



# Broken Promises

The U.S. response to the UNGASS Declaration of Commitment on HIV/AIDS 2001

*An advocacy brief produced by U.S. civil society for the UNGASS Review on HIV/AIDS*

April 2006

In June 2001, representatives from 189 member states met during the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS and signed the *Declaration of Commitment on HIV and AIDS*, a monumental international pledge to substantially increase both resources and attention to fighting HIV/AIDS. This paper evaluates how the United States has fulfilled its commitment as a donor. A separate paper, published by Public Health Watch, evaluates the progress made by the US to fulfill its commitments domestically.

## ■ Background

Over the past five years, the United States dramatically increased its commitment to global HIV/AIDS. In May 2003, the U.S. Congress, responding to President Bush's call, approved spending of up to \$15 billion over 5 years. This program is known as the President's Emergency Plan for AIDS Relief (PEPFAR) and set the following requirements for expenditure:

- 55% should be spent on the treatment of individuals with HIV/AIDS (and in FYs 2006 through 2008, 75% of this is to be spent on the purchase and distribution of antiretroviral drugs)
- 15% should be spent on the palliative care of individuals with HIV/AIDS
- 20% should be spent on HIV/AIDS prevention (of which at least 33% is to be spent on abstinence until marriage programs)
- 10% should be spent to help orphans and vulnerable children (and in FYs 2006 through 2008, at least 50% (of the 10%) is to be provided through non-profit, non-governmental organizations including faith-based organizations that implement programs at the community level).

The U.S. initiative, while commendable, is marred by policies that hinder the effectiveness of programs in several critical areas. In fact, some of these policies are in direct conflict with reaching many of the goals laid out in the Declaration of Commitment.

## ■ Financing

In 2001, the global need to fight HIV/AIDS was identified as \$7 to \$10 billion U.S. dollars per year in the Declaration of Commitment. Since then, UNAIDS in partnership with the international community has increased estimates of global need to \$18.1 billion for 2007. The U.S. government is the largest bilateral donor for global HIV/AIDS programs and has responded to the call for increased resources, but much more is needed. The Declaration of Commitment also urges developed

countries to meet the target of .7 percent of gross national product (GNP) to go towards official development assistance. In comparison to other developed countries, the U.S. is at the bottom, contributing just .22 percent of its GNP in 2005 to official development assistance according to the OECD. In 2003, the U.S. Congress authorized up to \$15 billion over 5 years for PEPFAR. Of the total \$15 billion, \$5 billion was "old money" to continue existing U.S. bi-lateral programs for global HIV/AIDS, \$9 billion is "new money," and \$1 billion was money proposed to go to the Global Fund to Fight AIDS, TB, and Malaria. Each year, Congress must approve PEPFAR's annual budget.

- FY 2004: President Bush requested \$1.9 billion for PEPFAR; Congress increased his ask resulting in a total of \$2.4 billion for PEPFAR
- FY 2005: Congress approved a \$2.701 billion budget for PEPFAR.
- FY 2006: Congress approved approximately \$3.2 billion.
- FY 2007: President Bush has requested approximately \$4 billion (including \$300 million for the Global Fund). However, Congress has yet to approve this number.

## **The U.S. and the Global Fund**

The Global Fund to Fight AIDS, TB, and Malaria represents perhaps the most tangible demonstration of donor commitment since the UNGASS on HIV/AIDS in 2001. The Declaration of Commitment called for this emergency fund to expand the global effort, which has now approved programs in more than 130 countries. The U.S. made the founding contribution to the Global Fund. When PEPFAR was announced, President Bush signaled that \$1 billion of the \$15 billion would go to the Global Fund (\$200 million a year over five years). In FY06 and FY07, President Bush increased the request to \$300 million per year. By U.S. law, the total U.S.

**U.S. Contributions to the Global Fund 2001–2005**

|                               | 2001-2002     | 2003          | 2004          | 2005          |
|-------------------------------|---------------|---------------|---------------|---------------|
| Total Contributions           | \$947 million | \$937 million | \$1.5 billion | \$1.5 billion |
| U.S. Appropriations           | \$300 million | \$348 million | \$547 million | \$435 million |
| U.S. Contributions*           | \$300 million | \$323 million | \$459 million | \$414 million |
| U.S. Share of Contributions** | 32%           | 33%           | 32%           | 31%           |

\*reflects actual contributions, which can be lower than appropriations in any given year due to several factors.

\*\*based on cumulative totals, reflecting all previous years' contributions.

contribution in any given year may not exceed 33% of all contributions from other donors.

This chart demonstrates that the U.S. has historically provided 1/3 of the Fund's financing. Assuming that the U.S. contributes \$544 million (as the U.S. Congress has appropriated) for FY 2006, the U.S. will account for 30% of all current cumulative pledges to the Fund through 2006 and Europe will account for 55%. If the U.S. appropriates just \$300 million for the Fund in 2007 (as the President has requested and Ambassador Tobias pledged), the U.S. share of pledges to the Fund for 2007 would be just 19% and the U.S. share of cumulative pledges through 2007 will fall to 28%—and both of these numbers could possibly drop even lower. These numbers could drop even lower because a follow-up Replenishment Conference to the one held in 2005 is scheduled for July 2006 in Durban, South Africa and additional pledges are expected from donors at that time.

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## ■ Prevention

The Declaration of Commitment clearly underscores that vulnerable groups must be given priority in the response to HIV/AIDS. For example, the Declaration makes clear that all approaches to HIV prevention, treatment, and care must include vigorous efforts to use legislative, regulatory and other measures to eliminate all forms of discrimination against vulnerable groups; to promote human rights; and to combat stigma and social exclusion. It further supports development of national strategies for advancing women's empowerment and human rights by eliminating all forms of violence against women and girls, including harmful traditional and customary practices, abuse, rape and other forms of sexual violence, battering and trafficking in women and girls. Finally, the Declaration calls on governments to address those factors that make individuals particularly vulnerable to HIV infection, including underdevelopment, economic insecurity, poverty, lack of education, social exclusion, illiteracy, discrimination, and lack of information and/or commodities for self-protection. These guarantees and protections extend to all vulnerable and marginalized groups in society, including commercial sex workers, IDUs, men who have sex with men and others.

The United States supports a range of prevention activities, from mother to child transmission, blood safety, expanded HIV testing and the "ABC" approach ("abstinence, be faithful, and condoms"). Funding in all these areas has increased, but a number of restrictions on this funding undermine the effectiveness of US-funded prevention programs.

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## ■ Prostitution Loyalty Oath

U.S. law requires organizations receiving U.S. global HIV/AIDS funds to adopt policies that oppose prostitution. The requirement compels organizations to adopt speech consistent with a U.S. government position for all programs, irrespective of funding sources. This policy has the potential to exacerbate stigma and discrimination against already-marginalized groups, and to preclude recipients of U.S. funds from using the best practices at their disposal to prevent HIV/AIDS and promote the fundamental human rights of all persons. Some have refused U.S. funding

rather than sign the pledge. In 2005, for example, the Brazilian government rejected \$40 million in HIV/AIDS grants because they were concerned that they would have to abandon programs that have helped reduce the spread of HIV. There are two legal challenges to the requirement pending.

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## ■ Abstinence-Only-Until-Marriage

Despite the Declaration's support for comprehensive, human rights-based HIV-prevention, PEPFAR fails to support comprehensive HIV-prevention for everyone, including young people and the general, adult public. In the U.S. Global AIDS Act of 2003, Congress required that at least 33 percent of all funding for bilateral prevention programs be spent on abstinence-until-marriage programs. This was a "soft" or non-binding earmark from FY 2003 through FY 2005 and became a "hard" or binding earmark in FY 2006. The Office of the Global AIDS Coordinator (OGAC)—which oversees all U.S. global AIDS funding—is authorized to spend more than 33 percent. OGAC also has the discretion to define the content and indicators of success of abstinence-until-marriage programs, as well as the types of organizations to implement the programs. Although the current Administration purports to be applying a comprehensive "ABC" method of HIV prevention, OGAC guidance and grants reveal that abstinence and faithfulness programs have been defined as narrowly as possible, becoming what are in effect "*abstinence-only-until-marriage*", so-called secondary abstinence programs (i.e. promoting renewed abstinence for sexually active young people), and "*be faithful*" programs, the vast majority of which operate in isolation of other interventions. Current policy and funding supports providing information on condoms only to so-called "high-risk groups" even in generalized epidemics where rates of casual sex are high.

According to official reports, the U.S. spent \$76 million in the 15 PEPFAR focus countries to promote abstinence and/or faithfulness in 2005 alone. Overall, PEPFAR is likely to provide at least \$665 million over five years to abstinence-until-marriage programs in the 15 focus countries. In 2005, the U.S. government states that they had reached 24,862,000 individuals with prevention activities that promote abstinence and/or being faithful and 8,000,000 individuals with prevention activities that have abstinence as their primary behavioral objective.

There is no scientific evidence that "abstinence until marriage" programs or approaches are effective in reducing the rate of HIV infection or protecting individuals or groups at risk. The Society for Adolescent Medicine in a recent position paper on abstinence-only programs stated that, "U.S. emphasis on abstinence may also have reduced condom availability and access to accurate information on HIV/AIDS in some countries." These policies stand in contravention of internationally recognized public health standards and in violation of international human rights norms.

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## ■ HIV Prevention for Injection Drug Users

The UN estimates that outside of Africa, one-third of new HIV infections are attributed to injection drug use. The 2001 Declaration of Commitment clearly notes the importance of access to sterile injection equipment and other measures to

reduce HIV transmission related to drug use. Nonetheless, despite overwhelming evidence that needle exchange significantly reduces the spread of HIV and does not increase drug use, the U.S. government remains the only one in the world to ban the use of federal funds for needle exchange. In recent years the US has gone further, trying to remove references to needle exchange from international agreements and UN strategy documents related to both drug control and HIV prevention. If the U.S. is unable to provide funding under federal law, it should not stand in the way of others wishing to do so.

Substitution therapy with medications such as methadone, another approach proven effective in reducing HIV risk and increasing adherence to HIV treatment for those infected, is supported by the US government, which has provided modest funding for methadone pilot programs in Asia. The U.S. State Department, however, has yet to release official guidance on substitution therapy or to engage forcefully in diplomatic efforts to legalize and scale up access to this therapy in countries with injection-driven epidemics. In Vietnam, a PEPFAR focus country where the majority of infections occur among injection drug users, there were still no patients on methadone at the close of 2005.

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## ■ Treatment for HIV

The U.S. government has made a commendable and substantial impact to increasing the number of people on anti-retrovirals (ARVs) in sub-Saharan Africa. President Bush acknowledged the potential for low-cost ARVs to increase access to treatment for people living with AIDS. The price President Bush cited in his State of the Union Address was only available only from generic manufactures. While the U.S. is to be commended for its commitment to providing ARVs, there is still little evidence that the Bush administration is availing itself of low prices offered by generic producers or that generic ARVs approved for use are being procured with US government dollars wherever possible. In addition, advocates have raised concerns regarding the way in which the people being treated through PEPFAR are counted—namely, that people who are not directly gaining access to treatment because of PEPFAR funding, are still being counted by PEPFAR.

## ■ Procurement

On May 16, 2004, in an attempt to deflect the ensuing international criticism challenging the refusal to purchase generic AIDS drugs and FDCs, the U.S. government announced a “Fast Track” process through the Food and Drug Administration (FDA) for reviewing generic and brand-name AIDS drugs whether fixed-dose combination (FDC) or co-packages, as well as a process for single doses. FDA tentative approval clears the product “for consideration for purchase and use outside the United States under the President’s Emergency Plan for AIDS Relief” pending approval by the Office of the Global AIDS Coordinator. These products may not be marketed in the U.S. because of existing patents and/or data or marketing exclusivity. The US FDA approval system for generic AIDS drugs has created needless duplication of the WHO system for pre-qualifying essential medicines, as well as new regulatory obstacles to gaining access to generic drugs. While U.S. officials argued that the US uses “more stringent” standards than WHO, in reality the standards of testing efficacy and safety do not differ: both bodies

assert that if a generic drug is absorbed by the body in the same way as the innovator drug (i.e. if bioequivalence is proven), then the safety and efficacy is the same. The difference, however, lies in the numerous regulatory hurdles built into the process by U.S. law for applicants and the fact that applications to the FDA require some tests to be redone rather than accepting dossiers already submitted to WHO or other Stringent Drug Regulatory Authorities (SDRAs) such as in Europe.

Relying on single-source suppliers can and does result in shortages and stockouts. Last year, major U.S. media outlets reported on shortages of GlaxoSmithKline’s Epivir (known as lamivudine or 3TC), Merck’s Sustiva (known as efavirenz), and Bristol Myers Squibb’s ZERIT (known as stavudine or d4t) leaving PEPFAR-funded programs scrambling to continue treatment for their patients. Some mission hospitals and clinics were told by drug companies to stop adding people to their treatment rolls, although the capacity existed to treat many more, because of the shortages. At the time of the reports, generic versions of 2 out of the 3 drugs were listed on the WHO pre-qualified list. At a Congressional briefing in April 2005, Ambassador Tobias was asked by a Member of Congress to use his right to waive regulations and barriers to generic sources of drugs, given the severe drug shortages, yet he refused to do so.

## ■ Supply Chain Management System

On September 27, 2005, USAID announced a contract to a consortium of 15 companies and institutions for a Supply Chain Management System (SCMS). The consortium is charged with management, procurement, quality assurance, and delivery of all medicines and medical commodities for HIV/AIDS treatment and care programs receiving PEPFAR and US government funding in developing countries. The primary concern with a centralized U.S.-run system is that it is not a sustainable or efficient solution to persistent problems in supply chain management at the local level in all overseas HIV/AIDS programs receiving U.S. funding. In addition to the 15 focus countries, PEPFAR funds in at least 80 more countries, and, in two years, all countries receiving funding from the Global Fund to Fight AIDS, TB, and Malaria will also be eligible to utilize the SCMS.

While the SCMS may be described as a “one-stop shop” by OGAC and USAID, each country has a different matrix of indigenous supply chain capacity drawing on public, private, and NGO distribution networks. Additionally, the SCMS promotes privatization instead of public sector capacity. The majority of the partnership members are private for-profit U.S. corporations and exclude many local civil society organizations that have a track record in this area. By not promoting national ownership and initiative in improving current procurement systems, the SCMS risks undermining national efforts and initiative.

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## ■ Health Systems Strengthening

The 2001 Declaration of Commitment on HIV/AIDS called on signatories to actively support the development of national strategies to strengthen health care system capacity by 2003. The U.S. government has become increasingly aware that to meet its HIV/AIDS targets, it must help address the health

workforce shortage facing many developing countries. Increased U.S. investments in health workforce development include the 2004 launch of USAID's Capacity Project, which uses USAID and PEPFAR funds to provide technical support in health workforce development. However, there is no comprehensive and coordinated response to the health workforce crisis. PEPFAR focus countries have not been required to develop a health workforce strategy.

Congress is now requiring OGAC to report on the additional health workers required to achieve PEPFAR targets without reducing the capacity of the health system to deliver other interventions, and to report on its strategies for meeting this needs. OGAC should, from this time forth, require at the least that all focus countries develop strategies on meeting these workforce needs. Of equal importance and in line with its commitment to improve the capacity and working conditions of health care personnel by 2005, including implementing universal precautions in health care settings by 2003, the U.S. should financially and politically support health worker recruitment and retention through new sources of long-term, designated funding for health workforce development and health system strengthening. This funding should be flexible and responsive to health worker concerns and system shortcomings, allowing support for expanded pre-service training, human resources management, living wages, ample supplies of essential medicines and functioning equipment, safe working conditions and decent accommodations. This will require that the U.S. expand its funding parameters to encompass salary support in the public sector. Such an approach will support HIV/AIDS programming by allowing health workers the ability to perform their jobs, increasing morale and fostering retention.

Finally, the U.S. should promote investment in health systems by using its role as an influential member of Executive Board of the International Monetary Fund (IMF) to oppose

loans or other IMF programs that do not contain the spending levels in health sectors required to attain universal access by 2010, the health-related Millennium Development Goals (MDGs) and other international AIDS-related commitments. Too often, fiscal policy decisions supported and encouraged by the IMF, such as caps on wage bills for health workers, have also been supported by the U.S. The U.S. should support change to these short-sighted IMF policies of fiscal restraint.

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## ■ HIV Travel Ban

The U.S. is one of only 15 countries in the world to ban HIV-positive visitors—placing it in the company of Iraq, Libya, Russia and Saudi Arabia. This is contrary to the goals set out in the Declaration of Commitment to enforce measures to eliminate all forms of discrimination against people living with HIV/AIDS. The restriction was first put in place in 1987 when President Reagan and Congress added AIDS to the list of “dangerous, contagious diseases for excluding persons from the United States.” Despite wide criticism, the restriction remains on the books because it requires an act of Congress to remove it. The U.S. allows for an HIV visa waiver which provides for legal entry under certain circumstances such as attending conferences, receiving medical treatment, conducting business, or visiting family members. This process is highly cumbersome and stigmatizing. The Declaration of Commitment clearly states that countries should pay particular attention to respecting privacy and confidentiality of people living with HIV/AIDS. The visa waiver process may take upwards of three months to obtain and requires a personal interview at the U.S. Embassy. The person's passport is stamped to indicate that the person may not enter the U.S. without such a waiver that this person may not enter the US without the waiver. Additionally, the waiver must be renegotiated on each entry. This can cause further HIV disclosure issues on entering other countries, where immigration officers may want to know why the passport holder is barred from the US. ■

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## For More Information:

*The following people and organizations monitor U.S. global AIDS policy:*

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