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AIDS in Africa

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SUMMARY

Sub-Saharan Africa has been far more severely affected by AIDS than any other part of the world. The United Nations reports that 29.4 million adults and children are infected with the HIV virus in the region, which has about 10% of the world's population but more than 70% of the worldwide total of infected people. The overall rate of infection among adults in sub-Saharan Africa is 8.8%; compared with 1.2% worldwide. Twelve countries, mostly in east and southern Africa, have HIV infection rates of more than 10%, and the rate has reached 38.8% in Botswana. As of 2001, an estimated 21.5 million Africans had died of AIDS, including 2.2 million who died in that year. AIDS has surpassed malaria as the leading cause of death in Africa, and it kills many times more Africans than war. In Africa, 58% of those infected are women.

Experts relate the severity of the African AIDS epidemic to the region's poverty. Health systems are ill-equipped for prevention, diagnosis, and treatment. Poverty forces many men to become migrant workers in urban areas, where they may have multiple sex partners. Poverty leads many women to become commercial sex workers, vastly increasing their risk of infection.

AIDS' severe social and economic consequences are depriving Africa of skilled workers and teachers while reducing life expectancy by decades in some countries. An estimated 11 million AIDS orphans are currently living in Africa, facing increased risk of malnutrition and reduced prospects for education. AIDS is being blamed for declines in agricultural production in some countries, and is regarded as a major contributor to the famine threatening southern Africa.

Donor governments, non-governmental organizations, and African governments have responded primarily by attempting to reduce the number of new HIV infections, and by trying ameliorate the damage done by AIDS to families, societies, and economies. The adequacy of this response is the subject of much debate. Spending from all sources on HIV/-AIDS in sub-Saharan Africa was estimated at $500 million for FY2000, while U.N. experts believe the region could effectively absorb $4.6 billion to combat the pandemic.

Treatment of AIDS sufferers with medicines that can result in long-term survival is reportedly available to fewer than 30,000 Africans. Advocates of expanded treatment argue that in view of recent drug price reductions, treatment is an affordable means of reducing AIDS damage to African economies, reinforcing prevention programs, and keeping parents alive. Skeptics argue that treatment is still too expensive to be an option for most Africans and would require costly improvements in health infrastructure.

U.S. concern over AIDS in Africa grew during the 1980s, as the severity of the epidemic became apparent. Legislation enacted in the 106th and the 107th Congresses increased funding for worldwide HIV/AIDS programs. H.R. 1298, which passed the House on May 1, 2003, and the Senate on May 16, would authorize $15 billion over five years for international AIDS programs. President Bush has announced an International Mother and Child HIV Transmission Initiative that will benefit 8 African countries, and 12 are slated for added support under the global aids initiative announced in the January 28, 2003 State of the Union message. Nonetheless, activists and others urge that more be done in view of the scale of the African pandemic.

MOST RECENT DEVELOPMENTS

On May 16, 2003, the Senate, by voice vote, passed H.R. 1298, the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003, authorizing $15 billion over 5 years for international AIDS, tuberculosis, and malaria activities. The Senate version of the bill was amended to enhance debt relief for poor countries stricken with AIDS. The bill, which passed the House on May 1, would establish a Coordinator of United States Government Activities to Combat HIV/AIDS at the Department of State and authorize up to $1 billion for the Global Fund to Fight AIDS, Tuberculosis, and Malaria in FY2004. Amendments included a provision requiring that 33% of funds for prevention be expended for abstinence-until-marriage programs. (For further details, see below **Legislation**). After House passage, President Bush issued a statement urging the Senate to act quickly on the bill, which he said was consistent with the Emergency Plan for AIDS Relief announced in his 2003 State of the Union message. The President had also endorsed H.R. 1298 in a White House Rose Garden speech on April 29.

On May 7, 2003, the General Accounting Office (GAO) released a report (GAO-03-601) on the Global Fund to Fight AIDS, Tuberculosis, and Malaria. The report, prepared at the request of Representative Jim Kolbe, Chairman of the House Appropriations Subcommittee on Foreign Operations, found that the Global Fund had made progress in several areas but faced a critical lack of resources for funding grants.

For further information, see CRS Report RS21181, *HIV/AIDS International Programs: Appropriations, FY2002-FY2004.*

BACKGROUND AND ANALYSIS

Sub-Saharan Africa has been far more severely affected by AIDS than any other part of the world. In November 2002, UNAIDS (the Joint United Nations Program on HIV/AIDS) reported that in 2002, 29.4 million people were living with HIV and AIDS in sub-Saharan Africa, up from 28.5 million in 2001. Africa, where an estimated 3.5 million people were newly infected in 2002, has about 10% of the world's population but more than 70% of the worldwide total of infected people. The infection rate among adults is about 8.8% in Africa, compared with 1.2% worldwide. Through 2001, an estimated 21.5 million Africans had lost their lives to AIDS, including an estimated 2.2 million who died in that year(UNAIDS, *Report on the Global HIV/AIDS Epidemic, 2002*). UNAIDS estimates that by 2020, an additional 55 million Africans will loose their lives to the epidemic. In Botswana, the worst-affected country, 55.6% of urban pregnant women aged 25-29 and attending ante-natal clinics were HIV positive in 2001. Rising infection rates continue to be seen in Zimbabwe, Namibia, and other countries as well. AIDS has surpassed malaria as the leading cause of death in sub-Saharan Africa, and it kills many times more people than Africa's armed conflicts.

Reports by scientists at the XIV International AIDS Conference, held in Barcelona in July 2002, noted that the HIV virus probably could not be eliminated by drug treatment, due to its newly discovered ability to "hide" in cells of the immune system for decades. Thus, drug therapy, once begun, would have to be provided throughout a patient's lifetime. Some

progress was reported in vaccine research, but most reports suggested that an effective vaccine was still years in the future. The limited availability of AIDS treatment in Africa was another focus of the meeting, but success was reported in small-scale treatment programs. Some successes in prevention were also noted, and many speakers urged sharply increased spending both for treatment and prevention.

Characteristics of the African Epidemic

- HIV, the human immunodeficiency virus that causes AIDS, is spread in Africa, most experts believe, primarily by heterosexual contact. (A February 2003 article published by David Gisselquist and others in the *International Journal of STD and AIDS* asserted that the importance of unsafe medical practices in the spread of HIV may have been underestimated and called for further research. The article has caused some controversy, and the Senate Health, Education, Labor, and Pensions Committee held a hearing on March 27 to examine the issue.)

- Women make up an estimated 58% of the HIV-positive adult population in sub-Saharan Africa, as compared with 50% worldwide — according to UNAIDS. Young women are particularly at risk. In 2001, an estimated 6% to 11% of African women aged 15 to 24 were HIV positive, compared with 3% to 6% of young men. (UNAIDS, *AIDS Epidemic Update, December 2002).*

- Southern and eastern Africa have been far more severely affected than West Africa, but infection rates in a number of West African countries are rising. In seven southern African countries, 20% or more of the adult population is infected with HIV, and the rate has reached 38.8% in Botswana. In Cameroon, a West African country, the adult infection rate has jumped from 4.7% in 1996 to 11.8% in 2001. In Nigeria, with a population that exceeds 125 million, an estimated 5.8% of adults were HIV positive in 2001, and infection rates in some Nigerian states have reached levels seen in neighboring Cameroon. The U.S. National Intelligence Council, in a September 2002 report on the "next wave of HIV/AIDS," predicted that by 2010, 10 to 15 million Nigerians, or 18% to 26% of adults, would be infected by HIV.

- The African AIDS epidemic is having a much greater impact on children than is the case in other parts of the world. According to UNAIDS, more than 600,000 African infants become infected with HIV each year through mother-to-child transmission, either at birth or through breast-feeding. These children have short life expectancies, and the number currently alive may be about 1 million.

- In 2001, an estimated 11 million children orphaned by AIDS were living in Africa, and an authoritative report estimates that by 2010, 20.1 million children will have lost one or both parents to AIDS. Because of the stigma attached to the AIDS disease, AIDS orphans are at high risk for being

malnourished, abused, and denied an education. The number of orphans due to all causes is expected to total 42 million in 2010, including 6.7 million in Nigeria, 5 million in Ethiopia, and 2.3 million in South Africa. (UNAIDS, UNICEF, and U.S. Agency for International Development, *Children on the Brink, 2002, a Joint Report on Orphan Estimates and Program Strategies*, p. 28.)

Explaining the African Epidemic

AIDS experts emphasize a variety of economic and social factors in explaining Africa's AIDS epidemic, placing primary blame on the region's poverty. Poverty has deprived Africa of effective systems of health information, health education, and health care. Thus, Africans suffer from a high rate of untreated sexually-transmitted infections (STIs) other than AIDS, and these increase susceptibility to HIV. African health systems typically have limited capabilities for AIDS prevention work, and HIV counseling and testing are difficult for many Africans to obtain. AIDS treatment is generally available only to the elite.

Adult HIV Infection Rates (%), end of 2001

Botswana	38.8
Swaziland	33.4
Zimbabwe	33.7
Lesotho	31.0
Namibia	22.5
Zambia	21.5
South Africa	20.1
Malawi	15.0
Kenya	15.0
Mozambique	13.0
Cent. Af. Republic	12.9
Cameroon	11.8
Cote d'Ivoire	9.7
Rwanda	8.9
Burundi	8.3
Tanzania	7.8
Congo Brazzaville	7.2
Sierra Leone	7.0
Burkina Faso	6.5
Ethiopia	6.4
Togo	6.0
Nigeria	5.8
Angola	5.5
Uganda	5.0
Congo Kinshasa	4.9
Benin	3.6
Chad	3.6
Equatorial Guinea	3.4
Ghana	3.0
Eritrea	2.8
Guinea Bissau	2.8
Sudan	2.6
Mali	1.7
Somalia	1.0
Senegal	.5
Madagascar	.3
Mauritius	.1

Source: UNAIDS, Report on the Global HIV/AIDS Epidemic, July 2002. Data not available for the following countries: Comoros, Djibouti, Gabon, Gambia, Guinea, Liberia, Mauritania, Niger.

Poverty forces large numbers of African men to migrate long distances in search of work, and while away from home they may have multiple sex partners, increasing their risk of infection. Some of these partners may be women who have become commercial sex workers because of poverty, and they too are highly vulnerable to infection. Migrant workers may carry the infection back to their wives when they return home. Long distance truck drivers, and drivers of "taxis," who transport Africans long distances by car, are probably also key agents in spreading HIV.

Some behavior patterns in Africa may also be affecting the epidemic. In explaining the fact that young women are infected at a higher rate than young men, Peter Piot, the Executive Director UNAIDS, has commented that "the unavoidable conclusion is that girls are getting infected not by boys but by older men," who are more likely than young men to carry the disease. (UNAIDS press release, September 14, 1999.) UNAIDS notes that ""with the downward trend of many African economies ... relationships with (older) men can serve as vital opportunities for financial and social security, or for satisfying

material aspirations." (*AIDS Epidemic Update, 2002).* Many believe that the infection rate among women generally would be far lower if women's rights were more widely respected in Africa and if women exercised more power in political and economic affairs. (For more on these issues, see Helen Epstein, "AIDS: the Lesson of Uganda," *New York Review of Books*, July 5, 2001; and "The Hidden Cause of AIDS," *New York Review of Books*, May 9, 2002.)

The breakdown in social order and social norms caused by armed conflict is also contributing to the African epidemic. Conflict is typically accompanied by numerous incidents of violence against women, including rape, carried out by soldiers and guerrillas. Such men are also more likely to resort to commercial sex workers than those living in a settled environment.

Leadership Reaction in South Africa and Elsewhere

Many observers believe that the spread of AIDS in Africa could have been slowed if African leaders had been more engaged and outspoken in earlier stages of the epidemic. President Thabo Mbeki of South Africa has come in for particular criticism on this score. In April 2000, President Mbeki wrote then President Clinton and other heads of state defending dissident scientists who maintain that AIDS is not caused by the HIV virus. In March 2001, Mbeki rejected appeals that the national assembly declare the AIDS pandemic a national emergency, and in September of that year, the South African government attempted to delay publication of a South African Medical Research Council report, which found AIDS to be the leading cause of death, accounting for 40% of mortality among South Africans aged 15 to 49. The Council predicted that South Africa's death toll from AIDS would reach a cumulative total of between 5 and 7 million by 2010, when 780,000 people would be dying annually from the disease. Life expectancy would fall from 54 years at present to 41 by the end of the decade, according to the Council.

Under mounting domestic and international pressure, the South African government seemed to modify its position significantly after an April 17, 2002 cabinet meeting on the AIDS crisis. The cabinet announced that it would triple the national AIDS budget, end official opposition to the provision of antiretrovirals for rape victims, and launch a program for universal access to drugs to prevent mother to child transmission, possibly by December. AIDS activists welcomed the policy changes, but some expressed concerns about implementation or pointed out that South Africa was still far from providing access to treatment for all those in need.

On July 5, 2002, South Africa's Constitutional Court denied the government's appeal against lower court decisions ordering it to begin providing the antiretroviral drug Nevirapine nationwide to reduce the transmission of HIV from pregnant mothers to their newborns. The South African Treatment Action Campaign (TAC) had launched the suit in August 2001, demanding a comprehensive program to prevent mother-to-child transmission (MTCT). TAC maintained that MTCT trials involving 18 pilot projects providing Nevirapine to HIV-positive pregnant women were inadequate and that 20,000 babies could be saved by a nationwide program. The German firm Boerhringer-Ingelheim offers the Nevirapine drug free in Africa for MTCT programs. South African officials maintained that safety precautions required further testing of Nevirapine but accepted the Constitutional Court's decision.

The April 2002 cabinet pledges and the court decision eased tensions in South Africa over AIDS policy for some months, but activists undertook a new civil disobedience campaign in March and April 2003, charging two government ministers with "manslaughter" for failing to provide treatment to those suffering with AIDS. Government officials responded that the cost of providing universal treatment was still being determined, and the ruling African National Congress accused TAC of "bully boy tactics." (*South African Press Association*, March 26, 2003.) On April 11, 2003, South Africa failed to sign an agreement with the Global Fund to Fight AIDS, Tuberculosis, and Malaria on a grant approved in 2002 for HIV/AIDS projects in AIDS-stricken KwaZulu-Natal Province. Global Fund Director Richard Feacham had been in South Africa for the signing, which South African officials said had to be postponed for technical and financial reasons. On April 2, the House International Relations Committee reported H.R. 1298 (H.Rept. 108-60), the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003, authorizing $15 billion over 5 years for international AIDS, tuberculosis, and malaria activities.

In the rest of Africa, meanwhile, many heads of state and other leaders are now taking major roles in fighting the epidemic. President Yoweri Museveni of Uganda has long been recognized for leading a successful prevention campaign against AIDS in his country, and Uganda's ABC (Abstinence, Be Faithful, or Use Condoms) transmission prevention program has won wide praise. ("Uganda Leads by Example on AIDS," *Washington Times*, March 13, 2003.) The presidents of Botswana, Nigeria, and several other countries are widely seen today as in the forefront of the AIDS struggle as well. Several regional AIDS initiatives have been launched.

Social and Economic Consequences

AIDS is having severe social and economic consequences in Africa, and these negative effects are expected to continue for many years. A January 2000 Central Intelligence Agency National Intelligence Estimate on the infectious disease threat, made public in an unclassified version, forecasts grave problems over the next 20 years.

> At least some of the hardest-hit countries, initially in sub-Saharan Africa and later in other regions, will face a demographic catastrophe as HIV/AIDS and associated diseases reduce human life expectancy dramatically and kill up to a quarter of their populations over the period of this Estimate. This will further impoverish the poor, and often the middle class, and produce a huge and impoverished orphan cohort unable to cope and vulnerable to exploitation and radicalization. (CIA, *The Global Infectious Disease Threat and Its Implications for the United States* [http://www.odci.gov], "Publications and Reports".)

The estimate predicted increased political instability and slower democratic development as a result of AIDS. According to the World Bank,

> The illness and impending death of up to 25% of all adults in some countries will have an enormous impact on national productivity and earnings. Labor productivity is likely to drop, the benefits of education will be lost, and resources that would have been used for investments will be used for health care, orphan care, and funerals. Savings rates will decline, and the loss of human capital will affect production and the quality of life for years to come. (World Bank, *Intensifying Action Against HIV/AIDS in Africa*.)

In the most severely affected countries, sharp drops in life expectancy are occurring, and these will reverse major gains achieved in recent decades. According to UNAIDS, as a result of AIDS, average life expectancy in sub-Saharan Africa is now 47 years, whereas it would have been 62 years without the epidemic. South Africa and some other countries in southern Africa could face population declines by the end of the decade, according to experts.

According to many reports, AIDS has devastating effects on rural families. The father is typically the first to fall ill, and when this occurs, farm tools and animals may be sold to pay for his care. Should the mother also become ill, children may be forced to shoulder responsibility for the full time care of their parents. The Food and Agriculture Organization of the United Nations reports that since the epidemic began, 7 million agricultural workers have been killed in Africa. The agricultural workforce has been reduced by more than 20% in five countries (FAO, *HIV/AIDS, Food Security, and Rural Livelihoods*, May 2002), and a number of experts are relating the current famine in southern Africa to production losses caused by AIDS. (See "Cursed Twice Over — AIDS and Famine in Southern Africa," *The Economist*, February 15, 2003.) World Food Program Executive Director James Morris, testifying before the Senate Foreign Relations Committee on February 25, 2003, and the House International Relations Committee on February 27, said that HIV/AIDS was a central cause of the famine.

AIDS is being blamed for shortages of skilled workers and teachers in several countries. A May 2002 World Bank study, *Education and HIV/AIDS: A Window of Hope*, reported that more than 30% of teachers are HIV positive in parts of Malawi and Uganda, 20% in Zambia, and 12% in South Africa. AIDS is also claiming many lives at middle and upper levels of management in both business and government. Although unemployment is generally high in Africa, trained personnel are not readily replaced.

AIDS may have serious security consequences for much of Africa, since HIV infection rates in many armies are extremely high. Domestic political stability could also be threatened in African countries if the security forces become unable to perform their duties due to AIDS. Peacekeeping is also at risk. South African soldiers have been widely expected to play an important peacekeeping role in the Democratic Republic of the Congo (DRC, formerly Zaire) and perhaps other countries in coming months and years, but estimates of the infection rate in the South Africa army run from 17% to 40%, with higher rates reported for units based in heavily infected KwaZulu-Natal province.

Responses to the AIDS Epidemic

Donor governments, non-governmental organizations (NGOs) working in Africa, and African governments have responded to the AIDS epidemic primarily by attempting to reduce the number of new HIV infections, and to some degree, by trying ameliorate the damage done by AIDS to families, societies, and economies. A third possible response — treatment of AIDS sufferers with medicines that can result in long-term survival — has not been widely used in Africa, largely due to cost, although some treatment is now being offered at private clinics or through programs offered by a few large employers. Demands for large-scale treatment are mounting in Africa, and are drawing support from outside the continent among AIDS activists and others concerned for the region's future. (For more information

on the international response to the epidemic, see CRS Report RL30883, *Africa: Scaling Up the Response to the HIV/AIDS Pandemic*.)

Programs and projects aimed at combating the epidemic typically provide information on how HIV is spread — and on how it can be avoided — through the media, posters, lectures, and skits. Donor-sponsored voluntary counseling and testing (VCT) programs, where available, enable African men and women to learn their HIV status. Those testing positive are typically referred to support groups and advised on ways to protect others from contracting the disease; while the majority testing negative are counseled on behavior changes that will keep them HIV-free. The U.S. Agency for International Development (USAID) is currently supporting VCT centers in 10 African countries. AIDS awareness programs can be found in many African schools and increasingly in the workplace, where employers are recognizing their interest in reducing the infection rate among their employees. Many projects aim at making condoms readily available and on providing instruction in condom use. USAID is a major provider of condoms in Africa. Pilot projects have had success in reducing mother-to-child transmission by administering the anti-HIV drug AZT or Nevirapine, during birth and early childhood.

Church groups and humanitarian organizations have helped Africa deal with the consequences of AIDS by setting up programs to provide care and education to orphans. The Farm Orphan Support Trust in Zimbabwe tries to keep sibling orphans together and in a family living situation; the Salvation Army sponsors a pilot, community-based, orphan support program in Zambia, providing education and health care to vulnerable children. (*Report on the Presidential Mission on Children Orphaned by AIDS*.) A United Nations study has found that community-based organizations, sometimes with the support of NGOs, have emerged to supply additional labor, home care for the sick, house repair, and other services to AIDS-afflicted families. (UNAIDS, *A Review of Household and Community Responses to the HIV/AIDS Epidemic in Rural Areas of Sub-Saharan Africa*, 1999.)

Public-private partnerships have also become an important vehicle for responding to the African AIDS pandemic. The Bill and Melinda Gates Foundation has been a major supporter of vaccine research and a variety of AIDS programs undertaken in cooperation with African governments and donors. The Rockefeller Foundation, working with UNAIDS and others, has sponsored programs to improve AIDS care in Africa, and both Bristol-Myers Squibb and Merck and Company, together with the Gates Foundation and the Harvard AIDS Institute, have undertaken programs with the Botswana government aimed at improving the country's health infrastructure and providing AIDS treatment to all who need it. (See "A Small Nation's Big Effort Against AIDS," *Washington Post*, December 2, 2002.)

USAID estimates that in FY2000, all donors and lending agencies, together with African governments, spent approximately $500 million in combating AIDS, but donors have committed to scaling up the response. On July 23, 2000, leaders at the G-8 world economic summit in Okinawa pledged to reduce the number of young people infected by the HIV virus by 25%. The World Health Organization estimated that this pledge, and G-8 pledges to attack malaria and tuberculosis as well, would cost at least $5 billion per year for 5 years. The World Bank launched its Multi-Country HIV/AIDS Program (MAP) for Africa in September 2000, and a Bank official said in October 2002 that to date, $1 billion had been committed. Since July 2002, such funding is being provided exclusively as grants.

The MAP, designed to be both flexible and rapidly disbursing, according to the Bank, helps fund AIDS prevention, care, and treatment programs in countries that have developed a strategic approach. (According to some reports, however, MAP recipients have had difficulty in disbursing funds in a timely way. Sebastian Mallaby, "An AIDS Policy that Makes Sense," *Washington Post,* December 2, 2002.) On December 9, 2001, Peter Piot, executive director of the Joint United Nations Program on HIV/AIDS (UNAIDS), told an international AIDS conference in Burkina Faso that assistance to fight HIV/AIDS in sub-Saharan Africa should be increased "many-fold," and that the region requires $4.6 billion per year to confront the pandemic. (For more information, see CRS Report RL30883, *Africa: Scaling Up the Response to the HIV/AIDS Pandemic*.)

The Global Fund to Fight AIDS, Tuberculosis, and Malaria was created in January 2002, and to date more than $3 billion has been pledged to the organization. The first grants were announced in April 2002, and of the $616 million to be awarded over two years worldwide, Africa is to receive 60%. However, the disbursement of funds for these grants has been delayed while monitoring and other procedures are put in place. On November 22, the Global Fund announced that it had signed agreements to provide $6.5 million to Ghana, including $4.2 million for HIV/AIDS prevention and treatment. The agreements were the first to be concluded by the Fund. A grant announced on February 27, 2003, will benefit an AIDS program in Uganda. The Global Fund's website is at [http://www.globalfundatm.org].

Further information on the response to AIDS in Africa may be found at the following web sites:

CDC: [http://www.cdc.gov/nchstp/od/nchstp.html]
European Union: [http://europa.eu.int/comm/development/aids/]
The Global Fund to Fight AIDS, Tuberculosis, and Malaria:
[http://www.globalfundatm.org]
International AIDS Vaccine Initiative: [http://www.iavi.org]
International Association of Physicians in AIDS Care: [http://www.iapac.org/]
Kaiser Daily HIV/AIDS Report: [http://report.kff.org/aidshiv/]
UNAIDS: [http://www.unaids.org/]
USAID: [http://www.usaid.gov/], click on "Health."
World Bank: [http://www.worldbank.org/], click on "Topics."

Effectiveness of the Response

The response to AIDS in Africa has had some successes, most notably in Uganda, where the rate of infection among pregnant women in urban areas fell from 29.5% in 1992 to 5% in 2001 (UNAIDS, *AIDS Epidemic Update, December 2002).* HIV prevalence among young urban women in Zambia has also reportedly fallen, and UNAIDS indicates that urban sexual behavior patterns among young people in cities in other countries may be changing in ways that combat the spread of HIV. However, increases in infection rates continue in cities in several other countries. South Africa has recorded a drop in infections among pregnant women under 20, and Senegal is credited with preventing an AIDS epidemic through an active, government-sponsored prevention program. Despite some success stories, however, available evidence indicates that the epidemic is deepening in most of Africa.

Experts point out that there are a number of barriers to a more effective AIDS response in Africa, such as cultural norms that make it difficult for many government, religious, and community leaders to acknowledge or discuss sexual matters, including sex practices, prostitution, and the use of condoms. However, experts continue to advocate AIDS awareness and AIDS amelioration as essential components of the response to the epidemic. Indeed, there is strong support for an intensification of awareness and amelioration efforts, as well as adaptations to make such efforts more effective. With respect to amelioration, UNAIDS has recommended that donors find ways to strengthen those indigenous support institutions that are already helping AIDS victims and their families. (*A Review of Household and Community Responses.)* There is also support for a stronger focus on treatment of non-HIV sexually-transmitted infections, which studies show can dramatically lower the rate of HIV transmission.

The lives of infected people could be significantly prolonged and improved, some maintain, if more were done to identify and treat the opportunistic infections, particularly tuberculosis, that typically accompany AIDS. Millions of Africans suffer dual infections of HIV and TB, and the combined infection dramatically shortens life. Tuberculosis can be cured by treatment with a combination of medications over several months, even in HIV-infected patients. However, according to the World Health Organization, Africans often delay seeking treatment for TB or do not complete the course of medication (*Global Tuberculosis Control: WHO Report 1999,* Key Findings), contributing to the high incidence of death among those with dual infections. Pfizer Corporation has signed an agreement with South Africa to donate the anti-fungal Diflucan (fluconazole) for treating AIDS-related opportunistic infections, including cryptococcal meningitis, a dangerous brain inflammation. On December 1, 2001, Pfizer announced that it would sign memoranda of understanding on donating fluconazole with six other African countries. UNAIDS and the World Health organization recommended on April 5, 2000, that Africans infected with HIV be treated with an antibiotic/sulfa drug combination known by the trade name Bactrim in order to prevent opportunistic infections. Studies indicate that the drug could reduce AIDS death rates at a cost of between $8 and $17 per year per patient.

AIDS Treatment Issues

Access for poor Africans to combinations of AIDS medications or "antiretrovirals" (ARVs) is perhaps the most contentious issue surrounding the response to the African epidemic today. Administered in a treatment regimen known as HAART — highly active antiretroviral therapy — these drugs can return AIDS victims to normal life and lead to long-term survival rather than early death. Such treatment has proven highly effective in developed countries, including the United States, where AIDS, which had been the eighth leading cause of death in 1996, no longer ranked among the 15 leading causes by 1998. (U.S. Department of Health and Human Services Press Release, October 5, 1999.)

Advocates of making HAART widely available in Africa argue that the therapy would keep parents alive, slowing the growth in the number of AIDS orphans; and keep workers, teachers, civil servants, and managers alive as well, thus reducing the economic impact of the epidemic. Moreover, proponents argue, treatment will strengthen prevention efforts, since the possibility of treatment will create strong incentives for participation in VCT programs. Some also see a moral obligation to try to save lives when the medications for doing so exist. Other, however, argue that as long as resources for combating AIDS are

limited, the focus should continue to be on prevention, which, they maintain, is more cost effective in saving lives.

The high cost of HAART treatments has been the principal obstacle to offering the therapy on a large scale in Africa, where most victims are poor and lack health insurance. The cost of administering HAART was once estimated at between $10,000 and $15,000 per person per year. On May 11, 2000, five major pharmaceutical companies announced that they were willing to negotiate sharp reductions in the price of AIDS drugs sold in Africa. UNAIDS launched a program in cooperation with the pharmaceutical companies to boost treatment access and, in June 2001, reported that 10 African countries had reached agreement with manufacturers. The agreements significantly reduced prices in exchange for health infrastructure improvements to assure that ARVs are administered safely. Patented AIDS medications are now reportedly becoming available in several African countries, at prices ranging from a few hundred dollars to just over $1000 per patient per year, for a three-drug treatment comparable to that available in developed countries. On April 28, 2003, GlaxoSmith-Kline, the largest manufacturer of AIDS pharmaceuticals, announced further price reductions for poor countries, including all of sub-Saharan Africa.

Private clinics in some African cities are now offering HAART, and Uganda as well as Cote d'Ivoire are providing treatment in publicly-funded programs to several hundred patients. Nonetheless, UNAIDS estimates that only about 30,000 Africans are receiving treatment. A Nigerian program to treat 15,000 AIDS patients with generic antiretrovirals imported from India was launched in December 2001, but has encountered organizational problems and difficulties in drug distribution. (*Africa News*, April 5, 2002; *Agence France Presse*, May 21, 2002.) In Kenya, a law came into force on May 1, 2002 permitting the importation or manufacture of generic copies of more expensive patented AIDS drugs, although even these medications would likely cost more than most Kenyan AIDS patients can afford. (*BBC*, May 1, 2002.) Anglo American, the South African mining firm, announced on August 6, 2002, that it would provide antiretroviral drug therapy to employees requiring it. Other mining companies subsequently made similar announcements. The Global Fund maintains that its initial round of grants will make possible a six-fold increase in the numbers being treated in Africa over five years.

The degree to which Africa's poorly developed health infrastructure prevents the wider availability of HAART is controversial. AIDS activists believe that millions of Africans could quickly be given access to AIDS drugs. Others maintain that African supply channels cannot make the drugs consistently available to millions of patients and that regular monitoring of patients by medical personnel is not possible in much of the continent. Monitoring is necessary, they maintain, to deal with side effects and to adjust medications if drug resistance emerges. Many fear that if the drugs are taken irregularly, resistant HIV strains will emerge that could cause untreatable infections worldwide. In February 2002 Senate testimony, Dr. E. Anne Peterson, Assistant Administrator for Global Health at USAID stated that USAID would be launching four treatment sites in Africa in 2002 to provide "critically needed answers" to the challenges of providing antiretroviral therapy.

AIDS activists also advocate "parallel imports" of drugs and "compulsory licensing" by African governments to lower the price of patented medications. Through parallel importing, patented pharmaceuticals could be purchased from the cheapest source, rather

than from the manufacturer; while under "compulsory licensing," an African government could order a local firm to produce a drug and pay a negotiated royalty to the patent holder.

Although both parallel imports and compulsory licensing are permitted under Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS agreement) of the World Trade Organization agreement for countries facing national emergencies, U.S. officials once strongly opposed such measures on grounds that they could lead to infringements of intellectual property rights. Advocates for the pharmaceutical companies argued that parallel importing and compulsory licensing could reduce profits, and that this would hinder the ability of manufacturers to conduct research on new drugs, including drugs that might be even more effective against HIV. A third view has been that some combination of subsidization, price reduction, and local manufacturing might be found that would make the drugs much more widely available while maintaining drug company revenues through the sheer volume of African sales.

On May 10, 2000, then President Clinton issued an executive order stating that the United States would not seek to prevent sub-Saharan countries from promoting access to HIV/AIDS pharmaceuticals or medical technologies consistent with the World Trade Organization's TRIPS agreement. On February 22, 2001, an official of the U.S. Trade Representative's office said the Bush Administration was not considering any change in current "flexible policy" on this issue. On November 14, 2001, a ministerial level meeting of the World Trade Organization in Doha, Qatar, approved a declaration stating that the TRIPS agreement should be implemented in a manner supportive of promoting access to medicines for all. The declaration affirmed the right of countries to issue compulsory licenses and gave the least developed countries until 2016 to implement TRIPS. The question of whether countries manufacturing generic copies of patented drugs, such as India or Thailand, should be permitted to export to poor countries was left for further negotiation through a committee known as the Council for TRIPS.

Although the Doha declaration drew broad praise, some AIDS activists criticized it for not permitting imports of generics — cheap copies of patented medications. Some in the pharmaceutical industry, on the other hand, expressed concern that the declaration was too permissive and might eventually open the way to such imports. Others, however, argued that the declaration would have little practical impact, since most AIDS drugs are not actually patented in many of the countries most heavily affected by the epidemic. From this perspective, poverty rather than patents is the principal obstacle to drug access in Africa. (See Amir Attaran and Lee Gillespie-White, "Do Patents for Anti-retroviral Drugs Constrain Access to AIDS Treatment in Africa?" *Journal of the American Medical Association*, October 17, 2001.)

The Council for TRIPS failed to reach agreement by December 2002, the deadline set by the Doha meeting, on allowing poor countries to import generic copies of essential patented medications. Reportedly, an accord was stalled by U.S. objections to the number of diseases and countries that some delegations wanted to include. Nonetheless, on December 20, the U.S. Trade Representative announced that the United States was pledging "not to challenge any WTO member that breaks WTO rules to export drugs produced under compulsory license to a country in need."

The United Nations convened a General Assembly Special Session (UNGASS) on HIV/AIDS on June 25-27, 2001 in New York. Much of the debate at the session centered on the issue of whether large-scale treatment with antiretroviral drugs could be provided in Africa. The Special Session concluded with passage of a resolution emphasizing the need for "widespread and effective prevention," but "recognizing that care, support, and treatment can contribute to effective prevention."

U.S. Policy

A July 2000 *Washington Post* article called into question the adequacy and timeliness of the early U.S. response to the HIV/AIDS threat in Africa. (Barton Gellman, "The Global Response to AIDS in Africa: World Shunned Signs of Coming Plague." *Washington Post*, July 5, 2000). Nonetheless, U.S. concern did begin to mount during the 1980s, as the severity of the epidemic became apparent. In 1987, in acting on the FY1988 foreign operations appropriations, Congress earmarked funds for fighting AIDS worldwide, and House appropriators noted that in Africa, AIDS had the potential for "undermining all development efforts" to date (H.Rept. 100-283). In subsequent years, Congress supported AIDS spending at or above levels requested by the executive branch, either through earmarks or report language.

USAID states that it has been the global leader in the international response to AIDS since 1986, not only by supporting multilateral efforts but also by directly sponsoring regional and bilateral programs aimed at combating the disease. (USAID, *Leading the Way: USAID Responds to HIV/AIDS*, September 2001). The Agency has sponsored AIDS education programs; trained AIDS educators, counselors, and clinicians; supported condom distribution; and sponsored AIDS research. USAID claims several successes in Africa, such as helping to reduce HIV prevalence among young Ugandans and to prevent an outbreak of the epidemic in Senegal; reducing the frequency of sexually transmitted infections in several African countries; sharply increasing condom availability in Kenya and elsewhere; assisting children orphaned by AIDS; and sponsoring the development of useful new technologies, including the female condom. USAID reports that it spent a total of $51 million on fighting AIDS in Africa in FY1998 and $63 million in FY1999 (*Leading the Way*, 121). In addition, some spending by the Department of Health and Human Services was going toward HIV surveillance in Africa and other Africa AIDS-related efforts.

As the severity of the epidemic continued to deepen, many of those concerned for Africa's future, both inside and outside government, came to feel that more should be done. On July 19, 1999, Vice President Gore proposed $100 million in additional spending for a global LIFE (Leadership and Investment in Fighting an Epidemic) AIDS initiative to begin in FY2000, with a heavy focus on Africa. Funds approved during the FY2000 appropriations process supported most of this initiative. On June 27, 2000, the Peace Corps announced that all volunteers serving in Africa would be trained as AIDS educators.

Bush Administration

The Bush Administration has continued to support increases in HIV/AIDS spending for Africa, and the President has appointed a cabinet level task force, co-chaired by Secretary of

State Colin Powell and Secretary of Health and Human Services Tommy Thompson, to develop and coordinate HIV/AIDS policy. An interagency policy coordinating committee headquartered at the White House has been established to back up the task force. Moreover, as noted above, President Bush made the "founding pledge" to the Global Fund. On June 19, 2002, President Bush announced a $500 million International Mother and Child HIV Prevention Initiative (IMCPI) to support programs to prevent mother to child transmission of the virus. Eight African countries were named as beneficiaries. Secretary of State Colin Powell, speaking on November 13, 2002, at a dinner honoring U.N. Secretary General Kofi Annan, said that the HIV/AIDS pandemic is "the biggest problem we have on the face of the earth today." Nonetheless, editorials, AIDS activist organizations, and others continued to criticize the Administration's response to AIDS in Africa. On December 18, 2002, the Congressional Black Caucus wrote to President Bush seeking sharply increased spending for AIDS programs in Africa and worldwide.

In his January 28, 2003 State of the Union message, President Bush announced a new Emergency Plan for AIDS Relief to channel $10 billion in "new money" over five years to fighting the pandemic in 12 African countries as well as Haiti and Guyana. Budget documents released at the beginning of February indicated that $450 million was being requested in FY2004 for a new Global AIDS Initiative (GAI), the principal component of the Emergency Plan, to be headquartered at the State Department. The objectives of this initiative include preventing 7 million new infections, providing anti-retroviral drugs for 2 million infected people, and providing care for 10 million infected people, including orphans. Many AIDS activists and others hailed the President's initiative, while critics said that the amount requested for FY2004 showed that it was getting off to a "slow start."

Table 1. U.S. Bilateral Spending on Fighting AIDS in Africa
($ millions)

	FY2000	**FY2001**	**FY2002**	**FY2003** Projected	**FY2004** Request
USAID	109	144	183	250.4	325
IMCPI	-	-	-	?	?
CDC	34	78	79	?	?
IMCPI	-	-	-	?	?
GAI (State)	-	-	-	-	?
DOD	0	5	14	7	0
FMF	0	0	0	2	1.5
DOL	0	3	6	0	0
Total	**143**	**230**	**282**		

Table 1 indicates recent U.S. spending levels on AIDS programs in Africa. USAID and the Centers for Disease Control (CDC) of the Department of Health and Human Services are the principal channels for assistance. In addition, the Defense Department (DOD) has undertaken an HIV/AIDS education program with African armed forces. Funds from the Foreign Military Financing (FMF) program are also used to support this initiative. Meanwhile the Department of Labor (DOL) has undertaken a program that supports AIDS

education in the African workplace. Determining the amount to be spent in FY2003 is not yet possible, since the amounts to be committed under the International Mother and Child HIV Prevention Initiative (IMCPI) are not yet available. The Omnibus Appropriations measure for FY2003 (H.J.Res. 2/P.L. 108-7) made funds available for this initiative, but their allocation is not yet known. As noted above, the FY2004 budget proposal includes additional funds for the initiative and for the new Global AIDS Initiative (GAI). Again, information is not yet available on allocation plans for these funds. (For more information, see CRS Report RS21181, *HIV/AIDS International Programs: Appropriations, FY2002-FY2004.*)

USAID is targeting three heavily affected African countries — Kenya, Uganda, and Zambia — for a rapid scale up in HIV/AIDS activities intended to show measurable results in one to two years. Ten African countries have been identified for "intensive focus" to reduce prevalence rates as well as mother-to-child transmission and to increase support services for people living with or affected by AIDS within 3 to 5 years. USAID will maintain basic programs, including technical assistance, training, and provision of commodities in eight other African countries. In July 2002, USAID announced that it had launched pilot antiretroviral treatment projects in Ghana, Kenya, and Rwanda. Additional U.S. funds reach Africa indirectly through the AIDS programs of the United Nations, including the World Bank, and the Global Fund to Fight AIDS, Tuberculosis, and Malaria.

Legislative Action, 2000-2002

In August 2000, the Global AIDS and Tuberculosis Relief Act of 2000 (P.L. 106-264) became law. This legislation authorized funding for fiscal years 2001 and 2002 for a comprehensive, coordinated, worldwide HIV/AIDS effort under USAID. In the 107th Congress, a number of bills were introduced with international or Africa-related HIV/AIDS related provisions. A major international AIDS authorization bill, H.R. 2069, passed both the House and Senate during the 107th Congress but did not go to conference. (For information on appropriations for HIV/AIDS programs, see CRS Report RS21114, *HIV/AIDS: Appropriations for Worldwide Programs in FY2001 and FY2002*.)

Legislative Action in the 108th Congress

The FY2003 Omnibus Appropriations measure (H.J.Res. 2/P.L. 108-7), signed into law on February 20, 2003, funded a number of programs and initiatives that will support the struggle against AIDS in Africa. For further information, see CRS Report RS21181, *HIV/AIDS International Programs: Appropriations, FY2002-FY2004.* Several bills with provisions related to the African AIDS pandemic have been introduced early in the 108th Congress and referred to committee, including:

H.R. 390 (Waters)/S. 185 (Daschle), African Famine Relief Act of 2003
H.R. 643 (Waters), Debt Cancellation for the New Millennium Act
H.R. 1145 (Millender McDonald) Peace Corps HIV/AIDS Training Enhancement Appropriations Act of Fiscal Year 2003
S. 250 (Durbin), Global Coordination of HIV/AIDS Response Act (Global CARE Act)

H.R. 1298, a major AIDS authorization entitled the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003, was introduced on March 17 by

Representative Henry Hyde, Chairman of the House International Relations Committee, Representative Tom Lantos, and others. This bill, which passed the House on May 1, is summarized below, under *LEGISLATION*.

The legislative agenda released by Senate Republican leaders on February 14, 2003, includes a measure to substantially increase funds authorized for international AIDS activities. However, a March 19, 2003 Senate Foreign Relations Committee meeting to consider provisions of such a bill was postponed, reportedly because a draft did not sufficiently promote abstinence over condom use as a means of preventing the spread of HIV. (*Washington Times*, March 20, 2003.) Moreover, while the draft did not specify an amount for the Global Fund, some were reportedly concerned over a lack of controls on Global Fund spending. Earlier reports indicated that the bill was being delayed by disagreements over the application of the "Mexico City policy" to international AIDS spending. The policy prohibits international family planning clinics from receiving U.S. funds if they promote or perform abortions. (*New York Times*, March 6, 2003.) For additional information on the Mexico City Policy, see CRS Issue Brief IB96026, *Population Assistance and Family Planning Programs: Issues for Congress.*

LEGISLATION

H.R. 1298 (Hyde)

United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003. Authorizes $3 billion for each of the fiscal years 2004 through 2008 for international AIDS, tuberculosis, and malaria activities. AIDS-related provisions include the following: requires the President to establish a comprehensive, integrated, 5-year strategy to combat global HIV/AIDS; requires the President to report on the implementation of the strategy, including discussion of the promotion of abstinence, monogamy, faithfulness, and use of condoms; establishes at the Department of State a Coordinator of United States Government Activities to Combat HIV/AIDS globally; states that public-private partnerships should be a priority part of U.S. global HIV/AIDS strategy; authorizes up to $1 billion of the $3 billion authorized for FY2004 for the Global Fund to Fight AIDS, Tuberculosis, and Malaria for FY2004 and such funds as shall be necessary through 2008, but U.S. contribution to the Fund not to exceed 33% of total funds contributed by other sources unless the President determines an international health emergency threatens national security; requires withholding of Global Funds contributions equal to any amount granted a country that supports terrorism or to any amount spent for administrative expenses in excess of 10%, both provisions subject to waiver; establishes a U.S. technical review panel to provide guidance to U.S. representatives to the Global Fund; requires the Comptroller General to monitor and evaluate projects supported by the Global Fund; amends the Foreign Assistance Act of 1961 to authorize the President to furnish assistance to prevent, treat, and monitor HIV/AIDS in countries of sub-Saharan Africa and other countries; authorizes a pilot program to place health care professionals in overseas areas affected by AIDS, tuberculosis, and malaria; authorizes the procurement of HIV/AIDS pharmaceuticals; authorizes such sums as may be necessary for a pilot program of assistance for children and families affected by HIV/AIDS, and for a pilot program on family survival partnerships. Markup version adds provisions calling for 10% of funding to be used to help children whose parents have died of AIDS; requiring organizations receiving funds to explicitly oppose prostitution and sex trafficking; giving

priority to organizations that are already administering MTCT programs; reducing contributions to the global fund by an amount equal to Fund grants to governments on the State Department terrorism list; and ensuring that physicians assistants can participate in the pilot program for the placement of health care professionals.

H.R. 1298 was introduced in the House on March 17, 2003; referred to the Committee on International Relations; marked up and reported (H.Rept. 108-60) April 2. During floor debate on May 1, House agreed to Tauzin amendment to establish distribution of resources and priorities to reflect size and demographics of specific nations, to withhold funds in an equal amount if administrative expenses of the Global Fund exceed 10%, and for other purposes; Crowley amendment requiring that HIV/AIDS teaching programs for men and boys emphasize gender equality and respect for women and girls; Biggert amendment stating sense of Congress favoring a public information program in support of the Global Fund; Stearns amendment to withhold funds in an equal amount if the top salary level at the Global Fund exceeds that of the U.S. Vice President; Ballance amendment stating sense of Congress that countries with large populations living with HIV and AIDS should accept U.S. food assistance; Lantos/Millender-McDonald amendment calling for a pilot program to ensure the inheritance rights of women in families affected by HIV/AIDS, particularly in Africa; McCollum amendment to ensure that not less than 10% of amounts appropriated be expended for orphans and vulnerable children affected by HIV/AIDS; Jackson-Lee amendment stating sense of Congress that U.S. businesses should be encouraged to provide HIV/AIDS assistance in sub-Saharan Africa; Smith of New Jersey amendment clarifying that organizations receiving funds not be required to endorse, use, or participate in a prevention method or treatment program to which it has religious or moral objections; Pitts amendment requiring that 33% of funds for prevention shall be expended for abstinence-until-marriage programs. (For text of amendments, see H.Rept. 108-80.) H.R. 1298 passed the House (375-41), May 1, 2003.

During Senate consideration on May16, Biden amendment to expand debt relief for AIDS-stricken countries through the Enhanced Heavily Indebted Poor Countries Initiative (HIPC) accepted by voice vote; bill, as amended, approved by voice vote, May 16, 2003.

S.Con.Res. 23 (Nickles)

Congressional Budget Resolution. Amendment by Senator Kerry to increase international AIDS funding by $800 million to match levels in a proposed authorization measure defeated (47-51), March 26, 2003.