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Speech

[Note: Speech delivered in French
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French translation to follow]

Opening of 15th International Conference on AIDS and STIs in Africa

"Africa's Response: Face the facts."

Dakar, 3 December 2008

Speech by
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I must first salute the Government of Senegal and my old friends, conference co-chairs Professor Pape Salif Sow and Professor Suleymane Mboup for organizing this 15th ICASA. It is good to be back in Dakar, in the company of so many key actors on AIDS and STIs in Africa.

I arrived here yesterday from South Africa, where I saw very positive signs of strong new leadership on AIDS. The National AIDS Council has a clear agenda, and it is good to see government and civil society really rallying together to achieve this.

Before South Africa I was in the Democratic Republic of Congo – where my own African roots lie. It was great to catch up with friends and colleagues, and to see the progress being made. But it was a sobering visit. The conflict in the east – and its impact on the civilian population – is horrific. I can only echo the calls of the United Nations Secretary General and others for an immediate end to the violations of men, women and children in this part of the country.

These two visits highlight three things: the enormous needs for action on AIDS in Africa; the tremendous difference in those needs from country to country (and even within countries); and the increasing energy and commitment Africa itself is investing in meeting those needs.

They also highlighted the importance of this conference. The International Conference on AIDS and STIs in Africa provides a vital opportunity for Africa and the rest of the world to really focus on AIDS across this, the hardest hit continent of all.

This particular meeting comes at a critical moment – both in terms of the AIDS response and Africa's development.

My friends, we've reached a new phase in the response to the epidemic – a phase that will be long and challenging.

In this new phase, AIDS investments are finally beginning to generate real results in Africa. In 2007, there were fewer new HIV infections and fewer deaths from AIDS – evidence that HIV prevention and treatment programmes are starting to have impact.
Meanwhile, it has become increasingly obvious that AIDS, like climate change, is a highly complex, long-wave event. It will require serious attention from a wide variety of actors for generations to come.

For although we have made progress, AIDS remains the top cause of death in Africa. It is still killing young adults, at their productive and reproductive prime. And women are still disproportionately affected. People are getting infected with HIV faster than they are starting

on treatment. Those who say AIDS is over, or that too much money is going to fight AIDS, are deluding themselves.

Our capacity to tackle AIDS effectively over the longer term will largely depend on our ability – and willingness - to urgently find answers to some key questions: Where is the epidemic going? How do we respond to AIDS in the future? Who will pay for the response, and how? How can we sustain leadership for AIDS over the longer term and how can we create positive linkages with other health and development programmes – including those focusing on STIs?

In response to the first question, it is important to recall that the AIDS epidemic is a heterogeneous one. In Africa, prevalence ranges from below 2 per cent – lower than in Washington DC! – here in Senegal to over 25 per cent in countries such as Botswana and Swaziland. Not only that, transmission patterns and trends vary enormously both between and within countries.

The epidemic is also continually evolving. New waves of infections appear constantly. Infection levels are rising among drug users in Kenya and Mauritius, and there's recently been a resurgence of infections among pregnant women in parts of Mozambique. In many countries, infection rates among people in stable heterosexual relationships are growing. Infections are also increasing among men who have sex with men.

Future epidemiological trends will depend on a wide range of factors – many of them social and economic. We cannot ignore the impact of conflict and natural disasters. We need to start anticipating those trends accurately now, so we can target AIDS strategies where they are needed most.

So what do we need to do?

First we need more of the same – a lot more. Coverage of HIV prevention and treatment is still far too low to have lasting impact.

Second, if we are to treat AIDS effectively in the future, more people need to know their HIV status, and health systems need to be stronger. This means we must team up with those working to strengthen health systems and the health workforce. Though it's a good thing we didn't listen to those who said we should wait until health systems were stronger before rolling out treatment access: I dread to think where the two million people now on antiretroviral therapy would be today if we had waited.

We also need to have the right drugs and get them to the people who need them. We will require more durable and better tolerated first and second line regimens, and – conceivably – effective third line drugs. Pricing will remain a key issue. So will equitable access.

Ultimately, however, our ability to treat aids in the future will depend on the extent to which we have been able to prevent new HIV infections in the first place.

To seriously reduce new HIV infections, we need to do four things.

One, customize programmes to meet local realities.

Two, follow the example of the Avahan project in India and bring in real business expertise.

Three, tackle tough social issues so we reduce risk and limit vulnerability.

Four, mobilize the same levels of activism – and action – around HIV prevention that we've seen around treatment.

The third question is how will we pay? Because, whatever some people say, there's not too much money going to AIDS. In fact, there is a shortfall of billions of dollars. The current financial crisis clearly makes bridging this gap all the more challenging. International development aid and domestic budgets are – or will be - feeling the strain worldwide. Our challenge now is to ensure support for what's been started, and secure funding for scale up.

This will require us to reassess what resources we need and adapt to fit the new realities around us. It is time for us to get better at identifying real needs and improving efficiency. Above all, we must focus 100 per cent on results – on saving lives.

The fourth and final question relates to the longer term. This means sustaining the high levels of leadership that have enabled us to make progress in the first place. It means empowering multi-sectoral national AIDS councils to develop and implement multi-year programmes. And it means shifting *now* to a more stringent focus on HIV prevention, on building closer synergies with other health and development issues, and on structural and social change.

Having been involved in AIDS in Africa for the past 25 years, I am absolutely convinced that unless that long term view prevails, we will never get ahead of the epidemic.

Friends, at the end of this month, I will leave UNAIDS. I want to take this opportunity to thank you all for your incredible commitment, for your support, and – above all - for your friendship. There are so many heroes in this room I can’t begin to name you all. But I do want to acknowledge my debt to you all.

I also want to end with a promise. I may be leaving UNAIDS, but I will not stop working on AIDS. Nor will I stop working with Africa.