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Speech

WOODROW WILSON INTERNATIONAL CENTRE FOR SCHOLARS

20 September 2007

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Good morning.

It's a real pleasure to be back here. This is the third time I've spoken here at the Woodrow Wilson Center. I've spent a lot of time in Washington over the years, and this has been always an important stop. The research and the activism at the Woodrow Wilson Center are really crucial for our campaign to fight AIDS.

And it was wonderful to hear Congresswoman Lowey and get her perspective. You'll see that some of the points that I will make are very similar to hers.

A quarter of a century into this epidemic, we're at a turning point. A turning point that, I believe, should force us to take a long-term view for a sustainable response, in addition to the much-needed crisis management we still need to respond to the fact that thousands of people continue to die because of AIDS every day.

I will briefly talk about a few trends of the epidemic, the response, and then give our perspective on the future and what we have to do.

So, what are the trends? First of all, the epidemic is still expanding; it is globalizing. We heard the figures from Nita Lowey. I won't repeat them, but want to highlight something that is not well known: that a disease that was not even known 26 years ago is now the fourth cause of death in the world; the fourth cause after heart diseases, strokes, and respiratory illness.

Secondly, the feminization of the epidemic. It's a trend that I've discussed here before, but it's continuing. In every single region in the world, the number of female infections is increasing – including here in the United States.

Thirdly, we are starting to see the real impact of this epidemic in the worst affected countries. We're starting to see a sort of reverse development - an undevelopment - because of the tremendous human and social capital loss to this epidemic.

We estimate that by 2010, the five most affected countries in Africa will have lost about one in five workers because of AIDS. It is already throwing some sectors into crisis at national level. For example, the mining industry in Botswana loses more than eight per cent of its profits every year

because of costs related to HIV. And in Zambia's tourism industry - one of the future assets of the country – HIV-related costs stand at nearly 11 per cent every year.

And we could devote an entire panel to the issue of orphans and vulnerable children in Africa and elsewhere.

I should say at this point that we need to improve our understanding of the societal drivers of this epidemic. We have had, I think, a good understanding of the biological drivers of the epidemic. But the societal drivers - which are basically the reason why we have this epidemic - have not been studied that well.

It is often said that AIDS is a disease of poverty. It is more accurate to say that it is a disease of inequality. Gender inequality is one of the most striking inequalities – leading to social and economic imbalances that increase women's vulnerability. But when you look at

HIV infection rates by income, it's the highest income category in most African countries that had the highest HIV rates. This is unlike any other health problem. When you look at maternal mortality or child mortality, there's a direct link with low income, but it's less true for AIDS.

I was in China the week before last, and it is clear what is going on there. One day I was having a drink in Shanghai with a Chinese colleague who said, "AIDS in China is about 3M." He explained: "3M: Mobile Men with Money." I would add Mobile Men Without Money, as well. China has a floating population of 150 million: the poor workers who are constructing the Olympics. That's some 150 million men away from their families – many of them with no access to services. Add these to the entrepreneurs and the mobile men with money. And then we see how rapid economic growth and transformation of societies can also become a driver of the AIDS epidemic in some parts of the world. We're seeing that in Vietnam, we're seeing that in China, perhaps tomorrow also in India.

So, economic inequality, social inequality, marginalization of groups because of sexual orientation or drug use; immigrants, gender inequality, lack of access to services; all that creates a perfect storm in which AIDS thrives.

AIDS is very different from other health issues because it's mostly transmitted by sex. We have to remember this when we design AIDS strategies. It's just another illustration of the exceptional nature of AIDS. AIDS is unlike any epidemic that we've known. It's not just one of many infectious diseases; it really belongs in the league of climate change, nuclear threats and so on.

But I feel that while we're at a turning point, there is real hope today. And it's evidence-based or evidence informed hope; it's not just something that we wish will happen. It's supported by facts.

Take treatment, for example: there are around two and a half million people on antiretroviral therapy today in the developing world. When we had the historic special session in the General Assembly on AIDS in 2001, only about 100,000 men and women - particularly men then - were on antiretroviral therapy in the developing world. Most of them were living in Brazil because it was the first country in the developing world to offer treatment at state expense. This is major progress.

We are also starting to see results of prevention efforts. There are declines in infection rates in most East African countries - even in Zimbabwe – in Cambodia, in Barbados and in the Bahamas; on every continent except the former Soviet Republics.

It's true, as we just heard, that in Uganda we're starting to see a reversal in some communities - just as we are seeing it in gay communities in Western Europe. But for the first time in the history of this epidemic that we're seeing some real, positive results on a large scale.

A less well known, but I believe equally important development, is that investments in the fight against AIDS are having an impact beyond AIDS. Let me give you just a few examples. A recent study done by FHI in Rwanda showed that those primary health care centers where basic AIDS activities were introduced and were added, have seen a much higher coverage and uptake of services beyond AIDS - maternal and health services, reproductive health services, particularly.

We are also seeing that because of AIDS, there has been more investment in programs on violence against women, sexual violence; something that of course long predates the AIDS epidemic, but an issue that had received very little attention except at micro project level.

So we're seeing how work on AIDS can open many doors for action on some long-standing issues, and for development.

However, despite this progress, there is no scope for complacency. All these lives saved, all these positive results are directly due to the significant increase in the world's commitment to fighting AIDS. When UNAIDS began its work in 1996, about $250 million was spent on AIDS in developing countries. This year we estimate this to rise to about $10 billion. This is a huge increase;

unprecedented in development, I would say. And while this is still not enough, it's a pool of money with which we can do quite a bit, so it's about time we started to see results.

In recent years, the world has established new mechanisms to fight the epidemic; the Global Fund to fight HTB malaria is the main multilateral instrument to do this. It was created in 2002, and it is also starting to have a true impact on the lives of people. Next week in Berlin there will be a replenishment conference for the Global Fund, where all the donors are coming together to make their pledges. This will be a new test for the commitment of the international community.

But the most significant infusion of leadership, of money and commitment, has come from the United States, through PEPFAR. I would say that US leadership has truly transformed the global response to AIDS and the course of the epidemic. As we've heard, it really enabled us to make a qualitative and a quantum leap forward.

I remember when in 2000, at the International AIDS Conference in Durban, I called for a shift from the M word to the B word, from millions to billions, because then we were talking about adding a few million, maybe a hundred million dollars for AIDS. It sounds totally ridiculous retrospectively, but when I called for that I had some real problems with some of the donors, who said that somebody in my position should not make these kinds of irresponsible statements, and that in any case, that money is not there. But seven years later, there's $10 billion on the table. And that's really in the first place thanks to American leadership. So I would really like to pay tribute to Mark Dybul and his team at PEPFAR, and all the many partners for having done the impossible – or what appeared to be impossible.

At the 2005 G8 summit at Gleneagles, the leaders of the most powerful economies of the world made a commitment that was incredibly bold, to come as close as possible, as the text said, to universal access to HIV prevention, treatment, care and support. This was further agreed by the General Assembly of the United Nations. And this is really our ultimate goal. We cannot rest until the last person living with HIV has access to treatment. We cannot rest until we're reaching everybody with prevention activities, and transmission is stopped.

This is a crucial mission, but today we're not on track to achieve this. At the current pace, there will be fewer than 5 million people on treatment by 2010; just over half of the people who will need it. And when you look at coverage of mother-to-child transmission prevention programs, they are very, very, very low in many countries, although some, like Botswana, have done remarkably well. And this is not politically controversial; it's not about sex and drugs – it's about mothers and children.

So there's clearly a problem there. The only solution is to increase our efforts. We're at a turning point in the epidemic, and a turning point here in Washington and in many other capitals because there's a change in leadership. You're electing a President next year. In France, Germany, the UK, Italy, there's been a change of Prime Minister or President over the last 12 to 18 months. In Africa, President Obasanjo, a great AIDS activist, has now also retired, so we are in a new era of leadership.

I have a new boss too: Secretary General Ban Ki-moon, who comes after Kofi Annan - a major AIDS activist, if you want - a great supporter. And I am happy to say that Secretary General Ban Ki-moon also has declared that AIDS is one of the priorities for his tenure.

But we still have to work to maintain AIDS as a priority. We must move forward in what we're doing, or we will slip backwards. Sometimes I hear "AIDS is done." Because when you have some positive results, the easiest thing to do is say, "It's done," and move to the next thing. And there are so many problems in the world that this is understandable.

But AIDS is not done.

Let me now turn to what I see as key issues for the next phase of PEPFAR. These are largely based on some surveys we've done in the field. I should add here that we really have an excellent collaboration on the ground with PEPFAR.

I'd like to mention three areas, and some of them very similar to what we just heard from Nita Lowey.

The first one is building on PEPFAR's successes - to promote a truly global effort through increased funding.

The second is to add a sustainability strategy to our current emergency management and response.

The third is to maximize the effectiveness of investments through partnerships and better coordination.

Okay, on the first point, on funding -- as I mentioned this year, $10 billion, more or less, will be spent. This is only slightly more than half of the global need. If you're going to achieve universal access to HIV prevention, treatment, care, we will need a major increase in funds.

As far as PEPFAR's reauthorization is concerned, Congress will soon debate the funding levels of PEPFAR over the next few years. President Bush has requested $30 billion, which works to about $6 billion per year. That is a very large sum to be sure, but more is needed. So I urge Congress and the President to go further, to continue on the same upward trajectory that Congress and the administration have been following during the first five years of PEPFAR.

I am not alone in calling for a significant increase. A recent poll by the Keiser Family Foundation tells us that 60 per cent of Americans say that the US has a responsibility to spend more to fight AIDS in developing countries. So we simply can't afford to drop the ball now on a path to universal access to HIV prevention, treatment, and care. What are some of the reasons?

Just consider five points. One - the most obvious one - is that failure to increase efforts will not meet the increased needs, and will result in far more deaths. That's one thing.

The second point, I think, is very important. It's something we've learned in AIDS, it's true for a number of other issues: act now, or pay later.

If we had acted with the same resources and determination and political will that we have today 10 or 20 years ago, the AIDS bill would have been much cheaper. We would have not only fewer deaths, but we would not have the disaster we have today. So if we delay increasing investments now, five years from now the bill will be even higher - particularly if we continue to fail on HIV prevention. That's a real, major reason to act now.

Thirdly, as I mentioned, AIDS action is key to improving health systems, if only because in many countries 50 percent of hospital beds are occupied because of AIDS. AIDS is adding to the already enormous burden on health systems in many countries. If we can't reduce that burden through antiretroviral therapy, the situation will only get worse.

Fourth, we will be more efficient and more cost-effective in the future. A lot of energy and time has been invested in setting up systems - supply chain management, procurement, community activities. Building on this will mean we have more economies of scale in the future.

And lastly, we must not waste the investments that have been made. If we do not continue on the trajectory that we've been on for the last five years, we'll undo the good that has been done.

As a European, I can also say that putting more money into PEPFAR will compel the rest of the world to do the same. When President Bush announced in his State of the Union Address in 2003 that this country would put $15 billion on the table in the fight against AIDS, others followed - first the UK, and then others. This has happened again and again. That's the power of American leadership. It may not be visible here in Washington, or generate more credit here, but from a global perspective it is extremely important.

These are all compelling reasons to go beyond what is being done now, and not go for more or less flat continuation of the effort.

Moreover, as well as increasing funding, we must maximize the effectiveness of our investments through partnerships and better coordination - the point that we just heard from the Congresswoman. And we must make that money work more for people on the ground.

It's not just a case of needing more money, but of making sure that the money there is spent more efficiently; that we get more for it. "Making the money work" is our mantra in UNAIDS. Every staff member knows that this is what we're doing at country level with PEPFAR and with the Global Fund. It means maximizing our effectiveness by improving coordination among donors, government implementers, and so on.

As you know, we have a framework for this coordination: the Three Ones. And we have seen how it works. PEPFAR and other efforts have had their greatest successes, for example, in Rwanda, where governments are full partners, and the US AIDS effort is fully integrated with national strategies. This may all sound a bit tedious and even bureaucratic, but it is actually the difference between fighting AIDS effectively or losing ground.

And finally, this is the time to add a long view, long-term view – to add sustainable strategies to the emergency response: the "E" in PEPFAR.

An emergency response was - and remains - absolutely necessary. And shifting towards sustainability has a number of implications. First, it means supporting a country-driven and flexible response that

allows for an enhanced focus on prevention. I won't repeat what the Congresswomen said, but do want to remind you that for every person who is put on antiretroviral therapy, six become infected with HIV.

To get ahead of this epidemic, greater investments in prevention are absolutely essential. And prevention approaches must be designed according to the epidemic in the country, and the cultural and social context. It means minimizing programmatic set-asides to foster an appropriate balance among prevention, treatment, care and support in each country - and increasing support for gathering evidence about solutions that work.

As I've said so many times, anything that has the word "only" in it doesn't work for AIDS, whether it's treatment only, prevention only, condoms only, abstinence only, male circumcision only. I get all these letters saying, "If only Dr. Piot would do this, we'd stop this epidemic." But this is never true: we need it all – a truly comprehensive approach.

This means investing systematically in countering the drivers of this epidemic. We've mentioned inequality and stigma. The issue I'd like to highlight is the low status of women. This is the major driver of the epidemic in many countries, and an area where we need to have a far more rights-based approach.

This means tackling some tough questions. Yesterday I was at the CSIS, at a panel on gender and AIDS and PEPFAR. And as Geeta Rao Gupta said, "It can be done." This is not something that is a hypothetical intellectual framework; it can be done. We have examples of solutions that work. For example, how violence against women and male attitudes and behavior can be changed by programmes like Stepping Stones in Africa and elsewhere, the IMAGE microfinance programme, and so on.

So I urge everybody working on AIDS to ask ourselves, "Does this program work for women?" If our work doesn't work for women, it doesn't work at all.

And then we must invest also more in strengthening the systems to deliver. Health systems, human resources for health, absolutely, but more than these. Because in the case of HIV, prevention is largely happening outside the health sector. It's not going to be fixed by more doctors, more nurses; it's outside. So we need to invest, also, in the capacity of communities to respond and in countries' capacity to manage their programs.

Let me conclude by saying that we have, without any doubt, made major, major progress in the fight against AIDS worldwide, and that this is a real tribute to American leadership.

But today, as we prepare for the years to come, and as we make our budgets and formalize our plans, we must commit ourselves to not simply continue our efforts. We must intensify them and adapt them to the new reality on the ground; the new reality that we've all created.

We cannot predict the future, but we can create it.

The mark that AIDS makes on history from this day is not out of control. We have the evidence now; it's largely in our hands.

So my question is really, Washington, are you ready to make another breakthrough in the fight against AIDS?

Thank you.