SPEECH 10

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DATE: 25 May 2010

PLACE: Parliament Hill, Ottawa, Canada

OCCASION: Parliamentary Breakfast on the G8/G20 and HIV/AIDS.

Good morning distinguished Members of Parliament, distinguished Ambassadors, President Silas and members of the Canadian Federation of Nurses Unions, health officials and civil society representatives.

I am delighted to be here with you this morning.

I am glad to be addressing you today, May 25, when we commemorate the founding of the Organization of African Unity which is today the African Union. Africa indeed remains the epicentre of the AIDS epidemic, with Sub-Saharan Africa being home to 67% of all people living with HIV worldwide. So it is fitting that we should be discussing the epidemic today.

Firstly, I would like to thank our hosts, the Canadian Federation of Nurses Unions, and to pay tribute to the Federation for its active role in joining forces with trade unions worldwide in delivering a decisive message, about the need for the provision of Universal Access to core HIV services, to the Canadian presidency, and to all governments at this year's G8 and G20 Summits.

I am particularly pleased to be part of a discussion of how the G8, under the leadership of Canada, can be a potent force in improving human health across the globe. Not just in the milieu of AIDS, but in all the health and development issues that the epidemic touches and is touched by.

Today in 2010, the world is intensely focused on issues like climate change and terrorism, with good reason. But having travelled to forefronts of the HIV epidemic this year, I can say that the other great global issue is inequity—the growing gap between the rich and poor, between the socially powerful and the powerless. HIV shines a harsh spotlight on that inequity, revealing how, in ugly and dramatic fashion, the poor die when they get sick while

the rich live. HIV remains one of the central threats to global health, international development and stability.

I am confident that Canada will show leadership during its G8 presidency and strongly welcome the engagement of Parliamentarians, labour and civil society in setting the compass for our destination. Our common destination is the achievement of all the Millennium Development Goals. The international community has made progress, although uneven. Reaching the goals is feasible, but we need sustained political will and resources. As the UN Secretary-General said here in Ottawa last week “the upcoming G8 and G20 summit meetings provide an opportunity to deliver for the world's poor and most vulnerable people.” “Canada must provide leaders in the G20 and G8 with a new resolve to meet previous global pledges to the poor.”

The United Nations Programme on HIV/AIDS which I represent is a Joint Programme which brings together the efforts and resources of ten UN system organizations and the Secretariat in the AIDS response. UNAIDS is encouraged by the sharp focus of the Canadian G8 presidency on child and maternal health. We all agree that efforts to improve maternal and child health need a big push. What is less well-known is that HIV is the leading cause of death among women of reproductive age. It is a major cause of childhood illness and death and a critical factor in the resurgence of other infectious diseases, especially TB. The global response to AIDS can – and must – be leveraged more effectively to meet women’s health needs.

In developing countries, more than 500,000 women die each year in pregnancy and 9 million children die before the age of five. Reducing the number of children who die before the age of five is the fourth Millennium Development Goal, while reducing the death rate for mothers during pregnancy or childbirth is the fifth goal. They are the two MDGs that are furthest from being achieved by 2015.

Under the maternal and child health initiative, health-care interventions will include a wide range of interventions across “the continuum of care for both mothers and children, including training and support for frontline health workers; better nutrition and provision of micronutrients; treatment and prevention of diseases such as pneumonia, diarrhoea, and sepsis; screening and treatment for sexually transmitted diseases, including HIV; proper medication; family planning; immunisation; and clean water and sanitation.

This comprehensive approach is in line with the Secretary-General’s emphasis on the need for concerted attention to maternal and child health. We know that good maternal and child health is an engine of development. Last month, the UN launched a global Joint Plan of Action with governments, businesses, foundations and civil society organizations to focus on

the health of women and children. As the Secretary-General said here last week “No woman should have to pay with her life to be a mother”. This effort on women’s and children’s health is an essential investment for stable and productive societies. He added that “It will be crucial for the G8 to support this effort in very concrete ways next month.” “It is time to say “Women and children first”.

The reduction of child mortality and improvement of maternal health are often referred to as the health related Millennium Development Goals, along with the combating of HIV/AIDS, malaria and other diseases.

As Canada moves forward to set G8 priorities, it is essential to keep an eye on the linkages among these three MDG priorities. In fact, to achieve the Millennium Development Goals, we will need renewed commitment to integrated approaches to development, in particular HIV and maternal and child health must be hand in glove. And I would add to that glove, issues of women’s sexual and reproductive health. Reproductive health requires a comprehensive approach, including contraception, family planning and, yes, access to legal, safe abortion.

MDG 4, the reduction of child mortality, and MDG 5, improving maternal health, cannot be accomplished without a strong commitment—and real action—on universal access to HIV prevention, treatment, care and support.

There is compelling evidence of increased risk of maternal death among women with HIV. For example, in South Africa from 2005-2007, the maternal mortality ratio was nearly 10 times higher in women known to be HIV positive. In 10 southern African countries, HIV causes up to one half of all maternal deaths.

Children born with HIV stand a 50% chance of dying before the age of two if they do not receive timely diagnosis and treatment. Prevention of mother-to-child transmission is therefore critical to reduce child mortality and effective programmes to do this on the ground translate into tens of thousands of infants’ lives saved every year. Evidence shows that timely administration of antiretroviral drugs to HIV-positive pregnant women significantly reduces the risk of HIV transmission to their babies.

Prevention of mother-to-child transmission is a proven, inexpensive, and effective intervention. Last year UNAIDS called for the virtual elimination of mother-to-child transmission of HIV by 2015. This is a concrete, achievable goal as mother-to-child transmission is almost entirely preventable where services are accessible. We have seen it happen in high-income countries and in countries such as Botswana, Namibia and Swaziland. We must convince all countries that protecting babies from HIV is an attainable goal that will reduce child mortality and reverse the spread of HIV.

Yet, there is still huge potential to further reduce child mortality. In 2008, an estimated 430,000 infants were infected with HIV through their mother – 90 per cent of them in Sub-saharan Africa. This could have been prevented.

On the positive side, global coverage of services for the prevention of mother-to-child transmission (PMTCT) increased from 10 to 45% between 2004 and 2008. Some 200,000 new infections among children have been prevented since 2001 as more HIV positive pregnant women have access to antiretroviral therapy. PMTCT programmes provide an excellent platform for integrated service delivery. HIV positive pregnant women and mothers would previously rarely access services catering to maternal, child and sexual and reproductive health and rights. The recent scale up of mother-to-child transmission programmes enables women to receive sexual and reproductive services at the facilities where they receive PMTCT services. AIDS programming is increasingly integrated with health planning, including the strategic use of AIDS resources to train and retain health workers. There are real synergies to be had here.

The AIDS response is also intertwined in each of the non-health MDGs as well. Reducing HIV infections and providing treatment to those infected so they can work, make a living and enjoy healthy, productive lives is tied into reducing poverty and hunger (MDG 1). At the same time, strategies to eradicate extreme poverty and promote food security mitigate the epidemic's impact by strengthening HIV prevention programmes and expanding antiretroviral therapy.

Universal education initiatives (MDG 2) are associated with delayed sexual debut in young women and reduced HIV risk behaviours among youth.

Women, the focus of MDG 3, now represent 60% of all people living with HIV in sub-Saharan Africa, due in large measure to their disempowerment and numerous social, legal and political disadvantages. Global efforts to promote gender equality play an essential role in reducing women's and girls' vulnerability to HIV infection. There is an inextricable link between gender, maternal health, child mortality and AIDS. A comprehensive approach to health must include eradication of gender inequalities, guaranteeing women's rights, elimination of violence against women and understanding of the power dynamics between women and men.

So where are we with the AIDS response today?

In fact, the global AIDS response is at a tipping point.

The 2010 G8 Summit was meant to be the year that the G8 could celebrate the achievement of universal access to HIV prevention, treatment, care and support. Yet, while four million people are now on treatment globally – a ten fold increase over a span of only five years - and new HIV infections worldwide have dropped by 17 per cent since 2001, HIV prevention services are only reaching a fraction of the people who need them. For every two people starting treatment, another five become infected with the virus. In fact over 7,400 people are newly infected with HIV every day, and almost 5,500 people die of AIDS every day. We have yet to break the trajectory of the epidemic.

The global crisis in public financing threatens the significant progress made in curbing the epidemic's spread. In countries like South Africa, Zambia and Tanzania, the economic crisis is affecting access to treatment. Where treatment is available, people living with HIV may not have enough food to be able to take antiretroviral drugs, or enough cash to take the bus to go to the clinic.

And as we welcome the World Health Organization's new treatment guidelines that recommend an earlier start to treatment which reduces rates of death and disease, we are reminded that our goals are more distant than we had believed—an estimated 15 million people need life-saving treatment. The goalposts have shifted and we are still far from extending treatment to all those that need it. The number of new infections continues to outpace our efforts to stop the spread of HIV. Nothing less than a quantum leap is needed to build on the progress made so far and extend hope to millions of people whose lives depend on it.

UNAIDS has estimated that universal access to prevention, treatment, care and support will cost some US $25 billion per year, but the current annual funds available for AIDS are some $15.6 billion (2008). Yet in this same world, countries spend a total of almost 1.5 trillion dollars on global military expenditures (2008).

What can the G8 do?

Let me start by acknowledging that the G8 has already done a lot – but much remains to be done.

The call for Universal Access came from the G8 in 2005 (and was reaffirmed by the UN General Assembly in 2006). It is imperative – in 2010, the year in which Universal Access was to be reached – that the G8 reaffirm its commitment to making Universal Access a reality – if not progress on maternal and child health will continue to be slow in many countries.

The G8 recognized in 2007 that achieving the goal of universal access for all and strengthening of health systems will require substantial resources. It committed to continue efforts to provide at least a projected US$ 60 billion from 2007 to 2010.

In 2008, the G8 created the G8 Health Experts Group to develop the Toyako Framework for Action on Global Health.

In 2009 existing commitments on global health were reaffirmed including universal access to HIV treatment by 2010. And the first G8 accountability framework was published, showing individual country progress against some key G8 commitments. The G8 tasked a Senior Level Working Group to produce a full G8 accountability review in 2010.

The G8, and the G20, have tremendous influence on positioning of global issues. It is therefore critical that these fora recognize that progress on each of the MDGs positively impacts the others. The G8 and G20 need to have an integrated approach to the MDGs.

As the host, the Prime Minister of Canada can set a bold agenda for the Summit.

The Summit provides an opportunity for Canada to demonstrate leadership by placing universal access squarely at the centre of the G8 agenda as a key vehicle for progress on maternal and child health. This is an excellent occasion to deliver on earlier G8 commitments and continue to reduce child mortality and improve maternal health.

Now is the opportunity for the G8 to make a clear pledge to ensure a fully funded Global Fund, which is critical to combat AIDS, malaria and tuberculosis. The G8 promised to ensure universal access to HIV treatment, yet the Fund lacks the financing to achieve that life-and-death goal. This is a key priority.

It is also time for the G8 to put in place a ‘real’ accountability mechanism – pledges of support by Heads of State in the context of the G8 don’t always translate into real or new funding, but it is vital to the G8’s credibility that commitments are honoured.

Under Canada’s leadership the G8 must acknowledge that commitments for Universal Access have not been lived up to and that this is a key parameter for the slow progress on maternal and child health.

How can you help?

One of the key strengths that the AIDS response has brought to the development table is its capacity to connect and mobilize a wide array of constituencies in the response. These

partnerships can serve as models for the types of response that will be required in adapting to other social and economic development challenges.

The countries and the communities that are most threatened must be at the core of all thinking and planning. In the case of AIDS, it was the most affected communities—represented by civil society—that were able to generate the social engagement that galvanized political support, increased financing, improved accountability and tailored specific responses.

We need a similar social engagement for the MDGs and the AIDS community must be ready to be part this movement to secure integrated approaches for progress on all MDGs. Collective success will require building a strong coalition that is inclusive of all stakeholders groups, including People Living with HIV.

Parliamentarians have a special role. The AIDS epidemic consistently places complicated demands on lawmakers because it links public health and human rights in a way that requires governments to achieve health, education, non-discrimination and gender equality for all those vulnerable to or living with HIV.

As representatives of the people, you reflect and give voice to the concerns of all people, including the marginalized. You can be the voice of the vulnerable. Some 84 countries have laws and regulations that present real obstacles for vulnerable sub-populations to access HIV prevention, treatment and care. Punitive laws that fuel stigma and discrimination are widespread: 49 countries have HIV-specific laws that criminalise HIV transmission or exposure; 86 countries have laws that prohibit homosexuality, with seven providing the death penalty for it; and numerous countries criminalise harm reduction measures in the context of drug use.

Many of you will be aware of a recent sad example of criminalisation of individuals based on their sexual orientation. Last week two men in Malawi were each sentenced to 14 years of imprisonment and hard labour. This is a setback for human rights and hampers HIV-related programmes. The effectiveness of the HIV response will depend not just on the sustained scale-up of HIV prevention, treatment and care, but on whether the legal and social environment supports or hinders programmes for those who are most vulnerable. Having the right legislation is essential to progress on the Millennium Development Goals.

As lawmakers, you can address stigma and discrimination for example by working with peers in other countries to eliminate HIV-related travel restrictions. It is egregious that 51 countries still have some form of HIV-specific restriction on entry, stay and residence. Such restrictions are outdated and do not protect public health. Canadian parliamentarians can

play a vital role in helping to remove unfair, discriminatory laws and restrictions by encouraging other countries to lift their bans.

As lawmakers, you can design, adopt and oversee the implementation of legislation that protects human rights and advances effective HIV programmes. You can unlock the political, legal and institutional barriers that increase people's vulnerability to infection and hinder people living with HIV from accessing the services that they need to survive.

As overseers of government activity, you can ensure that government commitments on HIV are respected.

And as overseers of budget appropriations, you can ensure that adequate funding is invested in activities that make a difference in people's lives.

As Canadians, you can help shape the agenda for the G8 and its work on AIDS this year. Interestingly, the number of people in the world living with HIV – 33 million people – is equal to the population of Canada. This year you are all in a position to exercise your global leadership as never before. The focus on maternal and child health represents a unique opportunity for Canada to demonstrate to the G8 how well this ties in with G8 commitments on AIDS. It also represents a unique opportunity to highlight to the G8 the importance of accountability and monitoring of progress on previous commitments.

Ultimately, this is about priorities and accountability. To achieve real progress on maternal and child health, an effective AIDS response must remain a priority. The AIDS response can only be effective if G8 commitments are honoured. Hopes rose from 2001 to 2003 when cheaper generic antiretroviral drugs became available, Secretary General Kofi Annan formed the Global Fund and the U.S. President initiated the President's Emergency Plan for AIDS Relief, or PEPFAR. Then, we were at a tipping point in the right direction. We need Canada's leadership in the G8 and G20 to ensure that we are not now at a tipping point in the wrong direction.

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Leveraging the AIDS response, UNAIDS works to build political action and to promote the rights all of people for better results for global health and development. Globally, it sets policy and is the source of HIV-related data. In countries, UNAIDS brings together the resources of the UNAIDS Secretariat and 10 UN system organizations for coordinated and accountable efforts to unite the world against AIDS.
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