

HIV and AIDS

Background

HIV/AIDS remains among the most devastating infectious diseases the world has ever known—continuing to ravage the health workforce, the military, mothers, and young children in the global South. The emergency is far from over, yet attention seems to be flagging.

The response to HIV/AIDS has driven a new approach to global health and development that emphasizes accountability, adequate resources, community engagement, attention to the needs of the most vulnerable groups as well as the general population, and a sense of urgency in demonstrating impact. HIV/AIDS services through PEPFAR have had wide-ranging benefits for general health services, demonstrating that programs focused on the most deadly infectious diseases can serve as a platform from which to strengthen overall health systems, yielding broad results.

U.S. investment in HIV/AIDS has saved an estimated 1 million lives through bilateral programs and millions more through the Global Fund to Fight AIDS, Tuberculosis, and Malaria. Clear and encouraging outcomes are being seen at a population level: rebounds in life expectancy, reduced overall adult mortality,¹ reduced infant and maternal mortality,² and a positive impact on HIV incidence³ and other diseases, including reduced incidence of TB⁴ and sexually transmitted infections (STIs).⁵

Nonetheless, HIV/AIDS continues to be a leading cause of preventable death in many nations. AIDS treatment, care, and prevention remain a development and security imperative when a third to a half of the nurses, teachers, and soldiers in countries like Uganda, Democratic Republic of Congo, Botswana, and South Africa are HIV positive. New studies identify HIV as a leading cause of maternal death. In Zimbabwe, for example, HIV is the culprit in one of every four maternal deaths⁶ while in South Africa the figure is half.⁷ In one Johannesburg study, only two of the 108 maternal deaths examined had access to antiretroviral drugs that could have saved their lives.⁸ There remain important opportunities for PEPFAR to expand treatment and scale up prevention programming to reverse findings of the Government Accountability Office (GAO) that PEPFAR has had a minimum impact on HIV prevention.⁹

Recognizing the continued urgency, President Obama made a campaign pledge of \$50 billion for AIDS over 5 years and the full U.S. fair share of the Global Fund, a pledge joined by then-Senators Clinton and Biden.¹⁰

Taking Our Foot Off The Gas?

Our Work is far From Complete

With PEPFAR and Global Fund support flat-lined in 2009, and the global financial crisis undermining the fight against AIDS, plans to expand treatment and prevention efforts are stagnating—with countries including Tanzania, Uganda, Swaziland, South Africa, and Botswana pulling back planned services.¹¹ Some AIDS service providers have reported that, because of financial limitations, they have been forced to scale back services, ration care, or cease initiating new patients on treatment.¹² A recent World Bank report estimates that treatment for over 1.7 million people could be at risk by year's end.¹³

In 2005 the U.S. joined the world in promising Universal Access to AIDS treatment, care and prevention by 2010. Yet, today **the majority** of adults in immediate need of treatment *still lack access* and the majority of HIV-positive pregnant women go without treatment that would prevent mother to child

transmission.¹⁴ Experts suggest **well below half** of people in the global South **have the information and tools they need to prevent infection**; men who have sex with men, sex workers, and IV drug users have even less access to those services. The unmet need amongst children is even greater: only **38% of children** in need **currently access treatment**¹⁵ and only a tiny fraction of children born to HIV-positive mothers are tested.¹⁶

Now is the Time for Renewed Commitment

The Global Health Initiative presents a crucial opportunity for the current Administration. The Administration must recommit to universal access goals, while using HIV programs as a platform for the delivery of other vital health services and building on the bipartisan commitments established through the Lantos-Hyde Act passed in 2008.

Positive Synergies Between HIV funding and Maternal, Reproductive, Child, and Primary Healthcare

HIV/AIDS programs *are* an important maternal, child, reproductive, and primary healthcare intervention. Increases in HIV services in Uganda, Botswana, and South Africa were accompanied by decreases in infant and child mortality of as much as 83%, as parents not only lived but thrived.¹⁷ A study in South Africa, meanwhile, showed a 75% reduction in tuberculosis after anti-retroviral therapy was rolled out.¹⁸ Women being treated for HIV are more likely to access antenatal care, deliver children in healthcare settings, and access vaccination.¹⁹ Clearly HIV programming is not enough; testing programs, prevention of mother-to-child transmission, and wrap-around services depend on a strong underlying health system. Supporting people living with HIV must necessarily include improved maternal, child, reproductive, and primary care health programs for success.

The new Global Health Initiative should continue to expand successful HIV/AIDS programs to provide lifesaving treatment, care, and prevention, while simultaneously using HIV/AIDS infrastructure as an opportunity to build out other direct services, such as maternal and reproductive health and nutrition programs. Additionally, the US must also separately increase support to ensure a move toward universal, comprehensive primary health care.

Targets

The U.S. should live up to its HIV treatment, care, and prevention pledges and targets to support, by 2013:

- Putting 6 million people on HIV/AIDS treatment;²⁰
- Preventing 12 million new HIV cases;
- Supporting care for 12 million people including 5 million orphans/vulnerable children;
- Training and retaining at least 140,000 new professional health care workers; and
- As a six, rather than five-year strategy, the GHI should reflect increases for 2014.

Costs

Last year, then-Senators Obama, Clinton, and Biden joined a bipartisan group of lawmakers in co-sponsoring the Lantos-Hyde Act, which re-authorized U.S. HIV/AIDS, TB, and malaria programs and set the targets listed above and the funding levels needed to reach them. In order to reach the global goal of universal access, UNAIDS estimates that approximately \$172 billion will be needed in the six years covered in the Obama Global Health Initiative. The U.S. should lead the world by giving the previously pledged one-third, or \$57

billion, of this total need. Congress provided the authorization to reach this level of funding through the passage of the Lantos-Hyde Act, and President Obama’s campaign pledge to increase global AIDS funding by \$1 billion per year was also consistent with funding needs.²¹

Table 1 below reflects fulfillment of the Lantos-Hyde Act authorization of \$48 billion in total over five years, from 2009 to 2013, including \$39 billion for HIV/AIDS. Since the Administration added an additional year to the GHI, 2014 levels are included for a total of \$50 billion for HIV/AIDS.

Table 1: Yearly Appropriations to Reach Lantos-Hyde Act Authorization Levels (US \$Billions)						
	FY09 Enacted	FY10 Assumed	FY11	FY12	FY13	FY14
Bilateral (PEPFAR, not including HIV or non-PEPFAR TB)	5.028	5.128	7	8.2	9.5	10
Global Fund	0.9	1.05	2	2.25	2.5	2.75
Global Fund Portion to HIV (50%)	0.45	0.525	1	1.125	1.25	1.375
AIDS Total	5.478	5.653	8	9.325	10.75	11.375
HIV/AIDS Total						
5-Year TOTAL	\$39 B					
6-Year TOTAL	\$50 B					

Despite campaign pledges of \$50 billion for global AIDS, the FY2010 budget put global AIDS funding far below these levels and as a result, significant “catch-up” will be needed in FY2011. These budget numbers make the difference between clinics halting prevention and treatment scale up or continuing bold growth as promised. These funding levels are specific to HIV/AIDS needs and do not include TB or Malaria specific needs.

Needed Policy Changes: HIV and AIDS

In addition to increased funding to ensure continued scale up, a key set of policy changes are needed to ensure that U.S. global AIDS programs and the Global Health Initiative can be most effective:

Support Multilateralism & the Global Fund

- A key partner to bilateral programs, the Global Fund to Fight AIDS, Tuberculosis, and Malaria has proven one of the most effective and transformative development initiatives in existence—demonstrating transparency, collaborative country-driven programming, and results-based funding that U.S. programs should model. The U.S. should lead the world in supporting the Global Fund—increasing U.S. funding while encouraging other nations to follow suit.

Support Evidence-Based Programs

- The administration should launch a full review of its prevention

portfolio to be completed within three months and *eliminate funding for programs not based on sound evidence*, such as abstinence-only programs. It must also lift the policy barriers to proven health interventions such as syringe exchange.

Promote Integration

- Encourage program implementers to bring together funding streams to provide a range of interrelated services in single locations.

Invest in Health Workforce to Strengthen Health Systems

- PEPFAR should play a leading role in increasing the number of doctors, nurses, and midwives—ensuring that the 140,000 new health workers envisioned in Lantos-Hyde are in fact new workers who can be leveraged for broader health outcomes.

Provide Transparency

- PEPFAR and all U.S. programs should make public all contracts, program evaluations, and planning documents via the internet.

Drive Down Commodity Prices

- PEPFAR should fully embrace transparent, competitive bidding for health commodities and make use of bulk purchasing power to drive down prices. Supporting the development of local generic production capacity in Africa and crafting strategies to drive down the cost of 2nd and 3rd line ARVs will be essential.

Utilize Local Capacity & Public Sector

- Wherever possible, U.S. global AIDS programs should make use of local NGOs and public sector partners in ways that strengthen the overall health system. Where local and public systems do not possess capacity to provide lifesaving treatment and prevention services, specific strategies should be implemented to build such capacity.

Re-Emphasize TB-HIV Integrated Care

- Tuberculosis is the most common AIDS-defining illness and the leading cause of death among persons with HIV in the developing world. Though PEPFAR has been a leader in this area, more must be done. In every PEPFAR-supported clinic, continued funding should be based on making TB screening routine, infection control strong, and ensuring those who receive positive HIV tests in TB settings are actually linked to HIV treatment.