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Mercy and Drugs in Africa

Inside the Bush Administration's New AIDS Policy

The Bush Administration has launched a $15 billion initiative to fight AIDS in Africa. The initiative, called the President's Emergency Plan for AIDS Relief (PEPAR), will give billions of dollars in assistance to fourteen of the most afflicted countries—a dozen in Africa and two in the Caribbean. The plan has won the president praise from people unaccustomed to speaking well of him, including Nelson Mandela, Live Aid Founder Bob Geldof, and Richard Gere. But there are still unanswered questions as to how the initiative will work, and there are skeptics both in the U.S. and in Africa.

The Administration has set lofty goals for PEPAR. In his State of the Union address, President Bush called the AIDS initiative a "work of mercy beyond all current international efforts to help the people of Africa." Within its five year span, the initiative aims to prevent 7 million new infections, distribute drugs to 2 million people, and care for 10 million AIDS victims and orphans. Thus far, the House of Representatives has approved only two-thirds of the $3 billion the White House earmarked for the AIDS initiative this year. In response, the Senate approved a non-binding "sense of Congress" resolution that requests the entire $3 billion for 2004, even if the amount exceeds the ceiling mandated by the annual budget resolution.

Much of President Bush's initiative is modeled after an AIDS program that has been largely successful in Uganda. In little more than a decade, that country has reduced its HIV infection rates from 30 percent of the population to less than five. Like the Ugandan program, PEPAR will follow a "network model" approach by working with national governments, existing hospitals, clinics run by faith-based and non-governmental groups, and local healthcare practitioners. A newly appointed official in the State Department, with the unwieldy title of "Coordinator of U.S. Government Activities to Combat HIV/AIDS Globally," will oversee the program. Randall Tobias, former CEO of pharmaceutical giant Eli Lilly, has been appointed the first such coordinator.

Like the Ugandan program, PEPAR will emphasize marital fidelity, abstinence, and—surprisingly to some—condom use. The Bush plan will also sponsor education programs and an awareness campaign similar to one that's worked in Uganda. The "ABCDs" of HIV, an ad tells Ugandans, are to "abstain," change "behavior," use "condoms," or "die." The Bush version is slightly less ominous; it talks just of the "ABCs": trying "abstinence," "being" faithful, and using "condoms." It isn't clear whether the Bush plan will also replicate the Ugandan ad series testifying to the pleasures of safe sex ("So strong, so smooth," says one ad promoting condom use).

The Bush program will also pay for the purchase of antiretroviral drugs and other AIDS medicines. Though no vaccine or cure for AIDS seems imminent—indeed, this summer twenty-four leading medical researchers called for an "AIDS Manhattan Project" to inject massive resources into the search for new drug treatments—existing drugs can substantially improve the standard of living and increase the lifespan of AIDS patients. In his speech announcing the initiative, President Bush stressed that the distribution of AIDS medicines will be one of the most important pillars of his AIDS initiative. Through fiscal years 2006-2008, 55 percent of the AIDS funding is to be spent on therapeutic treatment of HIV-infected individuals. (Ten percent is allocated for the care of AIDS orphans.)

Some experts, however, have voiced doubts about the effectiveness of drug distribution in controlling the epidemic. Robert Gallo, one of the co-discoverers of the HIV virus, worries that "throwing drugs" at destitute Africans will exacerbate the problem. Gallo warned that without proper education and close monitoring of patients' drug regimens, patients would use the powerful antiretroviral drugs improperly, leading to an increase in drug-resistant viruses. "There'll be great happiness with the drugs being made available for two to five years," he told Reuters, "and then we're going to start seeing problems if it is not done right."

A lack of education and medical resources is only half the problem. Widespread corruption, administrative burdens, and high customs levies have blocked African patients' access to drugs, sometimes even when those drugs were offered at no cost. If the South African government were to make AIDS drugs available right away, then 1.7 million HIV-infected South Africans who would otherwise be dead by 2010 would have a real chance to still be alive, according to a government report leaked to the *Cape Times* in July. The London-based *Financial Times* recently reported that a German pharmaceutical company, Boehringer Ingelheim, has been offering free drugs for pregnant women in African countries since 2000, but only two—Uganda and Botswana—have accepted the medicine. Daniel Berman of Doctors Without Borders argues that complex regulations and a weak healthcare infrastructure have made it so difficult for African countries to accept donations of free drugs that "some African countries prefer to just buy the drugs … My advice would be to sell the drug at a cheap price and then you will see the orders skyrocket." Drugs are also being siphoned off by smugglers, who sell them on the black market in Western countries. Last year, *The Guardian* revealed that $18 million worth of drugs had been shipped back to Europe by profiteers, including a Senegalese official working with the government organization Africa Helps AIDS.

Richard Tren, director of a South African health advocacy group called Africa Fighting Malaria, told a Capitol Hill forum last April that without a change in infrastructure any drug program would fail. "Fifty percent of medical resources are stolen," he said. "Poverty, ignorance, social stigma, the imbalance of doctor-nurse ratios to patient populations, and lack of treatment facilities and proper infrastructure contribute to the high AIDS death rates in most African countries." In fact, said Tren, "Western assistance to Africa often does more harm than good, owing to corrupt and inept governments, which are the recipients of this aid. Perhaps, particularly in the case of AIDS funding, the proposed $15 billion allocated by Bush's initiative would be better administered by international charities, foundations and NGOs actually committed to this cause."

Roger Bate, the U.S. director of Africa Fighting Malaria, suggested that fundamental political reform is necessary to combat AIDS in the region: "[U]ltimately you need to see more African governments becoming more democratic," he said. "Regardless of how much money is spent on AIDS, the long-run solutions for Africa are not going to come from [Western] aid, but from free trade and commerce and the evolution from dictatorship to democracy."

So far, some African leaders have resisted attempts to address Africa's AIDS troubles, partially due to their resentment of Western technological superiority and a deep suspicion of Western motives. South African President Thabo Mbeki has pushed for an "African remedy" to the AIDS epidemic and denigrated Western solutions. He has claimed that AZT is toxic and has questioned the relationship of HIV to AIDS. In 2000, during municipal elections, Mbeki told South Africans that the West was exploiting Africans, using them as "guinea pigs" for their research, and that AIDS medicines constituted "biological warfare of the apartheid era." Just this year, South Africa delayed signing an agreement with the Global Fund worth $41 million in donations because the government claimed it had not been approved first by the South African National AIDS Council. Libyan leader Muammar Khaddafi sounded a similar note at the African Union summit in Mozambique on July 13. He declared that AIDS was a "peaceful virus" and, along with malaria, was one of "God's forces defending Africa" from recolonization: "AIDS, AIDS, AIDS. We hear about nothing else. This is terrorism. This is psychological warfare. AIDS is a peaceful virus. If you stay clean there is no problem," Khaddafi said.

African culture has also contributed to the spread of AIDS. Traditional practices such as widow "cleansing," polygamy, wife sharing, and female circumcision all increase the chances of an individual contracting HIV, as does a male-dominated sexual culture, which subjugates women's health to the sexual enjoyment of men. In some parts of Africa, men view women as chattel and consider promiscuity proof of virility. There is no concept of marital rape in many African cultures, and women find it near impossible to convince their partners to wear condoms. One practice common in much of sub-Saharan Africa, dry sex, encourages women to dry out their vaginas in order to please their partners—thus increasing the chance of vaginal lacerations through which HIV can pass, and suppressing the body's natural STD-fighting mechanisms. Worse still, some African men believe that having intercourse with a virgin will cure AIDS, leading to an

increase in sexual violence—including the horrifying and rampant rape of children and infants in sub-Saharan Africa. Such attitudes on the part of men make women, who are already biologically more likely to contract HIV, all the more vulnerable. Indeed, according to Dr. Patrick Orege, Deputy Director of the National AIDS Control Council in Kenya, up to 80 percent of infections among women occur in "stable relationships" in which the man has contracted HIV from another partner.

More understanding of this issue is needed, most of all among Africa's leaders. Some analysts fear that as drugs become more available and AIDS becomes more manageable, infected individuals will relax their vigilance, leading to an increase in new infections. Worse, drug-resistant strains of the virus may proliferate. Even with the Ugandan government distributing free drugs to its HIV-infected citizens, that country's declining death rates are to some extent due to the fact that so many infected Ugandans have already died. Without some fundamental change in behavior—on the part of ordinary Africans and governmental officials—drug programs are likely to have limited success.