

# Keeping our Promises to Poor Countries: Our Next President Must Support \$50bn for the US Global AIDS Initiative

**BACKGROUND:** In 2003, due to activist pressure, President Bush and Congress launched a 5-year, \$15 billion program to fight AIDS, including \$10 billion in new money, called the President's Emergency Plan for AIDS Relief (PEPFAR). This program promises to prevent 7 million new infections, and treat 1/3 of those in clinical need of treatment—2 million people. PEPFAR funds treatment, prevention, and care for people living with and at risk for HIV in 15 focus countries. Because of ongoing advocacy by people living with HIV/AIDS and allies for additional funding for the Global AIDS Fund and other parts of the program, the US is likely to spend \$19 billion by the time PEPFAR expires at the end of 2008. In fact, this year President Bush requested \$5.8 billion for global AIDS, TB and Malaria funding, and Congress is on track to appropriate almost \$6bn for AIDS alone.

On May 30, 2007, in a speech in the Rose Garden, President Bush dramatically undercut his own program by proposing to "double" PEPFAR to \$30 bn over 5 years. As stated above, the US is already on track to spend \$6 billion in 2008 alone, so what the President announced is not a doubling, but in fact a rapid slow down in a program that should be accelerating dramatically. This deceleration of PEPFAR is most apparent in the targets for the number of people who have their treatment supported by the US government. By the end of the first five years of PEPFAR (2008), we are aiming to treat 2 million. But, by the end of the 2<sup>nd</sup> five years (2013), we're aiming to only treat 2.5 million, or an additional ½ million over five whole years. This is simply unacceptable. Because the US controls 1/3 of the world's economy, our government should fund 1/3 of the response to the global AIDS crisis, which is estimated to be \$50 billion during the next five years of the US Global AIDS Initiative, and provide treatment for 1/3 of those in clinical need globally.

**THE ROLE OF OUR NEXT PRESIDENT:** The next 5 years of PEPFAR will cost \$50 billion. This breaks down to:

- \$28 BILLION FOR FOCUS COUNTRIES<sup>1</sup>: When PEPFAR was announced, the US agreed to get 2 million people—1/3 of those in clinical need—on treatment by the end of the first 5 years of the program. We must continue to treat 1/3 of those in clinical need of HIV treatment, which would require approximately doubling the number of people on treatment. Additionally, people receiving treatment for several years will become resistant to first-line treatment, and will need to begin second-line therapy. Although the price is falling rapidly for second-line treatment, it still remains more expensive than first line therapy. It would be negligent of the US to put people on treatment, and then not continue to treat the people who were promised medication. PEPFAR should also expand beyond the 15 focus countries to add small, high-prevalence countries like Malawi, which will mean additional funding for new countries hard-hit by the AIDS epidemic.



<sup>1</sup> This estimate assumes that the cost gradually rises from \$5.75 billion in Fiscal Year 2010 (FY10) to \$10 billion in FY14, reflecting the costs of achieving Universal Access to HIV treatment in Focus Countries (as pledged at the United Nations and G8 meetings).

- **\$8 BILLION FOR THE GLOBAL FUND TO FIGHT AIDS, TB, AND MALARIA (GFATM)<sup>2</sup>:** In 2001, the Global Fund was created as a multilateral, country-driven funding mechanism to fight AIDS in developing countries. Donor countries, like the US, contribute to the GFATM, and recipient countries and organizations that work in poor countries write proposals for funding. Unlike US bilateral aid, which works only in 15 countries and has restrictions on how prevention funding can be spent, the GFATM works in over 140 countries around the world, and prevention funding does not have strings attached. This means the money can be used for proven effective programs like comprehensive sex education and needle exchange. In April 2007, the GFATM Board of Directors agreed to a target funding size of \$8 billion. The US must dramatically increase our support for the global fund by increasing the yearly contribution to \$2.7bn by 2013.
- **\$6 billion for non-focus countries<sup>3</sup>:** Before PEPFAR, the US was slated to spend approximately \$5 billion on global AIDS programs between 2004 and 2008. These programs have seen only marginal increases in funding since PEPFAR began, and many development groups are seeking modest increases to funding levels.
- **\$8 billion for a new initiative on healthcare workers<sup>4</sup>:** The US will not achieve our stated goals of treating 2 million people by 2008, or coming as close as possible to universal access to HIV treatment by 2010 if we do not invest significant new resources in the training and retention of health workers in Africa. Right now, there is a shortage of 1.5 million health workers in sub-Saharan Africa, which limits the ability to treat people who need access. This is due to a number of reasons, including lack of training opportunity, poor pay and working conditions, and US and Western countries' immigration policies that lure trained doctors and nurses out of their countries to help address our shortage. The International Monetary Fund also plays a role by placing conditions on countries that limit the amount they can spend on health and education. These factors, and others, must be addressed in a new initiative to fund healthcare workers in Africa.

The global AIDS crisis is a massive challenge - 40 million people are living with AIDS. There will be 20 million AIDS orphans by 2010. 7 million people need treatment right now, and only 2 million have access to it. Due in part to President Bush's dramatic increase in funding for global AIDS, we have come a long way from the days in the late '90s when less than 1% of people have access to treatment. But it is shameful that only 28% of people in clinical need have access to treatment. We must meet our promises to people in the developing world - of getting 2 million people on treatment by 2008, and coming as close as possible to universal access to treatment by 2010 - and in order to do that, our next President must fight for \$50 billion for the second five years of the US Global AIDS Initiative.

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<sup>2</sup> GFATM projects a \$1.4 billion request from FY10 onward. This is a conservative estimate--the GFATM Board recently agreed to a target size of \$8 billion that would need the US share to reach \$2.7 billion annually.

<sup>3</sup> "Non-Focus Countries" have been more or less flat funded and many are being left aside. Many development groups and implementing agencies seek increases in these accounts.

<sup>4</sup> Four years of a five-year initiative that the World Health Organization estimates will cost \$8 billion over 5 years. \$8 billion is the US fair-share of WHO cost estimates needed to train, retain and support enough health workers to double the overall workforce and meet basic health needs in sub-Saharan Africa, starting at \$650 million, and rising over five years to \$2.6 billion.