UNAIDS EXECUTIVE DIRECTOR'S REPORT

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OPENING OF THE 38TH MEETING OF THE
UNAIDS PROGRAMME COORDINATING BOARD

Ending the AIDS epidemic by 2030

A new declaration to end AIDS

Ladies and gentlemen, dear friends, members of the Programme Coordinating Board: good morning and welcome to the 38th meeting of the Board.

Let me begin by saying thank you to each of you. Without this Board, our progress would not have been possible. You have been a leading force, not only in shaping the future of the AIDS response, but also in ensuring that we do not fear it. And that is very important. You have been transparent. You have been unafraid to discuss difficult issues. UNAIDS is what it is because of you. I am proud to have you behind us and challenging us.

Without you, we would have not been able to secure the Political Declaration on Ending AIDS at the United Nations General Assembly High-Level Meeting on Ending AIDS, held in New York, United States of America. I know what you did behind the scenes, working day and night to get the necessary commitments. I want to personally thank Switzerland and Zambia for their leadership and all of our colleagues for working long hours to make sure that strategic communications were shared with Member States and civil society, creating important space for participation and dialogue. Finally, I want to thank our Cosponsors, who enabled us to come together and set the agendas that will pave the way to the end of AIDS.

Let me take a moment to recognize the contributions of our friends Colin McIff of the United States Mission in Geneva, Alice Ouedrago of the International Labour Organization and Paul Spiegel of the Office of the United Nations High Commissioner for Refugees. You have been true partners of the Joint Programme, and we will miss your leadership. We wish you the best of luck in your next assignments.

I want also to acknowledge Alexander Fasel, who is a true friend and a tireless champion for global health. You pushed to ensure that AIDS would be placed centrally within the Sustainable Development Goals. You organized multiple dinners, bringing together many influential partners around the table to shine light and generate debate on how to frame our work to end the AIDS epidemic. You always know how and when to compromise while keeping an eye on the goals to be achieved and on helping people. This is a mark of your capacity as a great diplomat. This is your last Board meeting, and you will be truly missed. Thank you.

Everything we need

The negotiations around the Political Declaration were complex and intricate. We were expecting that after going through the process of approving the UNAIDS strategy document in this room. We knew that opinions would be polarized. But I am proud of what Member States have negotiated. This Political Declaration is bold, ambitious, forward-looking and balanced. We started at draft zero by including all the things we wanted and then negotiated tirelessly with North, South, East and West. The result was complete and very progressive. This Political Declaration has everything we need to go forward.

The Political Declaration affirms the need to Fast-Track the AIDS response. It recognizes that there is not one epidemic but multiple and diverse epidemics. It promotes focusing on populations and locations where we can have the greatest impact, with regional differentiation and targets. And it emphasizes that people living with and affected by HIV are critical to its implementation.

Previous United Nations high-level meetings on AIDS in 2001, 2006 and 2011 were more high-level political meetings. Now, as we focus on the practical steps we need to take to end AIDS by 2030, our 2016 high-level meeting was really an implementers' meeting, with people coming together to talk about issues, trying to find ways to close the gaps, quicken the pace and accelerate. That is what we wanted from the start: to have implementers in the room.

And we have recognized that the critical implementers for the end of AIDS are at the community level. This is why the Political Declaration calls for investing in civil society and community service delivery, which are critical to reaching everyone who needs services. If we have a breakdown, if we cannot generate more resources and strengthen communities and service providers, we cannot reach the people being left behind.

I remember visiting China with my friend Ren Minghui and seeing the emergence of civil society. We visited groups implementing the first outreach for men who have sex with men and for people who inject drugs. This transformation would never have happened if the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) had not provided seed funding. In many places where I travel now, I see the Global Fund investing in places and partners where governments are not funding civil society. Countries' investment in the Global Fund must continue to ensure that we reach people being left behind because of how they live and who they love.

New frontiers

The Political Declaration is historic in so many ways. It abandons old language, such as abstinence and fidelity, and puts forward new concepts—including the needs of transgender people. Who would have thought that possible just a few years ago? Other


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new concepts involve the treatment of prisoners, reproductive rights and gender norms. These concepts have not been explicitly mentioned in previous Political Declarations. Member States also committed to action not covered in other intergovernmental processes. Examples include harm reduction, which we have never had the opportunity to mention, and combination prevention, including pre-exposure prophylaxis.

Member States also committed to doubling the number of people receiving treatment by 2020, from 15 million in 2015 to 30 million five years from now. This will be a great challenge to governments and to communities, but it is worth every effort to break the back of this epidemic and prevent 21 million people from acquiring HIV and prevent 11 million people from dying from AIDS-related causes.

The Political Declaration also includes new numerical targets on congenital syphilis, tuberculosis and hepatitis C that will take the AIDS response even further out of isolation. It makes incredibly strong commitments to eliminate gender inequalities and gender-based violence and to protect the health and human rights of women and girls. And it makes a significant commitment to increasing and front-loading investment to fully fund the response.

The Political Declaration reaffirms the critical role of UNAIDS and strengthens elements of the UNAIDS 2016–2021 Strategy:

- It commits to a super Fast-Track to provide antiretroviral therapy for 1.6 million children by 2018.
- It sets specific targets for reducing the number of adolescent girls and young women acquiring HIV globally.
- It addresses gender in a wider societal sense—not limited to gender norms—and commits to ending gender-based violence.
- It explicitly commits to addressing the needs and human rights of people with disabilities as well as sexual and reproductive health care services.

Faster, smarter

But AIDS is not over, and we continue to face challenges. We can recognize achievements, but more needs to be done.

We cannot let up on HIV prevention. Most people newly infected with HIV still acquire it through sexual transmission. In sub-Saharan Africa, 85% of the people acquiring HIV are infected through sexual transmission. The focus on population and location and the growing global commitment across all regions to the cities initiative are helping us to advance innovations in HIV prevention programming where it is needed most.

Eastern and southern Africa still account for almost half of the people acquiring HIV. Much more needs to be done—especially for adolescent girls and young women. In eastern and southern Africa, UNAIDS has engaged political leaders at the highest level on the AIDS response in the region. Along with the Government of Zimbabwe, we are in the process of establishing a regional platform on revitalizing HIV prevention in eastern and southern Africa. Engagement with Latin America and Caribbean mayors within the Fast-Track cities approach has opened up dialogue at the community level to provide test and treat to hard-to-reach populations, including key populations and youth.

We urgently need more effective prevention services for young people and other marginalized populations and populations at higher risk. We must turn off the tap of new infections or we will drown in growing costs. To this end, we must accelerate our efforts towards getting one quarter of all HIV investment focused on innovative combination prevention programming. We should work together to push for an acceleration framework to Fast-Track prevention. This will have clear milestones, roles and responsibilities, which we propose to develop together in the coming months.

I was in Kazakhstan earlier this month and learned about an opioid substitution therapy pilot that will go to scale. This is an important signal for eastern Europe and central Asia, where people who use drugs account for 51% of the people acquiring HIV. We see similar steps being taken in Belarus and Ukraine. The commitment of the Ministry of Health of Kazakhstan to move to United Nations procurement of antiretroviral therapy through the United Nations Children's Fund (UNICEF) can save millions of dollars and thousands of lives. These types of focused initiatives inspired by public health are critical to reach populations still being marginalized and left behind. I am glad to see countries embracing a pragmatic and comprehensive health and human rights approach.

I also attended the Fifth International Eastern Europe and Central Asia AIDS Conference in Moscow, Russian Federation, earlier this year. This was a unique opportunity to get eastern Europe and central Asia on the Fast-Track for prevention and treatment. I want to highlight the leading contribution from the Government of the Russian Federation for this conference and its support to UNAIDS' work in Armenia, Belarus, Kyrgyzstan and Tajikistan.

I want to thank the Minister of Health of the Russian Federation for making a clear commitment at the high-level meeting to remove the remaining HIV-related travel restrictions in the Russian Federation at the earliest possible opportunity. It is high time that wherever such laws exist, we take concrete action on age of consent laws, laws related to HIV non-disclosure, exposure and transmission, policy provisions and guidelines that restrict access to services among adolescents, travel restrictions and mandatory testing, including of pregnant women and others.

Our new Special Ambassador, the First Lady of Panama, is advancing an exciting new zero discrimination campaign for Latin America and the Caribbean. In Asia and the Pacific,

several countries have demonstrated progress in protection for people living with HIV and for key populations. Sri Lanka's Supreme Court issued a landmark decision, prohibiting HIV discrimination in education settings and became the first court in southern Asia to make a general pronouncement recognizing the human rights of all people living with HIV. Meanwhile, in the Philippines, a hair stylist living with HIV won an important labour discrimination case. These decisions are helping to advance the human rights agenda in the region.

Twenty-eight countries in Asia and the Pacific have conducted reviews or participatory consultations on legal and policy barriers to universal access to HIV services under the umbrella of the Economic and Social Commission for Asia and the Pacific (ESCAP) Regional Framework for Action on HIV to 2015 and ESCAP Regional Framework for Action on HIV Beyond 2015. Laws and policies are being strengthened to support the expanded availability of HIV treatment and prevention options, including HIV treatment, condoms, needles and syringes, opioid substitution therapy and community-based HIV testing. The legal protections for people living with HIV are being enhanced through legislative and judicial measures in the key areas of protection from discrimination, breach of confidentiality and informed consent. Legal rights and recognition for transgender people are being improved through court and legislative measures in at least seven countries, Finally communities are being empowered to monitor the quality and accessibility of HIV services, stigma and discrimination using the smartphone app iMonitor +.

UNAIDS and the Inter-American Commission on Human Rights of the Organization of American States published a joint regional report on violence against lesbian, gay, bisexual, transgender and intersex people in the Americas. The report addresses the varied forms of violence perpetrated against each of these population groups and establishes a connection between discriminatory laws and violence. Implementation of polls on human rights has maintained dialogue on human rights issues in the Caribbean.

Thanks to the *Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive*, the number of children dying from AIDS-related illnesses was reduced by more than 60% around the world. This has mainly been achieved by preventing children from acquiring HIV. Four countries—Armenia, Belarus, Cuba and Thailand—are now certified as achieving elimination. Following Cuba's certification for eliminating mother-to-child transmission of HIV, UNAIDS, the Pan American Health Organization and UNICEF conducted joint missions to support efforts by Haiti, Jamaica and Trinidad and Tobago towards eliminating mother-to-child transmission of HIV and congenital syphilis. Fourteen countries in the Caribbean, including Jamaica, are planned for validation in 2016. Many countries in eastern Europe and central Asia are also close to elimination. I encourage all countries to redouble their efforts so we can celebrate this amazing public health success story.

More than 90% of pregnant mothers living with HIV in eastern and southern Africa have access to services to eliminate new infections among children. UNAIDS is working closely


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with the World Health Organization (WHO) and several countries in the region—Botswana, Rwanda, Seychelles, South Africa and Zimbabwe—on expressing interest in the validation of elimination of mother-to-child transmission of HIV. Coverage of HIV treatment to prevent mother-to-child transmission in the Middle East and North Africa remained high at 85% in 2015. Countries in the Middle East and North Africa have also made progress towards eliminating mother-to-child transmission. For example, Oman and the United Arab Emirates have become the first and second countries to reach most of their elimination targets, and Oman has started its process of certifying elimination.

The First Lady of Ghana chairs the Organisation of African First Ladies against HIV/AIDS. The First Lady and the First Ladies of Cameroon, Chad and Côte d'Ivoire have been very supportive and working hard to ensure that we achieve an HIV-free generation in western and central Africa. Seven countries in the region have more than 80% coverage of services to prevent mother-to-child transmission, and the elimination target can be reached if this is sustained.

But can we stop our work on preventing mother-to-child transmission now? No, because we have not yet stopped adolescent girls and young women from acquiring HIV. Each year we have seen the number of pregnant women living with HIV stay the same or increase. Stopping children from becoming newly infected with HIV requires protecting adolescents and young women from HIV. If we don't do this, we cannot achieve our 90–90–90 treatment target.

Every day, 1000 adolescent girls are newly infected with HIV. Adolescent girls and young women 15 to 24 years old years are at particularly high risk of acquiring HIV, accounting for 20% of the adults newly infected with HIV globally in 2015, despite comprising only 11% of the adult population. In sub-Saharan Africa, adolescent girls and young women accounted for 25% of the adults newly infected with HIV, and women accounted for 56% of the adults newly infected with HIV.

The risk of acquiring HIV among young women and adolescent girls is increased because of harmful gender norms and inequalities, insufficient access to education and sexual and reproductive health services, poverty, food insecurity and violence. Protecting adolescent girls and young women means increasing access to reproductive and sexual health services. If we don't do this, the number of people newly infected, the number of unwanted pregnancies and the number of unsafe abortions will increase. The individual, social, health and economic costs will be enormous.

This is why we have a launched a new initiative with the United States President's Emergency Plan For AIDS Relief (PEPFAR) called Start Free, Stay Free, AIDS Free. This is a super Fast-Track framework for ending AIDS among children, adolescents and young women by 2020.

HIV treatment has been a great success story in recent years. The world has achieved so much. Prices were brought down while protecting innovation and the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement). Dosages have fallen from 18 pills a day to 1. An injection every three months will soon be offered. Local pharmaceutical production—especially in Africa—is now being discussed seriously as a means of addressing the long-term access to and affordability of medicines in the region facing the heaviest burdens of HIV and associated infections. We look forward to the UNCTAD ministerial meeting in Nairobi, Uganda, next month as an important step in this process.

Treatment access has more than doubled in Asia and the Pacific and in eastern and southern Africa, covering the vast majority of people living with HIV globally. Despite the prevailing challenges in the Middle East and North Africa, many countries have shown great progress in achieving the targets of the Arab AIDS Strategy. For the first time, in both Algeria and Morocco, the number of people starting HIV treatment has exceeded the number of people newly infected, and Algeria has achieved more than 80% treatment coverage. Latin America and the Caribbean continues to report the highest coverage of HIV treatment among low- and middle-income countries: 58% of children and 54% of adults. Argentina, Brazil and Mexico have started offering test and treat based on the 2015 WHO guidelines on antiretroviral therapy, and all remaining countries are working towards adopting the new criteria by the coming year.

Just before the high-level meeting, the First Lady of Côte d'Ivoire and UNAIDS Special Ambassador presided over a historic meeting on accelerating treatment for children. This includes initiating a partnership that will address a major gap in our response—children being left behind.

And yet we still have serious work to do. Despite the progress made, western and central Africa is still lagging behind. In this region, four of five children and two of three adults do not have access to life-saving antiretroviral therapy. The region is increasingly being constrained by political instability and terrorism and was recently plagued by the Ebola virus disease. As we speak, there is also an outbreak of yellow fever in some countries that negatively affects service provision.

There should be no excuse for failure to act now and acting very swiftly. Governments and key stakeholders have been mobilized to meet these challenges and to scale up a people-centred approach to the AIDS response: leaving no one behind. We are grateful to all the civil society organizations, networks of people living with HIV and international organizations such as Médecins Sans Frontières for their work in the region. As I pledged during the high-level meeting, I will make sure that this region is on track for the next success story in the AIDS response. In this regard, we are finalizing an emergency plan on to how to close the gaps within the shortest possible time, with special attention on seven countries accounting for about 84% of the burden of disease.

We have changed the paradigm by using treatment for prevention. But we have to go faster if we want to reach 90–90–90. We have to be smarter.

Country after country is adopting test and treat, and I want to thank WHO for developing these guidelines. Several countries in eastern and southern Africa have embraced innovative approaches to HIV treatment and prevention, with Botswana and South Africa recently announcing that all people living with HIV will be given HIV treatment regardless of their CD4 count. Now we have to normalize testing and reach every one of the 19 million people who do not know their HIV status.

Globally, we now have the largest youth cohort ever. We must ensure that they have the right information and the right services at the right time through comprehensive sexuality education. HIV prevention is not meeting the needs of young people: 620 000 people 15 to 24 years old acquired HIV in 2014—just 17% fewer than in 2010. Young people account for 16% of the global population but comprise 34% of the adults acquiring HIV. Young people are not getting the information they need to protect themselves. Only 36% of young men and 24% of young women in low- and middle-income countries correctly know how to prevent HIV. Levels of knowledge have changed little in recent years. Even countries with the highest HIV rates have relatively few examples of scaled-up, sustainable comprehensive sexuality education programmes. Evidence clearly shows that comprehensive sexuality education positively influences sexual and reproductive health. Comprehensive sexuality education contributes towards reducing HIV, sexually transmitted infections and early and unintended pregnancy, and we must use it effectively as a key element of our response. We must also continue to challenge harmful ideas about masculinity and gender expectations.

A rights-based approach, including guaranteeing sexual rights, is essential to Fast-Track. Addressing sexual rights is critical to ending AIDS. Sexual relations are the primary mode of HIV transmission; in addition, the central tenants of sexual and reproductive health and rights, including the right to information, autonomy, consent and non-discrimination, are critical to successful AIDS responses.

We will never deliver on the UNAIDS strategy if people cannot or will not access services. Key populations are still being pushed to the shadows. It is essential to our goals that everyone, everywhere has access to the services they need. More than 90% of the people newly infected with HIV in central Asia, Europe, North America, the Middle East and North Africa in 2014 were from key populations and their sexual partners. Specific efforts need to be made to identify and focus on ensuring services reach the key populations most severely affected in different regions. These include sex workers, men who have sex with men, people who inject drugs, transgender people and prisoners, as well as migrants.

We must ensure that key populations are fully included in responses and that they are able to access services. Evidence shows that, when services are made available within an

environment free of stigma and discrimination, the number of people newly infected with HIV declines significantly. An inspiring example is the Thai Red Cross Tangerine Community Health Centre, which I visited in January. It is Asia's first public clinic to provide a full range of health care and counselling services specifically for transgender people, setting a global model and transforming health services for key populations, ensuring that no one is left behind.

We have also noted major progress in the access of key populations to prevention services in many countries in the Middle East and North Africa. The Islamic Republic of Iran, Lebanon and Morocco have expanded opioid substitution therapy programmes in communities and prisons, and more than 70% of the people who inject drugs can inject safely. In Lebanon, 75% of men who have sex with men reported both knowledge of their HIV status and condom use. Algeria and Lebanon report that more than 80% of female sex workers use condoms. Djibouti, the Islamic Republic of Iran, Jordan, Morocco and Tunisia report rates between 50% and 80%. In Djibouti and Lebanon, nearly two thirds of female sex workers reported knowing their HIV status.

I want to thank Deborah Birx and PEPFAR, who are changing the way we all work together, building bridges between science and civil society so we are all ready to make bold decisions at the right moment. They are accelerating support to key populations through a new US$ 100 million fund, and we applaud this initiative.

The Fast-Track approach is the only way to end AIDS. And I cannot stress enough that resources are needed now. International funding is flat-lining and declining in many cases. I have said it many times before: we either pay now or we pay for ever. Later is too late. Later is already now—later is today.

We are at a flexion point in the course of the epidemic and need to act immediately. We need to cement our investments and gains now or run the risk of an ever-increasing burden of HIV and related costs that will be unsustainable. We will all feel the negative costs of inaction. Our generation is the only one that will have this chance. And if we miss it, I do not think our children and grandchildren will understand.

Yesterday's Financing Dialogue was a critical opportunity for us to discuss our current situation, and I do not want to repeat what was said yesterday. The Joint Programme has been innovative in finding ways to ensure that we are as productive and cost-effective as we can be with the limited resources we have.

We recognize that these are difficult economic times, and that everyone in this room is facing new and daunting challenges. And yet we cannot forget our commitment of solidarity with the millions of people we are already reaching with HIV services, and the millions of other people we still have to reach to fulfil the commitments our Member States expressed only a few weeks ago at the high-level meeting.

I come from Mali, and as a child I learned at an early age how to squeeze the maximum toothpaste out of a toothpaste tube. But I also learned that, at a certain point, no matter how hard we squeeze, no amount of pressure or folding will get any more toothpaste out of the tube. The Joint Programme has now reached that point, where we simply cannot be asked to continue to do more without the toothpaste we need to get the job done.

As we heard clearly from many of you yesterday, this is not the time for us to allow the Joint Programme to waiver or fragment its efforts. Today, as the Executive Director, I am faced with a series of impossible tasks: to do even more with even less. And so I turn the questions back to you, as my Board, for your guidance and input, since all of us together need to answer these questions.

If we do not have the resources to implement the ambitious strategy adopted by this Board last year and the Political Declaration adopted by our Member States in New York earlier this month, what and where should we cut? Should I cut our spending on the HIV prevention portfolio? Should I shift resources away from critical human rights and policy work? Should we spend less on 90–90–90 and Fast-Track? Should we stop funding critical support for civil society networks and networks of young people, adolescent girls and young women? Should we start to close country offices?

These are fundamental questions, and your clear guidance on how we should proceed is important to me, since I should not make these decisions alone.

But I am convinced that, whatever we do, we must find a way to protect our core work in advocacy, in delivering the best global health data and strategic information, in engaging civil society, in supporting key populations, in ensuring an inclusive response based on human rights and in leveraging investment by PEPFAR and the Global Fund.

As Mr Fasel said yesterday, we cannot afford to simply throw away the last 30 years of efforts, investment and achievements in the global response to AIDS. We surely must protect our collective investment and push our successes forward into the future we have all agreed on.

To conclude, we must address these challenges together if we are to deliver on both the AIDS response and broader health and development challenges. The Sustainable Development Goals are underpinned by the concepts of inclusion, equity and social justice. This is what the AIDS response has always been about.

AIDS is not over, but it can be.

We can and we must do it—for everyone, everywhere.

Thank you.

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