TAC and partners announce universal access campaign

By *moderator*
Created *2010/05/28 - 1:28pm*
28 May, 2010 - 13:28 ? moderator

- **TAC and partners to march for universal access**
- **Africa wins every time you INVEST in HIV and TB**
- **Letter to President Barack Obama from TAC and partners**
- **Letter to President Jacob Zuma from TAC and partners**
- **Letter to United States Vice President Joe Biden**

1) TAC and partners to march for universal access

On 17 June 2010, TAC and partners will be holding a peaceful demonstration in Johannesburg. We will be calling on governments and funders to scale up funding to meet the targets for universal access to HIV treatment, prevention and care. The demonstration will be held during the World Cup, targeting world leaders in attendance to meet their funding commitments for HIV and health.

The campaign will be held in partnership with:

Médecins Sans Frontières
SECTION27, incorporating the AIDS Law Project
AIDS Rights Alliance of Southern Africa (ARASA)
Congress of South African Trade Unions (COSATU)
Community Media Trust (CMT)
World AIDS Campaign
AIDS Consortium
SAfAIDS
Soul City
Children?s Rights Center
Equal Education

Included in this newsletter is information on why we are marching ?Africa wins every time you INVEST in HIV and TB?. Also included are copies of letters sent by TAC and partners to South Africa President Jacob Zuma, United States President Barack Obama and United States Vice President Joe Biden. In these letters we call on the Presidents and Vice President to take leadership to ensure that universal access targets are met across the region and funding is expanded to meet these targets.

2. Africa wins every time that you INVEST in HIV and TB!

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

Commitments to meet universal access by 2010 were made in July 2005 by G8 nations. This created the momentum that led to a global commitment to universal access by 2010, as endorsed by country leaders at the 60th session of the United Nations General Assembly. The global commitment to universal access is also reflected in the Millennium Development Goals ? particularly, MDG 6 ? which in addition to universal access, also commits countries to the target of halting and reversing the spread of HIV by 2015.

Yet today we are far from meeting universal access targets and governments and funders have already begun to backtrack on their funding commitments - threatening to undermine the gains made and future access to treatment, care and prevention. Worldwide about 4 million people are receiving antiretroviral treatment (ART) ? however, this represents only 42% of the people who need it. Further, less than a quarter of HIV positive pregnant women have access to prevention of mother to child transmission (PMTCT).[1]

Reaching universal access is necessary to reducing AIDS mortality, opportunistic diseases and new infections as well as upholding our fundamental right to health.

RESOURCES FOR HEALTH

Developed and developing nations are not meeting their funding commitments for HIV and health. International financing mechanisms for health and HIV such as the Global Fund are struggling to secure the finances necessary to continue to expand programmes. A reduction in HIV funding will lead to millions of avoidable deaths across the region.

The Abuja Declaration

In 2001 African nations committed (in the Abuja declaration) to placing the fight against HIV/AIDS ?at the forefront and as the highest priority issue in our respective national development plans? for the first quarter of the 21st century?.[2] Related to this was the pledge to expand funding for health to 15% of their annual budgets.[3] Yet today African nations continue to spend far too little on health and only 6 of 52 African nations have met or surpassed the 15% target.[4] African nations remain particularly reliant on external funding to support their ART programmes. It is estimated that Global Fund support is responsible for at least 40% of people on treatment in Southern and West/Central Africa, and 80% of people on treatment in East Africa.

The President?s Emergency Plan for AIDS Relief (PEPFAR)

In the past, the United States (US) has been a global leader in its response to HIV/AIDS and expanding access to ART through PEPFAR. Yet today, under the Obama administration, the US is turning away from PEPFAR in favour of the new Global Health Initiative (GHI). The GHI broadens the mandate of health interventions without expanding funding, resulting in less funding for HIV. The financial year 2010 and 2011 budget requests have included a flat-lining of AIDS funding, and decreased funding for treatment.[5] Expanding funding for other health interventions and priorities should be done but not at the expense of patients on and in need of ART.

It is also extremely distressing that the US has stated that PEPFAR will move away from providing ?direct care? in favour of ?technical assistance.? PEPFAR funded programmes could be forced to close their doors as the US moves away from funding direct care. Across the region PEPFAR programmes have already begun to slow or in some cases even cap enrolment onto ART.[6]

The Global Fund to Fight AIDS, Tuberculosis and Malaria (GLOBAL FUND)

The move away from funding ART by the US is part of a larger global trend away from funding HIV in favour of other millennium development goals (MDGs) and health interventions (below we will address a number of these arguments). This trend is threatening the future of the Global Fund, the single largest multilateral funding mechanism for the health sector and HIV. The Global Fund has saved nearly 5 million lives since 2005, or 3,600 people a day. The Global Fund finances ART treatment for almost two thirds of people in the developing world.[7] The Global Fund must raise $20 billion for its upcoming round to increase the scale-up of ART and build on efforts to meet universal access.[8]

ART ? IMPROVING HEALTH OUTCOMES AND MEETING MDGs

Expanded access to HIV treatment, prevention and care is necessary to meeting universal access but it is also necessary to meeting a number of other MDGs and improving health outcomes.

ART and prevention

Governments and funders have argued that funding for prevention should be prioritized over ART. However, it is becoming increasingly clear that ART is necessary as part of a package of prevention services to reduce HIV incidence. Studies have shown that ART reduces the risk of sexual transmission of HIV in sero-discordant partnerships when the HIV positive partner is adhering to treatment.[9] (ART is effective as part of a package of prevention services and sero-discordant partners should continue to use condoms). ART is already used as a prophylaxis treatment to prevent HIV transmission to infants and rape survivors, yet access to these services remains limited.

ART and maternal health

HIV continues to be the leading cause of maternal and infant mortality in the African region. In at least 4 Southern African countries (South Africa, Lesotho, Botswana and Namibia), more than 50% of deaths in children under 5 are attributed to HIV.[10] Expanded access to HIV treatment, prevention and care is necessary to reducing maternal and infant mortality and meeting MDGs 4 and 5.[11]

Initiating mothers onto ART treatment earlier will reduce maternal mortality. 84% of maternal deaths occur in women whose CD4 counts fall below 350 cell/mm3 before initiating treatment.[12] Expanded access to ART is also necessary to reducing infant mortality. ART (HAART or PMTCT) during pregnancy and breastfeeding have been shown to reduce HIV transmission from mother to child to below 2%. Further, for HIV positive infants, immediate access to ART can reduce mortality by 75%.[13]

ART and opportunistic infections and mortality

Evidence has shown that initiating ART at a CD4 count of 350 cells/mm3, rather than below 200 cells/mm3, reduces opportunistic diseases and death.[14],[15] (The START trial, which is currently enrolling patients, will provide more evidence on the optimum time to initiate treatment.)[16] Further ART is necessary to the successful treatment of a number of diseases. In line with this, South Africa has updated its HIV treatment guidelines to provide earlier ART to all patients co-infected with HIV/TB.

ART and health system strengthening

Health system strengthening is necessary to effectively responding to an HIV epidemic and to improving health outcomes. Further, any reduction in funding for ART will increase opportunistic infections and AIDS related diseases - thereby increasing the burden on health systems. Experiences in a number of countries have shown that AIDS programmes have begun to strengthen health systems. In 2009, Médecins Sans Frontières reported that HIV/AIDS programmes have had a positive impact in terms of human resources for health, improved laboratory monitoring and pharmacy capacity and management, and more effective health management information and procurement systems.[17]

NOW IS THE TIME FOR UNIVERSAL ACCESS ? BUILDING ON SUCCESSES

South Africa, the epicenter of the epidemic, is turning the tide in its AIDS response. For the first time there is real political will to reduce new infections and to ensure that all people in need are able to access treatment. This is evident through expanding funding for HIV as well as the implementation of updated evidence based policies and treatment guidelines.[18] It would be a tragedy if these gains were undermined by the international backlash away from funding HIV.

With expanded funding, HIV programmes across the region are positioned to expand treatment and care, reduce new infections, build country health systems, support universal access targets and lay the path to meeting a number of other MDGs. Now is the time for governments and funders to leverage the successes of HIV programmes and partnerships built to strengthen their global health responses and expand access to ART to all people in need.

Governments and funders - close the gap for universal access

3. Letter to President Barack Obama from TAC and partners

President Barack Obama
The White House
1600 Pennsylvania Avenue NW
Washington, DC 20500
Fax: +001 202 456 2461

cc: Ambassador Donald H. Gips
Consulate General Cape Town
2 Reddam Ave, Westlake
Cape Town, 7945
Tel: +27 021 7027300
Fax: +27 021 702 7493

cc: Embassy of the USA
PEPFAR
P.O.Box 9536
Pretoria, 0001
Tel: +27 012 431 4209
Fax: +27 012 342 6167

18 May 2010

Dear President Barack Obama,

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

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

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

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

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

commitments on HIV/AIDS.

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

The approved $48 billion did not make it into the 2010 Congressional budget, and Congress increased PEPFAR funding by just 2.2% for 2011, the smallest in the programme?s history.[19] Further, President Obama, during your electoral campaign you committed to expanding funding by $1 billion per year, yet you only asked for a $366 million increase for 2010. These unmet PEPFAR funding commitments will undermine efforts to meet universal access.

In the past year the number of HIV positive people that PEPFAR started onto treatment was the smallest it has been for four years.[20] Programmes across the region are feeling the effects of contracting PEPFAR funding. In some countries where programmes are heavily PEPFAR funded, most-visibly Uganda, the flat-lined budget has resulted in patients who are eligible for treatment being turned away from facilities without receiving care.

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

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

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

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

President Obama, in 2006 you visited Africa as an advocate of people living with HIV. In Kenya you took an HIV test to encourage others to get tested and lessen the stigma and discrimination faced by people living with HIV. In South Africa you visited the Treatment Action Campaign?s Khayelitsha offices and spoke to HIV educators working in township schools. After visiting Africa you campaigned around the need to strengthen and expand PEPFAR stating: ?We are all sick because of AIDS - and we are all tested by this crisis.?[21]

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

Opponents of HIV funding argue that money should instead go to other MDGs and particularly infant and maternal

health. Yet, HIV continues to be the leading cause of maternal and infant mortality in the African region ? in at least 4 Southern African countries (South Africa, Lesotho, Botswana and Namibia), more than 50% of deaths in children under 5 are attributed to HIV.[22] It is estimated that every minute a child is born with HIV.

It is clear that expanded access to HIV treatment, prevention and care is necessary to reducing maternal and infant mortality and meeting MDGs 4 and 5.[23] Initiating mothers onto ART treatment earlier will reduce maternal mortality - 84% of maternal deaths occur in women whose CD4 counts fall below 350 cell/mm3 before initiating treatment.[24] Expanded access to ART is also necessary to reducing infant mortality. ART (HAART or PMTCT) during pregnancy and breastfeeding have been shown to reduce HIV transmission from mother to child to below 1%. Also, for HIV positive infants, immediate access to ART can reduce mortality by 75%.[25]

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

In 2009 Medicins Sans Frontieres reported that HIV/AIDS programmes have had a positive impact in terms of human resources for health, improved laboratory monitoring and pharmacy capacity and management, and more effective health management information and procurement systems.[26]

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

In addition, we are seeing increasing evidence that ART is an effective method of prevention and that expanded access to ART, is necessary as part of a comprehensive package of prevention services. ART is already used in the region to prevent mother to child transmission (PMTCT) and for post exposure prophylaxis (PEP) for rape survivors. However it is now recognized that ART is an important prevention method to reduce to risk of sexual transmission of HIV in sero-discordant partnerships ? to the extent that experts based at the World Health Organization have suggested immediate treatment of all people living with HIV as a potential strategy for eliminating the epidemic.[27]

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

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

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

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

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

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

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

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

Yours respectfully,

Vuyiseka Dubula
General Secretary of the Treatment Action Campaign

Endorsed by:

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

4. Letter to President Jacob Zuma from TAC and partners

President Jacob Zuma
Office of the President
Private Bag X1000
Pretoria 0001
Tel: +27 (0)12 323 8246
Fax: +27 (0) 12 323 8246
Email: president@po.gov.za

cc: Mr Mandisi Mpahlwa
Economic Adviser to the President

thembani@po.gov.za

27 May 2010

Dear President Jacob Gedleyihlekisa Zuma,

RE: South Africa must take leadership to push for universal access for HIV treatment, prevention and care at the 2010 G20 Summits

President Jacob Zuma, over the past few months, under your leadership, we have finally begun to see the political will needed to address the HIV epidemic in South Africa. We commend you for your leadership and for putting in place evidence based policies to effectively respond to the epidemic. We urge you now to show leadership to meet universal access targets for HIV prevention, treatment and care across the region.

Over the past few months, the policies that have been put in place by you and the Minister of Health, Aaron Motsoaledi, have put South Africa on the path to achieve universal access targets. South Africa must spearhead universal access through proper funding and implementation of the updated policies.

This year South Africa will participate in the 2010 G20 Summits to be held in Canada during June and South Korea during November. South Africa is the only African country on the G20 and therefore represents the needs of the entire region and other developing countries. We urge you, President Zuma, to use this global platform to advocate for universal access targets to be met across the region. Meeting universal access targets will require expanded and sustainable funding from developed and developing nations.
In July 2005, the G8[29] made a commitment to support universal access to HIV prevention, treatment and care by 2010. This created the momentum that led to a global commitment to universal access by 2010, as endorsed by country leaders at the 60th session of the United Nations General Assembly.[30] A key target was that 80% of people who need HIV prevention, treatment and care must have access to these services. The global commitment to universal access is also reflected in the Millennium Development Goals (MDGs) ? particularly, MDGs 4,5 and 6 ? which in addition to universal access, also commits countries to the targets of halting and reversing the spread of HIV, reducing child mortality and improving maternal health.

Today universal access remains a distant target. About 4 million people globally are receiving antiretroviral treatment ? however, this represents only 42% of the people who need it.

It is particularly concerning that, despite how far we are from meeting our targets for universal access, funders have already begun to backtrack on their commitments. Without expanded funding, programmes across Africa will be unable to continue to initiate new patients onto treatment. Further, the emphasis of funders away from supporting ?direct care? to providing ?technical assistance? will jeopardise future access to treatment for many patients receiving treatment from programmes supported by international funding.

We call on you to take leadership at the G20 Summits to protect millions of lives across the region. To ensure the sustainability of current treatment programmes and to ensure future access to treatment for new patients the following steps need to be taken:

1. Developed nations must recommit to supporting universal access targets. Further, developed nations must ensure that sufficient and sustainable resources are made available to meet these targets. Cuts in international funding for HIV must be reversed.

2. African governments need to continue to scale-up funding to improve health outcomes, strengthen healthcare systems and meet universal access targets.

1. Cuts in international funding for HIV must be reversed. Developed nations must recommit to supporting universal access targets. Further, developed nations must ensure that sufficient and sustainable resources are made available to meet these targets.

a) Global Fund to Fight AIDS, TB and Malaria (Global Fund)
The Global Fund to fight AIDS, TB and Malaria acts as the single largest multilateral funding mechanism for the health sector.[31] The Global Fund has saved nearly 5 million lives since 2005, or 3,600 people a day.[32] It accounts for two-thirds of international funding for TB treatment, 70% of international funding for malaria treatment and prevention,[33] and pays for two-thirds of those receiving ART.[34]

Despite commitments from developed nations to support universal access, the Global Fund has been chronically underfunded. While the Global Fund originally aimed to generate $10 billion from the G8 annually by 2008 only $3 billion was yearly given by these countries.[35] Over the past year there have been a number of worrying signals and statements indicating that the Global Fund will be unable to secure sufficient funding for upcoming rounds.

President Zuma, we call on you to champion the replenishment of the Global Fund at the G20 Summits. Sustainable and expanding funding for the Global Fund is necessary to meeting universal access targets.[36]

b) President?s Emergency Plan for AIDS Relief (PEPFAR)
It is estimated that, from 2003-2009, PEPFAR treatment support saved over 3 million adult lives.[37] PEPFAR programmes were set to expand in 2008 when the United States Congress reauthorized the programme for five more years at a cost of $48 billion. However it has now become clear that developing countries may never see this level of funding.

$48 billion did not make it into the 2010 Congressional budget, and Congress increased PEPFAR funding by just 2.2% for 2011, the smallest in the programme?s history.[38] Further, while President Barack Obama?s electoral campaign platform pledged to give $1 billion a year, he asked for only a $366 million increase for 2010.[39] In the last year, the number of HIV-positive people that PEPFAR started on treatment was the smallest it has been for four years, even while demand increases as patients live longer and the disease continues to spread unabated.[40]

In countries where ART programmes are heavily PEPFAR funded, most visibly Uganda, the flat-lined budget has resulted in patients being turned away from facilities without receiving care. Civil society and doctors in Uganda have reported that they have already been instructed to stop enrolling new patients onto PEPFAR funded ART programmes.

In the past, the United States has championed expanding access to treatment and today millions of patients across the region rely on PEPFAR funded programmes for ART. A move away from funding lifelong treatment programmes by PEPFAR would be unconscionable. Further, the need for treatment has not been met, and PEPFAR?s unmet funding commitments are undermining efforts to meet universal access.

South Africa must reinforce the continued need for the United States to be a leader in expanding access to prevention, treatment and care. Especially as the US?s move away from funding HIV is based on flawed arguments (see below: Why the arguments of the opponents of HIV funding are flawed).

c) Financial Transactions Tax
The Financial Transaction Tax (FTT) is a proposed financing mechanism to raise money for health and other social needs. South Africa should champion the mechanism at G20 Summits to close the gap between service provision and need.

The FTT would be a modest levy placed on all financial transactions to raise revenue to help finance the fight against AIDS, maternal mortality, extreme poverty, climate change and other development challenges. South Africa and the region continue to face a wide range of developmental needs as well as mounting anger and dissatisfaction about poor

service delivery and therefore we must support this initiative for health financing. The FTT would be an important source of funding to address a number of these needs.

2. African governments need to continue to scale-up funding to improve health outcomes, strengthen health care systems and meet universal access targets.

Developed countries have argued that they are backing away from HIV funding to promote country ownership of ART programmes. Concern about under spending on health by developing countries is valid. Developing countries are not meeting their financing commitments for health. Most notably, African heads of state committed, in the Abuja declaration of 2001, to:

*?placing the fight against HIV/AIDS at the forefront and as the highest priority issue in our respective national development plans for the first quarter of the 21st century.?**[41]***

Related to this commitment was a pledge to ?set a target of allocating at least 15% of our annual budget to the improvement of the health sector?. However, no clear roadmap towards achieving this target was set at either the regional or national levels.

Almost ten years later, progress towards the Abuja target remains extremely slow. East Africa has recorded the greatest increase in regional average spending on health, going from 7.9% in 2001 to 9.4% in 2010. Southern Africa has increased only marginally from 10 ? 10.3%, while West/Central Africa has recorded almost no increase in regional average spending on health. Throughout sub-Saharan Africa, only six countries have achieved or surpassed the Abuja target.[42]

African government can no longer rely solely on international funders to support their treatment programmes. Governments must take steps to expand funding for health and HIV as well as set out clear plans to meet the Abuja targets.

President Zuma, we call on you to champion meeting the Abuja targets across the region by expanding funding for health. We call on you take a firm stand against recent rhetoric by African Finance Ministers dismissing their development declarations.

Why the arguments of opponents of HIV funding are flawed

Developed countries, and particularly the United States, have been increasingly shifting away from funding HIV in favour of other health interventions and millennium development goals. A number of the arguments against funding HIV are flawed and below we will respond to some of the key arguments raised by developed countries as justification for reducing HIV funding.

Opponents of HIV funding have argued that HIV funding is isolationist and has crowded out funding for other health interventions and millennium development goals (MDGs). A global health priority that is being championed as a critical area for focus, over HIV (MDG 6), is that of maternal and child mortality (MDGs 4 and 5). However, a wealth of scientific evidence has shown this thinking to be deeply flawed. HIV continues to be a leading cause of maternal and child mortality in the African region ? in at least 4 Southern African countries (South Africa, Lesotho, Botswana and Namibia), more than 50% of deaths in children under 5 are attributed to HIV.[43]

It is clear that expanded access to HIV treatment, prevention and care is necessary to reducing maternal and infant mortality and meeting MDGs 4 and 5.[44] Initiating mothers onto ART treatment earlier will reduce maternal mortality. 84% of maternal deaths occur in women whose CD4 counts fall below 350 cell/mm3 before initiating treatment.[45] Expanded access to ART is also necessary to reducing infant mortality. ART (HAART or PMTCT) during pregnancy and breastfeeding have been shown to reduce HIV transmission from mother to child to below 1%.

Further, for HIV positive infants, immediate access to ART can reduce mortality by 75%.[46]

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

In addition, ART is essential to the successful treatment and prevention of many other diseases rife in sub-Saharan Africa. These medicines are a major contributor to reducing opportunistic infections and AIDS related diseases.

President Zuma, our South African government has recognized that improving a number of health outcomes can only be done through integrated health services and health systems strengthening. South Africa is now taking steps to integrate ART delivery with other needs including sexual health, antenatal care and treatment for tuberculosis as well as strengthening health systems.

In high prevalence countries, responding effectively to HIV and other health needs cannot be done without health systems strengthening and integration of health services. In many countries HIV programmes have laid the groundwork to do just this. Undermining HIV programmes will worsen health outcomes and weaken health systems. Instead, strengthening health systems and responding to a range of health needs should be done in partnership with, not at the expense of, HIV programmes. HIV is not over funded ? health is underfunded.

Opponents of HIV treatment have further argued that HIV treatment receives too much attention, which undercuts investment in prevention. There is increasing evidence that ART is necessary as part of a comprehensive package of prevention services including: expanded access to male and female condoms; reproductive health and family planning services; medical male circumcision; PEP; PMTCT and safe infant feeding methods.

ART is already widely used for prevention of mother to child transmission (PMTCT) and post-exposure prophylaxis (PEP) for rape victims. Evidence is now showing that HIV positive patients adhering to ART have a reduced risk of transmitting HIV to their sexual partners ? to the extent that experts based at the World Health Organisation have suggested immediate treatment of all people living with HIV as a potential strategy for eliminating the epidemic.[47]

A more recent study, the Partners in Prevention HSV/HIV Transmission Study, which followed 3,408 couples in 7 African countries, confirmed that ART reduces the probability of transmission of HIV. The study found that: ?ART use is associated with substantially lower risk for HIV transmission among heterosexual, African, HIV serodiscordant couples, where the HIV-infected partner did not meet national criteria for ART initiation at enrollment.?[48] ***[49]***

Lack of access to treatment is indirectly responsible for many new infections and for hindering other goals of the HIV response. As such, investing in ART now could lead to tremendous cost savings down the line ? not only for HIV transmissions, but also for other morbidities such as tuberculosis that are associated with untreated HIV. While prevention undoubtedly needs more attention and resources, this must go hand in hand with treatment ? not instead of treatment.

Moving forward ? recommitting to universal access

We have demonstrated that the trend away from funding HIV is based on flawed arguments. The fatal miscalculation in the arguments to reduce HIV funding is that they do not contextualize the devastating human, social, political and economic impacts of reducing access to treatment. HIV has disproportionately affected young adults in the developing world ? the backbone of any economy. A reduction in treatment for HIV would be reflected through the economy impairing development. Further, vulnerable segments of the society, especially women, have the highest rates of HIV

prevalence. Reducing access to health services would further marginalize these groups.

President Zuma, during the G20 Summits this year you will represent the health and social needs of the region. It is clear that HIV remains an emergency in our societies across the region. However a strong framework has been built to scale-up and expand access to prevention, treatment and care and, with expanded and sustainable funding, universal access can become a reality.

There is a need for strong leadership to rally support for expanded and sustainable funding to achieve universal access targets. We call on you, President Zuma, to take leadership to rally this support. At the 2010 G20 Summits, G20 governments must recommit to ensuring that these targets are met.

Yours respectfully,

Vuyiseka Dubula
General Secretary of the Treatment Action Campaign

Endorsed by:

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

5. Letter to United States Vice President Joe Biden

Vice President Joe Biden
The White House
1600 Pennsylvania Avenue NW
Washington, DC 20501
United States of America
FAX: 202 456 2461

cc: Ambassador Donald H. Gips
Consulate General Cape Town
2 Reddam Ave, Westlake
Cape Town, 7945
Tel: +27 021 7027300
Fax: +27 021 702 7493

cc: Embassy of the USA
PEPFAR
P.O.Box 9536
Pretoria, 0001
Tel: +27 012 431 4209
Fax: +27 012 342 6167

28 May 2010

Dear Vice President Biden,

RE: Request for meeting to discuss the future of the President?s Emergency Plan for AIDS Relief and achieving universal access targets for HIV treatment, prevention and care.

The Treatment Action Campaign (TAC) and partners would like to request to meet with you to discuss the future of HIV/AIDS funding and the President?s Emergency Plan for AIDS Relief (PEPFAR) during your visit to South Africa in June 2010.

PEPFAR, established in 2003 under former President George W. Bush, has expanded access to antiretroviral treatment across the developing world. Over the past decade the United States has expanded access to treatment for over 2.4 million people living with HIV/AIDS. During a time when many governments refused to acknowledge the crisis of HIV/AIDS, PEPFAR secured the right to life for millions by funding access to treatment.

In its seventh year, PEPFAR is strategically positioned to expand treatment and care, reduce new HIV infections, build country health systems, support universal access targets and lay the path to meeting a number of other Millennium Development Goals (MDGs). In Africa, expanding access to antiretroviral treatment is necessary to achieving MDGs 4,5 and 6 ? to reduce child mortality, to improve maternal health and to halt and reverse the spread of HIV.

Yet, despite PEPFAR?s unique positioning to strengthen the impact of global AIDS programmes and global health outcomes, the US is backing away from its commitments on HIV/AIDS. The US is turning away from PEPFAR in favour of the new Global Health Initiative (GHI). The GHI broadens the mandate of health interventions without expanding funding, which will result in less funding for HIV. The financial year 2010 and 2011 budget requests have included a flat-lining of HIV/AIDS funding, and decreased funding for anti-retroviral treatment.

We are deeply concerned that:

the US has flat-lined funding for HIV and that funding for antiretroviral treatment is decreasing, and,
PEPFAR is moving away from providing ?direct care? in favour of ?technical assistance?.

The flat-lined budgets have already resulted in the capping of patient enrolment onto ART and, in some cases, patients are already being turned away from facilities without receiving care. Targets to meet universal access to HIV treatment, prevention and care, endorsed by the USA, cannot be met without expanded funding for HIV.

Also, while there is a great need for technical assistance to build health care systems in the developing world, this investment should not be made at the expense of the care that millions are receiving through PEFAR funded programmes.

In his previous visit to South Africa, President Barack Obama, visited TAC?s Khayletisha office and spoke to HIV educators working in the township?s schools. At this point he expressed support for expanding access to HIV treatment, prevention and care. The need to expand access to these services remains an emergency in Africa - less than half of people in need are able to access treatment.

On May 19th we wrote to President Obama outlining these concerns.[50] We hope to address these issues with you directly during your visit to South Africa. We will also be organising a mass march to your Consulate in Johannesburg on June 17th in order to demonstrate to you and the world the growing concerns and fears around this issue.

We look forward to your response and to introducing you to TAC and our partners.

Yours sincerely,

Vuyiseka Dubula
General Secretary of the Treatment Action Campaign

Endorsed by:

Médecins Sans Frontières
SECTION27, incorporating the AIDS Law Project
AIDS Rights Alliance of Southern Africa (ARASA)
Congress of South African Trade Unions (COSATU)
Community Media Trust (CMT)
World AIDS Campaign
AIDS Consortium
SAfAIDS
Soul City
Children?s Rights Center
Equal Education

[1] Medecins Sans Frontieres. Punishing Success? Early Signs of a Retreat from Commitment to HIV/AIDS Care and Treatment. 2009
[2] Ibid.
[3] Abuja Declaration adopted at the 24-27 April 2001 summit in Abuja, Nigeria
[4] The Global Fund to Fight AIDS, Tuberculosis and Malaria, Third replenishment (2011-2013). Trends in Development Assistant and Domestic Financing for Health in Implementing Countries. March 2010. http://www.theglobalfund.org/documents/replenishment/2010/Trends_in_Development_Assistance_and_Domestic_Finan
[5] Memo from US activists. **Administration Global AIDS Funding Levels and Policies Risk Undermining Success. May 2010.**
[6] Stockman F. US seeks to rein in AIDS programme. *The Boston Globe*, April 11 2010. http://www.boston.com/news/nation/washington/articles/2010/04/11/us_seeks_to_rein_in_aids_program/
[7] Global Fund. The Global Fund 2010 Innovation and Impact Results Summary. 2010. http://www.theglobalfund.org/documents/replenishment/2010/Progress_Report_Summary_2010_en.pdf
[8] Global Fund Press Release. Donors meet to discuss Global Fund resource needs. March 2010.
[9]Donnell D et al. ART and Risk of Heterosexual HIV-1 Transmission in HIV-1 Serodiscordant African Couples: A Multinational Prospective Study. CROI Paper #136 2010
[10] Medecins Sans Frontieres. Punishing Success? Early Signs of a Retreat from Commitment to HIV/AIDS Care and Treatment. 2009.
[11] The MDG4 is to reduce child mortality and the MDG5 is to improve maternal health.
[12]Venter F. IAS Conference Symposium, Fifth International AIDS Society Conference on HIV Pathogenesis, Treatment and Prevention, July 2009
[13]Violari A et al. Early antiretroviral therapy and mortality among HIV-infected infants. N Engl J Med. 2008 November 20. 359, 2233-44. http://www.ncbi.nlm.nih.gov/pubmed/19020325
[14] Severe P et al. A randomized clinical trial of early versus standard antiretroviral therapy for HIV-infected patients with a CD4 T cell count of 200-350 cells/ml (CIPRAHT001). Paper presented at: 49th Interscience Conference on Antimicrobial Agents and Chemotherapy; Sep 12-15 2009; San Francisco, CA. Abstract H1230c.
[15] Emery S et al. Major clinical outcomes in antiretroviral therapy (ART)-naive participants and in those not receiving ART at baseline in the SMART study. J Infect Dis. 2008;197(8):1133-1144.
[16] Community statement on the START trial and the change in the US DHHS treatment guidelines. May 2010 http://www.tac.org.za/community/node/2861

[17] Medecins Sans Frontieres. Punishing Success? Early Signs of a Retreat from Commitment to HIV/AIDS Care and Treatment. 2009
[18] The Treatment Action Campaign. Detailed commentary on updated ART guidelines. April 2010.
[19] Paul K. AIDS Programme Hit Setback in Africa. *Newsweek*, April 27 2010. http://www.newsweek.com/id/237037
[20] Ibid.
[21] President Barack Obama. ?Barack Obama: Fighting HIV/AIDS Worldwide.? (Campaign material) 2008.
[22] Medecins Sans Frontieres. Punishing Success? Early Signs of a Retreat from Commitment to HIV/AIDS Care and Treatment. 2009.
[23] MDG4 is to reduce child mortality and the MDG5 is to improve maternal health.
[24] Venter F. IAS Conference Symposium, Fifth International AIDS Society Conference on HIV Pathogenesis, Treatment and Prevention. July 2009.
[25] Violari A et al. Early antiretroviral therapy and mortality among HIV-infected infants. N Engl J Med. 2008 November 20. 359, 2233-44. http://www.ncbi.nlm.nih.gov/pubmed/19020325
[26] Medecins Sans Frontieres. Punishing Success? Early Signs of a Retreat from Commitment to HIV/AIDS Care and Treatment. 2009.
[27] Granich R et al. Universal voluntary HIV testing with immediate antiretroviral therapy as a strategy for elimination of HIV transmission: a mathematical model. Lancet 2009; 373: 48?57.

[28] Minister of Health Aaron Motsoaledi. Media Briefing: HIV and AIDS: Business as usual? 10 November 2009.
[29] For full details of G8 commitments made in 2005, see http://data.unaids.org/Topics/UniversalAccess/postg8_gleneagles_africa_en.pdf. For information on progress towards these commitments, see http://www.iasociety.org/Web/WebContent/File/IAS_GC%20Backgrounder_%2019%20Nov%202009.pdf
[30] For full details of UN commitments see http://www.who.int/hiv/universalaccess2010/worldsummit.pdf
[31] Plus News. Fund gets results, but will it get funding? 8 March 2010. http://www.plusnews.org/report.aspx?ReportID=88357
[32] Sapa-AFP. Global disease fund needs money. 28 April 2010. http://www.timeslive.co.za/world/article420975.ece/Global-disease-fund-needs-money
[33] Ibid.
[34] ARASA. Groups warn of funding threats to HIV treatment access. March 8 2010. http://www.arasa.info/node/269
[35] The International Treatment Preparedness Coalition. Missing the Target 8: Rationing Funds, Risking Lives: World backtracks on HIV treatment. April 2010.
[36] The Global Fund has produced the following scenarios on what it can achieve depending on the amount of money received for its upcoming round. US $13 billion would effectively hold back scale-up of treatment but sustain existing patients, US $ 17 billion would enable scale-up at a rate similar to what is currently observed and US $20 billion would result in increased scale-up with a greater likelihood of meeting the millennium development goals.
[37] TAC. PEPFAR Threatened: What does this mean for HIV treatment and prevention programmes? February 10 2010. http://www.tac.org.za/community/node/2810.
[38] Paul K. AIDS Program Hit Setback in Africa. *Newsweek*, 27 April 2010. http://www.newsweek.com/id/237037
[39] Stockman F. US seeks to rein in AIDS programe. *The Boston Globe*, 11 April 2010. http://www.boston.com/news/nation/washington/articles/2010/04/11/us_seeks_to_rein_in_aids_program/
[40] Paul K. AIDS Program Hit Setback in Africa. *Newsweek*, 27 April 2010. http://www.newsweek.com/id/237037
[41]Abuja Declaration adopted at the 24-27 April 2001 summit in Abuja, Nigeria
[42]The Global Fund to Fight AIDS, Tuberculosis and Malaria, Third replenishment (2011-2013. Trends in Development Assistant and Domestic Financing for Health in Implementing Countries. March 2010. http://www.theglobalfund.org/documents/replenishment/2010/Trends_in_Development_Assistance_and_Domestic_Finan
[43]Medecins Sans Frontieres. Punishing Success? Early Signs of a Retreat from Commitment to HIV/AIDS Care and Treatment. 2009
[44]MDG4 is to reduce child mortality and the MDG5 is to improve maternal health.
[45]Venter F. IAS Conference Symposium, Fifth International AIDS Society Conference on HIV Pathogenesis, Treatment and Prevention. July 2009

[46]Violari A et al. Early antiretroviral therapy and mortality among HIV-infected infants. N Engl J Med. 2008 November 20. 359, 2233-44. http://www.ncbi.nlm.nih.gov/pubmed/19020325
[47]Granich R et al. Universal voluntary HIV testing with immediate antiretroviral therapy as a strategy for elimination of HIV transmission: a mathematical model. Lancet 2009; 373: 48?57.
[48] Donnell D et al. ?ART and Risk of Heterosexual HIV-1 Transmission in HIV-1 Serodiscordant African Couples: A Multinational Prospective Study.? CROI Paper #136. 2010.
[50] Letter to President Barack Obama from TAC and partners ? why we need expanded funding for HIV. 19 May 2010. (http://www.tac.org.za/community/node/2871).

n/a
