Malcolm Potts
Integration of reproductive health with HIV/AIDS

Nafis Sadik emphasized last night that the current economic crisis is going to hurt the poorest and most vulnerable families most.

I want to look at the big picture – three things:

- the burden of disease in PPD member countries,
- the resources available to help the poorest economic groups; and
- the evidence base that interventions to help the poor are effective.

When I was president and CEO of Family Health International, working with partners in Ghana, I helped finance the first HIV prevention in Africa with commercial sex workers.

I have watched this terrible disease unfold and there are not words enough to describe the pain it has brought to countries like Uganda.

Originally I saw this as a catastrophe as a global self-sustaining heterosexual epidemic. Fortunately we now know this is not going to happen.

Four out of ten AIDS infections are in 4% of the world's population. We can be sure the PPD members such as Tunisia, Pakistan, and Bangladesh are not going to have a self-sustaining heterosexual epidemic. HIV will remain largely confined to gay men, IV drug users and sex workers – who are infected by their clients.

The Philippines is an another country with no self-sustaining epidemic, in this case demonstrating the power of male circumcision – male circumcision has been genuinely called an 'anatomical vaccine.'

HIV represents 5.3% of global burden of disease measured in DALYS, but receives 43.1% of US foreign aid, while acute respiratory infections, which account for almost as many disability adjust life years lost as HIV/AIDS, account for only 2% of all foreign aid.

Having had executive responsibility for the first large scale US investments in HIV, looking back I have to be honest and humble and admit that did little to slow the generalized heterosexual epidemic in Africa. It was President Museveni who recognized that concurrent sexual partnerships greatly accelerate HIV spread and he had the perspicacity to call for 'zero grazing.'

Despite all this, MDG 6 "to halt and begin the reverse the spread of HIV/AIDS" is one of the few MDGs which have been achieved. The peak incidence of HIV infections is now past in nearly all countries.

Given that the global economic crises will mean less money to help the poor we must be carful not to put our limited resources in the wrong places.

Brazil, which has an HIV prevalence of 0.6%, spends $2,600 on each case of HIV/AIDS, but only $312 on each case of diabetes, with a prevalence of 6.2%.

The global economic crisis forces us to look at the most cost-effective use of resources, As the First Lady said at the opening ceremony, Partners has a special responsibility to build evidence-based policies.

The most cost-effective way of slowing the vertical transmission of HIV from mother to child, in a country like our host Uganda is not VCT and ARVs in antenatal clinics, but improving access to family planning. When we meet the unmet need for family planning then many of unintended pregnancies prevented would have also involved vertical transmission. More over such a strategy reaches those women who are unable to reach an antenatal clinic,

As a man, I am forced to agree with Dr Nafis Sadik that much of the HIV epidemic is largely driven by "male behavior." Making contraception widely available empowers women to escape from the insatiable male drive for sex with its consequent rise in HIV infections or unintended pregnancy.

Most of the other MDGs are not likely to be achieved in the world's poorest countries, although most will be accelerated if we reposition family planning. It is imperative that we reverse the growing inequities Harry Joosery referred to where there are more unintended pregnancies in Kenya today than there were at time of the ICPD.

When we assess the MDGs we must avoid looking a percentage changes because that conceals the truth. Between 1990 and 2001 the number of people living on a dollar a day or less in sub Saharan Africa increased by 2%, but because of rapid population growth this translated into 87.7 million more people enduring the misery of abject poverty.

We cannot find a country – other than oil rich city states such as Dubai, which have escaped from poverty while still having an average family size over 4 or 5.

In the case of MDG 5 to reduce the maternal mortality ration by three quarters between 1990 and 2015 we have made little or no progress in the worlds poorest regions, and in absolute terms as a result of population growth, in areas such as Northern Nigeria, more women may die from pregnancy childbirth and abortion in the next 12 months than in any year in human history.

The harsh reality is that while, as an obstetrician I am totally in favor of improving emergency obstetric care, I know that we are not keeping up with growing numbers of poor women and that the only way to begin to reach MDG 5 is to go beyond the formal health system and empower village women to use misoprostol to control PPH and to reposition family planning so that all women have access to family planning,

A colleague in Sweden calculates that if we take today's excellent obstetric record in the West and apply it to the fertility pattern Sweden had in 1900 then there would be about one third more deaths, even one of the best health services in the world. Family planning saves women's lives.

I recognize the sincere differences which exist over induced abortion, but it is a fact that a low MMR is impossible without access to safe abortion.

While I fear the contribution of the North to HIV has been limited, in the case of voluntary family planning we can document a great many successes.

In a recent study at Berkeley we found that the cost per maternal death averted is $4,400 ifs we invest in training skilled health providers and building facilities, $900 if we invest in misoprostol to control PPH at the village level and a $23 if we invest in family planning and safe abortion. We need to do all three, but let us begin with an unambiguous commitment to repositioning family planning as Minister Li Bin, Drs Nafis Sadik, Fred Sai and Mr Harry Joosery expressed so forcefully this morning,

In particular I want to congratulate the People's Republic of China for their generous donation of contraceptives to Partners for distribution in Africa.

One of the things I learned running FHI and I know my wife Dr Campbell also saw directing the population program in the David and Lucile Packard Foundation, is that when you have power and money, colleagues in the South tend, for good reason, to guess what those in the North want to do, rather than asking for what those in the South really want..

We need a new partnership between the North and South where we look at the burden of disease and ask in as objective a way as possible – what is the best way to use our resources to help the poor and vulnerable to the greatest extent possible.

In Rwanda HIV prevalence among adults is 3.1%. The foreign budgets for HIV/AIDS is $187 million. The MoH budget for all aspects of health care is a mere $37 million. I suspect this is an example of Northern pressures rather than Southern priorities.

All of us who are privileged to the guests of Partners are delighted that America has had the good sense and political courage to elect w new president whose father was born in Africa. We have a unique opportunity to chart a new course based on the needs of the poor and on proven cost-effective interventions.