U.S. FOREIGN AID AND THE AFRICAN AIDS EPIDEMIC

By Nicoli Nattrass

Abstract — U.S. foreign aid has been crucial to the international AIDS response, especially to the rollout of antiretrovirals (ARVs) in Africa. The unprecedented scale of funding that has been raised to combat this disease evolved out of fears that AIDS was a both a humanitarian disaster and a threat to international security and economic development. U.S. commitment to fighting AIDS in Africa has traditionally been, and still is, buoyed by bi-partisan support. This support has remained strong post-2007. Even so, the view is widespread that African country governments ought to take greater ownership of combating the problem and reducing aid dependency in managing it. One of the most effective interventions the United States could make to this end would be to ensure that trade negotiations facilitate, rather than impede, the supply of affordable ARVs for developing countries. Boosting U.S. development assistance to the international target of 0.7% of national income would also help.

Introduction

The United States is not a particularly generous donor when it comes to foreign aid. Whereas other states in the Organization for Economic Co-operation and Development (OECD) allocate about half a percent of their Gross National Income to foreign aid, the United States allocates a mere one-fifth of a percent.1 It is also not a particularly generous donor in sub-Saharan Africa—accounting for little over a quarter of OECD aid in 2010 to that region. But when it comes to fighting the global AIDS epidemic, U.S. support has been crucial.

The United Kingdom, Ireland, Denmark, and Sweden allocate a greater share of their national income than the United States to fighting AIDS,2 but in absolute terms, the

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United States forms the backbone of the international response. According to the latest available data, the United States constitutes 59% of total donor funding for AIDS to low- and middle-income countries. Additionally, in total spending to combat sexually transmitted diseases (including AIDS) in Africa, the United States contributes one and a half times as much as the rest of the OECD put together (Figures 1 and 2).

**Figure 1.** International aid for AIDS from donor governments to low- and middle-income countries (U.S.$7.6 billion in 2011)

![Figure 1](http://www.kff.org/hivaid/upload/7347-08.pdf)

**Figure 2.** Aid from the OECD Countries (2010)

![Figure 2](http://www.oecd.org/)
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The American contribution to fighting AIDS in Africa is channeled primarily through the President’s Emergency Fund for AIDS Relief (PEPFAR) – an initiative launched by President George W. Bush in 2003 and continued under President Barack Obama. Since its inception, PEPFAR has benefited from strong bipartisan support ranging from the religious right (which saw HIV prevention as an opportunity to export conservative sexual morality and to expand the church in Africa) to leftist and gay activists with a strong human rights agenda centered on pressuring drug companies to lower ARV prices.³

PEPFAR has been criticized for being overly influenced by conservative values: its initial ban on funding allocated to interventions for sex workers is a testament to this criticism, as is the initial insistence that significant HIV prevention resources be channeled to abstinence-only programs. Over time, however, PEPFAR’s policies have become more evidence-based, context-specific, and aimed at treating all at-risk populations. Other important changes to PEPFAR include its shift in supplying cheaper generic medications in place of branded drugs, involvement of nurses in managing ARV delivery (task shifting), and greater support for the strengthening of health systems.⁴

PEPFAR was transformative. In its first five years, the program allocated $15 billion to the fight against AIDS – ten times more than had been spent on combatting AIDS by the United States over the previous one and a half decades.¹⁵ And as can be seen in Figure 3, this commitment grew throughout the 2000s, even after the 2007–08 financial crisis when international public health funding from other OECD countries slackened. In 2004, PEPFAR initiated 66,700 Africans on ARVs. By 2011, this number had risen to 3.9 million and by mid-2012, 4.5 million.⁶

Figure 3. Health AID to Sub-Saharan Africa: U.S. and the Rest of the OECD

![Graph showing health aid to Sub-Saharan Africa](http://www.oecd.org/statistics/)
AIDS as a Global Health, Development and Security Issue

U.S. prioritization of HIV/AIDS as a tool of foreign policy was rooted in fears that the epidemic could undermine both international security and economic development. Such concerns helped mobilize an international response to a disease that was unique in pace and scale. From less than $1 billion allocated for AIDS programs in 1999, total international funding for AIDS rose to over US$16 billion by a decade later (of which US$7.6 billion was from donors).

‘AIDS exceptionalism’ was initially framed by U.S. gay-activists who pointed out the problem of stigmatization in dealing with AIDS and demanded a rights-based approach, which prioritized patient confidentiality and voluntary counseling (as opposed to more conventional public health approaches such as routine testing and automatic partner notification).

By the mid-1990s, ARV treatment had transformed AIDS from a death sentence into a chronic disease. Due to this shift, many U.S.-based activists in turn, redirected their attention to the developing world, arguing for universal access to ARVs.

These efforts were further supported by development and health economists who presented AIDS as a threat to economic development, especially in Africa. In 1999, the World Bank warned that what distinguished AIDS from other illnesses is its “unprecedented impact on regional development. Because it kills so many adults in
the prime of their working and parenting lives, it decimates the workforce, fractures and impoverishes families, orphans millions, and shredς the fabric of communities.”

That same year, the U.S. Central Intelligence Agency highlighted AIDS’ negative impact on productivity and growth, as well as its negative impact on security. This security risk was most notably seen in the ‘lost generation’ of orphans: “these countries will be at risk of further economic decay, increased crime and political instability as young people become radicalized and exploited by various political groups for their own ends, the pervasive child soldier phenomenon may be one example.” By 2001, the U.S. Agency for International Development (USAID) was echoing similar concerns about development impact and security with Secretary of State Colin Powell describing AIDS as a “national security problem.”

Such policy discourse culminated in June 2001 at the UN General Assembly Special Session on HIV/AIDS in New York. There, it was recognized that HIV was a threat to human development and security and much of the debate focused on managing ARV treatment and HIV prevention services in Africa. That year, the World Health Organization’s (WHO) Commission on Macroeconomics and Health reported that expanding the coverage of crucial health services—including the provision of antiretroviral therapy (ART)—to the world’s poor could “save millions of lives each year, reduce poverty, spur economic development and promote global security.” The 9/11 terrorist attacks on the United States strengthened its commitment to combatting AIDS as part of a broader human security agenda.

The U.S. response to AIDS was also framed as an emergency response. In 2003, a briefing to Congress warned that AIDS was probably contributing to famine in Africa, and the UN Food and Agricultural Organization highlighted the threat posed by the AIDS epidemic on food security and rural livelihoods. Thus, by the time that Congress first authorized PEPFAR spending in 2003 (the five-year spending program was reauthorized in 2008), AIDS had been framed as a humanitarian emergency, a threat to national security, and a disaster for economic development. Later that year, Lee Jong-wook, Director General of the WHO joined Peter Piot, the Executive Director of UNAIDS, and Richard Feachem, Executive Director of the Global Fund to Fight AIDS, Tuberculosis and Malaria, to declare the lack of access to ARVs in developing countries a ‘global health emergency,’ thereby launching the WHO’s ‘Treat 3 million by 2005’ campaign.

International aid to combat the HIV/AIDS epidemic grew sharply in the 2000s, as shown in Figure 2. This was facilitated by the ‘Make Poverty History’ movement and the G8’s pledge at Gleneagles (2005) to double aid to Africa and to provide universal access to ARVs in Africa by 2010. By this time, the world economy had enjoyed sustained growth for over half a decade and pledges to end global poverty and provide treatment for all resonated as utopian, but achievable, given global solidarity. Unfortunately, the 2007–08 global financial crisis inaugurated a tougher funding environment. In 2011, the UN produced a further declaration on AIDS, committing member states to scale up efforts for a comprehensive HIV prevention plan and treatment program.

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56  Yale Journal of International Affairs
too, described AIDS as a global emergency, a human catastrophe, and a development disaster requiring an exceptional response. It called on donor countries to allocate at least 0.7% of their national income to aid, and African countries to meet the Abuja target (set by the Organization for African Unity in 2001 at a conference in Abuja, Nigeria) of allocating 15% of their national budgets to health.\textsuperscript{18} While these objectives are economically achievable, the political climate for expanding resources for AIDS is challenging and there are worrisome signs of donor fatigue.

\textbf{Current political and economic challenges}

UNAIDS and other advocacy organizations face the argument that, looking back, the earlier rapid mobilization of donor funding for AIDS came at the cost of other development objectives. The discourse of AIDS exceptionalism is now decried as exaggerated. For example, Altman and Buse argue that:

“The political reality is that AIDS cried wolf too often, and the more dire warnings have failed to materialize. In most parts of the world AIDS is not a security or development crisis, and the perception that the response has received too much attention and funding is growing.”\textsuperscript{19}

The notion that the strong early response to AIDS came at the expense of other health initiatives has hardened into a stylized fact in the minds of many development bureaucrats and donors. This is unfair. While AIDS funding certainly grew at unprecedented rates, it is worth noting that from the mid-2000s, other health-related funding also rose in absolute terms (Figure 2). And, as the international AIDS response matured beyond its initial emergency phase, it sought greater synergy within the public health sector (such as stream-lining HIV and TB treatment services). While officially classified as AIDS-related funding, the formidable resources from early-on indeed served to improve maternal and child support services as well as strengthen domestic health systems in general.\textsuperscript{20}

Another argument in the backlash against AIDS funding is that in the rush to provide ARV and HIV prevention services, ‘vertical’ or ‘parallel’ health-care delivery systems were created, potentially undermining public health systems (for example, by poaching skilled staff). A collaborative effort of health care professionals, activists, and academics examined the available evidence on this, concluding that most disease-specific funding strengthened health systems but greater synergies were possible.\textsuperscript{21} UNAIDS and the Global Fund subsequently placed even greater emphasis on building partnerships with national governments and ensuring that significant AIDS resources (about a third in the

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case of the Global Fund) were channeled to strengthening health systems. Even so, the perception that AIDS has received too many resources persists in development circles.

At this time, in the stressed economic context of many nations, continued U.S.-support for AIDS programming has been crucial. On World AIDS Day, (1 December) 2011, President Obama announced a fifty percent increase in PEPFAR's treatment goal, augmenting treatment objectives to six million people. In 2012, Secretary of State Hillary Clinton injected new energy into the fight against mother to child transmission (calling for an ‘AIDS-free generation’22) and was quick to emphasize that ARV treatment is a form of prevention, and further, that the societal and economic benefits of treatment outweigh the costs.23 However, even the United States emphasizes, along with the rest of the OECD and UNAIDS, that recipient (primarily African) countries have to take greater country ownership of the response to AIDS.

That said, it should be pointed out that taking greater ownership is a challenge for many African states. As seen in Figure 3, ARV coverage across African states still measures less than 50% (which means that more than half of those in need of ARVs are failing to access them). Countries with high ARV coverage (e.g., Rwanda, Botswana, Zambia) account for a relatively small share of AIDS patients. Further, the bulk of African countries most severely afflicted by AIDS are tested by additional challenges of fighting AIDS stigma, and designing and implementing appropriate HIV prevention and treatment programs. Arguing that African governments need to ‘take greater ownership of the AIDS response’ and ‘reduce aid dependency’ without considering the great development leaps this would require, and the country-specific political and economic obstacles in the way, is not particularly helpful. Neither is the appeal that African countries should develop greater capacity for the domestic production of ARVs. While for some states, economic policy strategy may align with goals of domestic ARV production as part of support for a domestic pharmaceutical industry, it is likely that in many cases, the wiser choice is to import generics from countries with established mass production capacity (like India and Brazil) and to concentrate domestic resources to industries where domestic comparative advantage exists.

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According to a recent UNAIDS estimate, if African countries comply with the Abuja target (to allocate 15% of national budgets to health), then the overall aim to reduce disease burden and expand public health expenditure, in line with economic growth, would meet HIV prevention targets and ensure that universal access to ART remains achievable.24 But just because it is possible does not mean that such a scenario is likely. In reality, very few African countries have even gotten close to achieving the Abuja target.
Building partnerships with national governments to strengthen the AIDS response is obviously a good idea—but only if the national governments are committed to doing so. This point is often lost in the current development discourse of greater country ownership. For example, in South Africa during the Mbeki Presidency (1998–2008), the Health Ministry was reluctant to facilitate—indeed actively undermined—25 the public provision of ARVs. Instead, ARV rollout was forged by non-governmental organizations (NGOs), often in partnership with local and regional governments, and by PEPFAR-funded programs to help local physicians provide ARVs free of charge to poor patients. Global Fund financing, which by rule must be funneled through government-dominated “Country Co-ordinating Mechanisms” were also significant, but suffered from roadblocks often set by national governments. The lesson here is that insisting on country ownership is not necessarily the most progressive option—it may, depending on the case, be better to support civil society directly (through NGOs), and to help people hold their governments accountable to citizens through strong AIDS advocacy groups.

Fortunately, South African AIDS policy has improved dramatically, and the country pays for most of what is now the largest ARV program on Earth. Still, the recent UN-AIDS approach argues that middle-income countries like South Africa can and should contribute even more.26 PEPFAR appears to be shifting in a similar direction in that country-specific support is increasingly targeted at resource-constrained regions.

This may well be a signal of a U.S. funding withdrawal for combatting AIDS in Africa. Despite strong continued bi-partisan support for PEPFAR, the current U.S. economic environment is not conducive to expanding foreign aid. According to the most recent national survey by the Kaiser Family Foundation,27 there is strong popular support for overseas development aid in the arena of international public health, but that when forced to choose between two options, two thirds of respondents said that the U.S. government should fix problems at home rather than allocate more money to the international AIDS response. Given the difficult economic circumstances facing the second-term Obama administration—notably the budget deficit and the need to spur domestic job growth—the national ownership agenda is likely to resonate in Washington.

Meeting the challenge today

So far, the United States has maintained strong support for HIV prevention and treatment programs despite the fact that it has scaled back support in better-off countries of southern Africa. While countries like South Africa can gradually afford to allocate more domestic resources to AIDS programs, the cost of ARVs will pose limits to access. It is in this respect that U.S. trade policy is particularly worrying.

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U.S. trade negotiators are known for their robust promotion of intellectual property rights in international trade agreements—including the supply of pharmaceuticals. The Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement of the World Trade Organization allows countries to offer compulsory licenses to produce or import generic copies of patented drugs if necessary for public health. However, in bilateral negotiations, and the current negotiations over the Trans-Pacific Partnership Agreement, U.S. representatives push for so-called “TRIPS-plus” provisions, which rule out the kinds of flexibilities provided by the TRIPS agreement for essential medicines. Health professionals and AIDS activists now worry that the sharp decline in “first-line” ARV therapy (from over $10,000 per patient per year in 2000 to about $150 today) will never be possible for newer drugs (whose prices are significantly higher) if these more stringent provisions spread28 — thereby again limiting the extent and quality of the ARV rollout in Africa over the longer term.29

In this context, a repositioning of U.S. trade agenda could have a major impact. U.S. pharmaceutical companies, of course, stand to lose from a trading environment that is more conducive to the production and importation of cheap generic formulations. But even in a more competitive environment, branded drug companies could still make money. The Clinton Foundation, which has brought drug companies and governments together to improve access to ARVs in developing countries, has demonstrated that profitable deals can be struck where lower prices are accompanied by new drug formulations and high volumes. These sorts of innovative bargains should be encouraged and expanded.

The 2011 UN political declaration on AIDS stressed that protection and enforcement measures for intellectual property rights should be compliant with TRIPS and “should be interpreted and implemented in a manner supportive of the right of Member States to protect public health and, in particular, to promote access to medicines for all.”30 It also called on developed countries to reach the 2015 target of allocating 0.7% of gross national income to official development assistance (par 14). If the United States complied with both calls, the international response to AIDS in Africa would be greatly invigorated. Y

– Catherine Nelson served as Lead Editor for this article.

NOTES

The Next America Meets the Next China

By Stephen S. Roach

Abstract—The world’s two largest economies both face major rebalancing challenges. The United States needs to wean itself from excess consumption and subpar saving, while China needs to do the opposite — greater emphasis on private consumption and the absorption of surplus saving. These transformations are daunting but provide major opportunities for both nations. They also and entail risks — especially those of an “asymmetrical rebalancing” whereby China would move more quickly than the United States. By drawing down its surplus saving to promote internal private consumption, China would reduce its current account surplus and its related demand for dollar-denominated assets. Who would then fund the external deficits of America’s saving-short economy? And on what terms?

It is extremely rare for the world’s two most powerful nations to face tightly aligned leadership and political cycles. Yet that was precisely the case for both the United States and China in November 2012. U.S. President Barack Obama experienced a tough re-election battle at the same time that China was coming to grips with its Fifth Generation leadership transition.

Political cycles don’t always bring out the best in nations — especially when it comes to their relationships with others. In the run-up to the transitions of 2012–13, the bilateral relationship between China and the United States was subjected to major stresses and strains. China bashing became a central element of the campaign rhetoric of both Obama and his challenger, former Governor Mitt Romney. China upped the ante on the international security front, sparking tensions in both the South and East China Seas that forced an American “pivot” in its long-vital military engagement strategy in Asia.

As the dust now settles on these twin transitions, it is critical to look beyond the political posturing that has framed the U.S.-China debate in recent years. Rhetoric aside,