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Subcommittee on Africa and Global Health

"U.S. Investments in HIV/AIDS: Opportunities and Challenges Ahead"

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Chairman Payne, Ranking Member Smith, and distinguished members of the subcommittee: thank you for inviting me to discuss the opportunities and challenges ahead for U.S. investments in HIV/AIDS programs.

The results of these investments to-date have been remarkable, and were simply unthinkable only a few short years ago. PEPFAR has provided live-saving anti-retroviral treatment to 2.4 million people, and the Global Fund to Fight AIDS, TB and Malaria has supported treatment for an estimated 2.5 million.

The House Foreign Affairs Committee – and in particular members of this subcommittee – have been instrumental in crafting and supporting our response to the pandemic through the original authorizing legislation for the U.S. AIDS initiative and through leadership and oversight in its implementation. In 2008 Congress voted overwhelming to sustain and accelerate this progress. In fact, it was exactly two years ago yesterday that the Foreign Affairs Committee reported out the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act, which authorized $48 billion over five years to build on what has been achieved and ramp up the fight against these three diseases.

Despite this clear, bipartisan mandate, there is a significant gap between the vision expressed in Lantos-Hyde Act and its realization expressed in the President's Fiscal Year 2011 budget request and the Global Health Initiative. We have a tremendous opportunity to build on our momentum, but our achievements are in jeopardy unless we act.

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Funding Shortfalls

I would like to briefly review the funding situation we currently face before turning to important opportunities to increase the impact of our response.

The Administration's budget suggests a new approach to our global health portfolio in which U.S. funding supports a response to AIDS that is more closely linked to other health priorities. This is a welcome sentiment, but the evidence shows that this approach only works when programs are fully funded. Smart linkages between programs are not free. This approach – to broaden the set of priorities on which we focus without necessarily adequately funding any of them – could have serious consequences for people living with or at high risk of contracting HIV.

The President's Fiscal Year 2011 budget request essentially flat funds our global AIDS programs. The budget includes an additional $141 million or 2 percent increase in bilateral AIDS funding – this in the face of 7 to 10 percent inflation in Africa. If we were on pace to reach the Lantos-Hyde authorization

levels, the request this year for global AIDS should be $2.2 billion more.

The budget also proposes a $50 million cut to the highly effective Global Fund to Fight AIDS, TB and Malaria at the very time when the Global Fund's impact is accelerating, and a miniscule $5 million increase for bilateral TB, the leading killer of people with HIV/AIDS. As I will discuss in further detail, under-funding these initiatives will prohibit us from seizing major opportunities in our global AIDS response, and undermine efforts to cut deaths due to TB and malaria as well.

My colleagues on this panel are better equipped to discuss the impact on the ground of halting the scale-up of HIV/AIDS funding, but I share their concern that our departure from the vision of the Lantos-Hyde Act will leave too many waiting in line for treatment, prevention and care.

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When there are such yawning gaps in access to health services in the developing world, there is no shortage of opportunity to make significant, life-saving impact. I would like to highlight three opportunities to dramatically reduce the burden of HIV/AIDS and fundamentally alter the course of the epidemic in the coming years.

Treatment as Prevention

The first opportunity is to continue to scale up treatment – not just as a medical and human rights imperative, but as a public health strategy for reducing transmission of HIV. There is a growing body of evidence that widespread access to early treatment is an essential component of a comprehensive prevention strategy.

ARV drugs can help prevent HIV transmission by dramatically reducing the viral load in an infected person. The public health potential of this biological fact was re-confirmed in a study released last month. Across seven African countries, researchers closely monitored 3,400 "discordant" couples – couples where one partner is HIV positive and the other negative. Where the positive partner was on AIDS treatment, there was a 92 percent reduced risk of infection for the discordant partnerships. In South Africa researchers are using modeling techniques to investigate the potential impact of "test and treat" strategies, which involve widespread testing and early initiation of anti-retroviral treatment. The models suggest that this strategy, if combined with smart combination prevention, could effectively halt transmission of HIV in five to ten years. Certainly more work needs to be done, but the implications are enormous. And if this seems utopian or unachievable, recall that it was less than a decade ago that we were counting the number of people in Africa on ARVs in thousands rather than millions.

Some policy makers have expressed concern about a "treatment mortgage" and the long term cost implications of AIDS treatment. What this new data shows us is that we have a stark choice. We can invest up front in achieving the promise we made to reach universal access to AIDS medicine and break the back of the epidemic. WHO estimates show that within five years, the costs would then begin to fall, becoming manageable for countries in the medium term. Or we can do half-measures, in which case the epidemic will continue to grow and the costs will rise without end as millions of the most productive members of Africa's economy die each year.

"Treatment vs. prevention" is not just a false dichotomy, but a dangerous one. We must certainly expand an array of effective prevention strategies. And we must also continue to scale up AIDS treatment, not only as an urgent lifesaving medical intervention, but as an essential public health

strategy to prevent transmission.

TB-HIV

Another critical opportunity to accelerate our progress in fighting AIDS is to fight tuberculosis – the leading killer of people with HIV/AIDS. Despite being the leading killer, globally less than 4 percent of people with HIV/AIDS are screened for TB. People on anti-retroviral treatment are still dying for lack of $20 worth of TB drugs. Scaling up our investment in TB is *the* low hanging fruit opportunity to save lives, and we have yet to seize it.

TB preys on those whose immune systems have been compromised by HIV. In some sub-Saharan African countries, the proportion of TB patients living with HIV can exceed 50 percent. TB transmission and the progression from latent to active disease are dangerously accelerated in people living with HIV/AIDS, which is why sub-Saharan Africa has the highest rates of TB in the world. People living with AIDS who develop active TB will die in a matter of weeks without effective treatment, making routine screening for TB, rapid treatment, and infection control urgent priorities. This deadly synergy of TB and HIV threatens to undermine our progress in fighting both diseases.

As the U.S. pursues a global health strategy centered on women and girls, TB control must be strengthened. TB is the third leading killer of adult women on the planet, and women who develop the disease are more likely to die from it than men. The risk of premature birth or having a low birth weight baby doubles for women with TB, and those who receive a late diagnosis are four times as likely to die in childbirth.

With inadequate investment in TB control and decades of neglect of research and development for new and better TB tools, multi-drug resistant (MDR) and extensively drug resistant (XDR) TB have emerged. They demonstrate that we are steadily and surely manufacturing more deadly, difficult and costly strains of this airborne infectious disease. And now the first cases of XXDR or extremely drug resistant TB suggest we are on the way to creating forms of the disease that are completely untreatable. This is a public health failure of the first order.

The deadly synergy of TB and HIV is nowhere more evident than with XDR. In the first reported cases of XDR-TB in Tugela Ferry in South Africa, 52 out of 53 patients died and a number of the first cases were transmitted in a support group for people on anti-retrovirals. As the South African experience shows, drug-resistant TB threatens HIV/AIDS progress and threatens public health overall, including here at home. The Department of Homeland Security has identified XDR-TB as an “emerging threat to the homeland.”

PEPFAR has been a leader in driving an integrated response to the TB and HIV co-epidemic in sub-Saharan Africa, with strong policies and a TB-HIV budget line that increased from virtually nothing in PEPFAR’s first year to $140 million in FY08. But TB-HIV activities make up only 4.3 percent of PEPFAR’s operating budget, which is simply too little to ensure that PEPFAR meets the basic standards of care for diagnosing and treating co-infection in the programs it supports. To emphasize, this is *the leading killer of people with HIV* in PEPFAR focus countries. Despite successful pilot efforts, PEPFAR has so far failed to take TB-HIV efforts to scale. And now, despite PEPFAR’s commitment to continue expanding its delivery of TB-HIV services, OGAC has proposed flat funding these activities in the next fiscal year. We can’t afford to slow down in this area. We need to build on PEPFAR’s successes to date and take the prevention and treatment of TB-HIV to scale.

Despite some promise within PEPFAR, our investment in bilateral USAID TB programs outside of PEPFAR is grossly insufficient to leverage our investment in HIV/AIDS. Unfortunately, TB is where the President's proposed Global Health Initiative departs most dramatically from the Lantos-Hyde Act. The GHI consultation document proposes TB treatment targets that are inexplicably well below what is mandated in the bill. The President's budget requests $230 million for TB in FY11 – a $5 million increase – well short of a path to reach the five-year $4 billion authorization in the bill and provide investment commensurate with the scale of devastation of this disease.

As a killer of 1.8 million people every year, TB warrants increased investment on its own. And as the leading killer of people with HIV/AIDS, TB control should be an integral part of our AIDS response.

Global Fund to Fight AIDS, Tuberculosis and Malaria

Third and finally, we have a tremendous opportunity to accelerate our global health efforts by increasing our support for the Global Fund to Fight AIDS, TB and Malaria. I am honored to serve as the Northern Civil Society Delegate to the Global Fund Board, and proud of the annual Results Report released by the Fund just this week. This report should be required reading for any policy maker involved in shaping our global health strategy. I believe the Global Fund is *the most effective tool we have* in the fight against HIV/AIDS, TB and malaria.

This Committee should be justifiably proud of the Global Fund's impact, having helped shape its creation and evolution. Since its inception just eight short years ago, the Global Fund has supported 2.5 million people on anti-retroviral treatment, 6 million treatments for TB, and the distribution of 104 million bednets to prevent malaria and some 108 million malaria treatments. The impact of the Fund has gone well beyond Millennium Development Goal 6 to reverse AIDS, TB and malaria, and extends to Goals 4 and 5 on child and maternal health by addressing the biggest killers of women and children. In Africa, AIDS, TB and malaria account for over half of all deaths of women of reproductive age, and malaria alone accounts for up to 18 percent of child deaths. The Global Fund has also provided 790,000 HIV-positive pregnant women with treatment to prevent vertical transmission of HIV to their children.

The Global Fund's impact has been truly global, with investments in programs and efforts catalyzed in 144 countries. These efforts have saved 4.9 million lives – and this is only the beginning. The coming years will bring more results more quickly as half of total disbursements by the Global Fund have been made within the last two years. The full return on our investment has yet to be realized.

The success of the Fund is not just what's been achieved, but in *how* it's been achieved. On a broad range of best practices – transparency, accountability, performance-based financing, country-led development – the Global Fund is on the cutting edge of translating aid effectiveness theory into practice.

Congress is rightfully concerned with stretching our limited foreign aid resources. Every dollar we contribute to the Global Fund goes to support programs in country, and the operating expenses of the Secretariat are covered by the interest earned on contributions. By relentlessly focusing on value for money at all levels – management, implementation, and procurement – the Global Fund has identified $1 billion in efficiency savings. Here's one example. Global Fund programs are required to procure commodities through a competitive process, and then report price information on key products like anti-retroviral drugs and bednets to a publicly accessible database. This information facilitates cost comparisons, and gives leverage to other programs to negotiate lower prices.

Responding to country demand, the Global Fund has provided resources to strengthen national health systems as countries respond to AIDS, TB and malaria. Sixteen percent of Global Fund financing has gone to health system strengthening priorities like improving supply chain management and increasing the capacity for monitoring and evaluation.

In an effort to strengthen primary health care through investments in HIV/AIDS and malaria, Ethiopia has trained and deployed over 30,000 community health workers. The result is not only an astounding scale of up AIDS treatment, but rapid improvements in broader maternal and child health indicators. Between 2005 and 2008 – just three years – measles immunization rates have increased from 61 to 77 percent, and births attended by a health professional have jumped from 13 to 25 percent.

The Global Fund's flexible but targeted support for Ethiopia is enabled by a country-led approach. For the Fund, "country" means much more than just the central government. In fact, diverse civil society participation in proposal development is a prerequisite for Global Fund grant approval. This process results in funding disbursements that strengthens civil society voices and seeks to reflect who's actually delivering health services on the ground. Thirty-six percent of Global Fund grants are distributed to non-governmental organizations who are using these funds to take community based programs to a massive scale. For example, the Churches Health Association of Zambia (CHAZ), a network of faith-based organizations and a primary recipient of Global Fund financing, provides half of all rural health care services in Zambia.

2010 will be critical in determining if the Global Fund will be allowed to accelerate its successful efforts or be forced to curb its growth – with dire consequences for AIDS, and TB and malaria. This year other donors will make three-year funding commitments as part of the Global Fund's once-every-three-year replenishment conference. While the U.S. has not historically made a formal multi-year replenishment pledge, as the largest contributor to the Global Fund our FY11 allocation will send an important signal to other donors. Flat or reduced funding will exert no leverage on other countries to increase their contributions, and might even trigger a downward spiral. Increased funding from the U.S. could change the course of the replenishment. The President's proposed $50 million cut is alarming in light of its potential multi-year impact on other donor countries' commitments, and would leave the U.S. well behind the $1.75 billion that constitutes our fair share this fiscal year.

Here's what's at stake. The Global Fund estimates that to maximize its impact on achieving Millennium Development Goal 6 and other international health targets, it will need to meet $20 billion in demand for quality proposals over the next three years, including both scaled up efforts and continued support for successful programs. With this investment the Fund estimates that by 2015 we could virtually eliminate vertical (or so-called “mother-to-child”) transmission of HIV, eliminate malaria as a public health threat in many endemic countries, and contain the spread of multi-drug resistant TB. These are audacious goals, but they are worthy of our support and achievable if we are willing to make the right investments.

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It is sometimes difficult to articulate how profoundly U.S. investments in HIV AIDS have affected the lives of millions of people. The numbers never quite tell the whole story. In trying to capture the impact of our efforts, one of the better stories comes from my friend Winstone Zulu, a TB and AIDS activist from Zambia. Winstone was the first person to go public with his HIV status in Zambia and he lost all four of his brothers to TB.

When asked about the impact of U.S. investments in AIDS and TB, Winstone told me that these days when he visits a village, if he doesn't see a friend or family member around, he won’t hesitate to ask where they are. Happily, the news is often they’ve gone off to work somewhere in another town, they’re off at school, or away visiting relatives. Ten years ago, he says you never asked that question because if a friend was absent, it was nearly certain that they had passed away from AIDS.

Our investments have done more than deliver drugs and diagnostics, more than shift our perception of how we can deliver health services in resource poor settings. This is nothing short of the transformation of despair into hope, and in an astonishingly short period of time.

Congress has the opportunity to work with Administration to solidify and accelerate this transformation. I am grateful for the leadership of members of this committee to work toward this goal, and I look forward to your questions.