

Attention: **Eric Goosby**
United States Global AIDS Coordinator
Washington, DC

Cc: **Ezekiel Emmanuel**
Special Advisor for Health Policy
Washington, DC

25 September 2009

Dear Dr Goosby,

We, the undersigned 60 civil society organisations and networks of people living with HIV and TB, working in 28 countries across Southern Africa and the world, write to express our dismay at your statement that a target of achieving universal access for HIV prevention and treatment in Southern Africa by 2015 is 'unrealistic' because the resources required to enable this will not be found.

1. Your rhetoric sets a dangerous precedent

In addition to the betrayal of promises that this statement conveys, as the United States had previously endorsed this target and committed to mobilizing resources to enable its achievement, we also worry that your rhetoric sets a dangerous precedent for further backtracking on commitments made to achieving universal access in the region.

This comes at a time when we have already seen a dampening of efforts towards fulfilling these commitments – such as in some PEPFAR-funded programmes in Uganda¹ – which threaten the health and lives of the more than 3 million people already on treatment, the 63% of people living with HIV in low and middle income countries who still do not have any access to ARVs, as well as the unknown number of people who will acquire infection as prevention programs feel the strain of inadequate resources.

¹ Mugenyi P (2009) Flat-lining funding for PEPFAR: A recipe for Chaos. Lancet 2009;374(9686):275

We acknowledge that there are numerous challenges that impede progress towards universal access, but believe that redoubled efforts, and not resignation, are the appropriate response to these challenges.

2. The consequences of not achieving universal access for HIV are far reaching, and cut across the health and other socio-economic sectors

We call on the Obama administration to realize that the impact of decelerating treatment access is not limited to the loss of individual lives, although this is grievous enough in itself, but has far-reaching socio-economic consequences² – and as such, consequences for the development of the region as a whole.

Furthermore, in high-prevalence countries, many of which are found in Southern Africa, an adequate response to HIV is integral to the realization of a range of other health goals. This includes maternal and child health – for example, 43.6% of maternal deaths in South Africa are due to HIV³. In Lesotho and South Africa, the leading cause of infant and under-five mortality is HIV: 56% and 57%, respectively, of under-5 deaths are HIV-related.⁴

Tuberculosis, which was in 2005 declared a public health emergency in the African region, is unambiguously tied to the HIV epidemic: of the 37% of notified TB cases in the African region who are tested for HIV, 51% are HIV-positive, but only 33% of these are started on ARVs – often due to access barriers.⁵ Unsurprisingly, the African region has the highest mortality rates for TB.

We welcome the increased attention given by the Obama administration to broader health systems strengthening, as this is the critical foundation upon which all disease-specific interventions are built, but emphasise that it is a tragic fallacy to pursue this at the expense of HIV programs –rather it needs to happen in concurrency with the accelerated expansion of HIV programs. As is increasingly being documented, “HIV scale-up is contributing to expansion of control efforts for related conditions, enhancing utilization of sexual and reproductive health services, promoting

² See UNAIDS (2008) *Global Report on the AIDS epidemic*, p159

³ South Africa National Department of Health, National Committee for Confidential Enquiries in Maternal Deaths, Saving Mothers 2005 – 2007: *Fourth report on confidential enquiries into maternal deaths in South Africa*.

⁴ HEARD (2008) *Reviewing “Emergencies” in HIV and AIDS-affected Countries in Southern Africa: Shifting the Paradigm in Lesotho*

⁵ World Health Organisation (2009) *Global Tuberculosis Control: Epidemiology, Strategy, Financing*. page 46

access to safer water and nutrition, improving infection control in health care facilities, promoting task-shifting and health worker training, enhancing infrastructure, record-keeping, and laboratory services, and facilitating a shift from an episodic model of care to a continuity model of care.”⁶ The lessons that we have learnt about strengthening health systems through expanding HIV services should be built upon, not detracted from, to intensify health systems gains from HIV programming in future.

We also caution against detached economic calculations that pit one health need against another and suggest an increased focus on cheaper health investments, in favour of more costly investments such as HIV treatment.⁷ These distinctions are false and unconstructive –while there may be a separation between interventions, different health needs often co-exist within the same individuals; and as such, diverting money from one to another only serves to alter the specific morbidities that individuals face and destabilize health systems.

Decelerating the response to HIV will not only reverse gains that have already been made at high cost, but further generate additional costs: through the broader impact of the epidemic in this region, examples of which are outlined above, and through potentially increasing drug resistance as a result of treatment interruptions.

3. The real crisis is a crisis of priorities

While the economic crisis poses a challenge to the availability of resources, we believe that the real crisis determining the fate of HIV and TB programs in Southern Africa is a crisis of priorities. A mere 1% of the money invested by the United States government in the bank bailout, which was considered a priority investment, would cover the US’ fair share to global AIDS funding. Similarly, at national level, large sums of money are lost in this region to political extravagance, military expenditure and corruption – which could make a substantial contribution to advancing access to prevention and treatment and thus saving lives.

We therefore challenge the view that resources cannot be found, and point out that even before the economic crisis, HIV, TB and health in general were critically under-funded both by international

⁶ International Center for AIDS Care and Treatment Programs (2008) *Leveraging HIV Scale-up to Strengthen Health Systems in Africa*. Page 5

⁷ Denny C, Emanuel E. *US Health Aid Beyond PEPFAR. The Mother & Child Campaign*. JAMA. 2008;300(17):2048-2051.

donors and national governments. To sustain the progress that has been made towards universal access and achieve all of the health-related MDGs, a much broader paradigm shift is needed in the approach to health in this region. Your statement dismisses one of the most important health goals for the region, and thus implicitly detracts from civil society's efforts to motivate such a paradigm shift.

4. PEPFAR needs to work with civil society to decrease irrationalities and increase accountability

Nonetheless, we support your call for developing a robust response that will ensure that all available resources are used to the best, and welcome the stated willingness of the US government to work with civil society to achieve these aims. In that spirit, we conclude with the observation that there continue to be striking irrationalities in implementation of HIV treatment programmes in this region, which civil society has attempted to highlight but for which a stronger leadership stance is required of PEPFAR.

A key example is the continued over-reliance on highly centralized, expensive, doctor-dependent models of care that do not only limit access to care, but also impede successful treatment outcomes. Decentralization and task-shifting to allow nurses and community health workers a greater role in the initiation and management of ART is crucial for sustained and cost-effective progress.⁸

Another example is the lack of infection control in many health care facilities, which results in high nosocomial transmission of communicable diseases that disproportionately affect people living with HIV – not least, TB. Only 34 of the 63 countries that account for 97% of the global TB-HIV co-epidemic have infection control policies in place.⁹ Basic preventive and hence cost-saving measures continue to be ignored by programmes across the region, thus generating avoidable morbidities, mortalities and costs.

The bottom line is accountability. Just as we expect the United States government to be accountable, and not to walk away from commitments it has made to universal access, so we expect the same of

⁸ Tugume G.p, et al., *Task shifting – an approach for expanding quality and cost effective community antiretroviral therapy*, 5th IAS Conference on HIV Pathogenesis and Treatment, 2009

⁹ World Health Organisation (2009) *Global Tuberculosis Control: Epidemiology, Strategy, Financing*. page 46

our own national governments. In this regard, a greater partnership is needed between PEPFAR and civil society groups at the country level, to ensure that there is transparency and efficiency in the use of donor funding for health; and to hold national governments accountable for funding commitments that they have made.

However, we emphasize that regardless of the extent of country-level input, international solidarity will always be necessary to sustain a response to HIV, and as such PEPFAR has a critical role to play – both substantive, in that PEPFAR funding is needed to support country efforts; and symbolic, in that the US government, as a world leader, needs to lead the drive for sustained and increased commitment to this public health and human rights imperative.

Now, more so than ever, we cannot afford to lose momentum – and for this reason, we call on the Obama administration to publicly demonstrate that prioritising HIV treatment was not solely the domain of the previous administration, but that this commitment will continue to be upheld in coming years.

We call on you to set the record straight: urgently communicate your commitment to achieving universal access, and to ensuring that PEPFAR is fully funded so that the program targets, including treating 3 million people and training and producing 150,000 new professional health workers, can be met.

When you are next in the Southern African region, we would appreciate a meeting between you and civil society groups to discuss these issues.

We look forward to your response.

Signed:

ORGANIZATION

1. ACTION SIDA
2. ACT-UP
3. African Services Committee
4. Agua Buena Human Rights Ass

COUNTRY

Comoros
USA
USA
Costa Rica

5. AID for AIDS International	USA
6. AIDS and Rights Alliance for Southern Africa	Regional – Southern Africa
7. AIDS Care Watch	USA
8. AIDS Law Unit - Legal Assistance Centre	Namibia
9. AIDS Legal Network	South Africa
10. AIDS Response Trust	South Africa
11. Asia Catalyst	USA
12. Batanai HIV & AIDS Support Group	Zimbabwe
13. Centre for Health Policy & Innovation	South Africa
14. Centre for Human Rights	South Africa
15. CHESO Society	Tanzania
16. Coalition for Women Living with HIV & AIDS	Malawi
17. Delhi Network of Positive People	India
18. Development for Peace	Lesotho
19. Dialogo Asociacion para promover el dialogo entre culturas y los Derechos Humanos	Uruguay
20. Enviamos el apoyo de la siguientes Organizaciones Sociales de Uruguay	Uruguay
21. Family-In-Need Trust	Zimbabwe
22. Forum Francophone de lutte contre la TB	Burkina Faso
23. FoTAC	United Kingdom
24. Global AIDS Alliance	USA
25. GNP+	Netherlands
26. Grupo Esperanza y Vida	Uruguay
27. HealthGap	USA
28. ITPC	Global
29. Just Associates Southern Africa	Zimbabwe
30. Mecanismo Social de Control y apoyo al VIH	Colombia
31. MOCPAT	Cameroon
32. Movimiento Latinoamericano y del Caribe de Mujeres Positivas	Uruguay
33. National Association of PLHA in Nepal (NAPN)	Nepal
34. National Women' Lobby Group	Malawi

35. NEPHAK	Kenya
36. Network of Men Living with HIV/AIDS	Kenya
37. PLUS Coalition Internationale Sida	France
38. Positive Generation	Cameroon
39. Presbyterian AIDS Network	USA
40. Prisons Care and Counselling Association (PRISCCA)	Zambia
41. Protection enfants SIDA	DRC
42. Public Personalities against AIDS Trust	Zimbabwe
43. RAPT	Zimbabwe
44. RAVANE+	Mauritius
45. Red de PVVS de la Frontera Uruguay	Uruguay
46. REDLA+	Uruguay
47. Results	USA
48. Southern African Treatment Access Movement (SATAMo)	
49. SCARJOV	Angola
50. Senderos Asociacion Mutual	Colombia
51. SISAL	Madagascar
52. STOP AIDS Campaign	UK
53. Stop-TB eForum Resources team	India
54. Swaziland Positive Living	Swaziland
55. THAI AIDS TAG	Thailand
56. Treatment Action Campaign	South Africa
57. Treatment Action Group	USA
58. Umunthu Foundation	Malawi
59. United Belize Advocacy Movement	Belize
60. Vermont Global Health Coalition	USA
61. Zimbabwe Lawyers for Human Rights	Zimbabwe