Can We Halt the Epidemic in Eastern Europe and Central Asia? Facing the Prevention Challenge

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Speech by

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I am honoured that the organizers of this first-ever conference on AIDS in Eastern Europe and Central Asia have asked me to speak on the topic of HIV prevention. When UN Secretary General Kofi Annan asked me to serve as his personal AIDS envoy to this region, it was with the hope that we could help prevent Eastern Europe and Central Asia from experiencing what certain other regions have endured since the beginning of the epidemic. Prevention, of course, is the key to avoiding a major AIDS catastrophe in this region.

As the founding President of the International AIDS Society, I am also delighted that the idea to arrange an IAS co-sponsored AIDS conference in this region has finally come true.

It was exactly 25 years ago that the first cases of AIDS were identified in Los Angeles and New York City. More than 20 years have passed since HIV was isolated in the laboratory and an antibody test made available.

Yet despite this wealth of information on effective strategies to prevent HIV transmission, the epidemic has continued its relentless expansion throughout the world. In only 25 years – a short period from a historical standpoint – the epidemic has spread to every region of the world. Today, nearly 40 million people worldwide are living with HIV and roughly 25 million have died of AIDS.

In light of this tragic history, it might be tempting to conclude that perhaps our prevention strategies are not as effective as we might think. The truth, though, is that our arrogance and complacency are to blame for our failure to reverse the epidemic. In country after country, a common reaction has been that "AIDS does not affect me" -- "this is NOT Africa."

This desire to pretend that one can be walled off from the effects of HIV can have disastrous consequences. In the late 1980s, for example, many of us who were engaged in the international response to the epidemic warned the Soviet authorities that HIV also posed a threat to that country. Our warnings were waved away. The Soviet Union is not at risk of a major HIV outbreak, it was argued, because as we heard on that famous

television broadcast twenty years ago, “There is no sex in the Soviet Union," a joke which underscored the irony of the epidemic that was to follow. Tens of millions of people were tested for HIV every year, but few prevention measures were put in place in the intervening years, even after the Soviet Union collapsed. Today, the successor states of the former Soviet Union account for 90% of the 1.6 million HIV cases in Eastern Europe and Central Asia. The Russian Federation now has the largest AIDS epidemic anywhere in Europe, while Ukraine has the region’s highest HIV prevalence.

In the brief time I have available, I wish to emphasize several key messages. First, AIDS is an urgent problem of all of us. If we pretend otherwise, we will soon face national epidemics in this region that are many times more serious than they are today. Second, to fight AIDS effectively, we must understand the ways in which AIDS is different from other infectious diseases and we must base our response on a clear understanding of the evidence . Third, we need to urgently enhance the coverage and the intensity of our prevention programmes, particularly for at-risk populations who are most vulnerable to HIV.

Let us initially explore how AIDS is different from other infectious diseases. Most epidemics are characterized by a sudden onset, a peak of disease, and a comparatively rapid decline after some months or so.

By contrast, HIV does not come, strike, then disappear. HIV is a retrovirus which causes a PERSISTENT infection. Within hours of infection, HIV is incorporated in the genetic materials of our own cells and stays there for the rest of our lives. In the absence of treatment with antiretrovirals, the virus requires many years from the point of initial infection to cause death. During this period, of course, the infected individual is capable of transmitting the virus to others. It is one of the deadly ironies of HIV that it converts individuals who radiate health, strength and youthful beauty into carriers of a deadly infection. Having entered into the genetic material of tens of millions of people throughout the world, the virus is not likely to go away anytime soon. To conquer AIDS, we need to dispel any illusions we have about the disease itself. Prevention is currently the only tool we have to stop the spread of this epidemic.

At first glance, the basic technologies and strategies to prevent HIV transmission can seem beguilingly simple. Sexual transmission, of course, can be successfully prevented through proper and consistent use of condoms among those who are sexually active.

The starting point for HIV prevention is **information**. People who are or will be sexually active need accurate information on condom use. Individuals who inject drugs require information on the importance of always using clean needles and on how to obtain sterile injecting equipment.

Yet if there is one thing we have learned in the course of the epidemic, it is that information alone is not enough to produce long-term behaviour change. It is an illusion to expect that one-time provision of information will help people adopt safer behaviours. Prevention programmes that reinforce prevention messages over time have proven to be more effective than simple information transfer. Similarly, experience indicates that peers are often the most effective deliverers of HIV prevention messages and services, and that celebrity role models, such as sports figures, can sometimes get the attention of young people to understand the risk of HIV in ways that school teachers or even parents cannot.

In Eastern Europe and Central Asia, 1.6 million people were living with HIV as of the end of 2005. The epidemic is rapidly expanding in the region, with 270,000 new infections last year alone. The vast majority are among young people, and there are alarming signs that a growing share of new infections are related to sexual transmission. In 2005, over 41% of the newly reported cases of HIV in Ukraine were among women, two-thirds of which were infected through sexual transmission. In Moldova, over half of the newly reported cases last year were related to sexual transmission.

Fortunately, there is good news to report. There are signs that the political leadership that is essential to an effective national response to AIDS is being intensified at the highest levels, especially in the region's two largest countries, Russia and Ukraine. The Russian Federation has significantly increased its financial commitments to AIDS programmes, with spending by the federal government increasing from $5 million in

2005 to $105 million in 2006. Only a few weeks ago, President Putin said the country would embark on an urgent programme to fight the epidemic.

In Ukraine, President Yushchenko has taken personal responsibility for the national response to AIDS, including through several meetings with the All-Ukrainian Network of people living with HIV. The Ukrainian National Coordination Council on HIV and AIDS serves as a model for the engagement of all government sectors, as well as civil society.

While political commitment is growing, even in these countries, the number of people living with HIV continues to increase rapidly from year to year. The reason is simple. When it comes to prevention of HIV -– we are still not doing enough, we are not always doing it right, and we are certainly not doing it at a scale that makes a measurable difference.

Here were are – twenty five years since the AIDS epidemic began, and most countries in the region have yet to implement the kind of comprehensive and intensive prevention programmes needed to stop the spread of HIV.

The first vivid example of this is the prevention of vertical transmission from mother to child. This is one of the few areas where we are seeing progress and we now have the tools to make this a complete prevention success.

If the average rate of MTCT just ten years ago was over 20% across the region of Eastern Europe, today the rates are falling quickly. But today the average rate of transmission in Western Europe is now less than 1.5%. How did they do it? The most powerful weapon is HAART – triple therapy for the pregnant women with HIV. Despite the relatively high cost of HAART during pregnancy, it is considerably cheaper than providing a child born with HIV with a lifetime of treatment. But if we look at the rate of mother to child transmission in many countries in the CIS region, from over 10% in Moldova to 8% in Ukraine and Belarus, the rates are not falling as quickly or as low as they should be. In an era when the technology and preventative treatment are available, it should be an easy task to eliminate the transmission of HIV from mother to child in this

region. But our obligation is not just to prevent vertical transmission of HIV, but also to ensure that newborn children are properly cared for. For this reason, PMTCT Plus, which ensures that the mother continues treatment with HAART post-partum, must be come the standard of care in this region, as it is in many parts of the world.

Yet it is relatively easy to access pregnant women with prevention services. One of the more daunting challenges we continue to face in this region is the sub-optimal quality and coverage of primary prevention programmes for populations most at-risk for HIV. If we look at commercial sex workers, according to recent UNGASS data from six countries in Eastern Europe, only two countries, Georgia and Kyrgyzstan reported prevention coverage of over 70%.

If we then look at the sentinel prevalence of HIV among commercial sex workers in these same countries, we see the inverse -- very low prevalence in those countries with high coverage rates, and alarmingly high infection rates among sex workers in the capital cities of Moldova and Ukraine. With commercial sex workers at the front-lines of the shift toward heterosexual transmission of HIV, we need to be doing much more to protect them. We must also recall that many women in sex work are also victims of trafficking, which greatly increases their vulnerability to violence, exploitation and HIV. We need to do much more to empower these women than simply provide them with information, condoms and access to services. It is by protecting their human rights that they can then protect themselves and their clients from HIV.

The challenges we face with prevention among injecting drug users are even more severe. There has been much evidence of the growing proportion of new cases of HIV related to heterosexual transmission. However, particularly in many CIS countries, the leading mode of transmission remains injecting drug use, which is an area where prevention is clearly not doing enough. There have been many pilot harm reduction programs for IDUs supporting VCT, condoms, syringe exchange and referrals to other services. But the coverage and quality of these programmes are still inadequate to be having an impact on the epidemic. Here we see some of the alarming results.

In seven of the CIS countries that provided recent UNGASS data on HIV prevalence among injecting drug users, three reported prevalence rates among IDUs in the capital cities over 20%, with the sentinel prevalence among IDUs in Minsk over 30%, and in Kyiv almost 50%. Even these disturbing data do not tell the whole story, as in regions such as Siberia in Russia or Crimea in Ukraine, the epidemic among IDUs is even worse than in the capitals of Moscow or Kyiv.

If we compare this to data from other Eastern European countries, we see that the epidemic there is largely under control, particularly among these same most at-risk populations. In the Czech Republic, Hungary, Slovenia, Slovakia, Bulgaria and Romania, the HIV infection rates among IDUs have remained around or below 1%. Even in countries where the prevalence among IDUs is closer to 10%, such as Estonia, Latvia and Poland, there is evidence that the epidemic among IDUs is serious but under control.

What accounts for the difference between the success of prevention programmes in some countries of Eastern Europe and the alarming failure of these same programmes to control to spread of HIV in many other countries, particularly in countries in the CIS region? Perhaps during this conference we can, for the first time in this region, consider these questions seriously.

From the point of public policy, I can suggest a few possible answers. First, we cannot really claim to have covered the majority of our target populations until we have reliable estimates of the number of people in need of prevention services. These estimates are generated and updated on a regular basis in many Eastern European countries. However, few of the countries in the CIS region have developed scientific estimates of how many commercial sex workers and IDUs need prevention services. We cannot always rely on the official statistics of the Ministries of Health or Internal Affairs. Without reliable estimates of the size of our target populations, we can never know whether our prevention programmes are covering the majority of those in need, or a small minority, which is more likely the case.

Second, we have to ensure to provide comprehensive prevention programmes. When we are working with sex workers, if we can't also provide women with access to

voluntary rapid testing for HIV and other STIs, and referrals to free treatment, they may not have much use for our brochures. If the woman is a victim of violence or trafficking, then preaching about condoms may not help.

Our piecemeal approach to prevention is even more inadequate in our work with injecting drug users. I firmly believe that we will not make significant progress in controlling the epidemic among IDUs if we do not immediately enhance harm reduction programmes to include substitution therapy for opioid-addicted injecting drug users. Perhaps what I am saying is controversial, but those countries in Eastern Europe that are still hesitating about harm reduction and substitution therapy cannot afford to ignore the facts.

The success of substitution therapy in HIV prevention is supported by extensive international scientific evidence. Successful methadone programmes that have been actively supported by governments in Poland and Slovenia have helped to successfully control the spread of HIV among injecting drug users for over ten years. Clearly the facts are being studied by some, as pilot programmes for substitution therapy are now being implemented in Ukraine, Belarus, Moldova and Kyrgyzstan, and they should be applauded for finally taking steps to implement a solution to this serious problem.

Third, most successful prevention programmes in Eastern Europe are actively supported by local and national governments. In those countries where the epidemics are most severe, such as in Ukraine or here in Russia, the majority of prevention programmes among most at-risk populations, particularly sex workers and IDUs, continue to be supported by external donors. For any prevention programmes to go beyond their pilot scope, and ensure long-term sustainability, they must be supported by national and local governments, both financially and politically.

I have deliberately focused on the hundreds of thousands injecting drug users and commercial sex workers in this region that are still not covered by any effective prevention programmes. We can spend a lot of time and effort to promote greater public awareness about HIV, and inform people that HIV is not transmitted via mosquitoes. But

this will not prevent a single case of HIV infection. So let us not mislead ourselves with a false sense of security because we have printed brochures or given a public lecture.

In closing, let me attempt to place the prevention challenge in its proper context. If countries in this region do not act quickly and effectively, the future will inevitably be grave, potentially even disastrous. More young people will be stricken in the most productive years of their lives, families and households will be devastated, children will be orphaned. National productivity will suffer, and health care costs will significantly increase.

By contrast, health economists earlier this year worked to estimate the effect of a scaled-up prevention effort would have on the global epidemic. Published in the journal *Science* earlier this year, the results indicate that an expanded prevention response in Eastern Europe would avert more than 700,000 new HIV infections projected to occur between 2005 and 2015.

Of course, this comes at cost of over nine thousand dollars per infected adverted over the ten year period. But such as investment ultimately saves over two thousand dollars for each infection averted, as the lifetime cost of treatment for these cases would still be much higher.

Every day in Eastern Europe and Central Asia, over seven hundred people become infected with HIV. Just in the time I have been speaking, there were approximately fifteen people who were newly infected with HIV. We must focus on those who most urgently need access to effective and sustainable prevention services. With the epidemic continuing to spread out of control in many countries in our region, we can no longer afford to neglect those that most need our attention and support.

In short, we cannot afford to neglect prevention imperatives. HIV prevention is a human right and economic necessity. History will judge us harshly if we allow prejudice, lack of will and lack of determination to keep us from saving millions of lives. Let us vow not to permit this to happen.