**2017 Human Rights Council Social Forum**

**Panel 9: The way forward**

**Statement by Mariângela Simão**

Thank you, Ambassador.

Let me first thank the leadership of Belarus and Brazil in taking us this far, for guiding us throughout the program and being present here. I would also like to thank our partners and our colleagues who have worked hard to make this forum a reality, including the cosponsors of UNAIDS, we have eleven agencies who are part of the joint program. I have some reflections from UNAIDS, as we get to the closing and also addressing the issues raised by the Ambassador. What we heard in these three days here were not news, we have heard these things before in our workplaces, places we visit and from people we talk with. These things have already been said, and people have been saying them over and over again. I would like to emphasize five points, and I’ll try to be brief:

Firstly, we have heard here how discrimination affects different people, different groups in different ways. How it increases marginalization and how that, by itself, hampers access to services like health, education and access to different public goods. And actually this, in our field of work, impacts directly in premature deaths and years lived with ill health or with a disability. We had multiple examples which came from the HIV field. For example, we had Phylesha speaking on behalf of the transgender movements in the Asia Pacific region. And we have data from our recent reports which was launched here on Monday, which says that 40% of trans people did not seek health care because they were afraid that they would be discriminated. So there are several ways to tackle discrimination, and throughout these three days, we discussed some of them. It is not impossible to deal with it - WHO and UNAIDS have launched, last year, an agenda for zero discrimination in the health sector and this actually includes the health workforce, because many times health workers are also subject to discrimination, and we have had many cases where health workers living with HIV were discriminated or criminalized in suspected cases of transmission. So we heard how Hepatitis C is affected by discrimination, and we heard from the plenary someone saying that leprosy is probably the disease that caused most discrimination throughout the history of humankind. Discrimination can be addressed and should be addressed by all of us.

Secondly, we heard how the engagement of people most affected, makes all the difference. This morning, the ambassador from Switzerland was citing how the inclusion of civil society in boards was making a difference. For example, the UNAIDS board has a representation of governments, UN agencies and civil society. An inclusion of civil society as board members is probably something that we all should push for as a new agenda that the Secretary General is putting forward on the table for us. This is in a way how we make the voices of civil society, in the global forum, more heard, if they come in an organised way as a part of the structure of the governance bodies.

The third issue, which was raised by Elena Villanueva-Olivo, is a determinant of how care is organized today. The issue of us, dividing the diseases in communicable and non-communicable, and how this is out of context nowadays. For instance, HIV moved from being an emergency to being a chronic condition that people live with and fortunately, one day they will die of other causes if they have access to treatments. But we see it in context of Ebola where we need to have an acute and emergency type of response which was not there at the time.

The way HIV started and evolved to be something that people would be better off without it, but if they had it, they could live with it, but they cannot live with the discrimination. HIV started as a very democratic virus because we had upper middle class affected in the developed countries and we had the same class of people also affected in the developing countries. And then this became a global concern, and as it moves forward towards something that is chronic and does not have a cure yet, the risk moves towards the more marginalized groups. So, risk in the case of HIV is not determined by the same things anymore. For example, being a gay man in the US is not a factor to determine the risk, because those affected by HIV is not middle class, white gay men, but the Blacks and Latinos. There are so many different epidemics, and I am saying this because this is the context that we live now, the different phases of the different conditions in which they have a common denominator. It is inequality and inequity in access to health services, because in principle, they are all avoidable.

The fourth point that I wanted to make is related to the panel this morning on access to health care products. We could see that it is still largely driven by who you are and where you were born. We heard about the impact of monopoly on prices and how intellectual property, while protecting innovation, is also causing high prices, and Hepatitis C was used as a global example. It was the first time in many years that the developed world, had to face an impact of a high-cost medicine. The cost of production of this medicine was known to be around $300, and in the US people were paying $1000 per pill.

I have been living in Switzerland for seven years now, my husband has a chronic disease, and he takes this one medicine which was under patent in Switzerland. I used to buy it every two months, and it used to cost around 190 CHF. This drug was in the market since I graduated from the medical school, which was a long time ago. One day, I went to the pharmacy, and the lady asked me if I wanted a generic because the patent expired, and instead of paying 190CHF for the tablets, I paid 45CHF. This impacts all our lives, and not only people in developing countries, however the mechanism to cope with the cost differs.

We also see that there are methods which can be used like TRIPS flexibility, but are not being used in most countries. But we had good news about Malaysia, recently issuing a compulsory life sensing for Hepatitis C. And we also heard a message of MSF about the alternatives to the current research and development framework systems. We heard mentions of the high-level panel recommendations on access to medicines, and for those interested in the access agenda, I think it is very important to read since there are very solid and actionable recommendations given. If we follow these recommendations, we will be able to deal with many bottlenecks that we have in the access to medicines and health commodities in general. At the end of the day, we want people to have access to the medicines they need, at the right time, without having to pay more for it. We also want the prices to be sustainable and to do that, we need both things.

The fifth thing is about the importance of data. I would like to share something that my boss Michel Sidibé has to say, which always touches me. He says, “We measure what we treasure.” There are many challenges when we are talking about the data related to the diseases and people affected by these epidemics and invisibility is used many times. I heard a colleague from the member state, when I was the AIDS director in Brazil, we had all these discussions in UNAIDS board about LGBT population and he was telling me, “No, we do not have gay men in my country but do not worry, if they are sick, we treat them.” Therefore, showcasing and using data to decrease the invisibility of inequalities, inequity and access to services of all population is extremely important.

Finally, I would like to end by saying, I have a Brazilian friend who works in Public health for a long time and once he told me something that stuck with me. I am talking in the framework of SDGs now, to finalize. He was saying: “you see, population has problems, and the good willing people in government make programs to address the problems. So you create a policy, a program, and by the time it is finished, and you get all the boxes in place, many times you see that whatever came out as a result of consensus, political will, the available funds, etc., does not have anything to do with the problem that originated this program.” So, we need to ensure the SDG framework, because many of them are no-brainers. I was talking on a panel last week in Geneva and I was saying that to say that health is society, and peaceful societies need to be interlinked, it should be a no-brainer because the man and woman on the street know that it is better to live in a safe place and have access to services than live in an unsafe place.

It is how we take the SDG framework, to ensure it will make sense in real life, that is the key to the achievement of this wonderful framework. My last word is, I heard from a colleague of mine from the Bahamas, long time ago, he said, “our hope is that when it is all said and done, we have more done than said” and I hope those of you who will be here in 2030 will be accountable for the 2030 Agenda.

Thank you very much!