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# HIV/AIDS and Development: The U.S. Response

## An interview with USAID Administrator Andrew Natsios

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*Andrew Natsios was sworn in as Administrator of the United States Agency for International Development on May 1, 2001. He also served USAID as director of the Office of Foreign Disaster Assistance (1989-1991) and as assistant administrator for the Bureau for Food and Humanitarian Assistance (1991-1993). Natsios served as chairman and chief executive officer of the Massachusetts Turnpike Authority and as vice president of World Vision U.S. He joined The Fletcher Forum's Ben Sklaver on December 2, 2002, to discuss USAID's response to the HIV/AIDS epidemic, future trends, constraints, and lessons learned.*

*In this interview, Administrator Natsios reviews USAID's progress in combating the epidemic. The global nature of the disease is highlighted in the recent expansion of USAID programs in Asia, and funding challenges related to the Global Fund to Fight AIDS, TB and Malaria are addressed. Natsios examines the pressures that drove him to change USAID policies on the use of antiretroviral medications in Africa. He concludes with commentary on the relationship between the "War on Terror" and the HIV/AIDS epidemic.*

**FORUM:** On November 13, in a speech awarding United Nations Secretary-General Kofi Annan a "Visionaries Award" from the United Nations Association in New York, Secretary of State Colin Powell called HIV/AIDS "the biggest problem that we have on the face of the earth today."<sup>1</sup> What are your thoughts on his assessment?

**NATSIOS:** It's certainly one of the most serious problems we're facing, particularly in Africa. In certain parts of sub-Saharan Africa—for example, Botswana and Namibia now have 38 percent HIV/AIDS infection rates for the adult population. In a number of other countries in southern Africa the rate is about 20 or 22 percent.

In southern Africa, many people spend their weekends simply going to back-to-back funerals. People are being buried on top of each other in the graveyards because there is no space left. It is a very serious problem.

But the root of all this is weak healthcare infrastructure and poverty. If countries were not as poor as they are, and they had much stronger public health care systems, we would not be facing the crisis that we're facing now. And now, of course, it's spreading beyond sub-Saharan Africa. The highest growth rates—not infection rates, but growth rates—are in India and Russia.

**FORUM:** To talk then about Asia, the UNAIDS estimate for China is that currently there may be as many as one and a half million people infected with HIV. Infections could rise to 10 million by 2010. What programs is USAID sponsoring in China and South Asia to assist these countries?

**NATSIOS:** Well, our programs worldwide I can go to in a minute, but we were just given approval to do one of our first health programs in China. As you know, China does not normally get foreign assistance from the United States government. This is an exception to that rule. Congress has said that it is okay in this particular case because of the severity of the crisis that the world is facing. We are beginning a program, but that is only recent in China.

We've had extensive HIV/AIDS programs in Thailand. We are just starting one up in Burma now through nongovernmental organizations, and we have a large program in Cambodia. And we have a program in Bangladesh that is quite extensive, and in India.

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In terms of what the program consists of, about 70 percent is prevention, 20 percent is care and treatment, and 10 percent is what we would call maintenance. Many of

our programs are integrated with other sectors. For example, in Rwanda and Uganda now, the HIV/AIDS program works in addition to, or with, the "Food for Peace" program. In many villages where the HIV/AIDS rate is so high, no one is planting crops and there are higher rates of acute malnutrition, almost famine levels in some areas, because there are no adults to plant the crops. So we are combining a food program with an HIV/AIDS program.

We are also beginning a treatment program in Ghana with antiretrovirals [ARVs]<sup>2</sup> as a beginning program to see how it works and what problems we encounter with it, and then will see if it's feasible to extend it.

But what we have had success at is a number of interventions. For example, we know that we can cut the teenage girl infection rate by about 50 percent with one-to-one counseling. If you do it as a large group, it doesn't work, but one-to-one counseling will reduce the date on which girls start becoming sexually

active. And they are much more vulnerable to infection when they are younger than when they are older, due to the nature of the disease.

Secondly, we know that treating a pregnant mother with nevirapine—it's a free drug that has been developed in the United States; the drug company is giving it free—will reduce by 60 percent the infection of newborns.

A third thing we've discovered is doing testing, giving immediate results from tests for HIV/AIDS, which affects people's behavior. Once people know they are HIV/AIDS positive, then it's easier to get them to treatment programs in some countries.

And we know we can increase the number of people willing to be tested—because many people refuse to be tested—by about 50 percent if we use a new kind of test that provides immediate results rather than having to wait.

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Anyway, there are about a dozen of these programs that we have field tested that actually work in reducing the spread of the infection, increase the use of condoms among teenagers, increase the level of abstinence. And these programs are effective. Our big challenge now is extending these out from pilot programs to a national scale in some of the countries affected.

We know they work because one of our earliest programs was in Uganda. Uganda has reduced the infection rate from 21 percent to seven percent. And Uganda is one of our most extensive programs.

**FORUM:** Could you tell me more about the antiretroviral program in Ghana? Early in your career as administrator, you were somewhat opposed to these ARV programs in Africa. What changed your mind?

**NATSIOS:** It's been a lot of public pressure, and it's been very effective. We have bowed to it, and our staff is moving now to test these antiretrovirals.

There are new drugs coming on the market, which will be simpler to administer, but there are still going to be challenges. The condition of the healthcare system in these countries is a critical factor in whether or not antiretrovirals will work.

Botswana is now moving into trials where they have a small number—I think a couple hundred people—working through the Centers for Disease Control and the Gates Foundation. We don't have a USAID mission working in health in Botswana. So they are doing the program there.

But we are trying it, and if it works, we are going to extend it. Anything we can do to reduce the spread of the disease, and keep people alive, we are going to do.

**FORUM:** How do you balance the need for appropriate global access to nevirapine and ARVs, while still encouraging private pharmaceutical research?

**NATSIOS:** Let me first say that the President has proposed a \$500 million five-year nevirapine program, mother-to-child transmission program. We are gearing up with the Centers for Disease Control for a fairly massive program to immunize mothers for their children. And that is an already existing technology that is on the market.

I guess what has happened is there has been a change of national policy on the question of the use of antiretrovirals and their price. The price has dramatically dropped. Even since I took this job, there has been a dramatic drop in price. It was, when I started, \$10,000 per person per year. Eight months ago, it was \$1,000—it dropped from \$10,000 to \$1,000, and it's dropped even further in some areas to \$200 or \$300. So the price is coming down, and there is a whole debate on how to do that, obviously.

**FORUM:** Regarding funding, the Global Fund to Fight AIDS, Tuberculosis and Malaria is almost a year-and-a-half old now, and it seeks roughly \$10 billion a

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year to fight these diseases. The Fund has thus far received pledges for only about \$2.1 billion over four years. What do you think could be done to close the resource gap?

**NATSIOS:** First, I don't think I've ever read that they are asking for \$10 billion. The argument was that we need \$10 billion total from all sources. Some of that will come from the World Bank directly to countries and ministries of health, some of that comes from this Fund, some of it comes through bilateral aid programs. For example, USAID plus the Centers for Disease Control and

the National Institute of Health will spend in 2003 \$1.3 billion on HIV/AIDS in the third world. That is an increase of 30 percent over 2002 figures.

We are already spending more than any other country in the world by far—\$1.3 billion for this current fiscal year. I think about \$100 million of that is the mother-to-child transmission program. In terms of this international fund, 50 percent of the money that is in the fund now comes from the United States. We have done a great deal to support the fund.

But we're also running direct programs from USAID and the Centers for Disease Control to the clinics, and the NGOs, and the missionary hospitals, and the ministries of health directly, and not through any international fund. The total amount that countries are being asked to spend on this is \$10 billion—not just through the Fund.

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**FORUM:** How do you see USAID adapting over the next decade to address the new developments and concerns arising from HIV/AIDS—namely the explosion in the number of orphans and the effects of the disease on livelihoods and famine?

**NATSIOS:** Let me deal with the second question first, and that is over the question of orphans. They are expecting maybe 20 to 25 million orphans in Africa by 2010, and we already have millions of orphans right now. So the question is how to deal with them.

The most effective way in the context, particularly of sub-Saharan Africa, are community-based care programs. The amount of money that orphanages cost, for example, is so high, and it is not in the African tradition. Typically kids are adopted by other members of the extended family and the tribe when they become orphaned. So what we are doing is putting a lot of money into pilot programs to see how the community-based programs can work most effectively. And we are having good results with it.

What will happen is the kids in many cases, if they are teenagers, will stay in the family house after their parents have died. Their neighbors and aunts and uncles will be given resources to ensure that the kids get fed, they have their school fees paid, and that sort of thing.

The second question you asked was about the question of food security, which is a serious problem, as I mentioned earlier, in many countries in sub-Saharan Africa. A lot of the breadwinners have died who are farmers normally. We have a major effort to increase the amount of money we are spending on agricultural development in Africa. The President has decided, and USAID is implementing, a major administration initiative to increase funding and programs in agriculture in sub-Saharan Africa. But in many countries with high HIV infection rates, we will be focusing our efforts in preserving food security in those areas where there are high rates because there is a relationship between food insecurity and the pandemic.

**FORUM:** You have been to Africa several times in the past few months to observe first hand the effects of famine in the region. What links have you seen between famine and HIV/AIDS in southern Africa?

**NATSIOS:** We know from our own research and from field reports that malnutrition will kill a person with HIV/AIDS much faster than it would a person who started out being healthy. We also know that there are opportunistic diseases like TB, malaria, and pneumonia that, when you have HIV/AIDS and you complicate that with declining nutritional conditions, people die much more quickly.

It's very difficult now to tell whether people are dying from AIDS or TB. A third of all HIV people in Africa who have HIV/AIDS have TB too. And so there is a terrible pathology that develops: a triangular pathology between

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HIV/AIDS, these infectious diseases, and the famine that is facing not only southern Africa but also the Horn of Africa.

The severity of the drought in Eritrea and Ethiopia is as bad in terms of the number of people affected, 30 million people, as it is in southern Africa.

**FORUM:** Are there aid programs which are focused on HIV-positive individuals in these areas?

**NATSIOS:** What we're doing is focusing on poor people who are HIV/AIDS positive. Anybody who is food insecure is the focus of our program in the countries that we are allowed to do work in. We have thus far pledged 500,000 tons of food for the southern African drought, which is about 50 percent of what the UN has asked for. And that is being focused in the areas that have the highest food insecurity, which also means the highest AIDS infection rates. That is, if a person is wealthy or upper middle class, we obviously are not going to provide food aid for them, even though they are HIV/AIDS positive, because food insecurity is somewhat related to social class.

**FORUM:** You have mentioned several times that there are areas in which you are not able to work. What issues have arisen with USAID's HIV/AIDS strategy in these places?

**NATSIOS:** In some countries in southern Africa, there have been problems with the countries' national leadership really not wanting to put money into nevirapine treatment. If the ministry of health tells us we can't do a certain treatment, then we can't do it. I mean we are in their country, it is not our country, even though that is the standard program that we run across Africa and will be ramped up to a much higher level in the future.

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I think there has been a recent change on that in southern Africa, but there are countries where this is a very sensitive issue politically, socially, and culturally. So the governments put restrictions on what we can do.

The second problem that we are finding with our programs is the whole issue of social stigma. In many areas, if a woman is judged to be HIV positive—of course, they have a much higher infection rate because women are much more vulnerable to the disease than men are—then they are thrown out of the village they live in. They can even be killed. And so we have a problem with people not wanting to admit they have AIDS, even though they have been tested for it and shown to be positive. And so the whole issue of social stigma makes it very difficult to treat some people in the community setting because of the stigma.

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**FORUM:** USAID's HIV/AIDS strategy relies foremost on prevention through education, condom distribution, and promotion of abstinence. Has the prevention model been applied to Afghanistan, or are there any HIV/AIDS programs being run in that region?

**NATSIOS:** Well, the public health indicators for Afghanistan are among the worst in the world. We do not have any data at this point on HIV/AIDS there. Because it is such a conservative Muslim society, I suspect the rates will be quite low. The chaos from the civil war may make the rates slightly higher than other Muslim countries. It is a very conservative society, and Muslim countries tend to have lower rates, particularly in Africa and the Middle East.

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**FORUM:** What challenges has USAID's prevention strategy faced in Muslim societies?

**NATSIOS:** It is difficult in some societies to talk about AIDS because, if there is a huge stigma attached to it, then people do not want to deal with it. It depends on the country, but we have programs in a number of countries that have large Muslim populations. Indonesia is one of them. Bangladesh is one of them. So we do have programs run through clinics and the NGO sector. But social stigma is a major impediment to what we do in many countries.

**FORUM:** Does USAID have a specific HIV/AIDS office or branch?

**NATSIOS:** Yes. We have a Bureau of Global Health that deals with family planning, child survival, maternal health, nutrition, infectious disease, and AIDS. There is a special office that works just on AIDS.

We have a comprehensive worldwide strategy which is on our website, if you want to look it up. It is somewhat laborious and a little dry, but it is there. We have countries that have been categorized as requiring intensive focus and support right now because of the risk they are at. If you have an infection rate of above six percent, the disease tends to spread much more rapidly. The cutoff point for rapid evolution of the disease is about five or six percent, because below that you can get it under control more easily.

**FORUM:** Roughly how many people work in the Bureau of Global Health at USAID?

**NATSIOS:** I don't know the figures, but our most common sectoral specialty within USAID, if you ask the career officers what degree do you have, the most common degree is in public health, but that is for all aspects of it.

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You see, our health officers do not just run the HIV/AIDS programs in the field, they run the infectious disease programs, they run the child nutrition programs, they run the population family planning programs, because these programs in the field operations are integrated. If you are doing condom distribution, are you doing it for family planning reasons or are you doing it for HIV/AIDS? And so these problems tend to overlap. When you do a distribution of nevirapine, is that a child survival program—it is a child survival program—it's also an HIV/AIDS program.

**FORUM:** Do you see HIV/AIDS as a destabilizing global threat, and, if so, is there, or should there be, a link between the “War on Terrorism” and the war on HIV/AIDS?

**NATSIOS:** What do you mean by destabilizing?

**FORUM:** Like you mentioned, 25 million orphans over the next decade, destabilizing governments, promoting refugee flows...

**NATSIOS:** No. We need to be careful about how we characterize HIV/AIDS. HIV/AIDS is a disaster from a health perspective, from an economic development perspective, because its rates tend to be higher among better educated people. And many of these countries do not have that many educated people. So,

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it is a disaster from an economic development standpoint. It is a disaster from a food security standpoint, an agriculture standpoint, because adult populations are not there to plant the crop.

But, I think, it's a little bit, probably, at least at this point in the research, I am not sure I would go so far as to say it is politically destabilizing if we don't have evidence of that yet. Is it a controversy? Yes, it is. Does it cause refugee flows? Not that I'm aware of. But there are problems.

**FORUM:** Is there work being done with foreign militaries?

**NATSIOS:** Yes, the Defense Department runs a number of programs in cooperation with us, because militaries tend to have some of the highest infection rates in society, next to sexual workers.

**FORUM:** You said that research has not been done on the destabilizing effects, if any, of the disease. Is USAID looking into the issue?

**NATSIOS:** We have a conflict mitigation and management office that we have

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just set up, and that certainly is one of the issues that we will be looking at as the office comes online. But at this point I have not seen any persuasive empirical research that would suggest a relationship between conflict levels and political instability and HIV/AIDS. It's bad enough as it is without adding that into it, believe me.

**FORUM:** Thank you very much for your time.

**NATSIOS:** Thank you. ■

#### **NOTES**

- 1 Secretary of State Colin L. Powell speaking at the United Nations Association of the USA "Visionaries Awards" dinner honoring United Nations Secretary-General Kofi Annan, November 12, 2002.
- 2 Antiretrovirals (ARV) are a class of drugs used to treat people with HIV/AIDS. They work by interfering with HIV reproduction inside the body. A person may take one drug, or might take several together. Common ARVs include nevirapine, AZT, ddI, ddC, d4T, 3TC, and saquinavir.