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AIDS in Africa

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AIDS in Africa

SUMMARY

Sub-Saharan Africa has been more severely affected by AIDS than any other part of the world. The United Nations reports that 25 million adults and children are infected with the HIV virus in the region, which has about 10% of the world's population but nearly two-thirds of the worldwide total of infected people. The overall rate of infection among adults in sub-Saharan Africa is 7.5%, compared with 1.1% worldwide. Ten countries, mostly in east and southern Africa, have HIV infection rates of more than 10%; the rate has reached 38.8% in Swaziland. As of 2003, an estimated 23 million Africans had died of AIDS, including 2.2 million who died in that year. AIDS has surpassed malaria as the leading cause of death in Africa, and it kills many times more Africans than war. In Africa, 57% of those infected are women.

Experts relate the severity of the African AIDS epidemic to the region's poverty, the relative lack of empowerment among women, high numbers of men living as migrant workers, and other factors. Health systems are ill-equipped for prevention, diagnosis, and treatment.

AIDS' severe social and economic consequences are depriving Africa of skilled workers and teachers while reducing life expectancy by decades in some countries. An estimated 12.3 million AIDS orphans are currently living in Africa, facing increased risk of malnutrition and reduced prospects for education. AIDS is being blamed for declines in agricultural production in some countries, and is regarded as a major contributor to hunger and famine.

Donor governments, non-governmental organizations, and African governments have responded through prevention programs intended to reduce the number of new infections and by trying to ameliorate the damage done by AIDS to families, societies, and economies. The adequacy of this response is the subject of much debate. U.N. experts estimate Africa's resource needs for fighting AIDS in 2004 at \$8 billion, but project expenditures of \$6 billion from all sources, including households.

Treatment of AIDS sufferers with medicines that can result in long-term survival is reportedly available to 150,000 Africans at present. However, U.S. and other initiatives are expected to sharply expand the availability of treatment in the near future. Advocates see expanded treatment as an affordable means of reducing the impact of the pandemic. Skeptics question whether treatment can be widely provided without costly improvements in health infrastructure.

U.S. concern over AIDS in Africa grew during the 1980s, as the severity of the epidemic became apparent. Legislation enacted in the 106th and the 107th Congresses increased funding for worldwide HIV/AIDS programs. H.R. 1298, signed into law (P.L. 108-25) on May 27, 2003, authorized \$15 billion over five years for international AIDS programs. President Bush announced his Emergency Plan for AIDS Relief (PEPFAR) in the 2003 State of the Union message. Twelve of the 15 focus countries are in sub-Saharan Africa, and are slated to receive just over \$1 billion through the State Department's new Global AIDS Initiative under the FY2005 budget request. Nonetheless, activists and others urge that more be done in view of the scale of the African pandemic.



MOST RECENT DEVELOPMENTS

On September 14, 2004, the Office of the Global AIDS Coordinator at the Department of State issued an interim report stating that as of July 31, 24,900 AIDS patients were receiving antiretroviral therapy (ART) either directly through the President's Emergency Plan for AIDS Relief (PEPFAR), or indirectly through programs supported by PEPFAR. The report stated that PEPFAR would be providing ART to 200,000 by June 2005 and that by meeting this goal it would double the number of patients receiving ART in sub-Saharan Africa. In response, the Global AIDS Alliance, an activist group, issued a statement maintaining that PEPFAR was moving too slowly toward its 2008 goal of treating 2 million. The Alliance also criticized the program for using more costly patented drugs rather than generics. Reports released at the 15th International AIDS Conference, held July 11-16 in Bangkok, Thailand, indicated that the African HIV/AIDS pandemic remains pervasive, with 3 million new infections in 2003 and 2.2 million deaths. The overall infection rate of 7.5% in the adult population is stable, although rates continued to climb in a few countries, such as Madagascar. Rates have declined in Uganda and in parts of other countries. Continent-wide, an estimated 25 million Africans were carrying the infection in 2003.

For further information, see CRS Report RS21181, *HIV/AIDS International Programs: Appropriations, FY2002-FY2004*; CRS Report RL31712, *The Global Fund to Fight AIDS, Tuberculosis, and Malaria: Background and Current Issues*, and CRS Report RS21609, *The WTO, Intellectual Property Rights, and the Access to Medicines Controversy*.

BACKGROUND AND ANALYSIS

Sub-Saharan Africa has been far more severely affected by AIDS than any other part of the world. In July 2004, UNAIDS (the Joint United Nations Program on HIV/AIDS) reported that in 2003, 25 million people were living with HIV and AIDS in the region, including 3 million newly infected during the year. Africa has about 10% of the world's population but nearly two-thirds of the worldwide total of infected people. The infection rate among adults aged 15-49 averages an estimated 7.5% in Africa, compared with 1.1% worldwide. According to cumulative UNAIDS estimates, approximately 23 Africans have died of AIDS since the beginning of the epidemic, including an estimated 2.2 million who died in 2003. UNAIDS projects that between 2000 and 2020, 55 million Africans can be expected to lose their lives to the epidemic. (*Report on the Global HIV/AIDS Epidemic, 2002*, p. 46.) AIDS has surpassed malaria as the leading cause of death in sub-Saharan Africa, and it kills many times more people than Africa's armed conflicts.

Characteristics of the African Epidemic

- HIV, the human immunodeficiency virus that causes AIDS, is spread in Africa, most experts believe, primarily by heterosexual contact. (A February 2003 article published by David Gisselquist and others in the *International Journal of STD and AIDS* asserted that the importance of unsafe medical

practices in the spread of HIV may have been underestimated. A February 2004 article in *The Lancet* rejects this hypothesis, and affirms that sexual transmission “continues to be the major mode of spread” of HIV.¹⁾

- Women make up an estimated 57% of the HIV-positive adult population in sub-Saharan Africa, as compared with 48% worldwide, according to UNAIDS. Young women are particularly at risk. In 2003, an estimated 6.9% of African women aged 15 to 24 were HIV positive, compared with 2.1% of young men. (UNAIDS, *2004 Report on the Global AIDS Epidemic*).
- According to UNAIDS, the adult infection rate or prevalence has stabilized in sub-Saharan Africa in recent years, as both the total adult population and the number of infected people increase. Prevalence is still increasing in Madagascar, Swaziland, and a few other countries, while Uganda and localized areas in some other countries have experienced declines. Southern Africa, where 6 countries have adult infection rates above 20%, is the most severely affected region (**Table 1**). However, populous Nigeria, where an estimated 5.4% of adults are infected, has an estimated 3.6 million infected people — the largest number in the region apart from South Africa, where UNAIDS estimates that 5.3 million are infected. This is the largest infected population worldwide. (The South African government statistics agency places its estimate at 3.8 million. *Reuters Health E-Line*, July 28, 2004.)
- The African AIDS epidemic is having a much greater impact on children than is the case in other parts of the world. According to UNAIDS, more than 600,000 African infants become infected with HIV each year through mother-to-child transmission, either at birth or through breast-feeding. Most die before their second birthday. Nonetheless, an estimated 1.9 million African children under 14 were living with AIDS at the end of 2003. In South Africa, a sample survey reported by the Human Sciences Research Council in May 2004 showed that 6.7% of children between the ages of 2 and 9 were HIV positive.
- In 2003, there were an estimated 12.3 million AIDS orphans in Africa — that is, children 17 and under who had lost one or both parents to the disease.² Because of the stigma attached to the AIDS disease, AIDS orphans are at high risk for being malnourished, abused, and denied an education. UNICEF released a report, *Africa’s Orphaned Generations*, on November 26, 2003, predicting that there would be 20 million AIDS orphans in Africa by 2010 and that in a dozen countries they would account for 15% to 25% of children under 15. Among other measures, the report recommended efforts to strengthen the capacity of families to protect and care for orphans.

¹ George P. Schmid and others, “Transmission of HIV-1 Infection in Sub-Saharan Africa and Effect of Elimination of Unsafe Injections,” *The Lancet*, February 7, 2004.

² UNAIDS, UNICEF, and U.S. Agency for International Development, *Children on the Brink*, July 2004.

Explaining the African Epidemic

AIDS experts emphasize a variety of economic and social factors in explaining Africa's AIDS epidemic, placing primary blame on the region's poverty. Poverty has deprived Africa of effective systems of health information, health education, and health care. Thus, Africans suffer from a high rate of untreated sexually-transmitted infections (STIs) other than AIDS, and these increase susceptibility to HIV. African health systems typically have limited capabilities for AIDS prevention work, and HIV counseling and testing are difficult for many Africans to obtain. Until very recently, AIDS treatment has been generally available only to the elite.

Table 1. Adult HIV Infection Rates (%), end of 2003

Swaziland	38.8	Tanzania	8.8	Chad	4.8	Eritrea	2.7
Botswana	37.3	Gabon	8.1	Ethiopia	4.4	Sudan	2.3
Lesotho	28.9	Cote d'Ivoire	7.0	Burkina Faso	4.2	Mali	1.9
Zimbabwe	24.6	Cameroon	6.9	Congo Kinshasa	4.2	Benin	1.9
South Africa	21.5	Kenya	6.7	Uganda	4.1	Madagascar	1.7
Namibia	21.3	Burundi	6.0	Togo	4.1	Gambia	1.2
Zambia	16.5	Liberia	5.9	Angola	3.9	Niger	1.2
Malawi	14.2	Nigeria	5.4	Guinea	3.2	Senegal	.8
Central Af. Rep.	13.5	Rwanda	5.1	Ghana	3.1		
Mozambique	12.2	Congo Brazzaville	4.9	Djibouti	2.9		

Source: UNAIDS, Report on the Global HIV/AIDS Epidemic, July 2002. The Zimbabwe estimate represents a technical correction issued in 2003. Updated estimates are expected in July 2004.

Poverty forces large numbers of African men to migrate long distances in search of work, and while away from home they may have multiple sex partners, increasing their risk of infection. Some of these partners may be women who have become commercial sex workers because of poverty, and they too are highly vulnerable to infection. Migrant workers may carry the infection back to their wives when they return home. Long distance truck drivers, and drivers of "taxis," who transport Africans long distances by car, are probably also key agents in spreading HIV.

Some behavior patterns in Africa may also be affecting the epidemic. In explaining the fact that young women are infected at a higher rate than young men, Peter Piot, the Executive Director UNAIDS, has commented that "the unavoidable conclusion is that girls are getting infected not by boys but by older men," who are more likely than young men to carry the disease. (UNAIDS press release, September 14, 1999.) UNAIDS notes that "with the downward trend of many African economies ... relationships with (older) men can serve as vital opportunities for financial and social security, or for satisfying material aspirations." (*AIDS Epidemic Update, 2002*). Many believe that the infection rate among women generally would be far lower if women's rights were more widely respected in Africa, if women exercised more power in political and economic affairs, and if donors and governments would support fidelity campaigns primarily aimed at African men. (For more on these issues, see Helen Epstein, "AIDS: the Lesson of Uganda," *New York Review of*

Books, July 5, 2001; “The Hidden Cause of AIDS,” *New York Review of Books*, May 9, 2002; and “The Fidelity Fix,” *New York Times Magazine*, June 13, 2004.) A Human Rights Watch study released on August 13, 2003, reported that domestic violence made women in Uganda more vulnerable to HIV infection — for example by depriving them of the power to negotiate condom use.

The breakdown in social order and social norms caused by armed conflict is also contributing to the African epidemic. Conflict is typically accompanied by numerous incidents of violence against women, including rape, carried out by soldiers and guerrillas. Such men are also more likely to resort to commercial sex workers than those living in a settled environment. (“Cycle of War is Spreading AIDS and Fear in Africa,” *Washington Post*, November 13, 2003; “AIDS Lurks as War Scourge in Congo,” *Washington Times*, November 13, 2003).

Leadership Reaction in South Africa and Elsewhere

Many observers believe that the spread of AIDS in Africa could have been slowed if African leaders had been more engaged and outspoken in earlier stages of the epidemic. President Thabo Mbeki of South Africa has come in for particular criticism on this score. In April 2000, President Mbeki wrote then President Clinton and other heads of state defending dissident scientists who maintain that AIDS is not caused by the HIV virus. In March 2001, Mbeki rejected appeals that the national assembly declare the AIDS pandemic a national emergency, and in September of that year, the South African government attempted to delay publication of a South African Medical Research Council report, which found AIDS to be the leading cause of death. The Council predicted that South Africa’s death toll from AIDS would reach a cumulative total of between 5 and 7 million by 2010, when 780,000 people would be dying annually from the disease. Life expectancy would fall from 54 years at present to 41 by the end of the decade, according to the Council.

Under mounting domestic and international pressure, the South African government seemed to modify its position significantly after an April 2002 cabinet meeting on the AIDS crisis. The cabinet announced that it would triple the national AIDS budget, end official opposition to the provision of antiretrovirals for rape victims, and launch a program for universal access to drugs to prevent mother-to-child transmission. AIDS activists welcomed the policy changes, but some expressed concerns about implementation or pointed out that South Africa was still far from providing access to treatment for all those in need. Nonetheless, tensions on the treatment issue eased for some months, but when the treatment program had not begun by March 2003, activists undertook a new civil disobedience campaign. Government officials responded that the cost of providing universal treatment was still being determined, and the ruling African National Congress accused the Treatment Action Campaign (TAC) of “bully boy tactics.” (*South African Press Association*, March 26, 2003.) According to a *Financial Times* report on July 9, 2003, a representative of the United Nations Development Program (UNDP) said that South Africa had fallen 28 places on the UNDP Human Development Index since 1990 — to 111th place out of 175 countries — primarily due to AIDS. (In 2004, South Africa ranked 119 out of 177.)

On August 8, 2003, the South African cabinet instructed the health ministry to develop a plan by the end of September to provide antiretroviral treatment nationwide. Again, the decision was welcomed, but by March 2004, TAC was threatening a lawsuit unless the

program was actually launched. Finally, on April 1, 2004, the government began offering treatment at 5 hospitals in Gauteng province, centered on Johannesburg. Officials said they expected 50,000 patients to be on antiretrovirals by the end of the year and 1.4 million to be receiving the drugs by 2009.

In the rest of Africa, many heads of state and other leaders are now taking major roles in fighting the epidemic. President Yoweri Museveni of Uganda has long been recognized for leading a successful prevention campaign against AIDS in his country, and Uganda's ABC (Abstinence, Be Faithful, or Use Condoms) transmission prevention program has won wide praise. ("Uganda Leads by Example on AIDS," *Washington Times*, March 13, 2003.) A Senate Foreign Relations Africa Subcommittee hearing on May 19, 2003, focused on "Fighting AIDS in Uganda: What Went Right." Dr. Anne Peterson, Assistant Administrator for Global Health at the U.S. Agency for International Development (USAID), testified that the "Uganda success story is about prevention." She said that successes had been recorded in promoting abstinence and faithfulness to partners, while increased condom use in recent years had also contributed to the decline in prevalence. Sophia Mukasa Monico, a member of the Global Health Council and a former AIDS worker in Uganda, testified that all three program elements need to be in place for prevention to work. Mukasa Monico noted that "the epidemic is still raging in Uganda, and we have much to do before we can claim victory...." On June 10, 2003, during a meeting with President Museveni at the White House, President Bush praised the Ugandan leader's "extraordinary leadership on HIV/AIDS in your country." In June 2004, the Ugandan government began providing free, generic antiretroviral drugs in a program aimed at treating all 100,000 patients in need. The Global Fund to Fight AIDS, Tuberculosis, and Malaria is supporting the initial phase of the project.

Meanwhile, the presidents of Botswana, Nigeria, and several other countries are widely seen today as in the forefront of the AIDS struggle as well. Several regional AIDS initiatives have been launched. For example, in August 2003, the Southern African Development Community (SADC) agreed to an AIDS strategic framework, including the creation of a \$10.5 million regional fund to fight the disease.

Social and Economic Consequences

AIDS is having severe social and economic consequences in Africa, and these negative effects are expected to continue for many years. A January 2000 Central Intelligence Agency National Intelligence Estimate on the infectious disease threat, made public in an unclassified version, forecasts grave problems over the next 20 years.

At least some of the hardest-hit countries, initially in sub-Saharan Africa and later in other regions, will face a demographic catastrophe as HIV/AIDS and associated diseases reduce human life expectancy dramatically and kill up to a quarter of their populations over the period of this Estimate. This will further impoverish the poor, and often the middle class, and produce a huge and impoverished orphan cohort unable to cope and vulnerable to exploitation and radicalization. (CIA, *The Global Infectious Disease Threat and Its Implications for the United States* [<http://www.odci.gov>], "Publications and Reports".)

The estimate predicted increased political instability and slower democratic development as a result of AIDS. According to the World Bank,

The illness and impending death of up to 25% of all adults in some countries will have an enormous impact on national productivity and earnings. Labor productivity is likely to drop, the benefits of education will be lost, and resources that would have been used for investments will be used for health care, orphan care, and funerals. Savings rates will decline, and the loss of human capital will affect production and the quality of life for years to come. (World Bank, *Intensifying Action Against HIV/AIDS in Africa*.)

In the most severely affected countries, sharp drops in life expectancy are occurring, and these will reverse major gains achieved in recent decades. According to UNAIDS, as a result of AIDS, average life expectancy in sub-Saharan Africa is now 47 years, whereas it would have been 62 years without the epidemic. A U.S. Bureau of the Census report [<http://www.census.gov/prod/2004pubs/wp02-2.pdf>], released on March 23, 2004, predicted population declines by 2010 in South Africa, Botswana, and three other African countries due to AIDS.

According to many reports, AIDS has devastating effects on rural families. The father is typically the first to fall ill, and when this occurs, farm tools and animals may be sold to pay for his care. Should the mother also become ill, children may be forced to shoulder responsibility for the full time care of their parents. The Food and Agriculture Organization of the United Nations reports that since the epidemic began, 7 million agricultural workers have been killed in Africa. The agricultural workforce has been reduced by more than 20% in five countries (FAO, *HIV/AIDS, Food Security, and Rural Livelihoods*, May 2002), and a number of experts are relating serious food shortages in southern Africa in 2002 and 2003 to production losses caused by AIDS. (See “Cursed Twice Over — AIDS and Famine in Southern Africa,” *The Economist*, February 15, 2003.) World Food Program Executive Director James Morris, testifying before the Senate Foreign Relations Committee on February 25, 2003, and the House International Relations Committee on February 27, said that HIV/AIDS was a central cause of the famine. On June 22, 2004, Morris said that southern Africa was in a “death spiral” due to the consequences of the AIDS pandemic, including the loss of human capacity and the devastation of rural areas, with resulting negative consequences for food security (WFP press release).

AIDS is being blamed for shortages of skilled workers and teachers in several countries. A May 2002 World Bank study, *Education and HIV/AIDS: A Window of Hope*, reported that more than 30% of teachers are HIV positive in parts of Malawi and Uganda, 20% in Zambia, and 12% in South Africa. AIDS is also claiming many lives at middle and upper levels of management in both business and government. Although unemployment is generally high in Africa, trained personnel are not readily replaced.

AIDS may have serious security consequences for much of Africa, since HIV infection rates in many armies are extremely high. Domestic political stability could also be threatened in African countries if the security forces become unable to perform their duties due to AIDS. Peacekeeping is also at risk. South African soldiers are expected to play an important peacekeeping role in Africa in the years ahead, but this could be threatened. Estimates of the infection rate in the South Africa army run from 17% to 40%, with higher rates reported for units based in heavily infected KwaZulu-Natal province.

Responses to the AIDS Epidemic

Donor governments, non-governmental organizations (NGOs) working in Africa, and African governments have responded to the AIDS epidemic primarily by attempting to reduce the number of new HIV infections through prevention programs, and to some degree, by trying to ameliorate the damage done by AIDS to families, societies, and economies. A third response, treatment of AIDS sufferers with antiretroviral drugs that can result in long-term survival, has not been widely used in Africa until recently; but treatment programs are expanding. (See below, **AIDS Treatment Issues**).

Programs and projects aimed at combating the epidemic typically provide information on how HIV is spread and on how it can be avoided through the media, posters, lectures, and skits. Some success has been claimed for these efforts in persuading young people to delay the age of “sexual debut” and to remain faithful to a single partner. The United States is now advocating an expansion of prevention programs focusing on abstinence until marriage as an effective means of slowing the spread of HIV, although some critics maintain that this may be unrealistic in a social environment destabilized by poverty. Some also question whether approaches stressing abstinence and faithfulness can benefit poor married women in Africa, who have little power to deny their husbands, whether infected or not.

Donor-sponsored voluntary counseling and testing (VCT) programs, where available, enable African men and women to learn their HIV status. In Botswana, HIV tests are now offered as a routine part of any medical visit, and many experts are urging that this be done continent-wide. AIDS awareness programs can be found in many African schools and increasingly in the workplace, where employers are recognizing their interest in reducing the infection rate among their employees. Many projects aim at making condoms readily available and on providing instruction in condom use. Several projects have had success in reducing mother-to-child transmission by administering the anti-HIV drug AZT or Nevirapine, before and during birth, and while the mother is nursing. Some are concerned, however, that this temporary use of antiretrovirals may encourage the emergence of drug-resistant strains of HIV. In their view, it would be far better to put all infected pregnant women into long-term treatment programs, which would also reduce the likelihood that the child will become an orphan.

Church groups and humanitarian organizations have helped Africa deal with the consequences of AIDS by setting up programs to provide care and education to orphans. The Farm Orphan Support Trust in Zimbabwe tries to keep sibling orphans together and in a family living situation; the Salvation Army sponsors a pilot, community-based, orphan support program in Zambia, providing education and health care to vulnerable children. (*Report on the Presidential Mission on Children Orphaned by AIDS.*) A United Nations study has found that community-based organizations, sometimes with the support of NGOs, have emerged to supply additional labor, home care for the sick, house repair, and other services to AIDS-afflicted families. (UNAIDS, *A Review of Household and Community Responses to the HIV/AIDS Epidemic in Rural Areas of Sub-Saharan Africa*, 1999.)

Public-private partnerships have also become an important vehicle for responding to the African AIDS pandemic. The Bill and Melinda Gates Foundation has been a major supporter of vaccine research and a variety of AIDS programs undertaken in cooperation with African governments and donors. The Rockefeller Foundation, working with UNAIDS and others,

has sponsored programs to improve AIDS care in Africa, and both Bristol-Myers Squibb and Merck and Company, together with the Gates Foundation and the Harvard AIDS Institute, have undertaken programs with the Botswana government aimed at improving the country's health infrastructure and providing AIDS treatment to all who need it.

The Global Fund to Fight AIDS, Tuberculosis, and Malaria, created in January 2002, commits about 60% of its grant funds to Africa, and about 60% of its grants worldwide go toward fighting AIDS. For further information, see CRS Report RL31712, *The Global Fund to Fight AIDS, Tuberculosis, and Malaria: Background and Current Issues*.

Nonetheless, UNAIDS maintains that a significant funding gap remains. In September 2003, the organization issued a report entitled *Accelerating Action Against AIDS in Africa*, which estimated that \$8 billion is required to fight the African AIDS epidemic in 2004, whereas \$6 billion is likely to be provided from all sources, including donors, the Global Fund, African governments, and African households. UNAIDS expects the resource gap to widen further in 2005.

Further information on the response to AIDS in Africa may be found below under **AIDS Treatment Issues** and at the following websites:

CDC: [<http://www.cdc.gov/nchstp/od/nchstp.html>]

Global Fund to Fight AIDS, Tuberculosis, and Malaria: [<http://www.theglobalfund.org/en/>]

International AIDS Vaccine Initiative: [<http://www.iavi.org>]

International Association of Physicians in AIDS Care: [<http://www.iapac.org/>]

Kaiser Daily HIV/AIDS Report: [http://www.kaisernetwork.org/daily_reports/rep_hiv.cfm/]

UNAIDS: [<http://www.unaids.org/en/default.asp>]

USAID: [<http://www.usaid.gov/>], click on "Health."

World Bank: [<http://www.worldbank.org/>], click on "Topics."

Effectiveness of the Response

The response to AIDS in Africa has had some successes, most notably in Uganda, where the rate of infection among pregnant women in urban areas fell from 29.5% in 1992 to 5% in 2001 (UNAIDS, *AIDS Epidemic Update, December 2002*). The infection rate has continued to drop, and in 2003, adult prevalence nationwide was 4.1%, compared with 5.1% in 2001. HIV prevalence among young urban women in Zambia has also reportedly fallen, and UNAIDS indicates that urban sexual behavior patterns among young people in cities in other countries may be changing in ways that combat the spread of HIV. (However, increases in infection rates continue in cities in several other countries.) South Africa has recorded a drop in infections among pregnant women under 20, and Senegal is credited with preventing an AIDS epidemic through an active, government-sponsored prevention program. Despite some success stories, however, the number of infected people in Africa continues to grow.

Experts point out that there are a number of barriers to a more effective AIDS response in Africa, such as cultural norms that make it difficult for many government, religious, and community leaders to acknowledge or discuss sexual matters, including sex practices, prostitution, and the use of condoms. However, experts continue to advocate AIDS awareness and AIDS amelioration as essential components of the response to the epidemic. Indeed, there is strong support for an intensification of awareness and amelioration efforts,

as well as adaptations to make such efforts more effective. With respect to amelioration, UNAIDS has recommended that donors find ways to strengthen those indigenous support institutions that are already helping AIDS victims and their families. (*A Review of Household and Community Responses*, 1999.) There is also support for a stronger focus on treatment of non-HIV sexually-transmitted infections, which studies show can dramatically lower the rate of HIV transmission.

The lives of infected people could be significantly prolonged and improved, some maintain, if more were done to identify and treat the opportunistic infections, particularly tuberculosis, that typically accompany AIDS. Millions of Africans suffer dual infections of HIV and TB, and the combined infection dramatically shortens life. Tuberculosis can be cured by treatment with a combination of medications over several months, even in HIV-infected patients. However, according to the World Health Organization, Africans often delay seeking treatment for TB or do not complete the course of medication (*Global Tuberculosis Control: WHO Report 1999*, Key Findings), contributing to the high incidence of death among those with dual infections. Pfizer Corporation has signed an agreement with South Africa to donate the anti-fungal Diflucan (fluconazole) for treating AIDS-related opportunistic infections, including cryptococcal meningitis, a dangerous brain inflammation. On December 1, 2001, Pfizer announced that it would sign memoranda of understanding on donating fluconazole with six other African countries. UNAIDS and the World Health organization recommended on April 5, 2000, that Africans infected with HIV be treated with an antibiotic/sulfa drug combination known by the trade name Bactrim in order to prevent opportunistic infections. Studies indicate that the drug could reduce AIDS death rates at a cost of between \$8 and \$17 per year per patient.

AIDS Treatment Issues

Access for poor Africans to combinations of AIDS medications or “antiretrovirals” (ARVs) has been perhaps the most contentious issue surrounding the response to the African epidemic today. Administered in a treatment regimen known as HAART (highly active antiretroviral therapy) these drugs can return AIDS victims to normal life and permit long-term survival rather than early death. Such treatment has proven highly effective in developed countries, including the United States, where AIDS, which had been the eighth leading cause of death in 1996, no longer ranked among the 15 leading causes by 1998. (U.S. Department of Health and Human Services Press Release, October 5, 1999.)

The high cost of HAART treatments has been the principal obstacle to offering the therapy on a large scale in Africa, where most victims are poor and lack health insurance. The cost of administering HAART was once estimated at between \$10,000 and \$15,000 per person per year. On May 11, 2000, five major pharmaceutical companies announced that they were willing to negotiate sharp reductions in the price of AIDS drugs sold in Africa. UNAIDS launched a program in cooperation with the pharmaceutical companies to boost treatment access and, in June 2001, reported that 10 African countries had reached agreement with manufacturers. The agreements significantly reduced prices in exchange for health infrastructure improvements to assure that ARVs are administered safely. Patented AIDS medications are now reportedly available in several African countries, at prices ranging from a few hundred dollars to just over \$1000 per patient per year, for a three-drug treatment comparable to that available in developed countries.

Meanwhile, initiatives to expand the availability of HAART are intensifying. According to the World Health Organization's Accelerating Access Initiative, 150,000 AIDS patients in Africa were receiving treatment with antiretrovirals in December 2003, up from 75,000 six months earlier.³ However, the number being treated is expected to increase even more sharply in coming months and years as the treatment programs of the President's Emergency Plan for AIDS Relief (PEPFAR), the Global Fund, and other public and private groups begin or expand operations. On December 1, 2003, World AIDS Day, the World Health Organization formally released its own \$5.5 billion "three by five" plan to treat 3 million AIDS patients in poor countries by 2005, with resources to come from the Global Fund and donors. On October 23, 2003, former President Bill Clinton announced that his foundation had organized a program to provide generic three-drug antiretroviral treatment for AIDS patients in Africa and the Caribbean for about \$.38 per day. Generic pharmaceutical manufacturers in India and South Africa would make the drugs, and funding would come from private donors, some donor governments, and other sources. On April 6, 2004, the Clinton Foundation announced an agreement with UNICEF, the World Bank, and the Global Fund to expand the program to more than 100 developing countries worldwide. As a result of the impending increased availability of treatment, estimates of the numbers likely to be receiving treatment soon are soaring. For example, the Kenyan health minister said on February 12, 2004, that 140,000 Kenyan AIDS patients would be receiving free antiretrovirals in 2005. As noted above, Uganda has launched a program eventually intended to treat 100,000.

Whether African countries are ready to "absorb" dramatically increased funding for treatment has been another issue. AIDS activists believe that millions of Africans could quickly be given access to AIDS drugs. Others maintain that African supply channels cannot make the drugs consistently available to millions of patients and that regular monitoring of patients by medical personnel is not possible in much of the continent. Monitoring is necessary, they maintain, to deal with side effects and to adjust medications if drug resistance emerges. Many fear that if the drugs are taken irregularly, resistant HIV strains will emerge that could cause untreatable infections worldwide; although a September 2003 report indicated that African patients follow their AIDS therapy regimens more consistently than American patients.⁴ For some, the correct response to weaknesses in Africa's basic health care systems is to devote resources to strengthening those systems.⁵

Botswana's President Mogae told a November 12, 2003 meeting, convened in Washington by the Center for Strategic and International Studies, that the widely-praised treatment program in his country is being hampered by a "brain drain" of health personnel. Physicians, nurses, technicians, and other are often hired away by foreign governments, international organizations, and non-governmental organizations. The health minister of Mozambique, which has launched a pilot antiretroviral treatment program, said in May 2004 that the country was unable to launch a nationwide program because of serious shortages of staff and equipment.

³ Press release reported in the Kaiser Daily HIV/AIDS Report, March 19, 2004.

⁴ "Africans Outdo Americans in Following AIDS Therapy," *New York Times*, September 3, 2003.

⁵ Holly Burkhalter, "Misplaced Help in the AIDS Fight," *Washington Post* op-ed, May 25, 2004.

AIDS activists have urged that African governments issue “compulsory licenses” to allow the manufacture or importation of inexpensive generic copies of patented AIDS medications. In November 2001, a ministerial-level meeting of the World Trade Organization (WTO) in Doha, Qatar, approved a declaration stating that the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS agreement) should be implemented in a manner supportive of promoting access to medicines for all. The declaration affirmed the right of countries to issue compulsory licenses and gave the least developed countries until 2016 to implement TRIPS. The question of whether countries manufacturing generic copies of patented drugs, such as India or Thailand, should be permitted to export to poor countries was left for further negotiation through a committee known as the Council for TRIPS.

Although the Doha declaration drew broad praise, some AIDS activists criticized it for not permitting imports of generics. Some in the pharmaceutical industry, on the other hand, expressed concern that the declaration was too permissive and might reduce profits that, they argued, were used to fund research. Others, however, maintained that the declaration would have little practical impact, because in their view, poverty rather than patents is the principal obstacle to drug access in Africa. (See Amir Attaran and Lee Gillespie-White, “Do Patents for Anti-retroviral Drugs Constrain Access to AIDS Treatment in Africa?” *Journal of the American Medical Association*, October 17, 2001.) On August 30, 2003, the WTO reached agreement on a plan to allow poor countries to import generic copies of essential medications, but the debate over access to antiretrovirals in Africa seems likely to continue. For more information, see CRS Report RS21609, *The WTO, Intellectual Property Rights, and the Access to Medicines Controversy*.

On November 6, 2003, then Prime Minister Jean Chretien of Canada proposed legislation to allow generic drug manufacturers in Canada to supply inexpensive copies of patented medicines to poor countries under “compulsory licenses.” The Canadian parliament completed passage of the bill in late May 2004, and implementation is expected later in the year after regulations have been published and approved.

U.S. Policy

U.S. concern over AIDS in Africa began to mount during the 1980s, as the severity of the epidemic became apparent. In 1987, in acting on the FY1988 foreign operations appropriations, Congress earmarked funds for fighting AIDS worldwide, and House appropriators noted that in Africa, AIDS had the potential for “undermining all development efforts” to date (H.Rept. 100-283). In subsequent years, Congress supported AIDS spending at or above levels requested by the executive branch, either through earmarks or report language. Nevertheless, a widely discussed July 2000 *Washington Post* article called into question the adequacy and timeliness of the early U.S. response to the HIV/AIDS threat in Africa. (Barton Gellman, “The Global Response to AIDS in Africa: World Shunned Signs of Coming Plague.” *Washington Post*, July 5, 2000. See also Greg Behrman, *The Invisible People: How the U.S. Has Slept Through the Global AIDS Pandemic, the Greatest Humanitarian Catastrophe of Our Time* (New York: Free Press, 2004).

As the severity of the epidemic continued to deepen, many of those concerned for Africa’s future, both inside and outside government, came to feel that more should be done.

On July 19, 1999, then Vice President Al Gore proposed \$100 million in additional spending for a global LIFE (Leadership and Investment in Fighting an Epidemic) AIDS initiative to begin in FY2000, with a heavy focus on Africa. Funds approved during the FY2000 appropriations process supported most of this initiative. On June 27, 2000, the Peace Corps announced that all volunteers serving in Africa would be trained as AIDS educators.

USAID reported in 2001 that it had been the global leader in the international response to AIDS since 1986, not only by supporting multilateral efforts but also by directly sponsoring regional and bilateral programs aimed at combating the disease. (USAID, *Leading the Way: USAID Responds to HIV/AIDS*, September 2001). The Agency had sponsored AIDS education programs; trained AIDS educators, counselors, and clinicians; supported condom distribution; and sponsored AIDS research. USAID claimed several successes in Africa, such as helping to reduce HIV prevalence among young Ugandans and to prevent an outbreak of the epidemic in Senegal; reducing the frequency of sexually transmitted infections in several African countries; sharply increasing condom availability in Kenya and elsewhere; assisting children orphaned by AIDS; and sponsoring the development of useful new technologies, including the female condom. USAID reported that it spent a total of \$51 million on fighting AIDS in Africa in FY1998 and \$63 million in FY1999 (*Leading the Way*, 121). In addition, some spending by the Department of Health and Human Services was going toward HIV surveillance in Africa and other Africa AIDS-related efforts.

Bush Administration

The President's Emergency Plan for AIDS Relief (PEPFAR) is expected to result in major spending increases for HIV/AIDS prevention, care, and treatment in 12 focus countries in Africa: Botswana, Cote d'Ivoire, Ethiopia, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, and Zambia. President Bush announced the creation of PEPFAR in his January 2003 State of the Union address, pledging \$10 billion in "new money" worldwide, that is, spending in addition to then current levels, for fiscal years 2004 through 2008. The objectives of PEPFAR, which is to include 15 countries altogether, are to prevent 7 million new infections, provide anti-retroviral drugs for 2 million infected people, and provide care for 10 million infected people, including orphans. The new funds are coming through the Global AIDS Initiative (GAI), headquartered at the Department of State. The GAI is headed by the United States Global AIDS Coordinator, Randall Tobias, who coordinates not only the GAI programs in the focus countries, but also the HIV/AIDS programs of USAID and other agencies in both focus and non-focus countries. Funding for the GAI was part of the FY2004 Omnibus Consolidated Appropriations (P.L. 108-199), signed into law on January 23, 2004.

On February 23, 2004, the Department of State issued a report [<http://www.state.gov/s/gac/rl/or/c11652.htm>] providing details on the PEPFAR initiative. At the same time, the Administration announced plans to release PEPFAR funds for treatment programs conducted by the Elizabeth Glaser Pediatric AIDS Foundation, Harvard's School of Public Health, Colombia's Mailman School of Public Health, and Catholic Relief Services.

In May 2001, President Bush had made the "founding pledge" of \$200 million to the Global Fund, and on June 19, 2002, he announced a \$500 million International Mother and Child HIV Prevention Initiative (IMCPI) to support programs to prevent mother- to-child

transmission of the virus. Eight African countries were named as beneficiaries. President Bush made AIDS a special focus of his five-day trip to Africa in July 2003. On July 10, speaking in Botswana, the President said “This is the deadliest enemy Africa has ever faced, and you will not face this epidemic alone.” On July 8, in Senegal, the President told Africans “we will join with you in turning the tide against AIDS in Africa.” The President also spoke on the epidemic in South Africa on July 9. On September 22, 2003 Secretary of State Powell told a U.N. General Assembly special session on AIDS that the epidemic was “more devastating than any terrorist attack” and that the United States would “remain at the forefront” of efforts to combat the epidemic.

Many AIDS activists and others have praised the President’s initiatives, but critics maintain that PEPFAR in particular is getting off to a slow start and have urged increased appropriations. Some also see the program as too strongly unilateral and would like the United States to be acting in closer cooperation with other countries and donors, particularly the Global Fund to Fight AIDS, Tuberculosis, and Malaria. In FY2004, Congress appropriated \$547 million for the Global Fund, more than twice the Administration’s \$200 million request. The Administration has requested \$200 million for the Fund again in FY2005.⁶ Some observers are also questioning whether PEPFAR will do enough to strengthen African health care institutions and capabilities for coping with AIDS over the long term; or whether the funds will flow primarily to U.S.-based organizations. The Council on Foreign Relations released a report on May 17, 2004, describing the current U.S. approach to fighting the pandemic as “too narrowly focused.”⁷ The report called for a broader, long-term effort to meet basic health needs in affected countries.

U.N. Secretary General Kofi Annan, during an interview at the July 2004 AIDS conference in Bangkok, urged the United States to contribute \$1 billion annually to the Global Fund to Fight AIDS, Tuberculosis, and Malaria; but U.S. Global AIDS Coordinator Randall Tobias said “It’s not going to happen.” (For further information, see CRS Report RL31712, *The Global Fund to Fight AIDS, Tuberculosis, and Malaria: Background and Current Issues*.) Annan asked the United States to show the same leadership in the AIDS struggle that it had shown in the war on terrorism. U.S. State Department spokesman Richard Boucher rejected the implied criticism, saying that the Bush Administration had taken the AIDS crisis very seriously and that the \$15 billion pledged to fight the epidemic over five years was an “enormous and significant amount.” In a speech interrupted by protestors, Tobias told the conference that “At this point, perhaps the most critical mistake we can make is to allow this pandemic to divide us.”

Generic Fixed Dose Combinations. The *Financial Times* reported on April 6, 2004, that the United States was withholding support from a program intended to treat 140,000 AIDS patients in Kenya with antiretrovirals because the program would rely on a generic 3-drug combination (FDC) pill. Many favor approval of FDCs, including copies of drugs manufactured by different companies, on grounds that they are simpler to prescribe and need to be taken just once or twice a day. U.S. officials had expressed concerns that further study was needed to assure that their widespread or improper distribution did not contribute

⁶ For funding details, see CRS Report RS21181, *HIV/AIDS International Programs: Appropriations, FY2002-FY2005*.

⁷ *Addressing the HIV/AIDS Pandemic: A U.S. Global AIDS Strategy for the Long Term*, p. 1.

to the emergence of resistant HIV strains. The issue was submitted to a panel of experts instructed to report by mid-May 2004. Several members of Congress subsequently wrote to President Bush asking that the United States join an international consensus that generics are safe and essential for the treatment of AIDS. On May 16, 2004, Health and Human Services Secretary Tommy Thompson announced that the United States Food and Drug Administration was instituting an expedited process that could lead to the approval of the use of FDCs in programs funded by PEPFAR. Many hailed the announcement as a step forward in making cheaper and more reliable antiretroviral therapy available in Africa, but critics said it placed an unnecessary hurdle in the way of distributing such pills. They maintained that the United States should have relied on the approval process of the World Health organization, which had already cleared such pills. An HHS fact sheet said that approvals were anticipated within six weeks of application.

Spending. Table 2 reports available information on recent U.S. spending levels on AIDS programs in Africa. Where information is not available, "NA" has been entered into the table. Under the FY2005 request, GAI assistance to the 12 focus countries in sub-Saharan Africa will total just over \$1 billion, or 72% of the total requested for the GAI. An estimated \$264.2 million is being spent in bilateral programs with the Africa focus countries in FY2004, and these countries will also benefit from centrally funded GAI mechanisms, including Antiretroviral Therapy, Safe Injections, and Abstinence/Faithfulness. Prior to the launching of PEPFAR, USAID and the Global AIDS Program (GAP) of the Centers for Disease Control (CDC) in the Department of Health and Human Services were the principal channels for HIV/AIDS assistance to Africa. In addition, the Defense Department (DOD) has undertaken an HIV/AIDS education program with African armed forces. Funds from the Foreign Military Financing (FMF) program are also used to support this initiative. Meanwhile, a Department of Labor (DOL) program supports AIDS education in the African workplace. (For more information, see CRS Report RS21181, *HIV/AIDS International Programs: Appropriations, FY2002-FY2004.*) Additional U.S. funds reach Africa indirectly through the AIDS programs of the United Nations, including the World Bank, and the Global Fund to Fight AIDS, Tuberculosis, and Malaria.

Table 2. U.S. Bilateral Spending on Fighting AIDS in Africa
(\$ millions)

	FY2000	FY2001	FY2002	FY2003	FY2004 Est.	FY2005 Request
USAID	109	144	183	320	231.0	231.0
CDC (GAP)	30	77	84	107	NA	NA
GAI (State)	-	-	-	-	487.9	1,041.4
DOD	0	5	14	7	4.2	0
FMF	0	0	0	2	1.5	2.0
DOL	0	3	6	5	NA	0
Total	139	229	287	441		

Nonetheless, the scale of the response to the pandemic in Africa by the United States and others remains a subject of intense debate. At the September 21, 2003 opening of an

international conference on AIDS in Africa, meeting in Nairobi, the U.N. Special Envoy for HIV/AIDS in Africa, Stephen Lewis, said he was “enraged by the behavior of the rich powers” with respect to the epidemic. The singer Bono said he had a “good old row” with President Bush in a September 16 meeting on the level of U.S. funding for fighting the international AIDS epidemic. As Congress considered FY2004 appropriations, a number of editorials called for increased AIDS spending in Africa and elsewhere. (See, for example, summaries by the Kaiser Family Foundation Daily HIV/AIDS Report, September 25, 2003, [http://www.kaisernetwork.org/daily_reports/rep_hiv.cfm/]). Nonetheless, as noted above, others argued that Africa’s ability to absorb increased AIDS funding is limited, that health infrastructure will have to be expanded before new funds can be spent effectively.

Legislative Action, 2000-2002

In August 2000, the Global AIDS and Tuberculosis Relief Act of 2000 (P.L. 106-264) became law. This legislation authorized funding for fiscal years 2001 and 2002 for a comprehensive, coordinated, worldwide HIV/AIDS effort under USAID. In the 107th Congress, a number of bills were introduced with international or Africa-related HIV/AIDS related provisions. A major international AIDS authorization bill, H.R. 2069, passed both the House and Senate during the 107th Congress but did not go to conference. (For information on appropriations for HIV/AIDS programs, see CRS Report RS21114, *HIV/AIDS: Appropriations for Worldwide Programs in FY2001 and FY2002.*)

Legislative Action in the 108th Congress

In May 2003, Congress approved and President Bush signed into law H.R. 1298/P.L. 108-25, the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003. This bill backs the President’s Emergency Plan for AIDS Relief by authorizing \$3 billion per year for FY2004 through FY2008 (a total of \$15 billion) and creating the office of the Global AIDS Coordinator at the Department of State. Appropriations measures have supported a variety of programs helping Africa fight the pandemic; for further information, see CRS Report RS21181, *HIV/AIDS International Programs: Appropriations, FY2002-FY2004*. Several bills with provisions related to the African AIDS pandemic have been introduced in the 108th Congress and referred to committee, including the following.

- H.R. 390 (Waters)/S. 185 (Daschle), African Famine Relief Act of 2003
- H.R. 643 (Waters), Debt Cancellation for the New Millennium Act
- H.R. 1145 (Millender McDonald) Peace Corps HIV/AIDS Training Enhancement Appropriations Act of FY2003
- H.R. 1857 (Hastings) Humanitarian Assistance to Combat HIV/AIDS in sub-Saharan Africa and the Caribbean And National Security Act of 2003
- H.R. 2470 (Waters), Medicines to Eliminate Diseases in Developing States Act or the “MEDDS Act”
- H.R. 4191 (Millender-McDonald), to provide for the establishment of pediatric care centers to care for children with HIV/AIDS in certain developing countries.
- S. 250 (Durbin), Global Coordination of HIV/AIDS Response Act (Global CARE Act)
- S. 859 (Corzine), Microbicide Development Act of 2003
- S. 1067 (Alexander), AIDS Corps Act of 2003
- S. 2500 (Lugar), Assistance for Orphans and Other Vulnerable Children in Developing Countries Act of 2004.

LEGISLATION

P.L. 108-287, H.R. 4613

Department of Defense Appropriations Act, 2005. Conference version provides not less than \$7.5 million in FY2005 for HIV prevention education in connection with U.S. military activities primarily in Africa (Title VI); House version had provided \$10 million, while the Senate version lacked a comparable provision. Passed the House, June 22, 2004; passed the Senate, June 24; House and Senate agreed to conference report (H.Rept. 108-622), July 22; signed into law (P.L. 108-287), August 5, 2004.

H.R. 4061 (Lee)

Assistance for Orphans and Other Vulnerable Children Act of 2004. Amends the Foreign Assistance Act of 1961 to affirm the willingness of the United States to assist orphans and vulnerable children; authorizes the President to provide assistance in developing countries providing basic care for orphans and vulnerable children; authorizes the President to provide treatment, including antiretroviral treatment and mental health for orphans and vulnerable children with HIV/AIDS; authorizes assistance for school food programs, increasing educational opportunities, and protecting inheritance rights; establishes an Office for Orphans and Other Vulnerable Children at USAID; requires a report on implementation. Introduced on March 30, 2004, and referred to the Committee on International Relations; reported (H.Rept. 108-479) May 5, 2004; passed under suspension of the rules, June 14; received in the Senate and referred to the Committee on Foreign Relations, June 15.