Sound Like a Plan?

The President's Emergency Plan for AIDS Relief supports millions of HIV-positive people around the world—but questions about its policies remain. *POZ* helps clear the air.

July 1, 2008 By Nicole Joseph

In 2003, President George W. Bush launched what would become the largest commitment ever made by a single country to address a specific international health concern—the President's Emergency Plan for AIDS Relief (PEPFAR). Pledging $15 billion over five years, the plan promised treatment for 2 million people living with the virus, as well as prevention programs and support for millions infected with or affected by HIV.

But even as Bush, in the waning days of his administration, tries to point to global AIDS relief as the humanitarian hallmark of his presidency, PEPFAR faces a number of criticisms. Many AIDS advocates have challenged, for example, what they consider a "moral" slant to the program, saying it supports only conservative agendas, failing to address HIV among sex workers and IV-drug users. Activists have also questioned the antiretroviral drugs the program has favored in developing countries—saying it supported the distribution of brand-name drugs over generic versions. Then there are those who don't think we should spend so much globally when the needs of HIV-positive people aren't being fully met at home. Indisputable, however, is the lifesaving support PEPFAR has given to millions of HIV-positive people around the world. "PEPFAR has helped create a real movement around global AIDS," says Gene Copello, executive director of the AIDS Institute.

On April 2, 2008, the House of Representatives approved a bill to boost the next five-year allocation to $50 billion; if approved by the Senate, the bill could mean treatment for 3 million people and the funds to support the prevention of 12 million new HIV infections. But with additional funds come more questions about where and how the new money could—and should—be spent. To help answer them, *POZ* asked PEPFAR's head, U.S. Global AIDS Coordinator Ambassador Mark Dybul, to debunk common misconceptions about the program.

Myth #1: PEPFAR values prevention more than treatment—or vice versa.
Dybul: Currently about 46 or 47 percent of the funds goes to treatment. That's not just [funds for] drugs—that's [for] infrastructure, laboratories, salaries, logistics…. Drugs don't do any good if you don't have a system to get them to people, or people to provide them. About 29 percent goes to prevention, if you include counseling and testing. [The rest] goes to orphan care and care for HIV-positive people. Given the treatment goal, you will always have a significant amount of money

dedicated to treatment, but prevention is [also] critical. And prevention fortunately is less expensive than treatment…so the fact that 29 percent is [earmarked] for prevention is not saying treatment is more important than prevention.

Myth #2: PEPFAR provides support exclusively for organizations that teach abstinence-only sex education.
We've never done abstinence-only programs. It's not part of the law and it's not in any policy document or report we've ever provided. It's an ABC approach, which includes abstinence, being faithful, and correct and consistent condom use. The [program has] provided 1.9 billion condoms since PEPFAR began.

***POZ*: Some say there's an emphasis on abstinence, as in big "A," little "b," little "c." Is that true?**
Abstinence [is important], but we're not saying people should never engage in sexual activity. Abstinence is delaying when you become active and having socially responsible sexual behavior and reducing your number of partners. All three components of ABC are needed in a generalized epidemic. You [need] different messages depending on how old you are and what your risk factors are; that's good science.

Myth #3: The program does not address HIV transmission among intravenous-drug users.
That is patently untrue. Vietnam was [added as] our 15th focus country because we [wanted] to be engaged in a place that had a potential for an explosive epidemic, and where we [could work to combat] intravenous-drug use. We support what has been proven to be the most effective of the interventions in intravenous-drug users for reducing HIV: substitution therapy, methadone or buprenorphine. We have pushed hard in Vietnam, and they now have methadone in the country. We're working hard in other places so that we can expand substitution therapy.

***POZ*: Then why doesn't the program support needle exchange for injection-drug users who don't have access or won't go to substitution centers?**
As far as needle exchange, it's a policy issue; with our [limited] resources, we support substitution therapy. If others choose to adopt other things, that's fine with us. [Also], intravenous-drug abuse is not a social disease; it's a clinical addiction. Clinical addiction requires clinical therapies, [like] substitution therapy. There's data from places that have adopted substitution therapy, [which shows that] people go back to work, and crime is reduced because they're not [committing] petty crimes to get money to use the drugs. Transmission goes down because they're not using needles to begin with. This is a clinical treatment for a clinical disease, and that's the right position for our government.

Myth #4: PEPFAR won't support organizations that work with sex workers.
[PEPFAR] began as a compassionate program, and you cannot provide compassionate services if you don't work with everyone infected with and affected by this disease. Most people involved in prostitution aren't there because they choose to be; they're there for economic reasons—they're trying to feed their family [or] send their kids to school.

We have about 130 programs specifically dedicated to [sex workers]. We know prostitution is one of the leading causes of the spread of HIV in concentrated epidemics. Also, how on earth do you have gender-equal systems when you're promoting abuse of women? The only thing required by our policy is that organizations be opposed in principle to prostitution and sex trafficking. That's a policy that people have to have that has absolutely no impact on the ground, unless [organizations] don't like the policy. We're not preventing anyone from working with people who engage in prostitution.

MY PEPFAR

An HIV-positive mother shares how her daughter has stayed HIV negative.

Since PEPFAR's inception, its Prevention of Mother-to-Child Transmission (PMTCT) program has worked to reduce HIV infections among children by linking HIV-positive women to prenatal treatment and counseling. Last January, one of those women—Tatu Msangi, an HIV-positive woman from Moshi, Tanzania—and her then 2-year-old HIV-negative daughter, Faith, joined First Lady Laura Bush at the president's State of the Union address. *POZ* spoke with Msangi, who now works as a counselor helping other HIV-positive moms-to-be.

***POZ*: What concerns remain for HIV-positive mothers in your country?**

Msangi: [Many] mothers have babies who are healthy, but some who are single parents can't get their children to school. It's difficult for people who don't have any income to care for their family. And sometimes mothers get infected very young—and need to go to school [themselves].

What do you think has been one of the greatest benefits of PEPFAR for people with HIV in Tanzania?

Where I come from, many people cannot [access] services, because [they live] too far from the institutions. I'm happy now that the program has expanded, because I think it will reach people in these places.

Why did you decide to name your daughter Faith?

It has a great meaning. When I found out I was HIV positive, I was given instructions and provided therapy to prevent infection [of my child]. I knew that [my child] was going to be HIV negative—I had to believe that. So I thought, I have to call this child Faith.

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