

Speech

Economic Commission for Africa

Entering a new phase in the response to AIDS in Africa

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Mr Chair, Mr Janneh, distinguished delegates. I am pleased to speak to you today on behalf of the United Nations Joint Programme on HIV/AIDS.

It's really good to be back among you. It is nearly nine years since I first had the honour to address you, at a time when the AIDS epidemic in Africa was continuing to spread in a silent way without much response. Today it is a big change. Like climate change, AIDS is a global issue that affects us all. And like climate change, its impact on Africa is particularly extreme. It is critical to address both – there can be no question of concentrating on either climate change or AIDS. So I welcome the fact that the Commission has put the two items so prominently on the agenda.

I also welcome this opportunity to resume an important dialogue. Finance and planning ministers have a crucial role to play in responding to AIDS – as vital, in different ways – as that of health ministers.

I want to take this opportunity today to highlight three things. First, I want to start with a reminder of the impact of AIDS – social, demographic, and economic. Second, I will describe some of the progress made so far on addressing the epidemic – and paying for it. Third, I want to look ahead and take a long-term view of the AIDS response.

(SLIDE 2: spread of HIV in Africa) More than 22.5 million people are currently living with HIV in sub-Saharan Africa – that's the equivalent of the entire population of Ghana. This slide maps not only how the HIV has rapidly spread across the continent, but also that there is a high diversity of HIV prevalence among countries – and, I should add, also within countries. Some countries have the highest HIV prevalence in the world, and others have lower HIV prevalence than Washington DC.

Despite the tremendous advances in the provision of antiretroviral therapy in recent years, AIDS continues to be the leading cause of death for African adults. **(SLIDE 3: causes of death in Africa)** Some 1.6 million people died of AIDS in sub-Saharan Africa last year, preceding malaria and pneumonia as causes of death.

The implications for economic development are all too clear. AIDS increases demands for state spending on health and welfare, and at the same time depletes the workforce, reducing governments' ability to raise taxes - in some cases (Botswana for example) by 20%. Research shows that in severely affected countries, AIDS can reduce annual GDP growth by up to 1.5% over the short to medium term.

The effect is particularly marked because AIDS mostly kills young adults in their productive and reproductive prime. **(SLIDE 4: HIV prevalence and income inequality in sub-Saharan Africa)** And, contrary to popular belief, AIDS is not just a disease of poverty, it is foremost a disease of inequality – as shown here on this graph. The countries with the highest GNI coefficient have grosso modo also the highest HIV prevalence. In addition, HIV incidence in Africa has tended to be

most concentrated among wealthier – and more educated – groups, with serious implications for the skills base. **(SLIDE 5: income and HIV)** This slide shows that in six of eight countries, HIV prevalence is highest among the wealthiest women. The same is true for men. As a result, several countries are already seeing a decline in skilled workforces – including in the health sector – partly due to migration, partly because of AIDS.

However, it is the poor who are most affected by AIDS. Affected families – particularly those who are already poor - struggle to make up for lost income and cover AIDS care and support costs. One frequent casualty is investment in the next generation's human capital - notably education **(SLIDE 6: Change in Mean Years of Schooling by Local HIV Prevalence)**. This graph shows how higher infection rates result in a decrease in schooling.

Previous to this session, we had a lively debate on climate change, which has emerged from a long-wave event to an acute crisis. It will take many years to overcome this challenge. AIDS is still a crisis by any standard, with nearly 6,000 deaths a day, but it is now emerging as a long-wave event. Therefore we must adapt our AIDS responses to include this long-term perspective.

This may sound like a lot of bad news, but there is good news too. Many African countries have made real progress on treating people living with HIV and preventing new infections. During my recent visits to countries across Africa, I have been really struck by how far we have come since I first started working on HIV in the early 1980s, in what was then known as Zaire. We are clearly entering a new phase in the response to AIDS in Africa, where progress is revealing new challenges.

(SLIDE 7: number of people on ART in SSA 2002-7) The single most impressive statistic is that two million Africans are now taking anti-retroviral treatment – this was an unthinkable development back in 1999, when combination antiretroviral therapy was very new and very expensive. Imagine for a moment what would have happened to those two million people without this expansion in treatment. Most would be dead by now, and they would not be contributing to economic growth in the region. Countries such as Botswana, Namibia and Rwanda have almost reached universal access to antiretroviral treatment (80% of those in need), and in our host country, over 40% of those in need have started treatment. I fully expect the national progress reports submitted to the United Nations this year to reveal that more African countries are closing in on this target. This is a remarkable achievement – even though 5 million Africans still require antiretroviral treatment, and will die if they are not able to obtain it.

(SLIDE 8: estimated number of new infections 1990-2007,) The other good news is that overall, new HIV infections in many countries are falling. These are signs that HIV prevention is working. But this is not the case everywhere. Indeed, in a few countries where HIV infections had previously dropped, such as Mozambique and Burundi, new infections are now on the rise. HIV prevention is not a short-term project – it must be doggedly pursued day after day for decades to come.

So, today Africa is showing the world that AIDS is a problem with a solution. Africa is fighting back with results. This is new, along the lines of Prime Minister Meles Zanawi's speech this morning. Progress has been made for a number of reasons.

First, countries make headway on AIDS when leaders make it a priority. I remember how in 1999, I spoke in this very same room. The initial reaction to my speech was dead silence. Then the Minister of Planning from Benin, Albert Tevojerou, spoke up. And after that one minister after another added something – often a personal story. I knew then that the silence on AIDS had been broken.

In April 2001, two years later, African heads of state agreed on the “Abuja Declaration on AIDS, Tuberculosis and Other Infectious Diseases” at the African Union Summit hosted by President Obasanjo. They described AIDS as a “state of emergency” for the continent. They pledged to place the fight against AIDS as the highest priority issue in national development plans, and to allocate 15 per cent of annual budgets to improve the health sector.

Now, in some 30 African countries, national AIDS bodies are headed by the president, vice-president, or prime minister. This reflects the fact that the AIDS response depends on the close involvement of ministries such as education, development, social services, defence and your own ministries of finance and planning. It also shows how many aspects of HIV prevention fall outside the health sector. This is why national AIDS programmes must be included in poverty reduction strategies, national development plans, the country strategy papers of the African Development Bank and the country assistance strategy of the World Bank.

A second key factor in the progress against the epidemic has been a dramatic increase in funding for AIDS in low and middle income countries since the General Assembly held its first Special Session on AIDS in 2001. **(SLIDE 9: funding 1986-2007)** Remarkably, the General Assembly at that time set a goal to mobilize at least US\$ 7 billion a year for AIDS by 2005, and for once we achieved that goal. Last year, global investment in AIDS went up to US \$10 billion. Two thirds of that money was provided by bilateral channels – predominantly the US President's Emergency Plan for AIDS Relief – and multilateral channels, notably the Global Fund to Fight AIDS, Tuberculosis and Malaria. The other third came from low- and middle-income countries themselves.

Around US\$ 4 billion of donor assistance was spent in Africa, with bilateral donors providing around US\$ 3 billion and multilaterals almost \$1 billion. African countries themselves – particularly the high middle income countries of southern Africa - have been increasing their own investment in AIDS strategies. For example, the AIDS budget in South Africa is an impressive close to 4 billion rand – about half a billion US dollars – and the Government of Botswana finances 80% of the country's AIDS effort. **(SLIDE 10: domestic public per capita expenditure on AIDS in SSA countries)** It is important to note, however, that in some countries, much of domestic expenditure is “out of pocket” – paid by the people themselves.

But even this increased funding still falls a long way short of what is required. In some countries, the cost of meeting antiretroviral treatment needs alone is more than 25% of the existing health budget. On top of this are other, non-health-related costs - such as caring for orphans, provision of food support and social welfare, tackling gender inequities and establishing sex education programmes in schools. Some of these costs are recurrent. Others are one-off start-up expenditures, such as introducing sex education programmes. Once it is introduced into the curriculum of the public school system, it becomes part of the system. UNAIDS projects AIDS resource needs for sub-Saharan Africa to stand at US\$7.5 billion in 2010 – if current rates of service provision scale-up are to continue. **(SLIDE 11: resource needs – phased scale-up projection)** Financial needs will continue to go up for many years to come, mainly because more and more people living with HIV will require treatment. So there is still a very serious funding gap for the AIDS response. Our task today is to find ways to assure that funding, and sustain it through the decades to come. And obviously, given all the different priorities competing for funding, we must not only consider funding for AIDS, but all the other Millennium Development Goals, many of which are under-funded.

Overall official development assistance for Africa in 2006 stood at some US\$41.5 billion. As I mentioned, some US\$3 billion of this was spent on AIDS. **(SLIDE 12: OECD DAC spending on health 2000-5)** But as we see here, ODA spending on health by the OECD Development Assistance Committee members increased steadily in the first five years of this century. And although AIDS spending has gone up more than other elements of the health sector, it has not done so at their expense, except for reproductive health. The increase has largely come from new sources.

There is an argument that it may make better financial sense to invest more in the health sector, because this will automatically improve HIV treatment services. But the reverse is also true, as we can see here in Ethiopia, where Global Fund and PEPFAR funds are being used to construct new health facilities and reinforced overall laboratory capacity and pharmaceutical distribution systems. And in Rwanda, AIDS funds have paid for the refurbishment of health centres, human resources, and a health insurance scheme.

In many countries, HIV treatment keeps desperately needed health workers alive, well, and able to work. And in countries where a large proportion of hospital beds are occupied by patients with AIDS, HIV treatment is reducing hospitalizations, freeing up health workers and valuable resources to dedicate to other health care.

Responding to AIDS cannot be disconnected from overall development efforts. That is why AIDS responses must be at the centre of overall development strategies. Making headway on AIDS is critical to making progress on other Millennium Development Goals – particularly those related to health. **(SLIDE 13: Changes in under-5 mortality)** Increases in under-five mortality in Zambia, South Africa, Zimbabwe, Botswana, and Swaziland are largely due to high HIV prevalence rates. Surveys in Malawi and Zimbabwe suggest that the risk of

pregnancy-related death is eight to nine times higher in women who are HIV positive. A recent review on progress toward reaching the MDGs argues that the AIDS epidemic represents the greatest emerging threat to TB control. So our challenge today is to ensure that AIDS funding is generated and spent in ways that achieve optimal results – for AIDS and for development in general.

The key here is, as I mentioned earlier, to plan for AIDS in terms of a long-wave event. **(SLIDE 14: Epidemic curve, Barnett)**. The epidemic has now evolved more than 25 years – a short time from a historic perspective – and the epidemic is still evolving. For example, HIV infection patterns are changing in many countries in eastern and southern Africa, with most people now being infected outside high-risk sexual behaviour. And new drug resistances emerge, creating a need for new lines of antiretroviral treatment.

This brings me to my last point: the response to AIDS is entering a new phase, a phase that must combine continuing crisis management and a long-term, sustainable response. Tackling this will require a major, sustained effort by countless players. The advantage we have now – that we didn't have when I spoke to you last – is that we have results to build on. Our challenge is to both amplify those results, and to respond to new challenges, such as the long-term costs of antiretroviral therapy.

But the main gap here is HIV prevention. So far, progress on HIV prevention has lagged a long way behind progress on treatment. For every person who starts taking antiretroviral treatment in Africa today, another 2.5 become newly infected with HIV. So the lines of people needing HIV treatment are getting longer. The financial implications of this are obvious.

So we have to do two things. We have to do more and do better today – and we have to lay the foundations for a comprehensive AIDS response that is strong enough to meet needs in 10, 20, 30 years time. You cannot deal with AIDS on a fiscal year basis. Efforts to finance AIDS programmes must consider what is needed now, and what is needed over the longer term. At the same time, we must increase efficiency.

First, let's look at financing mechanisms. Clearly, most countries in the region will struggle to cover the cost of responding to AIDS and meeting other development needs for the foreseeable future without external support. **(SLIDE 15: volatility slide)** Nevertheless, as is well documented, there is a risk of being too dependent on external sources, in part because of their volatility, as shown on this graph.

As is always the case with AIDS, there is no one-size-fits-all. It is critical that each country – particularly the most affected – build a medium- and long-term (5, 15-25 years) financing map based on the pattern of the HIV epidemic, existing financial mechanisms and the economic situation. The AIDS epidemic dramatically highlights the need to develop much-needed health insurance schemes to cover catastrophic illness. These insurance schemes are being started or planned in several countries.

In several countries most affected by AIDS, additional fiscal space is required for the AIDS response. How this space is created must depend on the individual situations of each country, not on externally imposed schemes which don't take into account the devastating impact of the epidemic.

At the same time, there is a clear need for more external funding, and for ensuring that funding is available for years to come. At the moment, it is difficult to predict the amount of external funding that will be available for AIDS in five years, much less 20 years. By contrast, we do know that AIDS will continue to be a major challenge in 20 years time. So I cannot overemphasize the importance of donor countries making better progress on their commitment to move towards devoting 0.7% gross national income to foreign assistance and to move from ad-hoc annual funding cycles to multi-year contributions.

It is also time to change the eligibility criteria for ODA. Economic eligibility criteria are not enough on their own: it is also important to base funding decisions on the extent of the AIDS epidemic. In this spirit, the middle-income countries in southern Africa that are so dramatically affected by AIDS must have access to the most favourable funding mechanisms, and the IMF, the World Bank and individual donor countries must adapt their policies to the reality of the epidemic.

Second, we must increase efficiency. This brings me to one of our mantras at UNAIDS: Making the Money Work. **(SLIDE 16: Tanzanian spaghetti)**. A major issue is harmonization and alignment. Here you see spaghetti of various institutions and funding mechanisms of the AIDS response in Tanzania. Without serious harmonization and alignment, the transaction costs are enormous, and I sometimes wonder who absorbs whose capacity. This pattern of funding flows will be familiar to many of you. Full implementation of the 2005 Paris Declaration on Aid Effectiveness – by both donor and recipient governments - is critical.

(SLIDE 17: Three Ones) This is why the Three Ones Principles were agreed by a broad set of countries and development partners – one agreed AIDS action framework, one national AIDS coordinating authority, and one agreed country-level monitoring and evaluation system. But the Three Ones is not just for donors. It also calls for new levels of cooperation from different ministries, including finance, planning, health, justice, women, and education – as well as non-governmental partners and the UN system. And it requires a high level of adaptability – and accountability – from us all. It requires a change in how all of us do business – to use the motto of Health Minister Tedros Adhanom of Ethiopia, “speed-volume-quality”.

One way to increase efficiency is, obviously, to bring down unit costs. **(SLIDE 18: Uganda)** Over the past ten years, we have made some quite remarkable progress on reducing the cost of antiretroviral drugs, as you can see on this graph of Uganda. The World Trade Organization agreement in Doha in 2001 took a major step forward when members agreed to allow countries facing public health emergencies to waive patents and import generic versions of drugs – provided some compensation was provided to the patent holder. Since then the Clinton

Foundation has continued to work to reduce prices further. Today, the cost of keeping one person on treatment for one year is down to US\$ 130-150. But the problem has by no means been solved - particularly when it comes to the second and third line drugs required by people who've developed resistance to first line treatment.

However, improving cost efficiency is about more than cutting the cost of antiretroviral drugs. It's also about optimizing economies of scale - improving performance and increasing technical efficiency. **(SLIDE 19: variation in unit costs)**. For example, this slide shows the enormous variation in the cost of providing voluntary testing and counseling. And I am sure similar graphs can be drawn for many other services. We must do better, and we must invest much more in developing capacity.

Finally, it is important to stress that a long-term response to AIDS not only has financial and programmatic aspects – there is also an important political element, even sovereignty. Just consider the political implications of depending on foreign aid to keep hundreds of thousands of individual alive, day after day.

So where does this leave us? I believe we are at a crossroads – at the start of a new phase in the AIDS response. It is a new time, along the lines of what Prime Minister Meles told us this morning. This region has pioneered some of the most dramatic progress on AIDS so far. We have a real chance now to magnify that progress and build a healthier, more prosperous Africa.

The task is a complex one that requires new approaches and new collaborations – within and between countries.

First, this means keeping promises – such as the one made in Abuja in 2001. The G8 and other major donors must also make good on their pledges to increase official development assistance – and making it as simple as possible for countries to access and use those resources.

Second, to make the money work we must all do our utmost to strengthen the capacity of national AIDS bodies, of health and social systems and community structures so they can fulfill their leadership, governance and implementation roles. Key to this is improving the flow of resources from national level to the communities who need them. As Dr Pachauri reminded us, for climate change, the answer must come from local community. The answer can only come from within. From the outside we can support the country. And there's also a need for closer regional and south-south cooperation to increase efficiency, including on the regulation, production and distribution of antiretroviral drugs and new products. But above all, we must intensify social mobilization, social change and economic development to ensure that the young generation of Africans remains HIV free.

Thank you.