

RECOMMENDATIONS AND BACKGROUND INFORMATION

**FOR HIV RELATED PROGRAMS AND SERVICES
FOR THE**

OBAMA-BIDEN TRANSITION TEAM

November 24, 2008

This paper accompanies a memo submitted by organizations engaged with HIV implementation and/or policy that outlines priority areas for HIV related programs that the Obama-Biden Transition Team should consider.

This paper includes both short and long term recommendations for the new Administration. These recommendations were compiled through a consultative process with a number of organizations who participated in subworking groups of the Global AIDS Roundtable. Not all members of the Global AIDS Roundtable, a coalition of organizations engaged with HIV/AIDS policy and implementation and convened by the Global Health Council, endorses all of the recommendations.

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Strengthening Global HIV/AIDS Prevention Programs

The President's Emergency Plan for AIDS Relief (PEPFAR), P.L. 110-293, is providing unprecedented funding for the expansion of programs addressing HIV and AIDS worldwide, primarily for expanded access to anti-retroviral therapy. In regard to prevention programs, some important gains were realized in the reauthorized legislation, including the setting of targets for expansion of programs to prevent maternal-to-child transmission, new support for programs to prevent transmission among men who have sex with men and the establishment of an Interagency Working Group to promote more effective coordination. Nevertheless, the 2008 PEPFAR reauthorization law contains and perpetuates numerous misguided policy restrictions that undermine critical programs, including those aimed at preventing new infections in the general population and among sex workers. Some of these restrictions have been shown through independent reviews by the Government Accountability Office (GAO) and the Institutes of Medicine (IOM) to be undermining evidence-based prevention strategies and programs in turn dramatically reducing the effectiveness of U.S. funds spent on stopping the spread of HIV.

In an epidemic in which there are five new infections for every two people put on treatment, efforts to prevent HIV - based simultaneously on the best available evidence and on strategies to reduce stigma, discrimination and inequity -- need to be redoubled to slow this pandemic.¹ The following recommendations are aimed at ensuring that U.S. global HIV/AIDS efforts prevent the greatest number of new infections through the wisest use of scarce U.S. taxpayer funds. Until existing problems with the law are remedied through legislation – something the Administration should make a priority and encourage Congress to do – the new Administration can dramatically improve the effectiveness of our strategies by taking the following actions:

Make a Commitment to Prevention and Sustainability Support for HIV/AIDS

The President and members of the new Administration should commit to using all the tools at our disposal to help prevent the further spread of HIV. Human beings are complex, and their own needs and behaviors change over the course of the life-cycle, so ensuring the broadest possible range of information and services to prevent infections is a wise and long-term investment. The new Administration needs to give priority to prevention, and establish an in-depth, coordinated and comprehensive strategy that confronts the real-life needs of individuals and communities and addresses the underlying social and structural causes of vulnerability driving this global epidemic. New country guidance for prevention programs is an urgent priority. Among other things, this new country guidance should be supportive of fully comprehensive approaches to prevention of new infections; ensure that country teams adopt evidence-based strategies and provide the widest possible range of evidence-based programs, services, and information; and require as part of the deliverables against which prevention funding is measured direct engagement with civil society in setting priorities and responding to the specific needs of the communities and vulnerable populations most affected by the epidemic in diverse contexts.

Promote Country-Level Decision-Making for Investment in Prevention

As documented in the published recommendations of the Government Accountability Office², the Institutes of Medicine³, and other experts, countries need greater flexibility in determining how to prevent the greatest possible number of new infections. Current PEPFAR legislation stipulates that in those countries with generalized epidemics, the Global AIDS Coordinator must develop a strategy for prevention of sexual transmission of HIV that ensures that at least half of such funding supports “activities promoting abstinence, delay of sexual debut, monogamy, fidelity

¹ United Nations General Assembly. *Declaration of Commitment on HIV/AIDS and Political Declaration on HIV/AIDS: Midway to the Millennium Development Goals*. New York: United Nations, 2008. http://data.unaids.org/pub/Report/2008/20080429_sg_progress_report_en.pdf.

² Global Health Spending Requirement Presents Challenges for Allocating Prevention Funding under the President's Emergency Plan for AIDS Relief, Government Accountability Office, April 2006 - <http://www.gao.gov/new.items/d06395.pdf> accessed September 12, 2008

³ PEPFAR Implementation: Progress and Promise, Institutes of Medicine, March 30, 1007 - <http://www.iom.edu/CMS/3783/24770/41804.aspx>, p. 113 - <http://books.nap.edu/openbook/0309109825/gifmid/113.gif>, accessed September 12, 2008

and partner reduction.” The Coordinator must report back to Congress on any country plans that do not meet this goal.

To ensure the most effective use of tax-payer dollars and to prevent the greatest number of new infections possible, the success of such strategies should be measured on outcomes achieved or progress made toward ultimate goals rather than on inputs per se. Therefore, when calculating these expenditures, the Administration should “count” toward the 50 percent threshold any program whose services promote outcomes including protected sex, abstinence, delay of sexual debut, monogamy, fidelity and partner reduction, including both stand-alone programs and components of comprehensive programs and interventions that achieve such outcomes.

Mitigate the Harm of the Anti-Prostitution Pledge in PEPFAR

The global AIDS law, as a condition of eligibility for funding, requires recipient organizations to have a policy opposing prostitution. This policy has impeded PEPFAR’s ability to work with some of the organizations most trusted by the women who are among the most vulnerable to HIV, and has discouraged PEPFAR-funded organizations from engaging these vulnerable populations out of concern that engagement may be misinterpreted as support for prostitution. Moreover, in August 2008, a federal court found the requirement unconstitutional as applied to U.S.-based organizations. The U.S. Agency for International Development (USAID) and the Department of Health and Human Services (HHS) should revise their guidelines as applied to domestic and foreign NGOs to comply with the court ruling as well as to allow for the most effective foreign groups to partner with the United States in the fight against HIV/AIDS.

Support Better Integration of HIV and other Reproductive and Sexual Health Services

Actively promote effective integration of essential, life-saving prevention services

A broad consensus exists on the importance of better integration between HIV services and reproductive health services. Global commitments made by the Joint United Nations Programme on HIV/AIDS (UNAIDS), the World Health Organization (WHO), and the United Nations Population Fund (UNFPA) and input from service providers and networks of people living with HIV all have stressed how critical these two program areas are, together, in the fight against HIV/AIDS. Moreover, newly released research shows the clear benefits of linking HIV and reproductive health services. A systematic review conducted by the Institute for Global Health at the University of California, San Francisco found that the majority of HIV-reproductive health programs studied have led to increased condom or contraceptive use, improved quality of services and increased uptake of HIV testing. In addition, some programs showed a decrease in the incidence of HIV and other sexually transmitted infections (STIs).⁴

The primary interventions for HIV prevention—education, information, services and programs that ensure couples and individuals engage only in consensual and safer sex practices—are also effective for reducing other adverse outcomes of unprotected sex, such as acquisition of other sexually transmitted infections, unintended pregnancy, and morbidity and mortality related to complications of pregnancy. In sub-Saharan Africa, for example, 80 percent of new infections are transmitted sexually and women make up more than half of those infected with HIV. Rates of unintended pregnancy in most countries of the region remain quite high among women (irrespective of HIV status), as do rates of maternal mortality and morbidity, and other sexually transmitted infections, underscoring the gross lack of access to effective reproductive and sexual health education, information, and services throughout the region. Therefore, better integration of HIV/AIDS services with broader reproductive and sexual health services helps save the greatest number of lives by linking essential programs and services while using scarce taxpayer funds in the most cost-effective manner possible.

Coordinated and integrated services – across all prevention, treatment, and care programs – are needed to meet the diverse needs of women and men, whether they are HIV-negative or HIV-positive. Providers of HIV prevention and treatment services can play a key role in ensuring that both their HIV-negative and HIV-positive clients have access to a range of sexual and reproductive health services, including voluntary contraceptive services; safe pregnancy and

⁴ Almers L, et al. Linking Sexual and Reproductive Health and HIV: Evidence Review and Recommendations, presentation at the *XVII International AIDS Conference*, Mexico City, August 5, 2008.

delivery services; prevention, diagnosis and treatment of STIs other than HIV; and referral for safe, legal abortion services. At the same time, reproductive health providers could make a significant contribution in closing the gap in HIV prevention, with HIV testing, prevention counseling (including information on the importance of male and female condoms) and referral for prevention of mother-to-child transmission (PMTCT) services. All such services should be provided by health care workers trained to provide integrated services and referrals with compassion and respect, and to understand and respect the sexual and reproductive health needs and rights of all individuals.

According to a 2008 report by UNAIDS, WHO and UNFPA, the potential benefits of linking sexual and reproductive health and HIV/AIDS programs include:⁵

- improved access to sexual and reproductive health and HIV services
- increased uptake of services
- better sexual and reproductive health services, tailored to meet the needs of women and men living with HIV
- reduced HIV/AIDS-related stigma and discrimination
- improved coverage of under-served and marginalized populations, including sex workers, injecting drug users and men who have sex with men
- greater support for dual protection against unintended pregnancies and sexually transmitted infections, including HIV
- improved quality of care
- enhanced program effectiveness and efficiency

The next President must ensure that sexual and reproductive health services and counseling (including family planning and maternal health) are strong components of, or well-linked to, any U.S. funded HIV prevention or PMTCT program, by issuing new guidance to the field. Additionally, authority should be given that enables PEPFAR programs funds to be used to purchase contraceptives. Taking these steps will help save the greatest number of lives possible while using scarce taxpayer funds in the most cost-effective manner possible.

Place male circumcision in the context of comprehensive prevention strategies

Male circumcision has been shown to greatly reduce – but not eliminate – the risk of new infection among HIV-negative men during vaginal intercourse. Research published in 2007 in *BMC Infectious Diseases* suggests that a significant increase in the prevalence of men circumcised will result in a noticeable reduction in HIV prevalence at the population level over time. However, at the individual level even circumcised men must continue to practice safer sex. PEPFAR should strive to ensure that all men who desire to be circumcised will ultimately have access to the procedure, performed in a healthcare setting by a trained professional, and accompanied by education for both men and women about the benefits and risks, to reduce their risk of HIV infection.

It must be noted that there is no conclusive evidence that male circumcision provides a protective effect to either female or male partners of circumcised men, nor is there evidence that circumcision reduces transmission among HIV positive men per se. Additionally, the procedure may not be suitable for all males and does not address non-sexual transmission of HIV. Furthermore, given the incomplete protection the procedure provides, even circumcised men must be counseled to take additional steps to reduce their risk of HIV infection, such as reducing their number of partners and correct and consistent use of either male or female condoms negotiated consensually with a partner.

Male circumcision should therefore be provided as one component of fully comprehensive prevention strategies (national level) and programs (client level), and should be accompanied in all cases by counseling about the benefits, risks and responsibilities of the procedure and of practicing safer sex. Such services also should be linked directly to programs aimed at challenging social norms and changing individual behaviors with the goal of reducing unsafe sexual practices, gender-based violence, and reduction of rape and sexual assault.

PEPFAR must continue to ensure that all USG-funded medical male circumcision services include effective training, backed up by monitoring and evaluation, and access to quality supplies and equipment .PEPFAR should

⁵ *Linking Sexual and Reproductive Health and HIV/AIDS: Gateways to Integration: A case study from Kenya*, WHO, UNFPA, UNAIDS, IPPF, 2008.

adhere to forthcoming WHO/UNAIDS guidance and tools to implement a quality assurance program. When provided by a trained health provider, male circumcision is a very safe procedure, and complications are rare.

Implement 80 Percent PMTCT Coverage Target and Immediately Convene Expert Panel

Globally, prevention of mother to child transmission (PMTCT) coverage rates continue to be low, particularly in resource-poor settings, in spite of the fact that mother-to-child transmitted infections are almost entirely preventable. In fact, by the end of 2007, only 34 percent of HIV-infected pregnant women around the world received the medicines they need to prevent transmission of HIV to their babies.⁶ Today there are 2.5 million children living with HIV or AIDS worldwide.⁷ The majorities of these infections occurs in sub-Saharan Africa and are transmitted from mother to child during pregnancy, labor, delivery or breastfeeding. Preventing HIV infection among women of childbearing age and helping HIV-positive mothers avoid unintended pregnancies are critical components of reducing mother-to-child transmission.

With the goal of dramatically scaling up PMTCT services around the world and preventing thousands of new pediatric HIV infections, the PEPFAR reauthorization established a target for the prevention of mother-to-child transmission of HIV that, by 2013, PEPFAR supported programs will reach at least 80 percent of pregnant women in those countries most affected by HIV/AIDS in which the U.S. has HIV/AIDS programs. The new law also established an expert panel, bringing together the foremost experts on PMTCT, to provide an objective review of services on the ground and to make recommendations to the Administration and to Congress on what specific actions can and should be taken to achieve the statutory target. The Administration should convene the expert panel as quickly as possible and develop a specific, focused and coordinated strategy on PMTCT, outlining the new and different steps they will take in order to dramatically scale up PMTCT access and achieve the 80% target.

Minimize the Harm of the Refusal Clause

Under the reauthorized PEPFAR legislation, organizations receiving U.S. global AIDS funds may refuse to participate in, make a referral to, or provide services related to any HIV prevention, treatment or care service, activity or program to which the organization claims a religious or moral objection, irrespective of the evidence base on which such programs/services/interventions may be supported. Language in the 2008 reauthorization expands the refusal clause to include care, where previously it only pertained to prevention and treatment. For example, under the current law, care may be denied to those whose identity or life circumstances are considered to be objectionable and referrals for family planning and related services refused. Refusal clauses deny individuals access to critical information and services, and grossly undermine U.S. investments in fighting the HIV/AIDS epidemic. The allocation of U.S. global AIDS funding should be determined on the basis of the most effective, evidence-based public health strategies. While diverse religious views should be accommodated to the extent possible in the provision of global AIDS funding, real questions arise when funding recipients can not provide programs or services based on objective evidence of what works. Safeguards must be put in place in allocating funding for prevention, treatment and care such that no one religious belief compromises the health and well-being of individuals or communities infected with or affected by HIV and AIDS. Unfortunately, the law is silent on these issues as well as on the importance of ensuring the rights and needs of patients are met first and foremost. The President should take regulatory action to clarify the refusal clause to ensure there is no delay, disruption, or diminished quality of care in the provision of services for HIV/AIDS prevention, treatment, or care.

Strengthen Prevention Efforts for Young People

Young people under the age of 25 continue to comprise half of all new HIV infections annually according to UNAIDS estimates.⁸ Stemming the tide of the global epidemic during the next five years of PEPFAR implementation will require an emphasis on evidence-based prevention interventions for young people that have proven efficacy in lowering rates of transmission.

⁶ UNAIDS, July 2008 Report on the global AIDS epidemic.

⁷ UNAIDS, July 2008 Report on the global AIDS epidemic

⁸ UNAIDS Report on the Global Epidemic, 2008

PEPFAR reauthorizing legislation requires the U.S. Global AIDS Coordinator to include in the PEPFAR annual report “a description of the strategies, goals, programs, and interventions to address the needs and vulnerabilities of youth populations; expand access among young men and women to evidence-based HIV/AIDS health care services and HIV prevention programs, including abstinence education programs . . .”⁹ While abstinence is the only 100 percent effective way to prevent transmission of HIV, abstinence education alone, or solely in conjunction with education on monogamy (“being faithful”) has *not* been shown to be as effective as comprehensive prevention interventions.^{10,11} Comparatively, comprehensive prevention programs, which emphasize a multitude of behavioral tools (abstinence, monogamy, negotiating skills, correct and consistent condom use) as part of a young person’s set of options to reduce the chance of transmission, have been proven to be more successful than the segmented versions of the ABC model originally implemented for youth during the first five years of PEPFAR.¹²

New guidance on prevention policy should be drafted promptly so it applies to the next fiscal year’s Country Operational Plans and it should:

- be based on local determinations of epidemiology and note places in which youth are at high risk of transmission because of general socio-cultural and/or socio-political norms which may disempower young people due to a lack of access to:
 - comprehensive, medically accurate transmission prevention information
 - youth friendly healthcare services, including youth-friendly family planning and HIV counseling and testing
 - contraceptive commodities that can be used to help prevent sexual transmission of HIV.
- not allow segmentation by population of the ABC (Abstinence, Be Faithful, use Condoms) Model of prevention education as studies have shown that ABC is always more effective when taught in combination than when separated into its component parts.
- not assume seronegativity among young people as many young people, infected perinatally or during adolescence have the right to unique psychosocial support and prevention services that recognize their sexual and reproductive health needs.
- adjust *Orphans and Vulnerable Children (OVC) Guidance* to recognize that many OVC are not young children; in fact, almost half of all orphans who have lost one parent and two-thirds of those who have lost both parents are aged 12 through 17.¹³ These vulnerable adolescents may be living on the street, supporting siblings, and/or forced into survival sex. They are at high risk for HIV infection and, therefore, programming must respond to the unique needs of these OVC.

Furthermore, the Administration should encourage countries to collect age-disaggregated data, based on the following age ranges: 0-9, 10-14, 15-19, and 20-24. A lack of consistency in ages in data collection hampers efforts to effectively gather information on the needs of young people, even though they constitute half of all new infections globally each year.

⁹ House Resolution 5501, The Tom Lantos and Henry Hyde U.S. Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008, p. 38.

¹⁰ UNAIDS. *Impact of HIV and Sexual Health Education on the Sexual Behavior of Young People: A Review Update*. [UNAIDS Best Practices Collection, Key Material] Geneva, Switzerland: UNAIDS 1997.

¹¹ Institute of Medicine, Committee on HIV Prevention Strategies in the United States. *No Time to Lose: Getting More from HIV Prevention*. Washington, D.C.: National Academy Press, 2001.

¹² Ibid.

¹³ UNICEF (2006b). *Africa’s Orphaned and Vulnerable Generations: Children Affected by AIDS*. New York: 2006; p. 6.

Strengthen Prevention and Support for Young People Living With HIV and AIDS

Young people living with HIV and AIDS (YPLWHA) are completely absent from PEPFAR reauthorizing legislation. While the “inclusion of people living with HIV and AIDS” in policy and programmatic designs is mentioned in PEPFAR law, the absence of HIV-positive young people from this group is particularly concerning. As PEPFAR continues to make antiretroviral therapy more widely accessible, a new cohort of young people are coming of sexual and reproductive age having been infected with HIV their entire lives.¹⁴ These young people have the right to accurate information about their sexual and reproductive health so they can make informed and responsible decisions about their sexuality and sexual activity.

Furthermore, even though the U.S. Leadership Act of 2003, the original PEPFAR legislation, recognized HIV-positive status as one of several qualifications that deemed a child “vulnerable,” the current *OVC Guidance* does not acknowledge the increased vulnerability of HIV-positive children and youth (many of whom do not know their status) barring a scant reference to health care for them. Rather, the *OVC Guidance* overwhelmingly assumes that most OVC are HIV-negative. The *OVC Guidance* is extremely short-sighted in not acknowledging this vulnerability. New PEPFAR legislation mandates that the Office of the Global AIDS Coordinator “provide a plan to address the vulnerabilities and needs of orphans and children who are vulnerable to, or affected by, HIV/AIDS.”

- Given this mandate, the *OVC Guidance* should address critical links to voluntary counseling and testing and to sexual and reproductive health services in order to determine youth’s HIV status, link infected youth with ART and other care, and help them prevent unintended pregnancies

Strengthen Prevention Efforts for Men Who Have Sex With Men (MSM)

Men who have sex with men (MSM) are 19 times more likely to be infected with HIV than the general population in low- and middle-income countries¹⁵. Globally, less than one in twenty MSM has access to the prevention, care and treatment services they need.¹⁶ These gaps have serious consequences: several studies from African settings report men believing that unprotected sex between men does not carry any risk for HIV.^{17,18,19} Even where MSM are aware of the risks inherent in their sexual behavior, many are driven underground by stigma, discrimination, homophobia and criminalization of same-sex practices, making it virtually impossible for them to seek out - or for health care workers to reach them with - appropriate health services. Given the high concentration of HIV infections reported among MSM, the fluidity of social and sexual networks and the need to target those most recently infected with information and training on safer sex practices, MSM-specific HIV services must be a high priority in the global response to AIDS.

The PEPFAR reauthorization includes specific provisions to provide “assistance for appropriate HIV/AIDS education programs and training targeted to prevent the transmission of HIV among men who have sex with men”, as well as “establishing appropriate systems to...evaluate the effectiveness of prevention efforts among men who have sex with men, with due consideration for the stigma and risks associated with disclosure.”

¹⁴ Birungi, Harriet, et al. “Sexual and reproductive health needs of adolescents perinatally infected with HIV in Uganda.” FRONTIERS, Population Council, the AIDS Support Organization, Uganda Bixby Fellowship Program 2008.

¹⁵ Baral S, S. F. (2007). Elevated Risk for HIV Infection among Men Who Have Sex with Men in Low- and Middle-Income Countries 2000-2006: A Systematic Review. *Public Library of Science (PLoS) Medicine*, 4(12): e339. doi:10.1371/journal.pmed.0040339.

¹⁶ UNAIDS. 2006. *Policy Brief: HIV and Sex Between Men*. Geneva.

¹⁷ Population Services International. (2006). *Togo (2006): Santé sexuelle des gays et VIH/SIDA au Togo*. (Rapport de Recherche).

¹⁸ Focused discussion groups conducted by the International Gay and Lesbian Human Rights Commission (IGLHRC), Accra, Ghana, September 20, 2006 and Mombasa, Kenya, June 9, 2006; as cited in Johnson, C. A., “Off The Map: How HIV/AIDS Programming is Failing Same-Sex Practicing People in Africa” (IGLHRC, 2007).

¹⁹ International HIV/AIDS Alliance (United Kingdom), “Meeting the Sexual Health Needs of Men Who Have Sex with Men in North Africa and Lebanon (MSM/MALE Project):1; 2006; as cited in *Off The Map* (IGLHRC, 2007).

The implementation of this new policy will require great attention to the sensitivities surrounding same-sex consensual acts in what can be very hostile environments. Ten of the fifteen PEPFAR focus countries criminalize consensual sex between men,²⁰ and anti-gay prejudice is often rampant, even in countries where this behavior is not illegal. In such a context, prevention services for MSM delivered through the typical channels – such as at the primary clinic in the middle of a town or village – are unlikely to reach many men at risk. Local collaboration with groups who understand and have the trust of MSM, and deliberate efforts to reach out to sub-groups—including men who self-identify as gay, men who engage in “situational” male-male sex such as that that occurs in prisons and military, male sex workers, MSM who also engage in injection drug use, and adolescents and young men is vital.^{21,22} The USG should also support efforts to collect data on the extent of HIV infections among MSM in routine demographic surveys and other special studies with attention to the challenges posed by the fact that collecting these data are fraught with challenges such as its potential to ‘out’ men accessing services, leading to their possible persecution. At the same time, these data are critical to be able to understand HIV prevalence among MSM as compared to the general population, and will provide National AIDS Councils the information they need to direct appropriate funding and programming efforts toward the most severely affected groups in their local epidemic.

Specific asks of the new Administration include:

- Establish an MSM coordinator at OGAC to coordinate the implementation of MSM prevention programs and to oversee the evaluation of said programs
- Ensure that the MSM coordinator drafts policy guidance and develops the program strategy for MSM-specific prevention programs in collaboration with key community stakeholders, including regional consultations on pathways to scaling up access for MSM to HIV/AIDS prevention, care, treatment, and support programs. Urgently develop indicators for reporting progress in prevention for MSM
- Utilize proven tools to develop culturally appropriate, evidence-based HIV prevention, treatment, care, and support programs in consultation with affected populations, including:
 - Rapid Assessment and Response Adaptation Guide on HIV and Men Who Have Sex with Men (WHO)
 - Practical Guidelines for Intensifying HIV Prevention (UNAIDS)
 - Framework for Monitoring and Evaluating HIV Prevention Programs with Most at Risk Populations (UNAIDS)
- Provide resources sufficient for scaling up programs with adequate human and financial resources toward achieving universal access to HIV /AIDS programs for MSM
- Establish a budget code to track funding spent
- Require PEPFAR grantees to report on all five of the UNGASS (UN General Assembly Special Session) indicators related to MSM²³
- The U.S. should take a leadership role in the defense of Universal Human Rights as an essential component of the global response to HIV. Highlighting the need for decriminalization of consensual same-sex practice as a pillar of effective HIV prevention for MSM would go a long way in this regard
- The annual U.S. Department of State Human Rights Report currently requires reporting on sexual orientation. Embassies should also be required to report on violence or discrimination based on gender identity, in addition to sexual orientation

²⁰ Ottoson, D. 2007. *State-Sponsored Homophobia: A World Survey of Laws Prohibiting Same Sex Activity Between Consenting Adults*. International Gay and Lesbian Association (ILGA).

²¹ Niang, Cheikh Ibrahima, Et al. “Meeting the Sexual and Reproductive Health Needs of Men Who Have Sex With Men in Senegal.” (USAID, Horizons, Population Council, 2002.)

²² Niang, Cheikh Ibrahima, et al. “Men who have sex with men in Burkina Faso, Senegal, and The Gambia: The multi-country HIV/AIDS program approach.” (Int. Conf. AIDS. 2004 Jul 11-16; 15: abstract no. WePeC6156).

²³ An analysis of 128 UNGASS country reports submitted in 2008 found that almost half failed to report any data whatsoever on HIV/AIDS among MSM, and fewer than one-third reported on more than three of the five UNGASS indicators. Seventy-nine countries (62%) did not report on HIV seroprevalence among MSM. PEPFAR Focus Countries that did not report on MSM in their 2008 UNGASS Country Reports were: Botswana, Ethiopia, Mozambique, Namibia, Rwanda, South Africa, Uganda

Prevent Transmission of HIV Amongst HIV-Positive and HIV-Negative Injecting Drug Users (IDUs)

Remove non-legislative barriers to allowing federal funding for syringe exchange

The next President should direct the Secretaries of Health and Human Services and State to remove all non-legislative barriers to allowing federal funding for syringe exchange. Outside of sub-Saharan Africa, one-third of all new HIV infections are related to drug injection. The effectiveness of syringe exchange in reducing the spread of infectious disease without increasing drug use is well documented.²⁴

Direct OGAC to modify guidance to conform to the Tom Lantos and Henry J. Hyde Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008 (Public Law 110-293)

1. Modify guidance to enable funding of needle and syringe exchange services. Currently, USAID and the State Department voluntarily apply to foreign assistance a domestic ban on federal funding of needle and syringe exchange.²⁵ This greatly limits PEPFAR's ability to prevent HIV infection among IDUs. For example, in Vietnam, a country funded by PEPFAR, the U.N. estimated that there were 260,000 people living with HIV in 2005 with 57% of HIV cases among injecting drug users.²⁶ There is no law that directly requires OGAC to deny funding for syringe exchange. The Secretary of State should rescind guidance denying funds for syringe exchange. This recommendation is also endorsed by domestic HIV/AIDS organizations.

OGAC may choose to first undertake a review through the newly authorized interagency task force tasked to review "policies that may be obstacles to reaching targets." This process may be facilitated by the Secretary of HHS making a re-certification that syringe exchange is effective in reducing the transmission of HIV without increasing drug use. However, such a recertification is not necessary for the State Department to act.²⁷

2. Authorize medication-assisted drug treatment (methadone and buprenorphine) regardless of HIV-status. Current guidance only allows pilot treatment programs for HIV-positive people. The reauthorization clarifies that such treatment is allowed for "individuals with HIV or at risk of HIV."

²⁴ See: Institute of Medicine (2006). *Preventing HIV Infection among Injecting Drug Users in High-Risk Countries; An Assessment of the Evidence*. Washington, D.C.: National Academies Press. See also: Wodak A, Cooney A. Effectiveness of Sterile Needle and Syringe Programmes. *Int J Drug Policy*. 2005; 16S:S31-S44.

²⁵ See: Guidance on the Definition and Use of the Child Survival and Health Programs Fund and the Global HIV/AIDS Initiative Account FY 2004 Update, *United States Agency for International Development* July 22, 2004. See Also: The U.S. President's Emergency Plan for AIDS Relief HIV Prevention among Drug Users Guidance #1: Injection Heroin Use, March 2006, *U.S. State Department* referenced at:

<http://www.state.gov/documents/organization/64140.pdf>. Currently, United States Agency for International Development (USAID) and OGAC provide guidance stating that PEPFAR funding may not be used to support needle or syringe exchange programs. OGAC appears to justify this denial of funding as a voluntary extension of the annual Congressional enactment of a ban on federal funding for needle exchange programs in the Labor, Health and Human Services, Education and Related Agencies appropriations bill.

²⁶ UNAIDS, "At Risk and Neglected: Four Key Populations." *2006 Report on the Global AIDS Epidemic*; 26

²⁷ Note: U.S. Code (42 U.S.C. 300ee-5) under the AIDS Amendments to the Health Omnibus Extension Act of 1988 contains a ban on funding syringe exchange programs that contains an exception allowing funding if the Surgeon General certified that such programs "would be effective in reducing drug abuse and the risk ... [of AIDS]." In 1998 and again in 2000 the Secretary of Health and Human Services and the Surgeon General stated that there was conclusive scientific evidence of both propositions [see: Shalala, D.E., Secretary, Department of Health and Human Services, Press release from Department of Health and Human Services (April 20, 1998) and U.S. Surgeon General Dr. David Satcher, Department of Health and Human Services, [Evidence-Based Findings on the Efficacy of Syringe Exchange Programs](#); An Analysis from the Assistant Secretary for Health and Surgeon General of the Scientific Research Completed Since April 1998 (Washington, DC: Dept. of Health and Human Services, 2000)]. Legal observers and domestic HIV/AIDS organizations believe that these statements meet the conditions of the exception. There remains a more limited ban on the use of Ryan White CARE Act funds to fund syringe exchange. None of these laws require the State Department to deny funding for syringe exchange.

3. Review and modify data collection systems as needed so as to include data on specific HIV prevention strategies for IDUs and the number of IDUs, by country, reached by such strategies.
4. Direct the IOM to include IDUs in the mandated study that evaluates “the impact of prevention programs on HIV incidence in relevant population groups.”
5. Identify countries with rapidly growing IDU-driven epidemics in need of increased aid, as provided for in the reauthorization bill.

Strengthen Prevention Efforts for Men and Women Engaged in Sex Work

Under U.S. policy, organizations successfully using specific prevention strategies aimed at men and women engaged in sex work have found signing the prostitution pledge to be extremely problematic. Their approaches are successful precisely because they are non-judgmental about sex workers and their activities. Signing the pledge not only sabotages the trust that beneficiaries and clients have in service-providers, but it also critically undercuts the success of prevention programs.

Guidance must be issued, to be applied to both foreign and U.S.-based NGOs, that is clear and supportive of public health best practices--such as empowerment programs and drop-in centers—which have been proven to effectively reach men and women engaged in sex work with the services they need the most.

Strengthen Wrap-Around Programs and Align Policies for Effective Programming

Repeal the Global Gag rule

One of the barriers to creating linkages between PEPFAR and other wrap-around programs is that funding streams for each of those programs may come with their own restrictions or requirements – and some of those policies may be in conflict. For example, the Global Gag Rule (GGR) which denies desperately needed U.S. family planning aid to foreign organizations unless they stop using their own funds for legal abortion-related services or to advocate for safe abortion laws and policies, has created confusion for implementing program partners. Projects that provide a range of health services and receive funding from both USAID for family planning services, and PEPFAR for HIV/AIDS services, have been uncertain whether GGR applies to PEPFAR funding (which it does not). Due to fear of being in violation of U.S. policy, and the risk of losing desperately needed U.S. assistance, programs either shy away from greater integration of family planning and HIV prevention services, or staff are required to maintain burdensome financial paperwork to ensure funds are kept separate – a waste of human and financial resources. The new President should immediately repeal the GGR, allowing for greater access to HIV preventative services for women around the world.²⁸

Provide \$1 Billion for International Family Planning Programs

According to *The Power of Partnerships: The U.S. President’s Emergency Plan for AIDS Relief – 2008 Annual Report to Congress*:

“PEPFAR supports linkages between HIV/AIDS and voluntary family planning programs, including those supported through USAID’s Office of Population and Reproductive Health (PRH). Along with providing linkages to family planning programs for women in HIV/AIDS treatment and care programs, PEPFAR also works to link family planning clients with HIV prevention, particularly in areas with high HIV prevalence and strong voluntary family planning systems. Voluntary family planning programs provide a key venue in which to reach women who may be at high risk for HIV infection. PEPFAR supports the provision of

confidential HIV counseling and testing within family planning sites, as well as linkages with HIV care and treatment for women who test HIV-positive. Ensuring that family planning clients have an opportunity to learn their HIV status also facilitates early up-take and access to PMTCT services for those women who test HIV-positive. PEPFAR's efforts remain focused on HIV/ AIDS prevention, treatment and care, complementing the efforts of USAID/PRH programs and other partners".²⁹

For these reasons, as well as the other public health benefits supported by these efforts, we strongly urge the President to include \$1 billion for international family planning programs in the first budget request submitted to Congress. **United States funding support for family planning has eroded precipitously even** as our commitment to global HIV/AIDS efforts has risen exponentially in the past five years. Since its apex in 1995, U.S. funding for international family planning programs has declined by almost 40 percent (adjusted for inflation) while the number of people in their reproductive years is growing exponentially. HIV prevention efforts are undermined by the constant erosion of family planning programs. A \$1 billion contribution to international family planning programs would help PEPFAR reach its goal of preventing the most HIV infections possible.³⁰

Restore Funding to the United Nations Population Fund (UNFPA)

The United States has failed to support the critical work that UNFPA does to promote voluntary family planning and HIV prevention in 150 countries, and its role as a cosponsor of UNAIDS. More than 170 countries contributed to UNFPA in 2007, including such nations as Haiti, Afghanistan, and all the countries of sub-Saharan Africa. UNFPA programs provide family planning and contraceptives, pre- and post-natal care, prevention of HIV/AIDS and other sexually transmitted infections, as well as addressing social inequities that stand in the way of good health, among other health services. Over the last seven years, the Bush Administration has distorted the application of the Kemp-Kasten law to justify its political decision to withhold all appropriated U.S. funding for UNFPA. The new President should instruct the State Department to conduct an unbiased review of the law's requirements in relation to UNFPA's work, taking into account the numerous investigations of UNFPA's activities, to make a fair determination about UNFPA's eligibility for a U.S. contribution for FY 2009 and beyond. Based on the evidence, this should allow the United States to rejoin the community of nations in supporting the critical work of this important UN agency.

Interagency Task Force

Convene the Interagency Working Group on HIV/AIDS

The PEPFAR reauthorization law established an Interagency Working Group on HIV/AIDS led by OGAC with members from USAID and HHS. It has a broad mandate with areas relevant to increasing the effectiveness of prevention funds. The Office of the Global AIDS Coordinator should convene the Interagency Working Group on HIV/AIDS and ask it to:

- Examine PEPFAR's success in meeting the targets outlined in the reauthorized law;
- Identify changes in U.S. prevention policy that can help meet global HIV targets under PEPFAR, and
- Identify countries with rapidly growing concentrated epidemics, where targeted prevention efforts are needed and could benefit from PEPFAR support.

The Administration should convene this task force immediately and begin its work to ensure effective implementation within the current confines of the law.

²⁹ <http://www.pepfar.gov/documents/organization/100029.pdf>

³⁰ Singh, S., Darroch, J., Vlassoff, M., and Nadeau, J., "Adding It Up—The Benefits of Investing in Sexual and Reproductive Health Care." New York: The Alan Guttmacher Institute, 2003, pp. 18-19.
http://www.unfpa.org/upload/lib_pub_file/240_filename_addingitup.pdf.

Recommendations for Improving Ways to Address Gender Issues within HIV/AIDS Programs

I. Recommendations for Immediate Action by the Incoming Administration

In order to implement the letter and the spirit of the PEPFAR reauthorization bill's provisions addressing gender, we encourage the incoming administration to make the following institutional changes within Office of the Global AIDS Coordinator :

- Create an **Office of Gender Integration** directly under the Global AIDS Coordinator, which would have the authority and the mandate to ensure that women and men, girls and boys, are able to benefit equally from PEPFAR's prevention, care and treatment programs, and to ensure that programs address the different needs and vulnerabilities of women/girls and men/boys, as well as of sexual minorities such as men who have sex with men. The office would be responsible for developing and implementing a plan to ensure that this gender perspective is thoroughly and consistently integrated throughout PEPFAR's programs. The plan should define the systems, tools and capacity needed to respond to gender concerns.
- Dedicate **sufficient central funding to support gender integration activities throughout PEPFAR**, including hiring of staff with sufficient gender expertise within each country program, systematic use of gender analysis for use in strategic planning and project design, training of field staff in using the analysis to design and implement field programs, and supporting research, monitoring and evaluation of gender-responsive interventions. Activities should endeavor to create an enabling environment for clients across the complete gender spectrum to access HIV information and services, including sexual minorities such as MSM.
- **Assign a budget code to gender program activities**, to allow for more accurate tracking of expenditures. Currently, there is no such budget code for gender program activities, although other cross-cutting program activities (such as health system strengthening) are assigned budget codes. (The expenditures attributed to gender activities included in OGAC's annual report to Congress are calculated by a method which leads to highly misleading results.)

In addition, we echo the GAR Prevention Working Group's call for the following changes to program guidelines and activities, which are essential in order to ensure that women and girls, including those in high risk groups, have the broadest possible access to HIV information and services.

- Issue new guidance that supports the integration of HIV and other reproductive health services, by providing access to HIV testing and counseling, as well as information and services to prevent other sexually transmitted infections, to clients within reproductive health programs, and by encouraging treatment programs to provide HIV- positive women access to reproductive health information, counseling and services to enable them to choose whether to have children or to prevent a pregnancy
- When calculating expenditures toward the 50 percent spending target for abstinence and be-faithful activities set by Congress , "count" all funds for these activities -- whether in stand-alone AB programs or part of a more comprehensive set of interventions.
- Revise guidelines on prostitution pledge requirement to comply with the August 2008 court order that found the existing requirements violate free speech rights.

II. Recommendations for Longer-term Implementation of the Gender Provisions in the PEPFAR Reauthorization Bill

Gender Issues within the Five-Year Strategy. The reauthorization legislation requires PEPFAR to produce by October 1, 2009 a five-year strategy that includes, among other things, "a plan to address the immediate and ongoing needs of women and girls." The legislation calls for the plan to establish specific goals and targets, provide operational guidance to the field, set forth gender-specific indicators, and highlight the issues of inheritance rights, life skills training, prevention of gender-based violence and assisting GBV victims. We strongly encourage OGAC

to go beyond the articulation of its current five priority gender strategies to thoroughly address all of these issues. In addition, we urge that the plan address:

- the leadership and mandate to prioritize attention to gender within OGAC;
- the systems and tools for addressing gender issues, particularly the use of gender analysis for developing country plans, and for individual projects,
- intentions for increasing human and financial capacity to address gender concerns ;
- the degree to which PEPFAR can support programs that confront larger legal, economic and social barriers (e.g. social norms condoning violence against women, lack of legal protection against gender-based violence or in favor of property and inheritance rights) that underlie the vulnerability of women, girls and sexual minorities to HIV infection, given that the legislation authorizes assistance for programs that address “underlying vulnerabilities. . . especially those of women and girls, through structural prevention programs” ;
- issues of internal policy coherence, given the potential for certain restrictions to undermine the success of gender-responsive approaches -- such as the requirement to spend 50 percent of funds for prevention of sexual transmission on abstinence and be-faithful programs
- the alignment between PEPFAR’s gender strategy and the newly adopted gender equality strategy and sexual minorities strategy of the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Research, Monitoring and Evaluation. The reauthorization bill expands monitoring and evaluation and operations research to include collection and analysis of data on gender-responsive interventions, and to develop gender indicators.

We are pleased that PEPFAR disaggregates some program indicators when measuring the number of people served by its programs, particularly in the area of treatment. However, as the report accompanying the Senate bill notes, it is “important . . . to ensure that data are disaggregated by risk factors, including sex, age, marital status, and other factors relevant to local epidemics.” This is particularly the case given the exceptionally high rate of infection among African girls and young women, ages 15-24, and among married women in some countries with generalized epidemics.

In addition, it is important to adopt gender-specific indicators to measure the degree to which PEPFAR programs are addressing the particular needs and vulnerabilities of women and girls in relation to those of men and boys. We have been tracking the development of OGAC’s “second generation” indicators with respect to gender. We believe that the proposed new indicators for gender are an improvement on the current system, which simply counts program “activities” that address one of the five gender priority strategies (increasing gender equity in HIV programs and services, changing male norms, reducing violence and coercion, increasing women’s legal protection, and increasing women’s access to income and productive resources), without any regard to the scope of the activity, the number of people reached, and most importantly, the outcomes or impact of the activity. The proposed new gender indicators would count the number of people reached by interventions addressing the latter four of these five priority strategies.

However we have at least two concerns. First, we understand that it is unlikely that all four indicators will be adopted by OGAC as standard, required indicator. Yet it makes little sense to adopt only one or two of the four indicators, thereby failing to measure the number of people reached by interventions that address the other gender strategies. Second, and even more important, all of the proposed indicators simply count individuals reached and do not measure outcomes or impact on these individuals. Without indicators to measure outcome or impact, it will be very difficult to assess the effectiveness of gender-related program interventions. This suggests that OGAC will be unable to fulfill the legislative stipulation that OGAC’s annual reports to Congress should address “effectiveness in reducing transmission among women and girls.”

We also encourage PEPFAR to invest substantially in operations research that will help provide a more solid body of evidence examining the relationship between women’s, girls’ and sexual minorities’ vulnerability to HIV infection and, for example, poverty and food insecurity, gender-based violence, limited access to education and information, criminalization of same-sex consensual behavior and lack of legal protection.

Consultation with and Participation of Outside Gender Experts

At present, there are no regular channels of consultation and dialogue between OGAC and individuals or organizations that can offer valuable expertise or skills related to gender concerns. The membership of the interagency Gender Technical Working Group is limited to administration officials and the group very rarely consults with outside gender experts. Similarly, in PEPFAR's overseas country programs, there are no standardized mechanisms by which local or national organizations with such gender expertise can contribute to the country's planning or implementation activities.

We note that the reauthorization law calls upon PEPFAR to hold "annual consultations with nongovernmental organizations in partner countries that provide services to improve health, and advocating on behalf of the individuals with HIV/AIDS and those at particular risk of contracting HIV/AIDS, including organizations with members who are living with HIV/AIDS." Furthermore, as part of the required five-year strategy, the legislation also calls for a prevention plan that "provide(s) for consultation with local leaders and officials to develop prevention strategies and programs that are tailored to the unique needs of each country and community," and it also calls upon OGAC, when negotiating compacts with countries, to ensure that governments "take into account local level perspectives of the rural and urban poor, including women." In addition, the report accompanying the Senate PEPFAR reauthorization bill calls for "expanded local input from women, including women living with HIV/AIDS. Similarly, additional technical assistance may be needed to help encourage the participation and involvement of women in drafting, coordinating, and implementing the national HIV/AIDS strategic plans of their countries."

In keeping with these legislative directives, we strongly urge PEPFAR to establish mechanisms for regular consultation with outside gender experts both at the level of Washington headquarters and at the level of overseas country programs. It is essential that the emphasis be on consultation with those who can provide knowledge and skills to address gender, rather than simply on their male or female status. It might be necessary to reach beyond the health sector to find this expertise.

We encourage PEPFAR to consult with and involve gender experts in the development of the following planning and operational decisions:

- the gender plan for the 2009-2013 five-year strategy;
- operational guidance on gender for PEPFAR field programs;
- annual or bi-annual country operational plans; and
- compacts with recipient country governments

Recommendations for Increasing and Improving Access to HIV Treatment Programs

The next Administration, supported by a new United States Congress, should adopt the following policies within 100 days after Inauguration by executive order, policy guidance or new legislation:

1. **Ensure continued US leadership in the global AIDS treatment efforts with policy statements and instructions to relevant government agencies to clarify policy areas under P.L. 110-293, the reauthorized and expanded PEPFAR program:**
 - A. Clarify that *the United States intends to support AIDS treatment for **the greater of** four million people with HIV or one-third of those in clinical need in developing countries* as estimated by UNAIDS. At least three million should be achieved through bilateral programs, with the remainder the result of AIDS treatment funded through ongoing support for at least one-third of the budget needs of the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM);
 - B. Clarify that *drugs to treat and prevent opportunistic infections will be provided for free* at PEPFAR-supported facilities;
 - C. Instruct PEPFAR and SCMS to *adopt competitive transparent bidding processes on medicines and other health commodities* for US-funded programs and to use economies of scale to drive down costs, while ensuring competition through multiple adequate suppliers.;
 - D. *Collect and report annually on detailed drug pricing* data and data regarding how much PEPFAR funding was spent procuring generic medicines, as authorized by P.L. 110-293;
 - E. *Adopt and actively promote implementation of regularly updated standards of care*, including clinical practice and treatment regimens and protocols for HIV and opportunistic infections and adherence support. Treatment and care programs supported by the U.S. should be similar to WHO recommended standards of care for resource-poor settings.³¹ The Office of the Global AIDS Coordinator should develop metrics to measure the quality of the projects and care provided under PEPFAR (including measurements of treatment adherence, death rates, and patient satisfaction.);
 - F. *Fund the purchase and maintenance of necessary medical equipment, diagnostics and medical supplies*, including those needed to address pediatric care needs as well as TB/HIV co-infections.
 - G. *Issue a general waiver of buy-American requirements* for medicines and other health commodities under PEPFAR;
 - H. Develop a strategy for *achieving the law's requirement that the proportion of children receiving care and treatment in focus countries is proportionate to the numbers of people living with HIV in each* by 2013.
2. **Promote availability of affordable life-saving medications and protect public health in developing countries by issuing an Executive Order and specific instructions to relevant public officials:**
 - A. **Issue an Executive Order or instruction to USTR that:**
 - o *Forbids the use of threats and punitive actions*, such as under the Special 301 Watch List and/or withdrawal of Generalized System of Preferences benefits, in response to a country's use of TRIPS-compliant flexibilities or refusal to adopt TRIPS-plus measures;
 - o *Commit to not enforce existing TRIPS-plus³² provisions in trade agreements* that impact access to medicines, and adopt a policy not to include TRIPS-plus measures in future or pending trade agreements;
 - B. **Instruct USTR to:**
 - o *Reaffirms the US commitment to the 2001 WTO Doha Declaration on TRIPS and Public Health*, permitting use of WTO-compliant flexibilities³³ by Member Countries to increase access to medicines for all, and

³¹ The US is currently funding substandard therapy, including drug regimens that are rarely initiated in wealthier countries due to toxicity profiles. OGAC, PEPFAR recipients and PEPFAR's country-level representatives should facilitate adoption of relevant WHO standards for treatment regimens, adherence support and clinical standards of care in resource poor settings, and play an active role in improving quality of care.

³² "TRIP-plus" policies exceed the WTO's TRIPS regulations and further limit the ability of developing countries to use generic competition in the public interest.

³³ TRIPS-compliant flexibilities include but are not limited to: strict standards for the granting of patents consideration, compulsory licenses, non-granting of exclusive rights on test data, compulsory licenses for exportation, limited exceptions, and parallel importation

actively supporting and promoting through law and policy countries' efforts to implement those flexibilities;

- Assure fair and adequate representation by advocates for public health and access to medicines on federal advisory committees to the U.S. Trade Representative.

C. Instruct NIH Director to:

- Adopt public interest licensing agreements for medications developed with significant public funding, such as open licensing, non-enforcement of patents in developing countries and licensing of such products to the UNITAID patent pool;
- Establish an initiative to develop, produce and provide low-cost fixed dose drug formulations, pediatric formulations and diagnostics as well as drugs for HIV/AIDS and neglected diseases established under the supervision of NIAID. The initiative should promote innovation with incentives free from marketing and monopoly interests, including reward prizes, and ensure that resulting products are available in developing countries under humanitarian licensing policies.

D. Instruct HHS Secretary to:

- *Certify medicines approved by the internationally accepted WHO Drug Prequalification Programme as eligible for purchase* by US global health assistance programs, as per PL 110-293, *and support the expansion of the WHO Prequalification Programme to cover other diseases;*
- *Commit to fully implementing the 2008 WHO Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property*³⁴ and to explore new mechanisms to stimulate innovation that are consistent with universal access to medicines;
- Review the PEPFAR requirements regarding the use of Advance Market Commitments (AMCs) to ensure that such arrangements are cost effective and consistent with sustainable access to products, when compared to alternative methods of encouraging innovation;
- Fully repeal the now-legally baseless federal travel ban on people with HIV/AIDS by removing HIV/AIDS from the list of 'diseases of public health significance' which bar entry to the US.

³⁴ World Health Assembly Resolution 61.21, adopted by WHO Member States in May 2008

Recommendations for Strengthening Health Workforce Capacity for HIV/AIDS-Related Programs and Services

Massive health worker shortages in many African and other developing countries and extensive health system weaknesses are major obstacles to effectively and significantly scaling up and sustaining HIV and other health services. Building on the important new authorities and targets in PL 110-293 to begin to address these issues, the next Administration, supported by a new United States Congress, should adopt the following policies within 100 days after Inauguration by executive order, policy guidance or new legislation:

1. **Commit to launching and funding a health systems initiative grounded in and building on the program and policies set by the recently reauthorized PEPFAR law P.L 110-293.** The new law requires the United States to assist countries to achieve WHO minimum health workforce densities of 2.3 doctors, nurses and trained midwives per thousand country residents to provide primary care, and strengthen their overall health workforce and health systems. The law additionally requires the US to increase the supply and support retention for at least 140,000 new health workers, with a priority on new health professionals. The initiative should set specific country goals in at least 15 select countries with the greatest health needs and most severe health system and health workforce deficiencies, including but not limited to PEPFAR focus countries. Additional funding may well be necessary beyond what was included in PEPFAR reauthorization.

The initiative should convene public and private stakeholders at the country level to:

- a. Fund and support country-led implementation of comprehensive multi-year plans to strengthen national health systems and to train, retain and equitably distribute new health workers in numbers sufficient to fulfill US commitments to achieve universal access to AIDS prevention, care and treatment and the MDGs, and achieve the 2.3 doctors, nurses and trained midwives per-thousand country residents as supported by US law. As part of this effort, support pre-service training, deployment retention for 140,000 new health primary care professionals.
- b. Work with country partners to train, equip, compensate and deploy enough health auxiliaries (such as pharmacists, lab techs, and community health workers) to achieve minimum WHO-recommended densities of 1.8 per 1000 country residents, including community health workers supported with a living wage, adequate supervision and equipment.³⁵
- c. Ensure that health workers and facilities in these countries are well-managed and are equipped with adequate medical equipment and supplies necessary to meet or exceed regularly updated WHO recommended standards of care for resource-poor settings.
- d. Remove financial and other barriers to access, improve health sector governance and accountability, and address other health system constraints that are significant barriers to improved health outcomes.³⁶

Stakeholders include government ministries, organizations representing women and youth, people with HIV/AIDS and other patient groups and marginalized populations, as well as health professionals, community- and faith-based organizations providing health services, development partners and implementing agencies.

2. **Direct relevant US officials, including the heads of USAID and CDC, to improve retention and ensure health and safety for patients and health workers in US-funded programs in developing countries, including:**

³⁵ Use of community health workers should be in accordance with the normative guidelines for task-shifting that were developed by WHO with PEPFAR support and released in January 2008: <http://www.who.int/healthsystems/TTR-TaskShifting.pdf>

³⁶ Removing such barriers would include new support to strengthen country-level planning, management, monitoring and evaluation; support for health facilities in rural areas, patient and health information systems, laboratories systems, procurement and supply systems; and patient and community health literacy, participation, and empowerment, as well as removing user fees and inaccessible or affordable transportation to care facilities.

- a. Support for health care for health workers, including confidential AIDS treatment and prevention programs for health workers, and training and supplies needed to implement universal precautions and other forms of infection control (including safe injecting devices);
 - b. Training and other activities to respect the rights of all patients, reduce stigma and discrimination and ensure dignified and ethical treatment, in health services;
 - c. Support for recurrent costs such as equitable health worker salaries in public and non-public sectors, and renegotiation of any existing policy barriers to wage supports.
- 3. Remove international financial institutions' macroeconomic policies that harm the ability of poor nations' ability to meet health needs by:**
- a. Issuing an Executive Order or policy directive instructing the US Treasury Representative to the International Monetary Fund Board to oppose any agreement or policy instrument that does not exempt health and education budgets in developing countries from restrictive fiscal and monetary policies that limit country efforts to increase spending to train and retain the increased health workforce needed to achieve universal access to AIDS prevention, care and treatment and the MDGs. In light of economic crises, any modification of existing IMF authority and responsibilities should similarly require the IMF to exempt expanded health and education spending from restrictive policies;
 - b. Instructing the US representative to the IMF to require that any gold sales or other solvency measures adopted by the IMF not create a permanent endowment for funding operational expenses that would prevent future policy reviews, inputs, and controls on IMF policies, and to establish as a condition of such gold sales support for debt relief. Any modification of existing IMF authority and responsibilities, or sale of gold reserves, should be further conditioned on elimination of monetary and fiscal macroeconomic restraint policies, including inflation and deficit spending targets that negatively impact developing countries' ability to invest as needed in health and education sectors.
- 4. Announce the goal of greater U.S. health workforce self-sufficiency and ethical recruitment by:**
- a. Directing HHS to devise and implement a strategy to increase the supply of domestically trained nurses and doctors, including:
 - i. Identify barriers to increasing the supply and retention of US healthcare workers, including evaluating the quantity and quality of clinical providers engaged in HIV care, and recommend strategies for Federal and State governments to follow to remove these barriers;
 - ii. Recommend changes to Federal law that would increase the supply of domestically trained health workers (including nursing faculty);
 - iii. Grants, loans, and other incentives that would increase the domestic education of new nurses and other health workers;
 - iv. Identify the effects of nurse (and other health worker) emigration on health systems in countries of origin, and recommend changes to Federal law to minimize the effect on health systems of health worker immigration in countries of origin;
 - b. Publically encourage recruiters and health employers to adhere to the Voluntary Code of Ethical Conduct for the Recruitment of Foreign-Educated Nurses to the United States and commit to supporting a WHO code of conduct on international recruitment of health personnel that provides sufficient protections and support for health and the health workforce in countries suffering severe shortages.
 - c. Incorporate into the FY10 budget request increased funding for Nursing Workforce Development programs (Title VIII of the Public Health Services Act).

The Administration and Congress should follow through in the months ahead to ensure that health systems initiatives are launched, new policies on health worker and patient safety and on macroeconomic policies are adopted, and programs and policies to increase U.S. health worker self-sufficiency are developed and begin to be implemented. The Administration should request the level of funding that will enable the programs, policies, and initiative described above to be fully, effectively, and comprehensively implemented.