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Joint United Nations Programme on HIV/AIDS

Statement to the U.S. House of Representatives Subcommittee on International Monetary Policy and Trade of the Committee on Financial Services

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--- Check against Delivery ---

Thank you, Mr. Chairman, Distinguished Members, for the opportunity to address the Subcommittee on International Monetary Policy and Trade of the Committee on Financial Services on behalf of UNAIDS.

In the time you have graciously provided, I would like to briefly address three sets of issues related to the work before the Committee:

- **First**, a 5 point update on the epidemic and our collective response;
- **Second**, 5 essential elements missing from the multilateral response to the HIV/AIDS epidemic in Africa; and
- **Third**, why we need a Global AIDS Fund, and 5 key areas it needs to focus investments on together with the multilateral organisations.

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Mr. Chairman, With respect to the staus of the epidemic and the global response, I would draw your attention to the two page statement on the epidemic prepared just a week ago by a group of top experts from around the world in the areas of public health, development, law, finance, medicine and community mobilization. This group was convened as part of our preparation for the Special Session of the United Nations General Assembly Special Session on HIV/AIDS, which will take place at the end of next month in New York.

The statement speaks for itself with respect to the current cost of the epidemic in human terms, the continuing need and opportunity for the global community to act, and the order of magnitude increase in investments required for an effective response.

I would like to expand on 5 key points of potential relevance to the work of the Committee.

First, we are still very early in the natural course of this epidemic. It has not "maxed out" by any means. The rate of new HIV infections continues to exceed the number of HIV deaths. This is particularly the case for countries in Asia – especially South Asia – and for the countries in Eastern Europe and the former Soviet Union where we see the most rapid rise in new infections. But it is also true for Africa. Despite our observing for the first time this past year the number of new infections in Africa holding steady with respect to the previous year, the current death rate -- our best overall indicator of the indicator's impact -- is still behind the rate of new infections. Consequently, the overall number of infected individuals continues to increase. I would not want to give the impression that the natural course of the epidemic cannot be changed. In fact, we have very clear "proof of principle" in an increasing number of countries – Uganda, Senegal and now Zambia – where efforts are having a dramatic effect. Clearly, significant investments early in the course are much more effective than much larger investments later in the course.

Second, in most places – including in Africa – we are still at the very beginning of the response. Investments in Africa were estimated at around USD 165 million for 1997, were probably around USD 400 million last year and could make it to USD 600 million

this year. This should be compared with the roughly USD 4 billion that is now generally agreed to be the minimum investment required in Africa for a credible response. It is a generality – but unfortunately one that applies – that we have barely scratched the surface of the epidemic in Africa.

Third, there is now general acceptance of the principle, learned through both positive experience and neglect, that investing in youth remains our most effective strategy in altering the course of the epidemic. This is true regardless of country and regardless of the state of the epidemic in those countries. Even in highly endemic areas, such as eastern and southern Africa, a new cohort of young people present themselves every year – every day actually – that require our assistance in preventing HIV infection.

Fourth, it is now more generally appreciated that our prevention and care objectives are inextricably linked. AIDS care and support can no longer be viewed as a "private good" in contrast to HIV prevention being viewed as a "public good". We have learned that to slow the epidemic, we must do two things everywhere.

- make the epidemic visible in communities, and
- reduce the stigma associated with HIV/AIDS

Even if we were not motivated by our humanitarian concerns, we would be compelled to address AIDS care for and support if we hope to be successful in achieving our prevention objectives. The availability of care in and of itself reduces the stigma associated with HIV/AIDS, and engages families and communities, religious institutions and local governments in daily action on the epidemic. It creates the incentives for knowing one's HIV status critical to prevention efforts – and increases demand for voluntary counseling and testing which is the common gateway to both care and prevention services – such as the interruption of HIV transmission from mothers to their infants.

My **fifth point** is that anti-retroviral drugs are an important part of the solution. We have learned that:

- we need to use them in all countries;
- where we use them, we need to use them appropriately according to rigorous guidelines; and that
- even under the best of circumstances, resistance is inevitable – probably more rapidly than we have been thinking.

Consequently, we will require an ongoing stream of new HIV/AIDS drugs that only the research and development focussed pharmaceutical companies – working in closer partnership with our public and private sector financed research institutions – can provide us. There are individuals more knowledgeable and capable than I to address the pharmaceutical industry's profit margins and their intellectual property rights, and how they relate to their basic business model. However, I would simply caution that if we continue a confrontational approach to their engagement in the response, we risk driving them out of this partnership, and we will pay dearly for that in Africa and elsewhere in the developing world with a high toll in human lives.

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Mr. Chairman, I would like to suggest to the Committee that as you continue your review and oversight of the multilateral institutions in Africa, that attention be given to 5 essential elements currently missing from the response to the HIVAIDS epidemic.

First, a focus on accountability for HIV/AIDS related results. Twenty years into this still expanding epidemic, it is past time to begin holding ourselves accountable for what we are doing – and what we are not doing – in the response. As a start, our economic modeling and policy advise must take HIV/AIDS fully into account. While there is certainly room for debate on what extent a 7% or a 15% inflation rate effects economic growth, we should be past the stage where we can pretend that a 30% HIV prevalence does not. HIV is not currently being factored into the macro-economic models we are using in any meaningful way – nor have we seriously looked at how our macro-economic frameworks are impacting on the epidemic. For major investments in Africa – including short run stabilization programmes – an "AIDS Impact Assessment" should be included as the World Bank has begun to do.

Second, we need to get beyond the summary tables, and ensure that our sectoral investment strategies are appropriately and effectively addressing HIVAIDS. Currently, it is the exception when they do, either in the:

- productive sectors, notably in agriculture, the services sector including tourism, and the manufacturing sector, where AIDS has become a disincentive to international investments;
- "protective sectors", especially the health, education and social services sectors where the very institutions that are required to serve as societies' front line in the epidemic are themselves reeling under its impact; and finally those areas that could be termed
- "propagating sectors", in particular the informal commercial sex sector, but also including those sectors where employment entails the separation of men and women from their families for prolonged periods of time such as in the uniformed services, the transport sector, and the mining industry.

Third, the current response lacks urgency and intensity. Time bound goals for institutions to complete their reorientation to HIV/AIDS and incorporate it within their mainstream work, and specific targets for how much of their resources should be addressing the epidemic, are entirely appropriate in an emergency of this type – and largely absent.

Fourth, the response lacks sufficient leverage from communities and governments in the response in Africa. In the former case, communities affected by AIDS are already spending very considerable sums as a consequence, but the means have not been provided to assist in maximizing the value of those investments. With respect to governments, a good but incomplete start has been made through the HIPC process. For example, in some 13 countries for which we have data, USD 43 million was budgeted for HIV/AIDS this year compared with less that USD 2 million last year, roughly 90 % attributable to new resources provided through debt relief. The downside is that with 2 exceptions – both in relatively low endemic countries – less that 10 % of debt savings were reprogrammed into efforts directly addressing HIV/AIDS. Several non-HIPC countries – notably Botswana, Nigeria, South Africa and Zimbabwe – have substantially increased their HIV/AIDS investments. Be we are far short of the 1 percent of public spending (0.25% of GDP) that would get us to a reasonable $800 million annual investment by African governments.

Fifth, the current response lacks sufficient coordination among the partner organizations. I would not like to suggest that the primary obstacle to a more coordinated response is simply a lack of will within organizations to work effectively with their partners, but rather insufficient investment and internal incentives to do so. Coordination is human resource intensive, and where there is insufficient resource to coordinate, there is little incentive to make the investment of scarce human resources required. Our coordination model also requires review. If you will forgive the analogy, the multilateral organizations would perhaps benefit from more of a "NATO-like" approach – building a platform on which governments and civil society partners can more effectively respond to the epidemic – rather than serving themselves as the prime actors in the response.

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Finally, Mr. Chairman, I would also like to share a few thoughts on why we need to urgently complete the work initiated here over a year ago by Congressman Leach and Congresswoman Lee and many others within this House to establish a Global AIDS Fund to "jump start" our expanded response to the epidemic. This important undertaking came closer to reality with the important and welcomed announcement of President Bush this past week, and the new energies provided by Secretaries Powell and Thompson within his Administration.

In the face of an expanding epidemic and the compelling epidemiological, humanitarian and economic arguments for early action, our first priority must be an effective response – and we should be prepared to sacrifice some efficiencies in the short-run to achieve that.

It would have been an enormous mistake to simply wait for the existing multilateral mechanisms, that should be addressing the epidemic, to work as efficiently as possible before substantially increasing our investments in Africa addressing HIV/AIDS.

But it will be an even larger mistake to undertake this scale-up in a way that duplicates the work of these mechanisms or gives the impression that a Global HIV/AIDS and Health Fund would somehow obviate the need for multilateral and bilateral organizations to do much more, and to do it more effectively.

Our rapid scale up through the global fund mechanism must go hand-in-hand with our directly addressing the organizational issues that have stood in the way of translating awareness into action on the epidemic. We should view the global fund as a critical instrument in a leveraged "structural adjustment and refocusing exercise" to get the best out of the multilateral organizations in the response to the epidemic. Resources – in particular new resources- will help to focus and accelerate the organizational reform. The new commitments to the global fund cannot be seen as an alternative to increasing investments and demanding results from our multilateral organizations in Africa.

Each of the existing multilateral and bilateral mechanism available to us needs to be looked at anew to see where and how we can get the best value from our past and current investments. Where existing mechanisms are working well, the global fund should operate through them. Where they do not work well, some hard-nosed triaging will be required to determine:

- where sufficiently rapid improvements can be achieved,

- where interim bridging mechanisms are required to complement existing mechanisms when necessary improvements will take longer, and
- where existing mechanism simply don't exist, or are occupying space they can't fill, or consuming resource that could be better spent elsewhere.

As this effort continues, there are 5 key areas that we would suggest require focus within the multilateral organizations to more effectively mobilize additional resources to and within Africa, namely:

First, for central governments, in particular to increase their capacities to coordinate a scaled-up, multisectoral response; to strengthen HIV/AIDS related policy and planning in a range of key sectors; and to accelerate decentralization of programme delivery. UNDP and the World Bank mechanisms have obvious comparative strengths in these areas which need to be built upon.

Second, for implementing partners in the NGO and the private sectors at national level. UNICEF and ILO in particular have important mechanisms and capacities to build on, as do UNFPA, UNESCO,WHO and ILO.

Third, for local governments to increase their capacities to respond to the epidemic and its impact, including their capacities to build and finance local partnerships with the private sector and civil society organizations. Here again, UNDP and World Bank mechanisms exist which can be built upon, drawing on the valuable experience of UNICEF, UNFPA and the specialized agencies, in particular WHO and UNESCO.

Fourth, with new international partners in the response, including the foundations; NGOs in OECD countries looking to build links with developing country counterparts; and the private sector, in particular the pharmaceutical industry. The United Nations Foundation has brought new capacities to this area. WHO and UNICEF have effective mechanisms to support drug procurement and distribution, as does UNFPA in the area of reproductive health commodities.

Finally, major new investments are required to support the capacities of regional institutions and technical networks in a full range of policy and programme areas so that they can more effectively reinforce and support national efforts in the response.

Mr. Chairman, Distinguished Members, on behalf of the Joint United Nations Programme on HIV/AIDS and its many partners, we wish to commend you for your leadership on this issue here today and again thank you for the opportunity you have provided UNAIDS to address your Committee.

Attachment

AIDS: the time to act

*A Statement issued by an expert group convened by UNAIDS, The International AIDS Society and the Bill and Melinda Gates Foundation**

AIDS is a crisis of unprecedented proportions. It is the most devastating pandemic in human history. 36 million people around the globe are living with HIV, 22 million men, women and children have died, there are 15,000 new infections every day. If current trends do not change, by 2010, in Africa alone, more than 40 million children will have been orphaned by AIDS.

In the worst affected countries, the epidemic is eroding decades of development gains, undermining economies, threatening security and destabilising societies.

In sub-Saharan Africa, where the epidemic has already had a devastating impact, the worst is yet to come. Overall, the epidemic is in its early and mid stages, particularly Asia where the majority of world's population lives.

But the world is not powerless to respond. We now have an historic opportunity to commit the political will and the billions of dollars required to change the course of the epidemic. Investment now will prevent tens of millions of new infections and extend the lives of millions already living with HIV.

Over two decades of experience we have developed tools of prevention, treatment and support. Their effectiveness has been shown in many communities, and in diverse national contexts including Brazil, Thailand, Uganda and Senegal.

We have learnt that prevention and care are inextricably linked. Prevention, medical treatment and social support are all critical components of effective responses. Their effectiveness is immeasurably increased when they are used together. They must also meet the unique needs of men and women and address the underlying causes that make some people more vulnerable to HIV than others.

Inexpensive and effective drugs to treat and prevent opportunistic infections exist. They are urgently needed and should be made rapidly available, together with broader care and support, including in the poorest countries.

Where it has been available, antiretroviral therapy has reduced mortality and prolonged healthy lives. Recent reductions in prices create an historic opportunity to extend this benefit across the globe. Antiretroviral therapy can and should be made widely available in all countries. The degree to which poor countries are able to extend access to antiretroviral therapy varies, but in every case a beginning can be made. The poorest countries need donor resources to extend this capacity. In all cases, antiretroviral therapy must be used in a careful and monitored manner, to improve adherence and reduce the risk of resistance.

While the changed global environment has increased attention to the treatment side of the equation, the core strategy of all countries must continue to emphasise widespread

and effective prevention, including education, information and condoms. However the scale of this work must be dramatically increased, especially among young people.

Building on existing programmes, many countries, and many of the poorest, have shown political commitment and made detailed preparations and are ready for greatly scaled up treatment and prevention programmes. What they lack are the resources.

In view of the urgent need and opportunity, the recent call to action by Secretary-General and the decision of the UN General Assembly to hold a special session on AIDS, is especially appropriate. We agree the time to act is now.

Based on an analysis of the cost of effective responses, we estimate that global funding for AIDS in middle and low-income countries should rise to not less than $7 billion per year within 5 years. This commitment must be sustained for at least a decade.

At the forthcoming UN General Assembly Special Session on AIDS we call on the world's political leaders to commit the financial resources and the political will to bring this epidemic under control. We call on citizens around the world to lend their support. We will not succeed until leaders in every sector of society come together in a historic global response to this most urgent of crises.

The time to act is now.

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* UNAIDS, including its Cosponsoring agencies UNICEF, UNDP, UNFPA, UNDCP, UNESCO, WHO, and the World Bank, convened a meeting together with the International AIDS Society and the Bill and Melinda Gates Foundation, from May 6th-8th at Mont Pèlerin, Switzerland, with the following individuals, at the meeting in their personal capacity as medical, behavioural and policy experts:

Professor Peter Aggleton, University of London, UK; Professor Roy Anderson, Imperial College, UK; Dr Stefano Bertozzi, Instituto Nacional de Salud Publica, Mexico; Dr Mabel Bianco, Ministry of Health, Argentina; Rev. Gideon Byamugisha, Church of Uganda; Dr Hoosen M. Coovadia, University of Natal, South Africa; Dr Tim Evans, The Rockefeller Foundation; Dr Margaret Gachara, National AIDS Control Council, Kenya; Dr Duff Gillespie, USAID, USA; Dr J. Edward Greene, Assistant Secretary-General, The Caribbean Community & Common Market; Mr Anand Grover, Lawyers Collective, Fort Bombay, India; Mr Moustapha Gueye, African Council of AIDS Service Organisations, Sénégal; Dr Scott M. Hammer, Colombia University, USA; Dr Catherine Hankins, McGill University, Canada; Professor Michel Kazatchkine, Agence Nationale de Recherches sur le SIDA, France; Professor Marie Laga, Institute of Tropical Medicine, Belgium; Ms Marina Mahathir, Malaysian AIDS Council, Malaysia; Dr Purnima Mane, The Population Council; Dr Nancy Padian, University of California San Francisco, USA; Dr Gordon Perkin, Bill & Melinda Gates Foundation; Professor Praphan Phanuphak, Thai Red Cross Society, Thailand; Mr J.V.R. Prasada Rao, Ministry of Health & Family Welfare, India; Professor Jeffrey Sachs, Harvard University, USA; Mr Eric L. Sawyer, HIV/AIDS Human Rights Project, USA; Mr Wojciech Tomczynski, Badz Z Nami, Poland; Ms Sandra Thurman, Washington D.C., USA; Dr Stefano Vella, President, International AIDS Society; Ms Wendy Wertheimer, National Institutes of Health, USA; Dr Alex Wodak, St Vincent's Hospital, Australia.