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**International AIDS Society
Keynote Speech
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Access and Hope

*Professor Michel D. Kazatchkine, M.D.
Executive Director
The Global Fund to Fight AIDS, Tuberculosis and Malaria*

Minister Abbott, Distinguished Guests, Dear Colleagues and Friends:

Good evening.

It is an honour for me to speak at this opening ceremony of the 4th IAS Conference on HIV Pathogenesis, Treatment - and now, Prevention - and a pleasure to be back in Australia and in the beautiful city of Sydney.

Thank you Pedro, thank you David

Et bonsoir à tous les collègues et amis francophones.

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My message today is really one of hope. Not mere optimism, but **hope, based in reality**, such as the real progress we have now made in expanding global access to HIV treatment. Hope, because of the opportunities that exist for prevention. Hope, because of the encouraging advances in science that will be discussed at this conference. Hope, **because the world is coming together as never before to act on health.**

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We have witnessed major changes since many of us gathered for the first of these conferences, in Buenos Aires, just six years ago. The slide lists a number of these changes that I will briefly illustrate in this presentation. (READ) It is worth recalling that the seeds of much of our success to date were planted in that year, 2001, with the first UN General Assembly on HIV/AIDS, the publication in *Science* of the first global resource needs estimates for AIDS, and the call by Kofi Annan for the creation of a "global fund" for health.

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First: In the last six years there has been a **major change in paradigm about the relationship between health, and development.** Today, health is no longer seen as a happy by-product of development. Schools, bridges, even clean water - those traditional markers of development - are clearly no guarantee that people will be healthy. Rather, in the age of AIDS, we understand much better that people must be healthy for their

societies to fully develop. And the health sector, originally considered as a non-profitable expenditure, is now seen as a necessary investment for development.

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We see this in the Millennium Development Goals. We, in the AIDS community, are primarily concerned with Goal 6: combating AIDS and other infectious diseases. But there is a health dimension to all of the MDGs. Agriculture accounts for one third of GNP in most affected countries, and it has been estimated that up to 20 % of agriculture workers in southern Africa could die of AIDS by 2020. Fighting AIDS is key to progressing against other goals, such as educating the young, and empowering women. We simply **cannot advance on any one aspect of development without also thinking how we must work to stop this epidemic.**

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Secondly, the mobilization of the political world. Since the G8 meeting in Okinawa and the United Nations General Assembly in 2001, through to this year's G8 in Germany, **health - especially AIDS – has been on the political agenda as never before.** In this region, Minister Downer deserves great credit for this. But as priorities change we must make sure that AIDS and global health remain high on the political agenda.

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In the political realm, let us also acknowledge the role of **civil society**. AIDS has served as a powerful catalyst to reveal the dysfunctions in our societies and in the relationships between the rich and the poor, the powerful and the weak. Look at **how AIDS treatment activism has politicized health**, first in the developed world, then Latin America, Asia and now Africa. "Journalists Against AIDS Nigeria", "Treatment Action Campaign", "the Thai Drug Users Network" and "REDLA-plus" are but some of the justly angry and impatient voices that have brought a new sense of urgency to the fight against AIDS in developing countries. And the International Treatment Preparedness Coalition comes as a remarkable example of the new, global reach of civil society. It is hard to believe that only six to eight years ago, none of these groups existed. And it is not just their moral authority that has made the difference. At the Global Fund, we are presented with evidence every day of the critical role civil society also plays in implementation and ensuring accountability.

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Resources: As we considered Phase II data on atazanavir and debated structured treatment interruptions in Buenos Aires, the world was spending less than two billion dollars a year on fighting AIDS, up from only a few hundred million dollars just a few years before. Since then, commitments have continued to increase, to reach nearly nine billion dollars a year in 2006. We have the Global Fund, PEPFAR, the World Bank's MAP and other efforts. This money is now making an enormous difference in the countries where it is needed most.

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In just the last five years, the Global Fund has committed nearly eight billion dollars in 136 countries. It is funding almost 25% of AIDS programs globally, and two-thirds of the

world's malaria and TB programs and now estimated to save around three thousand lives a day in the three disease areas. Major increases in coverage have been achieved in just the last year, as shown on the slide.

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From a mere 200,000 people on antiretroviral treatment in 2001, more than two million people in developing countries now benefit from therapy. Thailand, Brazil and Botswana have universal access. In Asia, there has been a sevenfold increase in the number of people on treatment in the last five years.

Of course, more needs to be done, especially in reaching children with HIV, and the most vulnerable. In particular, it is essential that we take serious steps to ensure that injection drug users with HIV and sex workers in Indonesia, China, Vietnam and many countries in Eastern Europe and Central Asia have access to the essential prevention, treatment, and support that they need. Not only doing what is easy, but doing what is right. This is our collective responsibility.

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Treatment outcomes now show that treatment in resource-poor settings is feasible and effective. Virologic responses are as good in South Africa as they are in Switzerland. So are adherence rates. Because fewer drugs are used, regimens are changed less frequently in South Africa than in Europe or the US, helping to minimize resistance. Our concerns now include reducing rates of loss to follow-up, diagnosing people sooner so that they get the full benefit of treatment, and addressing the major challenge of tuberculosis co-infection.

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Progress on prevention has been slower, and it is harder to measure. But we have moved well beyond the treatment versus prevention debate. Donors know that they must support - and all countries have committed to implementing - comprehensive programs. Our way of thinking has changed because we must now do prevention in the context of treatment, harnessing the benefits of both. (This means treating the mother, as well as preventing transmission to the child. It means more routine HIV testing in high-prevalence settings so that people with HIV are not only brought into care, but are helped to prevent transmission to others.).

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For a long time we have talked about the need for operational research in resource-poor settings. Often, our questions have greatly outnumbered the answers. How can we best integrate treatment and prevention? What are the most effective models of service delivery? How do we best support adherence in a Senegalese village? For a long time, the programs at these conferences seemed oblivious to such questions. Now - as we shall see in the coming days - new research methods and collaborations are helping to answer them. We have been learning, for example, from multidisciplinary observational research, that the availability of ART in Africa impacts positively on motivation for testing and disclosure. That there is a lower likelihood of risky behaviours

in treated people. That clinical research can be done and done well even in resource-limited settings.

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Early in the decade some – among them prominent scientists - claimed it would be a mistake to move rapidly to large scale access to AIDS treatment in resource-limited settings. A number of claims were made at that time. In fact, operational research has now invalidated those claims.

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Let me now turn to my hopes, and to the challenges and some of my concerns, for the near future.

In 2005, the G8 set the goal of coming “as close to possible to universal access to HIV treatment” by 2010. Every UN Member State has since adopted the goal, including universal access to prevention and care, as well. While my presentation today is focused on access to treatment, we all recognize that we will only be successful in winning the fight against this epidemic if treatment is coupled with intensified efforts on prevention.

These are some of the considerable challenges we face in the next three and a half years if we are going to make universal access into reality.

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First, resources. UNAIDS has estimated that 18 billion dollars was needed this year to fund a comprehensive global response to AIDS, 22 billion next year and up to 23 billion dollars by 2010. On the supply side, long-term and sustainable donor commitments are needed to meet these funding needs.. Donors are responding to the call for much higher level of sustainable funding. In Germany, the G8 leaders endorsed the proposal of a 3-fold increase – that is 6–8 billion US dollars - in annual resources channeled through the Global Fund by 2010 and President Bush has proposed doubling the resources currently committed to PEPFAR. We must all do our part in living up to our commitment, in the implementer community, to maximize the effectiveness of the resources by harmonizing and aligning our efforts, not the least because our collective performance in aid coordination will determine our ability to secure more funding.

Sustainability of resources in the long-term is not just the responsibility of donors. Many developing countries have committed to increasing the amount that they themselves spend on health, and they must honor these commitments. For this to be possible without excluding the poor, innovation is needed.

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The fight against AIDS gives countries the opportunity to begin thinking about how the building blocks of sustainable social protection - including health insurance - can be put in place. In most cases, in the developing world, the purchase of medicines and health spending are at the direct expense of households. Each year, over 100 million families fall below the threshold of poverty because of health-related expenses. In addition, the

inequity that prevails in health systems in poor countries, increases the health deficit of the poorest segments of the population. This slide shows that the wealthiest 20% of the population benefits from over 40% of health-related services. Rwanda provides an inspirational example in the form of *mutuelles*, community-based health insurance schemes that use a Global Fund grant as seed funding to pay health insurance premiums for the poor. Health insurance - properly implemented - gives people better financial access to health services, contributes to sustainability, and - on current evidence - increases utilization of health facilities by up to three to five times.

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Drugs currently account for well over 50% of AIDS program costs in some countries. While the best price for first-line regimens is now less than 100 dollars per person per year, the option of replacing D4T with tenofovir in first-line regimens would increase the annual cost of treating an adult for one year in a developing country from around a hundred dollars to over four hundred dollars in the best case scenario.

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In addition, second line treatment is needed for 5-10 % of patients by 2008-2010, and TB-HIV co-infection demands even more expensive first line treatment- mean that total drug costs will inevitably rise in the years ahead on a population-wide basis. We must begin planning for this, at the same time as we maintain advocacy for lower drug prices, encourage greater competition in the drug market, and strongly defend the right of countries to respond to AIDS as a public health emergency.

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AIDS has highlighted the fragility of health systems in developing countries, and perhaps our major challenge is to build health systems **at the same time as we invest in the response to AIDS** and other diseases. By this I mean improving the basic infrastructure needed to deliver AIDS services: beds, waiting rooms, laboratories, basic equipment, drug supplies, and above all, the health workforce. It is no coincidence that the countries experiencing the worst shortages of health workers are to a large extent also those with the highest HIV prevalence. Human resources are now rightly seen as the most precious and scarce resources of all.

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Tuberculosis remains a prominent cause of illness and death among people living with HIV in developing countries, **even in the era of increased access to antiretroviral therapy**. Chronic neglect and lack of investment in TB control and research have meant that TB programs in many countries are unable to cope with the rising rates of TB caused by the HIV epidemic, leading to unnecessary deaths and the development and spread of drug resistance. Urgent, massive investment in TB research is the only way we are going to find better ways to prevent, diagnose and treat TB in people living with HIV.

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Next, we must further invest in improving the quality and scope of data that show the **impact - rather than just the processes and inputs - of scaling up.** (Without good evidence that investing in AIDS will have a significant and enduring impact on survival, mortality, health systems and the epidemic, it will become ever more difficult to sustain commitments from donors and countries). This is a key challenge for the next couple of years.

Malawi offers one example. Shown here is how the Global Fund-supported introduction of treatment has led to a significant decline in mortality in its major electricity company.

Haiti is another, with a broad range of **system-wide benefits** demonstrated through its AIDS and TB efforts. (We expect that the five year evaluation of the Global Fund that is now underway will contribute many more such insights).

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The final challenge I wish to highlight is the need to further develop policy and advocacy in two key areas. One important argument for the public subsidy of health is that there are **strong society-wide benefits from disease control interventions.** As the Sydney declaration calls for, we need to think much more seriously about how, as an international community, investment in drugs and other health technologies can be further encouraged.

Secondly, human rights. The debate around inequity and poverty has led to the realization that economic development cannot occur without access to human rights, **including that of access to health.** Let us be more vocal about the link between rights – specifically the right to health - and democracy.

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Dear friends and colleagues: **Together, in six short years, you have given hope to millions, where none existed.** You **have** begun to deliver. Let us now work to **make hope a reality** for the millions who are still waiting.

Thank you very much.