Wait of the world falls on Bush's ambitious AIDS plan

President Bush in May signed his celebrated five-year, \$15 billion AIDS initiative for African and Caribbean countries. But skeptics—including researchers, lobbyists and budget experts—are waiting to see whether and how he fulfils his promise.

"The test is putting your money where your mouth is," says Kelly O'Brien, associate director for public affairs at the American Public Health Association.

The legislation calls for a first installment of \$3 billion in 2004. Despite the president's public enthusiasm, however, his budget for the year allots only \$1.7 billion. Final funds will probably tally between \$2–3 billion, says Paul Zeitz, executive director of the Global AIDS Alliance.

Most lobbyists maintain that the funds are unlikely to approach the full \$3 billion. Given the sluggish economy and a skinny federal purse, they also question where the money will come from. The answers will not be forthcoming until autumn at the earliest, and possibly not until early next year.

About 25% of the money for foreign HIV-related programs is expected to come from the Department of Health and Human Services—primarily the National Institutes of Health—and 75% from the US Agency for International Development.

International health organizations say they will fight any proposals that would divert funds from existing maternal and child health programs in developing countries or at home. If the plan is funded with 'new' money, it will

Hungry for help: Two-year-old Biniam Alemu, an AIDS patient in drought-stricken Ethiopia.

spare existing programs but will also exacerbate the deficit.

Money for high-priority projects is sometimes created with emergency supplemental legislation—such as for the war with Iraq—says Kei Koizumi, director of the Budget and Policy Program at the American Association for the Advancement of Science. "That puts this legislation in a slightly better position than run-of-the-mill domestic legislation," he says.

The new legislation also calls for up to \$1 billion for the Geneva-based Global Fund to Fight AIDS, Tuberculosis and Malaria, a collaboration between the United Nations and the G8 group of developed nations. Here again, the president's budget asks for only \$200 million. "That leaves the Global Fund in a precarious situation," says Zeitz (*Nat. Med.* 9, 632; 2003). "It may not be able to fund the next round of grants in the fall."

To encourage other nations to contribute to the Global Fund, the legislation also specifies that the US can contribute only one-third of the Fund's budget. Still, the response from those countries has thus far been limp.

How all the AIDS funds will be disbursed also remains unclear. For example, the legislation earmarks a third of the money for prevention to promote its program of abstinence (*Nat. Med.* 9, 629; 2003)—a clause some organizations are hoping to reverse during appropriations.

In theory, the 2004 appropriations process is expected to begin this July and conclude by 1 October. The 2003 appropriations were not completed until early this year, however, so how long the debates will last is anyone's guess. "Congress wants to keep the hard choices vague for as long as possible," says Koizumi.

Even after the 2004 process is complete, Koizumi points out, the legislation will face four more annual battles. "There's always a possibility that politics will get tangled up in it again," he says. "Each year is going to reopen domestic political struggles."

Still, the administration may be forced to keep its word, says Mark Isaac, vice president for government affairs at the Elizabeth Glaser Pediatric AIDS Foundation. "They have made a high-profile promise—advocates are not going to hesitate to point that out," Isaac says. "Our work is to make sure funding happens."

Tabitha M Powledge, Hollywood, Maryland

Cancer fears stall trials for testosterone replacement

Despite popular demand, trials to evaluate testosterone replacement therapy (TRT) for men are to remain on hold pending publication of a review by an independent panel of experts. Recommendations of the Institute of Medicine task force—including design, safety and ethics of clinical trials, and whether such trials are even warranted—are due this November.

A number of studies involving relatively few individuals indicate that TRT might provide some benefits, such as improved muscle, bone strength and increased sex drive to men with 'low' levels of the hormone. Although most aging men maintain testosterone levels within the normal range, levels decrease in some older men.

A large-scale TRT trial had already passed scientific review by the US National Institute of Aging. But concerns about potential side effects

urged some scientists, including National Cancer Institute director Andrew von Eschenbach, to call for the independent assessment. "This will mean a delay of some months," says Stanley Slater, deputy director of the institute's Geriatrics and Clinical Gerontology Program.

Proponents of TRT say a large-scale trial is critical in light of the growing number of men who are receiving the therapy. Nearly 819,000 men received TRT in 2002, an increase of 29% over the previous year, according to the market research company IMS Health. Surprisingly, most men receiving TRT are under 65 years of age; 58% are between 45 and 65 years of age, and 28% are between 18 and 45.

"TRT is going on and will continue to go on," says University of Washington researcher Alvin Matsumoto, principal investigator of a pro-

posed trial. "People are being put on this therapy without knowing the full risks and benefits."

Critics like von Eschenbach says the risks of TRT—including prostate cancer—outweigh the benefits. "I would rather accept as a downside that some men will not benefit from improved quality of life, rather than put them at risk of prostate cancer," von Eschenbach said at the most recent meeting of the task force.

Others say it is impossible to evaluate the risks without first conducting a trial. "The data are all over the map with regards to testosterone and prostate cancer," says Ian Thompson, professor of urology at the University of Texas Health Science Center in San Antonio. "It is not clear to me that testosterone replacement is a risk factor for prostate cancer," says Thompson. "A large-scale trial is the only way to know."

Laura Bonetta, Bethesda