



Prevention Funding Under The President's Emergency Plan for AIDS Relief: Law, Policy and Interpretation

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Background

According to UNAIDS, there are an estimated 40 million persons infected with HIV worldwide.¹ Less than nine percent of the six million people in immediate need of anti-retroviral (ARV) treatment have access to drugs.² With five million new infections each year, successful responses to the HIV epidemic will require strong political and financial commitment to effective, evidence-based prevention programs that address the core factors underlying the spread of HIV worldwide. Sexual transmission is the single most important factor in the spread of HIV worldwide and is the source of approximately 80 percent of new infections in sub-Saharan Africa.³ Preventing the spread of HIV must, therefore, include efforts to address sex, sexuality, and other factors underlying the sexual transmission of HIV, while enabling all persons to realize safe, healthy, and consensual sexual lives.

Under the President's Emergency Plan for AIDS Relief (PEFAR), President Bush set out the goal of preventing seven million new infections by 2008.⁴ In this policy brief, we examine both the law authorizing U.S. global AIDS programs and the policies interpreting the law, and we underscore the ways in which current U.S. law and policies as interpreted by the Bush Administration are undercutting efforts to achieve the President's stated goals.

What does the law say?

The law authorizing U.S. global AIDS programs, the *United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003* (Global AIDS Act), established earmarks for funding of prevention activities within PEFAR. Funding for prevention, as for all U.S. Global AIDS programs, is overseen by the Office of the Global AIDS Coordinator (OGAC).

The law contains "soft," or non-binding, earmarks in fiscal years 2004 and 2005. These are in "sense of Congress" guidance meant to inform the policies interpreting a law. It was the "sense of Congress" that 20 percent of all bilateral AIDS funding be allocated to prevention activities. It was also the "sense of Congress" that at least 33 percent of bilateral prevention funding be expended for abstinence-until-marriage programs in 2004 and 2005. Congressional report language also contains soft earmarks suggesting that funding for prevention of maternal-to-child HIV transmission be funded out of the bilateral HIV treatment budget, thereby preserving a greater amount of overall prevention funding for prevention of sexual transmission.

Congress placed a "hard," or binding, earmark in the law for prevention funding from 2006 through 2008. As of 2006, the law requires that at least 33 percent of all funding for bilateral prevention programs be spent on abstinence-until-marriage programs. Other soft and hard earmarks are found within the legislation for treatment, care, and programs focused on orphans and vulnerable children.⁵

What discretion does the Global AIDS Coordinator have in funding and implementation of prevention programs?

Even given these earmarks, the Global AIDS Coordinator has considerable discretion in interpreting the Global AIDS Act in the following ways:

Exceeding the earmark. In both cases--the soft and hard 33 percent earmarks--represent a floor, not a ceiling, for funding of abstinence-until-marriage programs. The Coordinator can spend more than 33 percent of the total prevention budget on abstinence-until-marriage programs, whether at the global or the country level.

Defining program content. OGAC has the discretion to define the content of abstinence-until-marriage programs eligible for funding, the types of interventions used to promote the intended outcome of such programs, the types of indicators or measures of success to be used in determining the effectiveness of such programs, and the types of organizations to fund in achieving these outcomes.

Deciding how to meet the 33 percent earmark and determining the net level of funding to abstinence-based programs. The Global AIDS Coordinator's office has the ability to decide among several options for meeting the abstinence-until-marriage earmark, including:

- **Defining the budget from which earmarked funds are drawn.** OGAC may determine whether or not to include in the total prevention budget funding for prevention of mother-to-child HIV transmission (PMTCT). By following 2004 Congressional report language suggesting that PMTCT be funded out of the treatment budget, for example, OGAC would preserve a greater amount of money for prevention of sexual HIV transmission, the single greatest factor in HIV transmission.
- **Counting funds spent on abstinence and delay of sexual debut *within* comprehensive programs toward fulfilling the earmark, or only counting those funds spent on programs *discrete from* comprehensive programs.** OGAC can decide whether to count each dollar of funding allocated to any program promoting abstinence and delay of sexual debut among unmarried adolescents, or whether to require that any abstinence-based program promote "only abstinence," without any safer sex content, information, training, or technologies.
- **Determining what share of the prevention budget goes toward prevention of sexual transmission.** The Global AIDS Coordinator can decide what share of the total prevention budget goes to prevention of sexual transmission.

How has OGAC interpreted the law in formulating policy?

OGAC, in keeping with the agenda of the Bush Administration, has interpreted the law in ways that undermine effective prevention strategies and has effectively eliminated comprehensive programming by:

Exceeding the earmark. The inclusion of PMTCT funding in the denominator for all prevention activities hides the true share of funding for abstinence programs. In addition, abstinence-until-marriage and faithfulness programs (AB) are being funded at a rate far higher than 33 percent of all funding for prevention of sexual transmission. In 2004, for example, OGAC spent 59 percent of all funding for prevention of sexual transmission on AB programs.⁶ At the country level in 2005, the share of funding for prevention of sexual transmission spent on AB programs reached as high as 53 percent in Ethiopia, 60 percent in Uganda, and 70 percent in Nigeria. For a breakdown of funding of AB programs as a share of funding for sexual transmission, see country fact sheets at <http://www.genderhealth.org/AIDS.php>.

Defining program content narrowly. In interpreting the law, the Coordinator has chosen the narrowest possible definition of programs eligible for funding, ignoring a vast amount of public health evidence on rates of infection and risk factors.

All PEPFAR focus countries in sub-Saharan Africa are experiencing generalized epidemics,⁷ with prevalence rates ranging from over 5 percent in Uganda to around 37 percent in Botswana. In a generalized epidemic, all sexually active individuals are considered at risk of infection. In fact, the highest rates of new infections in sub-Saharan Africa are occurring among those ages 15 to 24 and among married women in their twenties and thirties.⁸ In Nigeria, for example, with an HIV prevalence rate of nearly six percent, 55 percent of persons ages 15 to 24 are sexually active and in Uganda, with a prevalence rate of five percent, 66 percent of persons ages 15 to 24 are sexually active.⁹ See Table 2. These and other facts indicate an urgent need for programs that promote safer sex within the general population.

Comprehensive HIV prevention programs promote all aspects of prevention simultaneously, including abstinence and delay of sexual debut, fidelity and partner reduction, and information and training on safer sex practices, including but not limited to condom use. Such programs recognize that, ultimately, virtually all persons will become sexually active and that, when they do, they need information, skills, and technologies to make healthy choices in meeting their individual circumstances. Such programs ideally reach everyone at risk—including married and unmarried individuals, sero-discordant couples and all other groups—with consistent, accurate information; seek to fill gaps in knowledge about sex, reproduction and transmission of infection; address critical factors, such as the rights of all persons to be free of sexual violence and coercion, and provide information and training to both women and men on negotiating safer sex and consensual sex, even within marriage.

PEPFAR-funded programs effectively ignore both reality and public health practice by eliminating comprehensive programs in favor of discrete AB programs. Examination of OGAC guidance and HIV/AIDS grants reveal that abstinence and faithfulness programs have been defined as narrowly as possible, becoming what are in effect “*abstinence-only-until-marriage*” (i.e. promoting only abstinence), so-called secondary abstinence programs, and “*be faithful*” programs, the vast majority of which operate in isolation of other interventions. There is no evidence that these programs are effective in reducing the rate of HIV infection or protecting individuals or groups at risk.

Isolating so-called “high-risk” populations and ignoring those at risk within the general population. OGAC policy requires that condom outreach, distribution, and marketing programs be focused only on “high-risk” groups, which it defines, for example, as commercial sex workers and truck drivers. This again defies the sum total of data and evidence from the countries in question.

Including PMTCT in the denominator for prevention funding. OGAC has defined the denominator of prevention funding to maximize the net amount of funding to abstinence-only-until marriage and be faithful program. Beginning in 2004, the Coordinator has funded PMTCT programs out of limited bilateral prevention funding, instead of out of the budget for treatment, despite the sense of Congress on paying for funding of PMTCT out of the treatment budget. As a result, the net amount of monies dedicated to abstinence-until-marriage programming is greater than, and the net amount of monies dedicated to programs promoting safer sex less than, these would be had PMTCT funding been included in the treatment budget.

Requiring that each dollar of funding toward the earmark be counted only from discrete AB rather than comprehensive programs. OGAC could, but does not, count a dollar from a comprehensive program that includes abstinence and delay of sexual debut toward the earmark, and instead insists that these programs exist in isolation.

Ensuring that AB programs make up a minimum of two-thirds of all funding for prevention of sexual transmission. For fiscal year 2006, new OGAC guidance requires that PEPFAR focus countries spend a minimum of 50 percent of prevention on sexual transmission and two-thirds of their funding for prevention of sexual transmission on abstinence-only-until-marriage, secondary abstinence, and faithfulness programs,¹⁰ thereby using this calculation to meet the one-third earmark.

In sum, with respect to stemming the spread of HIV infection through sexual transmission, the Global AIDS Act is a bad law made worse through narrow interpretation of law into policy.

Table 1. Funding of abstinence and be faithful programs as a share of prevention of sexual transmission under PEPFAR, FY 2004 and 2005.

Country	FY 2004 (percent)	FY 2005 (percent)
Nigeria	46	70
Rwanda	54	60
Uganda	60	60
South Africa	36	57
Ethiopia	81	53
Kenya	57	53
Namibia	57	48
Zambia	31	47
Tanzania	51	50

Sources:

United States Department of State Office of the Global AIDS Coordinator. 2004. *Emergency Plan for AIDS Relief Fiscal Year 2004 Operational Plan*. Washington, D.C., USA: United States Department of State.

United States Department of State Office of the Global AIDS Coordinator. 2005. *FY2005 Data- Planned Funding Amount and Percentage by Program Area*. Washington, D.C., USA: United States Department of State. January 2006.

Table 2. Age at marriage and sexual activity, nine PEPFAR countries in sub-Saharan Africa.

Country	Median age first marriage, female	Share of population ages 15-24 sexually active (percent)
Zambia	18.1	75
Namibia	26.2	74
Tanzania	18.4	71
Uganda	17.8	66
Kenya	19.9	64
South Africa	N/A	64
Nigeria	17.2	55
Ethiopia	16.4	40
Rwanda	21	20

Sources:

Central Statistical Office [Zambia], Central Board of Health [Zambia], and ORC Macro. 2002. *Zambia Demographic and Health Survey 2001-2002*. Calverton, Maryland, USA: Central Statistical Office, Central Board of Health, and ORC Macro, p. 11.

Ministry of Health and Social Services (MOHSS) [Namibia]. 2003. *Namibia Demographic and Health Survey 2000*. Windhoek, Namibia: MOHSS, p. 9.

National Bureau of Statistics [Tanzania] and Macro International Inc. 2000. *Tanzania Reproductive and Child Health Survey 1999*. Calverton, Maryland: National Bureau of Statistics and Macro International Inc., p. 8.

Uganda Bureau of Statistics (UBOS) and ORC Macro. 2001. *Uganda Demographic and Health Survey 2000-2001*. Calverton, Maryland, USA: UBOS and ORC Macro, p. 9.

Central Bureau of Statistics (CBS) [Kenya], Ministry of Health (MOH) [Kenya], and ORC Macro. 2004. *Kenya Demographic and Health Survey 2003*. Calverton, Maryland: CBS, MOH, and ORC Macro, p. 13.

Department of Health [South Africa], and Macro International Inc. 1998. *South Africa Demographic and Health Survey 1998*. Calverton, Maryland: Ministry of Health and Macro International Inc., p. 8.

National Population Commission (NPC) [Nigeria] and ORC Macro. 2004. *Nigeria Demographic and Health Survey 2003*. Calverton, Maryland: National Population Commission and ORC Macro, p. 11.

Central Statistical Authority [Ethiopia] and ORC Macro. 2001. *Ethiopia Demographic and Health Survey 2000*. Addis Ababa and Calverton, Maryland, USA: Central Statistical Authority and ORC Macro, p. 6.

Office National de la Population (ONAPO) [Rwanda] et ORC Macro. 2001. *Enquête Démographique et de Santé, Rwanda 2000*. Kigali, Rwanda et Calverton, Maryland, USA: Ministère de la Santé, Office National de la Population et ORC Macro, p. 11.

FACT SHEET: Prevention Funding Under PEPFAR: Law, Policy and Interpretation

¹ At the end of 2005, an estimated 40.3 million (range 36.7-45.3 million) people around the world were living with HIV, including the 4.9 million (range 4.3-6.6 million) people who acquired HIV in 2005. The epidemic claimed an estimated 3.1 million (range 2.8-3.6 million) lives in 2005. Two-thirds of all people living with HIV are in Sub-Saharan Africa as are 77% of all women with HIV. UNAIDS. *UNAIDS Questions & Answers*. Available at: http://www.unaids.org/en/resources/questions_answers.asp.

² According to World Health Organization estimates released in July 2004. http://www.wpro.who.int/3by5/docs/update_30July2004.pdf.

³ Based on estimates that while sexual transmission accounts for 99 percent of current infections in sub-Saharan Africa, MTCT, medical transmission and unsafe blood combined account for about 20 percent of new infections.

World Health Organization (WHO). *The World Health Report 2002: Reducing risks, promoting healthy life*. Geneva: WHO, 2002.

http://www.who.int/whr/2002/en/whr02_en.pdf, p.9.

World Health Organization (WHO). *Expert group stresses that unsafe sex is primary mode of transmission of HIV in Africa*. March 14, 2003.

<http://www.who.int/mediacentre/statements/2003/statement5/en/>.

USAID. *Prevention of Mother-to-Child Transmission of HIV*.

http://www.usaid.gov/our_work/global_health/aids/TechAreas/mtct/mtctfactsheet.html.

⁴ Please see the Department of State, Office of the Global AIDS Coordinator (OGAC) website at:

<http://www.state.gov/s/gac/countries/fc/index.htm>.

⁵ The law specifies that not less than 55 percent of the amounts appropriated for global HIV/AIDS programs be used for "therapeutic medical care" (treatment) of people infected with HIV. Of this 55 percent, at least 75 percent must be used for ARV distribution and purchase, and at least 25 percent must be used for related care. The treatment earmark is suggested for 2004-2005 and required for 2006-2008. In addition, the law suggests for 2004 and 2005 and then requires for 2006-2008 that not less than ten percent of global HIV/AIDS appropriations be used to assist orphans and vulnerable children. Of this amount, at least 50 percent must be provided to non-profit NGOs to implement community-level programs.

⁶ Department of State. *Fact Sheets: Funding for Prevention, Care and Treatment in the Focus Countries FY2004, FY2005*. December 15, 2005.

⁷ Please see CHANGE publication *Country Fact Sheets: Risk and Reality - U.S. Funding of HIV Prevention Programs* at:

<http://www.genderhealth.org/AIDS.php>.

⁸ See Stanecki, Karen. *The AIDS Pandemic in the 21st Century*. Draft Report. U.S. Census Bureau. July 2002 (showing 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. 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). See also UNAIDS. *Africa Fact Sheet*. April 3, 2005; UNAIDS/WHO. *AIDS Epidemic Update*. December 2003.

⁹ See CHANGE's country fact sheets at <http://www.genderhealth.org/AIDS.php>.

¹⁰ Department of State. *FY2006 Country Operation Plan (COP) Guidance for the President's Emergency Plan for AIDS Relief (PEPFAR)*.

<http://www.genderhealth.org/pubs/COPGuidanceFY06.pdf>.