Order Code RL30883

Report for Congress
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Africa: Scaling Up the Response To the HIV/AIDS Pandemic

Updated May 29, 2002

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Congressional Research Service ❖ The Library of Congress

Africa: Scaling Up the Response To the HIV/AIDS Pandemic

Summary

Sub-Saharan Africa's AIDS pandemic continues to spread – an estimated 3.4 million people were newly infected by HIV in 2001. International resources for combating the pandemic are increasing, and there is continuing interest in proposals for a further "scaling-up." In December 2001, the House passed the Global Access to HIV/AIDS Prevention, Awareness, and Treatment Act (H.R. 2069), finding that the African pandemic has become a national security and development crisis and authorizing increased funding.

AIDS experts see three dimensions to the effort to curb the spread of HIV/AIDS and reduce the death toll: prevention, care, and treatment. They estimate that by 2005, Africa could effectively absorb about $4.6 billion in the struggle against the pandemic and that about $3 billion would have to be provided by donors. Donor contributions were estimated at several hundred million dollars in 2001, and whether they will be providing $3 billion annually by 2005 remains to be seen.

Nonetheless, HIV/AIDS assistance from the United States and other donors has been increasing. U.S. bilateral spending on African AIDS programs is expected to rise from $238 million in FY2001 to $292 million in FY2002. The United States has pledged $500 million to the Global Fund to Fight AIDS, Tuberculosis, and Malaria, which announced its first grants in April 2002. About 52% of the $378 million to be initially disbursed will go to Africa. The scale of future increases in U.S. spending is unclear; but several bills that would boost the U.S. contribution are currently before Congress.

The focus in the struggle against AIDS in Africa to date has been on prevention – only an estimated 25,000 to 30,000 African AIDS patients are currently receiving treatment with the antiretroviral drugs that have sharply reduced the AIDS death toll in developed countries. AIDS experts favor a continued scaling up of prevention measures, including media campaigns, school-based programs, and condom distribution. At the same time, there is strong support for expanding the availability of antiretrovirals to prevent mother to child transmission of HIV during birth.

Beyond prevention, many advocates want to enhance home-based care for AIDS patients and their families and sharply expand programs to care for Africa's burgeoning population of orphans. Many also believe that antiretroviral treatment must be made much more widely available, both on moral grounds and because it can stem the loss of adults in their most productive years.

In addition to governments, non-governmental organizations, foundations, and the private sector are expanding their involvement in the campaign against AIDS in Africa. Community and faith-based organizations are playing key roles in caring for those affected by AIDS, including orphans and vulnerable children. U.S. government agencies, meanwhile, have undertaken steps to enhance their policy making and coordination capabilities, although some observers would like to see additional efforts in this area.

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Introduction[1]

In Africa, more than 28 million people are infected by the HIV virus, and 19 million have already lost their lives to the AIDS disease. An estimated 2.3 million died of AIDS in 2001, and 3.4 million were newly infected.[2] Sub-Saharan Africa has about 10% of the world's population, but about 70% of the worldwide total of HIV-infected people live in the region. The HIV infection rate among adults exceeds 10% in 16 countries, reaching 25% in South Africa and 38% in Botswana. Life expectancy is plunging in these countries, and the social and economic consequences of widespread illness and death are expected to be severe. Botswana's President Festus Mogae, told the June 2001 United Nations General Assembly Special Session on HIV/AIDS (UNGASS) that "We are threatened with extinction."[3]

To date, progress in curbing the HIV/AIDS pandemic has been very limited, and Uganda and Senegal are the only countries cited by experts as clear-cut "success stories" in the fight against the disease. Uganda has sharply reduced HIV prevalence among adults through an intensive AIDS prevention campaign, and Senegal has evidently avoided a major AIDS epidemic through safe sex education in the schools, the promotion of condom use, and other measures.[4] In both cases, "outspoken and frank" leadership from the highest levels of government is credited with much of the success in the struggle against AIDS.[5] UNAIDS, the Joint United Nations Program on HIV/AIDS, also reports some evidence that young people in Zambia and South Africa are modifying their behavior to avoid HIV infection.[6]

In view of the continuing threat posed by AIDS to Africa's people, and to the region's future, interest in expanding or "scaling up" the response to the pandemic

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[1]For background on AIDS in Africa, and for current legislation, see CRS Issue Brief IB10050, *AIDS in Africa.*

[2]United Nations Joint Project on HIV/AIDS (UNAIDS), *AIDS Epidemic Update*, December 2001: 2.

[3]Maggie Farley, "At AIDS Disaster's Epicenter, Botswana is a Model of Action," *Los Angeles Times*, June 27, 2001.

[4]UNAIDS, *Acting Early to Prevent AIDS, the Case of Senegal*, June 1999.

[5]World Health Organization, *Macroeconomics and Health: Investing in Health for Economic Development.* Report of the Commission on Macroeconomics and Health, chaired by Jeffrey D. Sachs. Geneva, December 20, 2001: 52.

[6]Ibid, 16.

is strong. It was at an April 2001 Organization of African Unity (OAU) summit on HIV/AIDS that U.N. Secretary General Kofi Annan called for the creation of a global trust fund that would spend $7 billion to $10 billion annually to combat the pandemic worldwide.[7] Negotiations on the creation of this fund, named the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM or Global Fund) were completed in December 2001, and to date, $1.9 billion has been pledged for combating the three diseases worldwide. The United States has pledged $500 million.[8]

The final declaration of the UNGASS meeting noted that HIV/AIDS threatened social cohesion and political stability in Africa and required urgent national, regional, and international attention. The declaration set ambitious targets for reducing HIV prevalence among young men and women, expanding access to information about AIDS, reducing mother to child transmission (MTCT) of HIV, and enhancing AIDS care and treatment.

In Congress, the House passed the Global Access to HIV/AIDS Prevention, Awareness, and Treatment Act (H.R. 2069) in December 2001. This bill finds that "the HIV/AIDS pandemic in sub-Saharan Africa has grown beyond an international public health issue to become a humanitarian, national security, and developmental crisis." It authorizes increased funding both for bilateral HIV/AIDS programs and for a U.S. contribution to a global health fund. Other bills currently before committees in both the House and Senate would increase spending, launch new initiatives, and strengthen AIDS policy coordination in order to intensify the struggle against HIV/AIDS in Africa and worldwide.[9]

The purpose of this paper is to summarize the objectives for scaling up the response to the AIDS pandemic in Africa, review the estimated costs of scaling up, and describe the measures against the pandemic that AIDS experts seek to expand. In addition, the report discusses the types of organizations, including faith-based and private sector organizations, that will likely play important roles in an enhanced response, and reviews issues surrounding AIDS policy making and coordination in U.S. agencies as the U.S. role increases.

Objectives of Scaling Up

Two U.S. authorities on the African pandemic, Helene Gayle of the Bill and Melinda Gates Foundation, and Peter Lamptey of Family Health International, an Arlington-based non-profit focusing on reproductive health, have recently called for "an expanded and comprehensive HIV/AIDS response." They argue that such a

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[7]The Global AIDS and Tuberculosis Relief Act of 2001 (P.L. 106-264) had directed the Secretary of the Treasury to seek the creation of such a fund.

[8]Testimony of Secretary of Health and Human Services Tommy Thompson before the Senate Foreign Relations Committee, February 13, 2002.

[9]See CRS Issue Brief IB10050, *AIDS in Africa*, for a listing.

response would "effectively and rapidly deliver large-scale, comprehensive, and sustained HIV/AIDS programs"[10] in order to meet five objectives:

> A substantial reduction in new HIV infections; a substantial reduction in AIDS-related morbidity (illness) and mortality; improved quality of life for people infected and affected by HIV/AIDS; reduced HIV/AIDS stigma and discrimination; (and) reduced impact of the epidemic, especially on children and other groups.

During his speech at Abuja, Nigeria, in April 2001, UN Secretary General Annan laid out a broadly similar set of objectives for scaling up, but specifically mentioned expanded access to treatment as a goal. According to the Secretary General, scaling up should aim at

(1) preventing the further spread of the epidemic, particularly by giving young people the knowledge and power to protect themselves
(2) preventing mother to child transmission of HIV, which Annan called "the cruellest, most unjust infections of all"
(3) putting care and treatment, including treatment with advanced AIDS medications, "within everyone's reach"
(4) delivering scientific breakthroughs by giving a higher priority to finding a cure and a vaccine
(5) protecting those made most vulnerable by the disease, particularly orphans who "are growing up malnourished, under-educated, marginalized, and at risk of being infected themselves."[11]

AIDS experts generally argue that these objectives can be achieved by a substantial expansion in programs aimed at preventing the spread of HIV, and in programs that provide care and treatment to those affected by the pandemic. These approaches are discussed in greater detail below.

Cost Overview

In December 2001, Peter Piot, executive director of the Joint United Nations Program on HIV/AIDS (UNAIDS), told an international AIDS conference in Burkina Faso that assistance to fight HIV/AIDS in Africa should be increased "many-fold," and that the region required $4.6 billion per year to confront the pandemic. This estimate reflected detailed work done by Bernhard Schwartlander of the World Health Organization and UNAIDS, with others, and published in *Science* magazine

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[10]Peter R. Lamptey and Helene D. Gayle, eds., *HIV/AIDS Prevention and Care in Resource-Constrained Settings, A Handbook for the Design and Management of Programs* (Arlington, Virginia: Family Health International, 2001): 685. This publication was funded by the United States Agency for International Development.

[11]Secretary General Proposes Global Fund for Fight Against HIV/AIDS and Other Infectious Diseases at African Leaders Summit. UN Document SG/SM/7779/Rev.1 (April 26, 2001).

in June 2001.[12] The Schwartlander article looked at "feasible and necessary" increases in prevention programs on a country by country basis and concluded that by 2005, Africa could effectively absorb about $1.56 billion in increased expenditures on prevention. With respect to care and treatment, including treatment with antiretroviral drugs, the article found that $3.07 billion per year could be used effectively in Africa by 2005, yielding a total cost for prevention, care, and treatment of $4.63 billion.

Antiretroviral Therapy

A large part of the cost of enhanced treatment and care in the Schwartlander estimates is accounted for by antiretroviral (ARV) treatment – the drug therapy that has done so much to reduce AIDS-related illness and death in the United States and other developed countries. According to the relief organization *Medecins sans Frontieres* (MSF, or Doctors Without Borders) ARV treatment, also known as highly active antiretroviral therapy (HAART), is currently available to only 25,000 to 30,000 AIDS patients in sub-Saharan Africa,[13] and some of this treatment is probably ineffective, because many patients can afford the antiretrovirals only sporadically.[14] An estimated 4 million Africans are in the advanced stages of the disease and most likely to benefit from antiretroviral therapy. Schwartlander estimates that 2.2 million people could be treated by 2005, at an estimated cost of $450 per patient for antiretroviral drugs.[15] This degree of coverage would cost nearly $1 billion per year.

Costs in 2005 and Beyond

Schwartlander estimates that of the total of $4.63 billion per year needed for a scaled up response including prevention, care, and treatment by 2005, $3 billion would need to be provided by donors. He sees the remainder coming from increased spending in the health sector by African countries themselves, resources available from the World Bank/International Monetary Fund Highly Indebted Poor Country Initiative (HIPC), and the private sector.

Beyond 2005, experts see the cost of a scaled up response increasing.[16] This is because Africa's capacity to absorb increased resources for dealing with AIDS is currently quite limited. For example, under current practice, antiretrovirals for preventing mother to child transmission (MTCT) of HIV are only administered to pregnant women who have been tested for HIV and are delivering in a health facility. This number is believed to be only a fraction of the total number of African women

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[12]B. Schwartlander and others, "AIDS Resource Needs for HIV/AIDS," *Science*, June 29, 2001: 2434-2436.

[13]MSF spokesperson quoted in "AIDS Drug Access Still Poor in Africa," *Chicago Sun-Times*, March 29, 2002.

[14]*Macroeconomics and Health*: 51.

[15]Schwartlander assumes that this would be the cost of the drugs in low income countries. In view of continuing reductions in drug costs, some reports estimate lower costs.

[16]For an in-depth analysis, see *Macroeconomics and Health*.

at risk of passing HIV on to their babies. At present, it is estimated that fewer than half of all births in Africa are attended by health professionals.[17] Scaling up, however, will strengthen Africa's health infrastructure and make it possible to offer HIV testing and delivery in health facilities to larger numbers of women, leading to higher costs for providing MTCT prevention. The capacity to deliver long-term antiretroviral therapy will also increase over time, making it possible to treat larger numbers.

Recent Scaling Up

U.S. and other donor support for HIV/AIDS programs in Africa has increased significantly in recent years. Table 1 indicates that U.S. spending through bilateral programs has more than doubled since FY2000. The largest bilateral programs are those of the U.S. Agency for International Development (USAID) and the Centers for Disease Control and Prevention (CDC) of the Department of Health and Human Service. USAID has undertaken an "expanded response" to the global AIDS pandemic "designed to enhance the capacity of developing countries to prevent an increase in HIV/AIDS and provide services to those who are either infected and/or otherwise affected by the epidemic (orphans, vulnerable children, and other family members.)"[18] USAID has identified three African "rapid scale-up" countries – Kenya, Uganda, and Zambia – to receive significantly increased resources with the goal of achieving measurable impact "within one to two years."[19] Ten more African countries and the West African region have been designated for "intensive focus" and will also receive added resources to combat the disease.

Table 1. U.S. Bilateral Spending on Fighting AIDS in Africa

($ millions)

	FY2000	**FY2001**	**FY2002** estimate
USAID	109	144	183
CDC	34	86	89
DOD	0	5	14
DOL	0	3	6
Total	**143**	**238**	**292**

CDC's Global AIDS Program (GAP) provides assistance to 17 African countries in infrastructure and capacity development; primary prevention, including voluntary

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[17]Ibid., 445.

[18]USAID, *Leading the Way: USAID Responds to HIV/AIDS* (Washington, 2001): 21.

[19]USAID, "USAID's Expanded Response to the Global HIV/AIDS Pandemic" (undated).

counseling and testing for HIV infection; and care and treatment, including treatment of tuberculosis and other opportunistic infections associated with AIDS.

Meanwhile the Department of Defense (DOD) has launched an AIDS education program with African armed forces, and the Department of Labor (DOL) has begun an International HIV/AIDS Workplace Education Program. This program aims at strengthening prevention education in the workplace, reducing stigma and discrimination, and helping labor unions, employers, and governments to build capacity to fight the epidemic.

The degree to which HIV/AIDS spending will increase in FY2003 is not yet clear. Under the Administration's FY2003 budget request, USAID spending for HIV/AIDS in Africa would increase to $250.4 million. It seems unlikely that CDC spending in Africa could increase significantly under the budget request, however, since the Administration is proposing to fund the worldwide GAP program at the same level as in FY2002. No new funds have been requested for the DOL or DOD programs, although $2 million has been requested under the Foreign Military Financing program to support the DOD effort.[20] The Administration's budget request for a $200 million U.S. contribution to the Global Fund in FY2003 is the same amount pledged for FY2002.

Multilateral Programs and the Global Fund

United Nations agencies, including the World Bank, are expanding their commitments to the struggle against AIDS. In September 2000, the World Bank announced that it was making an initial commitment of $500 million to a new Multi-Country HIV/AIDS Program (MAP) to assist African countries in scaling up their response to the AIDS pandemic. By October 2001, $155 million in loans had been approved under the MAP program and $15 million had been disbursed. In 2002, the Bank is programming an additional $500 million for MAP.[21]

On April 25, 2002, the Global Fund announced its first grants, approving $378 million worldwide over two years, of which 60% is going to fight AIDS and 52% is for African projects.[22] Actual spending will probably be larger than this, since the Fund board agreed to a fast track process to approve additional loan requests once certain conditions are met. Moreover, the Fund expects to solicit a second round of proposals in 2002.

Funding Gap

According to Schwartlander, of the $3 billion required from donors for scaling up the response to AIDS in Africa, only a "few hundred million dollars" was

[20]For more information, see CRS Report RS21181, *HIV/AIDS International Programs: FY2003 Request and FY2002 Spending*.

[21]*World Bank Intensifies Action Against HIV/AIDS*, World Bank Issue Brief available at [www.worldbank.org].

[22]Press release available at [http://www.globalfundatm.org].

provided in 2001.[23] In view of the scaling up that is occurring in 2002, it seems likely that considerably more, perhaps several hundred million dollars, is currently being spent. Thus, a gap of well over $2 billion per year remains to be filled if Schwartlander/UNAIDS target of $4.6 billion is to be met by 2005.

Whether donors will contribute these sums remains to be seen. Many regard scaling up as both a moral and security imperative in view of the massive loss of life, economic difficulties, and political instability that could result if the African pandemic is not curbed. Harvard economist Jeffrey Sachs wrote in a February 10, 2001 Op-Ed article that the amount required for scaling up is "tiny compared with the great annual wealth of the well-off nations," adding that "to turn our back on Africa over this small sum would constitute one of the greatest moral failings in our history."[24] On March 25, 2002, twenty eight U.S. religious leaders urged a major increase in AIDS spending worldwide, writing that "AIDS has become the worst infectious disease crisis to confront the world since the bubonic plague of the 14th century halved the population of Europe within five years."[25]

Others may contend, however, that the African HIV/AIDS pandemic does not affect the core economic and security interests of the United States and other donors sufficiently to justify expenditures at the levels suggested by scaling-up proposals, particularly those including ARV therapy. There may also be skeptics who will question whether expanded resources for combating AIDS can be spent effectively or achieve results in view of the difficult political, economic, and social conditions prevailing in many African countries. Moreover, some may maintain that the need to fund AIDS programs in the former Soviet Union and Asia, where epidemics are worsening, will limit the capacity of donors to increase funding for HIV/AIDS programs in Africa.

Scaling Up Strategies

Most HIV/AIDS experts see three dimensions to the effort to curb the spread of HIV/AIDS in Africa, as in other regions, and to reduce the AIDS death toll: prevention, care, and treatment. To date, the focus in Africa has been on preventing the spread of the HIV virus, and some argue that prevention is still the most cost-effective means of dealing with the pandemic in view of the limited resources available.[26] But others strongly maintain that all three dimensions must be scaled up quickly if headway is to be made against the pandemic. This is partly because the availability of care and treatment is seen as essential to persuading people to

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[23]Schwartlander, 2436.

[24]"The Best Possible Investment," *New York Times,* February 10, 2001. Sachs has since accepted a new position at Columbia University.

[25]This letter, an appeal to Congress for $2.5 billion in budget authority for AIDS efforts worldwide, may be found at the website of the Global AIDS Alliance [http://www.globalaidsalliance.org/]. Click on "News."

[26]Elliot Marseille, Paul B. Hoffman, and James G. Kahn, "HIV Prevention Before HAART in Sub-Saharan Africa," *The Lancet*, May 25, 2002.

volunteer to be tested for HIV infection, and testing is regarded as a key step in persuading both the infected and the uninfected to modify their behavior in ways that will prevent the spread of the virus. At present, only an estimated 5% of Africans know their HIV status.[27]

More broadly, it is argued that expanded care and treatment are essential to keeping alive parents, teachers, health workers, and others playing vital social and economic roles; and to protecting and educating children orphaned by AIDS or made vulnerable when their parents fall ill. If these needs are not met, many argue, widespread social disruption and economic devastation will result.[28] Finally, many believe that since ARV treatment reduces the "viral load" in AIDS patients, it likely reduces the risk that these patients will pass the disease on to others. This hypothesis is not yet proven, however.[29] Schwartlander maintains that in sub-Saharan Africa, where so many are infected by HIV and ill with AIDS, 66% of HIV/AIDS resources should be devoted to care and treatment.[30]

Prevention

An effective vaccine against HIV would be the ideal preventive measure for stopping the African AIDS pandemic. Although one potential vaccine is showing some promise in human tests, experts believe that a broadly effective AIDS vaccine will not be available for general use for at least a decade.[31] Many who are concerned about the African pandemic favor increased spending on vaccine development, emphasizing vaccines that work against the varieties of HIV found in Africa. The International AIDS Vaccine Initiative (IAVI), which seeks to accelerate vaccine development with the support of numerous foundations and development agencies, estimates that $430 million to $470 million is currently being spent per year on HIV vaccine research and development worldwide,[32] and has appealed for an additional $1.1 billion.[33] The World Health Organization has endorsed the creation of a Global Health Research Fund to support research of all types in order to assure that medical advances now taking place in the developed countries also benefit the developing countries, including those in Africa.[34]

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[27] *Marcoeconomics and Health*: 52.

[28] Ibid., 51.

[29] Lamptey and Gayle in *HIV/AIDS Prevention and Care*: 688-689.

[30] In Asia, by contrast, where the epidemic is still emerging, 32% of resources should go toward care and treatment and 68% toward prevention. Schwartlander, 2434.

[31] Associated Press, "AIDS Vaccine Likely Still a Decade Off, Doctor Says," March 16, 2002. This article cited Dr. Anthony Fauci, director of the National Institute of Allergy and Infectious Diseases at the National Institutes of Health.

[32] International AIDS Vaccine Initiative, "Delivering an AIDS Vaccine," briefing document prepared for the World Economic Forum, January 2002. Available at [http://www.iavi.org].

[33] IAVI briefing paper, July 21, 2001.

[34] WHO press release, April 30, 2002, at [http://www.who.org].

A microbicide gel or cream that would kill the HIV virus is another means of prevention long sought by those fighting the African AIDS pandemic. Women in Africa, many experts argue, often lack the power to negotiate the use of condoms with their partners, even though condoms are highly effective in preventing HIV infection. A microbicide, experts maintain, would be more under a woman's control, and could afford African women the means of protecting themselves against the virus. Several microbicides are currently being studied and advocates maintain that with increased spending by governments and foundations a microbicide product could be ready by 2007. Advocates seek $100 million annually in U.S. government support, as compared to the $49 million they estimate is currently being spent.[35]

In the absence of a vaccine or microbicide, a number of other strategies have been used in an effort to prevent the spread of HIV in Africa, and advocates of scaling up hope to see them all expanded. The importance of voluntary counseling and testing (VCT) in achieving behavior change has already been noted. Those testing positive for HIV in VCT programs are counseled on how they can prevent spreading the infection, and the majority, who test negative, are advised on the means of avoiding infection. Uganda reports considerable success with a behavior modification program known as "ABC" (Abstain, Be faithful, or wear a Condom), which focuses on sexual abstinence before marriage and fidelity within marriage.[36] Other prevention "interventions," as they are known to health experts, include mass media campaigns, AIDS education in schools, making condoms widely available, treatment of sexually transmitted infections that increase susceptibility to HIV infection, the screening of blood used for transfusions, and peer counseling among sex workers.[37]

There is also growing support for scaling up the MTCT prevention of HIV by providing ARVs to pregnant mothers. It is estimated that in 2000, approximately 486,000 African babies were born infected through mother to child transmission,[38] but treatment of mothers with antiretrovirals could reduce MTCT by one-third to one-half.[39] In July 2000, the German pharmaceutical manufacturer Boehringer Ingelheim announced that it would offer the ARV Nevirapine free of charge for five years in developing countries for the prevention of MTCT. However, as noted above, experts believe that scaling up MTCT prevention will require substantial improvements in health care services in many countries. The Global AIDS and Tuberculosis Relief Act of 2000, in Section 111, requires that not less than 8.3% of the funds it authorizes be devoted to MTCT prevention strategies.

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[35]News report at the IAVI website, [http://www.iavi.org], February 28, 2002.

[36]*New Republic*, May 27, 2002.

[37]For an in-depth review of prevention strategies, see USAID's *HIV/AIDS Prevention and Care in Resource Poor Settings.*

[38]Based on data appearing in "*Transmission de VIH de la Mère à l'Enfant*," UNAIDS fact sheet at [http://www.unaids.org].

[39]*HIV/AIDS Prevention and Care in Resource-Constrained Settings*: 437.

Care

The care dimension of an expanded response to AIDS in Africa includes an expansion of resources to care for those who are HIV positive or have developed the AIDS disease, and for those, such as AIDS orphans, who are affected by the epidemic even though they are not themselves infected. Those found to be HIV positive through VCT programs need continuous psychosocial and medical support, AIDS experts maintain, if they are to maintain risk reduction behavior changes and cope with the stigma associated with infection. Post test support groups made up of people living with HIV/AIDS exist in several countries and can be helpful,[40] but they have limited capabilities in dealing with employment discrimination or the social stigma often inflicted upon those known to be HIV positive.

The limitations of Africa's health care systems mean that HIV-infected people have limited or no access to treatment for the chronic diarrhea, wasting syndrome, and opportunistic infections, including tuberculosis, that occur as HIV inflicts mounting damage on their immune systems. Since July 1998, the World Health Organization and UNAIDS have recommended prescribing the drug isoniazid, effective against tuberculosis, to every HIV-positive person in areas where TB is prevalent.[41] The drug Bactrim[42] is effective against the most common pneumonia among HIV/AIDS victims,[43] and against bacterial and parasitic infections associated with HIV infection. Studies indicate that given as a prophylactic, Bactrim can significantly reduce illness and death in HIV outpatients generally.[44] These drugs are inexpensive by western standards. In 1998, it was estimated that isoniazid as a TB preventive would costs less than $6 per patient per year,[45] while long term treatment of pneumonia with Bactrim would cost less than $12.[46] Nonetheless, such costs are high in the African context, and such drugs are not widely available.

Pfizer Inc. is making its anti-fungal drug Diflucan (fluconazole) available for free in the 50 least developed countries most heavily affected by AIDS – countries that are primarily in Africa. Diflucan can be used to treat cryptococcal meningitis, a dangerous fungal inflammation that swells the lining of the brain and spinal column and occurs in 10% of AIDS patients in late stages of the disease. The drug is also effective against esophageal candidiasis, a painful opportunistic infection reported

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[40]See Rachel Baggaley, Ignatius Hawaye, and David Miller, "Counseling, Testing, and Psychosocial Support," in *HIV/AIDS Prevention and Care in Resource-Constrained Settings:"* 568-569.

[41]Elizabeth Marum et al., *Assessment of Home Based Care Services in Malawi*, Umoyo Network (March 2000).

[42]Trimethoprim-sulfamethoxazole, also known as TMP/SMZ, cotrimoxazole, and Septra.

[43]*Pneumocystis carinii* (PCP).

[44]*CDC Global AIDS Activity:* 77.

[45]UNAIDS, *Best Practice Materials*, Technical update (October 1998).

[46]Ibid.

in 20% to 40% of HIV/AIDS patients. This disease can prevent swallowing in some patients, leading to physical deterioration.[47]

Home Based Care. In Africa's resource-poor environment, home based care (HBC) rather than care at a health facility is often the only option for meeting the needs of patients ill with AIDS. Two experts have described the ideal home based care situation:

> At its best, patients can remain in familiar surroundings with loving family members during repeated illnesses and die with peace and dignity. Competent home care staff make regular visits to assess patient needs and ensure appropriate nursing, medical, psychological and spiritual support – not just for the patient, but for the entire family. Staff help plan for future needs of children and other dependents, and the home care visits provide an opportunity for HIV education and prevention efforts with the family and wider community.

In Africa, however, HBC programs typically lack the means of meeting this standard. Reports indicate that care-givers, where available, often lack soap, rubber gloves, simple medications, or other basic elements of nursing; and do not have the training required to combat depression in their clients or provide advice on preventing the spread of HIV. HBC programs may not be able to offer supplementary food to the ill and their families, at a time when household income may have fallen sharply due to the illness of a parent.[48] At its worst, some argue, "home care is a euphemism for home neglect."[49] A Malawi-based study partly funded by USAID recommends that donor agencies help HBC programs provide all home-based patients, volunteers, and health workers, with standardized kits including basic medications and other items needed for effective HBC.[50]

Orphans and Vulnerable Children. A report issued in 2000 by the U.S. Agency for International Development (USAID) put the number of maternal or double AIDS orphans under 15 years of age and then living in 26 African countries at 6.5 million.[51] The report projected that by 2010, there will be 15 million maternal and double AIDS orphans in Africa; in southern African countries, where HIV adult

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[47]Pfizer Inc. press release, June 6, 2001, at [http://www.pfizer.com].

[48]Marum, *Assessment of Home Based Care Services in Malawi*. At the time of writing, Dr. Marum was a technical advisor in the U.S. Centers for Disease Control and Prevention and USAID, Malawi. The *Assessment* was funded by USAID and others.

[49]Jackson and Anderson, "Home Care for People with AIDS:" 585.

[50]Marum, *Assessment of Home Based Care Services.* This report lists the recommended contents of such kits

[51]USAID, *Children on the Brink,* 2000 update. Data on paternal orphans due to AIDS were not available for this study. According to UNAIDS, by 1999, a cumulative total of 12.1 million African children had been orphaned by AIDS. Over time, many of these had grown to adulthood or died.

infection rates are near or above 20%, 30% of all children will be orphans.[52] Maternal, paternal, and double orphans due to all causes will total 40 million in 2010, according to the report. Orphans face severe disadvantages in securing access to adequate nutrition, health care, and education, and large numbers become "street children" in Africa's cities, where they are highly vulnerable to HIV infection. But children who are not orphans, or not yet orphans, are also made vulnerable by HIV when one or both parents become infected. They may be forced to drop out of school, for example, because school fees can no longer be paid and because they are needed at home as care givers.

In view of the scale of Africa's orphan crisis, and the speed with which it is intensifying, many argue that attempting to respond by expanding institutional care would be impractical.[53] Most advocates of scaling up seem to emphasize programs to strengthen the capacity of extended families to support orphaned children of relatives, as well as programs to support community-based organizations helping orphans.[54] With the help of families and the community, it is hoped, orphaned children will be able to attend school and receive adequate nutrition. Some may even be able to stay in their homes, with an older child serving as head of the household supported by relatives or community aides.

An alternative view, however, is that it is unreasonable to expect impoverished African families and communities to care for large numbers of orphans, particularly since, in the most heavily affected countries, families and communities are themselves being shattered by AIDS. Father Angelo D'Agostino, founder of the Nyumbani Orphanage for HIV positive orphans in Kenya, has testified that the children in that orphanage attend school and receive necessary medical care and psychosocial support. This does not occur in a community foster care program, also sponsored by the orphanage, because the community, in Fr. D'Agostino's words "is overstretched in its ability to survive, and soon will be reduced to a level of existence we cannot imagine."[55]

The degree to which an expanded response to Africa's orphan crisis should include support for institutions is thus an issue in debate. In congressional testimony, E. Anne Peterson, USAID's Assistant Administrator for Global Health, has noted the high cost of institutional care and the benefits to a child of remaining in a family and community. According to Peterson, where "circumstances prevent immediate care within a family, care in an orphanage is best used as a temporary measure until more

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[52]Susan Hunter and Susan Parry, "Orphans and Other Vulnerable Children: Approaches to Care and Protection Programs," in *HIV/AIDS Prevention and Care in Resource-Constrained Settings*: 637.

[53] UNAIDS, *AIDS Epidemic Update, December 2000*; "Children and AIDS," *Harvard AIDS Review* (Spring-Summer 2000). Both sources also argue that orphanages create various problems for children and societies, but others maintain that such institutions can provide nurturing environments.

[54]*Children on the Brink*: 7-9.

[55]Testimony before the House International Relations Committee, April 17, 2002.

appropriate placement or fostering within a family can be arranged."[56] Father D'Agostino, meanwhile, is launching a "Village of Hope," where 600 orphans will live together with 400 elderly people who have lost the adult children they had expected to support them in their old age. The two generations can mutually support one another, and the presence of elders is expected to help assure the transmission of cultural values and traditions. The village, which is to be a self sustaining farm, has received a pledge of $1 million in support from the U.S. charity Samaritan's Purse.

The Global AIDS and Tuberculosis Relief Act of 2000 (P.L. 106-264) made orphans a significant priority in the U.S. HIV/AIDS program. According to Section 111 of the Act, not less than 20% of the $300 million in Development Assistance authorized for HIV/AIDS programs in both FY2001 and FY2002 is to be available "as part of a multi-donor strategy to address the support and education of orphans in sub-Saharan Africa, including AIDS orphans." Section 113 states that the President shall coordinate the development of the multi-donor orphan strategy.

Treatment

Cost estimates and the rationale for providing expanded access to treatment of AIDS with antiretroviral drugs have already been discussed. Cost is less an issue in providing antiretroviral therapy than two years ago, when a standard triple drug regimen cost an estimated $10,000. In May 2000, five major pharmaceutical manufacturers announced their willingness to reduce prices on their patented ARVs in order to boost treatment access in Africa. Their AIDS medications are now available in Africa at a fraction of their U.S. prices, and a three-drug combination can reportedly be prescribed for several hundred dollars per year or somewhat more.[57]

The Indian pharmaceutical CIPLA, which manufactures generic copies of patented medications, offers a three drug combination for $350 per year – a cost that still exceeds per capita income in many African countries, but would sharply reduce the cost of scaling up. In March 2002, the World Health Organization listed CIPLA products among the drugs that meet its quality standards for AIDS treatment, although the move drew criticism from the International Federation of Pharmaceutical Manufacturers, which questions the quality and service CIPLA can provide. The Federation maintains that an alleged lack of after sales service by generic manufacturers could lead to misuse of the drugs and the emergence of drug-resistant strains of HIV.[58] WHO, however, defends its decision, saying it was made in accordance with a process approved by international experts.

The need for testing and monitoring of AIDS patients undergoing ARV treatment also complicates efforts to expand access to the therapy in Africa. AIDS

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[56]Ibid.

[57]Michael Waldholz and Rachel Zimmerman, "Bristol-Myers Slashes AIDS Drug Prices – Company Will Sell Below Cost in Africa," *Asian Wall Street Journal,* March 16, 2001.

[58]"Generic AIDS Medicines Win Approval from U.N. Agency – Pharmaceuticals Giants Criticize Decision," *Wall Street Journal*, Europe edition, March 22, 2002.

medications can cause a variety of side effects, and over time, the effectiveness of a particular combination of drugs against HIV is likely to wane. Thus, patients in developed countries are continuously monitored through tests requiring laboratories and equipment that are not widely available in Africa. Some fear that in the absence of such testing, patient safety may be jeopardized and that treatment failure will go undetected, allowing drug resistant HIV strains to spread. Advocates of scaling up hope to see advanced laboratory testing become more widely available in Africa, and at the same time, they are urging the development of less expensive testing procedures and equipment. In April 2002, the World Health Organization released guidelines for treatment that listed a number of alternative approaches to testing and monitoring in poor countries. For example, white blood cell counts and examination for the clinical signs of AIDS, rather than more costly tests used in developed countries, could be substituted to monitor the effectiveness of therapy,[59] according to WHO.

U.S. efforts in support of providing antiretroviral therapy have been limited to date. Small-scale test projects in Uganda and Cote d'Ivoire, conducted in cooperation with pharmaceutical manufacturers, are receiving technical support from the CDC.[60] USAID has announced that it will launch four treatment sites in Africa in 2002, partly in order to explore how treatment can best be provided in the face of many "challenges," such as the cost of ARVs and the lack of sufficient laboratories or trained personnel.[61] However, support for treatment is building, and several of the grants announced in April 2002 by the Global Fund to Fight AIDS, Tuberculosis, and Malaria, are aimed at strengthening treatment programs. Some of the funds will be used to purchase drugs. Jim Yong Kim, of Harvard Medical School and an AIDS advocate, said the Fund grants mark "the first time there has been a commitment that we shouldn't let people in Africa die when we had the drugs available to keep them alive." Jeffrey Sachs, who recently coordinated a major World Health Organization study on investing in health care to promote economic development, called the grants a possible "meaningful startup," but still "grossly inadequate" in view of the scale of the problem.[62]

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[59]Donald G. McNeil, Jr., "WHO Moves to Make AIDS Drugs More Accessible to Poor Worldwide," *New York Times*, April 23, 2002.

[60]Uganda Ministry of Health, *Preliminary Report, UNAIDS HIV/AIDS Drug Access Initiative, August 1998-2000;* Cote d'Ivoire Ministry of Health, *HIV/AIDS Drug Access Initiative, Preliminary Report Covering the Period August 1998-March 2000.*

[61]Testimony of E. Anne Peterson, Assistant Administrator for Global Health, before the Senate Foreign Relations Committee, February 14, 2002.

[62]Both were quoted in John Donnelly, "World Health Fund Designates $1.6b," *Boston Globe*, April 26, 2002.

Participants in an Enhanced Response

Governments and government agencies in both the donor and recipient countries seem certain to play a major role in an expanded response to the African AIDS pandemic. USAID, CDC, and the World Bank, a multilateral organization made up of governments, are major actors in the struggle against AIDS, and African governments are increasingly engaged. African heads of state, at their April 2001 meeting in Abuja, Nigeria, issued a Declaration on HIV/AIDS, committing their governments to allocating at least 15% of government spending to the improvement of the health sector. Whether this goal will soon be met remains to be seen – most are currently spending between 4% and 9%;[63] but African health ministries, with donor support, are deepening their involvement in the struggle against AIDS.

The Global Fund is also expected to play a growing role in responding to the pandemic in the years ahead. To date, nearly $1.9 billion has been contributed to the Fund, primarily from governments, but also by private organizations. Formally chartered as a non-governmental organization headquartered in Geneva, Switzerland, the Fund's governing board consists of representatives of seven donor nations and seven developing countries, as well as one each from a "southern" non-governmental organization (NGO), a "northern" NGO, a foundation, and the private sector. The Fund accepts proposals from "Country Coordination Mechanisms" (CCMs) that also have a mixed government, NGO, and private sector makeup. The Fund plans to keep its staff small, and it has established a simplified grants process designed to speed funds to organizations that are already at work fighting the pandemic.

Some observers worry that the Fund may be too "lean" as an organization to effectively monitor the projects it supports.[64] These observers fear that contributions to the Fund may dry up if a number of its projects fail and it comes to be seen as an organization that wastes resources. Supporters of the Fund's approach note that each CCM, as part of the application process, is required to develop comprehensive monitoring plans, making use as much as possible of existing, in-country monitoring capabilities. Moreover, the work of the Fund is closely integrated with the work of other donors and international agencies that have a long-established presence in the countries where grants are being made. These donors and agencies are themselves monitoring the performance of HIV/AIDS programs and projects, as well as the performance of the health sector generally in African countries. Thus, many believe that parallel Global Fund monitoring procedures would be duplicative, and likely to impose burdensome new reporting requirements on African agencies that are already weighed down with such requirements.

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[63]Based on 1998 data, the most recent available, reported in World Health Organization, *World Health Report, 2001*: 160-167. U.S. Government health spending was 16.9% of total expenditures, according to this source.

[64]"The AIDS Fund Gets Going," *Washington Post* editorial, April 29, 2002.

Non-Governmental Organizations and the Private Sector

Non-governmental organizations, including community organizations, faith-based-groups, and the private sector, including U.S.-based non-profits, are also heavily engaged in efforts to scale up the response to the African AIDS pandemic. These organizations are valued for their capabilities in delivering assistance to those in need, providing technical assistance and leadership, developing innovative responses to the pandemic, and mobilizing resources.

Delivery. Community and faith-based groups in Africa are typically on the front line in delivering assistance to those affected by HIV/AIDS. They are regarded as particularly well qualified to do so because of their close and regular contact with their communities, and their knowledge of community needs.[65] Speaking of faith-based organizations, Dr. Paul De Lay, Acting Director of USAID's Office of HIV/AIDS, has said that "We have increasingly recognized how important religion is, not only in the care and support of people who are affected by AIDS, but also in our ability to prevent new infections." USAID has launched a program known as the CORE (Communities Responding to the HIV/AIDS Epidemic) Initiative to make small grants to faith-based and community-based organizations on the front lines of the AIDS struggle.

Community and faith-based groups have taken on major responsibilities for AIDS orphan care and for caring for children infected by HIV. In Johannesburg, South Africa, for example, Sparrow Ministries, an inter-denominational organization, has been providing hospice care for small numbers of HIV-infected adults and children for some years, and is building a new facility that will accommodate 450 in a village-like environment. Many other faith-based and volunteer groups are assisting orphans in South Africa.

In Kenya, the Nyumbani orphanage, mentioned previously, shelters abandoned children until their HIV status can be determined. Those found not to be infected are placed in appropriate settings outside the orphanage, while the HIV positive children remain and receive care.[66] The home, where 70 to 79 children live, has begun to provide antiretroviral treatment, using drugs donated by Brazil. Meanwhile, faith-based groups have created numerous orphan-care projects in Uganda as well.

Faith-based and community groups are providing home based care in several African countries. In Zimbabwe, for example, the Mashambanzou ("dawn of a new day") organization, headed by medical missionary Sister Margaret McAllen, employs 60 staff and 450 volunteers. In 2001, Mashambanzou reportedly cared for nearly 9,000 patients in their homes and 12,000 in community centers.[67] In Uganda, TASO (The AIDS Support Organization), founded by people living with HIV and AIDS,

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[65]Peter Okaalet, "The Role of Faith-based Organizations in the Fight Against HIV and AIDS," testimony before the Senate Foreign Relations Committee, February 13, 2002.

[66]See the website [http://www.nyumbani.org].

[67]Isabelle Ligner, "Finding Hope in Harare for People with AIDS." *Agence France Presse*, March 28, 2002.

reports that it has provided care to 60,000 people since the epidemic began. TASO is also known for its prevention services, and for its AIDS advocacy, both in Uganda and at the international level. Groups with experience in providing care could become major actors in future efforts to provide antiretroviral drugs on a large scale in Africa, since patients will need to be monitored for adverse reactions and to assure that they are taking their medications as prescribed. Church-run clinics and hospitals, which reportedly account for 30% or more of the hospital beds in some countries,[68] will likely also be heavily involved in efforts to scale up care and treatment in Africa.

Technical Assistance. U.S. based contractors, including non-profits, are heavily involved in the struggle against AIDS in Africa, where they are providing technical assistance to health ministries, training, and management support. In April 2002, USAID announced that it was awarding $162 million over five years to Family Health International, the reproductive health non-profit mentioned above.[69] This award marked the continuation of a relationship that began in 1997, when USAID funded FHI's Implementing AIDS Prevention and Care (IMPACT) project, which according to FHI, "builds the capacity of local governments and non-governmental organizations to design, manage, and evaluate HIV/AIDS prevention and care projects in more than 30 countries worldwide."[70] The international division of John Snow, Inc., a research and health care consulting firm, is helping to manage and implement the USAID-funded Zambia Integrated Health Package (ZIHP), which involves working with communities, the private sector, and health workers to strengthen the quality and availability of health services. The Johns Hopkins University and Population Services International (PSI) are also participating in this project. PSI is known for its work in promoting "condom social marketing," which makes condoms widely available through local markets and other key outlets, including bars, at prices low income buyers can afford.[71] PSI is also helping several African countries implement voluntary counseling and testing programs.

Leadership. Africa's churches have sometimes been criticized for moving too slowly in response to the AIDS threat,[72] but today, some churches and church leaders are increasingly outspoken as leaders on AIDS issues. Anglican Archbishop Njongonkulu Ndungane, who chaired a four-day conference of Anglican leaders on HIV/AIDS in August 2001, has urged African governments to declare an AIDS state of emergency.[73] Ndungane has asked Anglican clergy and lay leaders to be tested for HIV as a model to others, and demanded in strongest terms that the South African government provide MTCT prevention therapy to impoverished pregnant women. Meanwhile, the ecumenical "Religious Coalition for Reproductive Choice" is

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[68]Okaalet testimony, cited above.

[69]USAID press release, April 3, 2002.

[70]IMPACT project description at [http://www.fhi.org].

[71]More information is available at [http://www.psi.org].

[72]Zambia's former president, Kenneth Kaunda, recently told a major ecumenical meeting in Lusaka that the church response to date had been "inadequate." *The Post* (Zambia), March 15, 2002.

[73]*Anglican Journal*, October 2001.

assisting South African churches in efforts to reduce teenage pregnancy.[74] In Uganda, Muslim, Catholic, and Anglican organizations and volunteers have been credited with helping to lead Ugandans toward the behavior changes that have sharply cut HIV infection rates.[75]

Many churches and faith-based organizations beyond Africa are taking lead roles in responding to the pandemic. MAP (Medical Assistance Programs) International, a Georgia-based Christian organization dedicated to promoting health, has worked with African churches, clergy, and seminarians to help them show leadership in responding to AIDS.[76] In February 2002, Samaritan's Purse, which describes itself as a non-denominational, evangelical Christian assistance organization, held a week-long conference in Washington intended to inspire Christians to do more in response to the pandemic worldwide. Entitled "Prescription for Hope," the conference focused heavily on the AIDS situation in Africa. The Rev. Franklin Graham, who heads Samaritan's Purse, told the meeting that "We need a new army of men and women who are prepared to go around the world to help in this battle."[77]

Other non-governmental groups exercising leadership roles in responding to the pandemic include Doctors Without Borders which is a key advocate for expanding access to AIDS treatment in Africa, and the Global Business Council on HIV/AIDS, headed by the former U.S. Ambassador to the United Nations, Richard Holbrooke. The Council seeks to increase business involvement in fighting HIV/AIDS.

Foundations have also been leaders in organizing the response to the pandemic. The Bill and Melinda Gates Foundation has given grants in support of AIDS prevention, assistance to orphans, and care that directly benefit Africa; and the foundation backs vaccine development and microbicide development as well. The Rockefeller Foundation is a major backer of microbicide development, and in April 2001, sponsored a major conference in Uganda on enhancing AIDS care in Africa.

Innovation. Non-governmental organizations have been responsible for many innovations in HIV/AIDS prevention and care, and some are developing new approaches to treatment. The Clinique Bon Sauveur project, though located in Cange, Haiti, is thought by some experts to have particular relevance to Africa's treatment needs. The project operates under the direction of Dr. Paul Farmer of the Harvard Medical School, and his medical charity, Partners in Health. It provides antiretrovirals to about 44 patients using diagnostic and monitoring techniques that do not require expensive laboratory tests. Local workers are trained in a strategy known as "directly observed therapy," long used in tuberculosis treatment, and maintain continuous contact with patients to be sure the "cocktail" of AIDS drugs is taken as prescribed. Some experts see the Clinique Bon Sauveur approach as a

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[74] *The Christian Century*, February 13, 2002.

[75] Okaalet testimony, cited above.

[76] Okaalet testimony. See also [http://www.map.org].

[77] Caryle Murphy, "'Army' of Christians Needed in AIDS Fight, Evangelist Says." *The Washington Post*, February 19, 2002.

means of quickly scaling up treatment in Africa, though others worry about the risks of treating large numbers of patients without regular laboratory testing.

Some private companies operating in Africa have developed innovative approaches to AIDS prevention and treatment. Debswana, the diamond mining company in Botswana, has developed a comprehensive program of AIDS prevention education for its employees and provides antiretroviral therapy for those infected with HIV – about 29% of its 6,000 person workforce.[78] Debswana also requires that all companies doing business with it also have comprehensive AIDS in the workplace programs. In South Africa, Daimler Chrysler has launched a comprehensive AIDS program for its employees and will also provide antiretroviral therapy. While these innovative AIDS in the workplace programs could serve as models to other employers in Africa, many might require assistance in order to create something comparable. Such assistance, some might argue, could be part of a scaled up international response to the pandemic.

Botswana is the site of a "public-private" partnership that has drawn considerable attention. Merck and Company and the Bill and Melinda Gates Foundation, each of which has contributed $50 million, have joined with the Botswana government in a five-year effort to strengthen Botswana's primary health care system, and eventually provide universal treatment for AIDS patients needing antiretroviral therapy. Replicating the Botswana model elsewhere, however, would be problematic unless substantial new resources become available for fighting AIDS. Botswana is a resource-rich country with a population of just 1.6 million. Other heavily affected countries are poorer and must deal with an AIDS threat to much larger vulnerable populations.

The pharmaceutical firm Bristol Myers Squibb has committed $115 million to its own AIDS initiative, "Secure the Future." According to Bristol Myers, it works with African governments and communities under this initiative to develop "innovative ways to prevent and treat HIV/AIDS among women and children, and to help communities deal with the crisis."[79] More than fifty grants have been made under this program, including a recent one to the University of Natal in South Africa for research on protecting HIV positive mothers and children from opportunistic infections, such as pneumonia.[80]

U.S. AIDS Policy Making and Coordination

As the U.S. response to the global AIDS pandemic has expanded, efforts have been made to enhance policy making capabilities in the AIDS issue area, and to enhance coordination among the agencies involved. President Bush has named Secretary of State Colin Powell and Tommy Thompson, Secretary of Health and

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[78]Ed Susman, "Diamond Company Battles AIDS in Botswana," *UPI Science News*, July 9, 2001.

[79]Press release, March 14, 2001.

[80]*Africa New Service*, February 17, 2002.

Human Services, as co-chairs of a Cabinet-level task force on the global HIV/AIDS threat. This cabinet-level task force is backed up by an interagency policy coordinating committee (PCC), chaired by Scott Evertz, who heads the White House Office of National AIDS Policy (ONAP), and Jendayi Frazer, Senior Director for African Affairs at the National Security Council.

Within the PCC, an interagency working group has focused on the negotiations surrounding the launching of the Global Fund. This group is chaired by Dr. Jack C. Chow, Deputy Assistant Secretary of State for Health and Science, and William R. Steiger, Special Assistant to the HHS Secretary for International Affairs. Dr. Chow serves in the Bureau of Oceans and International Environmental and Scientific Affairs, which falls under the authority of Paula Dobriansky, Under Secretary of State for Global Affairs. In addition, he has been named Special Representative of the Secretary of State for HIV/AIDS with the rank of Ambassador, subject to Senate confirmation.

Meanwhile, USAID and HHS are re-organizing internally with the goal of dealing more effectively with the HIV/AIDS epidemic. USAID's HIV/AIDS Division is becoming the HIV/AIDS Office in a new USAID Global Health Bureau. Technical staff who have been involved in implementing HIV/AIDS programs in USAID's regional bureaus are being moved into the HIV/AIDS Office. At HHS, Steiger has been named Director of a new Office of Global Health Affairs. In this position, his current responsibilities with respect to the PCC continue. At the same time, what had been known as the Office of International and Refugee Health (OIRH), based in Rockville, Maryland, has been subsumed by the new office and brought under Steiger's authority. Like OIRH, the new office offers technical assistance and policy advice in fighting global HIV/AIDS within HHS and to other agencies, including USAID, the Office of the U.S. Trade Representative, and the Departments of State, Labor, and Defense.

Despite these changes, concerns over HIV/AIDS policy making and coordination continue. Some worry that there is no single point person responsible for leading the U.S. response to the global epidemic, a role that, in their view, was filled during the Clinton Administration by Sandra Thurman, who directed ONAP and helped develop that Administration's enhanced response to the international epidemic in 1999. While many welcome the involvement of Secretary Powell and Secretary Thompson in the cabinet-level task force, there is concern that neither official can focus fully on the AIDS pandemic, particularly in view of new responsibilities arising from the September 11, 2001 terrorist attacks. Moreover, Secretary Powell is bearing additional burdens as a result of the Israel-Palestinian confrontation.

With respect to the reforms within USAID, some worry that Africa could be affected as AIDS experts with long experience in the Bureau of African Affairs are transferred to the Global Health Bureau. The reforms at HHS, some argue, fall short in that they do not integrate the Health Resources and Services Administration (HRSA) into the making of international AIDS policy. From their perspective, HRSA, which has long experience in developing and implementing health initiatives in poor settings in the United States, ought to be more engaged in the U.S. response

to AIDS in poor countries overseas.[81] Some also question whether the activities of the National Institutes of Health (NIH), including its Office of AIDS Research (OAR), are adequately integrated with the overall U.S. response to AIDS. OAR supports more than 175 overseas research projects, and are seen by NIH as strengthening health infrastructure in developing countries.

Supporters of the Bush Administration's approach to policy making and coordination maintain that the Cabinet-level task force, backed up by the PCC, creates a stronger policy coordination mechanism than in the Clinton Administration. Moreover, the re-organizations at USAID and HHS, supporters argue, are raising the priority given HIV/AIDS and other international health issues, while at the same time bringing together health experts in ways that will promote a more effective and better coordinated global AIDS response.

Conclusion

Funds for fighting the HIV/AIDS pandemic in Africa through bilateral and multilateral assistance programs are increasing; and a new international institution, the Global Fund to Fight AIDS, Tuberculosis, and Malaria has been created to channel new resources to the struggle. AIDS experts have identified ways of expanding prevention, care, and treatment programs better to combat the disease, and governmental agencies, as well as NGOs and faith-based organizations, are enhancing their capabilities for responding. Nonetheless, the degree to which the international response to AIDS in Africa will be scaled up remains in question. Donors face competing demands on their resources, and may be cautious in making contributions sufficient to fill the funding gap until existing AIDS programs more clearly demonstrate that they can achieve sustainable results. AIDS activists and many experts, however, would argue that until the complex array of programs and projects required to fight AIDS in Africa is significantly enhanced, it will be impossible to slow the pandemic. In their view, this requires that the funding gap soon be closed.

[81]In FY2001, HRSA received $3 million from the CDC budget in exchange for technical assistance.

Acronyms

ABC	Abstain, Be faithful, or wear a Condom. A Ugandan prevention program.
AIDS	Acquired immuno-deficiency syndrome, the AIDS disease.
ARVs	Antiretroviral drugs.
CCM	A Country Coordination Mechanism, eligible to apply to the GFATM.
CDC	Centers for Disease Control and Prevention of HHS.
CORE	Communities Responding to the HIV/AIDS Epidemic Initiative, A USAID program.
DOD	Department of Defense.
DOL	Department of Labor.
ECR	Expanded and Comprehensive HIV/AIDS Response.
DOTS	Directly Observed Treatment Short Course for TB.
G8	Group of Seven leading industrial nations plus Russia.
GAP	Global AIDS Program of the CDC.
GFATM	Global Fund to Fight AIDS, Tuberculosis, and Malaria.
HAART	Highly-active anti-retroviral therapy, usually consisting of three ARVs.
HBC	Home-based care.
HHS	Department of Health and Human Services.
HIPC	Heavily-indebted poor country; also the initiative aimed at reducing the debt of these countries.
HIV	Human immuno-deficiency virus, the cause of AIDS.
IAVI	International AIDS Vaccine Initiative.
IGA	Income Generating Activity.
MAP	World Bank's Multi-Country HIV/AIDS Program for Africa.
MTCT	Mother to child transmission of HIV.
NGO	Non-governmental Organization.
OECD	Organization for Economic Cooperation and Development, an international organization of developed countries.
OI	Opportunistic infection.
ONAP	Office of National AIDS Policy at the White House.
PCC	Policy Coordinating Committee.
PLWA	People Living with AIDS, sometimes PLWHA: People Living with HIV/AIDS.
PVOs	Private and voluntary organizations.
STD	Sexually-transmitted disease.
STI	Sexually-transmitted infection.
TB	Tuberculosis.
UNAIDS	Joint United Nations Project on HIV/AIDS, consisting of seven U.N. agencies.
UNECA	United Nations Economic Commission for Africa, headquartered in Addis Ababa, Ethiopia.
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
USAID	U.S. Agency for International Development.
WHO	World Health Organization.
VCT	Voluntary counseling and testing for HIV infection.

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