



Speech

CHECK AGAINST DELIVERY

**11th Meeting of the UNAIDS
Programme Coordinating Board**

Geneva, 30 May 2001

**Speech by
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Minister, colleagues and friends,

I am just back from New York where there was more than a week of negotiations on the declaration of commitment for the UN General Assembly Special Session on AIDS. The debate by member states was engaged, passionate - and lengthy. In fact negotiations are still going on, which is the reason Deputy Executive Director Kathleen Cravero cannot be with us here.

I am sure that this year will be remembered as one of the most significant in the history of the epidemic. For the first time, the global perspective joins care for those infected to the task of ensuring those not infected remain so. It is a year when resources are coming, and when political leadership is at unprecedented levels. The UN General Assembly Special Session on AIDS will be one of its high points.

This meeting of the Programme Coordinating Board therefore takes on added weight.

It comes as UNAIDS reaches the end of its first five years of existence. It also falls a week before the twentieth anniversary of the first report of the disease that came to be known as AIDS - 9 paragraphs in the CDC's Mortality and Morbidity Weekly Report about an unusual pneumonia affecting five previously healthy homosexual men.

At the time, I read the report with great interest, but I never imagined I was looking at the first sign of an epidemic that in just 20 years would have infected 60 million people, killed 22 million and achieved the status of the most devastating epidemic in human history.

So as we begin this meeting, I want to take the opportunity to reflect on the road travelled by UNAIDS over the past five years - and by UNAIDS I mean the Cosponsors and the Secretariat. I won't go into the details my report, which you have in front of you.

The question I posed before the first meeting of the Programme Coordinating Board was: can we be actors who change the course of the epidemic?

In all modesty my response is yes: we have undoubtedly become actors who have shaped the global response to the epidemic, playing a part in a wider AIDS movement that includes many national, international and civil society allies. That is a start. And in shaping the global response, we are beginning, collectively, to shape the epidemic itself - but here we still have as many challenges as we have achievements.

Let me take half-a-dozen issues where over the past two years the global agenda has been reshaped by UNAIDS. Our success has come by using the UN system to its best advantage: as a facilitator, advocate, setter of international standards, and universal point of reference.

First, we have helped put AIDS on the top of the world's political agenda and made it a real issue for public opinion in the North and South. It took years of data-based global advocacy.

The UN Security Council held its first ever debate on AIDS in January 2000 - the first time it had ever looked at a health or development issue. I have returned twice to the Security Council since then, and AIDS is now part of its core agenda.

Five years ago, calling AIDS a multisectoral issue was largely rhetoric. Now, it is a reality:

- in the 18 high level national commissions on AIDS in Africa, the majority chaired by the Prime-Minister or Vice President;
- in the increased AIDS focus of CARICOM, the OAU, ASEAN, the G8 and others; and
- in the mainstreaming of AIDS in poverty reduction and debt relief strategies.

I could add a long list of impressive responses in individual countries.

The second shift in the global agenda has been a paradigm shift. The new paradigm has four key elements: AIDS is now seen as an issue central to development. Care and prevention are now understood not as competing priorities but as mutually reinforcing strategies, which work best when they work together as twin pillars of a total social mobilisation against AIDS. The new paradigm considers both risk and vulnerability: what places people at risk of AIDS as well as the underlying forces that explain why they are vulnerable. And the new paradigm stresses the overriding importance of focussing on youth - a clear result of the last five years of our work, not least the World AIDS Campaign.

Third, the nature of country action has been reshaped along four key paths: involving multiple sectors, taking a partnership approach, decentralizing, and capacity building. Now the need is to improve national coordination, focus on results, cost priorities and deliver more efficient support to communities.

At the regional level, the International Partnership Against AIDS in Africa and the Pan-Caribbean partnership Against AIDS have established the principles for action - bringing 5 constituencies together- led by national governments with the UN, donors, the community sector and the private sector.

Fourth, the last two years, and especially recent months, have seen a sea change in access to care.

You may recall that at the thematic PCB meeting in Nairobi in 1997 you laid the foundation for our work on increasing access to HIV care, at a time when even discussing care for the developing world met with the greatest resistance from many quarters. We now talk of benchmark prices for combination antiretroviral therapy in developing countries that are less than 10% of the prices paid in high-income countries.

The principle of preferential pricing for HIV drugs for developing countries has been accepted by most in the industry. It has taken a variety of levers:

- dialogue between industry, governments and the UN system - including the Secretary-General himself,
- attention to the Brazilian model of public access to antiretroviral therapy and local production, and attention to generic production; and
- the pressure of media attention and of public opinion in both North and South.

Yesterday, the Contact Group reviewed how 34 countries are involved in the accelerating access initiative, and ten have concluded new price agreements with pharmaceutical companies - including generic suppliers. Only last week, WHO convened a meeting that has set in train the development of technical guidelines on

antiretroviral therapy in developing countries.

Finally, the court case in South Africa has truly sensitised global public opinion to the critical importance of access to HIV care in the developing world, and has opened new opportunities for access to HIV treatment.

Despite the emphasis of the media headlines on antiretroviral prices, within UNAIDS we have kept our eye on the comprehensive care agenda, from opportunistic infections to strengthened health infrastructures.

Let me take a fifth example of substantive change: preventing mother to child transmission. When in 1998 we saw a preliminary report of a study from Thailand showing that a relatively short-course of AZT could substantially reduce mother to child transmission, I believed the time had come to take serious steps to avoid the annual toll of half a million infected infants. A meeting in March 1998 organised by the UNAIDS Secretariat with WHO and UNICEF laid the foundations to translate these findings into a programme response.

State-of-the-art guidelines on antiretroviral therapy and infant feeding for HIV-infected mothers have been developed. UNICEF has taken the lead in our system to support programmes in an increasing number of countries. As part of the accelerating access to care initiative, in July 2000 Boehringer-Ingelheim offered free nevirapine for the prevention of mother to child transmission in all developing countries, and work by UNICEF and WHO is helping take up of the offer.

Having established the evidence base, the task is now shifting to scaling up interventions. Voluntary counselling and testing needs to go beyond the 1 per cent of women in sub-Saharan Africa it currently reaches. Antenatal care infrastructure will have to expand. And we have to make safe infant feeding by HIV-infected mothers a real choice, not a theoretical one.

The sixth sea change: the coordination of the UN system itself. When UNAIDS came into being in 1996 we were the new face of a daring experiment in UN system reform. That experiment has become our daily reality, globally and in country support.

At the last PCB you completed the development of a Global Strategy Framework and Leadership Commitments - the first comprehensive global AIDS strategy seen for many years. It has already been put to work - providing the conceptual underpinnings for the UN General Assembly Special Session on AIDS.

We have also compiled an unprecedented UN System Strategic Plan covering the AIDS-related work of 29 agencies. It is before you at this meeting, as is the Unified Budget and Workplan - again, quite unique in the multilateral system.

At country-level, UN Theme Groups on HIV/AIDS have become prime platforms for UN reform. They are increasingly making a difference and their continuous improvement is a top priority for all of us in the system.

There is no doubt that every UNAIDS Cosponsor has put AIDS at the top of their agenda.

We now speak with one voice, never more clearly than in the increasing role of Secretary-General Kofi Annan as the world's number one AIDS advocate. Just as national AIDS programmes are immeasurably boosted when Prime Ministers and Presidents take up the cause, so too the UN and global effort is enhanced by

leadership from the top.

In his speech to the Organisation of African Unity's special summit on AIDS in Abuja last month, the Secretary-General advocated greatly increasing the level of resources devoted to the AIDS fight, including through the creation of an International AIDS and Health Fund.

So my final sea change of the past two years is the shift from millions to billions.

It is hard to believe it was only in April 1999 in London that donors met for the first time on AIDS in Africa - and we started building the case for greatly increased resources to contain this epidemic. When we issued the estimates of the billions of dollars needed to be serious about prevention and care in Africa at the World AIDS Conference in Durban in the middle of last year, the word "irresponsible" was not far away. But everything since has vindicated this position.

We now know with a reasonably high degree of accuracy that 7 to 10 billion dollars is needed to meet the main prevention and care needs of low and middle income countries. Roughly half that amount is needed for prevention and half for care. Regions with the highest numbers already infected - in particular sub-Saharan Africa, need a higher proportion spent on care. In regions such as Asia with large populations but lower HIV prevalence, the majority is needed for prevention.

Spending 7 to 10 billion dollars directly on AIDS is not realistic this year or even next, but it is a realistically achievable target for five years hence. Nor are we asking donors to provide the full amount. Presently, something under 2 billion dollars is spent directly on AIDS in low and middle income countries, from a mix of private and out-of-pocket expenditure, national government budget allocations and international support.

These are challenging targets - but not impossible ones. More AIDS spending by national governments is easier if they have more funds through debt relief or debt cancellation. But there is also no escaping the need for the world's high-income countries to make a shift in the order of magnitude of their support for the global response to AIDS.

So let me give you a few thoughts in the talk of the day: the global fund.

The idea of creating a global fund has only recently hit the headlines, but the idea has been brewing for some time. It began following the G8 summit in Okinawa last year, and its profile was raised by the UN Secretary-General in his Abuja call to action on AIDS. The UNAIDS Secretariat and Cosponsors are involved, and have developed a joint position in favour of a single fund with a specific window for AIDS, and separate windows for malaria and TB.

What is envisaged is an international fund open to government and private donors. It will be an innovative and equal partnership between developing countries, funders and the multilateral system. To make this partnership effective, early involvement of all stakeholders in planning for the fund is now critical - and so a broad consultation will occur in Geneva this Sunday and Monday, with representatives of finance and health ministers from 48 developing and middle income countries, as well as the OECD countries, foundations, bilateral and multilateral organisations and civil society.

Let me stress that such a Fund cannot be the sole source of international funding, it should not replace existing funding channels, and it must provide additional

resources.

The creation of a substantial new international fund is just one sign of the sweeping changes in the global AIDS response: changes which taken together have laid the basis for a new paradigm.

Three weeks ago, with the International AIDS Society and the Bill and Melinda Gates Foundation, I convened a meeting of thirty of the world's leading scientists and policy thinkers at Mont Pèlerin. What emerged from the meeting was a new global consensus on the AIDS response.

What are its elements?

First, the new paradigm understands we are still in the early stages of the epidemic and must prepare ourselves for the long haul response - we are in a marathon, not a sprint.

Second, it recognizes investment now will save millions of lives later, especially when the focus is on young people. Very importantly, declining trends in HIV prevalence in young people in Cambodia, the Bahamas, Zambia, Tanzania and South Africa, are the result of prevention efforts.

Third, prevention and care are mutually supportive pillars of the new paradigm.

Fourth, antiretroviral therapy is critical in the new paradigm, but it is not a magic bullet. Resistance means any one combination of these drugs has less than two years of benefit, so a large armamentarium of drugs, and careful planning and monitoring are essential.

Fifth, the lack of resources is a key barrier to scaling up prevention and treatment, not so-called 'absorptive capacity'. And we need to start planning the replacement of social and human capital.

So, this new paradigm challenges us to create an AIDS response whose scale and reach is sufficient to make a difference in every quarter of the globe.

Mr Chairman,

The progress of the epidemic is sobering -

- massive impact in sub-Saharan Africa,
- explosive growth in Eastern Europe,
- the Caribbean and Central America second only to Africa in prevalence,
- growth in the world's most populous countries in Asia, and
- no reductions in the epidemic in high-income countries.

To turn it back, we must meet the challenge of scale. Half-measures do not work against this epidemic - and at the moment we are not even taking quarter-measures.

Talking of half-measures, I was truly shocked when I attended a meeting in Istanbul last month with Ms Obaid from UNFPA to hear of the enormous shortage of condoms in the world- largely due to a lack of donor support. And condom supply is something that takes only millions, not billions.

What are the challenges for UNAIDS in this reinvigorated effort?

As my report says, there are six: the transition to scale, tailoring support to different regions, strengthening coordinated UN action at country level, demonstrating our impact on the epidemic, generating new resources, and building on the momentum of the past two years.

With some important exceptions, in many countries the shift from pilot projects to comprehensive, routine, widespread programmes is still to occur.

The challenge of scale forces us to build better partnerships. Our tools in the UN are in the first place influence and leverage, not control.

For example, UNAIDS partnerships with the corporate sector are focussing not on money but on their strengths - like distribution networks and brand recognition. MTV knows a great deal more about how to hold the attention of a teenager than I ever could.

And to take another example, in Gaoua, on Burkina Faso's border with Cote d'Ivoire, the modest input of UNAIDS has been leveraged into a full-scale local response involving local government and civil society. It includes safer sexual behaviour, care provision, resource mobilization, and a model that has great potential for application elsewhere. Such a truly integrated model avoids the schism between various sectors and between prevention and care that we see in the wealthy nations that have adopted nearly universal access to HIV treatment, but where there is a disconnection between the care and prevention responses.

The detailed and independent analysis of the first five years of the work of UNAIDS and of the global response will add to our knowledge and help to further improve it, which is the main reason I look forward to its results. Since the outset, a commitment to transparency and open self-critique has been a hallmark of the programme - even though there are basically only disincentives to such an approach. I know of no other international organisation or global effort that has been so much under the microscope!

Let me now turn to the agenda of the next few days.

The Unified Budget and Workplan represents a major advance in transparency and unity of the core of the UN system's response to AIDS. It significantly improves the existing budget and workplan by further clarifying priorities and roles of the Secretariat and Cosponsors and will be a major instrument of accountability.

The relatively modest increase proposed in the budget is focussed in three areas.

First, the provision of ten additional country programme advisor posts, responding to continuing demands from countries and UN country teams for whom these posts are essential to expanding the response.

Second, a doubling of the size of the Cosponsor Core Component with a consequent doubling of the resources available at country level.

And third, a small increase in the Secretariat activity budget where we have brought "within the budget" the previous extra-budgetary grants from the World Bank to support regional technical assistance activities.

The PCB has consistently emphasised the need for a 'results based' budget with

clear outputs linked to achievable objectives and measurable indicators of success. This Budget goes a long way to meeting this objective, but will not rest here, with further work to be done on developing progress milestones and on harmonising budget outputs between agencies and within regions.

This PCB meeting also receives for the first time a UN system strategic plan for the next five years, bringing together not only UNAIDS and the cosponsors, but the AIDS activities of a total of 29 UN organisations and agencies. It is the direct result of the original call by the PCB for a UN system plan, which went on to be endorsed by the UN Economic and Social Council (ECOSOC) and the Administrative Committee on Coordination chaired by the UN Secretary-General.

The UN system plan before you today represents a significant achievement in transparency and coordination. The process has taken a lot of hard work and in some cases required the involvement of agency governing boards. It brings together the consolidated work of the UN system for the first time. It maps out a strategy to guide and give coherence to the UN system over the next five years.

I am proud of both the Unified Budget and Workplan and the UN System Strategic Plan, and I commend both of them to you. They are a clear demonstration that the UN has the capacity to lead the response to the epidemic into the future, and meet the challenge of turning back the epidemic.

The decisions you take at this meeting, and the decisions you and your governments make over the next month, will have a lasting impact on the epidemic.

Later this week - beginning Sunday - broad consultations will start on the establishment of a Global AIDS and Health Fund. As Kofi Annan said two weeks ago in his speech at the World Health Assembly: "Let us rise above turf battles and doctrinal disputes. The battle against AIDS is too important for us to risk side-tracking it by championing one institution of project at the expense of others. Only the results should matter. And the only acceptable result is that we replace suffering with hope."

I count on your active involvement as PCB members to come to a rapid resolution and to ensure that the architecture of this Fund fully meets the needs and aspirations of all of us - but particularly developing countries, their civil societies, and communities affected by AIDS.

Finally, your reaching out as PCB members to other nations, other agencies and other community organizations will make a difference to the General Assembly Special Session on AIDS. You can help to ensure the highest possible level of political representation at the Session - 20 heads of State and Government are so far planning to attend, but overwhelmingly from the South - it is important that high level representation comes from both North and South. And you can help to ensure that the session and outcome declaration makes a permanent, sustainable and measurable difference in responding to the epidemic.

Let me now conclude.

AIDS is a tale of globalisation: of the rapid global spread of a mainly sexually transmitted virus, of global inequities, and of the need for a truly global response and solution. As we contemplate the next five years of UNAIDS, that must be our vision. As the title of the declaration of commitment from the General Assembly Special Session puts it : Global crisis - global action.

A global audience will be looking to the Special Session for evidence that the nations of the world, gathered together, are serious in their resolve to tackle the epidemic and that there is a clear vision of what is to be done to succeed in this struggle.

At this meeting of the UNAIDS Programme Coordinating Board we have the chance to demonstrate our part in leading that global vision.

Thank you.