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Joshua W. Busby [a]
[a] Lyndon B. Johnson School of Public Affairs, The University of Texas at Austin, Austin, Texas, USA

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Editorial

Global AIDS Policy in the Age of Obama

JOSHUA W. BUSBY, PhD

Lyndon B. Johnson School of Public Affairs, The University of Texas at Austin, Austin, Texas, USA

In 2006, then-U.S. Senator Barack Obama and his wife Michelle traveled to Kenya, Obama's father's homeland, where many of the senator's extended family still lived. The Obamas publicly took an HIV test during their trip, an important moment as sub-Saharan Africa is the region most affected by the HIV/AIDS crisis, with more than two-thirds of the world's infections. For every outspoken leader on HIV/AIDS like Uganda's Yoweri Museveni, there have been as many or more AIDS denialists like South Africa's former president Thabo Mbeki and his shamefully ignorant health minister Manto Tshabalala-Msimang who at one time suggested that beetroot and garlic were effective treatments for HIV. Given the new U.S. president's Kenyan heritage, Barack Obama may be uniquely placed to speak to the African people about the dangers of HIV and steps they can take to protect themselves. While Obama may have this special connection, larger currents will constrain his ability to advance the fight against HIV, a product of both the positive and negative legacies of the George W. Bush administration.

THE MOBILIZATION OF CONCERN

Over the past eight years, the world witnessed the incredible mobilization of resources to fight the global AIDS pandemic. Within less than a decade, rich world donors went from providing the developing world less than $200 million per year in the late 1990s to fight HIV/AIDS to about $7.38 billion in 2007.[1] In less than 5 years, the number of people on antiretroviral

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Address correspondence to Joshua W. Busby, Lyndon B. Johnson School of Public Affairs, The University of Texas at Austin, P.O. Box Y, Austin, TX 78713-8925, USA. E-mail: busbyj@mail.utexas.edu

treatment (ARVs) in poor and medium-income countries went from 400,000 in December 2003 to about 3 million by the end of 2007 (World Health Organization [WHO], 2008). While this effort has sadly fallen short of the goals for universal treatment, where an estimated 8 to 10 million people likely need treatment, the successful extension of ARVs to millions in the developing world could scarcely have been imagined a decade ago.

The Global Fund rightly deserves praise as a new institutional financing mechanism in the fight against AIDS, but credit should also go to former U.S. President George W. Bush, whose unlikely and unprecedented generosity of more than $15 billion, through the President's Emergency Plan for AIDS Relief (PEPFAR), made the extension of ARV treatment for millions of HIV-positive people in the developing world a reality. As of September 30, 2008, the U.S government was supporting more than 2 million people on antiretroviral drug therapy, up from 155,000 in September 2004 (Office of the U.S. Global Aids Coordinator, 2008a).

A HIGH-WATER MARK FOR FUNDING

In 2009, however, we may have reached the high-water mark for AIDS funding with the goal of universal treatment slipping farther out of reach. The financial crisis has contributed to some compassion fatigue among donors, perhaps accelerating the natural cycle of issue attention away from AIDS. Other constituencies—such as the areas of population planning and maternal health—have jealously eyed the AIDS community's ability to leverage funds and are eager to get their piece of the pie. In the years ahead, now that George W. Bush is no longer president, more congressional Republicans, long hostile to foreign assistance, will likely oppose Obama's spending priorities on aid.

If past financial crises are any guide, other governments will find it harder to justify extensive overseas commitments while their own citizens are suffering.[2] Before that confluence of factors takes the steam out of the global movement to fight AIDS, advocates should reappraise their goals while the stream of funding for HIV/AIDS remains high. At the top of the list should be a major investment in HIV prevention, including an effort to scale-up male circumcision.

THE SITUATION ON THE GROUND

Having recently returned from South Africa, I have a deeper appreciation for the devastating legacy that denialist beliefs have had on a country that only hoped for better coming out of apartheid. Upward of 2.5 million South Africans died from AIDS between the end of apartheid in 1994 and 2007 (UNAIDS/WHO, 2008). Seventeen percent of the world's total population living with HIV is in South Africa, and the country has the largest number

of people infected with HIV, an estimated 5.7 million of a total population of 48 million (UNAIDS Regional Support Team for Eastern and Southern Africa, 2008b).

Despite the obstacles posed by the South African government to extending treatment, about 700,000 South Africans now have some form of access to ARVs (South Africa Good News, 2009).[3] PEPFAR alone is estimated to have put 550,000 South Africans on treatment (Office of the U.S. Global Aids Coordinator, 2008b). Thanks to programs like the Cape Town–based Mothers2Mothers, a major beneficiary of PEPFAR funds, the percentage of HIV-positive pregnant women in South Africa who have access to ARVs increased from 15% in 2004 to about 57% in 2007. However, UNAIDS estimates that between 1.3 million and 2.1 million South Africans are sick enough to need treatment, meaning that between 600,000 and 1.4 million South Africans still lack access to treatment (UNAIDS, 2008).

Perhaps most disturbing from my conversations with AIDS activists, scientists, the business community, and health practitioners is the sense that the prevention agenda is not working nearly as well as it should or must. Of the 1.5 million new infections in eastern and southern Africa in 2007, South Africa accounted for nearly one-third of new infections, almost 475,000 people (UNAIDS Regional Support Team for Eastern and Southern Africa, 2008a). Dr. Gita Ramjee, a prominent microbicide researcher in South Africa, described the tragedy unfolding in a rural community north of Durban in Kwazulu Natal. In a 3-year follow-up study conducted between 2005 and 2008, she noted that for every 100 women followed up for 1 year, 9.1 became infected with HIV-1, despite receiving counseling on AIDS prevention. These were wives and girlfriends, just women in the community, not sex workers.

Despite the widespread visibility of HIV in programs like *Soul City*, a popular South African soap opera, the stigma associated with AIDS remains. People still do not want to get tested and are wary of even going into buildings associated with testing or treatment.

LOOKING AHEAD: FUNDING AND THE PREVENTION CHALLENGE

So what should be done? Activists are looking to the United States to see what kind of leadership President Obama will provide. PEPFAR was reauthorized in July 2008, with funding up to $48 billion over 5 years, $39 billion for AIDS alone (Brown, 2008). However, in the U.S. system, that money now has to be appropriated by Congress. Although President Obama's proposed fiscal year (FY) 2010 budget includes a 9.5% increase in foreign aid over FY 2009 (some $4.5 billion), it is unclear how much of that increase will go for AIDS (Stolberg, 2009). During my recent visit, development officials in

South Africa thought the U.S. figure might stay flat, despite the still staggering number of new infections and the gap in treatment. In 2008, the United States provided more than $550 million for PEPFAR in South Africa (which accounted for more than 95% of the total foreign assistance the country received from the United States).

A full appropriation of the $39 billion for HIV over 5 years would imply average appropriations of $7.8 billion per year. In the FY 2009 omnibus budget, the U.S. Congress appropriated about $6.3 billion for global HIV/AIDS efforts, including $900 million for the Global Fund. Suppose the Congress does increase the appropriation to $7.8 billion in FY 2010. Unless Congress tops up the total foreign assistance request, that would imply that more than 40% of the additional funds the Obama Administration requested for all foreign assistance would go for global AIDS efforts ($1.8 billion of $4.5 billion).

Even if those additional funds are fully appropriated, the Obama Administration faces some key choices about how much money should go to the Global Fund versus bilateral programs, how much emphasis should be placed on prevention over treatment, and what the focus of prevention programs should be.

In 2008, academics and practitioners began to realize that in the absence of successful prevention, the extension of treatment could become so expensive that the focus on HIV would come at a cost of other health and foreign assistance priorities. Mead Over of the Center for Global Development noted that by 2016 the United States could be spending as much as $12 billion per year on treatment in developing countries, equivalent to about half of all U.S. overseas development assistance in 2006 (Over, 2008).

In 2015, UNAIDS estimated that to provide phased-in access to universal treatment, between $41 and $58 billion would be needed to put 18.6 million people on ARVs (UNAIDS, 2007). While that estimate includes a significant investment in prevention ($15.4 billion), it is hard to see the politics in this current climate supporting such a precipitous increase in spending.

A dramatic change of course is needed to break the cycle of new infections. One option that has great promise is male circumcision, which can reduce the risk of transmission of HIV infection by approximately 60%, perhaps the closest solution to a vaccine that we may hope to have. Despite widespread recognition of the utility of male circumcision, exaggerated fears of cultural resistance have slowed the rollout of more robust programs to train and equip local medical staff (Busby, 2008). Donor efforts, sensitive to local beliefs and the role of local leadership, should be able to overcome some of these cultural constraints. In August 2008, Kenya's Prime Minister Raila Odinga, whose ethnic group, the Luo, typically does not circumcise males, threw his weight behind the practice (AlterNet, 2008). Donors should reach out to Odinga to encourage other African leaders to embrace the effort. Perhaps the important person Odinga could call is Jacob Zuma, the newly

elected president of South Africa. Zuma is a Zulu, the ethnic group in South Africa that is perhaps most affected by AIDS and one that no longer practices circumcision as it once did.

Another provocative idea would be to put any HIV-positive person on treatment as soon as their status is detected, rather than wait for their $CD4^+$ count to decrease below 200 cells per μL, as is current practice in the developing world. By putting people on treatment while viral loads are still high, transmission of the virus could be dramatically reduced. Based on models of South Africa, a January 2009 study in *The Lancet* suggested that a universal testing program for HIV, coupled with putting people on treatment at the first detection of infection, could within a decade reduce the incidence of HIV to negligible levels. That program would require substantial upfront investment, peaking at $3.4 billion for South Africa in 2015. However, the authors see this as ultimately being much cheaper than the UNAIDS phased-in estimate, which would require almost $7 billion for South Africa in 2015 (Granich, Gilks, Dye, Cock, & Williams, 2009).

While many questions remain about the capacity of the South African government and donors to implement such a scheme, such a strategic rethink is needed, lest the global community unwittingly commit to policies that prove ineffective in the long run.

CONCLUSION

Given that there is no cure for AIDS, the extension of treatment to those who are HIV positive is perhaps a deeper responsibility than people realize. Donors assume moral responsibility to extend ARV therapy for the remainder of those people's lives. Repudiation or interruption of that commitment would be extremely damaging, as those people would die unless the cost of treatment were picked up by some other donor, the person's government, or the individuals themselves. Of course, people who never receive treatment will also die, but it would be even more unseemly to extend treatment only to later take it away. Before the donor community continues the practice of putting people on treatment when they are already quite sick, leaders should reevaluate the efficacy of those efforts.

At the same time, it would be a tragedy if the global community decided to "walk off the field" by allowing their attention to lapse or stray. Nearly a decade into the world's ambitious effort to address the AIDS pandemic in the developing world, there is a great danger that the financial crisis, other priorities, and the continued spate of new infections will cause donors to lose heart. The Obama Administration should seize the moment to infuse the donor community with a new sense of purpose, focusing on the most promising avenues to reduce the rate of new infections. That would be change we could believe in.

NOTES

1. In a 2001 paper in *The Lancet*, Amir Attaran and Jeffrey Sachs estimated that between 1996–1998 rich donors averaged about $170 million a year for HIV/AIDS activities in the developing world. Of this total, only $69 million per year was dedicated to HIV/AIDS projects in sub-Saharan Africa (Attaran & Sachs, 2001, p. 57). With the creation of the Global Fund and other bilateral and multilateral programs, donors rapidly scaled up funding for HIV/AIDS treatment and prevention programs, making available about $4.987 billion bilaterally in 2007 and another $2.387 billion through multilateral institutions (OECD, 2009).

2. After previous financial crises, foreign assistance dipped significantly. For example, a 1991 Nordic financial crisis led to a 10% decline in Norway's foreign assistance budget, a 17% decline in Sweden, and a 62% decline in Finland. In the midst of Japan's economic malaise of the 1990s, Japan's foreign aid fell 44% between 1990 and 1996. Data from peak to trough, adjusted for inflation (Roodman, 2008).

3. Conservative estimates from a 2008 Harvard study suggested that about 365,000 of those people could have been put on ARVs between 2000 and 2005 had the South African government not been obstructionist on treatment (Chigwedere III, Gruskin, Lee, & Essex, 2008).

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