

HEALTH JUSTICE AND THE FUTURE OF DEVELOPMENT

M. Michel Sidibé, Executive Director of UNAIDS
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SPEECH

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I want to begin by thanking The Lancet for pushing the scientific and social frontiers of global health. It is a unique global forum which molds influential thinking around the world. The Lancet has and always will shape our future.

As editor-in-chief, Richard Horton is respected for cutting through rhetoric and illuminating the important, and often controversial, global debates around the human right to health. His leadership will be essential over the next three years to keep health high on the post-2015 political and development agenda.

It is appropriate that we are meeting at University College of London to discuss these issues. UCL is a unique, progressive center for the exchange of new ideas. As we just heard Malcolm Grant say, the university is committed to the debate around human rights and the changes that are needed to make society better. That is why he has facilitated this type of interaction and dialogue for the past 10 years.

I am also happy to see this room full of young people. You are the ones who will help us lead the transformation I will be talking about.

The early European philosopher Jeremy Bentham, UCL's spiritual father, was among the first to raise concerns about public health, particularly for the poor and socially marginalized. In 1878, UCL was the first university in the UK to admit women.

You can easily understand what an honour and privilege it is for me to present the Lancet Lecture here tonight.

From despair, to hope, to unprecedented success

At the outset, let me say that the history of AIDS has been characterized as a journey from despair to hope. Let us not forget that 30 years ago, it was being called the "Slim Disease," the "Shun Disease" and the "Gay Plague." I remember when it seemed that all the beds in Africa were filled with sick people. People were afraid of each other and there was no hope. But over the years, AIDS has instead brought people together. The AIDS response, with its focus on universal access and social justice, forged a new compact between the global North and South. It managed to create space for a social movement that broke the conspiracy of silence. Not only were we able to mobilize resources, but we were able to demonstrate that when you place people at the center of your approach to a disease, you

are completely transforming that approach. You are no longer thinking only about the disease—you are thinking of how to make the life of this person easier. You are bringing a holistic approach to your dynamic of thinking.

Because of this unique strategy, the AIDS response has been one of the most successful public health initiatives of the last 50 years. It united science, communities and policy-makers in common cause. And that is important, because any time you work in isolation, you will lose. You will not be capable of harnessing this synergetic effect to create change.

Over the course of this epidemic, we have amassed a treasury of evidence, science and results. We have put more than 8 million people on lifesaving treatment, when just a few years ago, we were being told that large-scale prevention programmes will never work. The only success stories we had were Thailand and Uganda. But today, more than 56 countries have been able to stabilize and even significantly reduce their number of new infections.

We have also shown that young people really can change their behaviours and reduce their risk. They no longer want to be passive beneficiaries of our programmes; they want to be actors of change—to lead the prevention revolution and to make sexuality education universal around the world.

Today, the dialogue on AIDS has shifted from applauding incremental scale-up to expressing a true belief that we will end this epidemic. But we have reached a moment of uncomfortable truth. A moment of profound transformation. The world has changed and our results will not be sustainable if we do not reflect on our next move.

Let us not be naïve. The world faces one of its most serious crises. It is not just a financial or budgetary crisis. It is an ethical crisis. A crisis of trust between people and their leaders. When you have this widening confidence gap between citizens and their governments, it becomes very difficult to inspire the social change needed for a new movement in development.

We are living in times characterized by a global seismic shift: in urbanization; in new and serious health challenges; in the growing influence of young people using powerful social media to create new forms of activism.

We face levels of interdependency and complexity never experienced before. Today, there are multiple poles of geopolitical power, and they are moving from North to South, from West to East. New systems of global governance are emerging; while multilateralism is in crisis, we are seeing new forms of “minilateralism.”

Karl Marx described well what we are experiencing. He said: “There are moments in life which are like frontier posts marking the end of a period, but at the same time clearly indicating the new direction. At such a moment of transition, we feel compelled to view the past and present with an eagle’s eye so we can be conscious of our real position.”

We need to understand and integrate the magnitude of the changes that are happening into a new narrative for global health—one that will help us move from a disease-specific approach to one that is patient-oriented—that is to say, a people-centred approach. I want to highlight five areas where I believe we can make a large impact.

New architecture for global health

First, we must change the architecture of global health. This will require nothing less than a paradigm shift. Old parameters based on “givers” and “takers” are blurred and obsolete. The new architecture will focus on country ownership, shared responsibility and joint leadership.

Many low- and middle-income countries are seizing ownership and slowly gaining independence from international aid, and those results are very encouraging. But globally, progress has been patchy and unsustainable.

Countries cannot deliver universal health on their own. We could save the lives of many more poor people—especially women and children—if governments, implementing countries and major global health players were more effectively and strategically working together.

The global health architecture requires shaking up, simplifying and integrating. Centrally, it needs a health financier, an agency for the establishment of norms and standards and an advocacy and accountability mechanism or agency. I think that is all. Why would we need any more complexity than this?

We need to have the courage to disrupt the architecture. I suggest that we put the great minds of change management and health policy to work on a new design. This is the perfect time to begin to build the structures and leadership that will serve people in the coming decades.

New voices

Second, we must bring new voices to the debate. Emerging countries and regions offer unique perspectives and solutions. They come with fresh experiences from the frontiers of economics, technology and innovation. Many of these countries are experiencing the fastest economic growth rates in the world today. Others are demographic powerhouses—more than half of the world’s population lives in Asia today.

How do we make sure they are part of the global health transformation we want to see? What are the technological and economic strengths they can bring to the table?

It is not just the players who are different now—the game itself is changing. I am seeing different types of partnerships today: between China and Africa. Between Africa and India. We need to really understand this game and to be able to really leverage it in the interests of people. This calls for new approaches to global governance and partnerships—grounded securely in shared responsibility and global solidarity, and built with sustainability in its bones—not just financial, but social sustainability. These new approaches are reflected in the African Union’s ground-breaking Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria, which outlines clear actions and results on diversified investments, pharmaceutical security and strengthened governance.

This Roadmap is very important—first, because it recognizes without a doubt that there is a dependency crisis. The Continent will not be able to keep millions of Africans on treatment for a lifetime using only the resources that come from outside. Second, it calls for exploring new modalities for investing in health—a new investment framework that will help us maximize the returns. Why—when we have 7%, 8%, even 14% growth in some parts of Africa—shouldn’t countries start thinking about health insurance and universal health care for their people? What kinds of approaches should be put into place to accompany those transformations?

New delivery approaches

It is time to rethink the ways we deliver health. Until now, we have been thinking about how to reach millions of people. But it is no longer about millions—our paradigm has to enable us to reach billions with services. When you consider the scope and numbers of non-communicable and other diseases in the future, health delivery becomes a very different game.

This means addressing the ethical dilemmas and lack of trust people have towards public health systems, and rebuilding relationships between patient and provider. We need to move from treating diseases to putting people—healthy and sick—at the centre of health systems and care.

Most critically, it means completely rethinking our approaches to delivery. We can gain real advantages through community-based and task-shifting approaches, and by tapping into non-conventional capacities and alternative delivery mechanisms. We must no longer think of a community health worker as a nice person who helps out. We need to try and make them an integral part of the structures of health.

It is also important for us to think beyond *coverage, coverage, coverage* and to focus more closely on quality and impact. I meet regularly with Ministers of Finance. Many of them would never consider health as an investment. They continue to believe that health is just a cost. If we do not engage them on this issue, we will never have the resources we need.

To consider serving billions of people, we need better prioritization. We must learn to see choices through a prism of geography and population, using the most sophisticated mapping of where our resources will make the biggest difference. We can no longer look at global health or any disease through the lens of infinite money. The unit costs of producing any result should be reduced, and we need to do it by bringing the discussion around to integration.

I know that without the exceptionalism of AIDS, we would not have arrived where we are. But for the past several years I have been saying that it is time to take AIDS out of isolation. We need to look into the future 20 to 25 years: How can AIDS spearhead a movement that will project us into global health reform? How can AIDS be an entry point into maternal and child health, reproductive health, NCDs and other areas?

When I first began talking about taking AIDS out of isolation, people from civil society told me what I was doing was very dangerous. But now I am happy to say that nothing else has been as beneficial as our work to build bridges between AIDS and reproductive health, maternal health, child health, women's health, TB—I could go on and on. We have seen how the AIDS response can strengthen and transform health systems in Ethiopia, Rwanda and many other places. That is the power of integration.

Innovation and technology

Health care is becoming ever more expensive, making it ripe for fresh ideas and inventions that will maximize investment benefits. There is massive potential for innovation through information technology, tapping emerging markets in developing countries and generating low-cost solutions to new and old challenges.

There is a technological revolution in Africa. More than 700 million people have mobile phones. In South Africa, there are more mobile phones than the population. So what can we do with this? It is very important that we learn how to leverage technology to deliver services differently, more creatively and with less cost.

For example, if the 10 million people waiting for HIV treatment today had to use a CD4 machine to initiate treatment, it would cost \$700 million. But the new tool created by Imperial College to check CD4 in the blood takes just a few minutes and costs just \$1 or \$2 per use. Can you imagine the cost savings, and how that could transform a delivery system?

But we must avoid the “access/innovation dilemma” described by Thomas Pogge of Yale. If we facilitate access to new treatments by artificially lowering costs so people can afford them, we risk stifling competition and discouraging innovation. By stimulating innovation through strong patents, we risk obstructing access for people who need these treatments.

This is indeed a challenge, but there are many opportunities here. We have learned much from the AIDS response and its pursuit of affordable, innovative and large-scale treatment. We must make room for new players and new avenues for creative solutions—always making sure we listen to people directly affected by disease, poverty and social inequity. This is what I call the democratization of problem-solving.

Health justice

The last area for making an impact on global health is, to me, the most important—to put human rights and gender at the center of the movement. The unique success of the AIDS response was possible because justice was at the core of our global movement.

Putting human rights and gender equity at the centre of the AIDS response has been responsible for our greatest victories. From the earliest people-powered movements in San Francisco, New York and London, people living with and affected by HIV launched an approach to global health and development that is firmly tied to the principle of “nothing for us—without us.” AIDS forever changed the focus, role and participation of affected communities as essential partners in global health responses.

I have seen that those countries where human rights and dignity are accepted as fundamental are also the ones that have seen great transformations in terms of their people’s access to those services. And I have seen what happens without it. Look at Eastern Europe and Central Asia, where there has been a 250% increase in HIV in the past 10 years. Why? People are hiding themselves and are out of reach of services. It is the same in countries with homophobic laws—almost 79 of them.

The world’s health challenges cannot be conquered in a climate of subversive discrimination. There is no place for false and bigoted distinctions between those who deserve help and those who do not. If justice is not secured as a core principle for universal health coverage, it will never reach or help those most in need. We need to ensure a basic package of services for all, and make special efforts to reach the marginalized and stigmatized. Indeed, we need an enabling legal, social and economic environment conducive to a progressive interpretation of universal health coverage.

Beyond health, people are demanding stronger social safety nets, including universal education and social security schemes. These are also cornerstones for protecting health, dignity and human rights, and they need to be part of what we build.

As we transform global health and development in the coming years, we must recognize the central principle that every human being has a right to dignity and health. This principle must reside dominantly within larger national agendas for health, development, gender equality and social justice. The push for a new Framework Convention on Global Health, based on the right to health, is a good new start. It would define the obligations of states and the international community to provide the conditions in which people can be healthy. It has the

potential to convince people of every country that health care is a global human right that must be guaranteed.

Unfinished business

In closing, I want to acknowledge that in terms of AIDS, we have unfinished business to complete. A little more than a year ago, the 2011 Political Declaration on HIV/AIDS set 10 achievable targets. We have a very real chance to eliminate mother-to-child transmission of HIV and to achieve an AIDS-free generation by 2015. Because we are taking a geographical approach, we were able to reduce the number of babies born with HIV by 30% in just one year.

Learning from our experience with integration, we can prevent 350,000 deaths each year from TB coinfection. These deaths are occurring in fewer than 17 countries, and by targeting these areas we can reduce that considerably by the end of 2015.

We have demonstrated that we can meet the Millennium Development Goals and we must continue our efforts and not lose that focus. However, debate on the post-2015 development agenda has begun and we should not ignore it. Let us embrace it as an unprecedented opportunity to rewrite the future of global health.

We can use what we have learned over the 30-plus years of AIDS: to work horizontally and promote multisectoral action. One promising avenue is to fully exploit the synergies already before us—for example, leveraging efforts to improve education for women and girls to help them protect themselves not only from HIV, but from gender-based violence and social inequity.

Fundamentally, the debate on the future of global health should be guided by principles of equity, inclusiveness, the notion of dignity and the centrality of justice in ensuring the human right to health.

Thank you.

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Contact

UNAIDS Geneva | Sophie Barton-Knott | tel. +41 22 791 1697 | bartonknotts@unaids.org

UNAIDS

The Joint United Nations Programme on HIV/AIDS (UNAIDS) leads and inspires the world to achieve its shared vision of zero new HIV infections, zero discrimination and zero AIDS-related deaths. UNAIDS unites the efforts of 11 UN organizations—UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODC, UN Women, ILO, UNESCO, WHO and the World Bank—and works closely with global and national partners to maximize results for the AIDS response. Learn more at unaids.org and connect with us on Facebook and Twitter.