MYTHS v FACTS
RE: Global AIDS Legislation (PEPFAR)

MYTH: Holding up an AIDS Bill is Inhumane

FACT: It's inhumane to let millions die so that we can feel good about passing a bill no matter what it contains. It's inhumane to eliminate the current priority on treatment – one of the key elements of PEPFAR's success to date. This AIDS bill would destroy the most humane foreign aid effort since the Marshall plan:

- The funding for this bill is increased over current levels by more than 300%, but only increases treatment targets by 50%.
- The goal is to reduce and/or eliminate the scourge of AIDS. The goal is to save lives. 33 million have it. Less than 2 million in developing world have access to drugs. 6-7 million need treatment, or they will be dead in 2 years. This is still an emergency.
- UNAIDS predicts that 23 million people will need treatment by 2013. If you take the cases from industrialized countries out of that figure, it's still almost as high, and if you just include the 15 focus countries, it's still well over the 7 million our bill calls for.
- A recent report found that the death rate among adults in rural Malawi has declined by 10 percent since the introduction of antiretroviral therapy, and in areas with the highest death rate, it may have declined by up to 35 percent. That's humane.[1]
- The current PEPFAR program isn't "broken," yet the House and Senate reauthorization bills radically reverse the good policy in current law, without any data or credible rationale that the good policies are no longer needed or working well.

MYTH: "We Can't Treat Our Way Out of This Epidemic"

FACT:

- **We have to walk and chew gum** – we must prevent future infections but we must respond to the desperate and dying TODAY.
    - Prevention efforts may prevent new infections, and therefore prevent FUTURE treatment need, but prevention efforts do nothing to abate the treatment need in the next 5 years, which is the time period the reauthorization bills address.
    - Treatment need is determined by numbers infected 5-10 years ago.
    - This argument is like going into a post-Katrina New Orleans and spending most of the relief funds on building better levies to prevent a future disaster rather than rescuing the people waving frantically on rooftops for help.
    - Obviously both need to be done, but no one would claim that it was somehow more HUMANE to focus more effort and funding on the future prevention than the immediate humanitarian disaster.

[1] Jahn A et al. *Population-level effect of HIV on adult mortality and early evidence of reversal after introduction of antiretroviral therapy in Malawi.* The Lancet 371: 1603-1611, 2008.

- **Treatment IS Prevention.** Treatment prevents new infections several ways:
    - It requires dramatic scale-up of diagnostic screening – meaning we will identify most infected people.
    - It will give us the opportunity to do education and prevention messaging with the people who are transmitting HIV rather than wasting money on mass media campaigns targeting mostly uninfected people. Nobody ever got HIV from someone who wasn't infected with HIV.
    - It identifies pregnant women with HIV so that their babies can be saved from infection.
    - It lowers viral load. There are quite a few studies out now showing that reduced viral load dramatically reduces the transmission of the virus.[2]

MYTH: Flexibility - "Earmarks" or "Allocations" dictating how much money has to be spent on a certain activity are too inflexible and don't allow countries to respond to their needs appropriately:

FACT:

- **The allocations are not country-specific**, they apply to the whole pot of money. If one country needs to spend less money on treatment, there are other countries where treatment is particularly expensive and can use the extra.
- Other donors such as the Global Fund can come in and fund other priorities for the country – the American people are committed to treatment being the priority for PEPFAR.
- Public health has taught us how to control infectious disease and it doesn't require flexibility. It requires a formula – find every case, treat every case, work with every case to find other cases and prevent transmission to new cases. This doesn't change no matter what the circumstances on the ground are.
- **This argument is disingenuous** – the other side only wants to eliminate the allocations that take money away from the USAID beltway bandits – those for treatment and abstinence, because those contractors don't do treatment or abstinence. The other allocations have been left in the bill, and in fact, new ones added in the House version. You can't simultaneously criticize allocations but add in new ones.

MYTH: Drug prices have gone down so we don't need to reserve as much for treatment costs anymore to meet our treatment targets.

FACT:

- If it's now cheaper than expected to meet targets, then we should raise our targets to save and treat more people. We only are treating a small fraction of people in need of treatment in the developing world.

[2] Vernazza P et al. *Les personnes séropositives ne souffrant d'aucune autre MST et suivant un traitment antirétroviral efficace ne transmettent pas le VIH par voie sexuelle.* Bulletin des médecins suisses 89 (5), 2008., and Quinn et al. 2008. *Viral load and sexual transmission of human immunodeficiency virus type* 1. NEJM 342: 921-9

- The Coburn/Burr/Kyl bill eliminated the requirement in current law to spend most of the treatment money on drugs, so as drug prices come down, money allocated for treatment can be spent on delivering drug to more people and saving more lives.

MYTH: Eliminating baby AIDS (as called for in the Coburn/Burr/Kyl bill) is unrealistic.

FACT:

- **Dramatic gains are seen** when universal testing of pregnant women and newborns is provided and appropriate prophylaxis of infections that are identified through that testing.
    - In states in the U.S. that have adopted this standard of care, new cases have been virtually eliminated.
    - In Botswana, a country that used to have HIV infection rates as high as 50% of child-bearing-aged women, they instituted these policies. Now 92% of pregnant women are being tested, and the drop in HIV+ mothers delivering infected babies dropped from 35% to 4% from 2004-2007, with 13,000 HIV-infected moms being identified annually.[3]
    - A recent study, the largest to date, just came out with findings that 99 percent of babies were born uninfected if an infected mother was diagnosed and proper treatment was administered.[4]
    - However, a World Health Organization report found that access to AIDS drugs is severely limited in developing countries, with fewer than 10 percent of pregnant women with HIV in those countries having access to medication.[5]
    - As a result, about 1,800 babies become infected with HIV each day.
- Prevention of mother-to-child-transmission (PMTCT) is cheap per life saved: Estimated cost of PMTCT drugs to support treatment of (1) mother/child pair is US$167 (generics) and US$318 (branded).[6]
- We haven't even come close to meeting the need in PEPFAR focus countries
    - Estimated 1.15 million pregnant women with HIV/AIDS living in PEPFAR countries.
    - In 2006 PEFFAR proved ARV Prophylaxis to only 294,000 (25.5%)[7].
- And now PEPFAR is expanding beyond the focus countries to other countries – the need just will keep growing:
    - Estimated 2.1 million pregnant women estimated to be living with HIV/AIDS in developing countries (1.7 million in sub-Saharan Africa –85%).
    - Of the estimated 2.3 million (1.7−3.5 million) children under the age of 15 years living with HIV, well over 90% are thought to have become infected through mother-to-child transmission.[8]

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[3] PEPFAR Annual 2008 Report, "The Power of Partnerships", p. 12

[4] Townsend et al. *Low rates of mother-to-child transmission of HIV following effective pregnancy interventions in the United Kingdom and Ireland, 2000-2006*. AIDS. 22(8):973-981, May 11, 2008.

[5] WHO/UNAIDS Progress on Global Access to HIV Antiretroviral Therapy: A Report on "3x5" and Beyond. March 2006.

[6] WHO/ AIDS Medicines Diagnostics Service (AMDS), PMTCT Forecasting Template

[7] PEPFAR Annual 2008 Report, "The Power of Partnerships",

[8] WHO/UNAIDS. Towards Universal Access: Scaling up priority HIV/AIDS interventions in the health sector Progress Report, April 2007