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**An Alternative PATHWAY for Global HIV Prevention**

The new Democratic majority is entering Congress at a time of growing criticism of the government's international HIV prevention programs. Critics charge that not only do the funding restrictions push out other necessary programs, but they render impossible a comprehensive, social approach to preventing the epidemic's spread.

The divvying up of HIV prevention funding is rather convoluted and results in a strong religious bias: Under the law that established the President's Emergency Plan for AIDS Relief (PEPFAR), 20% of total PEPFAR appropriations have to go to prevention activities. And one-third of these prevention grants is reserved for programs espousing abstinence-until-marriage. Since the State Department focuses one-half of the HIV prevention moneys on sexual transmission, abstinence advocacy dominate that field.



**Your Taxes at Work in Kampala**  
 Source: ICIJ

A major effort to rectify the situation is the proposed PATHWAY Act ("Protection against

Transmission of HIV for Women and Youth Act"), introduced in the outgoing House of Representatives by Rep. Barbara Lee (D-CA) and 84 cosponsors. The bill involves much more than just removing the 33% abstinence requirement from PEPFAR funding. In great detail, the bill lays out a strategy that goes beyond the State Department's official ABC model (abstinence, be faithful, and "as appropriate" correctly and consistently use condoms) on both the individual and population level. It establishes a comprehensive, integrated, and culturally appropriate HIV prevention campaign to reduce the particular vulnerabilities of women and girls to HIV.

Whereas PEPFAR documents speak of promoting condoms only in specific populations at high-risk for HIV, PATHWAY talks of "dramatically" increasing access to female-controlled prevention methods, including expanded training in correct use of male and female condoms. It also mentions combating gender-based violence (including that based on HIV stigma) and promoting men's respect for women's rights. It calls on the government to coordinate HIV prevention efforts with women's healthcare services, including family planning. Further, PATHWAY requires promotion of women's independence through new laws as well as expanded education, job training and micro-loans for establishing small businesses.

Commenting on the PATHWAY Act, Congresswoman Lee said, "This is a comprehensive bill that speaks to the empowerment of women because once a woman understands what her rights are, that she has equal rights, then women will be able to begin to take control of their lives and of their destiny."

This line of thinking is in concert with a commentary published this month in the American Journal of Public Health by two Columbia University researchers. They wrote, "The first clear limitation of ABC approaches [is] the underlying assumption that individual decision making is the key site for risk minimization. This assumption ignores or negates the gendered contexts in which individuals attempt to enact behavioral change... [Secondly,] ABC approaches do not take into account economic contexts at all, even though prevention researchers have identified the critical intersection of poverty and women's HIV/AIDS risks... [Finally,] the ABC strategies fail to recognize the massive increases in migration around the world – both cross-border and internally. Instead, the solutions the ABC approaches offer are reduced to static individualized behaviors and morality (e.g., 'be faithful')."

#### **PEPFAR Prevention Faces Growing Opposition**

Rep. Lee has is requesting that one of the committees she sits on, the House International Relations Subcommittee, investigate the government's grants to faith-based organizations. That request was sparked by a series last October in *The Boston Globe*. Among other things, the *Globe* reported that the administration favored Christian groups over secular and Muslim ones when allocating PEPFAR grants. Secular groups were particularly hamstrung by the restrictions on promoting condoms and working with prostitutes.

This month, the International Center for Investigative Journalism posted on the Internet "Divine Intervention," a lengthy, country-by-country critique of PEPFAR activities, both prevention and care (<http://www.publicintegrity.org/aids/default.aspx>). According to the Center, its year-long investigation found that "ideology has at times trumped science in the Bush administration's rules, regulations and support of the organizations that have received taxpayer money." An especially galling aspect of the ICIJ's investigation was the

State Department's refusal to provide complete information on PEPFAR's grant recipients. Even a successful lawsuit couldn't pry out all the details.

Last April, Congress's investigative agency, the Government Accountability Office, released a critical analysis of the effects of the abstinence restrictions in PEPFAR's funding.

(<http://www.gao.gov/new.items/d06395.pdf>)

The GAO found that the rigid spending structure commonly undermines country teams' ability to integrate the components of the ABC model into effective programs. The PEPFAR requirements inhibited the development of culturally appropriate prevention campaigns and impaired the ability to reach high-risk groups. Other aspects of prevention, such as mother-to-child transmission, were slighted, too.

PEPFAR has a five-year goal of reducing the annual number of new HIV cases by 7 million – 1.4 million per year. It is too early to say what effect the program is having, and the available HIV incidence data are imprecise in any case. Globally, the UN says that the epidemic is steaming along this year as fast as ever. The United Nations AIDS Programme estimates that there will be 4.3 million new cases of HIV in 2006. 2.8 million of these cases will be in sub-Saharan Africa, where 59% of persons with HIV are female.

Uganda is one of the countries in which PEPFAR's abstinence promotion has had the greatest effect on public policy (see *HHSWatch*, November 2005). That country also has some of most detailed data on the HIV epidemic. Uganda's epidemic declined through the 1990s, and the country became a famous success story. But Uganda's HIV prevalence has shown signs of a recent uptick coinciding with the PEPFAR-funded increased emphasis on abstinence and monogamy. The Uganda Ministry of Health estimated that the country's HIV prevalence among 15-49 year-olds was 6.2% based on its

2002 survey, with 70,000 new infections occurring that year. The prevalence estimate derived from the 2004-2005 survey was 6.4%, which would suggest an extra 20,000 new infections yearly during the latest survey period.

The December 2006 UNAIDS epidemiological report states, "Further research is needed to validate these apparent trends, but the current findings do hint at the possible erosion of the gains Uganda made against AIDS in the 1990s. Such an interpretation finds support in national behavioural data which show erratic condom use (about half the men and women aged 15–49 years reported using a condom the last time they had sex with a casual partner) and rising numbers of men who had sex with more than one sexual partner in the previous year."

The increase in HIV prevalence may turn out to be a statistical fluke, and, in any case, its coincidence with the new PEPFAR funding does not by itself prove causality.

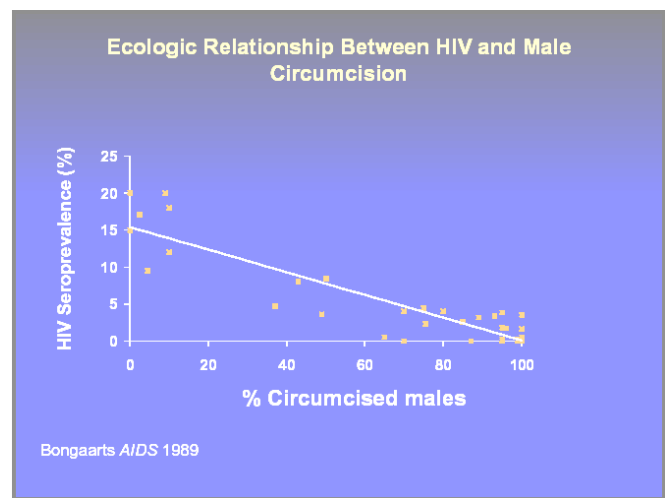
PEPFAR funding does help tip the prevention balance. Faced with a stagnant and perhaps growing HIV prevalence, there is considerable pressure on Ugandan authorities to try new approaches. Politically powerful local religious interests support emphasizing abstinence. In addition, President Yoweri Museveni and, particularly, his wife Janet Museveni are also morally conservative. On the other hand, the Uganda AIDS Commission released last August an HIV prevention "road map" that includes greatly expanded condom distribution as a priority goal.

### **Circumcision: An Option Long Ignored**

The Ugandan prevention road map also calls for preparing to institute "new technologies" – among them one that is truly ancient, male circumcision. (A quarter of Ugandan males are already circumcised, including nearly all Muslims.)

In early December, two randomized

circumcision trials, one with 2,800 Kenyans and the other in Uganda itself with 5,000 men, were terminated 7-10 months early because they had observed a 50% less HIV acquisition among the men receiving circumcision compared with the uncircumcised ones. These results follow slightly better ones in a South African trial reported over a year ago (*HHSWatch*, September 2005). They also are in line with almost 20 years of observational studies – see the figure below, summarizing data from a 1989 study that included 409 African ethnic groups.



**Circumcision's Promise was Apparent in the 1980s**  
Source: Ron Gray, Johns Hopkins, April 2006

The concept that a one-time removal of a thumbnail-sized piece of skin can halve a man's risk of acquiring HIV is quite intriguing. Underneath the foreskin lies a population of immune cells that are highly susceptible to HIV. Removing the foreskin removes the moist, nourishing environment in which HIV can take hold. It replaces that environment with a dry, tough layer of skin. The reorganized tissue is resistant to direct HIV infection and also blocks HIV's access to sensitive areas of the body.

As noted in the September 2005 issue of *HHSWatch*, the circumcision trials are really trials of circumcision within in the context of integrated prevention therapy, as all participants received safe sex counseling

and STD monitoring and care. Judging by the observational studies, circumcision is clearly protective in the real world. But without these extra prevention components, circumcision may not prove as protective as in the trials. In the trials' roughly two years of follow-up, there were only 65 new HIV infections among the 3,400 circumcised men. That's still a substantial 2% rate. It could grow in the years ahead if the circumcised men pay less attention to condom use or STD treatment due to the assumed protection that circumcision provides.

In the United States, public hostility to circumcision is growing. Medicaid and private insurers are increasingly resistant to paying for circumcision, medical societies no longer recommend it, and circumcision rates are falling to historic lows. Poor countries are still less capable of mass circumcision.

Kevin De Cock, Director of the Department of HIV/AIDS at the World Health Organization, said at a news conference, "We're at the very important point of beginning translation of these findings into policy and then potentially into practice." There have been initial consultations within and among African countries, but no concrete policymaking has occurred. De Cock commented further, "There has to be much more involvement of countries themselves; they have to own it if this is going to happen with outside support."

Rather than facing the logistic, financial and emotional challenges of public circumcision campaigns, national governments and international bodies waited until faced with inconvertible trial results. They could have anticipated those results years ago and greatly restricted HIV's spread. Now the epidemic is raging out of control, and the new nightmare scenario is that the demand for circumcisions will lead to unscrupulous practitioners to offer cheap, backstreet procedures. To bring in customers, the local entrepreneurs will likely exaggerate the protection against HIV. In truth, the frequent complications arising from their unsanitary

and nonstandard techniques may leave some patients worse off than before.

Mark Dybul, the US State Department's Global AIDS Coordinator, says that his agency stands ready to help governments implement circumcision policies. But the US will wait for others to take the initiative: "PEPFAR," Dybul said in a statement, "is awaiting normative guidance from international organizations or other normative bodies, and thereafter will support implementation of safe medical male circumcision for HIV/AIDS prevention based on requests from host governments and in keeping with their national policies and guidelines. It is important that male circumcision be safely provided and that it be integrated into, and not substituted for, a comprehensive HIV/AIDS prevention program."

This multilateralism is contrary to the go-it-alone spirit behind PEPFAR. The Bush administration established it as a direct funding entity independent of programs run by foreign governments and the United Nations. Given the abstinence restrictions on PEPFAR's prevention budget, it is not clear where Dybul will find the money for circumcision, let alone the comprehensive prevention programs that he says must accompany it.

### **Reauthorization at the Last Minute**

It couldn't pass a healthcare budget for fiscal year 2007, but the outgoing 109<sup>th</sup> Congress did manage in its closing minutes to reauthorize the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. Ryan White funds \$2 billion a year of AIDS treatment and care programs plus certain prevention activities (*HHSWatch*, November 2006). The logjam created by New York and New Jersey's senators was broken by a compromise that allowed a three-year authorization instead of five. During that period, large cities that have been the historic center of the epidemic are guaranteed a constant funding level.

Congress put off the year 4 and 5 changes in the funding formulas until next time the Ryan White comes up for consideration.

Certain features that negatively impact HIV prevention survived in the Congressional rush to adjourn. They include the move toward universal names reporting, as well as the requirement that 75% of state and local grants go to providing "core medical services" rather than counseling, advocacy and other social services. Also remaining in the bill is a \$30 million prevention grant program that is an inducement to states to adopt opt-out testing for pregnant women and patients at STD clinics as well as mandatory testing of newborns when the mother's HIV status is unknown. Opt-out testing dispatches with pre-test counseling and explicit informed consent. The bill provides no new money for these grants, and it's not clear which prevention pocket the annual \$30 million will come out of.

Ryan White reauthorization occurred as part of package deal that included reauthorization of the National Institutes of Health. The NIH reauthorization includes a

reorganization that was a favorite project of Joe Barton (D-TX), chair of the House Energy and Commerce Committee in the old Congress. As part of the effort to streamline the NIH, Barton's bill gives the NIH director wide latitude to close existing units, including those mandated by Congress. Among the mandated entities is the Office of AIDS Research (OAR), which coordinates HIV research across the NIH. "The OAR has ensured balanced funding across HIV fields," said Emily Byram, legislative analyst for the American Foundation of AIDS Research. "We are concerned about its continued existence." Prevention research may suffer without the OAR to advocate for it.

Both bills provide only minor funding increases for the activities they cover, and there will be a struggle in the new Congress to increase their appropriations as part of the budget-writing process. Immediate reauthorization was not needed to continue appropriating money, and it prevented a potentially more sympathetic Congress from polishing the bill's rough points.

*This HHS Watch was written by David Gilden*

*HHSWatch*, a watchdog newsletter from CHAMP, monitors and reports on activities related to HIV prevention at Health and Human Services agencies, including CDC, NIH, HRSA and SAMHSA.

*HHSWatch* is a resource for community members, policy advocates, researchers and anyone interested in more fully understanding and tracking the committees, panels and administrators whose recommendations and decisions affect our work.

*HHSWatch* is committed to providing an outlet for those concerned about infringements upon science-based HIV prevention and treatment, and will respect your wishes for confidentiality. If you are interested in contributing information or suggesting a story, please contact [champ@champnetwork.org](mailto:champ@champnetwork.org).



**COMMUNITY HIV/AIDS MOBILIZATION PROJECT (CHAMP)**

32 Broadway, Suite 1801 New York, NY 10004

tel. (212) 937-7955 x 10

[www.champnetwork.org](http://www.champnetwork.org)