

How Ideology Trumped Science

Why PEPFAR Has Failed to Meet its Potential

Scott H. Evertz January 2010

Sponsored by the Council for Global Equality



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Preface

The President's Emergency Plan for AIDS Relief has saved many lives and profoundly shaped the global response to HIV. But like the proverbial Trojan Horse, it has been let into the gates with a belly full of hidden contradictions—insufficient attention to marginalized communities, earmarks for unscientific programming, and forced “pledges” that both undermine sound reproductive rights programming and challenge basic rights to freedom of expression.

In this report, Washington insider Scott Evertz takes a serious look at the politics of one of our country's signature foreign assistance programs. Scott is the former director of President George W. Bush's Office of National AIDS Policy and an openly gay Republican, and his analysis reflects a degree of experience and honesty that is too often obscured by the rigid ideology and partisan policymaking that have—up until now—been the cornerstones of PEPFAR and the Bush administration's bilateral funding strategy.

Many of us who are active in the fight against HIV in Africa, where AIDS has hit the hardest and where most PEPFAR funds have been spent, watched with disappointment in the early days of PEPFAR as the Bush administration redefined the “ABC” approach as a preference for abstinence-until-marriage programming; as NGOs doing good work lost their funding as a result of the prostitution pledge; and as foreign governments, implementing agencies, and USAID program officers exhibited a stunning disregard for the needs of men who have sex with men and other HIV-vulnerable groups.

The fight against HIV/AIDS is far too serious for partisan ideology, for moralizing and marginalization, or for practitioners to shy away from self-critique and the determination to do better. A serious reassessment of the U.S. government's commitments to fighting HIV and providing prevention services, care, and support to those affected is long overdue. PEPFAR can still be the vibrant and inclusive initiative that the infected and affected—all of us—hoped it would be when it was launched. This will only happen if the Obama administration adopts the changes in policy and practice necessary to make PEPFAR a program worthy of its promise.

Cary Alan Johnson

Executive director of the International Gay and Lesbian Human Rights Commission and author of *Off the Map: How HIV Programs are Failing Same-Sex Practicing People in Africa*.

Executive summary

When President George W. Bush signed into law the United States Leadership against HIV/AIDS, Tuberculosis, and Malaria Act of 2003, also known as the Global AIDS Act, he created “the largest commitment by any nation to combat a single disease in human history.”¹ This legislation authorized PEPFAR, the President’s Emergency Plan for AIDS Relief, and the U.S. government has committed more than \$25 billion to the fight against global AIDS through this program since 2003.

PEPFAR has helped to bring life-prolonging antiretroviral treatment to more than 2.1 million people and provided HIV counseling and testing to nearly 47 million. It has contributed to the care of more than 4 million orphans and vulnerable children, and it has made services available to nearly 1.2 million pregnant HIV-positive women to prevent mother-to-child HIV transmission.² And PEPFAR plans to work in partnership with host nations worldwide by 2013 to support treatment for at least 3 million people, prevent 12 million new infections, and care for 12 million people, including 5 million orphans and vulnerable children.³

When President Bush called on Congress to reauthorize PEPFAR in 2008 and double the current funding levels to \$30 billion for five years, his words were greeted with near-unanimous applause from all sectors, and the program was hailed as his signature achievement.

Activist and lead U2 singer Bono called the president’s request “great news at a time when good news is hard to find.” “These AIDS drugs are a great advertisement for American leadership, innovation,” he said, “and the kind of John Wayne ‘get it done’ mentality that the greatest health crisis in 600 years demands.”⁴ Then-Senator Joe Biden (D-DE) said of the president, “His decision to launch this initiative was bold, and it was unexpected. I believe historians will regard it as his single finest hour.”⁵ And Rick Warren, pastor of Saddleback Church and author of the bestselling book *The Purpose Driven Life*, declared: “Certainly one of the president’s greatest legacies will be his insistence on putting compassion into action. No other president or world leader has ever done as much for global health as he.”⁶

PEPFAR has meant nothing less than another chance at life for millions of people around the world. And it provided a positive image of the United States at a time of controversial foreign policy entanglements.

Yet the reality is that the Bush administration's PEPFAR legacy is far more complicated and problematic. The program has proved deficient in many respects, most notably in prevention and reaching out to populations most in need of services. Some of these limitations are rooted in the statute or implementing regulations; others have played out on the ground through different interpretations of U.S. government policies; but most are due to a framework that placed ideology above science. The Obama administration now seeks to reverse these trends and infuse PEPFAR with its own vision and principles, in the context of its new \$63 billion, six-year Global Health Initiative to help the world's poorest countries.

This report looks at PEPFAR's development and considers how its flawed framework hindered, rather than supported, preventive efforts to stem the spread of HIV/AIDS. It also examines recent efforts to improve PEPFAR and offers recommendations to Congress and the Obama administration for how to make future PEPFAR programs more effective and better serve the needs those who have HIV/AIDS or are at risk of getting it.


The recommendations seek to build a response to the HIV/AIDS epidemic that is grounded in science—and not religious ideology—and that advances the human rights of lesbian, gay, bisexual, and transgender, or LGBT, populations as well as other specific subpopulations. These recommendations include the need to:

- Eliminate funding quotas and rules around abstinence and “be faithful” programs.
- Adopt a rights-based approach to intervention, including encouraging the repeal of laws that criminalize homosexual conduct and/or relationships, or impede LGBT groups' ability to register or provide services to their communities.
- Ensure PEPFAR funds are not directly or indirectly distributed to organizations or individuals engaging in antigay rhetoric.
- Integrate reproductive health services and family planning into PEPFAR programming.
- Ensure accountability and transparency measures are adequately applied to PEPFAR.
- Eliminate the antiprostitution loyalty oath.
- Fund syringe-exchange programs, now that Congress has lifted the federal ban on supporting such programs domestically.
- Support community-based sustainable development models.

The Obama administration has a historic opportunity to reframe PEPFAR as a program that champions the rights of all people, helps effectively stop the spread of HIV/AIDS, and humanely and competently treats those who already have it. The recommendations outlined in this report will help the administration navigate this reframing process and ultimately support a program that advances human rights, uses precious public health dollars efficiently, and signals America's commitment to funding programs based on facts.

Evolution of an epidemic

The first 20 years of HIV/AIDS

- 
- 1981** • The first cases of unusual immune system failures are identified among gay men in the United States.
- 1982** • Acquired immunodeficiency syndrome is defined for the first time and the three modes of transmission are identified: blood transfusion, mother-to-child, and sexual intercourse.
- 1983** • The human immunodeficiency virus is identified as the cause of AIDS. A heterosexual AIDS epidemic is revealed in Africa.
- 1985** • The scope of the growing epidemic becomes manifest. At least one case of HIV/AIDS has been reported in each region of the world.
- Film star Rock Hudson becomes the first international icon to disclose he has AIDS.
- The U. S. Food and Drug Administration approves the first HIV antibody test and HIV screening of blood donations begins.
- 1987** • Africa's first community-based response to AIDS—the AIDS Support Organization, or TASO—is formed in Uganda. It becomes a role model for similar activities around the world.
- The International Council of AIDS Service Organizations and the Global Network of People Living with HIV/AIDS are founded.
- The World Health Organization establishes the Special Program on AIDS, which later becomes the Global Program on AIDS.
- The first therapy for AIDS—azidothymidine, or AZT—is approved for use in the United States.

Background

HIV/AIDS history

When AIDS was emerging in the early 1980s, few foresaw that tens of millions of people would become infected around the world within only a few decades, or that the stigma of the disease and discrimination—against those living with HIV/AIDS and those most vulnerable to it—would remain formidable obstacles to crucial prevention and treatment services.

More than 20 million people had already died of AIDS by the time PEPFAR was established in 2003. Only 400,000 individuals in poor countries had access to antiretroviral treatment by that year, according to the Joint United Nations Programme on HIV/AIDS, and the world was spending less than half of what was needed to reach its goals for combating the disease. Infection spread rapidly during the 1990s, especially in sub-Saharan Africa, where approximately 250 people were dying every day. The United States had been criticized for not doing enough to fight the epidemic, and President Bush's announcement of a plan to create the \$15 billion PEPFAR initiative “completely changed the landscape,” said UNAIDS founder Dr. Peter Piot. “The most powerful man in the world moved from the ‘m’ word to the ‘b’ word—from millions to billions. In that sense, PEPFAR not only brought money, but elevated AIDS issues to one of the big political themes of our time.”⁷

But the program was politically charged from the start. The AIDS issue was starting to attract faith-based and other conservative groups that helped put George W. Bush in the White House. The response of such groups to HIV/AIDS had been indifferent at best and fanatical at worst during the 1980s and 1990s, with the Reverend Jerry Falwell, for example, referring to the disease as “the wrath of a just God against homosexuals” and “the society that tolerates” them.⁸ But that changed with the prospect of so many people dying—and the election of a born-again Christian to the White House. “AIDS has created an evangelism opportunity for the body of Christ unlike any in history,” wrote Ken Isaacs, a spokesperson for the Christian charity Samaritan's Purse, which is run by evangelical pastor Franklin Graham and receives PEPFAR funds for its prevention programs in Uganda and other countries.⁹

PEPFAR in practice

PEPFAR focuses on 15 countries—Botswana, Cote d’Ivoire, Ethiopia, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, Vietnam, and Zambia—selected because they were the hardest hit by the epidemic and thought to be the least equipped to adequately respond on their own.

The Office of the Global AIDS Coordinator directs the expenditures, but the money is distributed through a number of U.S. government agencies, including the U.S. Agency for International Development, the Department of Health and Human Services, the Department of Defense, the Department of Labor, the Peace Corps, and the Census Bureau. Several agencies are involved within HHS: the Centers for Disease Control and Prevention, the Health Resources and Services Administration, and the National Institutes of Health.

Organizations and governments that receive PEPFAR funds directly from a U.S. government agency are called “prime” partners. Many of these prime partners give grants to sub-partners. Money is provided for programs managed by U.S. teams in focus countries, and through central funding mechanisms for regional initiatives. Central programs—including Abstinence and Be Faithful, Blood Transfusion Safety, and Supply Chain Management—provide support for partners working in a number of countries.

The HIV/AIDS epidemic at a glance

- More than 33 million people are infected with HIV worldwide, and about 7,400 new infections occur every day.¹⁰
- Roughly 2.7 million people became infected in 2008, including 430,000 children, most of whom were infected through mother-to-child transmission.¹¹
- About 40 percent of all new adult HIV infections are young people, and fewer than 40 percent of young people have basic information about HIV.¹²
- Fewer than 20 percent of countries with generalized epidemics have government-implemented HIV prevention programs for men who have sex with men, or MSM, and fewer than 10 percent of those countries have nongovernmental programs for those men.¹³
- Scaling up available prevention strategies in 125 low- and middle-income countries could prevent more than 28 million new infections between now and 2015—the target date for achieving the Millennium Development Goal of reversing the spread of HIV/AIDS.¹⁴

- 1988** • Health ministers from around the world meet for the first time in London to discuss the HIV/AIDS epidemic.
- 1991-1993** • HIV prevalence in young pregnant women in Uganda begins to decrease, the first significant downturn in a developing country. The success is attributed to countrywide mobilization against the epidemic.
- 1994** • Scientists develop the first treatment regimen to reduce mother-to-child transmission.
- 1995** • An HIV outbreak in Eastern Europe is detected among injecting drug users.
- 1996** • The Joint United Nations Programme on HIV/AIDS is created. Evidence of the efficacy of Highly Active Antiretroviral Therapy, or HAART, is presented for the first time.
- 1997** • Brazil becomes the first developing country to provide antiretroviral therapy through its public health system.
- 1998** • The first short-course regimen to prevent mother-to-child transmission is announced.
- 1999** • The first efficacy trial of a potential HIV vaccine in a developing country starts in Thailand.
- 2000** • The U.N. Security Council discusses HIV/AIDS for the first time.
- 2001** • U.N. Secretary-General Kofi Annan launches his call to action, including the creation of a global fund to fight AIDS, tuberculosis, and malaria.

Source: Joint United Nations Programme on HIV/AIDS

PEPFAR provides \$200 million in HIV prevention and care grants through the New Partners Initiative to organizations that previously received little or no U.S. funding—including “community- and faith-based organizations.” The goal is to increase the number of PEPFAR partners and to build “the capacity of organizations at the community level, while also building local ownership of HIV/AIDS responses for the long term.”¹⁵

PEPFAR named 22 New Partners Initiative grant recipients in 2006, 14 in 2007, and 19 in 2008. The grants were intended to support local groups, but roughly half of the organizations chosen for the first two rounds are based in the United States or Europe, and only five of those awarded grants in 2008 are indigenous.¹⁶ PEPFAR views faith-based groups as “priority local partners” because in many focus countries “more than 80 percent of citizens participate in religious institutions” and “in certain nations, upwards of 50 percent of health services are provided through faith-based institutions, making them crucial delivery points for HIV/AIDS information and services.”¹⁷

HIV/AIDS and PEPFAR politics

Abstinence only takes hold

The U.S. federal government has for years been pouring money into programs to promote “abstinence only until marriage”—the social conservative’s approach to teen pregnancy prevention—despite scant evidence that such an approach is effective. The movement began under President Ronald Reagan, with passage of the Adolescent Family Life Act, signed into law in 1981 as Title XX of the Public Health Service Act. The legislation’s primary goal was to prevent premarital teen pregnancy by establishing “family-centered” programs to “promote chastity and self-discipline.”¹⁸

AFLA’s early grants went almost exclusively to far-right and religious groups, some of which took the law’s intent a step further by developing programs that explicitly promoted religious values. This drew the attention of the ACLU, which filed suit against the program, arguing that it violated the separation of church and state. An agreement was reached on the case 12 years later that put conditions on the grants, but the groundwork had been laid for future legislation that promoted religious values.

The Welfare Act of 1996, premised on the idea that out-of-wedlock pregnancy was the main driver of poverty in the United States, contained a provision establishing a new funding stream to provide grants to states for abstinence-only-until-marriage programs. All recipients of such funds had to adhere to a definition of “abstinence education” that specified that “a mutually faithful monogamous relationship in the context of marriage is the expected standard of all human sexual activity” and that “sexual activity outside the context of marriage is likely to have harmful psychological and physical effects.”¹⁹ Grant recipients could in no way advocate contraceptive use or discuss contraceptive methods except to emphasize their failure rates.

Congress created a third funding stream in October 2000, now called Community-Based Abstinence Education, which awards grants directly to community-based organizations. These programs created a booming business for abstinence education. HHS distributed much of the money through the Compassion Capital Fund, a program specifically designed to assist the grassroots organizations that were the focus of President Bush’s new faith-based and community initiative. Funding for CBAE increased more than 450 percent during its first five years from \$20 million to \$113 million; FY 2009 marked the first-ever cut to the program’s funding, to \$99 million.²⁰

Condom politics

Under the Bush Administration, an effort to discredit condom use gradually took shape, even though treatment and prevention were known by then to be complementary in fighting HIV/AIDS.

George W. Bush enthusiastically advocated federally funded abstinence-only programs as governor of Texas and during his 2000 presidential campaign, and he vowed to expand them as president. Soon after taking office, the president appointed as high-level HIV/AIDS advisors physicians who had questioned the effectiveness of condoms in preventing HIV/AIDS transmission, including former U.S. Representative (and now Senator) Tom Coburn (R-OK)—a staunch supporter of abstinence programs and opponent of family planning funds for organizations providing abortion services—and Joe S. McIlhaney, Jr., president of the Texas-based Medical Institute of Sexual Health and a recipient of federal abstinence-only funds. Coburn was instrumental in the passage of legislation in 2000 requiring studies and educational material on the “effectiveness or lack of effectiveness of condoms” in preventing human papillomavirus, or HPV, a move some saw as an effort to undermine confidence in the use of condoms against HIV.

An effort to discredit condom use gradually took shape, even though treatment and prevention were known by then to be complementary in fighting HIV/AIDS. A 1997 report by UNAIDS found that sex education for children and young people that included the promotion of condom use promoted safer sexual practices and did not increase sexual activity.²¹

Yet a fact sheet on the use of condoms to protect against AIDS was quietly expunged from the website of the Centers for Disease Control in 2002 and replaced by a new version without specific instructions on proper condom use.²² The CDC also discontinued its “Programs that Work” initiative, which identified five scientifically validated sex education programs that provided comprehensive HIV prevention information, including information about condoms. All information on condom effectiveness was similarly altered on the website of the U.S. Agency for International Development.²³

Representative Henry Waxman (D-CA), who had previously served for 17 years as chair of the House Health and Environment Subcommittee, protested the removal of the material, saying “We’re concerned that [the administration’s] decisions are being driven by ideology and not science, particularly [by people] who want to stop sex education. It appears that those who want to urge abstinence only as a policy, whether it’s effective or not, don’t want to suggest that other programs work, too.”²⁴

The CDC site was eventually updated with information explaining that while condoms were shown to be effective in preventing HIV transmission, they did not always provide protection from other sexually transmitted diseases. But as Terje Andersen, then executive director of the National Association of People with AIDS, pointed out, “Something doesn’t need to disappear for a year and a half to be updated.”²⁵

The ABC compromise

When it came to drafting the legislation that would create PEPFAR, some of President Bush's conservative backers were uncomfortable with the idea of promoting and supplying condoms to worldwide populations believing that it would implicitly endorse premarital sex. Instead, they found a compromise in a public health approach called ABC—Abstinence, Be faithful, and Correct and consistent condom use, which the Botswana government used in the 1990s.

The ABC slogan was not particularly controversial at the time in Botswana and was used primarily as part of an AIDS public awareness campaign, without attempting to define the circumstances under which individuals should take the ABC advice.²⁶

The ABC approach drew President Bush's attention because it was credited with helping reduce HIV prevalence in Uganda. Uganda was one of the first African countries to be hit hard by the HIV/AIDS epidemic, and unlike many others, it confronted the crisis boldly and, with international help, developed its own three-pronged ABC approach—preaching “Abstinence” whenever possible, encouraging married and cohabitating couples to “Be faithful,” and making “Condoms” easily available to everyone else. The HIV/AIDS infection rate in Uganda dropped to about 6 percent by the 2000s from a high of about 18 percent at the end of 1992.²⁷

The efficacy of the ABC approach lies to a certain extent in how it is defined. The UNAIDS definition, for example, neither emphasizes abstinence until marriage nor limits the promotion of condoms to those engaging in “high-risk” behaviors. It defines ABC as:

Abstinence or delayed first sex

Being safer by being faithful to one partner or by reducing the number of sexual partners

Correct and consistent use of condoms for sexually active young people, couples in which one partner is HIV positive, sex workers and their clients, and anyone engaging in sexual activity with partners who may have been at risk of HIV exposure²⁸

Yet PEPFAR adopted an ABC strategy of “population-specific interventions” that emphasized:

Abstinence for youth, including the delay of sexual debut and abstinence until marriage

Being tested for HIV and being faithful in marriage and monogamous relationships

Correct and consistent use of condoms for those who practice high-risk behaviors²⁹



A billboard in Malawi reflects a new and riskier approach to HIV prevention.

PEPFAR defined “those who practice high-risk behaviors” as “prostitutes, sexually active discordant couples [that is, couples in which only one partner is known to have HIV], substance abusers, and others.”³⁰ The definition did not mention the promotion of condoms to youth generally, but said that funds may be used for programs that provide age-appropriate “ABC information” for young people—with different standards for in-school and out-of-school youth—provided they were informed about failure rates of condoms and that the programs did not appear to represent abstinence and condom use as equally viable alternatives.³¹

PEPFAR’s ABC formula did not always translate as clearly as government officials may have presumed. An August 2007 *Foreign Policy In Focus* article on “The Flawed ABCs of PEPFAR” cites a Johns Hopkins University survey finding that: “Among youth between the ages of 15 and 25 that Johns Hopkins surveyed in Namibia, abstinence meant ‘to be absent’ and ‘faithfulness’ meant faith in the context of religion, rather than being faithful to one’s partner.”³²

And Kent Klindera, MSM Initiative manager for amfAR, The Foundation for AIDS Research, said, “In all my work, I’ve yet to see consensus on what ‘delaying sex’ actually means. Many youth define ‘sex’ as vaginal intercourse and anything else as abstinence, including oral and anal sex. Most young people I know in Africa are very confused.”³³

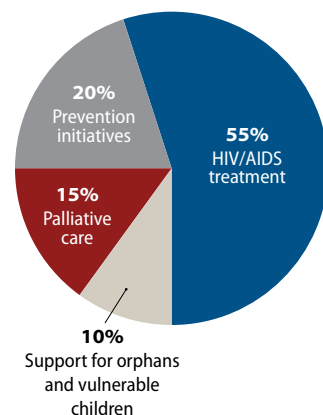
The determination to incorporate the ABC approach was only one of a series of agreements on the bill's provisions that mollified Bush's conservative base and made PEPFAR possible. "It's probably true that PEPFAR never would have gotten through Congress had it not been for these political compromises," said Lawrence Gostin, faculty director of the O'Neill Institute for National and Global Health at Georgetown University.³⁴

The PEPFAR funding formula

More significant than the ABC wording was the strict language contained in the authorizing legislation dictating how PEPFAR resources could be allocated. The law required 55 percent of funds to go to HIV/AIDS treatment, 20 percent to prevention initiatives, 15 percent to palliative care, and 10 percent to support for orphans and vulnerable children. In addition, one-third of the prevention slice of the funding pie was earmarked for abstinence-until-marriage programs, leaving all other prevention programs—including condom promotion, safe medical injections, sexual transmission prevention, and non-sexual transmission prevention—to divide up the rest of the money.

And then the Bush administration announced a new directive in 2005 specifying that "66 percent of resources dedicated to prevention of HIV from sexual transmission must be used for activities that encourage abstinence and fidelity," while the remaining one-third could be spent on "condoms and related activities"—thereby putting still tighter limits on spending for condoms.³⁵

Allocation of PEPFAR Funds



PEPFAR weaknesses

PEPFAR has saved numerous lives and brought needed attention to the HIV/AIDS epidemic. Yet its positive impact has been limited due to program requirements in the law that are based largely on a conservative religious ideology, rather than a sound, scientifically driven strategy. This section of the report outlines the biggest ideological obstacles that have restricted PEPFAR and actually harmed the health of certain populations.

Abstinence and the fidelity myth

Most public health scientists have disputed the wisdom of an abstinence-focused approach to HIV/AIDS prevention. “There is very little evidence that abstinence promotion works,” said professor and prevention expert Chris Beyrer of the Johns Hopkins Bloomberg School of Public Health. “The ‘be faithful’ message is in the same category.”³⁶ Michael Bennis, a senior associate at Bloomberg and executive director of Mpilohle, a PEPFAR recipient in South Africa, said, “I think the evidence is overwhelming that abstinence programs aren’t effective, [and] that they don’t reflect the reality of the world we live in.”³⁷

In the real world, abstinence and fidelity do not ensure that an individual will not become infected, and marriage in and of itself provides no protection from infection. For example, many people are unsure of their partner’s HIV status, and those who are faithful cannot be certain that their partner is practicing the same level of commitment. In addition, women are often unable to negotiate sex free from violence or coercion, or to exercise control over prevention methods.³⁸ “A focus on abstinence is unrealistic when the vast majority of new HIV cases internationally—estimated at 80 percent—are among married women or women in monogamous relationships,” writes Hayley Hathaway, grassroots coordinator for the Student Global AIDS Campaign.³⁹ In fact, one could argue that the largest HIV risk factor for young women in Africa is marriage.

Many researchers also warned early on that the PEPFAR funding formula would be especially ineffective in countries where the disease was mainly restricted to prostitutes, injecting drug users, and gay men—since programs that emphasize abstinence and fidelity generally have little success with those groups. “Anybody can abstain and be faithful if they have shelter and food,” said Alma Legesse, an Ethiopian sex worker and mother who has

been trained in HIV prevention by a PEPFAR-funded program. “But if I sleep in the street with no work and no one to protect me, I need to have condoms.”⁴⁰

The prostitution pledge

A major source of HIV infection is sexual transmission through commercial sex work.⁴¹ But the PEPFAR law requires organizations that receive PEPFAR funding to adopt a policy explicitly stating their opposition to prostitution and sex trafficking. This policy must apply to all the organization’s activities, even those funded by other donors.

The requirement was offered as an amendment to the 2003 Global AIDS Act by Representative Christopher Smith (R-NJ) during committee markup. The pledge was at first applied only to foreign nongovernmental organizations because the Justice Department concluded that applying it to U.S.-based organizations would be unconstitutional since they enjoy the full protection of the First Amendment. The department later reversed itself, however, and in June 2005 USAID issued a directive that only those organizations—U.S. and foreign—with policies explicitly opposing prostitution and sex trafficking should be provided funding.⁴²

USAID and the Department of Health and Human Services have retained the right to investigate all funding recipients’ activities to ensure that they are sufficiently opposed to prostitution. Federal guidelines state that U.S.-based recipients can have privately funded affiliates that do not pledge opposition to prostitution and sex trafficking, provided there is “adequate” physical and financial separation between the two groups. USAID and HHS are also authorized to determine “on a case-by-case basis ... whether sufficient physical and financial separation exists.”⁴³

Critics of the policy point out that it both runs counter to best practices in public health and undermines efforts to stem the spread of disease. According to the Center for Health and Gender Equity:

*Female, male, and transgender sex workers, some of whom have been trafficked, are among the most marginalized persons in any society. The organizations with the most effective anti-AIDS and antitrafficking strategies build their efforts on a sophisticated understanding of the social and personal dynamics faced by marginalized populations. These strategies are founded on the ability to generate trust and credibility among the population in question.*⁴⁴

CHANGE also points out that public statements against prostitution can “fuel public scorn against female, male, and transgender sex workers, further driving them underground and away from lifesaving services.”⁴⁵

“How do you
teach abstinence
to a sex worker?”

– Kevin Robert Frost, CEO,
American Foundation
for AIDS Research

PEPFAR has supported some projects in sub-Saharan Africa that provide outreach to drug users, but not those that provide needle exchange, treatment for drug dependency, and antiretroviral therapy targeted to drug users.

As a result, many groups that focus on the health, safety, and human rights issues of sex workers do not sign the oath and therefore do not qualify for U.S. funding. Some 200 organizations have protested this “antiprostitution loyalty oath” on the grounds that it infringes on free speech and makes it harder to work with a vulnerable population that is key to stopping the spread of AIDS. It has nonetheless remained embedded in U.S. global AIDS policy.⁴⁶

There has been some progress in the courts, however. A U.S. District Court judge issued a landmark opinion on May 9, 2009 declaring that the pledge requirement violates the First Amendment rights of plaintiffs Alliance for Open Society International and Pathfinder International. The Brennan Center has also filed a Freedom of Information Act lawsuit on behalf of the protesting NGOs, seeking a 2004 U.S. Office of Legal Council opinion concerning the constitutionality of enforcing an antiprostitution pledge requirement against U.S.-based NGOs receiving federal grants to do humanitarian anti-HIV/AIDS work abroad.⁴⁷

Injecting drug users

PEPFAR has helped to provide “antiretroviral therapy to 2.1 million people with HIV, almost all of whom live in sub-Saharan Africa, and has spent more than \$18 billion on the continent,” but it has failed to reach “thousands of injecting drug users in PEPFAR countries in Africa, many of whom have HIV,” according to a June 13, 2009 article in *The Lancet*.⁴⁸ And although heterosexual transmission is still the main means of HIV infection in sub-Saharan Africa, IRIN, a humanitarian news and analysis network, estimates that “there could be up to three million people who inject drugs, with more than 200,000 in Kenya and at least 250,000 in South Africa.”⁴⁹ According to Anne Gathumbi, of the Nairobi-based Open Society of East Africa think tank, “The criminal nature of drug use in these countries means drug users are usually arrested and imprisoned, rarely ever getting treatment for their addictions.”⁵⁰

Conservatives have long opposed giving clean needles to drug addicts on moral grounds, but the consensus among public health experts—including WHO and the American Medical Association—is that the strategy works to reduce the spread of HIV. A WHO review of more than 200 studies on the provision of sterile injecting equipment to reduce HIV transmission found “compelling evidence” that increasing the availability and use of such equipment “contributes substantially to reductions in the rate of HIV transmission.” The review cites a 2002 study showing an 18.6 percent average annual drop in HIV infection rates in 36 cities with needle and syringe programs, compared to an 8.1 percent average increase in 67 cities lacking such programs.⁵¹ Needle exchange programs can also act as a gateway through which users learn about safer health practices and gain access to therapy and treatment.

PEPFAR has supported some projects in sub-Saharan Africa that provide outreach and education to drug users, but not those that provide needle exchange, treatment for drug dependency, and antiretroviral therapy targeted to drug users. And needle exchange and similar programs are discouraged or illegal in many African countries, making it difficult for agencies to reach and help injecting drug users.⁵² Fortunately, in December 2009 the U.S. Congress lifted the 20-year ban on using federal funds for domestic needle exchange programs. This ban did not apply to international initiatives, but the domestic ban made funding international programs difficult. Now that this obstacle is removed, advocates hope that the United States will make a concerted effort to fund such efforts.

The LGBT community

Abstinence-until-marriage programs imply a lifetime of enforced celibacy for gays and lesbians who cannot legally marry and deny lifesaving information about safe sex. They also reinforce social stigmas and further isolate and drive underground many individuals in need of services, further perpetuating the epidemic.

The statistics reveal the consequences of this neglect. Some studies have found HIV prevalence among MSM to be as high as 25 percent in Ghana, 30 percent in Jamaica, 43 percent in coastal Kenya, and 25 percent in Thailand. According to UNAIDS, 5 to 10 percent of all HIV infections worldwide are due to sexual transmission between men.⁵³ And in 2007, the Global HIV Prevention Working Group, convened by the Bill & Melinda Gates Foundation and the Henry J. Kaiser Family Foundation, estimated that HIV prevention services reach only 9 percent of MSM.

HIV prevalence may be even higher among transgender people, especially those who transition from male to female. Data presented at the 2008 International AIDS Conference in Mexico showed an HIV prevalence of more than 25 percent among transgender people in three Latin American countries and from 10 to 42 percent in five Asian countries.⁵⁴

Yet resources allocated to HIV programs for MSM, lesbian, and transgender people fall far short of what is needed. Fewer countries at the June 2008 United Nations General Assembly High-Level Meeting on AIDS reported on services for these groups than for any other. Those reports that were available reflected, on average, lower coverage for the MSM population than for the general population or other most-at-risk groups.⁵⁵ The International Gay and Lesbian Human Rights Commission blames PEPFAR's ideologically driven approach for this outcome. According to IGLHRC, PEPFAR has "systematically excluded" LGBT people around the world, "many of whom are highly vulnerable to HIV infection and confront a crippling web of human rights violations."⁵⁶

MSM—like intravenous drug users and sex workers—have been particularly underserved in Africa, where homosexuality remains stigmatized and often criminalized. Two-thirds

of African countries ban homosexual sex, or at least male-to-male sex, with punishments ranging from imprisonment to death. At least 33 percent of funds allocated to prevention efforts through PEPFAR are devoted to abstinence-until-marriage programs, so it's not hard to see how the MSM population would get short shrift. Of the \$3 billion assigned to prevention in PEPFAR's initial outlay, most of which went to Africa, IGLHRC was only able to locate one program on the continent that addressed MSM—and that program received less than \$100,000.⁵⁷ “Not only have African men who have had sex with men been largely ignored with regard to HIV prevention services,” said Cary Alan Johnson, IGLHRC's executive director, “but avowedly homophobic organizations are receiving funding for programs that will only further stigmatize homosexuality.”⁵⁸

Relatively little data exists to substantiate the impact of male-to-male sex on the epidemic—but that may be changing. African political and public health leaders released a report at the 2008 U.N. meeting on AIDS calling for prevention among MSM and “good surveillance data and better monitoring” so that resources are “spent where they will do the most good.” In fact, many African countries now have reliable data sources—although very little of this data collection has been funded by PEPFAR. The report, “Securing Our Future: Report of the Commission on HIV/AIDS and Governance in Africa,” also called for protecting human rights, “promoting safer sexual behavior among these groups and their partners,” and “implementing policies and legal frameworks that do not criminalize and discriminate against target groups.”⁵⁹

At an International AIDS Society meeting in Cape Town, South Africa in July 2009, Ambassador Eric Goosby, President Obama's new U.S. Global AIDS Coordinator, said that PEPFAR will seek to use human rights-based strategies in reaching out to high-risk groups:

*MSMs, commercial sex workers, transgenders, injection drug users present different challenges in different cultures that require the development of special strategies that identify access points and retention strategies for these populations. This has to be an integral component of our care. For to forget to focus on those who do not easily reveal themselves to medical delivery systems creates an opportunity lost, but also a vulnerability for the continued transmission of HIV throughout the community.*⁶⁰

LGBT and human rights activists were alarmed, however, at Ambassador Goosby's later response to the controversy surrounding draconian antigay legislation proposed in the Ugandan Parliament by members of President Yoweri Museveni's majority party and to calls for funding cuts to Uganda's HIV/AIDS programs. In a November 27, 2009, *Newsweek* interview⁶¹, he indicated that he thought it would do more harm than good to connect U.S. government resources to particular prevention policy directives. He suggested, “My role is to be supportive and helpful to the patients who need services. It is not to tell a country how to put forward legislation. But I will engage them in conversation around my concern and knowledge of what this is going to do to that population.” Activists have also noted that Goosby does not specify which “population” he means.

Family planning and reproductive health

The United Nations estimates that 2.5 million children are infected with HIV/AIDS, and nearly 90 percent of them are in sub-Saharan Africa. Antiretroviral drugs have been at the forefront of preventing mother-to-child transmission, and through PEPFAR, the United States has been a global leader in that effort. “To date, we have supported Preventing Mother-to-Child Transmission of HIV services for women in more than 10 million pregnancies, of whom 800,000 were found to be HIV positive,” said Dr. Thomas Kenyon, principal deputy AIDS coordinator and chief medical officer for PEPFAR, in 2008.⁶²

It stands to reason, however, that a more efficient way to stop infections would be to prevent unintended pregnancies among HIV-positive women. Women constitute 60 percent of those living with HIV/AIDS in sub-Saharan Africa, and young women account for three-quarters of the 15- to 24-year olds living with the virus; yet only 1 in 10 HIV-positive women in Africa has access to antiretroviral medications.⁶³ “The immediate concern,” says Katie Porter, a senior policy advocate at CARE, “is that PEPFAR is not supporting access to [a variety of] contraceptives. While they support condom use, which is important, they are not providing other contraceptive commodities to women in what would be a very appropriate setting.”⁶⁴

PEPFAR programs generally do not address linkages between HIV and reproductive health; their only involvement in family planning has been to recommend methods that prevent the spread of the disease—namely, practicing abstinence and using condoms. Many PEPFAR supporters have defended the program’s approach, saying that PEPFAR’s job is to prevent transmission. They also point out that the U.S. government already has a voluntary family planning and reproductive health program through USAID’s Office of Population and Reproductive Health that includes a variety of contraceptives. Yet, other PEPFAR supporters say that good prevention requires recognition that AIDS is itself a sexual and reproductive health issue, and that the two services cannot be separated if prevention is to truly succeed.

Congress has imposed some constraints to integrating HIV, reproductive health, and family planning services, notably through the initial 33 percent funding earmark for abstinence-only programs. Other obstacles, according to an article by Janet Fleischman, occur on the ground in PEPFAR countries. “Some PEPFAR teams and partners simply avoid programming related to reproductive health issues, rather than risk jeopardizing their programs,” Fleischman writes. “One PEPFAR implementing partner described the perceptions about PEPFAR that inhibit innovation: ‘There are perceived restrictions in PEPFAR about what you can discuss with whom, so everyone is being very cautious ... People are afraid to discuss family planning, condoms, abortion—so many groups don’t address them at all.’”⁶⁵

Fleischman speculates that inevitably, “some U.S. policymakers will be uncomfortable with the premise of integrating reproductive health and family planning into HIV/AIDS

“[Contraception] tends to be the best-kept secret in HIV prevention.”

– Ward Cates, head of research for Family Health International

programs, often considering ‘reproductive health’ to be a euphemism for abortion services.” But a public health consensus is emerging in favor of such integration as the most feasible means of achieving multiple goals: preventing new infections, reducing PMTCT and the number of AIDS orphans, and supporting women’s reproductive rights and fertility choices.

The United States decreased during the Bush years the amount of money it gave to international organizations that provided reproductive health services and research. For example, the U.S. government cut off \$2.5 million in funding for the World Health Organization’s Department of Reproductive Health and Research in 2002 and cancelled \$34 million for the United Nations Population Fund, which supports women’s basic human rights to contraception and reproductive health services. The Bush administration also enforced a “global gag rule” that prevented U.S. funding from going to any organization that, even with other funding, counsels on, advocates for, or provides safe abortion services. The Obama administration lifted the global gag rule and restarted disbursements to UNFPA, but coordination with the agency to ensure integrated programs remains challenging in some settings.

PEPFAR transparency

PEPFAR states that it “employs the most diverse prevention, treatment, and care strategy in the world, with an emphasis on transparency and accountability for results.”⁶⁶ But the program has been criticized for its lack of openness and disclosure. For example, according to AVERT, an international HIV and AIDS charity based in the United Kingdom, “During its first two years of operation... PEPFAR published very little information about its activities and partner organizations. Some data were released by the Office of the Global AIDS Commissioner, by USAID, or by U.S. embassies, but it was impossible to track the flow of all PEPFAR money.”⁶⁷

The International Consortium of Investigative Journalists and the Center for Public Integrity published the results of a year-long joint investigation into PEPFAR activities in 2008. According to the report:

*During the investigation, reporters encountered PEPFAR officials who couldn’t answer basic questions about the program they oversee, recipients of PEPFAR money who were reluctant to criticize their donor out of fear of losing funding, and Freedom of Information Act requests that were stalled for months... Requests for interviews and information from OGAC’s Washington office were often ignored; dozens of phone calls and emails were never returned... In several instances, organizations receiving PEPFAR money had to request clearance from the U.S. government before talking to reporters.*⁶⁸

The ICIJ eventually took the State Department to court to try to gain access to their funding database. The State Department released a partial record for fiscal year 2004 to fiscal year

2006 a year later. And the Center for Global Development used this data in its report analyzing how PEPFAR funds had been distributed. According to CGD, PEPFAR “provides more than \$5 billion per year to prevent and treat HIV/AIDS yet little information about how this money is used is publicly available. While the U.S. government collects extensive information about how PEPFAR funding is used, only a small share of this data is publicly disclosed. Even PEPFAR staff are not able to access some of the collected data.”⁶⁹

In late 2008, in a memo to then-President-elect Obama, CGD called on the new administration to release more data, stating:

*Critical decisions, such as balancing prevention and treatment, or how to best allocate grants between international and local recipients, will impact program effectiveness. Yet, at present there is little access to expenditure data to help make or justify such decisions... The next administration should publish existing PEPFAR official data on obligations to prime partners, subpartners, and program areas to improve transparency and accountability.*⁷⁰

More importantly, public health researchers and advocates could use this data to help improve PEPFAR-supported programs, with the ultimate goal of having the greatest positive impact on people in the countries PEPFAR targets.

Preaching PEPFAR

There is nothing new about faith-based groups delivering humanitarian aid in distant and dangerous places: Catholic and Protestant groups have been running AIDS programs since the 1980s. Yet U.S. policy until recently clearly prevented the intermingling of government-funded programs and religious proselytizing. The intent was to adhere to the constitutional doctrine of separation of church and state and to ensure that individuals or groups do not forgo assistance because they don't share the religion of the provider. In the case of serious illness—such as AIDS, malaria, and tuberculosis—matters of life and death are at stake.

Yet many of these restrictions were removed during the Bush administration through a series of executive orders, clearing the way for faith-based groups to obtain substantial amounts of additional government funding. A 2006 *Boston Globe* series on Bush's ties to Christian groups describes how this reversal of policy also helped to “change the message American aid workers bring to many corners of the world, from emphasizing religious neutrality to touting the healing power of the Christian God.”⁷¹

Most significant was President Bush's order altering the longstanding requirement that groups not preach religion and administer government programs in the same space. The administration said that such conduct would be allowed, as long as the religious services did not take place at the same time as aid delivery. In other words, groups could schedule prayers immediately before or after dispensing aid. The administration also allowed recipients of government funds to require their employees to take a loyalty oath to a particular religion and to keep religious symbols in places where they dispense aid.

David Kuo, former special assistant to President Bush and deputy director of the White House Office of Faith-Based and Community Initiatives, describes a March 2004 event at which Bush told some 3,000 faith and charity leaders: “I got a little frustrated in Washington because I couldn't get [the faith-based charity] bill passed ... so I signed an executive order—that means, I did it on my own.” “The crowd erupted in applause,” Kuo writes. Within a year, he adds, “there was a \$144 million increase in the amount of HUD and HHS grant dollars that were granted to faith-based organizations.”⁷²

The *Boston Globe* article also cited findings from its analysis of more than 52,000 awards of contracts, grants, and cooperative agreements issued by USAID. Records obtained through the Freedom of Information Act showed a sharp increase in the amount of money going to faith-based groups between FY 2001 and FY 2005—from 10.5 percent to 19.9 percent of nongovernmental aid organizations.⁷³

The Children's AIDS Fund and Food for the Hungry, two organizations that received these funds, illustrate how these policy changes altered PEPFAR and the populations it serves.

Profiles of two groups that received administration grants

CHILDREN'S AIDS FUND

USAID awarded \$10 million to the Children's AIDS Fund in February 2006 to promote abstinence in Uganda. The 21-year-old organization, formerly Americans for a Sound HIV/AIDS Policy, is a leading proponent of abstinence-based AIDS prevention that lobbied against including HIV/AIDS status in the Americans With Disabilities Act. The organization is headed by Anita Smith, whose views on abstinence education President Bush promoted during his tenure as governor of Texas. As president, Bush named her to his Advisory Council on HIV and AIDS and appointed her husband, Shepherd Smith, to the Advisory Committee to the Director of the Centers for Disease Control and Prevention.

USAID Administrator Andrew Natsios overrode the recommendations of the agency's Technical Review Committee in awarding the grant to the Children's AIDS Fund, which found the organization "not suitable" for PEPFAR funds. Rep. Waxman requested information about the award in a February 15, 2005 letter to Global AIDS Coordinator Randall Tobias, saying that the grant raised questions of "political cronyism" and that approving programs deemed "not suitable for funding...can waste taxpayer dollars and undermine the credibility of our efforts to combat an international epidemic."⁷⁴

Ambassador Tobias justified the funding at a House International Relations Committee Hearing on the basis that Uganda had been a leader in the ABC approach and that it provided "the U.S. government with a unique opportunity to work directly with the first lady of Uganda and her Uganda Youth Forum prevention activities...a pioneer in abstinence and faithfulness messages."

"So when a technical review panel indicates it is not suitable for funding, you have the authority to use other means to go on and fund it that give you the confidence that it is suitable for funding?" Representative Barbara Lee (D-CA) asked. "That is right," Ambassador Tobias replied.⁷⁵

Human Rights Watch describes the Uganda Youth Forum as "an organization whose principal activity is to organize retreats in which boys and girls sign commitment cards to remain 'sexually pure' until their marriage day." Its leader, Uganda's First Lady Janet Museveni, is also known for her call for a national "virgin census" to determine the percentage of children and young adults who are virgins, have practiced "secondary abstinence" (for those who have already been sexually active), and are currently sexually active.⁷⁶

FOOD FOR THE HUNGRY

Food for the Hungry is an Arizona-based Christian relief organization founded in 1971 that implements development, health, and food programs in more than 45 developing countries. Its president, Benjamin K. Homan, chaired the Bush administration's USAID Advisory Committee on Voluntary Aid.

Food for the Hungry's HIV prevention and care activities were smaller side projects to its core food distribution and development programs until 2005, when the group was awarded an \$8.3 million grant through PEPFAR's Abstinence and Health Choices for Youth Program. Food for the Hungry applied for the grant as part of a coalition of faith-based groups called the Association of Evangelical Relief and Development Organizations, of which Homan was then president. Food for the Hungry was the lead agency and administrator of the prevention grant, which involved seven faith-based organizations—six of which had never before received U.S. government funding for HIV work.⁷⁷

The Center for Public Integrity says that the group "works with families and community and church leaders, and its officials say that they serve Christians, Muslims, and people of other religions equally." A reporter for the International Consortium of Investigative Journalists, visiting a Food for the Hungry distribution program in Ethiopia, found that not to be the case. PEPFAR HIV prevention activities "seemed more geared toward Christians... The manual that the organization uses to teach the classes relies on biblical references and stories, and on its website, Food for the Hungry describes its HIV work as 'Biblical training on abstinence and faithfulness, medical support, outreach, supporting orphans, and HIV/AIDS victims.'⁷⁸

The group's HIV prevention curriculum, Choose Life, was developed by the Baltimore faith-based group World Relief and features stories from the Bible. But World Relief Director of Health Programs Tom Davis said that it had been reviewed and edited by USAID officials to ensure that it did not breach church-state separation rules.⁷⁹

Yet according to the *Boston Globe* series referenced above, Food for the Hungry Kenya Director Robert Syner maintains that the group seeks to segregate religious activities from aid programs, but that most Kenyans don't believe in the concept of separation of church and state. "In Kenya, they don't separate things out." At Food for the Hungry's outpost in Lakartinya, the article says, "staff members spoke openly of how they preach about Jesus while teaching breastfeeding and nutrition."⁸⁰

The Uganda experience

The response to HIV/AIDS in Uganda is instructive because it was held up as a model for Africa in the fight against the disease and because the United States is the leading provider of HIV/AIDS assistance to that country. The U.S. government provided \$1.2 billion through PEPFAR to support comprehensive HIV/AIDS prevention, treatment, and care in Uganda between 2004 and 2008, and an additional \$285 million in 2009. Yet AIDS has still had a devastating impact on the country, killing more than 1 million people, significantly reducing life expectancy, depleting the workforce, reducing food security, and weakening educational and health services.⁸¹

The first AIDS case in Uganda was diagnosed in 1982, but it was not until the Ugandan civil war ended and President Museveni came to power in 1986 that the country had a real HIV prevention program. By then, the country was in the midst of a major epidemic, with prevalence rates as high as 29 percent in urban areas.⁸²

Uganda's first AIDS control program promoted the ABC approach, focused on ensuring the safety of the blood supply, and implemented preliminary population surveys. This early response was characterized by a combination of strong political leadership and grassroots involvement by a multitude of community organizations that set about educating their peers about HIV. One such organization was TASO, the AIDS Support Organization—at the time run by 16 volunteers who had been personally affected by the disease. TASO later became the largest indigenous AIDS service organization in all of Africa.

President Museveni, unlike most African leaders in the 1980s, recognized the danger and took swift action. The government launched an aggressive media campaign, targeting different messages to different groups. It encouraged young people to abstain, and sexually active people to practice “zero grazing”—a program devised by the Ugandans in the 1980s that meant staying with regular partners rather than engaging in casual sex with strangers.⁸³

The government initially opposed condom use, but that lessened as WHO and other international organizations promoted condoms as a way to reduce new infections and provided funds to make them more readily available. The number of condoms delivered to Uganda by international groups rose from 1.5 million in 1992 to nearly 10 million in 1996.⁸⁴ Procondom slogans on billboards and radio and television—such as “No Glove, No Love” and “Protect Yourself and Your Family”—were seen everywhere and began to make an impression on Ugandan citizens.⁸⁵

The multipronged strategy appeared to work. Uganda became the first African country to experience a significant drop in its infection rate, with HIV prevalence among adults falling from about 15 percent in the early 1990s to about 5 percent in 2001.⁸⁶

The Ugandan government—and later the Bush administration and its ABC promoters—gave abstinence and faithfulness the bulk of the credit for the nation's declining HIV/AIDS prevalence rate in the 1990s, and many agree that persuading Ugandans to change their sexual behavior made a difference. But it's more likely that a combination of other factors were at work. Helen Epstein notes in her book *The Invisible Cure: Africa, the West, and the Fight Against AIDS in Africa* that the decline in HIV infection rates coincided with the drop in the proportion of people having casual sexual encounters. She credits a balanced, realistic approach:

*Cheerful, sexy condom ads that fail to address the real dangers of AIDS may promote a fatal carelessness; but an exclusive emphasis on abstinence until marriage may well lead to an even more dangerous hysterical recidivism. The genius of the Zero Grazing campaign was that it recognized both the universal power of sexuality and the specific sexual culture of this part of Africa, and it gave people advice they could realistically follow.*⁸⁷

Dr. Sam Okware of the Ugandan Ministry of Health believes that all three factors of the ABC approach helped the country bring the epidemic to a more manageable level, in large part because ABC made no value judgments. “In the same individual, in the morning you are on mode A. In the evening you are on mode B. And maybe at night, after a small drink, you are on mode C.”⁸⁸

Another factor that probably contributed to the decline in HIV/AIDS prevalence is the rise in the number of AIDS-related deaths, since antiretroviral treatment was not widely available in Uganda at the



A billboard in Kampala, Uganda advises people to abstain from sex. Billboards urging condom use have disappeared from the capital. In their place are posters, some funded by the United States, encouraging youth to delay their sexual debut until they marry.

time. In general, it is likely that a combination of messages, approaches, behaviors, and epidemiological and demographic changes were responsible for the trend.

But the delicate balance that characterized Uganda's approach to its AIDS crisis began to shift in 2003 when Bush administration officials began working with Ugandan government officials to develop a new approach that, though not excluding condoms, would limit their promotion to a narrow high-risk segment of the population and emphasize instead PEPFAR's new version of the approach. The goal was to reach 9 million Ugandan youth with the message that the best way to avoid HIV/AIDS was not to have sex.⁸⁹

"PEPFAR really shifted the emphasis to A and B just because of the amounts of money being put into these programs."

– Sam Okare, senior Health ministry official and architect of Uganda's ABC model

A key part of the PEPFAR-funded youth abstinence campaign was a massive education effort in Uganda's schools. In contrast to a government policy document of the 1990s that read, "Correct information on condom use should be provided to young people," a new teacher resource book advised, "The use of condoms among unmarried young people ... does not arise. Young people do not need condoms; they need skills for abstaining from premarital sex." Students were encouraged to rely on self-esteem, patience, and the resistance of peer pressure.⁹⁰

The Museveni government enthusiastically embraced the Bush administration's approach,⁹¹ as PEPFAR began channeling large sums of money to Uganda, much of it through faith-based organizations. Billboards that used to advertise condom brands were replaced by displays touting the benefits of chastity. Evangelical churches within Uganda also took up the cause. According to AVERT, some leaders of small community-based organizations reported being aware that they were "more likely to receive money from PEPFAR ... if they mention abstinence in their funding proposal."⁹²

President Museveni deviated from his previous support for condoms just as the United States announced that Uganda would receive \$90 million in PEPFAR funds, lashing out against their distribution and use as "inappropriate for Ugandans." At the July 2004 International AIDS conference in Bangkok, he called condoms "an improvisation, not a solution," saying that he favored "optimal relationships based on love and trust instead of intentional mistrust, which is what the condom is all about."⁹³

An even more vociferous critic of condoms is Ugandan First Lady Janet Museveni. She disparaged those who distribute condoms to young people as "pushing them to go into sex" in August 2004, and stated that "it is not the law that our children must have sex."⁹⁴

Such statements by the first lady would appear to contradict the Uganda Ministry of Health's National Condom Policy and Strategy, which states that "correct and consistent condom use shall be widely and openly promoted to all sexually active individuals as an effective means of preventing HIV/STD transmission and as a family planning method."

Human Rights Watch reported that on at least one occasion, the Ugandan government supported an organization that spread false information about the effectiveness of condoms against HIV. “The Family Life Network, a faith-based organization that claims to have received a grant from the Ugandan government supported by the Global Fund to Fight AIDS, Tuberculosis, and Malaria, teaches young people that latex condoms contain microscopic pores that can be permeated by HIV pathogens.”⁹⁵

HIV/AIDS groups in Uganda also told HRW that activities of Population Services International, a large U.S.-funded social marketing organization that sells subsidized condoms, had been curtailed under pressure from the U.S. and Ugandan governments. HRW writes that it was “widely discussed among AIDS service providers in Kampala that First Lady Janet Museveni had accused PSI of distributing condoms at a promotional event designed to encourage abstinence among youth, and that the accusation had resulted in restrictions on PSI’s HIV prevention work.”⁹⁶

According to author Epstein, PSI had received funding from PEPFAR for an abstinence program in which they produced a comic book that was offensive to Pastor Martin Ssempea of Makerere Community Church. An ally of the first lady, Ssempea called her office to make sure that “George Bush’s money got into the right hands.”⁹⁷ According to Human Rights Watch, Ssempea’s church received \$40,000 in PEPFAR funding to provide an abstinence education program.

The condom recall

The situation reached a crisis point in October 2004, when the Museveni government issued a nationwide recall of condoms with the brand name Engabu, based on disputed claims that they were of poor quality. CHANGE describes what happened next:

*Condom supplies were further reduced when the government began requiring that all condoms entering the country, including those from the United States, undergo quality testing after delivery in Uganda, even in cases where preshipment quality tests had been performed. All condom stocks in government warehouses were impounded and further shipments of Engabu under the contract held with a German-Chinese consortium were rendered worthless.*⁹⁸

Jodi Jacobson, then executive director of CHANGE, stated, “The government took this drastic step with no backup plan in place, resulting in a major crisis in the country.” And to make matters worse, “new taxes and campaigns to discredit condoms have further reduced access to condoms and undermined public confidence in prevention technologies overall after years of successful efforts to promote safer sex.”⁹⁹

Martin Ssempe set fire to a box of condoms at Makerere University in Kampala in September 2004. According to press reports, Ssempe prayed over the burning boxes and said, “I burn these condoms in the name of Jesus.” He later testified before the House International Relations Committee that he did so because “those condoms had been banned by the government a few days earlier... they would pose a significant risk to the population at large. So I was simply fulfilling what the government had ordered, a recall a destruction of the condoms.” According to HRW, however, the Ugandan government did not issue the recall until nearly a month after Ssempe’s condom-burning ritual.¹⁰⁰

Millions of condoms were later incinerated by the government, and a severe shortage ensued in 2005. Stephen Lewis, the U.N. envoy for HIV/AIDS in Africa at the time, was one of those who believed that the United States was largely to blame for the shortages: “There is no question that the condom crisis in Uganda is being driven and exacerbated by PEPFAR and by the extreme policies that the administration in the United States is now pursuing ...”¹⁰¹ The Ministry of Health had imported 80 million rebranded condoms for free distribution by mid-2006 with assistance from the World Bank.

Praise for Uganda’s prevention efforts began to wane after the condom fiasco, and HIV/AIDS activists as well as Ugandan public health officials became alarmed that a whole generation of young people could be at risk of infection. The numbers seemed to back up this concern. The rate of HIV infections nearly doubled during the first two years of emphasis on youth abstinence—from 70,000 in 2003 to 130,000 in 2005.¹⁰² And while the infection rate among young people remained low at about 3 percent for those aged 15 to 24, there was growing evidence that more Ugandan youth were engaging in risky sexual behavior—with only about half reporting using condoms.¹⁰³

An organization that had promoted condoms in Uganda since the early 1990s told HRW that the shift toward abstinence was reversing their earlier successes. “We’re almost back to square one,” one of organization’s staff was quoted as saying.¹⁰⁴ A 2008 UNAIDS report suggested that the ratio of new infections in Uganda might be due to “a possible resurgence in sexual risk taking that could cause the epidemic to grow again.”¹⁰⁵

Yet the government of Uganda was rewarded for its work as late as June 2008 by being chosen to host the HIV/AIDS Implementers Meeting, sponsored by PEPFAR; the Global Fund to Fight AIDS, Tuberculosis and Malaria; UNAIDS; UNICEF; the World Health Organization; and the ` Global Network of People Living with HIV/AIDS. “The experience in Uganda in fighting HIV/AIDS is a true reflection of the meeting’s theme [“Scaling Up Through Partnerships: Overcoming Obstacles to Implementation”],” said Dr. Kihumuro Apuuli, director general of the Uganda AIDS Commission. “Uganda’s achievements in fighting the epidemic cannot be attributed to a single stakeholder or even a cluster of stakeholders, but the collective efforts of all.”¹⁰⁶

To be gay in Uganda

Homosexuals are a highly stigmatized and socially excluded group in Uganda, a status that puts them at particular risk of contracting HIV. They are both invisible and illegal to the government of Uganda. According to the Ugandan penal code, “Carnal knowledge of any person against the order of nature” is a criminal offense, punishable by between 14 years and life imprisonment. And in 2006, the Ugandan Parliament passed a constitutional amendment making same-sex marriages illegal.

As for the country’s ABC prevention campaign, “There’s no mention of gays and lesbians in the national strategic framework,” said James Kigozi of the Uganda AIDS Commission. “These two groups [gays and lesbians] are marginal. Their numbers are negligible.”¹⁰⁷ The Minister of State for Health, Jim Muhwezi, insisted that Uganda’s ABC approach was adequately addressing all groups in Uganda, including homosexuals. “They don’t deserve a special message,” he said. “They shouldn’t exist, and we hope they are not there. If they do exist they are covered under the three-pronged approach of ABC and should be content with that.”¹⁰⁸

IGLHRC announced in October 2007 that it had uncovered evidence that the U.S. government had funded groups in Uganda that actively promoted discrimination against lesbians and gay men. One of these groups was Martin Ssempe’s Makerere Community Church.¹⁰⁹ IGLHRC noted that Ssempe had been the “primary instigator” of a back-



Members of the Uganda National Pastors Task Force Against Homosexuality demonstrate in Kampala in December 2009. The group marched near embassies, telling the international community to back off from their criticism of the anti homosexual bill that is in the making in Parliament. The law that threatens a death sentence to homosexuals has attracted critics including President Obama.

lash against the “Let Us Live in Peace” campaign launched in August 2007 by Sexual Minorities of Uganda. Ssempe organized a rally in Kampala in which demonstrators, including government officials, demanded action against LGBT people.¹¹⁰

Because sexual minorities have never had a place in the Ugandan government’s fight against AIDS, there are no statistics on the prevalence of the HIV virus among these groups. By the same token, many gays and lesbians in Uganda say they are reluctant to report symptoms of sexually transmitted infections for fear of eliciting questions about their sexual orientation.

The Ugandan government is now considering a law that would reaffirm penalties for homosexuality and criminalize the “promotion of homosexuality.” The Anti-Homosexuality Bill of 2009 targets lesbian, gay, bisexual, and transgender Ugandans, their defenders, and anyone who fails to report them to the authorities. It also sets out provisions for what it calls “aggravated homosexuality,” covering sex with someone under 18, disabled, or considered to be a “serial offender.” This “offense” would incur the death penalty—contradicting the global trend toward a moratorium on capital punishment. The bill’s supporters have direct linkages to some of the most extreme antigay elements in the United States—for example, evangelical pastor Scott Lively, who has drawn parallels between Nazi Germany and modern homosexuality.¹¹¹

A coalition of Ugandan human rights groups is leading the effort to defeat the bill, in collaboration with the International Gay and Lesbian Human Rights Commission, the Council for Global Equality, Human Rights Watch, and other global organizations. The prime ministers of Canada and Great Britain, as well as the White House, have also spoken out against the proposed law.

Uganda is not alone among PEPFAR countries in imposing criminal sanctions against gay men, but it is the most repressive. Eight other focus countries have such laws—Botswana, Ethiopia, Guyana, Kenya, Namibia, Nigeria, Tanzania, and Zambia—and one was recently introduced in Rwanda. That represents about two-thirds of PEPFAR’s priority countries.

Improving PEPFAR

PEPFAR evaluations and reform

Two authoritative reports have called for improvements in the program. The U.S. Government Accountability Office released a report in April 2006 entitled “Spending Requirement Presents Challenges for Allocating Prevention Funding under the President’s Emergency Plan for AIDS Relief.” The report amounted to an indictment of U.S. prevention policies that prioritize abstinence and fidelity over scientifically proven methods of reducing infection. The report stated that some organizations supported by PEPFAR were concerned about “crossing the line between providing information about condoms and promoting or marketing condoms” and that staff felt “constrained” when young people ask specific questions about condom use.¹¹² The report also found that the effort to steer money toward abstinence had taken funds away from other anti-AIDS programs and that spending mandates for abstinence had created a program that was “ambiguous and confusing.”¹¹³

A March 2007 report by the Institute of Medicine, “PEPFAR Implementation: Progress and Promise,” criticized the division between country-managed and centrally funded programs as hindering PEPFAR’s commitment to “harmonization”—a concept that encourages each country to take ownership of its own HIV/AIDS response. The report also called for greater emphasis on prevention of HIV infection generally, improved data on prevalence and at-risk populations, and increased attention to the vulnerability of women and girls, as well as the legal, economic, educational, and social consequences of neglecting their needs.¹¹⁴

Representative Tom Lantos (D-CA), a powerful force for global and human rights who fought for a strong 2008 PEPFAR reauthorization bill but who died shortly before its passage, expressed concern that groups that favored distribution of condoms and work with high-risk groups had lost out to those that preached abstinence as an AIDS prevention measure. “Our global HIV/AIDS policy should be about saving lives,” he said. “It is inconsistent with this goal to place ideologically driven restrictions on the implementation of efforts to prevent spreading the virus.”¹¹⁵

And U.N. Secretary-General Ban Ki-moon in his August 4, 2008 address before the International AIDS Conference in Mexico City called on “politicians around the world to speak out against discrimination and protect the rights of people living with and affected by HIV, for schools to teach respect, for religious leaders to preach tolerance, and for the media to condemn prejudice in all its forms.” He added,

In countries without laws to protect sex workers, drug users, and MSM, only a fraction of the population has access to prevention. Conversely, in countries with legal protection and the protection of human rights for these people, many more have access to services. As a result, there are fewer infections, less demand for antiretroviral treatment, and fewer deaths. Not only is it unethical not to protect these groups; it makes no sense from a health perspective. It hurts all of us.¹¹⁶

PEPFAR reauthorization

President Bush signed into law the Lantos-Hyde Act, P.L. 110–293, in July 2008, reauthorizing the President’s Emergency Plan for AIDS Relief, but the bill faced strong opposition along the way.

The debate over progressive attempts to reform PEPFAR in Congress was contentious. Representative Lantos championed a revision that struck the abstinence-until-marriage earmark, the prostitution pledge, and other prevention restrictions, and sought to integrate family planning with HIV prevention, but was ultimately unsuccessful in incorporating all of these changes in the bill.

The act continued to impose arbitrary funding directives to encourage abstinence-only programs over effective, comprehensive prevention intervention. It failed to support integration of family planning and HIV services, and it retained the requirement that organizations pledge opposition to prostitution in order to receive funding.¹¹⁷

Some significant and welcome changes did occur during reauthorization of PEPFAR, and the Department of State and the Office of the Global AIDS Coordinator are sending hopeful signals that additional positive changes are coming, but there are still many valid concerns about both the authorizing language and the implementation of the PEPFAR program.

PEPFAR recommendations

The following recommendations would enhance the effectiveness of PEPFAR by reframing it as a program that is based on scientific knowledge rather than religious beliefs, and that protects and advances human rights, including those of sex workers and the overall LGBT population.

As a matter of priority, the Office of the U.S. Global AIDS Coordinator and under secretary for democracy and global affairs should work with White House officials, including those from the National Security Council, the Office of National AIDS Policy, and Global Health Affairs at the Department of Health and Human Services, to ensure that these recommendations are reflected in PEPFAR policy guidelines. And the new administrator for USAID should work with Centers for Disease Control and the National Institutes

of Health to develop clear guidelines for the immediate and effective implementation of these policy revisions. The Obama administration should also seek clear support from congressional leaders for these policy changes to ensure that sound health policy is recognized as critical to PEPFAR's ultimate success.

Eliminate funding quotas and rules around abstinence and be faithful programs.

The reauthorization of PEPFAR eliminated the legislative requirement that one-third of all prevention funds be directed to abstinence-until-marriage programming, but the new language includes a reporting requirement that calls on the U.S. global AIDS coordinator to offer an explanation to Congress if 50 percent of funds in countries with generalized epidemics are not directed to A (abstinence) or B (be faithful) programs. This change provides some additional opportunities for program implementers to conduct prevention programs as they see fit, but it has resulted and will continue to result in confusion and misinterpretation. People and organizations managing programs should be empowered to design and implement initiatives based on scientific evidence, cultural relevance, and local decision making and not be hindered by a congressional rule written in authorization language. This report recommends that Congress work to eliminate this rule in the appropriations process and/or subsequent reauthorizations.

Adopt a rights-based approach to prevention.

Vehemently antigay legislation proposed by members of the Ugandan president's majority party in Parliament illustrates the need for PEPFAR and the U.S. global AIDS coordinator to insist that those receiving PEPFAR funds, particularly prevention grants, adopt a human rights-based approach to prevention that is free from stigma and discrimination. The U.S. global AIDS coordinator should condemn prevention activities that do not incorporate a human rights-based approach and any proposed legislation that—by stigmatizing a vulnerable population—could make implementation of such an approach unworkable, if not impossible. The U.S. government's reaction to such activities and proposals should be swift and unequivocal to make clear to policymakers the potential negative consequences of funding PEPFAR prevention programs in environments where such funding would not be consistent with a rights-based approach.

The U.S. government should also use its diplomatic, legal, and other program assistance tools to encourage the repeal of laws that criminalize homosexual conduct and/or relationships, or that impede LGBT groups' ability to register or provide services to their communities. These laws, which are present in many countries around the world, discourage LGBT individuals from seeking access to HIV/AIDS services, thereby undermining sound health policy. Vigorous efforts to repeal these laws are critical to the success of PEPFAR prevention and treatment programs.

Ensure PEPFAR funds are not directly or indirectly distributed to organizations or individuals who engage in anti-gay rhetoric.

Organizations run by virulently antigay individuals received funds either directly under PEPFAR I or through a subcontract agreement to conduct prevention activities whose messages consisted of stigmatizing homosexuality and blaming homosexuals for the spread of HIV in their respective countries. The effect of prevention programs that stigmatize individuals, notably MSM, is to drive them further from access to prevention efforts that would enable them to avoid behaviors that put them at risk for contracting HIV. These prevention “programs” are not science based, have no place in a highly regarded development assistance program such as PEPFAR, and should not be funded with taxpayer dollars through PEPFAR partners or subcontractors.

What’s more, funding of virulently antigay individuals and organizations appears to have empowered others in their respective countries that have a broader antigay agenda and are attempting to criminalize homosexuality where it currently is not criminalized and to enhance punishments in those countries where it already is illegal. The U.S. government should not endorse such behavior, even tacitly, by sending foreign assistance in the form of PEPFAR grants to such individuals and organizations. Increased accountability measures should ensure that such programs are not currently receiving funds from PEPFAR and will not with subsequent appropriations.

Integrate reproductive health services and family planning into PEPFAR programming.

The PEPFAR reauthorizing language fails to mention family planning and reproductive health, and foreign development assistance continues to be distributed in a disease-specific fashion. As HIV remains largely driven by sexual transmission, this approach is inefficient and ineffective, creating more bureaucracy and limiting services.

PEPFAR also fails to integrate culturally relevant issues regarding femininity and the fertility aspirations of women living with HIV. Reproductive care and family planning—including access to and information about female condoms, cervical barriers, and microbicides—are essential components of HIV prevention, care, and treatment, and should be part of an expanded strategy. Sites delivering such services should be integrated into the PEPFAR program to enable women and men to access HIV services in those sites as well as those specifically designed for HIV care. To the extent possible, policy guidance should be provided to implementers to encourage and enable those serving in reproductive health service environments to provide HIV-related services.

Ensure accountability and transparency measures are adequately applied to PEPFAR.

Organizations working in the field of global health, such as the Commission on Smart Global Health Policy at the Center for Strategic and International Studies, have called for increased accountability and transparency and a focus on results within the PEPFAR program. The commission has called for publicly stated outcome targets; sound measurement frameworks in PEPFAR's Partnership Frameworks; comprehensive agreements with host governments that clearly define measures of success; and partner commitments to sustainability and accountability. This approach would provide increased accountability and transparency, which would ultimately lead to a more effective and efficient program that saves more lives and spends public dollars more wisely.

Measurement frameworks and increased transparency can be important tools in ensuring that radical antigay and inappropriate religious-based prevention "campaigns" are not funded through PEPFAR's prime and subpartner methodology. The Office of the Global AIDS Coordinator should therefore publish more information on prime and subpartner organizations and activities in which those organizations are engaged.

It is very difficult to track the flow of funds from U.S. government agencies through the various layers of funded organizations, although the government collects extensive data on disbursements. Even individuals working for O/GAC in Washington and PEPFAR focus countries have trouble accessing information on distribution of funds. O/GAC and relevant government agencies should openly and voluntarily disclose information on amounts of grants, background of recipients, and program specific information. This information is vital to justifying the continuation of programs that are working and the elimination of those that are underperforming. Enhanced transparency can only improve outcomes, and if necessary, O/GAC and relevant agencies should be encouraged to provide robust data on prevention programs to the public and their own staffs through requests from members of Congress.

Eliminate the antiprostitution loyalty oath.

The antiprostitution loyalty oath has done nothing to reduce the numbers of women and men who, for economic or other reasons, engage in commercial sex work. It has, however, impeded access to vital HIV prevention services among commercial sex workers and has had a chilling effect on organizations that work with them. In fact, some organizations have foregone PEPFAR grant monies rather than sign the oath.

Sexual activities remain the main route of HIV transmission, and commercial sex workers and their clients continue to be at increased risk for contracting HIV. Requiring those

engaged in outreach to these risk groups to adhere to the loyalty oath does nothing to stem the spread of HIV and it does not, as has been written, slow the growth of the business of prostitution. As long as the oath is in place, the Office of the U.S. Global AIDS Coordinator should issue policy guidance to make clear to countries receiving PEPFAR funds that those who do sign the oath, while being forced to denounce prostitution, are not prohibited from conducting campaigns of prevention, care, and treatment to commercial sex workers. Congress should consider introducing an amendment during the next PEPFAR appropriations process to eliminate the anti-prostitution loyalty oath entirely.

Fund syringe exchange programs.

Injecting drug users are at high risk for HIV because of the use of shared needles. Injection drug use is particularly high in Eastern Europe and Southeast Asia, two regions in which PEPFAR is increasingly active. Yet access to HIV prevention services is extremely limited for injecting drug users, leaving them at a higher risk of infection and impeding worldwide efforts to slow the spread of HIV. There is no evidence that syringe exchange programs increase the use of illicit drugs, but there is evidence that such programs reduce the transmission of HIV.

Congress overturned the 20-year ban on using federal funds to support domestic needle exchange programs in December 2009. This ban provided an excuse for PEPFAR's lack of funding to such initiatives. Now that Congress has removed this obstacle, the United States should fund these programs wherever possible. This will allow for a more effective and humane response that will both save lives and help prevent the spread of HIV. And President Obama should make it clear to the State Department that PEPFAR funds can and should be used to fund syringe exchange programs in those countries that need such programs now that he has signed this important legislation.

Support community-based sustainable development models.

PEPFAR's first iteration failed to invest in strengthening civil society organizations' long-term response to HIV/AIDS, in large part because the program was designed to respond to immediate health care needs. Now that the program is more established, and community-based health sector organizations are typically much better prepared to respond to epidemics within marginalized populations such as MSM, PEPFAR should focus on investing in such institutions, as well as in educational and legal groups that are equally critical to assuring long-term success.

The Centers for Disease Control and USAID should, in coordination with the State Department, place more emphasis in future funding cycles on awarding grants to organizations operating in PEPFAR-funded countries, since these groups have specific experience

working with marginalized populations in those countries. These agencies should also allocate PEPFAR funds as necessary to building capacity among these organizations to ensure sustainability. These groups are needed as long-term partners in the fight against HIV/AIDS, and the United States and other funding partners need to build their capacity for this ongoing work.

Conclusion

The Obama administration has an opportunity to resolve the more controversial aspects of PEPFAR, mainly those relating to prevention, human rights, equitable access, and a fair distribution of resources. President Obama's election pledge of "best practices, not ideology," and his decision to overturn the global gag rule to restore funding for some of the world's best family planning organizations, have encouraged hopes for positive changes to PEPFAR, as well.

Yet some advocates were stunned when the White House recently announced plans to reduce the number of people who receive antiretroviral treatment. The HIV/AIDS community was quick to respond, denouncing Obama's newly revealed plans and actually lamenting for the "good old days" of the Bush administration.¹¹⁸ Public health researchers and advocates will clearly need to strategically educate and engage the Obama administration on the best ways to improve PEPFAR. The recommendations in this report can help structure this process.

Despite its flaws, PEPFAR under the Bush administration was a bold and promising move. As the United States now enters a new era of global leadership, the State Department's ongoing foreign assistance review presents a well-timed opportunity to consider ways in which PEPFAR can be taken to a new level of responsiveness regarding the needs and priorities of recipients and transparency to taxpayers. PEPFAR will be most effective if it is addressed in the context of a range of interconnected global challenges—including poverty, hunger, and efforts to help create economic opportunity in the developing world—and based on smart, evidence-based policies that protect the health and rights of people worldwide.

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About the author

Scott Evertz served in two positions in President George W. Bush's administration. He was the first openly gay appointee in a Republican administration and served first as the director of the White House Office of National AIDS Policy and then as special assistant to the secretary of health and human services for global AIDS initiatives. In these roles he was keenly involved with the launching of two signature HIV/AIDS initiatives: The Global Fund to Fight AIDS, Tuberculosis, and Malaria and the President's Emergency Plan for AIDS Relief. He served while in the administration on the U.S. delegation to the Global Fund Board and on two of the board's standing committees. He also led the U.S. delegation to the Preparatory Conference of the first U.N. General Assembly Special Session on HIV/AIDS, meetings of the U.N. AIDS Programme Coordinating Board and the first Replenishment Conference for the Global Fund. Since leaving the government, he went on to serve on the private sector delegation of the Global Fund Board and has established his own consulting practice in the area of international affairs and government relations in Washington, D.C.

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