

DEBUNKING THE MYTHS IN THE U.S.
GLOBAL AIDS STRATEGY:
AN EVIDENCE-BASED ANALYSIS

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I. INTRODUCTION

On February 24, 2004, the State Department Office of the Global AIDS Coordinator released the *President's Emergency Plan for AIDS Relief: U.S. Five-Year Global HIV/AIDS Strategy* (referred to throughout this paper as “the Strategy”). Development of the Strategy was mandated by the *United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003* (Global AIDS Act 2003). (For a review of the legal and policy framework of the Global AIDS Act 2003, see *A Critical Review of the U.S. Leadership Against HIV/AIDS, Tuberculosis and Malaria Act: Implications for Women's Health and Human Rights*, Center for Health and Gender Equity, forthcoming March 2004.) The Strategy serves as the primary blueprint for spending billions of dollars of U.S. funds to prevent 7 million new HIV infections; treat 2 million people with HIV; and care for 10 million HIV-positive children orphaned by AIDS over five years.¹

A. WHAT IS THE U.S. GLOBAL HIV/AIDS STRATEGY AND WHY IS IT IMPORTANT?

Release of the Strategy was long anticipated for several reasons. First, it is the central policy document interpreting provisions of the Global AIDS Act 2003, and as such provides the first glimpse of how the Administration defines its operational priorities, policies, and programs and how these will guide global AIDS funding. Second, under the Bush Administration, HIV/AIDS prevention and treatment debates in the United States—regarding both domestic and international issues—have been driven by conflicts between political and fundamentalist religious ideologies and evidence-based responses to a global epidemic of HIV infections largely spread by unprotected sex. The Strategy therefore reveals whether and

¹ In his January 2003 State of the Union Address, President George W. Bush announced a major new initiative on global AIDS, declaring the plan “a work of mercy beyond all current international efforts....” In the speech, he committed to spending at least \$15 billion over five years on an “Emergency Plan for AIDS Relief” in 14 countries of Africa and the Caribbean. In May of that year, Congress passed the Global AIDS Act 2003, giving both the President and Congress the authority to spend \$15 billion and enacting the legal and policy framework for U.S. global AIDS efforts. In January 2004, Congress appropriated \$2.4 billion dollars for global AIDS.

how the Administration will act on available scientific, medical, and public health evidence on HIV/AIDS, and the degree to which ideology takes precedence over science. Finally, because the Strategy was developed through a closed process and did not include participation of key stakeholders in the global AIDS policy debate, the Strategy document is the first opportunity to engage the Administration on the details of its plans.

The Strategy outlines a series of priorities for action on prevention, treatment, care, and on funding mechanisms and other key issues as required by the authorizing legislation. In brief, the Strategy outlines the following programmatic priorities (for further details see Appendix, Boxes 1-4):

- Promoting HIV prevention through a focus on “abstinence and behavior change for youth,” and for providing condoms “as appropriate” to “high-risk” populations.
- Expanding access to treatment through rapid scale-up of existing clinical efforts and health care worker recruitment and training.
- Expanding palliative care through integrated & expanded services, and public-private partnership.
- Expanding care for orphans and vulnerable children through supported family and community responses and through faith-based organizations and public-private partnerships.
- Developing multi-lateral and bi-lateral approaches to global AIDS efforts.

B. PURPOSE OF THIS ANALYSIS

Today, women and girls represent the majority of those infected with HIV worldwide and two-thirds of those in sub-Saharan Africa.² In many countries in Africa and South Asia, new infections are rising most rapidly among married women and adolescent girls, as well as among those sub-populations, including sex workers and men who have sex with men, who face the highest levels of social marginalization due to widespread stigma and discrimination.

² UNAIDS 2003.

The Center for Health and Gender Equity (CHANGE) is a U.S.-based organization working to advance sexual and reproductive health and rights within U.S. international policy. We conduct research and policy analysis on issues related to health and rights in Africa, Asia, and Latin America, monitor the effects of U.S. policies and funding streams on women and girls on the ground in several countries, and conduct public education and evidence-based advocacy to inform policymakers and key constituencies of the most effective approaches to meeting the needs of vulnerable populations. We focus primarily on the effects of U.S. policies on access to basic sexual and reproductive health services, such as HIV prevention and family planning; on U.S. responses to gender violence and sexual coercion, especially as these relate to high rates of unintended pregnancy, HIV infection and other adverse outcomes; and on U.S. support for the economic and social empowerment of women, girls, and vulnerable sub-populations. We are therefore deeply concerned with both the content of and the conditions placed on U.S. global AIDS programs and funding streams.

In this analysis, we review the Strategy in relation to available evidence. For example, the Strategy emphasizes that policy decisions will be “evidence-based,” by declaring that:

We will make policy decisions that are evidence-based. We will build on the best practices established in the fight against HIV/AIDS and bring the resources of sound science to bear in selecting and developing interventions that achieve real results. (p. 8)

The Strategy further asserts that programs will be:

Implement[ed] [and] coordinated with the policies and strategies of host governments and...responsive to local needs. Countries and communities are at different stages of HIV/AIDS response and have unique drivers of HIV, distinctive social and cultural patterns (particularly with regard to the status of women), and different political and economic conditions. Effective interventions must be informed by local circumstances and coordinated with local efforts. The U.S. Global AIDS Coordinator will provide the strategic direction, the “what” for USG programs. Each U.S. Chief of Mission will lead a coordinated U.S. Government country team to identify the “how,” through program implementation that is directed by a USG country plan, responsive to local needs and circumstances, and coordinated with the host government’s national HIV/AIDS strategy. (p. 8)

Our objectives in analyzing U.S. Global AIDS strategies are to evaluate the degree to which the Administration’s Strategy fulfills its own stated objectives and to identify existing gaps in efforts to address those at risk of infection and those living with HIV/AIDS. We do so by asking the following questions:

- What is the U.S. Global HIV/AIDS Strategy as articulated by the Five-Year Plan released by the Global AIDS Coordinator?
- Are the strategies proposed for prevention and treatment based on the best available evidence? Do they indeed provide clear and objective strategic direction for the “what” of programs, and allow local conditions and needs to determine the “how?”
- Do the approaches outlined in the document address the needs of those most vulnerable, including women and girls and other vulnerable populations? Do they promote equitable access to information, technologies, and life-saving drugs?

Throughout this analysis, we review the core assumptions made in the Strategy document, focusing for now on the sections addressing prevention, treatment, and funding mechanisms. Data and evidence used in the critique by CHANGE are referenced throughout and draw from a range of scientific and public health literature, including scientific journals and evidence collected and disseminated by the Centers for Disease Control, UNAIDS, the Demographic and Health Surveys, and elsewhere.

We hope this analysis will be useful on several levels. First, to inform our colleagues in the public health and human rights communities, as well as policymakers, the media, and other concerned constituencies—including those in priority countries of the U.S. global AIDS policy—of both the framework for and the implications of the Strategy. Second, we hope to inform the evolution of the policy itself. Ambassador Randall Tobias, the U.S. Global AIDS Coordinator has repeatedly said that this policy is a “living document,” and as such will evolve in response to evidence and field experience. Having reviewed both the Strategy and the evidence in depth, we feel that immediate revisions are warranted in several key areas, as articulated below. Third, we hope to assist in the development of measures by which CHANGE and our colleagues in countries receiving U.S.

assistance will monitor implementation of the Global HIV/AIDS Strategy on the ground.

II. THE U.S. GLOBAL STRATEGY ON PREVENTION: A CRITICAL ANALYSIS OF ASSUMPTIONS AND APPROACHES

In this section, we review the evidence on the following: What does the Bush Administration's Strategy say in regard to prevention? What does the public health and related evidence say about who is at greatest risk of HIV infection? How well do the strategies supported by the Administration reflect the evidence, and will they increase the access of all groups and individuals at risk to accurate information, services and training on preventing transmission of HIV?

A. WHAT DOES THE STRATEGY SAY?

In regard to prevention, the Strategy states the following:³

Prevention remains the primary strategy to combat HIV/AIDS. Despite two decades of focused attention on prevention, however, we have yet to achieve widespread success. Inappropriate and inconsistent prevention messages, stigma, gender inequality, poor knowledge of HIV status, limited testing strategies, medical transmission of HIV through unsafe injections and blood supply and HIV transmission from mother to child continue to fuel the spread of HIV. President Bush's Emergency Plan is specifically designed to address these challenges by using evidence-based prevention programs, such as the "ABC" approach of Abstinence, Be faithful, and as appropriate, the correct and consistent use of condoms. (p. 8)

Clearly, HIV/AIDS cannot be defeated unless the number of new infections is dramatically reduced and eventually eliminated. (p. 23)

[T]he Emergency Plan will target prevention funds to methodologies that are effective in helping people avoid behaviors that place them at risk of HIV. (p. 24)

According to the Strategy, the Bush Administration's approach to global AIDS

prevention will focus on two populations identified in the document as though they were two mutually exclusive groups, "youth" and "high-risk." The Strategy repeatedly makes clear that efforts to prevent sexual transmission of infections among youth will focus on the promotion of abstinence-until-marriage, on "secondary abstinence" (for those who are already sexually active), and on messages about "being faithful within marriage." There is no assurance anywhere in the Strategy that U.S. programs will ensure that all individuals and groups at risk will have access to complete HIV prevention information, education, and training (including information on effective use of and access to male and female condoms, training in negotiation skills and frank discussions about sex and sexuality, or alternative means of practicing safer sex, such as through non-penetrative sexual contact). In fact, the Strategy constantly underscores that condoms are only to be made available to and in the 'vicinity of so-called high-risk populations.

A number of assumptions underlie the approach taken by the Bush Administration and are made both explicitly and implicitly throughout the Strategy document. These include the following:

- Unmarried adolescents represent the majority of persons at risk and should be the main target group of the strategy.
- The majority of adolescents in focus countries are not sexually active.
- Adolescents, whether currently sexually active or not, can be persuaded to practice abstinence without failure "until marriage."
- Risk elimination and abstinence-only strategies are the most effective approaches for reducing the spread of HIV infection.
- Marriage is a protective factor against HIV infection.
- "High-risk" groups are easily identified and isolated for the purposes of developing targeted prevention strategies.
- Strategies based on risk reduction, such as increased access to and effective and consistent use of condoms should be targeted only at "high-risk" groups and are not appropriate for other groups such as "youth."

The facts, however, overwhelmingly contradict the assumptions on which the Administration's Strategy is based. Consider the following:

³ Much more is said within the document to elaborate on these themes, but these two paragraphs effectively summarize later points.

B. WHO IS AT RISK?

A large share of unmarried adolescents in the priority countries cited in the U.S. Strategy are already sexually active and therefore at immediate and high risk of infection. Data show that the median age for first sexual encounter among women ages 15 to 24 is approximately 16.6 in Botswana, 19 in Ethiopia, 16.5 in Kenya, 16.6 in Tanzania, 16.6 in Uganda, and 16.8 in Zambia. The median age for first sex among men in the same age group, where data are available, is 22.1 in Ethiopia, 17.1 in Kenya, 16.8 in Tanzania, and 18.3 in Uganda.⁴ (See Appendix, Table 1.) These groups are in immediate need of programs to make accurate and informed choices about remaining sexually active, and to provide the information, skills training, and technologies needed to practice safer sex.

A large share of adolescents in the priority countries marries early and is in fact already married. In many countries with high HIV prevalence rates, average age-at-marriage is rising, but the majority of adolescent girls still marry early. Forty-seven percent of adolescent women are married by age 18 in South and East Africa, 55 percent in West Africa, and 62 percent in Asia.⁵ In many places, child marriage remains highly prevalent. A 1998 survey found that nearly 14 percent of girls between the ages of 10 and 14 in the state of Madhya Pradesh, India were already married. In Ethiopia and parts of West Africa, marriage of girls at ages 7 and 8 is commonplace, and in Kebbi State in northern Nigeria, the average age of marriage for girls is just over 11 years old, while the national average is 17 years of age.⁶ The population of adolescents is therefore highly diverse and includes a large proportion of both unmarried and sexually active adolescents and married, sexually active adolescents.

Increases in age-at-first-intercourse do not keep pace with increased age-at-marriage. Increased access to primary and secondary school and increased opportunities for women's employment all contribute to a rise in age-at-

marriage, which in turn is associated with a decline in overall fertility, improved child survival, economic security and other measures of family and community well-being. However, as age-at-marriage rises, the gaps between age-at-marriage and age of sexual initiation inevitably widen, leaving a large share of the adolescent and young adult population at high risk of infection. While in some settings programs have been successful in fostering delays in sexual initiation for a year or two, no data exist to support the notion that age-at-first sex keeps pace with age-at-marriage. Here again, effective prevention strategies aimed at encouraging delays in sexual initiation alongside efforts to provide the information, skills, and technologies to practice safer sex are essential.

Marriage is not a protective factor against HIV infection for married women and adolescents. In emphasizing "abstinence until marriage," the Strategy makes the critical but erroneous assumption that marriage is a protective factor against HIV infection. This could not be further from the truth. Indeed, as mounting evidence from throughout the world makes clear, it is married monogamous women who are today among the groups at greatest risk of infection. In fact, evidence increasingly indicates that because they often have few rights within marriage, marriage itself may be a key risk factor for HIV among women.

Data increasingly reveal that in many countries, HIV infections are high and rising among married women who are themselves monogamous. For example, an analysis by the United States Census Bureau shows that prevalence rates among women in sub-Saharan Africa peak at around 25 years of age, indicating that the majority of women and girls are contracting HIV *within marriage*.⁷ More than one in five pregnant women are HIV-infected in most countries in Southern Africa. In South Africa there has been a slight decline in HIV prevalence among pregnant teens ages 15-19, but this decline is offset by consistently high rates among pregnant women ages 20 to 24 and rising rates among those ages 25 to 34.⁸

These same patterns are evident in other regions. In Cambodia, a country with the highest HIV prevalence rates in Southeast Asia, prevalence

⁴ All data from the most recent Demographic and Health Survey for each country. Data for Rwanda and Uganda from 2000-01; Zambia from 2001-02; Kenya from 1998; and Tanzania from 1999.

⁵ Cravero 2004.

⁶ UNICEF 2004.

⁷ Stanecki 2002.

⁸ UNAIDS/WHO 2003.

rates among sex workers are dropping, while those among married women are increasing rapidly.⁹ In India, data from the National AIDS Control Organization show that women account for one fourth of all estimated AIDS cases in 2004.¹⁰ In some parts of India, HIV prevalence rates among women attending antenatal clinics have reached as high as eight percent, indicating a rapidly spreading epidemic among married women.¹¹ Moreover, in three recent studies of HIV infection patterns and risk factors, data revealed that over 80 percent of women who were infected were monogamous.¹²

Social norms and expectations often limit women's ability to negotiate safer sex.

High rates of HIV infection among women and girls, both within and outside of marriage, result from a combination of factors including social pressures on:

- Young girls to marry early, in some cases to older men.
- Girls and women to remain sexually inexperienced leaving them ill-prepared to negotiate safer sex.
- Married women to remain sexually available to their husbands upon demand.
- Boys and men to prove their “manhood” by engaging in sex early and often.

A number of surveys reveal that a large proportion of women and girls have little access to sexual and reproductive health education, and as a result little knowledge of their own bodies. Lack of knowledge and awareness and taboos against discussing sex, sexuality, and reproduction are all critical factors in women's risk of HIV infection even within marriage. A recent study based on data from the Indian National Family Health Survey (NFHS-2) suggests that only 5 percent of married women in India know how to prevent infection.¹³

Lack of knowledge and awareness is exacerbated by a range of economic and social conditions and traditional practices that often leave women dependent on men for economic security. In parts

of South Asia, for example, women often have little control over household income, even when they earn wages or contribute non-cash income to supporting their family. In Bangladesh, India, Pakistan, and much of sub-Saharan Africa, women often lack any legal rights to property, or are unable to enforce their legal rights where these exist. These and other factors create conditions in which women often must remain in partnerships in which they are unable to negotiate the timing, frequency or conditions of sexual intercourse.

Sexual violence and coercion—particularly within marriage—are among the leading risk factors for HIV infection among women and girls.

All of these conditions are further exacerbated in many settings by high rates of violence and sexual coercion within marriage. In Ethiopia, India, and Nicaragua, for example, 49 percent, 40 percent and 52 percent respectively of all women surveyed reported having experienced violence and sexual coercion by intimate partners (i.e. husbands or regular partners) in their lifetimes.¹⁴

In high-prevalence countries, everyone is at risk.

The Strategy repeatedly refers to making condoms available to or in close physical proximity of “high-risk” populations, citing most frequently prostitutes and sero-discordant couples. While efforts to reach marginalized populations are necessary and essential, they are far from efficient in high-prevalence settings.

As the evidence shows, in many countries HIV infection rates in the general population are extremely high, with one-fourth to one-third of the population already infected, meaning that virtually all those who are sexually active are at immediate risk of HIV infection. For example, in Botswana prevalence stands at almost 40% and in South Africa HIV prevalence rates among pregnant women rose from 1 percent to about 25 percent in the last decade.¹⁵ It is difficult to see the benefit in promoting safer sex only among “high-risk” target groups in such settings when *everyone* is at risk, and *everyone* needs access to all available information and means of protection. In countries with such high prevalence rates, it is also difficult to fathom a process by which those at high risk within marriage or otherwise would be easily isolated.

⁹ UNAIDS 2002.

¹⁰ NACO 2004.

¹¹ PFI and PRB 2003.

¹² Rodrigues et al. 1995; Solomon et al. 1998; and Newman et al. 2000.

¹³ Rajan and James 2004.

¹⁴ Cravero 2004.

¹⁵ UNAIDS/WHO 2003.

C. RISK ELIMINATION VERSUS RISK REDUCTION

The Strategy makes clear that, with the exception of so-called high-risk groups, efforts to reduce the rate of sexual transmission of infections will focus exclusively on *risk elimination through abstinence*—i.e. just say no to sex. This approach flouts a central principal of public health, that of *risk reduction*. Best practices in public health focus *simultaneously* on risk reduction *and* risk elimination. Risk reduction is a central principle of everyday life: Rather than eschewing driving for example, we wear seat belts to reduce the risks of injury and death in auto accidents.

Moreover, both human rights covenants and international bioethical standards require that governments provide individuals with the information and services necessary to make informed decisions about their health.¹⁶ Denying any group access to condoms or any other currently available prevention technology or strategy therefore violates both human rights principles and medical ethics.

Reliance on risk elimination in the case of adolescents will leave millions of people without the knowledge, information and skills necessary to prevent infections. HIV prevention strategies dependent upon risk elimination focus on only one element of behavior change, that of avoiding sexual relations entirely, and require *complete and consistent* elimination of risk over a sustained period of time. On the other hand, risk reduction encourages multiple avenues of behavior change for multiple circumstances, including in the case of HIV prevention, simultaneous efforts to encourage both abstinence and delays in sexual initiation, and the adoption of safer sex practices among those who may become or who already are sexually active.

In justifying the sole reliance on risk reduction, the current Strategy is based on a selective and misleading use of available evidence regarding what has worked to reduce the risks of both non-sexually active and sexually active adolescents in other counties. For example, the Strategy asserts that:

in its use of evidence-based prevention programs such as the “ABC”—Abstinence, Be Faithful, and as appropriate, correct and consistent use of Condoms—approach, proven successful in Uganda, Zambia, and Senegal, the Emergency Plan will target prevention funds to methodologies that are effective in helping people avoid behaviors that place them at risk of contracting HIV. (pp. 23-24)

To the contrary, effective HIV prevention strategies incorporate the universal promotion of safer sex, including condom use for all sectors of society, thereby enabling individuals to make informed choices about their health.¹⁷ The Administration concedes that “[e]vidence from Thailand suggests condom use is an important means of reducing, but not eliminating, risk” (p. 25). The Strategy again misuses the data however, when based on the Thai data it states “condom programs targeted to at-risk populations will be supported.” The Thai program to which the Strategy refers focused its condom promotion efforts simultaneously at “high-risk” groups, such as prostitutes and their clients, *and* at the general population.¹⁸ A search of the literature reveals no evidence supporting the assumption that focusing *only* on risk elimination is an effective means of preventing sexually transmitted infections, and no evidence, as the Strategy incorrectly suggests (p. 25) that dissemination of messages about condom use will undermine messages about abstinence and fidelity. Indeed the available data suggest just the opposite: that abstinence-only programs have high rates of failure in terms of both infection and other adverse outcomes, such as unintended pregnancy.¹⁹

So while the Strategy seeks to send a “clear message that best means of preventing HIV/AIDS is to avoid risk all together” (p. 29), the wealth of available public health data, along with human nature and human experience suggests that this is implausible at best. For these reasons, investments to ensure universal access to male and female condoms and other prevention technologies, and dramatically increased expansion of programs to train people in negotiating safer sex, are not only “appropriate” but urgently needed by all individuals who may

¹⁶ UNESCO 1994.

¹⁷ AGI 2003.

¹⁸ UNAIDS and MOH Thailand, 2000.

¹⁹ SIECUS 2003.

one day engage in sexual intercourse. As Bush Administration advisor and anthropologist Edward Green himself has stated, “The ABC approach is not about that great conversation-stopper ‘abstinence-only.’ It is about providing people with more options for preventing AIDS.”²⁰

Yet in focusing on risk elimination, the Strategy places what is effectively an “abstinence-only-until-marriage” approach at the core of its efforts to prevent sexual transmission of HIV infections among youth. In part, the focus on abstinence-only-until-marriage within the Global HIV/AIDS Strategy is a response to limitations set forth in the Global AIDS Act 2003, which called for a cap on prevention funding at 20 percent of the total appropriated for global AIDS, and mandated that 33 percent of all prevention funds be spent on abstinence-only strategies.²¹

The Strategy, however, goes much further. One, it includes activities such as prevention of maternal-to-child-transmission under the umbrella of prevention rather than under funding for treatment as had been suggested by Congress,²² thereby diminishing the overall amount of funds available for activities focused on prevention of sexual transmission. Two, because such heavy emphasis is placed on “youth and abstinence” as described in the Strategy, it strongly implies that a much higher proportion of limited funds for prevention will be spent on abstinence-only until marriage programs, despite evidence regarding the diversity of the youth population.

D. DEFINING RISK

Recognizing that condoms are an essential means of HIV prevention for “high-risk” populations, the Strategy proposes to undertake rapid scale-up of activities that target specific at-risk populations with outreach, prevention messages, testing, and condoms (p. 27). The Strategy defines “at-risk populations” to include prostitutes, the military, sexually active sero-discordant couples, substance abusers, and “others” (p. 27). Here the Strategy

assumes that it is both easy to identify all sub-populations at risk and to target them such that

condom distribution outlets [can be placed] near areas where high-risk behavior takes place [while] every effort [is] made to deliver a consistent “ABC” message so that the general population receives a clear message that the best means of preventing HIV/AIDS is to avoid risk altogether. (p. 29)

While it is true that in countries where the epidemic has not yet spread to the broader population specific steps can be taken to identify and create effective interventions for high-risk populations, this theory defies the reality and the data from the vast majority of countries targeted by the Bush Administration’s Strategy.

For example:

In high-prevalence countries, everyone is at-risk. As noted earlier, in many countries and particularly in sub-Saharan Africa and parts of South Asia, HIV infection rates among the adult population ages 15 to 49 are already very high. In 2002, for example, HIV prevalence in the general population in Swaziland reached almost 39 percent, while in 2001 the prevalence rate in Zimbabwe was at 34 percent.²³

The vast majority is unaware of its sero-status and is not likely to have universal access to testing any time in the near future. The reality is that in many countries, confidential voluntary counseling and testing services remain inaccessible to a large share of the population. Even where such services are available, stigma, discrimination, and fear of violence or retribution dissuade many people, and especially women, from getting tested. Furthermore, studies in the U.S. indicate that “sex without disclosure of HIV status is relatively common among persons living with HIV.”²⁴ Finally, lack of access to affordable drugs further undermines efforts to increase testing because there is no hope given to those who find themselves infected. It will take a good deal of time and investment to change this situation, even with adequate funding. In the meantime, people need to know how to protect themselves.

²⁰ Green 2003.

²¹ United States AIDS Leadership Against HIV/AIDS, TB, and Malaria Act of 2003; See also *A Critical Review of the U.S. Leadership Against HIV/AIDS, Tuberculosis and Malaria Act: Implications for Women’s Health and Human Rights*, Center for Health and Gender Equity, 2004.

²² See Conference Report 2003 (stating conferees’ sense that PMTCT activities be funded by monies allocated to treatment).

²³ UNAIDS/WHO 2003.

²⁴ Ciccarone 2003.

Millions of women are living in sero-discordant relationships but are unaware of their own high risk of HIV infection.

Many married women may erroneously believe that they are in mutually monogamous relationships, or may not know that their partner is HIV-positive and putting them at risk. These women are not an easily identifiable risk group, but rather represent the population at large, and can only be reached through broad-based campaigns that underscore the fact that everyone is potentially at risk, that everyone must practice safer sex, and that aim to destigmatize HIV infection and frank talk about sex.

Targeting “high-risk” populations can increase stigma and discrimination and contribute to a false sense of safety.

Unless done with great sensitivity, targeting condoms exclusively at already-stigmatized and marginalized populations can further exacerbate discrimination against these groups by focusing “blame” on them for spreading disease, increasing the stigmatization of condom use, and contributing to the perception of “risk” as something that only occurs outside of marriage. For example, in a recent survey of 300 HIV-positive married women in Zimbabwe, the majority of the women knew about HIV, but did not insist on condom use with their husbands or partners because they thought that they were not personally at risk and that condom use was only for those who visited sex workers.²⁵

E. DOES ABSTINENCE-ONLY WORK?

Throughout the section on prevention, there is constant reference to promoting “abstinence-until-marriage” among youth, and to promoting secondary abstinence among those who are already sexually active. No mention is made about encouraging behavior changes among sexually active youth to practice safer sex in the case of incomplete compliance with primary or secondary abstinence, nor is any strategy articulated for married adolescents or for women ages 20 and above who are married, monogamous, and at increasing risk of infection.

In support of this approach, the Strategy misrepresents the comprehensive effort used in

Uganda to dramatically reduce HIV infections. Exhaustive evidence shows that Uganda’s HIV prevention program emphasized abstinence, fidelity, partner reduction *and* correct and consistent condom use, along with messages aimed at catalyzing frank discussions about sex and sexuality among people of all ages.

This strategy has worked. According to an analysis by the Alan Guttmacher Institute of data from Demographic and Health Surveys and from other sources, the following changes occurred in Uganda:

- The share of adolescent women ages 15 to 17 that had ever had sex decreased from 50 percent in 1988 to 34 percent in 2000.
- Sexual activity among adolescent men also declined.
- Marked declines were realized in the share of sexually active persons with more than one partner, at least through 1995. Data show that the proportion of unmarried men with more than one partner rose again between 1995 and 2000.
- A marked increase in overall condom use, particularly among unmarried and sexually active individuals. The share of those who were unmarried, sexually active and using a condom in Uganda rose from 1 percent to 14 percent among women between 1989 and 1995, and from 2 percent to 22 percent among unmarried men in the same period.²⁶

Other data underscore this point. In Uganda, for example:

Age at first intercourse increased. Between 1988 and 2000-01, according to the Uganda Demographic and Health Survey, age at first intercourse increased for women by one year, from 15.6 years of age to 16.6 years of age.²⁷ Age at first marriage also increased during that period, to 17.8 years of age. This delay undoubtedly contributed to important reductions in HIV infection rates at the population level. At the same time, however, programs providing comprehensive information on practicing safer sex also reduced rates of transmission among those who remained

²⁵ Feldman and Maposphere 2003.

²⁶ AGI 2003.

²⁷ MOH and Institute for Resource Development/Macro Systems, Inc 1989 and (UBOS) and ORC Macro 2001.

sexually active or failed in achieving complete or sustained abstinence.

The majority still became sexually active prior to marriage. The issue of increased condom use in Uganda is critical because even despite the achievements of the program in encouraging delays in sexual initiation, available data show that *more than one-third of all women ages 15 to 17 remained sexually active and clearly in need of information and technologies for practicing safer sex for an indeterminate period of time.*²⁸

Without information and support for practicing safer sex among this population, a third of all adolescents would have remained at high risk of infection. These same trends are evident elsewhere. Based on analysis of DHS data, similar or larger gaps between age at first intercourse and age-at-first marriage exist in Kenya, Tanzania, and Zambia. In each of these countries, a large share of the unmarried adolescent population is or was engaged in sexual activity for more than a year before reaching the median age at marriage.

In fact, evidence from the United States itself strongly points to the failure of abstinence-only strategies for prevention of sexually transmitted infections. Findings from a recent study drawn from data on the sexual behavior and health of 12,000 U.S. teens collected by the U.S. Centers for Disease Control revealed that teens who took “virginity-until-marriage” pledges contracted sexually transmitted infections at the same rate as those who did not. The study found that while teens taking such pledges did delay sexual initiation, had fewer partners and married earlier, they were less likely than other teens to use condoms.²⁹

By not providing accurate and complete information on strategies for safer sex to adolescents who do choose abstinence, the Strategy assumes that all individuals will adhere perfectly to abstinence until marriage strategies and that marriage itself will protect individuals from infection, both of which assumptions are contradicted by the available evidence. Moreover, the Strategy completely sidesteps the question of what happens to the large share of the population ages 15 to 24 that are already sexually active whether or not they are married. These

assumptions raise serious moral and ethical questions about the Strategy, which appears to willingly leave very large segments of the adult population at risk of infection in pursuit of an unproven approach.

III. THE U.S. GLOBAL STRATEGY ON TREATMENT: A CRITICAL ANALYSIS

According to the Global AIDS Act 2003, 55 percent of the total funds appropriated for the U.S.-Five Year Global HIV/AIDS Strategy are to be spent on providing life-saving anti-retroviral drugs (ARVs) to people suffering from AIDS. Today, an estimated 4 million people in need of ARVs remain without access. The main goal of the Strategy is to increase the number of those with access to ARVs by 2 million people over the next five years, with a target of reaching 500,000 in the first year.

Without question, increased funding for treatment is urgently needed. However, even despite the appropriation by Congress of funding for ARVs, huge gaps will remain between the number who need treatment to live, and those who will have access to treatment in a timely manner. Therefore, the expansion of treatment access with U.S. funding also raises critical questions about efficiency and equity in the delivery of ARV therapy including questions about how and under what conditions access will be determined, and how efficiently available funds are spent.

The global debate on ARVs has become increasingly pitched in the past several years, as the numbers affected by AIDS continues to rise rapidly and the cost of drugs remains well out of reach of the vast majority of those in need. Prices of essential ARV drugs have fallen in the past several years, though not by enough to make a substantial difference in resource-poor settings. As a result, expanded access to generic drugs has been seen as essential to increasing access to those in need.

Generic fixed-dose combination drugs (FDCs) combine several brand name formulations in fewer pills, can be more easily administered and adhered

²⁸ Dailard 2003.

²⁹ Stanecki 2002.

to, and are significantly cheaper than brand-name multi-pill regimens. For example, FDCs now available in countries such as Brazil, India, South Africa, and Zambia cost approximately \$140 per person per year, in contrast to brand-name multi-dose ARVs designated for purchase by the US government at \$562 per person per year, three times the cost of generics.³⁰ The purchase by the United States of FDCs rather than brand-name drugs could therefore triple the number of those with access to life-saving treatment.

Over the past year, two major initiatives have brought renewed hope of greatly expanded access to ARVs. One is the campaign by the World Health Organization (WHO) to provide treatment to 3 million people by 2005 (known as “3 x 5”). The other is the U.S. Five-Year Strategy. While initially heralded as major breakthroughs, recent developments have raised a series of questions around program coordination and drug purchasing within the context of the U.S. Strategy. Rather than integrating its efforts with the 3x5 campaign, for example, the United States is developing what amounts to a parallel program. And because of reductions in U.S. contributions to multilateral efforts like the Global Fund, the goal promoted by the WHO to provide therapy to 3 million people by 2005 will face a setback.³¹

The Strategy outlines the following basic priorities for expanding access to ARVs (p. 34):

- Rapidly increase the capacity of established clinical programs by training and mobilizing health care personnel to provide treatment services and enhancing the capacity of supply chain management systems.
- Build capacity for long-term sustainability of quality HIV/AIDS treatment programs by strengthening national human resource capacity through health care worker recruitment and retention strategies and establishing, disseminating, and implementing treatment protocols.
- Advance policy initiatives that support treatment by building political commitment.

³⁰In October 2003, for example, the Clinton Foundation negotiated a price reduction in the generic fixed-dose combination of nevirapine, lamivudine (3TC) and stavudine (d4T) from \$400 to \$140 per patient per year.

³¹ HealthGAP 2003.

- Collect strategic information to monitor and evaluate progress and ensure compliance with Emergency Plan and national policies and strategies.

The Strategy, however, fails to answer several critical questions. These questions include: What are the implications for drug pricing, delivery, efficiency of services, and the use of scarce health care resources in developing countries if the Bush Administration decides to ‘go it alone?’ Will the Administration bow to pressure from the pharmaceutical industry and purchase only brand-name drugs, or will it purchase low-cost generic drugs and cover the greatest number of people at the lowest possible cost? What steps will be taken by the U.S. to ensure equity in access to drugs among women and other marginalized populations who generally face greater obstacles to gaining access to any kind of health care? Next, we examine these questions in relation to the main priorities outlined within the U.S. Strategy, and in recent testimony by the Global AIDS Coordinator.

The Administration is misrepresenting the science on the safety of generic drugs. In response to a question posed during the March 4, 2004 House International Relations Committee (HIRC) hearing on the global Strategy, Ambassador Tobias implied that the safety of generic drugs and fixed-dose combinations could not be assured and that, as a result, the purchase of these would not be a priority of the U.S. global AIDS effort. He stated that “the Strategy envisions acquiring safe and effective drugs at the lowest price—it is not important where the drugs come from.” However, he was concerned “about a standard by which to judge the safety and efficacy of these drugs.”

WHO has approved the safety and efficacy of FDCs, and many donors are now supporting the purchase of these drugs. Moreover, fixed dose drugs have been used in several pilot programs of Medicine Sans Frontiers (MSF) in South Africa and Ethiopia and data is now beginning to emerge that substantiate their bio-equivalence and efficacy.³²

By raising doubts about the “standards by which to judge efficacy and safety” the United States appears to be trying to deflect the real issues of generic versus branded drugs and of protectionism

³² MSF 2004.

towards the U.S. pharmaceutical industry, a move that will only create additional barriers to access to treatment, and one that clearly ignores the evidence on safety and efficacy provided by several successful pilot programs using ARVs.³³

Failure to support generic drugs means it will cost more to treat fewer people. The Strategy, and subsequent statements by Global AIDS Coordinator Ambassador Randall Tobias in hearings held by the House International Relations Committee on March 4th, 2004 raise questions about whether the U.S. will support distribution of generic drugs. For example, the Strategy fails to acknowledge the role of FDCs, or to reference the factors that have led to dramatic declines in the price of these drugs. Nor does it clarify why the U.S. will or will not use generic fixed-dose combination drugs in the PEPFAR countries. The only acknowledgement of price as a factor in access to drugs within the document is a statement that notes:

In the past the provision of treatment in the developing world was considered too costly for under-resourced nations and too complicated for developing-country health infrastructures. These concerns are real but can no longer be barriers to providing treatment to the millions who need it. (p. 34)

The choice of brand name over generics, however, immediately raises questions about the cost effectiveness of an additional dollar spent on treatment under one or another scenario, and ultimately determines the number of people who can reasonably be treated using the same pool of funds. Taken together, the Bush Administration's past opposition to the purchase of generic drugs and the lack of clarity on this issue within the Strategy document implies that generics will not be a central aspect of the Five-Year Strategy.

The Strategy gives scant attention to support for successful pilot programs, multilateral efforts and the public health sector. One of the stated objectives of the Strategy to rapidly scale up treatment is to

build on established clinical programs (p.34) [and to] help focus countries link communities with treatment services on an enormous scale. To facilitate

this, the President's initiative seeks to leverage the comparative strengths of a wide range of different public and private sector partners to dramatically increase the number and reach of organizations providing treatment services. (p. 40)

The Strategy reinforces the role of corporate sector partners in expanding treatment programs through workplace policies, delivery of services, and leveraging of commercial resources. It also specifically mentions supporting faith-based and community partners currently providing HIV/AIDS prevention and care services to "add treatment to their slate of services."

At the same time, however, it fails to mention critical actors in treatment access, such as the specific successful pilot projects already underway in several PEPFAR countries. For example, there is no mention in the document of pilot programs like those run by MSF that have been instrumental in building the critical evidence for treatment delivery, access and adherence in several high prevalence settings, including South Africa.

While working with new partners can be a critical addition to the effort to expand treatment access, these efforts must build on and be coordinated with existing public sector health services or risk drawing critical resources away from national health systems. In fact, the governments in these settings are indeed the most critical partners for sustainability and integration of care, among other things, and commitment to working with the public sector should be explicit.

A narrowly constructed vision of partnership in the U.S. Strategy will not only restrict the number of people that can be reached, but will ultimately limit the available evidence on what works and why. It may also create new management problems in PEPFAR countries where the establishment of several vertical programs could undermine coordination and efficiency, especially if programs supported by the US government exist side by side with other programs offering fixed-dose combination drugs, thereby requiring extensive training for different types of protocols for treatment, access, and adherence. It is unclear in fact how the US government is going to reconcile these conflicting goals in settings where there are other players supporting treatment, such as the Clinton Foundation or the Global Fund.

³³ Russell 2003.

Inconsistencies with other treatment efforts of the national public health system and other multilateral institutions will also undermine the Strategy's commitment to "collaborate closely with other donors to ensure complementary treatment efforts and the best use of treatment dollars (p. 34)."

The Strategy fails to adequately address gender equity issues in access to treatment. With limited resources, choices will inevitably be made about who will be treated and when, raising the issues of equity in access to treatment for sub-groups of those infected. Given that stigma and discrimination already pervades all aspects of prevention, treatment and care there is a need for efforts to ensure that treatment programs reach vulnerable groups – namely women and girls, sex workers, IV drug users and men who have sex with men – which, due to social, economic, and cultural discrimination and lack of access to health care, already face a disproportionately higher risk of infection.

Women often face disproportionate barriers to accessing health care, often resulting from limits on their physical mobility, decision-making power, lack of access to and control over income, conflicts between work and family responsibilities and stigma and lack of support for adherence due to a range of reasons including lack of access to or control over income, and poor quality of care.³⁴ Yet the Strategy is silent on the any specific steps to be taken to address these issues.

The treatment objectives do not explicitly state or address concerns of gender inequities and constraints on women's access to treatment in any way. While the Strategy links *prevention* to gender inequities by stating that "*prevention efforts are further hampered by the stigma surrounding HIV/AIDS and gender inequality that increases the vulnerability of women and girls*" (p. 23), it fails to address the fact that women's access to treatment will for the same reasons be constrained by factors outside their control.

³⁴ For a discussion of barriers to and recommendations for addressing gender disparities in access to treatment, see Center for Health and Gender Equity, *Gender, AIDS, and ARV Therapies: Ensuring Women Gain Equitable Access To Drugs Within U.S.-Funded Treatment Initiatives*, February 2004.

The Strategy gives only rhetorical support to women's needs within PMTCT and related programs. As part of its stated intention to invest in rapid expansion of existing programs, the Strategy supports dramatic expansion of prevention of mother-to-child transmission (PMTCT) programs. In doing so, the Strategy appropriately highlights the need to prevent new infections among infants. However, the approach underlined falls short by largely stopping there and by claiming support for efforts that the Administration has clearly abandoned in practice.

For example, the Strategy emphasizes integration of HIV prevention services and training with services for antenatal care, safe labor and delivery practices, breastfeeding, malaria prevention and treatment, and family planning. While this is laudable, the fact is that the Bush Administration has severely cut funds for antenatal care, family planning and other basic reproductive health services while shifting already allocated funds to other programs. As a result, the basic infrastructure for providing these essential services is being severely undermined.

Other problems with the approach to PMTCT are evident. While the Strategy claims that PMTCT provides a "critical link" to prevention and treatment for women, there is no clear indication anywhere in this document of whether and how pregnant women enrolled in PMTCT will receive follow-up treatment to ensure their own survival, no indication of whether they will receive comprehensive reproductive health and family planning services as a matter of course as a condition of their enrollment, and no indication of how the Strategy will move beyond pregnant women to ensure that all women have equitable access to treatment irrespective of their pregnancy status. Moreover, as noted earlier, the inclusion of PMTCT programs under the umbrella of prevention rather than treatment further diminishes the scarce funds available for supporting effective programs aimed at reducing the overwhelming contribution of unprotected sex to the spread of HIV. In the long run, the inclusion of PMTCT under prevention funding will backfire, as an increasing number of women with otherwise avoidable infections will have to be enrolled in such programs, further straining scarce resources.

The Strategy fails to effectively identify existing barriers, such as stigma, within health care systems.

The Strategy neither acknowledges nor addresses the stigma that is widespread in the health care system itself, which often mirrors the inequities that exist in homes and communities and has enormous implications for access to care. Recent studies show that adoption of and adherence to treatment access is lower in communities where these issues are not proactively addressed and are conversely higher in those settings, such as in Brazil and Khayelishta, South Africa, where intensive counseling and the involvement of people living with AIDS in community mobilization and accountability strategies have helped overcome such barriers.³⁵

IV. PARTNERSHIPS AND FUNDING MECHANISMS

Partnerships and funding mechanisms are the means through which the U.S. government disburses money for programs aimed at achieving specific objectives, ensures a level of consistency with U.S. international policy, and coordinates with both recipient and donor nations to achieve common aims. For more than 40 years, for example, the United States has used both bilateral and multilateral funding mechanisms to provide international assistance in public health, agriculture, industry and other areas, and to create centers of excellence in research, technical assistance, and program delivery that have benefited millions worldwide.

The Global AIDS Strategy refers to several types of partners and mechanisms for funding, including faith-based organizations, community partners, and the corporate sector. For example, the Strategy cites the role of the corporate sector in expanding treatment programs through workplace policies, delivery of services and leveraging of commercial resources. However, the Strategy also indicates that there are specific preferences for types of partners to be engaged by the Administration in its Global HIV/AIDS Strategy and that recent trends emphasizing bilateral funding and reducing the importance of multilateral efforts are likely to be exacerbated.

³⁵ Attawall and Mundy 2003.

A. FAITH-BASED ORGANIZATIONS

Calls for increasing the role of faith-based organizations (FBOs) in U.S. Global AIDS efforts have become axiomatic under the Bush Administration. Heavy emphasis is placed on FBOs in language throughout the Global AIDS Act 2003, the Strategy, and in sundry speeches on global AIDS made by Administration officials, including President Bush himself, Ambassador Tobias, and USAID Administrator Andrew Natsios.

To be sure, faith-based organizations have played a leading role in responding to the AIDS crisis, particularly in Africa, where numerous long-standing local and international organizations have provided support to and care for victims of AIDS for a number of years, indeed well before the surge of interest in these issues by this or previous U.S. Administrations. But the new emphasis on FBOs raises several questions:

- Which FBOs have been funded in the past and which will be funded in the future?
- By what means and based on what minimum standard of public health expertise do FBOs compete with non-sectarian public health institutions in responding to Requests for Proposals and other mechanisms set up to disburse U.S. Global HIV/AIDS funds?
- What measures will be taken to ensure that, in addressing a global epidemic, FBOs have certified experience and credentials in developing, managing, monitoring, and evaluating public health interventions, rather than just a “faith-based approach?”
- What measures will be taken to ensure that FBOs are not using government monies to evangelize or otherwise promote religious ideologies?
- What measures will be taken to ensure that FBOs with religious or other objections to public health interventions are not given funding to carry out such interventions?

The emphasis on FBOs raises red flags on a number of levels, not least because of the intense political climate surrounding all issues that have to do with sex, sexuality, marriage, and reproduction. One, the involvement of FBOs in prevention of sexual transmission of HIV immediately calls into question how organizations affiliated with different points of view will approach prevention strategies aimed at reducing sexual transmission of HIV. Two, the Bush Administration’s close

affiliation with its self-described “base” of evangelical Christians also raises questions about its own objectivity in developing health policies on issues so hotly contested by this and other fundamentalist religious ideologies. And three, evidence to date suggests there is little or no accountability in the ways in which U.S. funds for global AIDS programs are being granted to and used by “faith-based” organizations, and therefore no means to gauge whether these funds are being used to further a public health agenda or support a religious ideology.

There is no singular or monolithic agreement on what constitutes a “moral,” “ethical,” or “faith-based” view of sex, sexuality or reproduction. Views on sex and sexuality and answers to questions on morality and ethics differ greatly among faiths and within branches of the same faith, as can be seen in contemporary U.S. debates around the right to choose to terminate a pregnancy, the right to use contraception, and the rights of same-sex couples to marry. The question in a pluralistic world is: whose views prevail? And should any religious philosophy ever determine public health policy, trump evidence on best practices, or abrogate the rights of individuals and populations to accurate information about health interventions, such as the use of condoms and the means of practicing safer sex?

In current U.S. debates on these and other issues directly related to HIV prevention (and other areas of sex and reproduction), the term “faith-based” as defined by the Bush Administration actually translates into one *specific* interpretation of morality, values, and ethics, a worldview in which the only legitimate sexual contact is between two married persons of the opposite sex and only for the purpose of procreation. The huge amounts of money being invested by the Bush Administration in abstinence-only-until-marriage programs in the U.S. and now globally therefore directly reflect the religious political agenda of *one faith*, evangelical Christians—with philosophical agreement from the Vatican—not the diverse viewpoints and approaches held by diverse religious philosophies, and as the evidence clearly shows, *not* the approaches indicated by public health data or human rights concerns.

Many religious and political leaders in high-prevalence countries are opposed to the imposition by the United States of the abstinence-only agenda. Objections to the intrusion of religious ideology into government programs have been brushed aside by the Administration. For example, in response to concerns raised by members of Congress regarding what representatives of African countries have to say about the Strategy’s focus on abstinence-only-until-marriage programs in their own settings, Ambassador Tobias responded by asserting that only American groups, not Africans, objected to funding of abstinence-only-until marriage. Yet prominent African leaders do in fact support comprehensive approaches over abstinence-only strategies.

For example, First Lady Maureen Mwanawasa of Zambia, quoted in the Boston Globe, stated that: “Parents [in Zambia] are worried about children using condoms. But the reality on the ground, whether you like it or not, is that sex is taking place. Abstinence messages won’t work for a large segment of young people. How long can we go on pretending? We see young girls having babies at age 13. Sex is part of life.”³⁶ Similar statements—including strong support for widespread distribution of condoms and comprehensive strategies—have been made by a variety of African religious and political leaders, including Archbishop Desmond Tutu, who appeared in a public service announcement as early as 1996 promoting the use of condoms.

Despite both the diversity of viewpoints, and the public health evidence, the Bush Administration is using government funding to promote a religious ideology. Despite the evidence, recent reports, provided confidentially to CHANGE from within government agencies and by individuals and organizations on the ground in several countries in Africa suggest that religious ideological agendas are being promoted through undemocratic means of evaluating Global AIDS proposals and disbursing funds. Key informants from within relevant government agencies and from countries themselves have reported on preferential treatment now being given to “certain kinds” of “faith-based organizations.” Other concerns raised have included:

³⁶ Donnelly 2002.

- Incidents in which the recommendations of technical review panels vetting proposals for millions of dollars worth of grants for Global AIDS work are being heavily influenced by representatives of “faith-based organizations” allowed to sit in on grant proposal reviews.
- Technical recommendations made by government agencies overridden by the Office of the Global AIDS Coordinator.
- Technical proposal review checklists being altered to reflect the “faith-based” orientation of a specific organization submitting a proposal.
- Agency chiefs criticizing technical personnel who challenge funding to “faith-based” groups whose proposals do not demonstrate capacity to develop and implement a public health program.
- The exclusion of some faith-based groups with longstanding experience being passed over in favor of “new partners” from the evangelical Christian community despite the latter’s lack of experience.
- Incidents in which non-sectarian public health institutions with extensive field experience being similarly being displaced by FBOs.

There is little participation on the ground by local groups in shaping the programs to be funded by the U.S. government. Despite repeated assurances within the Strategy document that local governments, community organizations, and faith-based groups would be integral to the process of developing priorities and program responses suitable to local conditions, in fact the programmatic strategies at the country level are being crafted in closed-door meetings of U.S. embassy and government agency personnel with little or no input at the ground level. So while specific U.S. faith-based groups are now favored recipients of taxpayer money, country-based groups are being sidelined. Local community-based organizations, including faith-based groups in focus countries have reported frustration to CHANGE and to other colleague organizations regarding a lack of guidelines on how to access PEPFAR funding, a lack of access to the technical missions sent by the United States to specific countries, and lack of access to the program objectives and critical decisions made about funding in their countries.

Currently, the RFA process is ambiguous and leaves little room for community action and mobilization. For example, the process for the first round of grants did not involve any country review and was heavily weighted toward decisions made in Washington. In several cases, decisions made by the State Department overrode recommendations made by technical review panels at CDC and elsewhere. Right now, international NGOs and FBOs are receiving funding on behalf of local organizations and making decisions on expenditures in the field, access to resources, hiring, and implementation of programs. This exacerbates the long-standing imbalance in capacity between U.S.-based contractors and local groups.

The current Strategy will only perpetuate these problems because it fails to address the issue of FBOs dispassionately at any level, includes no reference to ensuring means tests for FBOs, or to evaluating their experience, capacity or willingness to put science and public health above “faith” in dealing with health issues. Moreover, the Strategy fails to acknowledge the need for, much less outline, a process by which transparency of selection or accountability of such organizations will be ensured.

B. BILATERAL AND MULTILATERAL FUNDING MECHANISMS

For virtually all of its tenure, the Bush Administration has shown a strong preference for bilateral funding of international health and development programs. The Strategy reiterates that preference, noting that “through bilateral programs coordinated by the Global AIDS Coordinator, the United States hopes to increase the worldwide availability of high-quality, sustainable HIV/AIDS prevention, care, and treatment programs. Consistent with this aim, the Strategy intends to promote bilaterally evidence-based HIV risk elimination and reduction programs” (p. 54). Giving priority to bilateral funding mechanisms allows the Administration to determine on its own what evidence to consider without having to justify its decisions to the international public health community, and further exert ideological control over how funding is spent.

According to the Strategy “duplication of program efforts and an uncoordinated response, especially in the most afflicted nations where so many have initiated programs, must be avoided. Harmonized proposal, surveillance, reporting, and accountability requirements will avoid placing additional burdens on governments already weighed down by the disease burdens of HIV/AIDS, malaria, and tuberculosis (p. 58).”

The Strategy goes on to say that

The U.S. government will use the full range of diplomatic tools to engage international organizations as partners in the fight against HIV/AIDS [and that] efforts will be made to strengthen U.S. participation on governing boards and to consult closely and often with both the leadership and working levels of the multilateral and other international organizations working on HIV/AIDS.

Again, looked at in the context of the current situation, the Strategy reveals how little commitment the Administration has to truly multilateral action even on the AIDS epidemic. For example, despite the rhetorical commitment to a coordinated response the Strategy does not mention any explicit coordination with the World Health Organization’s “3 by 5” Campaign intended to expand access to 3 million people by 2005.

Similar concerns are raised in respect to the Global Fund for AIDS, TB and Malaria, in which the U.S. has a ‘strong’ presence on the governing board with Health and Human Services Secretary Tommy Thompson acts as the Chair. In this instance, U.S. participation has basically translated into dramatic cuts in U.S. funding for the Global Fund. In the proposed FY ’05 budget, for example, the Bush Administration’s suggested contribution to the Global Fund (\$200 million) represented a 64 percent reduction in support over the previous year.

These and other instances in which the United States has either reduced its contribution to or otherwise undermined multilateral efforts raise serious questions about the sustainability of the global response to the AIDS epidemic, about in-country coordination of drug treatment and delivery, and about whose needs are being served in U.S. global AIDS policy.

Potential for lack of coordination is also created by the need to “promote evidence-based policies” in the Strategy for strengthening multilateral actions. The Strategy states that they will “use the ‘parallel project review’ process mandated by Congress to lead an internal USG review to ensure that all proposals recommended to the Global Fund Board for approval are technically and developmentally sound, demonstrate that added resources will bring results, and meet high programmatic and financial accountability standards (p. 60).” By requiring this review process, the U.S. seeks to further leverage its own power over the Global Fund, thereby undermining its autonomy and mandate, and attempting to impose the U.S. agenda on a multilateral organization.

V. GAPS IN THE GLOBAL STRATEGY

In several areas, the Strategy underscores important priorities for U.S. global AIDS programs, or mentions specific populations, while failing to outline any meaningful steps or strategies to address these. Notable gaps include the lack of any meaningful discussion of efforts to address stigma and discrimination against vulnerable groups such as men who have sex with men, or prostitutes; the lack of any explicit support for programs to dramatically expand access to the female condom; and the lack of meaningful efforts to address violence against women and girls.

Stigma and discrimination. The Strategy appropriately states that it will support specific interventions beyond ABC for vulnerable populations at highest immediate risk of infection (p. 30). Noting that prostitutes and their clients, men who have sex with men, and injecting drug users are among those who are most marginalized in society and have the least access to basic health care, the Strategy states as a priority the development of long-term prevention programs for these groups. Yet while acknowledging that stigma and discrimination against HIV-infected persons undermines prevention efforts, the Strategy does not outline any specific strategies for combating stigma and discrimination.

For example, HIV-positive women often face a double burden due to discrimination against them

as women, and because of their sero-positive status. Interventions to address stigma and discrimination against women must be undertaken at several levels simultaneously, including efforts to provide women with confidential and discrete avenues for testing, counseling, and for accessing basic sexual and reproductive health services; efforts to address norms and values at the community and family level, including barriers to access to health care that arise within families; to specific interventions and training programs aimed at health workers and other gate-keepers. Moreover, these efforts must be nested within a broader strategy of increasing women's economic, social, and political power. The Strategy offers no suggestions on addressing these issues.

Likewise, men who have sex with men and those whose sexual identities fall outside the majority "norm" are often highly isolated, especially in conservative societies in which identification and exposure of alternative sexualities is considered taboo or sinful. Individuals and groups who are therefore marginalized solely because of their sexual identity often face even higher risks of infection with HIV and similar diseases because of their social marginalization and the high levels of stigma and discrimination they face in every day life. Yet while the Strategy mentions efforts to "reach" men who have sex with men, it does so in passing, and only in reference to their status as a "high-risk" group, not in any way addressing the need to combat stigma and discrimination against these groups. The silence on these issues in the Strategy is in itself a form of stigmatization and discrimination, as it further underscores the broader silence in the mainstream U.S. debate about global AIDS of the health and rights of those whose sexuality and identity don't fit within the mold of "normality" cast by the conservative right.

Prostitutes are similarly both highlighted in the Strategy—as "high-risk" groups—and ignored as a group and individuals whose quest for health and rights deserve attention and support. Nowhere in the Strategy is there a discussion of the factors that lead women into prostitution - e.g. poverty, unemployment, and large-scale migration. Nor does the Strategy provide any specifics on how it proposes to "eradicate" prostitution without addressing any of the underlying factors such as poverty and economic deprivation that drive prostitution in the first place (p. 27), or the lack of rights and organization among prostitutes that

keep them vulnerable. Finally, the Strategy again implicitly assumes that those engaged in "prostitution" are always immediately identifiable. In reality, however, studies indicate that informal transactional sex is commonplace in many settings. In parts of sub-Saharan Africa, for example, adolescent girls exchange sex for food, school fees, and money,³⁷ and in many settings, transactional sex among even married women living in poverty is increasingly evident. The Strategy neither analyzes nor addresses these trends in any meaningful way.

Female condom safety and efficacy.

Reference to the female condom is nowhere to be found in the Strategy document,³⁸ and as such there is no coherent plan within U.S. global AIDS funding for increasing access to this vital prevention technology. Given the number of new infections each year worldwide and the rapid rise in new infections among women and girls, omission of the female condom from the Strategy represents a serious breach of ethical and moral responsibility in responding to the HIV/AIDS epidemic.

The female condom is a barrier method approved in 1993 by the U.S. Food and Drug Administration. Like male condoms, female condoms are effective in preventing both unintended pregnancy and sexually transmitted infections, including HIV.³⁹ Correct and consistent use of female condoms can

³⁷ Murray et al. 2003.

³⁸ The female condom is a polyurethane sheath (seventeen-centimeters long) with a ring at either end. It can be inserted by a woman up to 8 hours before intercourse with the inner ring placed over the cervix and held in place by the pubic bone, and the outer ring emerging from the vaginal canal to cover the vulva. It does not require individualized fitting or special storage or treatment, and although it is officially intended as a one-use only product, WHO recently published a re-use protocol that indicates that it can be used up to 7 times with washing (i.e. its structure remains intact and impervious to STI and HIV pathogens up to 7 washes) (WHO 2002).

³⁹ As a dual protection method it protects against both unwanted pregnancy and STI and HIV. As a contraceptive, its efficacy has been demonstrated both in laboratory as well as clinical studies to be around 95% with consistent use (Farr 1994). The 5% failure rate with consistent use is comparable to most other barrier methods that have failure rates ranging from 3-11% (Trussell et al., 1994). In vitro studies show that the female condom provides an effective barrier to organisms even smaller than those known to cause STIs (WHO 1997). A clinical study in the US showed FC to be at least equivalent to the male condom in preventing gonorrhoea, trichomoniasis and chlamydia (WHO 1997). Another clinical study has demonstrated that FC prevents re-infection with Trichomoniasis (Soper et al. 1993).

reduce the risk of HIV infection in each act of intercourse by more than 90 percent.⁴⁰

The female condom is the only currently available female-initiated and controlled prevention technology. Numerous studies have shown the method to be both acceptable to and desired by diverse populations of women. In studies conducted in Brazil, Kenya, Zambia, and Zimbabwe, female condoms were tested among women in prostitution and women attending family planning clinics, with acceptability rates of between 50 and 70 percent in both populations, an extremely high level of acceptability for a single product (WHO, 1997). In another study, among women attending family planning clinics and sex workers in South Africa, nearly 80 percent of the participant in the study indicated satisfaction with and willingness to use female condoms.⁴¹

Studies also reveal that programs providing both training and support for use of female condoms have benefits beyond increased knowledge of the method. For example, in both Kenya and Brazil, female condoms were introduced through pilot interventions that provided both training for use of the method as well as group sessions in which women were encouraged to talk openly about formerly taboo issues of sex and sexuality. The authors concluded that the female condom increased women's sense of ownership over their bodies and sexuality.⁴² A four country study funded by the WHO and UNAIDS concluded that the female condom be used as a tool to develop women's sexual confidence and autonomy, as it may open up the possibility of more equitable sexual relationships between men and women, and increase women's sense of self-worth and self-efficacy.⁴³ Other studies reveal that such training and support sessions also led to increased use of both male and female condoms within the same couples.

Female condoms have technically been introduced in more than 100 countries. Access, however, remains severely restricted in most settings due in large part to the high cost of female condoms relative to male condoms. The current cost of a single female condom—the global public sector

price is 55 cents—puts it out of the reach of the majority of women worldwide.⁴⁴ These and other barriers persist because donor countries, such as the United States, have completely failed to increase bulk purchases of the female condom or to invest in expanded production, strategies that have been used to lower the costs of and increase access to virtually all other reproductive health technologies, including male condoms, that are now available world wide. The failure by the United States Global AIDS Strategy to provide clear guidance on, or to commit to investing seriously in the purchase, dissemination, and program support needed to make female condoms accessible to women in Africa and Asia reveals just one of the many profound weaknesses of the Strategy in responding to the reality of women's lives.

Gender inequity, violence and coercion.

The Strategy points to efforts to reach and engage male populations to change male behaviors and address violence against women (p. 30; p. 31). However, the Strategy outlines only vague and limited steps to address these issues, and does not address head on the internal conflict between the heavy focus on “abstinence-only” and gender violence. A specific and critical issue for women is in negotiating condom use for the practice of safer sex. Yet the Strategy, in its extreme bias against condom use generally, ignores the links between sexual violence and coercion and condom use even in marital relationships, and the urgent need to increase effective communication and negotiation strategies between women and men to ensure safer sex, both aspects of which are essential to reducing women's vulnerability to infection.

More broadly, while noting that prevention efforts are hampered by “gender inequality that increases the vulnerability of women and girls” (p. 23), the Strategy fails to provide any specific activities to address this issue, other than offering a bullet in the latter half of the section on prevention entitled “address gender inequality,” thereby leaving the “how-to” to the imagination.

Although the need to address the specific vulnerability of women and girls is essential for achievement of the Strategy's goals—i.e.

⁴⁰ Trussel et al. 1994; WHO, 1997.

⁴¹ Pettifor et al. 2001.

⁴² Ankrah and Attika 1997.

⁴³ Rivers et al. 1998.

⁴⁴ Prevention Now: The Female Condom and HIV Prevention, Center for Health and Gender Equity, 2001 and 2003.

preventing seven million infections and treating 2 million persons, not to mention for addressing the explosion in AIDS orphans—it offers only the minimal rhetorical nod to these issues and no specific strategies nor measurable indicators to measure the progress of its efforts in these areas.

For example, the Strategy notes that most of the focus countries have established policies to promote gender equality, improve women's socioeconomic status, and address violence against women, but have failed to enforce these policies. The Strategy thus supports provision of technical assistance to countries to enforce of laws relating to sexual violence. These steps are necessary but not sufficient to address the critical economic, legal and social changes needed to advance women's rights and health, reduce violence, and stem the spread of HIV. However, no mention is made of working with governments or civil society to develop legislation that establishes women's rights to property, and addresses gender violence, including within marriage, or seeks to eliminate customary laws such as widow inheritance or widow cleansing. No mention is made of linking efforts to prevent AIDS to meaningful reform in the application of school fees, which represent barriers to access to girls education, or to other such economic obstacles to change.

Instead, by focusing very narrowly on individual behavior change and putting its faith in education and awareness to encourage abstinence, the plan completely fails to acknowledge or address the fact that individual sexual and risk behaviors for HIV are largely driven by structural or contextual factors including social and gender norms, economic factors, and laws. The Strategy may therefore actually undermine efforts to promote women's equality by pushing countries to develop programs to support abstinence until marriage and fidelity within marriage which in turn can be perceived as reinforcing the role of women only as wives and mothers and not as individual actors with rights to education, security, property and other resources.

VI. RECOMMENDATIONS ON THE U.S. GLOBAL HIV/AIDS STRATEGY

In summary, this analysis of the U.S. Global AIDS Strategy reveals the following:

- The Strategy is *not* evidence-based, and indeed in most respects ignores solid evidence on the risks and risk factors facing most populations in the high-prevalence countries that are the priority recipients of the first round of funding, ignoring the overwhelming evidence on levels of sexual activity, transmission within marriage and other factors.
- The approach to prevention goes much further than the law requires in the area of allocating 33 percent of all prevention funds to “abstinence-only” programs by 2006 by:
 - making abstinence-only-until-marriage the centerpiece of its effort;
 - immediately reducing the total funding available for prevention of sexual transmission by incorporating PMTCT into the prevention, rather than the under treatment funds, as per Congressional intent;
 - allocating *all* funds for prevention of sexual transmission--outside of those to be allocated to high-risk groups—to abstinence-only-until-marriage.
- The Strategy abrogates basic human rights principles by supporting programs that provide partial and misleading information on health and health risks to people at high risk of contracting what is for all intents and purposes a fatal infection.
- Decisions being made in several areas, including both critical prevention and treatment interventions, are being based on political rather than health and humanitarian grounds.

These and other observations are reinforced by the steps being taken legislatively and otherwise on Global AIDS by the Administration, but outside the immediate scope of the Strategy. For example, the FY'05 budget submitted by President Bush for

Congress once again included less than the \$3 billion committed by the White House to Global AIDS, creating a shortfall of \$800 million in the first two years of the U.S. global AIDS effort. The Administration pledged that HIV funding would be “additive” and would not undermine existing efforts to promote development, improve health, and sustain existing programs such as reproductive health programs. Yet despite the fact that these same programs represent the front line in HIV prevention especially for women and girls, the FY05 funding request cuts in these programs at a time when they need to be increased. And as of this writing the Global Coordinator’s Office is holding a meeting in Botswana at which it seeks to undermine international agreement on the use of generic drugs.

Our review of the U.S. Global HIV/AIDS Strategy arrives at two conclusions. One is that the prevention strategy is crafted more to cater to the ideological agenda of the Administration’s “base”—the far political and evangelical right—than it is to meet the urgent prevention needs of the millions of people now at risk of infection throughout the world. The second is that the treatment agenda is based far more on the interests of pharmaceutical companies than on the urgent needs for access to ARVS of the millions already suffering from AIDS. Thus, the Strategy does not meet the test set out by the President himself when he committed to a global HIV/AIDS effort that would “create a cycle of hope and promise that will benefit millions.”

This paper and other critiques test the promise made by the Global AIDS Coordinator that the Strategy would be a living document, evolving as new evidence and insights come to light. To fulfill this pledge, the Coordinator’s Office should act immediately to do the following:

Develop a comprehensive prevention strategy that is based on the best available public health information and on objectively evaluated best practices in the field. First, and critical to the success of this effort, the Global AIDS Coordinator must immediately make a clear public statement in support of the rights of individuals to have access to all available prevention information and technologies, and make a clear break with the biased focused of the existing Strategy document. Moreover, the Office of the Global AIDS

Coordinator should revise the prevention strategy such that, at a minimum, it is based on the following principles and revisions in the Strategy:

- *Adoption of both human rights and public health approaches to HIV prevention, thereby ensuring that all individuals and groups have access to the full range of information, skills, and technologies needed to make informed choices about health.*
- *Development of country-specific strategies that respond directly to the diverse needs of populations in high- versus low-prevalence settings; of unmarried sexually active, unmarried non-sexually active, and married persons of all ages, with specific attention to the approaches that will best address the vulnerability of adolescents generally, and of women and girls specifically.*
- *Creation of clear, transparent processes by which diverse constituencies within the countries in question can shape and give input into the development of country- and locale-specific strategies; mechanisms for meaningful participation in shaping objectives, indicators, and evaluation processes for the purpose of developing HIV prevention efforts in each setting; ready access to information on U.S. funding and programmatic strategies; and knowledge of and access to partner organizations receiving U.S. funding and carrying out programs.*
- *Creation of clear, transparent processes through which U.S. stakeholders in global HIV/AIDS efforts have meaningful input into and dialogue with the Office of the Global AIDS Coordinator and other relevant government agencies on the evidence, the objectives, and the outcomes of U.S. Global HIV/AIDS Strategy.*
- *Creation within the Strategy of explicit, specific, clear objectives and indicators for measuring progress toward programmatic interventions that address critical issues, such as increased knowledge of HIV transmission and prevention strategies among all populations at risk, access to comprehensive prevention services, access to training on sexual communication and negotiation; access to male and female condoms and to other prevention technologies as these become available, efforts to change social norms around sex, power, and violence, and for other critical areas.*

- *Creation of objective, clear, and transparent mechanisms for evaluating the success rates of various programmatic approaches, including those for “abstinence-only” programs.*
- *Support for “risk-taking” approaches that create new avenues for discussion on sex, sexuality, and power as appropriate to, and among diverse populations within specific settings. Sex, sexuality, and pleasure are fundamental to healthy human development. Making discussions about these issues easier to have—as has been done in Uganda—can propel dramatic changes in the environment for addressing previously taboo subjects, and create equally dramatic shifts in public health efforts.*
- *Clear public commitment to maintain funding for condom procurement and delivery, and dramatically increased support for and investment in efforts to expand access to the female condom.*
- *Transparent processes by which conditionalities set in the legislation, such as limitations on funding to groups working with women in prostitution are interpreted such that the policy process is clear and accountable. Transparent processes for the evaluation of these conditionalities and their effects on vulnerable groups. (See A Critical Review of the U.S. Leadership Against HIV/AIDS, Tuberculosis and Malaria Act: Implications for Women’s Health and Human Rights, Center for Health and Gender Equity, forthcoming March 2004.)*
- *Create an interagency task force to examine the means through which U.S. funded global AIDS efforts can be coordinated at the country level to ensure that critical linkages are made between programs—such as those working to improve nutrition and deliver agricultural assistance or increase access to clean water—are coordinated such that these have synergistic effects in those countries and communities ravaged by AIDS.*
- *Hold a high-level international summit including both US government agencies and donor representatives from other countries to create a new agenda to improve the lives of women and girls, including specific financial commitments to address gender bias and discrimination and a plan of action for changing laws and policies governing women’s access to land and property rights, campaigns aimed at changing social norms around violence, stigma, and discrimination, and in other critical areas. Such a summit must not only produce promises, but also substantial resources, coordinated with, not separate from Global AIDS efforts.*
- *Develop clear mechanisms for intra-country government, donor and civil society coordination, such that resources are used wisely and synergistically toward the same goals, and such that all stakeholders are involved in the process in meaningful ways.*

Develop a coordinated effort to increase treatment access to the greatest number of people and using mechanisms, such as the WHO 3x5 campaign, that are not tied to the needs or interests of specific political parties or to U.S. domestic interests.

Increase coordination within the U.S. government agencies with oversight on related programs, and between the United States and other donor agencies on the ground in all countries receiving U.S. Global AIDS funding.

The Global AIDS Coordinator is in a unique position to marshal the billions of dollars in U.S. international assistance for the purpose of creating a coherent strategy on global AIDS that will unquestionably have simultaneous and positive effects on other areas of development, health, and security. At a minimum, the Global AIDS Coordinator should do the following:

- *Immediate development through transparent and public processes involving key stakeholders of clear and objective guidance on the delivery of ARVs, including a policy guiding the purchase of generic drugs for those in need, support for the Global Fund, and specific mechanisms through which the United States government will work in collaboration with—and not separately from—existing multilateral efforts to treat as many people as possible.*

- *Priority decision-making power in the process of developing guidance on treatment access and drug regimens to groups, such as Treatment Access Campaign, that immediately represent the needs of those infected and on whose behalf such decisions can be more transparently be made.*
- *Inclusion in all stages of the process of civil society actors and others with direct experience on the ground in successfully providing and monitoring treatment, such as Medicines Sans*

Frontieres, and other such groups whose primary interest is in the health of individuals and populations, and that do not have ties to special interest.

These and other steps are critical to ensuring that the U.S. commitment to addressing global AIDS has integrity, moral clarity and strength, and is based on the urgent needs of individuals now at risk of contracting and already suffering from HIV/AIDS.

Correspondence about this paper should be directed to Jodi Jacobson, Executive Director, <jacobson@genderhealth.org> or Genevieve Grabman, Policy and Legislative Associate, <ggrabman@genderhealth.org>. All rights reserved by the Center for Health and Gender Equity. No part of this document may be reproduced, disseminated, published, or transferred, except with prior permission and appropriate acknowledgment of the Center for Health and Gender Equity. Suggested citation: Center for Health and Gender Equity. *Debunking the Myths In The U.S. Global AIDS Strategy: An Evidence-Based Analysis*. (Takoma Park MD, March 2004). For additional copies, email <info@genderhealth.org>.

VII. APPENDICES-

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BOX 1: PREVENTION ISSUES ADDRESSED BY THE STRATEGY**SCALED UP SERVICES**

- Abstinence and behavior change for youth
- Testing, outreach and condom distribution among high-risk populations
- Prevention of mother-to-child transmission
- Safe blood supply, medical practices and post-exposure prophylaxis

CAPACITY FOR LONG-TERM SUSTAINABILITY

- ABC model
- Expanded STI (including HIV) testing and treatment
- Interventions for high-risk populations
- Institutional capacity of implementing organizations

SUPPORTIVE POLICY INITIATIVES

- Protection against stigma and discrimination
- Routine testing
- Human resources policies at all levels of care
- Access to health information and care for all populations
- Gender equality
- Protection from sexual violence

PROGRESS EVALUATION AND COMPLIANCE

- Provider capacity
- Targeted evaluations
- Information management systems

BOX 2: TREATMENT ISSUES ADDRESSED BY THE STRATEGY**SCALED UP SERVICES**

- Access network capacity for treatment expansion
- Build on established clinical programs
- Rapidly train and mobilize health care personnel
- Enhance capacity of supply chain management systems

CAPACITY FOR LONG-TERM SUSTAINABILITY

- Health care worker recruitment, training and retention
- Treatment protocols
- Increased capacity of new partners
- Strengthened health infrastructure

SUPPORTIVE POLICY INITIATIVES

- Technical assistance in policy development
- Political commitment

PROGRESS EVALUATION AND COMPLIANCE

- Surveillance of HIV incidence, prevalence, and mortality
- Provider capacity
- Targeted evaluations
- Information management systems

BOX 3: PALLIATIVE CARE ISSUES ADDRESSED BY THE STRATEGY**SCALED UP SERVICES**

- Capacity of care services and personnel
- Integrated prevention, treatment and care services
- Use U.S. volunteers

CAPACITY FOR LONG-TERM SUSTAINABILITY

- Protocol development
- Twinning
- Curriculum in health professional schools
- Expanded and integrated hospice services
- Public-private partnership opportunities
- Provision of essential supplies

SUPPORTIVE POLICY INITIATIVES

- Human resources policy reform and development at all levels of care
- Recruitment and retention of care professionals
- Policy reforms to increase availability of pain medication

PROGRESS EVALUATION AND COMPLIANCE

- Provider capacity
- Targeted evaluations
- Information management systems

BOX 4: CARE ISSUES FOR ORPHANS AND VULNERABLE CHILDREN ADDRESSED BY THE STRATEGY**SCALED UP SERVICES**

- Strengthen the capacity of families to cope
- Mobilize and strengthen community-based responses
- Increase capacity of children to become proactive in meeting their own needs
- Integrate care services with existing prevention and care programs

CAPACITY FOR LONG-TERM SUSTAINABILITY

- Capacity of community and faith-based organizations
- Early interventions with at-risk youth
- Collaboration and coordination among partners
- Public-private partnership opportunities

SUPPORTIVE POLICY INITIATIVES

- Inheritances and succession
- Bereavement among children
- Child-headed households
- Education access
- Protective services (e.g., against abuse, trafficking, child prostitution, child labor)

PROGRESS EVALUATION AND COMPLIANCE

- Population-based surveys
- Provider capacity
- Targeted evaluations
- Information management systems

BOX 5: AT A GLANCE: DEBUNKING THE MYTHS**IT IS NOT POSSIBLE TO ACCURATELY DETERMINE WHO IS “HIGH-RISK”**

- HIV infection rates in many of the general populations are extremely high
- In Botswana, over 35 percent of people 15-49 are HIV-positive. In South Africa, HIV prevalence rates rose from 1 to 20 percent among people 15-49 in the last decade
- In such settings, it is impossible to isolate those who are “high-risk.” *Everyone* is at risk

MANY ADOLESCENTS IN THE PRIORITY COUNTRIES ARE AT IMMEDIATE AND HIGH RISK OF INFECTION BECAUSE THEY ARE ALREADY SEXUALLY ACTIVE

- Data show that the median age for first sexual encounter (penetrative sex) among women ages 15 to 24 is approximately 16.6 in Botswana, 19 in Ethiopia, 16.5 in Kenya, 16.6 in Tanzania, 16.6 in Uganda, and 16.8 in Zambia
- The median age for first sex among men in the same age group, where data are available, is 22.1 in Ethiopia, 17.1 in Kenya, 16.8 in Tanzania, and 18.3 in Uganda

THE GAP BETWEEN SEXUAL INITIATION AND MARRIAGE

- In many countries, age-at-marriage is rising, which can be especially beneficial for girls
- However, the large gap between sexual initiation and age-at-marriage leaves a proportion of the adolescent and young adult population at high risk of infection

MARRIAGE IS NOT A PROTECTIVE FACTOR AGAINST HIV INFECTION FOR WOMEN AND GIRLS

- Mounting evidence makes clear that *married, monogamous* women are among the groups at *greatest* risk of infection
- Infection rates among women in sub-Saharan Africa peak at around 25 years of age, indicating that the majority of women and girls contracted HIV *within marriage*
- In Cambodia, prevalence rates among sex workers are dropping, while those among married women are increasing rapidly
- In India, married women accounted for one fourth of all new cases in 2001 and 40 percent of all new cases in 2002

MANY ADOLESCENTS IN THE PRIORITY COUNTRIES ARE ALREADY MARRIED

- In many countries with high HIV prevalence rates, age-at-marriage is rising, but the majority of adolescent girls still marry early
- In many places, child marriage remains highly prevalent
- Forty-seven percent of adolescent women are married by age 18 in South and East Africa, 55 percent in West Africa, and 62 percent in Asia

TABLE 1: SEXUAL DEBUT, MARRIAGE AND CHILD BEARING AMONG WOMEN IN SELECTED AFRICAN COUNTRIES			
	Median Age of Women (25-49) at First Sex	Median Age of Women (25-49) at First Marriage	Percent Teenagers Who Have Begun Child Bearing
Uganda (2000-01)	16.6	17.8	31.4
Kenya (1998)	16.5	19.2	20.9
Zambia (2000-01)	16.8	17.8	31.6
Tanzania (1999)	16.6	18.1	24.5
South Africa (1998)	18.4	24.2	16
Rwanda (2000)	20.1	20.7	6.8
Mozambique (1997)	15.9	17.1	40

Source: DHS data available at <<http://www.measuredhs.com>>.