UNAIDS
JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS
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Special Theme:

Health, morbidity, mortality and development

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Uniting the world against AIDS

Mr. Chairman, Excellencies, Distinguished Delegates,

The Joint United Nations Programme on HIV/AIDS (UNAIDS) appreciates the opportunity to address the special theme of the 43rd session of the Commission on *Health, morbidity, mortality and development.*

As expressed in the Secretary-General's report (E/CN.9/2010/3) there has been an unprecedented decrease in mortality that has led to an increase in life expectancy across the globe. However the advent of the HIV pandemic has halted, and in some regions reversed, the progress made in the reduction of mortality and morbidity. It is estimated that about 2 million deaths occur worldwide due to AIDS-related illnesses.

Though life expectancy has increased tremendously in all other regions, it has been marginal in sub-Saharan Africa, while in Southern Africa – which is the hardest hit by HIV – several countries have registered a dramatic decline in life expectancy. In regions with high HIV prevalence, it is a major cause of childhood illness and death, and a critical factor in the resurgence of other infectious diseases, especially TB. While the epidemic's effects are most severe in sub-Saharan Africa, no region across the world has been spared. Furthermore, HIV has had a disproportionate impact on women and girls, and is the leading cause of death among women of reproductive age (15-49 years old) worldwide.

As of December 2008, an estimated 33.4 million people were living with HIV, including 2.7 million people who were newly infected in 2008 alone. The continuing growth of the population of people living with HIV reflects the combined effects of continued high rates of new HIV infections and the beneficial impact of life-saving antiretroviral therapy. The number of people receiving anti-retroviral treatment (ART) increased 10 fold in 2003–2008, reaching 4 million people in low- and middle-income countries. This has allowed slowing down the HIV-related mortality, which appears to have peaked in 2004.

The expansion of ART in low- and middle-income countries is an important achievement in modern global health and development history. In many parts of the world, ART programmes represent the first broad-scale introduction of chronic disease care for adults. Advocates for attention to non-communicable diseases in resource-limited settings are citing the success in expanding HIV treatment access as both inspiration and precedent for introducing programmes to manage other chronic conditions. ART programmes are pioneering new systems for procurement and supply management, establishing new clinical and operational practices, and changing health-seeking behaviours and long-term expectations of clients.

At the same time, it is important to note that despite the significant increase in ART coverage, more than half of all people in need of treatment still do not have access to it. There is an already unacceptably long queue of 8-10 million people waiting for treatment, and without significant scale up it will likely grow longer in light of the new WHO treatment guidelines which recommend earlier initiation of therapy[1].

It is equally worrisome that the progress has not been sufficient to profoundly alter the course of the epidemic. For every two persons beginning anti-retroviral treatment, five more are becoming infected. Over 7,400 new HIV infections occur daily, of which about 40% are among young people aged 15–24. Without significant progress in HIV prevention, it will not be possible to reverse the trajectory of the epidemic and sustain treatment.

Stigma, discrimination and lack of human rights undermine efforts to achieve universal access to HIV prevention, treatment, care and support, especially for those populations who need it most, including men who have sex with men, sex workers and people who use drugs.

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[1] WHO 2009 treatment guidelines recommend starting therapy once a patient's CD4 count falls below 350 cells/mm3, as opposed to previously recommended 200 cells/mm3.

This also undermines the spirit of the primary health care, which places emphasis of health care on people and their needs.

Mr. Chairman,

With 3 out of 8 MDGs related to health, the deliberations of the Commission this year are most relevant in the context of the upcoming GA High-level Plenary Meeting on MDGs in September. In the hardest hit countries HIV has undermined community resilience and traditional support networks, affected labor productivity and human capacity necessary for poverty reduction and provision of health and social services. By the same token, there are natural mutually supportive synergies between the AIDS response and other MDGs. The AIDS response must be leveraged with efforts to achieve the other MDGs. At the same time, progress in other MDGs will help move a mult-sectoral response to AIDS.

Let me share a few brief examples:

- Reducing HIV infections and providing treatment help increase productivity and the reduction of poverty and hunger (MDG 1). Conversely, strategies to eradicate extreme poverty and promote food security benefit HIV prevention programmes, the success of antiretroviral therapy and the mitigation of the epidemic's impact.

- Universal education initiatives (MDG 2) are associated with delayed sexual debut and reduced HIV risk behaviors. At the same time, ART scale-up in high-prevalence countries is helping slow the loss of teachers and educational administrators due to illness and death.

- Global efforts to promote gender equality (MDG 3) play an essential role in reducing women's and girls' vulnerability to HIV infection.

- The prevention of mother-to-child HIV transmission supports the reduction of child mortality (MDG 4). Without timely diagnosis and treatment, children born with HIV stand a 50% chance of dying before reaching the age of 2. In 2008 alone, over 60,000 at-risk babies were born HIV-free because their HIV-positive mothers received medicine to prevent HIV transmission. According to the Global Fund Report, the virtual elimination of mother-to-child HIV transmission by 2015 is within reach if current rates of progress are maintained.

- HIV epidemic slows progress in reducing maternal mortality (MDG5). According to recent *Lancet* article, nearly one out of every five maternal deaths – a total of 61,400 in 2008 – can be linked to HIV, while countries with high HIV prevalence have had the most difficulty reducing their maternal mortality ratio. The lack of sexual and reproductive health and family planning services for HIV-positive women further exacerbates the situation. At the same time, efforts to improve maternal health are accelerating the scale-up of primary HIV prevention services for women, as well as interventions to prevent mother-to-child HIV transmission.

- HIV programmes help to strengthen national health systems, attract financial resources for health and build systemic capacity in many resource-limited settings. Better health care systems support the reduction of leading infectious diseases (MDG 6).

These synergies can – and must – be fully leveraged. With only five years until the MDG deadline and the ever pressing need to save more lives, it is imperative for all stakeholders - governments, multilateral organizations, civil society and the private sector - to accelerate progress by maximizing the synergies across various MDGs. UNAIDS stands ready to work with all partners to this end.

Thank you.