Woodrow Wilson International Center for Scholars

# *PEPFAR and the Global AIDS Response*

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Woodrow Wilson International Center for Scholars

*Transcript:* **Rep. Nita Lowey (D-NY)**

I want to thank Dr. Piot from UNAIDS, assistant administrator Kent Hill for joining me today for what I hope will be an important dialogue on the future direction of US government assistance in fighting the global HIV/AIDS pandemic.

We all know the statistics, but they are certainly worth repeating. 39.5 million people living with HIV/AIDS around the world, 4.3 million new infections in 2006 -- an estimated 32 million deaths since the beginning of the pandemic. 8,500 people die of this disease daily. These statistics really are breathtaking. And they could have been paralyzing, but instead, when the American people learned of the suffering caused by this pandemic, we resolved to make a difference. And five years ago, under the leadership of many committed individuals and organizations, PEPFAR was launched. Five years later we can be proud of what it has accomplished. PEPFAR set a new tone for the global response to the HIV/AIDS pandemic. In choosing to -- addressing the need for treatment, the United States and its partners, both international and domestic, public and private, defied those who claim that providing antiretroviral therapy in the developing world was not possible.

And we were just talking before about -- a couple years ago, no matter where you went in Africa there were so many groups there, both governmental, nongovernmental. We saw all the foundations. Everyone was ready to work and ready to address these statistics. And the PEPFAR update from May of this year does demonstrate our success; 1.1 million people are receiving treatment. We committed ourselves to treatment, and the results speak for themselves. Unfortunately, we have not been as successful in addressing the need for better prevention. In many countries we have implemented a uniform prevention strategy that is often called “ABC;” A for abstinence, B be faithful, C use condoms model. Unfortunately, the cookie cutter approach has not worked universally, and some argue that we’re heading backwards in our efforts to slow the pandemic.

And I know there are many groups, both domestic and international, represented here today, and there are so many challenges here in the United States, wherever I go, and I just came back from five countries in Africa. You see incredible prevention programs; some really, really good ones. But somehow we are not replicating them on a scale large enough to make a dent. And frankly this is what’s happening in the United States as well, as you all know too well. We have an opportunity together to learn from these experiences and set a new way forward in the global fight against HIV/AIDS.

As I mentioned, I visited five African countries in August, including Uganda. And while I was there we spent a morning at TASO, the AIDS service organization with which many of you are very well acquainted.

We learned, we talked to people, we heard all about their treatment, care, and prevention programs, and we're all familiar with the debates surrounding Uganda's HIV/AIDS early prevention successes. Articles, conferences, and experts continue to investigate, debate -- what may have been the magic prevention bullet? Some claim that it was the ABC approach. Others credit the strong sense of fear that spread across the country as they watched thousands of their family members and friends die, especially HIV-positive pop star Philly Lutaaya, who spoke publicly about his infection in the late 1980s, while others attribute success to the zero grazing policy. During our many conversations I asked those who have been fighting the Uganda epidemic since 1987 what they thought made the difference, and their responses were striking. They reminded us of Uganda's long tradition of community, and understanding.

They talked about their efforts to educate their families and neighbors about HIV/AIDS so that they would choose to care for their brothers and sisters and accept them despite their illnesses. This education lead to a general community understanding about preventing infection and halting transmission. It was some combination of these factors that led many Ugandans to change their behavior, to reduce their number of sexual partners, to lead healthier sexual relationships. This understanding, resulting from extensive conversation and education, is what they believe led to their initial success.

However, unfortunately, recent evidence from Uganda suggests that the HIV incidence is rising again. Some working at TASO shared with us their belief that the introduction and availability of treatment was leading many Ugandans to see HIV/AIDS as a chronic disease rather than a death sentence.

This same phenomenon is seen in many countries, as I mentioned before, in the United States as well, and we have a huge challenge. And we must work with all of our partners to develop prevention programs that will be successful. With the expansion of treatment, PEPFAR must take a new look at prevention. And I'm sure you've had many of the experiences I've had in some countries, even with ABC. Even with requirements that the donors have put on their grantees, many people just ignored it because people were dying and lining up outside the clinics, so the focus for everyone has been treatment. So I do believe strongly that PEPFAR must focus on prevention. What worked in Uganda in the late 1980s and early 1990s was a homegrown solution, one that was very specific to Uganda's culture and needs. And any future prevention strategy must be country-led, and based on the culture and beliefs of that country.

Of course, donors should continue to support efforts that utilize effective medical innovations, but in the end the decision making process -- in my judgment -- and program implementation must be country and community driven. I understand that placing responsibility in the hands of others will make many of my colleagues uneasy; that's an understatement. As members of Congress we'd like to provide clear direction and guidance. But I would suggest that we rethink this approach as we work to reauthorize the global AIDS initiative. I believe that we must put our trust in the thousands of men and women who work every day in their own neighborhoods to address the HIV/AIDS pandemic. And I must say, in addition to the homegrown talent, I have never met a more dedicated group of people than our citizens who work around the world on these issues.

I continue to be impressed with their intellect, their commitment, their passion, their determination. And it is for this reason that I work so hard on the fiscal year 2008 appropriations bill to provide adequate resources to the initiative, and to provide flexibility in the way prevention funding is allocated. Countries must be empowered to design and implement prevention strategies that work for them, not on our Washington strategy that's based on the political agenda of others.

As we set priorities for reauthorization of the global AIDS initiative, again, prevention must be a priority. In 2006, for every person who received treatment, another six people became infected. This statistic translates into an additional 60 million infections by 2015 if the world has not dramatically shifted its prevention paradigm.

The first PEPFAR program changed the world forever by initiating treatment. Our next program must reflect a true commitment to prevention. Treatment programs required and enhanced emphasis on accountability. This laser-like focus on results has led to really good outcomes, but I'm concerned that these results were achieved at the expense of integration and collaboration between the global AIDS initiative program and USAID's ongoing health and development programs, which is another point that I want to emphasize. During my recent trip, I visited a hospital in Ghana, for example, that included a community-based maternal and child health program. This hospital and other similar health centers have achieved remarkable results, including a reduction in child mortality and significantly expanded contraceptive use as a part of a comprehensive health approach.

In fact, a recent UNICEF survey found that mortality of children under five is at an all-time low. We had hoped that the global AIDS initiative would build on these successes and incorporate lessons from these local health providers' experiences. Unfortunately, what I have found -- not just in Ghana -- in too many instances the global AIDS initiative did not build on these successful models, but rather chose to create an entirely new vertical HIV/AIDS program and system. I see some shaking heads here. And in some cases this was necessary, due to the stigma associated with HIV, and concerns that integrating HIV treatment into primary health centers would lead some women and children to avoid these clinics. Let me just say this: this is not just with HIV/AIDS. I'm looking at the whole delivery of services right now.

And wherever we went, whether it was Ghana, Uganda, Kenya, Liberia, I asked for a meeting with everybody in the community who was doing anything connected to the work. I think it's absolutely essential that we meet with other international donors on a regular basis. And Peter and I were talking about how this is happening more often now. The foundations are doing amazing work, individuals are doing amazing work. There are all kinds of NGOs that are working, and I don't think years ago we were making a strong enough effort as was necessary to get everyone in the room and really coordinate so we can all maximize our dollars, our efforts, our manpower, our womanpower, et cetera. It's better, but it's still not good enough. So as a result, opportunities to build on best practices and strengthen existing health systems -- I felt were lost there, as a vertical system was developed next to the other systems.

And now, of course, we have AID programs, we have Millennium Challenge programs, we have PEPFAR programs, and on and on and on. We really have to work together and coordinate

better. And that's not even talking about what DOD is doing in these areas, so we have a lot of coordination to do.

I mentioned before the education programs -- as you know, for years USAID has implemented basic education programs at the community level. In the early years of the global AIDS initiative, an opportunity, in my judgment, was lost for more extensive collaboration between these departments; getting young girls in school, keeping the young boys in school. What better way to deal with AIDS than providing that education? And I am pleased to hear that I think this has changed. USAID and the global AIDS initiatives are working better, together now, to include age-appropriate HIV/AIDS information in the classroom, as well as provide HIV/AIDS prevention information to teachers. I am very pleased to see administrator Hill here today. Expect that you will hear about the great programs that USAID is implementing to complement the investment of the global AIDS initiative.

USAID'S efforts are essential to our success in stopping the pandemic, and as we consider the next phase of the global AIDS initiative and our response to this unyielding pandemic, we must broaden our thinking and ensure that comprehensive community-based approaches with a development perspective are incorporated into our strategic plan. Now I mention education, I mention the hospitals. I could go on with agriculture, water programs; it can all go together. I remember a visit in Tanzania, and visiting a school: no water, no food, no books; barely a teacher. Just think what we can do with a school lunch program, with health programs, with fresh water, with trained teachers, and we can do it all together.

To me this is the important focus, and must continue to be the important focus of our efforts. I'm a firm believer in US government coordination -- I guess you could tell -- but that alone is not enough, as, again, I've learned firsthand we have to coordinate better with the global community, with other donors both public and private, as well as the multilateral organizations such as UNAIDS and the Global Fund to Fight AIDS, Tuberculosis, and Malaria. The success of these programs is critical. We must continue to be active partners in their efforts, and I am pleased that Congress has been able to support increased funding for the Global Fund and UNAIDS. I anticipate this will continue in the coming years. As you know, the Appropriations Committee will soon complete action, we think, on the fiscal year 2008 funding bills. I would like to say the House has succeeded in passing all the bills. The Senate has its own timetable; we'll see what happens there. We don't know if we're going to have an omnibus, a minibus, individual bills, but that's what makes this place a challenge, and interesting to all of us who work here.

One thing I'm sure of is that we will provide over $5 billion to address the global HIV/AIDS pandemic in FY 2008. And I'm very proud of this commitment. And as chairwoman of the committee, I have made -- with all of my partners -- combating HIV/AIDS a priority. I look forward to even exceeding the President's commitment of an additional $30 billion over the next five years. The decisions made in the coming months will determine the future of our global HIV/AIDS efforts, and I know that my colleagues working on the reauthorization of this important program will be courageous and visionary. So I look forward to supporting their efforts, working with them, working with all of you, working with our international, our domestic partners, in ridding the world of this devastating disease. Thank you very much for all you do, and let me apologize in advance. Unfortunately, I have to go back to the Hill and fight on

all kinds of other issues, but it's a pleasure for me to address you today. And thank you, thank you for your important work, both here and internationally.