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AIDS in Africa

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SUMMARY

Sub-Saharan Africa has been more severely affected by AIDS than any other part of the world. In 2005, the United Nations reports, there were about 25.8 million HIV-positive adults and children in the region, which has about 11.15% of the world's population but over 64% of the worldwide total of infected people. The overall rate of infection among adults in sub-Saharan Africa is 7.4%, compared with 1.1% worldwide. Nine southern Africa countries have infection rates above 10%, and the ten African countries with the largest infected populations account for over 50% of infected adults worldwide. By late 2005, an estimated 27.7 million Africans will have died of AIDS, including a 2005 estimate of 3.1 million deaths. 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 attribute the severity of Africa's AIDS epidemic to the region's poverty, women's relative lack of empowerment, high rates of male worker migration, 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, and reducing life expectancy by decades in some countries. There are an estimated 12.3 million AIDS orphans in Africa. They face increased risk of malnutrition and reduced prospects for education. AIDS is also blamed for declines in agricultural production in some countries and is seen as a major contributor to hunger and famine.

Donor governments, non-governmental organizations, and African governments have responded by supporting programs intended to prevent and reduce the number of new infections and by trying to abate the damage done by AIDS to families, societies, and economies. The adequacy of this response is the subject of much debate.

An estimated 500,000 Africa AIDS patients were being treated with antiretroviral drugs in June 2005, up from 150,000 a year earlier, but an estimated 4 million remain in need of such therapy. 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 epidemic's severity became apparent. Legislation enacted in the 106th and the 107th Congresses increased funding for worldwide AIDS programs. P.L. 108-25, signed into law 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 his 2003 State of the Union message. Twelve of 15 PEPFAR "focus countries" are in sub-Saharan Africa. Under the FY2006 budget request, they would receive a 54% boost in aid, to $1.2 billion, through the State Department's Global HIV/AIDS Initiative. Nonetheless, activists and others urge that more be done, given the scale of the African pandemic.

MOST RECENT DEVELOPMENTS

In late January 2006, the *New England Journal of Medicine* reported that multinational drug firms Gilead and Bristol-Myers Squibb had jointly developed once-daily AIDS treatments, seen as likely to increase access to and adherence to treatment, notably in poverty-stricken environments such as Africa. On January 12, 2006, former President Bill Clinton announced that his Clinton Foundation HIV/AIDS Initiative (CHAI) had negotiated new agreements to lower prices of WHO-evaluated HIV tests by 50% and for two antiretroviral drugs by 30%. These will be made available to the CHAI Procurement Consortium, a group of countries eligible to make purchases under CHAI agreements. It includes 50 developing countries. The Global Steering Committee, a new international effort to provide universal AIDS treatment access by 2010, was launched in Washington on January 10, 2006. The effort, spurred by recent U.N. General Assembly requests and G8 commitments, is intended as an attempt to overcome key challenges to global AIDS responses, such as sustainable financing and health care delivery system constraints, the need for development and distribution of low-cost drugs and tests, and AIDS-related stigma and social discrimination.

Events marking World AIDS Day, originated by the World Health Organization in 1988 to increase awareness about AIDS, were held on December 1, 2005. President Bush marked it by launching a new component of his President's Emergency Plan for AIDS Relief, the New Partners Initiative, described as an effort to identify and provide U.S. competitive grant-based support to "new partners," including faith-based and community health care organizations that are active in the developing world but lack experience in working with the U.S. government. At the 14th International Conference on AIDS and Sexually Transmitted Infections in Africa (ICASA), held in Nigeria in early December, UNAIDS director Dr. Peter Piot said that AIDS remains an uncontained, "acute threat to future generations" and called for "urgent and sustained action" to increase access to HIV prevention and treatment services in Africa. At ICASA, World Health Organization (WHO) head Jim Yong Kim praised the use of public health approaches in scaling-up access to AIDS drugs. He endorsed the use of simple, uniform fixed-dose drug regimens; drug distribution and use monitoring by nurses and community workers using simple clinical tools; and the participation of HIV-affected individuals and communities in program AIDS design and delivery. The Assistance for Orphans and Other Vulnerable Children in Developing Countries Act of 2005 (P.L. 109-95) was signed into law on November 8, 2005. On September 6, 2005, at a pledging conference in London, governments promised $3.7 billion to the Global Fund to Fight AIDS, Tuberculosis, and Malaria in 2006 and 2007. This amount would adequately fund renewals of existing Global Fund grants but not new grants. The U.S. pledged $600 million for the two years. For further information on AIDS, see CRS Report RS21181, *HIV/AIDS International Programs: Appropriations, FY2003-FY2006* and CRS Report RL31712, *The Global Fund to Fight AIDS, Tuberculosis, and Malaria: Background and Current Issues*.

BACKGROUND AND ANALYSIS

Sub-Saharan Africa ("Africa" hereafter) has been far more severely affected by AIDS than any other world region. In December 2005, UNAIDS (Joint United Nations Program on HIV/AIDS) reported that in 2005, 25.8 million adults and children were living with HIV and

AIDS in Africa, including 3.2 million newly infected during the year. Africa has about 1.15% of the world's population but approximately 64% of the global HIV-positive population. The infection rate among adults averages an estimated 7.2% in Africa, compared with 1.1% worldwide. According to UNAIDS estimates, about 27.7 million Africans will have died of AIDS since the beginning of the epidemic, including an estimated 3.1 million expected to die by the end of 2005. UNAIDS has projected that between 2000 and 2020, 55 million Africans will likely lose their lives to AIDS. AIDS has surpassed malaria as the leading cause of death in Africa, and kills many times more people than Africa's armed conflicts.

Table 1. African 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	Burkina Faso	4.2	Benin	1.9
Zimbabwe	24.6	Cameroon	6.9	Dem. Rep. of Congo	4.2	Mali	1.9
South Africa	21.5	Kenya	6.7	Togo	4.1	Madagascar	1.7
Namibia	21.3	Burundi	6	Uganda	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	0.8
Cent. Afr. Rep.	13.5	Rwanda	5.1	Ghana	3.1	Mauritania	0.6
Mozambique	12.2	Congo	4.9	Djibouti	2.9		

Source: UNAIDS, *Report on the Global AIDS Epidemic*, July 2004 [biannual country-specific HIV prevalence report]. Data were lacking for Cape Verde, Comoros, Equatorial Guinea, Guinea-Bissau, Mauritania, Sierra Leone, or Somalia.

Characteristics of the African Epidemic

Transmission. HIV, the human immunodeficiency virus that causes AIDS, is spread in Africa primarily by heterosexual contact, though some believe that the influence of unsafe medical practices in the spread of HIV may have been underestimated. Others, however, believe that sexual transmission remains the major mode of spread in Africa. Despite such debates, many experts believe that a range of blood exposure infections other than through sex are important factors in HIV infection in Africa. The prevention of the medical HIV transmission is a component of the President's Emergency Plan for AIDS Relief (PEPFAR).

Women. About 13.5 million HIV-positive women live in Africa. They comprise an estimated 57% of infected adults in Africa, compared with 46% globally. Young women are notably at risk. In 2005, an estimated 4.6% of African women aged 15 to 24 were HIV-positive, compared with 1.7% of young men. These figures had dropped from 6.9% and 2.2%, respectively, in 2004 (UNAIDS, *AIDS Epidemic Updates, December 2005/ 2004).*

Prevalence Trends. UNAIDS reports that Africa's adult HIV infection rate, or prevalence, has stabilized in recent years, as both the total adult and infected populations increase. Stabilization means that numbers dying approximate the numbers of newly infected. HIV has become endemic in many countries and at a minimum will affect several future generations. Prevalence is still increasing in Madagascar, Swaziland, and a few other countries, while there have been declines in Uganda and localized areas in certain countries.

Highest Rates. Southern Africa, where nine countries have adult infection rates above 10% (**Table 1)**, is the most severely affected region. With 1.68% of the world's population, these countries account for nearly 30% of infected people worldwide and 45% of those in Africa. However, populous Nigeria in West Africa, with an estimated 5.4% adult infection rate, has an estimated 3.6 million infected people — the largest number in Africa apart from South Africa, where UNAIDS estimates that 5.3 million are infected. South Africa has the largest infected population in the world. In January 2006, while visiting Nigeria, First Lady Laura Bush announced that in 2006 the United States would commit to Nigeria $163 million in PEPFAR funds for AIDS treatment and prevention.

Children. Africa's AIDS epidemic has a proportionally much greater effect on children than is the case in other world regions. According to UNAIDS, over 600,000 African infants become infected yearly with HIV through mother-to-child transmission, either at birth or through breast-feeding. Most die before the age of two. Nonetheless, an estimated 1.9 million African children under age 14 were living with AIDS in late 2003.

Orphans. In 2003, there were about 12.3 million AIDS orphans (children 17 and under who had lost one or both parents to HIV) in Africa. They made up 28.3% of all orphans. By 2010, t heir number is forecast to rise to 18.4 million, or 36.8% of all orphans.[1] Because of stigma attached to AIDS, HIV-positive orphans are at high risk for malnourishment, abuse, and denial of education. UNICEF has recommended that the capacity of families and communities to protect and care for orphans be strengthened, that social and state protection services be provided for orphans and vulnerable children (OVCs), and that public education about HIV-affected children be increased. In October 2005, Human Rights Watch alleged in a report that African governments have largely not addressed the myriad barriers to education faced by AIDS- affected OVCs. The Assistance for Orphans and Other Vulnerable Children in Developing Countries Act of 2005 (P.L. 109-95) became law in November 2005. It authorizes U.S. assistance for basic care for orphans and vulnerable children in developing countries, including aid for community-based care, school food programs, education and employment training, psycho-social support, protection of inheritance rights, and AIDS care.

Explaining the African Epidemic

AIDS experts attribute Africa's AIDS epidemic to a variety of economic and social factors, but place 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 often have limited capabilities for AIDS prevention work, and HIV counseling and testing are difficult for many Africans to obtain. Until very recently, AIDS treatment was generally available only to elites.

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[1] UNAIDS/UNICEF/U.S. Agency for International Development, *Children on the Brink*, July 2004. Estimates vary; in November 2003, UNICEF predicted that 20 million children would be orphaned by AIDS by 2010 and that in a dozen countries orphans from all causes would make up 15% to over 25% of children under 15; see *Africa's Orphaned Generations*.

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 also seen as key agents in spreading HIV. Meanwhile, poverty forces many women to turn to "transactional sex" in order to survive, greatly increasing their chance of contracting AIDS.

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 of 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 political and socio-economic power, 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). An August 2003 Human Rights Watch study 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.

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 at 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. Under mounting domestic and international pressure, the South African government seemed to modify its position significantly when the government announced after an April 2002 cabinet meeting that it would triple the national AIDS budget. When a treatment program had not been launched by March 2003, however, the South African Treatment Action Campaign (TAC) launched a civil disobedience campaign. In August 2003, the South African cabinet instructed the health ministry to develop a plan to provide antiretroviral therapy nationwide, but by March 2004, TAC was threatening a lawsuit unless the program was actually begun. Finally, in April 2004, the government began offering treatment at 5 hospitals in populous and highly urbanized Gauteng province. TAC reported in February 2005 that about 70,000 South Africans were receiving treatment, but of these only 27,000 were being treated through the public program; the remainder were under private care. An estimated 500,000 South Africans are in need of treatment.

The delays in South Africa's response to the pandemic have been costly, many experts believe. Survey data released in September 2004 by South Africa's Health Department

indicated that HIV infection rates were continuing to increase, though at a slightly slower rate than in previous years. Approximately 27.9% of pregnant women in South Africa were found to be HIV positive in 2003, up from 26.5% in 2002. The Health Department estimated that 5.6 million South Africans were infected. A September 2004 report by the Bureau of Market Research at the University of South Africa predicted that AIDS-related deaths would exceed 500,000 yearly from 2007 to 2011. Nonetheless, South Africa's Health Minister Manto Tshabalala Msimang continues to question the effectiveness of antiretroviral drugs and to insist that healthy diets and special foods, such as raw garlic and lemon peel, can offer protection from the disease (*Mail and Guardian Online*, May 5, 2005). Former President Nelson Mandela, seeking to combat the stigma associated with AIDS, announced in January 2005, that his son, Makgatho, had died of AIDS. The lower rate of growth in infections reported may be continuing; a November 2005 South African Human Sciences Research Council survey data release stated that South Africa's AIDS epidemic may be "levelling off."

In the rest of Africa, many heads of state, including the presidents of Uganda, Botswana, Nigeria, and several other countries, are taking major roles in fighting the epidemic. 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 regional fund to fight the disease. The New Partnership For Africa's Development (NEPAD), in partnership with the African Union, UNAIDS, and other multinational entities, has formulated a range of strategies for countering AIDS, though the products of these efforts appear to be limited at present.

Uganda's president, Yoweri Museveni, has long been recognized for leading a successful prevention campaign against AIDS in Uganda, where the ABC (Abstinence, Be Faithful, or Use Condoms) transmission prevention program has won wide praise. A Senate Foreign Relations Africa Subcommittee hearing in May 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 prevalence declines. Sophia Mukasa Monico, a member of the Global Health Council and a former AIDS worker in Uganda, testified that all three program elements are necessary for prevention to work but noted that the Ugandan epidemic was still "raging"and that much work to counter it remained to be done.

In February 2005, Johns Hopkins and Columbia University researchers released a study of Rakai, Uganda reporting that a local HIV prevalence decline was due to condom use and the deaths of infected people (see Maria Wawer, R. Gray, et al., "Declines in HIV Prevalence in Uganda: Not as Simple as ABC," *12th Conference on Retroviruses and Opportunistic Infections*, Boston). Abstinence and monogamy appeared not to be increasing. Some saw this as evidence that sexual behavior change programs were less important than expected. Others argued that behavior had likely changed substantially prior to the study. In July 2005, First Lady Laura Bush, speaking in South Africa during a trip to Africa that included visits with AIDS patients and orphans, said that the Uganda-developed ABC model was "successful" and added that "ABC stands for Abstinence, Be faithful, and correct and consistent use of Condoms." Conflicting reports appeared in late summer 2005 regarding a shortage of condoms in Uganda for preventing HIV. Some AIDS activists and others blamed the alleged shortage on an emphasis on abstinence in U.S.-funded AIDS prevention programs and a

change in policy by Ugandan government officials, who denied a shortage existed. A U.S. official attributed the problem to a shipment of defective condoms.[2]

Social and Economic Consequences

AIDS is having severe negative social and economic consequences in Africa, and these effects are expected to continue for many years, as suggested by a January 2000 Central Intelligence Agency National Intelligence Estimate on the infectious disease threats:

> At least some of the hardest-hit countries, initially in 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.cia.gov/]).

The estimate predicted that AIDS would generate increased political instability and slow democratic development. The World Bank (*Intensifying Action Against HIV/AIDS in Africa*, September 1999) has reached similar conclusions with respect to Africa's economic future:

> 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.

In the most severely affected countries, sharp drops in life expectancy are occurring, reversing major gains achieved in recent decades. According to UNAIDS, average life expectancy in Africa is now 47 years due to AIDS, whereas it would have been 62 years in its absence. A March 2004 U.S. Census Bureau report predicted absolute population declines by 2010 in South Africa, Botswana, and three other African countries due to AIDS.

Rural Livelihoods. Studies show that AIDS has devastating effects on rural families. The father is often the first to fall ill, and when this occurs, farm tools and animals may be sold to pay for his care, frequently leading to rapid impoverishment of often already poor families. Should the mother also become ill, children may be forced to shoulder responsibility for the full time care of their parents, farmsteads, and often of themselves, despite their frequently limited knowledge about how to carry out farm and domestic work. Many also become orphans. The U.N. Food and Agriculture Organization reported that since 1985, about 7 million agricultural workers have died in the 25 hardest-hit countries in Africa and could kill 16 million more before 2020, or about 18.9%, and as much as 26% of their agricultural workforces (FAO, *HIV/AIDS, Food Security, and Rural Livelihoods*, 2001).

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[2] "Condom Demand Rises," *New Vision* (Uganda), Sept. 6, 2005; "The Missing Condoms," *New York Times*, Sept. 4, 2005; "U.S. Denies Driving Uganda from Condom Use," *The Monitor* (Uganda), Sept. 1, 2005.

Some experts attribute serious food shortages in southern Africa in 2002 and 2003 to AIDS-related production losses (e.g., see FAO, HIV/AIDS and the Food Crisis in Sub-Saharan Africa, ARC/04/INF/8, March 2004). In February 2003, in separate testimony before the Senate Foreign Relations Committee and the House International Relations Committee, World Food Program (WFP) Executive Director James Morris said that AIDS was a central cause of the famine. In June 2004, Morris said that southern Africa was in a "death spiral" due to the effects 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). The FAO supports many programs to alleviate the diverse threats that AIDS poses to agricultural production and food security; see [http://www.fao.org/hivaids].

Workforce Depletion. AIDS is blamed, in part, for increasing shortages of skilled workers and teachers in several countries and is claiming many African lives at middle and upper levels of public and private sector management. Although unemployment is generally high in Africa, trained personnel are not readily replaced. Dr. Peter Piot, UNAIDS Executive Director, told a June 2, 2005, special U.N. General Assembly meeting on AIDS that by 2006, 11 sub-Saharan countries will have lost 10% of their workforce to the disease. A May 2002 World Bank study, *Education and HIV/AIDS: A Window of Hope,* reported that over 30% of teachers are HIV positive in parts of Malawi and Uganda, 20% in Zambia, and 12% in South Africa. Reports from diverse sources have since continued to mirror such findings.

Security. AIDS may have serious security consequences for much of Africa, since HIV infection rates in many militaries are reportedly 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, because South African soldiers are expected to play an important peacekeeping role in Africa in the years ahead. The infection rate in South Africa has been estimated at 23%, with higher rates reported for units based in heavily infected KwaZulu-Natal province (for a recent study, see Laurie Garrett, *HIV and National Security: Where are the Links*, Council on Foreign Relations, 2005).

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 (ARVs) 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**).

Anti-AIDS programs and projects 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 youth to delay the age of "sexual debut" and to remain faithful to a single partner. The Bush Administration advocates an expansion of prevention programs focusing on abstinence until marriage and marital faithfulness as effective means of slowing the spread of HIV, although some critics maintain that this may be unrealistic in social environments characterized by poverty and lack of education. Some also question whether such approaches can benefit poor married women in Africa, who have

little power to refuse the sexual demands of their husbands, whether infected or not — or, in some cases, to control their extra-marital activities. They are also often unable to refuse spousal decisions to take more than one wife, given that polygamous marriage is common and deeply embedded in many African societies. In January 2006, First Lady Laura Bush defended abstinence approaches, saying that she had "always been a little bit irritated by criticism of abstinence, because abstinence is absolutely, 100 percent effective in fighting a sexually transmittable disease." She added that "In many countries where girls feel obligated to comply with the wishes of men, girls need to know that abstinence is a choice"(Deborah Orin, "Laura Defends Sex Abstinence," *New York Post*, January 16, 2006).

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 medical visits, and many experts are urging that this be done continent-wide. AIDS awareness programs are found in many African schools and, increasingly, in the workplace, where employers are recognizing their interest in reducing infection rates among their employees. Many projects seek to make condoms readily available and to provide 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 during infant nursing. Many AIDS activists argue that it would be far better to put all infected pregnant women into long-term treatment programs, which would reduce the likelihood that their children would be orphaned.

In December 2004, the Associated Press reported that several flaws had been found in a study of the nevirapine conducted in Uganda under U.S. National Institutes of Health (NIH) sponsorship. According to the report, researchers acknowledged that thousands of bad reactions were not disclosed. The allegations sparked criticism in Africa, including a furious response from the South Africa's ruling Africa National Congress (ANC). In a December 17 statement, the ANC charged that top U.S. officials had "entered into a conspiracy with a pharmaceutical company to tell lies and promote the sales of nevirapine in Africa..." That same day, NIH issued a statement affirming that "single-dose nevirapine is a safe and effective drug for preventing mother to infant transmission of HIV." It termed as "absolutely false" any implication of thousands of adverse reactions in the Uganda study. AIDS activists and others worried that the controversy would discourage use of the drug, often the only available means of preventing mother to child transmission (MTCT) of HIV. The National Academies' Institute of Medicine, after investigating the Uganda study, reported that it was valid and that nevirapine should continue to be used for MTCT.

Church groups and humanitarian organizations have helped Africa deal with the consequences of AIDS by setting up care and education programs for orphans. 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 AIDS vaccine research and diverse AIDS programs pursued 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. In Uganda, Pfizer and the Pfizer Foundation fund Uganda's AIDS Support Organization and the Infectious Diseases Institute. It has trained 250 AIDS specialists annually, many slated to work in rural areas. In

January, the Swiss drug firm Roche said it plans to help African firms produce generic versions of its WHO-endorsed ARV, Saquinavir, under its Technology Transfer Initiative.

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*. Despite these responses, UNAIDS maintains that significant AIDS funding gaps remain. According to a recent study, $14.9 billion will be needed in 2006 to fight HIV/AIDS in low- and middle-income countries globally in 2006, whereas $8.9 billion is likely to be provided. The funding gap is projected to rise in future years (UNAIDS, *Resource Needs for an Expanded Response to AIDS in Low and Middle Income Countries*, June 2005).

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

— Centers for Disease Control (CDC): [http://www.cdc.gov/nchstp/od/nchstp.html]
— Global Fund to Fight AIDS, Tuberculosis & 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 Network: [http://www.kaisernetwork.org]; click “HIV Daily Reports”
— UNAIDS: [http://www.unaids.org/en/default.asp]
— USAID: [http://www.usaid.gov/our_work/global_health/aids/index.html]
— World Bank: [http://www.worldbank.org]; click “Topics >> AIDS”

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; 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 sexual behavior patterns among young urbanites in some other countries may be changing in ways that combat the spread of HIV, although increases among populations continue in many African cities. 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 contend that there are multiple social 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 public education and outreach efforts as essential components of the response to the epidemic. Indeed, there is strong support for an intensification of such efforts, as well as adaptations to make them more effective.

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 often accompany AIDS. Millions of Africans suffer dual infections of HIV and tuberculosis (TB), and their combined effects dramatically shorten life. TB can be cured by combined drug treatments over several months, even in HIV-infected patients. However, according to the World Health Organization (WHO), Africans often delay seeking treatment for TB or do not complete their drug regimens (*Global Tuberculosis Control: WHO Report 1999*, Key Findings), contributing to high death rates among those with dual infections. UNAIDS and the World Health organization have recommended 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. The Pfizer Corporation donates the anti-fungal Diflucan (fluconazole), used to treat AIDS-related opportunistic infections, such as cryptococcal meningitis, a dangerous brain inflammation, to patients in 18 African countries through the Pfizer Diflucan Partnership Program (DPP). DPP is a public-private effort in collaboration with health ministries, local clinics, and non-governmental organizations. In partnership with the International Association for Physicians in AIDS Care, Pfizer also supports education and training for health care providers in diagnosis and management of opportunistic infections.

AIDS Antiretroviral Treatment Issues

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

The high cost of HAART treatments has been the principal obstacle to a large scaling-up of access to therapy 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. In May 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 pharmaceutical firms 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. Initiatives to expand the availability of HAART continued, and treatment became a major focus of Global Fund and President's Emergency Plan for AIDS Relief (PEPFAR; see below) programs. In December 2003, the WHO formally launched its $5.5 billion "3 by 5" plan to treat 3 million AIDS patients in poor countries by 2005, with resources to come from the Global Fund and donors. Leaders of the G8, concluding their summit in Scotland on July 8, 2005, promised "a package for HIV prevention, treatment, and care, with the aim as close as possible to universal access to treatment for all those who need it by 2010."

In October 2003, former President Bill Clinton announced that his Clinton Foundation had organized a program to provide generic three-drug ARV treatment for AIDS patients in Africa and the Caribbean for about $.38 per day. Generic drug manufacturers in India and

South Africa would make the drugs, and funding would come from private donors, some donor governments, and other sources. In April 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 ARV scaling up efforts, an estimated 500,000 sub-Saharan patients were receiving HAART in June 2005, up from 150,000 one year earlier (World Health Organization, *"3 by 5" Progress Report*, December 2004, and *Progress on Global Access to HIV Antiretroviral Therapy, an Update on "3 by 5,"* June 2005). However, an estimated 4 million Africans remain in need of HAART. On April 11, 2005, former President Clinton announced a Clinton Foundation pediatric AIDS program intended to put 10,000 HIV-positive children on ARV therapy in at least 10 countries in 2005, thus doubling the number of children in treatment. In addition to its drug buying agreements, CHAI helps countries to implement large-scale, integrated care, treatment, and prevention programs. Partner governments take the lead, and CHAI provides technical aid, mobilizes human and financial resources, and promotes sharing of best practices.

Dr. Jim Yong Kim, head of the WHO AIDS programs, said in February 2005 that the 3 by 5 campaign was struggling to attain its goal ("Global AIDS Effort Still Short of Goal," *Boston Globe*, February 23, 2005). In Africa, Botswana and Uganda would likely meet their targets, but South Africa and Nigeria were lagging. South Africa's Health Minister, Tshabalala-Msimang, said in May that some were trying to "scapegoat" South Africa for the failure of 3 by 5 and that South Africa could not do a blanket rollout of ARV drugs because patients had to be closely monitored due to side effects produced by ARVs. She added that she would continue to inform patients that they had three options: improve their nutrition, take micronutrients, or enroll in an ARV program (*Mail and Guardian Online*, May 5, 2005).

Whether African countries are ready to "absorb" (effectively use) 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 Africa. 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 African patients reportedly follow their AIDS therapy regimens equally or more consistently than many American patients ("Africans Outdo U.S. Patients In Following AIDS Therapy," *New York Times*, September 3, 2003). For some, the correct response to weaknesses in Africa's basic health care systems is to devote resources to strengthening those systems (Holly Burkhalter, "Misplaced Help in the AIDS Fight," *Washington Post* op-ed, May 25, 2004).

Botswana's President Mogae told a November 2003 meeting, held 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, or the general draw of developed country job markets. The health minister of Mozambique, which has launched a pilot ARV drug treatment program, said in May 2004 that the country was unable to launch a nationwide program because of serious shortages of staff and equipment. The Harvard-based Joint Learning Initiative on Human Resources for Health and Development issued a report

in November 2004 finding that Africa had the lowest ratio of health workers to population of any region. At least one million new workers are needed, according to the report. In December 2004, Britain announced that it would provide $100 million to boost salaries of health workers in Malawi and increase the number of medical staff being trained.

AIDS activists have urged that African governments issue "compulsory licenses" to allow the manufacture or importation of inexpensive copies of patented AIDS drugs ("generic drugs"). 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) 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 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, fund medical research. Others, however, maintained that the declaration would have little practical impact; in their view, poverty, rather than patents, is the key 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). In August 2003, the WTO reached agreement on a plan to allow poor countries to import generic copies of essential drugs, but the debate over access to ARVs in Africa seems likely to continue. In March 2005, India's parliament passed patent legislation expected to sharply raise prices in Africa and elsewhere for Indian-manufactured generic copies of newly discovered AIDS medications. Cheap generic copies of existing drugs can still be sold, although sellers will have to pay licensing fees to patent holders.

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 (see Barton Gellman, "The Global Response to AIDS in Africa: World Shunned Signs of Coming Plague," *Washington Post*, July 5, 2000, and 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, 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 asserted in 2001 that its support of multilateral efforts and direct sponsorship of regional and bilateral programs had made it the global leader in the international response to AIDS since 1986, when it initiated AIDS prevention programs in developing countries (USAID, *Leading the Way: USAID Responds to HIV/AIDS*, September 2001). USAID had sponsored AIDS education programs; trained AIDS educators, counselors, and clinicians; supported condom distribution; and sponsored AIDS research. USAID claimed several successes in Africa. These included helping to reduce HIV prevalence among young Ugandans; preventing 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 having spent a total of $51 million on fighting AIDS in Africa in FY1998 and $63 million in FY1999 (*Leading the Way*, p. 121). In addition, some spending by the Health and Human Services Department supported HIV surveillance and other AIDS-related efforts in Africa.

Bush Administration

Combating the AIDS pandemic in Africa has been an important Bush Administration foreign assistance program goal. In May 2001, President Bush made the "founding pledge" of $200 million to the Global Fund, and in June 2002, he announced a $500 million International Mother and Child HIV Prevention Initiative to support efforts to prevent mother-to-child AIDS transmission. Eight African countries were named as beneficiaries. In his January 2003 State of the Union address, President Bush announced the launching of the President's Emergency Plan for AIDS Relief (PEPFAR), pledging $15 billion for fiscal years 2004 through 2008, including $10 billion in "new money," that is, spending in addition to then current levels. In February 2004, the State Department issued a report [http://www.state.gov/s/gac/rl/or/c11652.htm] providing details on the PEPFAR initiative, as well as plans to release initial PEPFAR funds for several "public-private partnership" treatment programs. PEPFAR aims to prevent 7 million new infections globally, provide ARV drugs for 2 million infected people, and provide care for 10 million infected people, including orphans. PEPFAR is resulting in major spending increases for HIV/AIDS prevention, care, and treatment in 15 "focus countries," 12 in Africa (Botswana, Cote d'Ivoire, Ethiopia, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, and Zambia). The new funds are being provided through the Global HIV/AIDS Initiative (GHAI), headquartered at the State Department. The GHAI is headed by the U.S. Global AIDS Coordinator, Randall Tobias, who coordinates not only the GHAI programs in focus countries but also the international AIDS programs of USAID and other agencies.

President Bush made AIDS a special focus of his five-day trip to Africa in July 2003. On July 8, in Senegal, the President told Africans, "we will join with you in turning the tide against AIDS in Africa." On July 10, speaking in Botswana, the President said that, "this is the deadliest enemy Africa has ever faced, and you will not face this epidemic alone." In September 2003, then Secretary of State Colin 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 started slowly 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, especially the Global Fund. Some question 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 go primarily to U.S.-based organizations. U.N. Secretary General Kofi Annan, during an interview at the July 2004 international AIDS conference in Bangkok, urged U.S. contributions of $1 billion annually for the Global Fund. U.S. Global AIDS Coordinator Randall Tobias responded by stating that "It's not going to happen" (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."

Senator Frist introduced a bill (S. 850) on April 19, 2005, to authorize a Global Health Corps that would send U.S. health volunteers abroad and expand the availability of health care personnel, items, and related services. That same day, the National Academies' Institute of Medicine (IOM) released a report calling for a U.S. Global Health Service to mobilize health personnel to work in the 15 PEPFAR focus countries. An initial deployment of 150 key professionals would be paid full salary; others would receive $35,000 fellowships and student loan repayments up to $25,000. Some suggested that funds might better be spent training and retaining indigenous health personnel, particularly in Africa; others noted that training was a key part of the IOM proposal, which they praised as a dynamic response to the AIDS crisis.

Treatment. The *Financial Times* reported in April 2004 that the United States was withholding support from a program intended to treat 140,000 AIDS patients in Kenya with antiretrovirals because it would rely on a generic three-drug combination (FDC) pill. Many favor approval of FDCs, including copies of drugs made 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 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 later wrote to President Bush asking that the United States join an international consensus that generics are safe and essential for AIDS treatment. In May 2004, then-Health and Human Services Secretary Tommy Thompson announced that the U.S. Food and Drug Administration (FDA) was instituting an expedited process that could lead to the approval of the use of FDCs in PEPFAR-funded programs . Many hailed the news 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. By June 2005, the FDA had reportedly cleared seven generic anti-retrovirals manufactured in South Africa and India. However, the *Boston Globe* reported on June 20 that four African countries, Nigeria, Uganda, Ethiopia, and

Tanzania, were refusing to accept generic FDA-approved drugs for use in U.S.-funded treatment programs. Instead, the countries sought approval of the drugs by WHO.

In March 2005, the Department of State released *Engendering Bold Leadership: The President's Emergency Plan for AIDS Relief*, the first annual report to Congress on the initiative. In an introductory letter to the report, Randall Tobias called PEPFAR "coordinated, accountable, and powerful." The report stated that 152,000 African patients were receiving AIDS treatment due to PEPFAR and that 119 million had been reached with mass media campaigns promoting abstinence and faithfulness, while 71 million had been reached with messages promoting other prevention measures, including the use of condoms. Critics have charged that funding for PEPFAR abstinence programs, notably in Africa, have increasingly replaced other HIV prevention measures and that the United States is today sending fewer condoms abroad than in 1990 (Center for Health and Gender Equity, *Prevention Funding Under* [PEPFAR]*: Law, Policy and Interpretation*, December 2005).

Spending. **Table 2** reports available information on recent U.S. spending levels on AIDS programs in Africa. Under the FY2006 request, GHAI assistance to the 12 focus countries in Africa would grow by 54% to just over $1.2 billion, or 61% or the total GHAI request. Prior to the launching of PEPFAR, the principal channels for HIV/AIDS assistance to Africa were USAID and the Global AIDS Program (GAP) of the Centers for Disease Control (CDC) in the Health and Human Services Department. The drop in USAID funding in Table 2 from FY2004 to FY2005 results from the shift in funds in the 12 GHAI focus countries in Africa to the Office of the Global AIDS Coordinator at the State Department. This was done to simplify the budget, enhance transparency, and stress the President's interest in fighting AIDS. Most USAID spending on AIDS in Africa is through the Child Survival and Health Programs Fund, but limited amounts are provided through the Economic Support Fund. Information on GAP spending in Africa for FY2004 and subsequent years is not yet available (NA) due to a change in budget structure at the Department of Health and Human Services. The Department of Defense (DOD) has undertaken an HIV/AIDS education program primarily with African armed forces. As in other recent years, the Administration has not requested funding for this program in FY2006, but in FY2005 Congress continued to support it by appropriating $7.5 million. Funds from the Foreign Military Financing (FMF) program are also used to support this initiative. A Department of Labor (DOL) program supports AIDS education in the workplace in four sub-Saharan countries. (For details, see CRS Report RS21181, *HIV/AIDS International Programs: Appropriations, FY2003-FY2006*). Additional U.S. funds reach Africa indirectly through the AIDS programs of the United Nations (U.N.), the World Bank, and the Global Fund.

The scale of the response to the pandemic in Africa by the United States and other donors remains a subject of intense debate. The U.N. Special Envoy for HIV/AIDS in Africa, Stephen Lewis, has been a persistent critic, telling a September 2003 conference on AIDS in Africa that he was "enraged by the behavior of the rich powers" with respect to the epidemic. Many activist groups have made similar critiques. The singer Bono said he had a "good old row" with President Bush in a September 2003 meeting on the level of U.S. funding for fighting the international AIDS epidemic. Nonetheless, as noted above, others have argued that Africa's ability to absorb increased AIDS funding is limited and that health infrastructure will have to be expanded before new funds can be spent effectively.

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

	FY2000	FY2001	FY2002	FY2003	FY2004 Est.	FY2005 Est.	FY2006 Request*
USAID	109	144	183	320	234.0	82.3	82.4
CDC (GAP)	30	77	84	107	15.0	14.8	14.8 est.
GHAI (State)	-	-	-	-	263.8	781.5	1,206.3
DOD	0	5	14	7	4.2	7.5	0
FMF	0	0	0	2	1.5	2.0	2.0
DOL	0	3	6	5	2.1	0	0
Total	**139**	**229**	**287**	**441**	**520.6**	**888.1**	**1,303.5**

* The Administration is currently making AIDS funding allocation decisions following enactment into law of P.L. 109-102, the FY2006 Foreign Operations FY2006 Appropriation.

Legislative Action, 2000-2004

In August 2000, the Global AIDS and Tuberculosis Relief Act of 2000 (P.L. 106-264) became law. It authorized funding for FY2001 and FY2002 for a comprehensive, coordinated, worldwide HIV/AIDS effort under USAID. In the 107th Congress, several 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*). 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 PEPFAR 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, FY2003-FY2006.*

Legislation in the 109th Congress

H.R. 1409 (Lee), the Assistance for Orphans and Other Vulnerable Children in Developing Countries Act of 2005, which was related to S. 350 (Lugar), was signed into law as P.L. 109-95. H.R. 3057 (Kolbe), the FY2006 Foreign Operations FY2006 Appropriation, contains significant AIDS funding. It was signed into law as P.L. 109-102. H.R. 3010, the Health and Human Services FY2006 Appropriations bill, which also contains substantial funding for international HIV/AIDS, was signed into law as P.L. 109-149. Bills introduced in the 109th Congress, with provisions related to the African AIDS pandemic, include the following: H.R. 155 (Millender-McDonald), Mother to Child Plus Appropriations Act for Fiscal Year 2005; H.R. 164 (Millender McDonald), International Pediatric HIV/AIDS Network Act of 2005; and S. 850 (Frist), Global Health Corps Act of 2005.