



**Frank A. Calderone Lecture
by Peter Piot, MD, PhD
Executive Director of UNAIDS
and Under Secretary-General of the United Nations**

April 30, 2003

Public Health Plus: Social Mobilization in the Response to AIDS

It is a very special honor to receive the Frank A. Calderone award from Allan Rosenfield, one of the great global leaders in public health and in reproductive health.

Under his leadership, the Mailman School of Public Health has grown to new heights, including in my own field of global AIDS. Not to mention, it is the school from which my deputy, Kathleen Cravero, graduated.

I feel enormously privileged to be able to pay tribute to Frank Calderone and his distinguished service to the cause of international health, for the World Health Organization and the United Nations. Let me also, given my field of work, acknowledge the contribution Mary Calderone made. Everyone in the battle against AIDS draws on her pioneering legacy in sex education and reproductive health.

This lecture has been an opportunity to reflect on where we are with the global response to the AIDS epidemic, and what lessons we can draw from 20 years of battling against what seems a relentlessly expanding epidemic.

October of this year will mark 20 years since I started working on AIDS in Kinshasa, and then in Zaire, with Bila Kapita, Joe McCormick and Tom Quinn. Very soon after the start of our

work, we became convinced that AIDS was also a heterosexual issue. I even remember the specific moment when I realized this--I will never forget what Freud calls the “Aha Erlebnis” when I walked with Dr. Kapita in the internal medicine wards of Mama Yemo Hospital – one of the largest hospitals in Africa. I saw tens of hospitalized, emaciated men and, particularly, women my age or younger; it was then that I suddenly knew that Africa was in trouble, that we would face a major epidemic among heterosexuals, and that it would change my life. It led to the start there, in 1984, of Project SIDA which was led by Jonathan Mann.

In the meantime:

- well over 60 million people have become infected with HIV and over 20 million have died;
- there are 14 million orphans in Africa because of AIDS and, last year, a million African children lost their teachers to AIDS;
- there is an unprecedented food crisis in Southern Africa exacerbated by the AIDS crisis;
- there is rampant spread of HIV in the former Soviet Union as well as in parts of India and China;
- there is still no vaccine and no treatment for those needing it most; and
- there is still widespread discrimination against those who are infected with HIV as well as resistance to life-saving sex education for young people, to life-saving promotion of condoms, to life-saving access and to clean needles.

Why is this, despite all the evidence ?

The global AIDS crisis is what the French call “une catastrophe annoncée” – an announced catastrophe. Today’s devastation could have been prevented if we had today’s means and political will 10 years ago.

The reasons the world hasn’t acted earlier, and is still only gradually taking up the challenge, have little to do with scientific evidence, schools of public health, or advances in

research, but everything to do with politics, global power relations, and taboos around sex and drugs. If it had not been Africa, but an economically or politically more important continent that had been most affected by AIDS, we may have seen a far more prompt global response and the necessary resources.

If HIV were not transmitted mainly through sex and needles used to inject illicit drugs, it may have been easier for leaders to speak up, allocate resources, and lead the response. We would not have wasted so much precious time. As President Bush said yesterday in the White House when he pushed Congress to adopt the Bill authorizing funding announced during his State of the Union Address: "Time is not on our side."

At every point in the short history of the epidemic, AIDS has challenged existing paradigms. It challenged the idea that the era of infectious disease epidemics was over. When I graduated from Ghent Medical School in 1974, both professors and students told me there was no future in infectious diseases – two years later, I was in the middle of the first known Ebola outbreak.

AIDS challenged the idea that the first world and the third world faced completely different disease threats – even though AIDS has predominantly become a problem of poor countries, it has been felt everywhere.

AIDS challenged the conviction most of us were trained with: that there are technical fixes for every health problem. This was, of course, dramatically untrue until antiretroviral therapy became available, but even when there is a vaccine and easier treatment, it is likely that our medical interventions will only be as successful as the supportive environment.

Lastly, AIDS challenged the still prevailing idea that health risk is mainly an individual life-style matter, instead of the result of a combination of genetic, behavior, social, etc. determinants. To put it in the extreme case, the current thinking is still that if you have a myocardial infarct or diabetes, you can only blame yourself because you didn't exercise. If you

have AIDS, it is because you did not behave...Blame the victim !
Now, tell this to the millions of women in Africa who became infected by their sole sex partner – their husband. Explain this to the girls sold to work in a brothel in Mumbai and elsewhere. What if their individual lifestyle is beyond their control ?

We increasingly understand the chain that runs from molecules and proteins in our cells to the health of populations and back again. We know a lot, certainly more than I can understand, but globally, from where I stand in UNAIDS, it is the wealth of nations and the degree of fairness with which that wealth is distributed within nations, that determines the health of populations. It is not much different with AIDS.

Does this mean that there is no escape from ill health and epidemics until the last of the poor get rich? Of course not. Just as a country such as Costa Rica and a state such as Kerala in India have shown the way to overall good health of the population, Uganda has shown the world that one of the poorest countries can drastically reduce the spread of HIV.

The keys for such successes are leadership, effective policies, gender sensitive policies, offering health interventions to all, adequate funding and mobilization of the community as a whole in a true campaign. AIDS is forcing us to go beyond today's medical model and today's public health.

Let me briefly discuss the set of five key elements that together are moving public health to a new stage--they are all in the UNAIDS Global Strategy Framework.

The first one, and perhaps the least appreciated by the public health community, is reducing vulnerability to HIV of individuals and whole communities by a set of societal actions. This is not an invitation for some vague social reform. Action can and must be very specific, as the founding fathers of public health knew so well. Let me give an historic example from my own country, Belgium.

As in so many newly industrialized nations, alcoholism among the working class was

rampant in the 1800s and early 1900s. In 1919, under pressure from unions and women's groups, the Socialist party succeeded for the first time, in having a law adopted in Parliament that made it illegal for workers to receive their pay in pubs (often owned by the employer) and banned hard liquor from pubs. Similar laws were passed around the same time in several European countries. This had a major impact on public health and is an illustration of what we now would call a "multisectoral response" when it comes to AIDS.

Let me give you three other examples:

Last year in Delhi, I visited an AIDS project for truck drivers who have to wait for a few days for customs formalities. This is, of course, an environment conducive to risk behaviors – reducing bureaucracy and waiting time would surely reduce commercial sex and risky behaviors, and may have at least as much impact on HIV transmission as condom promotion.

The same story is true for all the male miners in southern Africa living in hostels away from their families whose only options for sexual expression are commercial sex or sex with men. Uniting families would greatly reduce such risk behavior. If Southern Africa has such an AIDS problem today, it is largely due to the organization of labor going back to colonial and apartheid days.

It is well documented that the lack of women's property and inheritance rights are leading to increased vulnerability and poverty of women who may have to turn to prostitution as a "survival strategy."

These examples also illustrate why a ministry of health can't do it alone, why we need the engagement of all key departments and sectors in a country.

The second key element is reducing the risk of individuals acquiring or transmitting HIV.

This is the basis for prevention campaign investments in the West. Since we are dealing with

prevention of transmission through sex and sharing of needles, a formidable challenge here is to ensure that policies and interventions are evidence informed, rather than led, by the personal beliefs and prejudices we all have. It is the responsibilities of governments to ensure that young people have access to sex education, drug users to safe needles etc. Protecting the health of the public must be our overriding concern.

A related challenge is to use not only the most effective messages, but also the most effective messengers. This is why we, as health professionals, must look outside the box-- such as involving other partners (for example UNAIDS' work with MTV, reaching literally a billion teenagers), working with peers, being aware of cross cultural approaches. We still have a long way to go.

Third, we must break through the schism between HIV prevention and treatment. There is now a consensus that we need both prevention and treatment--but we need to make sure treatment becomes more accessible.

For too long, simplistic and ill-informed cost-effectiveness analysis leading to absurd conclusion blocked investment in HIV treatment in poor nations, particularly in Africa. However, while doing everything that is possible in order to ensure millions have access to treatment, we will need community-based models and to see beyond classic hospital ones.

Let us not impose our mistakes in the North on poor nations. In nearly all Western countries, the number of deaths has declined since the advent of combination antiretroviral treatment, but there are now at least as many people infected as 10 years ago, a clear failure of HIV prevention--which has been grossly neglected. We have to get it right for the developing countries: make sure that prevention continues when treatment becomes available.

Fourth, none of the above will happen on a large scale or is sustainable without genuine community mobilization.

This is as true in North America as in Africa – from Gay Men’s Health Crisis here in New York to TASO, the Ugandan mother of all community AIDS groups in Africa. Those who are infected with HIV and/or affected are well positioned to develop and execute programs.

With today’s major influx of funding for AIDS in the developing world, be it from the World Bank, the Global Fund to Fight AIDS, Tuberculosis and Malaria, or the new U.S. Presidential AIDS Initiative, ensuring this ownership is all the more crucial. We have to ensure that efforts for building local capacities continue rather than imposing interventions from the outside.

Fifth, accelerate our efforts to develop an HIV vaccine--you heard it from Dr Seth Berkley during the conference this morning.

This is a package deal – only a full-fledged response will ever turn back this epidemic. A 20% response will not do it. A single measure will not do it either. Let us once and for all forget about the single measure that will stop this epidemic. It requires combination prevention as much as combination treatment.

Before ending, let me highlight three conditions which will make the response successful, and have already proven their value.

- 1) Political action and leadership. Few in audiences like this one will be unaware that in the developed countries it is AIDS activism that made the difference in both prevention and access to treatment, together with, sometimes against, the public health community. This has been less so in the developing countries, where millions of people with HIV live and die. Brazil has been a notorious early exception, and has had very active AIDS community groups.

But this absence of AIDS activism in the developing countries is now rapidly changing because of the debate on access to antiretroviral treatment. South Africa is the most spectacular example, with an ongoing civil disobedience campaign by the Treatment Action Campaign (TAC).

It is a sign of our time that *Time Magazine* Europe nominated Zackie Achmat as one of its over 30 global heroes of 2003. Zackie is the face of TAC and is HIV positive himself. He is the only hero from the health field--together with a Palestinian surgeon--no famous Nobel Prize winning geneticist!

Leadership is needed both at the top, in the community, in business: look at what is happening in Cambodia, Brazil, Botswana, Uganda or the leadership played by Archbishop Ndungane in South Africa or President Bush with his announcement yesterday.

Some may feel that with AIDS, public health has become too politicized. I actually believe there is good evidence that public health has always been a very political pursuit – if only because budgets and priorities are politically controlled. Our job is to ensure that public health is at the top of the political agenda AND that science and public health values are the basis for policies.

2) A second condition is that the response can only be global. Saying that the health of every nation depends on the health of all others is not an empty slogan, but an epidemiologic fact. It is true for SARS, it is certainly true for AIDS – as recognized by the U.N. Security Council when it put AIDS on its agenda in January 2000.

When I started with UNAIDS, I was frustrated by the lack of interest in global AIDS on the part of the AIDS community in the U.S. with the outstanding exception of a few activists such as Eric Sawyer, Jairo Pedraza, and Mark Harrington who really helped a great deal to mobilize interest in global AIDS issues.

3) Finally, as we all know, no success is possible without serious funding. A well-funded response makes a difference. We are on the right track: last year about \$3.2 billion was spent on AIDS in developing countries from domestic and international sources (from \$300 million in 1996) or a 13 times increase in seven years. We have estimated that we need \$10 billion a year. Where will it come from? Necessarily, multiple sources, from

donor countries, but also domestic budgets in the developing countries. Here again, we still have a long way to go.

In conclusion, AIDS is not only pushing the frontiers of biomedical research, but also of public health. Public health “plus” is partly a return to the roots of public health of the pre-technology era, but is also maximizing the benefits of biomedical science, social prevention campaigns and democracy, and fully recognizing the global inter-linkages of health.

And, AIDS should also instil some humility in us as a profession, since it is clear that success is not only a matter of enough money and cost-effective interventions.

As Laurie Garrett put it in her book, *Betrayal of Trust: Public Health in the 21st Century*, the fate of public health will as much rise or fall with scientific and technical innovation and scaling up of interventions, as it will with the course of globalization, peace, and trade negotiations.

Some humility is also appropriate when we have seen with AIDS how transient and fragile progress in public health can be – and how easily it is reversed by wars, global economic shifts, or a new epidemic such as AIDS – as seen by the fate of public health in the former Soviet Union for example, or the impact of AIDS on life expectancy in Southern Africa. But with AIDS, we have also entered a time of wider accountability around public health.

The time has come when political careers and reputations are made or lost depending on what leaders throughout the world do with regard to AIDS, or whether they deny access to HIV treatment, clean drinking water, or a smoke-free environment for their citizens. This is perhaps the best hope we have for a better future.

And that is only right.