

The President's Emergency Plan for AIDS Relief

**Statement of Ambassador Eric Goosby, M.D.
U.S. Global AIDS Coordinator, U.S. Department of State
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Introduction

Chairwoman Lowey, Ranking Member Granger: thank you for this opportunity to discuss the President's Fiscal Year (FY) 2011 Budget request for the President's Emergency Plan for AIDS Relief, or PEPFAR.

You and your colleagues have been key partners in our work since the early days of PEPFAR, and the bipartisan support from both this Subcommittee and Congress overall has been an essential ingredient of the program's success.

And the support for this program, which was established by the Bush Administration, is reflected in a strong and enduring commitment to the fight against global AIDS by the Obama Administration. It is a central piece of the foreign policy and global health agenda outlined by both the President and Secretary of State Hillary Rodham Clinton.

In fact, PEPFAR is the cornerstone of the President's Global Health Initiative (GHI), which commits \$63 billion dollars over six years to support partner countries in improving and expanding access to health services. GHI represents a stunning level of investment that would have been unimaginable even 10 years ago. In addition to this funding commitment, GHI is about new emphases on integration, coordination, building capacity, and creating the conditions for long-term sustainability. I want to stress that this new Initiative will not change PEPFAR's emphasis on prevention, care and treatment of HIV/AIDS, but will allow us to ensure that communities affected by HIV have access to a comprehensive set of health services, to address the range of health needs they face. And I look forward to working with my colleagues across agencies, and in consultation with Congress, to ensure the success of GHI in improving the health of people and the health systems of partners around the globe.

Budget overview

Let me begin by providing an overview of the FY 2011 Budget request. In a time of tightening budgets and economic constraints, this request for the eighth year of the program is the largest request to date in a President's Budget. The U.S. is -- and under this Budget will remain -- by far the largest donor to global HIV/AIDS efforts, contributing more than half of the total global donor response to this epidemic. Despite the economic and budget challenges we face, the President's request demonstrates this Administration's continued commitment on HIV/AIDS.

The President is seeking \$6.99 billion for bilateral HIV/AIDS programs, bilateral tuberculosis (TB) programs and research, and contributions to multilateral efforts such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and the Joint United Nations Programme on HIV/AIDS

(UNAIDS). The request includes \$5.74 billion for bilateral HIV/AIDS programs, a \$197 million increase from the FY 2010 enacted level.

The U.S. remains by far the largest financier of the Global Fund, which is a central piece of the U.S. strategy to address global HIV/AIDS, TB and malaria. The President's request of \$1 billion (from all accounts) for the Fund represents the largest request made in a President's Budget to date, up from the FY 2010 request for \$900 million, and a doubling of the FY 2009 request of \$500 million by the previous Administration. U.S. contributions since the inception of the Global Fund through the FY 2009 contribution total more than \$4.3 billion. Including contributions from FY 2009 and FY 2010, the total U.S. contribution through FY 2010 is anticipated to approach \$5.5 billion.

In addition to direct financial contributions, the U.S. supports the Fund through planning support and technical assistance to facilitate grant implementation funded through U.S. bilateral programs. The Global Fund's success is our success, so the PEPFAR vision is one of greater collaboration at the country level, in addition to continued strong funding support.

The current global response

I'd like to offer some perspective on where the global response is today – where we have been, and where we are going under our new Five-Year Strategy, which was released in December 2009. For a deeper exploration of these topics, please refer to the Strategy at <http://www.pepfar.gov/strategy/index.htm>.

Seven years after the creation of PEPFAR, AIDS is still a leading cause of death in many countries, and a continued threat around the world.

According to UNAIDS, 33.4 million people are living with HIV worldwide, and approximately 2.7 million new infections occurred in 2008. For every two people who start treatment, five more are infected. Women and girls continue to face disproportionate impact of new infections. The World Health Organization (WHO) reports that AIDS is the leading cause of death worldwide for women in their reproductive years (ages 15-44) – and these women who die often leave behind children who are then themselves at higher risk for adverse health outcomes. Most-at-risk populations - including men who have sex with men (MSM), sex workers, and injecting drug users - continue to face stigma that limit their ability to obtain services, contributing to the wider transmission of HIV.

And, of course, AIDS remains an incurable, fatal disease. We can keep people alive with treatment, but we cannot yet cure them, nor do we yet have a vaccine to prevent infection.

The AIDS crisis is far from over. We must not become complacent, or prematurely declare victory in a fight that is a very, very long way from being won. Investments in PEPFAR, and the global AIDS fight overall, continue to be necessary.

At the same time, we should take note of the difference PEPFAR and other responses to HIV/AIDS have made.

As a clinician, I've been dealing with this disease both domestically and internationally for more than 25 years. A decade ago, those of us engaged in HIV work in sub-Saharan Africa were witnesses to daily

tragedies on a huge scale. Hospitals were not just full of people dying of AIDS, they were overflowing with multiple patients to a bed, spilling out onto the floors and into the hallways – any place where they could rest while waiting for some care.

While antiretroviral treatment had become widely available here in the United States during the 1990s, fewer than 50,000 people in all of sub-Saharan Africa were receiving it at the beginning of 2003. Even to those of us who had been responding to HIV/AIDS for decades, the sheer need, scope and inequity of this emergency were overwhelming. Many people thought treatment could never be scaled up in Africa because of weak health systems, the need for doctors and nurses, and the lack of resources in these countries.

Today, with American leadership, the task few thought was possible is well under way. Now, we're directly supporting almost 2.5 million individuals on treatment, the vast majority in Africa. And millions more are benefiting from prevention and care programs. In FY 2009 alone, PEPFAR supported HIV counseling and testing for nearly 29 million people, providing a critical entry point to prevention, treatment, and care. The program also supported care for nearly 11 million people affected by HIV/AIDS, including 3.6 million orphans and vulnerable children.

I would particularly like to note a marked increase in the results achieved by programs for prevention of mother-to-child transmission (PMTCT). In FY 2009, PEPFAR-supported programs provided services to millions of women, allowing nearly 100,000 babies of HIV-positive mothers to be born HIV-free, adding to the almost 240,000 infant infections averted during the previous years of the program. Our PEPFAR country teams deserve great credit for this significant boost in PMTCT efforts. FY 2009 results for all program areas may be found at www.PEPFAR.gov.

For those of us who saw the 'before' picture of AIDS in Africa, the 'after' picture we see today reflects extraordinary accomplishments. Or perhaps it's better to describe it as the 'during' picture, because right now we are really still in the early stages of what must be a sustained, global scale-up of the response.

When I visit countries now, I see the dramatic transformation this has brought about – not only for individuals, but for their families, their communities, and their nations. This change is not just reflected in hospitals and clinics, which are no longer overwhelmed by people dying of AIDS. It's reflected in the day-to-day lives of people.

I recently had the pleasure of visiting Nigeria, where I met with the Chief of the Gwagwalada Community near Abuja to discuss the impact of HIV/AIDS programming upon his community. At the meeting were men, women, and children who spoke about the ways that PEPFAR had impacted them – by providing treatment, by providing care, by providing support when their families were too sick to care for them. At the end of this meeting, the community took a vote of confidence in the PEPFAR program – a vote of confidence in the generosity of the American people.

Moving forward with PEPFAR and GHI

PEPFAR's core business has been and will continue to be prevention, care and treatment. But as we move forward, we are working to move from an emergency response to promoting sustainable, country-

led responses. I'd like to briefly discuss some of the themes which will guide us over the next few years, both in PEPFAR and the broader GHI.

Expanding existing commitments with a renewed focus on prevention

In recognition of the integrated nature of prevention, care and treatment in PEPFAR, the U.S. continues to support a portfolio of balanced activities tailored to the country context. All of these activities are routinely monitored and evaluated in order to ensure that they are of high quality. In keeping with the goal of sustainability, PEPFAR also supports the enhancement of local capacity to carry out monitoring and evaluation activities.

Prevention must be a central element of any successful country strategy. It remains the paramount challenge of the HIV epidemic globally, and preventing new infections represents the only long-term, sustainable way to turn the tide against HIV/AIDS.

A successful prevention program requires a combination of mutually reinforcing interventions tailored to the needs of different target populations. In recent years, several low-prevalence countries have had some success in containing their epidemics, concentrated in most-at-risk populations. However, only a few high-prevalence countries have significantly reduced HIV prevalence. Increased attention is critical for hyperendemic countries, while simultaneously continuing to respond to countries with both concentrated and generalized epidemics. Over the next phase, PEPFAR's prevention response is being guided by the following concepts:

- Supporting countries in reassessing their prevention response through mapping the epidemic, identifying the populations most impacted by new infections, and updating prevention strategies based upon these data;
- Assisting countries in implementing a combination of behavioral, biomedical, and structural interventions;
- Implementing, scaling up, and measuring the impact of proven and promising interventions, tools, and methodologies;
- Working with countries to target and reach most-at-risk populations, no matter how stigmatized or marginalized these populations may be;
- Expanding the evidence base around prevention, through monitoring, evaluation, and operations research of prevention programming; and
- Contributing to international efforts to develop harmonized indicators and new surveillance methodologies.

At the country level, multiple epidemics exist within diverse populations and social networks, including concentrated epidemics within larger generalized epidemics. Identifying and targeting interventions to match these needs is difficult, especially when such epidemics involve groups that are often marginalized and discriminated against. Stigmatized populations are frequently hidden and hard to reach with services. PEPFAR will support efforts to address the prevention, care and treatment needs of most at-risk populations. In addition, the disease's disproportionate impact on women and girls means that our prevention programs must focus on interventions – behavioral, biomedical, and structural – that will keep women and girls safe from infection. And an essential part of meeting the needs of women and girls involves working with men and boys to change attitudes around gender.

Supporting country ownership

A central focus of our Five-Year Strategy and of the GHI is promotion of country-led sustainable programs. We are committed to making sure efforts to fight global HIV/AIDS are lasting. Strong government leadership of the health system is integral to long-term success, and health systems are strongest where governments have leadership and technical skills to address health system weaknesses. As a result, PEPFAR will build partner government capacity to plan, oversee and manage programs; to support delivery of quality services with the participation of local civil society and communities; and ultimately, to finance health programs. Working from the basis of national health plans and engaging direct dialogue with partner country leadership, we will support countries in identifying the unmet needs their people face and identifying resources to meet them.

While a network of public and private partners delivers services, governments play the lead role in overseeing health systems among multiple actors at national, district, and community levels. In collaboration with other U.S. programs and international donors, PEPFAR supports governments to identify opportunities for health systems strengthening within their HIV and broader health and development sector plans.

Last August, I wrote to our U.S. Ambassadors in PEPFAR countries to ask for their leadership in supporting the transition from an emergency response to a sustainable program by increasing engagement and technical support for partner countries. I have been greatly encouraged by their efforts in response; they and their Embassy teams are on the front lines of our relationships with partner countries, so they see the value of this heightened emphasis. Under their leadership, our country programs are developing Partnership Frameworks and accompanying Implementation Plans with partner governments. These conversations are proving to be key forums for identifying what PEPFAR support for country ownership means on a country-specific basis, and we in turn are attempting to increase our ability to support their needs at the headquarters level. Our discussions are also laying the groundwork for some of our efforts to engage in partnership with countries more broadly through GHI.

Broader impact of investments on health systems and partner countries

Our Congressionally-mandated goals focus on individuals receiving services with PEPFAR support. Yet, just as the negative health and social impacts of HIV/AIDS have been far-reaching, successful interventions have had far-reaching effects.

PEPFAR and other programs benefit not only individuals, but their families and communities, and ultimately have a stabilizing effect for entire nations. A May 2009 study published in the *Annals of Internal Medicine* found that HIV-related mortality had dropped by 10.5% in the 12 PEPFAR focus countries analyzed by researchers - implying that about 1.2 million deaths were averted due to the work of PEPFAR. The individuals whose lives are saved are thus able to continue to work, or return to work. They can continue to provide and care for spouses and children who depend on them. To state the obvious, even the best program for orphans and vulnerable children cannot compare with keeping parents alive and families together in the first place.

Central to PEPFAR's impact to date, and a heightened focus under both our Five-Year Strategy and GHI, is support for strengthening of health systems. In order to improve the overall quality of their health services, we are supporting countries to make measurable improvements in the WHO's six

building blocks of health systems functions: service delivery; health workforce; information; medical products, vaccines and technologies; managing and financing; and leadership and governance.

By reducing the HIV burden on facilities and health workers, PEPFAR frees up existing capacity to address other health needs. It also helps to build new capacity in national health systems, particularly in areas like human resources for health. In countries like Ethiopia, Mozambique, Kenya, and Malawi, PEPFAR has supported health worker training that allows for “task-shifting,” which allows health care workers, where appropriate, to receive training to achieve higher-level tasks, maximizing their efficiency in clinics and treating more patients overall. We are also working aggressively to meet the legislative goal of supporting training and retention of 140,000 new health workers, dramatically expanding the capacity of national health systems.

Across Africa, PEPFAR is supporting investments in a lab infrastructure that can be used not only to process HIV tests, but also to be mobilized to identify H1N1 or other emerging infections. And the Supply Chain Management System, the mechanism through which PEPFAR supports countries in maintaining reliable supplies of life-saving treatment, is building country capacity to deliver not only HIV commodities, but the entire range of needed products. The most advanced warehouse management system in the Caribbean was developed with PEPFAR support, helping to ensure that drugs are delivered and stocked in a timely manner both for HIV and other diseases.

As we move forward, we will seek to ensure consideration of health systems dynamics in countries’ work to define, map, and implement plans to address country-level need, and develop robust indicators to track progress with health systems strengthening. PEPFAR is also working with countries to leverage additional donor resources and coordinate activities to realize broader impacts on overall health systems.

As part of GHI, PEPFAR will explore opportunities for joint programming and increased coordination around implementation and evaluation of health systems activities. In several PEPFAR programs we’ve been able to ‘wrap around’ services so that we’re not only serving the HIV needs of our clients, but also partnering with other programs of the U.S. and other partners to meet their other needs. For example, PEPFAR programs have worked with USAID education programs to address needs of HIV-affected orphans and vulnerable children, such as for school fees and supplies, meals, and vocational training, with special emphasis on keeping girls in school in countries such as Namibia, Uganda, and Zambia.

Fostering a shared global response

GHI and the PEPFAR Five-Year Strategy are built on the recognition that improving global health outcomes is a shared responsibility. The U.S. is joining multilateral, partner country, NGO, and private sector efforts to make progress toward achieving the health-related Millennium Development Goals.

In developing countries, all the elements of a national response to health needs – including HIV prevention, treatment, and care – require support from a mix of national resources and external resources. The U.S. cannot be the sole source of support. Rather, a global health response needs resources and investments from multiple sources, including country governments, other donors, multilateral organizations, and foundations.

I have already mentioned the strong U.S. financial support for the Global Fund, a multilateral financing organization that works through country-level mechanisms to support the response in three disease

areas. The Fund is critically important, because it provides a funding vehicle for nations that do not have significant bilateral programs as the U.S. does. I represent the U.S. on the Fund's Board, and under the GHI, we see the Fund's success in building country programs as being additive to PEPFAR programs in country. Our vision is one of greater collaboration at the country level to take full advantage of potential synergies that increase the number of people receiving services. The U.S. is the largest funder of this organization, but we do much more than provide funding. The U.S. also supports the Fund by funding planning support and technical assistance to facilitate Fund grant implementation. And we're working at the highest levels of the Fund to promote the concepts of country ownership.

Because the U.S. has done so much on HIV/AIDS, I sometimes sense a tendency for people to conclude that we can or should do it all. Even if we somehow could do it all, globally or in any country, that would completely undermine the principles of country ownership and sustainability, and leave sovereign nations at the mercy of outsiders.

This Administration is aggressively pursuing dialogue around a truly shared global response in multiple fora with partner governments, other donor governments, multilateral organizations, and foundations. We must all come together if we are going to win this fight.

Promoting a whole-of-government approach in PEPFAR and GHI

The people who lead the implementation of PEPFAR, both in the field (including locally employed staff) and at headquarters, are simply extraordinary. We owe them all a tremendous debt of gratitude. I take seriously the obligation to ensure that our leadership and management structures support them to the best of our ability.

PEPFAR has worked to decentralize programming and ensure that decisions on country-level activities are made by the U.S. country teams that are leading the ground-level response to the epidemic. For the past five years, these country teams have worked to rapidly expand and ensure quality health and social service delivery, while facing heavy reporting requirements. PEPFAR's interagency country teams ensure that programs meet the needs of the countries and communities where they work. PEPFAR is working to further integrate the field perspective into its policy and communications and reduce the reporting burdens and paperwork requirements placed on the field.

And I am pleased to note that PEPFAR's "whole of government" emphasis is being reinforced by the "one U.S. Government" focus of GHI. PEPFAR is assessing its innovative approaches to determine what elements contributed to interagency success at both the field and headquarters level, in order to replicate these more broadly through the GHI. PEPFAR is also working to emphasize the core competencies of each agency. By achieving better coordination and building upon the strengths of U.S. personnel, we can maximize our country-level impact in all of our U.S. programs.

Conclusion

Once again, Madam Chairwoman and Ranking Member Granger, I appreciate the Subcommittee's strong support. I look forward to our dialogue.