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Speech

NOTE: CHECK AGAINST DELIVERY

"Doing the right thing"

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Mr. Secretary-General,
Mr. Prime Minister,
Excellencies, delegates, colleagues and friends,

In the last few days, many of you will have read in newspapers that we have overestimated the severity of the HIV epidemic, that there are not as many people living with HIV as we previously thought. And it is true. Our data have improved, and we now know that infection rates in African cities do not always reflect the situation in rural areas, where infection rates tend to be lower. So the overall estimates of the number of people living with HIV have come down, (Slide 2) but not just for 2003. They have also been adjusted downward for past years as well. (Slide 2b) As you can see on this chart, which compares our global adult prevalence estimates from the 2002 and 2004 International AIDS conferences, the trend is the same – global HIV prevalence has steadily increased over time.

Confusion on this issue is a distraction and we can't afford to waste time on it. So let us be clear today about one thing: the estimates are lower because of better data, not because HIV infections are falling. (Slide 3) As you can see here, the number of people who have become infected with HIV has grown every year since 1990. You can see from the blue line that most new infections are still in sub-Saharan Africa. Just as disturbing is the much steeper rise in annual AIDS deaths (Slide 3b), which is seen here. We can see that the vast majority of the millions infected 10 years ago are now dying because of the gross inequities in the global distribution of antiretrovirals. Most of these deaths are occurring in sub-Saharan Africa, as is seen here in the orange line.

But I want to draw your attention especially to the spike in new infections worldwide (Slide 3c) that you can see since 2002. That spike means that close to five million people were infected with this preventable disease in 2003. We often say that we

know what needs to be done to prevent HIV, but those five million people bear witness to the fact that we are not doing enough or well enough.

New infections have been growing most rapidly in Eastern Europe and Asia. As we gather in this great and bustling Asian city, I'd like to turn my attention to the development of the HIV epidemic on this continent. By our estimates, more than seven million Asians are living with HIV. And whether or not we want to face the facts, the facts are these: most of the people who are living with HIV in Asia became infected while injecting drugs with dirty needles, or while buying or selling sex without condoms. Indeed the interaction between unsafe drug injection and unprotected commercial sex accounts for much of the spike that you see here.

Let's look at some specific examples from countries where national surveillance data show that the epidemic is growing rapidly. (Slide 4) On this slide, (Slide 4a) the red line shows the rise in HIV among injecting drug users in the Chinese province of Guangxi, and the green line shows the subsequent rise in HIV among sex workers. A similar pattern is seen in Jakarta (Slide 4b) and Hanoi (Slide 4c).

Why does HIV rise among sex workers a few years after it has begun to rise among drug injectors? (Slide 4d) As you all know, sharing needles is a very efficient way of spreading HIV. Therefore, HIV prevalence among drug injectors tends to be high. In many places in Asia, half of all injectors are HIV positive. But for a long time, we believed that drug injectors were not very sexually active. But take a look at this. (Slide 5) You can see on this slide that substantial proportions of male injectors in many Asian countries visit sex workers – more than 80% in Surabaya, and more than 50% in Hanoi and central Bangladesh. And most of them, shown in the red part of the bars on this slide, are not using condoms.

In some countries, including Vietnam and parts of China, a high proportion of female sex workers are also drug injectors. To prevent the sharp rises in infection that I showed you earlier, we have to make sure that injectors have access to clean needles, but also that condom use in commercial sex becomes the norm.

You may find these slides showing high risk and rising HIV infection discouraging. Certainly, the data from Asia are a cause for great concern. But the region also provides us with reasons to be optimistic. Those Asian countries that have faced the facts and taken action provide us with some of the best examples of effective prevention in the world.

The success of the "100% condom-use" campaign in our host country, Thailand, is already famous. HIV continues to spread among drug injectors in Thailand, and this is cause for concern, but it is not fuelling a sexual epidemic because condom-use rates in commercial sex are so high. In fact, if you look at this slide again, in Bangkok, the majority of injecting drug user's use condoms when visiting a sex worker.

Thailand's neighbour, Cambodia, has seen similar success with a programme that has encouraged young people to avoid risky behaviours, has tackled stigmatization through public information campaigns, and has actively encouraged men to use condoms when buying sex. (Slide 6) You can see here that rapid rises in condom use in commercial sex, has been accompanied by a significant decrease in HIV infection among sex workers. There is evidence that prevalence has also fallen among clients.

Another experience I'd like to share comes from Bangladesh, which has had the courage to confront the threat of HIV transmission among drug injectors. (Slide 7)

Politically, HIV prevention for drug injectors is usually the hardest thing to do. Technically, it is probably the easiest, and among the most effective.

The Bangladeshi city shown here has a harm reduction programme which provides clean needles and sexual health services for 88% of drug injectors. You can see that those who did not have access to the programme, the red bars, were far more likely to share needles and had more unprotected sex than those who did have access, and they were also less likely to seek appropriate treatment when they had a sexually transmitted infection.

But the really extraordinary thing about this example is that Bangladesh had the foresight to allow an NGO to set up this programme before HIV was detected in this population. And the programme has helped to keep prevalence low – no positive cases have yet been found in surveillance among drug injectors in this area. By contrast, in India, Indonesia, Myanmar, Thailand and Viet Nam, HIV infection among injecting drug users has shot from near zero to 50% or more in just a few years.

Why have I spent so much time on these examples? Because they show that Asia not only has the opportunity to take on the AIDS epidemic, it has the proven ability to beat it. (Slide 8) Countries that are beating the epidemic have taught us three things:

One. We have to tailor our response to the behaviours that are spreading the epidemic. In Asia that means drug injection, commercial sex and sex between men. This may be politically difficult in some countries, but those are the facts. Countries that have succeeded have been pragmatic, not judgemental.

Two. (Slide 8a) We have to provide services that directly reduce the risk of HIV transmission. That means moving beyond leaflets and banners, to providing easy access to condoms, lubricant, clean needles, and screening and treatment of sexually transmitted infections.

Three. (Slide 8b) We don't need to provide these services for everybody, but we do need to provide them for the great majority of the population with high-risk behaviour. Twenty years into the HIV epidemic, we should not be content with small demonstration projects.

You will hear a great deal in this conference about "Access", and especially about access to treatment for people living with HIV. Asia is in a rather fortunate position. Because the epidemics here are relatively recent, in many countries the number of people in immediate need of anti-retroviral therapy is still relatively limited. This means that the countries of the region can aim to achieve high coverage for treatment, while at the same time building up the systems which will be needed to reach more people in the future.

(Slide 9) However, as these data from Indonesia show, the greater challenge in this region is still to provide wide-scale access to prevention services. The estimates on this slide include only those at highest risk, and still there are around half a million people who are in daily need of prevention services, including condoms, clean needles and screening and treatment for sexually transmitted infections. That compares with around 8,500 men and women in need of antiretrovirals.

(Slide 10) I have focused a lot of my attention on Asia, the world's most populous region, and one that has rarely been in the spotlight in the global response to AIDS. Other regions have similar epidemics. Like Asia, many American and European countries have most new infections concentrated among people who inject drugs, have anal sex or share other behaviours that carry a high risk for infection. In

Eastern Europe, 80% of those infected are under 30 years of age.

In much of sub-Saharan Africa and parts of the Caribbean, with some of the oldest epidemics, more diffuse patterns of sexual networking, sex between people of different age groups, and high levels of sexually transmitted infections have combined to carry the virus deep into the general population. In sub-Saharan Africa, nearly 60% of people living with HIV are women. (Slide 11) And of the 10 million young people living with HIV worldwide, 6.2 million live in sub-Saharan Africa--75% of whom are young women.

Each of these epidemic types requires an appropriate response. We each need to look carefully at the data in our own countries in establishing effective responses with intelligent combinations of prevention services and treatment.

I would like to close, however, with two universal rules that many of you will consider self-evident: (Slide 12)

- Every person living with HIV who needs anti-retroviral treatment must have access to it and
- The more access we have to effective prevention, the fewer people will be in need of treatment.

Thank you for your attention.

Note: **For referenced slides see: "Doing the right thing" – Powerpoint presentation**