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President’s Emergency Plan for AIDS Relief: Health Development at the Crossroads

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President's Emergency Plan for AIDS Relief
Health Development at the Crossroads

Lawrence O. Gostin, JD

The United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003, which funded the President’s Emergency Plan for AIDS Relief (PEPFAR), was the largest commitment by any nation to combat a single disease in human history, authorizing up to $15 billion over 5 years. On July 30, 2008, President Bush signed into law the historic reauthorization of PEPFAR, dramatically increasing the financial commitment by authorizing up to $48 billion over 5 years, including $5 billion for malaria and $4 billion for tuberculosis. During the signing ceremony, the president said, “There is no way to quantify PEPFAR’s greatest achievement: the spread of hope...And spreading hope is in our moral interests—because we believe that to whom much is given, much is required.”

PEPFAR has been mired in controversy. To some, it exemplifies the United States’ extraordinary compassion and generosity; to others, it symbolizes the politicization of public health and unilateral approach to international health. The truth lies somewhere in between. The latest data on global health assistance predates the reauthorization, but includes the original PEPFAR. In 2007, the United States donated $21.8 billion in official development assistance, more than any other country, and the United States donated $21.8 billion in official development assistance, placing it last among G8 countries, with nearly 70% going to AIDS. The United States is the only country projected to meet the 2005 Group of 8 (G8) Gleneagles commitment to double aid to sub-Saharan Africa by 2010. Yet, in 2007, the United States devoted only 0.16% of its gross national income to official development assistance, placing it last among G8 countries, with nearly 70% going to AIDS. The United States is tied for last on aid effectiveness using a set of 10 critical indicators.

US health assistance to the developing world stands at a crossroad. As PEPFAR is scaled up, will it provide opportunities to fulfill basic human needs or will its limited focus pull resources from sustainable, capacity-building support in line with poor country priorities?

Spending Directives: Prevention, Treatment, and Care

PEPFAR is prescriptive on how the funds can be spent, irrespective of country priorities. The reauthorization requires half of bilateral aid spent on treatment and care, with at least 10% spent on orphans and vulnerable children. The focus on antiretroviral treatment is extraordinary, reflecting an ethic of universal access to lifesaving medicines for rich and poor alike. When PEPFAR was launched in 2003, only 50 000 Africans (<2% of the 4.4 million in need) received antiretroviral treatment, but by March 31, 2008, PEPFAR supported antiretroviral treatment for approximately 1.73 million people, mostly in focus countries in sub-Saharan Africa.

Treatment is a humanitarian triumph, rescuing individuals and their families from a dire fate, but from a population perspective it does little to stem the tide of the pandemic. For every individual to receive treatment, 2 to 3 others become newly infected. Although prevention and treatment are intertwined and it is unfair to pit one against the other, there are nevertheless inherent trade-offs in the use of scarce health resources. Treatment is, at best, a stop-gap measure that requires enormous resources because of the life-long need of millions of individuals. The current costs are approximately $2 billion annually, an amount that could increase to $12 billion by 2016, more than half of US official development assistance. The cost, moreover, could increase considerably with the increase in drug-resistant forms of HIV, requiring expensive second-line medications. Additionally, patient retention in treatment programs has often been relatively poor in sub-Saharan Africa; if PEPFAR treatment dollars are to be spent effectively, retention in care should become just as important as expanded enrollment.

The United States’ impressive leadership in global AIDS, therefore, would be more effective if PEPFAR focused on comprehensive behavioral strategies, condoms, male circumcision, and structural approaches such as social, economic, political, and environmental factors that have an evidence base for preventing new infections. It is for these reasons that the Institute of Medicine recommended eliminating PEPFAR’s spending directives, and the US Government...
ment Accountability Office proposed a more country-focused approach.12

More broadly, reliance on vertical or disease-specific programs is less effective than building health system capacity and human resources, as well as serving priority health needs as determined by the host country. Although it is primarily a single-disease program, PEPFAR deserves credit for strengthening the health workforce, promoting local clinics, supporting nutrition, and increasing integration with malaria and tuberculosis services. Nevertheless, focusing on “basic survival needs” such as clean water, sanitation, pest abatement, and essential medicines for a broad range of health conditions could save even more lives by addressing the major determinants of health.13

Politics of AIDS
AIDS policy has been enfolded in politics since the beginning of the HIV epidemic. The ideological aspects inherent in PEPFAR tarnish its reputation, but it is important to stress that without political compromise, AIDS funding on such an unprecedented scale would not have been politically possible.

Abstinence and Faithfulness. The PEPFAR reauthorization removes the 2003 requirement that 33% of prevention funds be spent on abstinence-until-marriage programs but still requires host countries to meaningfully and equitably support “activities promoting abstinence, delay of sexual debut, monogamy, fidelity, and partner reduction.”14 The administration must report to Congress if a host country spends less than half its prevention funds for these purposes. The “ABC” (abstinence, be faithful, and use condoms) approach can be effective, but PEPFAR prevention dollars may go to organizations that withhold information about condoms or other contraception services, thus restricting access to lifesaving information. Even worse, PEPFAR’s 2008 “conscience clause” allows organizations with a moral or religious objection to opt out of providing services to which they may object, and that could pave the way for PEPFAR funding recipients to refuse care based on their disapproval of a patient’s behavior or sexual orientation. The “soft” prescription to focus half of prevention funds on abstinence and faithfulness programs can distort priorities but will not have the same binding force as the abstinence-only mandate in 2003.

Family Planning: Gender and Youth. Family planning programs may receive funding for HIV services only, irrespective of their compliance with the Mexico City policy, which means that groups providing or counseling women about legal abortions are eligible for PEPFAR funding. The PEPFAR reauthorization admirably requires global HIV/AIDS prevention strategies to address the vulnerability of women and youth, with a target of 80% coverage for preventing mother-to-child transmission. Yet, PEPFAR misses an opportunity to better serve women and girls by strengthening critical linkages between family planning, reproductive health services, and HIV prevention—helping vulnerable groups with unmet needs.

Prostitution and Sex Trafficking. PEPFAR proscribes funding any group without a policy “explicitly opposing prostitution and sex trafficking,” thus requiring organizations to pledge opposition to marginalized individuals, driving them underground. A federal court of appeals upheld the same provision in the original PEPFAR, reasoning that “the government can—and often must—discriminate on the basis of viewpoint,”13 even though the organization believes that opposition to commercial sex work stigmatizes and alienates those most vulnerable to HIV/AIDS.

Immigration and Travel
In 1987, a time when HIV was poorly understood, the Secretary of the US Department of Health and Human Services, in response to congressional direction in the Helms Amendment, added HIV infection to the list of communicable diseases of public health importance, which restricted travel or immigration to the United States, whether for vacation, employment, or conference attendance. Although the Bureau of Citizenship and Immigration Services can grant a waiver, the conditions are restrictive.

By the early 1990s, recognizing the absence of a public health justification, the Department of Health and Human Services reversed its position, but the Immigration and Nationality Act of 1993 codified the ban; HIV is the only disease specifically named for exclusion from the United States. The ban has been widely condemned as arbitrary and discriminatory and led to the International AIDS Society refusing to hold its annual conference in the United States. The PEPFAR reauthorization ends the statutory exclusion of travelers and immigrants to the United States, thus demonstrating respect for the human rights and dignity of the person and restoring its reputation in the international AIDS community.

PEPFAR: A Turning Point for Global Health
AIDS advocates have been highly conflicted about PEPFAR, recognizing its unprecedented generosity but torn by its moralizing and constraining spending mandates. It is tempting to focus on PEPFAR’s undeniable deficiencies—prioritizing treatment over prevention, stressing abstinence and faithfulness, forcing clinicians to condemn sex workers against their beliefs, and not doing enough to empower women and youth. But beyond these deficiencies, PEPFAR has transformed lives and instilled a sense of hope in poor African communities ravaged by AIDS that is heartening and palpable on the ground.

PEPFAR represents a milestone in development assistance, but the United States and its rich global partners face a critical choice. PEPFAR can remain a vertical program of restricted travel or immigration to the United States, whether for vacation, employment, or conference attendance. Alternatively, rich countries can build on PEPFAR by making a historic commitment to international development assistance for health that is scalable and sustainable and that attacks the root causes of poverty, inequality, and early death. By ensuring the capacity of poor countries to take care of their own with decent living conditions, hy-
US Health Aid Beyond PEPFAR
The Mother & Child Campaign

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PEPFAR’s Purview
In 2003, Congress appropriated PEPFAR $15 billion over 5 years to combat HIV/AIDS in developing regions. By September 2007, the program had prevented mother-to-child transmission for 10 million pregnancies, supported outreach activities aimed at preventing transmission to 61.5 million people, and provided antiretroviral treatment (ART) to 1.45 million individuals.1 United States citizens generally strongly support PEPFAR, partly because of the devastating effects of HIV/AIDS—the disease claims 1.9 million lives annually in lower-income countries—but also because HIV/AIDS is one of the few major health problems the United States shares with the developing world, and because it primarily affects adults, who have greater economic and political power.2

Yet despite being “the largest commitment ever by a single nation toward an international health initiative,”1 PEPFAR fails to address many of the developing world’s most serious health threats. In lower-income countries, mundane but deadly diseases cause more harm than HIV/AIDS. Respiratory infections alone claim 2.86 million lives annually in lower-income countries.3 Respiratory infections alone claim 2.86 million lives annually in lower-income countries.

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Throughout his presidency, President George W. Bush emphasized the moral responsibility of the United States to support the health of the world’s least healthy people. The President’s Emergency Plan for AIDS Relief (PEPFAR) is a single nation’s response to a global health crisis. Yet doubling or tripling PEPFAR’s funding is not the best use of international health funding. In focusing so heavily on HIV/AIDS treatments, the United States misses huge opportunities. By extending funds to simple but more deadly diseases, such as respiratory and diarrheal illnesses, the United States could save more lives—especially young lives—at substantially lower cost. Rather than inflating PEPFAR funding, the newly pledged billions could launch a new proposal program called the Mother & Child Campaign.

REFERENCES

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