AIDS, Population and Development

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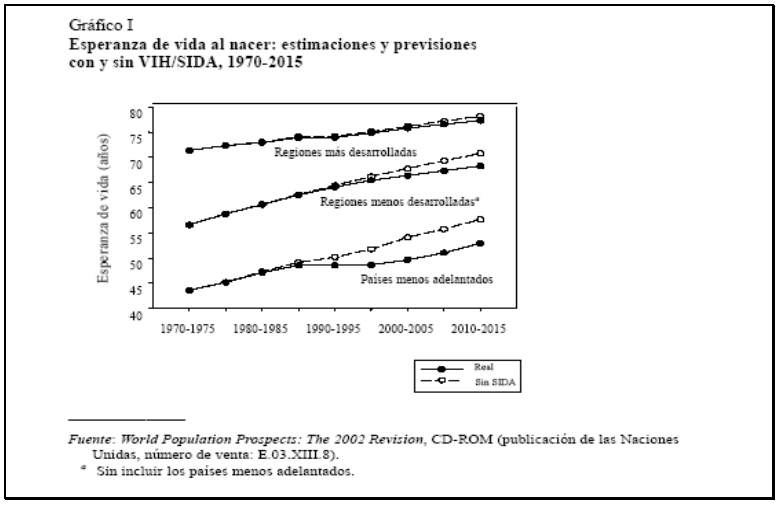
I'd like to start by thanking Hania Zlotnik, Director of the United Nations Population Division, for inviting me to speak to such a distinguished audience today.

It is of vital importance for the global fight against the HIV/AIDS epidemic that the Commission on Population and Development decided to include the theme in the agenda of this 38th session. The issue is being gradually included in the agendas of agencies, programmes and bodies of the United Nations and of other important multilateral institutions, but the fact that this commission recognizes that the HIV/AIDS epidemic and its control are key elements for the strategies centered on Population and Development, particularly those concerning the fight against poverty, is a historical fact that should be praised.

I would also like to congratulate the Population Division for the excellent documents they have prepared for this session.

The commission's report shows the interaction between AIDS, Population and Development in a conclusive manner.

Life expectancy and AIDS indicators are especially striking, as we can see in these charts:



Cuadro 6
Efectos estimados y previstos del VIH/SIDA en el tamaño de la población y el crecimiento demográfico, 1995-2015

	Tamaño de la población (millones)			*Tasa de crecimiento anual (porcentaje)*	
Grupo de países	*1995*	*2005*	*2015*	*1995-2005*	*2005-2015*
Total de los 53 países afectados por el VIH					
Sin SIDA	3 408	3 923	4 440	1,4	1,2
Con SIDA	3 399	3 874	4 312	1,3	1,1
Diferencia absoluta	-9	-49	-129	0,1	0,1
Diferencia porcentual	0	-1	-3	7,1	8,3
38 países afectados por el VIH en África					
Sin SIDA	539	709	914	2,7	2,5
Con SIDA	533	673	823	2,3	2,0
Diferencia absoluta	-6	-36	-91	0,4	0,5
Diferencia porcentual	-1	-5	-10	14,8	20,0
7 países con una prevalencia del VIH del 20% o más					
Sin SIDA	69	85	102	2,1	1,8
Con SIDA	68	76	77	1,1	0,0
Diferencia absoluta	-1	-9	-25	1,0	1,8
Diferencia porcentual	-1	-11	-25	47,6	100,0

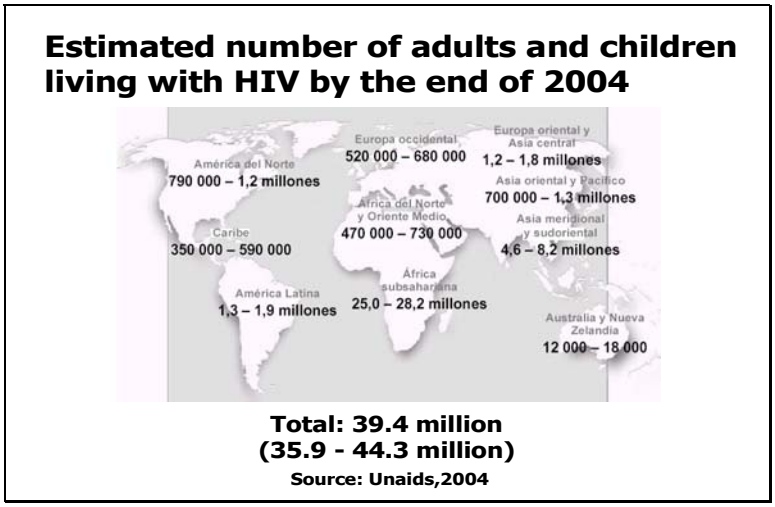
Fuente: World Population Prospects: The 2002 Revision, CD-ROM (publicación de las Naciones Unidas, número de venta: E.03.XIII.8).

For this reason, I want to take this opportunity to share with you the experience I have acquired in the implementation of actions to control the epidemic with my work in developing countries, through the WHO and UNAIDS. I would like specifically to mention the lessons Brazil learned in its long battle to prevent and control the AIDS epidemic in its population.

Although we should always avoid generalizations, I believe that much of this experience is universal and can be valuable to other developing countries.

The AIDS epidemic, as a public health catastrophe, does not find any parallel in the history of mankind.

Today, at least 40 million people live with HIV/AIDS in the world, most of them in poor and developing countries as you can see in this chart.



For the past 20 years, 22 million of lives have been lost to the epidemic, which does not show any signs of weakening. In this manner, every year, there are 5 million new infections and 3 million deaths by HIV/AIDS (UNAIDS, 2004), most of them people young and at a productive age.

AIDS in the world

40 million people HIV+

5 million contracted HIV in 2004

3 million deaths in 2004

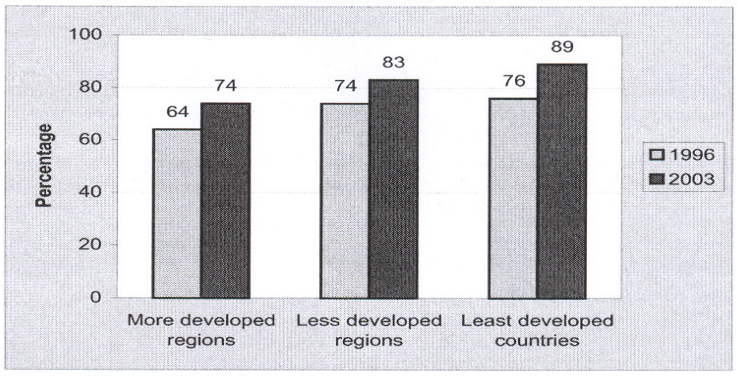
(95% of the AIDS cases in developing countries)

Source: UNAIDS

The increasing loss of human capital, as it has already been mentioned by the World Bank in 2003, can be clearly seen in the data presented in the report of the Secretary-General concerning the impact on many professional categories vital for the social and economic development of countries, such as doctors and teachers.

It is almost impossible to describe, due to its tragic character, the impact of the epidemic on families, by taking away the lives of breadwinners and leaving millions of orphans. Today, estimates say there are 11 million orphans of the epidemic worldwide, joined by another 640,000 of children every year.

Figure VII
Proportion of Governments reporting major concern about HIV/AIDS in the more and less developed regions and among the least developed countries, 1996 and 2003



Source: World Population Policies, 2003 (United Nations publication, Sales No. E.04.XIII.3).

Although today most of the countries affected have already adopted public policies and allocated funds to fight the epidemic, a much greater effort will be necessary from national leaderships and the international community to face the spreading of the infection, to treat the people affected adequately and to minimize its impact in our populations.

There are many reasons to believe that it is possible to change the scenario and make it more favorable for the populations affected.

Unprecedented funds, although not enough, are today available to fight the epidemic.

The creation of the Global Fund to Fight AIDS, Tuberculosis and Malaria, the presidential initiative of the United States, Pepfar, the AIDS Program of the World Bank and other initiatives, both governmental and non governmental, have brought renewed hope to the world.

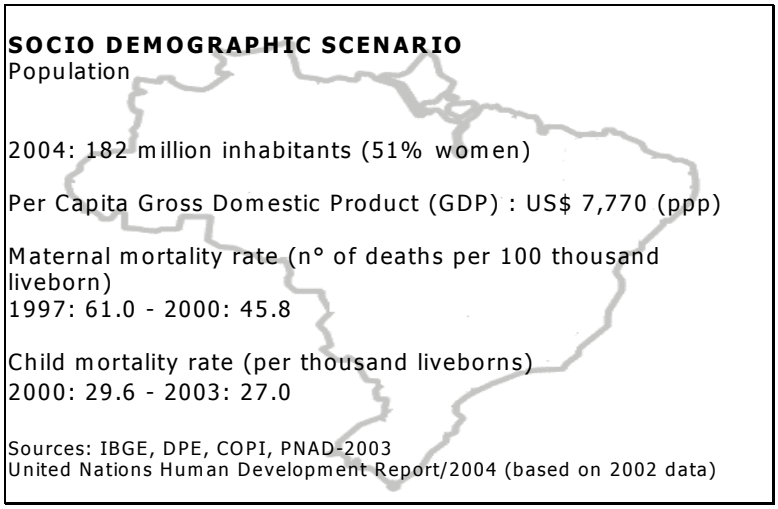
UNAIDS estimates that about 6 billion dollars have been invested for that purpose in 2004, most of it by the institutions I have just mentioned. Much more will be necessary. UNAIDS also estimates that in 2010, the international community will need to provide 12 billion dollars to fight the problem.

Although controlling the epidemic and offering the necessary support to affected people is a huge challenge, there are also sufficiently successful experiences in developing countries that may be taken into account to guide our future steps.

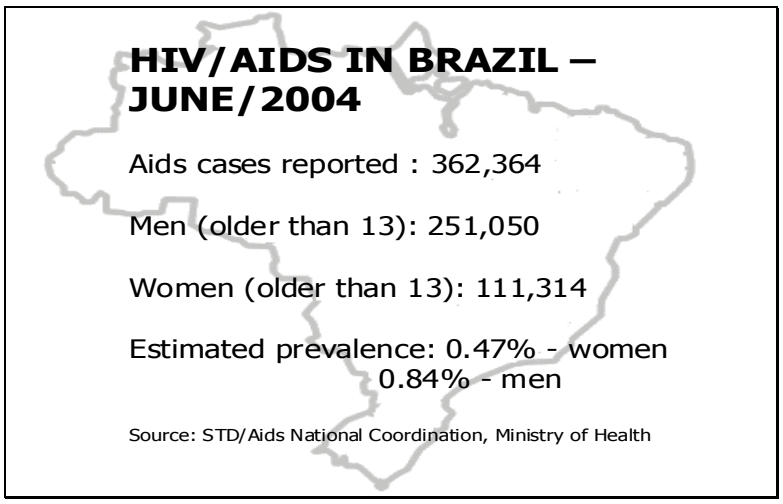
Countries like Uganda, Senegal, Malawi, Cameroon, Thailand, Brazil, Uruguay, Costa Rica and others have adopted national policies that have made it possible to change the course of the epidemic.

Please, allow me to mention, among others, the example of Brazil.

Brazil is a country of continental dimensions, with a population estimated at 182 million people in 2004. Although it has medium development rates, it also has enormous social inequalities that vary according to the region and the respective population groups that comprise it.



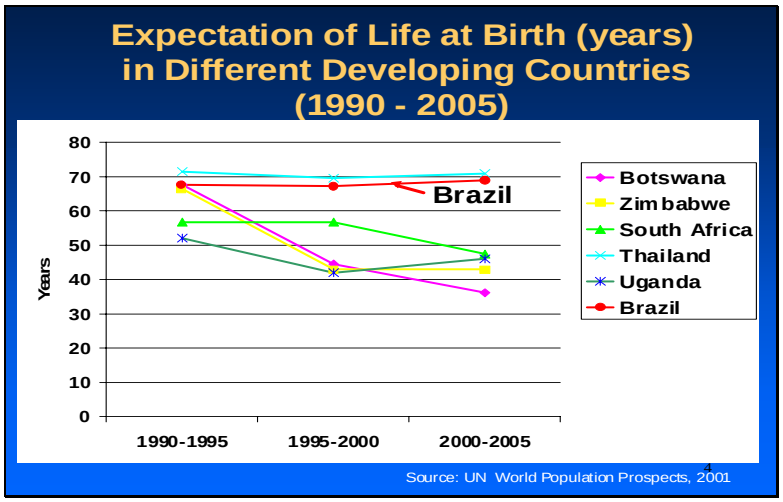
In the early 1980's, like many other developing countries, it started to live with the HIV/AIDS epidemic that was dangerously expanding.



However, with the engagement of the entire society and an aggressive and proactive program, we managed to get to the year 2000 with less than half the number of the estimated cases, in contrast with the catastrophic forecasts of experts. More than that, in the past 6 years the epidemic has entered into a clear **stabilizing** process.

So far, 350,000 cases of the disease have been reported and the prevalence has been kept below 0.6%, in contrast with many developing countries, like South Africa, which only 13 years ago shared a similar epidemiological profile and the same expansion trends with Brazil.

One of the most important and convincing indicators showing that this intervention was effective is the fact that the country has managed to keep the life expectancy of the Brazilian population at the same levels as before the epidemic, in contrast with what happened in so many sub-Saharan African countries. Note in this slide the favorable development of life expectancy of another country that implemented early and radical interventions: Thailand



- Treatment
- Prevention
- Advocacy of the rights of affected people

Components of the Brazilian Program

- Treatment
- Prevention
- Defending the rights of people affected

Source: STD/Aids National Coordination, Ministry of Health

The first conclusion we should draw from these experiences is that Brazil could not have reached any of these results without the adoption of a strategy including prevention, treatment and the advocacy of the human rights of affected people.

Along with other countries, both developed and developing, which have adopted the same approach, we are sure that this holistic approach is crucial for the attainment of good results.

The false dilemma between prevention and treatment, which for many years prevailed in the international debate, caused unnecessary losses, difficult to repair, and they should be avoided at any cost in the future.

It is not possible to wait for people to take in the messages of prevention, when their children, brothers and friends do not have the treatment that could save their lives. In this case, messages would be sent to deaf ears.

Impact of prevention interventions vulnerable populations

Drop in HIV infection rates

- Sex workers – From **17%** in 1992 to **6.1%** in 2000
- MSM - from **10.8%** in 1999 to **4.7%** in 2001
- IDU - from **21%** of AIDS cases 1994 to **11.4%** in 2000

Source: STD/Aids National Coordination, Ministry of Health

My second message is that prevention works, even when it involves groups of people that are difficult to reach.

The positive impact of anti-retroviral treatment, even in scenarios of adverse social and health structure, as we see in this slide, is real and can no longer be ignored. Mortality has been drastically reduced and survival and quality of life enhanced.

Moreover, access to treatment is certainly one way to facilitate and encourage prevention, because it puts people in closer contact with health, guidance and social work services.

Likewise, if there is fear of stigma and discrimination resulting from the violation of human rights of affected people, they will not be involved in prevention and control actions. In many countries, vulnerable groups, like injecting drug users, sex workers and homosexuals have been systematically excluded from prevention and treatment actions due to the absence of an approach that recognizes them as citizens and ensures their integrity. We have learned in Brazil that these groups will fully comply with treatment and prevention measures and that, therefore, there is no acceptable excuse for excluding them.

Investment in treatment may also bring benefits to health economy itself.

Cost of ARV treatment

Year	US$ million	Nº people under treatment
2004	172 million	150,000 people
2003	183,3 million	145,000 people
2002	172 million	130,000 people
2001	245 million	105,000 people
2000	303 million	95,000 people
1999	336 million	85,000 people

Source: STD/AIDS National Coordination, Ministry of Health

As prices fell in the international market and with a firm negotiation strategy with the pharmaceutical industry, the amount spent with ARV drugs in Brazil has gone down, although the number of patients has been continually increasing. In this manner, it is possible to see that in 1999 we spent about 336 million

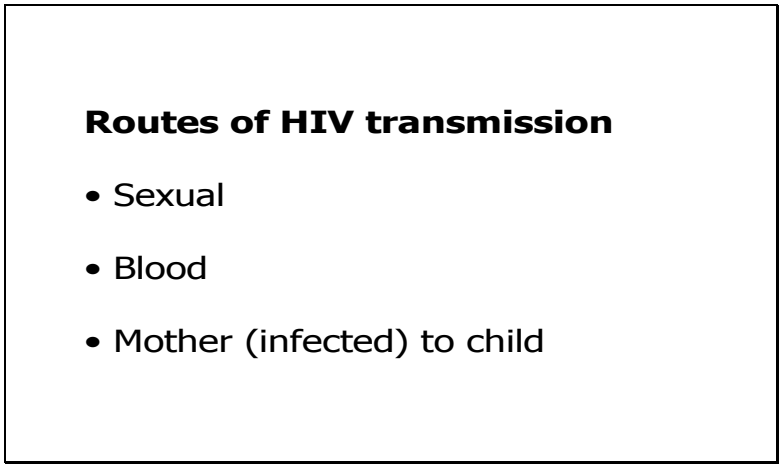
dollars in the treatment of 85,000 people, while in 2004 expenses were 172 million dollars to treat 150,000 people, which means 50% of the expenditure of 6 years ago.

As we can see, the impact of treatment and the consequent reduction in the use of hospital beds, the decrease in expenses related to treatment of tuberculosis, and others opportunistic diseases brought a positive balance of 200 million dollars to Brazil, between 1998 and 2002.

Let us see some unique features of each of these components.

The routes of HIV transmission and prevention strategies in all contexts are today perfectly well known.

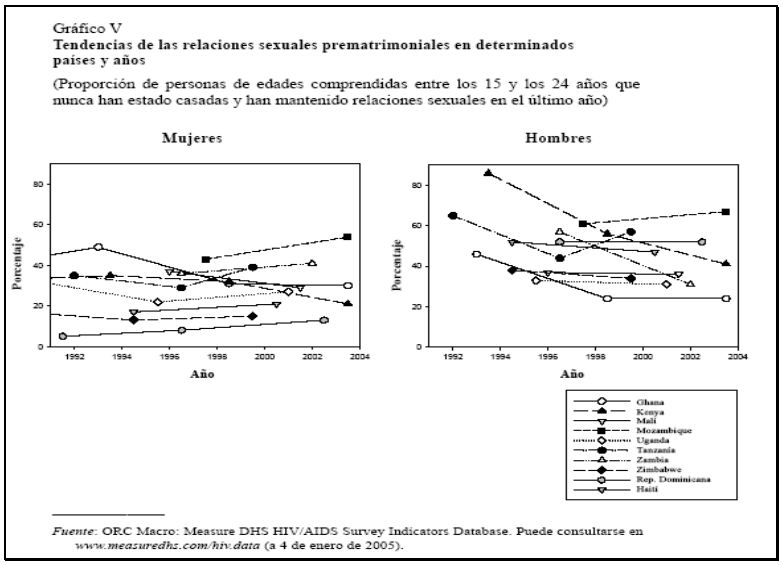
The routes of transmission are:
- Sexual
- Blood
- From (infected) mother to child



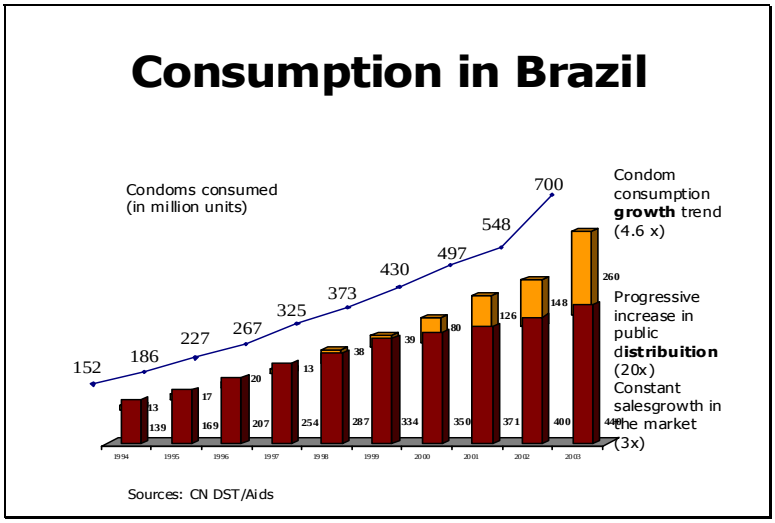
Throughout the world, most HIV/AIDS cases result from sexual transmissions.

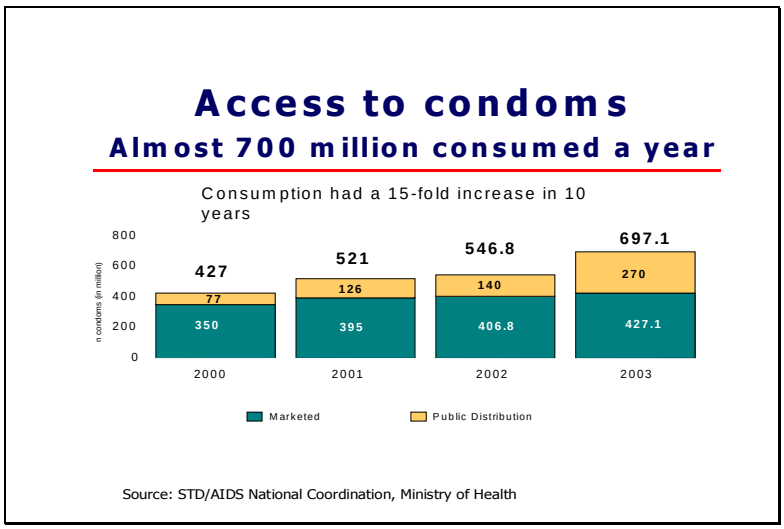
If we want to have effective control actions, we have to recognize that sexual activity is an inherent part of human behavior and that clear information and availability of inputs, such as male and female condoms, are the most realistic and safe way to promote prevention.

In Brazil and in all other countries where the epidemic was curbed and **decreased**, such as Thailand, Uganda, Senegal and Cuba, policies to promote the use of condoms were adopted, without exception.



Condom consumption in Brazil
Public supply and market



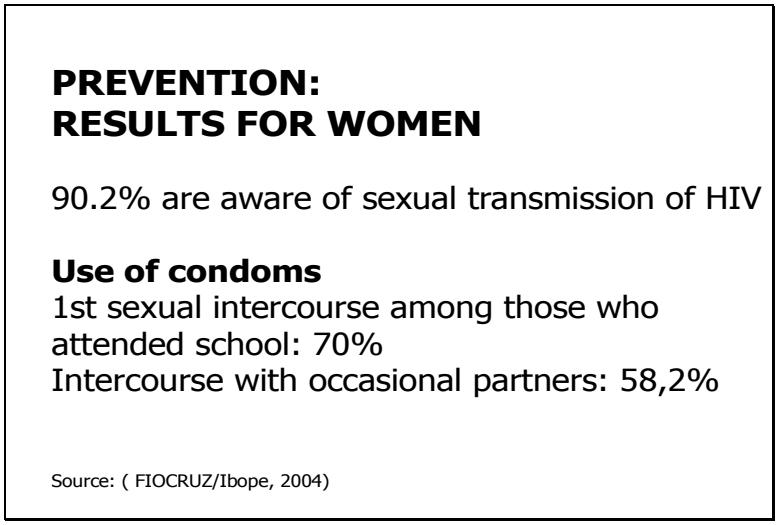


The results are remarkable, particularly among youth.

Prevention results

Recent studies (Fiocruz) have shown that youngsters, when suitably oriented, may incorporate the use of condoms in their first sexual relation.

One of the pillars of such work in Brazil was the inclusion of issues related to STD/AIDS prevention and drugs in high school curriculums.



A UNESCO survey shows that 70% of public and private schools, which represent 30 million youngsters, develop prevention actions on a regular basis.

To complement these activities, we have started a pilot project to distribute condoms in high schools of 230 cities in the country. It is interesting to note that a previous evaluation with the parents of the students involved in this strategy showed a degree of approval of 95%.

Based on international experiences, today there is no evidence whatsoever that moral recommendations, such as abstinence and fidelity, have any impact that might prevent infection and curb the epidemic.

Additionally, the Brazilian government considers that sexual practice is an intimate and private issue and that it should not be regulated by the State.

We are aware that the promotion of safer sex involves serious cultural, ethical, and religious matters, but we cannot allow them to become a barrier for prevention. Our governments and institutions should decisively cope with these difficulties if they expect to be successful in controlling the epidemic.

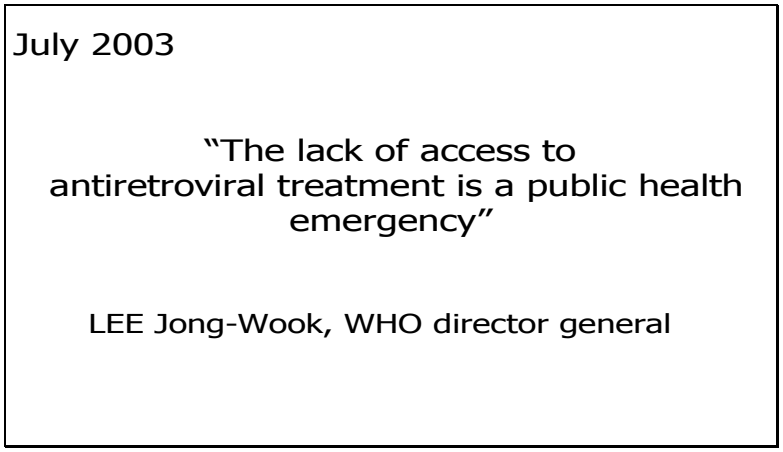
As the report itself described, inputs available for preventing sexual transmission do not reach more than 40% of the vulnerable population. This situation needs to be dramatically changed to ensure the access of vulnerable people to quality male and female condoms at a low cost and in the right amount.

Likewise, blood transmission between injectable drug users will continue to feed the epidemic in many regions, while the harm reduction strategy —with its distribution of disposable needles and syringes for drug dependents - is not adopted officially by governments.
It is also a bold measure that unleashes intense debate on the legality of such action everywhere.

The results in all the countries that adopted harm reduction were extremely positive. At the International AIDS Conference in Barcelona, July 2002, the Global HIV Prevention Working Group, a network comprising worldwide specialists, recommended that countries should adopt the strategy. Additionally, it is imperative to note that no country that adopted the strategy increased the use of illegal drugs. On the contrary, harm reduction projects may approach users to the health system and increase their chances of recovery.

We have to mobilize the entire national capacity and all international support to provide antiretroviral treatment.

"3 by 5 – Lack of access is an emergence"
In 2003, Dr. J. W. Lee, WHO executive director, stated that the lack of access is a Global Emergency in Health.



As I mentioned before, even in the most unfavorable contexts, it is possible to offer ARV treatment. Based on this experience, the WHO prepared simplified technical guides so that treatment can be offered

in places with limited infrastructure, based on simple laboratory tests and on the disease's clinical manifestations.

Together with UNAIDS, in December 2003 WHO launched a universal appeal to provide treatment to at least 3 million people by the end of 2005.

Although we have the necessary means, technical knowledge and financial resources, the number of people who benefit from them in developing countries is still unacceptably low.

One year after the adoption of the 3 x 5 strategy, the results are favorable the number of people treated in these countries had a two-fold increase. In December 2003, the number of people in treatment in developing countries was approximately 35,000, most of them in Latin America. In December 2004, the estimated number was 700,000, and the largest expansion took place in African countries.

Additionally, 56 countries adopted the strategy and included treatment in their national policies. Twenty-eight of these countries have already started treatment actions with WHO support.

There is much room for improvement. Among other measures, we need to move forward with strategies to reduce the price of ARV drugs and for the treatment of associated diseases.

The production of generic drugs proved to be a vital resource to provide treatment and should be expanded and consolidated through national policies and international agreements involving government, companies and multilateral bodies, such as the World Trade Organization. The DOHA declaration, of December 2001, was the first large step for these agreements.

The cost dropped dramatically and basic treatment schemes, such as those proposed by the new WHO guides, may cost less than two hundred dollars a year.

Here, we cannot shy away from an urgent discussion: the vast majority of people infected throughout the world, particularly in Sub Saharan Africa and in the Caribbean, simply do not have the minimum resources to pay for their treatment — which is long and requires great compliance and regularity.

No matter how low prices might be, these people will always be excluded unless our governments adopt universal and free access.

A few days ago WHO held a large seminar to study this aspect, considered essential to ensure compliance and effectiveness of ARV treatment, to offer subsidies in the matter to member countries and, soon, a report with recommendations should be published and distributed to member states. We should be attentive to these recommendations.

It is important to remember that — as it is extensively commented in the report of the Secretary-General — women are today the most vulnerable group to the epidemic in all developing countries.

The inequality of gender, poverty, sexual violence and difficulty to access health service feed the equation. Prevention and care actions cannot be dissociated.

While at least some of the younger women may be reached at schools, as several experiences have shown, in our view the only way to increase the possibilities of prevention and early diagnosis and treatment is to guarantee women's sexual and reproductive rights, as proposed by the International Conference on Population and Development, held in Cairo in 1994. The insufficient offer of sexual and reproductive health services has been extensively documented by the UNFPA. This situation can be

assessed by the low coverage we have today for the prevention of mother/child transmission in developing countries.

UNAIDS estimates that only a small portion of seropositive pregnant women is receiving prophylaxis for the infection of their babies in developing countries. Even in Brazil, in spite of all progress, the estimated coverage is only 60%.

Nothing would have been accomplished in these countries, if there were not, in addition to political decision, a major of multiple sectors.

We all have a role to play and a responsibility to take on: the government, private sector, churches and civil society. An example: Dom Paulo Evaristo Arns, former archbishop cardinal of S. Paulo declared, in 1986, in face of the threatening advance of the epidemic:

”Our brothers are in pain. In this scenario, the Church should not judge them, but rather comfort them and help them to preserve life in a more realistic manner”. With these words he determined that the São Paulo Catholic church organize itself to fight the epidemic. Ever since, all over the country, projects carried out by the Church have provided a huge contribution to the prevention and reduction of the impact on affected people, especially among the poor and marginalized.

It is also impossible to underestimate the importance of an organized civil society. The constructive partnership with non-governmental organizations is also a *sine qua non* condition for us to succeed. NGOs have a role to play in the advocacy of the rights of vulnerable groups and affected people, and they can likewise be effective prevention agents.

The scarce technical capacity is well known in many countries, particularly regarding treatment. In face of the resources today available and in order to use them in the appropriate manner, all cooperation and technical assistance mechanisms should be used. The organizations of the United Nations have a key role in guiding the global response and in coordinating the required care.

The experience gained, even when positive, shows, however, that in the long term it will be difficult to curb the AIDS epidemic, unless we have a vaccine.

The results of the many products being tested today in many countries are, unfortunately, disappointing. However, experts involved in research unanimously say that it is perfectly possible to overcome the technical barriers for the production of a vaccine and other resources necessary for developing countries, like microbicides, if there is the necessary investment.

At the end of World War II it was completely unthinkable to assume that Eastern European countries could recover from the massive destruction of their social and economic structure and that, less than 50 years later, their citizens would enjoy the highest level of social development and quality of life on the planet. The mobilization of billions of dollars by the USA was crucial for that achievement.

The tragedy we are facing today has similar proportions. We need richer countries like the USA, Japan and the European Union to play their role and adopt a new Marshall Plan.

This year, 2005, there will be special events at the United Nations to evaluate the results and commitments adopted by countries at the Millennium Summit and at UNGASS. It is vital that we arrive at a more optimistic scenario than today’s.

We need a global strategy that takes into account the AIDS epidemic in all actions to promote development and to fight poverty, including economic adjustment plans and foreign debt relief.

The resolutions that are adopted by the Commission on Population and Development will be fundamental and may be decisive to influence the way rich and poor countries, the United Nations and other multilateral institutions, like the IMF and the World Bank, will deal with the theme in the future.

I hope my talk may help your work and contribute to this Commission's decision making.

Thank you for your attention.