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STATEMENT AT AN INFORMAL BRIEFING ON AIDS

to the

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by

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Mr President, Mr Secretary-General, Excellencies, Honourable Delegates, Ladies and Gentlemen:

The AIDS virus swept across the world, silently, before we even knew it existed. The worldwide epidemic was well under way by 1981, when AIDS was first recognized and was given a name. Since then, six years have passed and it has taken these six years of discovery and struggle to learn enough to rise above the flood of ignorance and fear and view clearly the dimensions of this new threat to global health. However, if AIDS was destined to occur, we were at least fortunate that the epidemic came in the late 1970s and 1980s rather than 50 years ago. At that time, lacking modern scientific knowledge and technical expertise, we would literally not have understood what was happening to us. Yet today, remarkably, only six years after the disease was first recognized, we do know enough to seize the initiative to stop AIDS. I am grateful for this opportunity to describe to you the basis and shape of the Global Strategy against AIDS - the Global AIDS Plan.

For analytic purposes, it is useful to consider AIDS as three distinct yet intertwined global epidemics. The first is the epidemic of AIDS virus infection itself. The second epidemic, inexorably following the first, but with a delay of several years, is the epidemic of the disease AIDS. For unlike most infectious diseases, such as measles or yellow fever, in which the disease develops days or weeks after infection, AIDS may not occur until years or possibly even decades after the initial AIDS virus infection. Finally, the third epidemic, of social, cultural, economic and political reaction to AIDS, is also worldwide and is as central to the global AIDS challenge as the disease itself.

Because initial infection with the AIDS virus, now officially called the Human Immunodeficiency Virus (HIV), is silent, without signs or symptoms, the virus was able to spread widely, unnoticed and undetected, starting in the mid- to late 1970s.

We do not know the geographical origin of this virus. We consider speculation about the virus' origins, based on the limited information now available - to be just that - speculation. However we are beginning to receive considerable information on the current extent of AIDS virus infection. Based on this information, we estimate that between 5 and 10 million people worldwide may now be infected, and the AIDS virus appears to be present, at least to some extent, in virtually every country.

In addition, epidemiological studies from throughout the world have clarified how the virus spreads from person to person; this knowledge is most precious, for it tells us how to prevent the spread of AIDS. Fortunately, the AIDS virus is quite limited in its routes of spread - limited to sexual contact, blood, and spread from infected mother to child.

Sexual transmission accounts for the majority of AIDS virus infections in the world. Sexual spread of AIDS virus can occur from any infected person to his or her sexual partner - from infected men to women, from infected women to men, and from infected men to men. The risk from each unprotected sexual contact with an infected person appears small, yet infection can occur from a single sexual contact.

Spread of AIDS virus through blood occurs through specific identifiable practices and in specific, identifiable situations. These include blood transfusion, sharing of blood contaminated needles and syringes by intravenous drug abusers, or the re-use of any needle, syringe or other skin-piercing instrument without proper cleaning and sterilization.

Finally, the spread of AIDS virus from infected mother to child can occur before, during or shortly after birth. Recent studies have suggested that approximately half of the babies born to infected mothers will be infected with AIDS virus. AIDS in children is mainly due to AIDS virus infection in the mother.

AIDS spreads through sex and through blood - through specific, identifiable human actions, all subject to human influence and control; and thus, AIDS is controllable and preventable. Sexual behaviour can be modified, blood for transfusion can be screened, and needles and syringes can be sterilized. It is most important to emphasize that AIDS virus is not transmitted through food or water; it does not spread through insects or toilet seats, swimming pools or telephones, shaking hands, hugging, coughing or sneezing. Most importantly, there is no evidence, anywhere in the world, for casual transmission or for person to person spread in schools or in the work place. AIDS virus infection is spread by, and controllable through, conscious human behaviour.

The second epidemic, of the disease AIDS, follows the epidemic of infection, but with a delay of several years. The epidemic spread of AIDS virus in the mid- to late 1970s was followed by the global appearance of AIDS cases in the early and mid-1980s. Thus, in 1981, when AIDS was first described in the United States, AIDS cases were already occurring in several areas of the world.

As of 20 October 1987, a total of 62 438 AIDS cases were officially reported to the World Health Organization from 126 countries around the world. Thirty-four countries have each reported 100 or more cases, including 11 from the Americas, 10 from Europe, 12 from Africa and 1 from Oceania. Actually, reported cases are only a fraction of all cases; in some countries AIDS may not yet be recognized or reported to national health authorities, and some countries remain reluctant to speak openly or fully about AIDS. We estimate that the actual number of AIDS cases worldwide has been in excess of 100 000.

Since the disease AIDS occurs years after the AIDS virus infection, the number of AIDS cases occurring today does not tell us about the present level of infection in the population. We estimate that for each AIDS case, there are likely to be an additional 50 to 100 AIDS virus-infected people. Thus, AIDS cases are only the most visible part of a much larger AIDS virus-infected population.

Infection with AIDS virus is probably life-long. The AIDS virus inserts its genetic material into the genetic material of some of the infected persons' cells. Then, the virus can remain in the body, dormant and hidden, for years, or perhaps decades. Most infected people are unaware of their infection. Once the dormant AIDS virus is activated, it destroys a critical piece of the immune system and leaves the person vulnerable and defenceless against infectious diseases and some cancers. Some infected people suffer a less profound weakening of the immune system and develop other, usually less severe diseases, called "AIDS-related conditions". And, for reasons not yet understood, in some infected people the virus has remained dormant and thus they have remained healthy.

At present, we do not know what proportion of infected people will ultimately develop the disease AIDS. However, in the first five years after infection, 10%-30% of infected people will develop AIDS and perhaps 20%-50% more will develop AIDS-related conditions.

Therefore, we can expect that 10%-30% of the 5-10 million AIDS virus-infected people in the world may develop AIDS during the next five years. This would mean 500 000 to 3 million new AIDS cases or a greater than tenfold increase in the next five years, compared to the

total number of cases thus far. Unless a treatment is found to protect healthy AIDS virus-infected persons from developing AIDS, we will be helpless to avert this large wave of new AIDS cases.

What about vaccine to prevent infection and treatment for those already infected? A human vaccine has never before been made against a retrovirus such as the AIDS virus. Thus, vaccine researchers have been confronting the mysteries of the AIDS virus itself, at the frontiers of virology and immunology. The discovery in 1986 of a second AIDS-causing virus, now called Human Immunodeficiency Virus Type II (HIV-II), has further complicated the problem. Nevertheless, with unprecedented speed, the first candidate AIDS vaccines have been prepared; initial human studies are already and will soon be increasingly under way. However, these first trials are only the beginning. The final test - to determine if a candidate vaccine actually protects against the AIDS virus - must be completed before we can truly claim to have a vaccine. Under the best of circumstances and with luck, a safe and effective vaccine could possibly become available for use in large populations in about five years. However, many experts believe we will not have such a vaccine until at least the mid-1990s.

Remarkable progress has been made towards treatment of AIDS virus infection. A single drug, zidovudine, also called AZT, has been shown to be effective in the treatment of some categories of AIDS; although AZT has important side-effects and is quite expensive, it does prolong the life of persons with AIDS. Newer drugs, using similar principles of action, and taking full advantage of what has been learnt about the AIDS virus, are under development; it is just too early to tell if they will be effective and safe. Recently, important trials were started to see if AZT, or other drugs, can block the progression to AIDS in healthy AIDS virus-infected people. The personal and public health benefits of such protection against AIDS would be enormous.

The third epidemic relentlessly follows the first two epidemics. This is the epidemic of economic, social, political and cultural reaction and response to AIDS virus infection and to AIDS. This worldwide epidemic has only started, yet it is an integral part of the global AIDS problem. As public awareness about AIDS grows, as AIDS virus spreads and as the number of AIDS cases rises steeply during the next five years, this third pandemic can also be expected to intensify.

The impact of AIDS goes far beyond the health statistics. A worldwide AIDS epidemic is a major economic challenge. In industrialized countries medical care costs for each AIDS patient range from about US\$ 20 000 to over US\$ 100 000, while indirect costs dwarf the medical costs because it is the young and middle-aged who most often die of AIDS. In developing countries, the medical costs have yet to be measured. However, in these countries, the added cost of AIDS on already overburdened medical care systems must be considerable.

The impact of AIDS on social and economic development may be critical. AIDS may cause mortality rates among the economically and socially most productive age-groups, especially 20-45 year-olds, to double, triple, or rise even higher. In terms of social and economic development, AIDS robs societies of people who are in their most productive years. In areas where 10% or more of pregnant women are infected with AIDS virus, infant mortality from AIDS alone may exceed the infant mortality rate from all causes in industrialized countries. Thus, in some areas of the world, the projected gains in infant and child health anticipated through the child survival initiatives may be cancelled tragically by AIDS.

Fear and ignorance about AIDS continue to lead to tragedies: for individuals, families and entire societies. Unfortunately, as anxiety and fear causes some to blame others, AIDS has unveiled the dimly disguised prejudices about race, religion, social class, sex and nationality. As a result, AIDS now threatens free travel between countries and open international communication and exchange.

Societies now debate what to do with AIDS virus-infected people. Such persons should, and must, remain in society, for at least two reasons. The first is that except for unprotected sex, blood transfusions and needle-sharing - all of which can be prevented - AIDS virus-infected persons are simply not dangerous to others. AIDS virus-infected persons are not dangerous to others in any random or uncontrollable manner. The second reason is that

threatening infected persons with exclusion - or worse - will drive the problem "underground", wreaking havoc with education efforts and testing strategies. Therefore, how societies treat AIDS virus-infected people will not only test fundamental values, but will likely make the difference between success and failure of AIDS control strategies at the national level. To the extent that we exclude AIDS infected persons from society, we endanger society, while to the extent that we maintain AIDS infected persons within society, we protect society. This is the message of realism and of tolerance.

These three epidemics - of AIDS virus, of AIDS itself, and of social reaction and response - together constitute what the World Health Assembly has recently called a "worldwide emergency".

In response, as Dr Mahler stated, the Special Programme on AIDS has designed the Global AIDS Plan, has received funding from 14 countries for initial implementation of the Plan, and has received unanimous support from the World Health Assembly, with its 166 Member States, and the Economic and Social Council of the United Nations.

The Global AIDS Plan is based on the following concepts:

1. We know enough now about AIDS to stop its spread, even though a vaccine is not yet available.
2. Education remains the key to AIDS prevention and control.
3. AIDS control will require a sustained long-term commitment. AIDS came upon us rapidly, but it will not rapidly recede.
4. AIDS prevention and control must be integrated into, and strengthen national health systems.
5. AIDS prevention and control will require both national AIDS programmes and strong international leadership, coordination and cooperation.

The Global AIDS Plan has three objectives:

1. to prevent AIDS virus transmission;
2. to take care of AIDS virus-infected persons;
3. to unify national and international efforts against AIDS.

AIDS affects both the developing and industrialized world, and thus, every country will need a national AIDS programme. This is vital not only for national interests but also because ultimately AIDS cannot be stopped in any one country unless it is stopped in all countries.

At the national level, AIDS prevention and control first requires the political will to recognize the problem and to establish a broadly representative national AIDS committee. This committee is entrusted with the responsibility to develop a national plan for AIDS control. Towards this end, an initial assessment of the extent of AIDS virus infection in the country is essential. Then, epidemiological surveillance must be established, along with laboratory support for the diagnosis and testing. Health workers at all levels must be educated, for not only are they responsible for the care of people with AIDS, but they are vital sources of accurate information to the public.

Specific prevention programmes must be implemented:

- to prevent sexual transmission through information and education;
- to prevent blood transmission by:
 - o making blood and blood products safe,

- o preventing intravenous drug abuse and by educating and treating intravenous drug abusers,
 - o ensuring that injection equipment and other skin-piercing instruments are always sterile;
- to prevent mother-to-child spread.

Finally, a comprehensive national AIDS programme must help people already infected with the AIDS virus, including persons with AIDS, and also help them in their responsibility to protect others.

National AIDS programmes are being rapidly established throughout the world with the technical and financial support of WHO's Special Programme on AIDS. Thus far in 1987, the Special Programme is collaborating with over 100 countries throughout the world; by the end of 1988, the Special Programme will support every country in the world which requests this collaboration. With the implementation of national AIDS plans, the Special Programme will be closely involved in monitoring and evaluating the effectiveness of these efforts. Just as smallpox eradication became possible when an effective, epidemiologically-based strategy was developed, so strategy development is crucial to global AIDS control. Together, we must learn by doing and by rigorously and dispassionately evaluating what is accomplished. Finally, over the years, support from the Special Programme will continue and will evolve as these national programmes develop and new needs become apparent.

At the global level, the Special Programme is responsible for strategic leadership, developing consensus, coordinating scientific research (biomedical, social, behavioural and epidemiologic), exchanging information, assuring technical cooperation and mobilizing and coordinating resources. WHO alerted the international community to the global scope of AIDS and has continued to provide vital exchanges of technical and policy information. Recent meetings in Africa, Asia, Australia and the Pacific, Europe and the Americas have each marked turning points in national and regional AIDS awareness and action. In the last year, many important organizations, bilateral and multilateral aid agencies, UN agencies including UNDP, UNESCO, UNICEF, UNFPA and the World Bank, nongovernmental organizations like the League of Red Cross and Red Crescent Societies and other private voluntary organizations have contributed their energies to the Global AIDS Plan.

Thus, if AIDS had appeared 50 years ago, we would have been nearly defenceless against it - science would not yet have been able to define the cause, develop diagnostic and screening methods, and progress so rapidly toward treatment and prevention through vaccine. Yet there are at least three other ways in which today's world is well armed and equipped to combat AIDS.

First, the concept and infrastructure of primary health care is now well established throughout the world. Primary health care delivers basic and fundamental health services to people where they live. Primary health care stresses the capacity and responsibility of individuals and communities to prevent disease through information and education leading to changes in individual and collective behaviour. Primary health care is therefore vital to ensure active community participation and to guarantee delivery to the people of AIDS prevention services and programmes.

The second major factor is the development of modern social and behavioural science, which we are now applying to design efficient and socially acceptable public health information and education strategies.

The third factor is the emergence of a global capacity for action and a global conscience, expressed concretely in the bilateral and multilateral aid programmes of the world and through the deliberation of the United Nations.

As we look towards the future, we recognize that the AIDS situation (all three epidemics) will likely become even more serious during the new few years. We therefore consider AIDS to be an inescapable priority. Strengthened by biomedical and social science, equipped with the structures and philosophy of primary health care and health promotion, and endowed with the capacity for global action, we are now implementing a Global Plan against this new health problem, against AIDS.

That we are gathered here today to discuss AIDS is itself an historic event. In the face of this global emergency, we cannot give AIDS a "grace period", and the opportunity for prevention must not be lost. Thus we assume our collective and historical responsibility to take action now against a worldwide epidemic whose ultimate scope and dimensions we cannot yet predict. The awareness of our collective strength heightens our sense of responsibility. What has thus far amazingly been accomplished during the past six years is a credit to many throughout the world. The global challenge which lies ahead will truly demand the best of us all.

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