Woodrow Wilson International Center for Scholars

PEPFAR and the Global AIDS Response

Thursday September 20, 2007
Woodrow Wilson International Center for Scholars

Transcript: **Dr. Kent Hill**

You'll be relieved to know that I've left my speech at my desk over there. That's not quite as noble as you might think. I'm having eye surgery on Tuesday, because I see twice as many of you as there are here, and if I saw twice as many of my notes as I have, that would be very dangerous. So what I would like to do instead is to focus on four key areas. But before I do that, let me thank the Wilson Center for inviting me to be here. I admire the work that you are doing. I admire your passion for this topic on HIV. You have thought about it for a long time, you've hosted a lot of things, that's very important. I appreciate the effort you have given to looking at PEPFAR, and having dialogue about that. And I also want to mention something about the Congresswoman who spoke earlier. I've worked with her on a lot of issues, avian influenza and other things, and she is one of the most knowledgeable and committed people on the Hill.

Like her predecessor Congressman Kolbe, we are very fortunate that from both sides of the aisle you get people who are as committed and knowledgeable about important health issues as these folks are. And so it was a privilege to have her here, and to continue to work with her. And as for Peter Piot -- I have grown to really respect Peter in recent years. He was really ahead of the curve, internationally, in recognizing the fact that we just weren't making enough progress on the prevention. He co-hosted in Geneva, I guess it was last September, a major effort, bringing 25 or 30 experts from around the world to ask the tough question about what could we do differently in terms of the drivers of the spread of this epidemic, and there were some very interesting results from that meeting, and if I have a chance I'll say something about it in a few minutes, but it was the leadership of Peter that made that meeting possible. And if we have some success for the next few years, it's going to be because of that sort of leadership.

But the four issues I would like to just briefly touch on with you this morning -- I want to say something just in general about the US efforts on this, and what it means and how it's broken down. I want to address the question for a minute, what are the multi-sectoral dimensions of fighting HIV/AIDS, because it's more than a health issue. And in fact, that was the specific issue, Geoff, you asked me to deal with, and so I want to say something about that. And third, I want to talk about turning off the tap, about dealing with what the Congresswoman and what Dr. Piot talked about, which is, how do we actually begin to turn back this incredible number of new infections every year? And finally, just a quick word about cooperation and collaboration. Everybody knows that the President made a commitment for $15 billion originally. What folks I'm not sure are as aware of is that the actual total for the five years may be closer to $18.3 billion, and that the request level for '08 is $5.4 billion because of the nature of the scale up.

And of course more recently this summer, there was the commitment to go for doubling that to $30 billion. Just to give you a real quick snapshot of something I think you understand and know, how does that really break down in terms of what the USG does with those funds? In 2006, about half of those funds went for treatment, and there has been a tremendous scale up.

And those who are receiving treatment -- about 28 percent of that went for care, palliative care; it includes things like OVC, orphans and vulnerable children. And then the remaining part, about 22 percent, is prevention. And that expands to about 28, 29 percent if you were to include all the counseling that is done that will have a prevention component. Of that prevention, if you take the total HIV monies spent, about seven percent goes for sexual prevention in the categories of "abstinence" and "be faithful;" there's almost no "abstinence only;" it's usually in conjunction with fidelity programs or partner reductions as well. And then there is another six percent or so that is condoms and other sexual prevention activities, and so a grand total of about 13 percent for sexual transmission involving A, B, and C.

And I think the Congresswoman is right and Peter is right and others are right that are saying that in this next iteration of what the global committee does, if anything, we are going to have to have an increase in the amount of effort and the quality of the effort on prevention to make a difference there.

Now let me say something about the second point I said I wanted to address; the multi-sectoral point. People think that the work on HIV/AIDS has to do with just those categories I was talking about, and that when Congress gives money to Ambassador Dybul and PEPFAR, that is all it goes for; there isn't anything for the so-called "wraparound" programs. And really, what I want to suggest to you today is that could not be further from the case. We have learned, painfully sometimes -- we've known it for a long time, and even the authorizers of the original bill in 2003 had some language in the bill -- I don't have it right in front of me here -- which talked about allowing related activities. Now, why did they put that in there?

They sensed even at the beginning that it is not just the treatment and the prevention, et cetera, that is important here. There are related activities. Now, what am I talking about when I mention that? Peter mentioned, Congresswoman Lowey mentioned, and we have all been talking more and more about gender issues. You can't talk about abstinence and being faithful and use of condoms, et cetera, if women don't have the freedom to make choices or respond to any of those interventions. If you don't have a robust gender program to deal with the inequities, the inequalities between men and women, all the talk in the world about condoms or being faithful or abstinence doesn't work. When you have trans-generational sex in Africa, where older men are putting pressure on younger girls to engage in sexual activities when they don't want it, you better deal with male behavior. You better figure out a way to address those issues there.

Therefore, gender programs should not be disconnected from HIV/AIDS programs. There's a different category and different money. Sure, if you can get money from other sources, take it. But it's legitimate to use some HIV monies to address gender issues. Or take the issue of orphans. Everybody says you need to address orphans. Well, yeah, you need to address orphans, but what kind of needs do orphans have? Orphans are three times as likely to die because of being without parents as kids with parents. That is not just because they might end up being HIV-positive; they are three times as vulnerable to death. They are less likely to get education. If you don't have an education program for orphans -- if you insist on viewing education programs as disconnected from HIV, you won't meet the needs of orphans who are the

byproduct of the HIV pandemic. You have to address education; you have to collaborate with those who are doing education.

Or take the issue of nutrition. People say, "That's humanitarian. That's not HIV/AIDS." Nonsense. You can't do treatment for people who are on ARVs if you don't recognize that the impact of that treatment is going to be impacted by whether or not people have enough to eat. So you had better be cooperating with -- or if possible, even finding some funds for -- nutrition programs to address that.

Or take the issue of economic growth. People say, "Well, what does that have to do with HIV/AIDS?" It has a whole lot to do with it. HIV-positive people are often discriminated against, as Peter has noted. It's sometimes hard for them to get jobs. It's hard for them to keep jobs sometimes. Sometimes they can't work as easily at first as others. You need to address their needs. With the orphans, you need programs to train them to do things when they get older. You have to address employment issues. You have to address economic growth issues.

Or take health systems. You don't just address HIV by coming up with drugs. You have to improve the health infrastructure. You have to think about whether there are enough people out there to not just deliver the services. And if you help in this area, by the way, you will help in every health intervention, not just interventions that involve HIV/AIDS. Or think of family planning. Some say, "What's the connection between family planning and HIV?" Let me tell you what the connection is. If a woman is HIV-positive and she is pregnant, she not only needs to be tested to make sure that if she is positive she can take some actions that might have an impact, will have an impact, likely, on whether her infant, her child will be HIV-positive; she needs lots of other things as well. When you meet with a woman who's pregnant and HIV-positive, you can also help her a lot by giving her insecticide-treated bed nets, for example. You can help her, if she doesn't want more children or she wants to space her children, by directing her to or helping her gain access to family planning.

USAID, since 2002, for example -- between 2002 and 2006, I think, or maybe it's 2007 – we have increased by 63 percent the amount of family planning money that we are moving to the PEPFAR countries. That is where the need is particularly great. To the extent we've done that, that has a positive impact on HIV-positive women. They are connected. Now, the pot of money that goes to help them may not be HIV/AIDS monies. The money that goes to Ambassador Dybul and then usually on to USAID or HHS and CDC or the Peace Corps or whatever -- you can use other pots of money to do things that will make a difference. There is cooperation going on right now, for example, with the President's malaria initiative, which is being headed up really very well by Admiral Timothy Ziemer.

There is collaboration and coordination going on now with the President's malaria initiative and PEPFAR to make sure that those programs work very closely together. My main message here in this second point is, you cannot think of HIV as simply an isolated, one particular part of the health agenda. It's connected to lots of other development matters that you have to address at the same time if you are really going to succeed.

Let me say something about prevention. It's getting fashionable now to talk about prevention. And that's good news, but the cold hard facts are it doesn't matter if it's Gates speaking about it or former President Clinton in Toronto; it doesn't matter if you're talking about Democrats or Republicans. Anybody who can add, anybody who can look at the numbers, knows that something --

[break in audio]

-- about 4.3 million or so, or 4 million new infections a year. You could increase significantly, as we have done, the number of people on treatment. You could double, every several years, the amount of money that is going into this, and you can't keep up with the treatment demands that are going to be out there if you do not, as I heard one world health organization person put it -- if you don't "turn off the tap." We have to stop this unfortunate arguing about ABC and the prevention methods, et cetera. One of the reasons, I think, that PEPFAR and the USG and others who understand the importance of condoms and partner reduction, infidelity, and abstinence for younger folks -- the reason I think they're right to emphasize all three is because we're being criticized from all sides at the same time. I have to deal with folks who don't like us being the biggest exporter, in a sense, of condoms in the world. I have to deal with other folks who don't like us talking about sexual behavior. But if you're a public health expert, you have no choice but to do all the interventions that you can possibly do, and not just A, B, and C.

Now we have the opportunity to move forward on male circumcision, we have the need and the opportunity to work forward on gender issues, and all these things are going to be connected to any success we have on prevention. The tricky thing is, how in the world do you increase the percentage of the resources you spend on prevention when there are so many other compelling needs? And that is the painful question that people at UNAIDS and the Global Fund and PEPFAR and USAID and everybody else that works on these issues has to figure out what to do. But do the math. If we don't do better on prevention, we won't have the resources to deal with the number of orphans and the number of people who need treatment. So, I think it's appropriate to say that we need to move forward faster and more effectively on prevention.

Let me say one more thing. I promised I would say something about what Peter chaired in Geneva. One of the results of that -- well, we've noticed, for example, that there's some interesting things going on in the prevalence rates.

And by the way, one size does not fit all, as the Congresswoman put it. You don't have the same strategy for a country in Southeast Asia with a focused HIV prevalence rate mainly found among prostitutes or sex workers and drug users such as in much of Central Asia and Russia and a place where you have got general prevalence, as we do in some countries in Africa. The proportions of A, B, and C change. You have a lot more emphasis on condoms in places where you're dealing with sexually active people doing or engaging in risky behavior. You have different messages if the problem is elsewhere. You have to tailor your response to the place in question and come up with the right answer.

But we noticed a very interesting fact. It was mentioned by the Congresswoman that Uganda had had some success partly because of political leadership. And we noticed that it dropped

from the 20s to seven or eight percent prevalence. And now, disappointingly, it's leveled off lately, and people there tell me they've sort of backed away from some of the messages that helped them initially. But Kenya went down, Zimbabwe has gone down, Uganda has gone down. There has been improvement in some areas of Southeast Asia. But other areas, particularly in Southern Africa, the prevalence rates have been much more stubborn. And we have asked ourselves, why do some areas go down and some areas stay the same, or just disappointingly stay the same? And it's not condoms, because some of the places where it's stayed the same, the distribution of condoms is as high or higher than anyplace else in Africa.

And one of the conclusions of the experts is that it has something to do with the phenomenon of concurrent multiple partners. A lot of times people associate the spread of the disease with casual sex, or visiting prostitutes or sex workers. In fact, in much of Southern Africa it's stable relationships with people you know, and it's the number of relationships -- two, three partners. And what sexual networking studies have shown is that when that pattern exists, because of the way the disease spreads, spreading particularly quickly in the first six weeks of infection, if there is a network that's open, with lots of partners -- even just two or three partners, even with something like 1.74 partners -- it goes up exponentially. Serial monogamy, lots of partners, is not nearly as dangerous as concurrent multiple partners. Now, if that's what the evidence says, we better program effectively to get that message out, and then perhaps we can begin to see rates come down from the 30s and the 20s and go lower, and that will affect what we're trying to do. We have to program more effectively, with that specific thing in mind.

And fourth and final point I want to say something about is the importance of cooperation and collaboration. I know there are times when the international bodies and the bilaterals and others -- and even within the USG, for goodness' sake -- that agencies don't always cooperate as well as they ought to cooperate. But I must say after six-plus years at USAID, and about three of them in the global health bureau, and watching international -- and sitting on international bodies, et cetera -- I guess I am pleasantly surprised about how much goodwill and desire to cooperate there really is. And I think there is a lot of progress being made. A couple weeks ago I was in London at an event with the Prime Minister, launching a new health initiative that Prime Minister Brown is involved in, and I talked with Michel Kazatchkine, the head of the Global Fund. He told me that never had relations been better between PEPFAR and the Global Fund.

There is sort of a meeting of the minds on many, many things. There is a lot of – we have remained their biggest funder; there's a lot of cooperation going on. If you sit in as I must sit in on the approval of the operating plans for the 15 PEPFAR focus countries, you know that no plan can get through the USG, can get through PEPFAR, if it doesn't answer two questions. One, how does what we are proposing to do fit with what the other international donors are doing? Show us that this is not duplicative. Show us that this meets the gap. And then the second thing, they want to concretely see how that works out in practice. If the people who present the plan can't tell us what the others are doing and how we're collaborating, it gets sent back. Now that is the commitment to collaboration you simply have to have if this is going to succeed.

So actually, I'm quite optimistic that we are making progress on this front, but we need to be more aggressive in making progress, particularly on this prevention thing, so that we can divide the turf up. We don't have enough money to do everything, so we really need to do as well as

we can on that. You know, this is a really big issue, and we hsve got to not have tunnel vision when we look at it. We have to connect it to all the other development issues that we have something to say and do anything about. And I think if we redouble our efforts -- and not just our money, but if we work smarter and we cooperate better and we focus on prevention and deal with some of these prevention drivers that we haven't spent enough time on, we can make a difference, but it's going to require all of that for us to succeed. So thank you very much.