



Joint United Nations Programme on HIV/AIDS

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**Testimony to the hearing of the Committee on Foreign
Relations of the United States Senate on
‘Halting the Global Spread of HIV/AIDS: the Future of
U.S. Bilateral and Multilateral Responses,
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**by Peter Piot,
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Mr. Chairman, distinguished members of the committee, ladies and gentlemen.

I thank you for the opportunity to testify this morning, and I applaud you for your focus on the global AIDS epidemic.

I am here today on behalf of the UN System organizations responding to the global epidemic, and in particular the eight UN agencies whose collective efforts on AIDS make up UNAIDS, namely UNICEF, UNESCO, ILO, the United Nations Development Programme, UNFPA, UNDCP, the World Health Organization and the World Bank.

AIDS is different

And Mr. Chairman, I am here today to tell you that the AIDS epidemic is different from any other epidemic the world has faced, and as such, requires a response from the global community that is broader and deeper than has ever before been mobilized against a disease.

Twenty years since the world first became aware of AIDS three things have become clear:

- that humanity is facing the most devastating epidemic in human history, the impact of which threatens development and prosperity in major regions of the world.
- that for all the devastation it has already caused, the AIDS epidemic is still in its early stages; and
- that we are in a position to bring the epidemic under control.

The first twenty years in the history of an epidemic is only the blink of an eye. The other communicable diseases that ravage many parts of the world have been known for many centuries. Their patterns of spread have become well-established and predictable.

Mr Chairman, committee members,

AIDS is unlike any other epidemic that we have faced:

- It affects every strata of society – wealth is no protection against the virus;
- Young adults are its biggest target – so it kills people just when they are in the most productive – and reproductive – phases of their lives;
- It has far-reaching ripple effects, on the economy, on the family and for the generation of children left without parents;
- It remains surrounded by taboo and stigma – still a huge barrier to effective responses.
- It spreads silently, so millions can be infected with HIV in a population before the impact in illness and death becomes apparent

This silent spread and slow impact of AIDS have meant that the threat it poses has been consistently underestimated. For a moment, let us compare it to the much feared Ebola, a virus I have had first-hand experience of, dating back to when I was a member of the

team that investigated the first known epidemic of Ebola virus infection in 1976 in then-Zaire.

Ebola spreads rapidly and causes illness instantly, so there is never any doubt about the need for a rapid and comprehensive response. Today, when Ebola breaks out anywhere, action teams are dispatched without delay. The immediate and present danger it represents is readily recognized and the international community immediately mounts an appropriate response to halt the new epidemic – and Ebola has caused probably no more than 1000 deaths in total.

Now, let us imagine a much smarter virus than Ebola. A virus just as deadly, but one capable of creeping silently through whole populations before it revealed itself. A virus whose casualties from its local epidemics are not measured in the hundreds, but in the hundreds of thousands. A virus that kills slowly, and painfully, and generally only after stigmatizing and pauperizing the entire family of an infected person.

It is difficult to imagine a smarter, more devastating virus than the subject of this hearing, the virus that causes AIDS. And it is equally difficult to imagine a world unwilling to mobilise to slow the spread and eventually contain this virus. All the more so, given what we know about it, how long we have seen it coming, and where we can now see it going.

The state of the global epidemic

More than 60 million people worldwide have been infected with the virus – nearly double the population of California. Since the epidemic's start, twenty million of the sixty million people infected with HIV have died – a number equivalent to the populations of Texas or New York State.

HIV/AIDS is now by a large margin the leading cause of death in sub-Saharan Africa and the fourth-biggest global killer. Life expectancy in sub-Saharan Africa is now 47 years, when it would have been 62 years without AIDS. In 2001 alone, an estimated 5 million people became infected with HIV, and half of them were young people between the ages of 15 and 24. There were an estimated 800,000 children under 15 – mainly infants – infected with HIV in 2001, and 580,000 child deaths as a result of AIDS.

Sub-Saharan Africa is the region of the world where the epidemic has been worst and where its impact increasingly threatens the stability of whole societies.

Average prevalence in sub-Saharan Africa is 8.8 per cent in the adult population (15-49 years old). There are seven countries, all in the southern cone of Africa, where more than twenty per cent of adults are infected with HIV, and a further nine countries where infection rates exceed ten per cent.

We still do not know what is the upper limit for the extent of HIV spread in a population. Botswana is the country with the highest HIV rate to date with 36 per cent of adults infected. It is followed by Swaziland, Zimbabwe and Lesotho all between 24 and 25 per cent.

While the scale and impact of AIDS in sub-Saharan Africa is the worst in the world, HIV is a rapidly expanding problem in other regions.

HIV/AIDS is growing fastest in the countries of the former Soviet Union. There are a million cases in the region, and at least 250,000 new HIV infections in the past year – most of them in the Russian Federation. Ukraine has the highest prevalence with nearly 1% of the adult population living with HIV.

In Asia, China and India currently have relatively small overall prevalence, but given their huge populations, within each there are large numbers of people and locally high proportions that are infected with HIV. For example, the Indian states of Maharashtra, Andhra Pradesh and Tamil Nadu, each with over fifty million people, have HIV rates measured in pregnant women above three per cent, over four times the national average. In China, we have estimated that concerted action taken now will be able to avert ten million new HIV infections over the coming decade.

Adjacent to the U.S. mainland, the Caribbean is, next to Africa, the second-most affected region in the world. In a number of countries in the Caribbean and Central America more than two per cent of the population is HIV infected and adult HIV prevalence has risen to over 4% in Haiti and the Bahamas.

Nor can we declare HIV a problem that is over in the U.S., western European, and other wealthy countries - the rate of new infections in the U.S. and Western Europe has not been significantly reduced in the last decade. In the course of 2001, an estimated 30,000 adults and children became infected with HIV in Western Europe and 45,000 in North America, taking the total numbers living with HIV in these regions combined to 1.5 million. In these countries the face of the epidemic has changed, and it is among the poorer, ethnic minority and immigrant populations that the numbers infected with HIV are growing fastest. Ironically, access to more effective HIV treatment may also be associated with rises in unsafe sex among some of the populations that historically have shown the greatest level of behaviour change, such as gay men.

The Impact of AIDS: Every sector is affected

Mr Chairman, distinguished committee members,

AIDS is currently one of the greatest threats to global development and stability. It is a long-term humanitarian crisis of unprecedented proportions – the death and misery it has caused in the past twenty years dwarfs all of the natural disasters that have occurred in

that time combined. The HIV epidemic has not only disrupted many millions of individual and family lives, it has threatened the stability of entire societies.

Economic Impact

In the worst affected countries, AIDS has a major impact on business productivity, on livelihoods and the supply of food, and on professionals: from doctors through to police forces. For example, in Kenya, AIDS accounts for 75 per cent of all deaths in the police force over the past two years. AIDS not only affects the poor, but also the educated and skilled. In South Africa, for example, ING Barings Bank projects that one-third of the semi-skilled and unskilled workforce will be HIV-positive by 2005, 23 per cent of the skilled workforce and 13 per cent of the highly skilled workforce. In the mining industry throughout Africa there is now an acute problem in replacing skilled mine workers lost to AIDS. And in Zambia, nearly two thirds of deaths among managers have been found to be attributable to AIDS, a higher proportion than among middle-ranking workers.

Consequently, AIDS has a direct impact on rates of economic growth in the most affected developing countries. There is a direct relationship between the extent of HIV prevalence and the severity of negative growth in GDP. When the rate of HIV in a population reaches 5 per cent, per capita GDP can be expected to decline by 0.4 per cent a year. And when HIV reaches 15 per cent, a country can expect a one percentage annual drop in GDP.

The cumulative impact of HIV on the total size of economies is even greater. By the beginning of the next decade, South Africa, which represents 40 per cent of the region's economic output, is facing a real gross domestic product 17 per cent lower than it would have been without AIDS. Similar studies in the Caribbean suggest Jamaica and Trinidad and Tobago face a five per cent loss in GDP by 2005 as a result of AIDS.

In settings where subsistence agriculture predominates, measured economic productivity only scratches the surface of the total impact of HIV on livelihoods. For example, AIDS hits the long term capacity for agricultural production, as livestock is often sold to pay funeral expenses, or orphaned children lack the skills to look after livestock in their care.

Armies are among those most affected by HIV. HIV rates in the armed services are in many cases two or three times higher than those in the respective civilian populations. When armies are deployed they spread HIV in the populations where they are stationed, and when they are demobilized they spread HIV in the towns and villages to which they return.

Human Impact

But measures of per capita GDP in fact underestimate the human impact of AIDS, as AIDS kills people, not just economic activity. We should reflect on what it means for a society when 10, 20 or 30 per cent of the population is HIV infected:

- with today's rates of infection, there is a more than 80 per cent chance that a fifteen year old boy today in Botswana will eventually die as a result of AIDS;
- nurses and teachers are dying faster than they can be replaced. Last year there were around a million African schoolchildren who lost their teachers to AIDS. In Malawi 6 to 8 per cent of the teaching workforce die each year.

The immediate impact of AIDS is felt most acutely in families where one or more members are HIV infected. In South Africa, households will on average have 13 per cent less to spend per person by 2010 than they would if there were no HIV epidemic. In Cote d'Ivoire in West Africa, the household impact of HIV/AIDS has been shown not only to reverse the capacity to accumulate savings, but also to reduce household consumption. AIDS not only affects income, with lower earning capacity and productivity, it also generates greater medical, funeral and legal costs, and has long term impact on the capacity of households to stay together.

This is most manifest in the number of children orphaned by AIDS, which now totals nearly 14 million. In developing countries, before AIDS around 2 per cent of children were orphaned, but now in many countries, 10 per cent or more of children are orphans. The war in Sierra Leone left 12,000 children without families. AIDS in Sierra Leone has already orphaned five times that number.

A fundamental part of our response to the epidemic must address how families and communities will cope.

- How many orphaned boys, and particularly girls, will not go to school because there is no one to pay their school fees, or no one to dress them and get them out of the house in the morning, or because they have to help grow the food to feed the remaining family?
- What does it mean for society to have a significant proportion of desocialized youth?
- How many will end up desperate and easy prey for militias and warlords?

Progress in the global response

Mr Chairman, distinguished committee members, for too long we have been transfixed by the toll of the increasing HIV epidemic, unfolding before our eyes. Now we are shifting our gaze: success is squarely in our sights.

I believe that for the first time in the short history of this epidemic, the world is in a position to translate local and national examples of success into a truly global movement

against the HIV epidemic. This is a great leap forward from where we were even a few years ago.

Five major elements define what today gives us the ability to seriously and successfully approach this epidemic on a global scale.

First: there is manifestly **greater political momentum** dedicated to addressing AIDS. We have learned that political leadership is required at all levels to marshal the necessary commitment and resources for the social mobilization on which the response must be built.

- The level of political commitment to addressing AIDS has dramatically increased on every continent – and not least in this country, and very importantly, right here on Capitol Hill.
- Within the United Nations, increasing momentum is being led by the Secretary-General Kofi Annan. His public declaration that the fight against AIDS is his personal priority has helped to energise the whole of the UN system in its focus on AIDS, as well as opening doors to key political and business leaders around the world on this issue.
- In many cases, it has been when Presidents and Prime Ministers have taken control of the AIDS response that the most rapid advances have been made. Five years ago, we were challenged just to persuade Health Ministers that they ought to take AIDS seriously. Now, we find ourselves responding to Presidents and Prime Ministers throughout Africa, the Caribbean, the Americas, Asia and Eastern Europe who display deep personal commitment to the fight against AIDS.
- Some of the most prominent political leadership has been in Africa. For example, two years ago Botswana's President Mogae declared 'as long as we still talk derisively about the HIV/AIDS virus and its victims... the pandemic will remain the invisible monster that stalks us in the darkness'. With these words, he immediately opened up new opportunities across the nation for social dialogue and with his continuing strong leadership Botswana's AIDS response has since gone from strength to strength.
- Today, when political and other leaders come together, AIDS is on the agenda – from the G8 to the World Economic Forum to the Organization of American States.

The second major element is that we can now point to increasing **success in countries**. In the developing world there are a number of familiar examples. In Uganda, surveys in urban areas in the early 1990s found 30 per cent of pregnant women were infected with HIV, but there have been sustained drops since then to less than 10 per cent. In Thailand comprehensive prevention efforts mean that the number of new HIV infections today is less than a quarter of the number a decade ago. And Senegal is a prime example of a country where the HIV epidemic has been kept small.

But today I would also like to draw attention to less familiar examples of success. For example:

- In Cambodia, despite the pressures on a society emerging from genocide and conflict, the threat of HIV in the mid-1990s was responded to, and as a result there are measurable declines in both risk behaviours and in the levels of HIV - the infection rate among pregnant women in Cambodia declined by almost a third between 1997 and 2000.
- Elsewhere in South-East Asia, the Philippines has kept HIV rates low with strong prevention efforts and mobilization across society involving community and business organisations.
- Tamil Nadu state in India has recorded reductions in risk behaviour, reflecting the success of the state's comprehensive HIV prevention programme. Here, as everywhere, these efforts need continual renewal, with evidence that reductions in risky behaviour may have plateaued.
- In Africa, Zambia's focus on HIV prevention among youth and its efforts to involve business, farmers, schools and religion in the fight against AIDS have also shown success. In response to AIDS, young women in cities in Zambia have reported less sexual activity as well as increases in condom use, and the age at which they first become sexually active is increasing. As a result, the proportion of pregnant women under 20 who were HIV-positive had fallen from 27% in 1993 to 17% by 1998. In the Mbeya region in Tanzania, falls in HIV incidence have come through a decade of sustained action. Building local skills and infrastructure has been a core part this effort, along with generating political support and working through schools, health centres, churches, village committees and local businesses to deliver AIDS information and education, treat sexually transmitted diseases, deliver condoms, and provide community care for people with HIV.
- Brazil provides a leading example of integrating renewed commitment to prevention with comprehensive care. In 1994, the World Bank estimated that Brazil was heading towards 1.2 million HIV infections by 2000, but success in prevention in the second half of the 1990s kept the total down to 540 000. In 1996, Brazil established a legal right to free medication. The numbers of patients using antiretrovirals grew from 25,000 in 1997 to 100,000 today, and the number of AIDS deaths has fallen by 60 per cent.
- Similarly, in Barbados, planning for universal treatment access has been a core element of a major renewal in the national effort against HIV. With an expanding epidemic in a small population, Barbados is becoming a leading regional example with the strength of its government-wide AIDS response, led by the Prime Minister and supported by the World Bank.

The third major element is that there are now **widely accepted strategic approaches** which are derived from these successful country experiences. The Global Strategy Framework for AIDS which has been endorsed by all the members of the UNAIDS Programme Coordinating Board – including, of course, the US – sets out a common understanding of the dynamics of the epidemic and the leadership commitments that are required to reverse it. As a consequence within the UN system, 29 different UN system bodies share a common strategic plan.

The global response to AIDS has moved beyond the stage of trying small scale experiments to see what might or might not have an effect. We are now at the stage of translating proven approaches to full scale national responses. These approaches include:

- Building broad **coalitions between governments and other partners** from outside government, including community organizations and business, that expand the response to AIDS to include all fields of economic and social life.
- Addressing changes in the **behavior of individuals and equally of institutions**. The levers of change are to be found in pulpits and press rooms as much as they are in health centers. Changing the norms surrounding sex – which is at the heart of HIV prevention – has never been a task best left to men in white coats. We need doctors and nurses to provide treatments, but when it comes to HIV prevention, more lives will be saved by journalists, clergy, teachers and politicians.
- **Addressing the stigma surrounding HIV**. A major barrier to comprehensive AIDS prevention and care efforts remains stigma against people infected with HIV or against those groups where HIV is thought to be most common. We know we have a long way to go in fighting AIDS stigma when children from AIDS affected households are excluded from school, or AIDS patients are routinely turned away from medical services for even the most straight-forward of complaints. Responding to stigma requires involving people living with HIV centrally in the AIDS effort.
- Ensuring that **responses to HIV are on a scale commensurate with the scale of the epidemic itself**. We make a real difference to the epidemic when we ensure that local actors have the information they need to respond, and when the systems are in place that make sure they have the necessary resources available. By delivering responses that are rooted in communities, we build to the scale of response required.
- Responding to the epidemic with a **combination of efforts**. Just as combination therapy has proved the key to cracking the nut of HIV treatment, so too combination prevention is the key to stopping the spread of HIV. There will never be a single, one-size-fits-all solution to HIV.

The fourth major element, is that there is now a clear set of **global priorities** in the fight against AIDS.

- The series of benchmark targets adopted by all the world's countries in the UN General Assembly Special Session on AIDS last June in New York provide a common platform for accountability. Countries unanimously pledged themselves to a series of targets and goals, including a 25% reduction in the level of HIV among youth people in the hardest-hit countries by 2005, and a 50% reduction in the proportion of infants infected with HIV by 2010. Countries also pledged to promote access to vital drugs and ensure a supportive environment for children orphaned by HIV/AIDS. The most important legacy of that meeting has been the upsurge in country activity dedicated to meeting these targets.
- The clear international consensus that has formed around young people as a priority for action has been particularly important. Young women and young men need to take joint responsibility for reducing the impact of AIDS on their lives. They have proved themselves capable of changing the course of the epidemic if they have the right knowledge and support. In every country where HIV transmission has been reduced, it has been among young people that the most spectacular reductions have occurred. The UN General Assembly Special Session on children coming up in May will again be an opportunity for all the world's nations to set themselves on course to reducing the toll of AIDS on infants and young people. UNAIDS, and in particular our Cosponsor UNICEF, is ensuring that responding to AIDS is a core element of the global response to children's needs.

The **fifth major advance** is in the new realism about the resources required to tackle AIDS.

Additional resources required to address the AIDS epidemic.

Before I come to the total requirements, I will first try to put into perspective how additional resources could make a real difference to the epidemic. Let me take the example of a modest annual investment of \$10,000.

If we spent the money that money on voluntary counseling and testing in India, there are non-government organizations that would provide good quality HIV counseling and testing services to 10,000 people. Or in Gujarat, a hundred buses that could carry AIDS messages for a year, reaching many thousand town and village dwellers.

\$10,000 would allow the Brazilian Girl Guide and Scout movement to reach another ten thousand young Brazilians with an AIDS education kit. It would support 80 peer educators to reach hundreds of street children in every part of Brazil. It would allow the Living Positively project in the central Goiás state to reach more women with HIV, helping them to avoid transmission to their babies and training them as peer educators.

In Zambia, with \$10,000 there are 1000 orphans who could receive bursaries so they can stay in school. \$10,000 would let the Catholic church in Zambia train another 100 rural

caregivers a year in providing community home-based care. There are six more health workers who could be trained and supported to provide antenatal care and antiretroviral drugs to help prevent mother to child transmission.

What does this add up to?

There is wide global recognition, including from the UN General Assembly, that AIDS spending in low and middle income countries needs to rise to \$7 to \$10 billion annually for a comprehensive AIDS response. The task we face today is to strategically multiply the number of these \$10,000 investments until they reach the scale of the epidemic itself. It is no small undertaking – a million such investments make up the ten billion dollar target. But there are tens of thousands of communities that stand ready to take action and are desperate to do so, and there are hundreds of thousands more to which success could be spread.

A more detailed breakdown of the estimated total spending need has been made by an international group convened by UNAIDS and published last year in *Science* magazine. It shows there are major differences between regions in the balance of spending needed to respond to the HIV epidemic. In Africa, where 28 million people are already living with HIV, roughly two out of every three dollars would be needed for care and support. In Asia and other regions where the greatest opportunity still exists to prevent massive spread of HIV, the majority of funding would be directed toward prevention programs.

Almost one-quarter of the estimated need in prevention expenditure is for education, counseling and mass media communications aimed at youth to help them avoid becoming infected. We need to provide good information and support to youth before they become sexually active and provide better services and a safer environment once they do become sexually active.

Also included in the estimates are the costs to achieve the global goal to reduce mother to child transmission of HIV and thereby reduce the proportion of children infected with HIV by 20% by 2005 and by 50% by 2010. We can achieve this with known technologies that are appropriate in developing country settings. Our challenge is to build up the infrastructure and enhance human capacity to implement these programs for the largest possible number of women. Achieving this goal will save over 100,000 infant lives in 2005 and by 2010 the cumulative number of babies saved would be more than 1.3 million.

Assistance to communities and for school fees could require \$700 million in 2005. By 2005 there may be as many as 19 million children orphaned by AIDS. This number is so large that even extended families will find it hard to cope. We must assist the communities where these children live to provide care and support and provide special assistance to ensure that these children have educational opportunities and do not end up in the street.

The business sector has an important role to play in funding the expanded response. Approximately 7 % of the total resource need is for workplace prevention programs that can be funded by private enterprises. Many employers are also funding advanced treatment for their employees. Business involvement is crucial, not only because bottom lines are being hurt by AIDS, but also because business is often in the best position to reach its staff and the communities they live in. This is especially the case where there are mobile workforces, and men especially are removed from their families to find work – in this context, our definition of risk group need to expand beyond the obvious examples, like miners, to include others, for example trainee bank managers.

Roughly a quarter of the total resource need is for anti-retroviral drugs. Negotiations with the pharmaceutical industry have resulted in significant price reductions that are beginning to make it feasible to deliver these life saving drugs to those who need them. But progress in delivering treatment needs advances on three fronts simultaneously:

- finance;
- stronger health systems, so these drugs can be delivered and their health benefits maximized; and
- the expansion of voluntary counseling and testing services since the great majority of people around the world who are living with HIV do not know whether they are HIV infected, an obvious prior condition of treatment access.

Can extra resources be spent wisely and effectively?

Countries do have the capacity to programme substantially increased levels of new AIDS funds. UNAIDS has just finished an assessment of the current state of programme readiness which has shown that the majority of countries assessed have already completed much of the planning and programme development work required to be confident of success in expanding their responses to AIDS. There are still some gaps in programme preparedness, especially in the monitoring and costing of plans. However, it is clear that developing countries are seriously engaged in detailed strategic planning on AIDS.

AIDS planning was well developed in 93 out of the 114 countries assessed – though there remain major challenges in roughly a third of the countries assessed – particularly in Africa. There are five core components to AIDS readiness: national AIDS plans, the capacity to operationalize the plan, costings, a monitoring and evaluation strategy and mechanisms that can achieve coordination among governments, non-government actors, the UN system and bilateral donors. Across the globe, there are 24 countries assessed where all the elements of comprehensive AIDS programming are already in place. At the other extreme, there are 8 countries which are yet to develop any of the elements of readiness.

One of the ironic benefits of a well-advanced epidemic in much of Africa is that there are good estimates both of the scale of the epidemic and of the resources needed to mount a response. The sea change among African leaders and communities to deal frankly and

firmly with the challenge of AIDS is now apparent. Most governments have shown themselves willing to channel public resources to community and civil society organizations. But the systems to support the renewed commitment in most areas of prevention, treatment, care and impact mitigation remains weak. An important positive development has been the more effective and transparent use of resources. There are twelve African countries that have established a management capacity to deal with big increases in funding through the World Bank's Multi-country AIDS Programme for Africa and another 15 are establishing the fiduciary infrastructure required.

Our assessments of AIDS programming around the world also indicate that there is a compelling need for more intensive planning and programme development for effective responses in the education, social welfare, agriculture, and other sectors. Programme development in these sectors has lagged considerably behind the health sector.

The resources gap

Mr Chairman, committee members,

We are currently far from having secured the \$10 billion required for a comprehensive AIDS response in the world's low and middle income countries.

In these countries in 2002, somewhat over \$2 billion will be spent on AIDS, including the \$1.7 billion made available by the international community. International spending is joined by significant national government expenditures on AIDS, which in middle income countries like South Africa, Brazil or India run to the hundreds of millions, but elsewhere are much smaller.

The gap between current expenditure and total needs is so large, that moving to \$10 billion of expenditure immediately is impracticable. Instead, we need to envisage a route to a comprehensive response where the available funds progressively increase over the next four years.

If today's expenditure on AIDS were to be maintained only, next year's funding gap will be greater than \$2 billion growing to at least \$7 billion by 2005. The implications are quite clear and represent a major challenge for the development of vigorous resource mobilisation strategies.

To achieve our objective of scaling resource availability to keep pace with programming capacities, we need to see a **roughly 50 per cent increase in funding each year**, in each of the next four years.

The funding required neither could nor should come from a single source. Only when funds are maximized from all sources can we claim a comprehensive AIDS response.

There are five distinct groups of actors involved in responding to AIDS. Each of them has their own advantages in supporting a comprehensive AIDS response, both in relations to the resources they can mobilize but also in the tasks and responsibilities they perform best.

- First are developing countries themselves. National ownership and responsibility is a *sine qua non* of effective AIDS responses and it needs to be accompanied by budgetary allocations. A clear expression of commitment has come from the African continent with the Abuja Declaration adopted at the Organisation of African Unity's special summit on AIDS last year which included a pledge that 15 per cent of national budgets would be allocated to health to help fight AIDS and related diseases.
- Second are bilateral donors whose comparative advantage lies in being able to draw on domestic technical resources, for example within their universities and national programmes, and their capacity to build solidarity directly between their own communities at home and those in the recipient countries – for example through networks of non-profit organisations. Currently, the US accounts for approximately one-third of the bilateral resources focussed on HIV/AIDS.
- Third are multilateral organizations which are particularly well placed to ensure that internationally accepted scientific and technical standards are applied, to help promote consensus on the effective approaches to complex and difficult social issues, and in the case of the World Bank credits, to facilitate the internalisation of new resources within the budget and finance mechanisms of countries, contributing to longer term financial sustainability of programmes.
- The fourth group, international NGOs and business, is becoming increasingly important. The size, range and sophistication of business involvement in the fight against AIDS has grown enormously over the past few years, although it is still only a fraction of its potential. Business knows it needs to protect its investments in workforces and in markets against the impact of AIDS. Some of the most productive business initiatives in AIDS have capitalized on key business strengths. For example, UNAIDS has worked with MTV, which knows a lot more about holding the attention of a teenager than we do. UNAIDS is also working with Coca Cola in Africa – where in Kenya Coke's vast distribution network has been used to get out educational material on AIDS. There are also now a number of primarily US-based foundations that have made significant commitment to global AIDS efforts, notably the Bill and Melinda Gates Foundation. But as well, there are many other US-based foundations whose AIDS work joins their long history of concern about health and progress – the coalition of Foundations supporting the HIV prevention among women and prevention of mother-to-child transmission is just one of the many examples, and it includes the Rockefeller, Bill & Melinda Gates, William and Flora Hewlett, Robert Wood Johnson, Henry J. Kaiser Family, John D. and Catherine T. MacArthur, David and Lucile Packard, and UN foundations.

- The fifth and the newest actor is the Global Fund. Its comparative advantage must be in its ability to focus new resources, rapidly and directly, on the programmes with the best chance of success, in the countries with the greatest need.

The Global Fund to fight AIDS, Tuberculosis and Malaria

The establishment of the Global Fund to fight AIDS, Tuberculosis and Malaria has signaled the new decisiveness in global AIDS efforts. It was only April of last year that UN Secretary-General Kofi Annan declared at the Organisation of African Unity's Special Summit in Abuja that the world needed a new 'war chest' in the fight against AIDS. The Fund will approve its first proposals this April – less than a year after the Secretary-General's call to action.

In 2002 the Global Fund has around \$800 million available to it to disburse, and the sources of these funds are largely G-7 pledges. Of course, the Fund will be considering TB and malaria as well as AIDS, although AIDS clearly has the greatest proportion of the needs. The presentation I and Dr Brundtland, Director-General of the World Health Organization, made to the first meeting of the Board of the Global Fund estimated that AIDS accounts for 76 per cent of total global needs, tuberculosis 19 per cent and malaria per cent.

The Fund has been constituted as a financing instrument to complement the work and responsibilities of existing organizations. Its efforts will therefore be concentrated where they are most needed: on generating and making available additional resources. The Fund is there to support what is happening at community and country level – proposals have to be owned in the places where the money is going to.

The Fund is a public-private partnership – its Board includes business representation, as well as non-government organizations and representatives of the communities directly affected. The UNAIDS Secretariat, together with our Cosponsors the World Health Organization and the World Bank, sit on the Board. Part of our role will be to help countries in the development and preparation of proposals and to make available our expertise and networks available to the Fund to ensure it has the best possible advice about where its money will make a key difference..

Already, regional planning has taken place – earlier this month a meeting for the Asia-Pacific region demonstrated the enormous interest in the Fund from countries, and their preparedness to put forward the best possible proposals.

In calling for proposals, the Fund has declared its intention to promote partnerships among all relevant players within countries and across all sectors of society. It will build on existing coordination mechanisms, and promote new and innovative partnerships where none exist. Proposals will be considered through country coordination mechanisms, but eligibility for funding is not restricted to governments: public, private and nongovernmental programmes can be funded.

The Fund will support programmes both within and outside the health sector if they are technically sound, cost-effective and focus on performance by linking resources to the achievement of clear, measurable and sustainable results.

The support for the Fund in the US Congress was a crucial factor in meeting the rapid timetable for its establishment. The two tranches of \$200 million so far allocated to the Fund by the US government have also set the pace for pledges from the rest of the world: total pledges to the Fund now stand at just under \$2 billion. .

A very wide international coalition has come together in the Fund, and in spite of the range of interests represented, it is notable that key considerations set by the U.S.

Congress have been met including that:

- it will coordinate its activities with governments, civil society nongovernmental organizations, UNAIDS the private sector and donor agencies; and
- nongovernmental organizations, including faith-based organizations, will be eligible for assistance, and eligible areas include treatment and the provision of interventions to reduce mother-to-child transmission.

Mr Chairman, committee members,

Pledges to the Global Fund already represent a 50 per cent increase on the international funds available to fight AIDS. This is progress!

The challenge now is to build on this progress: to make the Fund work well by demonstrating that it can spend wisely, spend rapidly, and show results. If it does this, it is our hope that it will be an increasingly attractive proposition for donors, and the Fund will grow.

Moving Forward

Mr Chairman, committee members,

AIDS is a massive global problem, but it is a problem with a solution.

The tools for effective responses exist. In the vast majority of countries around the world, there are detailed plans for dealing with AIDS. There are countless communities ready to take action. And in order to build success, increased financial investment needs to be equally matched with investment in human resource and institutional capacities.

If we are to achieve success, we need to know how our progress is going. Critical US support in monitoring the epidemic and in evaluating the success of AIDS programs has put us in a better position than a few years ago. The cooperative framework for monitoring and evaluation that the UNAIDS Secretariat has been able to deliver has resulted in a level of consensus and influence at country level which has far surpassed what any one agency alone could have achieved.

Of course, for AIDS spending to be worthwhile, it needs to be able to flow efficiently to the levels it is needed. Improving both governance and the efficiency of resource transfer mechanisms remains a core priority for UNAIDS, including our Cosponsors, particularly UNDP.

Mr Chairman, committee members,

The fight against AIDS is a race, and so far, it is the virus that has been winning. But we are now in a position to make a leap forward – a leap that will for the first time put us ahead of HIV. I would be kidding myself as well as all of you if I said the task was an easy one. There are huge challenges:

First, the challenge of scale. There are perhaps a few thousand really effective AIDS programmes and activities around the world today. Unless we can rapidly escalate this number to a few hundred thousand, we will fall behind in the race.

Second, the challenge of coordination. Funding for AIDS has increased. The number of players has increased. Different parts of government are now substantively involved. International and national non-governmental players are increasingly important. But while we must celebrate this renewed level of activity, unless there is a corresponding increase in coordination, we will still fall behind in the race.

Third, the challenge of resources flow. There are still far too many blockages between resource availability at global level and resource needs at the local, village and neighborhood level. Unless we can unblock the resources pipeline, we will fall behind in the race.

Fourth, the challenge to be led by science. A pragmatic response to evidence must be our guide in the AIDS response, already too much effort has been diverted by those wishing to turn AIDS into their own private bandwagon. Responding to AIDS will always touch raw nerves around sexuality, drug use, relations between men and women, and the limits of personal confidentiality. But unless we can find the ways to agree to be guided by evidence and reason, then we will fall behind in the race.

Meeting these challenges requires us to marshal all we know about moving forward against the HIV epidemic. We know what to do. We know how to do it. We know it needs to be done at the right scale. We know what it costs. We are clearer than ever before about the ways in which increased spending would make a real difference to the course of the epidemic.

All these elements must now be put together. Success against the epidemic will be achieved when all the players involved play to their strengths.

Mr Chairman, committee members,

US support for the global AIDS effort is directed in three areas:

- One, to the multilateral system, in particular the international organisations including UNAIDS and our Cosponsors;
- Two, to the new Global fund to Fight AIDS, Tuberculosis and Malaria; and
- Three, in bilateral efforts, including those of USAID, Health and Human Services, the CDC and research efforts through the NIH, as well as other programmes including that of the Department of Labor.

The United States government has long supported global AIDS programs and underwritten a research effort that remains a beacon of hope for people affected by the disease. It remains to the enormous credit of the US Department of Health and Human Services through its Centers for Disease Control and Prevention that its expertise in identifying disease outbreaks was applied rapidly and effectively in the case of AIDS, and its continuing role both internationally and domestically has contributed enormously to the effectiveness of AIDS responses. More recently, initiatives have expanded - the US Department of Defense, through the LIFE project, has been a key player in responding to AIDS awareness among the uniformed services, working with UNAIDS together with the contribution of one of our Cosponsors, UNFPA.

The U.S. is the first developed country to publish its 2003 budget. Most others will be following suit in the next few months – and I hope they will be able to take note that U.S. proposals for international HIV/AIDS assistance for 2003 are on an upward trend. The U.S., like every other donor, will need to do more if the world is to respond effectively to AIDS. American bilateral efforts on HIV/AIDS – at USAID, Health and Human Services including CDC, and the Departments of Labor, Agriculture and Defense – and critically now the Department of State – will also require further strengthening to keep up with country needs. Unparalleled American know-how in such vital fields as medical training, core public health functions, and service delivery are needed more than ever to assist developing countries.

The US has already proved itself willing to take its leadership role in making the required leaps forward. We would strongly encourage you to continue in that leadership role, and look forward to our continued partnership with you in meeting this great challenge.

Thank you for your attention.