Written Testimony

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Testimony of
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Chairman Menendez and members of the committee, thank you for holding this important hearing today on the future of the United States' response to global AIDS, tuberculosis and malaria. I am Dr. Nils Daulaire, President and CEO of the Global Health Council, the world's largest membership alliance of over 5,000 health professionals and 480 service organizations working to save lives and improve health throughout the world.

Before I begin my remarks, let me applaud this committee for its commitment and dedication to global health issues, most notably HIV/AIDS. I congratulate the Committee for its bipartisan work on the United States Leadership Act Against HIV/AIDS, Tuberculosis and Malaria, the law that authorized the President's Emergency Program for AIDS Relief--PEPFAR. This historic legislation set the stage for an unprecedented U.S. government investment in the fight against a serious global health challenge. The importance of this massive investment cannot be overstated; it has literally transformed the concept of what is possible in the realm of global health. On behalf of the Council's members working in over 100 countries across the globe, and the millions whose lives are improved by U.S. government-supported global health programs, we thank you.

The Global Health Council's members include nonprofit service organizations, faith-based organizations, schools of public health and medicine, research institutions, associations, foundations, private businesses and concerned global citizens whose work puts them on the front lines of global health – delivering programs, building capacity, developing new tools and technologies, and evaluating impact to improve health among the world's poorest citizens. Our members work on a wide array of issues, including of course HIV/AIDS, but also other infectious diseases, child and maternal health, family planning, water and sanitation, and health systems strengthening.

I am a physician and have been personally engaged for more than three decades in the global effort to improve the health of the poor. When AIDS was first recognized just 26 years ago, few anticipated that it would grow to become the worst pandemic of modern times, and the world's initial slow response gave the virus a chance to establish its death grip on the lives of millions. But the past decade has been heartening to those of us who have taken on the challenge of building

health programs and services in the forgotten corners of the world. U.S. leaders, as well as leaders from other countries; the U.N.; The Global Fund to Fight AIDS, TB, and Malaria; and the Bill and Melinda Gates Foundation, have recognized both the severity and the moral call of HIV/AIDS, and the response has been unprecedented.

In fact, the response has begun to make a difference. As UNAIDS recently reported, new data show that the global HIV prevalence—the percentage of people living with HIV—has leveled off and that the number of new infections each year has fallen, in part as a result of the impact of HIV programs. However, in 2007 33.2 million [30.6 – 36.1 million] people were estimated to be living with HIV, 2.5 million [1.8 – 4.1 million] people became newly infected and 2.1 million [1.9 – 2.4 million] people died of AIDS.[1] When the reality is that every person with a new infection will need years of treatment and care, it remains clear that now is not the time to step back from U.S. leadership on this issue.

We need to continue the signal accomplishment of this new century- PEPFAR- the partnership between the Bush Administration and a solid bipartisan majority of the U.S. Congress that made PEPFAR the cornerstone of the largest prevention, care and treatment effort the world has ever seen. It is clear that PEPFAR has had some enormous successes over the last four years. We are here today in order to build on them and to make them lasting.

The things that have worked well need to be reinforced, and those that haven't worked so well need to be fixed. The reauthorization process provides us with an opportunity to examine ways to make this program more effective for the long run. To help provide constructive and informed input into the PEPFAR reauthorization process, the Global Health Council has for months now engaged a wide network of experts, implementers and advocates through the Global AIDS Roundtable and the more programmatic HIV Implementers Group. We look forward to continuing our work with this Committee to ensure that the next generation of this program continues its forward momentum.

This Administration's commitment to the fight against the global spread of HIV/AIDS has resulted in extraordinary accomplishments. Similarly impressive efforts have begun for malaria under the President's Malaria Initiative (PMI). But one thing is clear to those of us who engage daily in delivering these services: While an emergency response focused on a single disease can have remarkable, short-term results, it will not succeed as a model for the long-term response that is necessary for reversing the HIV/AIDS pandemic.

Early in his tenure, the President's first Global AIDS Coordinator, Ambassador Randall Tobias, was asked about the inter-relationships between the HIV/AIDS response and other public health interventions such as maternal and child health, family planning, nutrition, clean water, and other diseases. His response was to acknowledge that these were important problems, but that his charter was to combat HIV/AIDS through the sharp lens of prevention, care and treatment. Congress had set very ambitious targets, he told us, and he had to stay completely focused on them.[2]

His point was understandable. But I believe that, with experience, that view was short-sighted, a mistake of first principles. Over the past few years, it has become very apparent that, in the long

run, we cannot succeed in our efforts against HIV/AIDS without linking PEPFAR much more closely with these other interventions and with strengthening health systems more broadly.

Let me take as an example the issue of newborn infection with HIV, a preventable tragedy that occurs over half a million times a year.[3] PEPFAR addresses this through a program to test pregnant women and provide those who are HIV-positive the drug nevirapine, a low-cost highly effective intervention. This has been a priority program under PEPFAR. Yet throughout the world, most women are never tested for HIV, a small proportion of those who could benefit receive nevirapine, only a small dent has been made in the numbers of infected children born in poor countries, and even less impact has been seen on overall child death rates.[3-5] Why is this?

First, because women generally come to the health care system in the first place not for HIV care but for routine family planning and maternal and child health care.[6] Most of them don't even know they are HIV positive. So unless the HIV services are deeply integrated with family planning and maternal and child health services, most who need them will never know they need them, much less get them.

These women need help not just with their HIV infections. Their first priority is for a safe pregnancy and delivery. They and their newborns need to sleep under malaria bed nets. They need access to nutritious food. They need to know how they can prevent or delay their next pregnancy.

And their babies, whether HIV infected or not, need basic newborn and childhood care. After all, most children who die, even most children dying as a consequence of HIV infection, die from diarrhea, pneumonia, malaria and other common preventable or treatable childhood diseases.[7] Antiretroviral drugs alone can't save HIV-positive babies without the child health services that are currently not available because resources and manpower are being redirected towards HIV/AIDS.

The Global AIDS Coordinator, Ambassador Mark Dybul, acknowledges this reality, and has begun to explore programmatic linkages. I think he could use some help, and I believe that the Congress can provide that help by granting specific authority for, and even requiring, the Global AIDS Coordinator to link directly to the other U.S. agencies and programs that deliver these services and, when they are weak or inadequate, to support them directly with PEPFAR funds. Far from being a diversion of resources, this would assure that our HIV/AIDS dollars are spent most effectively.

Should PEPFAR then be the platform for all basic health services or bear the programmatic burden for the full array of health issues facing communities in the developing world? No. The appropriate U.S. policy approach must encompass, but not be based upon, responses to any single disease.

I will return to specific thoughts on PEPFAR reauthorization in a moment. But let me first offer you the bottom line here: While beyond the scope of this hearing alone, the U.S. government ultimately needs a comprehensive strategy to guide its engagement in improving the health of the world's citizens and, in turn, protecting the health of its own. This is my fifth appearance before Congress this year. I have testified about maternal and child health, malaria, tuberculosis and HIV/AIDS. I appreciate the opportunity to share perspective on each of these topics, but budget line items and various agency authorities have dissected a single experience – health – into disparate

funding, policies and programmatic approaches that undermine our ultimate goal: healthier individuals and families and therefore more stable and productive global communities. Investing in health is not just a humanitarian response. The returns on its investments are also seen in growing and stable political systems. With U.S. government investments in global health on the order of $6 billion (with nearly $5 billion committed to AIDS alone), don't we want to make the most of our investment?[8] I have been at this for decades, and I can tell you with confidence that single-disease, single-intervention or any other siloed approach simply will not succeed over the long run.

This hearing is about transitioning the U.S. response to the global AIDS crisis through PEPFAR from an emergency program to a sustainable one, because we recognize that the AIDS virus will be in our midst for generations to come. Our response to HIV/AIDS must now expand from a model designed to help get the emergency room up and running to one where the community clinic can successfully keep people out of the emergency room in the first place.

Of course, HIV-affected people must have access to antiretroviral drugs, but no one can survive on drugs alone. Just like everyone else, people who are living with HIV/AIDS – especially those who have gotten drugs to keep their infections in check – need good nutrition, clean water, vaccines, pre- and post-natal care for mothers and children and prevention, care and treatment for all the other major health threats that they face.

Let's face it, we are in a struggle to beat HIV/AIDS for the long haul—just like our battles to overcome cancer and heart disease at home. Now that HIV/AIDS is treatable, it has become a chronic disease, and chronic diseases require functioning health systems, working every day.[9, 10] Clinics must be open, staffed and supplied – and that can't be done just for HIV alone. Health providers must be trained, supervised, supported and paid – and no one dreams that this could be an AIDS-specific cadre. Ministries of health and non-governmental organizations alike must function smoothly and efficiently, with solid leadership and management skills – and these must be generalized skills because the systems they must support are necessary for each and every health intervention.

This is why beating HIV/AIDS demands more than HIV-specific prevention, care and treatment programs operating in isolation from other global health interventions. This is why the delivery of <u>all</u> essential health care services through strong and efficient health systems is necessary for the fight against AIDS. This is why greater integration and coordination of PEPFAR programs with other global health programs and services is the single-most important step the U.S. can take right now to maximize the program's effectiveness in the future. I call on Congress to make sure that this is supported and encouraged in your reauthorization bill.

PEPFAR can and should be better integrated on four different levels:

- Internally between its own prevention, treatment and care programs;
- Laterally across other U.S. global health programs addressing issues other than HIV;
- Nationally through the strengthening of health systems and support of expanded health manpower in countries with high burdens of disease; and
- Externally through enhanced coordination between PEPFAR and other HIV- and non-HIV specific programs managed by focus country governments and by other international donors.

Internal Integration

To date, PEPFAR's programs have been separated into the categories of prevention, treatment or care, with the focus and lion's share of funding largely on treatment. This approach can work with certain targeted populations, but there is always the risk that this construction will prove too rigid to optimize the use of resources and most effectively save lives.

Those who are at high risk of contracting HIV need to know how to stay HIV free and what treatment options exist if they do become infected. Those who are HIV-positive need to have access to the full range of prevention methods in order to improve their own health and to protect the health of those around them. It remains fundamentally true that treatment for people who are HIV-positive still needs to be expanded, but as we find that for every individual treated there are six new infections, it is clear that we will never be able to treat our way out of this epidemic. Prevention activities must be significantly scaled-up and built upon interventions that go beyond medical models to address the behavioral and social components of this disease.

I would be remiss if I did not flag two provisions within the current legislation that, if left unrevised, will undermine prevention, care and treatment activities. The first provision is the specific target that one-third of prevention funds be dedicated to abstinence-until-marriage activities. In communities where many young girls' first sexual encounter is by force or where being a young bride to an older man who has not limited his sexual encounters is the cultural norm, the current abstinence policy does not move us toward the desired outcomes—fewer HIV infections. Delayed sexual debut is ideal. However, a fundamental tenet of public health is that you tailor the intervention to local circumstances. A blanket abstinence target ignores this tenet and leaves too many young women without realistic recourse to protect their health.

The second provision is the anti-prostitution pledge which all organizations receiving PEPFAR funds must sign. This provision must be repealed. Although not politically correct, the truth is that in many areas including India, Thailand and the former Soviet Union the AIDS epidemic is driven in part by high-risk behaviors such as commercial sex work. Ideally, individuals would not engage in these activities. But, we cannot let the epidemic continue to spread because we take ideological issue with the behavior of a subset of men and women. Let us not tie the hands of organizations that are committed to providing the best interventions for people in their very real, complex, imperfect yet valuable lives. I strongly encourage the committee to consider the social and cultural complexities of the lives of people who experience this epidemic and to program accordingly.

Integration and Coordination Across U.S. Global Health Programs

Most people who are battling AIDS actually die from infections caused by other organisms that have found an open door due to HIV's suppression of the immune system; these are called Opportunistic Infections (OI's). Currently, tuberculosis (TB) kills about one-third of AIDS victims.[11] Pregnant women who contract malaria are at greater risk of HIV infection and those who are HIV-positive are at greater risk of malaria.[3, 12] And as I have noted, most children dying with HIV die as a direct result of common childhood infections whether or not their immune systems are compromised.[13]

By only addressing the HIV/AIDS-specific aspects of the health of a person with co-infections and multiple susceptibilities, PEPFAR is, in some ways, saving lives only to leave them vulnerable to

death or debilitating illness from other causes whose effects could have been minimized or eliminated with a more thoughtful and thorough programmatic response. A more comprehensive view of multiple disease risk and the appropriate response is needed. PEPFAR programs must have explicit linkages between their services and those other critical global health programs that focus on other diseases and health conditions.

A number of our member organizations do an excellent example of integrating HIV/AIDS programs with other health and development efforts. CARE has done some enormously creative and productive work towards that end. Family Health International (FHI) has also demonstrated the positive impact of an integrated response. A number of other Global Health Council members are engaged with RAPIDS – a PEPFAR funded project that covers 53 districts in Zambia to provide home- and community-based care for people living with HIV/AIDS and support for orphans and vulnerable children through a coordinated response.[15] In this example of successful coordination across U.S. programs, USAID, CDC, DOD, Peace Corps and the State Department have developed an intense, integrated and coordinated response in which it funded various organizations to take on projects that cut across all sectors. The project funds agriculture, economic growth, health, education and democracy while at the same time aiming to scale up prevention, treatment and care. As a result, thousands of people living with HIV in Zambia are accessing basic health and development services, and not just anti-retroviral therapy.

When PEPFAR was first announced, it was with assurances that this funding would be additive to funds already in place for global health and international development efforts. Sadly, we are seeing instances, such as in Ethiopia, in which PEPFAR and PMI funds have increased, while maternal and child health funds have been significantly cut.[16] Can the majority of that country's women and children who are dying despite being HIV-free, and whose deaths could readily be averted with effective, proven, low-cost interventions, consider this a victory?

Strengthening Health Systems and Building Health Manpower

HIV/AIDS has taken weak health systems in the most highly afflicted countries, particularly those in sub-saharan Africa, and stressed them to the point of collapse. A major contribution of PEPFAR was revealing the utterly desperate conditions of the world's national health systems. Once money and resources began to flow, we quickly realized that we lacked the trained professionals to delivery life-saving interventions; we lacked the management systems to implement programs and handle large infusions of resources – nearly every link in the health system left something to be desired. Weak health infrastructure and lack of an adequate human resource supply in developing countries limit the ability to support the integration and coordination of HIV/AIDS services.

While there is much to be done, perhaps the most pressing issue is the supply, type and training of health workers, particularly in the areas of expanding prevention services and detecting opportunistic infections. As the Institute of Medicine (IOM) recommends, PEPFAR must contribute to strengthening health systems and adequately train and support critically needed new health workers.[17]

External Coordination Between PEPFAR and Non-U.S. HIV- and Non-HIV Programs

Coordination is absolutely necessary within programs of the U.S. government. It is also essential with the governments of focus countries if we are to continue to build upon PEPFAR's successes. According to the IOM's report, PEPFAR country teams "have been largely successful in aligning their plans" with a recipient country's national HIV/AIDS strategies.[18] Serious concerns remain, however, about ensuring that the siren call of available PEPFAR resources doesn't result in situations where national HIV/AIDS strategies become seriously misaligned in proportion to countries' specific disease burdens.

When lives are at stake every dollar has to count. The U.S. government also must take care to chart whether other public or private donors are investing in the same kinds of programs and in the same places as PEPFAR so that duplication – or worse, destructive competition – is avoided.

Any discussion about vital coordination between PEPFAR and other HIV/AIDS efforts is incomplete without mention of the other cornerstone of the global response to this pandemic: the Global Fund to Fight AIDS, TB and Malaria. Early years saw aspects of unproductive competition between PEPFAR and the Global Fund. I applaud Ambassador Dybul for his efforts to assure closer coordination and cooperation with the Global Fund, and encourage efforts to assure that this continues and is expanded, since each of these mechanisms has its own particular strengths and advantages.[19]

Successful multi-donor coordination on HIV/AIDS programs is not only possible, it makes for better programs. In Malawi, the UK's Department for International Development, the Global Fund to Fight AIDS, TB and Malaria and Malawi's Ministry of Health together designed the Emergency Human Resource Plan to build human resource capacity to address the severe HIV/AIDS crisis in the country. This joint planning and coordination helped Malawi to double its output of nurses in just three years and increase pre-service training for doctors. The strategic coordination avoided duplicative efforts, allowing the program to address a wide range of problems related to health systems. [20]

Looking Forward

Even with its remarkable accomplishments over the past four years, PEPFAR faces an uphill battle against a virus that manages to stay ahead of the world's best efforts to defeat it. Just a few months ago, we heard about the failure of what had been considered our most promising vaccine candidate.[21] There is no doubt that more disappointments will follow. This will be a long struggle requiring persistence and patience.

As PEPFAR evolves with Congress's oversight, a number of issues must be addressed. First, the structure of U.S. global health assistance must be seriously reviewed and, I would recommend, redesigned. Each agency currently working as a part of the U.S. global AIDS response has a separate funding and procurement mechanism, different benchmarks for reporting, and different targeted communities. Under the current model, coordination and integration of HIV/AIDS is more difficult than it needs to be. Congress should take steps to correct this.

Congress must also assure that health systems and health manpower development are front and center in expanded efforts to address HIV/AIDS and other major causes of ill-health and death in highly affected countries.

Finally, the U.S., other donors and national governments must take under serious consideration the financial implications of a sustainable response to global AIDS, specifically, and basic health more broadly. While U.S. funding for global AIDS grew from $125 million in 1997 to $5.4 billion in 2007, it still remains below the levels needed for fully scaling up prevention and treatment in the focus countries, much less the need for HIV/AIDS services in non-focus countries where millions of people are infected or at-risk.[22] Treatment costs will rise with the need for second-line drugs and HIV-positive individuals living longer and requiring a wider array of health services.[4] Effective and widespread prevention services, although a wise long term investment, will add significant costs.

This need for expanded funding will continue from a finite pool of resources. Still, the funding currently available for global AIDS programs dwarfs the U.S. investments currently made in other global health programs. For example, USAID's child and maternal health and reproductive health accounts have remained at around $360 million and $400 million a year respectively, and yet three times as many children and women die globally each year from non-HIV related causes than from AIDS.[23, 24] Resource constraints as well as policy restrictions have impeded the successful "wrap around" of non-HIV services with HIV services.

Increased support for global AIDS programs must not come at the expense of other global health programs if we are to achieve both the goal of establishing an effective HIV/AIDS program and the goal of building comprehensive and efficient national approaches to all major global health threats.

Conclusion

The President's Emergency Plan for AIDS Relief may be relatively new, but the fight against the global spread of HIV/AIDS is not. We have reached a point where the emergency response is still necessary but no longer sufficient in our fight against HIV/AIDS. HIV/AIDS is inextricably linked with other diseases. To effectively combat this pandemic, we must expand our response, and a comprehensive approach to global health in developing countries is needed to do that successfully.

Today, I have proposed steps that could be taken in the near future to strengthen PEPFAR by better integrating PEPFAR services internally, across U.S. global health programs, with national health systems, and with external partners addressing HIV/AIDS in the developing world. We can improve upon the lessons learned through PEPFAR to improve our global AIDS response and reverse the HIV/AIDS pandemic.

In the long term, I urge Congress and the Administration to also consider the role of PEPFAR in the context of developing a comprehensive U.S. strategy for addressing all critical global health issues. The Global Health Council and our members stand prepared to help address the realities in which a third of the world's people live – and in which a disproportionate number die.

Thank you again for the opportunity to testify before you today. I welcome your questions.

References

[1] UNAIDS, World Health Organization. 2007. AIDS epidemic update. Available from: http://data.unaids.org/pub/EPISlides/2007/2007_epiupdate_en.pdf

[2] H.R. 1928. United States Leadership Against HIV/AIDS, Tuberculosis and Malaria Act of 2003. Public Law 108- 25. Available from: http://thomas.loc.gov/.

[3] UNAIDS, World Health Organization. 2006. AIDS epidemic update: December 2006. Available from: http://www.unaids.org/en/HIV_data/epi2006/default.asp

[4] World Health Organization. 2007. Towards universal access: scaling up priority HIV/AIDS interventions in the health sector. Available from: http://www.who.int/hiv/mediacentre/universal_access_progress_report_en.pdf

[5] Global Health Council. 2007. Our global responsibility to the world's children. Available from: http://www.globalhealth.org/images/pdf/conf_2007/child_health.pdf

[6] World Health Organization. 2005. World health report 2005: make every mother and child count. Geneva: WHO. Available from: http://www.who.int/whr/2005/en/

[7] Bryce J, Boschi-Pinto C, Shibuya K, Black RE, WHO Child Health Epidemiology Reference Group. 2005. WHO estimates the causes of death in children. *Lancet* 365(9465):1147-52.

[8] Global Health Council. 2007. Global health funding. Available from: http://www.globalhealth.org/view_top.php3?id=172

[9] Travis P, Bennett S, Haines A, Pang T, Bhutta Z, Hyder AA, et al. 2004. Overcoming health-systems constraints to achieve the Millennium Development Goals. *Lancet* 364:900-6.

[10] World Health Organization. 2006. World health report 2006: working together for health. Geneva: WHO. Available from: http://www.who.int/whr/2006/en/

[11] World Health Organization. Joint HIV/tuberculosis interventions. (accessed September 24, 2007), Available from: http://www.who.int/hiv/topics/tb/tuberculosis/en/

[12] Breman J, Alilio M, Mills A. 2004. Conquering the intolerable burden of malaria: what's new, what's needed: a summary. *American Journal of Tropical Medicine & Hygiene* 71:1-15.

[13] Prendergast A, Tudor-Williams G, Burchett S, Goulder P. 2007. International perspectives, progress, and future challenges of paediatric HIV infection. *Lancet* 370:68-80.

[14] Reynolds H, Janowitz B, Homan R, Johnson L. 2006. The value of contraception to prevent perinatal HIV transmission. *Sexually Transmitted Diseases* 33(6):350-6.

[15] USAID. HIV/AIDS multisector. (accessed September 20, 2007), RAPIDS]. Available from: http://www.usaid.gov/zm/hiv/hiv.htm

[16] Global Health Council. 2007. Global health spending: an analysis of the President's fiscal year 2008 budget request. Available from: http://www.globalhealth.org/

[17] Institute of Medicine. 2007. PEPFAR implementation: progress and promise report brief. Available from: http://www.iom.edu/Object.File/Master/41/807/PEPFAR%20report%20brief.pdf

[18] Sepulveda J, Carpenter C, Curran J, Holzemer W, Smits H, Scott K, et al., editors. *PEPFAR implementation: progress and promise*. Washington, DC: Institute of Medicine, 2007.

[19] Wakabi W. 2007. Global health agencies agree to HIV/AIDS partnership. *Lancet* 370:15-6.

[20] Medecins San Frontieres. 2007. Help wanted: confronting the health care worker crisis to expand access to HIV/AIDS treatment, the MSF experience in South Africa. Available from: http://www.msf.org/source/countries/africa/southafrica/2007/Help_wanted.pdf

[21] Kaiser Family Foundation. Merck halts international HIV vaccine trial. Kaiser daily HIV/AIDS report. September 24, 2007. Available from: http://www.kaisernetwork.org/daily_reports/print_report.cfm?DR_ID=47688&dr_cat=1

[22] Global Health Council. 2007. 10 year chart explanation. Available from: http://www.globalhealth.org

[23] U.S. Appropriations 1997-2007. 2007 (accessed March 12, 2007), Available from: http://www.thomas.gov/

[24] World Health Organization. 2004. WHO global burden of disease (GBD) 2002 estimates (revised). Available from: www.who.int/healthinfo/bodestimates/en