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World Chronicle

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AIDS EPIDEMIC UPDATE

Some 40 million people are living with HIV/AIDS today. That figure is higher than ever before. Despite unprecedented global efforts to combat the spread of the disease, the figure keeps increasing.

What accounts for the recent surges in HIV infections, especially in Asia and Eastern Europe? Why is the AIDS pandemic increasingly affecting women, and young girls? Can governments, businesses, and activists rise to the challenge of raising the estimated US $ 10 billion needed annually to combat AIDS worldwide?

These are some of the issues discussed in this episode of World Chronicle with the Director of the UNAIDS office in New York, Dr. Desmond Johns.

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ANNOUNCER: From the United Nations in New York, an unedited interview programme on global issues. This is **World Chronicle.** And here is the host of today's **World Chronicle.**

JENKINS: Hello, I'm Tony Jenkins.

Some 40 million people are living with HIV/AIDS today. That figure is higher than ever before – despite worldwide efforts to combat the spread of the disease.

What accounts for the recent surges in HIV infections? What can be done to reverse the spread of AIDS? Can governments, businesses, and activists rise to the challenge – and deliver on the promises made to those in urgent need of medication?

Our guest today is the Director of the UNAIDS office in New York, Dr. Desmond Johns.

Joining us in the studio are Judy Lessing of Radio New Zealand…and Philippe Bolopion of Radio France Internationale.

JENKINS: Dr. Johns, thank you for being here. I want start with a very obvious question. We have known how to prevent the infection with HIV for what? Ten fifteen years now – something like that? And still the numbers keep growing and they're growing dramatically. Why is that? Is this a problem that's still out of control?

JOHNS: In a sense – perhaps yes Tony – but the reality is while we know what needs to be done, where it needs to be done, we're not yet doing it on a wide enough scale. We've not yet moved from the phase of successful pilot to the stage of widespread, wide coverage national programmes. That's going to take a capacity, that's going to take resources and that is what we are picking up in the figures that continue to escalate.

JENKINS: Well, I'm glad you mentioned something about positive models - and I want to get into that later in the show - but the obvious question is why are we not doing more now? Why aren't the resources there? We've had commitments from the international community; the Bush administration pledged - what was it? - ten billion dollars to help with this problem. Why is this money not being spent? Why is the situation not under control?

JOHNS: Well, the reality by our estimates – we need to be spending about ten billion – with a "b", by next year. Ten billion dollars globally by next year…

JENKINS: ...Per year?

JOHNS: Per year…

JENKINS: …Globally….

JENKINS: Ten thousand million dollars a year?

JOHNS: …Yes, and to-date by our best estimates we are spending half that. Public expenditure is around four point seven to five billion as we speak. Ahhh.. in part, even though the money's available, money is not the only thing that one needs to get programmes off the ground and running. You need…

JENKINS: What is it? Political will?

JOHNS: Political will is there, that will explain the increases of resources that have come about. That we also need human capacity, we also need infrastructural capacity to roll these out; and in heavily affected countries, you're dealing with the attrition from the epidemic itself. AIDS in some parts of Africa are claiming one or two teachers a day, at best we're training between six or seven hundred a year. So, we certainly are barely keeping pace in terms of the human capital needs – let alone the infrastructural needs that are required in order to roll out the programmes.

LESSING: Then you're saying that there just not enough - not enough in each country of good health systems, there are countries that just don't have the resources even if they want to, to deal with this? Is that partly what you're saying?

JOHNS: Yes, that is in part true Judy, but much of the AIDS response takes place outside of the health sector. So for those who are now currently ill – you require an effective functional health system. But, in order to get the prevention health message across you must have an act of communication system, you must have an act of education system, we need to deal with some issues in societies around the status of women, gender equality, the kind of protection that we need to afford young girls so they are empowered to say no to older men. So there's a whole cascade of things that need to be done and we're not there yet.

BOLOPION: Right now as you were saying – one of the populations most affected by the disease are young women. Can you explain why? Why is it that that category of the population right now is the most affected by the disease?

JOHNS: To begin with at the biological level from any one encounter, by the nature of the female genital tract, women are twice as likely to contract any infection, as opposed to men, any sexually transmitted infection, and the younger the individual, the higher the risk; so that's the biological risk that we can't do much about. But we do have social and cultural risks. There are societies that afford women – particularly young women – a different status as opposed to men. There are some societies where women are forever considered minors so they are not financially empowered, neither are they empowered within relationships. Our ABC

message that you mentioned Tony that worked so well and that has been proven over the last ten years. Basically involves" Abstinence - the A; Be faithful – the B; and use Condoms – the C. If you place yourself in the shoes of a young woman in many poor, poor countries, the A, is not hers to enforce – you can't abstain on your own and be safe. Very often it's not women who are unfaithful but their male partners who have multiple, multiple partners. And because women are not on an equal footing with men in relationships. Even within committed relationships, a woman cannot insist upon her partner using a condom.

BOLOPION: How do you change that? How can you affect that kind of problem?

JOHNS: Well, at one level – now we can't wait for everything to be solved before tackling the problem of HIV/AIDS. So looking specifically through the HIV lens, what can we do? We can keep girls in school. We keep girls in school – that's the single most effective tool for women's empowerment, and surprisingly the single most effective public health intervention - educating girls. We can also make access to both the information and to the services that woman need much more available than what it is at the moment. We will recall that women are disproportionately represented amongst the poor; and especially so amongst the poorest of the poor. So, there are these other societal factors that will take a longer time to correct; those factors require that we change some of the cultural and societal norms that exist in societies and that men be converted to the struggle. Men must play a role – men and boys.

LESSING: But…

JENKINS: It's extraordinary. You know, almost every issue that comes into this show the answer seems from our guest seems to be educate women. Whether it's poverty, whether it's protecting the environment, ultimately the guest who sits in the hot seat where you are says educate women. It's extraordinary. But I just want to take you up on – sorry to butt in like that Judy – but on this business about women. Because I remember reading about an editorial in the Washington Post recently that said that that you were misguided in focusing on - I think what they called the feminization of AIDS – and they said that you should be focusing on "at risk groups", I think is what I think they talked about? What was that all about?

JOHNS: It, it depends...I remember reading that as well. It depends on where you are looking at the epidemic, which geographical region? If one bears in mind that, by a long shot, women are not the primary risk takers for sexual behaviours, so they don't usually visit sex workers; they don't usually have multiple extramarital affairs; neither are they more likely to be intravenous drug users than men. Men are all – the primary risk takers for these groups. But if you look at the statistics – in sub-Saharan Africa women now account for almost sixty percent of people infected with HIV/AIDS. If one looks at the younger groups – 15 to 24 -- young

women, we have a differential between young women and their male peers of between three to six to one in sub-Saharan Africa, two to one in the Caribbean, two to one in some parts of Asia. So they are at risk, and the focus, particularly if one has to focus on the most vulnerable of the vulnerable, you have to focus on young women, and young women in the broader context as I have just described.

JENKINS: So, the Washington Post essentially was being parochial in saying this…at risk groups in the United States may be where you should be focusing on --- and the rest of the world you should be focusing on women.

JOHNS: Yes because whenever HIV starts, it tends to start in the high-risk groups, which are, generically speaking, men who have sex with men, commercial sex workers and their clients, intravenous drug users and their clients. These are the high-risk groups within the epidemic first takes hold. But intravenous drug users may be homosexual, may be heterosexual. You have a mixing of the pool in either case.

JENKINS: And then it quickly spreads…

JOHNS: And then it quickly spreads.

JENKINS: Judy

LESSING: Now**,** I want to go back to something that you said very early on – which was the question of success stories. Now you know, I can sit here and do a mantra of Uganda, Senegal and perhaps even Brazil. But what are these countries teaching us? And what should we be picking up so that their example cannot be just kept within their national borders?

JOHNS: Well… the first thing that we've learned from these examples is that it is very, very difficult to change human behaviour. It's especially difficult to change human behaviour when it deals with something as sensitive as sex and parents talking to children about something like sex, intravenous drug use, commercial sex work; very difficult concept to deal with in even in the most enlightened societies – that's number one. But the second thing, even when we've overcome those hurdles, this is not something that cannot be tackled by half measures. You need to have the political commitment you mentioned, and the political commitment starts at the top. Number one, A, you have to address the stigma of discrimination, which tends to drive the epidemic underground and which prevents normal people from appreciating that they may, theoretically or in reality, be addressed; that's number one. Number two, if you have the political commitment, it's usually followed by the resources that one needs to mount a full scale response; and it doesn't necessarily… it costs money – yes, but it's within the means of relatively modest economies. Uganda, is a success story because President Museveni saw the damage this was reeking on his population and came out forcefully and

unequivocally in opposition to the epidemic. We've seen the Ugandan experience being replicated – they know where in the beginning of the epidemic in a place like Senegal where it's never risen above three or four percent of the population. We're now seeing success in urban areas of Ethiopia, as Ethiopian efforts begins to mark. We've seen changes in Kenya, a neighbouring country where there's been about a fifty percent, a twenty-five percent decline from twenty percent to about fourteen percent.

JENKINS: And of course you can contrast all of those examples with – dare I say it – your own country - where there wasn't the political will certainly in the beginning, I don't know if one can say there is the political will now, but South Africa is reaping the whirlwind as a result, isn't it?

JOHNS: Well exactly. South Africa at the time that the epidemic began to expand rapidly, which was in the early nineties, we were coming out of Apartheid, there was this excitement and exuberance about a new democratic society. But it took AIDS to go from zero point five percent to one percent in five years, and in the next five years from five percent to twenty percent.

BOLOPION: You mentioned several success stories. Now there are also other parts of the world with very troubling numbers, like Eastern Europe, Russia, where people are educated, there is health care system and, still, it seems that the disease there is gaining some ground. What's going on? Why is that happening?

JOHNS: The epidemic in Eastern Europe and Central Asia runs on two wheels. Young people and intravenous drug use, these are the drivers of the epidemic there. But as you mentioned, it is also an area of the world that is undergoing some socio-economic change, a degree of political uncertainty and increasing trafficking both in human beings and in drugs from Central Asia into the European Union. Unfortunately, we've not made the kind of inroads into social marginalization and stigmatization as we should have in this part of the world. It's young people, but it's also people involved in intravenous drug use who sit on the margins of these societies. So in some respect, this appears not to be a priority for the governments of that region, and we need to certainly see a far greater engagement by political players in this part of the world.

JENKINS: I think you answered the Eastern Europe part of Philippe's question. I'm not sure if you touched on East Asia and China - but hold on to that for a moment. Let me just say that this is World Chronicle and our guest today is the Director of the UNAIDS office in New York, Dr. Desmond Johns. How about China, what's going on there? I mean, it's a secular

society. Surely there aren't any religious components. Is there a problem talking about sex there? What's going on there?

JOHNS: Well China is the other region that accounts for perhaps the greatest growth over the past two years: 50% increase since 2002. Once again the epidemic has its root in political scandal. There was a blood selling scandal that took place in the providence of Henan in Central China, with some complicity of local officials ignored for a while until its now reached a level of a scandal, quite frankly. In addition, China has a large population of intravenous drug users. It has a floating population that people estimate at a hundred million who are away from their normal network, away from their normal support structures. So while the epidemic is still pretty much confined to these high risk populations, commercial sex workers and their clients and intravenous drug use, besides the blood scandal, people involved with the blood scandal or at least infected by that route, we see that the infection beginning to spread out of these high risk groups. Fortunately, the Chinese government has become far more engaged politically, and in a kind of society like China, with its - a measure of central planning, it's possible to mount this kind of response as we seen when they rolled out their TV programmes, when they rolled out their immunization programme. You can't do this on a massive scale in a country like China, and that, that calls for optimism.

JENKINS: Are they?

JOHNS: Yes. We are beginning to see, we are beginning to see a movement, we're beginning to see a movement certainly a greater degree of engagement but we've not yet seen it -- this transferring into numbers that are beginning to settle down or decline.

LESSING: But what about – we're talking about countries – and countries have borders. But then they abut other countries. I mean how can we deal, how can anybody deal with this only looking at what a country's government is doing, and a country itself is doing? What happens, because people move, whether it is a question of affluence people getting on planes, or poor people fleeing oppression and going over a border? What do you do? Don't you need regional plans is really what I really am saying?

JOHNS: Yes you do need regional plans. But regional plans or national plans are an aggregation of the engagement of societies as a whole, and it's getting societies as a whole to see this as more than just the government's problem but a problem which we all have a stake in, which we all have a roll to, in which we all have a role to play. So certainly it needs to begin once again we come back to the issue of stigma and discrimination. Governments need to see the AIDS statistics not as a barometer of national integrity or national moral fiber, but as a reality of a situation that exists - that populations are at risk possibly in large numbers through

no fault of their own, but a problem that needs to be addressed. And if we can, we can get beyond the stigma of discrimination, beyond the moral overtones that often accompany the epidemic, we can then get ordinary people to engage. We can get ordinary people to assess their risk and to take the appropriate measures.

BOLOPION: Don't you feel that people are not scared enough of AIDS right now because of all the progress and science, medication? Don't you need to remind to the people all over the world that this is still a very dangerous disease, and that it's not easy to live with it?

JOHNS: Absolutely. We've seen in the developed economies of Western Europe and in North America, a reversion to high-risk behaviour amongst the high risk groups - men who have sex with men, to a large extent because in some respects, AIDS has been changed into a chronic illness. But bear in mind in Philippe, that when you're dealing with this target population of men, our target population is predominately fifteen to twenty-four year olds. You're dealing with people who are furled with both the exuberance and sense of immortality that comes with being young. That's the reality that we have to deal with, and it's putting it in a context that they can understand, which to a large extent means we need to use people like MTV, like Beyonce Knowles, like Alicia Keys – pop icons who they can relate to in order to get the message across.

BOLOPION: Because in Northern America, in the USA, you have a problem of so many of the African Americans – what's going on with that part of the population? Why are they still so predominately affected by the disease?

JOHNS: Well, once again we come back again to the same high-risk groups but often African Americans and African American women in particular, are being affected because of undisclosed high risk behaviour on the part of their male partners be it intravenous drug use or covert homosexual encounters, this is what is driving the epidemic there. But we mustn't forget that the social conditions that apply in many inner city communities, even in developed countries, are very similar to those that exist in poor countries elsewhere. Poverty, the lack of education, the lack of access to basic services, education, health, etc. drive the epidemic as much in poor areas in rich countries, as they do in poor countries themselves.

LESSING: What about the ability of a country or region to get enough of the right drugs at a good price. I'm thinking about the ability to get, to import say generic drugs. They still cost money, very poor countries their going to make, they're going to balance their money and say, 'well no, actually what we want are roads.'

JOHNS: Well yes, governments always have to make these kinds of choices, but we believe that even poor countries must make an investment in their own people. You can't

designate the fact against HIV/AIDS a priority and then rely exclusively on donor money or donated resources to make it happen. So yes we have to get the level of expenditure up. The World Health Organization estimates that to get a reasonable health system going, you need to be spending on the order of twenty dollars per capita per annum. The reality is in many countries such expenditures in the order of seven or eight dollars per capita, per annum. The price of drugs has come down; the generics versus brand name drugs debated largely one that has settled down. It's now possible to get treatments at a hundred and forty, a hundred and fifty dollars per person, per year, at the lowest level. That, depending on the negotiating power, goes up to about four or five hundred. It still exceeds the resources available, but it is imminently more doable now than it was a few years ago.

JENKINS: Alright, let's talk a little bit about resources because following up on what Philippe was asking about – well people know that there are antiretroviral drugs out there, so it doesn't matter so much – that isn't the case for the continent where the problem is worse, which is Africa – I think three quarters of the current people infected with HIV are in Sub-Saharan Africa. You started off the show by saying that you need ten thousand million a year to treat this problem, and you have about half that much money available. Is that likely to change? Why haven't you got more money? What needs to be done? What are you doing about it? Sorry to fire so many questions at you...(all laugh)

JOHNS: Well certainly this amount of money that we've described is under the ideal circumstances, and we always have to pitch policy on what is the ideal rather than simply settle for the lowest common denominator, or what is actually available. What are the prospects for getting this? Well, AIDS and HIV is now squarely on the political agenda, just part of the Millennium Development Goals, which are going to be reviewed next year - the climate is right to advocate for greater resources. We need to be creative. As I've mentioned developing countries need to apply their own money, apply their own money to the problem. Donor resources could… there's possibly room for movement there as well.

JENKINS: I'm going interrupt because I want to pin you down. For example, President Bush committed - was it ten billion dollars to the AIDS?

JOHNS: Fifteen

JENKINS: Fifteen billion dollars

JOHNS: Over five years…

JENKINS: As I understand it, that money is not being dispersed as anything like the rate that was first anticipated when he first made that announcement. Is that the case? And if so, why?

JOHNS: That is the case, any part it's because absorptive capacity is developed sequentially, so most of the money in the PETFAR, which is the Bush plan, is back loaded. So it's going to come in the later years. I think just two billion was appropriated in, for the coming year.

JENKINS: So you're not disappointed with the United States?

JOHNS: No, not at all.

JENKINS: All right, how about Europe?

JOHNS: Europe – much of the resources from Europe flow via bilateral programmes. So while the U.S. accounts globally for fifty percent of the resources, we could perhaps see a ramping up of the resources from the European Union – but you must remember because AIDS is complex; if you spend money on girls education, do you count that as girls education, or do you count it as anti AIDS measures? If you apply money for orphans, given that we don't make a distinction between AIDS orphans and other orphans, how do you identify that money? Basically we're saying if you take the widest analysis of what anti AIDS measures are, we need to be spending ten billion. We're half way there, let's put more, let's not lock ourselves into perhaps little boxes in the way we want to identify the money.

BOLOPION: What's your wish for the new year, 2005? What would you like to see change? More money, more people, more awareness, what would you ideally see changing?

JOHNS: Well, ideally all of the above. But if I had to settle… certainly more money, more capacity to spend the money and then, finally, using the money effectively because often what happens at the country level - there are multiple entry points so that the monies are not being applied in the best possible way. There are multiple entry points, multiple funding, perhaps multiple plans that are not necessarily coherent as they could be, and multiple reporting requirements. We as UNAIDS are now speaking in terms of the three ones: we rally behind one national plan, with one national coordinating body and one monitoring and evaluation.

LESSING: But how do you know that the national plan is the right plan? Can you evaluate that and say to a country – look I know you have got a national plan, but you need to tweak it here and there because it isn't actually the most effective you can have?

JOHNS: Well, we as the UN are there when the plan – are supporting the government when the plan is drawn up. It's owned by the national government and is therefore appropriately prioritized in the national development strategy. And bilateral donors are also at the table with NGOs, with the business community when this plan is being drawn up. So, yes, it's well owned and yes, it's well founded.

JENKINS: We don't have much time left. I am going fire one last quick question cause you have used the word a couple of times…capacity. What do you mean by absorptive capacity? What do we need to be doing to increase capacity? Capacity what?

JOHNS: Well, it's not just the capacity to run with programmes and to administer them, it's also to account appropriately because donors…citizens in donor countries, want to be consoled by the fact that their money is being spent responsibility and effectively, and that it is making a difference. So having both the technical capacity in the education area, in the health area to roll out the programmes, but also to account for the money.

JENKINS: Let's hope that your New Year's wish comes true. That's all the time we have. Our guest today has been Dr. Desmond Johns, the Director of the UNAIDS office in New York. He was interviewed by Judy Lessing of Radio New Zealand, and Philippe Bolopion of Radio France Internationale. I'm Tony Jenkins, thank you for joining us we invite you to be with us for the next edition of **World Chronicle.**

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