Speech

The 22nd Meeting of the UNAIDS Programme Coordinating Board

Chiang Mai, Thailand

24 April 2008

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Thank you Mark for being our new chair, and above all for your inspiring leadership as the US Global AIDS Coordinator. I look forward to working with you and also with the new-Vice Chair, Dr Tedros. Three weeks ago I could see with my own eyes how Ethiopia is developing an original model for HIV prevention, as well as for strengthening health systems. Your experience will be crucial as we go into the evaluation of UNAIDS.

But first I want to start my comments by thanking Thailand, in particular Dr Suwit, for your leadership of the Board over the past year, and for supporting this 22nd meeting of the UNAIDS Programme Coordinating Board. I am also grateful to UNHCR for your dynamic chairing of the Committee of Cosponsoring Organizations, to the donors for your generosity in funding UNAIDS fully in the last biennium, to civil society for your activism, cooperation and support and to all the staff in our joint Programme

Yesterday we had a stellar start with the substantive debate on tuberculosis and HIV. And I hope today's discussions will equally focus on why we're here – to address the AIDS epidemic.

This morning I aim to cover three areas. I want to look at the epidemic in Asia and overall progress on scaling up to universal access to HIV prevention, treatment, care and support. I will then focus on some institutional issues and end with a discussion of some next generation challenges, and their implications for UNAIDS. I will not report on specific activities: the UNAIDS Annual Report for 2007 means you can read about what we've been doing as a joint programme.

On the epidemic, UNAIDS has just released detailed reports on the latest regional trends. Here in Asia, we are seeing declines in the proportion of people living with HIV in Cambodia, Myanmar, Thailand and parts of southern India, but increases in Indonesia (especially Papua) and Viet Nam – where 33% of all HIV infections now occur among women.

Injecting drugs with contaminated equipment remains a major means of HIV transmission in many countries in the region. Almost half of all infections in China are associated with injecting drug use. It is a serious issue in a number of other countries, including Pakistan, parts of India, and Thailand.

In just about every major Asian city for which we have data, there's been a significant increase of HIV among men who have sex with men. For example, in Beijing, a 2005 survey of men who have sex with men showed that 1% were living with HIV. Two years later, that figure had gone up to 6%. In Karachi, Pakistan, infections among male sex workers doubled to 8% in the same time frame. Here in Thailand, government figures for Bangkok show an increase from just under 19% in 2003 to 27% in 2007. Chiang Mai saw an increase from 11.4% to 15.5% over the same period.

These worrying trends confirm the need for us in UNAIDS to redouble our work with sexual minorities – as you approved in the Unified Budget and Workplan. In order to strengthen these efforts and as part of further

refining our division of labour, UNDP will now be the lead co-sponsoring agency on men who have sex with men. In addition, we have been working with AmfAR on some community programmes to support men who have sex with men – particularly in Asia. It will be useful to keep all this in mind when the Board discusses the gender paper.

Last month, UN Secretary General Ban Ki-Moon endorsed the report from the independent Commission on AIDS in Asia. I established this commission 18 months ago under the leadership of Professor Rangarajan because I felt that we lacked a thorough analysis of the AIDS situation in Asia that took full account of economic, social and cultural specifics. As we heard yesterday from Professor Rangarajan and Prasada Rao, this is the most thorough AIDS study ever carried out in the region. It is one of the most thought provoking I have read.

As the Secretary General observed when the Commission handed over the report: “There will be no equitable progress so long as some parts of the population are marginalized and denied basic health and human rights -- people living with HIV, sex workers, men who have sex with men, and injecting drug users……Legislation can also stand in the way of scaling up towards universal access -- in cases where vulnerable groups are criminalized for their lifestyles. We have to find ways to reach out to [these groups] ensuring that they have what they need to protect themselves.” I would therefore like to ask that the PCB take note of the recommendations made by the Asia Commission and specifically to endorse the recommendation that UNAIDS monitor implementation of the report’s recommendations at country level.

But the reality today is that in some countries, groups like injecting drug users are not only being denied basic human rights like access to health services but are also becoming objects of repression by law enforcing agencies using the justification of implementing supply reduction policies. Let us not forget that in this year of the 60th anniversary of the Universal Declaration on Human Rights it is appalling that such an abuse of human rights should prevail. We also need to make sure there is far better coordination between drug control authorities and policies, and the aids response.

Next Tuesday, the Secretary General will issue his Report to the General Assembly on Progress in Implementing the Declaration of Commitment on HIV/AIDS. This is based on reports by 147 out of the UN's 192 member states. These reports contain the most comprehensive data on the AIDS response ever compiled – at least partly because of our investment in building countries' monitoring and evaluation capacity. We are now analyzing these data as we prepare the 2008 Global AIDS Report, which will be released just before the International AIDS Conference in Mexico in August.

But we can already see that the data bear out what we've been saying for the past year or so: we really are making progress. There are now some 3 million people on antiretroviral treatment in low and middle income countries worldwide: 2 million of them live in Africa – where the majority of people on treatment are women. Back in 2001 at the time of UNGASS, how many believed that this would be possible? That we

would achieve ‘Three by Five’ only two years after the target date? Regrettably, the same obstacles to access chronic HIV treatment exist today as in 2001. And yet an achievement for which I can find no precedent is happening – thanks to a world wide movement, and international solidarity. It shows that in the face of a crisis we should not wait to act until all elements of infrastructure and systems are put in place. If we had waited, this would have meant millions of deaths over and above the 20 million who have already died from AIDS. Other good news is that a number of countries are reporting a reduction in HIV prevalence, and worldwide, HIV infections have fallen. There’s also been a major increase in availability of services to prevent mother to child transmission.

The bad news is that the epidemic continues to outstrip the response. There are 2.5 new infections for every person we currently start on treatment. This is not because we don’t know how to prevent HIV transmission. There is a wealth of local and national achievements in curbing HIV infection, and particularly since the PCB meeting of June 2005, widespread agreement of the need for “combination” HIV prevention along the lines of combination HIV treatment.

This all means that HIV prevention will remain a challenge for some time to come. We are currently working on a special edition of *The Lancet* to promote the latest thinking on this critical issue. We currently focus on three main areas. First to know your epidemic and act on that knowledge to channel action and funding where they’re needed. Second to mobilize demand for prevention through a coalition that involves people living with HIV and links up with other activist movements. Third to build

capacity at national and community level to scale up services to meet demand.

HIV prevention will be a key issue at the High Level Meeting on HIV/AIDS in New York this June. Our overall aim at this meeting is to revitalize commitment and accountability on AIDS among all participants and galvanize them to sustain and accelerate progress towards universal access to HIV prevention, treatment, care and support. And we will seek to position AIDS in the response to the MDG summit in September.

As the PCB has affirmed repeatedly, eliminating stigma and securing human rights is an integral part of the aids response. One manifestation of discrimination is the restrictions some countries impose on travel by people living with HIV. Last November, at the meeting of the Global Fund Board in Kunming, we agreed to convene an International Task Team looking at both long and short term HIV-related Travel Restrictions. The Task Team will present a report and recommendations at the 18th Global Fund Board meeting in November and the 23rd meeting of the UNAIDS Programme Coordinating Board.

Universal access also means strengthening health services and human resources for health. Two important meetings this year - the first international conference on Task Shifting in Addis and the Health Workforce Alliance meeting in Kampala – re-emphasized the seriousness of the health workforce crisis but also highlighted that concrete work is being done to find solutions. An additional solution is

now offered by the newly announced PEPFAR health care workers initiative.

We are engaging with initiatives like the International Health Partnership and the Global Campaign for the Health MDGs – to bring those working on health systems strengthening and the AIDS movement closer together. We can see in just about every region of the world that HIV funding is making a major contribution to health systems, including through funding from the Global Fund, PEPFAR and GAVI. As I said earlier I saw it myself earlier this month in Ethiopia. However, there is virtually no dialogue between the health systems proponents, and those of us working on priority health challenges. This results in misunderstanding, frustration, and even hostility. I can tell you, it's a long time since I've been booed at a meeting! But it happened in Kampala at the Health Workforce Alliance. However, the fact that I was there, forced a badly needed debate and the meeting ended with a request to UNAIDS to take the health system strengthening issue to the International AIDS Conference in Mexico. We will do this. And at the H8 we decided to stop using the polarizing terminology of "vertical", "horizontal" or "diagonal" programmes – basically concepts of the last century and not very helpful in solving todays problems.

I will now turn to UNAIDS. I reported at the last meeting that UNAIDS was taking part in the stocktaking exercise on Delivering as One. Let me first share a few thoughts on this. Overall, the stocktaking report made it clear that the joint UN teams on AIDS have proved a useful model in Delivering as One in pilot countries. But although joint teams are being formed, progress on joint programmes often lags behind. This is partly

because individual agency business practices do not generally favour joint progammes, and partly because headquarters agencies do not always give country offices all the support they need to make joint programming a reality.

The report also highlighted the need for greater adherence by the UN system to the OECD/DAC Paris Declaration. We are keen to do this and our response to the Global Task Team Review is currently being implemented. The Oversight Reference Group will report on progress tomorrow and provide a full review in December this year. In addition, we are a member of the so-called “H8” group of multilateral organizations along with the Bill and Melinda Gates Foundation and we will actively contribute to the Accra High Level Meeting on harmonization and alignment.

More recently we have begun, in collaboration with key partners such as the International Health Partnership to define a common approach for the validation of national AIDS strategies and programmes. I hope the process will strengthen country ownership and facilitate joint support as well as facilitating external financing for these plans, including enabling the Global Fund to include programmatic financing in its portfolio.

Making the money work is all about efficiency, effectiveness, and accountability. In December last year, the PCB approved a new UNAIDS performance monitoring and evaluation framework. However, it appears that this is not meeting the requirements of every single donor. If that is the case, I would suggest reviewing and modifying the existing

framework through a joint exercise, including member states and cosponsors, to arrive at a framework that everyone is happy with and which simplifies review processes. This process could take place within the proposed Subcommittee on Planning and Performance Monitoring, if the Board decides to establish one.

To continue on the accountability theme, I can report a “clean audit” from the external auditors for the 2006-7 biennium. Efforts are underway to simplify and streamline our operations, and we have just launched a management development programme in the secretariat. Given current concerns about the depreciation of the US dollar against other major currencies, we will have to pay more for goods and services than we have in the past.

Since WHO is responsible for the administration in support of UNAIDS, we will join it in introducing a new Enterprise Resource Planning System. This will have a significant impact on the management of the secretariat. While we are confident that in the long term this will bring benefits, a major slow down in operations is to be expected as we move to the new system. Unfortunately some of this is outside our control.

As mentioned at our last meeting, we also continue to improve staff safety. I am therefore seeking your approval of a special allocation to implement the recommendations of the independent review of safety and security of UN personnel and premises that should be completed in June. This is an issue that we will discuss with the Secretary General at the Chief Executives Board next week.

And now to my last point on the institutional side: a governance issue. The PCB has played a key role in creating the space for debate and when necessary to change the response and the direction of the Programme. Now that UNAIDS is well established it is time to strengthen its policy function on aids for the UN system as a whole and make our decision making more efficient. I also believe there is now a need to establish a clear mechanism for taking decisions between PCB meetings. The discussion on the second evaluation of UNAIDS is due to decide on a process for inter-sessional decision making by the Board with respect to the evaluation. It would be useful to have a clear mechanism which applies this to other issues as well, given that it is eight months until the next PCB meeting.

Friends, I will now turn to the last part of my speech today. As we prepare for the second evaluation of UNAIDS, it is time to ask ourselves: "What does the world need from UNAIDS over the next five to ten years and are we set up to meet those needs?"

Today, AIDS is on the global agenda. Since the 2001 General Assembly meeting on AIDS, there has been unprecedented political leadership and civil society mobilization, resulting in massive increases in resources and a huge expansion in aids responses. Millions of lives have been saved. Increased attention to AIDS has also stimulated debate around a wide range of complex issues - such as harm reduction, patents for HIV drugs, and sexual minorities, to name but a few. It has drawn attention to the need for high-quality monitoring and evaluation in development. And

it has created some serious tensions – prevention versus treatment, for example, or investing in AIDS versus health system strengthening.

These developments frame the work of UNAIDS today. So where does this leave us?

First of all, we cannot ignore that political agendas are becoming increasingly crowded. Also that in some circles, paradoxically, the progress we're making in the AIDS response is leading to the perception that AIDS is over funded and has been "dealt with" and therefore we can move to the next problem. We can not let the level of aids commitment be questioned or weakened at this very moment of results. As Amartya Sen observed, action is typically easier to mobilize for visible crises like famines than for chronic problems such as malnutrition. With declining mortality as a result of anti-retroviral treatment, this may happen for AIDS. So we are going to have to work harder and smarter if we are to keep AIDS on agendas and mobilize resources. This will mean nurturing a new generation of leaders like the people I met at the young leadership summit organized by Google and *aids2031* earlier this year. And it will mean generating new leadership within communities and civil society in general.

Second, we have to guard against an ongoing trend to "normalize" AIDS as just another disease. It is far too early to do this. Today nearly 6,000 people will die of AIDS and another 7,000 will become infected. AIDS remains the first cause of death in Africa. Discrimination continues to prevail – even to the extent that people living with HIV are prevented

from crossing some national borders. There is no technology yet to stop the spread – and treatment is still so expensive that for a long time to come there's a need to ring-fence funding for AIDS to assure there's enough money to pay for it. That said some aspects of AIDS do urgently need to be "normalized", such as facilitating access to antiretroviral treatment in regular health services and securing the rights of people living with HIV.

Third, we have to bear in mind the increasing complexity of the institutional landscape for development – particularly for health. The past few years have seen the emergence of new initiatives, mostly initiated by a donor country, new institutions like UNITAID, and proposals for a "global fund for health". Even policy development, monitoring progress, and convening – traditional UN system responsibilities are now increasingly taken up by institutions outside of the UN, backed by foundations, academic institutions and private individuals. UNAIDS, by our nature as a joint programme and our tradition of working with a diverse range of partners, should be well placed to operate in this ever evolving environment. Our operational and institutional relationship with the Global Fund is the key issue for an effective multilateral response to aids and I am pleased that this issue is a priority for our chair.

Fourth, despite significant investments in the aids response, the funding gap is getting bigger. We must broaden the resource base, make financing more predictable – and make AIDS money go further than it does today. This means finding new sources of financing, improving efficiency and accountability, and reducing unit costs. Again – we've started. But we're still only mobilizing half the funds needed to respond

to AIDS each year. And drug costs remain, for many, unaffordable. As more people require second and then third and fourth line treatment, treatment bills can only get higher.

Fifth, we must reinvigorate - if not rethink - HIV prevention. As I mentioned a few minutes ago what is really encouraging is that I see a whole new generation of HIV prevention advocates, led by people living with HIV.

Sixth, we must pay more attention to implementation – to making the money work! Generally speaking, development actors do not apply the science of implementation precisely enough nor use sufficiently sound business practices. This is certainly true of the UN system – for example where there may be hundreds of staff in a given country, compartmentalized in what are often small and less than optimally effective entities. And of governments, who may not fully capitalize on the potential of civil society and other partners.

If we're to do a better job on implementation, we would be well advised to adopt Dr Tedros' motto for the Ministry of Health in Ethiopia: "Speed, volume, quality!" We also need to better connect the operational and governance dots between the AIDS response and other development and health programmes. Sustainable HIV treatment and care need well-functioning health care services. But that won't be enough for sustainable and effective HIV prevention – these have to be embedded in social protection that strengthens community movements and connects with multiple sectors. And one last point on implementation -

while the principles of engagement are similar everywhere, it is clear that the response itself must be tailored as closely as possible to local needs.

Seventh, and finally: we cannot give up the search for a vaccine, a microbicide, new drugs and any technology that can help reduce transmission and eliminate death and disease. This means broadening the research agenda. It means mobilizing funding and attention to an operations research agenda and evaluation research. We need to stay at the cutting edge of what strategies work best under what circumstances and how best to deliver them so that we learn by doing. And it means researching novel approaches to 'implementation science' and interdisciplinary applications to give better insight into ways to systematically tackle the structural drivers of the epidemic.

In other words, we must now fully embrace a long-term view, while continuing with the still much needed emergency response to curb the number of people becoming infected and dying every day. Developing this long-term agenda is the purpose of *aids2031*, an initiative I took following the PCB's approval of some supplementary funds in June 2006. Its full report will come out by the end of next year.

The implications for the UN system's response to AIDS coordinated through UNAIDS are multiple, and I trust that the external evaluation will address these in an ambitious and pragmatic manner. Just as the first evaluation significantly reoriented our work towards country implementation, this second evaluation offers an opportunity to re-shape and equip the programme to confront an ever changing epidemic and

the challenges of a sustainable, long-term response to AIDS. This may require levels of boldness and a willingness to take risks. But remember, that's the spirit in which UNAIDS was created. We've done it before. We must do it again.

But I should make it clear to you now that what I have outlined will be taken forward under new leadership. As you know, the Secretary General reappointed me to serve as Executive Director for 4 years as of 1 January 2005. My term will therefore come to an end on 31 December this year. I believe that this comes at an opportune time for the organization, particularly as we implement the independent evaluation and wait for its recommendations and simultaneously prepare for the next UBW. Both of these developments provide space for my successor to shape the programme as they see fit and under your guidance.

Thank you