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**Halting the Global Spread of HIV/AIDS:
The Future of U.S. Bilateral and Multilateral Response**

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Mr. Chairman, I am grateful for the opportunity to appear here today, and commend you and other members of the Senate Committee on Foreign Relations for focusing on the global HIV/AIDS pandemic, a subject of profound urgency to U.S. foreign policy stakes.

I have the fortune of having just returned from a two-week visit to South Africa, where I witnessed firsthand the intense, combative debate there over national priorities, in the face of a pandemic that directly touches every family in that society and that threatens an entire generation. South Africa, like other acutely affected countries in Africa and elsewhere, is truly in the midst of a complex and painful national emergency that will be with it - and with us, by extension - for the next few decades. From where we sit, it is difficult to grasp the urgency, magnitude and innate controversy of what South Africans and others confront on a daily basis.

Also, I am a member of the international supervisory panel overseeing the evaluation of the first five years of the UNAIDS program.

I am here today however on behalf of the Center for Strategic and International Studies' Task Force on HIV/AIDS. The CSIS Task Force is a two-year effort, funded by the Gates and Catherine Marron Foundations, intended to strengthen U.S. international leadership on HIV/AIDS. I am grateful to Senators William Frist and John Kerry for agreeing to co-chair the Task Force.

Today, I will concentrate my testimony on how we might best design a five-year approach to battling HIV/AIDS. I and J. Stephen Morrison, Director of the overall CSIS Task Force, co-chair a working committee charged with looking into this question.

Such an approach will require a strategic vision that looks far beyond immediate responses. It will demand sustained U.S. global leadership, a reliable grasp of how the pandemic will likely evolve in coming years, and feasible, prioritized medium-range goals. To build support at the popular level and among foreign policy experts, this vision should also draw systematically upon the American people's growing awareness of the pandemic and their deepening well of support for a substantial U.S. commitment.

In this context, and because it is such an important element in any such strategy, I wish to discuss how the international debate over intellectual property rights and affordable access to essential medicines has changed in the past year. Several recent developments now focus our

attention particularly upon sustainment of access: through more reliable financing, greater transparency in global pricing, and strengthened infrastructure.

Looking Five Years Out

In the 1990s, ad hoc, stove-piped responses could not keep pace with the powerful, swift momentum of HIV/AIDS. We now recognize that combating HIV/AIDS requires attention not only to health, but also economic, social and cultural factors. Recent increases in U.S. high-level attention and resource commitments have achieved significant gains and brought greater coherence to U.S. efforts, and encouraged others to do more. In its first year, the Bush administration showed sustained leadership, even in the aftermath of September 11. It established the joint task force on HIV/AIDS, co-chaired by Secretaries Powell and Thompson, assembled a strong interagency team of experts, raised aggregate international spending levels on HIV/AIDS to over \$800 million in this fiscal year, and contributed substantially, both politically and financially, to the establishment of the Global Fund to Fight AIDS, TB and Malaria.

These commendable steps reflect the deepening awareness, among our leaders and the American public, that the AIDS pandemic threatens an unprecedented moral, human, societal and economic catastrophe, and that it demands an unprecedented mobilization that will stretch beyond this generation. Secretary of State Powell captured this reality very succinctly when he stated earlier this year: "I know of no enemy in war more... vicious than AIDS, an enemy that poses a clear and present danger to the world."

The risk remains, however, that fatigue or complacency with existing efforts may set in.

If the international community is to assert effective authority over the pandemic in coming years, the United States, in concert with partner governments, international organizations and others, will need a long-term, strategic, multi-sectoral, and highly collaborative approach that steadily enlarges the pool of resources, with a focus on clear, achievable priorities. To strengthen consensus and clarity of purpose, the Bush administration needs to join with Congress, on an urgent basis, in forging an ambitious multi-year plan of action. That plan should spell out clearly how U.S. leadership will be deployed strategically over the next several years to build on recent momentum.

The realization of the need for a long-term strategic international mobilization motivated broad endorsement of the detailed Declaration of Commitment on HIV/AIDS issued at the UN General Assembly Special Session on AIDS (UNGASS) in June 2001. It prompted the World Health Organization to launch the WHO Commission on Macroeconomics and Health, charged with analyzing the linkage between infectious diseases and economic productivity and proposing a multi-year plan of action to redress weak health infrastructures in developing countries. UNDP has subsequently committed itself to a broad based approach in all its country programs that links health, development and political action to stem the pandemic. UNGASS finally inspired the intensive international efforts that launched in early 2002 the Global Fund to Fight AIDS, TB and Malaria, first endorsed at the UNGASS in June. (The CSIS Task Force has also today released a briefing paper on the Global Fund that is available at this hearing in hard copies and accessible in electronic form through the CSIS web site.)

No less important, in the aftermath of September 11, an additional, powerful factor entered the debate over the HIV/AIDS pandemic: the awareness that runaway infectious diseases, accompanied by and contributing to broken states and damaged economies, are generating desperation and rising criminality. If we are to sustain an anti-terrorist coalition, we cannot afford a lackluster response to the threat that HIV/AIDS and related problems pose to developing societies.

The critical importance of U.S. leadership

Over the next five years and beyond, global outcomes in battling the HIV/AIDS pandemic will hinge, to an overwhelming degree, on U.S. leadership. Leadership means using our strengths, our economic resources, and our skills to enable and empower the world community working together to combat this disease. The US role is critical for several reasons:

The US plays a leading role in the international policy dialogue on HIV/AIDS and related infectious diseases -- in the G8, the UN Security Council, deliberations on the newly formed Global Fund to fight against AIDS, TB and Malaria, and elsewhere.

The US is the preeminent force in global scientific research and the development of new medical technologies.

The US funds half of the worldwide programmatic response to HIV/AIDS and related diseases, in the areas of prevention, care and treatment.

Washington is the best positioned of any power to move international trade policy to promote enhanced access to affordable medications.

So too, Washington is the best positioned power to link international debt relief and other poverty-alleviation programs to heightened local investment in public health interventions.

In exercising its leadership over the next five years, the United States should concentrate its efforts in three priority areas:

1. Expand existing U.S. strengths.

The United States should consciously build upon its core strengths. These include its leading role on global health issues; its record of appropriating an ample contribution to global funding; its vast institutional expertise in public health policy; its long developmental experience in strengthening local infrastructure in resource poor setting; and its predominant scientific research and development capacities across public, educational, philanthropic and corporate sectors.

A key challenge is ensuring that there is coherence and effective coordination of U.S. efforts, given the range and rising number of agencies operating overseas. Increasingly, there is overlap and duplication of effort, and it is frequently difficult to identify who at a senior level position is actually in charge of the overall U.S. campaign.

A related, pressing issue is which agency will carry lead responsibility in training skilled medical personnel to address the critical personnel shortfalls in acutely affected countries. If that role is to be filled by the agency within HHS responsible for such training, the Health Resources and Services Administration (HRSA), Congress will need to act quickly to provide it the legal mandate and funding to meet this requirement.

The Joint Task Force can, and should, pursue these issues on an urgent basis.

2. Build key bilateral relationships.

Modeled upon creative new public/private partnerships in Botswana, Uganda and elsewhere, the United States should give priority to forging new programmatic partnerships with institutions, public and private, in acutely affected countries. These partnerships should focus not only on HIV/AIDS assistance, but also trade and investment initiatives that will address poverty and weak infrastructure.

Integral to the success of those partnerships will be a new emphasis in U.S. diplomacy,

at the country level, on battling global infectious diseases. That calls for mainstreaming, and elevating within the foreign policy establishment, public health professionals. The State Department has taken an important step in this direction by creating the Office of International Health and Science, headed by Deputy Assistant Secretary Dr. Jack Chow. Equally important will be systematically integrating America's non-governmental organizations into U.S. programs and policy consultations.

3. Consolidate global coordination.

The United States will need to act in close concert with -- and leverage ample, focused contributions from -- UN agencies, the World Bank, major foundations, corporations, and other bilateral donors. It should work to develop an international steering committee on HIV/AIDS to ensure proper coordination and division of responsibilities between international donors, the Global Fund, UNAIDS, and bilateral programs -- limiting duplication and achieving an appropriate balance between research, prevention, treatment, and care.

The U.S. role will neither be to dominate, nor carry a disproportionate share of responsibility. The essence of its leadership will be to rise to the task of mobilizing the world community to better address this highly fluid, dynamic and complex pandemic. In practice, that means the U.S. will need to assign a far higher priority to forging greater conceptual integration and coordination among the far-flung agencies committed to battling the pandemic, both within the United States and internationally.

Strong support from the American people

This is a program that will receive strong support from the American people. Indeed the public will expect strong leadership by the Government in this area. The American public and American foreign policy elites now exhibit a surprisingly high knowledge of the HIV/AIDS pandemic, high levels of concern, and considerable support for substantial engagement overseas to combat the pandemic. Americans not only strongly support U.S. leadership but also are open to new, more robust initiatives from American leaders.

This dramatic shift from the opinion environment of the late 1990s is the core finding of a recently completed survey of popular and foreign policy expert opinion, that was conducted to inform the work of the CSIS Task Force. The survey was carried out by Public Opinion Strategies and Greenberg Quinlan Rosner Research, generously funded through the UN Foundation/Better World Foundation. Those surveyed were particularly responsive to information on the scope and gravity of the pandemic, its impact upon children, exhortations from Secretary Powell, and evidence that prevention and education programs are achieving concrete results.

Tracking the pandemic

A U.S. multi-year plan should be informed by how the pandemic will evolve in the next five years.

First, in the next five years the pandemic will have become ***globalized and will be seen by world leaders as such.***

The pandemic's epicenter will remain in Africa, where heightened attention will be paid to its course in Ethiopia, other areas of the Horn, and Nigeria. At the same time, the pandemic will have extended its reach more deeply into China, Russia, other states of the former Soviet Union, India, and the Caribbean states of Haiti, Dominican Republic and Jamaica.

Second, we will see ***regionally differentiated approaches.***

Africa will struggle overwhelmingly with acute constraints on access to health services, borne of insufficient financing, weak infrastructure, and insufficient trained health personnel. Young women and infants will bear the highest vulnerability, while millions of newly orphaned children will also attract significant attention. A handful of African states will likely dominate, intellectually, programmatically, and scientifically: Uganda, Botswana, Senegal, and Ivory Coast. Nigeria, South Africa and Kenya, if they can overcome respective formidable internal barriers to effective action, could each quickly advance ambitious national programs and establish prominent continental positions for themselves.

In Asia, the central preoccupation will be stemming at an early point the pandemic's spread. Strategies will vary widely.

In China, the focus will be upon mobilizing the inherited central command state and newly emergent, scattered private medical enterprises to combat China's deep social stigma and contain four sub-epidemics: rural blood markets; medical re-use of syringes; injecting drug use; and prostitution. Already, as new infections spread into the general population, the Chinese government is coming under intensive pressure to institute new, nationwide public health campaign. By 2007, that campaign will be fully operational.

In Thailand and Cambodia, the focus will be upon consolidating solid, state-led gains in reversing infection rates.

In India, the central challenge will be circumventing its dense federal and state-level bureaucracies, along with social and cultural barriers, in time to implement meaningful programs before infection rates mushroom. By 2007, the pandemic will have moved beyond the current six focal states to affect significantly virtually every state.

In Russia and former Soviet states, the priority challenge will be overcoming the collapse of the Soviet-era health infrastructure, in the midst of weak economies, and altering high-risk behavior among pariah sub-populations: of prisoners, prostitutes and injecting drug users. HIV is poised to break out of these sub-populations; hence the urgent need for a public education/prevention campaign in Russia and Ukraine.

Third, the struggle between the pandemic and efforts to control it will have generated **mixed results at the country level**. In many places, the disease will continue to out distance local and international responses. In many other places, however, determined, smart interventions will have begun to tame the pandemic.

In this context, ***individual country responses*** will inexorably have become increasingly ***differentiated***.

Several countries will have steadily distinguished themselves and thereby attracted a major share of new resource flows: those which demonstrate strong leadership and probity of national institutions; which make substantial budgetary commitments to health; and which aggressively build affordable access to medical products, indigenous skilled medical talent and scientific research capacity.

Occupying a middle tier will be states that struggle to overcome confusion, financial weakness and internal resistance. They will benefit from expanded international assistance, but on a comparatively more cautionary, and conditioned basis.

A third tier of distressed, internally conflicted or otherwise broken states will likely find themselves further on the margins.

Fourth, despite these differentiations, as the pandemic spreads and deepens, ***global norms*** will have evolved towards universal demand for expanded access to treatment.

This will intensify a debate: over prevention versus treatment; equity in the allocation of treatment (rich versus poor; urban versus rural); and the sustainability of antiretroviral regimes and palliative care in resource poor countries. This debate could become one of the most contentious and divisive of the 21st century unless we act now to address it and plan for its resolution.

The emergent agenda on affordable access

Because this debate will become so important, it is relevant to examine in more detail the direction of the debate on this issue so far, because it points to promising ways by which it can be resolved.

In the past two years, there have been several major developments that have broadened the landscape of debate over how best to promote affordable access to essential medicines by poor countries acutely affected by HIV/AIDS and related infectious disease.

First, the **prices of many essential drugs have fallen** radically.

The WHO Accelerated Access Initiative, begun in mid-2000, has brought now 70 countries into discussions with five pharmaceutical companies and provided enhanced technical expertise in determining which drugs are most appropriate. Negotiated and unilateral price reductions, along with increased availability of some new generic drugs, have reduced prices by as much as 90%, more in some instances.

Developing countries remain concerned that these price cuts may last only for a fixed period. Moreover, even at reduced prices, many of these drugs are still not affordable among the poorest countries: some expanded financing mechanism will be required, along with concerted investment in basic infrastructure, if essential medicines are to be deliverable in the poorest settings.

Second, the **intellectual property rights debate has shifted** significantly.

At the Doha world trade talks in November 2001, trade ministers agreed that intellectual property protection is not and should not be a barrier to access. They also agreed that the poorest developing countries will have no patent obligations until 2016; that means, in effect, that there are no legal arguments in those countries over patents or compulsory licenses.

Related to these developments, one recent study has shown that most essential drugs are not patented in the poorest countries (See Amir Attaran, "Do Patents for Antiretroviral Drugs Constrain Access to AIDS Treatment in Africa?" JAMA, 286, pp. 1886-1892, October 17, 2001). Also during 2001, litigation actions by pharmaceutical companies to enforce patent protection in South Africa and Brazil were dropped in the face of intense public and media criticism, and in both countries cooperative arrangements between the companies and the governments are being developed to provide adequate access.

Third, the **Global Fund to Fight Against AIDS, TB and Malaria**, will soon launch its efforts in April when it will respond to the first set of country funding proposals.

In 2001, the Fund will have up to \$700 million to disburse, some of it on a multi-year basis. An estimated 80% will go to countries in Africa. At least an equal amount will be available in 2002, perhaps more.

The Fund is uniquely well positioned to leverage the resources at its disposal to improve country-level coordination, and to assist developing countries to develop the technical capacity to refine their programs and negotiate most effectively with large international and corporate entities to strengthen their affordable access. Most obviously, the Fund is well positioned to press for far greater transparency and consistency in global pricing of essential medicines.

Fourth, the **WHO Commission on Macroeconomic and Health** completed its major work at the end of 2001. The committee headed by Dr. Richard Feachem developed a pragmatic framework for action, by "the pharmaceutical industry (both patent holders and generic producers) to agree jointly to guidelines for pricing and licensing of production for low income markets. The guidelines would provide for transparent mechanisms of differential pricing that would target low-income countries." (page 89) This proposal, which envisions a set of reciprocal obligations between industry and poor countries, is now in need of a plan to operationalize it. The Bush administration's Joint Task Force should make that a priority for 2002 and beyond.

Fifth are the emergent public-private partnerships now a conspicuous part of national efforts in Botswana and Uganda.

Nevertheless, important issues remain. In the next few years there will be continued debate over aspects of TRIPS, most notably rules governing parallel imports. But at the same time far greater attention will be paid to the *sustainability* of initiatives intended to deliver essential medicines at affordable costs. This is one of the principal issues that has troubled the South African Government and has inhibited that Government's willingness to make clear-cut policy decisions that are desperately needed.

So too, much urgent work will proceed on how best to balance complex, competing demands (how to block transmission from mother to child, while also caring for an infected mother), how to meet human skill and training requirements, how to measure the cost effectiveness of interventions, and how best to monitor and evaluate delivery systems. All of these issues must be addressed in a comprehensive response to the HIV/AIDS crisis.

Feasible, prioritized Objectives for 2002-2007

If the international community, with strong US leadership acts forcefully now and throughout the next five years, we can stem this pandemic and avoid a major world catastrophe. By 2007, we should be able and should commit ourselves to a situation where the pandemic should have ***reached a turning point*** in its history. The pandemic's speed should be far better contained than it is today, prevalence rates will have dropped significantly in several acutely affected areas, and efforts to mitigate the pandemic's impact on societies and economies will have begun to achieve concrete results.

To achieve this set of goals, we envision U.S. programs and policies put in place over the next five years organized around four priority areas:

1) Programmatic interventions

- Prevention is the mainstay, if in the next five years we are to see the rate of new infections *stabilized and reduced*. Most importantly, that means putting in place national interventions that overcome mass sero-ignorance and myths, and alter the behavior of high-risk populations. Cooperative efforts among governments, international organizations, NGOs, local communities, and religious organizations, will have been fostered in every affected country.
- The U.S. will have contributed significantly to strengthening healthcare infrastructures in the most heavily impacted countries, increasing the availability of treatment for opportunistic infections as well as direct HIV/AIDS treatment.
- The U.S. will also have given special attention to strengthening women's organizations to provide women greater protection and a greater voice in prevention, treatment, and care of family members.

- To more adequately address the challenge of AIDS orphans, communities will have also been strengthened with widespread assistance programs, scholarships, and other support services.

2) Bilateral and global resource mobilization

- The U.S. will have helped leverage significant increases in funding, from multiple sources, that narrow the gap between supply and demand.
- In 2001, approximately \$1.8 billion in external assistance worldwide went towards prevention, care and treatment in developing countries acutely affected by HIV/AIDS, of which slightly less than half came from public and private sources in the U.S.
- By 2007, that figure should have risen to the \$7-8 billion range annually, with aggregate U.S. contributions amounting to at least \$3 billion per year. That translates into a tripling of resources over the next five years, roughly the same level of growth between 1997-2002.
- None of the resources for HIV/AIDS must come from current and future programs for development and poverty alleviation. Rather, these latter programs should themselves be strengthened and increased because poverty alleviation will have a major impact on the capacity of affected countries to address in a sustained manner the many issues associated with this pandemic.

3) U.S. investment in research and technology.

- The current potential of U.S. research efforts will have been realized and significant progress made on vaccine development and trials.
- The U.S. will have collaborated on and contributed to significant research on social and cultural factors in every acutely affected country, enabling messages on prevention, especially among youth, to have greater impact.
- U.S. health institutions will also be mobilized and effectively engaged in strengthening the research and treatment capacities of the comparatively advanced healthcare infrastructures in Asia and CIS.

4) Concerted multilateral action

- The U.S. will have helped elaborate and strengthen a new global health architecture - centered on WHO, UNAIDS, and the Global Fund - that increases the capacity and reliability of surveillance systems, creates greater coherence and integration of responses, that mobilizes new financial flows, and that promotes exchange of data and debate of emergent issues.
- To increase financial transparency and affordable access to treatment, appropriate pricing and distribution policies and programs will have been established in all acutely affected countries, with a combination of private, host government, and international financing as appropriate. These policies will have been structured and financed in ways that assure universal access as well as continued private sector investment in new treatments and drugs.
- Major progress will have been made to control HIV/AIDS infections in international military establishments, preventing peacekeeping operations and other international deployments from further contributing to the pandemic.

Only with this degree of commitment and action, beginning now, can the world stem this crisis. But the good news is that if we so act now, we can do it and leave the next generation safe from this plague and its dire consequences.