House Committee on Foreign Affairs

Testimony – PEPFAR: From Emergency to Sustainability and Advances Against HIV/AIDS

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25 million: number of people who have died of AIDS since 1981. That's three quarters of the total number of military deaths for the whole of the 20th century – taking place in a quarter of the time. The comparison is staggering, and highlights a sad truth: that the greatest political hindrance to overcoming disease is the convenient passivity of not overcoming it. We don't have to lift a gun or drop a bomb to kill 25,000 infants in a day, as preventable diseases do. All we have to do is nothing at all.

For as far back as scientific literature goes, this peculiar violence of apathy has, for the large part, characterized public health responses at various levels. From maternal mortality to tuberculosis to child health, United Nations institutions and prominent academics speak reproachfully of "disquieting stagnation", of "time bombs", of "inexcusable neglect" – all references to the political tradition of public health neglect that, despite all this criticism, more often than not is tacitly excused.

HIV bucked this tradition, due in part to the unprecedented devastation that it wreaked on health and socio-economic systems, as well as to persistent advocacy that generated major global initiatives to combat HIV – leading to the establishment of PEPFAR in 2003, which represented an unprecedented response by the United States to a global health problem. Peter Piot, the founder of UNAIDS, wrote at the time that

> *"[PEPFAR] changed the landscape… elevated AIDS issues to one of the big political themes of our time."*

In 2008, under the leadership of this committee, you renewed and enhanced that commitment with the Lantos-Hyde act, which strengthened our resolve to fight HIV in African countries. The Lantos Foundation recently stated, and I wholeheartedly agree, that:

> *"To some, scaling up HIV treatment and prevention is seen as a burden on the U.S. taxpayer. Instead, it should be seen as an investment that has already paid for itself many times over in goodwill towards our country and hope restored in African communities."*

There is no question that PEPFAR has greatly raised the standing of the US in Africa and rightly so – it remains an initiative for which millions of people across the continent, such as myself, are grateful. It is

thus critical to recognize that when we assess the value of PEPFAR, as well as other instruments in the global HIV response such as the Global Fund, we need to do so not only in terms of dollars, cents and public health statistics – but also in terms of their political impact.

The scale and scope of political will – and correspondingly, the resources – that have been mobilized for the fight against HIV reverberated across the world, bringing hope that world leaders were finally responding to the ancient news that human realities such as disease cannot bend to economics; and so sustainable development necessarily requires that economics bend to human realities, or break – as many in sub-Saharan Africa had begun to do due to AIDS. In high prevalence countries AIDS is estimated to decrease GDP by an average of 1.5% per year, and is cited by UNDP as having played a more significant role in the reversal of human development than any other single factor. This apparent realization by governments led us to the hope that if we were long-sighted enough to make the necessary investment, we could bend the epidemic curves and undo what was then a relentlessly bleak reality; ultimately achieving the dream of an HIV-free generation – and finally, an AIDS-free world.

Which brings us to where we are today: on the brink of a watershed decision for global health, balancing precariously between the good news and the bad news. The good news is that we are not fighting a losing battle – there is evidence we are bending the curves, that the once-elusive dream of an HIV-free generation is eminently achievable. The bad news is that without increased resources now, our chance to defeat HIV may slip from our grasp and the carnage of AIDS will return.

> **The dream of an AIDS-free world is now so concretely achievable that it comes with a concrete bill , and the concrete bill comes with many, many concrete zeroes – changing the critical question from "can we?" to "do we *want* to?" – and that is the watershed decision that rests in part in your hands today.**

Let us first briefly examine the key arguments for "can we?" In the past few months, we have heard some of the most encouraging news in the history of the HIV epidemic. Following on from the first-ever global decline in AIDS deaths in 2007, we now know that there is also a global decline in HIV incidence – a decline that is being led by sub-Saharan African countries, once the spiraling hotbed of the epidemic. We know that, in an incredible stroke of public health serendipity, treatment has turned out to be our most effective biomedical tool against the transmission of HIV: a US-funded study of over 3,000 sero-discordant couples that was released this year found a 92% reduction in HIV transmission associated with the use of ARVs.

Extrapolating on this, some experts have suggested that in the absence of a vaccine, immediate treatment of all people living with HIV is our best hope for eliminating the epidemic. Mathematical models

have demonstrated that universal access to treatment for all people with CD4s under 350 *(an evidence-based and WHO-recommended threshold for initiation that is currently disallowed by PEPFAR with the exception of pregnant women and people co-infected with TB)* would result in a 17% decrease in HIV transmission over three years in the South African context, achieving cost breakeven within the same period of time.

There is also an abundance of retrospective good news. PEPFAR's investments over the past 7 years have resulted in incredible gains not just for people living with HIV, but for health systems across the board. In Rwanda, where I worked with the Clinton Foundation on supply chain management systems in close partnership with PEPFAR implementers, this was clearly demonstrated through the PEPFAR-funded revamp of national drug management systems, which improved supply of ARVs as well as other medical commodities; ultimately leading to long-term health systems strengthening.

This systems-wide impact has not only been infrastructural, but is also extremely well-documented with regards to challenges posed by co-morbidities such as TB; and maternal and child health. Studies have shown that that the use of ARVs is associated with up to 80% decrease in TB incidence in high-prevalence countries.

HIV continues to be the leading cause of death in children under 5 in several southern African countries, as well as the major contributor to maternal mortality in high prevalence countries such as South Africa, where 43% of maternal deaths are due to HIV. A region-wide analysis of maternal mortality data that was published by the Lancet earlier this year described HIV as a "major source of paralysis in improving maternal mortality" in sub-Saharan Africa: making it clear that PEPFAR's contribution to treatment scale-up in sub-Saharan Africa, from which at least 1.7 million women and children in the region have benefitted, has had a substantial impact on reducing maternal and child mortality; and needs to be sustained and increased if we are to achieve millennium development goals 4 and 5.

Now is not the time to slacken our efforts. The AIDS emergency is not over – only one third of the universal access target has been reached – and the future of socio-economic development in sub-Saharan Africa depends to a large extent on sustained progress in the fight against HIV. Even in low-prevalence countries that are now held up by HIV funding critics as examples of over-investment in HIV – such as Rwanda, where HIV has been infamously pitted against diarrhea in recent global policy debates on funding priorities – data from public hospitals in the capital city of Kigali, prior to the introduction of ART showed that 94% of chronic diarrhea cases were HIV-related.

No health need has been overcome, or can be overcome, in isolation. We should not let progress in the fight against HIV erase the lessons of the past; nor distract us into complacency. Far from being

evidence-based, the political pitting of various health needs against each other in competition for scarce resources, as has happened increasingly in the policy arena over the past year often with an underlying resistance to increased HIV funding, is neither evidence-based nor constructive.

President Obama's announcement of a Global Health Initiative is welcome in its recognition of the need for a comprehensive package of health services – including maternal and child health, reproductive health, neglected tropical disease and others. However, the lack of a sufficient increase in funding to support this expansion suggests that fulfillment of this broader mandate will happen at the cost of HIV, TB and malaria programmes. This is irrational and self-defeating. While health priorities may exist separately in policy, in reality they co-exist within the same individuals. As emphasised in a statement issued by close to 100 civil society organizations from around the world in November 2009:

> *"HIV is not over-funded: rather, health is under-funded... Shifting funding from HIV will not fill the yawning gaps in resources for health – this move is a cheap diversionary tactic that offers no genuine or long-lasting solutions for health systems. What is required is a shift in political will to prioritize and invest vigorously in health. Until this happens, neglect and dysfunction will continue to pervade health systems irrespective of what specific health needs we focus upon."*

The slackening of efforts to scale up HIV treatment take us one step further from this vision of adequate prioritization of health by governments around the world. While the USG has not decreased its overall HIV-dedicated funding in absolute terms, it is not meeting the plan set out by this committee in the landmark Lantos Hyde Act; which set forth a groundbreaking visionary direction for the future of US global HIV funding. That vision would help set the world on the path to defeating HIV.

Unfortunately, the marginal increases in the PEPFAR budget – estimated to be 2% in 2010 – have barely been adequate to sustain treatment programmes given current inflation rates. PEPFAR reduced its budget for treatment for the first time in 2009, from $1.56 billion in 2008 to $1.4 billion in 2009. Additionally, the Global Fund allocation requested by President Obama for 2011 was US$50 million less than what was given last year – and at current levels approximating US$1,1 billion, still falls far short of the US$2 billion per year that was authorised in the Lantos-Hyde legislation.

Communities, however, are worried not about money for its own sake, but about the impact that these financing decisions has on lives saved. A leaked 2009 memo from PEPFAR to Ugandan implementers warned them to expect "Flat-lined budget for ARV procurement" and directed that new patients could only be enrolled with outside funding or when others died or were lost to follow up. This combined with other challenges wreaked havoc on treatment scale-up efforts in Uganda. We are told this has been reversed after significant attention, but we worry that Uganda is only the highest profile example.

In Mozambique, Doctors Without Borders (MSF) has reported increasing treatment migrants at many of its sites—and noted that PEPFAR announced it will reduce its ARV supplies by 10-15% each year over the next four years. In the DRC, MSF's analysis shows that the U.S. ceased the purchase of any drugs for Opportunisitc Infections or renewable laboratory supplies. Simultaneously other donors also pulled out of supporting treatment and the Global Fund had to pick up the slack, reducing scale up from 1,000 new patients accessing treatment per month to 2,000 per year: which represents an 83% decrease in scale-up rate.

These developments pose immediate as well as imminent threats to accessing HIV treatment, and cast doubt on the future of the HIV response and hence the stability of socio-economic systems, particularly in sub Saharan Africa. We appreciate that the US cannot do it alone – earlier this year Ambassador Goosby wrote in a letter to civil society organizations that:

> *"one country alone cannot respond to the unmet needs that are present, either globally or in any particular country. In certain countries, the PEPFAR investment represents something on the order of three-quarters of all funding for HIV/AIDS. That is not a sustainable situation, either for a particular country or for the program worldwide. Every country must take a leadership role, including providing resources to the extent of its ability."*

We could not agree more. According to the Kaiser Family Foundation, the U.S. contributes 27% of the global investment in HIV when contributions by national governments and by patients themselves are included. This shows the US has undoubtedly taken on a considerable leadership role – one that needs to be increasingly shared among all countries – but requires continued strong leadership in that direction; not evasion of pre-existing commitments.

Much like the establishment of PEPFAR changed the landscape of the global AIDS response in the direction of universal access, so the current slackening of US government financial commitment to HIV, rather than encouraging an invigorated response from other countries, is instead leading a regression back to the landscape where HIV was a death sentence because the price tag of life was deemed too high by governments. However, the longer-term price tag will be even greater. The World Bank warned in a 2009 report about the impact of the economic crisis on HIV that "responding to immediate fiscal pressure by reducing spending on HIV treatment and prevention will reverse recent gains and require costly offsetting measures over the longer term."

Even more disappointingly, this reduced spending on HIV comes at a time when the fight against AIDS is showing encouraging signs of success; and when advocacy to hold national governments accountable –

both for adequate investment in health as well as responsible usage of health funds – is rapidly gaining momentum. The extensive community networks and movements that have been created through the HIV response have presented extraordinary platforms for mobilization around the broader challenge of holding national governments accountable for their action on resource allocation for health, including HIV treatment; on optimal use of these resources through improved policy and programming; and on intensified efforts to fight corruption. Decreasing funding will contribute to dismantling these platforms and undo the momentum that has begun to build up – at a time when we need it most.

The issue of national ownership that has increasingly become prominent in talk of PEPFAR phase II, while it entails a valid challenge to national governments, also serves as a defensive refrain for dwindling funding if its implications are not scrutinized beneath the surface of the overarching rhetoric. While almost everyone would likely support the essential concept of national ownership, it does not justify abdication of responsibility to uphold prior commitments; and further, it is requires a carefully and inclusively thought-out process, not a simple policy decision based on which substantial budget changes can reasonably be made, and support withdrawn. We would do well to reflect back on the United Nations Millennium Declaration (2000), in which heads of States and governments acknowledged that:

> *"in addition to [their] separate responsibilities to [their] individual societies, [they] have a collective responsibility to uphold the principles of human dignity, equality and equity at the global level"*

Yesterday, Tuesday the 28th of September, HIV NGOs mobilized civil society in a dozen countries across the African region to unite in a day of action for increased health funding; and through demonstrations, press conferences and public meetings called on global leaders to fully replenish the GF, and on AFrcan governments to meet the 2001 Abuja pledge to spend at least 15% of their national budgets on health. Some took action even in the context of repressive political circumstances, as in Swaziland where a memorandum was delivered, through a mass march, to the Ministry of Finance and the European Commission but unfortunately, was refused by the American embassy. Activists took this action recognizing that addressing the potentially devastating impact of a weakening HIV response necessitates courageous action even in adverse circumstances, and I call on you today to do the same.

This call is not directed at the US government alone: over the past few months, civil society organizations across the world have targeted Global Fund donors from several countries including Italy, Germany, France, UK and Japan – to name a few. In the African region, ARASA and others have led the mobilization of civil society organizations under the banner of the slogan "we are watching" – a slogan that symbolizes our commitment to sustained scrutiny of government budgets to ensure responsible allocation to health, tracking of expenditure, and improved transparency and accountability. This advocacy, although young, has already began to pay off in countries around the region – in Kenya, the

2010/2011 budget for HIV treatment doubled compared to previous years; in South Africa, the HIV budget increased by 33% over the past year. An increasing number of private African enterprises, such as Access Bank, have begun to make pledges to the Global Fund.

Our governments are beginning to realize themselves that increased investment in health is a socio-economic necessity – the IMF reported in April 2010 that African countries had sustained social spending, particularly on health and education, despite the economic recession – and further, that this social spending contributed significantly to cushioning the blow of the recession on countries in the region, ultimately allowing for better overall economic recovery. However, we still have a long way to go, and we are committed to intensifying our advocacy in the months to come: yesterday's day of multiple-country action merely was a starting point.

It is interesting to note that income status of countries in the African region is not the key predictor of their allocation to health budgets. Some of the best performing countries with regards to health expenditure in the region – such as Rwanda, Malawi, Tanzania – are also among the poorest. Some of the worst performing countries on health expenditure are among the richest. But regardless of geography and demography – the need for health, life, and human dignity remains the same, and the struggle for universal access to HIV services is ultimately about the fight for universal recognition and prioritization of these needs.

It is, quite simply, a question of political prioritization. We have heard from governments that there is restricted money for health and particularly, universal access to HIV treatment, in these times of economic difficulty. We hear these words with a sense of outrage and ironic bewilderment, coming as they do from the podiums of lavish conferences whose bills cost far more than the development funding pledges that emanate from these expensive discussions. People of the world are scrambling for crumbs from the high table, while more and more loaves are put aside for military expenditure, for corporate interests, for political extravagance, for the global web of complicity on corruption – for let us be honest: no corrupt man or woman is an island – be they in Uganda, Switzerland, or the United States of America.

We see billions and billions being wasted on these things that do nothing to advance human development, and are forced to ask ourselves how our priorities have become so skewed that we are willing to spend more on talking than we are on doing – the G8 summit this year cost more than the pledges that it generated for maternal and child health; willing to spend more on breaking down than we are on building up – expenditure on wars never seems to be diminished by economic crises; willing to

spend more on cushioning the rich than we are on supporting the poor. There is a striking and inevitably self-destructive obscenity in this.

I want to end this testimony with an optimistic outlook, but I cannot do so without acknowledging the pessimistic prognosis of the current approach to public health by most governments around the world, as has been demonstrated by the retreat from HIV funding. I do this because in order to make real, lasting progress we have to recognize that the real crises that we face are not of economics or microbes, but of priorities. I referred to this earlier as the peculiar violence of apathy, the death of millions of people annually that are very easily accomplished simply by us doing nothing at all.

When the Lantos-Hyde Act was passed in 2008, reauthorizing PEPFAR and the US contribution to the Global Fund, you took a very definitive landmark step away from that apathy; giving people living with HIV all around the world and their communities great hope that finally, a lasting precedent had been set for an energized global response to HIV, which would influence responses to other health needs as well. This impact has already been witnessed. AIDS programs have been not only the most effective public health programs of our time, but a hugely significant political tool. As has been shared by witnesses at this hearing, with adequate resources we stand to win on the public health front; but we also stand to make great strides on the political front and can continue to move the world in the right direction so as to ultimately overcome this epidemic. With adequate investment now, AIDS could be history in a few decades, making it the greatest public health success story of our time – but with inadequate investment, it could be a historical lesson in the danger of making decisions based on short-term fiscal convenience rather than on long-term socio-economic rationale. The choice between these two outcomes is not beyond our control – it is a choice.

Next week, donors will meet in New York to decide the fate of the Global Fund and the U.S. could transform the replenishment with the promise of a bold, 3-year pledge at the levels authorized by Lantos-Hyde, of up to US$2 billion per year. I have travelled here today to urge you to help make this happen and thus send the strong, trend-setting signal that the U.S. is committed to making history by winning the fight against AIDS. And as you move towards a more long-term strategy for PEPFAR, it is my hope that you will recognize that sustainability cannot be achieved by relaxation, but rather by intensification, of efforts – because while this might cost us more today, it will save us much more tomorrow – and that is true sustainable development. I hope that you will make a decision for tomorrow.