

U.S. Global AIDS Initiative, Round 2: From Emergency to Sustainability (*including future cost estimates*)

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In 2003, President George W. Bush made a historic commitment of \$15 billion over five years to fight HIV/AIDS in impoverished nations. With Congressional support, the United States pledged to support treatment for two million people with HIV in 15 “focus countries” by 2008 and prevent seven million new infections through the “President’s Emergency Plan for AIDS Relief” or PEPFAR.



The first five years of the program will draw to a close with the Bush White House, and the United States is currently on track to have contributed \$18-19 billion before this program expires. The current President will soon announce to Congress, public and G8 leaders his priorities for the second phase of PEPFAR.

Leading AIDS organizations have developed a detailed series of recommendations to advise and assist policy makers involved in determining the goals and guidelines of the successor to PEPFAR. This short paper is a summary of some of the key findings.

MAJOR RECOMMENDATIONS

1. **Financing: The next U.S. President will need to commit to \$45 billion to fight AIDS during his or her first term, between FY 2010-2013.**¹ This sum includes:

- A. \$28 b. for Focus Countries. This amount will sustain current support for 33% of people on anti-AIDS treatment worldwide while supporting the U.S. commitment to universal access in PEPFAR Focus Countries;
- B. \$5.5 b. to sustain existing non-Focus Country programs, many of which are countries with burgeoning epidemics that have been neglected under during the previous five years;
- C. \$6 b. The minimum U.S. share of funding for the Global Fund to fight AIDS, TB and Malaria;
- D. \$5.5 b. to fund the U.S. share of a new initiative to train and retain sufficient numbers of health workers and strengthen local health systems so that countries can deliver essential health services and to enable U.S.-supported AIDS and health programs to succeed.

2. **Treatment:**

A. **TARGETS: To sustain the current 33% figure of people supported on treatment by PEPFAR and to keep existing promises to support universal access, the next phase of U.S. global AIDS initiatives will need to more than double the number of people supported on treatment during the term of the next President from two million to at least four million**².

B. **BARRIERS TO GENERIC DRUGS:**

- I. **U.S. trade agreements will need to safeguard the rights of developing countries** to bypass patents and data protection and to promote generic competition when necessary to meet public health needs. This will require rolling back provisions of some current free-trade agreements which expanded drug company protection while limiting poor countries ability to introduce affordable generics.
- II. **Discard the costly and duplicative FDA "tentative approval" process** and permit developing countries to use generic medicines that are quality assured by the internationally accepted WHO Drug Prequalification program.

3. **Prevention: EVIDENCE-BASED PROGRAMS**

A. **COMPREHENSIVE, EVIDENCE-DRIVEN PREVENTION: Strike the abstinence-until-marriage earmark** to allow flexibility and to ensure that programs provide comprehensive messages, skills, tools, and services. **Revise the current guidance for prevention of sexual transmission to encourage comprehensive programming** for all individuals instead of arbitrary measures of “at-risk” populations. **Strike the “prostitution pledge”:** According to field research and the testimony from implementing organizations, requiring agencies to pledge to oppose sex work is undermining effective public health programs.

B. **OUTCOMES:** Evaluate abstinence, faithfulness, and condom use for prevention **outcomes**, rather than as stand-alone targets;

C. **CONDOMS:** Remove restrictions on condom access, and **increase funding for both male and female condom procurement and the programs required to ensure effective and consistent use.**

D. **INJECTION DRUG USE: Provide clean needles and syringes.** Every major medical association supports this intervention. Seven federally-funded studies found that it reduces HIV infection without increasing drug use.

E. **SEXUAL AND REPRODUCTIVE HEALTH:** Integrate comprehensive sexual and reproductive health programming and AIDS prevention efforts.

4. **Heightened Vulnerabilities of Women and Girls:**

A. **PRIORITIZATION: Adopt clear targets and strategies to reduce the rate of HIV infection among women and girls and expand treatment and care for those already infected.** Address gender norms that increase vulnerability of men and women.

B. **STATUS:** Address the **systemic factors that contribute to women’s and girls’ increased vulnerability to HIV infection by directly investing in improvements in their economic, social and legal status**, including women’s and girls’ access to education, income and productive assets (such as land, housing, inheritance) and freedom from all forms of gender-based violence.

¹ See *Costing Annex*

² As of 29 May 2007, new UNAIDS epidemiological projections are expected shortly.

5. Health Workers and Health Systems Strengthening

A. **NEW RESOURCES:** All efforts to combat AIDS and support public health in the developing world are thwarted by the dire shortage of trained health workers. For even *current* investments to succeed, **new investments must be made to recruit, train, support, and effectively utilize the number of professional and lay health workers needed** to keep U.S. pledges to Africa³. U.S. contributions should support development and implementation of **comprehensive national health workforce plans linked to country-level health systems strengthening programs**.

The US should contribute at least **1/3 of the funds needed globally to train, retain and support an adequate health workforce in sub-Saharan Africa. The U.S. fair share** is estimated to be **\$650 million for the first year** and scaling to **2.6 billion over time**, for a **five-year total of \$8 billion**. This includes urgently necessary assistance to country governments to provide salary support and sufficient compensation to retain trained professional health workers in the public sector in the public sector. These funds must be *new resources not* at the expense of AIDS or other health programs. (*This sum is included in the \$45 billion price tag.*)

B. **HEALTH WORKER TARGETS:** PEPFAR 2 should work with Focus Country governments to achieve new **minimum health workforce density targets**, recommended by WHO to be at least **2.3 doctors and nurses per thousand residents**.⁴

C. **COVER THE IMPACT:** Fill gaps caused by U.S. programs that hire scarce health professionals away from struggling public health systems by **launching training and retention initiatives for at least as many new health workers as are needed by U.S.-supported programs. Proactive measures must be adopted to avoid drawing health professionals from local primary care systems.**

D. **COMMUNITY HEALTH WORKERS (CHWs): Utilize the power of numerous informal care providers already working at the community level by training and supporting deployment of 250,000 CHWs** to provide primary care services, including voluntary counseling and testing, prevention education and related services, treatment literacy, adherence counseling and symptoms monitoring and reporting.

- I. PEPFAR should achieve minimum recognized densities of one CHW per thousand residents in all Focus Countries⁵;
- II. CHWs should be integrated into overall public primary care systems, and must be supported by sufficient numbers of new health professionals in numbers sufficient to provide supervision and care for CHW referrals⁶;
- III. Certified CHWs must be paid a living wages;

6. MACROECONOMIC BARRIERS:

A. **IMF REFORM: The Office of the Global AIDS Coordinator (OGAC) should work with the U.S. Treasury Department to reform International Monetary Fund fiscal and macroeconomic policies** in order to ensure that countries have the flexibility needed to absorb and spend national and donor investments in health and education.

B. **USER FEES:** Barriers to access such as user-fees for health and education should be eliminated. **The U.S. should provide funds to compensate for lost revenue** and to support increased utilization of services;

7. GLOBAL FUND TO FIGHT AIDS, TB AND MALARIA (GFATM):

The U.S. must predictably contribute its fair 1/3rd share of funding to the GFATM⁷; The US should also continue and increase its provision of technical assistance for proposal development and implementation for GFATM applicants at the country level and support and expand the role of the GFATM in health systems strengthening;

Potential shifts of bilateral funding to the GFATM do not alter the topline financial obligation of the US;

8. **COORDINATION AND PARTNERSHIP:** US assistance programs should adopt **new models for country-level, country-driven technical assistance** to generate **national ownership** and establish rational coordination of donor resources, as well as coordination of health planning by public and private providers.

A. U.S. bilateral country planning should support and implement the principles of the “Three Ones”⁸, and, seek merger over time, or, at minimum, consultation with the GFATM’s Country-Coordinating Mechanism infrastructure and processes;

B. Country Operating Plans should be developed with the Focus Country governments, in consultation with civil society health actors, including communities of people living with HIV/AIDS and vulnerable groups;

C. New Focus and non-Focus Countries shall be selected based on transparent epidemiological criteria that include prevalence rates, and formulas relating to incidence vs. rate of acceleration;

9. ORPHANS AND VULNERABLE CHILDREN: U.S. AIDS initiatives should adopt clear targets to meet the needs of children affected by AIDS, supporting community-based interventions including ensuring children a loving permanent home, food to nourish them, free public schools, laws and systems in place that protect them, access to medical care and training programs to learn how to make a living as adult.

³ Experts from the Joint Learning Initiative have estimated that \$2billion is needed from all sources in the first year of an effort to double the health workforce in sub-Saharan Africa. The U.S. share of this is \$650 million. According to the WHO, by 2015 the annual need will reach \$7billion simply to train and employ the additional 800,000 doctors, nurses, and midwives that Africa requires.

⁴ World Health Organization, World Health Report 2006 (2006), at 11-12. In addition to doctors, nurses, and midwives, a full range of other health workers are also needed, including pharmacists, laboratory technicians, mental health workers, community health workers, and the critical management, administrative, and other support staff. The 2.3 figures do not include these other health workers.

⁵ Many countries and programs have established a ratio of 1 (or more) CHW per 1,000 population. These include 1:780 in the Mosvold Health District, South Africa; 1-plus:1,000 in Malawi; 1:90-125 households according to the South African Department of Health’s Community Health Worker Policy Framework. With 750 million residents in sub-Saharan Africa, the U.S. share—1/3rd of the total need—is roughly 250,000 CHWs.

⁶ Recommended professional-to-lay health workers ratios are estimated at 1 health professional for every 7 CHWs. At 250,000 new CHWs, roughly an additional 45,000 new doctors, nurses and non-physician clinicians would be necessary for oversight and to care for CHW referrals.

⁷ The U.S. and all other board members agreed at the May 2007 GFATM board meeting to a Fund target size of \$6-8 billion by 2010;

⁸ “Three Ones” is an initiative supported by the U.S. to coordinate donor and country-level AIDS responses: www.unaids.org/en/Coordination/Initiatives/three_ones.asp

U.S. Global AIDS Initiative, Round 2: *Costing Annex*

How much will the Bush Administration have spent on global AIDS by 2009?

The U.S. has transformed the global response to HIV/AIDS and leveraged a much stronger contribution from other wealthy nations. The U.S. contribution in the area of AIDS treatment has been especially important, and the U.S. is currently pledged to provide treatment to about a third of those in clinical need of treatment by 2008, and to support worldwide efforts to achieve universal access to treatment, care and prevention by 2010.

When President Bush leaves office, the U.S. will be spending more than \$6 billion per year on “Global AIDS” which includes spending not only on AIDS but also on TB and malaria through bilateral programs and contributions to the Global Fund to AIDS, Tuberculosis and Malaria (GFATM). This level of spending has strong bipartisan support from Congress.

In 2003 President Bush pledged a five-year program to combat global AIDS, TB and malaria costing \$15 billion. In fact, by the time he leaves office the US will have spent at \$18-\$19 billion on these efforts, depending on final appropriation levels. This is because Congress corrected the President’s woefully inadequate contributions to the GFATM, an innovative, international partnership that leverages U.S. contributions by more than 2-to-1 – and also because of a welcome, new bilateral initiative on malaria. The White House has also requested, and received, more than was initially pledged for Focus Country bilateral AIDS programs.

What is Needed Between Fiscal Years 2010-2013:

Looking ahead to FY 2010-2013, one approach would be to maintain spending at roughly existing levels, with the total cost over the next four years amounting to more than \$24 billion. This sum does not include *anything* for non-optional items such as funding for the GFATM or for other already existing bilateral programs, estimated to require *at least an additional \$11 billion* during this period.

Taking this approach would be a mistake. HIV/AIDS is an expanding crisis, now growing at a rate of about 12,000 new infections a day. HIV/AIDS also results in an ever-growing number of orphaned children, estimated to reach 20 million by 2010⁹.

Thus, simply maintaining the existing funding level would be an abdication of leadership that leaves millions without treatment—including many who initiated therapy with U.S. support. This can lead to the emergence of widespread drug-resistant HIV epidemics.

In addition, there are additional reasons why this approach would be a serious mistake and why a larger investment in global AIDS spending is the right choice:

- To date, the response to HIV/AIDS has bypassed the world’s children. For instance, while adults have increasing access to AIDS diagnosis and treatment, a much smaller proportion of children have such access. Orphaned children, whether HIV positive or not, need community-based care and support, evidence-based prevention education, as well as nutrition and education. The United States budget for global HIV/AIDS does include some funding for care and support for orphans, and by law this must be 10% of the total. However, the number of orphaned children is growing exponentially. Keeping funding at existing levels would abandon millions of children who have lost their parents to HIV/AIDS.
- The Bush Administration and civil society groups recently agreed to an expansion of the GFATM. The Board of the Fund, where the U.S. has a seat, unanimously agreed on a size of between \$6 and \$8 billion by 2010. To maintain its current one-third proportion of funding of the GFATM, the US contribution would have to increase to \$2.7 billion a year. By flatlining funding for global AIDS, U.S. leadership at the Fund will slip and the US will miss a major opportunity to leverage greater contributions to the GFATM, where each dollar from the US has been matched by two dollars from other nations.
- The US has been providing support for AIDS treatment to one-third of those in clinical need of treatment. This proportion is appropriate since the US represents slightly more than one-third of the global economy. In addition, the U.S. promised to ensure universal access to treatment by 2010 as a part of the G8 declaration in 2005 and reaffirmed since. To sustain 33% who need treatment, the U.S. will need to *at least* double the numbers receiving therapy during the term of the next President, from a current target of 2 million to 4 million *or more* by 2013. If AIDS spending is simply kept at existing levels this one-third proportion will drop. It is unlikely other donors will adequately pick up the new gap, and, instead, the promise of universal access to treatment will be broken.
- Countries have faced major difficulties in absorbing and using effectively the external resources available from the U.S. and other donors for AIDS and health programs. There are simply not enough health workers available. Further, new bilateral AIDS, TB and malaria programs are hiring scarce doctors and nurses away from struggling public sector primary care systems, inadvertently weakening already struggling public health and frustrating the ability to achieve or sustain agreed upon health outcomes. New resources are required to help countries improve health care systems and train and retain the health care workers that are essential for program success. Targeted investments in health capacity building, however, would allow US dollars to be used more quickly and effectively to save lives and prepare for new threats. If the US simply maintains existing funding levels, without providing much greater help in the area of health care delivery systems, we will be unable to honestly keep or sustain our pledges, and countries fighting AIDS will lose the fight.

Defining a new proposal:

⁹ UNICEF, “Africa’s Orphaned Generations” 26 November 2003, <http://www.unicef.org/media/files/orphans.pdf>

The next 4 years of U.S. Global AIDS funding should respond to these inter-related challenges head-on, with a coordinated, comprehensive package. Instead of flatlining U.S. spending at roughly \$30 billion, the next President should propose a level of spending that:

- Showcases U.S. assistance to developing countries to help redefine perceptions about the U.S. role in the world;
- Keeps our country's promises to do its fair share to get ahead of the AIDS crisis and actually achieve goals on AIDS and health that have been set internationally;
- Maintains the current U.S. support for treatment of 33% of the people with AIDS in the world in clinical need, commensurate with the U.S. share of the global economy;
- Expands U.S. funding to take into account the growing number of children orphaned by HIV/AIDS;
- Makes maximum use of mechanisms like the GFATM, which supports country ownership and leverages more action by other donor nations, not only on AIDS, but also on tuberculosis and malaria (40% of GFATM resources are provided to malaria and TB programs);
- Provides essential strengthening to health systems so that countries use our aid more effectively and address primary public health problems that go beyond AIDS;
- Modestly increases U.S. assistance in non-focus countries where HIV/AIDS epidemics are growing rapidly.

What the next President should champion:

Cost of a Basic US Program on Global AIDS, FY 2010-2013	
\$28 billion	Funding for the 15 Focus Countries. This expansion would help the world reach achieve universal access for all HIV/AIDS services, including prevention, and it would double the overall number of people receiving treatment, sustaining our current 33% commitment. By law, at least \$2.8 billion or 10% of this would go to a broad range of programs for children.
\$5.5 billion	Funding to expand existing programs outside of Focus Countries, many of which are hot-spots for AIDS expansion, have been largely flat-funded during Bush Administration. As with Focus Countries, 10% would be spent on programs for children.
\$6 billion	Funding for the GFATM, about 60% of which goes to AIDS programs and 40% goes to TB and malaria programs. US contributions to the Fund have been matched two-to-one by other nations.
\$5.5 billion	Funding for new health systems strengthening initiative that trains, retains and supports health workers, helping to ensure US dollars are able to be used effectively and sustainably.
\$45 billion	Total cost of package over four years

This funding package would preserve US leadership in the area of HIV/AIDS, while addressing key bottlenecks, such as the weakness of healthcare systems, that have often frustrated progress. It is important to note that **this package goes beyond AIDS per se** in a number of ways:

- It provides a funding for community-based care and support for children, including food programs, training programs and more;
- It provides funding for health systems improvement and support;
- It addresses TB and malaria through the GFATM. The GFATM is also providing a significant amount of funding for programs to meet the needs of children infected and affected by HIV/AIDS, programs which go beyond AIDS treatment and prevention.