Center for Global Development

Opportunities for Presidential Leadership on AIDS: From an "Emergency Plan" to a Sustainable Policy

by Mead Over

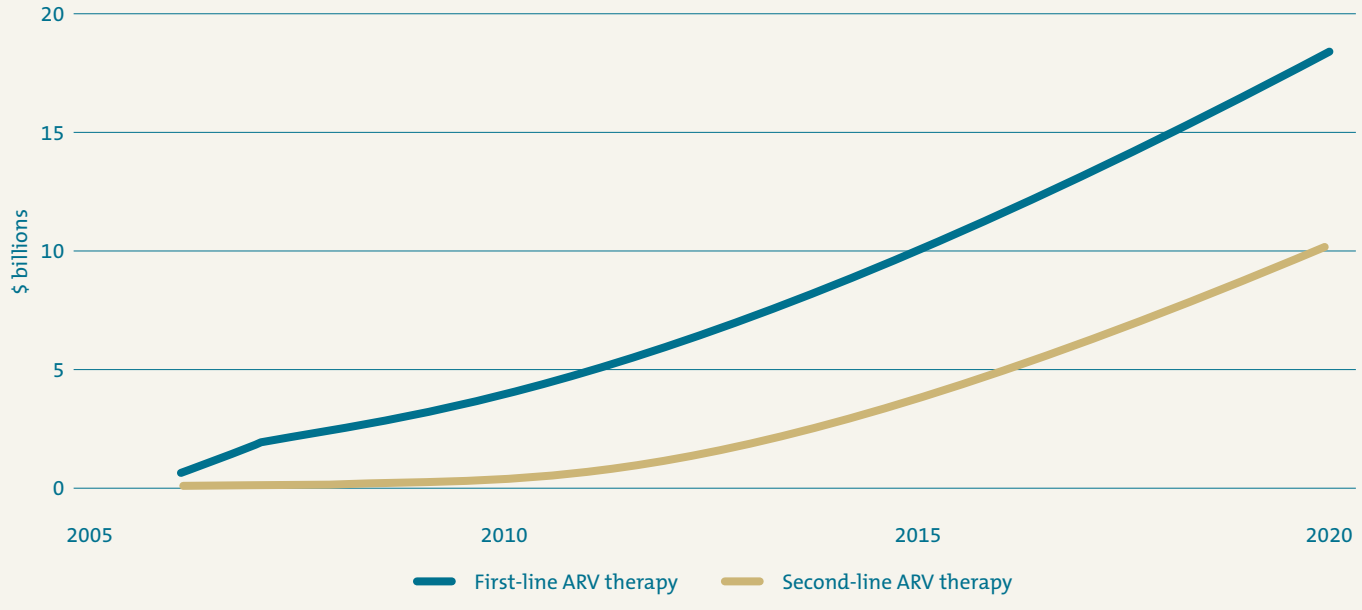
U.S. spending on global AIDS is widely seen as a significant foreign policy and humanitarian success. But this success contains the seeds of a future crisis. Treatment costs are set to escalate dramatically, mainly due to two factors: antiretroviral drugs have prolonged the lives of AIDS patients who require life-long treatment, and new HIV infections continue to outpace the number of people receiving treatment, due to inadequate prevention.

As a result of these trends, U.S. international AIDS spending—now $2 billion each year—could grow to $12 billion by 2016, consuming half the foreign assistance budget and squeezing out U.S. spending on other needs, including other health issues (see Figure 1). An increasing proportion of these expenditures will support patients on expensive "second line" therapy, which is administered when the AIDS virus becomes resistant and the cheaper first-line antiretroviral (ARV) drugs no longer work.

The United States has also unwittingly created a new global "entitlement" for countries receiving U.S. funds to fight AIDS—that is, an open-ended commitment that would be very difficult to halt. Any interruption in U.S. assistance now would mean certain death for funded patients and harm the reputation of the United States. The list of countries with entitled patients includes the fifteen "focus" countries where the President's Emergency Plan for AIDS Relief (PEPFAR) operates, and which depend almost exclusively on the United States for external AIDS assistance (see Figure 2).

Three bad options thus loom ahead for U.S. foreign policy: indefinitely increasing foreign assistance spending on an entitlement, eliminating half of other foreign aid programs, or withdrawing the medicine that millions of people depend upon to stay alive.

Figure 1. Projected cost of treating AIDS in the fifteen PEPFAR countries



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The White House and The World

Each day brings fresh evidence that Americans' well-being is linked to the lives of others around the world as never before. Accelerating advances in technology and the creation of new knowledge offer undreamed-of opportunities. Yet global poverty, inequality, disease and the threat of rapid climate change threaten our hopes. How will the U.S. president elected in November 2008 tackle these global challenges?

The White House and the World: A Global Development Agenda for the Next U.S. President shows how modest changes in U.S. policies could greatly improve the lives of poor people in developing countries, thus fostering greater stability, security, and prosperity globally and at home. Center for Global Development experts offer fresh perspectives and practical advice on trade policy, migration, foreign aid, climate change and more. In an introductory essay, CGD president Nancy Birdsall explains why and how the next U.S. president must lead in the creation of a better, safer world.

The White House and the World Policy Briefs present key facts and recommendations drawn from the book in a succinct form designed for busy people, especially senior policymakers in the executive and legislative branches of government. This brief is drawn from "Opportunities for Presidential Leadership on AIDS: From an 'Emergency Plan' to a Sustainable Policy" by CGD senior fellow Mead Over.

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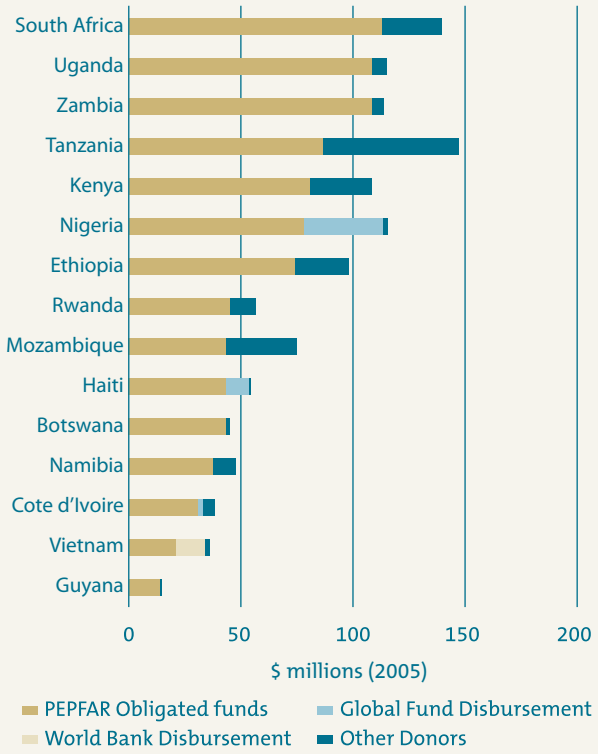
Figure 2. Countries depend heavily on PEPFAR for AIDS funding



Source: Mead Over, "Prevention Failure: The Ballooning Entitlement Burden of U.S. Global AIDS Treatment Spending and What to Do About It," Working Paper 144 (Washington, D.C.: Center for Global Development, 2008).

A global "AIDS transition"

The solution to this dilemma for the United States and for the world lies in the achievement of a global "AIDS transition," similar to demographic and epidemiological transitions that occurred in the past. The goal in this case would be to sustain the reduction in AIDS deaths while also preventing almost all new HIV infections, so as to gradually reduce the number of people needing AIDS treatment.

The importance of HIV prevention—as both a public health and fiscal imperative—cannot be overemphasized. Yet despite including prevention in its mandate, PEPFAR reduced prevention spending in nine of the fifteen focus countries and reduced total prevention spending by 9.3 million dollars in 2006, the latest year for which PEPFAR has released detailed spending data (see Figure 3).

A restructuring of PEPFAR to boost prevention is urgently required to change today's reality, where for each new individual on treatment there are four or five new infections. It is

depressing and even scandalous to see that after more than twenty years of donor-funded prevention efforts, so few of them have been rigorously evaluated.[1] PEPFAR should establish firm numerical objectives for reducing the number of new cases of HIV infection in each focus country.[2] Five neglected prevention strategies that could help achieve prevention objectives in PEPFAR countries are discussed below.

Five prevention strategies to strengthen PEPFAR

1. Target HIV-prevention efforts to hot spots

Focusing prevention efforts on places frequented by those at most risk of contracting and transmitting the infection is clearly an effective strategy. But the data to determine such spots and choose the most appropriate intervention is often lacking. According to the Institute of Medicine, "PEPFAR and [previous] US government-funded programs have supported the collection, analysis and appropriate application of both sentinel and behavioral surveillance data in many of the focus countries. . . . However, only a few of the countries have conducted behavioral surveys focused specifically on high-risk populations."[3]

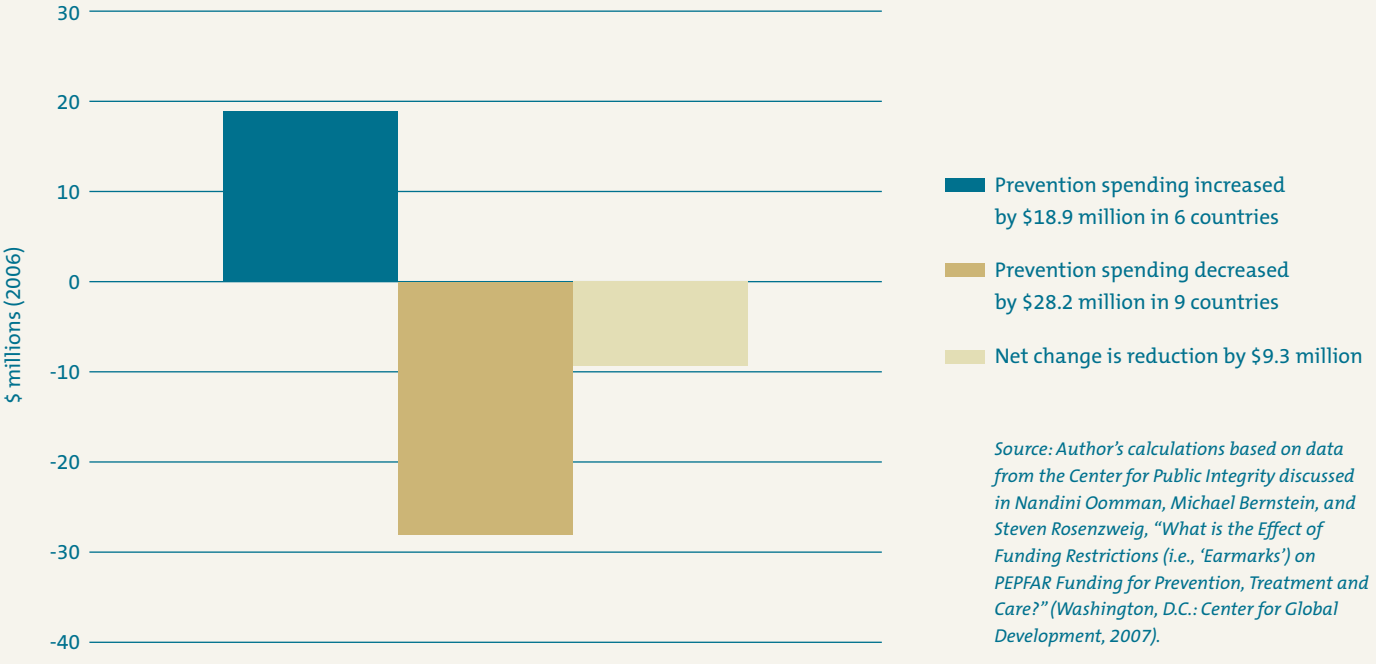
The great success of the 100 percent condom program in Thailand in the 1980s was predicated on the fact that brothels provided an easily identifiable focus for an effective prevention campaign.[4] A technique called the "PLACE Method" to determine local hot spots through street interviews was also developed in the last decade.[5] Although the formative research to develop this technique and field test it in a dozen African cities was funded by the United States Agency for International Development (USAID), neither that agency nor PEPFAR has attempted to evaluate the approach using rigorous methods or to scale up its implementation in order to saturate any region of any African country with prevention messages and condoms.

2. Mobilize AIDS patients for HIV prevention

AIDS patients who are in good health thanks to their precise adherence to their medication regime can be an important channel for reaching out to people whose risk behavior can lead to infection. With proper training, motivation and monitoring, patients can work to ensure that AIDS treatment does not engender complacency and disinhibition among non-patients but instead encourages reductions in risky behavior.

One way to enlist AIDS patients in prevention advocacy is to build on the structure of the adherence support organizations. When several such organizations exist in a community, they can be judged against one another not only by their success in getting members to take their medicine regularly but also on their efforts to reach non-members with HIV-prevention interventions. Organizations that do well only on adherence

Figure 3. PEPFAR spending on prevention declined between 2005 and 2006 in nine of its fifteen focus countries



Source: Author's calculations based on data from the Center for Public Integrity discussed in Nandini Oomman, Michael Bernstein, and Steven Rosenzweig, "What is the Effect of Funding Restrictions (i.e., 'Earmarks') on PEPFAR Funding for Prevention, Treatment and Care?" (Washington, D.C.: Center for Global Development, 2007).

would not lose their PEPFAR funding (since reducing funds might disrupt the treatment of their members), but neither would they receive funding to enroll additional members. Organizations that excel at both adherence support and outreach prevention would, on the other hand, be rewarded with funding for additional members. In this way, treatment subsidies could be made to leverage prevention efforts.

3. Expand access to male circumcision

Evidence that male circumcision protects men from HIV infection has accumulated now from both observational and experimental studies.[6] Furthermore, none of the studies found any evidence that circumcised men increase their risky behavior, which would offset some of the advantage of the circumcision.

Researchers have now turned from the question of efficacy to that of feasibility. Small-scale, non-random studies have generally supported the feasibility of scaling up access to male circumcision among the general population in Africa.[7] Building on these research results, PEPFAR should now allocate a substantial portion of its discretionary resources to making clean and safe circumcision at least as easily accessible as antiretroviral therapy in all the PEPFAR countries.

4. Integrate family planning with AIDS treatment

Another key strategy to prevent infections that has not been sufficiently deployed is family planning. Although programs to prevent mother-to-child transmission of HIV are having increased success, they remain complex and uncertain. Given the private and social cost incurred for each HIV-infected child, AIDS treatment programs and family planning programs should join forces to ensure that every HIV-positive woman has free and easy access to the birth control method of her choice without fear of stigmatization. Unfortunately, due to the lack of integration of family planning with AIDS treatment, there appears to be substantial unmet need for contraception among HIV-positive women.

As early as 1993, a study found that 60 percent of HIV-positive women would prefer not to have more children.[8] Several studies have found that family planning efforts are more cost-effective than interventions to prevent mother-to-child transmission once pregnancy has occurred.[9] Three of the authors of these studies have pointed out that the existing levels of contraception in sub-Saharan Africa have probably prevented 173,000 HIV-positive births each recent year and that providing family planning services to those with unmet needs would avert an additional 160,000 HIV-positive births every year.[10]

5. Reorient HIV testing toward couples

As a supplement to testing initiated by health providers, PEPFAR should evaluate the feasibility and effectiveness of wide-scale couple counseling in the home. Such counseling has been found to be effective with discordant couples (where one party is HIV-positive) and even more promising with concordant-negative couples (where neither person is yet infected).[11] Furthermore, some studies suggest that people are more likely to accept couple counseling in their homes than at health care facilities.[12] When couples learn each other's HIV status as well as their own, and receive counseling about the dangers of unprotected sex outside their partnership, they may increase condom use with other partners and even reduce the frequency of such partnerships. Thus, couple counseling, especially in the home, might discourage the practice of having multiple concurrent partnerships, which are thought to be a major contributor to the epidemic in Africa.[13]

Conclusion

President Bush's "emergency" AIDS assistance program to fifteen of the countries very badly affected by the epidemic is in the best, generous traditions of American foreign assistance. PEPFAR has already prolonged the lives of more than a million people, provided care and support for orphans and other vulnerable children, and prevented many cases of HIV infection. Although the evidence on the program's effects on the health care systems of all recipient countries is not yet in, some national systems seem to have benefited from positive spillover effects from PEPFAR. Together with the Millennium Challenge Account, PEPFAR is arguably the Bush administration's most notable foreign policy success.

However, as the number of people needing treatment rises, and as more of them require expensive second-line ARV therapy, it will become increasingly difficult for the United States to meet its implied commitment to current and future AIDS patients in PEPFAR target countries. Unless the United States acts to help recipient countries greatly reduce the number of new infections, President Bush's initial success will metamorphose into a shameful example of American over-reaching. We argue that the next president can build on PEPFAR in such a way as to prevent this scenario. If, in the fifteen PEPFAR countries, the next administration can effectively manage the current AIDS treatment entitlement, prevent the future need for treatment, and help ensure the AIDS transition to the point that the disease becomes a manageable chronic condition rather than a fatal one, then the next president will deserve a full measure of credit for the long-run benefits of PEPFAR—credit equal to or greater than that due to President Bush for launching the program.

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Endnotes

[1] J. Wegbreit et al., "Effectiveness of HIV Prevention Strategies in Resource-Poor Countries: Tailoring the Intervention to the Context," AIDS 20 no. 9 (2006): 1217–1235.
[2] Current legislation mandates a target number of infections averted without specifying how this number might be estimated. A better approach is to use surveys to estimate precisely the number of new infections now and to judge PEPFAR by the evidence that it this number has gone down by, say, 90 percent by 2012.
[3] Institute of Medicine, *PEPFAR Implementation: Progress and Promise* (Washington, D.C., 2007).
[4] M. Ainsworth and A.M. Over, *Confronting AIDS: Public Priorities in a Global Epidemic* (New York: Oxford University Press, 1997).
[5] S.S. Weir et al., "A Pilot Study of a Rapid Assessment Method to Identify Places for AIDS Prevention in Cape Town, South Africa," *Sexually Transmitted Infections* 78 Supplement 1(2002): i106–i113; S.S. Weir et al., "From People to Places: Focusing AIDS Prevention Efforts Where it Matters Most," AIDS 17 no. 6(2003): 895–903; S.S. Weir et al., "Where the Action Is: Monitoring Local Trends in Sexual Behaviour," *Sex. Transm. Inf.* 80 Suppl 2(2004): ii63–ii68.
[6] Randomized controlled trials in the last few years have shown that the association between male circumcision and HIV is indeed causal. In Kenya, the ethical review process halted a trial after observing that 22 of the 1,391 circumcised men became infected with HIV compared to 47 among the 1,393 uncircumcised group. Since the risk of becoming infected during the trial period was 53 percent less for the circumcised, the researchers concluded that male circumcision is comparable to a 50 percent effective vaccination. (R.C. Bailey et al., "Male Circumcision for HIV Prevention in Young Men in Kisumu, Kenya: A Randomized Control Trial," *Lancet* 369 Issue 9562(2007): 643–656.
[7] Whether this would be true in South Asia, where the foreskin is a distinction of Muslim men, is a separate and potentially more difficult question.
[8] S. Allen et al., "Confidential HIV Testing and Condom Promotion in Africa: Impact on HIV and Gonorrhea Rates," *Journal of the American Medical Association* 268 no. 23(1992): 3338–3343.
[9] H.W. Reynolds et al., "The Value of Contraception to Prevent Perinatal HIV Transmission," *Sex. Transm. Inf.* 33 no. 6(2006): 350–356; J. Stover et al., "Adding Family Planning to PMTCT Sites Increases the Benefits of PMTCT" (Washington, D.C.: USAID, 2003), http://www.fhi.org/NR/rdonlyres/earf7d7i4up5roh7hrpbxekmx55tprl5t5bcqq3tf4kfpprm3oprt3j4i6ztqznwv5g3qthqjk7zfc/FPPMTCTissuebriefrev102203enrh.pdf; M.D. Sweat et al., "Cost-effectiveness of Nevirapine to Prevent Mother-to-Child HIV Transmission in Eight African Countries," *AIDS* 18 no. 12(2004): 1661–1671.
[10] H.W. Reynolds, M.J. Steiner, and W. Cates, "Contraception's Proved Potential to Fight HIV," *Sex. Transm. Inf.* 81(2005): 184–185.
[11] M. Ainsworth and A.M. Over, 1997; S. Allen et al., 1992; S. Allen, J. Tice, et al., "Effect of Serotesting with Counselling on Condom Use and Seroconversion among HIV Discordant Couples in Africa," British Medical Journal 304 Issue 6842(1992): 1605–1609; S. Allen et al., "Pregnancy and Contraception Use among Urban Rwandan Women After HIV Testing and Counseling," American Journal of Public Health 83 no. 5(1993): 705–710; N.S. Padian et al., "Prevention of Heterosexual Transmission of Human Immunodeficiency Virus through Couple Counseling," *Journal of Acquired Immune Deficiency Syndrome* 6 no. 9(1993): 1043–1048; D.L. Roth et al., "Sexual Practices of HIV Discordant and Concordant Couples in Rwanda: Effects of a Testing and Counselling Programme for Men." *International Journal STD AIDS* 12 no. 3(2001): 181–188.
[12] C. Farquhar et al., "Antenatal Couple Counseling Increases Uptake of Interventions to Prevent HIV-1 Transmission," *J. of Acq. Imm. Defic. Syndr.* 37 no. 5(2004): 1620–1626; J.K. Matovu et al., "Sexually Transmitted Infection Management, Safer Sex Promotion and Voluntary HIV Counselling and Testing in the Male Circumcision Trial, Rakai, Uganda," *Reproductive Health Matters*. 15 no. 29(2007): 68–74; W. Were et al., "Home-Based Model for HIV Voluntary Counselling and Testing," *Lancet* 361 Issue 9368(2003): 1569.
[13] H. Epstein, *The Invisible Cure: Africa, the West, and the Fight Against AIDS* (New York: Farrar, Straus and Giroux, 2007); D.T. Halperin and H. Epstein, "Concurrent Sexual Partnerships Help to Explain Africa's High HIV Prevalence: Implications for Prevention," *Lancet* 364 no. 9428(2004): 4–6; M. Morris and M. Kretzschmar, "Concurrent Partnerships and the Spread of HIV," AIDS 11 no. 5(1997): 641–648.

Further Reading

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