Joint United Nations Programme on HIV/AIDS
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Speech

PROGRAMME COORDINATING BOARD

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Speech by
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Mr. Chairman, honourable members and distinguished colleagues, it is a pleasure to welcome you to this ninth meeting of the Programme Coordinating Board.

In my remarks this morning, I will report to you on the current status of the epidemic, highlight the most significant learning points that have emerged over the eleven months since I last reported to you. I will then map out the challenges that I believe the Programme currently faces.

Let me begin with a brief summary of the current status of the epidemic.

You are already familiar with the figures and I will not repeat them.

I would like to emphasize that the impact of the epidemic is now starkly visible in the worst affected countries. Impacts on productivity, including agriculture, lead to knock-on effects in households. In the private sector AIDS undermines development by killing skilled and unskilled labour alike, increasing expenditures and reducing revenue.

In the social sectors, it is well documented that AIDS has drained skilled human resources from health and education. Both teachers and students are affected. In some countries more than 30 per cent of teachers are living with HIV and more now die each year than graduate from teacher training programmes.

As you know, in countries where the institutional and human resource capacity is anyway limited, rebuilding a resource base will be a painstaking process, both in the private and the public sectors.

While the number of countries that experience this level of upheaval remains relatively small, they act as one window on the future. We know that, once the epidemic reaches a certain level – say 5 percent in the general population – the virus spreads very fast. And once this happens, huge social and economic disruption is inevitable. What has happened in the twenty one countries in the world with prevalence rates of over seven percent threatens to happen in many other developing and transition economies if action is not taken now, while the epidemic is still young.

The world's steepest HIV curve in 1999 was recorded in the newly independent states of the former Soviet Union. There is evidence of worsening epidemics in Central America and the Caribbean basin. Leading indicators in many countries in South and Southeast Asia show that there is considerable cause for concern.

And while it is true that we are beginning to see the impact of vigorous prevention programmes in some countries, these countries are still few in number.

Mr Chairman, let me turn now to the most compelling points that have emerged over the past year. I will make six points.

Firstly, the global political tide is beginning to turn.

Bill Foege, in his address to the World Health Assembly last week spoke about a point in every movement when a line is crossed. Of course only history will ultimately judge, but my perception, as I look back over the last year, is that it marks a point in which lines are being crossed in political commitment, in new resources, and new alliances and partnerships to combat the epidemic. In many countries and at an international level, there is, finally, the first indications of a tide turning.

What are these indications?

Most importantly, many countries in Africa have now declared AIDS to be a national crisis and a national priority. Political leaders are speaking out in unprecedented ways throughout the world. New domestic resources are being put into prevention and care programmes, and new international resources are being mobilised.

Shortly after the PCB meeting last year, at the UN General Assembly Special Session on Population and Development, governments agreed that HIV incidence in 15-24 years old should be reduced by 25 percent in the most affected countries by the year 2005.

Another indication: the year opened with the recognition of AIDS as an issue of human security. The UN Security Council debate on AIDS in Africa was a path-breaking event in the political response to the epidemic. It was also the first time that a health issue was discussed at the Security Council.

Furthermore, AIDS is now well understood as a fundamental threat to development. The G77 South Summit in Havanna recognised that the AIDS epidemic is undermining the social and economic development of many of the countries represented.

The far-reaching impact of the epidemic was underscored by the World Bank/International Monetary Fund Development Committee Meeting in Washington in April, which pointed to the fact that there is no other single factor at work in the world today that so systematically undermines the gains of five decades of investment in health, education and the well-being of whole nations.

And this movement in national and international agendas is mirrored by new success stories - in the Bahamas; in Zambia, where prevalence is declining among young people; in Botswana, where falling rates of syphilis and gonorrhoea are likely to be the precursor to a fall in new HIV infections; in evidence of behaviour change in Tamil Nadu in India; and in Brazil, where major steps in access to care are being achieved.

Why is this government-led turning of the tide important? Let me quote from Callisto Madavo, Vice-President of the World Bank. It is important because "only governments can put AIDS at the centre of the national agenda, and not just the health agenda. Only governments can take the tough decisions to create more favourable conditions for others to play their role. And only governments can protect the poorest and the most vulnerable".

So this is a time of great opportunity, but a time also of fragility.

Over the past year we have seen how great steps forward are possible. **But we have also seen how easily political gains can be reversed.**

There is no safe ground in fighting this epidemic, no absolute certainty that a line, once crossed, is safe from backlash and reversals. We have seen HIV positive wives of national citizens threatened with expulsion; people working on HIV prevention can even be imprisoned; continuing discrimination of people living with HIV; we have seen the questioning of the basic science that has taken two decades to accumulate; we see how in some high income countries support for HIV prevention is declining. We know that unsafe sexual behaviours are returning among gay men in some communities.

Indeed, we should remember that the nature of tides is that they turn.

My second point is this: **there is an absolute need to translate global political**

mobilisation into country level action.

While international political mobilisation is key to raising additional financial, human and technical resources, it can never substitute for work in countries. We have to ask how international commitments translate into practical actions, bringing real gains to countries, to communities, and to individuals. It is appropriate in this *global* forum, that we reflect on the value that global initiatives add to country work.

The International Partnership Against AIDS in Africa has at its heart the need to act differently at country level. It is not enough that we make international agreements and goals, if we do not have the will or the skills to translate these into new forms of institutional behaviour at country level. Work that has been done in moving the Partnership forward in countries shows that the concerns we have here in Geneva, or New York, or London are often not known about at country level; and perhaps do not always reflect the needs and realities of countries and communities.

Let us all work together to ensure that the gulf between international political rhetoric and real and lasting gains at country level does not become the widest gulf of all.

This leads directly to my third observation: we are now at a point where we have clearer opportunities to take forward coherent programmes than ever before.

We know what works.

When we look at successful action at country level or at state, district or community level, it has clear characteristics, which, over the past few years, UNAIDS has documented. Successful actions are characterised by 7 features:

1. the impact of all actors coming together under one powerful strategic plan
2. visibility and openness about the epidemic, as a way of reducing stigma and shame, and involving PWAs
3. addressing core vulnerabilities through social policies
4. recognising the synergy between prevention and care
5. targeting efforts to those who are most vulnerable to infection
6. focusing on young people, and
7. last but not least, encouraging and supporting strong community participation in the response.

I am sometimes challenged that the policy prescriptions of UNAIDS don't work. Some say that their epidemics continue to worsen. I reply that we are not offering magic bullets: every country, every community, must find its own way along these principles, and also let's not forget that it may take five years or longer for effective prevention campaigns to show up in incidence data. But the epidemiologic and behavioural surveillance evidence tells us, categorically, that the combination of factors that I have just listed does indeed translate into positive gains over time.

We should refuse to offer anything less. Our partners should refuse to accept anything less.

My fourth point: the AIDS epidemic is an immensely complex development challenge.

It is clear that the epidemic is taking us into uncharted territory in the political arena, and also into new social, medical, and public health spheres. Simple solutions are unlikely to be effective – I am sorry to say. The response to the epidemic is not just about best practice, but about *new* practice; new interpretations; new explanations.

Let me illustrate this:

Access to care for PWAs is undoubtedly one of the most complex development challenges that the world currently faces, raising ethical, political, economic and social issues that most of us would prefer not to have to face.

But we have learnt that complexity should never be a barrier to action. Indeed, we have learnt that the best way to deal with complexity is to wade in. Which is why we have agreed *A Joint Statement of Intent* with five pharmaceutical companies to explore practical and specific ways of working with countries and communities affected with HIV to make care and treatment more available.

We have a moral imperative to work with countries in addressing the complex dilemmas and choices that the HIV epidemic brings.

And now to my fifth point: Partnerships are not an optional extra, but the foundation of taking forward effective work against the epidemic.

Over the past few years, we have talked a great deal about Partnership. So much so that the term Partnership risks becoming devalued and exhausted. But the overwhelming importance of Partnerships in expanding the response is increasingly obvious. It is absolutely clear that we cannot, as individual sectors, provide what is needed to reverse the epidemic. It is equally clear that our default mode, institutionally, is to retreat into what we know and are most familiar with – government to government, UN to UN, donor to donor, NGO to NGO, business to business.

Yet, unless we break out of our boxes, and create new institutional mindsets, we will not tackle the problems that confront us. We cannot come at the problems of the twenty-first century with the mindset of the twentieth. We have to do business differently.

The negotiation, between all parties of a Framework of Action for the Africa Partnership is, I believe, a ‘first’. Representatives from all sectors have sat together and created this framework under which we all agree to work. This is not just some bureaucratic tool, but a process that signals our new intent to work with each other in practical and specific ways. This document does not belong to the UN system. It belongs to the Partnership.

We have seen this partnership process in many countries. In Brazil, between government and NGOs. In South Africa, the nation’s effort against AIDS is conceived and conducted as a partnership under the leadership of the President. In Senegal, in the involvement of the religious leaders in HIV prevention. In India, between state governments, NGOs and academic organisations. In Thailand, between the private sector, the government and civil society, and in the first large scale vaccine trials. In Malawi, between government, donors, NGOs and the UN System. We have also seen it between countries – South to South cooperation such as the Horizontal Technical Cooperation Group in Latin-America and the Caribbean.

And my final point: AIDS is now at the top of the UN agenda. There is the championing of AIDS by the UN Secretary General and Deputy Secretary General, as also reflected in the Secretary General's report to the Millennium Assembly, in which AIDS figures as one of the key challenges for this century. The Administrative Committee on Coordination (ACC), in April, strongly recommended that each UN organisation put AIDS at the heart of its agenda. There was the ECOSOC debate in July 1999 on the UN System's country work on AIDS. The commitments of particularly the World Bank, UNICEF, WHO and UNFPA to mainstream AIDS across their programmes has accelerated significantly over the past 12 months and AIDS is now becoming a true institutional priority. Following the World Education Forum in Dakar, UNESCO's executive board last week decided to make AIDS a priority for the organization and UNDP is reviewing its work on AIDS to do more where it has a comparative advantage. Our new cosponsor, UNDCP is increasingly active in the AIDS field; and increasingly in other UN organisations such as ILO, FAO, UNHCR, UNIFEM and the office of the High Commissioner for Human rights. We would be naïve if we claimed that this institutional commitment had already translated itself into the effectiveness of Theme Groups across the world. There is clearly along way to go. But there is now no doubt about policy commitments among our Cosponsors.

Mr Chairman, let me now, briefly turn to the challenges that face the Programme and the Secretariat over the coming year

There are six key challenges:

Firstly, to maintain and strengthen political mobilisation.

The response is gathering pace. Our task now is to ensure that clear strategies to respond to the epidemic are articulated, that sound evidence is presented on the returns of investing in programmes to address AIDS, and that governments and civil society together assume greater responsibility for responding to AIDS.

It is time for our advocacy to stress solutions, not problems. To stress hope, rather than despair.

Secondly, to accelerate national responses

The biggest challenge in many countries is 'going to scale' with the full participation of communities – and particularly people living with HIV - in the response. The outstanding task is to shift from small or isolated projects to full-scale national programmes

Let me focus on just three issues:

Firstly, identifying appropriate mechanisms to mainstream a response to AIDS is critical. In the last few months, the Secretariat and the Cosponsors have worked hard and with increasing success to demonstrate that AIDS needs to be a central pillar in countries' Poverty Reduction Strategy Papers, and that national AIDS budgets must be fully inserted into those countries' medium term public expenditure frameworks.

We are starting to see AIDS featuring importantly in the PRSPs in countries such as Burkina Faso, Malawi, Mozambique and Uganda. And under the HIPC Initiative, we are optimistic that a number of countries will use debt relief to significantly augment national spending on AIDS. This could lead to a doubling of current spending on

AIDS prevention and care. Pursuing this agenda is an immediate and real challenge.

Secondly, local responses and community mobilisation should become the heart of the response to AIDS. This is where true multisectoral action can happen, action that is relevant to meeting people's needs and aspirations and will result in a sustainable response to the epidemic.

Again, this will require institutional behavioural changes, and innovative mechanisms, particularly for channeling funds to local communities.

Thirdly, supporting an accelerated response in countries in conflict, or moving out of conflict is a still further challenge. The situation in Africa, Eastern Europe and in other areas of the world, makes this a hugely urgent priority for the Secretariat and Cosponsors in the coming year.

The third challenge – to make the International Partnership against AIDS in Africa fully operational and to demonstrate impact

Seventy five percent of the impact of this epidemic is in Africa.

The specific target for 2000 is to accelerate a response in at least 12 countries and a further 12 in 2001, essential if the International Development Target of reducing the rate of infection among young people is to be achieved in the most affected countries. The IPAA presents a single coherent challenge: work together to develop single, powerful national responses.

The fourth challenge: care and the prevention of mother to child transmission

The moral and humanitarian imperative to respond to the many millions of men, women and children suffering from HIV-related illnesses has become even more urgent over 1999. A focus on prevention alone is unacceptable as an international response.

Yet, despite the fact that we are two decades into the epidemic, many countries do not have standards for care worked out, and in place; many donor agencies don't have a strategy. Health systems in some of the worst affected countries have problems in providing basic palliative care. Many individuals are unable to access adequate treatment for TB, and other opportunistic infections, despite the fact that treatments are available and affordable.

Aside from this being a human tragedy, it also slows down prevention efforts. We know that once individuals can see that care is available, both prophylactic and palliative, their willingness to be tested increases. The same is true of Mother to Child Transmission (MTCT) interventions. The impact of going to scale is potentially enormous, raising the visibility of the epidemic and increasing both hope and expectations that this is a crisis with a solution.

The challenge for the Secretariat and Cosponsors is to provide, well-founded guidance and support to countries to assist in building the health systems that can respond to the epidemic, and to find ways of ensuring that community-level care initiatives are encouraged and supported.

This is the context in which to view the announcement that was made on May 11th. Our agreeing a statement of intent is just one step in the complex task of improving the care of people living with HIV. We need to ensure that the lowering of the price of

some medicines stimulates the development of more comprehensive care strategies. We recognise that even at heavily discounted prices, the cost of antiretroviral therapies will continue to be beyond the reach of public sector subsidies, and therefore unavailable to the majority.

Nonetheless, the initiative should ensure that drugs for opportunistic infections are introduced into national programmes safely; and that access to life-prolonging therapy increases by a significant factor over the next five years. We will continue to work on all avenues, including exploring opportunities provided under international agreements such as TRIPS to make care more affordable to the millions who need it. Following on from extensive discussions at the World Health Assembly last week we are in the process of establishing concrete next steps, particularly expanding the consultative process with other stakeholders to include governments, NGOs and donors. We hope that the PCB members will play a role in this process.

Our fifth challenge - to become a knowledge based, and communication-driven organisation.

From its inception, it was clear that the UNAIDS Secretariat was a unique organisational entity, catalysing and connecting, rather than undertaking development initiatives itself. As such, the role of the Secretariat within the UN system is truly as a twenty-first century organisation.

The most valuable commodities of the Secretariat are knowledge and communication. Hence our plans to invest significantly in communications both within the Secretariat and to our external partners. Becoming a powerhouse of information and knowledge, connecting people and ideas will require internal restructuring and refocusing. This is the task for the coming months.

Turning to our sixth challenge: mobilising the resources commensurate with the seriousness of this epidemic

Mr Chairman, we talk about AIDS as the first great challenge to the twenty-first century, yet when we look at the resources that are available to fight the epidemic, the gulf between our rhetoric and our action is overwhelming. The international community has been spending about $200 million a year in preventing HIV infection in Africa. Yet our current estimation is that Africa alone would need between $1.6 billion and $2.6 billion a year to achieve prevention levels at least comparable to what has been achieved in Uganda and Thailand, and a reasonable level of care.

It is true that there are signs of significantly increasing resources from some countries, which are highly welcome. But this is not the task of just one or two high income countries, but of the global community. It is the responsibility of the members of the PCB, and all other forums in which PCB members sit.

Mr Chairman, we will not succeed in driving back this epidemic without a real, substantial and sustained increase in global resources.

To turn to my concluding remarks

I believe that we stand at a turning point for the global response to the epidemic, and

for UNAIDS. Next year sees the evaluation of the first five years of the Programme. This is a highly welcome and important event that we propose to discuss further in more details tomorrow under Any Other Business.

I would like to finish this statement with a comment that I also made at the World Health Assembly last week. There is one commodity, indeed, the most precious commodity, that never shows up in cost-effectiveness and cost-benefit analysis, but which is the key to reversing this appalling epidemic. That commodity is hope, and it is our role as leaders to keep this hope alive.

Mr Chairman, ladies and gentlemen thank you for your attention, and I am looking forward to your guidance.