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Speech

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3rd IAS Conference on HIV Pathogenesis and Treatment

Special Lecture: The Status of the Response: What Will it Take to Turn the Epidemic Around?

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Speech by
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Good evening. Thank you very much, Helene, for your kind introductory words and for your leadership. I'm really pleased to be here with you this evening for several reasons.

One, the International AIDS Society is close to my heart, having served as its President, from 1991 to 1994 if I remember correctly.

And secondly, that the meeting is taking place here in Brazil. I consider Brazil truly a role model for all of us working on AIDS. I am pleased that we at UNAIDS have so many joint programmes with Brazil. In fact, I just signed another one, for an international center for technical support to be based in Brasilia. So there are many reasons why I am happy to be at this conference, quite beyond all the science.

Today it's fair to say that we are at a very different point from where we were 10 or even 5 years ago in terms of the global response to AIDS. Look where we were 10 years ago, about the time that UNAIDS was created.

Highly effective antiretroviral therapy – HAART – had just been introduced in wealthy countries, but with no prospect whatsoever for access to it for the millions of people living with HIV in poor countries.

And outside very well-defined gay populations in western countries and
Australia, there was hardly any prevention success or progress with the exceptions of Uganda and Thailand.

There were simply no programmes to prevent mother-to-child transmission.

And total spending on AIDS in developing countries was somewhere around $250 million, a fraction of the $8 billion that is likely to be spent this year on AIDS in low- and middle-income countries. There was no Global Fund, there was no U.S.
PEPFAR, and there was no World Bank Multi-Country AIDS Program.

And with a few exceptions, there was no top political commitment and leadership. Denial was the norm among leaders worldwide, including in the most affected countries in Africa.

However, things have changed, even if the epidemic has progressed much faster than the world's response. Last weekend I reread the speech I gave at the opening of the Vancouver AIDS conference in 1996. Then there were about 20 million people living with HIV in the world. That's about half of the number infected today.

In 1996 I called for access to the new antiretroviral treatments for people in developing countries, which was largely met by comments that this was a very irresponsible statement, because it's impossible to achieve. And now nearly 10 years later, one million people, or only 16% of those who need antiretroviral treatment, have access to it.

And as UNAIDS reported to the UN General Assembly last month, 25 years into the epidemic coverage of essential HIV prevention actions remains low to abysmally low in many countries. For example, averaged worldwide, HIV prevention services reach only 1 out of 10 men who have sex with men. And only one out of six sex workers. Even the coverage of a supposedly simple and straightforward medical intervention – the prevention of mother to child transmission – is below 5% in most African countries.

So the progress is very, very limited. And we're still a long way from universal access to

HIV prevention and universal access to HIV treatment, the only goals we can be content with.

And yet it's clear to me that we've entered a new era in the response to AIDS – the era of implementation on a large scale. We're in the middle of that and so our short-term agenda is crystal clear.

Our long-term journey is less clear. Though it's certainly no longer the big black hole it used to be. Let me turn to this agenda now; the long-term view that is largely unexplored. I'd like to focus on this issue, moving beyond the topic that was proposed to me. As I said in my closing speech at the Bangkok International Conference, today is the time to move from tactics to strategies, and to combine long-term investments with crisis management. Unfortunately, I still don't hear much of that debate at the conferences, but it is vital if we are to get ahead of the epidemic.

So what is the long-term agenda we need to start tackling now? Before trying to answer this question let me clarify two things. One, we are still in the midst of a global emergency requiring emergency planning, emergency action, crisis intervention. Think of all the people who are dying of AIDS every single day!

And two, almost without exception, nothing of long-term importance in AIDS can be left to be handled 10 to 20 years from now. In other words, I use "long term" only in the sense that something needs to be maintained over a long period of years, perhaps generations. Not that action can be delayed until then.

I'd like to highlight five challenge areas.

The first one is universal access to HIV prevention and treatment. Because our goal can only be to keep the current and future generations HIV free, and two, to ensure a long discrimination-free life for all those living with HIV. And to care for the orphans left behind. In other words, universal access to HIV prevention and treatment.

The '3 by 5' Initiative was a bold first step towards universal access to HIV treatment.
It clearly had a major catalytic impact in many countries, who for the first time even dared to consider offering antiretroviral therapy to their citizens. And as WHO and
UNAIDS reported last month, 51 countries have now doubled the number of patients benefiting from antiretroviral therapy since December 2003, largely because of the funding provided by U.S. PEPFAR and the Global Fund and in some cases by the governments of these countries. So let's build on '3 by 5' and join forces for universal treatment access, which is now endorsed by the richest nations of the world, at the G8 Summit in Gleneagles.

The long-term complexities of antiretroviral therapy on a large scale are enormous and hardly addressed and sometimes I wonder whether planners have internalized that the purpose of large-scale antiretroviral therapy is for people to stay alive and well for 30, 40, 50 years, just as long as those who are not HIV positive. Planning for this goal belongs, in a real sense, far more in the ministries of finance than in the public health community because we are talking really about very, very significant amounts of money.

Let me flag some key issues. First on pricing. The case of Brazil and the current controversy shows us that the issue of antiretroviral pricing is not behind us, particularly for the second and third generation and fourth generation of drugs that will come. Multiple sources of production and generic competition clearly have driven some prices down. But at the same time, you know better than anybody else in the world, innovations will continue to be crucial if we are to avoid a massive failure of therapy 10 to 20 years down the road. Because if no new drugs become available that's what will happen. And we know that historically patent protection has been the most effective incentive for industrial innovation.

So how do we solve this dilemma between the need for universal access to the products of innovation, and, on the other hand, the need for continuing innovation, which is only possible, I believe, with the kind of incentives offered by patent protection. Solving this dilemma will require renewed action at the highest political and industrial levels as the only answer is a global compact. Access for all can only work if governments and consumers in rich countries are willing to subsidize poorer countries directly through paying higher prices, or indirectly through subsidizing the R & D for products needed by poorer countries.

Next, with millions soon on antiretroviral therapy in developing countries, a sustainable supply of drugs may become a problem. We're increasingly getting reports of stock-outs of even first-line regimen molecules – even in countries like India that have a major generic production capacity. Stock-outs are of great concern not only because of the impact on the health of individuals, but also because of the worsening impact on viral resistance. So that's why the production capacity of both the research-based and generic sectors of the pharmaceutical industry is of crucial importance. This is also a good reason for encouraging local production in the bigger markets for AIDS drugs.

Third, how will we guarantee long-term funding for treatment in poor countries?
Millions of people's lives will soon directly depend on this. We now have basically created massive entitlement programmes – and it is absolutely the right thing to do, don't misunderstand me. But it has direct consequences that we need to address now. We should not wait until there is a major crisis and then say we're going to start planning how to find the money! No one thought that treatment could be rolled out in low-income countries without major and continuing and predictable donor support. But there's no precedent in international development, in international cooperation, for such long-term predictable funding. In addition, I'm afraid that soon even issues of national sovereignty of poor nations heavily affected by AIDS may come up, as these nations literally will depend on foreign aid for the survival of many of their citizens. To meet these likely challenges, we need bolder international agreements that we have today. But at the same time, domestic funding of antiretroviral therapy should grow over time even in low-income countries. They all should embark on schemes that offer universal medical coverage, even if this is not feasible from day one.

Let me now turn to universal access to HIV prevention. I was very pleased by the G8's endorsement of universal access to HIV treatment, but I was really puzzled, disappointed, angry that access to HIV prevention was not in that final communiqué. This is not only a failure of the G8 leadership, but also of all of us. With 5 million new HIV infections per year, HIV prevention must also be made available universally. It is no less essential that HIV treatment. Even reaching or sustaining universal HIV treatment will be impossible without effective HIV prevention. It is certainly not one against the other – both are needed. Last month, the UNAIDS Programme Coordinating Board, which is the body that sets AIDS policy in the UN system, for the first time agreed on a comprehensive package of proven and effective methods for HIV prevention based on evidence and human rights principles. We now need collectively to move this to the point where there is firm political and community support for universal access to HIV prevention just as there is now for HIV treatment.

HIV prevention actually poses equally formidable challenges in the long term as HIV treatment. HIV treatment is for life – but so is HIV prevention, a point we tend to forget. I'd like to repeat; HIV prevention is for life — throughout the life of a person, the life of a generation, and the life of the next generations. This means that we must not only accelerate HIV prevention in the short term, but we must take far more seriously the matter of bringing about sustainable changes in societal norms and values, as well as in the structural forces that make people more vulnerable to HIV. I have a whole list of these societal issues, including such issues as decriminalization of homosexuality; accepting harm reduction as a paramount principle whether as it relates to injection drug

users or to sex workers; promoting full rights for women; making violence against women and sexual minorities not just illegal but socially unacceptable; and empowering teenage girls to say no to unwanted sex. These things are usually relegated to the bottom of HIV prevention strategies, together with human rights, and with no funding attached to them. We in the AIDS movement must make strong strategic alliances with the movements to combat poverty and to promote education and gender equality.

In terms of HIV prevention, we must ensure that the supply of prevention commodities, such as male and female condoms, keep pace with expanding HIV programmes. The reality today is that are true shortages of condoms in many countries! And that the supply is getting problematic.

And we should not assume that antiretroviral therapy will automatically strengthen HIV prevention. There's definitely no evidence for that. It will require specific efforts, as recognized by the UNAIDS working group for HIV prevention, chaired by Helene. Otherwise both prevention and treatment will suffer.

Let me now turn to the second area of our long-term agenda, and that's the science and technology agenda. Scientific advances on AIDS have been remarkable but there's still a huge agenda ahead of us.

First on the non-biomedical side, a much better understanding of the long-term societal impact of the AIDS epidemic is urgently needed in every region, and even at the level of most countries. At UNAIDS we have embarked on such long-term scenario building in Africa and will expand this to other regions. This is important because such scenarios guide us to be more strategic in our investments today, they illustrate for example the absolute need to join prevention and treatment, and they offer great opportunities for top-level advocacy in dealing with the economy and the stability of the state.

Second, science and technology innovations in the AIDS field are crucial, be it for the development of antiretroviral drugs as I mentioned before, a vaccine or microbicides. So the real question is, can we accelerate the process of innovation? Is that possible at all? There are big books that have been written about it. I believe it's possible. The real challenge is to sustain this process over the long term when results are not immediately forthcoming. We've seen this challenge with efforts on HIV vaccines, where for many years after the hype and the promises that were not delivered on, there was a decrease of interest, which thankfully has now been ended. There's a clear need for much higher investments. But the key question is whether the incentives for such huge investments will continue. So again, we must strike a good balance between the imperative of making available universally every advance in technologies and the need to protect intellectual property, so that there is ongoing robust R & D for AIDS.

It's frustrating to me that even microbicide development is still not adequately funded, when it's only a matter of $280 million annually, just double the current investment. The Global HIV Vaccine Enterprise is a very good model and as you heard about that this week, I won't elaborate on it. But that's the kind of consortia that we need more of.

Let me turn to the third area for the future agenda, and that is how do we organize ourselves for the long run? Three issues here for me. One, I see growing pressure in many countries and even among some funders to consider AIDS as just another infectious disease and to merge the programmes, the research and everything with those for other infectious diseases. This would be disastrous. It would set the clock back 20 years. The current momentum would be lost, specific funding would wane and the strong engagement of communities and those infected would vanish. For a strong response to AIDS to be sustainable, distinctive AIDS programmes are needed, backed by top political commitment.

Two, at the international level, we're getting our act together, we are preparing for more effective long-term action through the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors. Coordination of all AIDS actors is not just a daydream of UN bureaucrats, it will truly save lives. There is still too much wastage of resources because of institutional rivalry and isolated initiatives, and I believe it's time for the scientific and academic community to join such united efforts.

And the third issue in terms of organizational challenges is that there is a huge challenge of institutional and human capacity, particularly in the countries most affected by the AIDS epidemic, notably in Africa. So we must invest much, more in capacity building, which means that we cannot be satisfied by quarterly reports because the results of these investments will not be evident for years. We must find ways to reverse the depletion of human and institutional capacities in countries highly affected by AIDS and aggressively protect capacity in countries where the epidemic has not advanced far. Preserving existing capacity means keeping people alive as one of the measures. In other words, we come back to universal access, including for professionals. But preserving capacity is just as much about HIV prevention. But above all, we need to think out of the box. This is not just about training doctors and nurses or building and equipping clinics, as much as that is necessary, but it's as much to do with strengthening community action, community groups, and people living with HIV. People living with HIV are a vastly under-utilized capacity. I've seen it now in so many countries, from Swaziland to Kenya to Uganda, that groups of people living with HIV can be agents, not only for change, but agents for treatment adherence, for nutritional support and so on. And addressing capacity constraints is not something that can wait until we have finished our little projects here and there. Our ability to get ahead of the epidemic depends on overcoming these constraints, and they have to be tackled right now.

Let me turn to the fourth challenge, and that's leadership and political commitment. This is possibly the most critical challenge, because as we all know, the half life of political commitment can be extremely short. There are innumerable examples of major issues that were in the global political spotlight that have since diminished in political favour, from child survival to population to the overall environmental movement. And also there are significant, competing, and very important global and local issues from climate change to terrorism, from extreme poverty to regional conflicts. So how do we keep AIDS at the top of the political agenda? I believe we need to move the response to AIDS into another league, on a par with other critical global issues such as climate change and extreme poverty, and not stay in our AIDS ghetto. Debating AIDS belongs as much in the UN Security Council as it belongs in scientific conferences.

Sustaining political commitment also means that there is a never-ending need for activism. And it means we must broaden our constituencies through new alliances. New alliances with people with whom we may not agree on 100% of things, but if we can move together and we agree on the basic goals, we can really make a big impact. But are we ready to do that and at what price?

And then the final long term challenge is, of course, money. Despite the greatly increased funding for the AIDS response, the financing gap is becoming wider and wider. And that's because the needs are growing, particularly in terms of treatment. We estimate that for 2008 alone, $22 billion will be needed. Where will that money come from? How are we even going to sustain what's available today? The replenishment conference of the Global Fund will be held in September and is a major challenge. Political sustainability is the basis for financial sustainability, as we all know. But sustaining the billions needed requires, in the first place, results. We need to be able to demonstrate that the money available now produces results in terms of saving lives, both in terms of preventing new infections and keeping people alive and well. And we need to do a better job in terms of maintaining support from mainstream public opinion. And we need to diversify sources of funding. And finally, we need to emphasize the need

to maintain special funding for AIDS for many years.

Before concluding, let me add that in everything we do in tackling AIDS there are a few non-negotiables. I will mention four. One is the promotion and protection of human rights. Two is equality between men and women. Three, that science is the basis of our policies and work. And four, accountability, not only to the funders, those who give us money, but to the people for whom we work.

And finally, the world must accept the exceptionalism of AIDS. There is simply no precedent in the history for such a crisis. And please let's not have an illusion that in a few years, one fine day the world will return to what it was before AIDS. No,
AIDS has simply rewritten the rules. And to prevail, we too, must rewrite these rules.
An exceptional threat demands exceptional action, be it on financing, development, trade rules, activist strategies, public service delivery or fiscal ceilings. So let us now design these longer-term strategies as otherwise we risk discouragement and demobilization. And we will achieve at best short-term results. Addressing AIDS in the long term will require even more of the best brains, of the most creative entrepreneurs, and of the most determined leaders.

I'm committed with UNAIDS to tackling this agenda with you.

Thank you very much.