Letter to President Barack Obama from TAC and partners - why we need expanded funding for HIV

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Dear President Barack Obama,

RE: Expanded and sustainable funding is needed to meet universal access targets for HIV treatment, prevention and care.

Over the past decade the United States has expanded access to treatment for over 2.4 million people living with HIV/AIDS. The Presidents Emergency Plan for AIDS Relief (PEPFAR), established in 2003 under former President George W. Bush, built treatment and care programmes and strengthened health systems across the developing world. When country governments refused to acknowledge HIV/AIDS, PEPFAR secured the right to life for millions.

In 2005, the United States, as a G8 nation, committed to supporting universal access to HIV treatment, prevention and care. This commitment was later endorsed by country leaders at the 60th session of the United Nations General Assembly. The global commitment to universal access is also reflected in the Millennium Development Goal 6 ? which in addition to universal access, also commits countries to halting and reversing the spread of HIV by 2015.

In its seventh year, PEPFAR is strategically positioned to expand treatment and care, reduce new infections, build country health systems, support universal access targets and lay the path to meeting a number of other millennium development goals (MDGs).

Today over 4 million people are receiving antiretroviral treatment, but this only represents 42% of people that need it. Expanded and sustainable funding is needed to meet universal access targets. Despite PEPFAR?s unique positioning to strengthen the impact of global AIDS programmes and global health outcomes, the US is backing away from its commitments on HIV/AIDS.

In 2008 PEPFAR was set to expand with the passing of the Lantos-Hyde legislation. This landmark legislation approved $48 billion for PEPFAR over the next five years, with $39 billion earmarked for HIV. However, over the past year, it has emerged that HIV/AIDS programmes may never see this level of funding as across the region PEPFAR programmes are capping patient enrolment.

The approved $48 billion did not make it into the 2010 Congressional budget, and Congress increased PEPFAR funding by just 2.2% for 2011, the smallest in the programme?s history.[1] Further, President Obama, during your electoral campaign you committed to expanding funding by $1 billion per year, yet you only asked for a $366 million increase for 2010. These unmet PEPFAR funding commitments will undermine efforts to meet universal access.

In the past year the number of HIV positive people that PEPFAR started onto treatment was the smallest it has been for four years.[2] Programmes across the region are feeling the effects of contracting PEPFAR funding. In some countries where programmes are heavily PEPFAR funded, most-visibly Uganda, the flat-lined budget has resulted in patients who are eligible for treatment being turned away from facilities without receiving care.

Further, the future of PEPFAR funded treatment programmes are threatened as the US aims to move away from providing ?direct care? to ?technical assistance?. The move away from providing direct care has been promoted to develop country ownership and funding of ART programmes as developing countries often spend far too little on health and HIV.

The lack of funding by developing countries is a valid concern, echoed by civil society across the region. The Treatment Action Campaign (TAC), the AIDS Rights Alliance of Southern Africa (ARASA) and partners launched a regional campaign in 2009, to pressure developing country governments to expand funding for HIV and health and to promote effective use of funds through civil society budget monitoring. We have already begun to see real gains in South Africa, the epicentre of the epidemic, in expanding funding to reach universal access targets.

In addition, while there is a great need for technical assistance to build health care systems in the developing world, this investment should not be made at the expense of the care that millions are receiving through PEPFAR funded programmes. The reality is that a premature move by PEPFAR away from providing direct care will have devastating health consequences in the region. Transferring patients from PEPFAR funded programmes, to government facilities without the drugs, capacity or resources to absorb the patients will result in treatment resistance, increased mortality and preventable new infections.

Why the move away from funding HIV/AIDS is based on flawed arguments with potentially profound and devastating consequences.

President Obama, in 2006 you visited Africa as an advocate of people living with HIV. In Kenya you took an HIV test to encourage others to get tested and lessen the stigma and discrimination faced by people living with HIV. In South Africa you visited the Treatment Action Campaign?s Khayelitsha offices and spoke to HIV educators working in township schools. After visiting Africa you campaigned around the need to strengthen and expand PEPFAR stating: ?We are all sick because of AIDS - and we are all tested by this crisis.?[3]

Today, under your administration, the United States? policy priorities are shifting away from HIV/AIDS programmes. This shift in priorities has been promoted by arguments that funding for HIV has crowded out funding for other diseases and has expanded at the expense of other MDGs and health systems strengthening. These arguments are flawed as a move away from funding HIV/AIDS will worsen health outcomes, set us back in meeting a number of other MDGs and destabilize health systems.

Opponents of HIV funding argue that money should instead go to other MDGs and particularly infant and maternal health. Yet, HIV continues to be the leading cause of maternal and infant mortality in the African region ? in at least 4 Southern African countries (South Africa, Lesotho, Botswana and Namibia), more than 50% of deaths in children under 5 are attributed to HIV.[4] It is estimated that every minute a child is born with HIV.

It is clear that expanded access to HIV treatment, prevention and care is necessary to reducing maternal and infant mortality and meeting MDGs 4 and 5.[5] Initiating mothers onto ART treatment earlier will reduce maternal mortality - 84% of maternal deaths occur in women whose CD4 counts fall below 350 cell/mm3 before initiating treatment.[6] Expanded access to ART is also necessary to reducing infant mortality. ART (HAART or PMTCT) during pregnancy and breastfeeding have been shown to reduce HIV transmission from mother to child to below 1%. Also, for HIV positive infants, immediate access to ART can reduce mortality by 75%.[7]

Another argument against HIV funding is that the HIV programme is isolationist, neglects other diseases and is carried out at the expense of health system strengthening. Experiences on the ground have shown this claim to be unfounded. In many cases HIV programmes have supported strengthening services for a wide range of diseases. HIV care has often included: early screening for cervical cancer, enhancing utilisation of sexual and reproductive health services, testing for and treating TB and malaria (which along with AIDS are responsible for most of the world's infectious disease deaths) and promoting access to safe water supplies and better nutrition.

In 2009 Medicins Sans Frontieres reported that HIV/AIDS programmes have had a positive impact in terms of human resources for health, improved laboratory monitoring and pharmacy capacity and management, and more effective health management information and procurement systems.[8]

Antiretroviral therapy is also essential to the successful treatment and prevention of many other diseases rife in sub-Saharan Africa. These medicines are a major contributor to reducing opportunistic infections and AIDS related diseases. Far too few patients are accessing treatment too late. The consequences of late treatment are more new infections, more opportunistic diseases, more AIDS-related disease and high rates of mortality.

In addition, we are seeing increasing evidence that ART is an effective method of prevention and that expanded access to ART, is necessary as part of a comprehensive package of prevention services. ART is already used in the region to prevent mother to child transmission (PMTCT) and for post exposure prophylaxis (PEP) for rape survivors. However it is now recognized that ART is an important prevention method to reduce to risk of sexual transmission of HIV in sero-discordant partnerships ? to the extent that experts based at the World Health Organization have suggested immediate treatment of all people living with HIV as a potential strategy for eliminating the epidemic.[9]

Another fatal miscalculation in the arguments to reduce HIV funding is that they do not contextualize the devastating human, social, political and economic impacts of reducing access to treatment. HIV has disproportionately affected young adults in the developing world ? the backbone of any economy. A reduction in treatment for HIV would be reflected through the economy, thereby impairing development. Further, vulnerable segments of the society, especially women, have the highest rates of HIV prevalence. Reducing access to health services would further marginalize these groups.

Now is the time to build on gains made in recent years and reach universal access across the region!

We call on the US to build on the strong partnerships it has nurtured across the developing world and leverage the lessons and successes of PEPFAR to strengthen its global health response in a rational, responsible and humane manner.

Today we are seeing the implementation and strengthening of evidence based policies for prevention and treatment in the region. We are positioned to eradicate mother to child transmission of HIV by 2015 ? with sufficient funding and political will. Further there is increasing evidence that antiretroviral treatment and prevention cannot be separated and that treatment must be scaled up, as part of a comprehensive package of prevention services, to reduce new infections.

South Africa, the epicentre of the epidemic, has 17% of the global burden of HIV and 28% of the global population with dual HIV/TB.[10] After years of dragging its feet and undermining HIV/AIDS efforts, the new South African government, under the leadership of President Jacob Zuma and Health Minister Aaron Motsoaledi, have put in place evidence based treatment policies as well as expanded funding for HIV. The government is also taking steps to strengthen the health system, overcome barriers and integrate the delivery of health services. In this new era of real political will to address the HIV epidemic, now would be the worst possible time for the US to back away from its HIV commitments.

Be a champion for the region! Be a champion for universal access!

During the 2010 World Cup in South Africa, TAC, ARASA and partners will march for the right to access treatment for all people and the need to ensure that sufficient and sustainable resources are made available. We will march for you, President Obama, not to turn your back on the President?s Emergency Plan for AIDS Relief and the lives supported by it. Further we will call on you to take advantage of the opportunities to end mother to child transmission, reach universal access and improve health outcomes across the region.

On 17 June 2010 we will be engaging in a peaceful demonstration in Johannesburg to demand expanded and sustainable resources for health. We ask that you come out and meet us, once again, to accept our march memorandum. We ask that you recommit to expanding funding for HIV/AIDS. Further, we call on the United States of America to take leadership by example to ensure that all developed nations uphold their commitments to universal access for HIV treatment, prevention and care.

Yours respectfully,

Vuyiseka Dubula
General Secretary of the Treatment Action Campaign

Endorsed by:

SECTION27
SAfAIDS
Médecins Sans Frontières
Community Media Trust
World AIDS Campaign
AIDS Rights Alliance of Southern Africa

[1] Paul K. AIDS Programme Hit Setback in Africa. *Newsweek*, April 27 2010. http://www.newsweek.com/id/237037
[2] Ibid.
[3] President Barack Obama. ?Barack Obama: Fighting HIV/AIDS Worldwide.? (Campaign material) 2008.
[4] Medecins Sans Frontieres. Punishing Success? Early Signs of a Retreat from Commitment to HIV/AIDS Care and Treatment. 2009.

[5] MDG4 is to reduce child mortality and the MDG5 is to improve maternal health.
[6] Venter F. IAS Conference Symposium, Fifth International AIDS Society Conference on HIV Pathogenesis, Treatment and Prevention. July 2009.
[7] Violari A et al. Early antiretroviral therapy and mortality among HIV-infected infants. N Engl J Med. 2008 November 20. 359, 2233-44. http://www.ncbi.nlm.nih.gov/pubmed/19020325
[8] Medecins Sans Frontieres. Punishing Success? Early Signs of a Retreat from Commitment to HIV/AIDS Care and Treatment. 2009.
[9] Granich R et al. Universal voluntary HIV testing with immediate antiretroviral therapy as a strategy for elimination of HIV transmission: a mathematical model. Lancet 2009; 373: 48?57.
[10] Minister of Health Aaron Motsoaledi. Media Briefing: HIV and AIDS: Business as usual? 10 November 2009.

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