

CHECK AGAINST DELIVERY

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“Why AIDS is exceptional”

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Why AIDS is Exceptional

Distinguished friends, colleagues, ladies and gentlemen: Good evening.

Let me start by thanking Tony Barnett, an old friend and a true pioneer in scholarship on AIDS, for inviting me to speak at this great institution of learning.

It is good to see other old friends and colleagues in this room. I'd like to commend Suma Chakrabarti, Robin Gorna and their colleagues at Dfid for their stellar leadership on the AIDS response.

Tonight, I hope to honour the LSE's great tradition of debate by raising for your scrutiny what, in my opinion, is by far the most pivotal issue concerning the AIDS pandemic.

This is, whether AIDS is such an exceptional threat to humanity that it must command an exceptional response, now and into the foreseeable future?

Let me restate this bluntly and in detail:

Is the AIDS pandemic so exceptional a threat that it is in a league altogether different to other infectious diseases or causes of ill health? Is the pandemic so exceptional a threat that its control should not be just one of many Millennium Development Goals but rather an overarching priority, a prerequisite to achieving the MDGs? Is the threat so exceptional that it demands a binding first call on the attention of political leaders as well as on finances? So exceptional that it demands that we undertake fundamental changes on many fronts if we are to succeed?

Ladies and gentlemen: AIDS *is* exceptional. The response to AIDS needs to be equally exceptional.

I know that this is a very risky assertion. Modern history is littered with examples of meritorious global issues for which this sweeping claim was made but not sustained, inevitably to the detriment of that cause.

So I have thought long and hard before publicly voicing the claim for the exceptionality of AIDS. But for the past year or so I have been certain that this case is beyond refutation. Tonight I want to lay out the case fully that AIDS is an exceptional threat as well as reflect on what I mean by 'an exceptional response'.

Before taking up these issues, I must emphasize that I am not arguing that AIDS should be the solitary top priority for policymakers and budgets. Rather, my argument is that the AIDS pandemic needs to be recognized to be one of the most serious threats to our prospects for progress and stability – on a par with such extraordinary threats as nuclear weaponry or global climate change. And, consequently, that the pandemic warrants a response as exceptional as that accorded to the control of nuclear weaponry or climate change.

Let me turn to the first of the issues that I have set out. What are the grounds for claiming that the AIDS pandemic is exceptional as a global crisis and threat?

This pandemic is exceptional because there is no plateau in sight, exceptional because of the severity and longevity of its impact, and exceptional because of the special challenges it poses to effective public action.

A first and crucial way in which the AIDS pandemic is exceptional is that an 'epidemic equilibrium' or plateau is nowhere in sight – not globally, not at the level of epidemics in most countries, and not over the long term. The pandemic has broken with the general pattern of diseases and natural disasters, which usually create their own brutal equilibrium, eventually enabling societies to cope. AIDS, so far, appears to be doing the opposite.

- Thus, in Botswana, Swaziland and other parts of southern Africa the HIV prevalence rate among adults is around 40 per cent and still rising.
- At the same time, the epidemic is globalizing increasingly rapidly, from West Africa to Eastern Europe, from China and India to the Caribbean and Central America.
- And in country after country, the tipping point is being reached – that ominous point, which varies between countries, after which AIDS no longer remains concentrated in so-called 'hot spots' but becomes a generalized explosion across the entire population. This has already happened in several countries in West Africa, including Nigeria with its population of nearly 140 million. Within the next decade, the Asia-Pacific region, with a population five times that of sub-Saharan Africa, could easily become the next epicentre of the epidemic, with every small increase in HIV prevalence translating into tens of millions of people infected.

Think about this, ladies and gentlemen: A mere disease, a disease that is not easily contagious, a disease that was a circumscribed epidemic just 25 years ago, has morphed into a pandemic of cumulatively over 65 million people! And this pandemic will continue to expand for decades!

The long gestation period that characterizes AIDS is only one reason why this epidemic will continue to expand. It would not be expanding so fast and without an apparent plateau were it not for the two other factors that I have already mentioned – the exceptionally damaging impact of AIDS and the exceptional challenges it poses to timely and effective public action. Let me turn to these.

The impact of AIDS is exceptional in that it is uniquely far-reaching – it sets off a chain of devastation, a toppling of dominoes. Tony was the first to put together irrefutable evidence of this, in a project that he led for Dfid in 1989 and which resulted in the landmark book, *AIDS in Africa: Its Present and Future Impact*. The process at work here, as you know, is that AIDS primarily kills adults, particularly young adults, who are not only the motors that drive economic growth, but – just as vital – the motors that nourish succeeding generations.

- To understand the outcome, consider the fact that in sub-Saharan Africa's worst-affected nations AIDS is steadily wiping out the labour force. How can governments function, public services operate, agriculture and industry thrive, and law enforcement and militaries maintain security, when they are being stripped of able-bodied and skilled women and men? How can any of the MDGs be met, whether child survival or education or poverty reduction? These are some of the questions we have been trying to address in a joint project with Shell on the long-term scenarios for AIDS in Africa, which we will launch next month. It is important to realize that this is not some future nightmare – it has been unfolding for some years. Let's recall that the southern African food crisis in 2002 and 2003 resulted not just from drought but from the progressive weakening of agriculture because of AIDS. And by next year, without far higher treatment rates, 11 sub-Saharan countries will have lost more than every 10th person in their labour force to AIDS – by 2010,

five will have lost more than every fifth person in their labour force.

- I must emphasize that in such severely affected countries, the long-term result – over another two generations or so – could literally be the unravelling of economic and social development. These countries are no longer ‘developing’ – they are ‘un-developing’. The key factor here would be the cumulative weakening from generation to generation of human and social capital: the severing of connections between one generation and another. Again, this is already underway. Within the next five years, every sixth or seventh child in the worst-affected sub-Saharan countries will be an orphan, largely because of AIDS. An FAO study last year already reports a long-term decline in transfer of farming know-how across sub-Saharan Africa due to AIDS. Can we even grasp the implications for the development prospects of these countries, let alone respond meaningfully? How can such a loss of human and social capital be replaced – what would it cost, how long would it take, even if undertaken with the greatest commitment of resources and will? Apart from chronic armed conflicts, such as in the DRC or earlier in Afghanistan and Angola, there is arguably no other cause today of such utter economic and social regress.
- One last but crucial point about the exceptional nature of the impact of AIDS. While it is in sub-Saharan Africa that we can see the terrible and lasting consequences of full-scale AIDS epidemics, the impact is severe on particular aspects of development even where HIV prevalence is relatively low. One of the most direct impacts is on poverty. Thus, a recent set of studies jointly undertaken by UNAIDS and the Asian Development Bank estimated, for instance, that AIDS will slow the rate of poverty reduction in Cambodia by 60 per cent every year between 2003 and 2015 and in Thailand, by 38 per cent annually. And AIDS magnifies ongoing development crises. In Russia, AIDS is accelerating the demographic crisis, with World Bank and UNFPA studies estimating that by 2025 AIDS will increase by nearly half the decline otherwise expected in Russia’s population.

I will move to highlighting a final way in which AIDS is exceptional as a threat. There is no escaping the fact that the sensitive issues that are at the heart of the pandemic – sex, gender inequality, commercial sex, homosexuality, drug use – have proved to be an enormous barrier to prompt and effective public action, that is action by government and civil society. If HIV were not mainly transmitted through sex and needles used to inject drugs – but through some innocuous means – we would probably not be experiencing the pandemic of today. Political leaders would have faced up to the gravity of the threat, they would have spoken up, allocated resources, led the response. But prejudice and discomfort about how HIV is transmitted are, unfortunately, still so widespread that they continue to silence many leaders, not just political leaders but also civil society leaders, including even, I am sorry to see, leaders of women’s movements in some countries. It also keeps many of them from acting, too often because of the inexcusable judgment that people at risk, or those already infected, are morally inferior.

This kind of exceptionality might seem to be of minor importance compared to the two other points I have emphasized – that the pandemic shows no sign of reaching an equilibrium, and that its impact is exceptionally severe and ultimately results in severe regress. I personally feel that it is a serious error to underestimate the implications of HIV-associated stigma and the attitudinal barriers to public action on AIDS. Amartya Sen has long pointed out that public action is typically more easily forthcoming on such ‘visible’ things as famines, natural disasters or outbreaks of

highly contagious diseases than on chronic or 'silent' problems such as poverty. With AIDS we are faced with not just a chronic or 'silent' problem, but one where the barriers to prompt and effective action are immeasurably magnified by taboo, denial and prejudice. In country after country, you can see the consequences of this exceptional aspect of AIDS – action comes too late, it does not protect the vulnerable or the poor, and the epidemic takes hold and expands.

Ladies and Gentlemen: I believe these three sets of facts show irrefutably why the AIDS pandemic is exceptional as a current crisis and long-term threat.

Yet, I find that too many influential and knowledgeable people still do not recognize this. Far-sighted thinkers like the late Stephen Jay Gould – who declared nearly 20 years ago that this pandemic is – and I quote – “potentially, the greatest natural tragedy in human history”, “an issue that may rank with nuclear weaponry as the greatest danger of our era” – have remained in a minority despite the evidence that has confirmed Gould’s worst fears. I find that a majority of the people who shape global policies continue to view the AIDS pandemic as just another health threat, as something on par with TB and malaria, as one of many MDGs. For instance, at the World Economic Forum, AIDS still does not figure under the “global issues” theme or as a separate theme like the environment. Just as telling, the excellent ‘Commitment to Global Development Index’ developed by the Centre for Global Development ranks rich countries on how their actions on several fronts help or hinder poor countries – but AIDS is still absent from this list, even though the index has always factored in damage to the global environmental commons.

Given this audience, I cannot help but point out that many economists, political scientists, and public health and public policy experts are at fault too. They have continued to regard AIDS as a matter for health specialists, rather than as a crisis of such gravity that they should chip in with their skills and influence. I hope the establishment of LSEAIDS under Tony Barnett’s leadership will go a long way towards correcting this neglect.

Ladies and Gentlemen: The upshot of this widespread failure to recognize that AIDS is an exceptional crisis and threat is that the response to the pandemic is not made commensurate to the challenges – and so the epidemic escalates even while it erodes our capacities to check it.

What would amount to an exceptional response to the AIDS pandemic given the point at which it is today and given what we know of its likely long-term trajectory?

I once thought that the answer was that we all had to do much more and to do it much better. I was wrong. Routine development or humanitarian approaches and financing are not sufficient as a response to the pandemic. AIDS is exceptional in so many ways that only an equally exceptional response will succeed – just as the exceptional threat posed by nuclear weaponry has led to the development of exceptional responses, including binding global treaties, closely monitored regimes and the constant attention of world leaders. The response to AIDS needs to be driven by that level of political will and public concern, it needs to move to that level of exceptional action.

In my vision of what would amount to an exceptional response, a response capable of turning around the pandemic in every way, there are three key elements – each of them essential, none sufficient by itself. On each of these fronts, an exceptional response is needed. This pandemic is now too globalized, its impact too large, and the barriers to prompt action still too pervasive, for routine development approaches

to suffice. I will cover each of these fronts in detail to emphasize the gap between the exceptional nature of what is needed on each front and the disappointing reality.

A first element, a foundational element, is real leadership and real activism in every country. And this leadership and activism must come from across the board, from politics, from civil society, from business, from churches, from the media – from every section of society.

This is not an extraordinary demand because it is precisely what AIDS has elicited, though not on the scale and intensity called for. The history of the pandemic shows that in virtually every country – rich, middling and poor – that has succeeded in curbing its epidemic, or shows the promise of doing so, it has been because of the interplay between activism and responsible governance. This is as true of the UK and the US as of Brazil and Thailand. And this is true too of the international response, whether in terms of action on HIV treatment access, human rights or financing the response.

And in practice, this activism has not belonged to any one sector of society. It has come from people living with AIDS in many cases – or by their relatives and survivors. Think of South Africa's Treatment Action Campaign, Uganda's TASO, Act UP in the US, and the Terence Higgins Trust here in the UK. It has come from communities threatened by HIV. Think of the sex workers collectives of Sonagachi and Sangli in India, of the Thai Drug Users' Network. It has also come from numerous human rights activists, members of the political elite, journalists, feminists and leaders in business. Think of Marina Mahathir in Malaysia or Mechai in Thailand – they are from the political elite. And Brian Brink of Anglo American is from the business elite but his efforts have been responsible for major breakthroughs in treatment access in South Africa.

Activism is vitally important to the response because it is the most potent force to get political leaders to overcome their unwillingness to act promptly on AIDS, a point that I have already emphasized. As so often in history, top leadership is a mix of personal vision and responding to pressure from civil society. And let us face the facts: The role of governments in initiating, leading and coordinating the response is paramount. We have never seen a single nation reverse its epidemic without the strong leadership of a President or Prime Minister, who looks at the numbers and evidence, admits the danger, and delivers the right kind of response. No partnership, no NGO, no business can replace this role. Only governments have the mandate to direct the *national* policy, *national* resources, and *national* leadership that is the foundation of a response to the epidemic at a scale that will actually make a difference. If we had seen real leadership in sub-Saharan Africa a decade ago – matched by equally real leadership from donor countries, a matter that I'll turn to next in the context of financing – the continent would not have over 25 million people living with HIV today. Nor would India and South Africa each have upwards of 5 million people infected. Nor would scores of other countries be at the tipping point or beyond today.

So a first need is for exceptional activism and responsible governance. The will for public action that results must then be focused on expanding people's rights and fundamental freedoms and reducing inequalities of all kinds. I know that many hard-nosed economists, political scientists and public health specialists are notoriously resistant to discussions of these matters – freedoms, human rights, inequality. But not only has Amartya Sen eased my task by his brilliant explanation of why these matters are central to development, but these matters are of special relevance to AIDS. This is so because the major drivers of this pandemic, universally, are the

failure to fulfil peoples' rights, discrimination or the curbing of the fundamental freedoms of particular groups, and inequality of all kinds, notably including gender inequality.

A second essential element of an exceptional response is adequate financing. Though funding for the response in low- and middle-income countries has soared from under \$300 million in 1996, when UNAIDS started, to \$6.1 billion in 2004, this is about half the amount required for 2005.

Though the shortfall remains enormous, I'm now guardedly optimistic that it may be closed. Low- and middle-income countries are making far greater domestic investments on AIDS. Since the Global Fund's inception three years ago, it has approved over \$3 billion in grants, with more than 60 per cent earmarked for sub-Saharan Africa. The World Bank's Multi-Country HIV/AIDS Program for Africa has disbursed over \$1 billion. And since President Bush's path-breaking commitment in 2003 to provide \$15 billion over five years for the response to AIDS, there has been real evidence that several donor governments are finally becoming serious about addressing the resource constraint. Prime Minister Tony Blair's decision last June to contribute £1.5 billion over the next three years the proposal to secure adequate, stable and the recent proposal to secure long-term financing for international development and AIDS through an International Finance Facility are promising developments. 2005 will be crucial. Under the UK's presidency of the G-8, mechanisms must be agreed to ensure that donor funding continues to rise to the levels needed over the long term. As I've emphasized, this pandemic will be with us for generations. So the financing has to be such that it allows exceptional action on the 'crisis' front – such as swiftly expanding access to antiretroviral treatment and support for orphans – as well as exceptional action on longer-term solutions, such as strengthened HIV prevention and the development of vaccines and microbicides.

I do want to put in perspective this recent evidence of deeper commitment by the leaders of donor governments, however laudable and important. The African countries worst affected by AIDS would gain far more in financial resources from the cancellation of debts, from the ending of rich-world agricultural subsidies and trade barriers, and from truly affordable prices for pharmaceuticals. It is hypocrisy and worse when rich countries dole out aid while their remaining policies serve to undermine the capacity of poorer countries to respond to the pandemic. I cannot but agree with the conclusion of the most recent report on the Commitment to Development Index – I quote – “No wealthy country lives up to its potential to help poor countries. Generosity and leadership remain in short supply.”

In terms of an exceptional response to AIDS, rich countries will only have lived up to their responsibilities when they agree to reform the gross inequities of prevailing trade and financial rules. For too many years, billions of dollars annually have gone to servicing debt that African countries could have put to use investing in the AIDS response, education or other critical development fronts. Because of AIDS, exceptions were made on access to generic medicines in the WTO rounds in Doha and Cancun, but they do not go far enough and are overly complex. An exceptional response to AIDS demands a new compact between the pharmaceutical industry and the world's poor. A just compact involves two elements. One is to give the pharmaceutical industry patent monopoly and good profits in rich countries – this is essential because new antiretroviral drugs are desperately needed all the time. The second is allowing poorer countries to legally manufacture and sell generics; at the same time, the pharmaceutical industry should further the competition by selling ARVs to poorer countries at 'cost-plus' prices. In this regard, I hope that the British Government will vigorously advocate for action on the progressive recommendations

on intellectual property and development made by the Commission on Intellectual Property Rights in its excellent report of September 2002.

One final point on the financial side. Public expenditure ceilings, such as those set in Medium Term Expenditure Frameworks, restrict the levels of investment across all sectors needed to mount an exceptional AIDS response. How can the goal of financing an exceptional response be balanced with fiscal and economic discipline and good sense? This is no longer an academic issue now that millions of pounds are flowing into developing and transition countries. I witnessed it in Uganda a few weeks ago. It must be possible to find a solution, just as solutions have been found for post-conflict or post-disaster situations. Let's not forget that the Marshall Plan for Europe required setting aside public expenditure ceilings! UNAIDS has emphasized the urgency of this point to the IMF and World Bank. Increased spending on AIDS must be recognized to be a capital investment, not just an expenditure item. These investments are going to restocking and protecting human capital. So why can't they be considered to be temporarily off-budget? I hope many of the economists here will take up the challenge of seeing how this can be done.

And then there is the need for exceptional implementation, for on-the-ground action. This is the third essential element of an exceptional response. Money raised and political will garnered has to be translated into bringing proven, successful services to the people who need them, whether it be treatment, HIV prevention, or impact alleviation.

On this front too, we need a complete break with past implementation practices. To have real results, implementation must focus on three goals.

A first goal must be a renewed commitment to prevention. We must not turn our backs on prevention because it is difficult and sensitive. We know very well what needs to be done on prevention – we know what works. We must break the cycle of new infections, or we will not be able to even sustain the cost of treatment. Crucially, HIV prevention efforts have to fit the realities of women's lives. We must promote real access to the female condom. We must speed up the development of microbicides. Girls need to be assured of an education. Governments must enforce laws to make domestic abuse illegal, and to treat rape as a real crime that is punished harshly.

A second goal should be to find ways to reverse the depletion of human and institutional capacity in countries highly-affected by AIDS and to aggressively protect capacity in countries where the epidemic has not advanced far. Suma Chakrabarti and I saw on a visit to Malawi last year the terrible dimensions of the human resource crisis. The crisis is worst in the health sector, because of AIDS, poor salaries, and – not least! – the active recruitment of nurses by the UK and others. The starting point is to preserve existing capacity – in other words, to keep people alive. This is why providing antiretroviral therapy is so critical. In the hard-hit countries, nothing else—*nothing*—will so directly or quickly arrest the plunge in capacity as this single measure. Antiretroviral therapy has reduced mortality by 80% in Brazil—what other capacity-building measure can show such a return? So a core part of an exceptional response is to ensure the success of '3 by 5', the campaign by WHO and UNAIDS to provide 3 million people with ARV treatment by 2005. While we press ahead on that campaign, it is imperative that we plan for the larger effort. Because increasing numbers of people will be on treatment for life, the more expensive second-generation therapies need to be made accessible globally – over the long term. But in the same breath let me emphasize that preserving capacity is just as much about prevention – about keeping uninfected people uninfected.

I must also emphasize that building capacity is not just about training nurses and doctors. It is foremost about supporting communities, particularly people living with HIV. This would raise capacity, empower people living with HIV, and help break the stigma around AIDS. This fact was freshly imprinted on my mind last month in Kenya and Uganda. Community efforts from the Kenya Women's Association – from TASO, the mother of all community AIDS groups in Africa, and the Our Lady of Africa Mbuya Parish were all working successfully with people living with HIV, not only to deliver antiretrovirals, but also on HIV prevention, support to orphans and efforts to keep girls in school. There can be no substitute for building capacity of this kind. Because it is the most empowering, it is the most sustainable.

Helping countries build and sustain human and institutional capacity has always been one of the most difficult challenges of development, but this challenge has taken on extraordinary urgency in the age of AIDS. I hope many of you here this evening will apply your minds to this challenge. We urgently need to improve the state of knowledge about how capacity can be built and preserved in the face of this pandemic.

One last goal for implementation, made increasingly imperative because of the major influx of funding for AIDS, is to harmonize our country-level efforts. Waste and inefficiency from duplicate efforts by donors are major obstacles to the response against AIDS. For example, in several countries in Africa and Asia, there have been 50 or more donor AIDS planning missions in the last year alone. With each visit, understaffed agencies push aside pressing work to take donors on site visits. Countries must often satisfy donor conditions that are not a part of their national AIDS strategy, and scarce staff time is absorbed filling out paperwork rather than saving lives. This problem, of course, has long been true of development work in every sector. On the AIDS front, I am happy to report some progress.

Last year, UNAIDS, in partnership with the UK and US governments, brokered a global agreement with all donors on supporting country-level action on AIDS so that donors and host countries can work together to shape a more effective and coordinated response. This agreement, known as 'The Three Ones' means that each country has ONE national AIDS strategy that integrates the work of all partners under national ownership and leadership; ONE national coordination authority to manage that strategy across all sectors; and ONE country-level monitoring and evaluation system to measure and determine what's working. This roadmap for harmonization and joint accountability now needs to be made a reality on the ground. The next step forward in this process is a meeting on 'Making the Money Work', which will be held here in London in March, bringing together civil society and ministers of international development and health from many countries at the invitation of Hilary Benn and myself.

To conclude: I hope I have convinced you that only an exceptional response will suffice to reverse this pandemic. This is an unprecedented crisis, in scale and nature, and we have no choice but to act in exceptional ways. This is also a crisis that will continue for some generations. So our basic choice is only whether we act exceptionally right now or later, when many more millions have died. But let us not fool ourselves. We cannot plead ignorance. If we don't live up to our responsibility as a generation, we have only ourselves to blame. So we have only one option, and that is to live up to our responsibility now – wherever we are, whoever we are.

Thank you.