

**2003 Year In Review
HIV/AIDS U.S. Policy
Briefing Papers**

Prepared on behalf of the November 24 March on White House Coalition

Summary:

Over 1000 people, including people living with HIV, their families, and members of organizations fighting HIV/AIDS in the United States and around the world, are marching on the White House one week before World AIDS Day, 2003. Bearing a banner reading “Voters Want AIDS Action, Not Weapons of Mass Deception,” they demand that the current President and all presidential candidates commit to a greatly enhanced response to the escalating HIV/AIDS epidemic.

In their “HIV/AIDS Federal Policy Year in Review,” they document trends in the Bush Administration, including:

- a disinvestment in effective strategies for HIV prevention, treatment and care, despite a growth in the population of people living with HIV due to treatment-related reductions in mortality and a troubling increase in infection rates in some communities;
- the use of deliberate misinformation and multiple attacks on community organizations to prioritize conservative religious values over sound science and public health; and
- the use of misleading rhetoric to mask the ongoing inadequacies of the U.S. contribution to the global epidemic

Key Findings:

1. The Bush Administration must adequately invest in the HIV treatment, care and prevention infrastructure in the United States:

In order to combat the AIDS epidemic in the United States, the Federal government has responded to the demands of people living with HIV and their loved ones by creating a limited but vital safety net of prevention, treatment and care services. This infrastructure has drastically reduced the rates of new infections from a peak in the mid-1980s and helped to reduce the AIDS death rate by providing medication, health care, and supportive services to people living with HIV.

In addition, adoption of rapid HIV testing in many areas of the country is expected to help even more people learn of their HIV status – but programs that assist those who have newly tested HIV positive are not receiving commensurate increases in resources.

Thus, our investment in the lives of Americans living with or at risk of HIV infection must continue to grow. Current programs lack resources to reach everyone in need, and any success in saving lives and helping more people learn of their HIV status will mean there will be even more people living with HIV seeking information, treatment and support.

Although distinct programs and budget pathways separate AIDS-related federal activities such as testing, surveillance, medical care, and prevention, these programs are inextricably linked in the lives of people at risk or living with HIV. Shortfalls in one program impact the other areas and jeopardize the capacity to curtail the epidemic in our country.

Public health professionals and CDC staff agree that it would take an additional \$300 million per year, for at least four years, to reach the goal of reducing by half the number of annual HIV infections in the United States by 2005 (AJPH, July 2001; NASTAD, July 2003). To meet the needs of a growing population of people living with HIV, we require at least \$500 million additional in the Ryan White CARE Act for fiscal year 2005, and at least \$60 million in additional funds for HOPWA (Housing Opportunities for People With AIDS).

Instead, the Bush Administration has recommended flat funding or actual decreases in the federal AIDS safety net, and by and large, Congress has concurred: fiscal year 2004 will mark the first year in CARE Act history when the entire Act has not received an increase.

2. The Bush Administration must prioritize sound science and public health information and strategies, and cease misinformation and multiple attacks on community organizations.

The fight against HIV in the United States was tragically delayed in the early days of the epidemic due to political indifference or outright hostility to communities most impacted by the virus. People with HIV and their loved ones mobilized to demand a governmental response, and fundamentally altered the relationship between “patients,” doctors, government, researchers and private industry.

However, conservative beliefs and biases have found an ally in the Bush Administration, once again seeking to limit honest, open discussion about sexuality, drug use, gender relations, and other matters so fundamental in controlling the epidemic. Audits of community AIDS prevention organizations have selectively fallen on those providing effectively explicit information for gay men, those in communities of color, and those taking a principled stand against abstinence-only education for youth.

In order to receive abstinence-only-until marriage funds – one of the few federal programs to receive healthy increases in recent years, without any proof of effectiveness – education systems and organizations must agree to censor information about condoms, substituting misinformation that cast doubts on their effectiveness.

- The Administration is exporting harmful AIDS policies as well, such as a mandate that 33% of all prevention funds in the President’s Emergency Plan for AIDS Relief (EPAR) be spent on abstinence-only-until-marriage programs and banning the funding of organizations working to secure the rights of sex workers to be free from violence and harassment. These policies disproportionately and negatively impact women and girls.

3. The Bush Administration must prioritize multilateral efforts in confronting the global AIDS epidemic - rather than undermining the Global Fund for AIDS, TB and Malaria (GFATM)– and remove obstacles from worldwide access to affordable treatment, in order to help meet the goal of 3 million people on treatment by 2005

Despite well-touted statements professing commitment to fighting global AIDS, the Bush Administration has continued to propagate harmful policies on intellectual property rights and patents as well as prioritizing its showy, limited, still-on-the-drawing-board Emergency Plan for AIDS Relief (EPAR) rather than working to ensure the success of the up-and-running, multilateral, but chronically underfunded GFATM. A continued push for bilateral trade agreements allows the Administration to chip away at the now-recognized right to health over profit, using divide-and-conquer strategies with a range of countries facing significant epidemics.

2003 Year In Review: HIV/AIDS Federal Policy Briefing Papers

HIV Prevention in the United States

In 2001, the Bush Administration announced a goal of reducing the number of new HIV infections in the US from an estimated 40,000 to 20,000 per year by the year 2005, with a stated focus on eliminating racial and ethnic disparities in new HIV infections. CDC staff and public health professionals estimate that it would an addition \$300 million public investment per year to reach this goal (AJP, July 2001, p 1022).

In April of this year, CDC announced an initiative called “Advancing HIV Prevention: New Strategies for a Changing Epidemic,” ostensibly to move towards this goal without no new funding. This initiative, which has been widely critiqued by a wide range of activists and advocacy organizations, would radically shift the profile of HIV prevention services in the United States, particularly in minority-led organizations that only began to receive targeted prevention funding with the passage of the federal Minority AIDS Initiative four years ago.

In this political environment, much of the recent work of domestic HIV prevention advocates has focused on blocking or reducing the implementation of ill-advised or potentially harmful policy initiatives, many of which parallel the priorities of religious conservatives closely allied with the Bush Administration, while continuing to support innovative strategies to further research into expanding prevention options.

Thus, advocates have covered a spectrum of issues in the past year, from resisting the expansion of misleading “Abstinence Only Until Marriage” programming to supporting innovative vaccine legislation that would give tax credits to small research and development organizations. In addition, this year has seen a fight to ensure that indigenous community based organizations retain resources to research, design and implement culturally competent, holistic HIV prevention interventions grounded in behavioral science. Despite significant challenges, activists have articulated the importance of scientifically-sound and community-based prevention strategies in the past year, and have:

- ensured that Advancing HIV Prevention will retain support for ongoing primary prevention services for HIV negative individuals.
- achieved a reduction in Congressional appropriations for scientifically-dubious, religiously-based “Abstinence Only Until Marriage” programs.
- supported small community-based organizations that use or produce targeted adult HIV prevention materials for those at high risk of HIV infection. Although these organizations have been subjected to federal harassment and retaliatory audits from ideologically-motivated members of Congress and the Executive Branch, not one agency has been forced to close as a result of such tactics, and all continue to provide service in their communities.

Recommendations for the Bush Administration include:

- Advocate for full funding of domestic HIV prevention services from the United States Congress -- HIV prevention remains our first and best weapon against a resurgent domestic epidemic, and admirable goals to halve new cases will take a significant investment in expanding our efforts.
- Oppose further governmental support of Abstinence Only Until Marriage Programs, which are scientifically unproven, mandate misinformation on condom efficacy and value-laden statements on sexuality, and which are uniquely devoid of value for millions of lesbian and gay youth in this country, whom still can not marry.
- Cease and oppose ideologically motivated attacks on providers and the research community. Behavioral science research provides the very basis for behavioral interventions to stop the spread of HIV, and community-led efforts can effectively reach people at highest risk.

National Institutes of Health (NIH)

The NIH is the premier biomedical and behavioral research institution in the world, and supports a comprehensive agenda in HIV/AIDS research, including basic biological, clinical, behavioral and social, and health services research. NIH-sponsored biomedical and behavioral research over the past two decades has led to significant advances in the development of HIV prevention interventions in three key areas: behavioral interventions to reduce sex and drug-use related risk; therapeutic interventions to reduce HIV transmission from mother to child; and diagnostic tools and related interventions to protect the blood supply. It is estimated that if such interventions had not been developed and implemented—with significant community involvement—we would see the infection rate in the U.S. remain at about 125,000 per year, as it was in the mid-1980s, instead of the 40,000 per year that we now have.

After a multiyear, bipartisan effort to double the NIH budget, HIV treatment and prevention research should be at the top of their game. New data showing a second wave of infections among men who have sex with men should provide impetus for a new federal initiative to research innovative prevention strategies among the nation's most at-risk populations. Instead, researchers have learned that working with stigmatized populations such as sex workers, gay men, or drug users (in other words, the vast majority of those at highest risk for HIV infection) could make them a target of government investigations. The climate of harassment and suspicion surrounding HIV prevention research has become so pronounced that Dem. Congressman Henry Waxman sent a letter to Health Secretary Tommy Thompson calling it “Scientific McCarthyism.”

- In April, the New York Times revealed that many HIV prevention researchers had received phone calls from their project officers at NIH warning them to avoid using hot button words such as “sex worker,” “anal sex,” “needle exchange,” and “men who have sex with men” in their grant applications. Some were even warned to avoid such phrases in email communications with NIH. The goal was to protect researchers from political surveillance, but the effect was intimidation.
- In July, Rep. Congressman Pat Toomey introduced an amendment seeking to defund six peer approved NIH grants that he deemed frivolous, including a study of HIV risk reduction among Asian immigrant sex workers in the Bay Area -- one of only a handful of HIV risk studies the NIH has ever funded among Asian Americans.
- At a Congressional hearing in early October, Rep. Congressman Joe Pitts and several other Republican members of the House Energy and Commerce Committee demanded that NIH director Elias Zerhouni defend the public health benefits of ten NIH grants that they deemed frivolous -- all but one related to sexuality or HIV.
- Later in October, when NIH staffers asked exactly which grants they should investigate, an unnamed congressional staffer “mistakenly” sent over a chart listing 289 NIH-funded grants, authored by the antigay Traditional Values Coalition -- an organization whose founder, Lou Sheldon, once called for AIDS leper colonies. The vast majority of the grants fund research into HIV prevention, risk reduction or AIDS-related stigma. The top names in HIV prevention research across the country received warning calls from NIH program officers. “The general feeling is one of fear and intimidation,” says Tom Coates, the former director of UCSF's AIDS Research Institute. Four of Coates' studies are mentioned on the TVC hit list.

Key recommendations for NIH:

- Demand that politics, ideology, and sectarianism not be allowed to trump scientific merit and peer review in the determination of grant awards, nor affect funding priorities, and that budgets for HIV prevention research at NIH related to sexual behavior and drug use remain robust.
- Demand that the Secretary of HHS and the Director of NIH publicly state their commitment to supporting scientifically meritorious research on human sexuality, sexual behavior, drug use and HIV-related risk among all relevant population groups and settings.

Housing Opportunities for Persons with AIDS (HOPWA)

The Housing Opportunities for Persons with AIDS program (HOPWA) provides housing assistance to low-income persons living with HIV/AIDS and their families through formula and competitive grants and technical assistance. The program helps homeless and unstably housed persons challenged with the disease to acquire housing or remain housed through rental assistance, short-term rent, mortgage and utility payments. People receiving help from HOPWA are extremely low-income; more than 90% of beneficiaries have incomes less than \$1,000 per month.

HOPWA helps pay the capital costs for development and operation of community residences as well as access to life-sustaining supportive services. According to HUD, in program year 2001, 63,344 households received some HOPWA assistance.

The FY 2003 amount of \$290 million for HOPWA supports the delivery of housing and services in 114 formula jurisdictions and 30 competitive grants, although real costs to serve those in need of assistance living with HIV/AIDS would exceed \$800 million dollars. Waiting lists across the country – in communities large and small— are growing. For example, in San Francisco, 4,000 await assistance while in St. Louis, 500 people are on the waiting list.

In addition, this year has seen new regulations that “redistrict” the administration of HOPWA into differently-configured regions, based on Metropolitan Statistical Areas (MSA) revisions. It is unclear how this regrouping will impact the waiting lists or other challenges.

Advocates recognize that the full funding need cannot be met in fiscal year 2005. However, a funding level of \$350 million would permit some small growth in existing programs and accommodate newly eligible formula jurisdictions.

Recommendations for the Bush Administration:

- Fund the HOPWA program at \$350 million for FY2005.
- Hold current formula jurisdictions harmless until the impact of MSA definition revisions can be studied.

Ryan White CARE Act Programs

The Ryan White CARE Act is the federal government's largest program dedicated solely to meeting the needs of people infected and affected by HIV. Serving more than 500,000 people a year through both formula-driven and competitive grants to states, cities, and non-profit organizations, the CARE Act is a model of efficiency and effectiveness. The government has reviewed the CARE Act more than ten times, each time certifying it as a well-administered and well-designed program reaching goals established by Congress.

The CARE Act is a "payer of last resort" to provide medical and support services to uninsured and underinsured people with HIV and their affected families and caregivers. The CARE Act subsidizes primary medical care, antiretroviral and other medications, mental health and substance abuse treatment, housing, nutrition, transportation, case management, and other services to ensure that HIV-positive individuals have access to continuing care.

Despite its effectiveness, the Bush Administration has repeatedly proposed flat funding for the CARE Act (excepting small increases for its drug assistance program - see the "ADAP" fact sheet). While client loads are increasing, the costs of medical care and supportive services are skyrocketing, and a weak economy is bringing more people to the point of needing CARE Act services, the President has refused to provide even cost-of-living adjustments in the budget for the CARE Act.

The Past Year:

For fiscal year 2004 (which began on Oct. 1, 2003, but for which the Congress has still not finished its budget process), the President proposed flat funding and cuts for most of the CARE Act. Despite pleas from people living with HIV and providers of CARE Act services, the President refused to increase the CARE Act. In fact, the Administration numbers invited Congress to cut funding levels from several key portions of the Act. The House did indeed approve these cuts, while the Senate achieved at least flat funding. *Fiscal year 2004 will be the first year in CARE Act history when the entire Act has not received an increase.*

Recommendations for the Bush Administration:

The CARE Act, currently funded at \$2 billion, requires at least \$2.5 billion in fiscal year 2005 to meet the unmet needs of people living with HIV in the United States. Due to antiretroviral therapy, people with HIV are living longer. However, this places additional financial strains on the CARE Act. As newly infected people need to access these services as well, and overall costs of care increase, significant funding increases are needed to meet the medical and support services needs of people with HIV.

The AIDS Drug Assistance Program (ADAP)

The AIDS Drug Assistance Program (ADAP) is a federal program funded primarily through Title II of the Ryan White CARE Act. It provides access to HIV/AIDS treatments for low-income people who are uninsured or lack adequate prescription drug coverage. It is administered by the states and, in some cases, augmented by state funding. Because it is administered by the states, programs vary widely from state to state, including number of available drugs on the formulary, financial and clinical eligibility criteria, and other program controls.

An estimated 90,000 people monthly utilize ADAP for their HIV medications. In 2002, 81% of the ADAP clients earn less than \$18,000 a year, 68 % are minority Americans (33% African American, 25% Hispanic).

ADAP is currently at a budget shortfall of \$145 million, largely a result of several consecutive years of underfunding compounded by increasing demand. Many ADAPs across the country are experiencing severe financial crises, resulting in limits to treatment access.

Nearly 600 people are currently on ADAP waiting lists across the country and cannot get lifesaving anti-AIDS drugs. 12 states have capped enrollment (Alabama, Alaska, Arkansas, Colorado, Idaho, Kentucky, Nebraska, North Carolina, Oregon, South Dakota and West Virginia). Three states (New York, Washington and Oklahoma) have restricted access using other means (lowering financial eligibility caps, reducing formularies) and at least six additional states (including Texas and California) have reported that they anticipate implementing substantial new restrictions.

If the current fiscal crisis continues, states may seek to control costs in ways that threaten the health of both the program and the thousands of Americans who rely on it. States are looking at lowering the financial eligibility criteria and capping new enrollment. ADAP medical advisory boards are dropping medications currently provided on formularies and delaying adding new anti-HIV drugs. States are also considering co-pays or medical pre-authorizations that may put the program out of reach for the most vulnerable and create additional barriers to access for many others.

America's investments in research, which have yielded increasingly effective therapies, will not be fully realized in health improvements due solely to the inability of Americans living with HIV to access these therapies.

There are several factors contributing to the ADAP problem:

- Inadequate federal funding: Congress appropriated less than half of the needed increase in FY03, while the demand on ADAP continues to grow. AIDS death rates in the U.S. have fallen from 40, 000 to 15,000 per year with corresponding drops in morbidity.
- Increases in costs of new treatments: Management of HIV disease has become increasingly complex, requiring new drugs to treat viruses that have become resistant to available therapies. New and effective treatments have recently been approved by the FDA, including three new drugs in the past year alone.
- Increase in HIV testing programs across the country: The new CDC rapid testing initiative will increase the number of people being tested, leading to increasing demand for treatment and care. A quarter of the estimated 1 million HIV positive Americans are unaware of their status, while more than 40,000 new infections continue to occur each year. Approximately 25% of these newly identified HIV positive individuals will need to access treatment and care through ADAP.
- Increase in the number of uninsured Americans: The current economic crisis has produced record unemployment numbers, increases in insurance premiums and co-pays, as well as Medicaid cut backs. *Without ADAP and Ryan White funded services, HIV + Americans with no healthcare coverage will have no access to life-saving medications and healthcare.*

Recommendations for the Bush Administration:

The fate of ADAP for the next year will be shaped by the omnibus spending package currently under discussion. In order to address the ADAP crisis, Congress must appropriate an increase of \$283 million in federal funding for ADAP for Fiscal Year 2004 This figure includes the current \$145 million shortfall plus an \$138 million increase needed in the next fiscal year to provide adequate financial relief to ADAP.

Global AIDS and the White House's Emergency Plan for AIDS Relief (EPAR)

President Bush made a stirring commitment to emergency action on the global AIDS epidemic, his Emergency Plan for AIDS Relief (EPAR), in his State of the Union Address ten months ago. But his plan, yet to be implemented, has serious programmatic flaws and continues to be underfunded by Congress under orders of the White House¹. Worse, the U.S. go-it-alone unilateral approach in fighting global AIDS is undermining the multilateral public-private partnership, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM).

The questions that should be asked of Bush, Secretary of Health and Human Services Tommy Thompson and AIDS Coordinator Randy Tobias (both in Zambia on December 1) are: "How well is Bush living up to his promise of emergency action on AIDS?" and, "How well does his effort contribute to what the World Health Organization now says is required to expand antiretroviral treatment to reach 3 million people by 2005?"

Important U.S. Global AIDS political progress in 2003:

- The White House effort to stop Congress from fully funding AIDS programs at the 3 billion dollar level in FY 2004² has provoked strong public reaction. Religious groups and archbishops from around the world, health care advocates, dozens of editorial boards in major US newspapers, and 52 African heads of state have called on Bush to back full, immediate funding for EPAR and the GFATM.
- 2004 presidential candidates Howard Dean, John Kerry and Richard Gephardt have publicly attacked the President on the issue, accusing him of failing to keep his promises.
- In November, led by Senator DeWine (R-OH), 89 Senators voted for an 18% increase (\$289 million) in AIDS funding. The debate continues in House-Senate conference.
- The Clinton Foundation announced in October record-low costs for triple combination therapy from generic producers for four initial countries in Africa.
- On World AIDS Day, thousands will urge the President to amend his FY 2005 budget proposal to \$5.4 billion to fight AIDS, tuberculosis and malaria during a national call-in day.

Problems in U.S. Global AIDS policy:

- The Administration's plan starts slowly (back-loading), with small amounts of funds stolen from other programs.³ Moreover, actual disbursements are back-loaded well into the future – meaning little money to address the problem today, with promises to give more over time.⁴
- The President is preparing to submit a global AIDS budget request for FY 2005 that is no greater than what Congress will likely provide in 2004.⁵
- Key areas with rapidly growing HIV epidemics are virtually ignored by the President's approach. India, China, Zimbabwe, Malawi and poor countries in Latin America are among the ineligible countries.
- The President's new Global AIDS Coordinator, Randy Tobias—a former CEO of a major pharmaceutical company—is developing the Bush plan largely without input of organizations working on the issues. Important questions about the implementation of abstinence-until-marriage programs and preferential support for groups that disparage condoms remain unaddressed, as does the administration's drug procurement strategies.

Recommendations for global AIDS policy:

- Full funding of EPAR – including the purchase of lowest-cost medicines for EPAR, enabling the treatment of as many people as possible -- and a minimum of \$1 billion in funding for the GFATM.
- Transparent implementation of EPAR with input from advocates, health care providers and other key non-governmental organizations.

¹ Despite the initial fanfare, the White House has since persistently undermined Bush's own plan by repeatedly asking Congress not to fund it fully in 2004 at levels originally stipulated in authorizing legislation, the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003.

² The White House's Director of National AIDS Policy has written to Congress at least three times since the President's Africa trip to try to stop Congress from providing full funding to global AIDS programs—both the U.S. plan and the GFATM. The President has used distortions and half-truths about Africa's lack of capacity to block expanded funding that would benefit all developing countries fighting AIDS.

³ Bush's proposed FY 2004 budget shows that the \$10 billion AIDS Initiative is not new money, but is taken from development aid to other programs including the Child Survival programs and the Millennium Challenge Account.

⁴ The White House target is \$2 billion in spending for FY 2004, when experts project the U.S. commitment should be at least \$3.5 billion for 2004, with at least \$2 billion for the Fund alone. Additionally, the aggregated \$1 billion for the fund is not "new money" since this is the same funding request the White House has made every year since 2001.

⁵ Under the President's spending plan, the US will provide just 16% of what the UN has stated is needed for a minimal response to AIDS by 2005 (\$10.5 billion), in contrast to the 33% the US has provided to effective international efforts against polio and smallpox.

Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM)

The Global Fund to Fight AIDS, TB, and Malaria (GFATM) was established in January 2002 as an innovative and efficient funding mechanism to enable developing countries to mount comprehensive treatment, care, and prevention programs targeting three pandemics: HIV/AIDS, tuberculosis, and malaria. Despite a specific request from the UN for a \$2 billion initial donation, the U.S. only provided \$200 million—one tenth of the requested amount—thereby setting the bar ankle-high for the rest of the major donor countries.

In 2003, instead of committing resources to rapidly utilize the existing programmatic capacity, the U.S. has systematically undermined the vision and resources of the GFATM. The U.S. should pay an equitable share based on its portion of the world economy (33%), meaning at least \$6 billion a year over the next five years, with half of that going to the GFATM. Instead of committing funding near this amount, the U.S. continues to debate whether to provide \$2.4 billion for AIDS worldwide in 2004 and whether it will increase funding to the GFATM above a paltry \$200 million. The GFATM has been unable to meet the need of the last grant requests and has to borrow against future years. Also, at the low funding levels from the U.S. and other countries, the GFATM has been able to attract or inspire large AIDS treatment proposals needed to ensure scale-up of antiretroviral (ARV) programs. *At a time when the pandemic is soaring, the global response through the most effective financing mechanism has actually diminished—resulting in fewer people anticipated to receive HIV/AIDS treatment in its latest round of grants than the previous round.*

Important Global Fund progress in 2003:

- Approved two rounds of funding and now services 224 programs in 121 countries;
- Has a highly competent and skilled technical panel that identifies worthy proposals based on merit;
- Approved proposals will reach 35 million with voluntary counseling and testing (VCT); provide treat 700,000 with ARVs; support 1 million orphans;
- Speeded up its disbursements (\$155 million by Nov. 2003).
- Received good review of performance and operations by the U.S. General Accounting Office (GAO).

Key problems in U.S. Global Fund policy:

- Tommy Thompson, the U.S.-imposed Chairperson, has been an apologist for U.S. policy and underfunding rather than a champion for people living with the three diseases;
- U.S. proposed a challenge grant whereby it would donate up to \$1 billion to the GFATM in 2004, and then the Administration reneged, seeking a \$200 million cap;
- U.S. convinced the GFATM to reduce the number of proposal rounds to one-a-year;
- U.S. “jealousy” and competition of GFATM led it to promise 93% of its resources to its own unproven, inoperational, and policy-flawed (abstinence-only) unilateral initiative, EPAR

Key recommendations for the Global Fund:

- U.S. commit to providing annual payments to the GFATM based on global need and the country’s portion of global wealth;
- At least 50% of U.S. funding to fight global AIDS be allocated to the Global Fund which helps facilitate a country-controlled and coordinated response to the three diseases;
- The U.S. pay its fair share for \$1 billion to the Fund for renewal of early rounds and for funding a robust Round Four of grants in 2004

Global Trade and Intellectual Property Rights (IPR)

The pharmaceutical industry is the most profitable industry in the United States, with rates of return on investment far exceeding every other Fortune 500 company. Strong ties between the Bush Administration and the pharmaceutical industry have resulted in a relentless drive for patent policies that will drive up the cost of medicines and suppress generic competition in countries around the world—even in places heavily impacted by AIDS and other diseases of poverty.

In countries where major pharmaceutical companies hold patents, AIDS medicines cost \$10,000-\$20,000 a year versus as little as \$140 a year for generic versions. In 2001 poor countries and activists won the Doha Declaration on the TRIPS Agreement and Public Health, an agreement clarifying developing countries' right to circumvent patent monopolies in the interest of public health. The U.S. then blocked a key element of the Declaration designed to permit exportation of low-cost generics to developing countries that cannot produce medicines on their own. Finally, on August 30, 2003, the WTO adopted a flawed measure addressing the export issue.

The U.S. is now turning its back on the Doha Declaration by negotiating bilateral and regional trade agreements that will greatly increase the cost of essential AIDS drugs in poor countries. In the past year, the U.S. has concluded negotiations with Chile and Singapore and is negotiating further bilateral agreements with Morocco, Thailand, the Dominican Republic, Panama, and Australia and regional agreements with Central America, the Andes, Southern Africa, and the entire Western Hemisphere (the FTAA). In each agreement, the U.S. is seeking standards for patent protection that would undermine both the Doha Declaration and the August 30 Agreement, stifle generic competition and drive up drug prices.

Important trade and IPR progress in 2003:

- Developing country solidarity rejecting disease restrictions in implementing the Doha Declaration;
- Activist opposition to bilateral and regional trade agreements, prompting demands that intellectual property rights be excluded from emerging trade deals;
- Deeply discounted generic antiretrovirals in fixed-dose combinations at less than \$140 a year;
- Pre-qualification of key generic antiretrovirals by the World Health Organization

Key problems in U.S. trade policy for 2004:

- U.S. divide-and-conquer strategy designed to pick off countries and smaller regions one by one, seeking ever higher patent protection restrictions;
- Flaws in the August 30 Agreement will impede easy access to exported generics;
- Attacks on drug price controls in other countries, demands for even more data/market exclusivity, biased technical assistance for poor countries changing their national patent rules, and secret trade pressure on countries to adopt tougher patent protection than the WTO requires.

Key recommendations:

- The Doha Declaration must be the ceiling for patent protection, and U.S. must stop seeking heightened intellectual property rights in bilateral and regional trade agreements;
- Demand the adoption of a more streamlined procedure for producing generic versions of patented medicines for export and amend TRIPS accordingly;
- Demand that, in highly impacted regions, drug companies relinquish their patent rights on AIDS medicines and permit access to their registration data to expedite market entry of generics.

Global AIDS and Gender Issues

Women now represent more than half the 42 million people infected with HIV worldwide, and nearly 60 percent of those infected in sub-Saharan Africa. New infections are rising rapidly among married women and adolescent girls in virtually every region. Women are four times more likely to contract HIV than men, due to greater biological and social vulnerability. In many countries, for example, sexual violence and coercion, discriminatory cultural practices (e.g., child marriage and dowry) and economic dependence on men leave even monogamous married women vulnerable. Today, more than 80% of new infections result from sex with primary partners. And poverty and social disintegration are driving increasing numbers of women and girls to rely on prostitution for basic survival.

The Bush Administration's record on women's health and rights worldwide is extremely poor, raising skepticism about whether and how U.S. implementation of the Emergency Plan for AIDS Relief (EPAR) will address the vulnerabilities of women and girls. For example, Bush has severely undercut international family planning programs by applying the Global Gag Rule, which strips US aid from organizations that discuss abortion. However, these reproductive health clinics often are the places women turn to for voluntary HIV counseling and testing. Now, the president is levying these same restrictions on HIV funding, undermining the very programs best poised to reach women and girls.

Important progress on women and global AIDS in 2003:

- A number of provisions in EPAR underscore the need to address gender violence and harmful traditional practices, improve access to micro-credit, and increase access to anti-retrovirals (ARVs) for pregnant women. However, measurable benchmarks are required only for MTCT (mother to child transmission) prevention programs.

Key problems in Bush's Emergency Plan for AIDS Relief (EPAR):

- Requires that 33 percent of all prevention funds be spent on abstinence-only-until-marriage programs. Similar politically motivated programs have not been proven effective in the U.S.
- Prevents funding of organizations working to secure the rights of prostitutes to be free from violence and harassment.
- Disproportionately emphasizes the role of faith-based groups, despite their poor track record in addressing gender violence or empowering women to negotiate safer sex.
- Fails to ensure that all women in MTCT programs get access to follow-up treatment or reduce obstacles to treatment in women writ large.
- Fails to require measurable benchmarks for many of the positive provisions above.

Key recommendations to be incorporated into U.S. global policies (including EPAR):

- Increase women's political, economic and social empowerment.
- Immediately and dramatically increase access to female condoms.
- Dramatically expand access to integrated family planning and STI/HIV prevention services.
- Address violence against women at every level.
- Promote equitable partnerships and new norms for male behavior.
- Provide comprehensive reproductive and sexual health and rights education.

Global AIDS and Abstinence-Only Strategies

The U.S. federal government has been funding abstinence-only-until marriage programs for more than two decades, despite the fact that little evidence exists of their efficacy. In one review of abstinence-only programs, nine out of ten failed to yield credible, scientifically valid results indicating success in promoting delays in the initiation or reduced frequency of sex. Comprehensive sexual education programs encourage abstinence as the best choice for teens but also provide accurate information on condom use, contraceptives, and other aspects of sexuality. Although comprehensive programs are endorsed by many major medical groups and have been shown to delay the age at which teens first have sex, reduce the number of sexual partners and increase the use of contraceptives, federal funding for such programs has been undermined by politics.

Despite the lack of evidence on the effectiveness of these programs in the U.S., the new US global AIDS bill mandates that 33 % of US-funded global AIDS prevention programs must be used for abstinence-only programs.

This bill ignores the realities faced by women and girls in many developing countries, where poverty, early marriage, and other factors leave women unable to control when and whom they marry, and when and with whom they have sex. Moreover, recent studies show that 25 to 50 percent of women throughout the developing world have experienced violence and sexual coercion at the hands of their husbands or primary partners—a reality that leaves them without the power to enforce abstinence and faithfulness.

Important progress on effective prevention strategies in 2003:

- No progress has been made. Despite the lack of evidence that they work, abstinence-only programs
- enjoy the strong support of the Bush Administration and have received disproportionate funding and
- political support at the expense of comprehensive programs proven to work.

Key problems in U.S. abstinence-only policy:

- U.S. programs have been proven largely unsuccessful. Global programs will be even more unsuccessful
- due to socio-cultural differences and gender disparities driving the epidemic throughout the developing world.
-
- With the high prevalence of HIV in Africa and Asia, abstinence-only programs are poised to fail
- miserably, and will only cause an increase in illness and death among the most vulnerable.

Key recommendations for the Global prevention programs:

- All abstinence-only restrictions should be removed from all US-funded global AIDS prevention
- programs.
-
- Include abstinence as part of comprehensive sexual education programs that emphasize skills for
- practicing safer sex, correct and consistent condom use, reductions in stigma and discrimination, and enhanced communications between women and men.

**2003 Year In Review
HIV/AIDS U.S. Policy
Briefing Papers**

Contact People and Resources for Further Information on these issues

Inclusion does not imply endorsement or membership in November 24 March on White House Coalition

HIV/AIDS Federal Policy

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Broken Promises & Betrayals: Africa Action Talking Points on President Bush's AIDS Policies:

<http://www.africaaction.org/action/brokenprom0309.htm>

Presidential Candidate Platforms & AIDS Vote 2004

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www.aidsvote.org (to go live on December 1)

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www.nastad.org/pdf/AHPNASTADStatement.pdf (regarding Advancing HIV Prevention)

www.nonewmoney.org (regarding abstinence-only)

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Related Articles: “Science Gets Sacked” *The Nation*:

<http://www.thenation.com/doc.mhtml?i=20030901&s=block>

“Watchdog Reveals Effort to Gag Anti-Bush Causes” *Village Voice*:

<http://www.villagevoice.com/issues/0332/lee.php>

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Save ADAP Committee of AIDS Treatment Activist Coalition: www.atac-usa/adap
www.nastad.org/ADAP/ADAPWatchNovember2003.pdf (regarding waiting lists)

Global AIDS and the White House's Emergency Plan for AIDS Relief (EPAR)

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Fund-the-Fund Campaign - <http://www.fundthefund.org/>
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Women and the Global AIDS Epidemic: a 10 Point Plan for the United States
<http://www.genderhealth.org/pubs/WomenGlobalAIDSMay2003.pdf>
Center for Health and Gender Equity – www.genderhealth.org
International Women's Health Coalition – www.iwhc.org
Development Gateway – www.developmentgateway.com/node/130625/
United Nations Development Fund for Women – www.unifem.org
International Center for Research on Women – www.icrw.org

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Marcella Howell, Advocates for Youth: 202-419-3420, www.advocatesforyouth.org
Ignorance Only: HIV/AIDS, Human Rights And Federally Funded Abstinence-Only Programs In The United States: <http://hrw.org/reports/2002/usa0902/>