

Because if they pass more money for maternal and child health, they're going to find more mothers that need the PMTCT treatment. If they do this, they're going to find more kids that need ARVs. And if they build more healthcare systems, I can assure you based on our experience in Ethiopia and Zambia and Malawi and Rwanda, and every place you work, they're going to have a lot of people showing up for treatment.

And who wants to build a nice new clinic that is nothing more than an office where someone says no? Thank you very much for coming in, here's your health status, now go away. So we're in a very difficult position here that we can work our way out of over the next two or three years, but I just want to urge you not to assume the bad faith of the White House or the administration.

The Director of PEPFAR, Dr. Eric Goosby is here. He had the guts to come here. He ought to get some kind of Purple Heart for showing up. [Laughter] Stand up Eric. Give him a hand. [Applause] Now what I want you to know is this is important. This man is your friend. He's been working on AIDS since before maybe the youngest people in this room were born. He went to China for our foundation to set up the AIDS program we did in China. He is a good man.

The other thing you need to know is that just last week he released new guidelines confirming that our funds can now be used for needle exchange to prevent HIV among injection drug-users. [Applause]

And finally, you need to know that the U.S. held off one year longer than most of the major European contributors to the global fund and shaving the contribution. But the European countries I think would like to do better too. So as all of you know, or many of you do, the new director of AID in the

State Department formerly worked for the Gates Foundation. He is your friend too.

I think you should have a joint strategy and I think you should lobby to Congress and I think you should educate people about not making a false choice. And I think that is a far more effective strategy.

Now, then the second thing I would say is we have to remind ourselves that more of the same is not good enough. Yes we've made progress on prevention but we don't do very much of it. And we know the AIDS epidemic won't end with the treatment options we have now. It will only end when we stop new infections and no one dies before their time. We're not doing enough ourselves.

First we have to do treatment better, specific drugs that can keep people healthy even when they aren't on ARVs. Better integration between HIV and TB therapy. Amazingly these two diseases although they are most often coincident in one body are still treated separately in most places. We need better and more durable combinations of drugs and testing that is simpler and quicker.

We have to do prevention better too. We have to scale-up what works. I'm thrilled that we now have indisputable evidence that circumcision works. We also have indisputable evidence, and Bill Gates will talk more about this when he speaks, that all these cultural things we were told about how

African men will never show up and do this turn out to be flat out wrong, that there's more demand for it than we thought, but there's not enough supply yet. And it has to be done in a safe way.

So we have to do more of it and we should invest more money in it. We have to target the right approaches to the communities based on the source of the highest rates of transmission. There are too many places where the main source of transmission is still men having sex with men and the political apparatus acts like it's not happening, they're in denial or they just got to be some sort of stigma attached to it. Meanwhile, people get sick and die.

We have to do something about that. There are too many places where the main source is injection drug use and there's no political constituency, so the first time there's a bump in the road that's easy to cut them off and think it's their own fault, in spite of the fact that as I said, and I will say it again, all the evidence is if you do substitution therapy and clean needles, drug use will go down, not up.

So, we need strategies that deal with the real issue. And we need to translate the latest science, not just in the pilot projects, but on a broad scale. This again cuts against flat lining either the global fund of PEPFAR now that we know the treatment may be the best prevention strategy we have. The numbers are very, very high. It's really important.

Look at the people who just were up here speaking before me. In Europe and Central Asia, the AIDS epidemic is driven primarily by intravenous drug use. We know what works, [inaudible] reduction.

And our foundation, for example, works in Ukraine and we've helped to get methadone moving there. But nobody's done it to scale. And we can no longer say we need to let 1,000 flowers bloom and pretend everything worked as well as everything else. We've got evidence now, and we don't have all the money in the world, we should find what works.

The third thing we have to do is to cut the cost of delivery. And I want to say a little about this. This is one of the things I guess I can do since I have been President and therefore, I was partly responsible for this for a period. In the last decade, we developed kind of an emergency model of channeling money through established organizations in respective countries that had fairly high upfront costs to get things started.

I think we need to change to a model where we fund national plans in developing countries more directly, with more funding to the governments and the local organizations who can delivery services well at far lower costs and less overhead.

I think in too many countries, too much money goes to pay for too many people to go to too many meetings and get on too many airplanes and provide too much technical assistance.

[Applause] Too much is spent on studies and reports that sit on shelves. And maybe when we got all the money in the world, this is regrettable but not tragic. But keep in mind, every dollar we waste today puts a life at risk.

It is time for the United States to lead the way and for other governments to be similar soul searching and hard-headed analyses, to see how we can take a higher percentage of every country's foreign aid budget and actually spend it in the countries that the money was appropriated for on the people the money was designed to help instead of on the apparatus and on the country in question.

And as I said, I don't want to blame anybody and I don't necessarily think there are any demons here. I was President for eight years and I had no idea this was as bad as it was. I was always attacked for knowing too much about the budget, turns out I knew too little.

But we can fix this. And the next thing I'd like to say is I think we help other countries to know they should change their own delivery systems. I mentioned that we've done work in other places, but we should be shifting tasks in any kind of new healthcare system from doctors to nurses where possible and from nurses to traveling community health workers where possible.

Spend the money more wisely and to delivery healthcare in a better and more timely way. A number of governments are

making real strides in this direction. South Africa as we all know, has shown remarkable leadership this year. They're now trying to test tens of millions of South Africans and more than double the numbers on treatment over the next few years.

It is more than double the number of health systems running AIDS treatment in the past four months and we'll redouble the number of centers again in the next six months. And we have been privileged to work with them on something that surprisingly is still not yet universal.

The work that CHI staff did with the South African Health Ministry is going to save them $280 million a year in paying for their AIDS medicine, at the current volumes. And they'll save about $45 million a year on their lab and testing. That money can all be plowed right back in to more treatment.

So I would say it's not right for anyone here, unless you really do know, to assume that all medicines and all commodities have already been purchased at the lowest available price.

And I just saw President Zuma when I went to South Africa to check on some of our programs, seeing Nelson Mandela as close as I could to his birthday. And I did see a couple of World Cup games too, but I can tell you something, Jacob Zuma is proud that is country is no longer a pariah in the fight against AIDS and I'm proud they found a way to save more than $300 million to put it into increasing treatment. [Applause]

The third thing I think we should do in this area is to challenge African and other governments when they come into vast sources of new money to put some of it into their own healthcare system. There is enormous wealth in Africa, there's enormous wealth in Central Asia, there was a great article the other day saying there may be a trillion dollars of wealth under the ground in Afghanistan.

As long as the world population continues to grow, there'll be more drilling and more mining even if we reduce greenhouse gas emissions by 80-percent. People will go after every conceivable kind of mineral and metal and I am terrified that people are going to go in, economic interests from outside African countries are going to go in there and make big bids and make huge amounts of money to go mine whatever it is you find in these countries or drill whatever oil they have and that none of it will go to benefit ordinary people, or that the money will all be spent on infrastructure or even on education.

It is what we, in this economic climate, with this many lives riding on it, if we knew our part and we get as much as we can, if a windfall comes into these countries and they have not a big funding base, it is acceptable to ask them to do what Rwanda and some other countries have done to kick in what they can and only what is fair to ask.

But I think it's a mistake to pretend that they shouldn't own some of this. And a lot of you know where this

has not happened. I think we all have to examine our own organizations. Bill gates talked to me about this problem of limited funding and rising need for treatment last January. And we promised to do what we could to lower our own delivery costs. And we're working on it.

We've thought we were doing about as well as we could and then we realized we could do better. We all should. I think those of you who come here primarily as donors need to think about this crisis and say from now on, I'm only going to support organizations that do things better, faster, and at a lower unit cost. I think we need to be more innovative in finding new private financing, making massive good work, thinking of other ways we could do it.

Maybe we could put $0.50 on sports tickets in rich countries, there are lots of other things we need to think about. But in the future, the real secret is going to be raising large amounts of money in small units from huge numbers of people.

When the tsunami hit South Asia in 2004, Americans gave a billion dollars and half of it they gave over the internet. The median contribution then was $56. When the earthquake hit Haiti, the Americans gave a billion dollars and they gave massive amounts through the telephones, their cell phones by just simply typing in Haiti and there was one number for the Red Cross and one number for Partners in Health, one number for

the fund we set up with former President Bush. It's amazing the Canadians did the same thing and in the US it was an automatic $10 contribution and in Canada all made a $5 contribution.

We've got to do this and you empower people who can think, who can never come to this conference, who maybe have young children, can't pay their bills, don't work for an NGO, but really are for you, they love what you're doing and they don't think they can matter. They don't think they can make a difference. If they do, they were part with a million they would happily give you $5 or $10 every now and then. We've got to do a better job of that and we need help with it.

Finally, I think the advocates should continue to advocate, but by demonstrations, I gave you my best judgment about what the real problem is in America and what the most effective strategy is. But I also think you should remember to educate as well as advocate.

Healthcare is not just a right, it's basically an extraordinarily good economic investment with a very high rate of return. Whenever people talk about what we do in healthcare is a development investment, some of the people like in our Congress and other places, their eyes glaze over and I find that ludicrous.

If you are going to build a coal-fired power plant in the United States, by law, the person who builds the power

plant can let you pay for it over 20 years on the theory that the useful life of a plant is even more than 20 years. Some states if you build a nuclear power plant, they let you pay for it over 30 years.

If you pay a pittance of that to save a child's life who will then live 70 years, they want you to count it as a cost today without considering the benefit. If these young people live to be 70 years old, what was it worth to provide their medicine? What was it worth to give them a chance to live full lives?

We need to make the argument on real economics, not phony economics. Talking about what healthcare costs today without talking about what benefits are long-run is a huge mistake. [Applause] Look, I guess what I'm trying to say is you've done great whether you're advocates or healthcare professionals or workers at NGOs or scientists, but we can do better. We can reduce the number of new infections dramatically.

I don't care what anybody says, we can achieve universal access. But we can't do it by walking away. I just took my annual trip to Africa as I said and I was reminded all over again in remote rural places, looking at our AIDS projects and some of our economic projects that intelligence and ability are evenly distributed but opportunities are not. And one of our agriculture projects, I can hardly talk about this, in

Southern Africa, we help people increase their farm yields and then earn a higher percentage of the sale price of their products.

So I met with all these farmers, but one who was the chosen spokesperson was a woman whose husband had died and she had only one child and her sole source of income was a quarter acre of land on which she grew soy beans. Last year she earned $80. So we gave her better seed, better fertilizer, a way to get rid of the pests, she increased her yield two and a half fold. Then, we directly marketed her soy beans to the processor so that she didn't have to go through an agent, that doubled that income, so instead of $80 on this little quarter acre, she made $400 this year. A fivefold increase.

Why? She didn't do anything different. She had a system that worked for her. Most of us that live in rich countries have systems that work for us all day every day. We get that kind of return all the time and we don't even think about it. That woman's kid deserves the same future that our children do, that our grandchildren do. It is not right, that was the first [applause].

So I will just close and I'll give you two thoughts in closing. A couple of years ago, there was a great movie, at least I thought it was, called The Bucket List, with Morgan Freeman and Jack Nicholson. And I know both those guys well and they had a terrific time doing this, but so Freeman pays a

guy who's really sick and he doesn't have long to live and he makes a list of everything he wants to do and he and Nicholson talk about what they want to do before Freeman dies and they go around these two old coots and they do it.

I'll soon be 64 so I think I'm old enough to join Jack and Morgan in making a bucket list. But I have an A list and a B list. The B list is stuff that would be fun to do, but doesn't amount to a hill of beans whether I get to do it or not. I'd like to climb Kilimanjaro before the snows melt and I'd like to run a long marathon before I give out, there's lots of things I'd like to do, but it doesn't matter whether I do it.

What I really care about if I could have my wishes, I'd like to live to see my own grandchildren and I'd like to live to know that all the grandchildren of the world will have a chance in the not too distant future to live their own dreams and not to die before their time.

For us, that means replenishing the global fund, helping donors, especially America, avoid the false choice between funding treatment and funding maternal and child health and health systems, it means doing our own business better, faster, with lower unit costs, better treatment, scaled-up and targeted prevention. It means a discipline, honest, non-backside covering way of cutting the cost of delivery and putting more of our taxpayers money and saving the lives of the

people that they've appropriate the money in the first place to save. It means better private investment, more opportunities for more people to give, it means educating about why this is good economics, that's a pretty worthy thing.

Now, a lot of people are cynical so this is the last point I want to make. In addition to all the AIDS related scientific advances in the last few years, just a couple of months ago there was a stunning discovery coming out of one of America's supercolliders in physics, reporting to show the first proven connection between physics and biology.

Since we are after all, atomic beings, now this will have to be confirmed, I should say, by the superconducting, supercollider that is about to open in Switzerland, which is the biggest is the world. But the preliminary indications of the American's test broke down all these subatomic particles and they have finally solved one of the biggest problems in physics which is how could life have ever begun in the first place since in traditional theories of physics positive and negative forces are supposed to have always been in balance.

Matter was constant, it may have changed form, but it was constant. How did this spark of life ever begin? According to the subatomic analysis done by our scientists, it turns out that these tiny particles called neurons where according to all traditional physics theories there have been an equal number of negative and positive ones, roll in the

hole, there were slightly more positive than negative neurons. And every tiny atom which may explain how we call end up coming out of the pre-mortal slide.

What's the relevance of this to you? That's the only chance we've got, the chance that we're going to solve the positive is just a little bigger than the negative. I'm betting that it is. Thank you and God bless you. [Applause]

FEMALE SPEAKER: Good morning ladies and gentlemen, it is my great pleasure to introduce our next speaker; he's Secretary of State for Social Affairs in charge of disabled person, Deputy Minister for Social Affairs and Public Health in charge of social integration. As Belgium's presiding on the Council of the European Union, the speech delivered will be on behalf of the European Union. Jean-Marc Delizee [Applause]

JEAN-MARC DELIZEE: Dear Mr. President, ladies and gentlemen and if I may, dear friends, good morning to you all. Let me tell you first it's an honor for me to address this very important conference at its start. And it's an honor to speak on behalf of the European Council of Health Ministers currently chaired by Belgium. But it's also a big challenge to speak right after President Clinton. Not only because of his eloquence, but also, as it has been said, because he has been very active in the fight against AIDS for so many years. So it's a big challenge because I have the impression the most important things have been said, and well said.

Well, the World AIDS conference is an important opportunity for our common endeavor to further strengthen the response to HIV/AIDS. We must do it at national and international levels. All partners must be involved, private, public, civil society, and international organizations.

Today, I reaffirm the commitments of the European Union to play a vital and leading role in the strengthenings of this response.

At a global level, the trend seems to be positive, but we are not there yet. The World Health Organization estimates that 2.7 million additional people were newly infected with HIV in 2008. The same year, there were 2 million HIV/AIDS related deaths. This is not acceptable. Those numbers remind us that we need to improve further policies, means, and tools.

The origin of the millennium, the development goals next September will clearly mark what needs to be done and how. HIV/AIDS continues to be a threat to development. The damages to life, health and well-being of individuals remain dramatic. And it's especially true for women and children. It's important to promote gender equality and empowerment of women. It will help them to say no to unsafe sex and to protect themselves from infections.

The health system must integrate HIV services and effective initiatives to achieve universal access to HIV prevention, treatment and care. Strengthening these services

is the only way to achieve the MDG goals by 2015. The European Council of Health Ministers reaffirms its strong support to attain these goals.

In times of economic crisis, we cannot lean back. The crisis cannot divert our attention. It cannot undermine our efforts in HIV prevention, testing, treatment and care. We must continue to fight HIV at every level in our society.

Now, what's the situation in Europe? The European Union and its neighboring countries are currently facing a particular challenge due to alarmingly high numbers of high infections. Early diagnosis, treatment coverage, focusing especially on the risk population will be crucial to stop this. Effective, human-rights based HIV policies need to be implemented. The EU communication, combating HIV/AIDS in the EU and neighboring countries and the action plan for 2009-2013 put forward coordinative actions of all member states, the European Commission, and its agencies to react firmly and coherently. We need to reduce new HIV infections. We need to improve access to treatment, care and support. We need to improve the quality of life of people living with AIDS.

Council conclusions adopted in November last year focused on actions to confront HIV/AIDS through external action. They include the need to fully respect human rights. The rights of every man to enjoy the highest attainable standard of physical and mental health. All people must have

access to information, to early diagnostics, to effective prevention and to treatment options.

Political leadership is crucial for an effective response to HIV. All European institutions have shown their commitment, but the European Union cannot do this alone. A close collaboration with international organization and with civil society is absolutely necessary if we want to reach our goals.

Let me now recall three crucial elements. First, prevention and screening. We must promote and scale up prevention efforts. This means improving information for all, especially young people who have missed the former successful HIV communication campaign. It means paying special attention to risk groups with a high prevalence of HIV. We must fully inform them of prophylaxis, HIV testing, and the treatment options available.

The biggest impact on the epidemic can be achieved when the situation of the population most at risk is addressed efficiently. Key populations at risk must be recognized. Their voices must be heard. Their needs must be met. This is relevant for all men and women, children and young people, regardless of their HIV status, sexual orientation, age, gender, ethnicity or any other status. Tailor-made approaches for key groups are essential in containing the epidemic.

The second crucial element is to reduce stigma. Particularly concerning is the high number of persons who are not aware of their infection. About 30-percent of people in the EU and up to 70-percent of people in several neighboring countries are not aware of their HIV status. This presents a serious concern for policy makers. And rightly so because late diagnosis usually leads to late treatment and tends to reduce life expectancy, lower quality of life, and to an increased danger of transmitting the virus to partners or babies.

We have to scale up screening and diagnostics. We have to overcome the stigma. We have to do more to ensure that people can be tested and all serenity and security without being blamed or questioned afterwards. People living with HIV are often still too frightened to come forward for help because they are afraid to be stigmatized. Promoting full adherence to human rights, the right not to be subjected to stigma and discrimination, must be guaranteed.

The third and final crucial issue I want to talk about is access to treatment. Economic operators and public authorities should cooperate to improve the provision of safe and affordable antiretroviral medicines to people in need. We need to strengthen our health systems, include HIV programs as broadly as possible, and make medication available to all. Local, public, private and community-based services must be supported to achieve universal access. These two words are

certainly the key words in this issue – universal access to HIV prevention, treatment and care.

Exchange of good practices on prevention, testing, treatment and care between country is also very important. This is especially beneficial in times of budget constraints. The cooperation and exchange of know-how between doctors, nurses and public health experts, as well as sharing quality data, will help to improve evidence-based prevention, state of the art testing and treatment services and to improve surveyance. Such joint efforts will reduce new infections, improve the life of people living with HIV/AIDS, and underline the value of good cooperation between neighbors.

Ladies and gentlemen, as a conclusion, we can affirm that we have improved our reaction to the epidemic. This is certainly positive. But this gives a false feeling of security. The threat remains for everyone and will last. Millions infected are not mere statistics. Behind every number is a human being who needs our support because she or he is fighting a disease that is still threatening all of us.

A lot has been done, but we still have a long way to go. President Clinton say it another way. This is the end of the beginning. Right here, right now. Yes, you're right. This is a call for solidarity. Let's continue this fight together. I thank you for your attention.

[Applause]

HELENE GAYLE: Good morning. It's now my pleasure to introduce Vuyiseka Dubula is the general secretary of the Treatment Action Campaign, where she founded several branches and programs. She has served as a member of the Treatment Action Campaign since 2001, and was elected to her current position in 2008. Vuyiseka is committed to ensuring that people living with HIV have a strong voice in the struggle, and that especially girls and women have access to health services and equality in a society free of gender and sexual violence. She is the national representative for the People Living with HIV in the South African National AIDS Council, and the chairperson of the AIDS Law Project, and a member of the Global Task Force on Women, Girls, Gender Equity and HIV.

She has presented and published in multiple national and international health and human rights conferences, and was nominated recently as one of *Mail & Guardian's* thirty young South Africans to have lunch with.

Vuyiseka holds a B.A. in Health Services and Social Services from the University of South Africa. She is currently completing her Honors in Psychology from the University of South Africa. She will speak to us this morning on positive health, dignity, and prevention.

It is my great pleasure to welcome to the podium Vuyiseka.

[Applause]

VUYISEKA DUBULA: Good morning. I'm really impressed by the room being filled in such an early time of the day. And already, as you heard, I'm going to be speaking about positive dignity, health and prevention. My comrades, colleagues, ladies and gentlemen, I am all protocols observed. I am very honored to be speaking before you.

I am very proud to be South African to speak today and stand before you after such beautiful words said by my deputy president, Kgalema Mothlanthe, yesterday emphasizing that the economic challenges that we all have should not be a barrier to scale up prevention treatment services, because otherwise, we will have much deeper, serious challenges on development. So development in AIDS is a development in economy as well.

So my focus today is going to be what we have achieved between Durban in 2000 and now in Vienna and why that we cannot retreat today. Also explain this new paradigm on positive health, dignity and prevention and universal access to treatment, but also talk a little bit about treatment as prevention and all what I'm going to be presenting is centered around what is the role for people living with HIV and how we want to be seen as part of the solution.

But also, I want to highlight, and I'm very happy that some of my messages are going to be delivered by people, some of them are in the panel, the member of parliament from Belgium, I have a message for the European Union. I am happy

if you can take that message. Also, to address issues around discriminatory laws, around human rights. Very strong issues around women and girls and HIV and inequality.

So, we are here today marking 10 years since Durban and today, we are now talking about at least we have saved 5 million lives, and that includes my life. I had the privilege to start treatment in 2004, and now I'm six years in treatment and thanks to access to affordable, cheap, generic drugs. And because we all know that this is not enough. We know that we have only saved half of those that we need to save, there is still more that we need to do. We are only covering 50-percent of the need.

And also because of continuous pressure from activists and people living with HIV, drug prices have dropped. We now have access to much more cheaper drugs. We can still do more. I don't need to repeat the statistics on the presentation because we all know that we still are faced with a growing epidemic. It is starting to stabilize in some countries. It is not yet clear whether it is stabilizing because of death or we actually are making progress.

But also, my biggest concern is the fact that still, new infections are still happening in high numbers amongst young women and amongst young people. At least 50-percent of people living with HIV globally are women. And at least 40-percent are young people. And in my region where I come from,

we still represent 67-percent of the global people living with HIV. So we carry the burden.

Because I am asked to speak about and I have to speak about this paradigm, and other people are going to be asking so what is this positive health and dignity and prevention? It's complicated. We just heard about treatment 2.0. There's just too many new paradigms. What is this positive health and dignity?

As you may remember that in 2001, we started hearing about the role of people with HIV in prevention, and it was called positive prevention. And basically that paradigm was talking about people living with HIV being seen not just as transmitters but also people who can also contribute towards prevention. And today we have expanded. We have had consultations with global networks of people living with HIV at national level and at a global level to define what do we think is the new shift because there's much more that people living with HIV can do and still need today that is not yet encompassed in positive prevention alone.

So this new paradigm is a shift designed by people with HIV, but also laid by people living with HIV. And it's aim is to support people living with HIV with their prevention needs, with the special focus on improving and maintaining all aspects of health and well-being. And in turn, this contributes to the health of our partners, our families and our communities. And

human dignity symbolizes respect and value for people living with HIV and it is enforceable and, therefore, there can be no exceptions. We need to combine positive health messages with messages and actions towards human dignity and respect.

And at the core of this paradigm of positive health, dignity and prevention, it's about policies, programs, that treat people living with HIV humanely and holistically to enable us to protect ourselves from HIV and also to protect others. Not through fear and coercion, but through empowerment and dignity. And policies and programs that recognize comprehensive experiences that needs of people with HIV are much more likely to have greater acceptance from people living with HIV, which in turn is much more likely to benefit public health.

We have to remember that prevention is everyone's responsibility. People with HIV don't have, only because they live with HIV have that responsibility. So it's everyone's responsibility to prevent new infections. Therefore, we must share that responsibility.

The importance of ensuring people living with HIV have access to preventative services remains critical. People need to have access to treatment and prevention tools and services that respect their human right, including sexual reproductive rights of women and gay men and gay women that promote gender equality and that provides social and economic empowerment and

support. Hence, universal access to treatment, care and support remains a critical goal.

There is progress. Yes, it has been painted yesterday in the opening session and this morning. And there is hope of universal access. Therefore, now is the time to accelerate efforts to prevent new infections. And this is not possible if we do not consider the following. Universal access remains a catalyst to support and realize a number of other MDGs, besides just MDG 6. Achievement on the other MDGs will also play a critical part in achieving positive health treatment and prevention for people with HIV. So governments must re-commit to universal access and achievement of MDGs to ensure that sufficient resources are made available to reach these goals. We need to address the human and financial resource challenges to meet these targets on treatment and MDGs.

The current trend on non-accountability in efforts towards universal access and the minimum development goals by African governments and global leaders is unacceptable. We urge all our global leaders to fulfill their commitments by replenishing the global fund to fight HIV, TB, malaria, at least by 20 U.S. billion dollars in October this year. This is at least, I reemphasize, we need more.

Universal access is not about 60-percent. Universal access is not about 80-percent. Universal access is about hundred-percent coverage.

[Applause]

We also demand that our African governments must honor their commitment they made in Abuja by spending at least 15-percent of their national budgets towards health. This is not an aspirational target as our African ministers of health have declared in March 2010. This is an investment in positive health treatment and prevention. And we know, we have seen in South Africa during the FIFA World Cup that it is possible to have resources to build very nice stadiums which we do appreciate. So it is also possible to reach the Abuja declaration.

[Applause]

I think also, we also demand that the private sector must take a responsibility in this epidemic beyond just corporate social investments. And this can be done by supporting the financial transaction texts to fill the gap on resources for health. They need to pay back the money that they were given by governments during the economy crisis. Now is their time that they are making profit to give back that money to resources for help.

[Applause]

And we continue to ask our president in South Africa to continue to be the champion for universal access on the G20 on behalf of the continent.

Now, combination prevention is very important and many of us have observed and participated in debates over the past year on treatment as prevention. Treatment as prevention is an important part of combination prevention. It provides us with an opportunity to think about preventative affects of antiretrovirals and how we can scale up.

Beyond treatment as prevention and other important elements of combination prevention include harm reduction measures, the reduction of multiple partners, prevention of vertical transmission, male circumcision, structural interventions, and ensuring human rights.

Key to combination prevention is also the research and development for new HIV technologies such as microbicides, prep, and vaccines to prevent new infections. Communities continue to express cushion and warning for the respect of individual human rights and relations to access to treatment and testing. Not to impose coerciveness, stigma and discrimination in health facilities. While we don't have enough evidence about how test and treat will unfold. At which CD4 is the right time to start. However, we're looking forward to the trial that is done by, the start trial that will provide much more evidence to tell us in terms of what is the best time to start treatment.

I also want to highlight some of the challenges that we need to start – now this is the message for the member of

parliament from Belgium. I am very happy to be sitting next to you to deliver this message personally. That the current European Union's negotiation on free trade agreements that pushes for longer pay terms, for harsher intellectual property enforcement measures that violate civil and political rights and threatens the production of cheaper and affordable medicines must be radically changed.

[Applause]

This threatens developing countries ability to import and export medicines. These new monopolies on medicines threaten the feasibility of developing countries to continue to have access to cheaper generic versions, to achieve universal access.

Also, we know that there is a second treaty on anti-counterfeiting reportedly supports the drafting of national laws on counterfeiting. The most fundamental problem about this treaty is classifying generic medicines as counterfeit. That is false.

[Applause]

Now, on human rights. I'm sure you already expected me to say, I'm not going to keep quiet about what is happening in Uganda and Malawi. Modern law explicitly promotes — [applause]. Modern law explicitly promotes human rights and gender sensitive approach to HIV related legislation. And this aims to ensure that human rights of those vulnerable to HIV,

people living with HIV, affected by HIV, are respected, protected and realized in the responses to AIDS. It is important to note that 84 out of 136 developing countries of U.N. AIDS reported having laws and regulations that present barriers to effective prevention, treatment and support for vulnerable populations.

Both the African Union and SADAC have drafted a number of codes, guidelines and protocols since 1997 that are meant to protect human rights of people living with HIV. And the AIDS Alliance Rights of Southern Africa has reported that major concern for legislatures in SADAC shows a continuing trend to address these concerns in a way that undermines human rights of people living with HIV.

And I want to mention what I am talking about. One is criminalization of HIV transmission. Still today, we are talking about universal access. Universal access, it is not possible if you do not have a legal framework that allows people to have access to services. Still today, European countries still impose laws that criminalize HIV. In Africa, east, west and central, west, central and southern Africa still are busy enacting and proposing laws that impose criminalization. And two, we are still criminalizing same sex relationships. There are a growing number of countries that continues to criminalize homosexuality. For example, what we have seen in Malawi and Uganda. And we still expect gay women

and gay men to go out there and access services under this condition. It is impossible and it is unacceptable.

[Applause]

Again, criminalization of sex work. And unfortunately, sex work has all the time gets to be forgotten. And we had a very hot debate during the World Cup in South Africa whether we should de-criminalize or not de-criminalize sex work and why that debate only becomes very hot when there's World Cup, I still don't know what is the rationale behind that. Because for me, sex workers are exposed to violations and brutality every day. And therefore, de-criminalization needs to happen today so that sex workers can be free to walk into work in the industries that they can work, but also they can be able to access services where they need to access services.

In most of African countries as well, they know that most of vulnerable groups in their countries are sex workers, but they cannot even name them in their national [inaudible] plans. They don't exist, but they do acknowledge that they contribute towards the epidemic of the country, but they don't have any plan to address them.

And, therefore, we must push for legislation and public health policy to protect vulnerable groups and expand access to treatment, prevention and care so that groups that often are unable to access health services and justice services are able to access them. And I want to name them – lesbian women

because they get to be forgotten. Hate crimes against lesbian women, they need to have access to justice services so that they can be protected. Men who have sex with men, transgender persons, prisoners, foreign nationals, mobile populations, migrants, refugees, sex workers, and people who use drugs. These names are not difficult. They can find their way in their national strategic plays and these are people.

We must not forget to put pressure on the Iranian government. It's been two years that Dr. Arash and Dr. Kamiar have been arrested on their work on AIDS. We can no longer keep quiet when we are talking about human resources for health, but two doctors are in jail for working on AIDS. It's not a crime to treat AIDS [applause].

Another issue is on women and girls and HIV. Women in my region constitute more than 50-percent of those living with HIV and they are particularly young women who are most at risk of HIV transmission. Still today we have very limited preventative tools that women can own that they can protect themselves from the risk of infection. The most challenging issue is the violence against women. That has become a human rights crisis of our time. Countries in Africa still forcefully mutilate women and this practice happen in communities throughout the world.

Violence continues to impose a lifelong threat to young women. This is increasingly alarming and pose this public

health crisis and statistics on violence against women and girls has become so common that we have forgotten that there are people behind the statistics. That is why I think we underplay the role played by violence in the epidemic. That is why we have very little investments to address it.

For example, in Zimbabwe during the political unrest, violence against women was used to intimidate women for political reasons and more then 800 women were raped. This is a crime against humanity. We all have to take a global responsibility to raise our voices to insure that African and international communities can prevent this from reoccurring. By the way, Zimbabwe will have elections in the next two years or year.

Well how are we going to make sure that this does not happen again or raise our voices that it does not happen again? Again, societal attitudes against women needs to change fundamentally to respect women; women's equality, freedom and dignity.

The last thing I want to talk about is social inequality. We also have to pay attention to the social inequalities that contributes to the factors that drives the epidemic. Although I come from a country that is regarded as emerging economy and the only middle income country in the G20, but South Africa has the highest number of people with HIV. It has the highest levels of unemployment. People live in

poverty; millions live in poverty. We also are faced with reduction in life expectancy because of HIV. Inequality between the rich and the poor in the same country has led us in status that is infamous. We are now number one, the most unequal country in the world.

Let's compare ourselves to the country that is hosting us. The country that is hosting us has end itself as status as in the top five countries in the world best quality of living. It's a home to the greatest classical composers of our time. It has nice palaces, museums and churches, yet I wonder. I want to ask a question. How much does the Austrian government contribute to fund the fight against HIV? Where is your global solidarity? What is your commitment to the Global Fund?

In conclusion, human rights here; human rights now means we cannot go back. Hope has just started, however I want to leave us with food for thought. It's time to support the leadership of people living with HIV and work with us and be accepted as leaders that we all can work together to realize positive health, dignity and prevention.

Also, social economy and human rights are non-negotiable. If we don't respect these rights by holding our governments and global leaders accountable for all our causes, history will judge us. We must reenergize. We must recommit to our chief universal access. We must defend our gains and

speak the truth to power because health is a global public good. Amaaaaathah! [Misspelled?] [Applause].

NORA VOLKOW: Good morning it's a pleasure for me to introduce Anya Sarang. Anya Sarang is President of the Andrey Rylkov Foundation for Health and Social Justice in Moscow where she works on advocacy for access to health and protection of human rights as well as dignity for people who use drugs and for humane drug policies.

For the past 11 years, her work has focused on developing and supporting the emerging harm reduction movement in Russia through various activities in training and networking activities. It's a pleasure to have Anya Sarang with us.

ANYA SARANG: Thank you so much Nora and good morning dear friends. It's a big honor for me to address such a large auditorium full of my fellow activists, scientists, doctors, health workers, politicians, officials and all of you who work in HIV. In just 20 minutes I have to share with you our experiences, our frustrations and our aspirations.

I know that for many of you the term harm reduction is not as familiar and important as for those of us who work in countries where people continue to suffer because of war on drugs. For some, our fight may seem small and less demanding then the situation in other parts of the world where HIV hits a larger proportion of people, not only or mainly drug users.

On the surface, advocacy for evidence-based and humane drug policies may not seem immediately relevant to the public health preventing and treating HIV. In a short time, I will have to explain why drug policy and human rights are so relevant and important to all of us.

I will start with a personal story. Not because I think that my life is so important and illuminating but because that's what I know best, and because I think that in every life we can find reflections of lives of others.

I know that for many of you the start of your work in HIV was connected with loss. Too many of people who I hear have lost their friends, their close ones, their loved ones, their neighbors to AIDS. That is what pushed many of us to commit your lives to fight with a disease, to building better healthcare in your countries.

This was totally not my situation. When they started to volunteer in one of the first outreach projects in Moscow Russia, back in 1997, none of us in the outreach theme knew anyone who had HIV. When the first of our clients, a homeless drug user, Sasha, got his HIV positive diagnosis, it was a huge shock for all our team. Some people had to go through psychological counseling to just accept the fact that they knew someone positive.

I remember back then I was reading in newspaper in Moscow which said that there were about 100 new infections in

my city of 15 million people. The epidemic was really small. It seemed something distant, something irrelevant, and something from another planet. Still, with the HIV prevention outreach, we had the great team of peer counselors and provided training for drug users. It was really one of the best things and it did great work. The only thing we couldn't do was something that we needed most. It was provision of clean needles to drug users.

Despite overwhelming international evidence that needle and syringe programs prevent HIV, the Moscow authorities were categorically against them. Medicines on Frontiers who operated our projects were threatened by the authorities with expulsion from the country if they started to provide clean needles to people who needed them most; and so we didn't.

Today the situation in my country is the same but also different. The same in the way that the Moscow authority still religiously opposes needle and syringe programs. The same that despite the case of strong evidence, these program are operating at very low scale. The same in the way that HIV prevention and outreach programs in my country still operate under the threat of closure; but different in the way that now I only have a few friends who do not have HIV.

HIV prevalence among drug users in some Russian cities reaches 75-percent and almost 1.5 million people are estimated to have the infection throughout the country. In Moscow the

city whose health authorities claim success in fighting the epidemic, every three hours a new person gets the official HIV diagnosis.

When the conference organizers invited me to deliver this plenary in spring I was just re-reading *Timequake* a book written by one of the greatest writers and humanists of all times, Kurt Vonnegut. In Vonnegut's fictional *Timequake*, the universe suddenly suffers a crisis of conscious. Should it keep spending or shrink back? It decides to take a pause and back up making everybody and everything do exactly what they did during the past decade; for good or ill a second time.

It was déjà vu that wouldn't quit for ten long years. There was absolutely nothing you could say during the rerun if you hadn't said it through the first time through the decade. You couldn't even save your own life or the life of a loved one if you had failed to do that in the first time through. So people had to repeat their lives the hard way, minute-by-minute; hour-by-hour, year-by-year. Betting on the wrong horse again, marrying the wrong person again, getting the clap again, you name it.

When I was reading this story, I was always imagining my own timequake. How unbearably hard it would be to relive the past 15 years that I worked in the AIDS field knowing what is going to happen, but not being able to change anything. The

memory brings me back to moments that were so hard to live through and moments that are alluring in their beauty.

The first thing that flashes in mind is the fourteenth International Harm Reduction Conference in Chiang Mai, Thailand back in 2003. Just several months prior to the conference the Thai government decided to toughen its war on drugs. It's good to fight drugs isn't it? And so the Thai Prime Minister gives instruction to the police that people charged with drug offenses should be considered security threats and dealt with in a severe and ruthless manner; any means in this world will do. The police take their instructions seriously and start to shoot people on the street on mere suspicion of drug sale.

So there we are in the middle of this terror, a community of international hard reduction activists totally outraged with the acts of police and with the Prime Minister, but completely paralyzed in an action as there is this fear that our loud advocacy can hurt even more.

I came to the conference together with my friends and my ex-husband; drug user activist from Russia. At the conference they will not provide us access to substitution treatment as Russia still stands alone in its federal ban on opiate substitution. Left without medical support my friends have to get out on the streets if Chiang Mai to get heroin. All I do throughout the conference is wait and fear; fear and

wait. Don't worry, somebody tries to cheer us up, they only kill Thai junkies.

I live through this again with the same feeling of terror, unable again to do anything to challenge the Thai government even that I know that in just several months after the conference the estimates of people who were just shot on the streets will go almost to 3,000.

Later, in the reports of human rights organization, these killings were referred to as extrajudicial. As opposed to judicial killings in countries like China where the UN ruled anti-drug day is marked with executions of drug offenders sentenced to death in front of crowds chanting, kill! Kill!

Last month, over a dozen were killed to mark the date. You may ask how does executions and cases of police brutality relate to HIV and many governments still don't get it. So let me ask you this question. If you were a drug user surrounded by violence and abuse aimed squarely at you, would you raise your head above the parapet and come forward for testing or prevention services?

HIV prevention and treatment programs will never be effective at their full potential when human rights abusers arrive. It's as simple as that. Years of experience have taught us this painful lesson. Fear of arrest, detention, and even a soul feeds HIV risk and hampers HIV prevention and access to treatment.

Thankfully, as my timequake continues I can move onto the happier moment of the next International Harm Reduction Conference of 2004 in Melbourne. Just 7,000 kilometers away from Thailand, Australia have proved to the world that scale-up of provision of sterile needles in combination with peer education and substitution treatment, and later safer injections rooms can really stop HIV.

Australia started to implement country-wide harm reduction programs at very early stages and still to date, less than 1-percent of people who use drugs are infected with HIV. It was also one of the first countries where drug users organized international league and demonstrated the meaningful involvement of effective communities plays a crucial role in halting the epidemic, shaping national health policy and building better services for drug users.

This conference was the happiest for me as I received the International Roll Stone Award [misspelled?] from the International Harm Reduction Association for my contribution to the development of harm reduction in Eastern Europe and Russia; something that I had to convince myself to accept and six years later I still don't feel like I deserved it as my country is still one of the worst in the world in regards to its harm reduction policies.

In my personal timequake and happiest moment in Melbourne, I'm greeted by my deer friends and colleagues from

all over the world; among them, Kamiar and Arash Alaei. The great harm reduction is from Iran who pioneered the triangular clinics, offering patient treatment with substitution medicine for drug addiction, antiretrovirals for HIV; counseling and treatment of sexually transmitted infections as well as clean needles and condoms.

Their work, like work in other regions before clearly demonstrated that drug users can very well adhere to antiretroviral treatment if provided with all necessary support and services tailored to their needs. In my timequake I'm so happy to see them again. As in reality it has been several years now since I last saw them; no one has. Just a little over two years ago the Alaei brothers were arrested for alleged conspiracy against the government and sentenced to three and six year's imprisonment. Their trial was a politically motivated mockery of justice. While many human rights activists and medical professionals have called upon the Iranian government to release them, the brothers are still in prison and we all hope that this conference can make another strong statement to support them.

The Alaei brothers [applause] are not the only public health professionals working in the harm reduction field that have been convicted on political grounds. Many of us were shocked once again with the recent story of Maxim Popov from Uzbekistan. Maxim was convicted for charges including the

distribution of harm reduction and safe sex educational materials. The government said the materials were offensive to Uzbek values and Maxim is now in prison for seven years.

The efforts of the international community and especially the international donors to liberate Maxim as well as the Alaei brothers are very humble and reserved indeed despite the fact that we realize that in totalitarian countries anyone, anytime can be arrested and sent to prison without due process or even hint of a just trial. It can be any of us.

The situation gets even worse. In many countries, even formality of courts is not required in order to deprive people of freedom. In countries of Southeast Asia and China over half million drug users are locked into long-term labor camps from a day-to-day treatment without their agreement; without adequate medical care for those who have HIV just by a positive urine test. This is not treatment. This human rights violation continues in countries where international organizations and UN agencies support the governments to fight aids among drug users. How can that be happening?

It seems that drug users are not genuinely considered as humans and so the concept of human rights doesn't apply. We all know that HIV comes with stigma. Drug dependency comes with such stigma that it's hard to comprehend. Drug use has become a label that provides the authorities with justification to act as they see fit however unthinkable the acts may be;

direct or indirect killings, torture, deprivation of freedom or health or dignity. They all will go with impunity.

At home in Moscow, later still in my timequake, I read in amazement the minutes of the meeting describing how the Russian Health minister, Tatyana Golikova, stands before our President in 2009 and says that according to evaluation of her ministry, needle and syringe programs in Russia proved ineffective and therefore the ministry will not support them. This is amazing because just a year before, the same Minister stood in front of the participants of a regional AIDS conference promising that the government would fund the programs, prevention and treatment that were previously supported by the global fund, including a needle and syringe programs.

Unfortunately she lied both times. The Russian Minister of Health have never done a scientific evaluation of effectiveness of needle and syringe programs; nor on substitution treatment programs that they denied and has never considered the wealth of international evidence on this matter. Today the Russian government doesn't provide any funding for HIV prevention among drug users or other vulnerable groups.

The theme of this conference is Right here; Right Now. So let's talk about here. Vienna, the home of the international drug control system. Despite the Russian governments inexcusable neglect of HIV among people who use

drugs, its appalling supporting human's right's records and its effort to impede harm reduction on the international stage. A long-serving Russian diplomat, Yuri Fedotov has just been appointed as the head of the United Nations Office on Drugs and Crime.

It is the lead urgency within the UNAIDS family for HIV among injecting drug users and prisoners. We hope, indeed we ask that Mr. Fedotov rise above Russia's policies and publically announce his agencies commitment to harm reduction and human rights [applause] in his first days in Vienna.

One last moment that I live through again in my timequake is the death of our friend, Russian HIV activist, Tai [inaudible]. Tai [Inaudible] was one of those brave activists who fought for HIV treatment in Russia. She was one of those activists who chained themselves to the doors of municipal governments in Kaliningrad and St. Petersburg when HIV treatment was already available and just not provided to drug users who were regarded as socially unproductive. Front AIDS fought with the slogan, we will leave; this is our policy [applause].

Just a couple of years later HIV medicines became more available in the country but Tai's life wasn't safe. She died two years ago in July 2008 of tuberculosis. Since she could get a bed in a TB hospital, but not the necessary support and treatment for her addiction, since in our country there is no

methadone, or Buprenorphine, she couldn't stay in the hospital long enough to be successfully treated.

Reliving this once again, I cannot stop Tai from dying like I couldn't do it on the first time. We could have made an effort and get her to a country where substitution treatment is available to TB patients and where she wouldn't die at 36 years of age, mother to a 12-year-old son, of a totally curable disease but there aren't many places in our region where this is true and as always, we wait too long before we act and we count on others and miracles and we don't believe that our friends can die until it happens. Each time it happens we realize that we could have done something differently; promptly, more effectively. But we cannot reverse the time.

In Vonnegut's book when the timequake is over free will kicks in again. At that moment people stop being robots of their past and stop running obstacles of thei9r own construction. At the end of the timequake, when people resumed control, many were depressed and gripped by apathy. Only the hero of the book is optimistic and helps to revive others by telling them, you were sick but now you are well and there is work to do.

So to all of us, we are sick but we can get better. There is much work to do. Better it is to holding the spread of HIV are obstacles of our own construction. We can't tear them down but just as before, when HIV treatment was not

available, we have to fight for each life. For each policy change. For each human right [inaudible]. We have to fight. Nothing will come just by itself. We have enough knowledge, resources and medicines to provide treatment and support; good quality of life for people affected. But do we have enough courage to challenge the governments who decrease funding to fight the epidemic and break their commitments? To challenge the authorities who refuse lifesaving medicine to our drug dependant friends. To confront those who tell us to turn away from HIV. To remember that we can resist. We can resist because we have the power of knowledge.

We know perfectly well how to prevent HIV and we are learning more each day on effective treatment. We know how to cure tuberculosis; how to put services in one place. We know that the dollar worth shot of naloxone can prevent someone dying of overdose. We have all the evidence for effective drug treatment and better drug policies. We can resist because we have the power of communication.

Today, information spreads with the speed of light and what happens in one part of the world becomes known immediately everywhere. We can transfer technologists and best practices. We can network and influence. Even the language is not debated here anymore.

We can resist because we have the power of unity we're all affected with one problem and it doesn't matter where it

comes from. People who are stigmatized for their HIV status can easily understand people who are stigmatized even more for being drug users. And this stigma is not only their weakness but also the strengths of our community. It gives us the power of solidarity.

We can resist because we have the power of love; love for our friends, those who pass and those still alive. Those whom we remember and those whom we don't want to lose. The power of love that keeps us together and gives us strength to carry each other and keep our fight. Just like 10 years ago at the AIDS conference in Durban where the world stood up for access to AIDS medicines. We now have to stand up for our human rights.

We have to speak up for better drug policies that don't kill or harm people. Many of us have done this by proudly signing the Vienna Declaration. And now a decade after the Durban Conference, we know that we can do it and just like AIDS drugs became better, cheaper, and more available, we have to make human rights and new essential medicine for all.

As now we know that without respect to everyone's human rights, the medicines and our prevention efforts won’t work. We need to be very clear. Health systems don't work if people are afraid to use them. Prevention won't be available; lives won't be saved.

Like the Durban declaration led to access to HIV treatment for many who needed it and culminated in the call for universal access by the UN General Assembly; this conference and the Vienna Declaration must be the call to end the war on drug users.

It must be the call to place human rights and evidence-based approaches at the front of HIV fight. We started out by mentioning that in my life, as in every life we can see reflections of the lives of others. My timequake speaks of my personal story but it also speaks of others as well of political conditions. We cannot reverse time but we should have the courage to build our future in the right way.

I don't think we in the AIDS movement lack that courage but when it comes to drug use and the war on drugs, I fear we have not drawn the necessary conclusion. My own timequake has led me to Romania. I ask you this week to listen, share, understand and draw your own. Thank you [applause].

[END RECORDING]