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Speech

Getting Ahead of AIDS: The Long-Term Agenda

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Speech by
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Thank you and good morning.

I greatly appreciate the work that the Center is doing on AIDS. The first time that Lee and I met, we challenged each other: he challenged me in terms of the foreign policy, political and security dimensions of AIDS, and I asked why he did not have a programme that dealt with AIDS – one of the 'make or break' issues of our time.

Congressman Leach, your leadership on AIDS is not only outstanding, but also longstanding. You have been a strong advocate for US leadership in the global fight against AIDS, for which I thank you, and I will come back to how important it is to continue that leadership.

It is also good to see so many friends and colleagues. The Center has always been a very stimulating intellectual environment for me, so this is not going to be a speech that is a collection of sound bites. Preparing for this speech has forced me to think about where we are going in the next 25 years with the response to this pandemic. As we just heard, 2006 is an unusual and highly symbolic year in the fight against AIDS, since it is the 25th anniversary of when, on 5 June 1981, the story of five gay men in Los Angeles with a mysterious pneumonia was published, since which time 65 million people have become infected and 25 million killed by HIV.

In addition, it is also the 10th anniversary of the discovery that antiretroviral treatment can stop the development of the disease and return people to their normal lives, which revolutionized the disease, at least in rich countries. It is only recently that this remarkable technological development is also becoming available in poorer countries, and it still remains a dream for many millions of people who need it today.

2006 also marks the fifth anniversary of the special session of the UN General Assembly devoted to AIDS – the first time that the UN, at the highest political level, with 35 heads of state present, discussed a health issue, over a period of three days, and transformed AIDS from a public health problem, which of course it still is, into an issue that is discussed at the highest political level. That special session had an enormous impact. At that time, I only saw the problems, but following the special session, the Global Fund was created, funding increased dramatically and, in many countries, national AIDS councils were set up, led by heads of government.

The landscape of the fight against AIDS has been transformed in the past 15 months since I last spoke here, on the eve of World Aids Day in 2004. Issues that were gathering momentum then have come to fruition, so I now look at 2005 as the 'least bad' year in the history of AIDS. It was a year when hope slowly took over from pure despair in many communities; things that seemed impossible even a few years ago started to become real in 2005.

For the first time ever, therefore, I believe that we have a real potential to get ahead of this epidemic, which is what has brought me back here.

Over the last two years, there have been four key developments, from a political and operational perspective.

First, funding for the global response to AIDS continued to increase at a record rate, from $5 billion in 2003, to about $8.3 billion last year; this is money spent, rather than commitments or budgets allocated. About one-third of that funding comes from low- and middle-income countries, many of which, such as South Africa, Brazil, India and Russia, are starting to devote significant domestic budgets to the fight against AIDS. This is extremely important, indicating that the issue of AIDS is being owned by the countries affected. As long as the fight against AIDS is perceived as something that is being driven from the outside, which is most visible in the area of funding, we have no chance of ending the epidemic.

The single biggest change that happened in the last five years in terms of funding, which moved the response from the millions to the billions, was the State of the Union Address in 2003, in which President Bush announced that he would request $15 billion for the next five years to fight AIDS around the world. This has been followed by many donor governments, which led to the quantitative leap that has allowed the world to embark on large-scale HIV prevention programmes and antiretroviral therapy – ART – programmes.

Second, not only has there been far more money mobilized in these years, but a strong movement has also developed to increase the efficiency of what we are doing: in other words, to make the money work for people on the ground. Obviously, it is not enough to have money – it has to reach the people who need it and, thanks to the work that UNAIDS catalyses, there is now far greater efficiency and better coordination, in terms of improved quality of what we are doing and value for money, which really saves lives.

The problem, however, is that the pace of progress has also been unacceptably slow. We are still far from the emergency pace demanded by the daily toll of 14,000 new HIV infections and 6,000 deaths from AIDS.

At the end of May, just before another special session on AIDS at the UN General Assembly, UNAIDS will issue a report that reviews country by country progress in a number of areas that are relevant to the response to AIDS. Some of the statistics are really sobering, since they show defeat on even what we thought would be the easier matters: for example, only one in 10 pregnant women in the world today has access to the means to prevent mother-to-child transmission, which is a straightforward medical intervention and something that is measurable, yet it is not being implemented on a large scale. There are some exceptions; for example, in Botswana, close to 50% of women have access to these services, so there are some ‘good news’ stories, but they are still the exception. We also know that only one in five people living with HIV who need ART have access to it. So I think the report issued in end-May will show that the picture is a mixed one, with good progress in some countries, no progress in others, and many countries in the middle.

Third, by the middle of 2005, there was a global commitment to making this not simply an era of large scale implementation, but the ambition was even greater, demonstrated by the language of the G8 summit in July 2005 at Gleneagles: ‘We are to come as close as possible to universal access to the whole range of essential HIV programmes’, which is the essential next step and the only way to change the trajectory of the epidemic.

Fourth and finally, by the close of 2005, there was very welcome new proof, from every continent, that we can get ahead of the AIDS epidemic and that our investments are starting to pay off. Until recently, whenever I was asked by people to demonstrate that it is possible to have an impact with HIV programmes, I could mention only Uganda and Thailand, and the credibility of pointing to only these two countries year after year became quite limited! Today, however, we can see in Kenya a nationwide decline in HIV infection, particularly in young

people; the same is true in Zimbabwe and in several Caribbean countries, as well as in the urban populations of many East African countries. There is, therefore, concrete progress, and it demonstrates that all of these investments are making a real difference to people's lives.

However, we still have both new and old problems, and the two issues that have been most on my mind over the last year or so are: One, in the immediate term, making the money work and ensuring that we invest in delivering the goods, besides mobilizing the money; and, second, over the next 25 years, ensuring that there is a sustainable and long-term response that will eventually end this epidemic. The latter is the kind of ambition that we now need to have. Of course, we still have an emergency, and I think that the 'E' in PEPFAR (President's Emergency Plan for AIDS Relief) is absolutely appropriate, and I hope that PEPFAR's successor can help get ahead of the emergency.

In any case, the long-term response requires us to do more of the same. It is obviously not the case that, when we move to a new phase, we throw away everything that has been done. We need to build on what has been happening, continuing to expand the programmes and to increase our effectiveness, which remain as important as ever. However, just think of what are now well over a million people who are benefiting from ART today, thanks to this new funding. We want these people to be alive in 20, 30 and 40 years from now, so how we will ensure that? It is not only a technical medical question around who will pay for it – what about the community's and the individual's sustainability?

I would like to go over seven critical long-term actions that will need to be sustained over the coming decades so that this epidemic can be ended. It is time that we start thinking in terms of decades, rather than years, when it comes to the response to AIDS. It is a political and financial nightmare, but we have to face the reality, and it will take nothing less than this complete agenda of action to end this epidemic.

The first action is that we must make real headway in addressing the fundamental drivers of this epidemic, most particularly AIDS-related stigma, the inferior position of women in many societies, and issues such as homophobia. Of course we should not count on or wait for the end of inequality, poverty, discrimination and stigma. However, based on what we have seen over the last 20 years, I strongly believe that we need to make serious headway on these drivers of the pandemic if we are to have any hope of ending it. This is not a call for a vague reform agenda, but we all know that there is a range of concrete things that must be done today, ranging from very practical aspects of women's empowerment to confronting homophobia and changing social norms and behaviour, particularly in terms of sexual behaviour. Before coming here, I met with Secretary Tommy Thompson, reporting on a visit that he led for the Center for Strategic and International Studies in Viet Nam. Discrimination was identified as one of the key obstacles to HIV programmes, so it is not only a matter of the respect for human rights, but also a core programmatic issue. So this whole range of issues, which are not immediately technically AIDS issues, are as important to stopping this epidemic as so-called 'AIDS interventions'.

The second action is that we have to sustain leadership and political support for the global fight against AIDS, not only from heads of state and leading politicians, but also in every walk of life – in every business, church, community organization etc – and it must remain a non-partisan issue, as I believe it is now. Because of this long-term need for political engagement and support in public opinion, I firmly believe that we need to expand the coalition of constituencies that are fighting AIDS, building new alliances, being less purist, and moving out of our narrow circle of AIDS 'bureaucrats' and activists. And I see that this is

now happening. What happened here in the US, was that a traditionally 'liberal' agenda has become the agenda of a much broader base in society and this is a very important development, which I see happening in other parts of the world. The day before yesterday, I devoted a speech at Georgetown University to what it takes to build this broad movement, in terms of the common values that should form its basis, and the deliverables that we can agree on. There are, of course, unavoidable conflicts, particularly when it comes to funding, and I see the backlash, ranging from the feeling that too much is being spent on AIDS, when the correct approach is to put AIDS into the broader context of development and security, where it should be, and not in competition with other diseases.

Next, we must sustain and increase financing, making it more predictable and guaranteed for the long term. The shortfall is already huge; even with this greatly increased funding, the gaps between the needs that can be met if the money is there and what is available are likely to increase. For this year alone, $15 billion will be necessary; for 2008, the figure is about $22 billion. That need is increasing, among other things, because more and more people living with HIV will, over time, need treatment. Also, as we roll out programmes, the capacity to spend the money is also increased. For some time, therefore, the financing needs will increase. However, they will not go up forever, since there should be a return on the investment after a number of years.

The question of course is: where will this money come from? A message that I bring wherever I go is that developing countries must contribute from domestic budgets – and more and more are doing so, as I mentioned. This is definitely a realistic course for so-called 'middle-income' countries with flourishing economies, particularly in Asia and Latin America.

However, for the poorest countries – those that are, not by chance, most affected by HIV – this is a nightmare, because, in an unprecedented way, millions of their citizens depend directly on foreign aid for their lives. This poses a major challenge as development assistance is quite unpredictable and volatile. Of course, we have international agreements, such as the Monterrey Consensus etc, and innovative new sources of development funding are now being examined, particularly in Europe, including an airline tax advocated for by France, which a number of countries are adopting, to the British proposal for an international finance facility, raising money from the capital markets. I think that these are all worth looking into; what matters, ultimately, is that rich countries identify the necessary money to continue the fight against AIDS. The key to continued financing is that we can show real results on the ground and that public opinion in the rich countries continues to appreciate that this is an issue of universal importance, that it is a global public good to fight AIDS 5,000 6,000 miles away from their hometown. Again, a broad coalition is critical to maintaining support for financing the AIDS response.

A fourth action is that HIV prevention needs to be put on an equal footing with HIV treatment. In 2001, when we had a debate in the UN General Assembly, member states spent literally entire nights debating whether there should be any reference to ART. In the end, there was a reference to it, but all donor nations – except France – and the African and Asian countries were against any reference to it; only the Latin American and Caribbean states were in favour. Five years later, that debate seems totally absurd, but it illustrates how far we have come. However, in many countries, we are now seeing that HIV prevention is slipping off the agenda, and there is simply no way, with five million new infections every year, that we will be able to provide ART to all of these people, not to mention that every new infection is one too many. Our goal should be to have an HIV-free generation: priority should be given to keeping young people free from HIV, which is more challenging and controversial than access to treatment, but we simply have to do it. In the long run, it will mean changing norms and values in society, as I mentioned.

Fifth, we need to finance innovation, just as much as we need innovation in financing, to accelerate technological development and, simultaneously, to put in place the systems and agreements that will guarantee wide and equitable access to microbicides, new generations of drugs, and vaccines.

Sixth, we must work urgently and immediately to strengthen the delivery systems, which are the 'Achilles heel' of many programmes. We are now paying the price, in the shape of the AIDS crisis, for the decades where investments were not made in public and private services to promote education and health, because governments and donors were focusing on projects, rather than on the staff and the 'bricks and mortar'. And in some African countries, we don't just have a professional 'brain drain', but a 'brain haemorrhage', with doctors and nurses being actively recruited and moving first to South Africa and then on to the UK, the US and Australia.

There are complex causes to the crisis in delivery systems but no simple solutions. Books have been published on it, but usually only describing the problem.

Fortunately, however, for HIV prevention, the healthcare system is much less critical. It is critical for the prevention of mother-to-child transmission, and for some counseling and testing programmes, but most HIV prevention takes place outside the healthcare delivery system. This is where the private and voluntary sectors can be extremely important. We need to start thinking 'outside the box', intensifying training programmes and setting up incentive schemes, and there are some good examples of this in Malawi and Zambia, but we will have to look beyond traditional western models of delivery systems to community delivery systems. I have seen that this can happen through church networks in Kampala, through women's groups in Nairobi, and through traditional structures in Swaziland. It is possible, but it requires healthcare professionals to become managers – assuring quality and training – instead of continuing to deliver the service directly. But most people did not go to nursing or medical school to do that kind of job, so a cultural revolution is necessary, and we need to think how to achieve that.

The bigger dilemma is that we cannot wait to deal with the AIDS epidemic until the health services and systems are fixed, which is the debate that I keep hearing. I heard it at the World Bank earlier this week, and I hear it from people who have, rightly, been interested in health systems. But that has been tried for many decades, so we need to move on the AIDS agenda, while simultaneously strengthening health, education and other systems. And I emphasize that it is not just private delivery, but the public sector across the board that must be strengthened, because in many countries the public sector is the only place for the poor to go to. We must, therefore, support not only private delivery systems, but also the public sector.

The seventh and final action is that for severely affected countries, particularly in southern Africa, we need to begin effectively countering the social and economic devastation caused by AIDS – the aftershocks that have massive knock-on effects from one generation to the next and which will transform some of the smaller countries, such as Lesotho, Swaziland and Botswana, which have already lost 30-40 years of life expectancy, into 'un-developing' countries.

Therefore, we need to begin addressing the societal impact of the AIDS epidemic in these countries, from both the general and AIDS perspectives, because the capacity and resilience in society is undermined every single day. That goes for agriculture – many of these

countries are now in a state of chronic emergency in terms of food security, because of AIDS – for service delivery, and for the transfer of knowledge in homes and schools because so many children are being orphaned. Compared to the unprecedented scale of the losses, next to nothing has been done on this impact alleviation.

We will need to see how the public sector can and will function in the worst affected countries. The focus is now on rethinking how services are being delivered and how knowledge is being transferred in the worst-affected countries. Much of what is needed is clearly 'hard work in the trenches': a combination of leadership, good management and strategic investments. These are not the most spectacular issues – they will often not make it to the headlines – but they are what will make or break programmes in terms of their success.

And it's clear that we need to go beyond narrow HIV interventions in order to deliver on AIDS, such as food, nutritional support and bicycles. Ann Venneman, Unicef's Executive Director, and I were recently in Tanzania, where we talked to people living with HIV and asked what their biggest problems were. They said that they had access to ART, but didn't have enough food or the bus fare to travel to the clinic 30 miles away. The question is whether we can build this kind of broader but essential support into the AIDS budget? I believe we have no choice if we are to deliver AIDS programmes.

To conclude, I would say that mobilizing action for this longer-term agenda should now also become a core priority for all of us. It is important that, today, we start preparing the future, post-PEPFAR, to ensure that the Global Fund continues to be funded, and that countries look beyond simply putting people on treatment, but also to keeping them on it.

Our effort in UNAIDS is partly to improve the evidence base for the longer-term agenda. We have been working with scenario developers, particularly from Shell, in looking at AIDS scenarios for Africa by 2025 and at what it takes, in terms of action today, to ensure that we reach the most favourable scenario. It clearly showed that we need to start looking at the wider agenda.

I would like to emphasize that our reaction to having to face up to these longer-term demands should not be paralysis. At the beginning of this epidemic, we were often paralyzed. But the recent years have demonstrated that, when we confront the epidemic in a strategic and systematic way, with strong leadership and good management, we really can make headway.

Let me state clearly that US leadership on the global AIDS response is irreplaceable, not just in terms of money but in terms of political leadership. The positive signals that are sent by the fight against AIDS becoming an integral part of US foreign policy and of the core international development agenda are invaluable.

The journey ahead is going to be very long. But a commitment on our part to this strategic agenda will mean that we will reach the beginning of the end of this epidemic.

Thank you very much for listening.