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PEPFAR Reauthorization
Part 2
Center for Strategic & International Studies
October 16, 2007

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J. STEPHEN MORRISON: —has been the Co-Chair of the CSIS Taskforce since 2004. He's been a very loyal and strong leader on a number of different dimensions of these issues, and we're very grateful to you, Senator Feingold, for all that you've done for us, and we're thrilled that you're here with us today at this very important discussion of reauthorization.

SEN. RUSSELL FEINGOLD (D-WISC): Thank you—

J. STEPHEN MORRISON: Thank you.

SEN. RUSSELL FEINGOLD (D-WISC): —Steve, very much, and I'm sorry if I was a little late getting here. I hope you're having a good morning. I'd like to first thank CSIS for helping to coordinate this event and for all their good work on HIV/AIDS and other key global challenges.

Additionally, I want to extend a warm welcome and my sincere appreciation to the other members of Congress and guests who have spoken at this morning's conference. It is exciting and inspiring to be in the company of so many distinguished experts and advocates, some of whom I've gotten to know over these years, and all of whom have contributed directly to fighting the HIV/AIDS pandemic.

I am pleased to have all of you as partners as we work together to explore how the United States can do more and do so efficiently, effectively and sustainably to contribute and have international efforts to prevent, contain and combat the

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HIV/AIDS pandemic and other related diseases that continue to plague populations, economies and essential infrastructure around the globe.

I know that a great number of you have been devoted to this issue and its victims for many years in varying capacities, so you experience and expertise are invaluable for my colleagues and for me as we consider the next steps for the United States government in this area.

Clearly, we are no longer in the early fact-finding trial and error phase of global HIV/AIDS, malaria and tuberculosis programs. Thanks to the substantial investment of the President's Emergency Plan for AIDS Relief and the Office of US Global AIDS Coordinator, the Global Fund, UNAIDS and the hundreds of implementing partners working to prevent, treat, care for and cure these deadly diseases, we are now actually building a body of knowledge about what works best in sometimes widely varying or different circumstances.

Now as PEPFAR's initial five-year stage draws to an end, we have a unique opportunity to collect, compare and consider these lessons that we have learned to inform the next phase of US and international global health efforts.

For example, I just spent part of the Congress's August recess in Uganda where I met with many HIV/AIDS experts to hear what they had to say about PEPFAR and the United States support for AIDS-related programs in general. As I sat down with some

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of these experienced and knowledgeable individuals in Kampala, their appreciation of US funding and PEPFAR was evident.

At the same time, however, they had a lot of suggestions for how US efforts could be improved to be even more helpful. As most of you here are aware, Uganda has been seen as a rare example of success on a continent facing a severe AIDS crisis. That government's prompt recognition of the crisis and comprehensive policies to address it, including a well-timed and successful public education campaign, are usually credited with helping to bring adult HIV prevalence down there in Uganda from around 15-percent in the early 1990's to just over 5-percent in 2001.

Unfortunately, though, in late 2005 UNAIDS estimated that 6.7-percent of adults were living with the virus, and in 2006 scientists suggested that Uganda's HIV prevalence rates may actually be rising again. Indeed, I heard that same concern from most if not all of the individuals I met as well as from the Ugandan President himself.

US HIV/AIDS programs and funds—Uganda is a PEPFAR focus country—have been criticized as at least to partially blame for this disappointing reversal, so while Ugandans are grateful for US HIV/AIDS funding, this support would be more effective if it is corresponded more closely to actual national needs, conditions and initiatives.

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The first message, which came up time and time again in my meetings with Africans, was that more needs to be done with respect to prevention. Given the rising infection rates in Uganda as in many other parts of the world, the emphasis on treatment fails to address the principal drivers of the epidemic.

It has become a common refrain that we cannot treat our way out of this global pandemic. In the global context the organization Family Health International reports that for each new person who received antiretroviral therapy in 2005, another seven people became infected. As long as infection rates are rising, treatment and care costs will increase, as will the disease's burden on key vulnerable populations as well as their families, communities and countries.

And I want to be candid here. When I came back from Dakar and some other countries in 2001, I was saying that there wasn't treatment anywhere in Africa. I was very concerned that that emphasis wasn't balanced, so this is an ongoing effort to make sure we get the balance right, and over time we have to have the integrity to make the adjustments that need to be made to make sure that we are actually addressing the problem the most intelligent way we can.

Treatment and care are essential reactive measures, and in many cases treatment services are an important entry point for prevention, an opportunity that should be capitalized on

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significantly. But the future on HIV/AIDS will depend on our ability to proactively restrain its spread.

A related issue is the importance of ensuring adequate flexibility so that US programs can be adapted to meet local needs and cultural standards. Rightly or wrongly, critics have accused the US of encouraging a shift in Uganda's HIV/AIDS prevention policy towards promoting abstinence only and away from promoting condoms, causing a severe national condom shortage.

I remember being concerned about this at a hearing that was held in the Formulations Committee a few years ago where a woman from Uganda was having some real concerns about some of the testimony she had heard because it seemed like the United States might be encouraging an undoing of a plan or a program that had worked by emphasizing one factor over another.

And this was a major point for discussion when I was in Kampala, and in fact I shifted the conversation to a heated debate about the shifting public face of the campaign, a shift they characterize as a disservice to the full ABC programs.

We clearly need to expand the scale and scope of our prevention efforts and reach out to critical populations more effectively since the continued spread of HIV now threatens the longer-time sustainability of global efforts to combat HIV/AIDS by the US and others.

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Now, one aspect of prevention is family planning, which including reproductive health and mother-to-child transmission. In many parts of Africa, Uganda and the developing world in general there is widespread demand for modern birth control methods, but these are not always available. How can HIV/AIDS be combated if these demands cannot be met?

Equally relevant, what effect does the rapid population growth occurring in many of these countries have on HIV/AIDS epidemics and efforts to combat the disease. My sense is that we must incorporate family planning into overall HIV/AIDS plans since the two are clearly interrelated.

Country-specific indicators should be vital factors in designing and adapting US assistance programs. Domestic, political and religious concerns should not preempt US or multilateral support for lifesaving supplies and programs. Family planning is a valuable service in and of itself, but when provided in the context of broader HIV prevention, such programs can have far-reaching health and livelihood benefits.

One of the central themes of this conference as well as numerous reports and seminars on PEPFAR and HIV/AIDS has been the disproportionate impact of the disease on women and girls. I met one of these girls at the Joint Clinical Research Center in Kampala. She was diagnosed with HIV at a very young age and had also lost her parents to the disease.

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I was so pleased to see that because of thorough treatment, which included not only the necessary drugs but also more general healthcare, solid nutrition and counseling, she was able to be now living a strong, healthy life.

In Uganda as well as in other parts of Africa I visited I have been reminded that without developing more specific strategies to address the vulnerabilities of women and girls, we cannot hope to turn the tide of the pandemic.

Congress recognized this reality when we passed the 2003 Leadership Act, which called the US Global AIDS Coordinator to develop specific strategies to meet the unique needs of women. Ambassador Dybul and his able team have initiated several such programs intended to empower women in interpersonal situations, to encourage the reduction of sexual violence and coercion and to increase women's access to employment opportunities and income, productive resources and microfinance programs. Now we need to consider how to expand and improve the effectiveness of these initiatives by integrating them with other programs.

PEPFAR was designed to be very results focused, which has helped demonstrate the effectiveness of its programs and to continue to solicit support within Congress and other key constituents is essential for its continuation.

On the other hand, the program's emphasis on a narrowly-defined set of observable indicators sometimes

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overlooks key dimensions of the epidemic beyond the health sector, for example: The preservation and enhancement of household livelihoods; fulfillment of basic nutrition requirements; interactions with other diseases, such as tuberculosis and sexually transmitted infections; and the functionality and adequacy of national health systems need to be considered and reflected in HIV/AIDS plans and programs if our investment is to have a substantial and sustainable impact.

We should also explore the role of the private sector of these efforts to maximize resources and reach. Something else that was made very clear to me in Uganda is that sending a proper and pragmatic message through our HIV/AIDS programs is essential. Our efforts must be consistent and focused if we are to overcome complacency and contribute to long-term behavior change, which is the only enduring solution to this health crisis.

Yes, the past four years have taught us a lot about how we can and must work together to contain and combat HIV/AIDS, malaria and tuberculosis around the world. But the battle is ongoing. There is no quick fix or shortcut to success, but the papers presented and ideas expressed at this morning's conference offer many valuable suggestions for ways to learn from the recent past, to guide the next few years of this national and international campaign.

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I am committed to maintaining and expanding the US response to the HIV/AIDS pandemic in the short and long term. So again, thank you to all the individuals and organizations in this room that are doing so much to advance this objective. I look forward to continuing to work with you as all Congress supports the continuation of US leadership to prevent, contain and combat HIV/AIDS, tuberculosis and malaria in a way that advances a wide range of global health and development objectives. Thank you very much for having me here. [Applause].

J. STEPHEN MORRISON: I think we have a few minutes. If we have the authors of the papers here, I think they would like input. We've had some wonderful suggestions that have come up, and I think CSIS wants to move this forward and has future plans for more meetings of this type. So the floor is open if any of you would like to address any of the prevention, manpower, harm reduction or, let's say, I won't call it harm reduction but drug treatment and gender issues.

SEN. RUSSELL FEINGOLD (D-WISC): We can start that off by just asking—there's been a number of comments offered along the way.

J. STEPHEN MORRISON: Do you want to respond to things you've heard?

SEN. RUSSELL FEINGOLD (D-WISC): Phil, do you want to offer some thoughts?

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J. STEPHEN MORRISON: Maybe things you heard from any of the speakers?

PHILLIP NIEBURG: Yes, just one quick comment about the issue of tuberculosis. Steve had mentioned that we're contemplating issuing a paper on tuberculosis and its links to HIV. And it's obviously a critical issue. AIDS is actually not the same as HIV. AIDS is HIV in somebody who has another AIDS-defining illness, and many of those AIDS-defining illnesses are tuberculosis. So prevention of the occurrence of active tuberculosis is actually essential to reduce the toll of AIDS.

And on the flip side, reducing the impact of—well, HIV works by reducing the function of the immune system and allowing TB to become an active disease, and so effective HIV prevention is yet another way of reducing the spread of active HIV—or active tuberculosis. I just wanted to get that on the table.

J. STEPHEN MORRISON: Janet, you want to—

JANET FLEISCHMAN: I think it's worth just reinforcing a point that Senator Feingold made in terms of family planning being a prevention strategy in itself because if you're able to provide women with the means to prevent unintended pregnancies, especially for positive women, you are preventing positive babies from being born.

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It’s also very important to be looking at a whole new range of issues that country programs are confronting now involving addressing the fertility desires of positive women. When they want to become pregnant, how can they be assisted to become pregnant as safely as possible, and what kind of services do we need to provide.

And we need to be looking at that issue because it’s emerging in all the PEPFAR countries, and the USAIDS strategy needs to be cognizant of important ways that that will affect issues of training and service providing.

MICHEL KAZATCHKINE: Before you come in, your paper I thought was in a way of introducing new things to the table for PEPFAR more that we hadn’t heard a lot about before. I’m wondering—we haven’t done very well in this country in drug treatment to say the least among our own population. And there’s really only one—I mean you make the point about Africa, but there’s really only Vietnam is the clear case.

I’m just wondering how hard you think in the legislation we should all push for the kind of issue that you raised. Tactically, what has been your experience with the Congress and NOSI’s experience? In our report we do address this but not nearly in depth as you have in your presentation.

JANET FLEISCHMAN: Right. Well, first off in the United States we certainly fall short of providing national coverage for drug treatment services, but we do for people who

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are addicted to heroine currently provide treatment for 250,000 people across the country. So I don't think we should underestimate the gains that we've made in this country and the lessons that we can provide to other countries.

One think that I think is remarkable in the discussion about PEPFAR, both in the original bill and again coming up for reauthorization is that what's happening in Africa is so overwhelming that it becomes the global strategy. And to the extent that people are traveling and learning about programs and trying to better understand the epidemic, they're doing that in Sub-Saharan Africa.

So I think for all of us there's a real challenge to keep the other countries on the agenda to make sure that we're engaging those partners in the debate and really trying to enable US policy to tailor interventions for different countries, and I return to that point over and over again.

When you look at the actual PEPFAR legislation, you don't need dramatic changes to address epidemics outside of Africa. You know you could design a very good US strategy for Russia, China, Malaysia, but there's no accountability for those initiatives.

So if you sit through a PEPFAR hearing right now, nobody says what progress have you made in China or what is happening in Russia. And so I think, you know, again, we need to engage in that conversation in a much more relevant—

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MICHEL KAZATCHKINE: Can I just say you—not to monopolize—but you raised something, Allen, which you actually asked me in the previous meeting we had two months ago when we were discussing the IOM Report when you asked the question whether the PEPFAR legislation, and we didn't discuss this much today, should stick to the 15 countries or whether in the reauthorization we ought to broaden the focus a little bit.

I don't know how others feel about that, but that's an interesting question because what we discussed on the IOM was more on prevention, and we didn't say, we didn't comment on the limit to the 15 countries, but most of what we heard today was really from our Congressional and Senators were 15 countries, focus countries. We didn't hear much at all about the other parts of the world.

So do you think that this is a good idea that we should be pushing or not? You asked me that question, so I'm asking it back to you. [Laughter].

ALLEN MOORE: Yes, I'm not a huge fan of saying let's add a focus country a year or add some particular number. I think we—the focus countries were originally identified because they incorporated half the known infections at the time. And the problem with adding—I mean there are a number of problems with adding focus countries: A) It tends to push resources in a particular direction because I'll remind you there are 15 focus countries and there are AIDS-supported programs in 80

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other countries, which gets a little bit to Zoe's comment that we're doing some things in these other places. And in a few instances, we're actually spending more in some very large non-focus countries than we are in some very small focus countries.

But her point is, which I concur with, that we need to pay attention to what we're demanding in these other places and think about it. You don't have to create a focus country. You can create a target country if you feel the need to do that. I mean you can create a whole other category.

There's a political dynamic you can't ignore, which is the moment we start talking about more countries, there are people in the Congress who say well, I've got a country. I got a candidate. It's one that I've been interested in for a long time. We saw a little bit of that the last time we added one extra focus country. We actually went into the Caribbean in part because of Congressional interest and part because of need.

I don't see a lot of discussion about moving out to other focus countries. It would be nice if we could avoid that battle, which isn't to say that it's not a legitimate issue. I think that there are some other things that we didn't talk about today. There were some references to speed and the importance of acting early, and I think that there are some good reasons to try to move sooner rather than later. I don't think we'll hit the Administration's hoped-for December 1st

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timetable, but it would be nice if early next year we could keep the momentum going.

And one thing you worry about is if there are lots of demands for new things, new mandates, new focus countries of specific targets, earmarks, et cetera, and there is certainly a demand for those things out there in the community. We could slow this down a lot, and you've got to be careful what you wish for. And to the extent that we like to invoke the good work of the IOM committee, which said dump the earmarks, you know, we ought to think twice about saying we're going to have a bunch of new mandates.

There's a whole issue of the size of what goes on. Mrs. Lee mentioned $50 billion. The President sought $30 billion. I'll remind everybody that although, you know, the ultimate size is going to be really important, that will be decided each year by the appropriators. That doesn't mean that the level of authorization is irrelevant. It is important, but in the first go-around we authorized $15 billion. We will spend over $18 billion. We're not bound by that number.

Having said that, I'm quite confident that they will come up with a bigger number. It needs some thought, but again, it's not going to totally bind us.

Finally, this whole prevention versus treatment issue, which we heard discussed in various ways by different people, some of whom would come and go, and it was interesting for

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those of us who heard all of it to say whether the pendulum is swinging or be careful or the pendulum needs to swing.

What I find particularly interesting about that prevention/treatment issue is that the existing law says 55-percent of the money must go to treatment, of which 75-percent must go to the procurement and distribution of drugs. We are ignoring that requirement without any significant repercussion. Ambassador Dybul said we're spending about 46-percent on treatment and considerably less than three-fourths of that on the drugs themselves because the drugs turned out to be a lot cheaper than we thought they were going to be.

Nobody's complaining about that. The law has a soft earmark on prevention that says we should be spending about 20-percent. It's not a hard earmark. What's hard, what is fixed in the earmark is the 33-percent of whatever we spend on prevention that must go for abstinence until marriage, but that requirement has been completely gutted also with basically the acceptance of the Congress because it is what was an abstinence until marriage earmark became an abstinence and fidelity and partner reduction and all sorts of other things.

So it's a mess. It's a problem, as you guys pointed out, but it's not the disaster that it could have been had these changes not occurred.

Having said that, I think this issue of treatment versus prevention is not going to go away, and as Mark said,

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you can’t do effective prevention without care and treatment. And as everybody recognizes, the long-term solution is more on prevention. So I think there’s more work that’s going to have to be done. The hallmark here of all of that, though, I think is going to be preserving flexibility to respond to local needs and local priorities and desires as well as our knowledge and the world’s knowledge about what makes the most sense.

MICHEL KAZATCHKINE: We’re going to close in a minute. I want to take advantage right now just to ask Zoe one other question. I mean one of the things that jumps out in your paper, and it is a new debate in a way. I mean it’s new to this sort of setting.

I mean one of the things that jumps out is that in many of the countries that have the highest burden of an IDU epidemic, the legal barriers are just stark to being able to do something. And we’ve seen this, I mean we saw this in our mission to Vietnam where there was some flexibility, but it was very, very, very slow and required years. We’ve seen this in the repeated visits to Russia, these problems.

Now, China is the great exception, and can you just talk a bit about that? About what you see as the implications of the turnaround or the shifts in Chinese approaches and what does that mean for people sitting here thinking about reauthorization?

ZOE HUDSON: That's the kind of question that one should think about [inaudible] [laughter], but what I would say is that the experience in China right now is very complicated. I think, you know, on the one hand they have done more to tackle HIV and drug use than any other country in the world at this point, and their targets are ambitious and historic, and they're spending a lot of energy trying to meet them and appear to be on track to meeting some of those targets.

When you visit the programs, there still are significant barriers to people actually receiving services, and so take the example of access to methadone in China right now. You have to have failed other types of drug treatment programs something like two times, you know, which means serving time in prison-like settings before you can access those programs.

And so you're talking about people who have years of increased risk of HIV infection before they can access a service that they should be able to get on demand. And I think the Chinese are struggling with how to do that differently, and there's a serious conversation going on about that. But I don't think the jury is out on the China experience right now.

On the flip side I think when you look at a country like Russia, which has refused to make any changes in the way that they address HIV and drug use, our best ally might be China. You know, the US has limited leverage in Russia, and it might be that the Russians will learn from the Chinese

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experience about how to do this better. But I think some of those exchanges are beginning to happen.

So you know, like the rest of the world, China just is a big player right now, and I think it's incredibly important to be engaged and to be supportive and to be thoughtful about what's happening there.

MICHEL KAZATCHKINE: So Steve asked me just to say a few words in closing, and I will do that. First to thank CSIS on behalf of all of us for organizing this event and for keeping the iron hot and the flame burning around PEPFAR and the need to keep it going.

As someone who's been in this now almost 20 years, this is a historic moment if we can keep it going. And I come away from today, Steve, feeling that without a doubt this is going to keep going. We're now debating amount and legislation, but I think that for those of us who have been in this for a long time, these are wonderful achievements. And politics aside, we should take pride in what our government has done and try to make it better.

But I heard today quite a few of the speakers talk about the apolitical or the bipartisan nature of this at a time when this has been pretty hard in our nation's history. And for that I think we owe a lot to CSIS I think because of the way you've handled this.

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I also think one other point that doesn't get talked about, and Allen, you reminded me of it by something you said. One of the things that the IOM chose not to comment on because it wasn't in our mandate but what we really saw was important and strengthened our recommendation to move this into a longer strategic planning mode looking at sustainability and trusting the countries was we were very impressed—I'd like to say I'm speaking now not as a member of the committee—but we were very impressed that what PEPFAR had done was taking a health issue in Africa in particular and put it at the Ambassador level.

And every ambassador we met was engaged, and in our history you don't, you know, even with smallpox eradication that was not the case. And I think one of the reasons we trusted as a committee the idea that you could leave things to the country level, that we were against—we didn't think the earmarks were needed—was we met incredibly dedicated US government staff from CDC, from USAID, from DOD, NGOs in the field really working together but with ambassadorial leadership.

And I think that's something we need to remember that PEPFAR has done for us, and the ambassadors would tell us there are four things we have to concentrate on, and we've been told by the Secretary of State that AIDS is one of them.

So although this doesn't come through in the report, I do want to remind us all that we've also changed the paradigm

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on the way health is seen in the field at least in Africa and in other countries, and we should think about building on this in the next Administration with other health issues because I think we've got a precedent here in making health a huge priority in the field.

And as we know, AIDS is not the only problem. Certainly, those of you working in child health, maternal health, feel that you haven't gotten the resources you deserve. And those of us, like myself who have really turned their careers to global health in general, really believe that AIDS like it often has done in this epidemic is showing us a way to hopefully get things done better.

And so I leave you with that thought and realizing, you know, what Senator Feingold said about other health problems and trying to see what we can learn from PEPFAR as we all think about what we do within AIDS and outside of AIDS. I just leave you that thought, and Steve, thank you very much for organizing today and thank you to all the people who put forward the papers, and thank you all for coming.

J. STEPHEN MORRISON: Thank you, Mike. [Applause].

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