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ASYMMETRY AND AGENCY: THE UNITED STATES PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF IN BOTSWANA, ETHIOPIA AND SOUTH AFRICA

Doctoral dissertation on International Relations, program "Política Internacional e Resolução de Conflitos," supervised by Professor Doctor Paula Duarte Lopes, and submitted to the School of Economics, University of Coimbra.

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List of Acronyms and Abbreviations

ABC	abstinence, be faithful and condoms policy
ACHAP	African Comprehensive HIV/AIDS Partnership
AFRICOM	United States Africa Command
AIDS	Acquired Immunodeficiency Syndrome
AGOA	United States African Growth and Opportunity Act
ANC	African National Congress
ARV	antiretroviral
BDP	Botswana Democratic Party
BEE	Black Economic Empowerment
BRICs	Group of Brazil, Russia, India and China
BSAC	British South African Company
CARE Act	Ryan White Comprehensive AIDS Resources Emergency Act
CDC	Centres for Disease Control
CSO	civil society organisation
EPRDF	Ethiopian People's Revolutionary Democratic Front
FBO	faith-based organisation
FDA	United States Food and Drug Administration
GHI	United States Global Health Initiative
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
HAPCO	Ethiopian HIV/AIDS Prevent and Control Office
HIV	Human Immunodeficiency Virus
IHR	International Health Regulations
NACA	Botswana National AIDS Coordinating Agency
NEPAD	New Partnership for Africa's Development
NGO	nongovernmental organisation
OVC	orphan and vulnerable children
PEPFAR	United States President's Emergency Plan for AIDS Relief
PPP	public-private partnership
SANAC	South African National AIDS Council
SARS	severe acute respiratory syndrome

Soviet Union	Union of the Soviet Socialist Republics
TB	tuberculosis
TPLF	Tigray People's Liberation Front
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Program
United Kingdom	United Kingdom of Great Britain and Northern Ireland
USAID	United States Agency for International Development
VCT	HIV/AIDS voluntary counselling and testing
WHO	World Health Organisation

Abstract

In the last thirty years, the discipline of International Relations has witnessed a shift of analytical scope from the conventional world of states towards population- and social forces-related concerns. According to major scholarship, this occurs as a result of interrelated processes of economic globalisation, United States hegemony and emergence of the human security paradigm among Western policy circles. However, this assumption has entailed problems to the research of human agency in the actual practice of international affairs, since Western hegemony is arguably entrenched in the international system to the point of “hijacking” sovereign states, as suggested by Oliver Richmond, particularly in the developing world.

Focusing its analysis on states, this dissertation sets out to argue that, rather than essentialised in the hegemonic structure, postcolonial states, notably in Africa, hold agency. When interacting with the leading international powers, and even if highly constrained by external policies and actions, they act with autonomy by identifying their own policy problems, defining strategies and seeking political goals. States’ agency is influenced by three independent variables: the broader realm of foreign policy relations maintained with international actors (public and private), namely leading states; the encompassing arena of domestic policies of the state at stake; and the actual practices of the state, particularly with its local constituents. The employed theoretical framework builds on Kenneth Waltz’s concepts of state as unit with agency in an international system that, nevertheless, is asymmetric. Moreover, the state is taken as a social relation, as suggested by Justin Rosenberg, in which internal and external spheres of state action are interconnected historically and sociologically.

The case study consists of the process of implementation of the United States President's Emergency Plan for AIDS Relief (PEPFAR) in Botswana, Ethiopia and South Africa. Since 2003, PEPFAR has been a major tool of United States foreign policy, especially in Eastern and Southern Africa, serving security, economic and humanitarian purposes. It is a very large public-private partnership that includes United States government agencies and United States-based nongovernmental organisations, governmental and nongovernmental entities from the countries under intervention, as well as international multilateral organisations. Through PEPFAR, the United States of America exerts significant power, at various levels (individual, community and national), in the countries that accept it, despite principles of 'shared responsibility' and country ownership. More broadly, PEPFAR displays the problems that arguably feature global health governance, namely as far as utter asymmetric relations between donor and recipient states are concerned, in which the latter are rendered the role of facilitator or 'rogue' with regard to the former's policies. Accordingly, the three states have acted as facilitators, with the exception of South Africa under President Thabo Mbeki.

This dissertation's argument is illustrated by the analysis of agency held by the three states in light of PEPFAR's implementation and overall relations with the United States of America. The Botswana state behaves towards the survival of the national population, since close to one quarter of the adult population lives with HIV/AIDS in a context of shrinking developmental prospects. In the case of Ethiopia, self-help is also the main concern, yet centralised in the current political regime, in which human development, including improvement of health care, is considered fundamental in that effort. Finally, in the case of South Africa, the

transmission of values domestically and internationally on the dignity of Africans has driven the way in which the governments have addressed the HIV/AIDS issue.

Resumo

Nos últimos trinta anos, a disciplina de Relações Internacionais tem assistido a uma transferência de enfoque analítico do mundo convencional dos Estados em direção a questões ligadas às populações e às forças sociais. De acordo com importantes autores, tal deve-se a processos interrelacionados ligados à globalização económica, hegemonia dos Estados Unidos da América e emergência do paradigma da segurança humana nos ciclos de decisão política ocidentais. Contudo, esta premissa tem levado a problemas referentes à investigação da *agency* humana na prática dos assuntos internacionais, uma vez que a hegemonia ocidental encontra-se, alegadamente, tão enraizada no sistema internacional ao ponto de “sequestrar” Estados soberanos, como sugere Oliver Richmond, em particular no mundo em vias de desenvolvimento.

Concentrando a sua análise nos Estados, esta dissertação argumenta que, em vez de se constituírem parte essencial da estrutura hegemónica, os Estados pós-coloniais, nomeadamente em África, retêm *agency*. Na sua interação com as principais potências internacionais, e mesmo quando altamente condicionados por políticas e ações externas, esses Estados atuam com autonomia através da identificação, por si próprios, dos seus problemas políticos, definindo estratégias e visando objetivos políticos. A *agency* dos Estados é influenciada por três variáveis independentes: o âmbito alargado das suas políticas relativamente a atores internacionais (públicos e privados), nomeadamente os Estados mais importantes; o setor mais amplo de políticas domésticas do Estado em causa; e as práticas efetivas desse Estado, nomeadamente com a sua população. O enquadramento teórico

utilizado assenta nos conceitos de Kenneth Waltz sobre Estado enquanto unidade com *agency* num sistema internacional que, não obstante, é assimétrico. Além disso, o Estado é tomado como uma relação social, como sugerido por Justin Rosenberg, em que as esferas interna e externa de ação do Estado estão interconectadas histórico-sociologicamente.

O estudo de caso consiste no processo de implementação do Plano de Emergência do Presidente dos Estados Unidos da América para a SIDA (PEPFAR, na sigla inglesa) em Botsuana, Etiópia e África do Sul. Desde 2003, o PEPFAR tem constituído um instrumento principal na política externa norte-americana, especialmente na África Oriental e Austral, servindo objetivos securitários, económicos e humanitários. Apresenta-se como uma extensa parceria público-privada que inclui agências do governo norte-americano, organizações não-governamentais norte-americanas, entidades governamentais e não-governamentais dos países sob intervenção, bem como organizações multilaterais internacionais. Através do PEPFAR, os Estados Unidos da América exercem um poder significativo, a vários níveis (individual, comunitário e nacional), nos países que o aceitam, apesar dos princípios de ‘responsabilidade partilhada’ e propriedade do país (*country ownership*). De modo geral, o PEPFAR ostenta os problemas que caracterizam a governação global da saúde, em especial as assimetrias profundas que separam doadores de recetores, em que os últimos cumprem funções de facilitadores ou de ‘*rogue*’ face às políticas dos primeiros. Os três Estados em análise têm atuado como facilitadores, com a exceção da África do Sul sob presidência de Thabo Mbeki.

Esta dissertação conclui que os três Estados detêm *agency* à luz da implementação do PEPFAR e relações em geral com os Estados Unidos da América.

O Estado do Botsuana age em prol da sobrevivência da sua população nacional, sendo que perto de um quarto da população adulta vive com o VIH/SIDA num contexto de perspectivas negativas de desenvolvimento. No caso da Etiópia, a autoajuda é também a principal preocupação, embora centralizada no regime político vigente, em que o desenvolvimento humano, que inclui melhoria dos cuidados de saúde, é fundamental nesse esforço. Finalmente, no que respeita à África do Sul, a transmissão de valores, no plano doméstico e internacional, sobre a dignidade dos africanos está na base do modo como os sucessivos governos têm lidado com o tema do VIH/SIDA.

Chapter 1 – Introduction

1.1. States, Populations and Social Forces

The last thirty years have witnessed a growing debate on what should ultimately constitute the subject matter of study by scholars of International Politics. Should the analysis primarily focus on states, populations or social forces? Traditionally, states, and the conflicts eminently associated with them in terms of military, economic and ideological expansion, have been the major topic of study in the discipline, as the classical literature by Edward H. Carr (1939), Hans Morgenthau (1948) or Kenneth Waltz (1979) shows. However, the emergence of agendas diverging from strict focus on states started to gain particular currency since the 1980s onwards (although, in some cases, proceeding from well before then), and challenged prominent state-centred conceptions of international affairs.

One agenda that started to shift the conventional scope of analysis towards an enlarged range of actors was introduced by the sub-discipline of Security Studies. By concentrating on the experience of humans living within states, or in-between states (for example, migrants), or natural phenomena (e.g. catastrophes), and the way they impact on societies, they examined those social and natural phenomena's implications for the stability of countries and regions. In this regard, social constructivism (Wendt, 1992), and its multi-theoretical variations, such as “post-structuralist realism” (Wæver, 1989: 38) – also known as the Copenhagen School –, has played a part in the exercise of identifying causalities that link human-related phenomena to security concerns.

To some extent, this agenda likened the one of Peace Studies, which had started years before with Johan Galtung (1969), and looked, often in a transdisciplinary fashion, at typologies of violence and peace, in which the conventional inter-state relationship was one of several realms of analysis. A thorough study of peace and violence implied looking inside countries, and social groups (defined by gender, ethnicity, among other criteria).

A prominent scholarly and policy consequence of the shift operated by those groups of scholars was the rise of the human security paradigm among the foreign policy agendas of a number of governments in the late 1990s, particularly among Western Europe and so-called 'Middle Powers' (Canada, Japan) (Behringer, 2005; Debiel and Werthes, 2006). However, the major proponent was the United Nations system, whose Human Development Report (1994) defined human security as 'freedom from need' and 'freedom from want.' Human security points to a whole range of phenomena that pose direct and indirect threats to the integrity of the human being and human conglomerates, such as hunger, disease, social disruption, and violence.

Another body of scholarship pertinent to this overview originated among scholars of globalisation and international organisations (Keohane, 2002; Ruggie, 2004). Although far from recent, globalisation as a process of integration of markets, territories and populations at a worldwide scale was exacerbated from the 1980s onwards thanks to increasingly sophisticated means of communication and information. From the early 1990s, with the demise of the Union of the Soviet Socialist Republics (henceforth Soviet Union), it was further pushed by perceived hegemony of the United States of America (Keohane, 1984). The relevance of non-

state actors in that process, namely private companies and nongovernmental organisations (NGOs), conglomerated around an idea of ‘retreat of the state’ and supremacy of ‘social and economic forces’ in terms of core objects of study.

The centrality of social forces, or structures, has been particularly evident in the domain of International Political Economy (Cox, 1981), but also in International Relations (Gilpin, 1987), in which ideological bodies such as liberalism, or neo-liberalism, became increasingly at the heart of analysis rather than individual states. Certainly, states remained very important actors, yet not as sovereign policy-making entities as they used to be (Jessop, 2003). In a context of expanding mechanisms of social, political and economic organisation based on public-private partnerships states are rendered the role of facilitators and mediators of an assemblage of public and private actors (Ibid.). This dissertation’s case study, the United States President’s Emergency Plan for AIDS Relief (PEPFAR), constitutes a striking example of such partnerships.

It should be added that the main geographical location of these bodies of authors and policy-makers is Northern America and Western Europe. As a result, even if unintendedly, their methods of constructing social reality may reflect the epistemological centrality of the West in world affairs. In this regard, not only ethno-centrism may permeate the study of International Relations but also a gender-biased approach. Critical Feminist scholars have stressed the leading universalising morality in the discipline who “turn out to characterize only certain, specific individuals (e.g., male, white, middle-class property owners)” (Hutchings, 1999: 20).

The constructivist character of the post-Cold War international world is exemplified by the realm of global health, in which one’s case study is situated.

Global health constitutes the space where manifold actors (states, international organisations, nongovernmental organisations, private companies, populations) and phenomena (e.g. epidemics) interact according to their different conflicting agendas, which are supposed to be governed. As Chapter 3 suggests, global health governance has been a failure, because there is no central government enforcing order upon it. Global health governance is driven by asymmetric relations between powerful and weak actors, notably states. Often the powerful actors correspond to funders of global health initiatives of different sorts, whereas the weak are, generally, the recipient of such initiatives. Still, the idea of population, its needs, duties and rights, lies at the core of global health debates, often hindering the issue of inter-state asymmetry.

As a result, the focus on human security and global social forces has resulted on the growing primacy of the population over states in terms of major actors of analysis. Eminently, population-related topics such as international development, migrations, epidemics, or human rights, became absolutely central in the day-to-day policy and analysis of international affairs. This prominence is visible in the recent readings, mostly by critical authors in the discipline, of the practice of development or human rights, based on the frameworks of biopower and biopolitics (Foucault, 1978; 1984), which reflect precisely on the issue of the population, and the management that it is subjected by global social forces (Douzinas, 2007; Duffield, 2007; Jabri, 2007). These social forces have macro and micro dimensions that, altogether, demonstrate a transfused sovereign power among diverse units, as several works in Anthropology have been suggesting in the area of development, health and HIV/AIDS (Escobar, 1984/1985; Ferguson, 1994; Nguyen, 2010). Sovereignty is not

solely characteristic of state institutions, but of different actors, whose power “to give life or impede it to the point of death” (Foucault, 1984) is absolutely crucial.

However, such “radical” (Chandler, 2009a) reading of the post-Cold War liberal order is found wanting for the fact that it does not allow for a perspective of human agency in it, as suggested by David Chandler (Ibid.). In one’s reading, human agency is formulated in terms of a deliberative power of states as political communities, no matter how complex they might be domestically, to institute its own policy *vis-à-vis* the constraints that affect their action. Eventually, this invites a reassessment of current population-centred approaches and shift analytical focus back to states, although, as discussed in Chapter 4, taking into consideration the complementarity of internal and external spheres of the state and their social forces. As such, the proposed refocus on the state does not entail the adoption of Waltzian theory as developed by the original author.

As Chapter 4 discusses, some critical scholars of postcolonial theory inspiration (Richmond, 2010; Ginty, 2010; De Goede, 2010) have researched agency inside states, at the population level, as expressions of local resistance against a hegemonic liberal structure. Nevertheless, one finds this assertion troublesome, since it often suggests that states, including so-called ‘weak states,’ typically from the developing world, are already embedded in that hegemonic structure. In fact, this dissertation’s purpose is to demonstrate that, despite highly constrained by the external structure, states are characterised by agency when behaving with other states, including highly stronger ones. Even if in a context of international asymmetry, states retain their ability to take decisions of their own and pursue strategies and policies autonomously, with a view to the accomplishment of national

interests. As it is shown throughout the empirical part (Chapters 6, 7 and 8), they do not necessarily bandwagon (Waltz, 1979: 126) with, or are “hijacked” (Richmond, 2010) by, the structural hegemonic powers in terms of policies and practices.

The process of state agency *vis-à-vis* powerful international structures, particularly the United States of America, consists of the dissertation’s dependent variable, and will be explained by three independent variables. Considering the character of the case study, discussed in the following section, the first independent variable corresponds to the nature of foreign relations between the beneficiary countries – Botswana, Ethiopia and South Africa – and the donor countries – in this case, the United States of America, within and beyond PEPFAR. The second independent variable refers to the nature of domestic policies of each individual country, and their interaction within and beyond the donor countries’ – United States of America – foreign policies. Finally, the third independent variable concerns local dynamics of policy implementation by the beneficiary countries’ governments/states and its connection with the donor country’s – United States of America – policy influence. The autonomous action of individual states is constrained by their broader intervention in the exterior (region, continent and even world) and inside their own borders, in relation with their national communities. States’ actions demonstrate their need for survival as a nation (Botswana) and as a political regime (Ethiopia), but also their will to transmit ideas and values across the region and the continent (South Africa).

Concepts of agency and structure in International Relations were originally theorised by Kenneth Waltz (1979) in *Theory of International Relations*. States are the units in the international structure, and they hold agency when acting with other

units. In that regard, they are sovereign; however, no matter how powerful the state, such sovereignty is constrained by the structure. Later authors in the same theoretical tradition as Waltz, i.e. structural neorealism (Keohane, 1984; Mearsheimer, 2001), as well as in other traditions (Bickerton, 2007), have argued that from the 1980s onwards the structure has become the hegemony of the United States of America, allies in Western Europe, and Japan. However, just like there is no absolute sovereignty, there is no absolute hegemony either. This means that a country, no matter how weak it can be in economic and military terms, still enjoys a degree of agency, especially when behaving with powerful states. Indeed, this dissertation's argument goes along those lines. However, this understanding of agency needs to bear in mind the context of asymmetry between powerful, hegemonic states and weaker states. One needs to recognise weaker states' "subalternity" (Ayoob, 2022). This asymmetry is primarily understood in function of the disparities of wealth and human development between regions, but also the origin of influential epistemologies and policies that consubstantiates the actual relationship. In the particular case of postcolonial Sub-Saharan African states, which are at stake in this dissertation, the question of context is very crucial.

Moreover, one ought to connect both external and internal dimensions of states in order to understand their behaviour with powerful states, reversing the neorealist postulate that both spheres should remain detached (Rosenberg, 1990, 1994). States' actions need to be informed by their historical and sociological experience. Furthermore, despite their specificities associated with the European colonial project, states in Sub-Saharan Africa are certainly part of the international

system, and should be subject of analysis in the discipline like states anywhere else (Brown, 2006).

1.2. Case Study

1.2.1. United States President's Emergency Plan for AIDS Relief (PEPFAR)

PEPFAR is the product of different interrelated security and humanitarian concerns that emerged among the William “Bill” Clinton Administration (1993-2001), crystallized around the political elite led by George W. Bush (2001-2009), and continued under the current Barack Obama presidency (since 2009). It constitutes a striking example of United States foreign policy in the area of global health/development and diplomacy, in which asymmetric relations between the United States of America and countries under implementation stand out. Moreover, given its all-encompassing character in terms of types and quantity of organisations involved and sectors of activity approached, PEPFAR holds a crosscutting impact on recipient countries' external, internal and local dimensions of governance.

Launched in 2003, PEPFAR was inserted in the context of the United States War on Terror (Lyman and Morrison, 2006; d'Aoust, 2006), and more broadly within the emerging nexus linking epidemics to security that came to the fore through several intelligence and think tank reports (National Intelligence Council, 2000; Gordon, 2002; Schneider and Moodie, 2002). The fear of an expanding global jihad exploiting social vulnerabilities provoked by AIDS in the worst-affected territories of Muslim majority or of Muslim ‘large minorities,’ such as Nigeria, South

Africa and Ethiopia (Lyman and Morrison, 2006), constitutes a serious motivation for action and scaling-up the response. Yet, linkages to security precede, not only September 11 2001 terrorist attacks, but also the very Bush Administration (Pereira, 2009).

Nevertheless, preventing global jihads and local instability through HIV/AIDS implementation does not represent, as such, the sole justification for PEPFAR which has allocated for its first phase (2004-2008) close to 15 billion US dollars. Other reasons were important too. First, there were domestic dynamics, i.e. arguably the need faced by the Bush Administration to respond to its pressuring Christian conservative constituency (the so-called Christian Right) vastly engaged in HIV/AIDS politics, and broadly in development in the Third World (Dietrich, 2007). Second, in the latest period of his mandate, President Bush has arguably ‘necessitated’ to deposit a positive policy-making legacy *vis-à-vis* very low popularity levels at home and abroad (Feffer, 2008). Nevertheless, as former United States Global AIDS Coordinator Mark Dybul (2009) aptly highlighted during the latest presidency’s transitional period, United States reputation was very high across PEPFAR’s focus countries and should be maintained.

Finally, philanthropy – often expressed as ‘compassion’ – has guided both fund allocation and implementation by a wide range of nongovernmental organizations across the fifteen focus countries and a number of others where the United States Agency for International Development (USAID) carries out activities in the field too. Various respondents with United States government implementing agencies have emphasised this aspect.

PEPFAR constitutes the largest financial bilateral initiative to fight a single disease ever. Building on the experience of the Ryan White Comprehensive AIDS Resources Emergency Act of 1990, whose scope was the growing domestic AIDS epidemic (Bowen et al., 1992), PEPFAR was established by the United States Leadership Against HIV/AIDS, Tuberculosis and Malaria Act of 2003. Five years later it was continued by the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis and Malaria Reauthorization Act of 2008. PEPFAR is managed by the Office of the United States Global AIDS Coordinator and gathers several implementing United States government agencies: USAID, Peace Corps, and Departments of State, Defence, Trade, Labour, and Health and Human Resources.

Channelled through United States government's agencies (primarily USAID) and diplomatic missions, PEPFAR has virtually reached the vast majority of countries where USAID is present. However, since the beginning, it has focused on fifteen countries which accounted for half of the global number of infections by HIV, according to the Joint United Nations Programme on HIV/AIDS (UNAIDS), most of them in Southern and Eastern Africa.¹ Irrespective of the particularities associated with the individual countries, all were generally presented by Dybul (2009) as the "future" of United States-led global order.

According to the Government Accountability Office (2008: 10), budgetary allocations for the 2004-2008 five-year period were mostly oriented towards antiretroviral (ARV)-based treatment (55%), the rest being dedicated to palliative care (15%), prevention (20%) and orphans and vulnerable children (10%). The

¹ The fifteen focus countries are Botswana, Cote d'Ivoire, Ethiopia, French Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, Vietnam and Zambia.

problem with PEPFAR treatment funding is that, rather than being used for contracting preferably less expensive, generic ARVs (and thus expanding scale-up efforts), was oriented for the purchase of United States ‘Big Pharma’ branded ARVs, comparatively more expensive (Thompson, 2007). As such, PEPFAR has worked as a governmental protectionist scheme for United States pharmaceutical companies to enter African markets. In this area changes have reportedly been taking place through the inclusion overtime of generic drugs.

It is important to affirm that, as a public-private partnership, host countries’ institutions are equally very relevant. As any annual report to the United States Congress demonstrates, ‘partnership’ has been a buzzword in the process of PEPFAR (2009a; 2009b; 2011a). PEPFAR policy documents have always been very keen in terms of ‘horizontalising’ relations, showing that, in these difficult times of AIDS, the United States government and proud nongovernmental organisations stand together with the world’s least advantaged populations. Illustratively, photographs line side by side President Bush or a United States ambassador with their counterparts or ‘civil society members,’ especially children and young people. In turn, the flag of the United States of America stands side by side with the host country’s flag. However, despite this rhetoric of horizontal relations, it becomes clear, as the coming pages show, that the United States government maintains the material hegemony over the partnership, the host governments, and nongovernmental organisations, remaining the weakest link in it.

Over the years PEPFAR has advanced different models of partnership. The latest incarnation has received the title of “partnership framework”² (PEPFAR,

² For the partnership frameworks signed with Botswana, Ethiopia and South Africa see Annexes 5, 6 and 7.

2009a) in March 2009, which replaces the previous, called “partnership compact” (PEPFAR, 2009b). Alleged differences between one and the other merely regard juridical definitions, as the newest denomination is not legally binding. Nevertheless, one can argue that, at the content level, one is essentially talking about the same, and thus it is pertinent to insert this quotation about “partnership compact” extracted from the 2009 annual report to the United States Congress:

To build on the success the American people’s partnerships have achieved to date and reflect the paradigm shift to an ethic of mutual partnership, the USG is working with host countries to develop Partnership Compacts: agreements that engage governments, civil society, and the private sector to address the issues of HIV/AIDS. The goal of Compacts is to advance the progress and leadership of host nations in the fight against HIV/AIDS, with a view toward enhancing country ownership of their programs. (...) PEPFAR will continue to be part of this new era of development that champions friendship and respect, mutual understanding and accountability — and trusts in the people on the ground to do the work. (PEPFAR, 2009e: 58)

In its March 2009 draft version, the Partnership framework’s guidance text states “an optional two-step process of developing a broad initial Partnership Framework and a subsequent more detailed Partnership Framework Implementation Plan” (PEPFAR, 2009a: 3). Moreover, the five-year co-joint strategic partnership framework is to fulfil principles of transparency, accountability, and the active participation of other key partners from civil society, the private sector, other bilateral and multilateral partners, and international organizations, and should support and strengthen national HIV/AIDS strategies” (Ibid.).³ Out of the different principles “country ownership” and flexibility are the most emphatic.

PEPFAR is articulated with the African Growth and Opportunity Act of 2000. Its latest report, of 2008, affirms that it “has helped African firms become more

³ It should be mentioned that PEPFAR’s budget includes the United States’ participation in the Global Fund. The other multilateral institution in which the United States is engaged is UNAIDS.

competitive internationally, thereby bolstering sub-Saharan African economic growth and helping to alleviate poverty in one of the poorest regions of the world” (Office of the United States Trade Representative, 2008: 7). However, such economic growth has not been large enough in order to reduce the large trade deficit Africa as a whole maintains with the United States of America (United States Department of Commerce, 2009: 41). As such, it is necessary to foster economic growth in order to enlarge a consuming market for United States products.

With the Obama Administration, the major novelty has been the Global Health Initiative, which aims at harmonising the different global health programs, such as PEPFAR and the President’s Malaria Initiative, and incorporating other epidemics with a focus on health systems and gender in eight focus countries (Office of the Spokesman, 2010).⁴ In a context of budgetary constraints, the Administration has decreased the pace of funding to the global health programs, including PEPFAR. Moreover, this is a phase of shifting the emergency mode towards sustainability and country ownership (Pereira, 2011a).

1.2.2. PEPFAR in Botswana, Ethiopia and South Africa

Apart from being PEPFAR focus countries,⁵ Botswana, Ethiopia and South Africa were chosen for being representative of different strategic rationales regarding security, development and overall political and economic reform.

⁴ Countries are Bangladesh, Ethiopia, Guatemala, Kenya, Malawi, Mali, Nepal, and Rwanda.

⁵ As discussed in Chapter 5, the category of focus country has disappeared from PEPFAR’s official policy literature after the first phase of implementation of the Plan (2004-2008). However, at the time of elaborating the doctoral project (2008), it was still featuring, and therefore it is employed throughout the dissertation.

On the one hand, Botswana's relevance is explained by a constructivist element of United States foreign policy. In the latest decades, Botswana's governments are considered exemplary for their commitment to economic growth, good governance, stability, and liberal institutions. Eventually, the country is put forward as a 'model' that the rest of the continent should emulate. In a context of persistent conflict and underdevelopment across the continent, Botswana is presented as the country everyone should aspire to be. Consensually, available literature presents this country as a major case of successful and peaceful postcolonial national development under a liberal framework based on partnership between the state and private interests (Mbabazi et al., 2002: 38-39; Mogae, 2006). Such success is much enhanced when this country is compared with other Sub-Saharan countries, mostly those whose economies rely on mineral resources. The example of HIV/AIDS further centralises that aspect, the national government being generally commended for its committed and "country-owned" (Whitfield and Maipose, 2008) response to advice on the social and economic impact of the epidemic (Osei-Hwedie, 2001; Bar-On, 2002; Noorbaksh, 2008; Gossett, 2010). In fact, the country has been severely affected by the epidemic, as close to one quarter of the adult population lives with the disease (WHO, 2010: 32).

On the other hand, Ethiopia and South Africa were chosen for their status as 'anchors' of strategic policy of the United States of America, in their corresponding regions, Horn of Africa and Southern Africa, and the African continent as a whole (Jefferson, 2006; Schraeder, 2006). As the United States Africa Command (AFRICOM) is launched with the aim of stabilizing the continent in more diplomatic

and humanitarian forms (Esquire, 2008), they reflect a harder version of power politics embedded in United States foreign policy.

As far as Ethiopia goes, its regional location has been featured by manifold threats such as state failure, epidemics, Islamic extremism, refugee movements and armed conflicts. In a context of complex relations between the United States of America and the countries in the Horn of Africa, Ethiopia emerges as the main United States local ally in the effort of stabilization inside Ethiopia and around the region (Somalia, Northern Kenya, Eritrea and South Sudan) (Lyons, 2006). 45 to 50% of the Ethiopian population is Muslim (Permanent Mission of Ethiopia to the United Nations, 2007), and therefore it is deemed worrisome. Concerning HIV/AIDS, although the prevalence rate among adults is relatively small (2.1% [WHO, 2010: 32], it affects close to one million people.

With regard to South Africa, the large size of the HIV/AIDS epidemic (18.1% of prevalence among adults [Ibid.]) poses itself security concerns from a United States foreign policy perspective. Most studies relating AIDS and security in South Africa (and Southern Africa in general) reflect upon impact in the military structures (Heinecken, 2003; Rupiya, 2006), war (Cheek, 2001), urban juvenile criminality (Schönteich, 1999) and recruitment of youths for extremist activity against Western interests (Lyman and Morrison, 2006: 56-57).⁶ Even though deeply integrated in the global capitalist economy and characterised by the rule of liberal political institutions and a vibrant civil society sector, the specificity of domestic dynamics on urban insecurity, violence, social exclusion, and increasing inequalities, often mirrored by the experience of HIV/AIDS, demands careful attention from a security perspective.

⁶ The Muslim population accounts for 1.5% of the total population of the country (South African Government, 2008).

1.3. Methodology

This is a qualitative study that involves analysis of policies and practices of different actors, with a focus on the government of the United States of America, Botswana, Ethiopia and South Africa. This study incorporates disparate types of data and techniques of data collection: revision of academic literature (theories of International Relations and International Political Economy, Global Health Governance, Security Studies, African Studies, United States Foreign Policy, Development Studies) and policy documents (primarily PEPFAR and United States government as a whole, and South African, Ethiopian and Botswana government); media reporting (on PEPFAR and the governments of all countries involved); semi-structured interviews with representatives of PEPFAR implementing organisations and other relevant actors; and, finally, observations of daily social and political life in Botswana, Ethiopia and South Africa.

Regarding the interviews, two sets of questions were defined. One set targeted prime implementers of PEPFAR, although, occasionally, sub-partners were also interviewed under the same set (Annex 1).⁷ The other set was applied to a range of stakeholders in the area of HIV/AIDS, health, development and governance, yet without being funded under PEPFAR (Annex 2). The purpose was to obtain outsider views on PEPFAR-funded projects and their effects.

Considering the vast number of implementers and time limitations, one opted out for prime implementers only. The identification of implementers was carried out

⁷ There are two types of implementing partners: prime and sub. The hierarchy is explained by the process of funding application, in which the prime secures the funding in the first place, and then channels it down to the sub-partner level.

through access to the country operational plans, downloadable on PEPFAR's website (www.pepfar.gov), to websites of the United States' Embassies in the three countries. This was done before and during the individual field enquiry periods. One contacted as many prime implementers as possible in order to obtain the largest possible number of interviews. Time limitations also posed constraints on the examination of the fullest scope of the dependent variable (the process of state agency).

Questions to PEPFAR implementers' representatives were conceived to be as broad and flexible as possible in order to accommodate the maximum amount of information on the implementing organization's mission and activities, and relations with the United States and national governments under PEPFAR. Questions also looked for opinions and perceptions about various relevant issues, such as the HIV/AIDS response, developmental achievements in the country, and, occasionally, security. Being a qualitative study, the manifold claims made by interviewees are merely informative with regard to one's broader discussions in this dissertation. They are taken as such and never as scientifically conclusive arguments. It is not one's concern to question the validity of such claims, but solely to build on the social, political and professional experiences that come attached to those claims, and the way they are put forward.

In terms of the relationship maintained between researcher and interviewees, a Waiver Consent/Authorization for Minimal Risk Research was issued by the PhD Program Coordinator at the School of Economics, University of Coimbra for this doctoral project, and submitted to each potential interviewee.⁸ The submission of this

⁸ Interviewees were assured orally that both their names and their organizations would remain anonymous in the dissertation. However, as expressed in the rules of the doctoral program, a list of

document was part of a larger introductory file with the researcher's biography, doctoral project's abstract, list of questions and institutional letters issued by home and host institutions in the three countries.⁹ In Ethiopia, the United States embassy in Addis Ababa also issued a letter of support.

In the case of South Africa, where field research took place between early September and late November 2009, the primary source of contacts was the lists of partners by South African province in 2009 obtained through access to the United States' embassy in South Africa's website. These lists included: name of institution, short presentation of mission and activities, type of PEPFAR-funded program area, physical location, and contact information (name, position, telephone number and e-mail address). This public display of contact information proved, compared to the other two countries, highly facilitating with regard to establishing contacts and requesting an interview. With the exception of Durban-based implementers, most interviews were carried out by telephone and some by e-mail. This had to do with the countrywide distribution of implementers' headquarters, whose personal visit would require a far longer field research period in the country. One interviewed 43 prime PEPFAR implementers and 4 entities not under PEPFAR funding, mostly nongovernmental entities based in the country or in the United States of America.

In Ethiopia, field research took place in two periods: from early February to mid-May 2010, and from early October to late November 2010. The reason for this

interviewees was made and delivered to the thesis' supervisor. The interviews were always carried out in English, which generally did not constitute a setback in the relationship between researcher and interviewee.

⁹ This project was hosted in South Africa by the Health Economics and AIDS Research Division (HEARD), University of KwaZulu-Natal, Durban; in Ethiopia by the Organization for Social Science Research in Eastern and Southern Africa (OSSREA), Addis Ababa; and in Botswana by the Centre for Study of HIV and AIDS (CSHA), University of Botswana, Gaborone.

exceptionally extended field research in Ethiopia had to do with the unsatisfying low number of interviews done after the first period when compared to the achievements in Botswana and South Africa, which had the potential to skew the comparative findings of the dissertation. This situation, thus, called for an extended effort in Ethiopia. The main source of PEPFAR prime implementers' contact persons was the 2009 Country Operational Plan for Ethiopia, which includes no contact details of implementers. Unlike in South Africa, the United States' Embassy in Addis Ababa did not make contacts available, either through online search or direct request. As such, one had to resort to browsing for contacts on the implementers' website when available and searching for their office and contact person around Addis Ababa and the country. In Ethiopia one sought to interview 15 PEPFAR implementers, mostly United States governmental and nongovernmental implementers. Although no Ethiopian governmental agency made itself available, one had encounters with members of the governmental party on an informal basis during the campaigning period of May 2010. All interviews were done at the interviewees' offices and other locations of their choice.

In Botswana, field research occurred from early June until late August 2010. Although working with the same kind of source of information as in Ethiopia (the 2009 Country Operational Plan, which does not display contact details of implementers), and therefore having to resort to online browse and physical search of offices and contact persons, this operation proved more effective than in Ethiopia. 23 PEPFAR implementers were interviewed, and from all types: United States and Botswana governmental and nongovernmental organisations. With one exception

(over the telephone), all interviews were done at the respondents' offices or other locations of their choice.

In face of the impossibility of arranging personal meetings with higher level members of national governments (e.g. Prime Ministers, Presidents of the Republic, Ministers of Health, diplomats), one resorted to sources such as media interviews with them and public speeches.

The information collected was treated qualitatively to frame and inform the analysis, as well as to illustrate, when deemed appropriate, certain dynamics and perceptions from different type of actors involved.

1.4. Field Contribution

This dissertation aims to make a number of contributions to Peace and Conflict Studies in general, although with a specific focus on Global Health Governance, Development Studies, African Studies and United States Foreign Policy. These contributions are both theoretical and empirical.

This dissertation engages in two central, ongoing discussions in Peace and Conflict Studies: security rationales and policies underneath international community's initiatives in the realm of peacebuilding and conflict prevention, and the interrelated question of external structural domination and national state sovereignty. On the one hand, one's case study is emblematic of a major initiative of the United States of America, whose scope stretches far beyond its primary goal of containing and treating the HIV/AIDS epidemic and interconnected social, economic and political dimensions. Together with other policy tools, PEPFAR maintains a

lasting influence in recipient countries, at the external, domestic and local levels, with a view of accomplishing a security-driven agenda, among other elements. As such, this PEPFAR's discussion offers a nuanced perspective over the prominence of security discourses and practices in the larger landscape of peacebuilding and development debates. On the other hand, by inquiring the fundamental concepts of agency and structure, unit and international system, and corresponding characteristics of hierarchy and anarchy, the dissertation addresses the question of whether or not policy initiatives advanced by the international community, and more specifically those of the United States of America through PEPFAR, reduce drastically or even terminate the sovereignty of countries under intervention. The exploration of agency in this context requires, however, the redefinition of the object of study centred on the state and not the population *per se*. Although useful in terms of rendering operational the concepts of agency and structure, one finds the Waltzian proposal limited, and therefore proposed a conceptualization that accounts for issues of asymmetry between states as well as the historical and sociological experience of the state.

A topic within International Relations that this dissertation directly contributes to is Global Health Governance. Being an area completely contemporary to the major research agendas that revolve around globalisation, human security and, thus, population-centred research and policy, this dissertation offers insightful theoretical and empirical inputs. The theoretical input concerns the role of states, their policies, and practices. From an empirical point of view, it deals with one of the most important case studies of 'global health' as a whole, i.e. the largest bilateral program on a major epidemic, and concomitant areas (medical, political, social,

economic). In a larger sense, this dissertation also contributes to Development Studies, addressing issues of dependency and agency crucial for studies of development aid.

With regard to African Studies, the dissertation contributes to interdisciplinary discussions on statehood in Sub-Saharan Africa and its presumed peculiarities within the international system. Additionally, this work focuses on three individual African countries, and corresponding implications for their surrounding regions and the African continent. It proposes a three-layered presentation of their foreign and domestic policies, and practices, in view of their major strategic choices and challenges. South Africa has received large attention by scholars in the field over the years, and sections dealing with it largely build on that scholarship. However, literature outputs specifically on Ethiopia, and most especially on Botswana, are not as available. Furthermore, the impact of one single program in these very different African states also enriches Comparative Politics literature. This dissertation may also appeal to scholars working on policy analysis, and how policy translates into practice. In this regard, and considering the case study, United States Foreign Policy was particularly central throughout the dissertation.

Finally, as a piece in the Social Sciences, it collaborates with the interdisciplinary and inter-scientific effort of improving the knowledge about the HIV/AIDS epidemic. Together with other epidemics and their determinants, it poses a severe constrain on the quality of life of millions of people around the world, and therefore demands a permanent reflection that ultimately allows for better individual, local, national and international responses.

1.5. Chapters' Roadmap

This dissertation is divided into nine chapters. After this Introduction (Chapter 1), Chapter 2 makes a historical incursion into the experience of postcolonial Sub-Saharan states. However, it focuses on the last three decades (1980-2010), particularly with regard to relations with the Western world. This exercise is done with the purpose of contextualising the dependent variable of this dissertation: the process of agency, i.e. autonomous, yet constrained, action, of postcolonial Sub-Saharan states in face of the international structure of Western hegemony. Although one's case study points to three individual states (Botswana, Ethiopia and South Africa), this chapter revolves around a generalised idea of the postcolonial African state, and underlines the tension of governmentalities that feature the postcolonial relationship with regard to development, survival and negotiation of aid and loans.

Chapter 3 focuses the discussion initiated in the previous chapter in the field of Global Health Governance. It reflects on the epistemological foundations of this field by emphasising their liberal and constructivist elements. It is argued that global health emerges as a Western construction contemporary to globalisation and the post-Cold War era, in order to make sense of new and old epidemics and their perceived effects around the world. Initiatives in the area of health with a global scope appear as policies that consolidate Western countries as primary donors, and countries with large disease burdens, such as those in Sub-Saharan Africa, as recipients, and rendered the role of either facilitators or 'rogues' in the implementation of those policies.

Chapter 4 presents the theoretical framework of this dissertation. Proposing the dialectics of agency and structure for the study of West-Africa relations, it

departs from a reading of Kenneth Waltz's (1979) conceptualisation of system, structure, unit and agency for the world of states, found basically useful for the empirical analysis that ensues. After reviewing several hegemony-based approaches to international relations, the chapter challenges them by questioning the essentialisation to the international structure that the postcolonial state in Sub-Saharan Africa is subject to by that body of claims, and concomitantly the lack of agency that comes associated. Finally, one proposes an analytical framework based on the dialectics of agency and structure, however, acknowledging the existent asymmetry between the West and Africa and the need to connect external and internal spheres of the state, informing them with historical and sociological experience.

Chapter 5 scrutinises the dissertation's case study: PEPFAR. It presents and discusses its origins, political rationales, policies and organisational design. The links to security and humanitarianism, as well as its sophisticated division of labour, are particularly examined, in order to understand not only the broader United States foreign policy, but also how this instrument engages with the host countries, especially state institutions.

Chapters 6, 7 and 8 are the empirical chapters. Each one corresponds to a separate independent variable that explains the process of agency of the three states (dependent variable). Chapter 6 addresses the nature of foreign policy of the three countries. Chapter 7 refers to the domain of domestic policy. Finally, Chapter 8 considers the actual practices of states/governments in face of the pressures posed by the international structure and domestic societies too. It shows the instances through which PEPFAR, as well as United States foreign policy at large, is incorporated or

rejected *vis-à-vis* strategic concerns of Botswana, Ethiopia and South Africa. It demonstrates the coherence across the three levels of analysis that consolidate distinguishable behaviours. In the case of Botswana, one identifies a concern for survival of the population, in a context of a very large HIV/AIDS burden. Ethiopia reveals a survival approach as well, yet driven by the political regime's self-help. Finally, South Africa's behaviour is characterised by a will to transmit specific ideas and values inside and outside the countries' borders, especially around Africa.

At last, Chapter 9 presents the conclusions.

Chapter 2 – African Postcolonial State in Last Three Decades (1980-2010)

2.1. Introduction

This chapter looks historically at political developments from the first wave of independences throughout the 1960s until the first decade of the 21st century. The period under analysis covers the last three decades, and is divided into two periods: the 1980s-1990s and the 2000s. Despite the continuities that characterise both periods, the differentiation is based on a fundamental policy change towards the region among Western organizations and states, and the reactions such change has provoked. As such, this chapter introduces the historical basis that inform the dependent variable of this dissertation, that is, the process of agency of postcolonial national states in Sub-Saharan Africa *vis-à-vis* the international system featured by Western hegemonic interventions in the region, particularly, but not exclusively, through development assistance.

Even though this dissertation analyses three specific countries (Botswana, Ethiopia and South Africa), this chapter focuses on a generalised idea of the ‘African state.’ It serves the purpose of setting the terms of the debate the empirical chapters engage with on the individual countries’ experience with PEPFAR. The relevance of framing the background debate based on a generalization has to do with a usual methodological approach to the study of African politics, which departs from generalisations moving then toward specific countries or issue areas. According to leading Africa scholar Jean-François Bayart, this should not imperil the research

“since geographical proximity has none the less brought about a relative commonality of historical destiny, of which the colonial interlude is only of secondary importance” (Bayart, 2009: 34). As Bayart further claims, “[this] allows us to construct a scientific object, to circumscribe a political area in a comparative perspective, even to talk of an ‘African’ civilization in the sense intended by Braudel as a reality of ‘great, inexhaustible length’” (Ibid.).

However, this choice is also explained by the regional character of the broader foreign policy that informs this dissertation’s case study – the launch and implementation of PEPFAR since 2003 in Botswana, Ethiopia and South Africa. Although it is part of a policy with a worldwide scope, PEPFAR has particularly been implicated in the broader United States foreign policy towards Sub-Saharan Africa. As one discusses in Chapter 5, PEPFAR’s rationale departs from a generalising approach to issues around security and stability, irrespective of the country at stake. The synthesis of these two drivers of analysis – the methodological ‘tradition’ in the political study of African affairs and the character of policy-making in the United States of America – leads to an approach to general Sub-Saharan African relations with the United States of America, and the Western world at large. To be more precise, one discusses the role of international aid and loan-giving overtime in such relationship.

This chapter is divided into four sections. The first section discusses the character of the postcolonial settlement between the newly African state and the former colonising powers. The second section focuses on the 1980s-1990s, in which, despite the powerful influence of the neo-liberalising structural adjustment programs of the time, the African national state sought to preserve autonomy through its

survivalist modes in very adverse circumstances. In turn, the third section covers the first decade of the 21st century, characterised by the securitization of external development programs and a policy centred on the imperative of strengthening the African state through policies of statebuilding. One witnesses the renewal of a purportedly active state setting out to attain different agendas, according to individual country's choices and old and new issues that they face, including social/human development and health-related ones. However, the current context is also one of diversification of donors and lenders, in which China, for instance, is playing a very important role. Indeed, the beginning of the 21st century has witnessed in the African scene an emergence of new and powerful actors, apart from Western governments and organisations. The final section connects the individual cases of South Africa, Ethiopia and Botswana to the contemporary debate paved by the previous sections.

2.2. Postcolonial Settlement

Although framed by a nationalist rhetoric, strong ties with the former colonial powers were generally maintained by the leaders of the former colonies. With a relatively small number of exceptions (Angola, Mozambique, Guinea-Bissau, Algeria, Zimbabwe and Namibia), transition towards formal independence occurred in a fairly smooth manner, in which power was formally delegated from the colonial administrators to the leadership of the nationalist parties that had reclaimed sovereignty. Regarding the major colonial powers in Africa, the United Kingdom of Britain and Northern Ireland (henceforth United Kingdom) and France, there generally were no incentives to contend by force those demands of independence,

arguably because resources allocated to the colonies were small and therefore did not justify military interventions. However, they sought a close relationship with the post-independence political regimes.

The most sensible solution (...) was to leave with every appearance of willingness, while establishing as good a relationship as circumstances allowed with the successor regimes – many of which were in any event led by politicians who were closely associated with the colonial power. (Clapham, 1996: 37)

The postcolonial elites essentially inherited the bureaucratic apparatus established during the colonial period, and thus reproduced the rational logic of a nation-state as the Weberian tradition puts it. Additionally, the porous character of state institutions, namely in technical areas such as education or health – largely realms of Western knowledge inculcation –, is explicable by the continual connections to the formal administrative and political power (Swidler, 2007). The character of the relationship between the newly independent Sub-Saharan African states and their former colonial powers was as intense as asymmetric. It “carried with it a constant remainder of the colonial past, and could never be entirely divorced from a sense of subordination” (Clapham, 1996: 77). In this regard, it is interesting to observe the role of the development apparatus in the postcolonial age.

Expatriate workers from the former metropolis frequently increased in number after the independence, especially in the francophone states, and provided a strong inducement for their home governments to help guarantee peaceful conditions and friendly relations with the African state. (Ibid.: 78)

In fact, the former colonial elites maintained an interest in keeping good relations with what they saw as “their Africa” (Ibid.: 79).

Although the key relationship tended to be with the former coloniser, close links were maintained by the postcolonial elites with the superpowers, usually one of the two world rivals (United States of America and Soviet Union). Nonetheless, even

though the average African postcolonial state is indeed porous, subaltern and to an extent subordinated, it does not mean that it does not have the capacity of taking independent actions, and as such does not necessarily conform permanently to the system's structural constraints and guidance. Here one looks particularly to the three last decades (1980-2010).

2.3. 1980s-1990s: Structural Adjustment Programs and Survivalism

The immediate post-independence period of the 1960s was heralded with optimism. Many African countries sought to attain levels of economic growth as part of a nascent developmental strategy driven by the state. This strategy aimed at building industries that would facilitate transition from a primary sector-based economic stage, contribute for the consolidation of sovereignty, and concomitantly reduce dependency from the former colonial rulers. At the same time, social welfare concerns were also incorporated in the development strategy. According to Africa historian J. D. Fage,

[with] independence (...) the new leaders of these countries almost without exception embarked on development strategies which involved increasing production for export of primary agricultural and mineral products, and taxing, and borrowing against, the resultant income from the world markets to provide funds for the development and diversification of the economy and the improvement of society. In particular they planned to improve education, health, housing and other amenities, so that more people could live in towns and work in new industries. The output of these industries should mean that less of the national income would need to be expended on imported manufactures, so that more funds would be available to pay interest on foreign borrowings and ultimately to reduce them. (Fage, 1988: 499)

However, those early achievements proved to be not lasting, as it became increasingly visible in the 1970s. Progressively larger import deficits at the average African country started to coexist with a spiral of negative economic growth and

depreciation of living conditions among the population (Ibid.). Both external and internal factors were pointed out. Externally, the lack of, or insufficient, integration by national economies in the global market place, despite the post-independence efforts was signalled (Ibid.: 499). Also, the great increases in oil prices in the 1970s certainly affected for the most part the number (at the time) of non-oil-producing countries, which required energy to fuel the nascent industries (Ibid.: 501). Furthermore, the increase in the burden of interest rates on the national economy was another obstacle.

Payments of the interest due on the foreign loans they had acquired to help finance their development programmes – let alone any repayments of the capital that had been borrowed – were becoming a very high proportion of their GNPs [gross national products], and were eating up more and more of their diminishing foreign earnings. (Ibid.: 505-506)

At the internal level, factors such as urbanisation and population growth were identified as explanatory of an increasingly difficult situation (Ibid.: 501-505). As put by the same historian,

From 1973 onwards, the problem of growing enough food in Africa to feed its growing and increasingly urbanized population was made much worse because there were a series of successions of years in which the amounts of rain received, particularly in the arid and semi-arid zones between 10° and 30° either side of the equator, were markedly less than the average. (Ibid.: 504)

But a second explanation lies on the character of the African state. The African state has been described as eminently neopatrimonial and clientelist, characterised by a system of “giving and granting of favours, in an endless series of dyadic exchanges that go from the village level to the highest reaches of the central state” (van de Walle, 2001: 51). This system functions in a hybrid manner, in which that practice of favour exchange takes place behind the façade of a modern state structure. The nature of the state in Africa has been thoroughly studied in the last

couple of decades (Bayart, 2009; Chabal and Deloz, 1999), but for the purposes of this chapter, one will refer to Nicolas van de Walle's description.

Outwardly, the state has all the trappings of a Weberian rational-legal system, with a clear distinction between the public and the private realm, with written laws and a constitutional order. However, this official order is constantly subverted by a patrimonial logic, in which officeholders almost systematically appropriate public resources for their own uses and political authority is largely based on clientelist practices, including patronage, various forms of rent-seeking, and prebendalism. (Ibid.: 51-52)

One critical feature of this neopatrimonial system is that "it results in a systematic fiscal crisis" (Ibid.). The same author argues that this crisis – fundamental to understand the relation maintained for so long with the international lenders – has not to do with a "big state," as believed by the leaders of the financial institutions, but with the revenue side.

Despite extensive state intervention in the economy [after the independence], cronyism and rent-seeking have siphoned off potential state revenues. Taxes are not collected, exemptions granted, tariffs averted, licenses bribed away, parking fines pocketed. As a result, revenues always lag behind expenditures. (Ibid.: 53)

In a context of external difficulties and given the domestic political characteristics, countries turned to the international financial institutions and Western Europe to provide them with funding. However, funding through Structural Adjustment Programs under the auspices of the International Monetary Fund, the World Bank, and national donors came with a set of conditionalities that has enlarged overtime.

Aid conditionality means that the granting of aid is tied to whether recipient countries adopt, or promise to adopt, certain recommended policies. At first only the granting of new short-term balance-of-payments aid was linked to policy conditionality, but over time most new programme and project aid became so linked. The policy conditions to which the granting of aid was linked initially concerned only macroeconomic matters but were soon extended into attempts to restructure the state-market relation. (Engberg-Petersen et al., 1996: 15)

The leading school of thought backing conditionality policies was eminently neoliberalism, which was re-emerging in Western Europe and North America in the late 1970s, early 1980s, and advocated drastic reductions of state bureaucracy and state interventionism in the economy. This school made thrives in several governments of the time, whose main concern was to control inflation in their countries. The purpose was to release societies from the constraints imposed by the state through liberalization of public-owned enterprises, so countries could respond more effectively to global market signals (Ibid.: 401).

It is not one's purpose to comprehend how neo-colonial, or neo-imperial, this process has *per se* been. Since the independence, the broader relationship between the postcolonial state and its former colonial master has been based on asymmetry, on dominance of the latter over the former, and therefore van de Walle's conclusion resonates with that premise: "The discourse and ideology of economic liberalization was clearly donor driven, with remarkably little local support." (van de Walle, 2001: 275) It is rather one's purpose to analyse the agency, i.e. the autonomous action, enjoyed by the national governments under that hegemony. Despite the narrower political manoeuvre room imposed by the design of the international interventions, national political elites have remained largely untouched, as they sought to navigate these conditionalities. As van de Walle shows in his discussion of the structural reforms, "measures have been partially undertaken, reserved, diverted, compensated for, and manipulated so they do not threaten leaders' control over discretionary state resources" (Ibid.: 274). Moreover, according to the same author, given the neopatrimonial character of the African state,

overall government consumption does not appear to have declined significantly over two decades of reform and, once aid resources to states are included, the total amount of resources controlled by governments has probably risen by several percentage points of GDP in the last twenty years. (Ibid.)

This behaviour constitutes what Christopher Clapham has coined the “politics of state survival” (Clapham, 1996). Accordingly, survivalism has taken many shapes and forms from appealing to foreign funding aimed at resolving issues of poverty and underdevelopment to facilitating foreign direct investment, in a context in which state institutions and government elites generally coincide. As part of the growing privatisation of international relations throughout the 1990s, those appeals are targeted both at foreign governments and, most prominently perhaps, NGOs, which exploded in their visibility and influence, and private companies (Ibid.: 244). The governmentality of the liberalizing structural adjustment programs was confronted with another governmentality: the governmentality of neopatrimonialism (Bayart, 2009: 268).

Aid has arguably helped to assure the elites the status quo. However, it did so at a very high cost in terms of reduction of human development. It is not one’s purpose to assess the results of these programs in their various dimensions, as, for instance, Poul Engberg-Pedersen and colleagues (1996) have done with regard to a group of countries in the areas of agriculture, industry, poverty reduction or the environment. However, even liberal reformist observers such as van de Walle recognise that the reduction of the state functions resulted in “a progressive withdrawal of governments from key developmental functions they had espoused in an earlier era” (van de Walle, 2001: 276). In other words, states lost capacity to address conveniently the critical issues of social welfare and improvement that

heighten development. Conversely, the provision of social services started to be provided by donors and NGOs who occupy those areas. At that level, the dependency of countries have augmented, and while it is fair to emphasise the neopatrimonial character of governments, it has to be stressed the extent to which those adjustment programs are responsible for such outcomes too.

By the end of the 1990s, early 2000s, the international establishment altered its perspective by shifting policy focus away from a reduced state to a ‘capable’ one. Rather than reducing the African state, the purpose became to rebuild it, empower it, and make it act ‘responsibly’ towards the international community.

2.4. The 2000s: Development Securitization, Statebuilding and the Developmental State

Both the international financial establishment and its body of critics acknowledged that the structural adjustment interventions across Africa did not bear the ultimately intended results. However, they evidently put forward different reasons to explain the situation. The former generally refers to a conditionality which was not hard enough in terms of enhancing private investment and liberalizing public and parastatal¹⁰ companies (Engberg-Petersen et al., 1996: 8). In turn, critics focus on problems of translating neo-liberalism into practice. For some, the problem of neo-liberalism is that it is too “simplistic and misleading” (Ibid.). For others, who do not share the same radical stance, the neo-liberal paradigm is “basically correct,” but it ought to be adapted to local realities (Ibid.). But perhaps the greatest divide in

¹⁰ Parastatals are organisations that belong to the state apparatus, and whose budgets come, fully or partially, from external sources.

opinion between the former and the latter group has to do with how poor societies were before and after the programs. For the critics, the average people became much poorer, while the supporters claim the very opposite. The supporters also allude to a lack of a counterfactual in the critics' discourse; they claim one just would not know "what would have happened without structural adjustment" (Ibid.).

In any case, the statistical fact is that in terms of human development, the continent has remained in the lowest ranks of the Human Development Index. In 2000, the United Nations Millennium Summit established eight targets to be ideally achieved by 2015. The goals of the United Nations Millennium Development Goals are: to eradicate extreme poverty and hunger; to achieve universal education; to promote gender equality and to empower women; to reduce child mortality rates; to improve maternal health; to combat HIV/AIDS, malaria and other diseases; to ensure environmental sustainability; and to develop a global partnership for development. The Millennium Development Goals have constituted the basis of action for multilateral initiatives such as the 2001-established Global Fund to Fight AIDS, Tuberculosis and Malaria (henceforth Global Fund). However, major bilateral initiatives have been launched, such as the United States Millennium Challenge Account and theme-specific programs such as PEPFAR or the President's Malaria Initiative. Another type of initiatives consisted, for instance, on the Heavily Indebted Poor Countries, with an aim of reducing and restructuring the debt towards a fresh start for development.

But these initiatives occurred in a fairly different policy context compared to the late 1970s and 1980s described above. Since the end of the Cold War commentators and policy-makers have referred to a need of linking developmental

efforts to what they perceives as new threats to international security (Krasner and Pascual, 2005; Klingebiel, 2006; Adelman and Eberstadt, 2008; Patrick, 2008). Former British Prime Minister Tony Blair has alluded to them in this brief manner: “today the threat is chaos” (Rasmussen, 2002: 333). By this he meant the amalgamated phenomena that jeopardise the unprecedented wave of liberal power after the demise of the Soviet Union and throughout the 1990s, and that expanded across the world through trade and travel. It included the easier proliferation of migrations, and concomitantly epidemics; trafficking in drugs and weapons of mass destruction; and sophisticated transnational networks of terrorists. The purpose of external intervention, preferably through soft power means (Armitage and Nye, 2007), i.e. aid and business opportunities, but also through military solutions, ought to consist in containing phenomena like those.

The idea of linking security to development of populations is far from new, as has been shown in the case of epidemic interventions in colonial settings (Pereira, 2008).

The genealogy of securitization of infectious disease can be considered as old as the rise of liberal political regime in Europe since the 17th century, and whose global expansion and consolidation were favoured by international public hygienist surveillance as of the 1830s. (Ibid.: 8)

However, this time around, the novelty had to do with the observation that development had become a strategically-defined question of security as classically it used to be with regard to enemy states. This framework has been radically described as a governmentality in which the neo-liberal economics embedded in the Structural Adjustment Programs of the 1980s and 1990s was complemented by issues of denying life opportunities for the populations (Duffield, 2002; 2005; Dillon and Lobo-Guerrero, 2008).

Rather than serving purposes of progress and emancipation, for Duffield (2007), development has become a tool of contention of “surplus” postcolonial populations, and the pressures they put on global capitalism since the wave of decolonisation in the aftermath of the Second World War. This pressure has become more intense from the 1990s onwards, particularly after the attacks in New York and Washington, DC, on September 11, 2001, as contention is required for more specific goals rooted on security challenges, such as international terrorism and other perceived threats to the Western world. Development interventions are constructed in rhetorical and policy terms as preventing such threats, and managed by sophisticated mechanisms of “governance at a distance” (Duffield, 2005: 208-210). These tools build on a presumption of neutrality of developmental work, driven by professional experts, and aimed at overcoming stringencies that political struggle generates, as anthropologists Arturo Escobar and James Ferguson have shown (Dar and Cooke, 2008). This body of radical critics of development often constructs analyses through the employment of frameworks of biopower and biopolitics developed in the 1970s by Michel Foucault, as Chapter 4 discusses into more detail.

A burgeoning literature with strong impact on Western foreign policy circles has placed the problems of ‘new threats’ to security and development, not only but particularly in Africa, to the nature of the state in the developing world (Krasner and Pascual, 2005; Zartman, 1995; Reno, 1995; Ghani and Lockhart, 2008). Those states are described as eminently weak or even failed, and thus rendered dangerous. Robert Rotberg has defined two very academically and policy influential working definitions of weak and failed states.

Weak states (broadly, states in crisis) include a broad continuum of states: they may be inherently weak because of geographical, physical, or fundamental economic constraints; or they may be basically strong, but temporarily or situationally weak because of internal antagonisms, management flaws, greed, despotism, or external attacks. (Rotberg, 2004: 4)

In turn,

Failed states are tense, deeply conflicted, dangerous, and contested bitterly by warring factions. In most failed states, government troops battle armed revolts led by one or more rivals. Occasionally, the official authorities in a failed state face two or more insurgencies, varieties of civil unrest, different degrees of communal discontent, and a plethora of dissent directed at the state and at groups within the state. (Ibid.: 5)

In the aftermath of the September 11, 2001 attacks in New York and Washington, DC, United States Policy Advisor Stephen Krasner and United States Ambassador Carlos Pascual argued that

[in] today's increasingly interconnected world, weak and failed states pose an acute risk to the United States of America and global security. Indeed, they present one of the most important foreign policy challenges of the contemporary era. States are most vulnerable to collapse in the time immediately before, during, and after conflict. When chaos prevails, terrorism, narcotics trade, weapons proliferation, and other forms of organized crime can flourish. Left in dire straits, subject to depredation, and denied access to basic services, people become susceptible to the exhortations of demagogues and hatemongers. It was in such circumstances that in 2001 one of the poorest countries in the world, Afghanistan, became the base for the deadliest attack ever on the United States homeland, graphically and tragically illustrating that the problems of other countries often do not affect them alone. (Krasner and Pascual, 2005: 153)

As incongruent and possibly ironic as it might be, the reduction of the state advanced by the Structural Adjustment Programs of the previous decades have diminished the capacity of states to assure its territorial authority, let alone the provision of social goods and services, as noted above. It has long been asserted that many African postcolonial states, which inherited the administrative divisions of the colonial period, face an endogenous weakness regarding its identity and therefore its

predisposition to internal and cross-boundary conflicts (Clapham, 1996). Yet, the reduction of the state – and consequently its neopatrimonial character – has arguably enhanced the tendency towards fragmentation, as the struggle for resources became more intense. Rather than prescribing the reduction of the state as during the 1980s and 1990s, Western policy-makers emphasised the role of a strong state in the developing world as facilitator of a successful comprehensive foreign policy. Krasner and Pascual thus conclude

Today, stability requires more than maintaining a balance of power among strong states. Safety both here and abroad now depends on the ability of the United States and the international community to make sovereignty work—to establish democracies that improve the lives of ordinary individuals rather than of the ruling elite. The first step in this process must be to prevent conflict if possible, or to ensure a meaningful peace when conflict does occur. The world can do more to help those countries at risk of unrest or recovering from war. If successful, then over the longer term the United States will have enabled more people to enjoy the benefits of peace, democracy, and market economies. That can only be in everyone's best interest. (Ibid.: 163)

As for the practice of this foreign policy of statebuilding, this has been based on an ever-more intense tenet of partnership between governments and international organizations, constructed around 'mutual understandings' and 'mutual goals.' Countries in the developing world are encouraged to pursue 'good governance' and 'accountability,' thus remaining more responsive to the international community. The purpose is to raise a sense of responsibility within a liberal logic of respect for civil society, markets and human rights, and eventually 'own' the donor-induced policies and the donor-driven programs. Establishing a successful, effective indigenous state is a precondition for international security and prosperity.

David Chandler has argued that this foreign policy, in which large-scale development-related interventions promoted by Western countries are part of a

general politics of statebuilding in non-Western regions, is one of an “Empire in denial” (2006). This process is characterized by a marked depoliticization of relations, both between the international community and the countries under intervention, and between these latter and their societies. Whereas the national elites, given their dependence on the international community, work toward the fulfilment of international community’s requirements, the latter, rather than connected to the state institutions for public goods, increase their dependence on the system of international NGOs, private companies, and often criminal activity too. Relations are operated according to “a narrow and functionalist framework” (Ibid.: 5-6). This depoliticization is a symptom of the Western empire’s “denialism” of its power behaviour and accountability *vis-à-vis* their societies and, of course, the regions where it intervenes (Ibid.: 8-22). For Chandler, as far as relations with Africa are concerned, imperial denialism is visible in the establishment of partnerships (a key element in PEPFAR, as one will show) in opposition to the 19th century-type overt discourse and practice of government.

The new administrators of empire talk about developing relations of ‘partnership’ with subordinate states, or even of African ‘leadership,’ at the same time as instituting new mechanisms of domination and control. Gone is the language of Western dominance and superiority; replaced by the discourses of ‘capacity-building’ and ‘empowerment’ in the cause of the non-Western Other. (...) They are eager to deny that they have any interests or deciding influence at the same time as instituting new mechanisms of regulation which artificially seek to play up to the authority, rights and interests of those subordinate to them. (Ibid.: 9)

Indeed, this renewed form of empire is an ethical one in opposition to the traditional interest-based approach. Driven by liberalism, this is an empire concerned with implementing values such as those mentioned above, and not with conquering territories and founding colonies as it used to be. The ethics refer to a concern for the

survival, development and security of the populations under intervention framed in terms of ‘their (i.e. non-Western) needs,’ and not ‘our (i.e. Western) needs.’ “The needs of non-Western states and societies have assumed centre stage.” (Ibid.: 71) Unlike in the past, the post-Cold War era of Western dominance seems to have cleared “the context of ‘friend/enemy:’ the Other – the object of foreign policy – is more likely to be defined on the basis of needs” (Ibid.: 73). In this context, “Western states and international institutions appear less as external or coercive forces and more as facilitators, empowerers and capacity-builders” (Ibid.: 77). This has been very visible in the case of PEPFAR as a bilateral program of the United States government to provide primarily HIV/AIDS relief in a number of countries, but also in other overarching policy initiatives in and for Africa, such as the United States Millennium Challenge Account or the United Kingdom’s Commission for Africa (Ibid.: 83-86).

Parallel to these policy developments in the West, a discourse on African Renaissance emerges in South Africa with resonance across the continent. It stretches back to the immediate post-apartheid foreign policy of South Africa through Deputy President Thabo Mbeki.

Mbeki formally introduced the idea of a renaissance in an address to an American audience in April 1997. Also in 1997, a document entitled *The African Renaissance: A Workable Dream* was released by the Office of South Africa’s then-Deputy President. (Taylor, 2005: 33)

Having generated a flourishing literature of debate and critique,¹¹ African Renaissance essentially alludes to a “third moment” of Africa’s postcolonial existence, after decolonization (1960s), followed by democratization (1990s), and featured by “social, political democratization, economic regeneration and the

¹¹ For a very comprehensive list of publications see http://userpage.fu-berlin.de/afrosi/documents_pdf/AfricanRenaissanceBibliography.pdf (accessed 14 December 2011).

improvement of Africa's geopolitical standing in world affairs" (Maloka, 2001). Although it was alluding to Africa as a whole, it became questionable to what extent this was a strategy of regional hegemony by the far most powerful economy in Africa to engage profitably with the rest of the continent in a new (post-apartheid) context (Cheru, 2002: xii; Lesufi, 2004; Owusu, 2006). Still, it backed the latest pan-African plan for development in the continent, the New Partnership for African Development (NEPAD), set up as a result of collaborative efforts by a group of African countries (Algeria, Egypt, Nigeria, Senegal, South Africa), supported by the Organisation of African Unity and endorsed by the group of the eight most industrialised countries in the world (G8) (Maloka, 2001). Established in 2001, it promised a break away from the ineffective neoliberal policies imposed on African countries by structural adjustment policies and serious improvements in national governance through further democratization, openness to civil society, transparency and accountability (Ibid.).

This intellectual and policy event was further complemented by the reintroduction of the theory and practice of the developmental state in policy discussions about Africa (Stein, 2000). As mentioned, the link between the state and development was relatively vivid in the immediate post-independence phase, reduced drastically by the end of the 1970s when African states turned to the neo-liberally-driven financial institutions for funding. The idea of a dirigiste state that drives the economy towards growth, yet respecting the marketplace, found inspiration in the fairly recent success stories of the so-called East Asian Tigers (Malaysia, South Korea, Singapore) as well as in the more distant European cases of post-Second World War Germany and the Scandinavian countries, who sought to grow

economically at a quite fast pace. In Africa, only Botswana (White, 2006) and Mauritius (Meisenhelder, 1997) served as examples in this regard. It can be argued that this resurgence happened in reaction to three policy trends. First of all, as already discussed, critics of the Structural Adjustment Programmes galvanized the argument that giving the primacy to the market at the expense of a minimal state led to disastrous results. Secondly, as also referred, according to leading Western foreign policy strategists, the postcolonial experience has made evident that many African states have limited capacity; they are weak or even failed, to the point of generating threats to international stability, and therefore require measures that rebuild them and make them capable. Therefore, rebuilding them and making them agents of development is an important prospect (Fritz and Rocha Menocal, 2007). Finally, several economic perspectives, converging on something one could call “Afro-pessimism,” argued that not only development in Africa was impossible but also its elites were inherently rent seekers and corrupt. Yet, Thandika Mkandawire counter-claimed that there is firm historical evidence of developmentalist experiences that delivered positive results.

Most arguments on the impossibility of developmental states in Africa are not firmly founded either on African historical experience or in the trajectories of the more successful ‘developmental states’ elsewhere. Africa has had examples of countries whose ideological inclination was clearly ‘developmentalist’ and that pursued policies that produced fairly high rates of growth and significant social gains and accumulation of capital in the postcolonial era. (Mkandawire, 2001: 309-310)

As Ian Taylor has convincingly argued in his comprehensive critique of NEPAD, not only this partnership has been a continuation of the previous hegemonic neoliberal framework (the ‘Washington Consensus’) – this time around initiated by Africans rather than by Washington, DC-based institutions – but also a renewal of

the neopatrimonial and clientelist paradigm of the postcolonial era. Generally, NEPAD has been run by the same old elites, and did not lead to the fresh start it alleges. By 2005 Taylor's commentary was put in these terms:

In this light, grand pronouncements regarding the importance of good governance and democracy or of economic liberalization are made redundant by the behaviour and actions of the very same people responsible for drawing up and/or committing themselves to such aims. Again, the divorce between rhetoric and reality is stark and more and more palatable. (Taylor, 2005: 275)

From a political-economic perspective, Ishmael Lesufi (2004) and Francis Owusu (2006) have corroborated Taylor's idea that African Renaissance-driven NEPAD was a tool of South African foreign policy toward expansion across the continent, thus following Mbeki's domestic policy of liberalization in exchange for foreign direct investment. Yet, while acknowledging Taylor, Lesufi and Owusu's critiques, it is important to highlight that the 2000s era cannot be described in the same vein as the one before. Even though survivalism is still an arguable feature among many African countries today, the current period offers new, or renewed, intellectual but also policy choices. Thandika Mkandawire leaves a note of caution in that regard, as he appeals to a non-static view of the African polity.

Having presented key actors as irredeemably greedy, corrupt and captured by rent seekers and economies of affection and African states as preternaturally disposed to predation, the misreading denies us the opportunity to think creatively of modes of social organization at both macro and micro-level that can extricate African countries from the crises they confront" (Mkandawire, 2001: 310)

The 2000s has indeed been witnessing interesting changes in the 'traditional' commentary about Africa. Impressive economic growth has spawned across some countries with spill-over effects in terms of improvements in human development. Among United States development analysis circles this has been seen with large interest. Whereas for Steven Radelet with the Centre for Global Development argues

that some countries are already enjoying some “emerging” status in the regional economy given their recent high rates of economic growth (Radelet, 2010), Daniel Kaufmann with The Brookings Institution gives it a “tempered optimism:”

Many African countries are now recording positive (and sometimes substantial) growth, reducing poverty rates and attracting more foreign investment. However, it may be premature to declare success across the African region. (...) Yet, most of the remaining SSA [Sub-Saharan African] countries still face substantial governance and economic constraints to growth. It is important to recognize that performance is very varied across the African region and that many countries, like Gabon, still face daunting governance challenges. (Kaufmann, 2011)

Other analyses have pointed to the enlargement of the middle class as very important indicator (Ncube et al., 2011).

There has also been a diversification of donors and lenders to look at. In fact, the first decade of the 21st century has been one where, first and foremost, China is holding an undisputed influence across the continent through direct investment and provision of loans for development projects (Garner, 2007; Lancaster, 2007; Kragelund, 2011). Intellectually too, it is observable the renewed interest in several Asian models of growth, especially China, as many African students of development economics and other fields obtain opportunities to study in that country. Thirdly, Africa-focused international organizations, such as the United Nations Economic Commission for Africa and the African Union (2011), advocate an increasing dirigiste role for the state in order to achieve higher economic growth and development in a context of renewed optimism about the domestic state-based capabilities to deliver.

While there certainly are continuities from the previous decades, the first decade of the 21st century has undergone policy changes at the structural level of

relations between the West and Sub-Saharan Africa, especially as far as the role of the state in the latter region is concerned. As Western policy-makers call for a merging between security and development and statebuilding as policies for African states in order to consolidate their goals of stability and peace, or “Empire in denial” as suggested by Chandler, the latter in turn adopt, or readopt, policies of developmentalism based on the state. At the same time, as new donors and lenders, particularly China, come forth, some African states are achieving remarkable economic results.

2.5. South Africa, Ethiopia and Botswana and the African Postcolonial State Experience

The previous sections delineated two periods of political-economic relations between African states and the international financial and development community, following a debate built on a generalized idea of the ‘African state’ that one aims at linking to the individual cases under scrutiny in this dissertation. South Africa, Ethiopia and Botswana offer distinct experiences not just between themselves but also regarding the characterisation given above. Yet, they certainly remain ‘African’ not only for their obvious geographical location in the continent, but also for the important part they play, in their different ways, within the debate of the postcolonial state in Africa.

Botswana is one of the two countries (the other is Mauritius) that developmental state proponents in the beginning of the 2000s were presenting as a democratic governmental state. It is still part of the very small number of countries

that are presented as ‘models’ of good governance, economic growth and improvement in human development by the international community. Yet, lasting repercussions of the state’s commitment to development only started to trickle as a public-private partnership for the exploration of diamonds in the country, Debswana, was established between the state and the mineral giant company De Beers (Froitzheim, 2009). Ethiopia is assigned to the opposing majority of countries. Ethiopia is a historically very poor country, with low levels of development, and ridden by long violent political conflicts. As such, Ethiopia corresponds to the leading descriptions made above about the African state, whereas Botswana does not. Interestingly, one of the promoters of Botswana as a model inside the continent has been the Ethiopian Prime Minister Meles Zenawi in his 2006 unpublished academic thesis “African Development: Dead Ends and New Beginnings” (Zenawi, 2006), which includes a chapter dealing specifically with Botswana. Here Zenawi discusses Botswana as a successful case in the context of what he conceives as the failures of the liberal, or neo-liberal, reforms in Africa in the 1980s and 1990s.

The basic issue that the Ethiopian leadership holds in hand in terms of a long, sustainable dynamic of development is the very low stage in which the country still finds itself in. Despite recent propelled double digit growth annually, Ethiopia is still struggling with very strong dependence on subsistence agriculture, let alone limitations in infra-structure, human resources, etc. In addition to that, problems of internal insurgencies undermine the prospects of development. Nevertheless, Ethiopia is part of the small group of African countries (together with South Africa and Liberia) with an “idea of the state” (Clapham, 1996) outside the usual colonial structure. With the exception of the Italian occupation period and brief British

administration that followed, at the turn of the mid-20th century, Ethiopia was never part of a European empire. Despite European influences for centuries, the modern state apparatus was initiated indigenously, even if according to a logic of internal colonial-like processes of domination, in which the Amhara ethnicity has predominated (Gilchrist, 2003). In turn, Botswana as a sovereign nation is not only recent, established in 1966, but also inherited the apparatus of the British Protectorate era.

The case of South Africa is very peculiar in the broader African context. It is so because it has been the far most economically advanced country in the continent, and therefore being in opposition to the average, poor, less developed African country. However, the persistence of a white minority regime of separate development (apartheid) during much of the postcolonial age rendered it problems of international recognition and acceptance, namely among African countries. Although South Africa did not share a pariah state status, i.e. non-recognition, with the similar-minded regime of the former Republic of Rhodesia (today's Zimbabwe), this dual situation – being economically very advanced and influential yet in a context of exclusion of large sectors of its population – was observed by the end of the 1980s “a major threat hanging over the future of the continent, constituting a problem Africans had to continue to face and for which there seemed to very little hope of finding any quick or peaceful solution” (Fage, 1988: 498). After the 1994 governmental elections and dismantlement of the apartheid, South Africa, with a multiracial government led by the African National Congress, has emerged as a vibrant influence across the continent, especially in Southern Africa. Remaining a “regional hegemon” (Shillinger, 2006), South Africa has arguably reverted its negative reputation and is

increasingly observed – not just in Africa but around the world – as a benign power both economically and militarily through engagement in the already mentioned NEPAD as well as in peacekeeping missions. It has become a liberal-idealist power, even if with flaws (Geldenhuys, 2008).

2.6. Conclusion

This chapter has provided a background discussion on policy trends focusing on the role of state in Sub-Saharan Africa before the analysis of the national government's autonomous action under PEPFAR's process of implementation. It discussed the dissertation's dependent variable: the historical process of agency by postcolonial African national states and governments in relation to the West-led international community, notably formal colonial powers. This agency is particularly analysed in two contexts of Western structural hegemony. The first are the 1980s and 1990s, in which donors and lenders, primarily Western countries and international organizations, inculcated neoliberal structural adjustment policies with the aim of reducing budget deficits and enhancing private investment. The second corresponds to the first decade of the 21st century, characterised by policies linking security to development, and aimed at building, or reforming, state institutions in the developing world (statebuilding).

A major case of agency by Sub-Saharan African states is found in the politics of development that featured the immediate post-independence period in much of Sub-Saharan Africa. Developmental concerns, centred in raising education, health, and living conditions in general, were indeed part of a nation-building political

agenda in many countries in the region with the aim of attaining economic independence after legal recognition was already obtained. Although it delivered fairly positive results during the first couple of decades of independence, by the late 1970s, many governments ended up running very large deficits that demanded negotiation for external support. As remarked previously, such high deficit has been explained by external and internal reasons, an internal one being the neopatrimonial character of the state. However, such funding was granted in exchange for the commitment to the compliance of conditionalities that reduced drastically the state's initial agenda of provision of social services, and moreover, arguably, exacerbated tendencies toward disaggregation and conflict. Despite the governmentality of those organisations, and the difficult circumstances that came about in terms of pursuing the national developmental agenda, African states, and their elites, sought to survive, even if through their own governmentality of neopatrimonialism. The optimism of development as a means towards further national independence as conceived by the independence governmental elite retreated to the hardship of having to survive as elite and, at the same time, as a state, since more than often both coincide. Such difficult survival was not only contemporary to manifold armed conflicts but also to a significant decrease in the living conditions of many African countries' populations.

However, by the early 2000s, the ideology of the developmental state re-emerges intellectually and politically in Africa. This is partly justified by the international community's reversal of its policy: from promoting state reduction to supporting statebuilding and renewing a development agenda under the auspices of the Millennium Development Goals. The return of the politics of state-driven

development in Africa occurs as a response to the “decay” (Clapham, 1996) experienced by Sub-Saharan Africa as a whole throughout the 1980s and 1990s, but also in the context of a rhetoric of African Renaissance animated by the continent’s major power, South Africa, which had just established a multiracial democracy. Together with the endorsement of the role of the state by important pan-African institutions, such as the United Nations Economic Commission for Africa and the African Union, this change took place at a time of exciting economic growth by several countries and diversification of international funders (first and foremost, China).

The next chapter frames the discussion developed throughout these last pages within the context of global health governance. It reviews the main narratives in that domain – both theoretical and policy-related. Then it draws attention to the condition of the postcolonial African state as receptor of external funding and policies within the study area, and moreover the predominant patterns of behaviour within that sector of global governance.

Chapter 3 – Global Health Governance

3.1. Introduction

The previous chapter introduced the post-independence experience of African states *vis-à-vis* the international system dominated by the Western powers and the major international financial institutions. Departing from a generalised approach to African statehood and Western power, it pointed to a pattern of mutually struggling relations by both sides, yet under a background of asymmetry in this relationship.

Before proceeding to the dissertation's theoretical chapter, and considering the specificities of the case study, it is important to discuss the specific realm of relations within which PEPFAR is implemented and the role of the postcolonial African state in it. This realm consists in what has come to be named as 'global health governance.' The engagement to be pursued throughout this chapter departs from an exercise of reflexion on the leading narratives on this topic in the field of Political Science and International Relations by scholars, activists and policy-makers. It does not seek to test the empirical consistency (or the lack of it) that ground the causalities that construct those narratives. The relevance of looking at the narratives that frame the analysis of global health and discussing them has to do with the fact that they impact on the terms of analysis of broader relations between, in the case of this dissertation, the United States government through PEPFAR and the national governments of the countries where PEPFAR has been implemented. By looking at and discussing these narratives one aims at a more critical understanding of the role the postcolonial African state as recipient state is meant to play.

This chapter is divided into five sections. The first four discuss the leading narratives on global health governance in the discipline. The first introduces the context in which global health was elaborated through social constructivist and liberal-institutional tools in parallel with the emergence of human security as a paradigm of Western foreign policy for the post-Cold War, and its consequences in terms of the ‘securitization’ of health-related issues. The second looks more specifically at the dimension of social change inside the West in the last three decades under the influence of the Sociology of Risk. The third departs from David Fidler’s liberal-institutional approach to global health governance based on the centrality of the World Health Organization’s (WHO) International Health Regulations’ (IHR) revision of 2005 towards a radical, post-Foucauldian explanation of liberal power transmitted by medical intervention inside and outside the West. The fourth section considers the argument around contestation, incoherence and, eventually, failure of any governance of health at a global scale. The idea that there is no government in this domain invites the appraisal of the traditional actors – states – in the domain. The fifth, and last, section focuses on the case of the postcolonial African state in a context of international asymmetry, in which it is rendered the primary role of recipient of the major Western states. It finally idealises two types of behaviour: the state as facilitator, and the state as ‘rogue.’

3.2. Human Security and the Construction of Global Health

The realm of health affairs outside the domain of individual states is traditionally denominated as international health. Since 1948, with the establishment of WHO, it remained mostly confined to its interstate framework and its IHR created

in 1969. Another landmark was the signature in 1989 of the WHO's "Health for All Declaration," also known as the Alma-Ata Declaration, in which member states committed to the attainment of the best health conditions to their populations. However, it also featured in development aid to the Third World and military agendas during the Cold War. Nevertheless, in retrospect, David Fidler (2005: 180) argues this was a field of "low politics" compared to the supreme politics of war and peace under United States-Soviet bipolarism that neorealist theories of International Relations prominently explained and reinforced.

The end of the Cold War in the late 1980s, early 1990s brought about foreign and security policy consequences that started to be conceptualized in another way, including in the domain of international health. One consequence was the rise of an understanding of security based on individuals and population groups rather than on states. Human security (UNDP, 1994) is the 'paradigm' that growingly started to be laid down onto the nascent European defence and foreign security policies and the Middle Powers Initiative (Behringer, 2005; Debiel and Werthes, 2006; Martin, 2007), for instance. It derived from the intellectual labour of an amalgamation of liberal-cosmopolitan, social constructivist and critical-theoretical authors in the discipline, who urged for attention to forms of violence and insecurity beyond the formal inter-state warfare. It was also very influential among the United Nations system in conflict prevention, peacekeeping and post-conflict reconstruction missions. It was so defined by the United Nations Development Program (UNDP):

Human security can be said to have two main aspects. It means, first, safety from such chronic diseases as hunger, disease and repression. And second, it means protection from sudden and hurtful disruptions in the patterns of daily life – whether in homes, in jobs or in communities. (UNDP, 1994: 23)

As a result, human-related phenomena such as epidemics, migration, trafficking in drugs or environmental damage began to be conceptualized as threats to stability inside countries, regions and even the world, in a context in which state confrontation was growingly understood as obsolete. So-called ‘new threats’ like those are far more disruptive and killing than wars between armies, and hold indirect consequences for the Western world. As far as epidemics go, they deteriorate many populations’ living standards in developing countries, particularly in Africa, and thus contribute to the damage caused by phenomena such as civil wars (Kaldor, 1999) and “failed states” (Zartman, 1995), that is, states “unable or unwilling” to offer the residents basic public goods such as food, access to health or public security. Human security appeared together with familiar agendas for the post-Cold War such as human rights, democratization, the rule of law, and the market that, once implemented, could reduce instability and conflict in general. In addition to that, viruses emerge as threatening in terms of the globalization of trade and travel at a larger geographical scale, particularly in the context of outbreaks.

As a result, while traditionally states attracted analytical focus, in the last ten years, entities such as viruses, and the diseases and epidemics that they provoke, were growingly elaborated as threats to security. Indeed, pathogenic agents only constitute threats to humans when they, first, infiltrate human ecology and afterwards penetrate and develop themselves within the human body. Viruses as such do not pose any threat. What is actually convertible to a threat status are peoples, societies and, in the last analysis, states, as part of a complex social and political impact that the multiplication of infected people feeds and arguably provokes in a context of fast global relations (Schneider and Moodie, 2002; Elbe, 2003; Ban, 2003; Brower, 2003;

Saker et al., 2004; Owen and Roberts, 2005; McInnes and Lee, 2006). If one perceives detection, prevention, care and eventual cure of populations as the major measures against disease, one defines as security objective the contention of the multiplication of the number of people carrying the agent, despite the ethical problems it may entail (Elbe, 2006). The linking of viruses to security is consummated in the depiction of ‘securitized people’ as those “at risk,” “vulnerable,” and making up “dangerous classes” (Hardt and Negri, 2004). In other words, they are a reflection of the epidemiological estimates on the several diseases, yet, particularly, the major epidemics. In the case of HIV/AIDS, in Southern and Eastern Africa they are the general population, while in China, India, Russia, and the West, they are drug injectors, migrants, homosexuals and the general mass of the marginalized ones. Eventually, they led to the almost blurring of traditionally separate fields such as International Relations and Public Health.

Together with an exercise of social constructivism, liberal-institutionalist approaches gained prominence in the analysis and policy recommendation of international/global mechanisms of response to the manifold viral and epidemic manifestations. The ‘securitization’ of health and disease was embedded institutionally under the revised International Health Regulations of 2005, and is found in the rhetoric and rationale of multilateral and bilateral initiatives, such as the Global Fund, established in 2001, or PEPFAR, launched in 2003.

3.3. The Western Risk Society and the Politics of Technicalization

Global health is eminently a Western invention with the aim of making sense of globalization and a new paradigm of human security-based foreign policy. As remarked, the problems of health and disease were already subject to international discussion. However, the West-led hegemony of globalization in terms of worldwide socio-economic relations fuelled by technological advances in information and communication created a landscape in which those problems, among other human/population-related ones (migrations, environmental degradation, scarcity of energy resources, urban insecurity), were bound to have direct and indirect security consequences for the Western world and its lifestyle. In other words, ‘threats’ like those were undermining of what Anthony Giddens has called “ontological security” (Giddens, 1995), building on the notion of “risk society” (Beck, 1992) as a latest stage of Western modernity, in which, after wealth and power, risk and impotence emerge (Beck, 1995). Although in the industrial age there was already a notion of risk, it was considered a price to pay for the material progress of societies through social protection systems and other compensatory mechanisms. Accordingly, Western societies do not aim at maximizing risks, yet minimizing them through the implementation of emergency measures against increasingly incontrollable risks, such as nuclear proliferation, global warming or even large-scale pandemics. For Beck (2006), the best response is “precaution through prevention.”

This sociological reading has proved to be very influential in the way responses to epidemics and viral outbreaks started to be conceptualized by political analysts and policy-makers of global health. Along with human security policies, the inevitability of the occurrence of direct and indirect effects at a global scale has led

to a very large epistemological consensus around the definition of preventive and curative measures aimed at the sources of those risks. As a result, global health governance has become, in the words of James Ferguson (1994), an “anti-politics machine.” Global health governance became an eminent ‘technical’ field, in which what largely is at stake is the formulation and implementation of ‘good’ policies, informed by ‘good practices,’ and accompanied with disbursement and allocation of resources to projects serving those in need. In the case of the major epidemics (HIV/AIDS, tuberculosis and malaria), this is observed in the manner biomedical responses attained supremacy, although preventive measures were also clearly emphasised. Rather than an implication of the political communities, as it used to happen during the Cold War, global health governance bypasses political contingencies and aims at ‘fixing’ the ‘issues.’

3.4. Global Health Governance’s Constitutionalism

A major feature of the post-Cold War international environment, namely in the area of health and disease, is the dissemination of governmental alongside nongovernmental actors. Apart from states and WHO, international organisations such as the United Nations constellation and the World Bank joined in, followed by many old and new large developmental and humanitarian NGOs, philanthropic organisations and initiatives and private companies, such as pharmaceutical companies. Often many of these entities have sat together under the aegis of public-private partnerships (PPP), a model of governance that got boosted in the context of post-Cold War acceleration of neoliberal reforms led by the major Western states, the World Bank and the International Monetary Fund, as described in the previous

chapter. In the domain of global health two major examples of PPP are the multilateral Global Fund and the bilateral PEPFAR. After a previous phase of being rendered to “low politics,” influential David Fidler observes this change of landscape, in which health and disease concerns attain centrality in the foreign policy of major states and generates many actors and agendas, as a “revolution” (Fidler, 2008).

However, for Fidler (2004), it was not until September 11, 2001 attacks in the United States of America, the so-called case of “Amerithrax” soon after September 11, and the 2003 outbreaks of the Severe Acute Respiratory Syndrome (SARS) that global health governance’s “constitutionalism” was reconfigured. Eventually, the WHO’s IHR were revised and incorporated an element of security in it. From a juridical-institutional point of view (Pereira, 2008), Fidler understands the role of WHO and its IHR as the key contents of international health’s constitutionalism, whose historiography, obviously, stretches way back in time. It kicked off in the 1830s as the first international hygienist conference takes place to search for a response to a cholera epidemic affecting Europe at the time. Afterwards, other international conferences alike occurred throughout the 19th and early 20th century. Finally they paved the way for the League of Nations’ Office of Health Affairs and WHO. Founded in 1948, WHO has gained reputation for inculcating an international cooperation regime based on the 1969 IHRs, consolidating what Fidler (1999) has called *Microbialpolitik*, that is, an international agenda fundamentally guided by allied fight against disease. In Fidler’s view, the 2001-2003 events above and their corresponding structuring responses of contingency constitute a turning point in the understanding of epidemics as object of national and international security. This

period inaugurates ‘the new world order in public health,’ in which global health governance likens the United States federal model in the context of crisis in health at the global scale. The functions of that model are: provision of national security; regulation of international trade; preparedness support and response to epidemic crisis; and protection of human rights (Fidler, 2004). Broadly, such ‘new order’ reiterates the post-September 11 counterterrorist response, in which all areas of governance in the United States of America were merged towards a more efficient and engaged reaction. However, this shift is still troublesome. The 2005 revision of the IHR diverted WHO away from its mandate, since it may be specifically serving national and international policies.

Less clear is whether the new IHR might embroil WHO in the politics of national and international security to the detriment of its core public health functions. Although it makes some experts uncomfortable, the potential for terrorism involving weapons of mass destruction connects public health to security concerns. (Fidler and Gostin, 2006: 92)

The 2005 IHR revision calls for the necessity to establish partnerships with other “interested” sectors, notably the armed forces. At the same time, the new IHR allows the possibility of “containment at the source,” beyond the typical border controls for people and goods (WHO, 2007). Such situation allows foreign interventions to be triggered regardless of state sovereignty, namely with military means, for the sake of epidemic contention. In sum, these novelties reflect a real change in the purposes of the IHR.

Fidler’s juridical-institutional explanation has been complemented by a more radical approach in terms of whom and what constitutes the governance of global health. This approach implies that a plethora of other defining actors, such as private companies, non-governmental organizations, networks and partnerships and even

Hollywood “celebrities” (Drezner, 2007) needs to be inserted together with the traditional actors. Like major states and WHO, those agents maintain intense power agendas and regulating capacities, particularly under a framework which jeopardises national sovereignty given the possibility of “containment at the source,” as presupposed in the 2005 IHR. Moreover, since Fidler’s constitutionalism seems to overestimate the role of epidemic crisis and response as contextual facts, i.e. the outbreak event and the demanded quarantine measure, a complementing approach that embodies structural elements in the machinery of public health, such as surveillance and hygiene mechanisms administered by national and international agents, is required.

An historical analysis of disease surveillance stretches back to the 17th century, as epidemic surveillance departs nationally in metropolitan Europe, and increasingly expands onto the colonies. This regime is consolidated with the international hygienist arrangements of the 1830s (Bashford, 2006). As a result, it has helped to consolidate a system of security that one recognizes today. Michel Foucault’s (1984) work on the analytics of liberal political power from the 17th century onwards has been found highly helpful in this regard. Rather than simply deposited on domestic and international institutions of statehood, power permeates an insidious, comprehensive web of institutions and practices, governmental and non-governmental, local and international, yet commonly affiliated to ideals of liberalism and free trade. Unlike in earlier Absolutist regimes, power is conceived to both foster life and impede it to the point of death. The object of such power consists on human beings at the aggregate level, as well as life in general. Designated as “biopower,” it expresses the 18th century scientific effort of measuring and regulating

all dimensions of life, such as birth, mortality, schooling, employment, criminality, etc. This change has implied thinking the human being as an *être biologique*, a natural species, yet with political life and power. Biopower is therefore ‘totalitarian’ in the way that it is aimed at the totality of the population. Issues of health and disease become particularly pertinent in this framework of analysis of power.

Contrarily to previous Absolutist regimes, biopower, or biopolitics as it was later reformulated, necessitates to be rationalized, justified (Foucault, 1984: 258), and Foucault’s later concept of governmentality embodies that necessity. It accounts for a discursive-material device (*dispositif*) of security embodying rationalities and technologies of government. They comprise “discourses, institutions, architectural forms, regulatory decisions, laws, administrative measures, scientific statements, philosophical, moral and philanthropic propositions” (Foucault, 1980: 184). These technologies do not necessarily use violence to force people to do what the sovereign likes (Lemke, 2001). A major manifestation of the sovereign power’s governmentality is found in the figure of the “medical police” (Carroll, 2002). In fact, governmentality as rationalities and technologies of government largely corresponds to a general idea of police activity: “practices of inspection and surveillance, information and intelligence gathering, and direct intervention (to the point of deadly force) in private, familial and commercial matters” (Ibid.: 465). The medical police did not resort to deadly force; yet it pursued a variety of sanitary techniques in order to guarantee “health and safety” among the population from now onwards (Ibid.).

A number of historical examples from the British Empire demonstrate the century-old political importance of medical intervention at a global scale. Alison

Bashford (1999) has looked at the 1881 smallpox epidemic in Sydney, Australia, as an illustration of the more administrative facet of such medical policing through the establishment of the local health authority, i.e. the Board of Health in the British Colony of New South Wales. Although smallpox epidemics were not “uncommon” in the 19th century, that one precipitated key bureaucratic changes. Policing was primarily about carrying out activities animated by socio-political concerns rather than exhibiting state presence. Thus, one should mention the police role that charities pursued, as Carroll (2002) shows in the case of colonial Dublin, Ireland, hygienic activities in the 18th century. The ultimate function of health policing was to potentiate the general health status of the populations, not just for the sake of political economy, but also to prevent scarring contagions and epidemics that could undermine the body politic. Bashford (2006) reports that, in function of the establishment of border epidemical check-ups and quarantine systems, surveillance mechanisms were installed at the global scale uniting metropolises and colonies. National surveillance and hygienist measures moved beyond from the national sphere on to the rest of the world, cementing Western power territorially and biologically, as the 1881 smallpox epidemic in Sydney above illustrated. As mentioned, a cholera epidemic affecting the European powers in the 1830s paved the way for the several international hygienist conferences during the 1800s that led to the establishment of the international sanitary institutions in the two world wars’ interval.

Yet, in that period, health issues were essentially taken as technical matters by the League of Nations’ Health Office, a predecessor of WHO. According to Bashford, its mission was to collect information from the national administrations, in

order to control diseases such as malaria, smallpox and sleeping sickness, in close collaboration with the Economics Office of the organization. General population-related dossiers tended to be studied in its migratory and trade dimensions, excluding issues such as birth control, and sexual and reproductive health. The author provides several examples on how, despite direct enquiry, those latter matters were untouched by the League of Nations under the basis of not being part of the organisation's mandate.

An important role in the systems of information on populations between colonies and metropolises was played by the educational transnational institutions of tropical medicine of the British Empire. Founded in the late 19th century, the schools of Tropical Medicine in London and Liverpool were instrumental in the research and dissemination of epidemiological facts and practices at the field level. Supported by organizations such as the Rockefeller Foundation, the Red Cross, the business community of Liverpool (with vested interests in the Caribbean, West Africa and Latin America), the schools' agendas ranged "from the medical concerns of a fading Empire to a national and international school of public health, moving towards integration of domestic and global health concerns" (Wilkinson and Power, 1998: 288). Tropical medicine as a distinctive discipline in the curricula of medical studies was born with the objective of facilitating the settlement of Britons and other Europeans in threatening environments characterized by pests such as smallpox, malaria or yellow fever (Arnold, 1997). But it also held the mission of improving the lives of natives engaged in the colonial businesses, therefore pursuing the 'benevolent' task assigned to imperialism. Nevertheless, Cameron-Smith identifies tropical medicine across the British Empire "as a discourse that constructed the space

of the tropics as Other and thus as racially pathological” (Cameron-Smith, 2007: 16). In turn, Jama Mohamed (1999) shows how colonial rule on medicine in Somaliland during the first half of the 20th century benefited from health interventions, vaccination namely, as it improved public health. The medical mission was therefore to “[popularize] the Government, and [to identify] the administration with the people’s welfare” (Ibid.).

The integration of tropical medicine’s culture and history when linked to the rise of “medical police” is particularly illustrative of both the character of this early securitization of infectious diseases and the apparatus of biopolitical instrumentalization at the global level. Beyond international and national political institutions, culture, science and medical practice informatively contribute to the historical power regime. In more recent times, hygienism remained notably instrumental with regard to the implementation of powerful white-supremacist regimes such as the one South African experienced during the apartheid period (Youde, 2005a). According to Youde, the legacy of public health intervention as historically anti-black population transpires from the 2000 conflict between South African government, notably President Thabo Mbeki, and the international AIDS community. Mbeki claimed that the international community’s AIDS discourse was a Western neo-colonialist discourse expressing Africans’ inferiority as a race to tackle their own problems (Ibid.). This episode was particularly dramatic since South Africa was holding, as it still does, the highest rate of HIV infections in the world.

The conceptualisation started by Foucault on liberal power as driven by political-economic ideology and not institutions leads to an image of an assemblage of various entities. “*Nébuleuse*” is an apt alternative word to assemblage that one

borrowed from Robert W. Cox (2005) to model the “constitutionalism” in global (health) governance, contrasting with Fidler’s adoption of the United States federal model. The end of the Cold War and the rise of global neo-liberal agendas performed by an enlarged quantity of institutions in many different sectors of activity (trade, development, humanitarian, etc.) and at different scales (local, national, regional, global) confirmed the reformulation of the state as sovereign political unit and accelerated the networking of biopolitical-like modes of power. This “*nébuleuse*” builds on strong political density, where many networks of governmental and non-governmental agents interact formal and informally at a global level. Global public health constitutes a quite solid domain for the analysis of those phenomena and the power relations they embody. They feature grand public-private, bilateral and multilateral funding, managing and implementing programs, initiatives and entities: WHO, PEPFAR, Global Fund, World Bank, UNAIDS, Clinton Initiative, Bill and Melinda Gates Foundation, and a vast range of international NGOs in the field. Once inserted in the broader global governance, the health system as a regime of global surveillance consolidates the supremacy of an international arena dominated, not by anarchical relations of individual units of sovereignty in the form of states, as put by the neorealist tradition of International Relations (Waltz, 1979), but by a hegemonic world system of liberal sovereignty (Bickerton, 2007). In the field of ‘global health’ ultimate examples of such endeavour stretches as far as the project of medicalization of populations, as explored by Stefan Elbe (2010). If it is true that this explanation is not fully applicable to the whole world, namely in terms of the “modern world” of powerful states of regional prominence, such as India, China and Russia (Cooper, 2004), this is particularly compelling with regard to the postcolonial world.

3.5. The Failure of Global Health Governance?

While the narratives around post-Cold War Western foreign policies rooted on human security and globalization have arguably dominated the global health governance literature, another narrative, focusing on the contradictions that the international political economy of health has exposed, has gained its own currency.

Adrian Kay and Owain Williams (2008) have drawn attention to the fact that global health governance is highly part of the larger processes of global governance, based on liberalisation and commodification. The results of global liberalisation and commodification are particularly noticeable in a number of instances. Since the market of health professionals has opened itself up to ‘globalisation,’ it has allowed an easier transfer of human resources from lower-paying countries to better-remunerating ones. As a result, countries and regions already with very low scores in terms of health care find themselves struggling even more with the loss of medical and nursing personnel. In turn, as far as the manufacture and distribution of drugs go, particularly antiretroviral ones, the protection of patents pursued by, mostly, West-based pharmaceutical companies and their states, in order to maintain high levels of profit, constitutes another front undermining access to better health in poorer countries. For Kay and Williams, the leading global health governance literature fails to take contradictions like those into account.

The current literature on GHG [global health governance] constructs a concept of global health that implicitly naturalises the neoliberalisation process and pushes analysts to seek technocratic and political solutions to adverse trends in population health across the globe. (Ibid.: 21)

Another set of incongruences have been put forward by authors that aggregate around the ethics of human rights and social justice, concerned with the social

determinants of health, i.e. by having a structural perspective of health condition's political economy (Williams and Rushton, 2009: 11-12). Mainly disseminated by the activist nongovernmental community and some academics (MSF, 2008; Schrecker, 2009), mostly from North America and Western Europe, this discourse is eminently targeted at Western countries as donors and leaders of globalization. This ethics appeals to further international regulation of negative practices (such as contracting health staff from the Global South or protecting resolutely pharmaceutical patents) and further financial commitment to global health programs. This stance fails to have a lasting influence in terms of actual political change. Yet, even if they could have it, their terms of the debate are located under a population-centred framework, in which affected political communities, particularly poorer, developing states, are supposed to have little or no autonomy in face of larger states and private companies.

As a result, global health governance started to be regarded as a domain of failure, since the alluded contradictions and disputes do not suggest coherence of policies (Ibid.). The idea of governance of the 'global' does not mean that there is an actual governmental form for that 'global,' although the social constructivism that permeates much of the analysis suggests it. Here, Fidler's (2004) post-Westphalian, liberal-institutional 'constitutionalism' is found wanting, since the international system is still primarily driven by a more traditional set of actors, namely states. In turn, the radical, post-Foucauldian readings are also flawed, since they leave limited or no room for human agency by introducing a rejoinder that points at neoliberal totalitarianism (Chandler, 2009a).

3.6. Global Health Governance and African Postcolonial State

The failure of global health governance as a domain of coherence among the many actors that struggle inside it invites a reassessment of the character of such domain, by looking precisely at the most stable and consistent in the international arena: states. In an article, James Ricci (2009) criticises an overemphasis by global health governance authors on the propelled reduced relevance of the state in the field. He cautions against the overreliance on the pulverization of non-state actors of different types as redefining the post-international juridical feature of governance. He argues that, despite the prominence of such organizations as the Bill and Melinda Gates Foundation, states are still main funders of global health initiatives, PEPFAR being a case in point (Ibid.: 7). However, Ricci's state-centred perspective does not account for the problem of asymmetry as crucial feature of the international system, particularly between the Western and African states, instrumental for any meaningful discussion in global health governance. Ricci does not explore the particular case of the postcolonial African state within that arena of relations.

However, the same applies to the discussion on African states' participation in global health security talks by Lenias Hwenda and colleagues (2011). Accordingly, even when considering African states as honourable diplomatic players in the international realm, the issue of structural asymmetry is left underdeveloped. Lenias Hwenda and colleagues (2011) affirm that African countries' health-related interests have been overwhelmed by the positions of developed countries. They point at debates on health security initiated by Europe and North America under WHO to demonstrate the need for serious political African engagement in such discussion. However, their recommendation does not consider the issue of asymmetry either,

finding themselves stranded in the idealism of institutional equality. It thus becomes necessary to explore the character of the intervened state, namely in the context of Sub-Saharan Africa, bearing in mind the asymmetric state structure of relations in global health governance.

Certainly, the problem of inequity in health has received significant attention by ethics-based authors and organisations. As mentioned above, they have constantly emphasised the manner through which richer countries easily drain health professionals from the Global South and constrain access to drugs at affordable prices. However, their principal focus on the population dimension does not consider the particular and, arguably, prominent contingency of state relations in global health governance.

This dissertation proposes two different antagonistic types of state that emerge out of the literature and policy debates in global health governance. One is the facilitator state, in which the recipient state behaves according to what is expected by the community of funders and policy-makers. Another type is the ‘rogue’ state, in which states deviate from compliance in several regards, from adoption of the ‘right’ policies to tackle health issues to management and employment of received funds according to pre-established purposes. Certainly, the proposed types are idealised categories within the framework, and therefore subject to debate over the addition of further categories and gradations. Nevertheless, they are applicable to the postcolonial African state in particular as opposed to donor countries. This ought to be clearly remarked since suggestions about playing roles as facilitators and/or ‘rogues’ have also been suggested for donor countries and their

policy choices and stances. Moreover, these ideal types do not exclude their coexistence within a single country, i.e. the same country can incorporate both types.

The leading narratives on global health governance largely reduce the African state to the status of recipient of external funding in exchange for compliance with the policies recommended by the funder, multilateral or bilateral. However, it should be remarked that there are differences between multilateral and bilateral arrangements in terms of participation.

Multilateral structures such as the Global Fund and the broader United Nations system tend to favour the inclusion of representatives and citizens of recipient countries in technical and even leadership positions. For instance, at time of writing Michel Sibidé of Mali is the head of the UNAIDS, and Tedros Adhanom of Ethiopia was the chair of the Global Fund until September 2011. In turn, bilateral programs are majorly led by the donor country, as it happens in the case of PEPFAR. Although recipient countries are made part of a ‘partnership,’ it is clear, as it will be discussed in the case of PEPFAR in Chapter 5, that the relationship is vertical, rather than horizontal. In either case, national governments of recipient countries in Africa are urged by major governments and NGOs from donor countries and international organizations to behave with ‘responsibility’ and ‘leadership’ in the adoption of recommended institutions and policies. As a result, several governments in Africa, namely those of the countries under analysis in this dissertation, with the exception of South Africa for a certain period, have responded positively to the external pressures toward observance of international community’s policies, and engaged in a relationship with those institutions, even if in asymmetric terms. In this framework, the state is assigned the role of mediator and facilitator in the process of providing

goods and services for the populations in need. In turn, this role as mediator or facilitator is enhanced and ameliorated through policies of direct assistance to state agencies and their representations (e.g. clinics, hospitals and health-extension programmes) and ‘capacity-building’ in several organizational areas. However, sovereignty is not conceived as a characteristic of this type of state. In this regard, Bob Jessop suggests:

[The] state is no longer the sovereign authority. It becomes but one participant among others in the pluralistic guidance system and contributes its own distinctive resources to the negotiation process. As the range of networks, partnerships, and other models of economic and political governance expand, official apparatuses remain at best *primus inter pares*. (...) The state's involvement would become less hierarchical, less centralized, and less *dirigiste* in character. (Jessop, 2003: 8)

However, as it was pointed out in the previous chapter with regard to NEPAD, African states have been organising themselves around regional arrangements towards collaboration with the international community’s major policies. A major example has to do with the so-called Abuja Declaration of 2001, according to which the cosignatory governments pledged to allot at least 5% of their annual budget to health expenditure in order to complement international funding.

The assumption of a highly obedient state to the international community opens up the possibility of an inverse case. By not being (entirely) compliant with good policies and behaviours (if not opponent to them), the state is attributed features of ‘roguehood’ by the international community. As far as global health governance in Sub-Saharan Africa is concerned, the most striking case of ‘roguehood’ concerns the reduction and suspension of antiretroviral treatment programs in South Africa by the African National Congress-led (ANC) government of former President Thabo Mbeki and his Minister of Health Manto Tshabalala-Msimang. Due to his self-proclaimed

dissidence in unequivocally buying into the drug-based response to the HIV/AIDS epidemic in his country and around Africa, he was considered denialist by many home and international activists and his country's regime a "rogue democracy" (Baker and Lyman, 2008).¹² Headed by HIV-positive, former male prostitute and ANC member Zachie Achmat, South Africa-based (with large international support) Treatment Action Campaign (TAC) initiated a series of civil disobedience actions with the aim of reverting government's position. Achmat himself decided to stop his therapy until everyone in South Africa who would need it would resume or initiate their therapies. In 2002 and 2003 the TAC has won a court cases against the state that allowed provision of antiretrovirals (ARV) to infected pregnant women and to people with advanced AIDS.

However, when in 2008 Mbeki was removed from his position following an African National Congress' (ANC) congress, the transitional President Kgalema Motlanthe dismissed Tshabalala-Msimang (Associated Press, 2008), and antiretroviral programs were reactivated. Currently not only "denialism" has been publicly dismissed, but the opposite direction is actually pursued. In 2010 President Jacob Zuma announced mass voluntary counselling and testing (VCT) campaigns, after he had himself taken an HIV test, which was observed as the burial of denialism by the South African government (Mail & Guardian, 2010). At the 2010 International AIDS Conference, Minister of Health Aaron Motsoaledi reiterated policy change, expressed commitment and requested assistance from foreign donors

¹² Outside Africa a striking case of 'rogueness' in global health governance corresponds to the invocation of sovereign rights by the Indonesian government over the decision of not sharing A/H5N1 flu virus samples with the World Health Organization. (Reuters, 2007) This position was adopted under the belief that, once disbursed for research and development of a vaccine, Indonesia would hardly benefit from it, since it would too costly to be purchased with the major Western pharmaceutical companies.

(Motsoaledi, 2010).¹³ The South African case clearly reveals a shift between ‘rogue’ and facilitation.

In a broader sense, the major example of ‘rogue’ recipient state behaviour is the real or perceived deviation of funds disbursed for policy implementation for what is considered illegitimate ends. In other words, this type of behaviour corresponds to the discussion carried out in the previous chapter on the neopatrimonial character of many polities across Sub-Saharan Africa. Often framed in Western circles as “corruption,” this practice sits along other troubling practices associated with the functioning of the social and political fabric, namely electoral misconduct, abuse of state violence and disrespect for the rule of law. As a result, donor countries are often uncomfortable with assisting governmental structures directly (although they still do it) and prefer NGOs, even if, in some cases, the locally-based ones, in some way or another, belong to the state/governmental division of labour, as it happens in the case of Ethiopia. As Chapter 5 on PEPFAR’s political origins and political rationales discusses, one major reason for opting out for bilateral mechanisms at the expense of multilateral ones (even though also participating in them) concerns precisely the will to augment surveillance over the expenditure of the recipient state by assigning an exclusive auditing mechanism (Interviewee 33, 2010).

3.7. Conclusion

Global health governance as a specific realm of relations in the international arena appears in the discipline of International Relations in function with broader

¹³ Chapters 6, 7 and 8 offer a comprehensive discussion of the South African case.

post-Cold War developments associated with human security-based foreign policies in Western powers, globalisation-provoked ‘new threats’ to international security, neoliberalism, and human rights agendas. Given the diversity of interests and agendas by the manifold actors that compose this field, analysts so far have been concurring in arguing about the failure of achieving coherent ‘governance’ of phenomena as disparate as viral outbreaks and epidemics, with different incidences across the globe. Addressing a gap in the global health governance literature, this chapter explored the role of recipient states and their governments in this realm. Bearing in mind the particular case of the postcolonial African state discussed in the previous chapter, it proposed two types of recipient state behaviour: facilitator and ‘rogue.’ While the first alludes to the idea of a state compliant with international structures and policies, in which it mediates and facilitates the implementation of those policies, the second looks at the ‘darker’ side of the state from a global health governance perspective. Apart from the well-documented case of South Africa under the Mbeki Administration, which will be further scrutinized ahead in this dissertation, the problem of ‘corruption’ across state structures is regarded as a negative factor that ought to be suppressed.

From a reflexive point of view, one could argue that the intellectual constitution and development of ‘global health governance’ as a distinguishable realm of relations within the discipline of International Relations offers an example of how liberal and social constructivist theories came to dominate the analysis of the international arena. Global health governance is certainly influenced by the explosive proliferation of governmental and nongovernmental, national and transnational, not-for-profit and for-profit actors in the field, which are seductive for liberal-

institutionalist, cosmopolitan approaches to international relations in the post-Cold War era. In turn, social constructivism is strikingly visible in the construction of causalities (for instance, the link between epidemics and security) that give sense to the enhancement of the international-political study of health programs, the same applying to the post-Foucauldian use of it, mentioned previously.

When framed in the broader theoretical discussion of the discipline, the preponderance of liberal-institutional, social constructivist and critical approaches, in which disparate health-related phenomena with global implications require global responses, have led to the inversion of the terms of analysis of the international arena altogether. The following chapter discusses how these leading approaches elaborate the international system as hierarchical and the agents within as anarchical, rather than the other way around, as taught by classical authors such as Kenneth Waltz. Yet, the next chapter evolves toward the re-inversion back to the traditional structure-agency relationship, although adapted to the reality of the postcolonial African state. Departing from this chapter's exercise of exploration of the recipient state's behaviour's types, the next chapter will also propose a conceptual framework of analysing the postcolonial African state's agency within the structure based on the Waltzian assumption, yet complemented with a sociological approach that accounts for the contingencies affecting the African state that derive from its asymmetric position *vis-à-vis* the West. Departing from the issues of structure-agency and hierarchy-anarchy within International Relations theory, it seeks to conceptualize the individual behaviour of African states in function of their governments' larger political and strategic agendas. Building on neorealist and sociological accounts of

state and structure, it conceptualises agency as ability of the African colonial state to act autonomously, even if in subalternity to the international structure.

Chapter 4 – Asymmetric Relations in Global Health Governance

4.1. Introduction

Chapter 2 showed that postcolonial relations between the West and Sub-Saharan Africa have been characterised by a tension of governmentalities (Bayart, 2009), in which both sides try to condition and resist policy choices and practices in a context of asymmetry between them. After the failure to live up to the expectation of achieving domestic development and achieving integration in the world economy after the first two decades of independence (1960s and 1970s), many African governments often found no alternative but to negotiate development assistance from the West, whose conditionalities aimed at altering the domestic and foreign behaviour of these developing countries. The underlying policy tendencies pursued by the key Western capitals in the last three decades stretched from the preconisation of a neo-liberal political philosophy (1980s and 1990s) to a merge of security and development and statebuilding (2000s) in the developing world, namely in Sub-Saharan Africa. The following chapter inserted the broader discussion in the specific field of health program relations, and emphasises the asymmetric character between (Western) donors and (African) recipients, the latter rendered facilitators and ‘rogues’ in the implementation of policies and programs. Nonetheless, postcolonial African states, and their elites, who have generally coincided, have sought to exert a capacity to survive under very difficult circumstances, particularly in the 1980s and 1990s, and to restore, during the early 2000s, the developmentalist agenda that had characterised the immediate post-independence period. This chapter frames the tension between the West and the postcolonial African state in light of the dialectics

of agency and structure in the context of West-Africa relations. This exercise is divided into four sections.

First of all, drawing on Kenneth Waltz's (1979) *Theory of International Relations*, one revisits the concepts of agency, international system, anarchy and hierarchy. Although finding Waltz's contributions limited, as the third section shows, this dissertation acknowledges their basic utility in the clarification of the terms of analysis. Agency is defined as the ability to act autonomously, even if under constraints exerted by the structure. Conversely, agency is a characteristic of states, which are the units in the international system. These units are featured by domestic hierarchical political relations, while the international system is eminently anarchical, i.e. characterised by no central authority.

Secondly, one reviews the multi-theoretical body of literature (neorealist, neoliberal and critical-theoretical) on relations between the West and the developing world that point at an unabated hegemonic character of the West. It discusses the consensus within International Relations and International Political Economy on the idea of a structural hegemony led by the Western world. Especially, critical-theoretical authors argue that Western hegemony has gone so far to the point of having forced an inversion of the international systems' structural and unitary characteristics. Rather than a structure featured by anarchy and units by hierarchy, the Western foreign policy space constitutes the sphere of hierarchy that seeks to tame the anarchy taking place inside developing states through more or less coercive measures based on military presence and development assistance. Eventually, this has led to an analytical shift in terms of what constitutes structure and unit.

The third section challenges the body of claims made in the previous section by highlighting the low degree of agency granted to the postcolonial African state within the West-led international system. Often, the state in Africa is presented as part of the leasing West-led international structure itself. Regarding the particular case of West-Africa relations, the article “Africa and international relations: a comment on IR theory, anarchy and statehood” by William Brown (2006) is very instructive. However, it also builds on David Chandler’s (2009a; 2009b; 2010) propositions on the problem of human agency and the use of ‘radical’ frameworks of analysis.

Finally, building on the previous sections, one proposes the analytical lens for the dissertation. On the one hand, one acknowledges Waltz’s contribution, however, adapted to the asymmetric character of West-Africa relations. Given Waltz’s elitist approach to the structure, which virtually excludes large parts of the world, his neorealist conceptualization of agency and structure is informed by the idea of “subalternity” (Ayoob, 2002) of developing world’s states *vis-à-vis* the West. On the other hand, the dialectics of agency and structure developed by Waltz is complemented with a historical-sociological approach that conceives the state as a social relation (Rosenberg, 1990; 1994). This means that inter-state relations are to be assessed beyond the conventional detachment of the external sphere, as ‘international sphere,’ from the internal one, by assuming inclusiveness among both. As such, one lays the framework for the five remaining chapters.

4.2. State Agency and International System

Kenneth Waltz was the first author in International Relations to propose a scientific depiction of the international system,¹⁴ divided between structure and units.

In his *Theory of International Relations*, Waltz explains

A system is composed of a structure and of interacting unities. The structure is the system-wide component that makes it possible to think of the system as a whole. (...) A structure is defined by the arrangement of its parts. Only changes of arrangement are structural changes. A system is composed of a structure and of interacting parts. Both the structure and the parts are concepts, related to, but not identical with, agents and agencies. (Waltz, 1979: 79-80)

The international system is composed of units – states – and likens a free market led by the principle of self-help. “International-political systems, like economic markets, are formed by the coaction of self-regarding units. (...) International politics is structurally similar to a market economy insofar as the self-help principle is allowed to operate in the latter.” (Ibid.: 91) States’ self-help is driven by a basic goal of survival in the international system, since that is the basis for any other pursuit “from the ambition to conquer the world to the desire merely to be left alone” (Ibid.).

Though not the only actors in the international system, for Waltz, states are the most important ones, as they “nevertheless set the terms of the intercourse, whether by passively permitting informal rules to develop or by actively intervening to change rules that no longer suit them” (Ibid.: 94). A remark made by the same author is particularly relevant for one’s discussion of the African state. Positing that the states’ predominance will be long-ranging, Waltz famously wrote:

¹⁴ Initiated by Waltz, the agenda in International Relations on system, structure and agency was later enhanced by Alexander Wendt (1999) and Collin Wight (2006), among others. However, for the purpose of this dissertation one is confined to Waltz’s propositions.

The death rate among states is remarkably low. Few states die; many firms do. Who is likely to be around 100 years from now – the United States, the Soviet Union, France, Egypt, Thailand and Uganda? Or Ford, IBM, Shell, Unilever, and Massey-Ferguson? I bet on the states, perhaps even on Uganda. (Ibid.: 95)

Certainly that today the Soviet Union – chief part of Waltz' thesis on the balance of power among major state units as condition for world peace – is no longer around. However, the resilience Waltz attributed to an African state should be emphasized, particularly considering the elitism that cuts across his work, i.e. the primary attention he gives to the world's more powerful states.

Another aspect to be highlighted on Waltz' work is his understanding of state sovereignty, which is not synonym to absolute independence from others' constraints. In this important passage, Waltz frames the terms of how state agency sets out:

Sovereign states may be hardpressed all around, constrained to act in ways they would like to avoid, and able to do hardly anything just as they would like to. The sovereignty of states has never entailed their insulation from the effects of other states' actions. To be sovereign and to be dependent are not contradictory conditions. (Ibid.: 96)

Ability to act with choice occurs in a relational manner, in which sovereignty is never an absolute property of states and requires conducts of interdependence. This means that, even though states have different capabilities (Ibid.: 105), in principle, all of them – United States of America or Ethiopia – enjoy agency, that is, an ability of act autonomously, within different gradations of constraint in the structure.

Considering the discussion on hegemony and what it means for West-Africa relations, which ensues in the next section, the distinction between hierarchy and anarchy should be discussed too. For Waltz, whereas the state-units are featured by hierarchy (Ibid.: 81-88), the international system is characterised by anarchy, i.e.

absence of central authority (Ibid: 102-116). In a clear separation between internal and external, Waltz argues that states have domestic levels of leadership enforcing the country's law, while outside them there is virtually no entity with that ability.

A government, ruling by some standard of legitimacy, arrogates to itself the right to use force – that is, to apply a variety of sanctions to control the use of force by its subjects. If some use private force, others may appeal to the government. A government has no monopoly on the use of force, as is all too evident. An effective government, however, has a monopoly on the legitimate use of force, and legitimate here means that public agents are organized to prevent and to counter the private use of force. Citizens need not prepare to defend themselves. Public agencies do that. A national system is not one of self-help. The international system is. (Ibid.: 103-104)

However, Waltz's claim has been questioned in the last thirty years, especially since the end of the Cold War, and what that event meant in terms of the expansion of United States power worldwide. Hegemony-based approaches to international politics, including neorealist ones, have stressed the particular powerful feature of the United States of America and major allies (Western Europe and Japan) in the leadership of the international system and its consequences for the external anarchy-internal hierarchy debate.

4.3. Reverting Traditional International Relations Postulate

The concept of hegemony has been thoroughly used by International Relations scholars within the different mainstream theoretical strands (neorealism and neoliberalism) since the 1980s. Neorealist authors such as Robert Gilpin (1987) or John Mearsheimer (2001) have explored hegemony in terms of a stabilizing power of the United States of America in a broader context of anarchy in the international system, i.e. a system characterised by the absence of central authority, in opposition

to hierarchy within the domestic realm of the units of that structure, the nation-states, as described by Waltz above. Neorealist authors, such as Mearsheimer, tend to be pessimistic about this character, since they might motivate 'adventurist' foreign policies by the hegemonic power. This interventionist feature of great powers has become particularly acute since the end of the Cold War, and perhaps constitutes the major point of contention between neorealists and their neoliberal colleagues, who, like Robert Keohane (1984), have regarded United States hegemony as an opportunity for leading international cooperation. Much political analysis of United States-driven global health and development initiatives derives from Keohane's inputs on international cooperation. Concepts such as "soft power," or "smart power" (Armitage and Nye, 2007), i.e. power transmitted through international development assistance and international trade, appear as an alternative to military coercion in order to establish and consolidate an advantageous position for the United States of America. Unlike neorealist authors, who are generally amoral with regard to states' international relations, neoliberal authors are rather idealistic about foreign policy. Although recognizing the anarchic international system, they animate the belief that the implementation of Western domestic liberal values worldwide – liberal representative democracy, market capitalism, civil society, limited government, human rights – will ameliorate the prospects of international security, stability and peace (Ibid.). The taming of anarchy is not envisaged merely for the external sphere of relations between nation-states but also for the domestic sphere. This has happened both in practice and, increasingly, in theory, especially after the Cold War, as narratives about 'new threats to security' appeared throughout the 1990s. International security is not merely a function of great powers' balance of power, as

put by Waltzian theory, but also of the impact of marginal, impoverished countries in the developing world. Issues around state failure, which one alluded to in Chapter 2 as featuring relations between the West and Sub-Saharan Africa in the last couple of decades, illustrate the concern mainstream theorists of International Relations have started to show about the domestic sphere of sovereign states and the need to contain the threats emanating from inside them (Bickerton, 2007).

The actual practice of this soft power-based policy – in which PEPFAR is a clear example of in many countries – conjugated with the maintenance of “hard power,” i.e. military power in such contexts as Iraq and Afghanistan – has had relevant theoretical consequences. The broader policy of prevention of state failure and promotion of statebuilding led to a renewed understanding of the international system as one characterized, not by anarchy or interdependence, but by hierarchy as central government (Ibid.). Conversely, the domestic sphere of postcolonial states is featured by anarchy, i.e. absence of central government (Ibid.). Christopher Bickerton has summarised it in these terms:

The highly influential theory of state failure led to a reworking, perhaps even an inversion, of the basic categories of International Relations (IR). Traditional IR theory was built on the assumption that state sovereignty was the precondition for social and political order within domestic society. In the absence of any ultimate political authority, the international realm, by contrast was seen as a domain of strife, where all political and legal order was undermined by the ever-present possibility of conflict. Thus one of the traditional problems for liberal theories of international politics in the last century was how to ‘domesticate anarchy’: that is, how to make the world order more like the domestic order. (Ibid.: 94)

In the case of inter-state West-Africa relations, this claim has been animated by authors such as Kevin C. Dunn and Timothy M. Shaw (2001) encompassing a body that William Brown (2006) calls “the Africanist critique of International Relations.”

The discussion of the ‘intrusiveness’ of the international liberal order in domestic realms has been expanded by the application throughout the last 10 years of Michel Foucault’s concepts of biopower, biopolitics and governmentality, originally developed to explain the historical rise of liberal power in France and Germany. In his 1975-76 *Collège de France* lecture *Society Must Be Defended!*, Foucault (2006) contradicts Claus von Clausewitz, claiming that “politics is the continuation of war by other means,” and not the other way around, as the celebrated war strategist put it. This remark has been found instructive in terms of the shifts of conceptualizing power – liberal rather than absolute – from the 18th century onwards, with the end of the religious wars and the rise of what later became known as capitalism and liberal democracy. This sense of politics is less territorial and juridical and increasingly more deterritorialized and intensively political (Ibid.). Accordingly, the nature of liberal power lies less on the utmost capacity and willingness of the sovereign of taking life as such but on the possibility of “either fostering life or impede it to the point of death” (Foucault, 1984).

This characterization of sovereign power – biopower – builds on the idea presented prior to that lecture in the first volume of *The History of Sexuality* that a new type of power centred in human beings at the aggregate level and in life in general was emerging (Ibid.). This power emanates from the parallel expansion of scientific thought and shrinking of the religious influence, as a result of the Nietzschean “death of God.” Foucault dedicated an entire volume – *The Birth of Clinic* (Foucault, 1994) – to the particular role of medicine and its branches in this revolution in human knowledge about human beings and others and nature around him, particularly in Europe. Biopower was exercised through the effort of measuring

and regulating all dimensions of both biological and social life through Biology, Medicine, Sociology: birth, mortality, criminality, education, employment. Biopower is pungently ‘totalitarian,’ since it is targeted at the totality of the population and life manifestations. Liberal power is particularly complex in comparison with its former form, Absolutism. It requires rationalization and justification so it can be accepted, although, sometimes – as the very case of medicine, for instance, demonstrates – it is applied by force. Thus, power described by Foucault is presented as “power/knowledge” in order to explain the striking influence, namely moral one, of epistemic communities, i.e. groups of scientists and others legitimated by the scientific “truth” and agreeing on the measures to be taken to tackle with a specific issue (Haas, 1992), as the case of the politics of HIV/AIDS (Youde, 2007) exemplify. Basically meaning the agent of biopower, the later concept of biopolitics (Lemke, 2001) was introduced, to which one shall add up the concept of governmentality. Described as “conduct of the conduct,” it is a discursive-material apparatus of security embodying rationalities and technologies of government, which account for “discourses, institutions, architectural forms, regulatory decisions, laws, administrative measures, scientific statements, philosophical, moral and philanthropic propositions” (Foucault, 1980: 184). These technologies are indeed designed to avoid the employment of violence to compel (Lemke, 2001). In a liberal, or liberalizing, context that would be very complicated to achieve from the perspective of the management of the system’s own sustainability. As such, frequently, control is exerted through “ideological manipulation or rational argumentation, moral advice or economic exploitation” (Lemke, 2000: 5).

These elaborations have been consistently used to explain the voracity of Western powers to intervene in non-Western settings, and enforce security (Jabri, 2007), human rights regimes (Douzinas, 2007), and development (Duffield, 2007; 2002; 2005). In a recent publication, Mark Duffield has reiterated the virtue of post-Foucauldian concepts to achieve a radical view of the security-development nexus discussed in the previous chapter, looking at the case of humanitarian/development organizations.

Following the lead of Foucault and the international political sociology of the Paris School (...), the development–security *nexus* can be understood as a *dispositif* or ‘constellation of institutions, practices, and beliefs that create conditions of possibility within a particular field’ (...). The nexus constitutes a field of development and security actors, aid agencies and professional networks, complete with their own forms of subjectivity, that call forth the conditions of need and insecurity to which collectively, and in competition, they seek to provide solutions. In this process, however, not only is risk normalized, but the origins and causes of the absences and instabilities these actors hope to rectify are also obscured and occluded. (Duffield, 2010: 56; italics in the original)

Authors such as Mark Duffield continue an avenue of research which, in the last analysis, was initiated at the Frankfurt School in its post-Auschwitz phase. Holding Modernity and its perverse developmentalist creed arguably on the basis of the Nazi horrors as object of critique, it founded Post-Development as a field of social critique, namely with regard to the Third World and development aid and rationales pushed by the international establishment (International Monetary Fund, World Bank, major governmental donors and large North-based NGOs). Initiated in the early to mid-1980s by Colombian anthropologist Arturo Escobar (1984/1985), it has influenced a number of authors in several fields seeking to demonstrate that development, rather than a process, is both means and end, heading to no other tangible outcomes than violence and subjection (DuBois, 1991; Brigg, 2002).

International development is subject to “governance at a distance” (Duffield, 2005: 208-210) through technologies of management such as the logical framework. These tools build on a presumption of neutrality of developmental and anti-poverty work, taking the shape of professional-technical intervention impinged to overcome political rigidities, as influential anthropological works of the mid-1990s by Arturo Escobar and James Ferguson (Dar and Cooke, 2008). Partnerships, notably transnational ones, integrate elements of reciprocity, mutuality and pluralism (Brinkerhoff and Brinkerhoff, 2004: 255; Kettl, 2008: 10). However, that does not mean they are more democratic (Roelofs, 2009), both in terms of inter-partner relations and between the partnership framework and a whole public lying at the margins: from taxpayers, who fund the partnership, to clients, who are subject to their activities’ ambitions and interventions. Flexibility does not mean more simplicity of relations, rather on the contrary: large partnerships tend to generate grand complexity, and are admittedly difficult to take hold from a theoretical perspective (Kettl, 2008; Roelofs, 2009; Milward and Provan, 2000). Similarly, goals based on empowerment and country ownership – subjectivities connected to hope, responsibility and self-reliance – are advanced too.

Country ownership is what recipient countries obtain when “urged to take ownership of development policies and aid activities in their country, to establish their own systems of coordinating donors, and only to accept aid that suits their needs” (Renzio et al., 2008: 1). According to Bill Cooke (2003), this system of ownership provision, promoted, for instance, by the World Bank and repeated by other donors, discloses close vicinity with colonial forms of administration, namely “indirect rule,” in which colonial administration was tentatively more profitable

when transmitted to native elites in order to prevent contestation. However, it is also important, as Katharina Welle (2001) has demonstrated, to bear in mind that partnership as an organizing model of transnational collaboration has had different meanings in contemporary development discourse and practice. In her examination of a collaborative project of water management in Ghana, Welle made the distinction between partnership as “discourse of solidarity” and as “discourse of efficiency” (Ibid.: 4). Whereas initially (i.e. early 1970s) partnership would stand for a commitment of solidarity as a mode of alternative development (Ibid.: 7) involving, primarily, nongovernmental partners in the North and South, later, from the mid-1980s until today, as large financial institutions started to implicate NGOs in their development financing (Ibid.: 9), partnerships started to be understood as means of achieving “good government” (Ibid.: 10) – or ‘good governance,’ as the current jargon put it – from an efficiency point of view.

The shift of level of analysis from the external to the internal obviously had an impact in terms of the scrutiny of agency within the structure of hegemony and empire. According to Oliver Richmond (2010), the national states and democratic institutions that receive the neoliberal policies of the great powers were “hijacked and captured” (Ibid.: 3), and therefore agency is left to be searched within the modes of local resistance to external neoliberal policies.

In these struggles [generated by the hegemonic liberal project], a possibility of a post-liberal peace emerges, in which everyday local agencies, rights, needs, custom and kinship are recognised as discursive ‘webs of meaning’. This might herald a more realistic recognition of the possibilities of, and dynamics of, contextual and local peacebuilding agencies within international peacebuilding, development and institutional architecture and policies. This move away from ‘imperious IR’ and a willingness to emphasise local context and contingency lays bare those paradoxes and tensions derived from territorial sovereignty, the overbearing state, cold institutionalism, a focus on rights over needs,

distant trustee-style governance and a hierarchical international system in which material power matters more than everyday life. (Ibid.: 4-5)

Informed by postcolonial-theoretical perspectives and by focusing on sectors of postcolonial populations, this agency/resistance has increasingly constituted a research agenda aimed at identifying forms of power hybridity (Richmond, 2010; Ginty, 2010). This agency/resistance to the liberal project of statebuilding and peacebuilding is presented as a local phenomenon of subversion and appropriation, capturing some nuances mentioned throughout Chapter 2, namely neopatrimonialism and the way it exemplifies a form of hybrid power (De Goede, 2010).

4.4. Hegemony-based Approaches and Problem of Agency

This thesis argues that African national governments hold agency in the international system. This means it assumes that African states/governments act on their own under those auspices, i.e. they hold the capacity of taking decisions independently, even if constrained and pressured by other states/governments and the structural social forces. This agency is a consequence of the postcolonial sovereign status achieved since the wave of independences. However, in order to properly analyse state action, one needs a more traditional approach to conceptualise agency and structure, as the first section suggested. In other words, the analysis should depart from the premise that the international arena is driven by anarchy and the unitary parts (states) are organized in a hierarchical way. As such, this dissertation contends with the hegemony-based claims made in the previous part. One concedes that hegemony-based approaches are very appealing, as they are unambiguous about the asymmetries that characterise the world of states, in which the United States

government's hegemony often leads to intervention within the domestic realms of less powerful states. However, those arguments are problematic for two reasons. On the one hand, they assume that the mere intellectual construction of the state in the African context is *per se* a colonial act by the Western world, i.e. an external imposition to regulate postcolonial relations. On the other, they essentialise the membership of weak African states to the structure of United States hegemony, and thus negate their agency.

In the first case, one follows Brown (2006) in his critique of the authors he calls "the Africanist critique of mainstream International Relations:"

Implicit in the Africanist critique is an idea that 'western IR' helps to reinforce Western dominance in the international system through, for example, aid donors' insistence on the adoption of particular reforms in Africa, centred on Western conceptions of the nation state. (Brown, 2006: 126)

For Brown, the understanding of the African state as under absolute domination displays an essentialisation, at the knowledge level: the comparative history of Europe, where state-centric theory was born, and Africa. Underneath the Africanist critique's positions lies "the notion of a one-way process of imposition of the Western ideal-state onto Africa as if Africans themselves had little to do with it" (Ibid.: 128). Brown further adds that, unlike the "Africanist critique" often suggests, "not only was the course of colonisation shaped by the interaction between Africans and Europeans but decolonisation and the foundation of independent states was a process in which Africans were actors, not simply acted upon" (Ibid.). This is consistent with Christopher Clapham's (1996) account of the post-independence arrangement under the Organization for African Unity, in which the tenets of

Westphalia (respect for state sovereignty; non-violation of state integrity; and state independence) were clearly remarked.

In the second case, the question of state agency, or the lack of it, is visible in the way authors such as Oliver Richmond (2010) conceptualize human agency, in which the state is deliberately bypassed. Accordingly, the state is an entity that is observed either as an external machination of potential oppression, often deriving from the colonial era, or as a plain superficiality. As such, these authors move straight away into the internal realm of the state. The search for agency within the domestic sphere of states in the developing world is symptomatic of an understanding of the national state as being not only unresponsive to citizens, and equivalently more attached to the prescriptions and guidance of the international community, but also violent and oppressive of those populations on behalf of the external project.

However, it is questionable to what extent the critique is directed at external policies and their consequences, namely at the level of national state violence or at liberalism itself. David Chandler has alluded to liberalism within the critique of international intervention as a ‘field of adversity.’

It would seem that at the core of the policy and radical critiques of the liberal peace is a critique of liberal aspirations rather than a critique of international interventionist policies and practices. The critique reflects the ease with which liberalism has become a ‘field of adversity’, through which both policy reform and critical claims for theoretical advance can both be made. The construction of a liberal ‘field of adversity’ seems to have little relation to policy realities. This is reflected in the fact that, while there is a consensus on the view that Western policies are problematic in that they are too liberal, there is much less attention to how the problems of the post-colonial world might be alternatively addressed. (Chandler, 2010: 16)

Chandler's remark follows from his critique of post-Foucauldian authors, particularly Mark Duffield, who arguably do not theorise, or even exclude, human agency that emanates from neoliberal policies. For Chandler, Duffield's approach

in effect, essentializes or naturalizes the concept of biopower to argue that 'liberal' discourses of progress are essentially new forms of governing and controlling population (and moreover) appears to throw the baby of human agency out with the bathwater of development, rejecting modernizing aspirations towards democracy and development for recreating oppressive neoliberal biopolitical frameworks of control and regulation (Chandler, 2009a: 99)

As Chapters 6, 7 and, especially, 8 show, those "liberal aspirations" are also shared across the three polities under consideration in this dissertation. Furthermore, Jan Selby (2007) and David Chandler (2009a; 2009b) have contested the search for the existence of an alternative political solution to liberalism within Foucauldian accounts.¹⁵ In this excerpt, Chandler compares the contemporary post-Foucauldian approach, which he calls the "poststructuralist critique" to the "liberal cosmopolitans" of the 1990s (authors such as Daniele Archibuggi or Mary Kaldor), who arguably set up the Western interventionist framework of today. He concludes there is no difference between them.

The radical discourse of poststructuralist post-territorial political community sought to critique this international order as a product of global liberalism, but the nature of the critique was in content and form little different from that of 1990s cosmopolitanism. There is little difference between the frameworks of the poststructuralist critics and the

¹⁵ Though not explicitly Marxist, Foucault shared an agenda deriving from Marxian analysis of society and economy borne out of the Frankfurt School. Hence, Marxism lays the foundations for Foucauldian application to International Relations, which, according to Jan Selby (2007), has not been properly acknowledged by the scholarly community. Explaining liberal practices, Foucault sheds precious light on how power works, or is meant to work, within capitalist societies, but, according to Selby (2007: 340-341), not why it works the way it does. For him, it is explained by Marxism: "the ceaseless accumulation of capital, and attendant conflicts amongst capitalists, classes and states" (Ibid.: 340). Hence, both traditions – Foucauldian and Marxist – are "mutually enriching" (Ibid.) and, moreover, reiterate the conclusion Foucault himself had come to when he stated that "for many of us [them] as young intellectuals, an interest in Nietzsche or Bataille didn't represent a way of distancing oneself from Marxism or communism. Rather, it was almost the only path leading to what we, of course, thought could be expected of communism" (Macdonald, 2002).

liberal cosmopolitans because the groundwork of the critique was already laid by the crisis within liberal thinking. (...)The radical critique of the cosmopolitan discourse of global rights offers a critique of sovereign power, representational politics and its grounding liberal ontology, but one that merely echoes, to the point of parody, that of its ostensible subject of critique. (Ibid, 2009: 68)

The dismissal of the state, and its agency, in the developing world, or its rendering to a rather passive part of a hierarchical international system, is problematic not because the study of emancipation in international politics from an anti-colonial perspective is unimportant but because, by radicalizing the argument about states as violent and therefore oppressive, it cuts off the prospect of reducing inequalities *vis-à-vis* powerful states. Despite the multitude of social forces in the international realm, states are still the centres of political power in that realm, and, as such, the attenuation or even change of hegemonic political power is a process that necessarily implicates states. However, it is relevant, first of all, to acknowledge the character of the African postcolonial state, in particular the relationship with the former colonizing powers. As mentioned in Chapter 2, as postcolonial states are created, often ties with the former colonial powers were not disrupted. Actually, they were retained, and, in the case of social policy (education, health), were intensified through mechanisms of development aid and cooperation. Despite the rhetoric of independence and sovereignty, often it was in the national elites' best interest to nurture these ties, which indeed constituted relevant means in light of the politics of neopatrimonialism. This aspect should be strongly emphasised, as it may be easily perceived as postcolonial 'politics of neo-colonialism.'

However, it should be added that the issues surrounding the state, and its agency, in Sub-Saharan Africa are not solely exclusive to that region of the world.

David Williams suggests that “the ambiguities about state agency that emerge are not at all unique to Africa. African states help to provide some of what we might call the ‘limit cases’ but the broad issues that emerge are ones that can be applied to thinking about state agency in general” (Williams, 2011: 3). Accordingly, “political and normative elements” (Ibid.) entrenched in the state render it special qualities, such as agency in the international system.

4.5. Agency, Asymmetry and “State as Social Relation”

Whereas Waltz’s conceptualization of agency and structure is useful for the analysis of postcolonial African relations, one does not advocate a complete return to Waltzian neorealist theory. Despite serving well as a “problem-solving theory” (Cox, 1981) for the objectivity of its definitions, a full engagement with neorealist theory is empirically limited (Ayoob, 2002).

Although a confessed neorealist, Mohammed Ayoob underlines the elitism of Waltz’s proposals, as they draw on the experience of major world powers (United States of America and Soviet Union), and their impact on the post-Second World War settlement in Europe. For Waltz, weaker states are almost inevitably inclined towards bandwagoning with the stronger powers, and there they remain: “As soon as someone looks like the winner, nearly all jump on the bandwagon rather than continuing to build coalitions intended to prevent anyone from winning the prize of power” (Waltz, 1979: 126). However, Ayoob has made the same criticism for neoliberal authors alike, whose “thesis on cooperation under anarchy skews the data in favour of affluent, industrialized democracies of the global North that form a small

minority of the total membership of the international system” (Ayoob, 2002: 36). Concentration on North America, Western Europe, Japan and a few more countries/regions excludes, or inhibits, the vast majority of states, which are generally much poorer and less developed and industrialized. This problem of exclusion is found in the specific field of global health governance. As mentioned in the previous chapter, James Ricci (2009) has called for a rescue of the state in that area. After all, states are the major financial contributors and defining policy-makers. However, Ricci’s introduction of International Society theory does not take into due account the character of asymmetry, and thus invisibility, of the recipient state. As such, his theoretical approach is mired in the same elitism that liberal-institutional and globalization scholars of global health mentioned above exhibit. This asymmetry is primarily understood in function of the disparities of wealth and human development between regions, but also the origin of influential epistemologies and policies that form the actual relationship. Although Ricci’s call for a renewed attention to the state is very pertinent, his International Society-based proposal as a fitter analytical framework suffers from the same theoretical problem that affects neoliberal and neorealist approaches, and that will be scrutinized into more detail in the Chapters 6, 7 and 8. By leaving it in silence, Ricci’s alternative, state-based proposal does not conceptualize the issue of asymmetry between states in global health governance. His allusion is mainly, if not exclusively, to donor countries, mostly Western, and large, powerful states such as China. His mention of the Indonesian government’s refusal to share A/H5N1 flu virus samples offers an example of how a smaller country conflicts with the major states; however, the background question of asymmetry within such (international) society is not

addressed. It should be added that the segregation faced by postcolonial African states lies at the core of the “Africanist critique of International Relations,” which one has discussed in the previous section. Accordingly, this silencing is handed as evidence that International Relations theory just does not serve the realities of regions such as Sub-Saharan Africa. This fact implicates an understanding of the contingencies that render those states generally a condition of subalternity and asymmetry *vis-à-vis* the major players in the international scene, who also happen to have been former colonial masters.

As a response, Ayoob proposes a version of neorealism he has called “subaltern realism,” which departs from a position in which the state is the central figure in the international arena, “despite the proliferation of nonstate actors and their increased capacity, in relative terms, to influence international and national outcomes” (Ibid.: 39). However, so it can have any significance, the state has to be effective and markedly Westphalian in order to achieve any real equality with the far more powerful states in the system. “Only by approaching the Westphalian ideal more closely can the postcolonial states provide stable political order domestically and participate on a more equal footing in writing and rewriting the rules of international order.” (Ibid.: 40). Ayoob prescribes these states as “strong states” (Ibid.) that can guarantee development and economic growth, even if contrary to the international establishment.¹⁶ But Ayoob’s proposal is not radical in its rejection of the (postcolonial) state as a violent demon. He regards postcolonial violence as a

¹⁶ In his article Ayoob (2002) refers to the Washington Consensus, since his earlier developments of the “subaltern realism” perspective started in the early 1990s, as the liberal developmental proposal based on market dominance and state structure reduction emerged victorious under the name of Washington Consensus. One could hypothesise that an example of “strong state” suggested by Ayoob corresponds to the revival of the ‘developmental state,’ as it will be discussed in this dissertation, particularly with regard to Ethiopia and Botswana.

contingency following the proclamation of juridical sovereignty and recognition as members of the United Nations. “In many cases, establishing effective statehood, to whatever extent this was possible, entailed the exercise of violence and counterviolence by the state and its opponents” (Ibid.: 43-44) As Hobbesian as he is about the need of central authority to regulate what alternatively would be a ‘brutish way of life’ among humans, violence is possibly necessary in order to build a nation that can prosper in the future. Ayooob’s rejoinder to neorealist theory is valuable as it reiterates the centrality of the state – and therefore its agency – in the international system while, at the same time, considering the subalternity most states, including those in Sub-Saharan Africa, have been experiencing since their existence as sovereign states.

However, as a committed neorealist theoretical perspective, Ayooob detaches external from internal spheres, and that is particularly limitative as a lens that captures the fullest possible levels of relations a state can have. Considering the porosity of the postcolonial state in terms of areas such as social development or health – mostly at stake in this dissertation, after all – it is necessary to establish a framework that connects external and domestic dimensions of inter-state action.

An envisaged framework that deals with the limits of neorealist theory for explaining the realities of postcolonial relations, while acknowledging its clarity in the definition of structure and agency, is one that is sociologically-informed by the work of Justin Rosenberg (1990; 1994). Taking states as social relations, Rosenberg argues that such state-specific property as sovereignty, and the very international system, is partially the product of inter-state relations. Reflecting on the emergence of the nation-state in Europe after the Peace of Westphalia in 1648, Rosenberg

argues that internal and external developments to states combine and consolidate the international system of relations.

We are viewing, in the emergence of sovereign nation-states, the consolidation of a structure of political power whose core institution (sovereignty) is a point of continuity between the domestic and the 'international.' The mustering of administrative power domestically is inescapably bound up with relations between states – and vice-versa. (Rosenberg, 1990: 254)

Although the author reflects on the specific case of Europe, it is worth applying to relations with states in Sub-Saharan Africa, which, despite their nuances, discussed throughout Chapter 2, are members with agency in the international system. In another piece, Rosenberg repeats his appeal for an attention to the social component of states and their relations beyond a dogmatic separation between external and internal. Yet, here he addresses the problem of the risk of treating any state as a mere Western construction, hollowed out of its specificities.

If one cannot look at those social relations, then one must treat the state as an irreducible actor. And to do this is to invest the specifically modern Western form of the state with an elemental status which abstracts it from its social and historical reality. (Rosenberg, 1994: 94)

Understanding the state as a social relation implies that the existing hierarchy found inside the state/units is the result of relations between political, social and economic forces, internal and external to the unit. This sociologically-informed theory of the state allows for the comprehension of a sophisticated public-private partnership, PEPFAR, under analysis here, and its process of implementation in different national settings. And this applies not only to the recipient governments but also to the donor one. Likewise, the structure upon which states sit and interact is also historically and socially-informed by social forces.

In this dissertation, one organizes those social relations that constitute the state along different levels. In the case of recipient countries of international (or bilateral, in this case) development programs, one divides the analysis along three interconnected levels. One level corresponds to the conventional international realm of relations at the higher diplomatic and military level featured by an encompassing foreign policy and national strategies. Relations between different states are analysed within the international system's context. A second level corresponds to the domestic sphere, in which state policies with a domestic scope engage with the international donor's influences. Accordingly, the focus is on how the international level is negotiated internationally in the governmental sphere. And the third level is the local and looks at the practices of the interaction of the recipient state and the international donor. This level allows the analysis of how the policies under scrutiny are rendered operational in the field. At each of these levels, despite the asymmetry of relations with the donor, the recipient state holds agency, i.e. it acts independently in the pursuit of its policy goals.

Indeed, it should be remarked that, apart from state policies, this sociological approach requires the full inclusion of all actors involved in the partnership, i.e. governmental and nongovernmental organizations, United States-based and established in the host countries, as well as international organizations (e.g. those belonging to the United Nations system). Yet, other stakeholders are also taken into consideration.

4.6. Conclusion

This chapter puts forward the conceptual proposal for the study of the agency of Sub-Saharan African national governments under the implementation of development aid programs. It started with a discussion of the concepts of agency, structure, anarchy and hierarchy in light of Kenneth Waltz' (1979) *Theories of International Relations*. His proposals are found basically useful to describe the autonomous behaviour of postcolonial African states, despite their structural constraints. One asserted Waltz's idea that all unit-states have agency and constraints, independent of their capacity. States are the key units of the international system, and are characterised by internal hierarchy, with the primacy of central government. In turn, the international system is featured by anarchy, i.e. the absence of central government who enforces law in the international realm.

The second section looked at the hegemony-based arguments that have emerged since the 1980s to describe the role of the United States of America in the international system. In order to understand the ambition, scope and intensity of West-led statebuilding and development policies and initiatives, particularly critical-theoretical perspectives have suggested an inversion of the 'classical' structure-agency relationship. Accordingly, the structure appears hierarchical rather than anarchical, and the state-unit is anarchical rather than hierarchical. However, the third section has challenged this view in two instances. First, one contested the idea held by what Brown (2006) has called "the Africanist critique of International Relations" that the modern Westphalian state is an intellectual and policy act of colonialism by the West in Africa. Following Brown (Ibid.), one reinforces that Africans were also part of the process of colonisation and postcolonisation, and thus

the integration of Africa in the world of states is also their responsibility. Second, building on Chandler (2009a, 2009b, 2010) one finds problematic the jeopardy, or even negation, of agency among postcolonial African states by critical theorists, namely when employing Foucauldian frameworks.

Finally, the fourth section proposes the analytical framework for the empirical chapters. Although basically useful for explaining states' ability to act autonomously, i.e. with agency, in the world system, Waltzian theory of International Relations is limited insofar as it was primarily elaborated to explain major states' behaviour. As such, it appears as an elitist proposition that hardly captures the realities of weaker and poorer states such as those in Sub-Saharan Africa. However, the same applies to other mainstream theories in the field, namely neoliberalism. An approach that looks at asymmetries is thus required, and Ayoob (2002) develops an approach that underlines the subalternity of smaller states. Although the idea of subalternity is correct, Ayoob's neorealism still detaches external and internal spheres of the state, and that is limited too as it does not help to grasp the interchange between the external and the internal dynamics. Building on Rosenberg (1990, 1994), it is argued that a sociologically-informed understanding of the state as a social relation allows for a more inclusive grasping of the postcolonial state's behaviour *vis-à-vis* the structure. However, this sociological approach implies the incorporation of actors that go beyond the 'mere' state institutions on both sides. It requires the full incorporation of the array of governmental and nongovernmental entities, based in the donor and recipient countries, as well as international organizations, whenever they are implicated. Inter-state social relations are divided along three levels – international, national, and local – that lay the analytical framework for the empirical

Chapters 6, 7 and 8. The next chapter presents and discusses the PEPFAR's history and connections to United States domestic and foreign politics.

Chapter 5 – PEPFAR: Evolution and Asymmetric Relations

5.1. Introduction

The previous chapter introduced this dissertation's analytical framework based on the ideas of agency by postcolonial African states, following Waltz's (1979) original proposition in *Theory of International Relations*, asymmetry of relations in the international system (Ayoob, 2002), and, finally, "state as a social relation" (Rosenberg, 1990, 1994). A sociological approach to the state is found needed in order to connect the traditionally divided internal and external spheres of states, and as such enhance the scope of analysis of inter-state relations between the West and Sub-Saharan Africa.

This chapter presents and discusses the case study in which the analytical framework is employed: the process of designing, establishing and implementing PEPFAR in Botswana, Ethiopia and South Africa. It looks at the origins, political rationales, policies and organisational design of PEPFAR, before proceeding to the actual experience of implementation in those three countries (Chapters 6, 7 and 8). It is informed by official documents from the Office of the Global AIDS Coordinator (PEPFAR's leadership); media articles; opinion pieces by several parties; academic articles and theses. But it is also informed by interviews carried out with PEPFAR implementers and other stakeholders in Botswana, Ethiopia and South Africa. This chapter focuses on the origins of the plan and the political rationales behind it.

5.2. The Origins of PEPFAR

The history of the United States government's international intervention in HIV/AIDS started in 1986 with a USAID request to Congress for funding specifically for that area (Sheehan, 2008: 126). The main reason for doing it had to do with the developmental implications that the rising epidemic could originate (Ibid.). This was sensitive in the context of the late Cold War, particularly in Africa, where two models of development and modernity were challenging each other for influence: one market-based, of United States/Western inspiration, and another state-led, of Soviet/Warsaw Pact support. This also happened in the context of the first international initiatives driven by the World Health Organization (WHO) to establish programs for monitoring and control of the epidemic (WHO, 2008). With the end of the Cold War in 1989, and despite an overall reduction of international development funding in the early 1990s, this intervention became part of a "second phase" of United States-Africa relations and the progressive construction of

concerns about under-development and humanitarian issues such as wars and armed conflicts, failed and collapsed states, poverty, HIV/AIDS and environmental catastrophes such as drought and famine and their collective impact on United States national security. (Francis, 2010: 11)

Hence, progressively, HIV/AIDS started to be referred to as an issue of development with increasingly security implications, as it came to be crystallized with the establishment of PEPFAR in 2003.

PEPFAR builds extensively on the experience of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990. It can be argued that PEPFAR constitutes a 'globalisation' (beyond United States borders) of the early experience of a domestic program. The CARE Act aimed at responding with a

character of emergency to a disease that had already killed 50 000 people by that year in the United States of America (Rankin, 2009: 2). It had four components: primary care for those infected in major metropolitan areas; supportive services; early intervention and prevention programs; and programs for women, infants, children, youth, and their families (Ibid.: 5), and it was reauthorized three times (1996, 2000 and 2006). This program was the result of years of activism, including by the person who gave name to the program, Ryan White, an infected haemophiliac. This activism emerged in face of years of neglect by the federal government, whose anti-gay stance had larger consequences to HIV/AIDS intervention in the country. Even though HIV can be transmitted in several ways, including blood transfusions, for a long time it was primarily associated with male homosexual practices, to the point of being called a “gay cancer” in the early moments of discovery of the disease (Fee and Parry, 2008: 54).

The commonality between both programs is visible in the way both have evolved. As it is discussed into more detail ahead in this chapter, both have started, as their titles make it explicit, as emergency programs for dealing with a crisis. Yet, they then pursued a strategy of transferring ‘ownership’ to the communities, which, in the case of PEPFAR, means largely the national governments and these countries’ civil societies. The comments and examples that Leslie Rankin has put forward are informative on that regard.

This approach is critical for HIV and AIDS services as localities are faced with many different issues. For example, an area that does not have coordinated public transit may allocate funding for van rides so that clients can be compliant with medical appointments, whereas an area with efficient public transit may chose to allocate funding for other purposes. By allowing localities the ability to prioritize rather than providing a standardized federal prioritization, funding can be used efficiently to provide effective services. (Rankin, 2009: 44)

Overtime the CARE program came to be confronted with the question of generating dependency. Considering that the program's funding is largely spent on the provision of lifelong antiretroviral medications, the enrolment of new patients who could not, and cannot, turn to an alternative medical scheme in this program has contributed for its increasing overall cost (Ibid.: 45).

It should also be mentioned that the current head of PEPFAR, Eric Goosby, was the first administrator of the CARE Act in 1991. Moreover, his career in the 1980s was spent in HIV/AIDS medical care (he is a medical doctor by training) primarily in the United States of America, and in the 1990s in the leadership of several other United States domestic initiatives.

5.3. Political Rationales

5.3.1. United States Foreign Policy and Security Strategy

In Chapter 2, one discussed the several linkages established by scholars and policy-makers in the West in the realm of infectious disease and other health-related issues and foreign policy, security and strategy. In the case of the United States of America, the topic of infectious diseases has been framed in the most recent strategic concepts.

New flows of trade, investment, information, and technology are transforming national security. Globalization has exposed us to new challenges and changed the way old challenges touch our interests and values, while also greatly enhancing our capacity to respond. Examples include: *Public health challenges like pandemics (HIV/AIDS, avian influenza) that recognize no borders*. The risks to social order are so great that traditional public health approaches may be inadequate, necessitating new strategies and responses. (The White House, 2006: 47, italics in the original)

HIV/AIDS' real or constructed implications, particularly in Sub-Saharan Africa, where the epidemic was found proliferating extensively since the 1980s too, have long become a subject of interest to the United States Department of State, namely its autonomous agency for international development, USAID. Addressed first as an issue of health and development, it increasingly became a topic in security discussions, even if asymmetrically, from the late 1980s through the 1990s. As the doctoral thesis by Carrie C. Sheehan (2008) on the securitization of HIV/AIDS in United States foreign policy shows, congressional hearings and presidential documents across the late 1980s through early 1990s demonstrate a security concern associated with the epidemic, both in its domestic (inside the United States of America) and international dimensions. After a sharp decline during most of the 1990s, it resurged in the late 1990s, yet with a larger emphasis on the link between AIDS and security than ever before (Ibid.: 163-164).

Richard Holbrooke, United States ambassador to the United Nations at the end of the 1990s, was arguably the key element in the United States government to elaborate a security discourse about the epidemic that eventually led to the first United Nations Security Council meeting on HIV/AIDS on January 10, 2000. His discourse pointed at two, yet interconnected, aspects. One had to do with the impact on the military when operating overseas, in peacekeeping missions or else, and another on potential social disruptions in sites characterized by a hyper-epidemic. In an interview in May 2006, Holbrooke commented on both aspects.

My first personal observation was in Cambodia in 1992 when I went there as a private citizen, and I saw the peacekeepers from the United Nations in Cambodia, and they were doing a good job. But at night I saw them wandering around the street drunk and going into whorehouses and so on and so forth, and I was quite upset about this. It was clear that they

were spreading AIDS, and they were going to take AIDS back with them. (Holbrooke, 2006)

And after a visit paid to ten African countries in 1999 he observed:

Watching kids sleep in the gutters in Lusaka [Zambia], knowing that they will become either prostitutes or rape victims, either getting or spreading the disease, because there's no shelter for them, and that the government is doing nothing about it, makes a powerful impression on you. (...) I said: "Look at the facts; it's not simply a humanitarian issue. If a country loses so many of its resources in fighting a disease which takes down a third of its population, it's going to be destabilized, so it is a security issue." (...) Anyway, that was years ago. That issue is over. Everyone now accepts our definition of AIDS as a security issue -- it's self-evident. (Ibid.)

Also in January 2000 the United States Central Intelligence Agency (CIA) published a report which presented HIV/AIDS as a security threat to the United States (National Intelligence Council, 2000), followed by another in 2002 about the "second wave" countries whose future experience with the epidemic will lead to disruptions with global consequences (Gordon, 2002). Following on these developments, Washington, DC-based think tank Centre for Strategic and International Studies (CSIS) has also published along these lines. According to CSIS analysts Mark Schneider and Michael Moodie (2002), after Southern and Eastern Africa, strategically crucial countries such as Russia, India and China, together with very populous African countries such as Nigeria and Ethiopia, were emerging as the next regions severely affected by the epidemic.

In International Relations scholarship, a first and very influent narrative highlighted scenarios of socioeconomic disruption, loss of state capability, violent conflictuality and terrorism within worst-affected societies in Southern and Eastern Africa (Elbe, 2003; Price-Smith, 2002; Altman, 2003). United States army official

Charlene Jefferson summarizes this complexity, where orphans and vulnerable children attract major attention:

Simply put, a disturbing new formula may be emerging; AIDS creates economic devastation. Economic devastation creates an atmosphere where stable governments cannot function. When stable governments cannot effectively function, terrorism thrives by exploiting the underlying conditions that promote the despair and the destructive visions of political change. (...) ...AIDS has created a steady stream of orphans who can be exploited and used for terrorist activities. (Jefferson, 2006: 6-7)

Princeton Lyman and J. Stephen Morrison (2006) have suggested that countries like Nigeria and South Africa offer safe havens for recruitment of children and youths for jihadist, anti-Western activities home and abroad, exploiting on the epidemic effects. The question of international peacekeeping forces deployed in the developing world and their exposure to the virus through engagement with female sex workers was also explored by Stefan Elbe (2003), Matthew L. Lim (2004) and Martin Rupiya (2006). In Russia, AIDS proliferation within the army also became a matter of national security by the government too, as a result of increasing incidence of the virus nationwide (Eberstadt, 2002; Sjösted, 2008). It should also be mentioned that AIDS has been likewise linked as a variable to other socially constructed threats, namely migrants and refugees (IRIN, 2006) and climate change (Australian Associate Press, 2008).

However, other authors, such as Laurie Garret (2005) and Alex de Waal (2006), expressed scepticism about the propelled causality. The nexus is eminently speculative (McInnes, 2006) and based more on intuition than on evidence (Barnett and Prins, 2006). AIDS is a long-wave event, and hence it requires the careful analysis of three generations so one can draw peremptory conclusions about its real impact.

Put briefly, an infected person has children, these are orphaned and may grow up to be infected, but not before they have themselves had children – who are orphaned in turn. Hence a basic unit of social structure in most human societies, the three-generation bond linking grandparents, parents and children in a continuously reproduced pattern is rent asunder. (Barnett, 2006: 298)

De Waal has led a research team in recent years whose empirical evidence argues against the HIV-security framework (de Waal, 2010). Still, independent of this discussion, the linkage was maintained and even adopted by the then-head of the United Nations Joint Programme for HIV and AIDS (UNAIDS), Peter Piot, as part of a strategic discourse of raising awareness and funding for the epidemic in the years that followed.

However, it is interesting to notice that at time of publication of the two CIA reports there was a change in United States Administration (from Clinton to Bush), where Bush's first remarks on Africa were of little engagement with the continent. In 2000, George W. Bush stated that “[while] Africa may be important, it does not fit into the national interests, as far as I can see them” (Francis, 2010: 10), something that seems contradictory with the growing presentation of the epidemic as an existential threat. Nonetheless, after the September 11, 2001 attacks in New York City and Washington, DC, there was a resurgence of that rhetoric under a more comprehensive policy framework linking (failed) states, counter-insurgency, development, and epidemics too, with Africa broadly constituting an important site of analysis and implementation. At the end of his tenure, former United States Global AIDS Coordinator Mark Dybul has used these terms:

Our future is Africa's future and Africa's future is our future. So there's very much that long-term vision for a stable world in which we play a role and have a role. And it's in our self-interest. (...) [These programs] have changed how people view America. (...) people know what we stand for when we stand with them. And eight of ten of the countries in

the world with the highest approval rating of the United States, sometimes higher than the United States itself, are in Africa. (...) These programs touch lives. (Dybul, 2009)

However, the growing influence of China in Africa has also led to reinforced attention to the geopolitical implications (Osikena, 2010: 169-170). An interviewee with a United States government agency in Botswana lamented that the United States of America does not get the same newspaper credit for the HIV/AIDS effort as Chinese building companies operating in the country do (Interviewee 16, 2010).

But it should be underlined that the foreign policy and security argument is not the only PEPFAR's driver. In broader domestic discussions about PEPFAR this general rationale comes together with what one could call 'conventional benign reasons,' such as humanitarianism and compassion for the sufferer. Recipient populations are presented as in utter need of United States compassion and charity (Pereira, 2011b: 10-11). However, this argument is still very relevant, especially in commentary about the public's perceived too high expenditure by the government in development and relief overseas.

5.3.2. Domestic Constituencies

The United States of America has a large constituency implicated both in the policy-making and practice of development-related issues, which can be seen as a product of the eminent rise as a military and economic superpower worldwide, particularly after the Second World War. Despite some resistance to allocating aid overseas by some advocates of a more inward, isolationist position, the majority of political leaders and their constituents, either for idealist or realist purposes (Ruttan,

1996: 2), are in favour of actively engaging in, and moreover leading, programs that aim at improving human development indicators in the developing world (education, health), as well as economic growth, democracy and civil society. This tendency has been recently confirmed by a survey published by the Council on Foreign Relations that found that

[there] is a widespread consensus in the United States that developed countries have a moral responsibility to work to reduce hunger and severe poverty and that helping poor countries develop serves the long-term interests of wealthy countries, including by developing trade partners and enhancing global stability. (Council on Foreign Relations, 2009)

It should be added that this “consensus” is basically shared with other developed countries, therefore showing that this cannot be seen as a United States distinctive trace, as many policy-makers and activists often seem to suggest in domestic settings when alluding to “American values” (Goodwin, 2007: 49; Ziker, 2008: 10; Schaefer, 2009: 142) The same case is verified when respondents are enquired on whether or not they would be eager to pay more taxes in the name of international development, and they answer they would not. This response is arguably based on “extremely exaggerated estimates” (Council on Foreign Relations, 2009) of the government’s actual expenditure on foreign aid.

As large and comprehensive as it has been, PEPFAR has sought to attract the interest (and sometimes the criticism too) of the relevant constituency composed by universities and nongovernmental voluntary organizations. In his mid-1990s account of the domestic politics of governmental foreign assistance in the United States, Vernon W. Ruttan claimed that these two types of organizations were generally facing a rather unpredictable future as “clients” of USAID (Ruttan, 1996: 203-251). The former’s relationship with USAID was declining since the early 1980s (Ibid.:

217) in an overall “long history of frustration (...) due in large part to the differing perceptions of administration and staff (...) on the appropriate role of the two institutions [university and USAID]” (Ibid.: 220). The latter were generally appreciated overtime for “stimulating community development and empowerment [in the developing world]” (Ibid.: 235). However, the same author and former USAID official concluded in 1996 that they

[unfortunately] (...) have not been able to convince either the development professionals in the assistance agencies or the journalists who report on their activities in the field either that they have been very effective in providing relief in a manner that does not generate dependency or of their capacity to implement and manage development projects that achieve sustainability. (Ibid.)

With PEPFAR these entities made a dramatic return, insisting publicly on their capacity to generate effective results.

A specific type of nongovernmental organization involved in PEPFAR’s division of labour that has been relatively distinctive is the faith-based organization (FBO). Even though very significant funding has been allocated to non-faith-based organizations (for instance, in the areas of research and community development), FBOs were subject to ‘positive discrimination’ by the Bush Administration, as one interviewee with a FBO implementing agency admitted:

As a faith-based organization we benefited from the policy preference of the Bush Administration. Now funding will be more dispersed among different organizations, secular and faith-based. Secular are more into distribution of condoms. We were discriminated positively. (Interviewee 32, 2009)

This applied in terms of access to funding and given freedom to adopt their privileged policy of action, particularly as far as prevention is concerned, in turn, as will be discussed below, already legally trimmed to suit their preferences for messages of abstinence and marital fidelity at the expense of condoms and other

‘liberal’ approaches. Several authors associate this presence to the ascendancy of the Christian Right in the country, and the support it gave to Bush’s consecutive elections (Dietrich, 2007; Buss and Herman, 2003; Marsden, 2008).

The Christian Right does not constitute, or agglomerate around, a single political entity in the United States political system. Therefore, several definitions have been advanced over time. For the purpose of this dissertation, one builds on the conceptualization by Lee Marsden, according to which

[the] term ‘Christian Right’ (...) applies to conservative evangelicals and right-wing Catholics within the Republican Party whose religious persuasion determines their attitudes to political questions. This grouping consists of organizations, politicians, activists and supporters who are generally Protestant evangelicals, but also includes right-wing Catholics supportive of conservative moral and fiscal values on issues such as abortion, sexuality and free markets (...) united in their opposition to abortion, euthanasia, stem-cell research, homosexuality, same-sex marriage, promiscuity, secularism and big government. (Marsden, 2008: 3-4)

In addition to that, the Christian Right supports the war in Iraq and other military operations, and hence are in principle persuaded by the security rationales underlying development interventions, let alone their Christian sympathy for those in need of salvation, material and spiritual. As far as HIV/AIDS goes, Marsden refers to opinion polls that claim that “between one-third and three-quarters considers AIDS to be a punishment from God” (Ibid.: 75).

It should also be added that Christian Right’s organizations have had their direct international relations with partners from all over the world, including Sub-Saharan Africa, where Christianity has grown exponentially in the last decades, “from 144 million in 1970 to 411 million by 2005” (Ibid.: 76). Many African Catholics with connections to the United States of America have traditionally been

associated with the Christian Right (Buss and Herman, 2003: 94), but the most recent “renewalists” (i.e. Pentecostals and Charismatics), 17% of the total Christian population in Sub-Saharan Africa, have stronger ties, and also have increased dramatically (Marsden, 2008: 76). As a result, they offer an ideological-institutional framework where the Christian Right’s influences can be disseminated, although, as Doris Buss and Didi Herman (2003: 95) have noted, it is not clear whether there is mutual share of worldviews between United States and African congregates. John W. Dietrich (2007: 290) points at Evangelical Janet Museveni, wife of Ugandan long-standing ruler Yoweri Museveni and head of Christian AIDS-funded Uganda Youth Forum, as an example of empathy between the United States Christian Right and Africa. However, Alex de Waal (2006: 99-100) has observed Janet Museveni’s move as a collaborative effort of the ruling couple of maximizing AIDS funding with several donors and their ideologies. Whereas the first lady works with abstinence-backing United States partners, the president was turning to condoms-driven European donors. This suggests the tendency for ‘subversion’ of external funding and prescriptions discussed in Chapter 2.

With the change from Republican to Democrat Administration, Christian Right-backed policies in PEPFAR, particularly the Mexico City Policy, that forbids any federal funding for family planning activities conducive to abortion, were reversed. This has given momentum to organizations on the opposite side of the spectrum, i.e. liberal and supportive of sex education, condoms and consented abortion. However, that does not mean a retreat of the Christian Right, rather on the contrary. In fact, recent Congressional debates on funding have reconsidered the reversal of that funding back to restriction.

5.3.3. The Presidency and Bipartisanship

Considering the name of the program, in which the President appears as the ‘sponsor’ of the program, one ought to scrutinize the role of the presidency in the establishment and execution of PEPFAR. The same applies to the bipartisan character of this initiative, in which, since the beginning, it has been stressed by policy-makers that it has been gathering both Republican and Democrat congressmen and senators in its endorsement, despite policy differences.

The figure of the President is regarded in itself as a cornerstone of foreign policy in the United States of America. As Glenn P. Hastedt claims in his in-depth study of United States foreign policy-making, “in the eyes of the public, it is the president who makes American foreign policy” (Hastedt, 2009: 184). Even though his advisors certainly play a role and hold their leverage on the defining decisions, examples throughout history demarcate the level of autonomy maintained by presidents (Ibid.: 184-186). In the case of PEPFAR, Bush has recognised the early advice he received from national security advisor Condoleezza Rice on establishing a HIV/AIDS program with a humanitarian as well as security focus (McGreal, 2010). According to Hastedt, the nature of the President’s personality has much to do with the decisions and initiatives that are pursued. One element of his personality that has been associated with PEPFAR concerns to his worldview, i.e. the president’s “politically relevant beliefs” (Ibid.: 188). Moreover, in the case of PEPFAR’s promoter and leader during most of the program’s history so far, George W. Bush, he is regarded, following terminology by James David Barber cited by Hastedt, as an example of “active-positive presidents [who] put a great deal of energy into being president and derive great satisfaction from doing so” (Ibid.).

In the previous section, the important role of the Christian Right in the process of election and re-election of George W. Bush in 2000 and 2004 was highlighted. Some commentators have regarded the adoption of specific policies as part of a Christian Right-led political structure (Dietrich, 2007; Rosen, 2006). However, another opinion emphasises that Bush's decisions derive from his own (Christian) values. For instance, when asked what drove the establishment of PEPFAR, a long-standing official with a United States government PEPFAR implementing agency has commented that "in [her] personal opinion, it relied on the Bush person, a conservative, charitable individual who believed that this was the best thing to do" (Interviewee 14, 2010). Eventually, both elements do match one another.

Over the years, George W. Bush was constantly implicated by the media and commentators with the program, often in a very personalized way, thus confirming the above claim of the President's centrality in (foreign) policy-making. This intimate connection to the program has been particularly emphasised in 2008 during the process that led to its reauthorization and his personal visits to African countries, in which he insisted on the maintenance and reinforcement of the program (Wolf and Page, 2008; Mail & Guardian, 2008; Medical News Today, 2008; Kaiser Network, 2008a; Loven, 2008; Schaefer and Kim, 2008). After his retirement in early 2009, George W. Bush has acknowledged that PEPFAR was a major aspect of his foreign policy (McGreal, 2010), and his global AIDS coordinator Mark Dybul even suggested that a Nobel Peace Prize should be awarded to Bush.

Dybul did say he believes that Bush deserves a Nobel Peace Prize for his work in Africa. "There was literally no global response until President Bush came forward and said enough is enough," he said. Dybul said that the global shift in the direction of development also warrants the prize.

“If you look at this objectively, no one can say that that is not the ring of a Nobel Peace Prize.” (Huseman, 2010)

However, other commentators in 2008 have argued that this engagement with PEPFAR and other presidential health initiatives, such as the President’s Malaria Initiative, was a way to save face *vis-à-vis* the rising economic recession affecting the United States of America and the unresolved problems in the major foreign policy and military sites, Iraq and Afghanistan (Feffer, 2008).

Since its inception, PEPFAR has been characterized by bipartisanship, as both leading political forces in the United States congress and senate, Republicans and Democrats, have approved the plan in 2003 and reauthorized it in 2008. Despite the prominence of the figure of the President and the strong support by his Christian Right’s constituency, more clearly visible in a number of policies, the almost simultaneous timings of reauthorization and election of the next president proved the necessary political flexibility in order to not only continue but even expand the plan. Apart from questions of budgeting, which some Republican senators contested for some time before the reauthorization (Kaiser Network, 2008b), the major dispute had to do with the notorious requirement that one-third of the prevention money had to be spent on abstinence-only education (Feller, 2008). Before the voting of the reauthorization some Democrat senators were reportedly standing in opposition to that abstinence obligation. Yet, even though that provision stayed in the Reauthorization Act, the former one-third requirement was erased (Moss, 2008).

As Barack Obama is elected in 2008 and inaugurates his mandate in early 2009, the presidential engagement in global health is upgraded towards the launch of the Global Health Initiative (GHI), which aims at strengthening health systems in countries with United States health and development assistance by building on the

experience of previous initiatives, most notably PEPFAR (PEPFAR, 2010). GHI is implemented in 73 countries worldwide, 8 of them, including Ethiopia, having “GHI plus” status.¹⁷ GHI plus countries receive additional technical and management assistance from the United States government, and were selected according to “criteria that include partner country interest, presence of the major GHI health programs, burden of disease, geographic diversity, and potential to leverage bilateral, multilateral, and foundation investments” (Kaiser Network, 2011: 7). The same applies to another development tool, the Millennium Challenge Corporation, which remains.

The importance of bipartisanism in United States politics is also visible in another case. When starting his mandate in 2001, Bush maintained the African Growth and Opportunity Act (AGOA) (Schneidman, 2008), a relevant tool in the United States-Africa relationship. Established by the Clinton Administration, AGOA was later articulated with the Leadership Against HIV/AIDS, Tuberculosis and Malaria Act of 2003 (Annex 3), which established PEPFAR, and has been serving as a component of the plan’s implementation since 2003.

5.3.4. Global Health Governance and United States Bilateralism

A remarkable feature of PEPFAR is its tendency to pursue a style of implementation mostly based on a bilateral relationship between the United States government implementing agencies and their counterparts and/or recipient organizations in the host countries. Although important fund allocations to the

¹⁷ The other countries are Kenya, Malawi, Mali, Rwanda, Bangladesh, Nepal and Guatemala.

Global Fund under PEPFAR have been occurring, the largest chunk of intervention has been done in a bilateral way.

The reason for this tendency has been explained as a need to secure autonomy with regard to policy decision, away from multilateral deliberation at the Global Fund and the United Nations system at large. A major reason for maintaining this bilateral orientation in global HIV/AIDS policy concerns the issues of abstinence-only and family planning, in which conflictive views between the Bush Administration and the Western European and United Nations establishment have persisted over the years (Ingram, 2005). For instance, in 2002, funding to the United Nations Population Fund, in charge of family planning intervention worldwide, was suppressed by the Bush Administration (Ibid.: 391). As a whole, this trend was confirmed time and again in other instances, especially in the area of gas emissions control and climate change.

Another reason has to do with United States policy-makers and development practitioners' factual knowledge or only perception about the *modus operandi* of (multilateral) Global Fund staff *vis-à-vis* theirs in terms of relations with the host countries' governments. An interviewee with a United States government agency commented that whereas Europeans (who work mostly through the Global Fund, apart from their own bilateral initiatives) have "little problems" with transferring funds directly to African ministries, the United States of America is much less complacent in that regard (Interviewee 33, 2010). According to this interviewee, the chances of having money lost to corruption are higher when the tighter control of the United States system is not in place. The need to keep funding under control is so relevant that, if necessary, accountants are hired to work at the national ministries

just to be sure that money is not stolen, i.e. directed to the minister's extended family, as the interviewee explained. For this respondent, local "theft" is still a fatality, yet one that can still be minimized if control is exerted directly by the donor country.

5.4. Policies: Prevention and Treatment, Emergency and Sustainability

The analysis of the United States Government Accountability Office (GAO) (2008: 10) of the Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003, that provided the guidelines and regulations for PEPFAR in the first phase, found that 55% and 10% of the budget were required to be spent in treatment and orphans and vulnerable children (OVC), correspondingly, between 2006 and 2008. In turn, 15% and 20% were recommended to palliative care and prevention. Out of those 20% for prevention 33% had to be spent in abstinence/faithfulness programs, while the remaining 66% could be spent in so-called "other prevention activities" (Ibid.). In addition to that, soon after his inauguration in 2001 Bush mandated the restoration of the Mexico City Policy, originally created by former President Ronald Reagan in 1984. This policy obliges USAID-funded

nongovernmental organizations to agree as a condition of their receipt of Federal funds that such organizations would neither perform nor actively promote abortion as a method of family planning in other nations. (Office of the Press Secretary, 2001)

The so-called "ABC (abstain, be faithful, condomise) strategy" and policies on family planning constitute a contested issue until today. The contestation relates to the propelled unscientifically proven ability of abstinence/faithfulness activities

really contribute for a decrease of infections (Centre for Health and Gender Equity, 2004: 10-11) and its suitability to the domestic realities of intervention. In the same report quoted above, GAO mentioned that according to its survey,

although more than half of the 22 experts we interviewed acknowledged benefits of PEPFAR's overall prevention spending directive, the same number of experts expressed concern about the AB directive's effect on country-based and evidence-based programming. (...) However, 13 of 22 experts expressed concern that the AB directive has posed obstacles to country-based programming, and 13 experts said it has hindered development of integrated prevention programs. (GAO, 2008: 20)

One major problem with the efficacy of prevention based on abstinence/faithfulness is that it does not fit one of the most vulnerable groups to AIDS, namely women who engage in sex work or transactional sex. This group certainly cannot abstain from sex; therefore prevention for them has to take another form. As for the Mexico City Policy, this policy inhibits the right of women to voluntarily access pregnancy interruption with United States funding, even if the country at stake has a favouring legislation. Answering to the question on the chief obstacles to implementation, an interviewee with a United States-based implementing NGO in South Africa said that "the major limiting factor is the people who take decisions in Washington who do not understand South African reality" (Interviewee 22, 2009). Along the same lines, another interviewee, yet with a South African NGO, affirmed critically that "we know better about the South African epidemic than United States politicians" (Interviewee 34, 2009).

Soon after the Obama election in 2008, the Mexico City Policy was reversed. This led to consequences, not only on family planning, which could be restored with larger choices, but even at the language level. Acknowledging Bush's role in the reauthorization, an interviewee with a South African NGO mentioned that "with the

new administration there are changes though. For instance, the GAG policy [i.e. Mexico City Policy] has retreated. Now we can call prostitutes and not commercial sex workers” (Interviewee 35, 2009).

But the problem of measuring ‘what works’ has not been merely in terms of abstinence/faithfulness and treatment as such but more broadly about how to comprehensively best tackle the epidemic. At the celebratory times after the reauthorization, Nandini Oomman and Steve Rosenzweig with the Centre for Global Development commented:

Why did Congress ignore the evidence by maintaining an earmark for treatment and care? One reason is that some senators, mired as usual in the desire to demonstrate short-term results at the expense of longer-term progress, wanted to ensure that funding was spent on activities where short-term gains are easy to measure and report. As a result, the reauthorizing legislation will continue to focus PEPFAR funding more on counting pills and patients and less on preventing new infections, despite the fact that 5 new people are infected with HIV for every 2 that are put on treatment. PEPFAR country teams and host country stakeholders will continue to be limited in their ability to fund activities crucial to long-term, sustainable AIDS responses. (Oomman and Rosenzweig, 2008)

As mentioned, the slightly over half of PEPFAR’s budget goes to treatment activities. As an example, according to GAO (2008: 12), the total allocation for treatment for the fiscal year 2007 alone was 1.16 billion USD. However, the acquisition of antiretroviral (ARV) drugs under PEPFAR is subject to strict rules. According to GAO (2005), all drugs that could be contracted by the recipient countries had to be approved by the United States Food and Drug Administration (FDA) and be of United States origin.

Because the Emergency Plan is largely funded under the Foreign Assistance Act of 1961, the purchase of ARVs with these funds is subject to a provision of the act that prohibits the purchase of any medication manufactured outside the United States if the manufacture of that

medication in the United States would be covered by a valid United States patent, unless the patent owner gives its permission. (Ibid.: 9-10)

As a result, in the beginning, and for a certain period, PEPFAR functioned as a protection scheme for United States pharmaceutical companies, which not only benefited economically from the program, but also sought to penetrate the most affected countries by the epidemic (Mann, 2003)

Nevertheless, the situation started to change overtime, as GAO recommended an exploration of not only a larger palette of ARVs but also less expensive solutions in harmony with other donors' policies.

The original ARVs provided under the plan are generally higher in price than the generic ARVs provided under the other initiatives. The differences in the prices, quoted to GAO during June and July 2004 by 13 manufacturers, ranged from \$11 less to \$328 more per person per year for original ARVs than for the lowest-priced corresponding generic ARVs provided under the other initiatives. At these prices, three of the four first-line regimens recommended by the World Health Organization could be built for less—from \$40 to \$368 less depending on the regimen—with the generic ARVs provided under the other initiatives than with the original ARVs provided under the plan. Such differences in price per person per year could translate into hundreds of millions of dollars of additional expense when considered on the scale of the plan's goal of treating 2 million people by the end of 2008. (GAO, 2005)

Eventually, policy changed, and in October 2009 it was already permitting 100 drugs, including 71 generics (Medical News Today, 2009). In this regard, a nongovernmental implementer in Ethiopia commented

In principle everything has to be American and licensed by the FDA [United States Food and Drug Administration]. However, experience showed that was not very feasible. So we turned to Indian companies, especially for generics. Some companies in the US resisted (Abbott) but others were cooperative. With this move we could decrease the cost per patient from 1000 USD to 85 USD. (Interviewee 3, 2010)

As the very name informs, PEPFAR started with a preoccupation of giving emergent relief in terms of making available treatment through ARVs and prevention of new infections. According to PEPFAR's first five-year strategy, the purpose was

to “rapidly mobilize resources” for fifteen countries in order to “provide treatment to 2 million HIV-infected people; prevent 7 million new HIV infections; and provide care to 10 million people infected and affected by HIV/AIDS, including orphans and vulnerable children” (PEPFAR, 2003). In addition to those core programs, the program would also develop supply chain management systems, be driven by scientific evidence, and build on public-private partnerships integrating both governmental and nongovernmental organizations, in which national “bold leadership” is mandatory for success.

Although some specific research on PEPFAR has occasionally raised concerns about the quality of evaluation (Over, 2009), the PEPFAR coordination, the United States presidency and other higher level leadership has alluded to a great success in terms of saving ‘millions of lives.’ This tension was found in several interviews conducted, although the tendency is to speak rather positively about the impact. A respondent with a United States government agency in Ethiopia enthusiastically said “[before] PEPFAR there was just no assistance to HIV-infected people. Almost every patient visiting our medical facility was HIV-positive. PEPFAR has saved lives” (Interviewee 36, 2010). A respondent with an NGO in Botswana simply mentioned “In many countries there was no response to AIDS. (...) And without PEPFAR countries would not be able to respond. I give a huge credit to PEPFAR” (Interviewee 29, 2010). In turn, a respondent with an international organization in Ethiopia receiving PEPFAR funding gave a more balanced view:

Since 2003 the assistance provided to the government has been improving, and the country is under way to reach universal access shortly. It was also good for tuberculosis and other opportunistic infections. There are more health centres too. The only shortcoming though is that it is only rooted on HIV/AIDS. (Interviewee 37, 2010)

Another interviewee with an international organization in the same country referred “people are now more informed. Although I do not know about the impact on infection and prevalence rates, I am aware PEPFAR has improved activities aimed at making people know their status” (Interviewee 38, 2010). In fact, the question of lack of measurement is found in another declaration, this time by an Ethiopian respondent with an Ethiopian NGO: “PEPFAR has had a significant influence, but I do not have evidence about its efficiency” (Interviewee 4, 2010).

The second phase was set up by the second five-year strategy plan that followed the Reauthorization Act of 2008 (Annex 4). Published in 2009, this document put forward an agenda aiming at achieving sustainability through country ownership in a spirit of “shared responsibility” between the United States government and its partners in the host countries, especially the governments, and enlarging the scope of PEPFAR towards strengthening the health systems (PEPFAR, 2009c: 5-6). This policy shift from emergency to sustainability was reinforced by the proposal of the GHI, an umbrella program for all of United States governmental health-related programs, in which PEPFAR maintains a leading role, while new dimensions, such as gender, are incorporated. The objective is to refrain from direct funding of service providing activities to the populations, but to capacitate host countries’ organizations to do it, as human resource capacity has long been identified as a major limitation to effective implementation (GAO, 2004). This shift also happens at a time when PEPFAR’s leadership has been forced to flatten or reduce the funding levels. However, it has also been noticeable the apparent disappearance of the “focus country” language in favour of a gradual enlargement of the number of countries benefiting directly from PEPFAR.

An early assessment of the health system impact of PEPFAR has not grounded its propelled goal. Although focusing on the 2000-2006 period, featured by the emergency mode, the comparison of PEPFAR focus and non-focus countries in light of WHO indicators “demonstrates no significant difference in improvement in PEPFAR focus countries when compared with non-focus countries” (Duber et al., 2010: 8). At the same time, and from another angle, an interviewee with a PEPFAR implementing NGO has made the following observation on the pervasiveness of PEPFAR:

I would distinguish between positive intended consequences and negative unintended consequences. The former is that PEPFAR has reduced deaths and prolonged lives. In many places there was just no supply chain and PEPFAR installed one. This is a benefit for the broad health system. The latter is that PEPFAR operates in a rather dysfunctional system. PEPFAR has pooled everything to HIV. It shifted resources allocated to TB, family planning and safe motherhood toward blood safety, ABC prevention, care and treatment and OVCs [orphans and vulnerable children]. (Interviewee 11, 2010)

As for sustainability through country ownership, it should be mentioned that it does not merely represent a development in United States policy, but a rather international one. Prior to the Reauthorization Act of 2008 and the latest five-year strategy of 2009, the 2004 UNAIDS-sponsored Consultation on Harmonization of International AIDS Funding’s “Three ones” principles (one national HIV/AIDS strategy; one national AIDS coordinating authority; one national country-level monitoring and evaluation system) and the 2005 Paris Declaration on Aid Effectiveness were already providing a policy framework in that direction (GAO, 2010: 4-6), as well as the 2002 United Nations International Conference on Financing for Development’s ‘Monterrey Consensus’ (PEPFAR, 2011a). In order to materialize that strategic goal, PEPFAR constitutes partnerships with the host partner

countries and non-state actors “to ensure that PEPFAR programs reflect country ownership, with partner governments at the centre of decision making, leadership, and management of their HIV/AIDS programs and national health systems” (Ibid.: 6). In turn, the Country Operational Plans (COP) provides “the information for funding review and approval and serves as the basis for congressional notification, allocation, and tracking of budget and targets” (Ibid.: 7). Moreover, COPs result of

an opportunity to bring the United States country team together with partner government authorities, multilateral development partners, and civil society as an essential aspect of effective planning, leveraging resources, and fostering sustainability of programs. (Ibid.: 8)

According to the GAO’s (2010) study on the alignment of PEPFAR policies with the countries’ strategies in four countries (two African, Uganda and Malawi; two Asian, Cambodia and Vietnam), which compared the national strategic and programmatic documents with PEPFAR’s and consulted with PEPFAR implementers, “PEPFAR activities generally support the goals laid out in partner countries’ national HIV/AIDS strategies” (Ibid.: 10). However, problems and limitations are also found. While some relate to “differences between PEPFAR indicators and national and international indicators” and “gaps in partner countries’ access to PEPFAR information” (Ibid.: 18-20), others concern “unwillingness or inability to commit resources, public corruption and financial mismanagement, and lack of technical expertise” (Ibid.: 20).

As referred above, one alleged reason for the unilateral stance of the United States of America *vis-à-vis* the multilateralism of many other donors has to do with tighter surveillance of spending by partner recipient governments in order to hamper corruption and mismanagement. As such, it is not surprising that, according to the latest PEPFAR report to Congress at time of writing, country ownership’s “key areas

of focus included surveillance, planning, analysis, management, and budgeting, at key national ministries as well as other levels of government” (PEPFAR, 2011b). Yet, another major issue has precisely to do with how capable recipient countries, namely their governments, are to continue the current, PEPFAR-initiated and -funded efforts. National governments are embracing the idea and concept of country ownership as part of their developmental concerns. However, the levels of disbursing resources – the question of “unwillingness or ability” quoted from the GAO’s report – vary greatly according to the individual country’s economic/developmental position. As far as the countries scrutinised in this dissertation go, while Botswana and even South Africa are allocating national resources that account to about 80% of the total expenditure in HIV/AIDS, Ethiopia is much lower.

To a large extent, the GHI, established soon after the inauguration of the Obama Administration in 2009, expands the ambition of the new policies on sustainability. This initiative seeks to pool together different ongoing plans – PEPFAR, the President’s Malaria Initiative – and include areas such as maternal and child health, family planning, reproductive health and neglected tropical diseases, avian influenza and other epidemic threats (Kaiser Network, 2010).

5.5. Organizational Design

PEPFAR is eminently rooted in a concept of partnership in which United States governmental and nongovernmental organizations are put together with host countries’ counterparts, and possibly international organizations (such as WHO, UNAIDS, United Nations High Commissioner for Refugees, World Food Program). The leadership of PEPFAR lies with the Office of the Global AIDS Coordinator, and

the United States government agencies involved are Department of State (namely embassies), USAID, Department of Defence (DoD), Department of Commerce, Department of Labour, Department of Health and Human Services (namely the Centres for Disease Control & Prevention [CDC]) and Peace Corps. There are two types of implementing partner: prime and sub-partner. The hierarchy is explained by the process of funding application, in which the prime secures the funding in the first place, and then channels it down to the sub-partner level. Generally prime partners obtain their funding from USAID, CDC or the United States embassies.

According to PEPFAR's (2004) 2004-2008 strategic document, 15 billion USD were requested to the Congress for funding the plan, most of it directed to 15 focus countries. Apart from Botswana, Ethiopia and South Africa, the list was composed of Cote d'Ivoire, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, Tanzania, Uganda, Vietnam and Zambia. In 2009 these countries were given that status since they were "home to approximately half of the world's estimated 33 million HIV-positive people and to almost 8 million children orphaned or made vulnerable by HIV/AIDS" (PEPFAR, 2009d). Still, funding was also extended to other countries, generally those where USAID was operating. However, in PEPFAR's second five-year period (2009-2013) strategy (PEPFAR, 2009c), the category of focus country virtually disappeared, later re-emerging under the auspices of GHI.

In addition to this division of labour, several PEPFAR-initiated projects have sought to include private companies in the host countries, and as such accomplish an idea of country ownership described by a joint public and private collaboration. Two

interviewees with different United States government agencies in Botswana gave two examples from that country:

[cell] phone technologies [in Botswana] are good. There is a deal in which Maskom [mobile communications provider] offers 100 Pula [Botswana currency] to its users when subscribing alert SMS for taking medications. This is a case of country ownership of the projects, in fact. (Interviewee 10, 2010)

For us, country ownership is not government ownership, but ownership by the government, privates and civil society. This is why you want Debswana [Botswana diamonds public-private partnership] to be involved in this too. (Interviewee 2, 2010)

Since the beginning, PEPFAR has attempted to constitute a change – if not a revolution – in two ways of organizing and implementing international aid. One way had to do with augmenting levels of inter-agency collaboration among the various United States government agencies. Although two senior officials with USAID and DoD (Interviewee 14, 2010; Interviewee 10, 2010) have claimed a prevailing view that historically both organisations have gone along very closely, PEPFAR’s coordination has found it necessary to appeal for them to “‘leave their uniforms at the door’ and come together in the common cause of turning the tide against the HIV/AIDS pandemic” (PEPFAR, 2011c). To an extent, this setting constitutes an experiment of a larger hypothesis of reformulating United States international development from a “whole-of-government” (Herrling, 2009) perspective. For instance, the inclusion of AGOA in PEPFAR’s division of labour is an example of that, especially in terms of the economic empowerment of people living with AIDS (PEPFAR, 2009e). Another way has concerned the character of relations between the United States government and their counterparts in the country of implementation. According to the 2009 PEPFAR report to congress, which focuses on partnerships,

PEPFAR aims to change relations by turning an asymmetric relationship into one between equals.

The United States is changing the paradigm for development, rejecting the flawed “donor-recipient” mentality and replacing it with an ethic of partnership that emphasizes country ownership, good governance, and accountability. Partnership is rooted in hope for and faith in people. Partnership means honest relationships between equals based on mutual respect, understanding and trust, with obligations and responsibilities for each partner. Partnership is the foundation of PEPFAR’s success and of what Secretary of State Condoleezza Rice has called “transformational diplomacy.” (PEPFAR, 2009e: 18-19)

The constitution of ‘partnership frameworks’ signed between the United States of America and host countries’ representatives include the principles of country ownership; sustainability; support for country coordination of resources; United States government interagency collaboration; engagement and participation; strategic framework; flexibility, progress towards policy reform and increased financial accountability; integration of HIV/AIDS into strengthened health systems and a broader health and development agenda; monitoring and evaluation; collaborative but not contractual; transparency; and “do no harm” (PEPFAR, 2011a). At time of writing, 21 partnership frameworks had been signed, including with Botswana (December 2010), Ethiopia (October 2010), and South Africa (December 2010) (PEPFAR, 2011d).

The theoretical discussion in this dissertation has focused on an understanding that the international system is characterized by asymmetry. In the case of international partnerships such as PEPFAR asymmetry is not just a question of one side possessing funds and exerting influence, and the other side possessing very little at those levels. Talking about research activities in Botswana, an interviewee with a Botswana government ministry has called “scientific imperialism”

(Interviewee 39, 2010) the way United States universities land in the country, request ethics approval, obtain blood samples, return to the United States of America and publish papers based on those samples, without being clear to what extent the ‘blood-donor country’ benefits from it. This asymmetry is further cemented on the security rationale attached to programs like PEPFAR, which views the subjects of intervention as threats to United States and international security, but also on bringing host countries’ institutions, namely governments, to closer external scrutiny, ripping apart the porous border between the postcolonial state and the international community.

However, perhaps the greatest example of the asymmetry between the United States of America and recipient societies is the dependency created by the unlimited free provision of lifelong drugs by the former to the latter. This dependency corresponds to what Mead Over (2008) calls the “ballooning entitlement” by recipient countries. This “entitlement” is a result of a continuing public commitment to free provision of ARVs by the United States leadership under PEPFAR in a context characterised by, on the one hand, growing financial difficulties to live up to that commitment, and, on the other, an increasing number of new infections. For Over this uneasy system of dependency holds potential negative effects in the long run. Over emphasises the problem of “entitlement” that recipient countries start to own with regard to receiving assistance from the United States of America, particularly in the case of antiretroviral drugs, which shall have to be handed to patients over the course of a lifetime so they have the desired lasting effect.

To the extent that AIDS treatment is viewed as an entitlement by all parties to the transaction, the donor governments and their citizens on the one hand and the recipient governments and their patients on the other,

the recipient governments and individuals might have diminished incentives to prevent HIV infection or to use efficiently the externally provided resources. Furthermore, it is human nature for people who are dependent on others to resent the dependency relationship.

In the extreme, it is possible that a strong AIDS program in these 15 countries will create a kind of postmodern colonial relationship between the US and these countries – undermining the quality of these bilateral relationships. (Ibid.: 19)

This type of colonialism is negative for United States international reputation, and thus it should drive a policy change towards a point of sustainability – a “AIDS transition”¹⁸ (Ibid.: 24-33) – that will not spark discontent against it.

If, in the existing fifteen PEPFAR focus countries, the next government can effectively manage the current AIDS treatment entitlement, prevent the future need for treatment, and help ensure the AIDS transition to the point that the disease becomes a manageable chronic condition, then the next president will deserve a full measure of credit for the long-run benefits of PEPFAR, credit equal to or greater than that due to President Bush for launching the program. (Ibid.: 33)

However, since this dissertation is ultimately concerned with agency by national governments, and how it manifests itself, it is interesting to explore how interviewed implementers address this question of asymmetry. Here one verifies a clear difference of perspective between respondents with a United States government agency, and other respondents who, although part of the division of labour, have a critical view of the process. For instance, an interviewee with the United States government reiterated that imperialism is not a United States foreign policy’s aim (Interviewee 16, 2010). Yet, two rather emblematic positions could be found in one’s inquiry. An African interviewee with a United States-based implementing NGO gave a rather pessimistic comment:

¹⁸ “**More generally the AIDS Transition must mean a refocusing of the rhetoric, goal-setting and results orientation that is gaining force in AIDS treatment to target also AIDS prevention.**” (Ibid.: 33, bold in the original)

Overall, before PEPFAR there were few ARVs available. Now there are more, and that means better health and less mortality, and thus less orphans. But now PEPFAR is changing priorities and countries in Africa are crying because they depend heavily on the ARV program PEPFAR initiated. It is sad that we put our fate in the hands of the West. (Interviewee 40, 2010)

Yet, another respondent with the same characteristics put it in rather different terms: “PEPFAR originates from early programs for the military overseas and seeks to attain objectives of United States security. It is up to the Africans to do the most they can from it.” (Interviewee 11, 2010) To an extent, Chapters 6, 7 and 8 respond to the latter interviewee’s observation.

According to a 2009 GAO report, major fund-channelling United States government agencies “CDC and USAID [had] developed and implemented practices to provide accountability over PEPFAR awards, such as reviewing programmatic reports and financial data and providing technical assistance to partners” (GAO, 2009: 28). These practices included required reports; expenditure data and work plans; site visit checklists and reports; direct assistance; umbrella grant managers (for sub-partners); sub-awards; and third-party technical assistance providers (Ibid.: 28-30). Yet, the same report found difficulties in the area of compliance due to lack of USAID and CDC staff; overburden; and different reporting timeframes (Ibid.: 32-35)

One of the main top-down disciplinary transmission belts is observed in the weight that bureaucratic compliance holds. While the implementation of surveillance practices is generally expectable to be pursued by funders and complied by recipients, several questions still arise. Focusing on the experience of non-United States government implementers, one such question has to do with how time-consuming and even difficult it can be to collect the required information, especially

when it is done by volunteers and in a context of scarcity of means of communication. An interviewee with a South African FBO commented:

The project relies vastly on lots of church volunteers, who nevertheless receive a small payment. It is difficult to get people to report, and thus match PEPFAR's requirements. Reporting is no less than monthly. What is required from field workers and volunteers is who has been reached, how were public gatherings. (...) Field workers report to their supervisors, and they report to the main office in Cape Town. The main obstacles are found in the lowest levels. Reporting is a matter of copying and faxing, but it takes a lot of time. (Interviewee 24, 2009)

Another interviewee with a sub-partner FBO, but in Botswana, lamented, while pointing at piles of sheets of paper in his small office to be delivered to its prime partner: "Funds come with conditions. It is difficult to be flexible. Look, this is the bureaucracy we have to go through!" (Interviewee 41, 2010) Another NGO respondent, yet in South Africa gave a different nuance:

Many organizations I have been working with have refused PEPFAR funding given the administrative overload and the reporting compulsiveness. This tendency has been augmenting. Besides, requirements are very stringent. We have to report every single month. We have to comply with the United States government. This is all about compliance or not. For PEPFAR it is more important to report than work in the field. Our office here is just to deal with bureaucracy. (Interviewee 42, 2009)

Another South Africa respondent insisted on the stringed need to report.

How can I put it diplomatically?... Partners have to do lots of reporting, to pay a lot of attention to numbers. PEPFAR is very much centred in obtaining numbers, and that is difficult to pursue by implementing organizations. In fact many implementing people are constantly worried about gathering numbers and thus showing service (to PEPFAR coordination). (Interviewee 43, 2009)

Another NGO interviewee in South Africa gave an interesting insight framed in terms of West *versus* non-West, and how apparently opposing institutions (funder and funded) 'ally' themselves:

We have deep links with the communities, and it is often difficult for them to comply with the reporting because it requires skills that people

do not have, for example, deadlines. People in the ground are not like us in the Western world; they are not used to deadlines. Another thing has to do with the fact that we are preoccupied with quality, but PEPFAR is too demanding with numbers. If we do not get them the numbers, we do not get any funding or we have to return the money. USAID understands our position, but they are with their hands tied. Flexibility is something lacking. But this is not a criticism, but a challenge. (Interviewee 44, 2009)

Another NGO respondent in South Africa gave yet another insight, pointing at inter-organizational level, which can be featured by competition and rivalry.

PEPFAR requirements are not in many instances relevant to the realities on the ground. For example, the way that PEPFAR demands that we count compromises on quality service provision and encourages competition among partners. (Interviewee 45, 2009)

5.6. Conclusion

PEPFAR has been an important tool of United States foreign policy worldwide, yet most notably in Sub-Saharan Africa. As the latest budget request by the head of the Bureau of African Affairs, Assistant Secretary Johnnie Carson (2011), shows, PEPFAR sits alongside the various initiatives in the area of conflict prevention, good governance, rule of law or economic growth, with whom it intersects, particularly the latter. Moreover, PEPFAR constitutes its own presidential initiative, and therefore increases its political and symbolic importance.

Initially building on the experience of the domestic CARE Act, several political rationales have been pointed out to justify PEPFAR's maintenance and expansion since 2003. It should be highlighted that, despite the security-strategic dimension attached to United States policy-making, the relevance of domestic constituencies is also very defining. The extent of the link between HIV/AIDS, and health and human development at large, and security is revealing, not so much for its effective power, which is seen in other cases, but for the broader rationale behind

United States policy-making and even advocacy. Although non-security reasons, coined as humanitarianism or compassion are attributed, and explain why, when and by whom PEPFAR was effectively established, as several comments on and by former President Bush demonstrate, they only add to the preceding security question.

The area of prevention and treatment policies gives two prime examples that interviewed PEPFAR implementers and a body of analysis have drawn attention to. In terms of prevention, the making and changing of policy at the Washington, DC institutions (Presidency, Congress and Senate) around abstinence/faithfulness or family planning, some implementers contend, are inadequate for the realities they are meant to intervene and improve. In turn, the core question of treatment – the highest recipient share of the budget – has shown, for some time, the protection of United States pharmaceutical companies. Much more expensive than, say, generics, their ARVs were sometimes the only that recipient countries could contract with the allocated funds.

Further examples are given on PEPFAR's organizational design. Although claiming to be a 'real' partnership, in which both sides are equal, an exploration into the practice of the partnership shows the very opposite. In addition to the previous examples, far more exemplary of United States hegemonic intervention is the dependency that has been created over the years between recipient countries, i.e. what Mead Over (2009) has called "postmodern colonialism." For Over, that colonial regime is very negative for the United States future relation with recipient countries, since it might generate discontent in the case the United States of America cannot keep up to its engagement. It is very informative of the regime of asymmetry and dependency that PEPFAR represents. Besides, the issue of oversight by the key

fundes over the implementing partners adds to the criticism made about policy's mismatch with implementation realities. Although reporting to fundes should not constitute anything particularly exceptional, several implementers have pointed at experiences in which time and resources (human, technological), or their absence, undermined activities, driving them away from what they perceive as 'real' and even spur rivalry among implementers.

After this presentation and discussion of the case study, the next chapter analyses the experience of the national governments of Botswana, Ethiopia and South Africa with PEPFAR, and the United States of America and the external world at large, from region to globe.

Chapter 6 – Foreign Policy of Postcolonial African States

6.1. Introduction

This is the first of a series of three chapters that analyse the agency of the states of Botswana, Ethiopia and South Africa in the process of PEPFAR's implementation, and relations with the United States of America and the world at large. The study of their agency occurs in light of three independent variables: foreign policies, domestic policies, and practices of the three individual countries. Particular relations maintained between the three states and PEPFAR, the United States of America, and the international system, are framed across three separate levels, which, nevertheless, are complementary, following the analytical framework presented in Chapter 4.

Thus, this chapter looks specifically at the foreign policy of Botswana, Ethiopia and South Africa. However, to begin with, it is relevant to depart from the principle that the participation of individual countries in the PEPFAR framework, outlined in the previous chapter, is not compulsory, but voluntary. So implementation can begin, recipient countries have to formally agree with the donors' plans through the signature of a partnership framework¹⁹ by host states' representatives. Moreover, host state institutions are strongly implicated in the process of policy-making – emphasized by the growing importance of the principle of 'country ownership' – and actual implementation, since significant funding is directly allocated to host governmental organizations, i.e. ministries and their

¹⁹ See Annexes 5, 6 and 7 for Partnership Frameworks between the United States government and the governments of Botswana, Ethiopia and South Africa, correspondingly.

national, regional and local subsidiary organisations. Even though PEPFAR embodies a strong ambition by the United States government to control the stakeholders, it should always be borne in mind that the host countries are definitely key in this process, and as such hold a degree of agency in the areas of policy-making and implementation, even if largely constrained. This hardly can be considered a colonial relationship, as William Brown suggests:

Indeed, aid is founded on an inter-state relationship, one in which legal equality rather than imperial or colonial subordination defines the formal relationship between the giver and the receiver. Even with institutions as powerful as the World Bank and IMF, or bilateral donors such as the USA, the relationship with recipient states is conducted with formally equal sovereign entities. While African policy autonomy may indeed be severely compromised by the aid relationship, the recognition of the right of African states to make their own (limited) policy choices is not seriously questioned. Whatever other powers donors have, a socially-recognised right to rule African societies is not one of them: this is fundamentally a non-colonial relationship. (Brown, 2009: 7-8)

Studying the host states/governments' agency *vis-à-vis* the influence of PEPFAR in particular, and the United States government at large, means analysing those countries' political strategies and goals in a broader perspective, i.e. beyond the mere terms of that partnership. Why do the governments of Botswana, Ethiopia and South Africa take the positions they take in terms of engaging (more or less) with, or opposing, the United States government via PEPFAR and/or other programs? The ability to be active and responsive to the external pressures, and not merely a vacuum where those external pressures sit, stands for the idea of possessing autonomy of decision and action.

The presentation of each country not only follows an alphabetical order but also is meant to distinguish two theoretical models of state behaviour in terms of their broader political and strategic agendas. The cases of Botswana and Ethiopia are

explained by an eminent concern for survival. Whereas in Botswana survival is directly linked to the HIV/AIDS epidemic *per se*, in Ethiopia it has to do with a broader geopolitical and developmental vision of the national government, in which the epidemic plays a role among other pressing issues, to assure the political regime's self-help while tackling the very low ranking of human development in the country. The South African experience displays a rather different case, in which the politics of the epidemic, including PEPFAR, have been implicated in the transmission of ideas and values domestically and abroad by the governmental leadership.

6.2. Survival of the 'Botswana Miracle'

The successful attraction of external sources by the Botswana government, particularly from the United States of America, is not explainable by the geopolitical situation of the country, as it happens in the case of Ethiopia and South Africa. In fact, a rather constructivist element of United States foreign policy-making has to be introduced. Botswana has long enjoyed an optimistic status in United States diplomacy as a 'model country' for Africa, i.e. one where market economic systems and liberal democracy have been put into place consistently throughout the whole postcolonial age. However, in contrast, Botswana's foreign policy overtime, since 1966 until today, has been rather realist in terms of its formulation and execution.

Transition to national sovereign rule was smooth, and the country never underwent internal mass-scale political violence, like in its neighbours (Namibia, South Africa and Zimbabwe), which nevertheless affected Botswana at times. The

national army itself was only established in 1977 as a consequence of a former Rhodesian army's incursion into Botswana in search for black insurgents. Later, in 1985 and 1986, bombings by the South African apartheid army took place in southern parts of the country (Kelebonye, 2010).

The reason for such smoothness has been found in the fact that the dominating elite ante- and post-independence was the one and the same, one of its great representatives consisting precisely on Seretse Khama, 'native' leader and the country's first President of the Republic (Varela, 2006: 266-267). Indeed, Tswana leaders benefited particularly from the regime of Protectorate administered by the United Kingdom. On the one hand, despite conceding to the crossing of the railways from the South African Cape colony to former Rhodesia (now Zimbabwe), they enjoyed military protection from the Boer neighbours, in the South. They could hardly retain independence from the Boer republics were they by themselves. On the other, since the United Kingdom was not engaged in exploiting Bechuanaland the way it did in South Africa and Rhodesia, the system of indirect rule under the Protectorate allowed for the increase of the national leaders' empowerment. One such manifestation was through the benefit of colonial capitalistic policies of cattle development, together with the White farmers of British descent.

This transition was led by the same local and colonist elites, and the developmentalist framework based on market economy and liberal multiparty democracy was clearly aligned with the West. However, it should be stressed that, despite this configuration, Botswana's political leadership maintained a rather realist understanding of its political situation and the way the bipolar politics of the Cold War was having an impact on its survival as a country, particularly from the late

1970s until the end of apartheid, and more broadly the Cold War, in the early 1990s. In one of the few political science articles on Botswana's foreign policy (already dating twenty years-old), James J. Zaffiro argues that

During the 1980s, Botswana was able to capitalize on friendly relations with both superpowers thus benefiting from their diplomatic support in times of crisis, such as in the aftermath of the 14 June 1985 South African Defence Force (SADF) raid in Gaborone. (Zaffiro, 1992: 59)

Although the domestic politics of the country were West-leaning, the reality of standing right in the core of numerous violent conflicts forced the Botswana leadership to engage with all parties involved in difficult circumstances.

Since 1966, year of the independence, Botswana became an Asian-style developmental state, whose initial goals consisted on developing basic infrastructure (roads, electricity, water) between the main towns.

Four “broad pillars” of Botswana's first national development plan included: (1) self-help; (2) assistance by other governments in major national undertakings beyond the resources of the country, such as the Shashi Dam and industrial development; (3) encouragement of private investment; and (4) education. (Ibid.: 62)

The “other governments” consisted mostly on the United Kingdom, provider of most of development funding; the United States of America, at a later stage and in a rather limited way (for instance, in the areas of education and training by the Peace Corps and some universities); the Soviet Union, even if indirectly (the Soviet anti-apartheid and pro-black liberation movements stances); and South Africa, the regional economic hegemon (Parsons, 1999).

The planning and execution of economic development took off in 1967-71 after the discovery of diamonds at Orapa. The essential precondition of this was renegotiation of the customs union with South Africa, so that state revenue would benefit from rising capital imports and mineral exports – rather than remaining a fixed percentage of total customs union income. This renegotiation was achieved in 1969. (Ibid.)

In fact, relations with South Africa were thorny. On the one hand, South African trade cooperation was needed. On the other, being a black-led country, Botswana was not racially aligned with the apartheid in South Africa and Namibia, and until 1980 the white minority-led former Rhodesia. Botswana was subject to air raids in 1985 and 1986 by South Africa since there was a suspicion that Botswana was hosting African National Congress (ANC) insurgents within its borders (Kelebonye, 2010; Parsons, 1999). The trade-off appeared to rely on both parties' commitment, if not to liberal, non-racial democracy, at least to capitalism.

International academic interest for Botswana started in the mid-1980s by authors such as Louis Picard (1987) driven by the impressive growth rate experienced by the country throughout the first two decades of independence. Between 1980 and 1989, Botswana achieved a 13% annual growth in GDP (Hillbom, 2008: 191). Botswana was one of the poorest countries in the world at the time of independence, and with the discovery and exploration of diamonds, it attained some of the highest growth rates in the world. At the same time, Botswana sought to maintain regular multiparty elections, presidential and parliamentary, even though they were always won by the same party, the Botswana Democratic Party (BDP). But that did not seem to be highly problematic for analysts, since post-Second World War Sweden and Japan also exhibited the same characteristics.

Some of the most impressive democratic developmental performers over the past half century, notably Sweden and Japan and more recently Botswana, have had one-party dominant systems, which, in their cases at least, seem to have combined the best of both developmental and democratic worlds. The dominant party was subject to regular democratic tests at the ballot box and constantly subject to the pressures of a free civil society, while at the same time maintaining the coherence, authority and capacity for long-term decision-making which is necessary for tackling the structural problems of development. (White, 2006: 66)

It should be added that this reversal of poverty was being obtained spectacularly and with “good governance,” but also in a context of relative impoverishment of African postcolonial economies and defection to authoritarianism (Mkandawire, 2001; Schraeder, 1994; Acemoglu et al., 2003: 80).

The conditions that made Botswana so successful and turned it into an upper middle-income country after some decades are arguably intrinsic to Botswana’s elites and the historical context of continuities from Protectorate’s time. Apart from governmental stability and a propelled “native initiator culture” (Acemoglu et al., 2003; Maundeni, 2001), the marginalization of nationalist, socialist movements and, increasingly, ‘traditional’ leadership allowed for the development of institutions and policies which facilitated backing from the Western powers, namely the United Kingdom (even if in decline), and their mining companies. Debswana, the public-private partnership for diamond exploration in Botswana, gathers the government and the South African mining giant De Beers, founded by Cecil Rhodes, the colonist millionaire who had established the British South African Company railways in the late 19th century (Froitzheim, 2009: 38). Yet, Botswana’s “right institutions” and “good policies” can be replicated once “individual actions” are put into place (Acemoglu et al, 2003: 113). The focus on good foundational developmental structures is emphasized by Beaulier and Subrick, who added up the inexistence of an army in the first decade of independence that could drain resources like in the rest of Africa (Beaulier and Subrick, 2006).

However, Botswana’s worldwide economic success occurred in a very specific context. Externally, it took place at a time when the general landscape of African countries was one of impoverishment and reversal to armed conflicts of

different natures and autocracy. Internally, by the 1990s Botswana was realizing the minerals-driven ambition of the pre-independence political-economic elite. These were conditions unique to Botswana, as stressed above. As such, despite maintaining or even expanding domestic inequalities without major changes in levels of poverty and unemployment and features of liberal authoritarianism, as a later bibliography has started to suggest (discussed in more detail in Chapter 8), Botswana easily stood out in the international arena as the ‘miracle’ of economic growth and stability in contemporary Africa.

Nevertheless, this propelled success has come under jeopardy by the HIV/AIDS epidemic affecting the country, and as such renewed Botswana political leadership’s concern for the country’s survival after the end of the Cold War and the apartheid. Considering the very large size of the epidemic, HIV/AIDS intervention has constituted a question of survival for the country. Self-help is visible in the way the government decided to launch an antiretroviral program – funded up to 80% with public resources – and sought to obtain support from external sources, namely the Bill and Melinda Gates Foundation, the Global Fund and PEPFAR. Botswana’s prevalence rate among adults aged 15 to 49 is 23.9% (WHO, 2010: 32). This accounts for the second biggest HIV/AIDS epidemic in the world after the small Southern African nation of Swaziland, whose rate is 26.1% (Ibid.). Considering that the national population is only of 1 921 000 (Ibid.: 158), one verifies how wide and serious is the magnitude of the epidemic. In 2007 an estimate of 300 000 adults and children were living with AIDS, which meant an increase of 20 000 cases in 2001 (UNAIDS, 2008: 214).

When the first case was identified at Princess Marina Hospital in Gaborone in 1985 (AIDS and Human Rights Research Unit, 2007: 3), the government was quick to launch one of the first control programmes in the continent. After consulting with the international agencies, it established a one-year emergency plan in 1987 (Heald, 2005: 4-5), and then two medium term plans (1989-1997 and 1997-2002) (AIDS and Human Rights Research Unit, 2007: 3) and the national strategic framework for 2003-2009, which framed HIV/AIDS in the broader question of development. After the creation of the National AIDS Council (NAC) in 1995 under the Office of the President, the National AIDS Coordinating Agency was set up in 1999 with the aim of implementing, coordinating, monitoring, evaluating and fundraising for HIV/AIDS, under the aegis of NAC (Ibid.: 9). In the late 1980s the adopted approach was based on “education and surveillance,” in which condoms played a central role (Heald, 2005: 5). However, there was “widespread disbelief” (Ibid.) among the populace, since there was no mortality to demonstrate the severity of the disease. By the mid-1990s that started to change, because of the increasing number of deaths. Yet, it was still called “the radio disease,” since most of the mass HIV/AIDS awareness-raising used to be done through the radio, as it still does today (Ibid.).

Given the disappointing results of these waves of intervention, governmental leadership slowly disengaged from the response (Ibid.: 7). However, the publication of a number of reports in the early 2000s (Econsult, 2007: 121-123), especially one by the Botswana Institute for Development Analysis (BIDPA, 2000), became a game-changer. Those reports presented grim demographic forecasts, whereby Botswana would dramatically lose its population in the case of absence of treatment programs for those living with AIDS. An interviewed medical expatriate with a

United States implementing NGO who first worked in Botswana in the 1990s commented that by that time “Botswana was faced with the fact that it had no choice. Ten years ago that was the burning issue. Survival was at stake. So, implementation had to start. (...) There was a need for new thinking in the country.” (Interviewee 13, 2010) Eventually, the country’s economy would suffer dramatically with decreasing figures of growth, consumption and productivity. A 2007-published study on the labour force of Debswana, the diamond public-private partnership, concluded that “among the 3 558 participants [of the survey], annual HIV incidence was estimated to be 3.4%, and HIV prevalence was 23.8%” (Riviello et al., 2007). It would also scare foreign investors away (Interviewee 14, 2010). Eventually, the government launched a massive treatment program in 2001 assisted by the African Comprehensive HIV/AIDS Partnership (ACHAP) of the Gates Foundation. In 2004 PEPFAR joined in, but only with the purpose of “filling the gaps” (Interviewee 11, 2010; Interviewee 10, 2010; Interviewee 12, 2010), since the biggest chunk, reportedly 80% of the expenditure, is taken up by the government (Froitzheim, 2009: 133). By “filling the gaps” stakeholders mean priority intervention in the areas of management and capacity-building of programs and organizations, as it is further discussed in the next chapter. It largely corresponds to PEPFAR’s second phase (2009-2013) purpose of sustaining ‘country ownership’ of actions carried out so far.

6.3. Security Architecture and Ethiopia’s Strategy

As mentioned in Chapter 2, the last decade has witnessed the emergence of a number of large international initiatives with the aim of improving the developmental status of many low- and middle-income countries. The Millennium Development

Goals constituted a framework upon which programs in several areas (health, education, gender, economic development) sit and set out to offer opportunities for those countries to ameliorate their records. However, this renewed policy and financial focus on development was accompanied by a growing concern about linking them to security and stabilization concerns by Western donor countries. For them development became a question of containment and management of populations, as critical analysts and theorists of International Relations, mentioned throughout Chapter 4, have emphasised, at the expense of more liberating approaches for those same populations. However, the question of the recipient country's state is left between irrelevance and plain membership to the Western hegemonic structure. One's argument is that not only recipient states are independent actors – they have agency – but also they can have an agenda that is not necessarily aligned with those Western goals. In the case of the Ethiopian government, this development-security architecture has become a source of opportunities, although some threats have been identified too.

The major opportunity that it is being offered to the Ethiopian government is the boost it gives to the current policy framework of state-led development and economic growth ('developmental state'). The following chapter will scrutinise the domestic politics of the developmental state in more detail. For now it suffices to explain that the very low stage of development Ethiopia still finds itself in requires the attraction of as much external funding as possible. Despite improvements in recent years, Ethiopia is the 13th worst positioned country in the 2010 edition of the United Nations Development Program's Human Development Report (UNDP, 2010: 145). Lately, apart from traditional Western Europe, Northern America, Japan and

Australia, the range of donors and lenders has extended to so-called ‘new partners,’ such as Turkey, Saudi Arabia, United Arab Emirates, India and China. The current diversification of ‘partners’ can be observed in recent statements by the Ethiopian Prime Minister Meles Zenawi.

We try to get help from every quarter... This is because we need all the assistance we can get. It would be stupid for us to say to the Indians for example, that we prefer Chinese assistance. It would also be stupid for us to say to the Brits now that the Chinese are helping out some infrastructure projects, keep your money. It doesn’t make sense. We want to get as much assistance as we possibly can because on balance we get about half of the average assistance that other African countries get in per capita terms. It’s not like we are overflowing with assistance. At this stage what we are trying to do is make the best use of every avenue we have. (Wallis, 2009)

It is hard to judge whether this diversification is the product of an intended governmental policy or just the result of a changing international environment, yet it is quite undeniable that it serves a government’s clear purpose. Diversification of ‘partners,’ especially non-Western ones, concerns the need to reduce dependency from the conditionalities attached to the provided funding. Those conditionalities refer to formalities around political and economic reform, as well as other sorts of pressure, such as statements by donor governments and embassies and reports by nongovernmental organizations with an impact on perceptions about the country and its government’s ruling leadership inside the donor countries and around the international community.²⁰ Nevertheless, although Zenawi has been claiming that Ethiopia is not a great aid per capita recipient, Ethiopia is the biggest African recipient of official development assistance (ODA), namely of Western countries, as Table 1 shows.

²⁰ However, this is not to suggest that non-Western partners do not impose conditions on the Ethiopian government, since they hypothetically do. The focus on Western aid relations with Ethiopia has to do with the dissertation’s case study, which is precisely an aid program by the leading Western power.

Table 1: Top 10 ODA recipients (USD million, net disbursements in 2008)

(Chang, 2010: 8)

Rank	Country	Net Disbursement	Percentage of ODA
1	Ethiopia	3 327	8
2	Sudan	2 384	5
3	Tanzania	2 331	5
4	Mozambique	1 994	5
5	Uganda	1 657	4
6	Congo Dem. Rep.	1 610	4
7	Kenya	1 360	3
8	Egypt	1 348	3
9	Ghana	1 293	3
10	Nigeria	1 290	3
11	Other recipients	25 411	58
	Total	44 005	100

The question of perceptions nurtured by donor countries and the international community at large about the country's current development efforts and the Ethiopian People's Revolutionary Democratic Front (EPRDF) leadership, particularly its main figure, Meles Zenawi, is reportedly very important in the country's relations with the West. Ethiopian leaders are aware of the negative constructed image of the country, especially since the mid-1980s, due to large public events such as 1985 Live Aid, as an eminent site of hunger, poverty, and underdevelopment. Therefore, they develop a foreign policy in order to show

otherwise, according to longstanding analyst of Ethiopian politics Patrick Gilkes (2010).

Although to a lesser extent than in Botswana, throughout the last decade Ethiopian leaders like Zenawi and Minister of Health Tedros Adhanom have enjoyed throughout the last decade a positive reputation as a new generation of African leaders who present themselves as unequivocally committed to good governance and stability (Zimeta, 2010; Aljazeera, 2010). Zenawi has been representing not just Ethiopia but the entire continent in international climate change summits (African Renewal, 2010), while Adhanom was the chair of the Global Fund until September 2011. Thus, while important international organizations and forums offer avenues of Ethiopian governmental promotion, it may also have an undermining effect. In effect, the Ethiopian government has been accused of manipulating international aid to reward supporters and punish opponents, legislating anti-democratic frameworks that impeded proper campaigning by the opposition in the latest governmental elections of May 2010, and violating the human rights of some ethnic groups. This also includes the jamming of the United States-based radio network Voice of America and the country expulsion of one journalist in 2010 (Catholic Information Service for Africa, 2010). This criticism has augmented after the elections' results were made public, in which the ruling government received 99% of votes under allegations of not meeting international standards (Press TV, 2010). In face of United States government criticism, the Ethiopian leadership has nonetheless remained responsive. Victorious Meles Zenawi was found stating in June 2010

the United States has every right to use its taxpayers' money as it sees fit (...). If they feel that the outcome of the elections is such that they cannot

continue our partnership, that's fine. We should be very grateful for the assistance they have given us so far, and move on. (Murdoch, 2010)

Despite the asymmetry between Western foreign governments and Ethiopia, it should be stressed that historically, and unlike many postcolonial African countries, whose subordination to former colonial masters is arguably persisting, the latter's consecutive regimes have been driven by a sense of equality among sovereigns (Furtado and Smith, 2007). As the host country of the Organization for African Unity (now African Union), and according to popular belief, an emblematic example concerns the tradition of granting free land to embassies worldwide, especially to African and donor countries, in order to attract further presence in the country. Addis Ababa has thus become one of the largest conglomerates of diplomatic representations in the world. In the case of relations with the United States of America, the country's biggest donor, the Ethiopian government has maintained a large ability to receive and manage assistance. This happened even in times of strong ideological differences that conduced to suspension of diplomatic relations, as it happened during the Soviet Union-backed military regime of the Dergue (Committee, in Amharic) between 1974 and 1991, during the famines of the 1980s (Kissi, 1997). Despite the policy of not assisting regimes created by *coups d'état*, which led to the withdrawal of USAID from the country in those years, assistance was still facilitated (Ibid.).

According to historian Edward Kissi (Ibid.), the United States maintenance of support during the Haile Selassie and Dergue periods, even when formally suspended, was primarily driven by humanitarian concerns.

Although geo-politics certainly played a role in United States relations with Ethiopia, some of the American proposals for the improvement of

the conditions of Ethiopia's peasants were motivated by a concern for the sons and daughters of the soil. (Ibid.: 432)

However, now the pendulum seems to swing more to the geopolitical side. Particularly after the failed military intervention in Somalia in 1994, but certainly after September 11, 2001, and the subsequent War on Terror, which highlighted the problem of Islamic extremism in the Horn of Africa, United States policy for Ethiopia has become increasingly more hard power-driven (Gordon and Mazzetti, 2007: 14-16; West, 2005). In this context, Ethiopia emerges as the sole actor the several post-Cold War United States Administrations can openly rely on (Ibid.). Yet, the same argument is applicable to the Ethiopian government. Its rationale for interacting, or 'partnering,' with the United States government is based on national security goals and improving the social welfare of the population. Whereas for the United States of America what is at stake is the contention against suspected Al-Qaeda affiliated groups together with a favourable resolution of Somalia's state failure (both inland and at sea), for the Ethiopian government what concerns chiefly is the consolidation of territorial integrity and its control (Gordon and Mazzetti, 2007). The purposes of the War on Terror in the Horn of Africa coincide quite explicitly with the EPRDF's own national policy of securing the borders and containing internal armed groups. As Zenawi has affirmed, "we don't look at this as us joining the United States on the war on terrorism, we see it as the United States finally joining us because we've been victims for many years" (West, 2005: 4). Nonetheless, policy contradictions are identified by experts.

While Addis Ababa is pursuing its traditional unaccommodationist and at times hostile policy towards these groups, Washington is encouraging all those Islamist movements that are interested in renouncing violence to participate in the political process. (Elmi, 2010)

In the midst of this, broader readings of security in the broader Horn of Africa have been emphasizing the overall lack of strategic thought, namely by the United States of America, in the resolution of the manifold conflicts taking place (Bah, 2009).

Unlike the cases of Botswana and South Africa, PEPFAR's implementation in Ethiopia is not justified for the scale of the HIV/AIDS epidemic alone, although in absolute terms it is a major health problem, since it affects close to one million people (UNAIDS, 2008: 214). Given the size of the population of around 80 million, HIV/AIDS sits alongside other pressing health concerns that have to do with all the direct and indirect consequences of urban and rural poverty, malnutrition, famine, population displacement and armed conflicts that affect the country. In addition to that, HIV/AIDS intervention often implicates activities around family planning, which moreover serves the goal of hampering population growth, considered a major obstacle to social development by policy-makers, academics and general commentators (Commission for Africa, 2005: 105-106; Bevan, 2006; Pausewang, 2009: 72; Dyer, 2009).²¹

HIV/AIDS as a distinct field of development/health intervention has represented an opportunity for the country to obtain resources from public and private donors, and simultaneously raise its international profile as the example of the Minister of Health Adhanom shows. Moreover, the history of the HIV/AIDS response in Ethiopia demonstrates a large deal of openness to the international community, and eagerness to interact with it. After the discovery of the first HIV/AIDS case in the country in 1984 (Kloos and Mariam, 2000: 17), a National

²¹ However, Berhanu Abegaz (2004: 321-322) emphasises that population growth should not be regarded as a primary cause of underdevelopment in Ethiopia.

Task Force was established in 1985 with the aim of tackling the spread of the virus, followed by the first department of AIDS control in Ethiopia at the Ministry of Health in 1987 (Kitaw et al., 2006: 210). Together with WHO, the then leading international organization in the field, two prevention and control programs were launched, for the 1987-1990 and 1992-1996 periods, but with “little impact on the growth of the HIV epidemic in the country” (Ibid.). Under another international institutional setting, as UNAIDS is launched in 1996, the Ethiopian health authorities designed with stakeholders National HIV/AIDS Strategic Plans for 2000-2004 and National AIDS Priority Strategies for 2001-2005. Finally, the HIV/AIDS Prevention and Control Office (HAPCO) was established in 2000, and has remained the leading HIV/AIDS authority for the country, headed by the President. However, according to interviews with senior professionals in the country, actual intervention remained very low, funded by the World Bank alone, until PEPFAR was established in the country in 2004 (Interviewee 37, 2010; Interviewee 2, 2010; Interviewee 7, 2010; Interviewee 46, 2010; Interviewee 47, 2010). In 2009, activities funded by PEPFAR in the areas of HIV/AIDS prevention and treatment and correlated medical and developmental activities (other epidemics, family planning, education, evangelisation) were upgraded to “Global Health Initiative (GHI) plus” status under that initiative. As discussed in the previous chapter, together with seven other countries, Ethiopia will receive further capacity and management support to pursue the efforts developed in the last seven years.

6.4. (South) African Renaissance: Post-Apartheid Politics

South Africa is generally observed by the international community as a continental power in Africa; actually a superpower in its immediate Southern African neighbourhood (Shillinger, 2006). Its hegemony is usually assessed in very classical terms: very large relative gross domestic product (GDP) (roughly half of Sub-Saharan Africa's total) and military capabilities. The recent invitation to join the group of emerging world economies with Brazil, Russia, India and China (the so-called 'BRICs') is symptomatic of the country's significance beyond its own neighbourhood and continent (IOL, 2010). While South Africa's regional hegemony has long constituted a solid fact, the country's foreign policy's development over the last decades has invited several explanatory approaches. The apartheid period is generally described by neorealist features, as potent military might was employed systematically inside and outside the country's borders in order to cement the regime's self-help (Geldenhuys, 2008: 2). However, in 1994, with the first multiracial elections and dismantlement of Apartheid, a shift was underway, as Deon Geldenhuys describes:

This reorientation flowed from a paradigm shift in South African foreign policy. The 'old' South Africa's realist thinking informed by the imperatives of survival in a hostile world, was replaced by a liberal idealist approach in which democratic South Africa would promote an ambitious reformist agenda abroad based on its internal experiences and values. (Ibid.)

According to scholarship, unlike apartheid, the democratic era has been characterized by the primacy of liberal idealism, as successive presidents (Nelson Mandela, Thabo Mbeki, Jacob Zuma) have been engaged in a new kind of pan-Africanism with the aim of promoting representative democracy, good governance and economic development around the continent for the new millennium (Ibid.: 7-

11). Rhetoric of African Renaissance and constitution of the New Partnership for African Development (NEPAD), mentioned in Chapter 2, constitute the cornerstones of this liberal-idealist agenda for the continent.

Independent of the domestic regime – of separate development (apartheid) or liberal-democracy, with black-majority²² – South Africa's relative capabilities *vis-à-vis* the regional neighbourhood and the rest of the continent render it hegemonic, at least unless other 'rivals' emerge. To a large extent, domestic regime change implied a change in international relations, particularly with Southern Africa, from an utterly isolationist position (apartheid) to friendly conviviality with neighbours, who moreover helped the leading political force, the ANC, to resist and eventually negotiate a regime transition (post-apartheid) (Schoeman, 2007). Indeed, while Apartheid South Africa had vivid military incursions in Mozambique, Angola, Zimbabwe, and even Botswana, let alone Namibia, which was part of South Africa until 1990, the ANC was assisted by the leadership of those countries, or at least groups inside them (e.g. Botswana), and also farther-away states, such as Zambia or Tanzania, not to mention political regimes and social movements around the world (Ibid.). Post-apartheid idealism is rooted on this mosaic of relations established during the anti-apartheid struggle, and resulted on the democratic will of sharing South Africa's relative wealth with the rest of the continent through aid, and prioritization of the African continent, and the Southern African subcontinent in particular, in terms of international trade and foreign investment (Taylor, 2005). Eventually, South African companies, or multinationals with earlier strong presence

²² It should be highlighted that the ruling post-apartheid party in South Africa, the African National Congress, follows a non-racialist policy, the same applying to the remaining parts of the governmental coalition, the South African Communist Party and the Confederation of South African Trade Unions (COSATU). However, the political regime is commonly referred to as of black majority.

in South Africa, increased their presence in key sectors like telecommunications, transport and distribution (Mutenheri, 2010).

This renewed hegemony of South Africa worked in diapason with the international framework of the United States of America and financial institutions, such as the International Monetary Fund and the World Bank, whose preponderance expanded with the retreat of the Soviet Union (Cox, 2005). Eventually, such hegemony proliferated to wider parts of Africa, whereby “many African elites contribute to making neo-liberalism accepted as the ‘only’ macro-economic framework and development strategy within which they (and by implication, all others) can work within” (Taylor, 2002: 21). Though not without some reservations, South Africa was accepted by the Southern African Development Community in 1994, a trade-facilitating organization whose predominance until then rested on Zimbabwe, but that soon became under South African dominance (Schoeman, 2007). South Africa’s post-apartheid liberal idealism constitutes a refoundation of the previous military power, yet with a benign tone. From a military point of view, the South African army is predicted to intervene merely in peacekeeping operations in the immediate and more distant abroad (Baker and Lyman, 2008: 9; Bond, 2006a: 152; Cilliers, 2008: 22). Furthermore, it has rolled back its nuclear armament program, and participates in international nuclear disarmament initiatives (Burgess and Purkitt, 2001).

The political-philosophical roots of post-apartheid South Africa, based on democracy, human rights and good governance, largely fits the United States of America’s tenets indeed, although some authors tend to favour an association with the ‘Middle Powers,’ such as Canada or the Scandinavian countries, let alone the

already mentioned BRICs (Geldenhuys, 2008). South Africa is one of the “anchor states” in the United States strategy for Africa, together with Ethiopia, Nigeria and Kenya (Chau, 2007: 6-7). Maintaining relations of alliance advances goals structured around regional/continental stabilization *vis-à-vis* perceived armed conflicts, human security threats and Islamic terrorism (Ibid.). Expansion of markets and access to mineral reserves is of utmost importance too. As far as United States of America-South Africa relations in particular go, they have shown a consistent pattern of proximity since the apartheid thru today.²³ In this regard, the African Growth and Opportunity Act (AGOA) concurs towards that goal, as it aims at facilitating trade relations between South Africa (and Southern Africa as a whole) and the United States of America. This whole framework is frequently headed by United States leadership discourses around the need for anchor states such as South Africa to hold “responsibility” both home and in the region (Clinton, 2009). South Africa is induced as a hegemonic leader that should set example towards the achievement of what, in the last analysis, are United States strategic goals, and which, after all, coincide with South African ones (Underwood, 2008).

The resilience of liberal democratic institutions and the primacy of the market posits South Africa as one of the very few countries in Africa not falling into any of the categories of “failed states,” “critically weak states,” “weak states” and “states to watch,” according to the United States influential “Index of State Weakness in the

²³ In fact, the United States of America backed the apartheid regime for a long time, at different levels (Underwood, 2008: 9; Campbell, 2008). The main reason for that concerns the Cold War geopolitical game at stake in Southern Africa. Given the military and diplomatic assistance that the Soviet Union was providing to the regimes in Tanzania, Mozambique, Angola and Zimbabwe, in turn hosting the ANC and other anti-apartheid movements, the United States of America assisted the South African regime as it was containing communism (Burgess and Purkitt, 2001: 85; Ndlovu-Gatsheni and Ojatorotu, 2010: 95). The CIA was active in the counter-terrorist domain (Hutton, 2010). At the same time, protecting South Africa meant protecting the capitalist political economy South Africa was grounded upon, namely United States companies working on South African soil (Bond, 2008).

Developing World” (Rice and Patrick, 2008). However, although the current military and police behaviour is no more aggressive, home and abroad, the levels of violence inside South Africa remain very high (Cilliers, 2008). Urban insecurity and criminality have amounted to thousands of deaths and injuries over the years, notably among the most vulnerable groups (i.e. women and children) in informal settlements, townships, cities and countryside (Chopra and Sanders, 2004; Cullinan, 2009).

It should also be emphasized the contribution of United States-based and transnational solidarity groups, often composed of black diasporas, which campaigned to change foreign policy in favour of the end of apartheid (Gramby-Sobukwe, 2005). Some of those groups eventually have been playing eminent roles in the post-apartheid period under the auspices of United States-South Africa programs of cooperation, namely the large mainstream Christian churches, i.e. Catholics, Anglicans and other Christian denominations (Ibid.: 796). One major program is certainly PEPFAR, in which implementers in South Africa have been the largest recipients (Bradbury and Kleinman, 2010).

Nevertheless, both countries have disagreed on the issue of United States Africa Command (AFRICOM), a consequence of post-September 11, 2001 policy of surveillance in Africa (Ndlovu-Gatsheni and Ojakorotu, 2010). It has been repeatedly rejected by South Africa and other countries across the continent, though not by neighbouring Botswana (Buchanan, 2008; McFate, 2008; Burgess, 2009). Another point of contention between them referred to the politics of HIV/AIDS and, consequently, PEPFAR. According to latest data, the prevalence rate among adults is of 18.1%, the largest epidemic in the world after neighbours Swaziland, Botswana and Lesotho (WHO, 2010: 32). This issue lasted for most of the Mbeki Presidency

and is, at least partially, explained by the post-apartheid liberal-idealism discussed so far.²⁴

In the early 2000s, building on some unsettled scientific disputes on the nature of the HI virus, animated by natural scientists such as Peter Duesberg, Mbeki claimed that the biological causes of AIDS were unclear (DeMeo, 1993). For him, what was rather clear was a social cause: poverty (Schneider and Fassin, 2002: 49; Youde, 2007a: 5). Furthermore, for Mbeki, the AIDS orthodoxy had become the West-led international community's new racist and colonialist mantra for showing to the world Africans' inferiority (Mackintosh, 2009: 33; Sitze, 2004: 770). In addition to that, he considered that this orthodoxy was paving the way for greedy pharmaceutical companies to sell highly toxic drugs to poor African countries (Mackintosh, 2009: 38). This argument was grounded on apartheid-time public health emergencies launched by the government which turned out to be particularly damaging for blacks. It also reflected cases of blacks' suspicion of public health measures (Youde, 2005: 424-426). However, as his biographer Mark Gevisser claimed in 2007, Mbeki did not mean to be "denialist," yet a "dissident," intellectually and politically (SABC News, 2007). In practice, many treatment

²⁴ This governmental "denialism," as put by pro-treatment civil society groups, has been alternatively explained in terms of an ethnic boundary that cuts across the South African society, which, in turn, leads to an absence of "collective shared risk," if not a collective state of denial between the different ethnic groups (Lieberman, 2009). Since government policy-making and implementation in such complex area as HIV/AIDS prevention and treatment requires a sense of collective risk among different ethnic groups in order to engender "compliance and consent" (Ibid.: 7) by the public, Lieberman concludes that the more ethnically stratified the national polity finds itself, the less the national community is inclined to accept the underlying idea of a shared collective risk and thus support policies of response. The author argues that the ethnic boundaries cutting across South African societies – broadly, between whites and blacks – led to a lack of "collective shared risk." Both ethnic groups were in a "state of denial." While whites would see the epidemic as blacks' problem, and blacks would vision it as whites' problem, the government did not step in aggressively, in a context of post-apartheid fragile national/ethnic relations. The opposite case in Lieberman's study was Brazil, whose efficiency of the government's response relied on the tenuous ethnic boundary existing across Brazilian society.

programs were suspended, and arguable “African solutions for African problems” for the epidemic were put forward. His Minister of Health, late Manto Tschabalala-Msimang, introduced a prescription based on garlic, olive oil, lemons and African potato (Kahn, 2009).

The politicization of HIV/AIDS in that period occurred in the context of post-apartheid race relations but also the advancement, home and across Africa, of the developmental rhetoric of African Renaissance. After the dismissal of Mbeki in 2008 after an ANC congress, Tschabalala-Msimang was also sacked by the transitional president, Kgalema Motlanthe. And once President Jacob Zuma was elected party leader and later elected country’s president, an absolute reversal of policy took place. Before that, in 2002 and 2003, the Treatment Action Campaign won court cases against the state that allowed provision of ARVs to infected pregnant women and to people with advanced AIDS (Oshry, 2007). The launch of PEPFAR in South Africa occurred precisely in the height of those disputes, and its first years of implementation (2003, 2004) were affected by the political context, which did not mean that the PEPFAR was launched without endorsement of the national authorities (Interviewee 25, 2009). It was endorsed, even if under difficult conditions, as a former official with a United States government implementing agency admitted: “When it was to get the [PEPFAR] memorandum of understanding it was difficult for us to find the person [among the South African government] to sign. It was a massive job. But now it is changing in terms of getting contacts.” (Ibid.)

Post-apartheid idealism of South African foreign policy can help to grasp Mbeki’s position. Even though it was a mostly domestic event, this position reflects a

will, eminently embodied in the figure of President Mbeki, of transmitting a set of values and ideas across Africa, and even the world, centred on the dignity of Africans and their resistance to prevailing racist and colonial images promoted by the West-led international community, as well as their ‘affiliates,’ i.e. activists, inside South Africa too. Although this presidential stance was observed as utterly unacceptable by the mainstream HIV/AIDS ‘epistemic community’ and irrational by the average international community, especially outside Africa, the idealist commitment to a set of values and ideas gave it meaning. It definitely was part of the project of African Renaissance – home and around the continent – to fight back the historical constructed images around African (read: black) sexuality and even humanity.

Particularly since the end of 2009, the South African government, both at presidential and ministerial levels, have started to engage more seriously with the epidemic and its different domestic and foreign activist interlocutors. The launch of substantial testing and treatment programs was so exciting that led the head of UNAIDS, Michel Sibidé, to address President Zuma as an “architect for AIDS strategy” on the 2009 World AIDS Day (SAPA, 2009). Relationship with funders like PEPFAR and its recipient organizations and the remaining HIV/AIDS community has improved to the point of Minister of Health Aaron Motsoaledi appearing as a guest speaker at the latest International AIDS Conference 2010 as a firm HIV/AIDS advocate (Motsoaledi, 2010). This was something almost unimaginable for a South African higher government official some years before. Yet, again, the permeating post-apartheid liberal idealism is found once again in the

rhetoric. Minister Motsoaledi promises commitment at home and sensitivity for other African nations.

Motsoaledi, the health minister, said his government wants to keep paying 80 per cent of its AIDS bill, an important commitment because it means more donor money will be available for countries in even direr need. While South Africa has the most HIV-positive people, other, poorer countries, including neighbours like Swaziland, are more burdened because a higher percentage of their citizens are HIV-positive. (Bryson, 2010a)

6.5. Conclusion

This chapter has focused on the relations between the states/governments of Ethiopia, Botswana and South Africa and the United States/PEPFAR, and the international community at large. This chapter showed not only that individual countries act in their own right as units of the system, i.e. they have agency, but also *how* they have acted throughout the years. Moreover, those countries maintain their specific political and strategic agendas that drive their action as they are constrained by their national, regional and international circumstances.

Despite the peaceful transition from indirect rule under the British Protectorate of Bechuanaland to formal independence in 1966, regional pressures during much of the post-independence period forced consecutive Botswana leaderships to realist strategic thinking. In practice, and although leaning domestically towards Western institutionalism and values (for a long time its main development funder was the United Kingdom), it demanded negotiation and some sort of relationship with all neighbours, independent of their domestic regimes, and both superpowers. Even if difficult until 1994, it obliged to a special relationship with the regional economic hegemon, South Africa. By the 1990s, due to spectacular

economic growth, the country rose to middle-income status, in opposition to the collapse of many regimes around the continent throughout the 1990s and 2000s. However, by then, and despite an improving regional environment with the end of apartheid in the southern neighbour, Botswana was challenged by another threat to survival: HIV/AIDS. Affecting roughly a quarter of the adult population, the country has acted – through allocation of domestic resources and attraction of PEPFAR support – to respond to a problem framed in terms of survival of the nation.

Whereas the case of Botswana points at a question of national survival, in which the country's population is under a severe threat, the Ethiopian situation is rather centred on domestic political regime's survival, which aims at securing the integrity of the current map of the country given the number of internal and external threats while enhancing development prospects domestically. The Ethiopian political history since Haile Selassie demonstrates that over the years different regimes have sought to advance their interests with the external powers, despite outside threats. As far as relations with the United States of America, even during the Dergue regime period (1974-1991), the government, formally assisted by the Soviet Union and therefore at odds with United States foreign policy, negotiated assistance of both geopolitical and humanitarian nature. The same applies today to the ruling EPRDF, who has been under criticism of Western diplomacy and human rights NGOs, but nevertheless secures significant assistance, namely through PEPFAR, from the United States of America. This set of goals largely coincides with the United States broader agenda for the Horn of Africa.

Unlike Botswana, HIV/AIDS does not pose a concrete threat to the Ethiopian population. Consequences of the epidemic for the political regime are rather indirect

and part of a comprehensive dimension, that is, human development. In spite of recent improvements, Ethiopia still occupies the 13th lowest position in the Human Development Report of the United Nations. However, rather than relying solely on the West-led international aid and security architecture as it used to be, now the Ethiopian political leadership is able to diversify its sources of assistance, as ‘new partners’ emerge, notably China, India, Saudi Arabia, the United Arab Emirates and Turkey. As such, dependency from Western aid and attached conditionalities is relaxed and allows for a more independent policy for the EPRDF.

South Africa’s case is rather different from Botswana and Ethiopia. The regional hegemony expressed by a relatively very large GDP and military capabilities implies an analytical predisposition to a neorealist perspective about South Africa, both during and after the apartheid regime. However, the post-1994 administrations led by the ANC have kept a rhetoric and policy aimed at transmitting, through aid and economic influence, values spoken as an African Renaissance, characterized by democratic participation, human rights and good governance, around the continent. This idealism had consequences at the level of HIV/AIDS intervention, particularly at home but also beyond. It consisted on a questioning, or self-proclaimed “dissidence,” by then-President Thabo Mbeki of West-led international community’s efforts in that area. In his opinion, it reiterated former derogatory colonial views of African sexuality that had to be rejected under African Renaissance. As a consequence, and even though scientific data pointed at a very large epidemic, state-sponsored treatment programs were suspended or reduced.

It is interesting to observe that this standpoint contradicts quite entirely the one taken by the government of neighbouring Botswana in the same period. Whilst

the South African government was reducing, or even suspending, treatment programs, its neighbour was launching the national mass-scale antiretroviral program. The Botswana government was convinced by international advice that pharmacological solutions were key to the survival of the population. In turn, important members of the South African government were reluctant, or ‘dissident,’ over the whole efficacy of such pharmacological intervention, preferring local (African) solutions, and shifted the focus to the social determinants of the epidemic (poverty) away from arguable treatment regimes. After Mbeki, as epidemic realities were recognised and generated an engaged response under President Zuma, South African governmental behaviour remained driven by a pan-Africanist concern, as the government’s fundraising rhetoric demonstrates, expressed in function of countries with lower economic capacity to afford therapies. Although South Africa is heavily affected by the epidemic and necessitates foreign assistance, there are other afflicted countries, yet poorer than South Africa, that somewhat need to be prioritized.

Chapter 7 – Domestic Policy of Postcolonial African States

7.1. Introduction

The previous chapter analysed the actions of the governments of Ethiopia, Botswana and South Africa in face of the opportunities and constraints that emerged in the international system, as well as in terms of continuities and changes concerning their foreign policies. Their behaviour, one argues, expresses agency as an ability to act with autonomy, even if in asymmetry, to fulfil their political and strategic agendas over time. Two distinct theoretical strands explain their behaviour with regard to the United States of America, and the larger international community. One stresses the concern for self-help, and is applicable to the cases of Ethiopia and Botswana. The other is based on the transmission of ideas and values structured around African Renaissance, and helps to grasp South Africa's policy, namely after 1994, the year the apartheid regime came to an end and full multiethnic democracy was inaugurated.

This chapter looks at the domestic dimension of inter-state behaviour. One's analytical framework departs from the Waltzian (1979) idea of state as an acting unit of the system, yet with a spectrum of asymmetric relations that do not confine themselves to the traditional international arena. Rosenberg's (1990, 1994) suggestion of "the state as a social relation" induces levels of inter-state relations below the mere international sphere, thus conceiving relations with an impact on internal politics and policies, as well as on local dimensions, to be reviewed in the next chapter. In effect, this chapter builds largely on the previous one, and expands the range of opportunities and constraints imposed by the (international) structure,

particularly as far as PEPFAR's policies and implementation is concerned. Therefore, it focuses on the behaviour of PEPFAR host countries in face of the PEPFAR's arguably most prominently pervasive policy: country ownership. After five years (2003-2008) of implementation under an 'emergency' mode, with the major aim of quickly putting in place cross-country systems of contracting and distribution of antiretroviral drugs, PEPFAR's second, current phase (2009-2013) is much more concerned with a transition towards sustainability through country ownership of the previously initiated interventions under United States government command. Although regarded as an example of 'structural' domination, country ownership has been interpreted and managed by the national governments in different manners, according to the broader political and strategic agendas of the individual countries.

This chapter follows the same structure of the previous one. It starts with Botswana, then proceeding to Ethiopia and finally South Africa. Botswana's section details the national-government-led response, in which PEPFAR fits, aimed at safeguarding the survival of the population. The section on Ethiopia focuses on the developmental policies of the national government since they are the most involved in the process of PEPFAR's implementation. Even though the national ministry of defence is also a PEPFAR implementer, suggesting a direct geopolitical implication to the intervention, one considers that the 'developmental state' policy offers the broadest platform for analysing the program in the country. Finally, as far as South Africa goes, it depicts the process of launch and implementation of PEPFAR under the domestic tensions and changes that affected the realm of HIV/AIDS intervention in that country over the years.

7.2. Botswana's National Struggle against Epidemic

As a sovereign state Botswana is the direct inheritor of the British Protectorate of Bechuanaland. This Protectorate was established in 1885 as a result of the necessity to prevent an alliance between the former Boer republic of Transvaal (now the Gauteng province of South Africa) and the former German South-West colony (now Namibia). Such alliance could undermine British access to former Southern Rhodesia (now Zimbabwe) from the former Cape Colony (Parsons, 1999).

Although it nominally formed a British domain, it was in the interest of the local Tswana rulers to maintain this alliance with the United Kingdom, given the record of conflict with Transvaal throughout the 19th century (Ibid.). Five years after the constitution of the Protectorate, the British South Africa Company (BSAC) was established to proceed with the construction of a railway across Bechuanaland. The British government considered the allocation of the Protectorate to that company, which generated a worrying reaction by the local rulers. In 1895 the three Tswana kings, Bathoen, Khama III and Sebele, travelled to London and requested the British government not to proceed with that measure in exchange for the maintenance of Protectorate administration. After a lobbying campaign the rulers were successful with that mission (Ibid.). Nonetheless, the Tswana monarchs had to concede to the BSAC enterprise. But, all in all, it can be argued that the Tswana leaders benefited from the regime of Protectorate administered by the British. On the one hand, despite conceding to CSAC, they enjoyed a military protection from the Boer republic that they could hardly afford. Furthermore, the system of indirect rule allowed for the increase of their actual empowerment of their leadership. For instance, the local elite

benefited from colonial capitalistic policies of cattle development, together with the British white farmers.

A reason why the United Kingdom was somehow easily persuaded to concede to the native rulers' request had to do with the fact that it always regarded Bechuanaland as a "temporary expedient" (Ibid.). Sooner or later, Botswana would be integrated either in former Southern Rhodesia or South Africa, since it was "a mere appendage of South Africa, for which it provided migrant labour and the rail transit route to Rhodesia" (Ibid.). Unlike the other two domains, subject to intense colonial rule and economic exploration, Botswana remained largely marginal in that process. In fact, no significant development was made in the country until the independence in 1966. For example, the construction of the capital city itself, Gaborone, only started in 1964. Until then the administrative centre was located in Mafikeng, on the South African side.

Transition to national sovereign rule was peaceful, and never seriously contested British principles of political and economic organization. The reason for such smoothness has been found in the fact that the dominating elite ante and post-independence was the one and the same, one of its great representatives consisting precisely on Seretse Khama (Varela, 2006: 266-267). A year before formal independence, in 1965, the first elections for self-government took place, and the moderate, liberal Bechuanaland Democratic Party, under the leadership of Seretse Khama, became the first Prime Minister of Botswana, and founding father of the modern state. With the independence, the Bechuanaland Democratic Party was renamed Botswana Democratic Party (BDP), and Khama became President of the Republic of Botswana. The BDP has won all multiparty elections until today, and

Khama governed until his death, in 1980. Ketumile Masire governed from 1980 to 1998 and Festus Mogae from 1998 to 2008. Ian Seretse Khama, son of the first president, is the current President.

The country never underwent internal mass-scale political violence like in all neighbours (Namibia, South Africa and Zimbabwe), which nevertheless affected Botswana, as the previous chapter discussed. The foundation of the Botswana Defence Forces in 1977 was a consequence of a Rhodesian army's incursion in Botswana in search for black insurgents. In turn, the South African apartheid army bombed parts of Southern Botswana (Kelebonye, 2010).

In 1966, at the time of independence, Botswana was one of the poorest countries in the world, and there was very limited power and communications infrastructure by then. The country received large developmental support from the United Kingdom, and later from the United States, especially in the area of education and health. But two decades into independence, the country experienced massive growth rates. With the discovery and exploration of diamonds, it attained some of the highest growth rates in the world, achieving a 13% annual growth in GDP between 1980 and 1989 (Hillbom, 2008: 191). This achievement was thanks to the discovery, exploration and trade of diamonds under the Debswana public-private partnership that put together the Botswana state and the mineral giant De Beers, founded by the early owner of the South African railway company, Cecil Rhodes.

Various reasons are advanced to explain why Botswana has been as "successful" as it has been. Zibani Maundeni (2001) argues that, comparing to neighbouring Zimbabwe, a major factor concerned the indigenous "initiator culture"

of developmentalism in Botswana embedded in the hegemony of the BDP over other political sensitivities and local chiefs.

In the case of Botswana, where there was an indigenous initiator state culture, new state elites emerged from the indigenous old state, revolutionised it from above, maintained discipline and coherence within the state, embarked upon state-led capitalist development and enjoyed the support of the general population. The Botswana Democratic Party (BDP) emerged out of the indigenous old state in response to the decolonisation and nationalism that were sweeping the African continent in the 1950s and 1960s. It opposed and displaced the populist nationalists. It displaced the chiefs from the centre of state power. (Ibid.: 129)

This “initiator culture” consisted of a consecration of institutions of “private property,” which “protect the property rights of actual and potential investors, provide political stability, and ensure that the political elites are constrained by the political system and the participating of a broad cross-section of society” (Acemoglu et al., 2003: 84). It materialized into “policies [that] served the interests of important coalition partners, the major cattlemen, and the foreign mineral extracting firms” (Froiztheim, 2009: 145). In sum, Acemoglu and colleagues indicate the following factors explaining, apart from the availability of unskilled labour, which stopped migrating to South Africa for the mining industry, the success of Botswana:

tribal institutions that encouraged broad-based participation and constraints on political leaders during the precolonial period; only limited effect of British colonization on these precolonial institutions because of the peripheral nature of Botswana to the British Empire; the fact that upon independence, the most important rural interests, chiefs, and cattle owners, were politically powerful; the income from diamonds, which generated enough rents for the main political actors to increase the opportunity cost of further rent seeking; and, finally, a number of important and farsighted decisions by the post-independence leaders, in particular Seretse Khama and Quett Masire. (Acemoglu et al., 2003: 84)

As Botswana achieved to upper-middle income status, by the mid-1990s, foreign agencies left the country, including USAID and the Peace Corps. This is an

instance of the post-independence path of agency walked by the national elite, which sought to employ strategically available political and material resources in the construction of a country that at time of the independence was underdeveloped. From a point of colonialism (Protectorate) and neo-colonialism (utter dependency on foreign resources for development), Botswana achieved an impressive degree of autonomy in the design and implementation of its own development policies that its integration in the global market of diamonds facilitated. Botswana emerged as one of the two developmental state stories (the other is Mauritius) in Africa in the 1990s.

However, in the early 2000s foreign assistance resumed in full force due to the HIV/AIDS crisis. In the case of United States support, this followed a personal request by President Festus Mogae to the United States Administration (Interviewee 17, 2010). HIV/AIDS emerged as one of the greatest threats to the country and its development prospects, together with the decreasing demand for diamonds. However, precisely because of the problem's magnitude, which undermines the survival of the nation, the government took an early decision of intervening actively in the epidemic. Assisting with the survival of a significant share of the population has evident consequences in terms of larger policies of development. Many studies about the social aspects of the epidemic have underlined over the years the severe impact on the development prospects of a country, since it primarily affects the most productive members of society, i.e. young adults (Arndt and Lewis, 2000; Bauer, 2006; Fourie and Schönsteich, 2001; Kim and Farmer, 2006; Santaaulalia-Llopis, 2008; Whiteside and de Waal, 2004; Whiteside, 2004; 2009).

HIV/AIDS intervention in Botswana has started in the mid-1980s, but it only became a matter of utmost importance for the national government in the beginning

of the 2000s. The national antiretroviral program was launched in 2001 primarily with domestic funds, complemented by other sources: the Bill and Melinda Gates Foundation's African Comprehensive HIV/AIDS Partnership (ACHAP), the Global Fund and, finally, PEPFAR. Responding to the epidemic was framed in terms of survival of the small national population of less than 1.5 million people, since the prevalence rate among adults corresponds to close to one quarter of the total adult population (WHO, 2010: 32). Arguably, due to the actual budgetary prioritization of HIV/AIDS by the Botswana government, HIV/AIDS became a topic associated with very much everything governance-related: a matter of public health, of course, but also of development and even national security (Molomo et al., 2007). For example, some programs, assisted by the United States government, targeted directly the Botswana Defence Forces (Interviewee 14, 2010).

PEPFAR was made part of a larger process ultimately aiming at the consolidation and expansion of an already developmental state in Botswana, while the perhaps more basic concern for survival is particularly salient. However, unlike the Ethiopian case, as one will show, PEPFAR is not a significant part in quantitative terms of the overall response. Often, interviewees referred to PEPFAR's role as one of only "filling the gaps" of the national, government-led response. PEPFAR's funded activities mainly revolve around medical research, prevention, and building organizational capacity. An interviewee with a United States government implementing agency stressed the 'invitee' character of her organization's presence in the country's effort against the epidemic, after a short period in which the Botswana government considered foreign assistance no longer necessary.

Our organization arrived in the country after the national independence and stayed until 1997. (...) However, ten years ago President Mogae

asked the US government to return to the country to support the fight against AIDS. (Interviewee 17, 2010)

To a large extent, PEPFAR's participation in the Botswana effort corresponds to the main goal for the second five-year implementation phase (2009-2013): to assist national organizations (government and civil society) towards a country-owned sustained response. Respondents with United States government implementing agencies are generally very glad about the process of PEPFAR's implementation *vis-à-vis* the final established goal. The country is generally regarded as a main leader of the overall process of implementation. One interviewee underscored PEPFAR's important role in terms of technical assistance and pointing at new policy directions (children and women). Yet, she stressed that the country – both the public and private sectors – engage strongly in the response, and thus 'own' it.

In Botswana, PEPFAR had a significant impact in assisting the government. But the country was already way ahead comparing with other countries. (...) In Botswana there are strong policies. Now the challenge is to roll out on gender and children. Our purpose is to fill gaps, and facilitate country-ownership. For us, country ownership is not government ownership, but ownership by the government, privates and civil society. That is why you want Debswana [diamonds company] to be involved in this too. (Interviewee 2, 2010)

Another respondent reiterated the government's leadership in the process and place PEPFAR next to the other private (Gates Foundation) and public (the European Union, through the Global Fund) donors.

Here the government has the lead. ACHAP is also leading. The EU [European Union] is also contributing, though more in education. And PEPFAR fills remaining gaps. (Interviewee 10, 2010)

A third respondent with a United States government implementing agency gives the example of military aid to show the assimilation foreign aid received by the Botswana government is subjected to its strategic goals.

My personal view is that mostly everywhere (...) aid is given to the recipient militaries, and they just take it without much questioning. But that is not the case of Botswana. They only take the projects they want. They own the projects. (Interviewee 14, 2010)

A fourth respondent underlines the national government's commitment and points at persisting difficulties of response.

The goal of country ownership is working well in Botswana, which depends on two things: political will and capacity. In Botswana there is good governance and the government shares the same core values with the US [United States of America]: caring for social welfare. There have not been obstacles, no major health system challenges. The only thing to be stressed is that there are very isolated rural populations, which is problematic in terms of prevention of transmission. That will require a lot of government commitment. (Interviewee 16, 2010)

Confidence in Botswana's capability to maintain a steady response to the epidemic is also shared by PEPFAR's nongovernmental sector. Interestingly, one has found two professionals originally from two neighbouring countries among the supporters of the idea of national leadership and ownership in Botswana. One restates the idea of Botswana as an 'African model,' this time around in the field of HIV/AIDS: "In Botswana the government is very committed. It has really been a model in Africa. It is not donor-dependent. Here PEPFAR only fulfilled gaps. The Botswana case should be repeated." (Interviewee 11, 2010) Another interviewee has comprehensively addressed a number of crucial implementation issues in which the government has been instrumental, from political involvement with public taboo matters to prevention to supply-chain.

Facilitating conditions are the embracing political environment, featured by good governance. The health minister's recent statements on HIV/AIDS in prisons are another good example of the political elite's commitment to the struggle against AIDS, namely on the side of prevention. This is facilitating prevention work. Accountability is also to be mentioned. Concerning infra-structures, this country has good roads which help in the supply chain process. (Interviewee 15, 2010)

As mentioned in the previous chapter, the country's openness to the international community's recipes from the late 1980s through today has been a very important feature. Independent of the actual results of those recipes once implemented, which, as mentioned, were assessed very negatively, today's policies are generally embraced by the government and are regarded as a proof of leadership in the struggle against AIDS, as interviewees state. An interviewee has commented that "[a] facilitating condition is the abundance of clear rules which trickle down from the international community to the government. Thanks to government's will many resources have been pooled together" (Interviewee 11, 2010).

From the national government's side, its leadership acknowledges the support given by external funders, including PEPFAR, in the struggle against the epidemic, namely in the social sphere.

PEPFAR supports OVCs [orphans and vulnerable children], and as such it helped to set up a network involving us plus the ministries of local government and health as well as civil society organizations. The government cannot do everything alone. (...) Without PEPFAR no CSOs [civil society organizations] would develop. It is assisting in building capacity for them. I worked at the district level, and what was working was peer-education by CSOs. They were important in mobilizing people. One of them was TCM [Total Community Mobilisation], funded by ACHAP.²⁵ People adhered well and chiefs were collaborative. (Interviewee 18, 2010)

Despite the recognizable engaged position of the government, most respondents, including one with a national ministry, have acknowledged the current worrisome economic situation. Considering the reliance on revenues associated with the diamonds trade, the decreasing global demand for that commodity sets out to undermine the costly effort. Despite decreases in drug prices, the program will

²⁵ TCM was described in these terms by Allen and Heald (2004: 1147): "One of the (...) strategies to complement the ARV programme was called 'total community mobilization'. This, as with so much else in Botswana, was designed as a top down intervention. An army of field-officers were to undertake door-to-door visits, and to talk at various community gatherings and hold workshops."

remain very expensive, in part as a result of more people surviving thanks to it. This will demand critical options and trade-offs by the government (Econsult, 2007: 118-120). Indeed, the pandemic in Botswana remains rampant, although consulting company Econsult in its report to the National AIDS Coordinating Agency (NACA) refers to “preliminary evidence of a fall in HIV prevalence rates amongst younger age groups suggests that these campaigns are effective, at least to a certain extent” (Econsult, Ibid.: 118). As a consequence, the struggling race for preventing the epidemic to reach more catastrophic results in Botswana tightens, and puts crucial dilemmas for the national leadership.

In their article of 2004, Allen and Heald (2004) provided an explanation why preventive efforts were not improving the situation. They argued that the open acceptance of international intervention strategies, based on voluntary testing, condoms promotion and general human rights approaches, were facing enormous social constraints, and eventually being counterproductive (Ibid.: 1152). As the epidemic’s mortality was increasingly becoming visible to the public’s eyes, “more coercive measures [were] being advocated and even then in the face of intense opposition from outside agencies” (Ibid.). Since 2004, numerous projects – some of them funded under the auspices of PEPFAR – have been launched in several fronts, but there is a strong lack of certainty among interviewees of ‘what works.’ In other words, assuming that there are ongoing programs which prevent transmission, one does not know exactly which actually work given the lack of measurement of impact. Nonetheless, what is taken for certain is the central role of the state/government in this process today and in the coming future. This centrality is expressed not only in terms of funding largely interventions, such as the ARV program, but also with

regard to formulation and enforcement of policy, including “draconian measures” (Ibid.) of surveillance that may undermine logics of human rights associated with HIV/AIDS, such as patients’ volunteerism. Despite the external constraints that Allen and Heald allude to, the national government is the main institution in charge in this realm, thus reproducing the traditional understanding of public health politics as a realm of the national state.

7.3. Ethiopia’s Rising Developmental State

The current ruling party in Ethiopia is the Ethiopian People’s Revolutionary Democratic Front (EPRDF), an assemblage of regional parties²⁶ that, under the leadership of the Tigray People’s Liberation Front (TPLF), combated and eventually ousted through guerrilla warfare the military regime of the Dergue in 1991.²⁷ Reasons motivating regime overthrow were the disastrous Soviet reforms, which imposed new cycles of famine and immiseration, as well as the so-called “national question” (Vaughan, 2003: 40-80). In a historical context of internal colonization led by the major Ethiopian ethnicity, the Amharas, over other ethnicities, whose power stretched back to the emperorship rule, the Dergue regime was not eager to concede in its “monolithic” (Berhe, 2004: 574) understanding of the Ethiopian nation and arguably rejected any alternative solution to the complex ethnic reality of the country.

²⁶ In the aftermath of the Dergue’s deposition these included, apart from the TPLF, Afar Liberation Front, Benishangul People’s Liberation Movement, Islamic Front for the Liberation of Oromia, Issa & Gurgura Liberation Movement, Ogaden Liberation Front (Horiale), Oromo Abo Liberation Front, Ogaden Liberation Front, Sidama Liberation Movement, United Oromo People’s Liberation Front, and Western Somali Liberation Front (Vaughan, 2003: 28).

²⁷ The Dergue was a regime established in 1974 in the aftermath of the overthrow of Emperor Haile Selassie. The process of overthrow began after civic protests against his absolutist rule, rising capitalist exploitation of the land, and incapacity to address several famines affecting the country.

As the Dergue's leader Haile Mariam Mengistu is driven out of power and forced into exile (in Zimbabwe, where he still lives at time of writing), the country's liberators proposed two fundamental policy frameworks for a new Ethiopia. The first is a political-administrative formula called "ethnic federalism," in which the country is regionally divided along ethnic lines, in order to respond to historical ethnic grievances. Nevertheless, the current political era has been considered by many analysts not far from a continuation of absolutist modes of rule, and regional opposition to the leading post-conflict formula of "ethnic federalism" persists. Often, this has involved armed means against the central government in Addis Ababa. The second is economic development. The main inheritor of the TPLF, the EPRDF, has been in power uninterruptedly since 1991. Its consecutive governments have put several five-year development plans over the years. Considering the low base of development the country finds itself in, these plans have received large assistance from the main international donors and lenders. One of the latest relevant programs of assistance was the World Bank's Poverty Reduction Strategy Program of 2002/3 (Ministry of Finance and Economic Development, 2006).

The current Growth and Transformation five-year plan was launched on December 2, 2010, and strives for the establishment of industry by 2020, building on double digit growth rates of recent years (Hassen, 2010). Although the accuracy of those rates is highly disputed by the political opposition and even the International Monetary Fund (Teklehaimanot and Asfaw, 2010), they animate the government's latest endeavour: the construction of the Millennium Dam on the Nile Basin entirely

with national funds.²⁸ In addition to this developmental project, the government has been running a process of “cheap” leasing of vast masses of land to foreign companies, mostly of Indian, Chinese, Pakistani and Saudi origin (Mariam, 2011). The minister of agricultural development has claimed “we [the government] hope that big commercial and intensive farms will solve the shortage of food in Ethiopia” (Ibid.). This policy indeed happens in a context of continuous need of food assistance, which, despite the impressive growth, still affects sectors of the population and has led the government to repeatedly call for external assistance (IRIN, 2011).

The principles of social mobilization of the masses of Leninist-Stalinist inspiration, acquired and developed by the TPLF during the armed struggle against the Dergue, are now being transferred to the developmental purposes of the EPRDF (Vaughan and Tronvoll, 2003). The party’s symbol is a bee, and it serves to illustrate how the party wants the Ethiopian peoples to be: united, sovereign and very laborious. These ideas have seeped into Ethiopians’ imaginary, shaping the vision they have of themselves. This was visible, for instance, when interviewing an EPRDF’s youth league member in May 2010, at a campaign booth in Arada, an Addis Ababa sub-city,²⁹ during the latest federal elections’ campaign. As she showed

²⁸ The strategic importance of the gigantic Millennium Dam is threefold. First, it responds to the demands of power supply that national development plans require. Ethiopia, notably its capital city, is often affected by power cuts during day and night that undermine business life, particularly for those without electricity generators. Second, it serves as an example of national commitment to a great cause, since the Dam is aimed to be primarily funded by domestic resources, despite the fear of a dramatic inflationary pressure (Giorgis, 2011). And finally, it challenges a historical geopolitical complex of inferiority with regard to Egypt, whose potential forceful intervention in Ethiopia in case of modification of the Nile water’s regime has long constituted a source of fear for Addis Ababa’s leaderships.

²⁹ Sub-city is an administrative division within a city in Ethiopia.

photographs depicting road improvements in the area and school children and adults attending HIV/AIDS awareness raising events, she argued

Our government believes every Ethiopian is capable of working, no matter little skills he might have, as long he is not disabled. We took many jobless people away from the roads and put them working. First we give them training and then we pay them 200 Birr [cc. 11 euro] per working day. The more a worker works the more he will earn. So if he is hard-working he can get 2 000 Birr or more a month. These are all Ethiopians. We believe everyone is capable of earning their money without assistance from anyone. We tell people not to give money to beggars. (Interviewee 31, 2010)

In turn, according to the EPRDF's leadership, abolishing poverty is the ultimate target of the current developmental enterprises. The fight against poverty is an argument recurrently used to contend political opposition.

The EPRDF has been underscoring the fact that poverty is the main enemy of the country and there is no worse enemy than poverty. Thus we have to beat poverty as quickly as possible and wage relentless battle against poverty since there is no lofty war than the war on poverty. Ethiopians should also benefit from every growth in proportion to the sacrifice they pay for growth and the yield obtained. The growth should therefore be rapid, sustainable and fair. By implementing these, we should quickly reduce poverty. [This] was the line of argument of the EPRDF which was countered by the opposition who could not understand the urgency of the call as poverty has been living with us since eternity. (Walta Information Centre, 2011)

The plan accounts for improvements in terms of social development, including the health dimension (Hassen, 2010). Although the Ethiopian government is highly dependent on external funding in the area of health, the ministry of health's reports emphasise the centrality of a "country-led" approach in policy-making, management and implementation while simultaneously acknowledging and committing to such external frameworks like the Millennium Development Goals (Federal Ministry of Health, 2008). This prospect of "country ownership" is widely shared by the Minister of Health Tedros Adhanom, who was also the chair of the board of the Global Fund until September 2011 (Center for Global Development,

2010). Respondents with two major United States implementing agencies – one governmental and another nongovernmental – have recognized the Ethiopian government's ownership at the level of planning but faulty in terms of funding the efforts' consolidation. According to the former,

The government has good policies and they have discipline to implement, something other governments of other countries do not have. (...) They have a lot of ownership. They have a plan and know where to go. This is my understanding of ownership: having a plan. Other countries do not even have that. But they will hardly be able to fund by themselves. They cannot even pay salaries. (Interviewee 1, 2010)

In turn, the latter respondent argued

[In] terms of ownership, [national] government agencies are keen to lead the process and enjoy taking credit for it. "We did this, we did that." They rarely give partners credit for achievements. But when problems occur they call partners to fix them and do not do it themselves. We are often called to fix problems we are not obliged to, and when we refuse to do it, they just leave the, say, machine, road, etc., abandoned. They always claim they ran out of funds. (Interviewee 3, 2010)

On the same matter, an Ethiopian interviewee with an Ethiopian NGO gave a nuanced reaction, yet concurring with the latter two.

We still need support from foreign governments because we are poor. Most of our activities are donor-dependent. (...) The idea is that Ethiopia will be independent from foreign aid in the future, but I do not know... I am not a politician, and I do not want to talk about it. (Interviewee 4, 2010)

According to the latest Health Sector Strategic Plan for 2005/6-2009/10, the ministry of health has ascertained clear policies in several areas: health service delivery and quality of care; health facilities construction and rehabilitation; human resource development; pharmaceutical services; information, education and communication; health management and management information system; monitoring and evaluation; and health care financing (Federal Ministry of Health, 2005). The comprehensiveness of the Ethiopian health plan seems to match what the

interviewee with a United States government agency quoted above has called PEPFAR's "wrap-around" character in Ethiopia (Interviewee 1, 2010). PEPFAR has been funding activities in a multitude of areas: treatment, support to orphans and vulnerable children, family planning, training of health personnel, and even refugees and food aid (Ibid.). The launch of the Global Health Initiative (GHI) of the United States government has rendered Ethiopia, precisely for this comprehensive nature of implementation, a "GHI plus" status together with other seven countries. As two interviewees with the United States government affirmed (Interviewee 2, 2010; Interviewee 1, 2010), this propensity has had to do with the very low base that current efforts build upon. After all, despite recent commendable improvements in the African context (Reuters, 2010), Ethiopia is still the 13th least developed country in the world, according to the latest Human Development Report (UNDP, 2010), with a population of around 80 million people.

As mentioned in the previous chapter, even during the Dergue, in which the politics of the Cold War put the United States of America and the Ethiopian regimes in adversarial camps, the Ethiopian government has seized opportunities deriving from United States foreign policy agendas (humanitarian or geopolitical or both). Apart from the geopolitical situation of the Horn of Africa, it can be argued that the latest 'opportunity' has been precipitated by HIV/AIDS and its forecasted implications notably in terms of the linkage between HIV/AIDS and security. A decade ago Ethiopia was considered a country belonging to the "second wave of the HIV/AIDS epidemic" (Schneider and Moodie, 2002), after the "first wave" of hyper-endemic Southern Africa. Ethiopia sat together with other countries with large populations with regional security status, such as Nigeria, India, China and Russia.

However, the epidemic is of relatively small proportions, 2.1% of prevalence rate among adults (WHO, 2010: 32). Still, it represents an absolute number of close to 1 million people. Nonetheless, the opportunity seizure has to do be understood in a context of commitment to developmentalism as state ideology and practice, actual allocation of state resources to human development, and articulation with different ‘new partners’ beyond the traditional Western European and Northern American donors. A recent manifestation of such commitment consisted on “a record 117.8 billion birr (6.98 billion USD) annual budget for next year, aiming to build infrastructure, health and education services” (IOL, 2011).

Apart from the question of financial sustainability, another constraint (an eventual consequence of that) concerns the limited presence of the state in the provision of services, especially in the rural areas where 82% of the population lives (World Bank, 2011). Despite the investment in health extension programs by the state, those who still have more influence in questions of health and disease are religious institutions, particularly the Ethiopian Orthodox Church and Islam, followed by other Christian denominations, such as the Catholic Church and a number of Protestant Churches (United States Department of State, 2011). Considering the policies around family planning in particular, the largest denominations and the Catholic Church pose obstacles to the dissemination of birth controlling services, namely those based on condoms. Family planning, which has been enhanced with the Obama Administration, is seen by several PEPFAR stakeholders as a solution for what is perceived as a major impediment to Ethiopian development (Interviewee 5; Interviewee 6; Interviewee 7). Several implementers work in vicinity with major religious churches with an aim to sensitize their

positions. The quest for implementing family planning in Ethiopia has long been contemplated, but always failed to materialize, as an Ethiopian senior professional with a United States-based NGO has declared: “Family planning started a long time ago, still in the time of Haile Selassie [1960s], but it did not go forward because of lack of resources, not political will” (Interviewee 7).

The problem of the limited presence of state institutions in the provision of goods and services in the area of health has to do with broader question of the state assuring actual control across the vastness of the country, and the persistence of regional movements struggling for further autonomy, if not independence from Addis Ababa. Anti-governmental armed opposition occurs in some parts of Oromia, the surrounding region of the federal capital city Addis Ababa, and the eastern region of Ogaden, neighbouring Somalia, suggest that the provision of health services by the federal state to the local populations is very limited. As a result, this situation constrains the developmentalist ambition of the national government, but at the same time draws attention to the question of survival of the political regime, in which the broader foreign policies, discussed in the previous chapter, together with domestic developmentalist ones aim to ultimately serve.

7.4. (South) African Renaissance At Home

The South African governmental response has been different from the two previous cases. Rather than engaged responses explained by concerns for national self-help, survival and development, the South African case reflected idealist foundations of African Renaissance home and abroad, especially during the crucial

Mbeki presidency. The idealism of that presidency cuts across the entirety of the post-apartheid period, and is embedded in the rhetoric and practice of African Renaissance that home and abroad seeks to elevate the dignity and potential of the postcolonial African. As a project, African Renaissance proposes aid and economic-based incentives as well as symbolic perspectives of African rehabilitation and world empowerment (Taylor, 2005).

As an epidemic affecting mostly the African continent, while treatment remains mostly a Western property, HIV/AIDS was framed by Thabo Mbeki himself and his Minister of Health, late Manto Tschabalala-Msimang, as a question of racism and prejudice against Africans by the West-led international community. As explained in the previous chapter, despite alternative explanations,³⁰ Mbeki's position, domestically and for the rest of Africa is aligned with the liberal-idealist politics of post-apartheid African Renaissance. Eventually, the government reduced and suspended treatment programs, which were only reinstated following several court decisions, and refused foreign assistance (Youde, 2005b). The court cases were initiated by a South Africa-based movement of contestation against the denialist position of the President (Oshry, 2007). Currently, not only 'denialism' has been publicly dismissed, but the opposite direction is actually pursued. Last year President Zuma announced mass VCT campaigns, after he had himself taken an HIV test. This was observed as the burial of denialism by the South African government (Mail & Guardian, 2010). At the latest International AIDS Conference, Minister of Health Aaron Motsoaledi reiterated this policy change, expressed commitment and requesting assistance from foreign donors (Motsoaledi, 2010). A recent public event

³⁰ See Lieberman (2009).

with Minister Motsoaledi in Washington, DC, was, as a participant exclaimed, “a celebration” of the South Africa’s renewed exemplary pledge (Motsoaledi, 2011). As also previously argued, this new position of the South African government reveals, again, liberal-idealism. It is visible not just in terms of engaging with the international community *per se* but by also by paying particular attention to the realities of poorer (than South Africa) countries in Africa.

Since the beginning, the process of PEPFAR’s implementation in South Africa has reflected the shifting dynamics of the national governmental policy and the relationship between national governments and the mainstream HIV/AIDS epistemic community. Therefore, PEPFAR’s early establishment was constrained by the context of opposition between the state/government and the nongovernmental arena, but the situation changed. Interviewees with different types of organization – South African and United States-based governmental and nongovernmental – have converged on the idea of initial mistrust between the national government’s leadership and PEPFAR’s policies, which has evolved overtime. NGOs have been those who most insisted on that idea. One respondent has claimed that

In the whole, in the beginning, there was a big problem. The government did not like [the offer of assistance] very much, because PEPFAR partners and the government were doing the same thing at the same time. This generated big delays. Government officials were not sure if they wanted PEPFAR or not. Now there is more involvement of the government. (Interviewee 19)

Another interviewee commented on the differences between the Mbeki and the current Zuma periods.

Government attitudes have changed dramatically. Now it is easier with Zuma than with Mbeki. In Mbeki days, civil society and community-based organizations were fundamental in confronting the adversarial attitude of the government. The new government now admits they need help. (...) Before PEPFAR there was no money. PEPFAR put money in.

However, PEPFAR had no framework for engaging with the government. They did not get along. Both were doing different things. NGOs were lying in between trying to do subterranean things, trying to escape government punishment. But now it is different. (Interviewee 20)

Another respondent reiterated the previous idea: “Collaboration with the government was a big obstacle in the beginning. But this issue has been addressed overtime.” (Interviewee 21) A fourth and a fifth interviewee reiterated the same opinion.

In the beginning, it was not very well coordinated between the South African and the United States governments. Two parallel roads. (...) But it got better over the last years. (Interviewee 22)

In the beginning, PEPFAR was much more about funding NGOs, namely American, and universities like Columbia. PEPFAR officials did not consult much the government. Back then, the government was holding a very strange position. Mbeki and the minister of health were negating the HIV and AIDS link and the whole AIDS ideology. (Interviewee 23)

However, as remarked in the previous chapter, so the partnership could begin, the South African government subscribed to the United States government’s proposal; otherwise PEPFAR could not be launched. Still, a South Africa National AIDS Council member organization, who is an ANC affiliate too, gave a comment with large political significance, which is also reflective of how the governmental position *vis-à-vis* HIV/AIDS evolved over time. Moreover, it looked at how PEPFAR failed, in her opinion, to reach major stakeholders like local political leaders.

I am an ANC member and in the beginning PEPFAR was in opposition to the [ANC] government. PEPFAR arrived in South Africa and wanted to enforce its own thing. We, civil society (sic), were not getting any support from PEPFAR for our projects at the community-based level. But more recently PEPFAR people realized they have to work with the communities. I am a councillor, and I am representing my community, and I did not see any support. Support was being given to the University of Natal, which was doing its stigmatizing work in black townships. They just go to Umlazi to do their research and analysis. Why do not they do that work in Glenwood and other white areas as well, and just confine

themselves to black areas? (...) Before 2003 we were in a state of denial. In the beginning, AIDS was seen as an African disease, but now we realized that it is out there and we have to act. (Interviewee 25)

The recent swift in the governmental policy for HIV/AIDS is also contemporary to a broader policy around development in the country. This is moreover coincident with a propelled left-leaning behaviour of the government after Mbeki's rather liberal approach to the issues of economic empowerment. Like Ethiopia, South Africa sets out to be a 'developmental state.' However, in South Africa, this orientation has not been so much a matter of enabling and feeding a process of economic growth and human development alone, but a question of conciliating that process with redistribution of wealth and social justice. Due to the regime of separate development instated by the National Party in 1948, which, drawn along ethnic lines, essentially strongly enhanced life opportunities (education, health, work) of a predominant minority (mostly of European descent) at the expense of a majority (mostly black). In practice, this system, which inherited many colonial elements, still finds continuities today, and generated diverging lifestyles of developed country-type for the upper-middle classes and developing country-type for the lower classes (Bond, 2004). Today, seventeen years into the end of the apartheid regime after the first multiracial, democratic presidential elections in 1994, South Africa is one of the most unequal societies in the world, resembling countries with similar historical trajectories like Brazil or Mexico. As a result, the ideology of the developmental state has emerged with an aim to redistribute wealth across society, restore justice and generate opportunities for historically disadvantaged social groups, such as Black Economic Empowerment initiatives. Nevertheless, despite the current Zuma Administration's endorsement of a more state-interventionist approach,

on the ground, the latest years have been featured by notable riots and protests by residents in townships and informal settlements for the absence of service delivery, leading to violent clashes with police forces, in a context of mounting unemployment, especially among the youth (Habib, 2005).

Several studies have linked the proliferation of HIV/AIDS to social determinants rooted in the apartheid regime and the current social condition of many South Africans and foreigners living in South Africa, notably the lack of medical assistance and forceful migrations (Hlongwane, 2003; Johnson, 2004; Marks, 2002). South Africa holds the fourth highest prevalence rate among adults (15-49) in the world, with 18.1% (WHO, 2010: 32), after neighbouring Swaziland, Botswana and Lesotho. However, only 28% of people with advanced HIV infection receive antiretroviral therapy, at a much lower position than Botswana (79%) and even Swaziland (42%) (Ibid.: 35). The population of South Africa is of 48 668 000 inhabitants (Ibid.: 164), meaning that a very large share of the population is not only infected but moreover affected by the pandemic. This includes adults and those dependent on them, notably children, as well as their own parents, who often have to be in charge of their grandchildren when parents fall ill and eventually die younger than expected (Bray, 2003; Tobin, 2010). Like in the case of Botswana, grim scenarios about the potential social, economic, and even security consequences of the pandemic have been put forward, particularly from the late 1990s on.

Although the government funds up to 80% of the overall response, PEPFAR has played a significant role in both quantitative and qualitative terms. South Africa has been the major PEPFAR focus country, and its focus areas have been very

diverse: medical research, treatment and palliative services, orphans and vulnerable children, and prevention through the ABC approach, among others. Whereas some organizations' work scope deals only with HIV/AIDS and correlative epidemics, like tuberculosis (for instance, medical research institutions and laboratories), many others have a wider developmental agenda upon which PEPFAR projects build. This was particularly visible among secular and faith-based development NGOs whose income generation activities for populations (primarily HIV-affected) living in historically disadvantaged areas, such as townships and informal settlements, together with facilitating access to social grants, especially by children, aimed at addressing the lack of economic opportunities and social security (Interviewee 44, 2009; Interviewee 45, 2009).

However, the government faces the dilemma of having to sustain the response after PEPFAR and other big donors leave. One encountered two types of reaction to that question, though. One type is eminently economic, and refers that sustainability is dependent on the economic recovery after current days' recession. Several interviewees argue, along with Minister Motsoaledi himself (Bryson, 2010a), that the government will not be able to take charge of the PEPFAR-initiated projects, due to the propelled economic downturn. Yet, another type of reaction is of rather ethical/judicial nature. For other stakeholders, sustainability is a matter of the government complying with its 'constitutional' responsibility of providing care for the humans living within the countries' boundaries, and thus allocating resources accordingly. This perspective is observable in this interviewee's comment about PEPFAR and the South African national response.

PEPFAR has (...) filled gaps in the South African HIV policy providing ARVs to groups including illegal immigrants and refugees. However

these groups should be able to receive treatment from the DoH [Department of Health] because constitutionally all people in South Africa are entitled to healthcare, not just citizen and residents. (Interviewee 28, 2010)

This respondent claims that PEPFAR has addressed a matter that the South African government should obligatorily do.

7.5. Conclusion

This chapter has discussed the way that PEPFAR interrelated with domestic policies of the three countries not only in the area of HIV/AIDS and health but national development as a whole. It showed how domestic policies contribute for the state's external behaviour described in the previous chapter. Whereas in the case of Botswana and Ethiopia, governmental action reflected a concern for survival, the South African situation reveals the will of transmitting pan-African values that target publics both inside and outside the country. However, as noted previously, Botswana's realist thinking is different from Ethiopia's, since the former acts in function of the survival of the nation conceived as population and the latter in function of the political regime's existence.

In the case of Botswana, the threat to the nation is expressed in terms of the large prevalence rate of HIV/AIDS, particularly among the adult population. Moreover, intervening for the sake of the population's survival represents the salvation of the whole developmental effort since the independence, apart from the political goal of terminating dependency from external donors for development purposes. That goal was accomplished in the 1990s, but had to be reverted, since

external donors, particularly the United States of America, were found needed to assist with the country's struggle against the epidemic. Since 2001, the national government, with assistance from public and private donors, has largely committed to a massive treatment program. From a 'country ownership' perspective, Botswana represents a successful case, since the state is funding up to 80% of the effort. Conversely, PEPFAR offers, primarily, technical support in prevention and other areas conceived as goals for the current five-year period of PEPFAR's implementation, centred on sustainability through country ownership. However, the recession that is affecting the international trade of Botswana's most crucial asset – diamonds – is worrisome, and is posing serious challenges to policy-makers in terms of how to conciliate different agendas. In this regard, despite external pressures, as suggested by Allen and Heald (2004), one is convinced that it is primarily dependent upon national political decision how to keep responding to the emerging issues associated with the epidemic and trade.

Compared to Botswana, the case of Ethiopia is more focused on the question of the political regime than on the population. The current governmental leadership of the EPRDF has been faced with challenges related to the political regime, posed by regionalist movements, and to the level of human development, which is still very low. The ruling government's developmentalist ideology and policy includes the provision of health goods and services, among other dimensions. PEPFAR has been integrated in the Ethiopian effort as a "wrap-round tool", since it covers manifold dimensions, beyond strict HIV/AIDS. In fact, unlike Botswana, this epidemic is not extremely dramatic in relative terms, although still affecting close to one million people. Planning capacity of the government is observed as an example of

ownership. However, the country is still highly constrained financially and in terms of actually being able to provide health services all around that immense country. Nevertheless, geopolitical issues regarding the threat to territorial integrity combined with humanitarian and developmentalist purposes consolidate the recipient status of the current regime. This reproduces the pattern from the 1980s, in which, despite the diverging politics of the Cold War, then-Ethiopian regime, the Dergue, and the United States of America maintained a relationship of cooperation. As such, despite strongly constrained externally in financial and policy terms, the Ethiopian government maintains its autonomy of action.

Finally, the part on South Africa looked at how domestic dynamics of policy change impacted on PEPFAR's implementation in the country throughout the years. The idealist politics of African Renaissance grounded Mbeki's scepticism on the HIV/AIDS orthodoxy's intentions on how to address the epidemic in his country and around Africa and the parallel search of 'African solutions for African problems.' As a result, PEPFAR's implementation at the crucial level of inter-governmental relations was faulty. Yet, after Mbeki, when policy changed, the HIV/AIDS orthodoxy was accepted, and the government started to reengage, the values are still present. Currently, this response – upon which PEPFAR sits importantly, as South Africa is the main recipient – is also integrated in broader developmentalist efforts.

In fact, compared to the case of the northern neighbour, Botswana, only quite recently the government engaged more deeply in terms of resource allocation, in the response to HIV/AIDS. The reason why this occurred is arguably explained by the differing politics that framed the two countries' governments' behaviour. Whereas Botswana was driven by the concern for survival of its small population of less than

1.5 million, the South African government uses its relative powerful position to transmit specific values and positions, through the HIV/AIDS realm, to its domestic and external publics. In the latter case, the content of those positions changed, but the framework did not, both when showing scepticism or endorsing mainstream HIV/AIDS science.

The next chapter looks at the local level of inter-state relations. It addresses the question of values and ideas embedded in national-governmental practices and their outcomes, and its interrelation with PEPFAR's implementation.

Chapter 8 – Local Dynamics

8.1. Introduction

This is the final chapter of a series of three that analysed the agency of the governments of Botswana, Ethiopia and South Africa in the context of inter-state relations with the United States of America under the implementation of PEPFAR. Whereas the first and second chapters looked at the international and domestic levels of inter-state relations, and, conversely, their link to broader foreign and domestic policies, this one assesses the local dimension. By ‘local’ one means the actual political and juridical practices pursued by the national governments, and the manner they consolidate specific values and ideas of social organization within their societies. The difference between the domestic, as well as the international, and local levels concerns the primacy of the object under analysis. Whereas the first and second chapters concentrated on policies with foreign and domestic scope, this one focuses on the practice and outcomes of those policies.

Proceeding from the previous two, this chapter aims at demonstrating that the national governments hold autonomy of action in practical terms. Moreover, it shows that the values and ideas underneath those practices either inhibit or reinforce the implementation of the leading international structure’s values and ideas. At the same time, the *locus* of implementation allows for looking at the contradictions that often arise from those tensions, especially in terms of constraints to action outside the realm of the state, social inequalities, and poverty of segments of the population. Considering this dissertation’s case study, values and ideas revolve around liberal

political and economic frameworks transmitted through PEPFAR, and their local political translation.

This chapter is divided into three sections, and maintains the same structure as in the previous two. The first section reflects on the problem of Botswana being characterised by a large degree of poverty and social inequalities despite having witnessed impressive economic growth in the last decades as a result of a developmental state endorsing liberal values. The second section addresses Ethiopia's ruling party's politics and the socio-political pressures toward liberalism in the country. Drawing on a number of interviews with PEPFAR implementers it discusses in particular the impact of the so-called 'Charities Law of 2009' on their action. Finally, the last section discusses South Africa, whose experience with liberal approaches to development derives from a domestic process of political change at the end of the apartheid. The South African experience offers a rather matured version of a liberal polity that precedes the contemporary set of external interventions, such as PEPFAR, at the level of values and practices.

8.2. Social Disparities in Botswana

The previous two chapters emphasised the developmentalist character of the Botswana state since the time of independence, and whose achievements have been recently challenged by the rampant social impact of the HIV/AIDS epidemic among significant shares of the population. It also shed light on the particular manner the international community, especially the West, has constructed, both academically and politically, the country as an "African model" or "African miracle." Those inputs

drew mostly on a mainstream body of domestic and international authors on development politics who have looked at the major macroeconomic wonders of the country. They particularly highlighted the governance capability of establishing a profitable partnership, Debswana, with a mineral resources giant such as De Beers, aimed at exploring diamonds in the country, and applying revenues in crucial national development initiatives (White, 2006; Picard, 1987; Schraeder, 1994; Acemoglu et al., 2003). At the same time, Botswana leaderships have maintained since the mid-1960s preferable – even if not exclusive – relations with the major Western countries, the United States of America and, principally, the United Kingdom, and as such attachment to liberal values, representative democracy and a market-based economic system.

The connection to liberal values throughout the post-independence period is of particular relevance. On the one hand, as mentioned in the previous chapter, the transition to independence was a soft process led by the same elite – local and colonist – of the time of the British Protectorate of Bechuanaland. As such, in principle, and considering that the United Kingdom constituted the most important development donor for many years after 1966, the embracement of liberal values would be somewhat expectable. However, considering how the region surrounding the country was ridden by rather ‘extremist’ politics on both sides (from the ‘leftist’ movements of liberation around the Southern African region to the ‘rightist’ South African apartheid regime), it is interesting to observe that the Botswana regime retained its liberal principles, no matter how weak and vulnerable it was, particularly until the formal end of apartheid. Botswana has basically remained a liberal country, even if at times constrained by the necessities of assuring the country’s self-help and

pressures by traditional leaders and leftist parties such as the Botswana National Party. However, the adherence to and practice of political and institutional liberal and developmental values does not mean the disappearance of contradictions in that process. As such, this section deals with a body of literature that critically assesses the achievements of the ‘Botswana miracle.’

Despite the impressive economic growth, structural social and political change was limited. According to Ellen Hillbom (2008), this framework is typical of “pre-modern growth,” in which a highly profit-making mining industry coexists with enduring forms of land tenure based on cattlemen and poor, subsistence agricultural practice. Employing Kuznet’s model of modern economic growth (Ibid.: 193-195), Hillbom argues that Botswana only matches two out six requirements for being a modern economy, i.e. “high rates of per capita and population growth, and high rate of productivity” (Ibid.: 194). From a technological point of view, Botswana has been stranded in low levels, especially in the agricultural sector, and with the exception of the mining industry (Ibid.: 195). At the level of the manufacturing sector, very little expansion has happened. Indeed, although supermarket and household lifestyle culture is booming in Gaborone, almost all products (except meat and milk) are imported from neighbouring South Africa. National production remains low, and Botswana remains a very subsistence-based society. This scenario is particularly bleak now, as the mining industry has peaked and has been tending to stagnate and decrease (Interviewee 29, 2010).

The registered high growth has not had the same repercussion in terms of decreases in poverty and unemployment. In fact, whereas the richest segment of society has grown richer, the poorest has even got poorer (Ibid.: 206). Arguably, that

is the outcome of ingrained historical socio-economic disparities deriving from pre-independence (Ibid.). In addition to this, social change through the emergence of a challenging civil society is occurring frailly. Two explanations are concurrent. One, alluding to the experience of all neighbouring countries, Botswana did not undergo high levels of political-economic conflict to the point of generating struggle organisations of alternative ideological inspiration. Another echoes some Ethiopian features discussed above, and argues that civil society “is readily co-opted into state structures (...) and is prepared to work within the parameters deemed permissible by the state – and not beyond” (Molomo et al., 2007).

Given the extraordinary mobilization around the HIV/AIDS epidemic, the experience of non-state organizations working in that realm is very useful for a political analysis. One of the reasons *inter alia* advanced to explain why prevention initiatives from the late 1980s thru the 1990s did not deliver positive results had to do with the non-involvement of traditional doctors, churches and local communities (Heald, 2005; Allen and Heald, 2004). These reasons are reportedly present and remain very challenging as two interviewees with PEPFAR implementing organizations emphasised. One, with a United States-based NGO, held that not only civil society, i.e. non-state organisations, have to be incorporated but also need to be taught how to intervene as such.

Skills are necessary to be given. We face the double challenge of having to implement and train people at the same time. People are used to receive from the government, but they need to change their mindset. Civil society has to take its role. (Interviewee 8, 2010)

PEPFAR has in fact been acting in terms of funding training activities, and the issue of civil society is also acknowledged by a respondent with a United States government agency: “Botswana is a middle income country. It offers good facilities.

People are trained. However, civil society is not part of the local culture.” (Interviewee 10, 2010) Yet, an interviewee with a Botswana governmental ministry also stressed the need for change in this area, and acknowledged PEPFAR’s role in it: “Without PEPFAR no CSOs [civil society organizations] would develop. It is assisting in building capacity for them. I worked at the district level, and what was working was peer-education by CSOs. They were important in mobilizing people.” (Interviewee 18, 2010)

Regarding the participation of outside-state organizations, nongovernmental organizations and networks dealing with youth, church attendants and other publics were allocated participative roles within PEPFAR’s partnership framework’s division of labour. Available scholarship tends to divide itself into positive and negative assertions, in turn depending on the overall appreciation of the outcomes of modernization and development in the country. Whereas endorsers of the idea of Botswana as a ‘model’ enhance the striving and free character of civil society in the country (Holm et al., 1996), critical evaluations tend to emphasize its redundancy in the context of a dominating state (Taylor, 2003; Good and Taylor, 2008). But some other studies seem to diverge from these polarized perspectives too. Kiley and Hovorka’s (2006) study of civil society organizations in the HIV/AIDS response underline their marginalization by the state-led response for different reasons: “geographical disparities, lack of financial and human resources and socio-cultural elements associated with HIV intervention strategies” (Ibid.: 176). They argue that when better integrated and assisted they could improve the response. Attempting at finding reasons why prevention has been recurrently failing, Strain (2008) argues along the same lines. However, one’s enquiry – which did not look for reasons why

prevention is failing, but how implementation happens – has identified a double pattern. On the one hand, civil society, notably the one funded by PEPFAR, is very collaborative with the state; with few exceptions, NGOs are not challengers of the norms imposed by the Botswana government (and the United States government for the same reason). Yet, on the other, the international integration of local NGOs and similar entities with transnational, often United States-based institutions, offers learning experiences which allow them, at least on paper, to adopt the liberal approaches and ideas disseminated across the PEPFAR apparatus. As such, within the constraints of a pre-modern economic growth society, they become sites of globalization and modernity. Also in this regard, civil society organizations in Botswana ought to be an exemplar model for others to follow.

Some NGO implementers have highlighted health indicators that emerge from a context of ongoing inequities and that PEPFAR-funded activities have helped to identify. One interviewee compared Botswana's health performance to neighbouring countries. "Non-HIV indicators are poor. The infant mortality rate is very high. It is very similar to Lesotho and Swaziland, and yet Botswana is so much richer." (Interviewee 29, 2010) Another focused solely on the country: "Here in Botswana mortality rate in general is still very serious." (Interviewee 12, 2010) However, a third implementer has shed light on a further health agenda: "So many areas are in need such as non-communicable and mental diseases. Botswana has a very high rate of suicide, for example." (Interviewee 11, 2010) Yet, on state-society relations, the interviewees seem to confirm Molomo and colleagues' quotation above, as they generally find themselves aligned with the state-led framework. This also suggests the paternalistic character of this policy, in which the state drives an

almost exclusive top-down biomedical approach (the treatment program) without incorporating and empowering its citizens. Furthermore, the perceived unsustainable nature of this approach is fed by the propelled '*nouveau riche*' attitude of the state elites, whose recent wealth has allowed them to invest 'luxuriously' in facilities and technologies that end up being barely maximized by professionals and clients, while, at the same time, there are clear indications that the national income is severely at risk in the post-diamond future (Interviewee 28, 2010).

Particularly since 2008, after the direct nomination by former President Festus Mogae of the current President, Lieutenant-General Ian Seretse Khama, a consolidating shift towards "liberal authoritarianism" (Molomo et al., 2007) has been occurring through the introduction of senior military staff in the civil service. Apart from that, extra-judicial killings and increasing levels of corruption among the elite have been reported by the media (Mmegi, 2010; Bryson, 2010b; Direng, 2010).

Recently, a major split within the BDP led to the formation of a new political party, the Botswana Movement for Democracy. Although these developments indicate a political change in Botswana at odds with the mainstream analyses, the basic liberal-institutional character of Botswana's postcolonial political regime seems to remain.

8.3. Disciplining Society in Ethiopia

The Ethiopian People's Revolutionary Democratic Front's (EPRDF) government in Ethiopia has been committed to the establishment of a state that is not only developmental, as discussed in the previous chapter, but also democratic and

inclusive of all Ethiopian peoples and nationalities. This was the promise made in 1991, when the alliance of movements that founded the EPRDF ousted the Dergue regime, accused of dictatorial and genocide policies between 1974 and 1991. After the change of regime the new government in Addis Ababa has sought to obtain large amounts of funding from the international community with the goal of helping economic and political reform.

However, according to foreign observers and opposition politicians, this has found limited support in reality (Human Rights Watch, 2010a; Aalen and Tronvoll, 2009; Epstein, 2010). The EPRDF has been ruling the country since 1991 without interruptions, and often resorting to illiberal measures that stretch from police and army violence to subtle, sophisticated censorship mechanisms to keep its power unchallenged (Human Rights Watch, 2010a). The Ethiopian regime is continuing the long tradition of Abyssinian absolutist power (Vaughan and Tronvoll, 2003), although this time around led by more ethnicities than the Amhara, especially the Tigrayan, and under a structure of democratic representation, with regular elections.

Especially over the course of the last five years, the EPRDF has fostered increasing repressive laws that hamper opposition politics and raise limitations to nongovernmental participation (Human Rights Watch, 2010a). This coincided with the aftermath of electoral process of 2005, in which 200 people were killed by police forces during public protests denouncing abusive governmental interference in the electoral process, and the latest elections in 2010, in which the EPRDF has won all but three seats in the national parliament (Press TV, 2010). The leader of the main opposition party running in the 2005 elections, Birtukan Mideksa, was kept in imprisonment for almost five years (Wadhams, 2010). In addition to this, a range of

intelligence measures that involved jamming Voice of America radio broadcasts and censorship of Internet sites with content that criticize the ruling executive and party have been adopted (Catholic Information Service for Africa, 2010). The government has been accused of persecuting ethnic group members assembled around the Oromia and Ogaden Liberation Fronts, considered ‘terrorist organizations’ by Addis Ababa (Davison, 2011). Moreover, great development initiatives such as the Millennium Dam and the land leasing programs affect the lifestyle and income of local subsistence peasants. It is not clear whether those projects and policies actually benefit the local populations or just contribute to their already marginalized socio-economic status. Finally, according to NGOs such as Human Rights Watch (2010b), the massive volume of international aid, namely food and fertilizers for the agriculture, has been allegedly used as a tool for rewarding party loyalty and penalizing dissent.

In 2009, the government issued new regulations on nongovernmental intervention with a potential constraining impact on PEPFAR-funded NGOs, based in Ethiopia and abroad. The goal is twofold. On the one hand, it aims at ensuring accountability and transparency. On the other, it establishes that “charities and civil societies should spend 70 per cent of the fund they solicit in the name of the public on activities to which they are established” (Ethiopian Weekly Press Digest, 2009a). Accordingly, NGOs receiving 10% or more funds from foreign sources are impeded to intervene in politically sensitive areas, such as:

the advancement of human and democratic rights; the promotion of equality between peoples, sexes or religions; campaigning for children’s rights or the rights of the disabled; conflict resolution and reconciliation; work on criminal justice issues. (Ethiopian Weekly Press Digest, 2009b)

Expectedly, this framework was subject to much criticism from the United States Embassy in Addis Ababa (Ethiopian Weekly Press Digest, 2009c) and the political opposition in Ethiopia (Ethiopian Weekly Press Digest, 2009d). It was regarded as another attempt by the government to impede a larger participation in activities that inevitably implicate discussing the issues above.

However, independent of the polemic, only two interviewed implementers declared having conflicts with the regulation. One respondent is with a major United States government agency (Interviewee 1, 2010), the other with a United States-based NGO. The latter had to resort to a strategy of circumvention of the law in order to maintain activities in the country. “We do not speak about rights anymore. But we still do advocacy, although we do not speak in that way” (Interviewee 6, 2010). Yet, other respondents explicitly expressed an alignment with the national government’s legal framework, as they see themselves as part of the government’s developmental policies. One Ethiopian interviewee with a United States-based organization has stated “we always work in line with government policies, in which we assist them in implementing programs” (Interviewee 5, 2010). Another interviewee with the same profile has emphasized the centrality of the government’s policy: “building capacity is an ideal. However, the government does not have capacity for it yet. Civil society still has to assist the government. Otherwise things can go backward” (Interviewee 7, 2010).

The EPRDF’s stance seems to largely continue a trend initiated by former Emperor Haile Selassie in the 20th century. Although attempting at modernizing social, economic and political structures through the constitution of a European type of state and some sort of capitalist exploration of the land, the maintenance of a

regime of illiberal absolutism of self-rule remained and was further nurtured by the Dergue regime (Vaughan and Tronvoll, 2003). The personalization of political life under the scenes of the façade of the modern state before, as cornerstone of the postcolonial African polity, is also found in contemporary Ethiopia, at the very political elite level (Ibid.). Every time forms of out-of-state contestation emerged they were faced with repression, as the leftist and ethno-nationalist movements of the 1960s, 1970s and 1980s – where the very EPRDF's origins are found – experienced. Writing about contemporary state-NGOs relations in the country, Sarah Vaughan and Kjetil Tronvoll argue that

National NGOs have often been the artificial product of the international need for tool to delivery of relief assistance and do not reflect the organic evolution and indigenous consolidation of civil society. (...) Without the experience of a collective struggle to establish its own legitimate space outside the remit of the state, the voluntary sector has lacked cohesion and solidarity, and been overly expectant of the largesse of state or international bodies in facilitating its activities. (Vaughan and Tronvoll, 2003: 62-63)

The EPRDF itself has formed NGOs and development associations (Ibid.: 65-66). In this context, it should be remarked the role of community-based credit and savings organizations, *iddirs* (Mengesha, 2002).³¹ However, it remains to be assessed to what extent *iddirs* do challenge political governance in Ethiopia.

Unlike South Africa, the field of HIV/AIDS has not represented complex, tense and conflicting situations between the Ethiopian government, Ethiopian civil society and the broader international community. One main reason has to do with the relatively small impact of the epidemic in the country and the concurrent most pressing health issues. Another reason relates to the fact that HIV/AIDS, rather than

³¹ Some *iddirs* have been involved in PEPFAR-funded intervention through Save the Children United States in terms of counseling, food donations and financial assistance (Kurata, 2008).

a threat to the government's worldview and historical experience (as in the case of South Africa), represented an opportunity for the Ethiopian government to raise its international profile in the context of national difficulties and great necessity to secure and augment donor support for development (Wallis, 2009). As it happens with the PEPFAR implementers mentioned above, entities representing people living with AIDS are incorporated in the national, government-led response (Federal HIV/AIDS Prevention and Control Office, 2008: 22).

The Ethiopian experience with PEPFAR suggests that an external project of transmission of values – presumably liberal ones – does not bear much fruit once implemented. The Ethiopian polity is still markedly illiberal, and this is visible in the instances given above on political affairs and NGO policies. The bastions of liberalism, advocating civil liberties and free enterprise in the country, are found in institutions engaged in modern knowledge production, such as Addis Ababa University. This is supported by a rising land bourgeoisie composed of land managers and small land owners (Lefort, 2010), and, very importantly, in the Diaspora, especially in the United States of America, where opposition members have been fleeing to. In other words, despite the propelled liberalism within interventionist policies and tools, the ruling government in Ethiopia in practice adapts these external pressures to its own agenda. This is not to say that the government does not still engage with the external institutions, and follow their prescriptions. Nonetheless, it maintains a large degree of control over the impact of those recommendations.

A recent example came after the adoption of an International Monetary Fund-proposed devaluation of the national currency, the Birr, in September 2010. As it

provoked almost immediately inflationary pressure on basic goods, the government decided to protect prices in face of the risk of mass public protest (Ethiopian News Agency, 2011). Another instance happened more recently. In the context of regional protests developing in several parts of the Arab world, including neighbouring Djibouti and Yemen, the government discouraged a planned “day of rage” against it for May 28, 2011, which was the day Meles Zenawi celebrated publicly twenty years in power in Addis Ababa’s major square, Meskel Square (Heinlein, 2011).

8.4. South African Liberal Polity

The case of South Africa accompanies Botswana in terms of the establishment of liberal values in function of domestic choices, although constraints associated with changes in the international system – end of the Cold War, demise of the Soviet Union and United States superpower hegemony – also played a role. The transition from apartheid to multiracial democracy was the result of concessions on both sides (supporters and opponents of the apartheid). One concession consisted on the inflection of the ‘revolutionary’ economic policy agenda of the far-left sectors of the African National Congress (ANC), aiming at the nationalization of the major industries (namely mineral resources) and land reform. The ruling government of the ANC adopted social-democratic politics, with alignment with the Western European Socialist ‘third-way’ parties, who themselves were initiating agendas in their countries after the Cold War based on privatizations and other liberalizing reforms (Bond, 2001). Comparing to Botswana, the South African experience of a much more advanced capitalist, technologically-advanced system, developed during the decades of apartheid, has enhanced a more matured case of a liberal polity. Yet, this

is a polity where the promises of social improvement in the post-apartheid era and the reality of social disparities often contradict each other very intensely.

According to the previous two chapters, the post-apartheid regime under the leadership of the ANC has embraced a liberal-idealist politics aimed at African empowerment through aid, economic opportunities and development, both at home and around the continent. Initiatives such as the Black Economic Empowerment (BEE), on the one hand, and the New Partnership for African Development (NEPAD), on the other, materialize the idea of African Renaissance underneath governmental idealism. BEE favours the inclusion of black citizens in the business world through company creation and management of bigger companies. However, although called “patriotic,” BEE has arguably generated “parasitism” (Southall, 2004) through state sponsoring.

The ANC is rather leaning towards construction of a procapitalist, interventionist state prepared to use its power, influence and divestment of assets to create a black bourgeoisie, expand the black middle class, and to generally produce a seismic transfer of wealth from white to black over a ten to twenty year period. Inevitably, with the state being so centrally involved in the task of class creation, the political connections enjoyed by individual capitalists become crucial in pulling down official loans, decisions and favours, with outright corruption a not uncommon outcome. Not surprisingly, therefore, there is already considerable evidence of Asian style, 'crony capitalism'. In short, there is often a very thin line between patriotism and parasitism. (Ibid.: 326-327)

Although Roger Southall argues that this model of economic governance is at the end not liberal in practice (Ibid.), the organization and implementation of social welfare programs really follows a liberal approach through the participation of public and private entities. The third-way social democracy of the ANC has maintained a commitment to liberal-capitalist economic policies includes implementing social policy for the excluded populations based on a mixed system of governmental and

nongovernmental intervention. Apart from income transfers to disadvantaged sectors of the population by the government (e.g. social grants to children), an array of private institutions participate in poverty alleviation and economic empowerment: parastatal organizations, NGOs, and for-profit private companies, such as insurance companies. As far as PEPFAR is concerned, this framework of social policy matches very neatly PEPFAR's own intervention rationales. It can be argued that the idealized profile for PEPFAR as grounded on liberally shared roles by the state and civil society is largely accomplished in South Africa, since the political-economic infra-structure intervention builds upon resembles the United States model. This was particularly remarkable to observe especially during the Mbeki presidency and the concomitant context of policy struggle between the government and the domestic and international mainstream epistemic community (Youde, 2007b) on how to conceptualize and respond to the HIV/AIDS epidemic. Even though, as noted by an interviewee with a NGO PEPFAR implementer (Interviewee 22, 2009), the South African and the United States governments were, in the beginning, "two parallel roads," their policy frameworks did match.

The difficulty to respond to the growing socio-economic disparities expressed through constant demonstrations and strikes over salary and working conditions and regular riots on social delivery (power, water, jobs) across the country, especially in the most deprived areas, has generated a Marxist critique that argues that the current post-apartheid regime is a continuation of the previous exclusionary politics. Accordingly, racial apartheid became "class apartheid" in a context of a "global apartheid" essentially drawn along the lines of Global North and Global South (Bond, 2004). This issue of tremendous social disparities and the contradictions they

produce has led to two political reactions. One has led to the engagement of “progressive social movements” implicated in struggles around housing conditions, the environment, and HIV/AIDS treatments, building on the anti-apartheid experience, and affiliated with the World Social Forum (Bond, 2006b). Perhaps more visible and politically more consequential, another concerns “nativist” resolutions for a future South Africa (Ndlovu-Gatsheni, 2009), such as those boosted by Julius Malema. Often inspired in the praxis of Zimbabwean President Robert Mugabe, the recently dismissed leader of the Youth League of the ANC has advocated the nationalization of mines, land reform towards black ownership and the political guidance of blacks, accompanied by other ethnicities that, in his view, fought apartheid, such as coloureds and Asians (IOL, 2009). Malema advocates the exclusion of whites from political and economic power structures, because they neither are African nor supportive of an anti-colonial political regime. Yet, for Sabelo J. Ndlovu-Gatsheni, the South African liberal tradition should prevail over nativism, even if under severe strain.

The Zimbabwean version of nativism has very open racial connotations. In a multi-racial society like South Africa, nativism immediately locked horns with a very strong liberal tradition that continues to defend a liberal trajectory. But in both countries, the future of liberal democracy remains uncertain. (Ibid.: 75)

Within the formal structures of government, the ANC government has realized the social problems of the post-apartheid era too. Published in June 2011, the “Diagnostic Overview” of the National Planning Commission of the Presidency of the Republic (National Planning Commission, 2011) concludes that, despite “relative success,” “eliminating poverty and inequality remain [the country’s] main strategic challenges” (The Presidency, 2011). Among several specific “challenges” (poor

location and maintenance of infra-structure, spatial marginalization of the poor, unsustainable growth path, uneven public service, corruption and societal divisions), the report stresses the “massive disease burden” of the health system (National Planning Commission, 2011: 20-22). The experts who elaborated the “Diagnostic” remark the state’s incapacity to address the HIV/AIDS issue.

While the country’s disease burden is rising, the health system is collapsing. This collapse is partly attributable to the nature of the disease burden; its breakdown lies also in institutional issues and implementation failures over a long period of time. (Ibid.: 21)

However, apart from the issues around capacity, another aspect concerns the dimension of the economic empowerment of patients, particularly women and children living with AIDS who already find themselves at the margins of society. Several PEPFAR-funded programs address this dimension, as remarked previously, in terms of policy rationale. Some assist in applications for social grants for children while others implement income generation activities (Interviewee 44, 2009; Interviewee 45, 2009). But it is interesting to verify that, when asked about a propelled link between HIV/AIDS intervention and economic empowerment, many PEPFAR implementing interviewees (not just in South Africa, but particularly in South Africa) do not establish any causality between one thing and the other. And when they do, they do not have evidence of that apart from the personal observation of their own projects. One interviewee with a South Africa-based implementing NGO gave a rather sceptical view. In fact, the potential economic impact of HIV/AIDS intervention is offset by the broader political-economic context of dire unemployment.

The South African government, which now is very much engaged in HIV/AIDS, is anxious to give good news about the epidemic. In fact people are healthier and living longer, however, unemployment prevents

people from those benefits. HIV/AIDS improvements are not having a direct contribution in labour productivity and economic development. (Interviewee 27, 2009)

Yet, another respondent with the same profile went much further in stressing the defining role of unemployment by deconstructing the alleged causality between HIV/AIDS treatment and economic opportunities, especially among NGO implementers.

PEPFAR's activities have nothing to do with social and economic development. That is the mantra they [the development industry] have to advance in order to justify themselves before the donors. In industrialized countries they could relate medical treatment to productiveness. However, we have 80% of unemployment where we work, so it does not make much difference if they live longer and theoretically become more productive, because they do not work. In fact, we could say that longer lives increases unemployment. I do not see a relation between AIDS treatment and higher GDP. To me AIDS work is a moral responsibility and nothing else. (Interviewee 30, 2009)

However, according to the South African Presidency's "Diagnostic," the problem of unemployment lies at the core of the national socio-development strategy. As such, it should not constitute a 'surprise' to what the previous two respondents have stated.

South Africa has extremely high rates of unemployment and underemployment. A large proportion of out-of-school youth and adults are not working. Those in low income households that are working support many dependants and earn little relative to the cost of living. This is a central contributor to widespread poverty. Inactivity of broad sections of society reduces our potential for economic expansion. (National Planning Commission, 2011: 9)

The self-reflected behaviour of the South African government on the achievements and challenges of the post-apartheid era that transpires from the "Diagnostic" demonstrates the maturity of the country's liberal polity. But this liberalism might be challenged by the potential consequences that the contradictions that the multiracial democratic resolutions of the early 1990s, in terms of social

movements and especially “nativist” proposals inspired in Zimbabwe’s Robert Mugabe. However, this liberal polity is the outcome of a socio-political process composed by different, often opposing, social forces, which is eminently domestic, although constrained externally too. The level of integration of the South African economy in the global circuits of capital renders the country a large degree of accommodation of liberal institutions of universal ambition, even if shaped by the post-apartheid state in terms of favouring the creation of a black capitalism, as suggested by Roger Southall. Moreover, this integration in global circuits of capital not only largely precedes the wave of West-led neoliberal intervention of the 1980s onwards in Africa but also supports South Africa’s role as key promoter of liberal developmentalism around the continent through NEPAD.

8.5. Conclusion

This chapter has analysed the local level of inter-state relations by focusing on the actual practices, and embedded values and ideas, of the national governments of Botswana, Ethiopia and South Africa in the domains of political, economic and social organisation. These practices are scrutinised in function of the external structural projection of values and ideas, in which PEPFAR plays a distinctive part in terms of HIV/AIDS, health and development policy. The external values and ideas are primarily rooted around liberal conceptions of organisation and reform, and therefore the action of the governments of these three countries is observed in terms of their convergence or divergence from the liberal tenets.

As in the other two levels of inter-state relations, the three governments exert agency in this process. However, several remarks need to be made. One of them is the issue of contradiction that emerges from individual countries' experiences. However, there are two types of contradiction: one type concerns the evolution of the nature of the national political regime, as the case of Botswana shows; another refers to the apparent mismatch between the external liberal structure and its national counterpart, as Ethiopia reveals.

In the case of Botswana, one witnesses a gradual shift from liberalism to 'illiberalism.' At the transition from protectorate status to formal independence, the Botswana elites embraced basic liberal institutions of political and economic governance through the primacy of representative democracy, regular elections and the market. However, recent years have been characterised to a resort to militarisation of social relations, namely through the unelected nomination of a top military officer to the presidency of the republic, Lieutenant-General Ian Seretse Khama. Indeed, it is interesting to verify that the external projection of liberal values, namely through PEPFAR, occurs at a time when there is an arguable retreat of those values domestically. Some have argued that the "African miracle" that used to be associated with Botswana is over, and now the country likens the average African regime, featured by bad governance and autocracy (Taylor, 2003; Good and Taylor, 2008; Taylor, 2006; Good and Taylor, 2006). But why was Botswana 'liberal' in the first place? The politics of transition to independence and the conflictuality of Southern Africa until 1994 provide answers. First of all, the elite that brought about the independence and has ruled the country ever since has been the same as in the colonial regime. Secondly, since the independence, the regional context, featured by

struggling politics structured around Left, Right and Black Nationalism, forced the national elite to adopt a 'centrist' position in order to retain agency in its difficult relations with very powerful neighbours South Africa (and Namibia) and, until 1980, former Rhodesia (Zimbabwe). In the last twenty years, with the absence of such regional hardship, the national regime and its opposition have moved beyond the liberal, consensual politics towards more fracturing ones, let alone effective popular dissatisfaction with elite's behaviour. Additionally, the postcolonial adoption of basic liberal institutions and values has contributed to impressive economic growth and development. However, it remained mired in 'premodernity' in terms of ameliorating the status of sectors of the population still living in poverty and subsistence modes, as well as encouraging civil society.

Conversely, the contradiction in the Ethiopian case is observed in the evident difference between the liberal values transmitted by the external structure and the practices of the Ethiopian ruling government, the EPRDF. Opposition politicians, media agents, academic experts, NGOs and foreign governments (including some of one's interviewees) have given examples of the 'illiberalism' of the government's rule in several areas. Even though accepting many external pressures, the government has sought to advance legislation, such as the Charities Law of 2009, and measures that assure conformity to the governmental policy and reduce opposition politics. The question to ask is: why do external liberal actors, such as the United States of America, operate with the EPRDF-led government in Ethiopia? The main reasons concern the geopolitical situation in the Horn of Africa, and the realisation by Washington, DC, that the EPRDF is the most credible actor towards the stabilisation of the difficult situation across the region. At the same time, this

contradiction is also present in the fact that, by prioritising the national government, the external intervention not only consolidates the government's power but also fails the liberal aspirations of the opposition. Again, as in the case of Botswana, realism explains this pattern of behaviour.

The case of South Africa emerges differently. In fact, South Africa reveals an arguably matured version of a liberal polity featured by a third-way social-democratic government, global integration of national capitalism and economic empowerment initiatives with pan-African and domestic scope. As far as social policy goes, a combination of public and private provision of goods and services illustrates the liberal approach of addressing the HIV/AIDS epidemic and other social questions in the post-Apartheid era. Liberal reform is explained by the post-Apartheid settlement, in which the ANC and more leftist political forces retreated from their agenda towards a 'centrist' stance that could be accepted by the Apartheid elite and the West (United States of America and United Kingdom). However, this explanation is only partial. Indeed, the liberal 'conviction' in South Africa has taken deeper roots, and is part of the liberal-idealist politics that one has been discussing throughout since Chapter 6. It is part of the idea of African Renaissance and NEPAD. However, this entrenchment of liberal politics and its social effects is leading to reactions that may undermine the leading liberal politics in the near future. An advanced, sophisticated capitalist system keeping many unemployed, poor, mostly young citizens at its margins has generated Marxist critiques by progressive social movements, but also 'nativist' proposals close to Zimbabwe's Robert Mugabe's policies. However, the ANC-led government has also initiated a self-reflection through the constitution of a National Planning Commission with the aim

of identifying those issues and develop solutions for them, yet under the liberal paradigm.

The overall discussion carried in the empirical chapters, as well as those preceding them, carries several conclusions – theoretical and empirical – to be presented in the next, final chapter

Chapter 9 – Conclusion

9.1. Introduction

The discipline of International Relations has witnessed a shift of analytical scope from the conventional world of states towards population-related and social forces concerns. This was the result of both scholarly and policy change in the last thirty years. Considering the problem that such shift has been posing with regard to the issue of human agency, and the limitations of leading hegemony-based approaches, particularly to relations between the West and Sub-Saharan Africa, this dissertation pursued an analysis centred on the action of states as units of the international system, as proposed by Kenneth Waltz.

However, the adoption of Waltzian concepts was not meant to be an open endorsement of his theory of structural realism, since it is not fully applicable to the reality of relations of Sub-Saharan African states with the West. First of all, structural realism is too elitist for the reality of the postcolonial state in Africa. Waltz's theory was originally conceived to explain the behaviour of world powers, such as 19th century Europe or the Cold War. That is not applicable to a realm of states with different capabilities, where propelled weaker states are expected not to have a strategy of their own beyond plain bandwagoning. Secondly, the methodological detachment of the external sphere of the state from the internal one does not help grasping the full set of inter-state relations. Understood as a social relation, the state is sociologically and historically informed by the experience of the state, being that what makes it distinct from others. As a result, one has divided the

analysis of the individual countries' interaction with PEPFAR, United States foreign policy and the international structure at large, along three independent variables: nature of foreign policies; nature of domestic policies; and actual state practices. Altogether they demonstrate a complex body of statehood which withholds agency in face of a globalised system.

9.2. West-Africa Relations: a Struggle of Governmentalities

The dissertation departed from the premise that relations between the West and Sub-Saharan Africa have been characterised by asymmetry. In part, this was due to the postcolonial settlement, strongly informed by the historical legacy of colonial regimes implemented by European powers. Difficulties of generating economic development, arguably explained by the neopatrimonial nature of the state, also contributed for such contrasting relationship.

From the late 1970s onwards, after a relatively short period of economic success subsequent to the first wave of independences (1960s), Sub-Saharan African governments engaged in negotiations of development assistance funds from major donor countries and international financial institutions with the aim of resuming a path of economic growth and development. These negotiations not only implied the reproduction of a pattern of dependency to the Western donor countries and international financial organisations but also a subjection to conditionalities with socio-political effects. This neoliberally-rooted approach was maintained throughout the 1980s and 1990s. However, from the early 21st century onwards it was supplemented with policies looking at specific unresolved problems structured around development, security and the state, in which interventions linking security

goals to development appeared hand in hand with a necessity to – once again – reform state institutions. These are examples pointing at a striking hegemony of Western states and international organisations in Sub-Saharan Africa, grounding an analytical shift from states to population.

However, the ‘governmentality’ of Western interventionism has been opposed by other governmentalities. Apart from the basic endowment that juridical territorial sovereignty attributes, the neopatrimonial character of Sub-Saharan African polity helped to retain important levels of independence. Despite the general context of underdevelopment of African societies, due to the reduction of investment in areas such as education or health, African elites sought to obtain external funding to retain their existence. As far as the attraction of external support is concerned, the 2000s heralded a diversification of sources. Although Western donors remain relatively central, ‘new partners,’ such as China, India and several Arab countries (e.g. Saudi Arabia and United Arab Emirates), have appeared as significant alternatives. Nevertheless, a major novelty was the return of the development state as ideology and policy, parallel to pan-African initiatives aiming at growth and development such as the New Partnership for African Development (NEPAD).

Despite reproducing traditional neopatrimonial practices and the serious negative impacts that might have on their national constituencies (Taylor, 2005), these new developments in Africa appeared as instances of challenge to the perspective that Sub-Saharan Africa is subject to a Western governmentality. In fact, the experience of the three last decades has been demonstrating the opposite, even with the asymmetry that persists between the West and Sub-Saharan Africa, as well as between the latter region and the ‘new partners.’

9.3. Postcolonial African States in Global Health Governance: Between Facilitators and ‘Rogue’

Global health governance as topic of study in the latest decades demonstrates eminently the analytical shift from states to populations, as it precisely draws on individuals and communities, and the health-related phenomena they are affected by. Moreover, global health governance is, arguably, a Western construction with the aim of making sense of postcolonial relations in the area of health and disease, on the one hand, and of addressing the post-Cold War perceived ‘new threats’ to international security and stability, on the other. It is also a matter of human security as an academic and policy paradigm, as it embodies the questions of “freedom from fear” and “freedom from want” that human security policies are supposed to address. It has generated technical responses to specific problems, such as epidemics (prevention, treatment and care) or viral outbreaks, potentially fuelled by other population-related phenomena such as travel/migration and trade.

This dissertation subscribes to the argument that the governance of global health has been a failure, despite the implementation of powerful mechanisms of control and intervention, such as the World Health Organisation’s International Health Regulations. The absence of a central government in the global realm that can enforce a single rule sustains this argument. Despite the importance of ‘social forces’ sharing, for instance, a commitment to liberal principles, the proliferating array of actors and agendas offers examples of the lack of such government. Consequently, the idea of a realm – global health – being governed with a large degree of coherence and consistence does not bear existence in reality. As a result, it is somewhat

inevitable to turn to the most stable entities in the system – states – in order to grasp its functioning. In spite of the prominence of private actors (private companies, philanthropic organisations, NGOs) in this field, the major actors are still states.

Expectedly, the main states are the United States of America, followed by Western European countries and Japan. As far as the most important epidemic of global repercussions in the last thirty years, HIV/AIDS, the United States of America launched in 2003 the largest bilateral program ever to tackle that disease: PEPFAR. Funding states such as the United States of America are essential in the definition of policies of where, how and on what to allocate available funds. Conversely, despite the reproduced discourse of equality between donors and recipients in terms of responsibility sharing, as the case of PEPFAR shows, governmental counterparts in Sub-Saharan Africa are often assigned a strict role of recipients.

According to the United States strategic concept, HIV/AIDS, and the manifold phenomena associated with it, poses a threat to international security and stability. Eventually, affected populations inside the recipient states are constructed as threatening agents, which, according to a security perspective, have to be contained. From a critical perspective, this security rationale has been denounced as a denigration of HIV-affected people in particular, and the most vulnerable populations to the disease in general. The postmodern feminist critique is particularly revealing in this regard, as the securitisation of HIV/AIDS reinforces in policy and practical terms the idea of women as vehicles of insecurity. As a matter of fact, together with children, women are but the most vulnerable to the epidemic, often through violent means, physical and symbolic (rape, transactional sex, prostitution). In addition to threats, the representation of recipient populations, and their countries,

as in need of United States wealthy ‘compassion’ further exemplifies the position of superiority of the United States of America *vis-à-vis* the recipient countries.

The field research conducted in Botswana, Ethiopia and South Africa points at other instances of the regime of superiority of the United States of America. Although some interviewed PEPFAR implementers acknowledge that it is a ‘necessary evil,’ a recurrently mentioned case is the large bureaucratic compliance which is demanded by PEPFAR’s leadership. Often, this is observed as a hamper to a better client-focused service. In terms of policy, the insistence of abstinence-based approaches to prevention is observed as another imposition of the United States government on how to best control the epidemic in the different national settings. The same applies to policies on family planning. Finally, the scientific practices of some actors are also under criticism, as research institutions based in the United States of America collect blood samples and other material, fly them to their headquarters, investigate them, and finally publish results. In the end, it is not clear to what extent does this benefit the recipient countries, which, in this case, functioned as donors of such samples. Despite the rhetorical emphasis on partnership and country ownership by PEPFAR’s leadership, it is clear for many interviewed stakeholders, who are not with United States government agencies, that the United States of America is the leader of PEPFAR’s process.

The asymmetry between donor and recipient has been dramatically at the core of health economist Mead Over’s argument on the “ballooning entitlement” generated under PEPFAR and other initiatives. It revolves around the uneasy system of dependency that those initiatives have generated, particularly at the level of antiretroviral drugs. In a context of still growing number of new infections in several

parts of the world and limited capacity to deliver by the major donors, affected countries might nurture grievances against donors for their reduced response. This kind of colonialism, as Over calls it, might entail negative repercussions for United States international reputation in the long run, especially in terms of rising anti-American sentiments in countries where the United States of America has been enjoying a large degree of support.

As recipients of main global health initiatives, Sub-Saharan African states are found behaving according to two antagonistic categories. Governments in that region have behaved either as facilitators, i.e. as good, reputable leaders, compliant with ‘good practices’ at different levels, as inculcated by the international community of donors, activists and scientists, and providers/distributors of goods and services provided by the benefactors. Alternatively, some have also acted as ‘rogue,’ that is, as challengers of those same ‘good practices.’ As noted, the field of global health is one where technical problem-solving approaches to health and disease-related problems (e.g. epidemics such as HIV/AIDS, tuberculosis or malaria) recur, and in which political consensus has to prevail. State structures (national, regional and local) are implementers in a larger partnership together with foreign and nongovernmental entities, and as such they should implement established policies and practices. These include all segments of intervention, from administration to actual provision of goods and services to the targeted population.

Concerning this dissertation’s study countries, all of them, except South Africa under President Mbeki, appear as striking cases of governments who really facilitate the implementation of international HIV/AIDS policies and ‘good practices.’ These are countries which, when the first cases of HIV were registered,

the national governments followed very early and very closely international advice. This occurred in terms of institution-building, through the creation of national AIDS councils, conglomerating both the public and private (civil society) spheres, and under higher leadership of the country's presidency. Implementation of prevention and testing activities supervised by WHO and later UNAIDS and funded by major donors also ensued quickly. In the case of Botswana, the national government has gone as far as funding itself up to 80% of the ARV program launched in 2001. In the Ethiopian case, the government does not engage that strongly in financial terms; nevertheless, it has favoured the establishment of institutions and policies that could maximise external assistance. Conversely, South Africa has, for some time, constituted a case of 'rogue' behaviour with regard to the governmental endorsement of internationally-disseminated institutions and practices as described in the Botswana and Ethiopian cases.

Frequently, 'rogue' behaviour is associated with real or perceived practices of mismanagement of external funding in the developing world, as several interviewees suggested. As a response, advanced mechanisms of financial control are put into place with the aim of securing the management of funds. However, that is not exactly the case of any of the three countries involved. In fact, any of them tends to be presented as a positive contrasting situation, i.e. a country where funds are managed and employed appropriately. In fact, 'rogue' behaviour is applicable to the specific relationship between the Mbeki Presidency at the higher level, namely, first and foremost, Thabo Mbeki and his Minister of Health Manto Tshabalala-Msimang, and the HIV/AIDS international epistemic community of scientists and activists. Building on some unsettled scientific disputes on the nature of the HI virus, Mbeki

claimed that the biological causes of AIDS were unclear. For him the evident cause was of social nature, i.e. poverty. Poverty was the cause of HIV/AIDS. Moreover, what the HIV/AIDS scientific ‘orthodoxy’ was displaying was a Western renewed colonialist discourse on the need to save Africans from their basic sexual instincts. In this regard, the experience of the apartheid was also remembered to demonstrate negative effects of Western biomedicine in the life, primarily, of black populations in the country. However, following change of government in 2009, the South African government quickly resembled a role close to its counterparts in Botswana and Ethiopia.

Table 2 shows that Botswana and Ethiopia have always been facilitators with regard to the adoption of internationally-backed institutions, policies (prevention, treatment and other public health measures) and, generally, the body of knowledge to tackle health problems, namely HIV/AIDS. South Africa under Mbeki appears as ‘rogue’ in terms of policies and knowledge.

Table 2 – Country Position *vis-à-vis* Global Health Leadership

	Institutions	Policies	Knowledge
Botswana	Facilitator	Facilitator	Facilitator
Ethiopia	Facilitator	Facilitator	Facilitator
South Africa	Facilitator	‘Rogue’ (Mbeki) Facilitator (Zuma)	‘Rogue’ (Mbeki) Facilitator (Zuma)

While it is true that the three recipient countries correspond to the role of facilitators (including South Africa after Mbeki) of external policies and practices and collaborate in envisaged goals, that does not mean that they are under strict control of donors and supervising institutions. As discussed in Chapter 6 in terms of broader foreign policy relations between them and the international system's leading state, the United States of America, there is a coincidence of goals to be achieved by all parts involved, although they are conceivable in different manners, i.e. whereas for the three countries preventing HIV/AIDS means improving the quality of life of some populations, for the main donors security through health intervention is one strategy of addressing their foreign policy concerns. States of countries under external intervention do retain agency, and that is visible in a several instances.

9.4. Botswana, Ethiopian and South African State/Government Agency

This dissertation demonstrates that, despite the unequivocal asymmetry that features the international system, less powerful states in Sub-Saharan Africa still act autonomously in that system, and, thus, pursue a strategic agenda of their own, even if under severe constraint. However, not only an element of asymmetry between states is required, but also a concept of state that encompasses its historical and sociological experience is demanded. Understood as a social relation, the state is sociologically and historically informed by the experience of the state, being that what makes it distinct from others. Each state/government analysed in this dissertation, and the characteristics of its agency *vis-à-vis* the international structure, reveal (and are revealed by) the historical experience of its construction and

development. Considering the group of three countries under analysis here, different dynamics of agency are identified.

The peaceful Botswana post-independence settlement derives from the circumstances of British-Boer colonial relations in Southern Africa. In the late 19th century, in face of pressures put by the Boer Republics in the South, Tswana leaders sought to exchange with the United Kingdom military protection for concession of Protectorate status and territory for the construction of a railway from the South African Cape colony to Southern Rhodesia (today's Zimbabwe).

Although the settlement was inclined towards the adoption of Western political and economic institutions, the harsh reality of lying at the core of Southern Africa, ridden by several high intensity armed conflicts, forced the Botswana leadership to engage with all parties involved. This implied positive relations with the United Kingdom, the main postcolonial development funder, the two world rivals (United States of America and Soviet Union), former Rhodesia, and, most importantly, South Africa. The latter not only was the regional economic hegemon, but also the host of De Beers, the partner in the public-private partnership Debswana, in charge of exploring the diamond mines in the country. Relations with South Africa and former Rhodesia were particularly difficult, since the white supremacy regimes in both countries suspected of the existence of black insurgents bases in Botswana, and actually raided and bombed some southern and northern parts of the country.

In the West, namely in the United States of America, in the context of Sub-Saharan Africa, Botswana is regarded as a 'miracle' of good governance, economic growth and development. It is observed as a politically stable and peaceful country due, not only to its smooth transition to independence, which occurred with almost

no incidents, but also to the transparent process of exploration of its mineral resources, primarily diamonds, and employment of the wealth associated with it. In 1966, year of independence, Botswana was one of the poorest countries in the world, and after few decades climbed up to a middle-income position. The country has had regular elections, always won by the same party (Botswana Democratic Party), and adopted characteristics typical to the developmental state model visible in Eastern Asia at the time, since public expenditure was targeted at creating strategic infrastructures (roads, power stations). However, it should be understood that such reputation has not only been built around the policies and actions of Botswana's leaderships but, moreover, the comparative analysis that is done between Botswana and the average Sub-Saharan African country. In fact, Botswana's political elites have been acting according to a strong logic of self-help. More recently, the major threat has shifted from aggressive behaviour of political regimes around it towards the HIV/AIDS burden that affects a quarter of the adult population, and, as such, constitutes a serious threat to the national survival.

The national government was fast persuaded by the international community (primarily WHO) about the necessity to intervene in order to prevent the disease. In the early 2000s, a number of studies on the economic impact of the epidemic persuaded the political leadership to advance towards the funding of a massive treatment program in order to contain the worrisome spread of the disease through the population. Initiated in 2001, this program has been assisted by the Bill and Melinda Gates Foundation, the Global Fund and, finally, since 2004, PEPFAR. This highly debated measure, considering the high costs involved, was put forward in the

name of national survival. For Botswana, HIV/AIDS has public health, economic, social and even security implications.

The Botswana government is regarded as the main leader of the overall HIV/AIDS intervention in the country. This happens especially in financial terms, as it funds 80% of the effort, but also politically. In this regard, PEPFAR's financial participation is relatively marginal, yet in diapason with the envisaged PEPFAR policies of country ownership and sustainability. As several respondents commented, "PEPFAR fills the gaps" of the overall response by addressing areas related to management and organisational capacity-building, something that should be replicated elsewhere. In this regard, again, Botswana appears as a facilitator of United States foreign policy.

Currently, the HIV/AIDS epidemic poses an even more complex challenge to the state. Despite decreases on the cost of drugs, the recession of the global trade in diamonds poses an additional pressure on the relative prioritisation that the HIV/AIDS response has enjoyed throughout the last decade, apart from the general flattening on global HIV/AIDS initiatives' funding. Therefore, it remains clear that HIV/AIDS policy and implementation, for the existential threat it constitutes for the country's small population of 1.4 million people, shall remain under the scope of the national government.

The case of Ethiopia is rather different from Botswana. The last decades have witnessed large-scale political violence across the country, together with serious problems of hunger, ill health and underdevelopment affecting several sectors of the country's large, and still growing, population. Inaugurated in 1991 with the ousting of the previous Dergue regime through guerrilla warfare, the current regime has been

putting forward policies aiming at resolving long-lasting problems undermining the country's development. Led by the Ethiopian People's Revolutionary Democratic Front (EPRDF) under Prime Minister Meles Zenawi, those policies are structured around 'ethnic federalism' and state developmentalism with the goal of resolving domestic ethnic grievances and lifting the country from the bottom of the United Nations' Human Development Index. At the same time, and concomitantly, the new regime has been engaging in a policy, often through heavy military means, of securing territorial integrity and inviolability that have been threatened by domestic "terrorist organisations" of ethnic/regional inspiration, as well as groups based in Somalia and allegedly affiliated with Al-Qaeda. As a result, the action of the national government in Addis Ababa is framed in terms of self-help, yet primarily concerned with the political regime's existence rather than, as in the case of Botswana, with the population as such.

As it was demonstrated in Chapters 6 and 7, the interaction with the international structure, particularly with the United States of America, reflects this concern for the regime's survival. Certainly, the issue of regime survival is something that, in principle, implicates all states, as Waltzian frameworks demonstrate. All regimes seek their self-help. Still, the interesting aspect about Ethiopia is that the previous regime (Dergue) was also driven by the same concern in its international action. Although officially assisted by the Soviet Union and the Warsaw Pact in light of Cold War politics, it received support, namely humanitarian, from the United States of America. Today, in the case of the EPRDF, assistance is sought from Western countries but also from 'new partners,' such as Turkey, Saudi Arabia, United Arab Emirates, India and China. In terms of international diplomacy,

the country has been represented by Zenawi and Minister of Health Tedros Adhanom at the higher international level: the former as African representative at summits on climate change, and the latter as chair of the Global Fund until September 2011.

Apart from basic geopolitical concerns, development indeed represents the major topic of foreign and domestic policy of the Ethiopian government. Since 1991 the government has been establishing five-year development plans that can be adapted to external assistance. The latest growth and transformation plan was launched in 2010 and looks forward to establish industry in 2020, based on the construction of the Millennium Dam on the Nile Basin and on leasing vast masses of agricultural land to foreign companies. Aiming at abolishing poverty in the long run, the plan underlines strongly a dimension of social development that includes improvement of health services under the guidance of the Ethiopian Ministry of Health. This is the part of the plan in which assistance through PEPFAR comes in, sitting alongside numerous other external (bilateral and multilateral) development initiatives, especially from Northern America, Western Europe and Japan.

Still, despite its small epidemic, it should be noticed that in the early 2000s, in the eve of PEPFAR's establishment, Ethiopia was presented as a country where the HIV/AIDS epidemic could reveal in the future a similar pattern of graveness as in Southern Africa, considering its enlarging population. Independent of the empirical confirmation of such scenario, the emergence of large amounts of funds to tackle the epidemic was welcomed by the Ethiopian leadership in order to address the background problem of very deficient health care around the country. Moreover, such openness has been witnessed since the late 1980s when the first cases were

identified in the country, and the international organisations in charge – first, WHO, then UNAIDS – came forth.

The committed and facilitating character of the Ethiopian government has been regarded as an example of “country ownership” by several respondents. However, the country’s ability to fund large-scale interventions is still quite limited. In addition to this constraint, the state maintains a low capacity to reach to large sectors of the population, especially rural ones, where 82% of the population live. From a broader perspective, considering the alluded security issues, the state has limited access to some regions of the country, especially the surrounding region of Addis Ababa, Oromia, and the Eastern region of Ogaden. Yet, this is precisely revealing of those problems of security, and how the regime in Addis Ababa addresses them in order to safeguard its survival. Intended or unintendedly, this strategic goal is favoured by the current diversification of donors, which allows the government in Addis Ababa to act with less conditionalities in domains at stake in a context of securitisation, namely civil and media liberties.

In South Africa, since the transition to multiracial democracy, in 1994, the country’s governments have leaned from hard military power during the apartheid towards a transmission of values that can be seen in a number of instances and eventually held repercussions in the area of HIV/AIDS. This ‘behaviour change’ is not only the result of the relatively peaceful regime transition but also a reflection of the relations formed during the apartheid struggle with fellow African states that assisted logistically and ideologically the anti-apartheid movements, specially the ANC. Whereas Botswana and Ethiopian dynamics point to self-help, South African behaviour emphasises the transmission of ideas, domestically and internationally,

consonant to the transition from apartheid to multiracial democracy. Post-apartheid politics are visible from the inception of the democratic regime on former President Mandela's insistence on good governance and democracy in Africa. Later, it was continued by President Mbeki in discourses of African Renaissance and dignity of the black African. In policy terms, this new South African stance in African and world affairs was consolidated through the collective establishment of the New Partnership for African Development in 2001. At home this was represented by initiatives such as Black Economic Empowerment. The 'new' South Africa appeared very much aligned with the major world powers and international organisations through the committed adoption of liberal reforms. Furthermore, South Africa has been increasingly associated with typical cosmopolitan policies of human security, prevention of armed conflicts, or peacekeeping operations.

Relations between South Africa and the United States of America are very peculiar in light of the apartheid and democratic experiences. In fact, with a very short intermission, which corresponded to the late 1980s, when economic sanctions against apartheid rule were put into place, both countries collaborated very intensely. During apartheid, the United States of America was counting on apartheid's anti-communism to contain Soviet influence in the region. Afterwards, with the end of the Cold War and the apartheid, relations were maintained under a spirit of humanitarian cooperation, as PEPFAR shows, but with a security perspective too. Together with Botswana, South Africa represents one of the few states which are not considered weak or failing in the African continent. Despite the coincidence of agendas, there have been issues of contention between both sides.

One has to do the establishment of the United States Africa Command (AFRICOM) in African soil, which South Africa has been barring determinately. Another regards HIV/AIDS, and how it came to be addressed by the South African leadership under Mbeki, yet arguably still in light of the idealist politics of African Renaissance. Mbeki appeared as a self-proclaimed 'dissident' of the biomedical recipes promoted by the international community, since it was detrimental to the dignity of black Africans in his country and around the continent.

Although mainly a domestic event, Mbeki's 'rogue' position echoed across the African continent. Arguably it reflected a will of transmitting a set of values and ideas across Africa centred on the dignity of Africans and their resistance to prevailing racist and colonial images. However, particularly outside Africa, this position was observed as unacceptable and even irrational, and this was the issue between the United States of America and the South African government at the time. However, when higher level positions on HIV/AIDS changed dramatically with President Jacob Zuma and his Minister of Health Aaron Motsoaledi, it was in light of the same liberal-idealist framework. In international events, the South African leadership exhibits a pan-African position by calling for attention of donors to the difficulties of poorer African nations in the struggle against the disease.

PEPFAR's implementation in South Africa began in the middle of the controversy with President Mbeki. As a consequence, particularly during the first phase (2004-2008), PEPFAR's stakeholders were confronted with the need to conciliate actual implementation of projects with state's approvals. However, since the beginning of Zuma's Presidency, and the 'burial of denialism,' similarly to Ethiopia, interventions in several areas (medical research, treatment and palliative

care, orphans and vulnerable children, prevention) under PEPFAR are incorporated in the state developmentalism that the ANC government is attempting to run with the purpose of overcoming the past of separate development and boosting economic empowerment. In fact, the government is now funding up 80% of the overall response. However, like Botswana, the economic recession affecting the country, as well as donors, poses challenges of sustainability.

Table 3 presents each country's agency in function of the policy problems identified, strategies devised and goals aimed. It is observable that Botswana and South Africa share the same policy problem (very large HIV/AIDS epidemic); however, the strategies and political goals do not entirely coincide. The former seeks survival; the latter envisages the dissemination of values. In turn, Botswana and Ethiopia attempt at similar goals (survival), even though the policy problem differs to an extent. For Botswana, the problem is eminently rooted in the epidemic; for Ethiopia, it lies generally on low human development. However, Botswana and Ethiopia share a strong state action. In the case of South Africa, despite a vivid governmental influence, the private sector's interference is remarkable too.

Table 3: State/Government Agency in Light of PEPFAR Experience

	Policy Problem	Strategies	Political Goals
Botswana	Very large HIV/AIDS epidemic	State-led response against HIV/AIDS, complemented by external assistance (Gates Foundation, PEPFAR, Global Fund)	National survival
Ethiopia	Very low human development	State-led developmentalism; diversification of international funders; international diplomacy (e.g. Africa, climate change, global health);	Political regime survival
South Africa	Very large HIV/AIDS epidemic	Transmission of values on the dignity of Africans; public-private developmentalism	Liberal multiracial democracy; 'African Renaissance'

9.5. Future Avenues of Research

9.5.1. Theoretical Frames of National Agency

The acknowledgement that less powerful states, namely postcolonial and developing ones, hold agency *vis-à-vis* not only the international structure but the actual hegemonic powers within it paves the way to new questions regarding the nature of this agency. From the research conducted, the cases of Botswana and Ethiopia suggest a rationale of self-help and survival in the international system, rendering neorealism a very suitable theory to describe both past and present policies. In turn, South Africa is arguably driven by a liberal-idealist approach, yet only since 1994, following domestic regime change. As recurrently mentioned, the transmission of values on the dignity of Africans is part of a strategy that seeks the

consolidation of liberal multilateral democracy and a transcending project of ‘African Renaissance.’ However, in the case of South Africa, the ante-1994 period requires a rather neorealist approach, considering the previous politics of the apartheid regime as well as the far wealthier and military capabilities of the state. Eventually, a combination of both theories can help with the analysis of South Africa’s behaviour, not only with regard to its broader relations with the region, the continent and the world, but also, and specifically with PEPFAR and the politics of HIV/AIDS inside and beyond borders. As such, despite the idealism, a full understanding of the policy requires the maintenance of a realist ‘analytical predisposition.’ Studying the nature of the agency identified along these lines also confirms the need to address these dynamics in a domestic/international dialectic approach, since domestic regime change has clearly influenced South Africa’s position internationally.

Nevertheless, the study of PEPFAR with implementers and other stakeholders in the area of HIV/AIDS, complemented with other sources on the socio-political and economic situation, has also drawn attention to various cross-cutting problems that point to local dynamics of social conflict. Often, this conflictuality refers to overarching issues on socio-economic inequalities, poverty and even armed violence, and contradicts major narratives about the states involved. This is particularly salient in the case of Botswana and South Africa, whose peaceful transitions to independence and multiracial democracy are generally considered remarkable through the adoption of liberal institutions and values. In this regard, the question of adoption of liberal values and institutions, particularly in the Botswana case, is at stake.

Liberal values are not merely an object of projection by the international structure in the last three decades in function of the rise of neoliberalism among Western states and international financial organisations in the last thirty years, as discussed throughout Chapter 2. As the case of Botswana shows, liberal forms of political and economic organisation have been experienced since the independence. The adherence of Botswana to liberal principles of organisation has been justified throughout the dissertation as deriving from the post-independence settlement, in which the same colonial and postcolonial elite – colonist and local/native – has prevailed. Maintaining an umbilical relationship with the United Kingdom, former protector and main development supporter after 1966, the adoption of liberal tenets represents a continuation of British influence, even if in a context of a sovereign, independent country. However, it is also explained by the position of the Botswana governments throughout the Cold War and, more importantly, the apartheid regime in South Africa. Located in the heart of a region struggling with several highly intense ideological conflicts (leftist and black nationalist movements, on the one hand; rightist and white supremacist, on the other hand), the acceptance of liberal institutions consisted of the ‘centrist’ position that the country’s survival and development depended on.

Although the combination of liberalism (e.g. regular elections, representative democracy, and market economy) with state developmentalism has consolidated the view of Botswana as an ‘African miracle,’ critical literature on national achievements started to question the validity of liberal values in contemporary Botswana. In spite of the fantastic economic growth in the 1980s, social disparities increased, as many Botswana citizens remained stranded in subsistence agriculture

and poverty. In addition to that, as the response to HIV/AIDS has shown, and several interviewed PEPFAR implementers confirmed, civil society, a critical bastion of liberalism, has not been significantly enhanced in terms of its participation in the country's main challenges. Moreover, in recent years, the country has witnessed a rising "liberal authoritarianism," materialised in the introduction of senior military staff in the civil service, extra-judicial murders and severe corruption. It is interesting to observe that a country with a liberal tradition seems to be receding at a time of alleged strong external diffusion of liberal values. How can one explain such apparent contradiction?

In South Africa the adoption of liberal values was the result of the post-apartheid compromise between the different political forces involved. To an extent, it implicated the retreat of revolutionary agenda of some sectors of the ANC and left wing parties. The ANC-led government became a social-democratic party, akin to the European Socialist third-way, with an aim of conciliating liberalisation of the economy with reduction of the deep-seated disparities inherited from apartheid. Major initiatives in this regard were the Black Economic Empowerment at home and NEPAD overseas. Additionally, it should be underlined the long-lasting integration of the South African economy, specially the mineral industries, in the global circuits of capital as a contributor for the relatively easy incorporation of liberalism in governance.

Social policy has clearly followed a liberal approach, in which a range of state and parastatal institutions, NGOs and private companies, including those funded under PEPFAR, intervened in the realm of marginalised populations. Nevertheless, social inequalities have not shrunk but rather increased, as frequent

demonstrations, strikes and riots on service delivery confirm. The recently published Diagnostic of the National Planning Commission has also reiterated the central problem that growing poverty and inequality poses in strategic terms. Eventually, dissatisfaction with the state of affairs has led to two political responses to the problems of liberal in the country. One is a Marxist critique promoted by social movements building on the anti-apartheid struggle that rally around problems such as housing or HIV/AIDS. Another is markedly more visible and emulates Zimbabwean President Robert Mugabe's 'nativist' proposals, which call for an absolute exoneration of white cadres in state and corporate structures, and nationalisation of the nation's strategic industries. Independent of the success of forces contesting liberalism, South Africa is clearly undergoing challenges to its post-apartheid settlement rooted around liberal premises.

Although committed to a democratic and all-inclusive state, the EPRDF government in Ethiopia has been severely criticised for its record so far. As mentioned, Ethiopia is the largest recipient in Africa of Western aid, which means that, in principle, is under significant exposure to conditionalities that promote liberal principles of governance, such as economic liberalisation or civil society promotion. However, according to many sources (opposition politicians, human rights NGOs, academics, foreign diplomats), the government has consecutively implementing 'illiberal' measures that stretch from police and army violence to subtle sophisticated mechanisms of censorship. These measures have been accompanied by legislation that limits opposition politics and nongovernmental activities, e.g. the Charities Law of 2009. This legislation has been mentioned by PEPFAR implementers, although not always receiving criticism.

The EPRDF is found reproducing a political pattern that comes from the time of Haile Selassie, in which, parallel to a modernising ambition of political and social life, out-of-state forces are regarded with suspicion. This has implications for what can be taken as civil society, since the tendency, once foreign development assistance is assured, is for the state to create its own apparatus of nongovernmental organisations to apply for and administer the funding. Nonetheless, and despite occasional criticism at the diplomatic level, international funding is not suspended. The Ethiopian political arena is still highly featured by political conflict, namely opposition exerted by regionalist armed groups against the sovereignty of Addis Ababa over their regions (particularly Oromia and Ogaden) whose demands stretch from decentralisation to actual secession. More recently, the projects on land leasing and the Millennium Dam pose serious issues to the survival of resident communities, whose benefit from these initiatives is unclear. These dynamics suggest that more or less conflictual domestic dynamics may also influence the level and nature of agency the country holds both nationally and internationally.

9.5.2. Emerging Countries in Global Health Governance

A recent relative fall in development/health expenditure in recipient settings by traditional Western donors combined with a relative increase of influence by non-traditional, non-Western donors is gradually changing the landscape of global health governance. Both in policy and implementation terms, Western donors face reducing capability to support multilateral and bilateral initiatives, at least the way they used to throughout the last decade. Even if this reduced capability arguably constitutes an undesired reaction to contextual events (financial-economic crisis), in the case of

PEPFAR, for instance, the focus on country ownership as a means to achieve sustainability reflects an interest in steadily stepping back from the initial effort. This change also occurs at a time of growing implication of national governmental institutions in health policy and implementation among recipient countries, as the three cases under examination here demonstrate.

Considering non-traditional, non-Western actors, countries such as Brazil or India, are allegedly evolving from a situation in which they appear as objects of external policy, e.g. as recipients of Global Fund assistance, towards subjects of foreign policy. Indeed, further research is necessary to better understand these countries' complex role as both donors and recipients of policy and intervention. Finally, as traditional, large-scale donors reduce their capabilities, recipient countries as a whole are challenged externally and internally to engage in health, and more expansively, social policy. Empirical evidence from Ethiopia, Botswana and, tentatively, South Africa, demonstrate the inclusion of such policy in larger state-developmental agendas. In the case of 'emerging' actors, particularly Brazil, research shows the relevance of their own domestic experience with the epidemic, and how it contributed to larger concerns around nation-building (Lieberman, 2009) but also an improvement of their international standing, the case of HIV/AIDS being a case in point.

9.5.3. Security-Development Nexus

Finally, the securitisation of development aid and humanitarian interventions that has been taking shape requires further research regarding its institutionalisation and its impact in the field of health governance.

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Annex 1 – Questions to PEPFAR Implementers

- 1) Apart from specific AIDS-related activities, in which areas of activity does your organization intervene?
- 2) Which are the main facilitating conditions and obstacles you find in your projects' implementation?
- 3) In what ways has PEPFAR funding enhanced the activities of your organization?
- 4) Have there been, in your understanding, any obstacles or facilitating conditions for PEPFAR's implementation in Botswana/Ethiopia/South Africa?
- 5) What changes do you observe in the struggle against AIDS before and after PEPFAR in Botswana/Ethiopia/South Africa (and elsewhere in the world)?
- 6) Apart from medical outcomes, which are the major results generated by PEPFAR in the field of economic development in Botswana/Ethiopia/South Africa (and elsewhere in the world)?
- 7) PEPFAR was reauthorized in 2008. But with a new United States Administration can you identify any changes at the implementation, framework or planning levels due to this change?

Annex 2 – Questions to Other Organisations

- 1) How do you generally assess PEPFAR's implementation in the province/country?
Could you please indicate facilitating conditions and obstacles influencing the process of implementation?
- 2) Which are PEPFAR's potentialities and weak links?
- 3) What changes do you observe in the struggle against AIDS before and after PEPFAR (around 2003)?
- 4) Apart from medical outcomes, which are the major results generated by PEPFAR-supported projects in the field of social and economic development?
- 5) PEPFAR was reauthorized in 2008. But with a new United States Administration can you identify any changes at the implementation, framework or planning levels due to this change?

**Annex 3 – United States Leadership Against HIV/AIDS, Tuberculosis,
and Malaria Act of 2003**

One Hundred Eighth Congress of the United States of America

AT THE FIRST SESSION

*Begun and held at the City of Washington on Tuesday, the seventh day of January, two thousand
and three*

An Act

To provide assistance to foreign countries to combat HIV/AIDS, tuberculosis, and malaria, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the “United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003”.

(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

Sec. 1. Short title; table of contents. Sec. 2. Findings. Sec. 3. Definitions. Sec. 4. Purpose. Sec. 5. Authority to consolidate and combine reports.

TITLE I—POLICY PLANNING AND COORDINATION

Sec. 101. Development of a comprehensive, five-year, global strategy. Sec. 102. HIV/AIDS Response Coordinator.

TITLE II—SUPPORT FOR MULTILATERAL FUNDS, PROGRAMS, AND PUBLIC-PRIVATE PARTNERSHIPS

Sec. 201. Sense of Congress on public-private partnerships.
Sec. 202. Participation in the Global Fund to Fight AIDS, Tuberculosis and Malaria.
Sec. 203. Voluntary contributions to international vaccine funds.

TITLE III—BILATERAL EFFORTS

Subtitle A—General Assistance and Programs

Sec. 301. Assistance to combat HIV/AIDS.
Sec. 302. Assistance to combat tuberculosis.
Sec. 303. Assistance to combat malaria.
Sec. 304. Pilot program for the placement of health care professionals in overseas areas severely affected by HIV/AIDS, tuberculosis, and malaria.
Sec. 305. Report on treatment activities by relevant executive branch agencies.
Sec. 306. Strategies to improve injection safety.
Sec. 307. Study on illegal diversions of prescription drugs.

Subtitle B—Assistance for Children and Families

Sec. 311. Findings.
Sec. 312. Policy and requirements.
Sec. 313. Annual reports on prevention of mother-to-child transmission of the HIV infection.
Sec. 314. Pilot program of assistance for children and families affected by HIV/AIDS.
Sec. 315. Pilot program on family survival partnerships.

TITLE IV—AUTHORIZATION OF APPROPRIATIONS Sec. 401. Authorization of appropriations.

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Sec. 402. Sense of Congress.

Sec. 403. Allocation of funds.

Sec. 404. Assistance from the United States private sector to prevent and reduce HIV/AIDS in sub-Saharan Africa.

TITLE V—INTERNATIONAL FINANCIAL INSTITUTIONS

Sec. 501. Modification of the Enhanced HIPC Initiative. Sec. 502. Report on expansion of debt relief to non-HIPC countries. Sec. 503. Authorization of appropriations.

SEC. 2. FINDINGS.

Congress makes the following findings:

- (1) During the last 20 years, HIV/AIDS has assumed pandemic proportions, spreading from the most severely affected regions, sub-Saharan Africa and the Caribbean, to all corners of the world, and leaving an unprecedented path of death and devastation.
- (2) According to the Joint United Nations Programme on HIV/AIDS (UNAIDS), more than 65,000,000 individuals worldwide have been infected with HIV since the epidemic began, more than 25,000,000 of these individuals have lost their lives to the disease, and more than 14,000,000 children have been orphaned by the disease. HIV/AIDS is the fourth-highest cause of death in the world.
- (3)(A) At the end of 2002, an estimated 42,000,000 individuals were infected with HIV or living with AIDS, of which more than 75 percent live in Africa or the Caribbean. Of these individuals, more than 3,200,000 were children under the age of 15 and more than 19,200,000 were women.
- (B) Women are four times more vulnerable to infection than are men and are becoming infected at increasingly high rates, in part because many societies do not provide poor women and young girls with the social, legal, and cultural protections against high risk activities that expose them to HIV/AIDS.
- (C) Women and children who are refugees or are internally displaced persons are especially vulnerable to sexual exploitation and violence, thereby increasing the possibility of HIV infection.
- (4) As the leading cause of death in sub-Saharan Africa, AIDS has killed more than 19,400,000 individuals (more than 3 times the number of AIDS deaths in the rest of the world) and will claim the lives of one-quarter of the population, mostly adults, in the next decade.
- (5) An estimated 2,000,000 individuals in Latin America and the Caribbean and another 7,100,000 individuals in Asia and the Pacific region are infected with HIV or living with AIDS. Infection rates are rising alarmingly in Eastern Europe (especially in the Russian Federation), Central Asia, and China.
- (6) HIV/AIDS threatens personal security by affecting the health, lifespan, and productive capacity of the individual and the social cohesion and economic well-being of the family.
- (7) HIV/AIDS undermines the economic security of a country and individual businesses in that country by weakening the productivity and longevity of the labor force across a broad array of economic sectors and by reducing the potential for economic growth over the long term.
- (8) HIV/AIDS destabilizes communities by striking at the most mobile and educated members of society, many of whom are responsible for security at the local level and governance

at the national and subnational levels as well as many teachers, health care personnel, and other community workers vital to community development and the effort to combat HIV/AIDS. In some countries the overwhelming challenges of the HIV/AIDS epidemic are accelerating the outward migration of critically important health care professionals.

(9) HIV/AIDS weakens the defenses of countries severely affected by the HIV/AIDS crisis through high infection rates among members of their military forces and voluntary peacekeeping personnel. According to UNAIDS, in sub-Saharan Africa, many military forces have infection rates as much as five times that of the civilian population.

(10) HIV/AIDS poses a serious security issue for the international community by—

(A) increasing the potential for political instability and economic devastation, particularly in those countries and regions most severely affected by the disease;

(B) decreasing the capacity to resolve conflicts through the introduction of peacekeeping forces because the environments into which these forces are introduced pose a high risk for the spread of HIV/AIDS; and

(C) increasing the vulnerability of local populations to HIV/AIDS in conflict zones from peacekeeping troops with HIV infection rates significantly higher than civilian populations.

(11) The devastation wrought by the HIV/AIDS pandemic is compounded by the prevalence of tuberculosis and malaria, particularly in developing countries where the poorest and most vulnerable members of society, including women, children, and those individuals living with HIV/AIDS, become infected. According to the World Health Organization (WHO), HIV/AIDS, tuberculosis, and malaria accounted for more than 5,700,000 deaths in 2001 and caused debilitating illnesses in millions more.

(12) Together, HIV/AIDS, tuberculosis, malaria and related diseases are undermining agricultural production throughout Africa. According to the United Nations Food and Agricultural Organization, 7,000,000 agricultural workers throughout 25 African countries have died from AIDS since 1985. Countries with poorly developed agricultural systems, which already face chronic food shortages, are the hardest hit, particularly in sub-Saharan Africa, where high HIV prevalence rates are compounding the risk of starvation for an estimated 14,400,000 people.

(13) Tuberculosis is the cause of death for one out of every three people with AIDS worldwide and is a highly communicable disease. HIV infection is the leading threat to tuberculosis control. Because HIV infection so severely weakens the immune system, individuals with HIV and latent tuberculosis infection have a 100 times greater risk of developing active tuberculosis diseases thereby increasing the risk of spreading tuberculosis to others. Tuberculosis, in turn, accelerates the onset of AIDS in individuals infected with HIV.

(14) Malaria, the most deadly of all tropical parasitic diseases, has been undergoing a dramatic resurgence in recent years due to increasing resistance of the malaria parasite to inexpensive and effective drugs. At the same time, increasing

resistance of mosquitoes to standard insecticides makes control of transmission difficult to achieve. The World Health Organization estimates that between 300,000,000 and 500,000,000 new cases of malaria occur each year, and annual deaths from the disease number between 2,000,000 and 3,000,000. Persons infected with HIV are particularly vulnerable to the malaria parasite. The spread of HIV infection contributes to the difficulties of controlling resurgence of the drug resistant malaria parasite.

(15) HIV/AIDS is first and foremost a health problem. Successful strategies to stem the spread of the HIV/AIDS pandemic will require clinical medical interventions, the strengthening of health care delivery systems and infrastructure, and determined national leadership and increased budgetary allocations for the health sector in countries affected by the epidemic as well as measures to address the social and behavioral causes of the problem and its impact on families, communities, and societal sectors.

(16) Basic interventions to prevent new HIV infections and to bring care and treatment to people living with AIDS, such as voluntary counseling and testing and mother-to-child transmission programs, are achieving meaningful results and are cost-effective. The challenge is to expand these interventions from a pilot program basis to a national basis in a coherent and sustainable manner.

(17) Appropriate treatment of individuals with HIV/AIDS can prolong the lives of such individuals, preserve their families, prevent children from becoming orphans, and increase productivity of such individuals by allowing them to lead active lives and reduce the need for costly hospitalization for treatment of opportunistic infections caused by HIV.

(18) Nongovernmental organizations, including faith-based organizations, with experience in health care and HIV/AIDS counseling, have proven effective in combating the HIV/AIDS pandemic and can be a resource in assisting indigenous organizations in severely affected countries in their efforts to provide treatment and care for individuals infected with HIV/ AIDS.

(19) Faith-based organizations are making an important contribution to HIV prevention and AIDS treatment programs around the world. Successful HIV prevention programs in Uganda, Jamaica, and elsewhere have included local churches and faith-based groups in efforts to promote behavior changes to prevent HIV, to reduce stigma associated with HIV infection, to treat those afflicted with the disease, and to care for orphans. The Catholic Church alone currently cares for one in four people being treated for AIDS worldwide. Faith-based organizations possess infrastructure, experience, and knowledge that will be needed to carry out these programs in the future and should be an integral part of United States efforts. (20)(A) Uganda has experienced the most significant decline in HIV rates of any country in Africa, including a decrease among pregnant women from 20.6 percent in 1991 to 7.9 percent in 2000.

(B) Uganda made this remarkable turnaround because President Yoweri Museveni spoke out early, breaking long-standing cultural taboos, and changed widespread perceptions

about the disease. His leadership stands as a model for ways political leaders in Africa and other developing countries can mobilize their nations, including civic organizations, professional associations, religious institutions, business and labor to combat HIV/AIDS.

(C) Uganda's successful AIDS treatment and prevention program is referred to as the ABC model: "Abstain, Be faithful, use Condoms", in order of priority. Jamaica, Zambia, Ethiopia and Senegal have also successfully used the ABC model. Beginning in 1986, Uganda brought about a fundamental change in sexual behavior by developing a low-cost program with the message: "Stop having multiple partners. Be faithful. Teenagers, wait until you are married before you begin sex."

(D) By 1995, 95 percent of Ugandans were reporting either one or zero sexual partners in the past year, and the proportion of sexually active youth declined significantly from the late 1980s to the mid-1990s. The greatest percentage decline in HIV infections and the greatest degree of behavioral change occurred in those 15 to 19 years old. Uganda's success shows that behavior change, through the use of the ABC model, is a very successful way to prevent the spread of HIV.

(21) The magnitude and scope of the HIV/AIDS crisis demands a comprehensive, long-term, international response focused upon addressing the causes, reducing the spread, and ameliorating the consequences of the HIV/AIDS pandemic, including—

(A) prevention and education, care and treatment, basic and applied research, and training of health care workers, particularly at the community and provincial levels, and other community workers and leaders needed to cope with the range of consequences of the HIV/AIDS crisis;

(B) development of health care infrastructure and delivery systems through cooperative and coordinated public efforts and public and private partnerships;

(C) development and implementation of national and community-based multisector strategies that address the impact of HIV/AIDS on the individual, family, community, and nation and increase the participation of at-risk populations in programs designed to encourage behavioral and social change and reduce the stigma associated with HIV/AIDS; and

(D) coordination of efforts between international organizations such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Joint United Nations Programme on HIV/AIDS (UNAIDS), the World Health Organization (WHO), national governments, and private sector organizations, including faith-based organizations.

(22) The United States has the capacity to lead and enhance the effectiveness of the international community's response by—

(A) providing substantial financial resources, technical expertise, and training, particularly of health care personnel and community workers and leaders;

(B) promoting vaccine and microbicide research and the development of new treatment protocols in the public and commercial pharmaceutical research sectors;

(C) making available pharmaceuticals and diagnostics for HIV/AIDS therapy;

(D) encouraging governments and faith-based and community-based organizations to adopt policies that treat HIV/AIDS as a multisectoral public health problem affecting not only health but other areas such as agriculture, education, the economy, the family and society, and assisting them to develop and implement programs corresponding to these needs;

(E) promoting healthy lifestyles, including abstinence, delaying sexual debut, monogamy, marriage, faithfulness, use of condoms, and avoiding substance abuse; and

(F) encouraging active involvement of the private sector, including businesses, pharmaceutical and biotechnology companies, the medical and scientific communities, charitable foundations, private and voluntary organizations and nongovernmental organizations, faith-based organizations, community-based organizations, and other nonprofit entities.

(23) Prostitution and other sexual victimization are degrading to women and children and it should be the policy of the United States to eradicate such practices. The sex industry, the trafficking of individuals into such industry, and sexual violence are additional causes of and factors in the spread of the HIV/AIDS epidemic. One in nine South Africans is living with AIDS, and sexual assault is rampant, at a victimization rate of one in three women. Meanwhile in Cambodia, as many as 40 percent of prostitutes are infected with HIV and the country has the highest rate of increase of HIV infection in all of Southeast Asia. Victims of coercive sexual encounters do not get to make choices about their sexual activities.

(24) Strong coordination must exist among the various agencies of the United States to ensure effective and efficient use of financial and technical resources within the United States Government with respect to the provision of international HIV/AIDS assistance.

(25) In his address to Congress on January 28, 2003, the President announced the Administration's intention to embark on a five-year emergency plan for AIDS relief, to confront HIV/AIDS with the goals of preventing 7,000,000 new HIV/AIDS infections, treating at least 2,000,000 people with life-extending drugs, and providing humane care for millions of people suffering from HIV/AIDS, and for children orphaned by HIV/AIDS.

(26) In this address to Congress, the President stated the following: "Today, on the continent of Africa, nearly 30,000,000 people have the AIDS virus—including 3,000,000 children under the age of 15. There are whole countries in Africa where more than one-third of the adult population carries the infection. More than 4,000,000 require immediate drug treatment. Yet across that continent, only 50,000 AIDS victims—only 50,000—are receiving the medicine they need."

(27) Furthermore, the President focused on care and treatment of HIV/AIDS in his address to Congress, stating the following: "Because the AIDS diagnosis is considered a death sentence, many do not seek treatment. Almost all who do are turned away. A doctor in rural South Africa describes his frustration. He says, 'We have no medicines. Many hospitals tell people, you've got AIDS, we can't help you. Go home and

die.’ In an age of miraculous medicines, no person should have to hear those words. AIDS can be prevented. Anti-retroviral drugs can extend life for many years * * * Ladies and gentlemen, seldom has history offered a greater opportunity to do so much for so many.”

(28) Finally, the President stated that “[w]e have confronted, and will continue to confront, HIV/AIDS in our own country”, proposing now that the United States should lead the world in sparing innocent people from a plague of nature, and asking Congress “to commit \$15,000,000,000 over the next five years, including nearly \$10,000,000,000 in new money, to turn the tide against AIDS in the most afflicted nations of Africa and the Caribbean”.

SEC. 3. DEFINITIONS.

In this Act:

- (1) AIDS.—The term “AIDS” means the acquired immune deficiency syndrome.
- (2) APPROPRIATE CONGRESSIONAL COMMITTEES.—The term “appropriate congressional committees” means the Committee on Foreign Relations of the Senate and the Committee on International Relations of the House of Representatives.
- (3) GLOBAL FUND.—The term “Global Fund” means the public-private partnership known as the Global Fund to Fight AIDS, Tuberculosis and Malaria established pursuant to Article 80 of the Swiss Civil Code.
- (4) HIV.—The term “HIV” means the human immunodeficiency virus, the pathogen that causes AIDS.
- (5) HIV/AIDS.—The term “HIV/AIDS” means, with respect to an individual, an individual who is infected with HIV or living with AIDS.
- (6) RELEVANT EXECUTIVE BRANCH AGENCIES.—The term “relevant executive branch agencies” means the Department of State, the United States Agency for International Development, and any other department or agency of the United States that participates in international HIV/AIDS activities pursuant to the authorities of such department or agency or the Foreign Assistance Act of 1961.

SEC. 4. PURPOSE.

The purpose of this Act is to strengthen United States leadership and the effectiveness of the United States response to certain global infectious diseases by—

- (1) establishing a comprehensive, integrated five-year, global strategy to fight HIV/AIDS that encompasses a plan for phased expansion of critical programs and improved coordination among relevant executive branch agencies and between the United States and foreign governments and international organizations;
- (2) providing increased resources for multilateral efforts to fight HIV/AIDS;
- (3) providing increased resources for United States bilateral efforts, particularly for technical assistance and training, to combat HIV/AIDS, tuberculosis, and malaria;
- (4) encouraging the expansion of private sector efforts and expanding public-private sector partnerships to combat HIV/ AIDS; and

(5) intensifying efforts to support the development of vaccines and treatment for HIV/AIDS, tuberculosis, and malaria.

SEC. 5. AUTHORITY TO CONSOLIDATE AND COMBINE REPORTS.

With respect to the reports required by this Act to be submitted by the President, to ensure an efficient use of resources, the President may, in his discretion and notwithstanding any other provision of this Act, consolidate or combine any of these reports, except for the report required by section 101 of this Act, so long as the required elements of each report are addressed and reported within a 90-day period from the original deadline date for submission of the report specified in this Act. The President may also enter into contracts with organizations with relevant expertise to develop, originate, or contribute to any of the reports required by this Act to be submitted by the President.

TITLE I—POLICY PLANNING AND COORDINATION

SEC. 101. DEVELOPMENT OF A COMPREHENSIVE, FIVE-YEAR, GLOBAL STRATEGY.

(a) **STRATEGY.**—The President shall establish a comprehensive, integrated, five-year strategy to combat global HIV/AIDS that strengthens the capacity of the United States to be an effective leader of the international campaign against HIV/AIDS. Such strategy shall maintain sufficient flexibility and remain responsive to the ever-changing nature of the HIV/AIDS pandemic and shall—

- (1) include specific objectives, multisectoral approaches, and specific strategies to treat individuals infected with HIV/AIDS and to prevent the further spread of HIV infections, with a particular focus on the needs of families with children (including the prevention of mother-to-child transmission), women, young people, and children (such as unaccompanied minor children and orphans);
- (2) as part of the strategy, implement a tiered approach to direct delivery of care and treatment through a system based on central facilities augmented by expanding circles of local delivery of care and treatment through local systems and capacity;
- (3) assign priorities for relevant executive branch agencies;
- (4) provide that the reduction of HIV/AIDS behavioral risks shall be a priority of all prevention efforts in terms of funding, educational messages, and activities by promoting abstinence from sexual activity and substance abuse, encouraging monogamy and faithfulness, promoting the effective use of condoms, and eradicating prostitution, the sex trade, rape, sexual assault and sexual exploitation of women and children;
- (5) improve coordination and reduce duplication among relevant executive branch agencies, foreign governments, and international organizations;
- (6) project general levels of resources needed to achieve the stated objectives;
- (7) expand public-private partnerships and the leveraging of resources;

(8) maximize United States capabilities in the areas of technical assistance and training and research, including vaccine research;

(9) establish priorities for the distribution of resources based on factors such as the size and demographics of the population with HIV/AIDS, tuberculosis, and malaria and the needs of that population and the existing infrastructure or funding levels that may exist to cure, treat, and prevent HIV/AIDS, tuberculosis, and malaria; and

(10) include initiatives describing how the President will maximize the leverage of private sector dollars in reduction and treatment of HIV/AIDS, tuberculosis, and malaria.

(b) REPORT.—

(1) IN GENERAL.—Not later than 270 days after the date of enactment of this Act, the President shall submit to the appropriate congressional committees a report setting forth the strategy described in subsection (a).

(2) REPORT CONTENTS.—The report required by paragraph

(1) shall include a discussion of the elements described in paragraph (3) and may include a discussion of additional elements relevant to the strategy described in subsection (a). Such discussion may include an explanation as to why a particular element described in paragraph (3) is not relevant to such strategy.

(3) REPORT ELEMENTS.—The elements referred to in paragraph (2) are the following:

(A) The objectives, general and specific, of the strategy.

(B) A description of the criteria for determining success of the strategy.

(C) A description of the manner in which the strategy will address the fundamental elements of prevention and education, care, and treatment (including increasing access to pharmaceuticals and to vaccines), the promotion of abstinence, monogamy, avoidance of substance abuse, and use of condoms, research (including incentives for vaccine development and new protocols), training of health care workers, the development of health care infrastructure and delivery systems, and avoidance of substance abuse.

(D) A description of the manner in which the strategy will promote the development and implementation of national and community-based multisectoral strategies and programs, including those designed to enhance leadership capacity particularly at the community level.

(E) A description of the specific strategies developed to meet the unique needs of women, including the empowerment of women in interpersonal situations, young people and children, including those orphaned by HIV/AIDS and those who are victims of the sex trade, rape, sexual abuse, assault, and exploitation.

(F) A description of the specific strategies developed to encourage men to be responsible in their sexual behavior, child rearing and to respect women including the reduction of sexual violence and coercion.

(G) A description of the specific strategies developed to increase women's access to employment opportunities, income, productive resources, and microfinance programs.

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- (H) A description of the programs to be undertaken to maximize United States contributions in the areas of technical assistance, training (particularly of health care workers and community-based leaders in affected sectors), and research, including the promotion of research on vaccines and microbicides.
- (I) An identification of the relevant executive branch agencies that will be involved and the assignment of priorities to those agencies.
- (J) A description of the role of each relevant executive branch agency and the types of programs that the agency will be undertaking.
- (K) A description of the mechanisms that will be utilized to coordinate the efforts of the relevant executive branch agencies, to avoid duplication of efforts, to enhance on-site coordination efforts, and to ensure that each agency undertakes programs primarily in those areas where the agency has the greatest expertise, technical capabilities, and potential for success.
- (L) A description of the mechanisms that will be utilized to ensure greater coordination between the United States and foreign governments and international organizations including the Global Fund, UNAIDS, international financial institutions, and private sector organizations.
- (M) The level of resources that will be needed on an annual basis and the manner in which those resources would generally be allocated among the relevant executive branch agencies.
- (N) A description of the mechanisms to be established for monitoring and evaluating programs, promoting successful models, and for terminating unsuccessful programs.
- (O) A description of the manner in which private, nongovernmental entities will factor into the United States Government-led effort and a description of the type of partnerships that will be created to maximize the capabilities of these private sector entities and to leverage resources.
- (P) A description of the ways in which United States leadership will be used to enhance the overall international response to the HIV/AIDS pandemic and particularly to heighten the engagement of the member states of the G-8 and to strengthen key financial and coordination mechanisms such as the Global Fund and UNAIDS.
- (Q) A description of the manner in which the United States strategy for combating HIV/AIDS relates to and supports other United States assistance strategies in developing countries.
- (R) A description of the programs to be carried out under the strategy that are specifically targeted at women and girls to educate them about the spread of HIV/AIDS.
- (S) A description of efforts being made to address the unique needs of families with children with respect to HIV/AIDS, including efforts to preserve the family unit.
- (T) An analysis of the emigration of critically important medical and public health personnel, including physicians,

nurses, and supervisors from sub-Saharan African countries that are acutely impacted by HIV/AIDS, including a description of the causes, effects, and the impact on the stability of health infrastructures, as well as a summary of incentives and programs that the United States could provide, in concert with other private and public sector partners and international organizations, to stabilize health institutions by encouraging critical personnel to remain in their home countries.

(U) A description of the specific strategies developed to promote sustainability of HIV/AIDS pharmaceuticals (including antiretrovirals) and the effects of drug resistance on HIV/AIDS patients.

(V) A description of the specific strategies to ensure that the extraordinary benefit of HIV/AIDS pharmaceuticals (especially antiretrovirals) are not diminished through the illegal counterfeiting of pharmaceuticals and black market sales of such pharmaceuticals.

(W) An analysis of the prevalence of Human Papilloma Virus (HPV) in sub-Saharan Africa and the impact that condom usage has upon the spread of HPV in sub-Saharan Africa.

(c) **STUDY; DISTRIBUTION OF RESOURCES.**—

(1) **STUDY.**—Not later than 3 years after the date of the enactment of this Act, the Institute of Medicine shall publish findings comparing the success rates of the various programs and methods used under the strategy described in subsection

(a) to reduce, prevent, and treat HIV/AIDS, tuberculosis, and malaria.

(2) **DISTRIBUTION OF RESOURCES.**—In prioritizing the distribution of resources under the strategy described in subsection (a), the President shall consider the findings published by the Institute of Medicine under this subsection.

SEC. 102. HIV/AIDS RESPONSE COORDINATOR.

(a) **ESTABLISHMENT OF POSITION.**—Section 1 of the State Department Basic Authorities Act of 1956 (22 U.S.C. 265(a)) is amended—

(1) by redesignating subsection (f) as subsection (g); and

(2) by inserting after subsection (e) the following: “(f) **HIV/AIDS RESPONSE COORDINATOR.**—

“(1) **IN GENERAL.**—There shall be established within the Department of State in the immediate office of the Secretary of State a Coordinator of United States Government Activities to Combat HIV/AIDS Globally, who shall be appointed by the President, by and with the advice and consent of the Senate. The Coordinator shall report directly to the Secretary.

“(2) **AUTHORITIES AND DUTIES; DEFINITIONS.**—

“(A) **AUTHORITIES.**—The Coordinator, acting through such nongovernmental organizations (including faith-based and community-based organizations) and relevant executive branch agencies as may be necessary and appropriate to effect the purposes of this section, is authorized—

“(i) to operate internationally to carry out prevention, care, treatment, support, capacity development, and other activities for combatting HIV/AIDS;

“(ii) to transfer and allocate funds to relevant executive branch agencies; and

“(iii) to provide grants to, and enter into contracts with, nongovernmental organizations (including faith-based and community-based organizations) to carry out the purposes of section. “(B) DUTIES.—

“(i) IN GENERAL.—The Coordinator shall have primary responsibility for the oversight and coordination of all resources and international activities of the United States Government to combat the HIV/AIDS pandemic, including all programs, projects, and activities of the United States Government relating to the HIV/AIDS pandemic under the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 or any amendment made by that Act.

“(ii) SPECIFIC DUTIES.—The duties of the Coordinator shall specifically include the following:

“(I) Ensuring program and policy coordination among the relevant executive branch agencies and nongovernmental organizations, including auditing, monitoring, and evaluation of all such programs.

“(II) Ensuring that each relevant executive branch agency undertakes programs primarily in those areas where the agency has the greatest expertise, technical capabilities, and potential for success.

“(III) Avoiding duplication of effort. “(IV) Ensuring coordination of relevant executive branch agency activities in the field. “(V) Pursuing coordination with other countries and international organizations.

“(VI) Resolving policy, program, and funding disputes among the relevant executive branch agencies.

“(VII) Directly approving all activities of the United States (including funding) relating to combatting HIV/AIDS in each of Botswana, Cote d’Ivoire, Ethiopia, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, Zambia, and other countries designated by the President, which other designated countries may include those countries in which the United States is implementing HIV/ AIDS programs as of the date of the enactment of the United States Leadership Against HIV/ AIDS, Tuberculosis, and Malaria Act of 2003.

“(VIII) Establishing due diligence criteria for all recipients of funds section and all activities subject to the coordination and appropriate monitoring, evaluation, and audits carried out by the Coordinator necessary to assess the measurable outcomes of such activities.

“(C) DEFINITIONS.—In this paragraph: “(i) AIDS.—The term ‘AIDS’ means acquired immune deficiency syndrome.

“(ii) HIV.—The term ‘HIV’ means the human immunodeficiency virus, the pathogen that causes

AIDS.

“(iii) HIV/AIDS.—The term ‘HIV/AIDS’ means, with respect to an individual, an individual who is infected with HIV or living with AIDS.

“(iv) RELEVANT EXECUTIVE BRANCH AGENCIES.— The term ‘relevant executive branch agencies’ means the Department of State, the United States Agency for International Development, the Department of Health and Human Services (including the Public Health Service), and any other department or agency of the United States that participates in international HIV/AIDS activities pursuant to the authorities of such department or agency or this Act.”.

(b) RESOURCES.—Not later than 90 days after the date of enactment of this Act, the President shall specify the necessary financial and personnel resources, from funds appropriated pursuant to the authorization of appropriations under section 401 for HIV/AIDS assistance, that shall be assigned to and under the direct control of the Coordinator of United States Government Activities to Combat HIV/AIDS Globally to establish and maintain the duties and supporting activities assigned to the Coordinator by this Act and the amendments made by this Act.

(c) ESTABLISHMENT OF SEPARATE ACCOUNT.—There is established in the general fund of the Treasury a separate account which shall be known as the “Activities to Combat HIV/AIDS Globally Fund” and which shall be administered by the Coordinator of United States Government Activities to Combat HIV/AIDS Globally. There shall be deposited into the Fund all amounts appropriated pursuant to the authorization of appropriations under section 401 for HIV/AIDS assistance, except for amounts appropriated for United States contributions to the Global Fund.

TITLE II—SUPPORT FOR MULTILATERAL FUNDS, PROGRAMS, AND PUBLIC-PRIVATE PARTNERSHIPS

SEC. 201. SENSE OF CONGRESS ON PUBLIC-PRIVATE PARTNERSHIPS.

(a) FINDINGS.—Congress makes the following findings:

- (1) Innovative partnerships between governments and organizations in the private sector (including foundations, universities, corporations, faith-based and community-based organizations, and other nongovernmental organizations) have proliferated in recent years, particularly in the area of health.
- (2) Public-private sector partnerships multiply local and international capacities to strengthen the delivery of health services in developing countries and to accelerate research for vaccines and other pharmaceutical products that are essential to combat infectious diseases decimating the populations of these countries.
- (3) These partnerships maximize the unique capabilities of each sector while combining financial and other resources, scientific knowledge, and expertise toward common goals which neither the public nor the private sector can achieve alone.

(4) Sustaining existing public-private partnerships and building new ones are critical to the success of the international community's efforts to combat HIV/AIDS and other infectious diseases around the globe.

(b) SENSE OF CONGRESS.—It is the sense of Congress that—

(1) the sustainment and promotion of public-private partnerships should be a priority element of the strategy pursued by the United States to combat the HIV/AIDS pandemic and other global health crises; and

(2) the United States should systematically track the evolution of these partnerships and work with others in the public and private sector to profile and build upon those models that are most effective.

SEC. 202. PARTICIPATION IN THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA.

(a) FINDINGS.—The Congress finds as follows:

(1) The establishment of the Global Fund in January 2002 is consistent with the general principles for an international AIDS trust fund first outlined by the Congress in the Global AIDS and Tuberculosis Relief Act of 2000 (Public Law 106– 264).

(2) Section 2, Article 5 of the bylaws of the Global Fund provides for the International Bank for Reconstruction and Development to serve as the initial collection trustee for the Global Fund.

(3) The trustee agreement signed between the Global Fund and the International Bank for Reconstruction and Development narrows the range of duties to include receiving and investing funds from donors, disbursing the funds upon the instruction of the Global Fund, reporting on trust fund resources to donors and the Global Fund, and providing an annual external audit report to the Global Fund.

(b) AUTHORITY FOR UNITED STATES PARTICIPATION.—

(1) UNITED STATES PARTICIPATION.—The United States is hereby authorized to participate in the Global Fund.

(2) PRIVILEGES AND IMMUNITIES.—The Global Fund shall be considered a public international organization for purposes of section 1 of the International Organizations Immunities Act (22 U.S.C. 288).

(c) REPORTS TO CONGRESS.—Not later than 1 year after the date of the enactment of this Act, and annually thereafter for the duration of the Global Fund, the President shall submit to the appropriate congressional committees a report on the Global Fund, including contributions pledged to, contributions (including donations from the private sector) received by, and projects funded by the Global Fund, and the mechanisms established for transparency and accountability in the grant-making process.

(d) UNITED STATES FINANCIAL PARTICIPATION.—

(1) AUTHORIZATION OF APPROPRIATIONS.—In addition to any other funds authorized to be appropriated for bilateral or multilateral HIV/AIDS, tuberculosis, or malaria programs, of the amounts authorized to be appropriated under section 401, there are authorized to be appropriated to the President up to \$1,000,000,000 for the period of fiscal year 2004 beginning on January 1, 2004, and such sums as may be necessary for

the fiscal years 2005–2008, for contributions to the Global Fund.

(2) AVAILABILITY OF FUNDS.—Amounts appropriated under paragraph (1) are authorized to remain available until expended.

(3) REPROGRAMMING OF FISCAL YEAR 2001 FUNDS.—Funds made available for fiscal year 2001 under section 141 of the Global AIDS and Tuberculosis Relief Act of 2000—

(A) are authorized to remain available until expended; and

(B) shall be transferred to, merged with, and made available for the same purposes as, funds made available for fiscal years 2004 through 2008 under paragraph (1).

(4) LIMITATION.—

(A)(i) At any time during fiscal years 2004 through 2008, no United States contribution to the Global Fund may cause the total amount of United States Government contributions to the Global Fund to exceed 33 percent of the total amount of funds contributed to the Global Fund from all sources. Contributions to the Global Fund from the International Bank for Reconstruction and Development and the International Monetary Fund shall not be considered in determining compliance with this paragraph.

(ii) If, at any time during any of the fiscal years 2004 through 2008, the President determines that the Global Fund has provided assistance to a country, the government of which the Secretary of State has determined, for purposes of section 6(j)(1) of the Export Administration Act of 1979 (50 U.S.C. App. 2405(j)(1)), has repeatedly provided support for acts of international terrorism, then the United States shall withhold from its contribution for the next fiscal year an amount equal to the amount expended by the Fund to the government of each such country.

(iii) If at any time the President determines that the expenses of the Governing, Administrative, and Advisory Bodies (including the Partnership Forum, the Foundation Board, the Secretariat, and the Technical Review Board) of the Global Fund exceed 10 percent of the total expenditures of the Fund for any 2-year period, the United States shall withhold from its contribution for the next fiscal year an amount equal to the average annual amount expended by the Fund for such 2-year period for the expenses of the Governing, Administrative, and Advisory Bodies in excess of 10 percent of the total expenditures of the Fund.

(iv) The President may waive the application of clause

(iii) if the President determines that extraordinary circumstances warrant such a waiver. No waiver under this clause may be for any period that exceeds 1 year.

(v) If, at any time during any of the fiscal years 2004 through 2008, the President determines that the salary of any individual employed by the Global Fund exceeds the salary of the Vice President of the United States (as determined under section 104 of title 3, United States Code) for that fiscal year, then the United States shall withhold from its contribution for the next fiscal year an

amount equal to the aggregate amount by which the salary of each such individual exceeds the salary of the Vice President of the United States.

(B)(i) Any amount made available under this subsection that is withheld by reason of subparagraph (A)(i) shall be contributed to the Global Fund as soon as practicable, subject to subparagraph (A)(i), after additional contributions to the Global Fund are made from other sources.

(ii) Any amount made available under this subsection that is withheld by reason of subparagraph (A)(iii) shall be transferred to the Activities to Combat HIV/AIDS Globally Fund and shall remain available under the same terms and conditions as funds appropriated pursuant to the authorization of appropriations under section 401 for HIV/AIDS assistance.

(iii) Any amount made available under this subsection that is withheld by reason of clause (ii) or (iii) of subparagraph (A) is authorized to be made available to carry out section 104A of the Foreign Assistance Act of 1961 (as added by section 301 of this Act). Amounts made available under the preceding sentence are in addition to amounts appropriated pursuant to the authorization of appropriations under section 401 of this Act for HIV/AIDS assistance.

(C)(i) The President may suspend the application of subparagraph (A) with respect to a fiscal year if the President determines that an international health emergency threatens the national security interests of the United States.

(ii) The President shall notify the Committee on International Relations of the House of Representatives and the Committee on Foreign Relations of the Senate not less than 5 days before making a determination under clause (i) with respect to the application of subparagraph (A)(i) and shall include in the notification—

- (I) a justification as to why increased United States Government contributions to the Global Fund is preferable to increased United States assistance to combat HIV/AIDS, tuberculosis, and malaria on a bilateral basis; and
- (II) an explanation as to why other government donors to the Global Fund are unable to provide adequate contributions to the Fund.

(e) INTERAGENCY TECHNICAL REVIEW PANEL.—

(1) ESTABLISHMENT.—The Coordinator of United States Government Activities to Combat HIV/AIDS Globally, established in section 1(f)(1) of the State Department Basic Authorities Act of 1956 (as added by section 102(a) of this Act), shall establish in the executive branch an interagency technical review panel.

(2) DUTIES.—The interagency technical review panel shall serve as a “shadow” panel to the Global Fund by—

(A) periodically reviewing all proposals received by the Global Fund; and

(B) providing guidance to the United States persons who are representatives on the panels, committees, and boards of the Global Fund, on the technical efficacy, suitability, and appropriateness of the proposals, and ensuring

that such persons are fully informed of technical inadequacies or other aspects of the proposals that are inconsistent with the purposes of this or any other Act relating to the provision of foreign assistance in the area of AIDS.

(3) **MEMBERSHIP.**—The interagency technical review panel shall consist of qualified medical and development experts who are officers or employees of the Department of Health and Human Services, the Department of State, and the United States Agency for International Development.

(4) **CHAIR.**—The Coordinator referred to in paragraph (1) shall chair the interagency technical review panel.

(f) **MONITORING BY COMPTROLLER GENERAL.**—

(1) **MONITORING.**—The Comptroller General shall monitor and evaluate projects funded by the Global Fund.

(2) **REPORT.**—The Comptroller General shall on a biennial basis shall prepare and submit to the appropriate congressional committees a report that contains the results of the monitoring and evaluation described in paragraph (1) for the preceding 2-year period.

(g) **PROVISION OF INFORMATION TO CONGRESS.**—The Coordinator of United States Government Activities to Combat HIV/AIDS Globally shall make available to the Congress the following documents within 30 days of a request by the Congress for such documents:

(1) All financial and accounting statements for the Global Fund and the Activities to Combat HIV/AIDS Globally Fund, including administrative and grantee statements.

(2) Reports provided to the Global Fund and the Activities to Combat HIV/AIDS Globally Fund by organizations contracted to audit recipients of funds.

(3) Project proposals submitted by applicants for funding from the Global Fund and the Activities to Combat HIV/AIDS Globally Fund, but which were not funded.

(4) Progress reports submitted to the Global Fund and the Activities to Combat HIV/AIDS Globally Fund by grantees.

(h) **SENSE OF THE CONGRESS REGARDING ENCOURAGEMENT OF PRIVATE CONTRIBUTIONS TO THE GLOBAL FUND.**—It is the sense of the Congress that the President should—

(1) conduct an outreach campaign that is designed to—

(A) inform the public of the existence of—

(i) the Global Fund; and

(ii) any entity that will accept private contributions intended for use by the Global Fund; and

(B) encourage private contributions to the Global Fund; and

(2) encourage private contributions intended for use by the Global Fund by—

(A) establishing and operating an Internet website, and publishing information about the website; and

(B) making public service announcements on radio and television.

SEC. 203. VOLUNTARY CONTRIBUTIONS TO INTERNATIONAL VACCINE FUNDS.

(a) **VACCINE FUND.**—Section 302(k) of the Foreign Assistance Act of 1961 (22 U.S.C. 2222(k)) is amended—

(1) by striking “\$50,000,000 for each of the fiscal years 2001 and 2002” and inserting “such sums as may be necessary for each of the fiscal years 2004 through 2008”; and
(2) by striking “Global Alliance for Vaccines and Immunizations” and inserting “Vaccine Fund”.

(b) INTERNATIONAL AIDS VACCINE INITIATIVE.—Section 302(l) of the Foreign Assistance Act of 1961 (22 U.S.C. 2222(l)) is amended by striking “\$10,000,000 for each of the fiscal years 2001 and 2002” and inserting “such sums as may be necessary for each of the fiscal years 2004 through 2008”.

(c) SUPPORT FOR THE DEVELOPMENT OF MALARIA VACCINE.— Section 302 of the Foreign Assistance Act of 1961 (22 U.S.C. 2222) is amended by adding at the end the following new subsection: “(m) In addition to amounts otherwise available under this section, there are authorized to be appropriated to the President such sums as may be necessary for each of the fiscal years 2004 through 2008 to be available for United States contributions to malaria vaccine development programs, including the Malaria Vaccine Initiative of the Program for Appropriate Technologies in Health (PATH).”.

TITLE III—BILATERAL EFFORTS

Subtitle A—General Assistance and Programs

SEC. 301. ASSISTANCE TO COMBAT HIV/AIDS.

(a) AMENDMENT OF THE FOREIGN ASSISTANCE ACT OF 1961.— Chapter 1 of part I of the Foreign Assistance Act of 1961 (22 U.S.C. 2151 et seq.) is amended—

(1) in section 104(c) (22 U.S.C. 2151b(c)), by striking paragraphs (4) through (7);
and

(2) by inserting after section 104 the following new section:

“SEC. 104A. ASSISTANCE TO COMBAT HIV/AIDS.

“(a) FINDING.—Congress recognizes that the alarming spread of HIV/AIDS in countries in sub-Saharan Africa, the Caribbean, and other developing countries is a major global health, national security, development, and humanitarian crisis.

“(b) POLICY.—It is a major objective of the foreign assistance program of the United States to provide assistance for the prevention, treatment, and control of HIV/AIDS. The United States and other developed countries should provide assistance to countries in sub-Saharan Africa, the Caribbean, and other countries and areas to control this crisis through HIV/AIDS prevention, treatment, monitoring, and related activities, particularly activities focused on women and youth, including strategies to protect women and prevent mother-to-child transmission of the HIV infection.

“(c) AUTHORIZATION.—

“(1) IN GENERAL.—Consistent with section 104(c), the President is authorized to furnish assistance, on such terms and conditions as the President may determine, for HIV/AIDS, including to prevent, treat, and monitor HIV/AIDS, and carry out related activities, in countries in sub-Saharan Africa, the Caribbean, and other countries and areas.

“(2) ROLE OF NGOS.—It is the sense of Congress that the President should provide an appropriate level of assistance under paragraph (1) through nongovernmental organizations (including faith-based and community-based organizations) in countries in sub-Saharan Africa, the Caribbean, and other countries and areas affected by the HIV/AIDS pandemic.

“(3) COORDINATION OF ASSISTANCE EFFORTS.—The President shall coordinate the provision of assistance under paragraph

(1) with the provision of related assistance by the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Children’s Fund (UNICEF), the World Health Organization (WHO), the United Nations Development Programme (UNDP), the Global Fund to Fight AIDS, Tuberculosis and Malaria and other appropriate international organizations (such as the International Bank for Reconstruction and Development), relevant regional multilateral development institutions, national, state, and local governments of foreign countries, appropriate governmental and nongovernmental organizations, and relevant executive branch agencies. “(d)

ACTIVITIES SUPPORTED.—Assistance provided under sub section (c) shall, to the maximum extent practicable, be used to carry out the following activities: “(1) PREVENTION.—Prevention of HIV/AIDS through activities including—

“(A) programs and efforts that are designed or intended to impart knowledge with the exclusive purpose of helping individuals avoid behaviors that place them at risk of HIV infection, including integration of such programs into health programs and the inclusion in counseling programs of information on methods of avoiding infection of HIV, including delaying sexual debut, abstinence, fidelity and monogamy, reduction of casual sexual partnering, reducing sexual violence and coercion, including child marriage, widow inheritance, and polygamy, and where appropriate, use of condoms;

“(B) assistance to establish and implement culturally appropriate HIV/AIDS education and prevention programs that focus on helping individuals avoid infection of HIV/ AIDS, implemented through nongovernmental organizations, including faith-based and community-based organizations, particularly those organizations that utilize both professionals and volunteers with appropriate skills, experience, and community presence;

“(C) assistance for the purpose of encouraging men to be responsible in their sexual behavior, child rearing, and to respect women;

“(D) assistance for the purpose of providing voluntary testing and counseling (including the incorporation of confidentiality protections with respect to such testing and counseling);

“(E) assistance for the purpose of preventing mother-to-child transmission of the HIV infection, including medications to prevent such transmission and access to infant formula and other alternatives for infant feeding;

“(F) assistance to ensure a safe blood supply and sterile medical equipment;

“(G) assistance to help avoid substance abuse and intravenous drug use that can lead to HIV infection; and

(H) assistance for the purpose of increasing women’s access to employment opportunities, income, productive resources, and microfinance programs, where appropriate. “(2) TREATMENT.—The treatment and care of individuals with HIV/AIDS, including—

“(A) assistance to establish and implement programs to strengthen and broaden indigenous health care delivery systems and the capacity of such systems to deliver HIV/ AIDS pharmaceuticals and otherwise provide for the treatment of individuals with HIV/AIDS, including clinical training for indigenous organizations and health care providers;

“(B) assistance to strengthen and expand hospice and palliative care programs to assist patients debilitated by HIV/AIDS, their families, and the primary caregivers of such patients, including programs that utilize faith-based and community-based organizations; and

“(C) assistance for the purpose of the care and treatment of individuals with HIV/AIDS through the provision of pharmaceuticals, including antiretrovirals and other pharmaceuticals and therapies for the treatment of opportunistic infections, nutritional support, and other treatment modalities. “(3) PREVENTATIVE INTERVENTION EDUCATION AND TECH

NOLOGIES.—(A) With particular emphasis on specific populations that represent a particularly high risk of contracting or spreading HIV/AIDS, including those exploited through the sex trade, victims of rape and sexual assault, individuals already infected with HIV/AIDS, and in cases of occupational exposure of health care workers, assistance with efforts to reduce the risk of HIV/AIDS infection including post-exposure pharmaceutical prophylaxis, and necessary pharmaceuticals and commodities, including test kits, condoms, and, when proven effective, microbicides.

“(B) Bulk purchases of available test kits, condoms, and, when proven effective, microbicides that are intended to reduce the risk of HIV/AIDS transmission and for appropriate program support for the introduction and distribution of these commodities, as well as education and training on the use of the technologies.

“(4) MONITORING.—The monitoring of programs, projects, and activities carried out pursuant to paragraphs (1) through (3), including—

“(A) monitoring to ensure that adequate controls are established and implemented to provide HIV/AIDS pharmaceuticals and other appropriate medicines to poor individuals with HIV/AIDS;

“(B) appropriate evaluation and surveillance activities;

“(C) monitoring to ensure that appropriate measures are being taken to maintain the sustainability of HIV/ AIDS pharmaceuticals (especially antiretrovirals) and ensure that drug resistance is not compromising the benefits of such pharmaceuticals; and

“(D) monitoring to ensure appropriate law enforcement officials are working to ensure that HIV/AIDS pharmaceuticals are not diminished through illegal counterfeiting or black market sales of such pharmaceuticals. “(5)

PHARMACEUTICALS.—

“(A) PROCUREMENT.—The procurement of HIV/AIDS pharmaceuticals, antiviral therapies, and other appropriate medicines, including medicines to treat opportunistic infections.

“(B) MECHANISMS FOR QUALITY CONTROL AND SUSTAINABLE SUPPLY.—Mechanisms to ensure that such HIV/AIDS pharmaceuticals, antiretroviral therapies, and other appropriate medicines are quality-controlled and sustainably supplied.

“(C) DISTRIBUTION.—The distribution of such HIV/ AIDS pharmaceuticals, antiviral therapies, and other appropriate medicines (including medicines to treat opportunistic infections) to qualified national, regional, or local organizations for the treatment of individuals with HIV/AIDS in accordance with appropriate HIV/AIDS testing and monitoring requirements and treatment protocols and for the prevention of mother-to-child transmission of the HIV infection. “(6) RELATED ACTIVITIES.—The conduct of related activities,

including— “(A) the care and support of children who are orphaned by the HIV/AIDS pandemic, including services designed to care for orphaned children in a family environment which rely on extended family members; “(B) improved infrastructure and institutional capacity to develop and manage education, prevention, and treatment programs, including training and the resources to collect and maintain accurate HIV surveillance data to target programs and measure the effectiveness of interventions; and “(C) vaccine research and development partnership programs with specific plans of action to develop a safe, effective, accessible, preventive HIV vaccine for use throughout the world. “(7) COMPREHENSIVE HIV/AIDS PUBLIC-PRIVATE PARTNER-

SHIPS.—The establishment and operation of public-private partnership entities within countries in sub-Saharan Africa, the Caribbean, and other countries affected by the HIV/AIDS pandemic that are dedicated to supporting the national strategy of such countries regarding the prevention, treatment, and monitoring of HIV/AIDS. Each such public-private partnership

should— “(A) support the development, implementation, and management of comprehensive HIV/AIDS plans in support of the national HIV/AIDS strategy; “(B) operate at all times in a manner that emphasizes efficiency, accountability, and results-driven programs; “(C) engage both local and foreign development partners and donors, including businesses, government agencies, academic institutions, nongovernmental organizations, foundations, multilateral development agencies, and faith-based organizations, to assist the country in coordinating

and implementing HIV/AIDS prevention, treatment, and monitoring programs in accordance with its national HIV/AIDS strategy;

“(D) provide technical assistance, consultant services, financial planning, monitoring and evaluation, and research in support of the national HIV/AIDS strategy; and

“(E) establish local human resource capacities for the national HIV/AIDS strategy through the transfer of medical, managerial, leadership, and technical skills.

“(e) ANNUAL REPORT.—

“(1) IN GENERAL.—Not later than January 31 of each year, the President shall submit to the Committee on Foreign Relations of the Senate and the Committee on International Relations of the House of Representatives a report on the implementation of this section for the prior fiscal year.

“(2) REPORT ELEMENTS.—Each report shall include—

“(A) a description of efforts made by each relevant executive branch agency to implement the policies set forth in this section, section 104B, and section 104C;

“(B) a description of the programs established pursuant to such sections; and “(C) a detailed assessment of the impact of programs established pursuant to such sections, including—

“(i)(I) the effectiveness of such programs in reducing the spread of the HIV infection, particularly in women and girls, in reducing mother-to-child transmission of the HIV infection, and in reducing mortality rates from HIV/AIDS; and

“(II) the number of patients currently receiving treatment for AIDS in each country that receives assistance under this Act.

“(ii) the progress made toward improving health care delivery systems (including the training of adequate numbers of staff) and infrastructure to ensure increased access to care and treatment;

“(iii) with respect to tuberculosis, the increase in the number of people treated and the increase in number of tuberculosis patients cured through each program, project, or activity receiving United States foreign assistance for tuberculosis control purposes; and

“(iv) with respect to malaria, the increase in the number of people treated and the increase in number of malaria patients cured through each program, project, or activity receiving United States foreign assistance for malaria control purposes.

“(f) FUNDING LIMITATION.—Of the funds made available to carry

out this section in any fiscal year, not more than 7 percent may be used for the administrative expenses of the United States Agency for International Development in support of activities described in section 104(c), this section, section 104B, and section 104C.

Such amount shall be in addition to other amounts otherwise available for such purposes. “(g) DEFINITIONS.—In this section: “(1) AIDS.—The term ‘AIDS’ means acquired immune deficiency syndrome.

“(2) HIV.—The term ‘HIV’ means the human immunodeficiency virus, the pathogen that causes AIDS.

“(3) HIV/AIDS.—The term ‘HIV/AIDS’ means, with respect to an individual, an individual who is infected with HIV or living with AIDS.

“(4) RELEVANT EXECUTIVE BRANCH AGENCIES.—The term ‘relevant executive branch agencies’ means the Department of State, the United States Agency for International Development, the Department of Health and Human Services (including its agencies and offices), and any other department or agency of the United States that participates in international HIV/ AIDS activities pursuant to the authorities of such department or agency or this Act.”.

(b) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—In addition to funds available under section 104(c) of the Foreign Assistance Act of 1961 (22 U.S.C. 2151b(c)) for such purpose or under any other provision of that Act, there are authorized to be appropriated to the President, from amounts authorized to be appropriated under section 401, such sums as may be necessary for each of the fiscal years 2004 through 2008 to carry out section 104A of the Foreign Assistance Act of 1961, as added by subsection (a).

(2) AVAILABILITY OF FUNDS.—Amounts appropriated pursuant to paragraph (1) are authorized to remain available until expended.

(3) ALLOCATION OF FUNDS.—Of the amount authorized to be appropriated by paragraph (1) for the fiscal years 2004 through 2008, such sums as may be necessary are authorized to be appropriated to carry out section 104A(d)(4) of the Foreign Assistance Act of 1961 (as added by subsection (a)), relating to the procurement and distribution of HIV/AIDS pharmaceuticals.

(c) RELATIONSHIP TO ASSISTANCE PROGRAMS TO ENHANCE NUTRITION.—In recognition of the fact that malnutrition may hasten the progression of HIV to AIDS and may exacerbate the decline among AIDS patients leading to a shorter life span, the Administrator of the United States Agency for International Development shall, as appropriate—

(1) integrate nutrition programs with HIV/AIDS activities, generally;

(2) provide, as a component of an anti-retroviral therapy program, support for food and nutrition to individuals infected with and affected by HIV/AIDS; and

(3) provide support for food and nutrition for children affected by HIV/AIDS and to communities and households caring for children affected by HIV/AIDS.

(d) ELIGIBILITY FOR ASSISTANCE.—An organization that is otherwise eligible to receive assistance under section 104A of the Foreign Assistance Act of 1961 (as added by subsection (a)) or under any other provision of this Act (or any amendment made by this Act) to prevent, treat, or monitor HIV/AIDS shall not be required, as a condition of receiving the assistance, to endorse or utilize a multisectoral approach to combatting HIV/AIDS, or to endorse, utilize, or participate in a prevention method or treatment program to which the organization has a religious or moral objection.

(e) LIMITATION.—No funds made available to carry out this Act, or any amendment made by this Act, may be used to promote

or advocate the legalization or practice of prostitution or sex trafficking. Nothing in the preceding sentence shall be construed to preclude the provision to individuals of palliative care, treatment, or post-exposure pharmaceutical prophylaxis, and necessary pharmaceuticals and commodities, including test kits, condoms, and, when proven effective, microbicides.

(f) **LIMITATION.**—No funds made available to carry out this Act, or any amendment made by this Act, may be used to provide assistance to any group or organization that does not have a policy explicitly opposing prostitution and sex trafficking.

(g) **SENSE OF CONGRESS RELATING TO FOOD ASSISTANCE FOR INDIVIDUALS LIVING WITH HIV/AIDS.**—

(1) **FINDINGS.**—Congress finds the following:

(A) The United States provides more than 60 percent of all food assistance worldwide.

(B) According to the United Nations World Food Program and other United Nations agencies, food insecurity of individuals infected or living with HIV/AIDS is a major problem in countries with large populations of such individuals, particularly in African countries.

(C) Although the United States is willing to provide food assistance to these countries in need, a few of the countries object to part or all of the assistance because of fears of benign genetic modifications to the foods.

(D) Healthy and nutritious foods for individuals infected or living with HIV/AIDS are an important complement to HIV/AIDS medicines for such individuals.

(E) Individuals infected with HIV have higher nutritional requirements than individuals who are not infected with HIV, particularly with respect to the need for protein. Also, there is evidence to suggest that the full benefit of therapy to treat HIV/AIDS may not be achieved in individuals who are malnourished, particularly in pregnant and lactating women.

(2) **SENSE OF CONGRESS.**—It is therefore the sense of Congress that United States food assistance should be accepted by countries with large populations of individuals infected or living with HIV/AIDS, particularly African countries, in order to help feed such individuals.

SEC. 302. ASSISTANCE TO COMBAT TUBERCULOSIS.

(a) **AMENDMENT OF THE FOREIGN ASSISTANCE ACT OF 1961.**— Chapter 1 of part I of the Foreign Assistance Act of 1961 (22 U.S.C. 2151 et seq.), as amended by section 301 of this Act, is further amended by inserting after section 104A the following new section:

“SEC. 104B. ASSISTANCE TO COMBAT TUBERCULOSIS.

“(a) **FINDINGS.**—Congress makes the following findings:

“(1) Congress recognizes the growing international problem of tuberculosis and the impact its continued existence has on those countries that had previously largely controlled the disease.

“(2) Congress further recognizes that the means exist to control and treat tuberculosis through expanded use of the DOTS (Directly Observed Treatment Short-course) treatment strategy, including DOTS-Plus to address multi-drug resistant

tuberculosis, and adequate investment in newly created mechanisms to increase access to treatment, including the Global Tuberculosis Drug Facility established in 2001 pursuant to the Amsterdam Declaration to Stop TB and the Global Alliance for TB Drug Development. “(b) POLICY.—It is a major objective of the foreign assistance program of the United States to control tuberculosis, including the detection of at least 70 percent of the cases of infectious tuberculosis, and the cure of at least 85 percent of the cases detected, not later than December 31, 2005, in those countries classified by the World Health Organization as among the highest tuberculosis burden, and not later than December 31, 2010, in all countries in which the United States Agency for International Development has established development programs.

“(c) AUTHORIZATION.—To carry out this section and consistent with section 104(c), the President is authorized to furnish assistance, on such terms and conditions as the President may determine, for the prevention, treatment, control, and elimination of tuberculosis.

“(d) COORDINATION.—In carrying out this section, the President shall coordinate with the World Health Organization, the Global Fund to Fight AIDS, Tuberculosis, and Malaria, and other organizations with respect to the development and implementation of a comprehensive tuberculosis control program.

“(e) PRIORITY TO DOTS COVERAGE.—In furnishing assistance under subsection (c), the President shall give priority to activities that increase Directly Observed Treatment Short-course (DOTS) coverage and treatment of multi-drug resistant tuberculosis where needed using DOTS-Plus, including funding for the Global Tuberculosis Drug Facility, the Stop Tuberculosis Partnership, and the Global Alliance for TB Drug Development. In order to meet the requirement of the preceding sentence, the President should ensure that not less than 75 percent of the amount made available to carry out this section for a fiscal year should be expended for antituberculosis drugs, supplies, direct patient services, and training in diagnosis and treatment for Directly Observed Treatment Short-course (DOTS) coverage and treatment of multi-drug resistant tuberculosis using DOTS-Plus, including substantially increased funding for the Global Tuberculosis Drug Facility.

“(f) DEFINITIONS.—In this section:

“(1) DOTS.—The term ‘DOTS’ or ‘Directly Observed Treatment Short-course’ means the World Health Organization-recommended strategy for treating tuberculosis.

“(2) DOTS-PLUS.—The term ‘DOTS-Plus’ means a comprehensive tuberculosis management strategy that is built upon and works as a supplement to the standard DOTS strategy, and which takes into account specific issues (such as use of second line anti-tuberculosis drugs) that need to be addressed in areas where there is high prevalence of multi-drug resistant tuberculosis.

“(3) GLOBAL ALLIANCE FOR TUBERCULOSIS DRUG DEVELOPMENT.—The term ‘Global Alliance for Tuberculosis Drug Development’ means the public-private partnership that brings together leaders in health, science, philanthropy, and private industry to devise new approaches to tuberculosis and to ensure that new medications are available and affordable in high tuberculosis burden countries and other affected countries.

“(4) GLOBAL TUBERCULOSIS DRUG FACILITY.—The term ‘Global Tuberculosis Drug Facility (GDF)’ means the new initiative of the Stop Tuberculosis Partnership to increase access to high-quality tuberculosis drugs to facilitate DOTS expansion.

“(5) STOP TUBERCULOSIS PARTNERSHIP.—The term ‘Stop Tuberculosis Partnership’ means the partnership of the World Health Organization, donors including the United States, high tuberculosis burden countries, multilateral agencies, and non-governmental and technical agencies committed to short- and long-term measures required to control and eventually eliminate tuberculosis as a public health problem in the world.”.

(b) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—In addition to funds available under section 104(c) of the Foreign Assistance Act of 1961 (22 U.S.C. 2151b(c)) for such purpose or under any other provision of that Act, there are authorized to be appropriated to the President, from amounts authorized to be appropriated under section 401, such sums as may be necessary for each of the fiscal years 2004 through 2008 to carry out section 104B of the Foreign Assistance Act of 1961, as added by subsection (a).

(2) AVAILABILITY OF FUNDS.—Amounts appropriated pursuant to the authorization of appropriations under paragraph

(1) are authorized to remain available until expended.

(3) TRANSFER OF PRIOR YEAR FUNDS.—Unobligated balances of funds made available for fiscal year 2001, 2002, or 2003 under section 104(c)(7) of the Foreign Assistance Act of 1961 (22 U.S.C. 2151b(c)(7) (as in effect immediately before the date of enactment of this Act) shall be transferred to, merged with, and made available for the same purposes as funds made available for fiscal years 2004 through 2008 under paragraph (1).

SEC. 303. ASSISTANCE TO COMBAT MALARIA.

(a) AMENDMENT OF THE FOREIGN ASSISTANCE ACT OF 1961.— Chapter 1 of part I of the Foreign Assistance Act of 1961 (22 U.S.C. 2151 et seq.), as amended by sections 301 and 302 of this Act, is further amended by inserting after section 104B the following new section:

“SEC. 104C. ASSISTANCE TO COMBAT MALARIA.

“(a) FINDING.—Congress finds that malaria kills more people annually than any other communicable disease except tuberculosis, that more than 90 percent of all malaria cases are in sub-Saharan Africa, and that children and women are particularly at risk. Congress recognizes that there are cost-effective tools to decrease the spread of malaria and that malaria is a curable disease if promptly diagnosed and adequately treated.

“(b) POLICY.—It is a major objective of the foreign assistance program of the United States to provide assistance for the prevention, control, and cure of malaria.

“(c) AUTHORIZATION.—To carry out this section and consistent with section 104(c), the President is authorized to furnish assistance, on such terms and conditions as the President may determine, for the prevention, treatment, control, and elimination of malaria.

“(d) COORDINATION.—In carrying out this section, the President shall coordinate with the World Health Organization, the Global Fund to Fight AIDS, Tuberculosis, and Malaria, the Department of Health and Human Services (the Centers for Disease Control

and Prevention and the National Institutes of Health), and other organizations with respect to the development and implementation of a comprehensive malaria control program.”.

(b) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—In addition to funds available under section 104(c) of the Foreign Assistance Act of 1961 (22 U.S.C. 2151b(c)) for such purpose or under any other provision of that Act, there are authorized to be appropriated to the President, from amounts authorized to be appropriated under section 401, such sums as may be necessary for fiscal years 2004 through 2008 to carry out section 104C of the Foreign Assistance Act of 1961, as added by subsection (a), including for the development of anti-malarial pharmaceuticals by the Medicines for Malaria Venture.

(2) AVAILABILITY OF FUNDS.—Amounts appropriated pursuant to paragraph (1) are authorized to remain available until expended.

(3) TRANSFER OF PRIOR YEAR FUNDS.—Unobligated balances of funds made available for fiscal year 2001, 2002, or 2003 under section 104(c) of the Foreign Assistance Act of 1961 (22 U.S.C. 2151b(c)) (as in effect immediately before the date of enactment of this Act) and made available for the control of malaria shall be transferred to, merged with, and made available for the same purposes as funds made available for fiscal years 2004 through 2008 under paragraph (1).

(c) CONFORMING AMENDMENT.—Section 104(c) of the Foreign Assistance Act of 1961 (22 U.S.C. 2151b(c)), as amended by section 301 of this Act, is further amended by adding after paragraph

(3) the following:

“(4) RELATIONSHIP TO OTHER LAWS.—Assistance made available under this subsection and sections 104A, 104B, and 104C, and assistance made available under chapter 4 of part II to carry out the purposes of this subsection and the provisions cited in this paragraph, may be made available notwithstanding any other provision of law that restricts assistance to foreign countries, except for the provisions of this subsection, the provisions of law cited in this paragraph, subsection (f), section 634A of this Act, and provisions of law that limit assistance to organizations that support or participate in a program of coercive abortion or involuntary sterilization included under the Child Survival and Health Programs Fund heading in the Consolidated Appropriations Resolution, 2003 (Public Law 108–7).”.

SEC. 304. PILOT PROGRAM FOR THE PLACEMENT OF HEALTH CARE PROFESSIONALS IN OVERSEAS AREAS SEVERELY AFFECTED BY HIV/AIDS, TUBERCULOSIS, AND MALARIA.

(a) IN GENERAL.—The President should establish a program to demonstrate the feasibility of facilitating the service of United States health care professionals in those areas of sub-Saharan Africa and other parts of the world severely affected by HIV/AIDS, tuberculosis, and malaria.

(b) REQUIREMENTS.—Participants in the program shall—

(1) provide basic health care services for those infected and affected by HIV/AIDS, tuberculosis, and malaria in the area in which they are serving;

- (2) provide on-the-job training to medical and other personnel in the area in which they are serving to strengthen the basic health care system of the affected countries;
 - (3) provide health care educational training for residents of the area in which they are serving;
 - (4) serve for a period of up to 3 years; and
 - (5) meet the eligibility requirements in subsection (d).
- (c) ELIGIBILITY REQUIREMENTS.—To be eligible to participate in the program, a candidate shall—
- (1) be a national of the United States who is a trained health care professional and who meets the educational and licensure requirements necessary to be such a professional such as a physician, nurse, physician assistant, nurse practitioner, pharmacist, other type of health care professional, or other individual determined to be appropriate by the President; or
 - (2) be a retired commissioned officer of the Public Health Service Corps.
- (d) RECRUITMENT.—The President shall ensure that information on the program is widely distributed, including the distribution of information to schools for health professionals, hospitals, clinics, and nongovernmental organizations working in the areas of international health and aid.
- (e) PLACEMENT OF PARTICIPANTS.—
- (1) IN GENERAL.—To the maximum extent practicable, participants in the program shall serve in the poorest areas of the affected countries, where health care needs are likely to be the greatest. The decision on the placement of a participant should be made in consultation with relevant officials of the affected country at both the national and local level as well as with local community leaders and organizations.
 - (2) COORDINATION.—Placement of participants in the program shall be coordinated with the United States Agency for International Development in countries in which that Agency is conducting HIV/AIDS, tuberculosis, or malaria programs. Overall coordination of placement of participants in the program shall be made by the Coordinator of United States Government Activities to Combat HIV/AIDS Globally (as described in section 1(f) of the State Department Basic Authorities Act of 1956 (as added by section 102(a) of this Act)).
- (f) INCENTIVES.—The President may offer such incentives as the President determines to be necessary to encourage individuals to participate in the program, such as partial payment of principal, interest, and related expenses on government and commercial loans for educational expenses relating to professional health training and, where possible, deferment of repayments on such loans, the provision of retirement benefits that would otherwise be jeopardized by participation in the program, and other incentives.
- (g) REPORT.—Not later than 18 months after the date of enactment of this Act, the President shall submit to the appropriate congressional committees a report on steps taken to establish the program, including—
- (1) the process of recruitment, including the venues for recruitment, the number of candidates recruited, the incentives offered, if any, and the cost of those incentives;
 - (2) the process, including the criteria used, for the selection of participants;

(3) the number of participants placed, the countries in which they were placed, and why those countries were selected; and

(4) the potential for expansion of the program.

(h) **AUTHORIZATION OF APPROPRIATIONS.**—

(1) **IN GENERAL.**—In addition to amounts otherwise available for such purpose, there are authorized to be appropriated to the President, from amounts authorized to be appropriated under section 401, such sums as may be necessary for each of the fiscal years 2004 through 2008 to carry out the program.

(2) **AVAILABILITY OF FUNDS.**—Amounts appropriated pursuant to the authorization of appropriations under paragraph

(1) are authorized to remain available until expended.

SEC. 305. REPORT ON TREATMENT ACTIVITIES BY RELEVANT EXECUTIVE BRANCH AGENCIES.

(a) **IN GENERAL.**—Not later than 15 months after the date of enactment of this Act, the President shall submit to appropriate congressional committees a report on the programs and activities of the relevant executive branch agencies that are directed to the treatment of individuals in foreign countries infected with HIV or living with AIDS.

(b) **REPORT ELEMENTS.**—The report shall include—

(1) a description of the activities of relevant executive branch agencies with respect to—

(A) the treatment of opportunistic infections;

(B) the use of antiretrovirals;

(C) the status of research into successful treatment protocols for individuals in the developing world;

(D) technical assistance and training of local health care workers (in countries affected by the pandemic) to administer antiretrovirals, manage side effects, and monitor patients' viral loads and immune status;

(E) the status of strategies to promote sustainability of HIV/AIDS pharmaceuticals (including antiretrovirals) and the effects of drug resistance on HIV/AIDS patients; and

(F) the status of appropriate law enforcement officials working to ensure that HIV/AIDS pharmaceutical treatment is not diminished through illegal counterfeiting and black market sales of such pharmaceuticals;

(2) information on existing pilot projects, including a discussion of why a given population was selected, the number of people treated, the cost of treatment, the mechanisms established to ensure that treatment is being administered effectively and safely, and plans for scaling up pilot projects (including projected timelines and required resources); and

(3) an explanation of how those activities relate to efforts to prevent the transmission of the HIV infection.

SEC. 306. STRATEGIES TO IMPROVE INJECTION SAFETY.

Section 307 of the Public Health Service Act (42 U.S.C. 242l) is amended by adding at the end the following:

“(d) In carrying out immunization programs and other programs in developing countries for the prevention, treatment, and control of infectious diseases, including HIV/AIDS, tuberculosis, and

malaria, the Director of the Centers for Disease Control and Prevention, in coordination with the Coordinator of United States Government Activities to Combat HIV/AIDS Globally, the National Institutes of Health, national and local government, and other organizations, such as the World Health Organization and the United Nations Children’s Fund, shall develop and implement effective strategies to improve injection safety, including eliminating unnecessary injections, promoting sterile injection practices and technologies, strengthening the procedures for proper needle and syringe disposal, and improving the education and information provided to the public and to health professionals.”.

SEC. 307. STUDY ON ILLEGAL DIVERSIONS OF PRESCRIPTION DRUGS.

Not later than 180 days after enactment of this Act, the Secretary of Health and Human Services, in coordination with other agencies, shall submit a report to the Congress that includes the following:

- (1) A thorough accounting of evidence indicating illegal diversion into the United States of prescription drugs donated or sold for humanitarian efforts, and an estimate of the extent of such diversion.
- (2) Recommendations to increase the administrative and enforcement powers of the United States to identify, monitor, and prevent the illegal diversion into the United States of prescription drugs donated or sold for humanitarian efforts.
- (3) Recommendations and guidelines to advise and provide technical assistance to developing countries on how to implement a program that minimizes diversion into the United States of prescription drugs donated or sold for humanitarian efforts.

Subtitle B—Assistance for Children and Families

SEC. 311. FINDINGS.

Congress makes the following findings:

- (1) Approximately 2,000 children around the world are infected each day with HIV through mother-to-child transmission. Transmission can occur during pregnancy, labor, and delivery or through breast feeding. Over 90 percent of these cases are in developing nations with little or no access to public health facilities.
- (2) Mother-to-child transmission is largely preventable with the proper application of pharmaceuticals, therapies, and other public health interventions.
- (3) Certain antiretroviral drugs reduce mother-to-child transmission by nearly 50 percent. Universal availability of this drug could prevent up to 400,000 infections per year and dramatically reduce the number of AIDS-related deaths.
- (4) At the United Nations Special Session on HIV/AIDS in June 2001, the United States committed to the specific goals with respect to the prevention of mother-to-child transmission, including the goals of reducing the proportion of infants infected with HIV by 20 percent by the year 2005 and by 50 percent by the year 2010, as specified in the Declaration of Commitment on HIV/AIDS adopted by the United Nations General Assembly at the Special Session.

(5) Several United States Government agencies including the United States Agency for International Development and the Centers for Disease Control are already supporting programs to prevent mother-to-child transmission in resource-poor nations and have the capacity to expand these programs rapidly by working closely with foreign governments and nongovernmental organizations.

(6) Efforts to prevent mother-to-child transmission can provide the basis for a broader response that includes care and treatment of mothers, fathers, and other family members who are infected with HIV or living with AIDS.

(7) HIV/AIDS has devastated the lives of countless children and families across the globe. Since the epidemic began, an estimated 13,200,000 children under the age of 15 have been orphaned by AIDS, that is they have lost their mother or both parents to the disease. The Joint United Nations Program on HIV/AIDS (UNAIDS) estimates that this number will double by the year 2010.

(8) HIV/AIDS also targets young people between the ages of 15 to 24, particularly young women, many of whom carry the burden of caring for family members living with HIV/AIDS. An estimated 10,300,000 young people are now living with HIV/AIDS. One-half of all new infections are occurring among this age group.

SEC. 312. POLICY AND REQUIREMENTS.

(a) **POLICY.**—The United States Government’s response to the global HIV/AIDS pandemic should place high priority on the prevention of mother-to-child transmission, the care and treatment of family members and caregivers, and the care of children orphaned by AIDS. To the maximum extent possible, the United States Government should seek to leverage its funds by seeking matching contributions from the private sector, other national governments, and international organizations.

(b) **REQUIREMENTS.**—The 5-year United States Government strategy required by section 101 of this Act shall—

- (1) provide for meeting or exceeding the goal to reduce the rate of mother-to-child transmission of HIV by 20 percent by 2005 and by 50 percent by 2010;
- (2) include programs to make available testing and treatment to HIV-positive women and their family members, including drug treatment and therapies to prevent mother-to-child transmission; and
- (3) expand programs designed to care for children orphaned by AIDS.

SEC. 313. ANNUAL REPORTS ON PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF THE HIV INFECTION.

(a) **IN GENERAL.**—Not later than 1 year after the date of the enactment of this Act, and annually thereafter for a period of 5 years, the President shall submit to appropriate congressional committees a report on the activities of relevant executive branch agencies during the reporting period to assist in the prevention of mother-to-child transmission of the HIV infection.

(b) **REPORT ELEMENTS.**—Each report shall include—

- (1) a statement of whether or not all relevant executive branch agencies have met the goal described in section 312(b)(1); and

- (2) a description of efforts made by the relevant executive branch agencies to expand those activities, including—
- (A) information on the number of sites supported for the prevention of mother-to-child transmission of the HIV infection;
 - (B) the specific activities supported;
 - (C) the number of women tested and counseled; and
 - (D) the number of women receiving preventative drug therapies.

(c) **REPORTING PERIOD DEFINED.**—In this section, the term “reporting period” means, in the case of the initial report, the period since the date of enactment of this Act and, in the case of any subsequent report, the period since the date of submission of the most recent report.

SEC. 314. PILOT PROGRAM OF ASSISTANCE FOR CHILDREN AND FAMILIES AFFECTED BY HIV/AIDS.

- (a) **IN GENERAL.**—The President, acting through the United States Agency for International Development, should establish a program of assistance that would demonstrate the feasibility of the provision of care and treatment to orphans and other children and young people affected by HIV/AIDS in foreign countries.
- (b) **PROGRAM REQUIREMENTS.**—The program should—
- (1) build upon and be integrated into programs administered as of the date of enactment of this Act by the relevant executive branch agencies for children affected by HIV/AIDS;
 - (2) work in conjunction with indigenous community-based programs and activities, particularly those that offer proven services for children;
 - (3) reduce the stigma of HIV/AIDS to encourage vulnerable children infected with HIV or living with AIDS and their family members and caregivers to avail themselves of voluntary counseling and testing, and related programs, including treatments;
 - (4) ensure the importance of inheritance rights of women, particularly women in African countries, due to the exponential growth in the number of young widows, orphaned girls, and grandmothers becoming heads of households as a result of the HIV/AIDS pandemic;
 - (5) provide, in conjunction with other relevant executive branch agencies, the range of services for the care and treatment, including the provision of antiretrovirals and other necessary pharmaceuticals, of children, parents, and caregivers infected with HIV or living with AIDS;
 - (6) provide nutritional support and food security, and the improvement of overall family health;
 - (7) work with parents, caregivers, and community-based organizations to provide children with educational opportunities; and
 - (8) provide appropriate counseling and legal assistance for the appointment of guardians and the handling of other issues relating to the protection of children.
- (c) **REPORT.**—Not later than 18 months after the date of enactment of this Act, the President should submit a report on the implementation of this section to the appropriate congressional committees. Such report should include a description of activities undertaken to carry out subsection (b)(4).
- (d) **AUTHORIZATION OF APPROPRIATIONS.**—

(1) **IN GENERAL.**—In addition to amounts otherwise available for such purpose, there are authorized to be appropriated to the President, from amounts authorized to be appropriated under section 401, such sums as may be necessary for each of the fiscal years 2004 through 2008 to carry out the program. A significant percentage of the amount appropriated pursuant to the authorization of appropriations under the preceding sentence for a fiscal year should be made available to carry out subsection (b)(4).

(2) **AVAILABILITY OF FUNDS.**—Amounts appropriated pursuant to paragraph (1) are authorized to remain available until expended.

SEC. 315. PILOT PROGRAM ON FAMILY SURVIVAL PARTNERSHIPS.

(a) **PURPOSE.**—The purpose of this section is to authorize the President to establish a program, through a public-private partnership, for the provision of medical care and support services to HIV positive parents and their children identified through existing programs to prevent mother-to-child transmission of HIV in countries with or at risk for severe HIV epidemic with particular attention to resource constrained countries.

(b) **GRANTS.**—

(1) **IN GENERAL.**—The President is authorized to establish a program for the award of grants to eligible administrative organizations to enable such organizations to award subgrants to eligible entities to expand activities to prevent the mother-to-child transmission of HIV by providing medical care and support services to HIV infected parents and their children.

(2) **USE OF FUNDS.**—Amounts provided under a grant awarded under paragraph (1) shall be used—

(A) to award subgrants to eligible entities to enable such entities to carry out activities described in subsection (c);

(B) for administrative support and subgrant management;

(C) for administrative data collection and reporting concerning grant activities;

(D) for the monitoring and evaluation of grant activities;

(E) for training and technical assistance for sub-grantees; and

(F) to promote sustainability.

(c) **SUBGRANTS.**—

(1) **IN GENERAL.**—An organization awarded a grant under subsection (b) shall use amounts received under the grant to award subgrants to eligible entities.

(2) **ELIGIBILITY.**—To be eligible to receive a subgrant under paragraph (1), an entity shall—

(A) be a local health organization, an international organization, or a partnership of such organizations; and

(B) demonstrate to the awarding organization that such entity—

(i) is currently administering a proven intervention to prevent mother-to-child transmission of HIV in countries with or at risk for severe HIV epidemic with particular attention to resource constrained countries, as determined by the President;

- (ii) has demonstrated support for the proposed program from relevant government entities; and
 - (iii) is able to provide HIV care, including antiretroviral treatment when medically indicated, to HIV positive women, men, and children with the support of the project funding.
- (3) LOCAL HEALTH AND INTERNATIONAL ORGANIZATIONS.— For purposes of paragraph (2)(A)—
- (A) the term “local health organization” means a public sector health system, nongovernmental organization, institution of higher education, community-based organization, or nonprofit health system that provides directly, or has a clear link with a provider for the indirect provision of, primary health care services; and
 - (B) the term “international organization” means—
 - (i) a nonprofit international entity;
 - (ii) an international charitable institution;
 - (iii) a private voluntary international entity; or
 - (iv) a multilateral institution.
- (4) PRIORITY REQUIREMENT.—In awarding subgrants under this subsection, the organization shall give priority to eligible applicants that are currently administering a program of proven intervention to HIV positive individuals to prevent mother-to-child transmission in countries with or at risk for severe HIV epidemic with particular attention to resource constrained countries, and who are currently administering a program to HIV positive women, men, and children to provide life-long care in family-centered care programs using non-Federal funds.
- (5) SELECTION OF SUBGRANT RECIPIENTS.—In awarding sub-grants under this subsection, the organization should—
- (A) consider applicants from a range of health care settings, program approaches, and geographic locations; and
 - (B) if appropriate, award not less than 1 grant to an applicant to fund a national system of health care delivery to HIV positive families.
- (6) USE OF SUBGRANT FUNDS.—An eligible entity awarded a subgrant under this subsection shall use subgrant funds to expand activities to prevent mother-to-child transmission of HIV by providing medical treatment and care and support services to parents and their children, which may include—
- (A) providing treatment and therapy, when medically indicated, to HIV-infected women, their children, and families;
 - (B) the hiring and training of local personnel, including physicians, nurses, other health care providers, counselors, social workers, outreach personnel, laboratory technicians, data managers, and administrative support personnel;
 - (C) paying laboratory costs, including costs related to necessary equipment and diagnostic testing and monitoring (including rapid testing), complete blood counts, standard chemistries, and liver function testing for infants, children, and parents, and costs related to the purchase of necessary laboratory equipment;
 - (D) purchasing pharmaceuticals for HIV-related conditions, including antiretroviral therapies;

(E) funding support services, including adherence and psychosocial support services;

(F) operational support activities; and

(G) conducting community outreach and capacity building activities, including activities to raise the awareness of individuals of the program carried out by the sub-grantee, other communications activities in support of the program, local advisory board functions, and transportation necessary to ensure program participation.

(d) **REPORTS.**—The President shall require that each organization awarded a grant under subsection (b)(1) to submit an annual report that includes—

(1) the progress of programs funded under this section;

(2) the benchmarks of success of programs funded under this section; and

(3) recommendations of how best to proceed with the programs funded under this section upon the expiration of funding under subsection (e).

(e) **FUNDING.**—There are authorized to be appropriated to the President, from amounts authorized to be appropriated under section 401, such sums as may be necessary for each of the fiscal years 2004 through 2008 to carry out the program.

(f) **LIMITATION ON ADMINISTRATIVE EXPENSES.**—An organization shall ensure that not more than 7 percent of the amount of a grant received under this section by the organization is used for administrative expenses.

TITLE IV—AUTHORIZATION OF APPROPRIATIONS

SEC. 401. AUTHORIZATION OF APPROPRIATIONS.

(a) **IN GENERAL.**—There are authorized to be appropriated to the President to carry out this Act and the amendments made by this Act \$3,000,000,000 for each of the fiscal years 2004 through 2008.

(b) **AVAILABILITY.**—Amounts appropriated pursuant to the authorization of appropriations in subsection (a) are authorized to remain available until expended.

(c) **AVAILABILITY OF AUTHORIZATIONS.**—Authorizations of appropriations under subsection (a) shall remain available until the appropriations are made.

SEC. 402. SENSE OF CONGRESS.

(a) **INCREASE IN HIV/AIDS ANTIRETROVIRAL TREATMENT.**—It is a sense of the Congress that an urgent priority of United States assistance programs to fight HIV/AIDS should be the rapid increase in distribution of antiretroviral treatment so that—

(1) by the end of fiscal year 2004, at least 500,000 individuals with HIV/AIDS are receiving antiretroviral treatment through United States assistance programs;

(2) by the end of fiscal year 2005, at least 1,000,000 such individuals are receiving such treatment; and

(3) by the end of fiscal year 2006, at least 2,000,000 such individuals are receiving such treatment.

(b) **EFFECTIVE DISTRIBUTION OF HIV/AIDS FUNDS.**—It is the sense of Congress that, of the amounts appropriated pursuant to

the authorization of appropriations under section 401 for HIV/ AIDS assistance, an effective distribution of such amounts would be—

- (1) 55 percent of such amounts for treatment of individuals with HIV/AIDS;
- (2) 15 percent of such amounts for palliative care of individuals with HIV/AIDS;
- (3) 20 percent of such amounts for HIV/AIDS prevention consistent with section 104A(d) of the Foreign Assistance Act of 1961 (as added by section 301 of this Act), of which such amount at least 33 percent should be expended for abstinence-until-marriage programs; and
- (4) 10 percent of such amounts for orphans and vulnerable children.

SEC. 403. ALLOCATION OF FUNDS.

(a) THERAPEUTIC MEDICAL CARE.—For fiscal years 2006 through 2008, not less than 55 percent of the amounts appropriated pursuant to the authorization of appropriations under section 401 for HIV/AIDS assistance for each such fiscal year shall be expended for therapeutic medical care of individuals infected with HIV, of which such amount at least 75 percent should be expended for the purchase and distribution of antiretroviral pharmaceuticals and at least 25 percent should be expended for related care. For fiscal years 2006 through 2008, not less than 33 percent of the amounts appropriated pursuant to the authorization of appropriations under section 401 for HIV/AIDS prevention consistent with section 104A(d) of the Foreign Assistance Act of 1961 (as added by section 301 of this Act) for each such fiscal year shall be expended for abstinence-until-marriage programs.

(b) ORPHANS AND VULNERABLE CHILDREN.—For fiscal years 2006 through 2008, not less than 10 percent of the amounts appropriated pursuant to the authorization of appropriations under section 401 for HIV/AIDS assistance for each such fiscal year shall be expended for assistance for orphans and vulnerable children affected by HIV/AIDS, of which such amount at least 50 percent shall be provided through non-profit, nongovernmental organizations, including faith-based organizations, that implement programs on the community level.

SEC. 404. ASSISTANCE FROM THE UNITED STATES PRIVATE SECTOR

TO PREVENT AND REDUCE HIV/AIDS IN SUB-SAHARAN AFRICA.

It is the sense of Congress that United States businesses should be encouraged to provide assistance to sub-Saharan African countries to prevent and reduce the incidence of HIV/AIDS in sub-Saharan Africa. In providing such assistance, United States businesses should be encouraged to consider the establishment of an HIV/AIDS Response Fund in order to provide for coordination among such businesses in the collection and distribution of the assistance to sub-Saharan African countries.

TITLE V—INTERNATIONAL FINANCIAL INSTITUTIONS

SEC. 501. MODIFICATION OF THE ENHANCED HIPC INITIATIVE.

Title XVI of the International Financial Institutions Act (22 U.S.C. 262p–262p–7) is amended by adding at the end the following new section:

“SEC. 1625. MODIFICATION OF THE ENHANCED HIPC INITIATIVE.

“(a) AUTHORITY.—

“(1) IN GENERAL.—The Secretary of the Treasury should immediately commence efforts within the Paris Club of Official Creditors, the International Bank for Reconstruction and Development, the International Monetary Fund, and other appropriate multilateral development institutions to modify the Enhanced HIPC Initiative so that the amount of debt stock reduction approved for a country eligible for debt relief under the Enhanced HIPC Initiative shall be sufficient to reduce, for each of the first 3 years after the date of enactment of this section or the Decision Point, whichever is later—

“(A) the net present value of the outstanding public and publicly guaranteed debt of the country— “(i) as of the decision point if the country has already reached its decision point; or “(ii) as of the date of enactment of this Act, if

the country has not reached its decision point, to not more than 150 percent of the annual value of exports of the country for the year preceding the Decision Point; and

“(B) the annual payments due on such public and publicly guaranteed debt to not more than—

“(i) 10 percent or, in the case of a country suffering a public health crisis (as defined in subsection (e)), not more than 5 percent, of the amount of the annual current revenues received by the country from internal resources; or “(ii) a percentage of the gross national product of the country, or another benchmark, that will yield a result substantially equivalent to that which would be achieved through application of subparagraph (A).

“(2) LIMITATION.—In financing the objectives of the Enhanced HIPC Initiative, an international financial institution shall give priority to using its own resources.

“(b) RELATION TO POVERTY AND THE ENVIRONMENT.—Debt cancellation under the modifications to the Enhanced HIPC Initiative described in subsection (a) should not be conditioned on any agreement by an impoverished country to implement or comply with policies that deepen poverty or degrade the environment, including any policy that— “(1) implements or extends user fees on primary education or primary health care, including prevention and treatment efforts for HIV/AIDS, tuberculosis, malaria, and infant, child, and maternal well-being; “(2) provides for increased cost recovery from poor people to finance basic public services such as education, health care, clean water, or sanitation;

“(3) reduces the country’s minimum wage to a level of less than \$2 per day or undermines workers’ ability to exercise effectively their internationally recognized worker rights, as defined under section 526(e) of the Foreign Operations, Export Financing and Related Programs Appropriations Act, 1995 (22

U.S.C. 262p–4p); or

“(4) promotes unsustainable extraction of resources or results in reduced budget support for environmental programs. “(c) CONDITIONS.—A country shall not be eligible for cancella

tion of debt under modifications to the Enhanced HIPC Initiative

described in subsection (a) if the government of the country— “(1) has an excessive level of military expenditures; “(2) has repeatedly provided support for acts of international terrorism, as determined by the Secretary of State under section 6(j)(1) of the Export Administration Act of 1979 (50 U.S.C. App. 2405(j)(1)) or section 620A(a) of the Foreign Assistance Act of 1961 (22 U.S.C. 2371(a)); “(3) is failing to cooperate on international narcotics control matters; or “(4) engages in a consistent pattern of gross violations of internationally recognized human rights (including its military or other security forces). “(d) PROGRAMS TO COMBAT HIV/AIDS AND POVERTY.—A

country that is otherwise eligible to receive cancellation of debt

under the modifications to the Enhanced HIPC Initiative described

in subsection (a) may receive such cancellation only if the country

has agreed— “(1) to ensure that the financial benefits of debt cancellation are applied to programs to combat HIV/AIDS and poverty, in particular through concrete measures to improve basic services in health, education, nutrition, and other development priorities, and to redress environmental degradation; “(2) to ensure that the financial benefits of debt cancellation are in addition to the government’s total spending on poverty reduction for the previous year or the average total of such expenditures for the previous 3 years, whichever is greater; “(3) to implement transparent and participatory policy-making and budget procedures, good governance, and effective anticorruption measures; and “(4) to broaden public participation and popular understanding of the principles and goals of poverty reduction. “(e) DEFINITIONS.—In this section: “(1) COUNTRY SUFFERING A PUBLIC HEALTH CRISIS.—The term ‘country suffering a public health crisis’ means a country in which the HIV/AIDS infection rate, as reported in the most recent epidemiological data for that country compiled by the Joint United Nations Program on HIV/AIDS, is at least 5 percent among women attending prenatal clinics or more than 20 percent among individuals in groups with high-risk behavior. “(2) DECISION POINT.—The term ‘Decision Point’ means the date on which the executive boards of the International Bank for Reconstruction and Development and the International Monetary Fund review the debt sustainability analysis for a country and determine that the country is eligible for debt relief under the Enhanced HIPC Initiative.

“(3) ENHANCED HIPC INITIATIVE.—The term ‘Enhanced HIPC Initiative’ means the multilateral debt initiative for

heavily indebted poor countries presented in the Report of G-7 Finance Ministers on the Cologne Debt Initiative to the Cologne Economic Summit, Cologne, June 18–20, 1999.”.

SEC. 502. REPORT ON EXPANSION OF DEBT RELIEF TO NON-HIPC COUNTRIES.

(a) **IN GENERAL.**—Not later than 90 days after the date of enactment of this Act, the Secretary of the Treasury shall submit to Congress a report on—

(1) the options and costs associated with the expansion of debt relief provided by the Enhanced HIPC Initiative to include poor countries that were not eligible for inclusion in the Enhanced HIPC Initiative;

(2) options for burden-sharing among donor countries and multilateral institutions of costs associated with the expansion of debt relief; and

(3) options, in addition to debt relief, to ensure debt sustainability in poor countries, particularly in cases when the poor country has suffered an external economic shock or a natural disaster.

(b) **SPECIFIC OPTIONS TO BE CONSIDERED.**—Among the options for the expansion of debt relief provided by the Enhanced HIPC Initiative, consideration should be given to making eligible for that relief poor countries for which outstanding public and publicly guaranteed debt requires annual payments in excess of 10 percent or, in the case of a country suffering a public health crisis (as defined in section 1625(e) of the Financial Institutions Act, as added by section 501 of this Act), not more than 5 percent, of the amount of the annual current revenues received by the country from internal resources.

(c) **ENHANCED HIPC INITIATIVE DEFINED.**—In this section, the term “Enhanced HIPC Initiative” means the multilateral debt initiative for heavily indebted poor countries presented in the Report of G-7 Finance Ministers on the Cologne Debt Initiative to the Cologne Economic Summit, Cologne, June 18–20, 1999.

SEC. 503. AUTHORIZATION OF APPROPRIATIONS.

(a) **IN GENERAL.**—There are authorized to be appropriated to the President such sums as may be necessary for the fiscal year 2004 and each fiscal year thereafter to carry out section 1625 of the International Financial Institutions Act, as added by section 501 of this Act.

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(b) **AVAILABILITY OF FUNDS.**—Amounts appropriated pursuant to subsection (a) are authorized to remain available until expended.

Speaker of the House of Representatives.

*Vice President of the United States and
President of the Senate.*

Source: PEPFAR (2012) “United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003” <http://www.pepfar.gov/documents/organization/108294.pdf> [19 March 2012].

Annex 4 – Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008

H. R. 5501
One Hundred Tenth Congress of the United States of America

AT THE SECOND SESSION

Begun and held at the City of Washington on Thursday, the third day of January, two thousand and eight

An Act

To authorize appropriations for fiscal years 2009 through 2013 to provide assistance to foreign countries to combat HIV/AIDS, tuberculosis, and malaria, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) **SHORT TITLE.**—This Act may be cited as the “Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/ AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008”.

(b) **TABLE OF CONTENTS.**—The table of contents for this Act is as follows:

Sec. 1. Short title; table of contents. Sec. 2. Findings. Sec. 3. Definitions. Sec. 4. Purpose. Sec. 5. Authority to consolidate and combine reports.

TITLE I—POLICY PLANNING AND COORDINATION

Sec. 101. Development of an updated, comprehensive, 5-year, global strategy. Sec. 102. Interagency working group. Sec. 103. Sense of Congress.

TITLE II—SUPPORT FOR MULTILATERAL FUNDS, PROGRAMS, AND PUBLIC-PRIVATE PARTNERSHIPS

Sec. 201. Voluntary contributions to international vaccine funds.
Sec. 202. Participation in the Global Fund to Fight AIDS, Tuberculosis and Malaria.
Sec. 203. Research on methods for women to prevent transmission of HIV and other diseases.
Sec. 204. Combating HIV/AIDS, tuberculosis, and malaria by strengthening health policies and health systems of partner countries.
Sec. 205. Facilitating effective operations of the Centers for Disease Control.
Sec. 206. Facilitating vaccine development.

TITLE III—BILATERAL EFFORTS

Subtitle A—General Assistance and Programs

Sec. 301. Assistance to combat HIV/AIDS. Sec. 302. Assistance to combat tuberculosis. Sec. 303. Assistance to combat malaria. Sec. 304. Malaria Response Coordinator. Sec. 305. Amendment to Immigration and Nationality Act. Sec. 306. Clerical amendment. Sec. 307. Requirements. Sec. 308. Annual report on prevention of mother-to-child transmission of HIV. Sec. 309. Prevention of mother-to-child transmission expert panel.

TITLE IV—FUNDING ALLOCATIONS

Sec. 401. Authorization of appropriations.

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Sec. 402. Sense of Congress. Sec. 403. Allocation of funds.

TITLE V—MISCELLANEOUS Sec. 501. Machine

readable visa fees.

TITLE VI—EMERGENCY PLAN FOR INDIAN SAFETY AND HEALTH Sec. 601. Emergency plan for Indian safety and health.

SEC. 2. FINDINGS.

Section 2 of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (22 U.S.C. 7601) is amended by adding at the end the following:

“(29) On May 27, 2003, the President signed this Act into law, launching the largest international public health program of its kind ever created.

“(30) Between 2003 and 2008, the United States, through the President’s Emergency Plan for AIDS Relief (PEPFAR) and in conjunction with other bilateral programs and the multilateral Global Fund has helped to—

“(A) provide antiretroviral therapy for over 1,900,000 people;

“(B) ensure that over 150,000 infants, most of whom would have likely been infected with HIV during pregnancy or childbirth, were not infected; and

“(C) provide palliative care and HIV prevention assistance to millions of other people. “(31) While United States leadership in the battles against

HIV/AIDS, tuberculosis, and malaria has had an enormous impact, these diseases continue to take a terrible toll on the human race.

“(32) According to the 2007 AIDS Epidemic Update of the Joint United Nations Programme on HIV/AIDS (UNAIDS)— “(A) an estimated 2,100,000 people died of AIDS-

related causes in 2007; and

“(B) an estimated 2,500,000 people were newly infected with HIV during that year. “(33) According to the World Health Organization, malaria

kills more than 1,000,000 people per year, 70 percent of whom are children under 5 years of age.

“(34) According to the World Health Organization, 1/3 of the world’s population is infected with the tuberculosis bacterium, and tuberculosis is 1 of the greatest infectious causes of death of adults worldwide, killing 1,600,000 people per year.

“(35) Efforts to promote abstinence, fidelity, the correct and consistent use of condoms, the delay of sexual debut, and the reduction of concurrent sexual partners represent important elements of strategies to prevent the transmission of HIV/AIDS.

“(36) According to UNAIDS— “(A) women and girls make up nearly 60 percent of persons in sub-Saharan Africa who are HIV positive; “(B) women and girls are more biologically, economically, and socially vulnerable to HIV infection; and

“(C) gender issues are critical components in the effort to prevent HIV/AIDS and to care for those affected by the disease. “(37) Children who have lost a parent to HIV/AIDS, who

are otherwise directly affected by the disease, or who live

in areas of high HIV prevalence may be vulnerable to the disease or its socioeconomic effects.

“(38) Lack of health capacity, including insufficient personnel and inadequate infrastructure, in sub-Saharan Africa and other regions of the world is a critical barrier that limits the effectiveness of efforts to combat HIV/AIDS, tuberculosis, and malaria, and to achieve other global health goals.

“(39) On March 30, 2007, the Institute of Medicine of the National Academies released a report entitled ‘PEPFAR Implementation: Progress and Promise’, which found that budget allocations setting percentage levels for spending on prevention, care, and treatment and for certain subsets of activities within the prevention category—

“(A) have ‘adversely affected implementation of the U.S. Global AIDS Initiative’; “(B) have inhibited comprehensive, integrated, evidence based approaches; “(C) ‘have been counterproductive’; “(D) ‘may have been helpful initially in ensuring a

balance of attention to activities within the 4 categories of prevention, treatment, care, and orphans and vulnerable children’;

“(E) ‘have also limited PEPFAR’s ability to tailor its activities in each country to the local epidemic and to coordinate with the level of activities in the countries’ national plans’; and

“(F) should be removed by Congress and replaced with more appropriate mechanisms that—

“(i) ‘ensure accountability for results from Country Teams to the U.S. Global AIDS Coordinator and to Congress’; and

“(ii) ‘ensure that spending is directly linked to and commensurate with necessary efforts to achieve both country and overall performance targets for prevention, treatment, care, and orphans and vulnerable children’.

“(40) The United States Government has endorsed the principles of harmonization in coordinating efforts to combat HIV/ AIDS commonly referred to as the ‘Three Ones’, which includes—

“(A) 1 agreed HIV/AIDS action framework that provides the basis for coordination of the work of all partners; “(B) 1 national HIV/AIDS coordinating authority, with a broadbased multisectoral mandate; and

“(C) 1 agreed HIV/AIDS country-level monitoring and evaluating system. “(41) In the Abuja Declaration on HIV/AIDS, Tuberculosis

and Other Related Infectious Diseases, of April 26–27, 2001 (referred to in this Act as the ‘Abuja Declaration’), the Heads of State and Government of the Organization of African Unity (OAU)—

“(A) declared that they would ‘place the fight against HIV/AIDS at the forefront and as the highest priority issue in our respective national development plans’;

“(B) committed ‘TO TAKE PERSONAL RESPONSIBILITY AND PROVIDE LEADERSHIP for the activities of the National AIDS Commissions/Councils’;

“(C) resolved ‘to lead from the front the battle against HIV/AIDS, Tuberculosis and Other Related Infectious Diseases by personally ensuring that such bodies were properly convened in mobilizing our societies as a whole and providing focus for unified national policymaking and programme implementation, ensuring coordination of all sectors at all levels with a gender perspective and respect for human rights, particularly to ensure equal rights for people living with HIV/AIDS’; and

“(D) pledged ‘to set a target of allocating at least 15% of our annual budget to the improvement of the health sector’.”.

SEC. 3. DEFINITIONS.

Section 3 of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (22 U.S.C. 7602) is amended—

(1) in paragraph (2), by striking “Committee on International Relations” and inserting “Committee on Foreign Affairs of the House of Representatives, the Committee on Appropriations of the Senate, and the Committee on Appropriations”;

(2) by redesignating paragraph (6) as paragraph (12);

(3) by redesignating paragraphs (3) through (5), as paragraphs (4) through (6), respectively;

(4) by inserting after paragraph (2) the following:

“(3) GLOBAL AIDS COORDINATOR.—The term ‘Global AIDS Coordinator’ means the Coordinator of United States Government Activities to Combat HIV/AIDS Globally.”; and

(5) by inserting after paragraph (6), as redesignated, the following:

“(7) IMPACT EVALUATION RESEARCH.—The term ‘impact evaluation research’ means the application of research methods and statistical analysis to measure the extent to which change in a population-based outcome can be attributed to program intervention instead of other environmental factors.

“(8) OPERATIONS RESEARCH.—The term ‘operations research’ means the application of social science research methods, statistical analysis, and other appropriate scientific methods to judge, compare, and improve policies and program outcomes, from the earliest stages of defining and designing programs through their development and implementation, with the objective of the rapid dissemination of conclusions and concrete impact on programming.

“(9) PARAPROFESSIONAL.—The term ‘paraprofessional’ means an individual who is trained and employed as a health agent for the provision of basic assistance in the identification, prevention, or treatment of illness or disability.

“(10) PARTNER GOVERNMENT.—The term ‘partner government’ means a government with which the United States is working to provide assistance to combat HIV/AIDS, tuberculosis, or malaria on behalf of people living within the jurisdiction of such government.

“(11) PROGRAM MONITORING.—The term ‘program monitoring’ means the collection, analysis, and use of routine program data to determine—

“(A) how well a program is carried out; and

“(B) how much the program costs.”.

SEC. 4. PURPOSE.

Section 4 of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (22 U.S.C. 7603) is amended to read as follows:

“SEC. 4. PURPOSE.

“The purpose of this Act is to strengthen and enhance United States leadership and the effectiveness of the United States response to the HIV/AIDS, tuberculosis, and malaria pandemics and other related and preventable infectious diseases as part of the overall United States health and development agenda by—

“(1) establishing comprehensive, coordinated, and integrated 5-year, global strategies to combat HIV/AIDS, tuberculosis, and malaria by—

“(A) building on progress and successes to date;

“(B) improving harmonization of United States efforts with national strategies of partner governments and other public and private entities; and

“(C) emphasizing capacity building initiatives in order to promote a transition toward greater sustainability through the support of country-driven efforts; “(2)

providing increased resources for bilateral and multi lateral efforts to fight HIV/AIDS, tuberculosis, and malaria as integrated components of United States development assistance;

“(3) intensifying efforts to— “(A) prevent HIV infection; “(B) ensure the continued support for, and expanded

access to, treatment and care programs; “(C) enhance the

effectiveness of prevention, treatment, and care programs; and

“(D) address the particular vulnerabilities of girls and women; “(4) encouraging the expansion of private sector efforts

and expanding public-private sector partnerships to combat

HIV/AIDS, tuberculosis, and malaria; “(5) reinforcing efforts to—

“(A) develop safe and effective vaccines, microbicides, and other prevention and treatment technologies; and

“(B) improve diagnostics capabilities for HIV/AIDS, tuberculosis, and malaria; and “(6) helping partner countries to—

“(A) strengthen health systems; “(B) expand health workforce; and “(C) address infrastructural weaknesses.”.

SEC. 5. AUTHORITY TO CONSOLIDATE AND COMBINE REPORTS.

Section 5 of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (22 U.S.C. 7604) is amended by inserting “, with the exception of the 5-year strategy” before the period at the end.

TITLE I—POLICY PLANNING AND COORDINATION

SEC. 101. DEVELOPMENT OF AN UPDATED, COMPREHENSIVE, 5-YEAR, GLOBAL STRATEGY.

(a) STRATEGY.—Section 101(a) of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (22 U.S.C. 7611(a)) is amended to read as follows:

“(a) STRATEGY.—The President shall establish a comprehensive, integrated, 5-year strategy to expand and improve efforts to combat

global HIV/AIDS. This strategy shall— “(1) further strengthen the capability of the United States to be an effective leader of the international campaign against this disease and strengthen the capacities of nations experiencing HIV/AIDS epidemics to combat this disease; “(2) maintain sufficient flexibility and remain responsive to— “(A) changes in the epidemic; “(B) challenges facing partner countries in developing and implementing an effective national response; and “(C) evidence-based improvements and innovations in the prevention, care, and treatment of HIV/AIDS; “(3) situate United States efforts to combat HIV/AIDS, tuberculosis, and malaria within the broader United States global health and development agenda, establishing a roadmap to link investments in specific disease programs to the broader goals of strengthening health systems and infrastructure and to integrate and coordinate HIV/AIDS, tuberculosis, or malaria programs with other health or development programs, as appropriate; “(4) provide a plan to— “(A) prevent 12,000,000 new HIV infections worldwide; “(B) support— “(i) the increase in the number of individuals with HIV/AIDS receiving antiretroviral treatment above the goal established under section 402(a)(3) and increased pursuant to paragraphs (1) through (3) of section 403(d); and “(ii) additional treatment through coordinated multilateral efforts; “(C) support care for 12,000,000 individuals infected with or affected by HIV/AIDS, including 5,000,000 orphans and vulnerable children affected by HIV/AIDS, with an emphasis on promoting a comprehensive, coordinated system of services to be integrated throughout the continuum of care; “(D) help partner countries in the effort to achieve goals of 80 percent access to counseling, testing, and treatment to prevent the transmission of HIV from mother to child, emphasizing a continuum of care model; “(E) help partner countries to provide care and treatment services to children with HIV in proportion to their percentage within the HIV-infected population in each country;

“(F) promote preservice training for health professionals designed to strengthen the capacity of institutions

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to develop and implement policies for training health workers to combat HIV/AIDS, tuberculosis, and malaria;

“(G) equip teachers with skills needed for HIV/AIDS prevention and support for persons with, or affected by, HIV/AIDS;

“(H) provide and share best practices for combating HIV/AIDS with health professionals;

“(I) promote pediatric HIV/AIDS training for physicians, nurses, and other health care workers, through public-private partnerships if possible, including through the designation, if appropriate, of centers of excellence for training in pediatric HIV/AIDS prevention, care, and treatment in partner countries; and

“(J) help partner countries to train and support retention of health care professionals and paraprofessionals, with the target of training and retaining at least 140,000 new health care professionals and paraprofessionals with an emphasis on training and in country deployment of critically needed doctors and nurses and to strengthen capacities in developing countries, especially in sub-Saharan Africa, to deliver primary health care with the objective of helping countries achieve staffing levels of at least 2.3 doctors, nurses, and midwives per 1,000 population, as called for by the World Health Organization; “(5) include multisectoral approaches and specific strategies

to treat individuals infected with HIV/AIDS and to prevent the further transmission of HIV infections, with a particular focus on the needs of families with children (including the prevention of mother-to-child transmission), women, young people, orphans, and vulnerable children;

“(6) establish a timetable with annual global treatment targets with country-level benchmarks for antiretroviral treatment;

“(7) expand the integration of timely and relevant research within the prevention, care, and treatment of HIV/AIDS;

“(8) include a plan for program monitoring, operations research, and impact evaluation and for the dissemination of a best practices report to highlight findings;

“(9) support the in-country or intra-regional training, preferably through public-private partnerships, of scientific investigators, managers, and other staff who are capable of promoting the systematic uptake of clinical research findings and other evidence-based interventions into routine practice, with the goal of improving the quality, effectiveness, and local leadership of HIV/AIDS health care;

“(10) expand and accelerate research on and development of HIV/AIDS prevention methods for women, including enhancing inter-agency collaboration, staffing, and organizational infrastructure dedicated to microbicide research;

“(11) provide 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 targeted particularly toward those most at risk of acquiring HIV infection;

“(12) make the reduction of HIV/AIDS behavioral risks a priority of all prevention efforts by—

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- “(A) promoting abstinence from sexual activity and encouraging monogamy and faithfulness;
- “(B) encouraging the correct and consistent use of male and female condoms and increasing the availability of, and access to, these commodities;
- “(C) promoting the delay of sexual debut and the reduction of multiple concurrent sexual partners;
- “(D) promoting education for discordant couples (where an individual is infected with HIV and the other individual is uninfected or whose status is unknown) about safer sex practices;
- “(E) promoting voluntary counseling and testing, addiction therapy, and other prevention and treatment tools for illicit injection drug users and other substance abusers;
- “(F) educating men and boys about the risks of procuring sex commercially and about the need to end violent behavior toward women and girls;
- “(G) supporting partner country and community efforts to identify and address social, economic, or cultural factors, such as migration, urbanization, conflict, gender-based violence, lack of empowerment for women, and transportation patterns, which directly contribute to the transmission of HIV;
- “(H) supporting comprehensive programs to promote alternative livelihoods, safety, and social reintegration strategies for commercial sex workers and their families;
- “(I) promoting cooperation with law enforcement to prosecute offenders of trafficking, rape, and sexual assault crimes with the goal of eliminating such crimes; and
- “(J) working to eliminate rape, gender-based violence, sexual assault, and the sexual exploitation of women and children; “(13) include programs to reduce the transmission of HIV, particularly addressing the heightened vulnerabilities of women and girls to HIV in many countries; and “(14) support other important means of preventing or reducing the transmission of HIV, including— “(A) medical male circumcision; “(B) the maintenance of a safe blood supply; “(C) promoting universal precautions in formal and informal health care settings;
- “(D) educating the public to recognize and to avoid risks to contract HIV through blood exposures during formal and informal health care and cosmetic services;
- “(E) investigating suspected nosocomial infections to identify and stop further nosocomial transmission; and
- “(F) other mechanisms to reduce the transmission of HIV; “(15) increase support for prevention of mother-to-child transmission;
- “(16) build capacity within the public health sector of developing countries by improving health systems and public health infrastructure and developing indicators to measure changes in broader public health sector capabilities;
- “(17) increase the coordination of HIV/AIDS programs with development programs;

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“(18) provide a framework for expanding or developing existing or new country or regional programs, including— “(A) drafting compacts or other agreements, as appropriate; “(B) establishing criteria and objectives for such compacts and agreements; and “(C) promoting sustainability;

“(19) provide a plan for national and regional priorities for resource distribution and a global investment plan by region; “(20) provide a plan to address the immediate and ongoing

needs of women and girls, which— “(A) addresses the vulnerabilities that contribute to their elevated risk of infection; “(B) includes specific goals and targets to address these factors;

“(C) provides clear guidance to field missions to integrate gender across prevention, care, and treatment programs;

“(D) sets forth gender-specific indicators to monitor progress on outcomes and impacts of gender programs;

“(E) supports efforts in countries in which women or orphans lack inheritance rights and other fundamental protections to promote the passage, implementation, and enforcement of such laws;

“(F) supports life skills training, especially among women and girls, with the goal of reducing vulnerabilities to HIV/AIDS;

“(G) addresses and prevents gender-based violence; and

“(H) addresses the posttraumatic and psychosocial consequences and provides postexposure prophylaxis protecting against HIV infection to victims of gender-based violence and rape; “(21) provide a plan to—

“(A) determine the local factors that may put men and boys at elevated risk of contracting or transmitting HIV;

“(B) address male norms and behaviors to reduce these risks, including by reducing alcohol abuse; “(C) promote responsible male behavior; and “(D) promote male participation and leadership at the community level in efforts to promote HIV prevention, reduce stigma, promote participation in voluntary counseling and testing, and provide care, treatment, and support for persons with HIV/AIDS; “(22) provide a plan to address the vulnerabilities and

needs of orphans and children who are vulnerable to, or affected by, HIV/AIDS;

“(23) encourage partner countries to develop health care curricula and promote access to training tailored to individuals receiving services through, or exiting from, existing programs geared to orphans and vulnerable children;

“(24) provide a framework to work with international actors and partner countries toward universal access to HIV/AIDS prevention, treatment, and care programs, recognizing that prevention is of particular importance;

“(25) enhance the coordination of United States bilateral efforts to combat global HIV/AIDS with other major public and private entities;

“(26) enhance the attention given to the national strategic HIV/AIDS plans of countries receiving United States assistance by—

“(A) reviewing the planning and programmatic decisions associated with that assistance; and

“(B) helping to strengthen such national strategies, if necessary; “(27) support activities described in the Global Plan to

Stop TB, including—

“(A) expanding and enhancing the coverage of the Directly Observed Treatment Short-course (DOTS) in order to treat individuals infected with tuberculosis and HIV, including multi-drug resistant or extensively drug resistant tuberculosis; and

“(B) improving coordination and integration of HIV/ AIDS and tuberculosis programming; “(28) ensure coordination between the Global AIDS Coordinator and the Malaria Coordinator and address issues of comorbidity between HIV/AIDS and malaria; and

“(29) include a longer term estimate of the projected resource needs, progress toward greater sustainability and country ownership of HIV/AIDS programs, and the anticipated role of the United States in the global effort to combat HIV/ AIDS during the 10-year period beginning on October 1, 2013.”.

(b) REPORT.—Section 101(b) of such Act (22 U.S.C. 7611(b)) is amended to read as follows: “(b) REPORT.—

“(1) IN GENERAL.—Not later than October 1, 2009, the President shall submit a report to the appropriate congressional committees that sets forth the strategy described in subsection (a).

“(2) CONTENTS.—The report required under paragraph (1) shall include a discussion of the following elements: “(A) The purpose, scope, methodology, and general and specific objectives of the strategy. “(B) The problems, risks, and threats to the successful pursuit of the strategy. “(C) The desired goals, objectives, activities, and outcome-related performance measures of the strategy. “(D) A description of future costs and resources needed to carry out the strategy.

“(E) A delineation of United States Government roles, responsibility, and coordination mechanisms of the strategy.

“(F) A description of the strategy—

“(i) to promote harmonization of United States assistance with that of other international, national, and private actors as elucidated in the ‘Three Ones’; and

“(ii) to address existing challenges in harmonization and alignment. “(G) A description of the manner in which the strategy

will—

“(i) further the development and implementation of the national multisectoral strategic HIV/AIDS frameworks of partner governments; and

“(ii) enhance the centrality, effectiveness, and sustainability of those national plans.

“(H) A description of how the strategy will seek to achieve the specific targets described in subsection (a) and other targets, as appropriate.

“(I) A description of, and rationale for, the timetable for annual global treatment targets with country-level estimates of numbers of persons in need of antiretroviral treatment, country-level benchmarks for United States support for assistance for antiretroviral treatment, and numbers of persons enrolled in antiretroviral treatment programs receiving United States support. If global benchmarks are not achieved within the reporting period, the report shall include a description of steps being taken to ensure that global benchmarks will be achieved and a detailed breakdown and justification of spending priorities in countries in which benchmarks are not being met, including a description of other donor or national support for antiretroviral treatment in the country, if appropriate.

“(J) A description of how operations research is addressed in the strategy and how such research can most effectively be integrated into care, treatment, and prevention activities in order to—

“(i) improve program quality and efficiency;

“(ii) ascertain cost effectiveness;

“(iii) ensure transparency and accountability;

“(iv) assess population-based impact;

“(v) disseminate findings and best practices; and

“(vi) optimize delivery of services.

“(K) An analysis of United States-assisted strategies to prevent the transmission of HIV/AIDS, including methodologies to promote abstinence, monogamy, faithfulness, the correct and consistent use of male and female condoms, reductions in concurrent sexual partners, and delay of sexual debut, and of intended monitoring and evaluation approaches to measure the effectiveness of prevention programs and ensure that they are targeted to appropriate audiences.

“(L) Within the analysis required under subparagraph (K), an examination of additional planned means of preventing the transmission of HIV including medical male circumcision, maintenance of a safe blood supply, public education about risks to acquire HIV infection from blood exposures, promotion of universal precautions, investigation of suspected nosocomial infections and other tools.

“(M) A description of efforts to assist partner country and community to identify and address social, economic, or cultural factors, such as migration, urbanization, conflict, gender-based violence, lack of empowerment for women, and transportation patterns, which directly contribute to the transmission of HIV.

“(N) A description of the specific targets, goals, and strategies developed to address the needs and

vulnerabilities of women and girls to HIV/AIDS, including—

- “(i) activities directed toward men and boys;
- “(ii) activities to enhance educational, micro-finance, and livelihood opportunities for women and girls;
- “(iii) activities to promote and protect the legal empowerment of women, girls, and orphans and vulnerable children;
- “(iv) programs targeted toward gender-based violence and sexual coercion;
- “(v) strategies to meet the particular needs of adolescents;
- “(vi) assistance for victims of rape, sexual abuse, assault, exploitation, and trafficking; and
- “(vii) programs to prevent alcohol abuse.

“(O) A description of strategies to address male norms and behaviors that contribute to the transmission of HIV, to promote responsible male behavior, and to promote male participation and leadership in HIV/AIDS prevention, care, treatment, and voluntary counseling and testing.

“(P) A description of strategies—

- “(i) to address the needs of orphans and vulnerable children, including an analysis of—
 - “(I) factors contributing to children’s vulnerability to HIV/AIDS; and
 - “(II) vulnerabilities caused by the impact of HIV/AIDS on children and their families; and
- “(ii) in areas of higher HIV/AIDS prevalence, to promote a community-based approach to vulnerability, maximizing community input into determining which

children participate.

“(Q) A description of capacity-building efforts undertaken by countries themselves, including adherents of the Abuja Declaration and an assessment of the impact of International Monetary Fund macroeconomic and fiscal policies on national and donor investments in health.

“(R) A description of the strategy to—

- “(i) strengthen capacity building within the public health sector;
- “(ii) improve health care in those countries;
- “(iii) help countries to develop and implement national health workforce strategies;
- “(iv) strive to achieve goals in training, retaining, and effectively deploying health staff;
- “(v) promote the use of codes of conduct for ethical recruiting practices for health care workers; and
- “(vi) increase the sustainability of health programs.

“(S) A description of the criteria for selection, objectives, methodology, and structure of compacts or other framework agreements with countries or regional organizations, including—

- “(i) the role of civil society;
- “(ii) the degree of transparency;
- “(iii) benchmarks for success of such compacts or agreements; and

“(iv) the relationship between such compacts or agreements and the national HIV/AIDS and public health strategies and commitments of partner countries. “(T) A strategy to better coordinate HIV/AIDS assistance with nutrition and food assistance programs.

“(U) A description of transnational or regional initiatives to combat regionalized epidemics in highly affected areas such as the Caribbean.

“(V) A description of planned resource distribution and global investment by region.

“(W) A description of coordination efforts in order to better implement the Stop TB Strategy and to address the problem of coinfection of HIV/AIDS and tuberculosis and of projected challenges or barriers to successful implementation.

“(X) A description of coordination efforts to address malaria and comorbidity with malaria and HIV/AIDS.”.

(c) STUDY.—Section 101(c) of such Act (22 U.S.C. 7611(c)) is amended to read as follows: “(c) STUDY OF PROGRESS TOWARD ACHIEVEMENT OF POLICY OBJECTIVES.—

“(1) DESIGN AND BUDGET PLAN FOR DATA EVALUATION.— The Global AIDS Coordinator shall enter into a contract with the Institute of Medicine of the National Academies that provides that not later than 18 months after the date of the enactment of the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008, the Institute, in consultation with the Global AIDS Coordinator and other relevant parties representing the public and private sector, shall provide the Global AIDS Coordinator with a design plan and budget for the evaluation and collection of baseline and subsequent data to address the elements set forth in paragraph (2)(B). The Global AIDS Coordinator shall submit the budget and design plan to the appropriate congressional committees.

“(2) STUDY.—

“(A) IN GENERAL.—Not later than 4 years after the date of the enactment of the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008, the Institute of Medicine of the National Academies shall publish a study that includes—

“(i) an assessment of the performance of United States-assisted global HIV/AIDS programs; and

“(ii) an evaluation of the impact on health of prevention, treatment, and care efforts that are supported by United States funding, including multilateral and bilateral programs involving joint operations. “(B)

CONTENT.—The study conducted under this para

graph shall include— “(i) an assessment of progress toward prevention, treatment, and care targets;

“(ii) an assessment of the effects on health systems, including on the financing and management of health systems and the quality of service delivery and staffing;

“(iii) an assessment of efforts to address gender-specific aspects of HIV/AIDS, including gender related constraints to accessing services and addressing underlying social and economic vulnerabilities of women and men;

“(iv) an evaluation of the impact of treatment and care programs on 5-year survival rates, drug adherence, and the emergence of drug resistance;

“(v) an evaluation of the impact of prevention programs on HIV incidence in relevant population groups;

“(vi) an evaluation of the impact on child health and welfare of interventions authorized under this Act on behalf of orphans and vulnerable children;

“(vii) an evaluation of the impact of programs and activities authorized in this Act on child mortality; and

“(viii) recommendations for improving the programs referred to in subparagraph (A)(i). “(C) METHODOLOGIES.—Assessments and impact evaluations conducted under the study shall utilize sound statistical methods and techniques for the behavioral sciences, including random assignment methodologies as feasible. Qualitative data on process variables should be used for assessments and impact evaluations, wherever possible. “(3) CONTRACT

AUTHORITY.—The Institute of Medicine may enter into contracts or cooperative agreements or award grants to conduct the study under paragraph (2).

“(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out the study under this subsection.”.

(d) REPORT.—Section 101 of such Act, as amended by this section, is further amended by adding at the end the following: “(d) COMPTROLLER GENERAL REPORT.—

“(1) REPORT REQUIRED.—Not later than 3 years after the date of the enactment of the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008, the Comptroller General of the United States shall submit a report on the global HIV/AIDS programs of the United States to the appropriate congressional committees.

“(2) CONTENTS.—The report required under paragraph (1) shall include—

“(A) a description and assessment of the monitoring and evaluation practices and policies in place for these programs;

“(B) an assessment of coordination within Federal agencies involved in these programs, examining both internal coordination within these programs and integration with the larger global health and development agenda of the United States;

“(C) an assessment of procurement policies and practices within these programs;

“(D) an assessment of harmonization with national government HIV/AIDS and public health strategies as well as other international efforts;

“(E) an assessment of the impact of global HIV/AIDS funding and programs on other United States global health programming; and

“(F) recommendations for improving the global HIV/ AIDS programs of the United States. “(e) BEST PRACTICES REPORT.— “(1)

IN GENERAL.—Not later than 1 year after the date of the enactment of the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008, and annually thereafter, the Global AIDS Coordinator shall publish a best practices report that highlights the programs receiving financial assistance from the United States that have the potential for replication or adaption, particularly at a low cost, across global AIDS programs, including those that focus on both generalized and

localized epidemics. “(2) DISSEMINATION OF FINDINGS.— “(A) PUBLICATION ON INTERNET WEBSITE.—The Global AIDS Coordinator shall disseminate the full findings of the annual best practices report on the Internet website of the Office of the Global AIDS Coordinator. “(B) DISSEMINATION GUIDANCE.—The Global AIDS Coordinator shall develop guidance to ensure timely submission and dissemination of significant information regarding best practices with respect to global AIDS programs.

“(f) INSPECTORS GENERAL.— “(1) OVERSIGHT PLAN.— “(A)

DEVELOPMENT.—The Inspectors General of the Department of State and Broadcasting Board of Governors, the Department of Health and Human Services, and the United States Agency for International Development shall jointly develop 5 coordinated annual plans for oversight activity in each of the fiscal years 2009 through 2013, with regard to the programs authorized under this Act and sections 104A, 104B, and 104C of the Foreign Assistance Act of 1961 (22 U.S.C. 2151b–2, 2151b–3, and 2151b– 4). “(B) CONTENTS.—The plans developed under subparagraph (A) shall include a schedule for financial audits, inspections, and performance reviews, as appropriate. “(C) DEADLINE.— “(i) INITIAL PLAN.—The first plan developed under subparagraph (A) shall be completed not later than the later of— “(I) September 1, 2008; or “(II) 60 days after the date of the enactment of the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008. “(ii) SUBSEQUENT PLANS.—Each of the last four plans developed under subparagraph (A) shall be completed not later than 30 days before each of the fiscal years 2010 through 2013, respectively.

“(2) COORDINATION.—In order to avoid duplication and maximize efficiency, the Inspectors General described in paragraph (1) shall coordinate their activities with—

“(A) the Government Accountability Office; and

“(B) the Inspectors General of the Department of Commerce, the Department of Defense, the Department of Labor, and the Peace Corps, as appropriate, pursuant to the 2004 Memorandum of Agreement Coordinating Audit Coverage of Programs and Activities Implementing the President’s Emergency Plan for AIDS Relief, or any successor agreement. “(3) FUNDING.—The Global AIDS Coordinator and the

Coordinator of the United States Government Activities to Combat Malaria Globally shall make available necessary funds not exceeding \$15,000,000 during the 5-year period beginning on October 1, 2008 to the Inspectors General described in paragraph (1) for the audits, inspections, and reviews described in that paragraph.”.

(e) ANNUAL STUDY; MESSAGE.—Section 101 of such Act, as amended by this section, is further amended by adding at the end the following:

“(g) ANNUAL STUDY.—

“(1) IN GENERAL.—Not later than September 30, 2009, and annually thereafter through September 30, 2013, the Global AIDS Coordinator shall complete a study of treatment providers that—

“(A) represents a range of countries and service environments;

“(B) estimates the per-patient cost of antiretroviral HIV/AIDS treatment and the care of people with HIV/ AIDS not receiving antiretroviral treatment, including a comparison of the costs for equivalent services provided by programs not receiving assistance under this Act;

“(C) estimates per-patient costs across the program and in specific categories of service providers, including— “(i) urban and rural providers; “(ii) country-specific providers; and “(iii) other subcategories, as appropriate.

“(2) PUBLICATION.—Not later than 90 days after the completion of each study under paragraph (1), the Global AIDS Coordinator shall make the results of such study available on a publicly accessible Web site. “(h) MESSAGE.—The Global AIDS Coordinator shall develop

a message, to be prominently displayed by each program receiving funds under this Act, that— “(1) demonstrates that the program is a commitment by citizens of the United States to the global fight against HIV/ AIDS, tuberculosis, and malaria; and

“(2) enhances awareness by program recipients that the program is an effort on behalf of the citizens of the United States.”.

SEC. 102. INTERAGENCY WORKING GROUP.

Section 1(f)(2) of the State Department Basic Authorities Act of 1956 (22 U.S.C. 2651a(f)(2)) is amended—

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- (1) in subparagraph (A), by inserting “, partner country finance, health, and other relevant ministries,” after “community based organizations)” each place it appears;
- (2) in subparagraph (B)(ii)—
- (A) by striking subclauses (IV) and (V);
- (B) by inserting after subclause (III) the following:

“(IV) Establishing an interagency working group on HIV/AIDS headed by the Global AIDS Coordinator and comprised of representatives from the United States Agency for International Development and the Department of Health and Human Services, for the purposes of coordination of activities relating to HIV/AIDS, including—

“(aa) meeting regularly to review progress in partner countries toward HIV/AIDS prevention, treatment, and care objectives;

“(bb) participating in the process of identifying countries to consider for increased assistance based on the epidemiology of HIV/AIDS in those countries, including clear evidence of a public health threat, as well as government commitment to address the HIV/AIDS problem, relative need, and coordination and joint planning with other significant actors;

“(cc) assisting the Coordinator in the evaluation, execution, and oversight of country operational plans;

“(dd) reviewing policies that may be obstacles to reaching targets set forth for HIV/ AIDS prevention, treatment, and care; and

“(ee) consulting with representatives from additional relevant agencies, including the National Institutes of Health, the Health Resources and Services Administration, the Department of Labor, the Department of Agriculture, the Millennium Challenge Corporation, the Peace Corps, and the Department of Defense. “(V) Coordinating overall United States HIV/

AIDS policy and programs, including ensuring the coordination of relevant executive branch agency activities in the field, with efforts led by partner countries, and with the assistance provided by other relevant bilateral and multilateral aid agencies and other donor institutions to promote harmonization with other programs aimed at preventing and treating HIV/AIDS and other health challenges, improving primary health, addressing food security, promoting education and development, and strengthening health care systems.”;

(C) by redesignating subclauses (VII) and (VIII) as sub-clauses (IX) and (XII), respectively;

(D) by inserting after subclause (VI) the following:

“(VII) Holding 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.

“(VIII) Ensuring, through interagency and international coordination, that HIV/AIDS programs of the United States are coordinated with, and complementary to, the delivery of related global health, food security, development, and education.”;

(E) in subclause (IX), as redesignated by subparagraph (C)—

(i) by inserting “Vietnam,” after “Uganda,”;

(ii) by inserting after “of 2003” the following: “and other countries in which the United States is implementing HIV/AIDS programs as part of its foreign assistance program”;

and
(iii) by adding at the end the following: “In designating additional countries under this subparagraph, the President shall give priority to those countries in which there is a high prevalence of HIV or risk of significantly increasing incidence of HIV within the general population and inadequate financial means within the country.”;

(F) by inserting after subclause (IX), as redesignated by subparagraph (C), the following:

“(X) Working with partner countries in which the HIV/AIDS epidemic is prevalent among injection drug users to establish, as a national priority, national HIV/AIDS prevention programs.

“(XI) Working with partner countries in which the HIV/AIDS epidemic is prevalent among individuals involved in commercial sex acts to establish, as a national priority, national prevention programs, including education, voluntary testing, and counseling, and referral systems that link HIV/AIDS programs with programs to eradicate trafficking in persons and support alternatives to prostitution.”;

(G) in subclause (XII), as redesignated by subparagraph (C), by striking “funds section” and inserting “funds appropriated for HIV/ AIDS assistance pursuant to the authorization of appropriations under section 401 of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (22 U.S.C. 7671)”;

(H) by adding at the end the following:

“(XIII) Publicizing updated drug pricing data to inform the purchasing decisions of pharmaceutical procurement partners.”.

SEC. 103. SENSE OF CONGRESS.

Section 102 of the United States Leadership Against HIV/ AIDS, Tuberculosis, and Malaria Act of 2003 (22 U.S.C. 7612)

is amended by adding at the end the following: “(d) SENSE OF CONGRESS.—It is the sense of Congress that—“(1) full-time country level coordinators, preferably with management experience, should head each HIV/AIDS country

team for United States missions overseeing significant HIV/ AIDS programs;

“(2) foreign service nationals provide critically important services in the design and implementation of United States country-level HIV/AIDS programs and their skills and experience as public health professionals should be recognized within hiring and compensation practices; and

“(3) staffing levels for United States country-level HIV/ AIDS teams should be adequately maintained to fulfill oversight and other obligations of the positions.”.

TITLE II—SUPPORT FOR MULTILATERAL FUNDS, PROGRAMS, AND PUBLIC-PRIVATE PARTNERSHIPS

SEC. 201. VOLUNTARY CONTRIBUTIONS TO INTERNATIONAL VACCINE FUNDS.

Section 302 of the Foreign Assistance Act of 1961 (22 U.S.C. 2222) is amended—

(1) by inserting after subsection (c) the following:

“(d) TUBERCULOSIS VACCINE DEVELOPMENT PROGRAMS.—In addition to amounts otherwise available under this section, there are authorized to be appropriated to the President such sums as may be necessary for each of the fiscal years 2009 through 2013, which shall be used for United States contributions to tuberculosis vaccine development programs, which may include the Aeras Global TB Vaccine Foundation.”;

(2) in subsection (k)—

(A) by striking “fiscal years 2004 through 2008” and inserting “fiscal years 2009 through 2013”; and

(B) by striking “Vaccine Fund” and inserting “GAVI Fund”.

(3) in subsection (l), by striking “fiscal years 2004 through 2008” and inserting “fiscal years 2009 through 2013”; and

(4) in subsection (m), by striking “fiscal years 2004 through 2008” and inserting “fiscal years 2009 through 2013”.

SEC. 202. PARTICIPATION IN THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA.

(a) FINDINGS; SENSE OF CONGRESS.—Section 202(a) of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (22 U.S.C. 7622(a)) is amended to read as follows:

“(a) FINDINGS; SENSE OF CONGRESS.—“(1) FINDINGS.—Congress makes the following findings:

“(A) The establishment of the Global Fund in January 2002 is consistent with the general principles for an international AIDS trust fund first outlined by Congress in the Global AIDS and Tuberculosis Relief Act of 2000 (Public Law 106–264).

“(B) The Global Fund is an innovative financing mechanism which—“(i) has made progress in many areas in combating HIV/AIDS, tuberculosis, and malaria; and

“(ii) represents the multilateral component of this Act, extending United States efforts to more than 130 countries around the world. “(C) The Global Fund and United States bilateral assistance programs—

“(i) are demonstrating increasingly effective coordination, with each possessing certain comparative advantages in the fight against HIV/AIDS, tuberculosis, and malaria; and

“(ii) often work most effectively in concert with each other. “(D) The United States Government—

“(i) is the largest supporter of the Global Fund in terms of resources and technical support; “(ii) made the founding contribution to the Global Fund; and “(iii) is fully committed to the success of the Global Fund as a multilateral public-private partnership. “(2) SENSE OF CONGRESS.—It is the sense of Congress that— “(A) transparency and accountability are crucial to the long-term success and viability of the Global Fund;

“(B) the Global Fund has made significant progress toward addressing concerns raised by the Government Accountability Office by—

“(i) improving risk assessment and risk management capabilities; “(ii) providing clearer guidance for and oversight of Local Fund Agents; and

“(iii) strengthening the Office of the Inspector General for the Global Fund; “(C) the provision of sufficient resources and authority to the Office of the Inspector General for the Global Fund to ensure that office has the staff and independence necessary to carry out its mandate will be a measure of the commitment of the Global Fund to transparency and accountability;

“(D) regular, publicly published financial, programmatic, and reporting audits of the Fund, its grantees, and Local Fund Agents are also important benchmarks of transparency;

“(E) the Global Fund should establish and maintain a system to track— “(i) the amount of funds disbursed to each sub-recipient on the grant’s fiscal cycle; and

“(ii) the distribution of resources, by grant and principal recipient, for prevention, care, treatment, drug and commodity purchases, and other purposes; “(F) relevant national authorities in recipient countries should exempt from duties and taxes all products financed by Global Fund grants and procured by any principal recipient or subrecipient for the purpose of carrying out such grants;

“(G) the Global Fund, UNAIDS, and the Global AIDS Coordinator should work together to standardize program indicators wherever possible;

“(H) for purposes of evaluating total amounts of funds contributed to the Global Fund under subsection

(d)(4)(A)(i), the timetable for evaluations of contributions from sources other than the United States should take into account the fiscal calendars of other major contributors; and

“(I) the Global Fund should not support activities involving the ‘Affordable Medicines Facility-Malaria’ or similar entities pending compelling evidence of success from pilot programs as evaluated by the Coordinator of United States Government Activities to Combat Malaria Globally.”.

(b) STATEMENT OF POLICY.—Section 202(b) of such Act is amended by adding at the end the following:

“(3) STATEMENT OF POLICY.—The United States Government regards the imposition by recipient countries of taxes or tariffs on goods or services provided by the Global Fund, which are supported through public and private donations, including the substantial contribution of the American people, as inappropriate and inconsistent with standards of good governance. The Global AIDS Coordinator or other representatives of the United States Government shall work with the Global Fund to dissuade governments from imposing such duties, tariffs, or taxes.”.

(c) UNITED STATES FINANCIAL PARTICIPATION.—Section 202(d) of such Act (22 U.S.C. 7622(d)) is amended—

(1) in paragraph (1)—

(A) by striking “\$1,000,000,000 for the period of fiscal year 2004 beginning on January 1, 2004” and inserting “\$2,000,000,000 for fiscal year 2009.”; and

(B) by striking “the fiscal years 2005–2008” and inserting “each of the fiscal years 2010 through 2013”;

(2) in paragraph (4)—

(A) in subparagraph (A)—

(i) in clause (i), by striking “fiscal years 2004 through 2008” and inserting “fiscal years 2009 through 2013”;

(ii) in clause (ii)—

(I) by striking “during any of the fiscal years 2004 through 2008” and inserting “during any of the fiscal years 2009 through 2013”; and

(II) by adding at the end the following: “The President may waive the application of this clause with respect to assistance for Sudan that is overseen by the Southern Country Coordinating Mechanism, including Southern Sudan, Southern Kordofan, Blue Nile State, and Abyei, if the President determines that the national interest or humanitarian reasons justify such a waiver. The President shall publish each waiver of this clause in the Federal Register and, not later than 15 days before the waiver takes effect, shall consult with the Committee on Foreign Relations of the Senate and the Committee on Foreign Affairs of the House of Representatives regarding the proposed waiver.”; and

(iii) in clause (vi)—

(I) by striking “for the purposes” and inserting “For the purposes”;

(II) by striking “fiscal years 2004 through 2008” and inserting “fiscal years 2009 through 2013”; and

(III) by striking “prior to fiscal year 2004” and inserting “before fiscal year 2009”;

(B) in subparagraph (B)(iv), by striking “fiscal years 2004 through 2008” and inserting “fiscal years 2009 through 2013”; and

(C) in subparagraph (C)(ii), by striking “Committee on International Relations” and inserting “Committee on Foreign Affairs”; and

(3) by adding at the end the following:

“(5) WITHHOLDING FUNDS.—Notwithstanding any other provision of this Act, 20 percent of the amounts appropriated pursuant to this Act for a contribution to support the Global Fund for each of the fiscal years 2010 through 2013 shall be withheld from obligation to the Global Fund until the Secretary of State certifies to the appropriate congressional committees that the Global Fund—

“(A) has established an evaluation framework for the performance of Local Fund Agents (referred to in this paragraph as ‘LFAs’);

“(B) is undertaking a systematic assessment of the performance of LFAs; “(C) has adopted, and is implementing, a policy to

publish on a publicly available Web site— “(i) grant performance reviews;

“(ii) all reports of the Inspector General of the

Global Fund, in a manner that is consistent with the Policy for Disclosure of Reports of the Inspector General, approved at the 16th Meeting of the Board of the Global Fund;

“(iii) decision points of the Board of the Global Fund; “(iv)

reports from Board committees to the Board; and

“(v) a regular collection and analysis of performance data and funding of grants of the Global Fund, which shall cover all principal recipients and all sub-recipients; “(D) is maintaining an independent, well-staffed Office

of the Inspector General that— “(i) reports directly to the Board of the Global Fund; and

“(ii) compiles regular, publicly published audits of financial, programmatic, and reporting aspects of the Global Fund, its grantees, and LFAs; “(E) has established, and is reporting publicly on,

standard indicators for all program areas; “(F) has established a methodology to track and is publicly reporting on—

“(i) all subrecipients and the amount of funds disbursed to each subrecipient on the grant’s fiscal cycle; and

“(ii) the distribution of resources, by grant and principal recipient, for prevention, care, treatment, drugs and commodities purchase, and other purposes;

“(G) has established a policy on tariffs imposed by national governments on all goods and services financed by the Global Fund;

“(H) through its Secretariat, has taken meaningful steps to prevent national authorities in recipient countries from imposing taxes or tariffs on goods or services provided by the Fund;

“(I) is maintaining its status as a financing institution focused on programs directly related to HIV/AIDS, malaria, and tuberculosis;

“(J) is maintaining and making progress on— “(i) sustaining its multisectoral approach, through country coordinating mechanisms; and

“(ii) the implementation of grants, as reflected in the proportion of resources allocated to different sectors, including governments, civil society, and faith-and community-based organizations; and “(K) has established procedures providing access by

the Office of Inspector General of the Department of State and Broadcasting Board of Governors, as cognizant Inspector General, and the Inspector General of the Health and Human Services and the Inspector General of the United States Agency for International Development, to Global Fund financial data, and other information relevant to United States contributions (as determined by the Inspector General in consultation with the Global AIDS Coordinator).

“(6) SUMMARIES OF BOARD DECISIONS AND UNITED STATES

POSITIONS.—Following each meeting of the Board of the Global Fund, the Coordinator of United States Government Activities to Combat HIV/AIDS Globally shall report on the public website of the Coordinator a summary of Board decisions and how the United States Government voted and its positions on such decisions.”.

SEC. 203. RESEARCH ON METHODS FOR WOMEN TO PREVENT TRANSMISSION OF HIV AND OTHER DISEASES.

(a) SENSE OF CONGRESS.—Congress recognizes the need and urgency to expand the range of interventions for preventing the transmission of human immunodeficiency virus (HIV), including nonvaccine prevention methods that can be controlled by women.

(b) NIH OFFICE OF AIDS RESEARCH.—Subpart 1 of part D of title XXIII of the Public Health Service Act (42 U.S.C. 300cc– 40 et seq.) is amended by inserting after section 2351 the following:

“SEC. 2351A. MICROBICIDE RESEARCH.

“(a) FEDERAL STRATEGIC PLAN.—The Director of the Office shall— “(1) expedite the implementation of the Federal strategic plans required by section 403(a) of the Public Health Service Act (42 U.S.C. 283(a)(5)) regarding the conduct and support of research on, and development of, a microbicide to prevent the transmission of the human immunodeficiency virus; and “(2) review and, as appropriate, revise such plan to prioritize funding and activities relative to their scientific urgency and potential market readiness.

“(b) COORDINATION.—In implementing, reviewing, and prioritizing elements of the plan described in subsection (a), the Director of the Office shall consult, as appropriate, with—

“(1) representatives of other Federal agencies involved in microbicide research, including the Coordinator of United States Government Activities to Combat HIV/AIDS Globally, the Director of the Centers for Disease Control and Prevention, and the Administrator of the United States Agency for International Development;

“(2) the microbicide research and development community; and

“(3) health advocates.”.

(c) NATIONAL INSTITUTE OF ALLERGY AND INFECTIOUS DISEASES.—Subpart 6 of part C of title IV of the Public Health Service Act (42 U.S.C. 285f et seq.) is amended by adding at the end the following:

“SEC. 447C. MICROBICIDE RESEARCH AND DEVELOPMENT.

“The Director of the Institute, acting through the head of the Division of AIDS, shall, consistent with the peer-review process of the National Institutes of Health, carry out research on, and development of, safe and effective methods for use by women to prevent the transmission of the human immunodeficiency virus, which may include microbicides.”.

(d) CDC.—Part B of title III of the Public Health Service Act (42 U.S.C. 243 et seq.) is amended by inserting after section 317S the following:

“SEC. 317T. MICROBICIDE RESEARCH.

“(a) IN GENERAL.—The Director of the Centers for Disease Control and Prevention is strongly encouraged to fully implement the Centers’ microbicide agenda to support research and development of microbicides for use to prevent the transmission of the human immunodeficiency virus.

“(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary for each of fiscal years 2009 through 2013 to carry out this section.”.

(e) UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT.—

(1) IN GENERAL.—The Administrator of the United States Agency for International Development, in coordination with the Coordinator of United States Government Activities to Combat HIV/AIDS Globally, may facilitate availability and accessibility of microbicides, provided that such pharmaceuticals are approved, tentatively approved, or otherwise authorized for use by—

(A) the Food and Drug Administration;

(B) a stringent regulatory agency acceptable to the Secretary of Health and Human Services; or

(C) a quality assurance mechanism acceptable to the Secretary of Health and Human Services.

(2) AUTHORIZATION OF APPROPRIATIONS.—Of the amounts authorized to be appropriated under section 401 of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (22 U.S.C. 7671) for HIV/AIDS assistance, there are authorized to be appropriated to the President such sums as may be necessary for each of the fiscal years 2009 through 2013 to carry out this subsection.

SEC. 204. COMBATING HIV/AIDS, TUBERCULOSIS, AND MALARIA BY STRENGTHENING HEALTH POLICIES AND HEALTH SYSTEMS OF PARTNER COUNTRIES.

(a) **IN GENERAL.**—Title II of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (22 U.S.C. 7621) is amended by adding at the end the following:

“SEC. 204. COMBATING HIV/AIDS, TUBERCULOSIS, AND MALARIA BY STRENGTHENING HEALTH POLICIES AND HEALTH SYSTEMS OF PARTNER COUNTRIES.

“(a) **STATEMENT OF POLICY.**—It shall be the policy of the United States Government— “(1) to invest appropriate resources authorized under this Act—

“(A) to carry out activities to strengthen HIV/AIDS, tuberculosis, and malaria health policies and health systems; and

“(B) to provide workforce training and capacity-building consistent with the goals and objectives of this Act; and “(2) to support the development of a sound policy environ

ment in partner countries to increase the ability of such countries— “(A) to maximize utilization of health care resources from donor countries;

“(B) to increase national investments in health and education and maximize the effectiveness of such investments;

“(C) to improve national HIV/AIDS, tuberculosis, and malaria strategies; “(D) to deliver evidence-based services in an effective and efficient manner; and

“(E) to reduce barriers that prevent recipients of services from achieving maximum benefit from such services. “(b) **ASSISTANCE TO IMPROVE PUBLIC FINANCE MANAGEMENT SYSTEMS.**—

“(1) **IN GENERAL.**—Consistent with the authority under section 129 of the Foreign Assistance Act of 1961 (22 U.S.C. 2152), the Secretary of the Treasury, acting through the head of the Office of Technical Assistance, is authorized to provide assistance for advisors and partner country finance, health, and other relevant ministries to improve the effectiveness of public finance management systems in partner countries to enable such countries to receive funding to carry out programs to combat HIV/AIDS, tuberculosis, and malaria and to manage such programs.

“(2) **AUTHORIZATION OF APPROPRIATIONS.**—Of the amounts authorized to be appropriated under section 401 for HIV/AIDS assistance, there are authorized to be appropriated to the Secretary of the Treasury such sums as may be necessary for each of the fiscal years 2009 through 2013 to carry out this subsection. “(c) **PLAN REQUIRED.**—The Global AIDS Coordinator, in

collaboration with the Administrator of the United States Agency for International Development (USAID), shall develop and implement a plan to combat HIV/AIDS by strengthening health policies and health systems of partner countries as part of USAID’s ‘Health

Systems 2020' project. Recognizing that human and institutional capacity form the core of any health care system that can sustain the fight against HIV/AIDS, tuberculosis, and malaria, the plan shall include a strategy to encourage postsecondary educational institutions in partner countries, particularly in Africa, in collaboration with United States postsecondary educational institutions, including historically black colleges and universities, to develop such human and institutional capacity and in the process further build their capacity to sustain the fight against these diseases.”

(b) CLERICAL AMENDMENT.—The table of contents for the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (22 U.S.C. 7601 note) is amended by inserting after the item relating to section 203, as added by section 203 of this Act, the following:

“Sec. 204. Combating HIV/AIDS, tuberculosis, and malaria by strengthening health policies and health systems of partner countries.”

SEC. 205. FACILITATING EFFECTIVE OPERATIONS OF THE CENTERS FOR DISEASE CONTROL.

Section 307 of the Public Health Service Act (42 U.S.C. 242l) is amended—

(1) by amending subsection (a) to read as follows: “(a) The Secretary may participate with other countries in cooperative endeavors in—

“(1) biomedical research, health care technology, and the health services research and statistical analysis authorized under section 306 and title IX; and

“(2) biomedical research, health care services, health care research, or other related activities in furtherance of the activities, objectives or goals authorized under the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/ AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008.”; and

(2) in subsection (b)—

(A) in paragraph (7), by striking “and” after the semicolon at the end;

(B) by striking “The Secretary may not, in the exercise of his authority under this section, provide financial assistance for the construction of any facility in any foreign country.”

(C) in paragraph (8), by striking “for any purpose.” and inserting “for the purpose of any law administered by the Office of Personnel Management;”; and

(D) by adding at the end the following:

“(9) provide such funds by advance or reimbursement to the Secretary of State, as may be necessary, to pay the costs of acquisition, lease, construction, alteration, equipping, furnishing or management of facilities outside of the United States; and

“(10) in consultation with the Secretary of State, through grant or cooperative agreement, make funds available to public or nonprofit private institutions or agencies in foreign countries in which the Secretary is participating in activities described under subsection (a) to acquire, lease, construct, alter, or renovate facilities in those countries.”.

(3) in subsection (c)—

(A) by striking “1990” and inserting “1980”; and

(B) by inserting or “or section 903 of the Foreign Service Act of 1980 (22 U.S.C. 4083)” after “Code”.

SEC. 206. FACILITATING VACCINE DEVELOPMENT.

(a) **TECHNICAL ASSISTANCE FOR DEVELOPING COUNTRIES.**—The Administrator of the United States Agency for International Development, utilizing public-private partners, as appropriate, and working in coordination with other international development agencies, is authorized to strengthen the capacity of developing countries’ governmental institutions to—

- (1) collect evidence for informed decision-making and introduction of new vaccines, including potential HIV/AIDS, tuberculosis, and malaria vaccines, if such vaccines are determined to be safe and effective;
- (2) review protocols for clinical trials and impact studies and improve the implementation of clinical trials; and
- (3) ensure adequate supply chain and delivery systems.

(b) **ADVANCED MARKET COMMITMENTS.**—

(1) **PURPOSE.**—The purpose of this subsection is to improve global health by requiring the United States to participate in negotiations for advance market commitments for the development of future vaccines, including potential vaccines for HIV/AIDS, tuberculosis, and malaria.

(2) **NEGOTIATION REQUIREMENT.**—The Secretary of the Treasury shall enter into negotiations with the appropriate officials of the International Bank of Reconstruction and Development (World Bank) and the GAVI Alliance, the member nations of such entities, and other interested parties to establish advanced market commitments to purchase vaccines to combat HIV/AIDS, tuberculosis, malaria, and other related infectious diseases.

(3) **REQUIREMENTS.**—In negotiating the United States participation in programs for advanced market commitments, the Secretary of the Treasury shall take into account whether programs for advance market commitments include—

- (A) legally binding contracts for product purchase that include a fair market price for up to a maximum number of treatments, creating a strong market incentive;
- (B) clearly defined and transparent rules of program participation for qualified developers and suppliers of the product;
- (C) clearly defined requirements for eligible vaccines to ensure that they are safe and effective and can be delivered in developing country contexts;
- (D) dispute settlement mechanisms; and
- (E) sufficient flexibility to enable the contracts to be adjusted in accord with new information related to projected market size and other factors while still maintaining the purchase commitment at a fair price.

(4) **REPORT.**—Not later than 1 year after the date of the enactment of this Act—

(A) the Secretary of the Treasury shall submit a report to the appropriate congressional committees on the status of the United States negotiations to participate in programs for the advanced market commitments under this subsection; and

(B) the President shall produce a comprehensive report, written by a study group of qualified professionals from relevant Federal agencies and initiatives, nongovernmental organizations, and industry representatives, that sets forth a coordinated strategy to accelerate development of vaccines for infectious diseases, such as HIV/AIDS, malaria, and tuberculosis, which includes—

- (i) initiatives to create economic incentives for the research, development, and manufacturing of vaccines for HIV/AIDS, tuberculosis, malaria, and other infectious diseases;
- (ii) an expansion of public-private partnerships and the leveraging of resources from other countries and the private sector; and
- (iii) efforts to maximize United States capabilities to support clinical trials of vaccines in developing countries and to address the challenges of delivering vaccines in developing countries to minimize delays in access once vaccines are available.

TITLE III—BILATERAL EFFORTS

Subtitle A—General Assistance and Programs

SEC. 301. ASSISTANCE TO COMBAT HIV/AIDS.

(a) AMENDMENTS TO THE FOREIGN ASSISTANCE ACT OF 1961.—

(1) FINDING.—Section 104A(a) of the Foreign Assistance Act of 1961 (22 U.S.C. 2151b–2(a)) is amended by inserting “Central Asia, Eastern Europe, Latin America” after “Caribbean,”.

(2) POLICY.—Section 104A(b) of such Act is amended to read as follows: “(b) POLICY.—

“(1) OBJECTIVES.—It is a major objective of the foreign assistance program of the United States to provide assistance for the prevention and treatment of HIV/AIDS and the care of those affected by the disease. It is the policy objective of the United States, by 2013, to—

“(A) assist partner countries to— “(i) prevent 12,000,000 new HIV infections worldwide; “(ii) support—

“(I) the increase in the number of individuals with HIV/AIDS receiving antiretroviral treatment above the goal established under section 402(a)(3) and increased pursuant to paragraphs (1) through (3) of section 403(d); and

“(II) additional treatment through coordinated multilateral efforts;

“(iii) support care for 12,000,000 individuals infected with or affected by HIV/AIDS, including 5,000,000 orphans and vulnerable children affected by

HIV/AIDS, with an emphasis on promoting a comprehensive, coordinated system of services to be integrated throughout the continuum of care;

“(iv) provide at least 80 percent of the target population with access to counseling, testing, and treatment to prevent the transmission of HIV from mother-to-child;

“(v) provide care and treatment services to children with HIV in proportion to their percentage within the HIV-infected population of a given partner country; and

“(vi) train and support retention of health care professionals, paraprofessionals, and community health workers in HIV/AIDS prevention, treatment, and care, with the target of providing such training to at least 140,000 new health care professionals and paraprofessionals with an emphasis on training and in country deployment of critically needed doctors and nurses; “(B) strengthen the capacity to deliver primary health

care in developing countries, especially in sub-Saharan Africa;

“(C) support and help countries in their efforts to achieve staffing levels of at least 2.3 doctors, nurses, and midwives per 1,000 population, as called for by the World Health Organization; and

“(D) help partner countries to develop independent, sustainable HIV/AIDS programs. “(2) COORDINATED GLOBAL STRATEGY.—The United States

and other countries with the sufficient capacity should provide assistance to countries in sub-Saharan Africa, the Caribbean, Central Asia, Eastern Europe, and Latin America, and other countries and regions confronting HIV/AIDS epidemics in a coordinated global strategy to help address generalized and concentrated epidemics through HIV/AIDS prevention, treatment, care, monitoring and evaluation, and related activities.

“(3) PRIORITIES.—The United States Government’s response to the global HIV/AIDS pandemic and the Government’s efforts to help countries assume leadership of sustainable campaigns to combat their local epidemics should place high priority on—

“(A) the prevention of the transmission of HIV; “(B) moving toward universal access to HIV/AIDS prevention counseling and services; “(C) the inclusion of cost sharing assurances that meet the requirements under section 110; and

“(D) the inclusion of transition strategies to ensure sustainability of such programs and activities, including health care systems, under other international donor support, or budget support by respective foreign governments.”.

(b) AUTHORIZATION.—Section 104A(c) of such Act is amended—

(1) in paragraph (1), by striking “and other countries and areas.” and inserting “Central Asia, Eastern Europe, Latin America, and other countries and areas, particularly with respect to refugee populations or those in postconflict settings in such countries and areas with significant or increasing HIV incidence rates.”;

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(2) in paragraph (2), by striking “and other countries and areas affected by the HIV/AIDS pandemic” and inserting “Central Asia, Eastern Europe, Latin America, and other countries and areas affected by the HIV/AIDS pandemic, particularly with respect to refugee populations or those in post-conflict settings in such countries and areas with significant or increasing HIV incidence rates.”; and

(3) in paragraph (3)—

(A) by striking “foreign countries” and inserting “partner countries, other international actors,”; and

(B) by inserting “within the framework of the principles of the Three Ones” before the period at the end.

(c) ACTIVITIES SUPPORTED.—Section 104A(d) of such Act is amended—

(1) in paragraph (1)—

(A) in subparagraph (A)—

(i) by inserting “and multiple concurrent sexual partnering,” after “casual sexual partnering”; and

(ii) by striking “condoms” and inserting “male and female condoms”;

(B) in subparagraph (B)—

(i) by striking “programs that” and inserting “programs that are designed with local input and”; and

(ii) by striking “those organizations” and inserting “those locally based organizations”;

(C) in subparagraph (D), by inserting “and promoting the use of provider-initiated or ‘opt-out’ voluntary testing in accordance with World Health Organization guidelines” before the semicolon at the end;

(D) by redesignating subparagraphs (F), (G), and (H) as subparagraphs (H), (I), and (J), respectively;

(E) by inserting after subparagraph (E) the following: “(F) assistance to—
“(i) achieve the goal of reaching 80 percent of pregnant women for prevention and treatment of mother-to-child transmission of HIV in countries in which the United States is implementing HIV/AIDS programs by 2013; and

“(ii) promote infant feeding options and treatment protocols that meet the most recent criteria established by the World Health Organization;

“(G) medical male circumcision programs as part of national strategies to combat the transmission of HIV/ AIDS;”;

(F) in subparagraph (I), as redesignated, by striking “and” at the end; and

(G) by adding at the end the following: “(K) assistance for counseling, testing, treatment, care, and support programs, including— “(i) counseling and other services for the prevention of reinfection of individuals with HIV/AIDS; “(ii) counseling to prevent sexual transmission of HIV, including— “(I) life skills development for practicing

abstinence and faithfulness; “(II) reducing the number of sexual partners; “(III) delaying sexual debut; and

“(IV) ensuring correct and consistent use of condoms; “(iii) assistance to engage underlying vulnerabilities to HIV/AIDS, especially those of women and girls; “(iv) assistance for appropriate HIV/AIDS education programs and training targeted to prevent the transmission of HIV among men who have sex with men; “(v) assistance to provide male and female condoms; “(vi) diagnosis and treatment of other sexually transmitted infections; “(vii) strategies to address the stigma and discrimination that impede HIV/AIDS prevention efforts; and “(viii) assistance to facilitate widespread access to microbicides for HIV prevention, if safe and effective products become available, including financial and technical support for culturally appropriate introductory programs, procurement, distribution, logistics management, program delivery, acceptability studies, provider training, demand generation, and postintroduction monitoring.”; and

(2) in paragraph (2)—

(A) in subparagraph (B), by striking “and” at the end;

(B) in subparagraph (C)—

(i) by inserting “pain management,” after “opportunistic infections,”; and

(ii) by striking the period at the end and inserting a semicolon; and

(C) by adding at the end the following:

“(D) as part of care and treatment of HIV/AIDS, assistance (including prophylaxis and treatment) for common HIV/AIDS-related opportunistic infections for free or at a rate at which it is easily affordable to the individuals and populations being served;

“(E) as part of care and treatment of HIV/AIDS, assistance or referral to available and adequately resourced service providers for nutritional support, including counseling and where necessary the provision of commodities, for persons meeting malnourishment criteria and their families;”;

(3) in paragraph (4)—

(A) in subparagraph (C), by striking “and” at the end;

(B) in subparagraph (D), by striking the period at the end and inserting a semicolon; and

(C) by adding at the end the following:

“(E) carrying out and expanding program monitoring, impact evaluation research and analysis, and operations research and disseminating data and findings through mechanisms to be developed by the Coordinator of United States Government Activities to Combat HIV/AIDS Globally, in coordination with the Director of the Centers for Disease Control, in order to—

“(i) improve accountability, increase transparency, and ensure the delivery of evidence-based services through the collection, evaluation, and analysis of data

regarding gender-responsive interventions,
disaggregated by age and sex; “(ii) identify and replicate effective models; and
“(iii) develop gender indicators to measure outcomes and the impacts of interventions; and “(F) establishing appropriate
systems to— “(i) gather epidemiological and social science data on HIV;
and
“(ii) evaluate the effectiveness of prevention efforts among men who have sex with
men, with due consideration to stigma and risks associated with disclosure.”;

(4) in paragraph (5)—

(A) by redesignating subparagraph (C) as subparagraph (D); and

(B) by inserting after subparagraph (B) the following:

“(C) MECHANISM TO ENSURE COST-EFFECTIVE DRUG PURCHASING.—Subject to subparagraph
(B), mechanisms to ensure that safe and effective pharmaceuticals, including
antiretrovirals and medicines to treat opportunistic infections, are purchased at the
lowest possible price at which such pharmaceuticals may be obtained in sufficient
quantity on the world market, provided that such pharmaceuticals are approved,
tentatively approved, or otherwise authorized for use by—

“(i) the Food and Drug Administration; “(ii) a stringent regulatory agency
acceptable to the Secretary of Health and Human Services; or “(iii) a quality
assurance mechanism acceptable to the Secretary of Health and Human
Services.”;

(5) in paragraph (6)—

(A) by amending the paragraph heading to read as follows: “(6) RELATED AND
COORDINATED ACTIVITIES.—”;

(B) in subparagraph (B), by striking “and” at the end;

(C) in subparagraph (C), by striking the period at the end and inserting “; and”; and

(D) by adding at the end the following: “(D) coordinated or referred
activities to— “(i) enhance the clinical impact of HIV/AIDS care and
treatment; and

“(ii) ameliorate the adverse social and economic costs often affecting AIDS-impacted
families and communities through the direct provision, as necessary, or through the
referral, if possible, of support services, including—

“(I) nutritional and food support; “(II) safe drinking water and adequate
sanitation; “(III) nutritional counseling; “(IV) income-generating activities and
livelihood initiatives; “(V) maternal and child health care; “(VI) primary health
care; “(VII) the diagnosis and treatment of other
infectious or sexually transmitted diseases; “(VIII) substance abuse
and treatment services; and

“(IX) legal services;

“(E) coordinated or referred activities to link programs addressing HIV/AIDS with programs addressing gender-based violence in areas of significant HIV prevalence to assist countries in the development and enforcement of women’s health, children’s health, and HIV/AIDS laws and policies that—

“(i) prevent and respond to violence against women and girls;

“(ii) promote the integration of screening and assessment for gender-based violence into HIV/AIDS programming;

“(iii) promote appropriate HIV/AIDS counseling, testing, and treatment into gender-based violence programs; and

“(iv) assist governments to develop partnerships with civil society organizations to create networks for psychosocial, legal, economic, or other support services;

“(F) coordinated or referred activities to—

“(i) address the frequent coinfection of HIV and tuberculosis, in accordance with World Health Organization guidelines;

“(ii) promote provider-initiated or ‘opt-out’ HIV/ AIDS counseling and testing and appropriate referral for treatment and care to individuals with tuberculosis or its symptoms, particularly in areas with significant HIV prevalence; and

“(iii) strengthen programs to ensure that individuals testing positive for HIV receive tuberculosis screening and to improve laboratory capacities, infection control, and adherence; and “(G) activities to—

“(i) improve the effectiveness of national responses to HIV/AIDS;

“(ii) strengthen overall health systems in high-prevalence countries, including support for workforce training, retention, and effective deployment, capacity building, laboratory development, equipment maintenance and repair, and public health and related public financial management systems and operations; and

“(iii) encourage fair and transparent procurement practices among partner countries; and

“(iv) promote in-country or intra-regional pediatric training for physicians and other health professionals, preferably through public-private partnerships involving colleges and universities, with the goal of increasing pediatric HIV workforce capacity.”; and

(6) by adding at the end the following:

“(8) COMPACTS AND FRAMEWORK AGREEMENTS.—The development of compacts or framework agreements, tailored to local circumstances, with national governments or regional partnerships in countries with significant HIV/AIDS burdens to promote host government commitment to deeper integration of HIV/AIDS services into health systems, contribute to health systems overall, and enhance sustainability, including—

“(A) cost sharing assurances that meet the requirements under section 110; and

“(B) transition strategies to ensure sustainability of such programs and activities, including health care systems, under other international donor support, or budget support by respective foreign governments.”.

(d) COMPACTS AND FRAMEWORK AGREEMENTS.—Section 104A of such Act is amended—
(1) by redesignating subsections (e) through (g) as subsections (f) through (h); and
(2) by inserting after subsection (d) the following: “(e) COMPACTS AND FRAMEWORK AGREEMENTS.—“(1) FINDINGS.—Congress makes the following findings:

“(A) The congressionally mandated Institute of Medicine report entitled ‘PEPFAR Implementation: Progress and Promise’ states: ‘The next strategy [of the U.S. Global AIDS Initiative] should squarely address the needs and challenges involved in supporting sustainable country HIV/ AIDS programs, thereby transitioning from a focus on emergency relief.’.

“(B) One mechanism to promote the transition from an emergency to a public health and development approach to HIV/AIDS is through compacts or framework agreements between the United States Government and each participating nation. “(2) ELEMENTS.—Compacts on HIV/AIDS authorized under subsection (d)(8) shall include the following elements:

“(A) Compacts whose primary purpose is to provide direct services to combat HIV/AIDS are to be made between—

“(i) the United States Government; and

“(ii)(I) national or regional entities representing low-income countries served by an existing United States Agency for International Development or Department of Health and Human Services presence or regional platform; or

“(II) countries or regions—

“(aa) experiencing significantly high HIV prevalence or risk of significantly increasing incidence within the general population;

“(bb) served by an existing United States Agency for International Development or Department of Health and Human Services presence or regional platform; and

“(cc) that have inadequate financial means within such country or region.

“(B) Compacts whose primary purpose is to provide limited technical assistance to a country or region connected to services provided within the country or region—

“(i) may be made with other countries or regional entities served by an existing United States Agency for International Development or Department of Health and Human Services presence or regional platform;

“(ii) shall require significant investments in HIV prevention, care, and treatment services by the host country;

“(iii) shall be time-limited in terms of United States contributions; and

“(iv) shall be made only upon prior notification to Congress—“(I) justifying the need for such compacts;“(II) describing the expected investment by the country or regional entity; and“(III) describing the scope, nature, expected total United States investment, and time frame of the limited technical assistance under the compact and its intended impact.

“(C) Compacts shall include provisions to—“(i) promote local and national efforts to reduce stigma associated with HIV/AIDS; and“(ii) work with and promote the role of civil society in combating HIV/AIDS.“(D) Compacts shall take into account the overall national health and development and national HIV/AIDS and public health strategies of each country.“(E) Compacts shall contain—“(i) consideration of the specific objectives that the country and the United States expect to achieve during the term of a compact;“(ii) consideration of the respective responsibilities of the country and the United States in the achievement of such objectives;“(iii) consideration of regular benchmarks to measure progress toward achieving such objectives;“(iv) an identification of the intended beneficiaries, disaggregated by gender and age, and including information on orphans and vulnerable children, to the maximum extent practicable;“(v) consideration of the methods by which the compact is intended to—“(I) address the factors that put women and girls at greater risk of HIV/AIDS; and“(II) strengthen elements such as the economic, educational, and social status of women, girls, orphans, and vulnerable children and the inheritance rights and safety of such individuals;“(vi) consideration of the methods by which the compact will—“(I) strengthen the health care capacity, including factors such as the training, retention, deployment, recruitment, and utilization of health care workers;“(II) improve supply chain management; and“(III) improve the health systems and infrastructure of the partner country, including the ability of compact participants to maintain and operate equipment transferred or purchased as part of the compact;“(vii) consideration of proposed mechanisms to provide oversight;“(viii) consideration of the role of civil society in the development of a compact and the achievement of its objectives;

“(ix) a description of the current and potential participation of other donors in the achievement of such objectives, as appropriate; and

“(x) consideration of a plan to ensure appropriate fiscal accountability for the use of assistance. “(F) For regional compacts, priority shall be given to countries that are included in regional funds and programs in existence as of the date of the enactment of the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008.

“(G) Amounts made available for compacts described in subparagraphs (A) and (B) shall be subject to the inclusion of—

“(i) cost sharing assurances that meet the requirements under section 110; and

“(ii) transition strategies to ensure sustainability of such programs and activities, including health care systems, under other international donor support, and budget support by respective foreign governments.

“(3) LOCAL INPUT.—In entering into a compact on HIV/ AIDS authorized under subsection (d)(8), the Coordinator of United States Government Activities to Combat HIV/AIDS Globally shall seek to ensure that the government of a country—

“(A) takes into account the local perspectives of the rural and urban poor, including women, in each country; and

“(B) consults with private and voluntary organizations, including faith-based organizations, the business community, and other donors in the country. “(4)

CONGRESSIONAL AND PUBLIC NOTIFICATION AFTER

ENTERING INTO A COMPACT.—Not later than 10 days after entering into a compact authorized under subsection (d)(8), the Global AIDS Coordinator shall—

“(A) submit a report containing a detailed summary of the compact and a copy of the text of the compact to—

“(i) the Committee on Foreign Relations of the Senate;

“(ii) the Committee on Appropriations of the Senate;

“(iii) the Committee on Foreign Affairs of the House of Representatives; and

“(iv) the Committee on Appropriations of the House of Representatives; and

“(B) publish such information in the Federal Register

and on the Internet website of the Office of the Global AIDS Coordinator.”.

(e) ANNUAL REPORT.—Section 104A(f) of such Act, as redesignated, is amended—

(1) in paragraph (1), by striking “Committee on International Relations” and inserting “Committee on Foreign Affairs”; and

(2) in paragraph (2)—

(A) in subparagraph (B), by striking “and” at the end;

(B) by striking subparagraph (C) and inserting the following: “(C) a detailed breakdown of funding allocations, by program and by country, for prevention activities; and “(D) a detailed assessment of the impact of programs established pursuant to such sections, including— “(i)(I) the effectiveness of such programs in reducing— “(aa) the transmission of HIV, particularly in women and girls; “(bb) mother-to-child transmission of HIV, including through drug treatment and therapies, either directly or by referral; and

“(cc) mortality rates from HIV/AIDS;

“(II) the number of patients receiving treatment for AIDS in each country that receives assistance under this Act;

“(III) an assessment of progress towards the achievement of annual goals set forth in the timetable required under the 5-year strategy established under section 101 of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 and, if annual goals are not being met, the reasons for such failure; and

“(IV) retention and attrition data for programs receiving United States assistance, including mortality and loss to follow-up rates, organized overall and by country;

“(ii) the progress made toward—

“(I) improving health care delivery systems (including the training of health care workers, including doctors, nurses, midwives, pharmacists, laboratory technicians, and compensated community health workers, and the use of codes of conduct for ethical recruiting practices for health care workers);

“(II) advancing safe working conditions for health care workers; and

“(III) improving infrastructure to promote progress toward universal access to HIV/AIDS prevention, treatment, and care by 2013; “(iii) a description of coordination efforts with rel

evant executive branch agencies to link HIV/AIDS clinical and social services with non-HIV/AIDS services as part of the United States health and development agenda;

“(iv) a detailed description of integrated HIV/AIDS and food and nutrition programs and services, including—

“(I) the amount spent on food and nutrition

support; “(II) the types of activities supported; and “(III) an assessment of the effectiveness of

interventions carried out to improve the health status of persons with HIV/AIDS receiving food or nutritional support;

“(v) a description of efforts to improve harmonization, in terms of relevant executive branch agencies, coordination with other public and private entities, and coordination with partner countries’ national strategic plans as called for in the ‘Three Ones’;

“(vi) a description of—

“(I) the efforts of partner countries that were signatories to the Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases to adhere to the goals of such Declaration in terms of investments in public health, including HIV/AIDS; and

“(II) a description of the HIV/AIDS investments of partner countries that were not signatories to such Declaration; “(vii) a detailed description of any compacts or framework agreements reached or negotiated between the United States and any partner countries, including a description of the elements of compacts described in subsection (e);

“(viii) a description of programs serving women and girls, including—

“(I) HIV/AIDS prevention programs that address the vulnerabilities of girls and women to HIV/AIDS;

“(II) information on the number of individuals served by programs aimed at reducing the vulnerabilities of women and girls to HIV/AIDS and data on the types, objectives, and duration of programs to address these issues;

“(III) information on programs to address the particular needs of adolescent girls and young women; and

“(IV) programs to prevent gender-based violence or to assist victims of gender based violence as part of, or in coordination with, HIV/ AIDS programs; “(ix) a description of strategies, goals, programs,

and interventions to— “(I) address the needs and vulnerabilities of youth populations;

“(II) expand access among young men and women to evidence-based HIV/AIDS health care services and HIV prevention programs, including abstinence education programs; and

“(III) expand community-based services to meet the needs of orphans and of children and adolescents affected by or vulnerable to HIV/AIDS without increasing stigmatization; “(x) a description of—

“(I) the specific strategies funded to ensure the reduction of HIV infection among injection drug users;

“(II) the number of injection drug users, by country, reached by such strategies; and “(III) medication-assisted drug treatment for individuals with HIV or at risk of HIV;

“(xi) a detailed description of program monitoring, operations research, and impact evaluation research, including—

“(I) the amount of funding provided for each research type; “(II) an analysis of cost-effectiveness models; and

“(III) conclusions regarding the efficiency, effectiveness, and quality of services as derived from previous or ongoing research and monitoring efforts; “(xii) building capacity to identify, investigate, and

stop nosocomial transmission of infectious diseases, including HIV and tuberculosis; and

“(xiii) a description of staffing levels of United States government HIV/AIDS teams in countries with significant HIV/AIDS programs, including whether or not a full-time coordinator was on staff for the year.”.

(f) AUTHORIZATION OF APPROPRIATIONS.—Section 301(b) of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (22 U.S.C. 7631(b)) is amended—

(1) in paragraph (1), by striking “fiscal years 2004 through 2008” and inserting “fiscal years 2009 through 2013”; and

(2) in paragraph (3), by striking “fiscal years 2004 through 2008” and inserting “fiscal years 2009 through 2013”.

(g) RELATIONSHIP TO ASSISTANCE PROGRAMS TO ENHANCE NUTRITION.—Section 301(c) of such Act is amended to read as follows:

“(c) FOOD AND NUTRITIONAL SUPPORT.—

“(1) IN GENERAL.—As indicated in the report produced by the Institute of Medicine, entitled ‘PEPFAR Implementation: Progress and Promise’, inadequate caloric intake has been clearly identified as a principal reason for failure of clinical response to antiretroviral therapy. In recognition of the impact of malnutrition as a clinical health issue for many persons living with HIV/AIDS that is often associated with health and economic impacts on these individuals and their families, the Global AIDS Coordinator and the Administrator of the United States Agency for International Development shall—

“(A) follow World Health Organization guidelines for HIV/AIDS food and nutrition services;

“(B) integrate nutrition programs with HIV/AIDS activities through effective linkages among the health, agricultural, and livelihood sectors and establish additional services in circumstances in which referrals are inadequate or impossible;

“(C) provide, as a component of care and treatment programs for persons with HIV/AIDS, food and nutritional support to individuals infected with, and affected by, HIV/AIDS who meet established criteria for nutritional support (including clinically malnourished children and adults, and pregnant and lactating women in programs in need of supplemental support), including—

“(i) anthropometric and dietary assessment; “(ii) counseling; and “(iii) therapeutic and supplementary feeding;

“(D) provide food and nutritional support for children affected by HIV/AIDS and to communities and households caring for children affected by HIV/AIDS; and
“(E) in communities where HIV/AIDS and food insecurity are highly prevalent, support programs to address these often intersecting health problems through community-based assistance programs, with an emphasis on sustainable approaches. “(2) AUTHORIZATION OF APPROPRIATIONS.—Of the amounts authorized to be appropriated under section 401, there are authorized to be appropriated to the President such sums as may be necessary for each of the fiscal years 2009 through 2013 to carry out this subsection.”.

(h) ELIGIBILITY FOR ASSISTANCE.—Section 301(d) of such Act is amended to read as follows:

“(d) ELIGIBILITY FOR ASSISTANCE.—An organization, including a faith-based organization, that is otherwise eligible to receive assistance under section 104A of the Foreign Assistance Act of 1961, under this Act, or under any amendment made by this Act or by the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008, for HIV/AIDS prevention, treatment, or care—

“(1) shall not be required, as a condition of receiving such assistance— “(A) to endorse or utilize a multisectoral or comprehensive approach to combating HIV/AIDS; or
“(B) to endorse, utilize, make a referral to, become integrated with, or otherwise participate in any program or activity to which the organization has a religious or moral objection; and “(2) shall not be discriminated against in the solicitation or issuance of grants, contracts, or cooperative agreements under such provisions of law for refusing to meet any requirement described in paragraph (1).”.

SEC. 302. ASSISTANCE TO COMBAT TUBERCULOSIS.

(a) POLICY.—Section 104B(b) of the Foreign Assistance Act of 1961 (22 U.S.C. 2151b–3(b)) is amended to read as follows:

“(b) POLICY.—It is a major objective of the foreign assistance program of the United States to control tuberculosis. In all countries in which the Government of the United States has established development programs, particularly in countries with the highest burden of tuberculosis and other countries with high rates of tuberculosis, the United States should support the objectives of the Global Plan to Stop TB, including through achievement of the following goals:

“(1) Reduce by half the tuberculosis death and disease burden from the 1990 baseline.

“(2) Sustain or exceed the detection of at least 70 percent of sputum smear-positive cases of tuberculosis and the successful treatment of at least 85 percent of the cases detected in countries with established United States Agency for International Development tuberculosis programs.

“(3) In support of the Global Plan to Stop TB, the President shall establish a comprehensive, 5-year United States strategy to expand and improve United States efforts to combat tuberculosis globally, including a plan to support—

“(A) the successful treatment of 4,500,000 new sputum smear tuberculosis patients under DOTS programs by 2013, primarily through direct support for needed services, commodities, health workers, and training, and additional treatment through coordinated multilateral efforts; and

“(B) the diagnosis and treatment of 90,000 new multiple drug resistant tuberculosis cases by 2013, and additional treatment through coordinated multilateral efforts.”.

(b) PRIORITY TO STOP TB STRATEGY.—Section 104B(e) of such Act is amended to read as follows: “(e) PRIORITY TO STOP TB STRATEGY.—In furnishing assistance under subsection (c), the President shall give priority to—

“(1) direct services described in the Stop TB Strategy, including expansion and enhancement of Directly Observed Treatment Short-course (DOTS) coverage, rapid testing, treatment for individuals infected with both tuberculosis and HIV, and treatment for individuals with multi-drug resistant tuberculosis (MDR-TB), strengthening of health systems, use of the International Standards for Tuberculosis Care by all providers, empowering individuals with tuberculosis, and enabling and promoting research to develop new diagnostics, drugs, and vaccines, and program-based operational research relating to tuberculosis; and

“(2) funding for the Global Tuberculosis Drug Facility, the Stop Tuberculosis Partnership, and the Global Alliance for TB Drug Development.”.

(c) ASSISTANCE FOR THE WORLD HEALTH ORGANIZATION AND THE STOP TUBERCULOSIS PARTNERSHIP.—Section 104B of such Act is amended—

(1) by redesignating subsection (f) as subsection (h); and
(2) by inserting after subsection (e) the following:

“(f) ASSISTANCE FOR THE WORLD HEALTH ORGANIZATION AND THE STOP TUBERCULOSIS PARTNERSHIP.—In carrying out this section, the President, acting through the Administrator of the United States Agency for International Development, is authorized to provide increased resources to the World Health Organization and the Stop Tuberculosis Partnership to improve the capacity of countries with high rates of tuberculosis and other affected countries to implement the Stop TB Strategy and specific strategies related to addressing multiple drug resistant tuberculosis (MDR-TB) and extensively drug resistant tuberculosis (XDR-TB).”.

(d) ANNUAL REPORT.—Section 104B of such Act is amended by inserting after subsection (f), as added by subsection (c) of this section, the following:

“(g) ANNUAL REPORT.—The President shall submit an annual report to Congress that describes the impact of United States foreign

assistance on efforts to control tuberculosis, including— “(1) the number of tuberculosis cases diagnosed and the number of cases cured in countries receiving United States bilateral foreign assistance for tuberculosis control purposes; “(2) a description of activities supported with United States tuberculosis resources in each country, including a description of how those activities specifically contribute to increasing the number of people diagnosed and treated for tuberculosis;

“(3) in each country receiving bilateral United States foreign assistance for tuberculosis control purposes, the percentage provided for direct tuberculosis services in countries receiving

United States bilateral foreign assistance for tuberculosis control purposes;

“(4) a description of research efforts and clinical trials to develop new tools to combat tuberculosis, including diagnostics, drugs, and vaccines supported by United States bilateral assistance;

“(5) the number of persons who have been diagnosed and started treatment for multidrug-resistant tuberculosis in countries receiving United States bilateral foreign assistance for tuberculosis control programs;

“(6) a description of the collaboration and coordination of United States anti-tuberculosis efforts with the World Health Organization, the Global Fund, and other major public and private entities within the Stop TB Strategy;

“(7) the constraints on implementation of programs posed by health workforce shortages and capacities; “(8) the number of people trained in tuberculosis control; and

“(9) a breakdown of expenditures for direct patient tuberculosis services, drugs and other commodities, drug management, training in diagnosis and treatment, health systems strengthening, research, and support costs.”.

(e) DEFINITIONS.—Section 104B(h) of such Act, as redesignated by subsection (c), is amended—

(1) in paragraph (1), by striking the period at the end and inserting the following: “including— “(A) low-cost and effective diagnosis, treatment, and

monitoring of tuberculosis; “(B) a reliable drug supply; “(C) a management strategy for public health systems; “(D) health system strengthening; “(E) promotion of the use of the International Standards for Tuberculosis Care by all care providers; “(F) bacteriology under an external quality assessment framework; “(G) short-course chemotherapy; and “(H) sound reporting and recording systems.”; and

(2) by redesignating paragraph (5) as paragraph (6); and

(3) by inserting after paragraph (4) the following:

“(5) STOP TB STRATEGY.—The term ‘Stop TB Strategy’ means the 6-point strategy to reduce tuberculosis developed by the World Health Organization, which is described in the Global Plan to Stop TB 2006–2015: Actions for Life, a comprehensive plan developed by the Stop TB Partnership that sets out the actions necessary to achieve the millennium development goal of cutting tuberculosis deaths and disease burden in half by 2015.”.

(f) AUTHORIZATION OF APPROPRIATIONS.—Section 302 (b) of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (22 U.S.C. 7632(b)) is amended—

(1) in paragraph (1), by striking “such sums as may be necessary for each of the fiscal years 2004 through 2008” and inserting “a total of \$4,000,000,000 for the 5-year period beginning on October 1, 2008.”; and

(2) in paragraph (3), by striking “fiscal years 2004 through 2008” and inserting “fiscal years 2009 through 2013.”.

SEC. 303. ASSISTANCE TO COMBAT MALARIA.

(a) **AMENDMENT TO THE FOREIGN ASSISTANCE ACT OF 1961.**—Section 104C(b) of the Foreign Assistance Act of 1961 (22 U.S.C. 2151–4(b)) is amended by inserting “treatment,” after “control,”.

(b) **AUTHORIZATION OF APPROPRIATIONS.**—Section 303 of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003, and Malaria Act of 2003 (22 U.S.C. 7633) is amended—

(1) in subsection (b)—

(A) in paragraph (1), by striking “such sums as may be necessary for fiscal years 2004 through 2008” and inserting “\$5,000,000,000 during the 5-year period beginning on October 1, 2008”; and

(B) in paragraph (3), by striking “fiscal years 2004 through 2008” and inserting “fiscal years 2009 through 2013”; and

(2) by adding at the end the following:

“(c) **STATEMENT OF POLICY.**—Providing assistance for the prevention, control, treatment, and the ultimate eradication of malaria is—“(1) a major objective of the foreign assistance program of the United States; and“(2) 1 component of a comprehensive United States global health strategy to reduce disease burdens and strengthen communities around the world. “(d) **DEVELOPMENT OF A COMPREHENSIVE 5-YEAR STRATEGY.**—

The President shall establish a comprehensive, 5-year strategy to combat global malaria that—“(1) strengthens the capacity of the

United States to be an effective leader of international efforts to reduce malaria burden;“(2) maintains sufficient flexibility and remains responsive to the ever-changing nature of the global malaria challenge;“(3) includes specific objectives and multisectoral approaches and strategies to reduce the prevalence, mortality, incidence, and spread of malaria;“(4) describes how this strategy would contribute to the United States’ overall global health and development goals;“(5) clearly explains how outlined activities will interact with other United States Government global health activities, including the 5-year global AIDS strategy required under this Act;“(6) expands public-private partnerships and leverage of resources;“(7) coordinates among relevant Federal agencies to maximize human and financial resources and to reduce duplication among these agencies, foreign governments, and international organizations;“(8) coordinates with other international entities, including the Global Fund;“(9) maximizes United States capabilities in the areas of technical assistance and training and research, including vaccine research; and

“(10) establishes priorities and selection criteria for the distribution of resources based on factors such as—“(A) the size and demographics of the population with malaria;

“(B) the needs of that population; “(C) the country’s existing infrastructure; and “(D) the ability to closely coordinate United States Government efforts with national malaria control plans of partner countries.”.

SEC. 304. MALARIA RESPONSE COORDINATOR.

Section 304 of the United States Leadership Against HIV/ AIDS, Tuberculosis, and Malaria Act of 2003 (22 U.S.C. 7634) is amended to read as follows:

“SEC. 304. MALARIA RESPONSE COORDINATOR.

“(a) **IN GENERAL.**—There is established within the United States Agency for International Development a Coordinator of United States Government Activities to Combat Malaria Globally (referred to in this section as the ‘Malaria Coordinator’), who shall be appointed by the President.

“(b) **AUTHORITIES.**—The Malaria Coordinator, acting through nongovernmental organizations (including faith-based and community-based organizations), partner country finance, health, and other relevant ministries, and relevant executive branch agencies as may be necessary and appropriate to carry out this section, is authorized to—

“(1) operate internationally to carry out prevention, care, treatment, support, capacity development, and other activities to reduce the prevalence, mortality, and incidence of malaria;

“(2) provide grants to, and enter into contracts and cooperative agreements with, nongovernmental organizations (including faith-based organizations) to carry out this section; and

“(3) transfer and allocate executive branch agency funds that have been appropriated for the purposes described in paragraphs (1) and (2). “(c) **DUTIES.**—

“(1) **IN GENERAL.**—The Malaria Coordinator has primary responsibility for the oversight and coordination of all resources and international activities of the United States Government relating to efforts to combat malaria.

“(2) **SPECIFIC DUTIES.**—The Malaria Coordinator shall—

“(A) facilitate program and policy coordination of antimalarial efforts among relevant executive branch agencies and nongovernmental organizations by auditing, monitoring, and evaluating such programs;

“(B) ensure that each relevant executive branch agency undertakes antimalarial programs primarily in those areas in which the agency has the greatest expertise, technical capability, and potential for success;

“(C) coordinate relevant executive branch agency activities in the field of malaria prevention and treatment;

“(D) coordinate planning, implementation, and evaluation with the Global AIDS Coordinator in countries in which both programs have a significant presence;

“(E) coordinate with national governments, international agencies, civil society, and the private sector; and

“(F) establish due diligence criteria for all recipients of funds appropriated by the Federal Government for malaria assistance.

“(d) ASSISTANCE FOR THE WORLD HEALTH ORGANIZATION.—In carrying out this section, the President may provide financial assistance to the Roll Back Malaria Partnership of the World Health Organization to improve the capacity of countries with high rates of malaria and other affected countries to implement comprehensive malaria control programs.

“(e) COORDINATION OF ASSISTANCE EFFORTS.—In carrying out this section and in accordance with section 104C of the Foreign Assistance Act of 1961 (22 U.S.C. 2151b–4), the Malaria Coordinator shall coordinate the provision of assistance by working with—

“(1) relevant executive branch agencies, including— “(A) the Department of State (including the Office of the Global AIDS Coordinator); “(B) the Department of Health and Human Services; “(C) the Department of Defense; and “(D) the Office of the United States Trade Representa

tive;

“(2) relevant multilateral institutions, including— “(A) the World Health Organization; “(B) the United Nations Children’s Fund; “(C) the United Nations Development Programme; “(D) the Global Fund; “(E) the World Bank; and “(F) the Roll Back Malaria Partnership;

“(3) program delivery and efforts to lift barriers that would impede effective and comprehensive malaria control programs; and

“(4) partner or recipient country governments and national entities including universities and civil society organizations (including faith- and community-based organizations). “(f) RESEARCH.—To carry out this section, the Malaria Coordinator, in accordance with section 104C of the Foreign Assistance Act of 1961 (22 U.S.C. 1151d–4), shall ensure that operations and implementation research conducted under this Act will closely complement the clinical and program research being undertaken by the National Institutes of Health. The Centers for Disease Control and Prevention should advise the Malaria Coordinator on priorities for operations and implementation research and should be a key implementer of this research.

“(g) MONITORING.—To ensure that adequate malaria controls are established and implemented, the Centers for Disease Control and Prevention should advise the Malaria Coordinator on monitoring, surveillance, and evaluation activities and be a key implementer of such activities under this Act. Such activities shall complement, rather than duplicate, the work of the World Health Organization.

“(h) ANNUAL REPORT.—

“(1) SUBMISSION.—Not later than 1 year after the date of the enactment of the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008, and annually thereafter, the President shall submit a report to the appropriate congressional committees that describes United States assistance for the prevention, treatment, control, and elimination of malaria.

“(2) CONTENTS.—The report required under paragraph (1) shall describe—

- “(A) the countries and activities to which malaria resources have been allocated;
- “(B) the number of people reached through malaria assistance programs, including data on children and pregnant women;
- “(C) research efforts to develop new tools to combat malaria, including drugs and vaccines;
- “(D) the collaboration and coordination of United States antimalarial efforts with the World Health Organization, the Global Fund, the World Bank, other donor governments, major private efforts, and relevant executive agencies;
- “(E) the coordination of United States antimalarial efforts with the national malarial strategies of other donor or partner governments and major private initiatives;
- “(F) the estimated impact of United States assistance on childhood mortality and morbidity from malaria; “(G) the coordination of antimalarial efforts with broader health and development programs; and
- “(H) the constraints on implementation of programs posed by health workforce shortages or capacities; and “(I) the number of personnel trained as health workers and the training levels achieved.”.

SEC. 305. AMENDMENT TO IMMIGRATION AND NATIONALITY ACT.

Section 212(a)(1)(A)(i) of the Immigration and Nationality Act (8 U.S.C. 1182(a)(1)(A)(i)) is amended by striking “, which shall include infection with the etiologic agent for acquired immune deficiency syndrome,” and inserting a semicolon.

SEC. 306. CLERICAL AMENDMENT.

Title III of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (22 U.S.C. 7631 et seq.) is amended by striking the heading for subtitle B and inserting the following:

“Subtitle B—Assistance for Women, Children, and Families”.

SEC. 307. REQUIREMENTS.

Section 312(b) of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (22 U.S.C. 7652(b)) is amended by striking paragraphs (1), (2), and (3) and inserting the following:

- “(1) establish a target for the prevention and treatment of mother-to-child transmission of HIV that, by 2013, will reach at least 80 percent of pregnant women in those countries most affected by HIV/AIDS in which the United States has HIV/AIDS programs;
- “(2) establish a target that, by 2013, the proportion of children receiving care and treatment under this Act is proportionate to their numbers within the population of HIV infected individuals in each country;

“(3) integrate care and treatment with prevention of mother-to-child transmission of HIV programs to improve outcomes for HIV-affected women and families as soon as is feasible and support strategies that promote successful follow-up and continuity of care of mother and child;

“(4) expand programs designed to care for children orphaned by, affected by, or vulnerable to HIV/AIDS;

“(5) ensure that women in prevention of mother-to-child transmission of HIV programs are provided with, or referred to, appropriate maternal and child services; and

“(6) develop a timeline for expanding access to more effective regimes to prevent mother-to-child transmission of HIV, consistent with the national policies of countries in which programs are administered under this Act and the goal of achieving universal use of such regimes as soon as possible.”.

SEC. 308. ANNUAL REPORT ON PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV.

Section 313(a) of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (22 U.S.C. 7653(a)) is amended by striking “5 years” and inserting “10 years”.

SEC. 309. PREVENTION OF MOTHER-TO-CHILD TRANSMISSION EXPERT PANEL.

Section 312 of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (22 U.S.C. 7652) is amended by adding at the end the following: “(c) PREVENTION OF MOTHER-TO-CHILD TRANSMISSION EXPERT

PANEL.— “(1) ESTABLISHMENT.—The Global AIDS Coordinator shall establish a panel of experts to be known as the Prevention of Mother-to-Child Transmission Panel (referred to in this subsection as the ‘Panel’) to— “(A) provide an objective review of activities to prevent mother-to-child transmission of HIV; and “(B) provide recommendations to the Global AIDS Coordinator and to the appropriate congressional committees for scale-up of mother-to-child transmission prevention services under this Act in order to achieve the target established in subsection (b)(1). “(2) MEMBERSHIP.—The Panel shall be convened and chaired by the Global AIDS Coordinator, who shall serve as a nonvoting member. The Panel shall consist of not more than 15 members (excluding the Global AIDS Coordinator), to be appointed by the Global AIDS Coordinator not later than 1 year after the date of the enactment of this Act, including— “(A) 2 members from the Department of Health and Human Services with expertise relating to the prevention of mother-to-child transmission activities; “(B) 2 members from the United States Agency for International Development with expertise relating to the prevention of mother-to-child transmission activities; “(C) 2 representatives from among health ministers of national governments of foreign countries in which programs under this Act are administered; “(D) 3 members representing organizations implementing prevention of mother-to-child transmission activities under this Act;

“(E) 2 health care researchers with expertise relating to global HIV/AIDS activities; and

“(F) representatives from among patient advocate groups, health care professionals, persons living with HIV/ AIDS, and non-governmental organizations with expertise relating to the prevention of mother-to-child transmission activities, giving priority to individuals in foreign countries in which programs under this Act are administered. “(3) DUTIES OF PANEL.—The Panel shall—

“(A) assess the effectiveness of current activities in reaching the target described in subsection (b)(1);

“(B) review scientific evidence related to the provision of mother-to-child transmission prevention services, including programmatic data and data from clinical trials;

“(C) review and assess ways in which the Office of the United States Global AIDS Coordinator collaborates with international and multilateral entities on efforts to prevent mother-to-child transmission of HIV in affected countries;

“(D) identify barriers and challenges to increasing access to mother-to-child transmission prevention services and evaluate potential mechanisms to alleviate those barriers and challenges;

“(E) identify the extent to which stigma has hindered pregnant women from obtaining HIV counseling and testing or returning for results, and provide recommendations to address such stigma and its effects;

“(F) identify opportunities to improve linkages between mother-to-child transmission prevention services and care and treatment programs; and

“(G) recommend specific activities to facilitate reaching the target described in subsection (b)(1). “(4) REPORT.—

“(A) IN GENERAL.—Not later than 1 year after the date on which the Panel is first convened, the Panel shall submit a report containing a detailed statement of the recommendations, findings, and conclusions of the Panel to the appropriate congressional committees.

“(B) AVAILABILITY.—The report submitted under subparagraph (A) shall be made available to the public. “(C) CONSIDERATION BY COORDINATOR.—The Coordinator shall— “(i) consider any recommendations contained in the report submitted under subparagraph (A); and

“(ii) include in the annual report required under section 104A(f) of the Foreign Assistance Act of 1961 a description of the activities conducted in response to the recommendations made by the Panel and an explanation of any recommendations not implemented at the time of the report. “(5)

AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Panel such sums as may be necessary for each of the fiscal years 2009 through 2011 to carry out this section. “(6) TERMINATION.—The Panel shall terminate on the date that is 60 days after the date on which the Panel submits

the report to the appropriate congressional committees under paragraph (4).”.

TITLE IV—FUNDING ALLOCATIONS

SEC. 401. AUTHORIZATION OF APPROPRIATIONS.

(a) **IN GENERAL.**—Section 401(a) of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (22 U.S.C. 7671(a)) is amended by striking “\$3,000,000,000 for each of the fiscal years 2004 through 2008” and inserting “\$48,000,000,000 for the 5-year period beginning on October 1, 2008”.

(b) **SENSE OF CONGRESS.**—It is the sense of the Congress that the appropriations authorized under section 401(a) of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003, as amended by subsection (a), should be allocated among fiscal years 2009 through 2013 in a manner that allows for the appropriations to be gradually increased in a manner that is consistent with program requirements, absorptive capacity, and priorities set forth in such Act, as amended by this Act.

SEC. 402. SENSE OF CONGRESS.

Section 402(b) of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (22 U.S.C. 7672(b)) is amended by striking “an effective distribution of such amounts would be” and all that follows through “10 percent of such amounts” and inserting “10 percent should be used”.

SEC. 403. ALLOCATION OF FUNDS.

Section 403 of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (22 U.S.C. 7673) is amended—

(1) by amending subsection (a) to read as follows: “(a) **BALANCED FUNDING REQUIREMENT.**—“(1) **IN GENERAL.**—The Global AIDS Coordinator shall—“(A) provide balanced funding for prevention activities for sexual transmission of HIV/AIDS; and
“(B) ensure that activities promoting abstinence, delay of sexual debut, monogamy, fidelity, and partner reduction are implemented and funded in a meaningful and equitable way in the strategy for each host country based on objective epidemiological evidence as to the source of infections and in consultation with the government of each host county involved in HIV/AIDS prevention activities. “(2) **PREVENTION STRATEGY.**—
“(A) **ESTABLISHMENT.**—In carrying out paragraph (1), the Global AIDS Coordinator shall establish an HIV sexual transmission prevention strategy governing the expenditure of funds authorized under this Act to prevent the sexual transmission of HIV in any host country with a generalized epidemic.
“(B) **REPORT.**—In each host country described in subparagraph (A), if the strategy established under subparagraph (A) provides less than 50 percent of the funds described in subparagraph (A) for activities promoting abstinence, delay of sexual debut, monogamy,

fidelity, and partner reduction, the Global AIDS Coordinator shall, not later than 30 days after the issuance of this strategy, report to the appropriate congressional committees on the justification for this decision. “(3) EXCLUSION.— Programs and activities that implement

or purchase new prevention technologies or modalities, such as medical male circumcision, public education about risks to acquire HIV infection from blood exposures, promoting universal precautions, investigating suspected nosocomial infections, pre-exposure pharmaceutical prophylaxis to prevent transmission of HIV, or microbicides and programs and activities that provide counseling and testing for HIV or prevent mother-to-child prevention of HIV, shall not be included in determining compliance with paragraph (2).

“(4) REPORT.—Not later than 1 year after the date of the enactment of the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008, and annually thereafter as part of the annual report required under section 104A(e) of the Foreign Assistance Act of 1961 (22 U.S.C. 2151b–2(e)), the President shall—

“(A) submit a report on the implementation of paragraph (2) for the most recently concluded fiscal year to the appropriate congressional committees; and

“(B) make the report described in subparagraph (A) available to the public.”;

(2) in subsection (b)—

(A) by striking “fiscal years 2006 through 2008” and inserting “fiscal years 2009 through 2013”; and

(B) by striking “vulnerable children affected by” and inserting “other children affected by, or vulnerable to,”; and

(3) by adding at the end the following:

“(c) FUNDING ALLOCATION.—For each of the fiscal years 2009 through 2013, more than half of the amounts appropriated for bilateral global HIV/AIDS assistance pursuant to section 401 shall be expended for—

“(1) antiretroviral treatment for HIV/AIDS; (2) clinical monitoring of HIV-seropositive people not in need of antiretroviral treatment; (3) care for associated opportunistic infections;

“(4) nutrition and food support for people living with HIV/AIDS; and

“(5) other essential HIV/AIDS-related medical care for people living with HIV/AIDS. “(d) TREATMENT, PREVENTION, AND CARE GOALS.—For each of

the fiscal years 2009 through 2013—

“(1) the treatment goal under section 402(a)(3) shall be increased above 2,000,000 by at least the percentage increase in the amount appropriated for bilateral global HIV/AIDS assistance for such fiscal year compared with fiscal year 2008;

“(2) any increase in the treatment goal under section 402(a)(3) above the percentage increase in the amount appropriated for bilateral global HIV/AIDS assistance for such fiscal year compared with fiscal year 2008 shall be based on long-

term requirements, epidemiological evidence, the share of treatment needs being met by partner governments and other sources of treatment funding, and other appropriate factors;

“(3) the treatment goal under section 402(a)(3) shall be increased above the number calculated under paragraph (1) by the same percentage that the average United States Government cost per patient of providing treatment in countries receiving bilateral HIV/AIDS assistance has decreased compared with fiscal year 2008; and

“(4) the prevention and care goals established in clauses (i) and (iv) of section 104A(b)(1)(A) of the Foreign Assistance Act of 1961 (22 U.S.C. 2151b–2(b)(1)(A)) shall be increased consistent with epidemiological evidence and available resources.”.

TITLE V—MISCELLANEOUS

SEC. 501. MACHINE READABLE VISA FEES.

(a) FEE INCREASE.—Notwithstanding any other provision of law—

(1) not later than October 1, 2010, the Secretary of State shall increase by \$1 the fee or surcharge authorized under section 140(a) of the Foreign Relations Authorization Act, Fiscal Years 1994 and 1995 (Public Law 103–236; 8 U.S.C. 1351 note) for processing machine readable nonimmigrant visas and machine readable combined border crossing identification cards and nonimmigrant visas; and

(2) not later than October 1, 2013, the Secretary shall increase the fee or surcharge described in paragraph (1) by an additional \$1.

(b) DEPOSIT OF AMOUNTS.—Notwithstanding section 140(a)(2) of the Foreign Relations Authorization Act, Fiscal Years 1994 and 1995 (Public Law 103–236; 8 U.S.C. 1351 note), fees collected under the authority of subsection (a) shall be deposited in the Treasury.

TITLE VI—EMERGENCY PLAN FOR INDIAN SAFETY AND HEALTH

SEC. 601. EMERGENCY PLAN FOR INDIAN SAFETY AND HEALTH.

(a) ESTABLISHMENT OF FUND.—There is established in the Treasury of the United States a fund, to be known as the “Emergency Fund for Indian Safety and Health” (referred to in this section as the “Fund”), consisting of such amounts as are appropriated to the Fund under subsection (b).

(b) TRANSFERS TO FUND.—

(1) IN GENERAL.—There is authorized to be appropriated to the Fund, out of funds of the Treasury not otherwise appropriated, \$2,000,000,000 for the 5-year period beginning on October 1, 2008.

(2) AVAILABILITY OF AMOUNTS.—Amounts deposited in the Fund under this section shall—

(A) be made available without further appropriation;

(B) be in addition to amounts made available under any other provision of law; and

(C) remain available until expended.

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(c) EXPENDITURES FROM FUND.—On request by the Attorney General, the Secretary of the Interior, or the Secretary of Health and Human Services, the Secretary of the Treasury shall transfer from the Fund to the Attorney General, the Secretary of the Interior, or the Secretary of Health and Human Services, as appropriate, such amounts as the Attorney General, the Secretary of the Interior, or the Secretary of Health and Human Services determines to be necessary to carry out the emergency plan under subsection (f).

(d) TRANSFERS OF AMOUNTS.—

(1) IN GENERAL.—The amounts required to be transferred to the Fund under this section shall be transferred at least monthly from the general fund of the Treasury to the Fund on the basis of estimates made by the Secretary of the Treasury.

(2) ADJUSTMENTS.—Proper adjustment shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or less than the amounts required to be transferred.

(e) REMAINING AMOUNTS.—Any amounts remaining in the Fund on September 30 of an applicable fiscal year may be used by the Attorney General, the Secretary of the Interior, or the Secretary of Health and Human Services to carry out the emergency plan under subsection (f) for any subsequent fiscal year.

(f) EMERGENCY PLAN.—Not later than 1 year after the date of enactment of this Act, the Attorney General, the Secretary of the Interior, and the Secretary of Health and Human Services, in consultation with Indian tribes (as defined in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b)), shall jointly establish an emergency plan that addresses law enforcement, water, and health care needs of Indian tribes under which, for each of fiscal years 2010 through 2019, of amounts in the Fund—

(1) the Attorney General shall use—

(A) 18.5 percent for the construction, rehabilitation, and replacement of Federal Indian detention facilities;

(B) 1.5 percent to investigate and prosecute crimes in Indian country (as defined in section 1151 of title 18, United States Code);

(C) 1.5 percent for use by the Office of Justice Programs for Indian and Alaska Native programs; and

(D) 0.5 percent to provide assistance to—

(i) parties to cross-deputization or other cooperative agreements between State or local governments and Indian tribes (as defined in section 102 of the Federally Recognized Indian Tribe List Act of 1994 (25 U.S.C. 479a)) carrying out law enforcement activities in Indian country; and

(ii) the State of Alaska (including political subdivisions of that State) for carrying out the Village Public Safety Officer Program and law enforcement activities on Alaska Native land (as defined in section 3 of Public Law 103–399 (25 U.S.C. 3902));

(2) the Secretary of the Interior shall—

(A) deposit 15.5 percent in the public safety and justice account of the Bureau of Indian Affairs for use by the Office of Justice Services of the Bureau in providing law

enforcement or detention services, directly or through contracts or compacts with Indian tribes under the Indian Self-Determination and Education Assistance Act (25

U.S.C. 450 et seq.); and

(B) use 50 percent to implement requirements of Indian water settlement agreements that are approved by Congress (or the legislation to implement such an agreement) under which the United States shall plan, design, rehabilitate, or construct, or provide financial assistance for the planning, design, rehabilitation, or construction of, water supply or delivery infrastructure that will serve an Indian tribe (as defined in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b)); and

(3) the Secretary of Health and Human Services, acting through the Director of the Indian Health Service, shall use 12.5 percent to provide, directly or through contracts or compacts with Indian tribes under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)—

(A) contract health services;

(B) construction, rehabilitation, and replacement of Indian health facilities; and

(C) domestic and community sanitation facilities serving members of Indian tribes (as defined in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b)) pursuant to section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a).

Speaker of the House of Representatives.

*Vice President of the United States and
President of the Senate.*

Source: PEPFAR (2012) “Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008” <http://www.pepfar.gov/documents/organization/108294.pdf> [19 March 2012].

Annex 5 – Botswana Partnership Framework for HIV/AIDS 2010 - 2014:

A Collaborative Effort between The Government of Botswana and The Government of the United States of America (December 2010)

Section 1 - Introduction

1. The Botswana Partnership Framework on HIV/AIDS outlines the strategy for the Government of Botswana (GOB) and the Government of the United States of America (USG) through the President's Emergency Plan for AIDS Relief (PEPFAR) to work together to continue to address HIV/AIDS in Botswana over the next five years (2010-2014). This Partnership Framework provides a strategic overview, defines key partner roles, and summarizes the harmonized contributions of the GOB, PEPFAR and other development partners.
2. The Partnership Framework was developed through a highly consultative process, between June-October 2009, and included all key government ministries and departments involved in leading the HIV/AIDS response in Botswana, as well as all USG (United States Government) agencies implementing the PEPFAR program in the country. Development partners and other relevant stakeholders drawn from the private and civil society sector were also involved in the Partnership Framework formulation process.
3. This consultative process was organized by the Framework Management and Communications Team, chaired by the National AIDS Coordinating Agency (NACA), and including GOB and USG representatives, who met on a regular basis throughout the entire process. The overall design of the document was initially established by a broad-based Framework Design and Implementation Committee, which included representation from GOB agencies and ministries, USG in-country PEPFAR agencies, and civil society, other donors and stakeholders. The technical details were provided by four Technical Working Groups (TWGs) that align with the goals of the GOB's Second National HIV/AIDS Strategic Framework (NSF II) as well as with the Partnership Framework goals. The TWGs were co-chaired by the GOB and USG, and membership included technical experts from the GOB and USG as well as other donor and stakeholder experts. Finally, the framework National Steering Committee (NSC), chaired by the National Coordinator of NACA and consisting of Executive level leadership from GOB departments and ministries, USG agencies, the US Ambassador, and the leadership of donor and stakeholder organizations, met to review the progress and evaluate the final Partnership Framework document.

4. The development of the Partnership Framework implementation will be subsumed into the National Operational Plan (NOP). No separate implementation plan will be developed. The operationalization of the Partnership Framework is expected to be outlined in a detailed National Operational Plan for the Second Strategic Framework for HIV/AIDS 2010 to 2016. The NOP will establish baselines, set targets and timelines and provide detailed information on specific activities and planned contributions by GOB, PEPFAR, and other donors and stakeholders in Botswana. The same consultative processes used for developing the Partnership Framework are expected to be used for the development of the detailed National Operational Plan. The planned steps required to develop the National Operational Plan are outlined in Section 5.
5. The planned activities described within this document are subject to availability of funds and continued needs in Botswana. Through a consultative process, this document may be modified or revised as needed with the written approval of both partners.

1.1 Background

6. Botswana is a middle-income country (nominal GDP per capita \$7,096 in 2009) in Southern Africa with a stable, democratic government, which has been implementing effective development policies since independence in 1966. Given this context, the wise use of the country's mineral wealth and the GOB's commitment, Botswana has seen significant growth and major reductions in the poverty levels of its citizens over the last 40 years. The country has one of the most developed public health systems in Africa, which is built on a strong health infrastructure system. Key successes include:
 - 97% antenatal care coverage
 - 94% of deliveries are attended by a skilled health worker
 - 97% of one-year-old children are fully immunized for DPT3
 - 100% of facilities providing antenatal care also provide HIV testing and counseling
7. However, HIV/AIDS remains the most significant social and public health problem in Botswana. The country is experiencing one of the most severe HIV/AIDS epidemics in the world, affecting both urban and rural areas with equal ferocity. UNAIDS estimated that in Botswana's population of about 1.8 million, close to one out of four adults aged 15-49 were HIV positive in 2007. In addition, national sentinel surveillance over the last five years found that one out of three pregnant women is HIV positive. Currently about 300,000 adults and children are estimated to be HIV positive and 160,000 are in need of antiretroviral therapy. Finally, more than 52,000 children have been orphaned after losing one or both parents as a result of HIV/AIDS.
8. Despite the strong health system foundation, responding to this massive epidemic has severely stressed the existing human resources and health

system infrastructure. There is a health personnel gap coupled with increased demand to focus on cost-effectiveness of service delivery, human resources and financial management issues. Procurements and logistics are weak areas and the Central Medical Stores needs significant efforts to strengthen its services.

9. The HIV epidemic has also severely impacted Botswana's labor force, affecting productivity and investment and increasing financial outlays by the Government to sustain existing programs and services. A 2006 report funded by the United Nations Development Program (UNDP) on behalf of NACA, *The Economic Impact of HIV/AIDS in Botswana*, estimated that in the next 20 years, the economy will be decreased by 30% due to the impact of HIV/AIDS. Furthermore, the GOB projects that by 2021 Botswana's population will be reduced by 18% from what it would have been in the absence of the epidemic.
10. Since the beginning of the epidemic, the GOB has shown a high-level of commitment in mitigating the impact of HIV/AIDS. The GOB investment of domestic resources to support AIDS prevention, care and treatment is estimated to be between 2-3% of GDP and the GOB contributes between 80-90% of the required resources for HIV/AIDS treatment. The national response is guided by clear national priorities and strategies outlined in the NSF II, the Tenth National Development Plan (NDP10), and HIV/AIDS related goals as contained within the nation's development blueprint, *Vision 2016*.
11. For the past several years the GOB has made commendable achievements in its fight against HIV/AIDS. Some of the success stories include:
 - The National Antiretroviral (ARV) Program covers almost 82% of citizens in need of treatment (approximately 133,032 as of September 30, 2009).
 - Prevention of Mother to Child Transmission (PMTCT) counseling and testing services reach over 95% of pregnant women, lowering HIV transmission to less than 4% of infants born to HIV positive mothers.
 - Strong national HIV/AIDS Counseling and Testing (HCT) and routine testing programs nationwide.

These achievements were made possible with financial and technical contributions from the US Government and other development partners.

12. Under PEPFAR I (2004-2008), the USG played a major role in assisting the GOB in mitigating the impact of HIV/AIDS. Through PEPFAR financial and technical assistance, a number of interventions were strengthened and new services have been established at all levels. For the past five years, GOB ministries and departments and civil society organizations have benefited from PEPFAR support. Some of the accomplishments of this support can be exemplified in the strengthening of the following programs: HCT, Orphans and Vulnerable Children (OVC), PMTCT, lab infrastructure, biomedical

transmissions, drug procurement and infrastructure development. Furthermore, PEPFAR technical assistance has contributed toward the development of various national guidelines, manuals and systems strengthening. In addressing human capacity needs, PEPFAR supported several programs aimed at strengthening the capacity of human resources for health.

13. PEPFAR has also developed strong partnerships with the National AIDS Coordinating Agency (NACA), the Botswana Defense Force (BDF), the Ministries of Health (MOH), Ministry of Local Government (MLG), Ministry of Education and Skills Development (MOESD), Ministry of Youth, Sports and Culture, as well as with civil society and private sector organizations.

1.2 Progressing Towards a Technical Assistance Model

14. Since the beginning of the national response, the GOB has led the way politically, technically and financially. The GOB covers the majority of the costs to support AIDS prevention, care and treatment, contributing an estimated 2-3% of gross Domestic Product (GDP). As a result, unlike many other PEPFAR countries, PEPFAR in Botswana does not directly support large scale delivery of a wide range of HIV/AIDS-related services. Instead, PEPFAR has played an important role in supporting Botswana's HIV/AIDS response by strategically filling service delivery gaps, while providing technical support to GOB and civil society's efforts to scale up and roll out services at national and local levels.
15. In Botswana, PEPFAR support already has several components of a technical assistance (TA) model such as support for policy and curriculum development. However, the continued need to strategically fill service delivery gaps remains. Given the declining revenues from diamond exports in Botswana and the fact that PEPFAR still supports critical services in the country, the transition to a pure TA model will be a gradual process. This process will be tied closely to Botswana's future economic conditions; however, purposeful planning on transitioning PEPFAR support services to the GOB will be pursued and negotiated targets established.

1.3 Alignment of GOB Strategies and the Partnership Framework Goals

16. This Partnership Framework was prepared during a period of transition from the first National Strategic Framework (NSF I, 2003-2009) to the Second National Strategic Framework (NSF II, 2010-2016), as well as the launching of its National Development Plan 10 (NDP 10, 2010-2016).
17. In 2007 a mid-term review (MTR) of the first NSF was undertaken to inform the development of the NSF II. The MTR found that although outstanding achievements were made in terms of treating and caring for those already infected, there was no corresponding achievement in prevention of new infections. While the MTR recognized the need to maintain the excellent

results in care and treatment, it was recommended that the next plan period should intensify and accelerate proven prevention efforts. Such an approach would maintain the required delicate balance between meeting the needs of those living with HIV and AIDS, and at the same time prevent new HIV infections.

18. As a result, the NSF II is built on the following four priority areas, which constitute the current strategic priorities of the national response to HIV and AIDS:

- Priority Area 1: Prevention
- Priority Area 2: Systems Strengthening
- Priority Area 3: Strategic Information Management
- Priority Area 4: Treatment, Care and Support

19. These four priority areas are ranked in order of their perceived importance as they relate to delivering a sustained and targeted impact on HIV transmission and AIDS related illnesses and deaths.

20. The Partnership Framework outlines goals and objectives aligned with the NSF II and the NDP 10, and summarize how PEPFAR resources are expected to be used over the next five years to support the GOB's national priorities for HIV/AIDS. This is envisioned to help direct PEPFAR's support to the national program, and in particular, the GOB's ongoing efforts to increase the cost effectiveness and quality of the Botswana national response. (Please see Annex 1, which contains the approved version of the NSF II.)

21. The Partnership Framework also takes into account the second phase of PEPFAR, which encourages USG support in all countries to begin to shift from providing emergency support toward supporting increased sustainability of each country's HIV/AIDS response. This shift is particularly critical for PEPFAR-supported programs in Botswana, given the likely decrease in PEPFAR support in coming years.

22. The consultative process utilized in developing the Partnership Framework has strengthened transparency and collaboration between USG, GOB and other partners in addressing the HIV/AIDS epidemic in Botswana.

1.4 Governing Principles

The development of the Partnership Framework was governed by the following principles:

- Demonstrate high level political commitment and ownership of the national response by the GOB and all the sectors involved in HIV and AIDS;
- Align with the national priorities that are clearly outlined in NSFII, NDP10 and other national frameworks including *Vision 2016*;
- Build on Botswana's strong national HIV/AIDS response;

- Promote the three ones: One National Strategy, One Coordinating Agency and One National Monitoring and Evaluation System;
- Promote true ownership and transparency in resource allocations;
- Partner with and strengthen civil society organizations in complementing national responses in the fight against HIV/AIDS, with a focus on financial resource management by local organizations;
- Increase involvement of affected communities especially people living with HIV/AIDS (PLWHA) and most at risk populations (MARPS);
- Consider gender sensitive approach in all programs;
- Promote public-private partnerships to enhance sustainability and additional resources;
- Leverage resources from other development partners;
- Ensure accurate and timely reporting and accountability resources.

Section 2 - Five-Year Strategic Overview

23. The Partnership Framework aims to support the GOB's existing plans by establishing a strategy for the use of PEPFAR resources over the next five years to support the national response to HIV/AIDS. The general principles outlined in key GOB strategic documents (as explained above in Section 1) have been used to help prioritize specific contributions and policy initiatives that the partners provide to each program area.
24. The Partnership Framework outlines how the partners envision working together to:
- Maintain critical HIV/AIDS services
 - Address existing gaps in Botswana's HIV/AIDS response
 - Include gender-sensitive approaches in all aspects of HIV programming and service delivery
 - Improve the quality and long-term sustainability of Botswana's HIV/AIDS response
 - Support policy development and implementation that enhances the national response
 - Leverage additional resources from other donors
 - Capacitate local organizations in program management and financial management to improve sustainability

2.1 Gender as a Cross-Cutting Issue

25. The NSF II guides all partners to include gender-sensitive approaches in all aspects of HIV programming and service delivery. The GOB and PEPFAR are also committed to working together to find solutions to gender-based violence, stigma, low male partner involvement and other drivers of the epidemic.

26. The NSF II states:

“The status of women, especially adolescent girls, is one of the most powerful drivers of the AIDS epidemic. Women are very often caught within a vicious set of circumstances. As they tend to have little power over their own bodies, they are put at risk by a combination of tacit social acceptance of male partners having more than one sexual relationship, inability to negotiate condom use, and sexual exploitation, especially among younger girls. Thus, socially as well as biologically, they are more susceptible to HIV infection. There is also growing evidence in the region on gender violence, sexual abuse and how they could be associated with risk to HIV infections. If the national response does not begin to deal effectively with this larger reality experienced by women and girls, it cannot hope to achieve the goal of Vision 2016.”

27. The pattern of HIV/AIDS in Botswana, particularly in the sexually active age groups, shows a gender bias. A number of factors fuel the spread of the epidemic, such as multiple concurrent partners (MCP), high population mobility, shifting social and cultural norms, stigma and gender-based violence (GBV). HIV prevalence is higher among females than males, 20.4% and 14.2%, respectively (Botswana AIDS Impact Survey, III, 2009), which is attributed to women's inability to negotiate for safe sex.

28. Gender-based violence (GBV) is a world-wide problem that poses significant health and human rights concerns to vulnerable populations. GBV fosters the spread of HIV/AIDS because it limits women's and girls' ability to negotiate sexual practices, to disclose HIV status and to access services due to fear of GBV.

29. The GOB, through the Women's Affairs Department (WAD) and the National AIDS Coordinating Agency (NACA) in collaboration with UNDP piloted a gender mainstreaming project in ministries. In 2008, a National Policy on Gender and Development recognized both men and women as vital resources for developing the country and identify and eliminate all obstacles impeding their economic, political and social participation. Furthermore, in the NDP10, the GOB plans include mainstreaming gender in all HIV/AIDS programs. Likewise, all planning, programming and service delivery under the Botswana Partnership Framework should also be held to these high standards and aim to bring gender equity in all program areas. Therefore, the programs supported by the Partnership Framework should include a gender focus in every program area. This focus should address not only the inequalities that women face, but also consider gender appropriate interventions targeting men and how they play a role in reduction of infections, as well as improved care and support for their female partners and the orphans and vulnerable children in their families and communities.

2.2 Achieving Sustainability through Empowering Local Organizations

30. Key to the success and sustainability of the Partnership Framework interventions is the intensive involvement of local actors and capacitating of these entities during the first few years of implementation. To achieve this aim, the Partnership Framework should serve as a guide to the partners in working toward a more cost-effective and sustainable model for the PEPFAR-supported components of HIV/AIDS services in Botswana. Key elements of this strategy are (1) to substantially increase the percentage of funding that is channeled through local organizations over the five-year period, (2) to ensure that local implementing partners are empowered and entrusted with decisions to develop and implement programs tailored to meet local needs, while international organizations support their efforts by providing much needed technical capacity where there is need with the intention to transition in the next two to three years of implementation of the framework to local organizations. The ultimate accountability for management decisions and results should also rest with local organizations. Together, this approach should be a significant departure from the old implementation modalities where significant resources were held through international organizations and local implementing partners were not always given the support they need to be successful, self-sustaining implementers.
31. During the development of the NOP, the team expects to set a baseline and targets for percentages of funding to be channeled through local organizations over the life of the Partnership Framework.

2.3 Partnership Framework Goals and Objectives

This Partnership Framework lays out the following goals:

- Goal 1: Prevention - “To reduce the number of new HIV infections by 50%.”
- Goal 2: Capacity Building and Health Systems Strengthening - “To increase the GOB, civil society and private sector ability to sustain high quality, cost effective HIV/AIDS services.”
- Goal 3: Strategic Information - “To strengthen strategic information management of the National Response to enhance evidence based planning.”
- Goal 4: Treatment Care and Support - “To provide comprehensive and quality treatment, care and support services to people infected and affected by HIV.”

2.4 Policy Strengthening

32. As one of the first countries to confront the HIV/AIDS epidemic in Africa, the GOB has a history of leading the way in policy development and implementation relating to HIV/AIDS that began well before PEPFAR. During the first five years of PEPFAR, the USG supported the GOB’s continuing efforts to develop and implement policies that improve access, quality, effectiveness and sustainability of HIV/AIDS services. The USG intends to continue to support the GOB’s policy strengthening efforts during

PEPFAR II by providing technical assistance in policy development, and financial and technical support in policy implementation.

33. Some of the remaining HIV/AIDS-related policy challenges that Botswana faces are very difficult issues, with complex short and long-term impacts. Many of these policy challenges are faced by other countries as well, and those countries may look toward Botswana for continued leadership in addressing them.

34. The Partnership Framework also represents the continuation and strengthening of the ongoing resolve of the GOB, PEPFAR and other donors and stakeholders to actively work together to find solutions to these policy challenges.

35. Key PEPFAR and GOB policy challenges for ongoing dialog, technical assistance and support include, but not limited to, the following:
 - Strengthening institutional arrangements, for example, the Central Medical Stores (CMS) for improved commodities management and logistical support in the country
 - Encouraging greater private sector involvement
 - Supporting livelihoods for OVC and people living with HIV (PLHIV) so they may be more self-sufficient
 - Enhancing the environment for improved civil society engagement and operations in the country
 - Providing services to the entirety of the population
 - Provision of quality and comprehensive services in a tightening economic environment through improved cost-effectiveness

36. Progress in addressing these policy challenges directly impacts the goals and objectives of the Partnership Framework. Shared support for the development and implementation of these and other policy-related issues are outlined along with other anticipated financial, service delivery and technical support contributions in the Roles and Expected Contributions section below.

Section 3 – Partner Roles and Expected Contributions

37. The following section outlines how the resources of the Government of Botswana, PEPFAR, and other donors and stakeholders should be harmonized in support of the GOB's national program. In addition, it also provides indicators, baselines and targets for program areas where that information has been mutually decided upon in the areas of Prevention and Treatment, Care and Support. The remaining indicators, baselines and targets, including those for the Health System Strengthening (HSS) and Strategic

Information (SI) goals, are expected to be included in the National Operational Plan.

3.1 The Government of Botswana

38. The Government of Botswana should develop strategies for implementation of the Second National Strategic Framework. The GOB would effectively lead all donors and stakeholders in designing, implementing and monitoring programs that support the national strategy. The GOB should move forward with its new Prevention Plan which will include a significant male circumcision strategy and provision for programs to reduce multiple concurrent partnering. The GOB should work with civil society, private sector and faith based organizations toward increasing their capacity for program implementation to enhance service coverage throughout the country
39. The GOB currently spends over \$200 million per year to address the HIV/AIDS epidemic. However, revenues have fallen sharply as a result of the global economic downturn, and the subsequent weakness in the diamond market – an important source of the GOB’s financial resources. The current economic outlook does not indicate that the diamond revenue will return to previous levels for a few more years. As a result, original plans to continue to absorb positions and programs currently funded by donors have had to be put on hold, and cuts have had to be made to the GOB’s own budgets.
40. Once the economy recovers, the GOB aims to increase spending as much as possible and revive plans to gradually absorb programs and positions currently supported by donors, including PEPFAR.

3.2 PEPFAR

41. The USG investment should focus on increasing technical assistance since past support and investment has gone largely to infrastructure development, support for staff positions and procurements. PEPFAR proposes to support research in prevention, treatment and care to improve the quality and cost-effectiveness of treatment and care interventions. PEPFAR also proposes to help build the capacity of local civil society and private sector organizations to design and manage programs that are identified as community priorities and to foster development of public-private partnerships to increase sustainability of activities over the coming years.
42. In 2009, PEPFAR contributed \$92 million to support the HIV/AIDS efforts in Botswana. However, this level of financial commitment is likely to slowly decline each year over the next five years. This increases the importance of finding cost-effective mechanisms and sustainable solutions in which to invest in over the next five years.

3.3 Other Donors and Stakeholders

43. The GOB should seek to leverage additional resources from other development partners such as the African Comprehensive HIV/AIDS Partnership (ACHAP), the World Bank (WB), the European Community (EC), the Clinton Foundation and the United Nations (UN) Agencies. GOB is currently working with these development partners under specific program areas such as Prevention, Systems Strengthening, Capacitation of local organizations and Treatment, Care and support.
44. Currently the African Comprehensive HIV/AIDS Partnerships (ACHAP), the public-private partnership between the GOB, the Bill & Melinda Gates Foundation and the Merck Company Foundation/Merck & Co, Inc., has recently made a second five-year commitment to support HIV programs in Botswana although with a limited budget. ACHAP is also shifting its program focus from treatment to prevention.
45. At the same time, the World Bank is launching a new \$50 million project to support the GOB's management of HIV programs and provide funding to communities for prevention activities. The European Community's current five-year plan focuses on human resources development across several sectors and supports a multi-sectoral approach to mainstreaming HIV/AIDS, as well as strengthening governance in local NGOs. UN agencies support prevention, treatment, care and support interventions and provide technical assistance to Government of Botswana while the Clinton Foundation assists the MOH to make cost-effective ARV purchases and strengthen pediatric AIDS treatment. In addition international academic institutions such as Harvard, Baylor, and the University of Pennsylvania are currently supporting GOB in research, clinical care and training. It is, however, also important to make sure that some of the activities in the country Global Fund proposals are also linked and complement the Partnership Framework.
46. Local institutions such as civil society, private sector and academia also contribute immensely to prevention, treatment, care and support programs. It is expected that their capacity will be strengthened during the course of implementation of this Partnership Framework.

3.4 Indicators, Baselines, Targets, and Specific Commitments

47. As Botswana transitions to the NSF II, and begins a parallel process of developing the NSF II National Operational Plan, more detailed indicators, baselines, targets and specific commitments should be identified upon in an open forum. The information provided here includes the high-level political commitments already accepted by the GOB and the PEPFAR teams. However, the participants intend to develop more specifics during the implementation planning phase. Subsuming the development of the Partnership Framework implementation plan with the NSF II National Operational Plan is intended to ensure the "Three Ones" principle is put into practice, i.e. one national plan and which helps avoid duplication of efforts

3.5 Goal 1: Prevention - “To reduce the number of new HIV infections by 50%

48. A number of critical strategies and interventions should be used to reduce new HIV infections in Botswana. These are expected to include implementing behavioural change interventions aimed at addressing the main drivers of the epidemic such as multiple concurrent sexual partnerships, intergenerational sex, high consumption of alcohol, high population mobility, shifting social and cultural norms, stigma, and gender based violence. Scaling up cost-effective clinical prevention programs including safe male circumcision is recognized as crucial to enhance HIV prevention, as well as strengthening the capacity of Community Based Organizations (CBOs) to develop and implement context specific strategies to improve access to and utilization of HIV and AIDS services.

3.5.1 Behavior Change Interventions and Communication (BCIC)

Strategic Objectives	GOB Expected Contributions	PEPFAR Expected Contributions	Anticipated Contributions from other Donors
To increase the adoption of safer sexual behaviors and practices	<p>Provide coordination and support to implementing partners across the public sector, civil society organizations and private sector in the following program areas:</p> <p>1) Mainstreaming and implementation of campaigns to reduce multiple and concurrent partnerships through mass media, community mobilization and peer education.</p> <p>2) Life skills and abstinence programs, mass</p>	<p>Support projects on MCP, condom distribution, HIV prevention; interventions for Most At Risk Populations, capacity building to districts in HIV prevention, mass media addressing HIV prevention</p> <p>Support community-based organizations and the Botswana Defense Force, HIV prevention projects</p> <p>Support capacity building projects for civil society and FBOs</p> <p>Support projects that target</p>	<p>ACHAP:</p> <p>Expressed desire to support this area (but formal agreement not concluded)</p> <p>World Bank:</p> <p>Support prevention to Ministry of Health; Ministry of Labor and Home Affairs; Ministry of Education and Skills Development; Ministry of Local Government</p> <p>UNFPA:</p> <p>Commodity provision (and</p>

	<p>media, community mobilization and peer education to strengthen social support for monogamy and reduced # of partners.</p> <p>3) Promotion of correct and consistent male and female condom use through targeted interventions.</p> <p>4) Strategic support to the uniformed forces on HIV prevention campaigns, distribute condoms and interventions that promote safer sex practices.</p> <p>5) Conduct behavioral studies to inform and evaluate interventions on prevention activities.</p>	<p>vulnerable girls, youth and parents</p> <p>Support programs that focus on gender equity</p> <p>Support Life Skills programs</p> <p>Support development of innovative interventions to address alcohol abuse and its links to the spread of HIV/AIDS</p>	<p>potentially financial support) to Ministry of Health; Ministry of Education and Skills Development; Ministry of Home Affairs</p> <p>Royal Netherlands Embassy:</p> <p>Financial support</p>
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*3.5.1.1 Behavior Change Interventions and Communication Indicators**

Indicator	Baseline	Target
Percentage of sexually active people who engage in multiple concurrent partnerships		Reduced by 50%
Percentage of sexually active women and men		Reduce by X% (To be determined during

aged 10-18 who have partners 10 or more years older		development of the Partnership Framework Implementation Plan)
Percentage of the population who have sexual intercourse before the age of 15	3.5%	Reduced by 50% to 1.75%
Percentage of the sexually active population who report correct and consistent condom use		Increased by X% (TBD in NOP)
Percentage of sexually active population who engage in risky sexual behaviors after consuming alcohol and other substances		Reduced by X% (TBD in NOP)
Percentage of the population who express accepting attitudes towards people living with HIV/AIDS		Increased by X% (TBD in NOP)
Number of people who experience gender related sexual violence and coercion.		Reduced by X (TBD in NOP)
Number of community interventions or services that explicitly address norms about masculinity related to HIV/AIDS		TBD
Number of community based interventions or services that explicitly address the legal rights and protection of women and girls		TBD
Number of services or interventions that explicitly aim at increasing access to income and productive resources of women and girls impacted by HIV/AIDS		TBD

* All baselines and targets should be finalized during the development of the National Operational Plan.

3.5.1.2 Male Circumcision (MC)

Strategic Objectives	GOB Expected Contributions	PEPFAR Expected Contributions	Anticipated Contributions from other Donors
To increase demand for safe male circumcision and circumcise 80% of males aged 0-49	<p>Financial and technical support</p> <p>Coordination and policy development</p> <p>Procurement of MC supplies and equipment</p> <p>Provision of in-service training to MC providers</p> <p>Recruitment of and salary support for MC providers</p> <p>Development of M&E tools</p> <p>Refurbishment of facilities for MC services</p> <p>Provide support to disciplined forces, private sector and CSOs to implement safe MC</p>	<p>Support for salaries of MC providers</p> <p>Integration of MC curricula into Health Training Institutes</p> <p>Refurbishment of MC procedure rooms, including at BDF clinics</p> <p>Development of IEC materials and branding of MC campaign</p> <p>Public Health Evaluations for MC service delivery</p> <p>Revisions and updates of MC training materials, guidelines and policies</p> <p>Coordination of US military trained physicians to support MC services for disciplined services</p>	<p>ACHAP:</p> <p>Financial and technical support</p> <p>WHO:</p> <p>Financial and technical support</p>

3.5.1.2.1. Male Circumcision Indicators*

Indicator	Baseline	Target
Percent of males aged 0-49 who are circumcised	11%	80% by 2016

* All baselines and targets should be finalized during the development of the National Operational Plan.

3.5.1.3 HIV Testing and Counseling (HCT)

Strategic Objective	GOB Expected Contributions	PEPFAR Expected Contributions	Anticipated Contributions from other Donors
To expand access to quality HIV Testing and Counseling services	<p>Financial and technical support of HCT services</p> <p>Coordination and Policy direction</p> <p>Increase and strengthen the provision of post test services for HCT clients</p> <p>Procurement, distribution, and quality assurance of test kits and testing reagents</p> <p>Strengthen capacity of CSO, private sector and armed forces to provide HCT services</p>	<p>Increase visibility of HCT services and new programs</p> <p>Build capacity, improve quality, provide M&E and increase uptake of RHT</p> <p>Financial and technical assistance in supply chain management of HCT commodities, M&E activities, and development of national guidelines and policies</p> <p>Financial and technical assistance for provision of VCT services and development of HCT protocols, interventions, and curricula adaptations into the local context</p> <p>Build capacity of civil society organizations to promote HCT services and link these services to HIV care and treatment</p> <p>Mentor potential HCT service providers and staying current on evidence based HCT interventions and inform GOB of new</p>	<p>ACHAP:</p> <p>Financial and technical assistance</p> <p>WHO to MOH</p> <p>UNICEF to MOH</p> <p>UNAIDS to MOH</p> <p>UNFPA to MOH:</p> <p>Financial and technical assistance</p>

		developments	
		Promote collaboration between RHT and VCT	
		Joint development of operational research projects & protocols	

3.5.1.3.1 HIV Testing and Counseling Indicators*

Indicator	Baseline	Target
Proportion of Batswana who have ever been tested	56%	Increased by X (TBD in NOP)
Number of Batswana who are referred to appropriate services		Increased by X (TBD in NOP)

* All baselines and targets should be finalized during the development of the National Operational Plan.

3.5.1.4 Prevention of Mother-to-Child Transmission (PMTCT)

Strategic Objectives	GOB Expected Contributions	PEPFAR Expected Contributions	Anticipated Contributions from other Donors
To increase access to quality PMTCT services	<p>Increase early infant HIV testing and diagnosis</p> <p>Coordination and policy direction</p> <p>Procurement, distribution, and quality assurance of test kits, infant formula, and antiretroviral (ARV) drugs for all service providers</p> <p>Provision of trainings, equipment, infrastructure</p>	<p>Provision of laboratory supplies and equipment for early infant diagnosis program</p> <p>Financial and technical assistance for logistics management information systems for infant formula, trainings and training curricula, psycho-social support activities, and increasing male partner involvement</p>	<p>Botswana-Harvard Partnership: Conducting HIV research to better inform PMTCT Program</p> <p>UNICEF and UNFPA: Financial and technical assistance to Ministry of</p>

	<p>and staff salaries for PMTCT activities</p> <p>Strengthen post-natal care services and linking PMTCT to HIV care and treatment services</p> <p>Ensure availability of family planning (FP) services at all health facilities and integrate FP into ARV services</p> <p>Review and update of guidelines and policies</p> <p>Joint development of operational research projects & protocols</p> <p>Strengthen community involvement in PMTCT</p>	<p>Improve data quality</p> <p>Financial and technical assistance for development of national guidelines and policies</p> <p>Joint development of operational research projects & protocols</p>	Health
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*3.5.1.4.1 Prevention of Mother-to-Child Transmission (PMTCT) Indicators**

Indicator	Baseline	Target
Percentage of pregnant women who access PMTCT services (prophylaxis uptake)	91%	100%
PMTCT rates	4%	<1%

* All baselines and targets should be finalized during the development of the National Operational Plan.

3.5.1.5: Medical Transmission (Blood and Injection Safety)

Strategic Objectives	GOB Expected Contributions	PEPFAR Expected Contributions	Anticipated Contributions from other Donors
To provide quality, safe, adequate and	Finalize and implement national blood	Financial and technical assistance for development of national	WHO: Provision of

<p>accessible blood and blood products in Botswana</p>	<p>transfusion policy</p> <p>Strengthen blood donor mobilization strategy through media, community mobilization and peer education to promote voluntary non-remunerated blood donation</p> <p>Recruit potential blood donors country wide in collaboration with Botswana Red Cross Society (BRCS)</p> <p>Scale up <i>Pledge 25</i> project in collaboration with Ministry of Education and Skills Development(MOESD) and Ministry of Youth, Sports and Culture (MYSC)</p> <p>Build Capacity of the NBTS through human resources, training, equipment and infrastructure</p> <p>Implement Quality Management System in National Blood Transfusion Service.</p> <p>Promote rationale use of blood</p> <p>Integrate blood safety with other programs (e.g., laboratory, care and treatment, HIV counseling and testing, injection safety and malaria)</p>	<p>guidelines and policies</p> <p>Financial and technical support for the development of communications interventions to promote blood safety</p> <p>Financial and technical support for the recruitment of blood donors</p> <p>Financial and technical support to National Blood Transfusion Service (NBTS) for the expansion of the <i>Pledge 25</i> project</p> <p>Financial and technical support for critical human resources (e.g., medical director), training, equipment and infrastructure</p> <p>Financial support for the implementation of a Quality Management System in the NBTS</p> <p>Financial support for promotion of rational use of blood</p> <p>Financial and technical support for integration of blood safety with other programs</p> <p>Financial and technical support strengthening M&E of blood safety and for improving data quality</p>	<p>financial and technical assistance to Ministry of Health</p>
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	Strengthen M&E and data management systems		
To develop and implement National Infection Prevention & Control Program	<p>Develop and implement the National Infection Prevention & Control Policy guidelines and standard operating procedures</p> <p>Integrate and scale-up Injection Safety, Phlebotomy and other related procedures with the national infection prevention and control structures</p> <p>Build capacity of the Occupational Health and Safety through human resource and training</p> <p>Scale up management of health care waste</p> <p>Strengthen HIV post-exposure prophylaxis</p> <p>Develop and implement training program and standards for infection control</p> <p>Develop and implement M&E and data management systems for infection control and healthcare waste management strategies</p>	<p>Financial and technical assistance for development of national guidelines and policies</p> <p>Financial and technical assistance for integrating and scaling-up Injection Safety, Phlebotomy and other related procedures with the national infection prevention and control structures</p> <p>Financial and technical support for critical human resources at the Occupational Health Unit of MOH and training</p> <p>Technical assistance in Scale up management of health care waste</p> <p>Financial and technical assistance for scaling up post-exposure prophylaxis</p> <p>Financial support for the development of communications interventions to promote infection prevention and control, including injection safety</p> <p>Technical assistance in developing and implementing a training program and standards for infection control</p> <p>Financial and technical</p>	<p>United Nations:</p> <p>Provision of financial and technical assistance</p>

		support to strengthen M&E and data management systems for infection control and healthcare waste management strategies	
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3.5.1.5.1 Medical Transmission Indicators

Indicator	Baseline	Target
Number of blood units collected per year	23,275	TBD
% of blood units screened for HIV in a quality assured manner	100%	100%
Proportion of health facilities receiving 100% of the blood units for transfusion from NBTS	80%(28 of 35 facilities)	100%
% of blood units discarded due to Transfusion Transmissible Infections (TTI) including HIV reactivity	4.6%	TBD
% of HIV prevalence in donated blood	1.5%	<1%
% increase in regular voluntary non-remunerated blood donors	TBD	TBD
% HIV incidence in regular blood donors	TBD	TBD
Number of healthcare workers who successfully completed an in-service training program in different aspects of blood transfusion	N/A	1,000
% of hospitals with operational blood transfusion committees	46% (16 of 35 hospitals)	100%
Number of hospitals performing blood transfusion which have hemovigilance system	0	35
Number of blood	0	3

transfusion centers with ISO 9001 certification		
Number of health facilities with designated Infection Control focal person	23% (8/34)	100% (34)
Number of health districts with designated Infection Control focal person	0	100% (29)
Number of health facilities implementing National Infection Prevention & Control policy guidelines	0	60% (472/786)
Number of healthcare workers trained in Infection Prevention & Control and health waste management	54% (8,153)	90% (13,500/15,000)
Number of health facilities that provide routine reports on sharps injuries quarterly to DEOH	0	100% (786)
Proportion health facilities that provide HIV PEP	TBD	TBD
Number of persons provided with post-exposure prophylaxis (PEP) By exposure type: Occupational, Rape/Sexual Assault Victims, or Other Non-Occupational	TBD	TBD
Proportion of Healthcare workers that received a complete vaccination of hepatitis B	<10%	95%
Percentage of health facilities with satisfactory health care waste management systems	0 (no National data)	85%

* All baselines and targets should be finalized during the development of the National Operational Plan.

3.6 Goal 2: Capacity Building and Health Systems Strengthening – “To increase the GOB, civil society and private sector ability to sustain high quality, cost effective HIV/AIDS services.”

49. To achieve the national goals for HIV/AIDS prevention, care and treatment, Botswana will need to strengthen the public health delivery system, build the capacity of civil society organizations and facilitate more effective participation of the private sector in the national response. The Partnership Framework should build on previous investments by the GOB in strengthening human resources for health (HRH), training in leadership and governance and improving infrastructure and procuring supplies and equipment, by taking a more comprehensive, strategic approach to building sustainable systems that creates efficiencies and improves overall service delivery.

*3.6.1 Human Resources for Health**

Strategic Objectives	GOB Expected Contributions	PEPFAR Expected Contributions	Anticipated Contributions from other Donors
To enhance and coordinate quality service delivery in the health system through increased human resources for health	<p>Put policies and structures in place to increase health worker training output at local health training institutes and absorption and retention of graduates into the workforce</p> <p>Implement critical elements of HRH Plan:</p> <ul style="list-style-type: none"> - Attraction and retention plan - Use, decentralization of the HRIS - Strengthen management of HRH <p>Develop appropriate policies, strategies and</p>	<p>Financial and technical assistance to expand staff, infrastructure and equipment as necessary to accommodate increased intake and improve quality of pre-service education</p> <p>Technical assistance to implement the HRH and retention plans and HRIS rollout</p> <p>Technical assistance to improve the management of human resources for health</p> <p>Technical assistance to strengthen in-service training for health workers (coordination and implementation of technical, managerial</p>	<p>WHO:</p> <p>Technical assistance in HRH to Ministry of Health</p> <p>University Partners:</p> <p>Support health worker training (for example: University of Pennsylvania (UPENN) and Baylor are contributing to the development of the medical school. UPENN also does</p>

	SOPs for new and established cadres	and leadership training)	clinical training in the hospitals and clinics;
	Strengthen the role and function of councils	Technical support to strengthen the role and functions of the councils	Harvard assists in the area of in-service training for the ARV program;
	Coordinate and provide leadership for HIV in-service training for health workers		Baylor does pediatric training)

* All baselines and targets should be finalized during the development of the National Operational Plan.

3.6.2. Health Systems Structures*

Strategic Objectives	GOB Expected Contributions	PEPFAR Expected Contributions	Anticipated Contributions from other Donors
To integrate and strengthen the national health system structures for effective service delivery	Implement and roll out the 10-year Essential health service plan Increase and strengthen the national warehousing and distribution system	Technical assistance to implement the health systems plan Financial and technical support to strengthen the health inspectorate to improve quality of service delivery Support the strengthening of the Central Medical Stores (CMS)	WHO to Ministry of Health ACHAP World Bank to Ministry of Health

* All baselines and targets should be finalized during the development of the Partnership Framework Implementation Plan.

3.6.3 Leadership/Governance/Coordination*

Strategic Objectives	GOB Expected Contributions	PEPFAR Expected Contributions	Anticipated Contributions from other Donors
<p>To strengthen, civil society and private sector capacity (leadership, governance, coordination and partner/sector mobilization) at all levels in order to achieve the objectives of the national response</p>	<p>Review and revise national coordination mechanisms and structures in order to harmonize and align all HIV actors under the Partnership Forum on AIDS</p> <p>Develop guidelines for partner engagement in HIV/AIDS</p> <p>Strengthen evidence-based planning and decision-making</p> <p>Regulate health-related activities and accredit health service</p> <p>Develop and implement National Community Mobilization Strategy</p> <p>Complete and implement the National Strategy for NGO Capacity Building</p>	<p>Financial and technical assistance to national NGO networks to coordinate, communicate with and represent their member NGOs and CBO's</p> <p>Financial and technical assistance to National NGOs that have affiliates countrywide and potential for broad reach to expand their services</p> <p>Financial and technical support in targeted districts in remote, underserved locations to provide strategic resources and linkages between the government at district level and local CBOs</p> <p>Provide financial support for development of national guidelines</p> <p>Provide technical support and funding to support HR policies, HR systems, good governance and quality care</p> <p>Funding and technical assistance to MLG district/city/village structures to support Community</p>	<p>World Bank:</p> <p>Funding to Ministry of State President - NACA</p> <p>ACHAP:</p> <p>Technical and financial assistance</p> <p>SIDA:</p> <p>Provide technical assistance</p>

		<p>Mobilization Strategy</p> <p>Technical assistance and funding for NGO networks including on-line ICT support, district coalitions and Centers of Excellence</p> <p>Ensure complementary funding for program and operational costs to civil society groups</p>	
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* All baselines and targets should be finalized during the development of the National Operational Plan.

3.6.4 Infrastructure and Maintenance*

Strategic Objectives	GOB Expected Contributions	PEPFAR Expected Contributions	Anticipated Contributions from other Donors
To create a conducive and supportive environment aimed at ensuring quality service provision through improved infrastructure and maintenance of facilities and equipment	<p>Construct a National Public Health Laboratory and National Quality control laboratory structures to improve service delivery</p> <p>Develop and implement a preventive maintenance plan of facilities and equipment</p>	<p>Provide technical assistance and funding to support transformation of Bio-engineering Department and the new laboratories including staffing, training, and operations</p> <p>Improve CSO facilities through provision of adequate office space, transportation and ICT</p> <p>Provide technical assistance for health facility management</p> <p>Solicit and fund</p>	<p>ACHAP:</p> <p>Turn over to Ministry of Health aligned with plan to transform Bio-engineering Dept</p>

		PPPs to operate ICT in remote areas	
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* All baselines and targets should be finalized during the development of the National Operational Plan.

3.6.5 Resource Mobilization/Financial Management*

Strategic Objectives	GOB Expected Contributions	PEPFAR Expected Contributions	Anticipated Contributions from other Donors
To provide sustainable financial support for cost effective interventions in the national response	Facilitate effective resource mobilization efforts for the national HIV/AIDS response	Provide funding and technical assistance for costs studies of prevention, OVC, care and support, and NSFII implementation plan	ACHAP: Financial and technical assistance
	Conduct and institutionalize National AIDS Spending Assessment (NASA)	Participate and support NASA exercise	WHO and UNAIDS: Technical assistance to Ministry of State President - NACA
	Carry-out costing studies	Provide technical assistance and funding to foster PPPs and complete the Health Financing Strategy	NGOs: Develop income-generation activities
	Review and revise procurement policies to reduce costs	Support NGOs for income generating activities and improved financial management and accountability	
	Review public-private partnership policies/incentives to increase contribution of private sector to GOB and civil society HIV programs	Provide financial and technical support towards development of the HIV/AIDS database	
		Technical assistance	

	Complete and implement the Health Financing Strategy (in IHSP)	to undertake the National Health Accounts	
	Develop comprehensive HIV/AIDS database for tracking resources mobilized and used in the national response	Financial support for the conduct of the sustainable financing study for HIV/AIDS programs	
	Conduct the HIV/AIDS sustainable financing study		

* All baselines and targets should be finalized during the development of the National Operational Plan.

3.7 Goal 3: Strategic Information – “To strengthen Strategic Information management of the National Response to enhance evidence based planning.”

- 50. Over the next five years, the Partnership Framework seeks to strengthen and implement a comprehensive and integrated monitoring and evaluation (M&E) framework. This is expected to be achieved by the GOB leading a review of the National M&E Framework, and the development of an M&E plan, operational manuals and standardized tools.
- 51. The GOB and other partners also expect to facilitate development of a prioritized national research agenda which includes evaluation, scientific research and surveillance. The partnership also seeks to strengthen documentation processes and information sharing mechanisms.
- 52. The Partnership Framework also seeks to strengthen Information Management systems through the development of a strategic plan led by the GOB. This plan should in turn guide the networking of computerization of hospitals and clinics, ensure the integration and interfacing of information systems, and provide guidance on record linkage, data security and assessment of patient identifiers.

*3.7.1 Strategic Information Management Systems**

Strategic Objectives	GOB Expected Contributions	PEPFAR Expected Contributions	Anticipated Contributions from other Donors
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To strengthen the strategic information management systems at all levels	Develop and implement a comprehensive and integrated HIV/AIDS M&E framework	Provide technical assistance and financial support for the review of framework, development of plan, operational manuals, and data audit tools	WHO and UNAIDS: Financial support and technical assistance to Ministry of State President (NACA)
	Lead review of national M&E framework, development of M&E plan, operational manuals and standardized tools		
	Build capacity of institutions	Continue supporting M&E positions until they are absorbed by the GOB Continue supporting M&E capacity building within civil society Provide financial and technical assistance to strengthen training and educational opportunities for M&E cadre	ACHAP: Financial support and technical assistance WHO and UNAIDS: Offer financial support and technical assistance to Ministry of the State President -NACA and BONASO
Provide leadership and guidance in expansion and integration of HIV and other health related surveillance activities and surveys	Provide financial support and technical assistance to develop and execute the strategic documents on HIV surveillance and the Evaluation Agenda. Continue to support operations	ACHAP: Financial support and technical assistance in areas in line with its Phase II objectives WHO and UNAIDS: Financial support and technical assistance to MOH and Ministry of State President - NACA	
Coordinate the development and execution of a national scientific research and			

	<p>evaluation agenda.</p> <p>Coordinate information dissemination to provide for a culture of information use for planning</p>	<p>research to ensure evidence- based interventions and cost effectiveness</p> <p>Provide financial support and technical assistance for information resource centers</p>	
	<p>Lead in the development of an HIMS strategic plan</p>	<p>Continue giving financial support and technical assistance in development of HIMS strategic plan and on integration & harmonization of systems</p>	<p>Stakeholders:</p> <p>Work together to engage private sector to assist with systems harmonization and integration</p> <p>ACHAP:</p> <p>Financial support and technical assistance</p> <p>UNAIDS:</p> <p>Financial and technical support to Ministry of State President-NACA and MOH</p>

* All baselines and targets should be finalized during the development of the National Operational Plan.

3.8 Goal 4: Treatment, Care and Support – “To provide comprehensive and quality treatment, care and support services to people infected and affected by HIV.”

53. In 2002, the GOB initiated the MASA Program, a national HIV/AIDS treatment program with the goal of universal access to treatment for all eligible citizens. The MASA Program now provides ART to more than 82% of PLWHA in need, making Botswana one of the few countries providing almost universal access. Throughout the life of this program, the GOB has provided strong leadership and management of the MASA Program, even during the period of rapid massive scale-up, allowing PEPFAR support to focus on technical capacity strengthening and training of personnel to promote quality – a relationship that the Partnership Framework seeks to continue to support.

54. The overall goal is supported by five objectives: Treatment, TB-HIV, Laboratory Services, Care and Support, and Orphans and Vulnerable Children (OVC).
55. To this end, sub-objectives include building the capacity of health care workers to provide quality services through pre-service and in-service training and improved staff retention. Improvement of the logistic and procurement mechanisms should streamline availability of safe and efficacious medicines throughout the country.

3.8.1 Treatment

Strategic Objectives	GOB Expected Contributions	PEPFAR Expected Contributions	Anticipated Contributions from other Donors
To decrease the morbidity and mortality of PLHIV	<p>Strengthen ART service delivery for improved coverage and access</p> <p>Policy formulation, coordination, implementation and financial support</p> <p>Build capacity of health care workers to provide quality care and treatment services</p> <p>Improve pediatrics and adolescents access and adherence to treatment</p> <p>Improve the supply chain management system of drugs including ARVs and other related commodities</p> <p>Strengthen the Drug Regulatory Unit (DRU) and the</p>	<p>Financial support and technical assistance in strengthening of procurement, warehousing and distribution of ARVs at CMS</p> <p>Training of health care workers</p> <p>Systems strengthening at Drug Regulatory Unit and National Drug Quality Laboratory</p>	<p>ACHAP:</p> <p>Technical and financial support</p>

	<p>National Drug Quality Control Laboratory(NDQCL) to ensure availability of safe, efficacious and quality medicines in the country</p> <p>Strengthen the management and capacity for infection control in health facilities</p> <p>Expand the participation of private partners in treatment programs</p> <p>Expand and improve electronic patient monitoring systems</p>		
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3.8.1.1 Treatment Indicators*

Indicator	Baseline	Target
The five year survival after initiation of ART	89%	95%
Percentage in need of ARV therapy receiving ART	82%	95%

* All baselines and targets should be finalized during the development of the National Operational Plan.

3.8.2 TB/HIV

Strategic Objectives	GOB Expected Contributions	PEPFAR Expected Contributions	Anticipated Contributions from other Donors
To reduce the burden of TB in Botswana, particularly amongst those infected by	Provide leadership in strategic planning and review of TB	Provide funding and technical support for pre-service and in-service training of	WHO: Provide technical support to the

HIV/AIDS	control efforts	health care workers	Ministry of Health in the development of policy and guidelines; conduct an impact evaluation
	Implement the findings of the national TB program evaluation conducted in 2009	Support the upgrading of TB laboratory services	ACHAP:
	Identify and institute appropriate institutional arrangements for MDR TB surveillance and management	Fund upgrading and maintenance of TB data management system	Provide technical support and funding
	Training health care providers on MDR TB management		Global Fund:
	Procure laboratory equipment and supplies, and anti-TB drugs		Work with the Ministry of Health to implement TB/HIV collaborative activities as per Round 5 proposal
	The BDF will improve TB/HIV clinical care through trainings and mentorship		
Conduct program-based operational research			

3.8.2.1 TB/HIV Indicators*

Indicator	Baseline	Target
Proportion of people seen in HIV care settings who are screened for TB	Not known	90%
Proportion of TB patients who test for HIV	68%	90%
Proportion of HIV-positive TB patients who receive	35%	90%

antiretroviral therapy		
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3.8.3 Laboratory

Strategic Objectives	GOB Expected Contributions	PEPFAR Expected Contributions	Anticipated Contributions from other Donors
To strengthen laboratory services for improved service delivery	<p>Establish a public health laboratory</p> <p>Provide capacity to the laboratory quality assurance and management systems</p> <p>Improve the supply chain management of laboratory commodities and maintenance of lab equipment</p> <p>Policy formulation and coordination</p>	<p>Provide technical assistance and funding to support the renovation of the existing National Health Laboratory</p> <p>Establish additional testing capacity and an integrated national quality assurance laboratory</p> <p>Establish collaboration and twinning program with other public health laboratory</p> <p>Provide technical support, adequate equipments and training to the biomedical engineering unit to strengthen the capacity for equipment maintenance and calibration</p>	

3.8.3.1 Laboratory Indicators*

Indicator	Baseline	Target
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Percentage of laboratories adhering to quality assurance	30%	100%
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* All baselines and targets should be finalized during the development of the National Operational Plan

3.8.4 Care and Support

Strategic Objective	GOB Expected Contributions	PEPFAR Expected Contributions	Anticipated Contributions from other Donors
To strengthen the provision of comprehensive quality care and support services	<p>Improve the quality of the management of OIs and other co-morbidities</p> <p>Increase access to quality end of life care for patients suffering from terminal AIDS</p> <p>Develop mechanisms for improving the civil society response in care and support services</p> <p>Develop strategies to improve the household economic livelihoods of families affected and infected by HIV/AIDS</p>	<p>Provide financial and technical support in the review of STI guidelines to incorporate management of Viral STIs and for PwP, MARPS and Partner tracing.</p> <p>Financial support for the evaluation of the STI program.</p> <p>Financial support for critical management and coordination positions and trainings</p> <p>Give financial and technical support for the procurement of opioids for pain management.</p> <p>Provide technical</p>	<p>WHO:</p> <p>Technical and financial support to MOH</p>

	<p>Improve coordination, monitoring and evaluation of care and support interventions</p> <p>Intensify nutritional support for children and adults</p> <p>Registration and regulation of pain control drugs including opioids and improving their supply chain management</p>	<p>support in the formulation of palliative care policy</p> <p>Provide financial and technical support for strengthening civil society organizations capacity and organizational ability to deliver community based care & support services.</p>	
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3.8.4.1 Care and Support Indicators*

Indicator	Baseline	Target
Percentage of registered community home based care patients receiving quality care and support	92%	100%

* All baselines and targets should be finalized during the development of the National Operational Plan.

3.8.5 Orphans and Other Vulnerable Children

Strategic Objectives	GOB Expected Contributions	PEPFAR Expected Contributions	Anticipated Contributions from other Donors
To improve the quality of life of orphans and vulnerable children by ensuring access to optimal care and support	Establish the National Children's Council and other child care	Support the GOB contributions through funding and technical assistance to	UNICEF: Provide support for technical exchange

protection structures as provided for in the Children's Act	continue their OVC service delivery efforts	visits/programs and/or provide technical support for research to Ministry of Local Government
Strengthen the coordination and monitoring of OVC program	Provide financial support to fill service delivery gaps, particularly in the areas of pre-school and psycho-social support	World Bank: Funds to support projects for the Ministry of Local Government
Facilitate and monitor implementation of policy and legislation for the protection of orphans and vulnerable children	Provide funding and technical assistance for cost-effective, sustainable OVC service delivery by building the capacity of community based organizations	SIDA: Provide financial and technical support to NGO networks for adolescent programs (Ministry of Local Government and Ministry of Youth, Sports and Culture)
Identify and implement mechanisms for increased access for OVC to essential services	Provide technical support to help explore opportunities and benefits of a livelihoods policy	
Strengthen the capacity of families and communities to protect, support and care for OVC		

3.8.5.1 Orphans and Other Vulnerable Children Indicators*

Indicator	Baseline	Target
Percentage of OVC receiving basic services	75%	90%

* All baselines and targets should be finalized during the development of the National Operational Plan.

Section 4 - Management and Communications Plan

56. Implementation of the Botswana PEPFAR Partnership Framework is expected to require increased coordination between the GOB and the USG as well as other donors and stakeholders. This increased coordination should improve coordination, harmonization and alignment, cost-effectiveness, and transparency. It should also hold all partners accountable to supporting the GOB's program through the expected contributions outlined in the Partnership Framework.
57. While existing mechanisms in Botswana are effective at information sharing at technical and program management levels, their mandates will need to be reviewed and or expanded to sufficiently meet the management and communications needs required for the implementation of this Framework. Therefore, the GOB, the USG and other donors and stakeholders intend to implement several initiatives to strengthen HIV/AIDS management and coordination within the framework of existing structures. The completed needs assessment on coordination, harmonization and alignment should inform the final structural arrangements for effective program implementation of the framework.
58. The structures used in the development of the PF should be integrated inline with structural arrangements for development and oversight of implementation of the Second National Strategic Framework National Operational Plan.
59. The existing Joint Oversight Committee (JOC) for the development and oversight of implementation of the Second NSF made up of executive-level leaders from key Government Ministries, USG agencies, and other donors and stakeholders, and chaired by the National AIDS Coordinating Agency (NACA), will provide leadership and oversight. This committee should meet semi-annually to review plans and reports from donors, and provide high-level strategic direction for the national HIV/AIDS program.
60. The Joint Oversight Committee (JOC) is a special committee of the Botswana Partnership Forum on AIDS that oversees the development and implementation of the NSF II and NOP. The JOC is chaired by NACA, and includes the USG team (in addition to other donors and stakeholders), and is responsible for coordinating the national response on a regular basis. This mechanism may also establish special management sub-committees, as needed, to provide coordinated management support, such as harmonizing M&E and donor reporting, tracking and supporting key policy initiatives, coordinating public communications efforts, improving cost-effectiveness of PEPFAR resources, or creating *ad hoc* committees to plan special national meetings or events. This team reports directly to the Joint Oversight Committee described above and to the bigger Partnership Forum.
61. Existing National Operational Plan Technical Planning Groups (TPG) aligned with the goals and objectives of the second National Strategic Plan for HIV/AIDS (NSF II) will be responsible for identifying challenges and proposing solutions to those challenges to facilitate effective program implementation. They are expected to report to the Joint Oversight Committee through the Management and Support Committee and also regularly share information with other larger existing committees or fora in their specific focus areas as well as the Partnership Forum.

Section 5 - Steps to Complete Implementation Plan

62. The goals and objectives outlined in the Botswana Partnership Framework are linked to specific Government of Botswana plans outlined in the *National Development Plan 10* (NDP 10) and the *Second National Strategic Framework for HIV and AIDS, 2009-2016* (NSF II). Many of the PEPFAR-supported objectives in these documents contain baselines, indicators and targets, which, when finalized, should be used as the starting point for those included in the National Operational Plan.
63. The following tasks are already underway as the Framework is undergoing final approvals:
- The Technical Planning Groups, which were originally TWGs that developed this document, have begun developing the NOP and looking at the baselines, indicators and targets in the national plans to analyze what gaps exist, and how these will be inclusive of the PEPFAR requirements.
 - As the Government of Botswana's planning cycle goes through 2016, it is necessary for all NDP 10 and NSF II targets in the National Operational Plan to show how PEPFAR will contribute toward those targets through 2014, i.e., through the end of PEPFAR II. Therefore, the TPGs are also analyzing the Government's planned seven year targets, and developing appropriate algorithms to estimate how PEPFAR is expected to contribute to those targets over the next five years.
64. The Management and Support Committee (MSC) with support from the TPGs has the responsibility for managing the National Operational Plan development process and the Joint Oversight Committee has the responsibility for reviewing and approving the final plan and oversight of its implementation

Section 6 - Signatures

Government of Botswana
Honorable Lesego Motsumi, Minister of Presidential Affairs and Public Administration

Government of the United States of America
Ambassador Stephen J. Nolan

Acronyms and Abbreviations

ACHAP	African Comprehensive HIV/AIDS Partnerships
AIDS	Acquired Immune Deficiency Syndrome

ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral
BAIS	Botswana AIDS Impact Survey
BBCA	Botswana Business Coalition against AIDS
BCIC	Behavior Change Interventions and Communication
BHRIMS	Botswana HIV/AIDS Response Information
BONASO	Management System
BRCS	Botswana AIDS Service Organisation
CBO	Botswana Redcross Society
CHBC	Community Based Organisation
CSO	Community Home-Based Care
CSO	Central Statistics Office
EC	Civil Society Organisation
HIV	European Commission
HRH	Human Immunodeficiency Virus
HSS	Human Resources for Health
ICT	Health Systems Strengthening
IEC	Information Communication Technology
JOC	Information Education and Communication
GOB	Joint Oversight Committee
GBV	Government of Botswana
M&E	Gender based Violence
MARPS	Monitoring and Evaluation
MC	Most At Risk Populations
MCP	Male Circumcision
MDR	Multiple and Concurrent Partnerships
MLG	Multi-Drug Resistant
MOH	Ministry of Local Government
MTR	Ministry of Health
MYSC	Mid-Term Review
NAC	Ministry of Youth Sport and Culture
NACA	National AIDS Council
NASA	National AIDS Coordinating Agency
NBTS	National AIDS Spending Assessment
NDP 10	National Blood Transfusion Service
NDQCL	National Development Plan 10
NGO	National Drug Quality Control Laboratory
NOP	Non-governmental Organization
NSF	National Operational Plan
OVC	National Strategic Framework
PEPFAR	Orphans and Vulnerable Children
PEP	President's Emergency Program for HIV/AIDS Relief
PMTCT	Post-exposure Prophylaxis
PPP	Prevention of Mother-to-Child Transmission
RHT	Public Private Partnership
SIDA	Routine HIV Testing
SRH	Swedish International Development Agency
	Sexual and Reproductive Health

STI	Sexually Transmitted Infection
TB	Tuberculosis
TPG	Technical Planning Group
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session (on HIV/AIDS)
UNICEF	United Nations Children's Fund
UPENN	University of Pennsylvania
USG	United States Government
VCT	Voluntary Testing and Counselling
WAD	Women Affairs Department
WHO	World Health Organization

Source: PEPFAR (2012) "Botswana Partnership Framework for HIV/AIDS 2010 - 2014: A Collaborative Effort between The Government of Botswana and The Government of the United States of America (December 2010)" <http://www.pepfar.gov/frameworks/botswana/158545.htm> [19 March 2012].

**Annex 6 – Five-Year Partnership Framework in Support of the
Ethiopian National Response to HIV/AIDS 2010 - 2014 Between The
Government of the Federal Democratic Republic of Ethiopia and the
Government of the United States of America (October 2010)**

Acronyms

ABC	Abstinence, Be faithful, Condom use
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Treatment
BCC	Behavior Change Communication
CHAI	Clinton Health Access Initiative
CSO	Civil Society Organizations
CT	Counseling and Testing
DFID	Department for International Development
EHNRI	Ethiopian Health and Nutrition Research Institute
EID	Early Infant Diagnosis
FBOs	Faith-Based Organizations
FGM	Female Genital Mutilation
GF(ATM)	Global Fund (to fight AIDS, Tuberculosis and Malaria)
GOE	Government of Ethiopia
HAPCO	HIV/AIDS Prevention and Control Office
HBC	Home-Based Care
HEW	Health Extension Worker
HSS	Health Systems Strengthening
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRH	Human Resources for Health
HSDP IV	Health Sector Development Program (2010/11-2014/15)
IGAs	Income Generating Activities
IHP+	International Health Partnership
LMIS	Logistics Management Information System
MAP	Multi-Country HIV/AIDS Program
MARPs	Most At Risk Populations
MCP	Multiple Concurrent Partner
MDG	Millennium Development Goals
M & E	Monitoring and Evaluation
MNCH	Maternal Neonatal and Child Health
MOE	Ministry of Education
MOH	Ministry of Health
NASA	National AIDS Spending Assessment

NHA	National Health Account
OI	Opportunistic Infection
OVC	Orphans and Vulnerable Children
PBS	Population Based Survey
PEPFAR	United States President's Emergency Plan for AIDS Relief
PF	Partnership Framework
PFIP	Partnership Framework Implementation Plan
PFSA	Pharmaceutical Fund and Supply Agency
PHCU	Primary Health Care unit
PLHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother-To-Child Transmission
PR	Principal Recipient
SI	Strategic Information
SNNPR	Southern Nations & Nationalities and Peoples Region
SOP	Standard Operating Procedure
SPM-I	Strategic Plan for Intensifying Multisectoral HIV and AIDS response in Ethiopia I (2004-08)
SPM-II	Strategic Plan for Intensifying Multisectoral HIV and AIDS response in Ethiopia II (2010-2014)
STI	Sexually Transmitted Infection
TA	Technical Assistance
TB	Tuberculosis
UHEW	Urban Health Extension Worker
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	The United Nations Children's Fund
VAT	Value Added Tax
WB	World Bank
WFP	World Food Program
WHO	World Health Organization

I. Purpose and Principles

This Partnership Framework reflects the outcome of joint discussions and respective contributions of the Government of Ethiopia (GOE) and the Government of the United States of America (U.S. Government) (hereinafter the Participants) to collaboratively expand, and sustain an effective response to the HIV/AIDS epidemic in Ethiopia over the next five years. The Partnership Framework goals and objectives are consistent with Ethiopia's Strategic Plan for Intensifying Multisectoral HIV/AIDS Response in Ethiopia 2010-2014 (SPM II) and the Health Sector Development Plan IV 2010/11-2014/15 (HSDP IV), the strategic plan of the

President's Emergency Plan for AIDS Relief (PEPFAR), and the principles of the U.S. government's Global Health Initiative. The Partnership Framework also seeks to ensure that U.S. Government contributions towards the SPM II and broader health sector development programs complement and leverage other stakeholders.

Through the signing of this Partnership Framework, both governments acknowledge a shared desire to strengthen their relationship, and increase the effectiveness, efficiency and sustainability of the national response to the HIV/AIDS epidemic in Ethiopia. The Partnership Framework supports the Government of Ethiopia's unique leadership role in coordinating and mainstreaming efforts among many sectors to create an efficient, effective and sustainable response to HIV/AIDS in Ethiopia. The Partnership Framework is intended to work in close collaboration with other Ethiopian collaborative arrangements such as the International Health Partnership (IHP+) and other multilateral and bilateral relationships.

This Partnership Framework between the GOE and the U.S. Government also articulates the joint understanding and commitment to the following principles to guide how the two governments intend to combine efforts to combat HIV/AIDS in Ethiopia:

Country Leadership: The Partnership Framework supports Ethiopian national plans and priorities, is responsive to national planning processes, and seeks to uphold national high level leadership and continued ownership of the response by the Government and people of Ethiopia.

Cooperation and Partnership: The Partnership Framework outlines plans to strengthen the ongoing relationship between the GOE and U.S. Government and recognizes the need to increase the GOE's management and financial responsibility for the national HIV/AIDS response. The Framework also builds upon a foundation of an organized and concerted joint planning effort from all stakeholders, including multiple government sectors, private sector, civil society, faith-based organizations, donor organizations, people living with HIV/AIDS, and communities at large to enhance HIV/AIDS programs.

Evidence based and strategic decision making: The HIV/AIDS response should be led by planning for implementation of programs that have evidence supporting their effectiveness. Programs should be rigorously monitored and evaluated. Decision making should be data driven and be based on the most strategic investment of available resources in order to maximize program impact.

Accountability: The Partnership Framework assumes that the two Governments meet all Framework objectives and may be answerable to interested constituencies. The Partnership Framework Implementation Plan should outline the schedule and method by which the governments expect to review progress toward Framework objectives.

Equitable, universally-accessible, quality care: The Framework is to be guided by the vision that systems and services related to HIV/AIDS should be equitable, move

towards universal access, be of high quality, and support a family and community based approach. Gender inequalities should be addressed by all sectors to ensure more effective HIV/AIDS prevention care, treatment and mitigation programs. Programs should also take into account and work towards ensuring that all people with disabilities receive equitable and accessible standard quality services.

Integration: The Partnership Framework should further support, where possible, the progressive and bi-directional integration of HIV/AIDS interventions with other health services, as well as integration of other needed services into those for HIV/AIDS.

While the U.S. Government's main modality of delivering development assistance is to be project support, U.S. Government investments in Ethiopia should be based on a joint plan, include country leadership in decision-making on where investments are made, be transparent and support the principles of the "Three Ones."

Financial Principles

In addition to the above Principles, the two Governments affirm their understanding of the importance of the following financial principles:

Recognition that, as U.S. Government and GOE resources are limited, prioritization is necessary to achieve the most immediate and durable public health impact, and planned investments are subject to the availability of funds.

Recognition that achievement of national HIV/AIDS goals may require resource levels beyond the ability of any one partner, and that the constraints on availability of funding from either Government or from other key partners may lead to a review and revision of priorities.

Recognition that where U.S. Government assistance is to be provided directly to the GOE under this Partnership Framework, GOE contributions are expected to meet host country cost sharing needs under U.S. foreign assistance programs and progressively cover recurrent expenditures. Details regarding the GOE's financial and/or in-kind contributions to programs under this Partnership Framework are to be provided in the Partnership Framework Implementation Plan.

Recognition that transparency in HIV/AIDS-related resource allocation and expenditures is expected from both Participants.

Recognition that both Participants should continue to work in collaboration with other stakeholders to reduce redundancies and inefficiencies in allocation of HIV resources for HIV/AIDS interventions.

Recognition that both Participants should support full and open competition in the funding of non-governmental implementing partners.

II. Background/Context

Ethiopia has a population of 80 million[1] and is the second most populous country in Sub-Saharan Africa. It is a low-income country with a real per capita income is US \$232[2] and an estimated 39% of the population living below the international poverty line of \$1.25/day.[3] It is also one of the least urbanized countries with 84% of the population living in rural areas.

Although improvements have been made, the health status of Ethiopia is still low, as in other Sub-Saharan countries. This is largely attributable to preventable infectious diseases and nutritional deficiencies associated with poor hygienic conditions, improper waste disposal practices, and insufficient access to clean water. Infectious and communicable diseases account for about 60-80% of the health problems in the country.[4] Life expectancy is 53 years of age, the infant mortality rate is 77 per 1,000 live births and the child mortality rate is 123 per 1,000 live births. Neonatal mortality contributes 30% of the under 5 mortality, with pneumonia and diarrheal disease contributing an additional 22% and 17% respectively. Access to and use of maternity services is very weak. Ethiopia has a high maternal mortality rate at 673 per 100,000 births and only 20% of births are attended by a skilled attendant. Predictably, neonatal mortality is also high at 39 per 1000 births with asphyxia, sepsis and preterm birth the major contributors.[5]

Ethiopia's HIV/AIDS epidemic has placed substantial demand on the country's already strained resources. Although Ethiopia's 2009 HIV point prevalence estimate of 2.3% is lower than many other Sub-Saharan countries, there are still over 1.1 million people living with HIV in Ethiopia. Of Ethiopia's estimated 5.4 million orphans, 855,720 were orphaned due to AIDS. Prevalence is higher in women than in men (2.8% and 1.8%, respectively). Ethiopia represents a low level generalized epidemic with wide urban to rural differences in prevalence (7.7% and 0.9% respectively), with most at risk groups driving the epidemic.[6] A National Prevention Summit attended by key stakeholders held in April 2009 reached consensus to strengthen prevention activities and also increase efforts to reach Most at Risk Populations (MARPs) with interventions. Population groups most at risk of HIV infection include female sex workers, migrant workers, long distance drivers, uniformed forces, discordant couples and men having sex with men. Common

[1] Based on the 2007 National Census (Central Statistical Agency) and extrapolated to include a 2.6% annual population growth rate.

[2] National 5 Year Growth Transformation Plan, Federal Ministry of Finance & Economic Development, August 2010

[4] Health Sector Strategic Plan (HSDP III) 2005/06-2009/10. Federal Ministry of Health.

[6] Strategic Plan for Intensifying Multisectoral HIV and AIDS Response in Ethiopia (SPM II) 2010-2014.

settings with MARPs include economic and infrastructure development schemes, brothels, high transport corridors, refugee camps and surrounding populations.[7]

The Government of Ethiopia has been innovative and has taken an active role in addressing the country's health challenges. This includes a doubling of the treasury budget for health over the past 5 years. Taking into account additional resources obtained through PEPFAR and the Global Fund, the annual per capita expenditure on health has increased from \$7.1 in 2004/5 to \$16.1 in 2007/8[8], although this is still well below the World Health Organization's recommended \$34 per capita. The contribution of the GOE to HSDP IV is expected to increase from \$249 million in 2009/10 to \$298 million in 2014/15; the 2009/10 contribution is 4.4% of the total national budget. Ethiopia is the largest recipient of grants from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) which together with PEPFAR resources provided 90% of donor support for HIV/AIDS in 2009. Other donors include the UN Joint Program, the World Bank, UNITAID and other bilateral donors. Ethiopia was one of the first signatories to the International Health Partnership (IHP+).

With PEPFAR support, the GOE has demonstrated strong leadership and commitment to addressing the HIV/AIDS epidemic with significant achievements. This has resulted in increased social mobilization, an expansion of health facilities and services, improved access to antiretroviral treatment (ART), and enhanced efforts to build human capacity. The number of facilities offering counseling and testing has almost tripled from 658 in 2005 to 1596 in 2009; coupled with significant efforts being made in community mobilization through the Millennium AIDS Campaign; as a result, HIV testing increased from 436,854 (2004/5) to 5,800,248 (2008/09). Service expansion and service uptake significantly and consistently increased during the Strategic Plan for Multisectoral Response (SPM I) period (2004-2008). In 2005, only 3 facilities were offering ART; by 2009, these services were available in 481 facilities. From a baseline of 8,226 persons ever started on ART in 2005, over 241,250 were started on treatment by 2009.[9] As of March 2010, there were 186,154 (62% of estimated need) persons still on ART. The dropout rate of those ever started and the current number of patients on ART is comprised of patients that have died, those that have transferred out, stopped treatment and the "true" lost to follow-up" which is estimated at around 7%. A significant lost to follow up is found among pre-ART patients.

Despite a three-fold increase in the number of sites providing PMTCT, only 8.2% of the estimated eligible number of HIV-infected pregnant women received prophylaxis. Due to limited access to quality ANC and maternity services, the challenges with reaching targets in PMTCT has been acknowledged by the GOE, partners and donors alike. Similarly, even with significant expansion of primary health care facilities, the health sector infrastructure falls well below the WHO recommended facility to population ratio. And, although the GOE has considerably expanded its number of health centers, a recent survey assessing health facilities illustrates that on average only 60% and 3.2%, respectively, had basic and high level supplies in place.[10] It is anticipated that through the hiring, training and deployment of 30,000 Health Extension Workers (HEWs) focused on health

promotion, disease prevention and provision of basic health care services and referrals, significant progress should be made at the community level to increase PMTCT services and the number of births managed by a skilled birth attendant.

Ethiopia is one of 57 countries recognized by WHO as having a health workforce crisis, marked by chronic under-production of trained personnel, especially at high and mid-levels, and poorly motivated underpaid staff with low retention. In addition, there are major rural:urban distribution disparities with health worker density ranging from 0.24 to 2.7 per 1,000 population, respectively. There are 2,151 physicians in the country, a ratio of 1 to 36,710 people which is far below WHO standards.[\[11\]](#) Ethiopia has been visionary in task-shifting HIV/AIDS services in order to compensate for the severe shortage of high and mid-level trained health workers to bring essential services to those in need.

The development of a Partnership Framework comes at a critical point. PEPFAR is moving from an emergency to a more sustainable response with greater emphasis on country ownership. This is outlined in the next 5-year PEPFAR strategy by which “PEPFAR will work through partner governments to support a sustainable, integrated, and country-led response to HIV/AIDS”.[\[12\]](#) Ethiopia is in the process of finalizing its Health Sector Development Plan 2010/11-2014/15 (HSDP IV) and has recently drafted the Second Strategic Plan for Intensified Multisectoral Response to HIV/AIDS 2010-2014 (SPM II). These strategic policy documents build upon the gains and lessons learned to date. Through this Partnership Framework, the U.S. Government and the GOE should consolidate the gains achieved through partnerships in the first five years and move forwards with an increased focus on country ownership and leadership, while strengthening health systems that integrate prevention, care and treatment services.

Policy Environment

The overarching health sector plan is outlined in the Health Sector Development Plan IV (HSDP IV) which is in final draft. This takes into account the Plan for Accelerated and Sustained Development to End Poverty (PASDEP 2007-2010) which is currently being updated. The Strategic Plan for Intensifying Multisectoral HIV/AIDS Response in Ethiopia 2010-2014 (SPM II) outlines in greater detail the country’s response to HIV/AIDS. In the development of this Partnership Framework and in the elaboration of the Partnership Framework Implementation Plan, policy issues have been identified. These include development of a National Condom Strategy, enforcement of free maternity services at primary health care level, ratification of policy on task shifting and broadening of the policy to allow urban health extension workers to distribute ARVs as part of PMTCT prophylaxis and revision of the social welfare policy. The status of the policy environment and how the policy agenda may be moved forwards should be further outlined in the PFIP.

The SPM II identifies selected strategies addressing gender inequality, including gender based violence. HIV programs should be encouraged to systematically mainstream gender, including integration into sectoral policies and programs. Awareness creation and punitive approaches should be implemented on perpetrators

of Gender based violence (GBV), which includes abduction, wife battering and female genital mutilation (FGM). HIV post exposure prophylaxis should be available to survivors of sexual violence. The SPM II also promotes the education of girls and gender norms to facilitate gender equality. The SPM II plans to conduct a stigma index study, advocate against stigma and discrimination, promote respect for human rights, protect from gender-based violence and multimedia censorship for minors, early marriage and FGM.

III. Five-year strategic overview

The U.S. Government recognizes that the national response to the HIV/AIDS epidemic in Ethiopia is led and coordinated by the Government of Ethiopia (GOE). The health sector spearheads the National HIV/AIDS response. HIV/AIDS programs are coordinated through and led by the Federal HIV/AIDS Prevention and Control Office (HAPCO) and the National AIDS Council, and involve a range of institutions including but not limited to the Ministry of Health, other line Ministries, the Ethiopian Health and Nutrition Research Institute (EHNRI), the Pharmaceutical Fund and Supply Agency (PFSA), and the Drug Administration and Control Authority (DACA). Within Ethiopia's federal system, there are also regional HAPCOs, regional health bureaus, and emerging regional AIDS Councils.

This Partnership Framework represents the joint work with the GOE designated members of the HAPCO team and PEPFAR. It also incorporates comments and inputs from other multi-lateral and bilateral donors, other government sectors and civil society. In August 2009, the U.S. Government Deputy Chief of Mission communicated the concept of the Partnership Framework to the Ethiopian Minister of Health, who designated HAPCO as the U.S. Government's key contact. The Partnership Framework was developed by a design team comprised of members of the GOE and the U.S. Government, in consultation with multi and bilateral donors and civil society. The GOE and the U.S. Government held a number of joint design team meetings over the intervening period. There was some delay as the GOE finalized their new five year strategy, with the U.S. Government and other multilateral donors, working with the GOE to rationalize some of the ambitious targets. Based on the finalization of the SPM II document, within the Partnership Framework, the U.S. Government has clearly defined what is within its manageable interest and focus by specifying expected U.S. Government contributions towards achieving the goals and objectives. A number of consultation meetings with other development partners were held to elicit their input into both the policy agenda and their expected contributions towards the goals and objectives as identified within the Partnership Framework. The U.S. Government also consulted with its implementing partners. HAPCO also called a broader stakeholder consultation to bring in other sectoral ministries and partners. Drafts of the Partnership Framework document have been shared with the GOE and other development partners at various points in the process and comments elicited.

The first government Strategic Plan for intensifying the Multisectoral Response to HIV/AIDS (SPM I) covered the period from 2004-2008. The Partnership Framework builds upon the Strategic Plan for Intensifying Multisectoral HIV/AIDS Response in

Ethiopia II: 2010-2014 (SPM II) and the HSDP IV. The SPM II places priority on the following thematic areas:

- Creating an enabling environment
- Intensifying HIV prevention
- Increasing access to and improving quality of HIV/AIDS care and treatment
- Intensifying mitigation efforts against the epidemic
- Strengthening the generation and use of strategic information

The Partnership Framework supports the SPM II, which also forms part of the HSDP IV. Health systems' strengthening is a broader goal which constitutes part of HSDP IV and is set forth within Goal 3 in the Partnership Framework. This Partnership Framework illustrates an enhanced coordination of resources and harmonization of goals and objectives between the GOE, PEPFAR and other key donors. Transitioning ownership of HIV/AIDS programs to Ethiopia's leadership is expected to require an organized, strategic approach that promotes sustainability of the programs. This Partnership Framework aims to create an enabling environment that ensures the active involvement and ownership across all sectors, enhances partnership under the "Three Ones Principles" and mobilizes appropriate use of resources.[\[13\]](#)

The Global Health Initiative (GHI) serves as the whole-of-U.S. Government approach to further coordinate and integrate the U.S. Government's global health efforts in partner countries and is intended to form the health component of future country development cooperation strategies. Through GHI, the U.S. Government intends to help partner countries improve health outcomes through strengthened health systems, with a particular focus on improving the health of women, adolescent girls, newborns and children through programs that address infectious disease, nutrition, maternal and child health, family planning, safe water, sanitation and hygiene. GHI should take into account and leverage the health and development efforts of partner countries, other bilateral donors, multilateral organizations, civil society, private sector, and faith-based and non-governmental organizations to achieve the greatest possible impact through U.S. Government investments. The GHI model has dual objectives of achieving significant health improvements and fostering effective, efficient and country-led platforms that deliver essential health care and public health programs sustainably. This Partnership Framework, although addressing primarily HIV/AIDS programs, also embodies the principles outlined in GHI.

The Partnership Framework aims to achieve the following four goals in support of the GOE's plan to address the HIV/AIDS epidemic:

Goal I: Reduce the national HIV incidence by 50% by 2014: Under this goal, the GOE, U.S. Government and other stakeholders recognize the importance of focusing efforts on evidence-based prevention and display their shared desire and commitment to increase comprehensive HIV knowledge and behavior change among the adult population, provide additional focus on intervention packages that are designed to reach MARPs, increase the availability of counseling and testing, and expand the availability of comprehensive youth focused ABC programs. Additionally, the two governments recognize the priority of putting into action efforts to significantly

increase the availability and utilization of PMTCT services. As a result of increased efforts for combination prevention [14] for the general population, and MARPs as well as higher uptake of PMTCT services, there should be an anticipated decrease in the incidence of new infections.

Goal II: To reduce morbidity and mortality and improve the quality of life for people living with HIV by expanding access to quality care, treatment and support by 2014: Under this goal, the U.S. Government plans to work jointly with the GOE and other stakeholders to ensure the continued provision of quality HIV/AIDS care, treatment and support services, including services to OVC with available resources. Emphasis should also continue to be given to enrolling more children into care and treatment and to ensuring, as with ARVs for adults, that available pediatric ARV formulations are available in an uninterrupted manner. As a result of investments in care, the increased detection and treatment of TB/HIV co-infection and other opportunistic infections, and improved treatment and follow-up services, it is anticipated that 12-months survival rate should increase. In addition, support for strengthening of psycho-social support for orphans and PLHAs, including improved access to livelihood options, should improve quality of life.

Goal III: Health systems necessary for universal access are functional by 2014. In partnership with the GOE, the U.S. Government and other stakeholders should work collaboratively to focus their activities and contributions towards creating a better-functioning health system. This is to include adequate human resources for health, expanded and improved physical infrastructure, increased capacity for planning, management, and finance of programs, especially at regional levels. This is to be based on functioning systems for health management information, surveillance, other sources of data and laboratory, all supported by adequate systems to ensure uninterrupted procurement and supply of essential HIV/AIDS commodities.

Goal IV: Multisectoral response in place to prevent the spread of HIV and mitigate its impacts by 2014. Under this goal, in partnership with the GOE, the U.S. Government and other stakeholders intend to promote the strengthening of leadership so that Ethiopia may coordinate and implement one multisectoral and strategic national response. Several GOE ministries have committed 2% of their budget to mainstreaming within their sector. The U.S. Government should engage with the GOE to strengthen coordinating bodies, accelerate implementation, enforce accountability of leadership, and intensify involvement of civil society and the private sector.

IV. OWNERSHIP

With the development of the SPM II and HSDP IV, the GOE demonstrates strong leadership and ownership in the proposed development of Ethiopia's health sector. The HSDP IV has applied the following principles:

1. Government leadership
2. Enhanced responsiveness to community health needs

3. Extensive consultation and consensus with stakeholders
4. Comprehensive coverage of priority health sector issues
5. Linkage between HSDP IV and sub-national HSDPs, strategies, programs on priorities and targets. [\[15\]](#)

The SPM II aspires to prevent and control Ethiopia's HIV/AIDS epidemic and to mitigate its impacts through intensified community mobilization and empowerment as well as through capacity building. The SPM II also aims to strengthen the active participation and involvement among all sectors. Creating an enabling environment is one of five strategic issues set forth by the GOE in the SPM II that helps to conceptualize the meaning of host country ownership for Ethiopia. Capacity building, community mobilization and empowerment, leadership and governance, mainstreaming, coordination and partnership are key components of Ethiopia's growing ability to create an enabling environment. Such an environment should strengthen the effective management, implementation and evaluation of Ethiopia's multisectoral and strategic response.

Specifically, the U.S. Government and the GOE intend to promote greater country ownership of programs and activities by the government, local organizations and other stakeholders through:

- Jointly deciding upon indicators that characterize ownership and outlining incremental and time-delineated steps to strengthen host country ownership.
- Increasing the proportion of local partners receiving PEPFAR funds in Ethiopia, including but not limited to the GOE.
- Increasing the proportion of PEPFAR funds that goes to local partners.
- Developing an appropriate plan to build local capacity that serves to enable transition from non-Ethiopian partners receiving PEPFAR funds.
- Ensuring that PEPFAR-funded activities are aligned and support other key GOE plans which include HSDP IV, SPM II, HMIS, HRH, Laboratory Master Plan, etc.
- Maintaining open, transparent, and regular communication between U.S. Government, the GOE, and other key partners such as primary recipients of GFATM and IHP+ partners.
- Aligning U.S. Government coordination for health activities with the MOH (federal and regional) and for multisectoral activities with the HAPCO (federal and regional).
- An evidence-based response, led by the GOE at all levels, with enhanced partnership of all stakeholders, including civil society and the private sector, under the principles of the "Three Ones" to institute the Partnership Framework principles and goals.

The U.S. Government anticipates ongoing discussions with the GOE to further define and progressively move toward greater country ownership.

Goal 1: To reduce the national HIV incidence by 50% by 2014.				
Under this goal, the GOE, U.S. Government and other stakeholders, recognize the importance of focusing efforts on prevention and display their shared desire and commitment to increase comprehensive HIV knowledge among the adult population, provide additional focus on combination prevention intervention packages that should reach Most at Risk Populations and vulnerable groups, increase the availability of counseling and testing and the availability of comprehensive youth focused abstinence, be faithful, and condom (ABC) programs resulting in behavior change. Additionally, the two governments recognize and should put into action significantly increasing the availability and utilization of PMTCT services.				
Objectives	Expected Contributions			Expected steps for development of PFIP and identified policy issues
	GOE	PEPFAR	Other[16]	
1.1: To increase HIV comprehensive knowledge among adult population aged 15-49 from 22.6% in 2005 to 80% by 2014.	<ul style="list-style-type: none"> · Intensify social mobilization through community conversation · Provide HIV prevention communication programs house to house to general population · Ensure provision of comprehensive workplace HIV prevention communication programs 	<ul style="list-style-type: none"> · Support outreach to the general population in high prevalence areas with comprehensive HIV prevention communication and behavior change programs · Support evidence-based programs that provide effective one-to-one or small groups based BCC interventions including CT and the development and dissemination of materials and training 	<ul style="list-style-type: none"> · Joint UN support for increasing knowledge among general population through integration of HIV into relevant sectoral interventions and community processes · Global Fund: Support training of community conversation facilitators · Support provision of comprehensive HIV prevention communication programs · World Bank: Support for community 	<ul style="list-style-type: none"> · Programmatic evaluation of effect of large scale general population activities on behavior change

			conversations, peer education groups under MAP II	
1.2: By 2014, increased percentage of MARPs are reached with HIV intervention programs.	<ul style="list-style-type: none"> · Before end of 2010, lead study on MARPs identification, size estimation, distribution, HIV prevalence and mapping of hotspots · Develop comprehensive HIV prevention services packages of HIV services and communication strategy for MARPs · Organize, coordinate, and ensure provision of HIV prevention services to MARPs 	<ul style="list-style-type: none"> · Support in MARPs identification, size estimation, and mapping of hot spot areas · Generate evidence of the level of multiple concurrent partnerships and modes of transmission · Support development and implementation of specific intervention packages including condoms, HIV/AIDS and STI treatment in Urban and Peri-Urban hot spots · Support efforts to decrease stigmatization of MARPs and ensure increased access to services · Support efforts for greater involvement by NGOs, FBOs and CSOs 	<ul style="list-style-type: none"> · Joint UN technical support for development of MARPS surveillance and intervention packages · Joint UN team provides normative and M&E guidance and implementation support for MCP interventions · Netherlands support for MARPs programs · Global Fund: Support provision of HIV prevention programs to MARPs · Global Fund: Supports increased involvement of FBOs · World Bank: MARPs focused peer education and support groups and small community based grants for IGAs and to support above activities under MAP II 	<ul style="list-style-type: none"> · Identify size and mapping of MARPs population, behavioral characteristics and HIV prevalence among the identified MARPs · Develop comprehensive prevention packages of HIV services and communication strategy for MARPs, · Policy decisions around new and most cost-effective interventions as they become available

<p>1.3: By 2014, the percentage of young people aged 15-24 who use condoms consistently while having sex with non-regular partners should increase from < 50% (2005) to 80%.</p>	<ul style="list-style-type: none"> · Ensure health facility based distribution of condoms · Provide condoms to development schemes through outreach programs · Ensure provision of condoms to MARPs 	<ul style="list-style-type: none"> · Provide condoms on free and social marketing basis to Urban and Peri-Urban areas · Participate in National Condom Strategy development · Support the development and strengthening of Condom Logistic management system · Support BCC efforts (including CT), materials and training that promotes condoms 	<ul style="list-style-type: none"> · Joint UN support to ensure supply and procurement of condoms and enhanced technical capacity for resource mobilization · DFID, IrishAid and Netherlands government support condom social marketing programs · UNICEF support in-school and out-of-school youth programs with MOE and MOYS · Global Fund Support provision of condoms to development schemes and youth centers · World Bank School based peer education programs, Anti-AIDS clubs, under MAP II 	<ul style="list-style-type: none"> · Develop national condom strategy · 100% of estimated national need and distribution of condoms is available by 2015
<p>1.4: By 2014, 85% of HIV positive pregnant women [17] and their infants receive complete</p>	<ul style="list-style-type: none"> · Intensify social mobilization for prevention of mother-to-child transmission of HIV · Lead integration of PMTCT with 	<ul style="list-style-type: none"> · Support comprehensive ethnographic studies to better understand cultural and utilization barriers for PMTCT services in order to increase 	<ul style="list-style-type: none"> · WHO provides strategic advice, including adoption of new global guidelines, and UNICEF supports training in PMTCT settings · UNICEF 	<ul style="list-style-type: none"> · Involvement of urban HEWs in appropriate aspects of PMTCT services including distribution of ARV

<p>ARV prophylaxis or treatment.</p>	<p>MNCH services</p> <ul style="list-style-type: none"> · Provide PMTCT at all PHCUs with outreach community services · Based on evidence, address barriers to access and utilization of PMTCT services 	<p>utilization of these services</p> <ul style="list-style-type: none"> · Support HMIS to use PMTCT cascade for program improvement · Support integration of PMTCT services into other maternal and child health programming · Support community based PMTCT programs, focusing on HEW, UHEW, and mother support groups as appropriate · Focus on measures that increases the quality of PMTCT services to encourage utilization · Support increased private sector involvement in PMTCT · Address gender issues in accessing PMTCT services · Contribute to health facility 	<p>support for integration of PMTCT services into MNCH</p> <ul style="list-style-type: none"> · Global Fund: Support provision of PMTCT service provision at facility and community outreaches · CHAI: Strengthen/initiate comprehensive PMTCT services in 30 Primary Health Care Units and hospitals 	<p>prophylaxis</p> <ul style="list-style-type: none"> · Plan for roll-out of new WHO guidelines related to PMTCT · Enforcement of free maternity services at primary health care level
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		and health worker skills		
		<ul style="list-style-type: none"> · Support infrastructure improvements to make sites more accessible and female- and family-friendly 		
1.5: A cumulative total of 42 million people counseled and tested for HIV by 2014.	<ul style="list-style-type: none"> · Intensify social mobilization for counseling and testing among vulnerable and most at risk population groups · Ensure provision of counseling & testing services at health facility and in community outreach activities · Expand sites for provision of counseling and testing service · Enhance targeting and quality assurance mechanisms 	<ul style="list-style-type: none"> · Support targeted CT program in hot spots · Increase CT to reach Most at Risk Populations and vulnerable groups · Strengthen couples/family CT · Evaluate home-based CT · Strengthen referral linkages and post test clubs · Support quality assurance mechanisms for CT · Strengthen supply chain for test kits · Support provider-initiated counseling and testing in clinical sites 	<ul style="list-style-type: none"> · Joint UN support for normative guidelines, service delivery enhancement and CT and periodic M&E · Global Fund: Support HCT services through supply of rapid test kits and expanding service delivery sites · CHAI: Pilot HIV C&T at rural health Post level · Strengthen HCT at hospital and HC level 	<ul style="list-style-type: none"> · Dialogue on improved targeting for testing populations at high risk of infection
1.6: Reduce	<ul style="list-style-type: none"> · Ensure 	<ul style="list-style-type: none"> · Support BCC 	<ul style="list-style-type: none"> · UNESCO, 	<ul style="list-style-type: none"> · Evaluation of

<p>percentage of young people aged 15-19 with sexual debut < 15 years from 8.4% in 2005 to 1.7%; 11.1% to 2.2% in females and male from 1.7% to 0.34% by 2014.</p>	<p>provision of age appropriate HIV/reproductive health services including BCC</p> <ul style="list-style-type: none"> · Expand school-based interventions · Encourage family-life education at schools and conversations at household level · Ensure implementation of education sector policies and strategies · Enforce policies prohibiting the access of minors to alcohol, illegal substances, etc 	<p>efforts (including CT), materials and training that promote delay of sexual debut for youth</p> <ul style="list-style-type: none"> · Involve FBOs, CSOs and communities · Address Gender and Male Norms related behaviors · Strengthen linkages with education programs – support in school and out of school programs which include training of teachers both in school and in TTIs, youth leadership development, mass media campaigns through school radio, TV, print serial dramas etc. · Engage youth in constructive afterschool activities (Peace Corps) 	<p>UNHCR and UNAIDS provide inputs to strategic planning, supportive supervision and enhanced management capacities for supplies to schools</p> <ul style="list-style-type: none"> · UNICEF and UNFPA HIV prevention work with young people in and out of schools and in tertiary education institutions · Global Fund: Support BCC programs in school youth and out of school youth · World Bank TA for school based programs 	<p>schools community conversations and anti-AIDS clubs</p>
<p>1.7 Increase availability of biomedical prevention measures: a) Universal precautions employed in</p>	<ul style="list-style-type: none"> · Enforce universal precaution standards in all health facilities · Implement quality assurance measures to 	<ul style="list-style-type: none"> · Support the provision of universal precautions in all health facilities · Support production of local low cost 	<ul style="list-style-type: none"> · Global Fund: Procure infection prevention materials and renovation of blood banks · WHO provides PEPFAR funded 	

all health facilities by 2014	screen all donated blood	locally customized IP supplies	TA for national blood transfusion service	
b) Ensure safe blood supplies are available throughout the country at hospital level	· Provide leadership in providing a national blood transfusion service	· Support renovation of blood banks, and provide training and supplies		
c) Accelerate access to male circumcision	· Ensure provision of male circumcision at major health centers and hospitals · Conduct targeted promotion of male circumcision geographical areas with lower rates of male circumcision	· Support the rollout of male circumcision in targeted areas		

Goal 2: To reduce morbidity and mortality and improve the quality of life for people living with HIV by expanding access to quality care, treatment and support by 2014.

Under this goal, the U.S. Government and other partners plan to work jointly with the GOE to ensure the continued provision of quality HIV/AIDS care, treatment and support services, including services to OVCs. This goal should focus on scaling up and sustaining treatment and care services with available resources.

Objectives	Expected Contributions			Expected steps for development of PFIP and identified policy issues
	GOE	PEPFAR	Other[18]	
2.1: By 2014, 12-month survival among those	· Strengthen adherence counseling and	· Support GOE in considering implementing new WHO guidelines;	· WHO provides TA for new guideline	· Funds identified for drug

receiving treatment is increased from 73% to 80%.	<p>follow up</p> <ul style="list-style-type: none"> · Ensure uninterrupted supply of ARVs and OI drugs · Adapt new WHO guidelines after considering cost implications and feasibility · Ensure access to and quality of chronic care and treatment services, including adherence, follow-up, etc · Provide leadership and coordination around program management 	<p>emphasize strengthening mechanisms for follow-up</p> <ul style="list-style-type: none"> · Support efforts for earlier access and initiation to ART · Enhance efforts to increase OI diagnosis and management · Expand EID access · Carry out efforts to better understand and address obstacles to optimal adherence · Provide costing data to facilitate decision-making and planning for increasing access to ART · Develop SOP to manage discordant couples 	<p>implementation</p> <ul style="list-style-type: none"> · CHAI: Introduce new products to improve patient adherence · UNICEF supports integrated IMNCI and Pediatric HIV services 	<p>procurement</p> <ul style="list-style-type: none"> · Implications of new WHO guidelines are assessed and costed
2.2: Increase ART enrolment from 73% to 95% of those eligible by 2014.	<ul style="list-style-type: none"> · Expand ART service by ensuring fulfillment of minimum standards for expansion of ART services · Expand number of sites for ART services 	<ul style="list-style-type: none"> · Provide TA to support increased skills at service points and increase capacity for ART, including task shifting · Provide costing data to facilitate decision-making and planning for increasing access 	<ul style="list-style-type: none"> · WHO support to enhance technical skills for the scale-up of ART and health center support · Global Fund: Support supply of 1st line ARVs, OI drugs, and reagents 	

	<ul style="list-style-type: none"> · Deploy health personnel for HIV and comprehensive health care services · Ensure uninterrupted supply of ARVs and OIs · Adopt new guidelines after considering costing implications & feasibility 	<ul style="list-style-type: none"> to ART · Support health facility infrastructure to improve ART accessibility · Invest in pre- and in-service education to increase the number and quality of human resources for health · Support case management to link positive persons to treatment 	<ul style="list-style-type: none"> Support expansion of ART services · CHAI: Supply pediatric and adult 2nd line ARVs until 2011 · Decentralize ART services to lower tier of health system (in 4 regions at identified 30 woreda level (Amhara, Tigray, Oromia and SNNPR)) · Strengthen client referral and tracking system 	
<p>2.3: An increased number of individuals in all age groups access a continuum of quality comprehensive clinical HIV/AIDS care and treatment services, including TB/HIV by 2014.</p>	<ul style="list-style-type: none"> · Strengthen service linkages and integration · Develop guidelines, SOPs, and formats for service linkages and referral systems · Ensure functional inter and intra facility community referrals to linkages 	<ul style="list-style-type: none"> · Identify and support measures that strengthen linkages between counseling and testing and getting into care · Support functional referral and follow up systems to ensure patients enter treatment early and remain in treatment · Integrate HIV/AIDS services into other health programs · Update guidelines, 	<ul style="list-style-type: none"> · Joint UN agencies to increase provision and utilization of treatment, care and support services for PLHIV and others (focus on quality assurance and strengthening referral/service integration and outcome monitoring) Global Fund: Support linkages of prevention and care services · CHAI: 	

		<p>training manuals and support pre and in-service training</p> <ul style="list-style-type: none"> · Support quality improvement processes at all levels · Support case management to better link clients to facility- and community-based services · Support increased range and quality of psychosocial services · Support basic care package (e.g. cotrimoxazole prophylaxis, Safe water) · Provision of therapeutic feeding for malnourished PLHIV 	<p>Strengthen PHCU capacity to provide comprehensive services including TB/HIV in 4 regions at identified 30 woreda level (Amhara, Tigray, Oromia and SNNPR)</p>	
<p>2.4: Increase care and support to needy PLHIV from 20% in 2008 to 50% by 2014.</p>	<ul style="list-style-type: none"> · Ensure implementation of GIPA · Strengthen IGA activities · Ensure provision of care and support to needy PLHIV 	<ul style="list-style-type: none"> · Support increased access to sustainable livelihood programs · Collaborate with other partners to increase household food security · Support HIV case management 	<ul style="list-style-type: none"> · UNFPA to enhance access to care and support packages UNICEF and WFP financial and food support to HIV – affected and food insecure HHs · Global Fund: Support PLHIV 	<ul style="list-style-type: none"> · Develop national standards for care and support service package

		provided by and for PLHIV to better link clients to facility- and community-based services	to engage in marketable IGA schemes · Support nutritional & HBC for PLHIV	
2.5: Increase care and support to needy OVC from 30% in 2008 to 50% by 2014.	· Ensure access to Education by OVC · Strengthen care & support to needy OVCs in their familial networks	· Support increased range, age-appropriate and quality of psychosocial services · Support increased access to sustainable livelihood programs · Collaborate with other partners to increase household food security · Support basic care package (e.g. Safe water) · Support Implementation of OVC minimum standards · Support strengthening of community-based organizations	· Joint UN support to increase provision of care and supportive supervision in delivering services to OVCs · UN supported social transfers to OVC HHs (e.g. cash transfers/vouchers child support grants, disability benefits, foster care grants, interest free micro-credit) UNICEF support to training of para-professional social work cadre & strengthening of social protection programs · Global Fund: Support schooling to OVC · Support for basic needs for the needy OVCs · Support guardian and	· Enforce implementation of national standards of OVC care and support · National OVC situational analysis is to be commenced · Operationalization of guidelines · Social welfare policy revision is to be commenced (including assessment of capacity and service provision).

			OVCs above 14 years to engage in vocational training & IGA	
			· CHAI: Link HCVs with orphanages	

Goal 3: Health systems necessary for universal access are functional by 2014.

Under this goal, the U.S. Government plans to collaborate with the GOE and other donors to strengthen health systems, including the involvement of private sector and civil society at all levels. This goal focuses on recruiting, training and retaining human resources as well as supporting the GOE in its implementation of the HMIS and the Health Network Model. Through this goal, health insurance, supply chain mechanisms and laboratory services have been identified as key objectives that should be reached in order to offer a functional health system to the people of Ethiopia. Key aspects of this goal include investments in pre-service training and infrastructure, policy reform and performance-based management.

Objectives	Expected Contributions			Expected steps for development of PFIP and identified policy issues
	GOE	PEPFAR	OTHER	
3.1: Increased availability of trained human resources for health to support accelerated scale up of comprehensive HIV/AIDS programs by 2014.	<ul style="list-style-type: none"> · Increase enrollment capacity of health professionals in training colleges and universities · Ensure continuous education provision to health professionals · Staffing health facilities is identified in GOE standards 	<ul style="list-style-type: none"> · Strengthen HR planning, leadership and management including task shifting, retention strategies, gender equity and HRIS. · Support pre-service and in-service training including capacity building of public and private training institutions · Support quality assurance through 	<ul style="list-style-type: none"> · Joint UN efforts to scale up HR capacity through training and supportive supervision to ensure sustainable & effective response to HIV/AIDS · Global Fund: Support the implementation human resource strategy and plan · CHAI: Enhance capacity of 	<ul style="list-style-type: none"> · There is a need to develop costed implementation plan for the HRH strategy. · Ratify policy on task shifting may be needed · Plan for the transfer of personnel currently supported through PEPFAR resources to regular budget

	<ul style="list-style-type: none"> · Enforce human resource strategy development · Help strengthen and coordinate in-service and pre-service trainings · Institute initiatives to improve retention and motivation from health workers · Institute performance-based management · Scale up task shifting 	<p>continued professional development, accreditation and licensing of health professionals.</p> <ul style="list-style-type: none"> · Support hospital management training for CEOs and other administrators to improve personnel management, facility maintenance and infrastructure, morale, and staff retention · Support the development of the public health workforce (e.g. Masters programs FELTP, HIT etc) · Support development of a public health workforce 	<p>PHCU (in 4 regions at identified 30 woreda level (Amhara, Tigray, Oromia and SNNPR)</p>	<p>support.</p>
<p>3.2: The health network model is improved by increased operational capacity at all levels— national, regional, zonal, woreda, facility and community by 2014.</p>	<ul style="list-style-type: none"> · Strengthen referral system · Strengthen service linkages and integration · Scale up task shifting and mentoring 	<ul style="list-style-type: none"> · Support the development of a standardized referral system · Expand technical assistance provided at the regional level · Focus on building the capacity of regional and sub-regional offices in planning and coordination of 	<ul style="list-style-type: none"> · UN support to system functioning ensuring effective service operations of regional coordination and functioning · Governance Pool Fund (DFID, Irish, Italian Cooperation) with HAPCO to increase capacity 	

		<p>HIV/AIDS and health programs.</p> <ul style="list-style-type: none"> · Support select construction of health facilities 	<p>and accountability at regional levels</p> <ul style="list-style-type: none"> · Global Fund: Support strengthening of referral system · World Bank capacity building support at RHB and woreda levels under MAP II 	
<p>3.3: Planning at all levels is evidence based.</p>	<ul style="list-style-type: none"> · Coordinate and lead evidence based multisectoral response planning at all levels 	<ul style="list-style-type: none"> · Support, facilitate and participate in planning at all levels · Support and participate in efforts to collect quality data and evaluate programs · Support efforts to use data for decision-making 	<ul style="list-style-type: none"> · Joint UN support for enhanced sector management and strategic planning · UNICEF, WHO and UNFPA support annual woredas based planning · Governance Pool Fund (DFID, Irish, Italian Cooperation) with HAPCO to increase capacity and accountability at regional levels 	<ul style="list-style-type: none"> · Prioritized planning at all levels takes into account evidence based information and available resources
<p>3.4: Health management information systems (HMIS) are functional throughout all regions by 2014.</p>	<ul style="list-style-type: none"> · Implement HMIS at full scale · Train workforce in HMIS and M and E (in service) 	<ul style="list-style-type: none"> · Support HMIS roll-out through technical assistance, training, and investments in HMIS and ICT infrastructure · Support the 	<ul style="list-style-type: none"> · WHO technical support towards 9 key components of HMIS Support HMIS implementation · CHAI targets HCs implement 	<ul style="list-style-type: none"> · Scale up staffing at the regional level for HMIS · Staffing in place for HMIS at health centers and

		<p>development of a community based information system</p> <ul style="list-style-type: none"> · Support efforts to improve the HMIS to meet evolving information needs to support decision-making 	<p>HMIS</p> <ul style="list-style-type: none"> · World Bank – TA support under MAP II 	<p>hospitals.</p> <ul style="list-style-type: none"> · Ongoing review and modification of HMIS to incorporate improvements
<p>3.5: Additional sources of strategic information provide timely inputs to evidence based planning for HIV/AIDS programs by 2014.</p>	<ul style="list-style-type: none"> · Ensure five-year implementation of master plan strategy for strategic information and surveillance. · Provide leadership and coordination to implement five year master plan 	<ul style="list-style-type: none"> · Support the collection and generation of strategic information at the national and regional level · Support the design and implementation of program evaluations as well as various surveys and surveillance 	<ul style="list-style-type: none"> · Operational research from pooled fund · UNICEF support operations research in using modern telecommunication for improved PMTCT uptake 	<ul style="list-style-type: none"> · 5 year master plan for Surveillance and other SI information is to be finalized and implemented
<p>3.6: Expanded social and community health insurance schemes and improved utilization of user-fee revenue by 2014.</p>	<ul style="list-style-type: none"> · Ensure implementation of social insurance 	<ul style="list-style-type: none"> · Address key policy challenges in health insurance in Ethiopia · Support the management of facility level user fees for effective utilization · Support community based insurance schemes for PLHIV · Support the training of 	<ul style="list-style-type: none"> · World Bank: TA to MOH for pilot community insurance schemes jointly working with PEPFAR funded partners under MAP II 	<ul style="list-style-type: none"> · Ratify legal framework for community health insurance and social insurance

		hospital/health system chief executive officers		
3.7: Primary health care infrastructure improved to support universal access to quality services by 2014.	<ul style="list-style-type: none"> · Ensure the achievement of quality universal primary healthcare coverage · Provide leadership and coordination for improved infrastructure · Ensure expansion of infrastructure for Universal Access · Continue renovation to provide continued quality care · Ensure maintenance of facilities 	<ul style="list-style-type: none"> · Support functioning basic amenities in facilities · Support limited construction of new high-burden health facilities 	<ul style="list-style-type: none"> · UN support in the procurement of supplies & management of HFs · Strengthen the capacity of PHCUs · World Bank through PBS II procurement of medical equipment, supplies, drugs at all levels. · UNICEF support improving water supply and sanitation in health centers 	<ul style="list-style-type: none"> · Standardization of facilities and services may be required · Inclusion of maintenance budget for all facilities
3.8: Chronic care sites covered with basic laboratory services by 2014.	<ul style="list-style-type: none"> · Ensure availability of laboratory services · Ensure implementation of national laboratory plan · Provide leadership and coordination · Ensure maintenance of 	<ul style="list-style-type: none"> · Focus on delivery of basic supplies and equipment · Focus on Lab quality assurance · Support national laboratory accreditation efforts · Support selected renovation or construction of 	<ul style="list-style-type: none"> · WHO and UNICEF to procure and supply lab commodities · World Bank through PBS II procurement of lab at all levels 	<ul style="list-style-type: none"> · National/regional Lab maintenance plan developed and implemented

	laboratories · Institute national quality assurance mechanisms	laboratories · Support program for training of laboratory technicians and maintenance specialists		
3.9: Supply chain system in place ensuring consistent availability of essential HIV-related drugs and commodities by 2014.	· Ensure the availability of essential drugs and commodities · Strengthen drug supply management system · Ensure implementation of national logistic master plan · Lead and coordinate the supply chain system	· Support the implementation of Pharmaceutical logistic management plan (PLMP) and logistics management information systems (LMIS) including the development of a handover plan	· Joint UN Technical support for uninterrupted supply of drugs and commodities · DFID, through MDG Performance Fund, support for commodities · World Bank TA to PFSA to strengthen procurement and financial management	· Plan developed for the GOE to subsume the distribution costs of all supplies and commodities which are currently covered through PEPFAR resources · Directives of the exemption of VAT for all health related commodities

Goal 4: Multisectoral response in place to prevent the spread of HIV and mitigate its impacts by 2014.

Under this goal, the GOE, the U.S. Government along with other partners intend to promote the multisectoral and strategic national response. The U.S. Government should join efforts with the GOE and other partners to strengthen local leadership and coordination, enforce accountability of leadership, and intensify involvement of civil society and the private sector.

Objectives	Expected Contributions			Expected steps for development of PFIP and identified policy issues
	GOE	PEPFAR	OTHER	
4.1: Ensure sustained commitment of leadership	· Strengthen leadership and governance of HIV/AIDS	· Focus on strengthening capacity at regional and sub	· Concerted joint UN support to enhance institutions.	· Plan for activation of Regional AIDS Councils and

<p>at all levels to take HIV/AIDS as strategic development issue and to enforce accountability</p>	<p>programs at all levels</p> <ul style="list-style-type: none"> · Ensure capacity building of leadership at all levels · Enforce accountability mechanisms to ensure responsiveness · Strengthen active multisectoral involvement at biannual program reviews 	<p>regional levels</p> <ul style="list-style-type: none"> · Aim for participatory governance of public health programs with the inclusion of the private sector, CSOs and other stakeholders · Identify and adapt best practices from other countries to enhance governance and leadership · Fund capacity building for planning, budgeting, management, accountability and technical oversight by regions, kebeles and woredas · Fund and provide training on strategic leadership for HIV/AIDS response · Fund and conduct periodic review of multisectoral response and provision of feedback from governing bodies · Provide technical 	<p>Structures and coordination capacities at all levels (focus on emerging regions)</p> <ul style="list-style-type: none"> · Governance Pool Fund (DFID, Irish, Italian Cooperation) with HAPCO to increase capacity and accountability at all levels · GF -Support capacity building for leadership and governance 	<p>coordinating bodies</p> <ul style="list-style-type: none"> · Active multisectoral involvement at bi-annual program reviews · Strengthen Regional AIDS Councils and coordinating bodies through active multisectoral involvement
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		assistance in administrative and fiscal management		
4.2: HIV programs are integrated into other sectoral budgets, work plans and review mechanisms by 2014.	<ul style="list-style-type: none"> · Ensure mainstreaming of HIV/AIDS into key strategic sectors · Build capacity for mainstreaming · Ensure provision of workplace policies and strategies 	<ul style="list-style-type: none"> · Strengthen coordinating bodies in multisectoral programming · Assist GOE to incorporate workplace and sectoral HIV/AIDS activities into sector plans and ensure implementation · Assist GOE in ensuring the sector management information system and review mechanisms tracks workplace HIV activities 	<ul style="list-style-type: none"> · Joint UN efforts to facilitate multisectoral integration of HIV and strengthen M&E capacity <p>GF Support mainstreaming of HIV/AIDS in key strategic sectors</p>	
4.3: Increased participation of civil society in the national response by 2014.	<ul style="list-style-type: none"> · Ensure civil society participation in multisectoral HIV/AIDS response at all levels · Strengthen partnership forums and networking 	<ul style="list-style-type: none"> · Increase CSO participation in governance and delivery of public health services by building their capacities · Advocate for participation and leadership from young people, women and PLHIV 	<ul style="list-style-type: none"> · Joint UN support to enhance multisectoral management and leadership capacity (focus on strengthening umbrella bodies, coordination, networking and advocacy capacities) <p>Global Fund</p> <ul style="list-style-type: none"> · Support community system strengthening 	

			<ul style="list-style-type: none"> · Support CSOs to provide HIV services · Support in strengthening partnership · World Bank TA to assist with development of improved social accountability and transparency at community level 	
4.4: Increased participation of the private sector in the national response by 2014.	<ul style="list-style-type: none"> · Ensure private sector participation in multisectoral HIV/AIDS response at all levels · Develop standardized guidelines for provision of services · Ensure implementation of private-public partnership guidelines 	<ul style="list-style-type: none"> · Improve access and quality of health services by creating well regulated, competitive environment for the private health sector · Continue to expand and enhance public-private partnerships · Continue efforts to educate and engage professional societies in the national response (e.g. EPHA, EMA, ESOG, etc.) 	<p>Global Fund:</p> <ul style="list-style-type: none"> · Support community system strengthening · Support private sectors to provide HIV services · Support in strengthening partnership 	<ul style="list-style-type: none"> · Further define roles and responsibilities within GOE for private sector · Identify what workplace programs are in place · Draw up list of private sector health education institutions; define accreditation standards · Guidelines on standardization of private-public partnership · Guidelines on standardization of private sector services

V. Partners Roles and Objectives

The Partnership Framework builds on the GOE's high level of ownership and shared objectives with the U.S. Government and other partners to controlling the HIV/AIDS epidemic. At the federal level, HAPCO is the national coordinating body for ensuring that all HIV/AIDS interventions in Ethiopia are harmonized and aligned with national priorities and strategies. The Goals and Objectives table outlines the various stakeholder contributions within the four Partnership Framework Goals. The goal statements are aligned with and, in several instances, excerpted directly from the SPM II (2010-2014) and the HSDP IV. Each goal is associated with several objectives which contribute towards the achievement of that goal. Expected contributions from government and other groups overall reflect an integrated national response.

Ethiopia receives a substantial amount of Global Fund resources. Currently the U.S. Government and the GOE have a Memorandum of Understanding (MOU) which delineates the complementary roles of Global Fund and PEPFAR resources. As an essential step in the development of the Partnership Framework Implementation Plan, the GOE and PEPFAR intend to review and harmonize their investments, within a revised MOU. The U.S. Government is a member of the Country Coordinating Mechanism (CCM) of the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM). Technical assistance is provided to the GOE to develop proposals for HIV, malaria and TB.

The GOE receives health sector development aid from a wide array of donors. It is the function of the Federal Ministry of Health to coordinate this assistance. However it is also incumbent on multilateral and bilateral donors to clearly provide their assistance in support of the GOE's priorities moving towards the principle of the "Three Ones". Coordination of donor response towards HIV/AIDS programs falls within the mandate of FHAPCO.

VI. Plans for developing the Partnership Framework Implementation Plan

The Partnership Framework Implementation Plan is to provide the opportunity to operationalize the high level goals and objectives expressed in the Partnership Framework document. The development of the Implementation Plan should focus chiefly on the detailed plans that may be required to achieve the identified goals and objectives, with identified annual targets and benchmarks. The U.S. Government is committed to strengthening joint planning of activities with the GOE and other development partners to achieve these goals and targets. An important component of this effort should be harmonization with the Plan of Action for all resources obtained through the Global Fund for AIDS, Tuberculosis and Malaria and the regular sharing of information regarding programming of resources for both GFATM and PEPFAR funding. The Implementation Plan should also address a prioritization of key activities based on available resources, to be evaluated annually and adjustments made as may be required. The development of the Implementation Plan should be a highly consultative process similar to that adopted for the Partnership Framework

document. The design team responsible for the Partnership Framework plans should guide the development of the Implementation Plan. Many of the details of the plan are already outlined within the SPM II and HSDP IV documents. In addition, U.S. Government and the GOE are committed to promoting the types of policy, strategies and guidelines that should foster success and maximize investments.

Estimated Timeline:

- End of December Submit draft Implementation Plan to OGAC
- January OGAC review Implementation Plan
- End of January Implementation Plan signed

VII. Management and communications

On signature of the Partnership Framework and the subsequent Implementation Plan, responsibility for monitoring the implementation of the goals and objectives should be steered by FHAPCO. Review of progress should be conducted on a bi-annual basis at the GOE's bi-annual review of the implementation of the SPM II. This well-attended meeting is to include participation from government ministries, donors, implementation partners and civil society. This forum should also allow for review of the ongoing policy agenda which should support the successful implementation of the Partnership Framework. Interim reviews should be commenced through established regular meeting schedules between the PEPFAR /Ethiopia team and GOE. High level oversight should be provided through regular meetings held between the Minister of Health and the US Ambassador.

VIII. Signatures

[3] UN country level statistics, Federal HIV/AIDS Prevention & Control office, Federal Ministry of Health.

[5] World Health Organization: The neonatal mortality breakdown is taken from the National child survival Strategy Document (which was based on the situation analysis document prepared before the development strategy).

[7] Strategic Plan for Intensifying Multisectoral HIV and AIDS Response in Ethiopia (SPM II) 2010-2014.

[8] 4th National Health Accounts; Federal Ministry of Health; April 2010 (2007/2008).

[9] Strategic Plan for Intensifying Multisectoral HIV and AIDS Response in Ethiopia (SPM II) 2010-2014.

[10] Five-Year Evaluation of Global Fund Health Impact Evaluation: Health Facility Report. Federal Ministry of Health, Ethiopian Health & Nutrition Research Institute (2008).

[11] Health Sector Development Program (2010/11-2014/15)

[12] PEPFAR Five-Year Strategy (2009)

[13] Strategic Plan for Intensifying Multisectoral HIV and AIDS Response in Ethiopia (SPM II) 2010-2014.

[14] Combination prevention can be considered as a multilevel approach that encompasses behavioral strategies integrated with biomedical and structural approaches, and treatment for HIV infection. Coates, T, Richter, L., Caceres, C., Lancet: 372:669-684 (2008).

[15] Health Sector Development Program IV (2010/11-2014/15) Ministry of Health, Federal Democratic Republic of Ethiopia.

[16] World Bank contributions: The current MAP II program is likely to end June 2011. There are ongoing discussions as regards future WB support – all inputs here outside MAPII are illustrative.

[17] 85% refers to total estimated number of HIV+ve pregnant women

[18] World Bank contributions: The current MAP II program is likely to end June 2011. There are ongoing discussions as regards future WB support – all inputs here outside MAPII are illustrative.

Source: PEPFAR (2012) “Five-Year Partnership Framework in Support of the Ethiopian National Response to HIV/AIDS 2010 - 2014 Between The Government of the Federal Democratic Republic of Ethiopia and the Government of the United States of America (October 2010)” <http://www.pepfar.gov/frameworks/ethiopia/158572.htm> [19 March 2012].

Annex 7 – Partnership Framework in Support of South Africa's National HIV & AIDS and TB Response 2012/13 - 2016/17 between the Government of the Republic of South Africa and the Government of the United States of America (December 2010)

1. Purpose and Principles

The purpose of this five-year Partnership Framework (2012/13–2016/17) is to improve the effectiveness, efficiency, and sustainability of the South African national HIV and TB response. To achieve this, the Governments of South Africa (SAG) and the United States of America (USG), through its PEPFAR program^[1], have dedicated themselves to improving coordination and cooperation to prevent and mitigate the impact of these epidemics.

In the reauthorization of the USG PEPFAR program in 2008, the scope of the U.S. program shifted from an emergency response to that of building and sustaining health outcomes and systems through a closer alignment with host country priorities. This Partnership Framework seeks to articulate this change in direction and to outline the parameters of engagement to guide how the two countries cooperate in the response to the HIV & AIDS and TB epidemics in South Africa.

While the Partnership Framework is a non-binding arrangement between the national governments, integration and implementation is intended to be coordinated across government departments at all levels, including provinces and districts, and to entail collaboration and partnership with non-state actors.

By the end of the five year period, and in line with national priorities outlined in SAG's official strategic documents^[2], the implementation of this joint framework is expected to result in the reduction of HIV and TB transmission, expanded and sustained national HIV and TB services, and the strengthening of the systems that underpin the national response.

The national HIV & AIDS and TB response is envisioned to be supported by PEPFAR's financial and technical assistance to help build the leadership and implementation capacity of SAG and civil society. Specifically, such capacity building should include, but not be limited to, performance management, policy analysis, strategic planning, monitoring and evaluation, coordination, financial resource management, and quality improvement.

This Partnership Framework details the broad strategic plan for cooperation and coordination between the two governments. The operational details of this Framework are intended to be developed in a Partnership Framework Implementation Plan (PFIP), as described in Section 5 below.

In considering how best to achieve this purpose, the USG and the SAG have dedicated themselves to the following principles:

1. South African Leadership

The SAG is at the center of decision-making, leadership, and management of the national HIV and TB response, including development partner programs.

2. Alignment

PEPFAR operations, including its civil society partners, should support national priorities, using national systems where possible.

3. Sustainability

Sustainability of the national response should be enhanced by mainstreaming the response to HIV and TB and through addressing the cost efficiency of operations, diversifying funding sources, investing in proven and scalable interventions, shifting appropriate USG-supported staff to SAG, and improving coordination across all partners.

4. Innovation and Responsiveness to the Epidemic

To improve the effectiveness of the national response, this partnership aims to promote knowledge-based interventions. The Partnership Framework encourages flexibility and innovation to achieve true value for money across the response.

5. Mutual Accountability

The relationship between the SAG and the USG is based on mutual accountability and transparency in resource allocation, expenditure tracking, the collection, use and sharing of strategic information, and programmatic decision-making.

6. Multi-Sectoral Engagement and Participation

The implementation of this Partnership Framework should be inclusive and participatory. It is intended to support SAG efforts to mainstream the national response across all government departments and strengthen engagement across different stakeholders (inclusive of community-based organizations, non-governmental organizations, the private sector, PLHIV, the academic sector, and other development partners).

7. Gender Sensitivity

Disproportional vulnerabilities to HIV infection and access to treatment and care are influenced by gender. The design and implementation of programs and policies aim to ensure full attention to this reality.

8. Expected Financial Contributions and Transparency

USG assistance to South Africa should support the government sector and be in line with defined national plans. Resource allocation decisions in the planning and implementation of this Partnership Framework, along with the underlining rationale, should be pro-actively shared by both governments.

The Partnership Framework recognizes that SAG and USG resources are limited and that achievement of national HIV and TB goals requires resource flows beyond the ability of any one partner. The proportion of USG contributions to total HIV and AIDS spending is likely to decline over time. In addition, planned USG investments are always subject to the availability of funds. Changes in budgetary requirements or availability of funds from either government or from other key partners could lead to a review and revision of priorities and activities.

9. Collaborative and Not Contractual

This Partnership Framework is a non-legally binding joint strategic planning document that outlines the goals and objectives to be achieved, and the expected roles and contributions of all participating Partnership Framework partners. The Partnership Framework is intended to facilitate communication and collaboration among partners, including ensuring that programs are more sustainable and integrated. The Partnership Framework does not alter existing USG or SAG rules, regulations, cooperative agreements or contracts, and does not constitute an obligation of funds.

2. Background and Context

South Africa represents 0.7% of the global population but carries 17% of the global burden of HIV & AIDS (approximately 5.7 million people living with HIV) and has the world's fourth highest incidence of TB (948/100,000 population/year). An estimated 31% of all TB-HIV cases in Africa occur within South Africa, and co-infection rates exceed 70%. HIV prevalence amongst adults (15-49 years) is estimated at 18%, with women and girls bearing 60% of the disease burden. Despite being a middle-income country, key maternal and child health outcomes and developmental milestones have declined over the last fifteen years due to the impact of HIV. South Africa is one of only twelve countries in which mortality rates for children younger than five-years have *increased* since 1990.

To respond to the TB and HIV epidemics, South Africa has reaffirmed its commitment to preventing and mitigating the impact by scaling up the national prevention and treatment response across all sectors. This is being led by the most senior members in government, and is bolstered by increasing financial resources. This leadership has included the strengthening of the South African National AIDS Council (SANAC) to coordinate and oversee the multi-sectoral national response, a structure that is replicated at provincial and district levels. Despite these efforts, the response still requires significant financial and technical inputs from stakeholders to match needs to resources.

PEPFAR in South Africa

The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) was launched in 2003 as an emergency response to the HIV epidemic with the goals of preventing new infections, treating those already infected and assisting those affected by the epidemic.

The USG PEPFAR team in South Africa is comprised of several government agencies, including the U.S. Centers for Disease Control and Prevention, the U.S. Agency for International Development, Peace Corps, State Department, and the U.S. Department of Defense.

PEPFAR leverages the multi-sectoral governmental response of the SAG by working with key departments at the national level and in all provinces. These include the Departments of Health, Social Development, Basic Education, Correctional Services, Defence, Public Service and Administration, and Treasury.

PEPFAR programs respond to SAG priorities primarily through grants and cooperative agreements with over 500 prime and sub-partners, including non-governmental organizations, private entities and universities, most of which are South African. Direct funding and technical assistance to the SAG, currently less than 10% of overall PEPFAR funding, includes funding provided to several SAG departments and parastatals.

The 2010 fiscal year^[3] budget is in excess of \$500 million (R3.5 billion). Over the period of the Partnership Framework, the U.S. expected contribution to the South African national response is likely to decrease, both in real terms and as a proportion of overall funding contributions from the SAG and other development partners. It is imperative, therefore, that additional resources are mobilized, that the contributions of other development partners are leveraged, and that current programs become more effective and efficient.

3. Five Year Strategic Focus

SAG provides strategic direction for the national HIV and TB response through the following strategic documents: **1)** the *Medium Term Strategic Framework*^[4]; **2)** the *Ministerial Negotiated Service Delivery Agreements*^[5]; **3)** the current and successive versions of the *National Strategic Plan for HIV & AIDS and STIs*^[6]; **4)** the *TB Strategic Plan*^[7]; **5)** the National HIV & AIDS and TB management policy; **6)** the Aid Effectiveness Framework for Health; **7)** the Department of Basic Education *HIV*

^[4] The Medium Term Strategic Framework (MTSF) is the guiding document on SAG priorities for the period 2009-2014

^[5] The Ministerial Negotiated Service Delivery Agreements (NSDAs) reflect the agreements between National Ministries and the Presidency on key deliverables. The NSDAs reflect the priorities of each department for implementing the MTSF.

& *AIDS Integrated Strategy (2011-2015)*; and **8**) the *Policy Framework for Orphans and Other Children made vulnerable by HIV & AIDS*.

Some of the long-term outcomes in these strategic documents include the following:

- Increasing life expectancy;
- Decreasing maternal and child mortality;
- Reducing HIV and TB incidence;
- Strengthening community systems to prevent the transmission, and mitigate the impact of HIV and TB in the home, the workplace, across the education system and in communities;
- Strengthening financial and accountability systems to improve planning, costing, and budgeting in order to optimize and leverage needed resources;
- Strengthening managerial capacity across the public sector, particularly in monitoring and evaluation, policy analysis, implementation and HIV mainstreaming;
- Increasing institutional capacities to deliver health system functions and initiating major structural reforms (particularly at the primary health care level); and
- Strengthening coordination of the national response across all sectors and levels (national, provincial and district).

The Partnership Framework aims to support the achievement of these outcomes. Critical to that effort is strengthening South African engagement and coordination with the PEPFAR program.

Goals and Objectives

The goals and objectives of the Partnership Framework cover the following areas:

PREVENT NEW HIV AND TB INFECTIONS: The prevention of new HIV and TB infections is the number one priority of the national response. Responsibility for the prevention agenda rests with all government departments, development partners, communities, civil society, and the private sector. The Partnership Framework is dedicated to this multi-faceted and multi-sector approach. The two countries intend to work together to *1) expand biomedical and behavioral prevention interventions that address the various drivers of the epidemics; 2) reduce vulnerability to HIV and TB infection, especially focusing on the needs of infants, girls and women; and 3) increase the number of persons who know their HIV and TB status and link them to appropriate services*. This goal seeks to create a social, political and operational environment supportive of the prevention agenda over the next five years. This effort is expected to be guided by stronger coordination mechanisms among all stakeholders, and a robust operational research and performance monitoring and evaluation plan to improve strategic decision-making for HIV prevention programming.

INCREASE LIFE EXPECTANCY AND IMPROVE THE QUALITY OF LIFE FOR PEOPLE LIVING WITH AND AFFECTED BY HIV AND TB: Under this goal, the Partnership seeks to address declining life expectancy by focusing on

reducing HIV and TB related morbidity and mortality and on mitigating the impact of the epidemics. The three-pronged approach includes *1) expanding integrated treatment, care, and support services; 2) decreasing infant, child and maternal mortality due to HIV & AIDS and TB; and 3) mitigating the impact of HIV & AIDS and TB on individuals, families and communities, especially orphans and vulnerable children.*

STRENGTHEN THE EFFECTIVENESS OF THE HIV AND TB RESPONSE

SYSTEM: This goal seeks to strengthen the leadership, planning, coordination, financing, and performance management capacity of state and non-state actors at national, provincial and district levels necessary to deliver the national response. Within this goal the two countries plan to work to *1) strengthen and improve access to institutions and services, especially primary institutions; 2) strengthen the use of quality epidemiological and program information to inform planning, policy and decision making; 3) improve planning and management of human resources to meet the changing needs of the epidemic; and 4) to improve health care and prevention financing.*

All three goals are interrelated and sufficiently broad in their respective scopes to ensure the long-term viability of the management and service delivery systems in the country while attempting to slow the spread of HIV and TB and support those South Africans already infected and affected. The PFIP should prioritize activities that support these goals and objectives.

Constraints and Challenges

South Africa faces explosive HIV and TB epidemics, a high burden of chronic illness, mental health disorders, injury and violence-related deaths, as well as the continued epidemic of maternal, neonatal, and child mortality. The country has the highest per capita health burden of any middle-income country in the world. The health care system is overstressed and experiencing a major crisis due to growing demands. To support the health and social needs of a country with the world's largest HIV burden and a worsening TB epidemic is anticipated to require additional investments in implementation effectiveness, financial management, infrastructure improvements, human capacity, and managerial competence across district, provincial and national levels.

POLICY IMPLEMENTATION CONSTRAINTS: The SAG has very progressive policies; however, implementing these policies has been a challenge. There is a shortage of adequate technical and management staff in most government departments at all levels. Similarly, there is a need to strengthen district-level systems to implement quality improvement strategies.

EFFECTIVE COORDINATION OF THE NATIONAL RESPONSE: The challenge of reducing HIV and TB incidence, mitigating its impact, and providing care and treatment requires that all government departments and sectors take greater responsibility for HIV and TB. This requires much more efficient engagement of all stakeholders by the SAG through strengthening the capacity of SANAC and the

Provincial and District AIDS Councils. This effort also requires stronger SAG leadership to coordinate all stakeholders (including development partners) engaged in the HIV and TB response.

THE NEED FOR SIGNIFICANT RESOURCE MOBILIZATION AND INCREASED EFFICIENCY: Although South Africa is an upper middle-income country, its health and social outcomes are those of a low-income country. There are insufficient resources devoted to providing HIV and TB prevention, treatment and care to all of those who need it. Although South Africa devotes 8.7% of its GDP to health, the allocation and management of these resources are fragmented, inequitably distributed between the public and private sectors, and, in some instances, inefficient.

The long-term budget requirements of the AIDS response in the country are significant – an estimated R35-R45 billion per annum (\$6.5 billion) by the year 2020^[8]. Currently, the collective spending on HIV & AIDS (public funding and development partner funding) in South Africa is only R17 billion (\$2.5 billion) in 2010, which represents an increase from R9 billion (\$1.2 billion) in 2008. Yet this falls short of the overall need. In order to ensure that South Africa is able to meet its own health and development outcomes, additional financial resources need to be mobilized both internally and from development partners. SAG must secure the necessary political leadership and support to devote increasingly significant portions of the government budget to overcome the HIV and TB epidemics for at least the next four decades. National efforts to improve the efficiency of public health expenditures should be coupled with much greater diversification, predictability, and coordination of donor support over the medium to long term.

USG CHALLENGES: PEPFAR's key focus is to address the HIV epidemic. This therefore limits the availability of PEPFAR funding to only HIV and related programs. Therefore, diseases such as TB, STIs, and others may only be addressed with PEPFAR funds through their relevance to the HIV epidemic.

PEPFAR has a comprehensive approach to HIV/AIDS programming that balances access to prevention, care and support, treatment, impact mitigation, and health systems strengthening. The percentage of funds devoted to each program should respect that balanced approach. This means that the entire PEPFAR budget for South Africa cannot be directed to a single program area, and has to be spread across all HIV & AIDS and related TB programs, including but not limited to improvement of community-based primary health care systems, strengthening quality of care, early initiation of ART, and enhanced procurement and management of commodities. However, at least 10% of the total PEPFAR program budget is currently earmarked for OVC programs and services, and 50% of total resources must be dedicated to treatment and care for PLHIV and preventing mother to child transmission of HIV.

MANAGING PEPFAR's TRANSITION: The alignment of the PEPFAR program to increased SAG leadership allows for a stronger partnership but also poses several significant challenges for both SAG and USG. For instance, the process of transitioning direct service delivery related responsibilities currently under PEPFAR (staffing, financing, monitoring and evaluation systems, and provision of services) to

SAG involves careful negotiation, planning and management through the PFIP. Similarly, increasing direct funding to the SAG may require strengthening the financial management and absorptive and fiduciary oversight capacity of the SAG.

In addition, the transition process should be done in a way that does not destabilize the SAG system. A comprehensive assessment of the direct services supported by PEPFAR is needed in order to jointly plan for a transition that avoids any potential disruption in services.

The PFIP aims to identify key, realistic benchmarks for the process, including which elements of the direct service delivery component of the USG's operations may be transferred (staffing, financing, M&E, provision of services), when, to whom, and how. Both SAG institutions and NGOs could be considered as potential recipients of financial and programmatic management responsibilities.

Sustainability

STRENGTHEN THE PREVENTION OF NEW HIV AND TB INFECTIONS:

Given the epidemiology of the epidemics in South Africa as well as the constraints on resources, South Africa cannot afford to focus its resources only on HIV and TB treatment. The sustainability of the SAG response is reliant on a reduction of new HIV and TB infections through adequately funding effective prevention interventions. South Africa, through the SAG and relevant structures (e.g. SANAC), intends to implement stronger coordination mechanisms to ensure that all stakeholders implement a single national prevention strategy.

FINANCIAL SUSTAINABILITY: To improve the financing of the HIV and TB response, the Partnership Framework aims to work to improve the cost efficiency of all HIV and TB interventions. Several SAG and USG initiatives are already underway to effectively cost their respective operations and identify areas where savings can be achieved. Chief among these are commodity procurement and human resource management.

The Partnership Framework is intended to support strengthening SAG capacity at national, provincial and district levels to budget, allocate, and manage financial resources efficiently so as to achieve desired results. The SAG also intends also continuously increase its financial contribution and diversify its funding base through greater engagement with the private sector and other development partners.

COMMUNITY SYSTEM STRENGTHENING: Community participation at the national, provincial and district levels of the HIV and TB response is critical. The Partnership Framework is expected to facilitate the strengthening of these community systems – social and professional networks, governance structures, and leadership – and work to build linkages between communities, civil society and the public sector to ensure a single comprehensive and coordinated national response.

4. Partners: Roles and Expected Contributions
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Goal 1. Prevent new HIV and TB infections
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SAG and USG plan to intensify prevention efforts using a comprehensive, multi-sectoral, integrated, and epidemiological focus. The Partnership Framework is intended to expand the coverage of an appropriate mix of biomedical, behavioral and structural interventions (combination prevention) and improve the coordination of all stakeholders in order to most effectively reduce the rate of new infections.

Objectives	Expected Contributions		
	SAG	USG	Other
1.1. Expand biomedical and behavioral prevention interventions that address the various drivers of the epidemics	<p>a) Increase the availability of and access to the full range of biomedical prevention interventions.</p> <p>b) Target interventions to address the health, social and structural drivers of the epidemics.</p> <p>c) Coordinate and align all stakeholders (government departments, private sector, civil society organizations, communities, development partners) around a single evidence-based national prevention strategy.</p> <p>d) Improve the quality, effectiveness and coverage of an optimal combination of prevention interventions.</p> <p>e) Identify and leverage HIV and TB research activities (of universities, parastatals,</p>	<p>a) Support SAG to improve the quality, effectiveness and coverage of an optimal combination of prevention interventions that address the biomedical, behavioral, and structural drivers of the epidemic.</p> <p>b) Strengthen SAG capacity in evidence-based decision making for effective prevention programming and resource allocation at all levels (national, provincial, district, and sub-district).</p> <p>c) Ensure that prevention interventions supported through USG funding are responsive to SAG priorities.</p> <p>d) Support SAG in the identification and execution of priority programmatic, behavioral and epidemiological HIV and TB prevention interventions.</p> <p>e) Support research activities that advance the SAG prevention agenda.</p>	<ul style="list-style-type: none"> · TB HIV integration (<i>Italy</i>) · Provision of Voluntary Medical Male Circumcision (<i>France, Germany [planned]</i>) · Provision of HCT (<i>Germany, Sweden</i>) · Behavior Change Communication and Social mobilization (<i>Germany, Global Fund R9</i>) · HIV prevention interventions (<i>Germany, Ireland, Netherlands</i>) · Capacity development and Technical assistance (<i>UN, Germany</i>) · Drug resistance surveillance and

	development partners and NGOs) to advance the SAG prevention agenda.		treatment monitoring of public sector ART program (UK)
1.2. Reduce vulnerability to HIV and TB infection especially focusing on the needs of infants, girls and women	<p>a) Increase HIV and TB prevention outreach at the community level.</p> <p>b) Strengthen interventions that address the vulnerability of infants, orphans and vulnerable children, girls and women to HIV and TB infection.</p> <p>c) Strengthen services and implement interventions targeted at youth (under the age of 26).</p> <p>d) Implement comprehensive HIV and TB programs across the social education system.</p> <p>e) Strengthen interventions that address unequal power relations and the role of sexual violence in HIV transmission.</p>	<p>a) Support SAG initiatives in community-led HIV and TB prevention interventions.</p> <p>b) Improve access to and availability of high quality evidence-based services to reduce the vulnerability of infants, orphans and vulnerable children, girls and women to HIV and TB infection.</p> <p>c) Improve the effectiveness of targeted prevention programs to reduce vulnerability to HIV and TB infection amongst the youth.</p> <p>d) Support SAG to leverage the education system to implement a comprehensive HIV and TB program.</p> <p>e) Strengthen SAG capacity to identify and implement interventions that address unequal power relations and the role of sexual violence in HIV transmission.</p>	<p>· Programs addressing youth at risk (<i>Canada, Germany</i>)</p> <p>· Programs addressing GBV and other high risk factors (<i>Denmark, Ireland, Italy, Sweden</i>)</p> <p>· Budgetary support to DoH for maternal and child health (<i>UK</i>)</p> <p>· Care and support to OVC and others (<i>Germany, Netherlands</i>)</p>
1.3. Increase the number of persons who know their HIV and TB status and link them to appropriate services	<p>a) Provide access to and increase uptake of quality HIV counseling and testing (HCT) services and TB screening and diagnosis through all</p>	<p>a) Support SAG to expand coverage of, demand for, and access to quality HCT services and TB screening and diagnosis.</p> <p>b) Provide technical</p>	<p>· Provision of HCT (<i>Germany, Sweden</i>)</p> <p>· Increase access to HIV & AIDS and sexual and reproductive</p>

	sectors of society. b) Reinforce linkages between and among prevention, treatment, care, reproductive health, and other relevant services and institutions with HCT and TB screening services. c) Implement evidence-based stigma reduction interventions.	assistance to reinforce linkages between and among prevention, treatment, care, reproductive health, and other relevant services and institutions with HCT and TB screening services. c) Provide technical assistance to improve the quality of counseling and referral services.	health information and services (<i>UK</i>) · Social mobilization in support of HCT and link to services (<i>Belgium, Germany, Global Fund Round 9</i>)
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Goal 2: Increase life expectancy and improve the quality of life for people living with and affected by HIV and TB

TB and HIV-related conditions are the leading cause of death in South Africa. Under Goal 2, SAG and USG plan to reduce HIV & AIDS and TB related morbidity and mortality by strengthening linkages between prevention, early diagnosis and related support, treatment, and care services. This goal should support SAG efforts to expand, integrate and decentralize treatment, care and support services and strengthen family-centered / community-based responses.

Objectives	Expected Contributions		
	SAG	USG	Other Partners
2.1. Expand integrated treatment, care and support services	a) Strengthen the expansion, integration and decentralization of HIV and TB services through the primary health care system. b) Improve the retention of TB and ART patients in care and support services. c) Strengthen family centered, community-based responses for protection, support and	a) Provide technical and financial resources to support the expansion, integration and decentralization of HIV and TB services. b) Support SAG efforts to strengthen surveillance and patient identification & tracking systems. c) Strengthen the quality and cost-efficiency of the	· TB-HIV integration (<i>Italy</i>) · Provision of TB/HIV/STI prevention, treatment care and support services (<i>Belgium, Netherlands</i>) · Direct funding or technical

	<p>care, including vulnerable children.</p> <p>d) Strengthen the implementation mechanism of the National Action Plan for OVC.</p>	<p>integrated services.</p> <p>d) Support the development and/or implementation of appropriate policies designed to enhance the delivery of the integrated services.</p>	<p>assistance to DoH for strengthening the delivery of PHC and HIV & AIDS services (<i>EU, UK, UN</i>)</p> <ul style="list-style-type: none"> · Provision of treatment literacy and HIV and TB education (<i>UK</i>) · Technical assistance to NDoH to support treatment expansion, integration & decentralization (<i>CHAI, UN</i>)
<p>2.2. Decrease infant, child and maternal mortality due to HIV & AIDS and TB</p>	<p>a) Improve early HIV and TB diagnosis and link identified patients into care, support and treatment programs.</p> <p>b) Support the expansion of PMTCT and sexual and reproductive health services.</p> <p>c) Expand the community component of the PMTCT and Integrated Management of Childhood Illnesses (IMCI) programs.</p> <p>d) Create HIV and TB competent communities.</p> <p>e) Strengthen community's ability to protect and provide access</p>	<p>a) Strengthen the implementation mechanisms designed to support and improve interventions for OVC.</p> <p>b) Support SAG's maternal and child health priorities to meet the Millennium Development Goal targets.</p> <p>c) Support SAG efforts to improve community health through stronger linkages between communities and health and social welfare services.</p>	<ul style="list-style-type: none"> · Addressing maternal and child health through NGOs (<i>Canada, EU</i>) · Direct budgetary support to DoH to strengthen maternal and child health programs (<i>EU, Global Fund Round 9 redirection, UK</i>) · TB-HIV integration (<i>Italy</i>) · Technical assistance to

	health and social welfare services for their most vulnerable mothers and children.		DoH to support treatment expansion, integration & decentralization (<i>CHAI, UN</i>)
2.3. Mitigate the impact of HIV & AIDS and TB on individuals and communities	<p>a) Strengthen community mobilization and support community-based services.</p> <p>b) Enhance coordination of OVC interventions to strengthen the national social safety net for children infected and affected by the epidemics.</p> <p>c) Strengthen the provision of psychosocial support.</p>	<p>a) Strengthen the capacity of SAG and civil society to deliver OVC services.</p> <p>b) Enhance the coordination of the national and provincial OVC programs.</p> <p>c) Provide technical assistance to strengthen SAG's social welfare system.</p> <p>d) Strengthen local civil society organizations to facilitate and support community-based mitigation efforts.</p> <p>e) Build monitoring and evaluation capacity to respond to the strategic priorities of the NSP and of the NAPOVC.</p>	<ul style="list-style-type: none"> · Programs addressing gender-based violence (<i>Denmark, Ireland, Italy, Sweden</i>) · Programs addressing HIV and alcohol (<i>Germany, Italy</i>) · Improving access to healthcare and psychosocial support for HIV positive children, other OVCs and their families (<i>Belgium</i>) · Holistic support to orphaned and vulnerable children and their care givers (<i>EU, Germany, Ireland, Netherlands, UK</i>) · Support programs for youth at risk (<i>Canada, UK</i>)

			· Poverty alleviation, food security and sustainable economic growth (Belgium, Canada, Italy)
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Goal 3: Strengthen the effectiveness of the HIV and TB response system

The achievement of Goals 1 and 2 is dependent on the efficient operation of the system that underpins the national HIV and TB response. To strengthen this system, Goal 3 aims to improve the implementation, coordination, and management of prevention, support, treatment, care, and impact mitigation interventions. Efforts are expected concentrate on the coordination of all partners engaged in the response – government departments, the private sector, communities, civil society organizations, and development partners – across the national, provincial, district, and local levels.

Objectives	Expected Contributions		
	SAG	USG	Other
3.1. Strengthen and improve access to institutions and services, especially primary institutions	<p>a) Strengthen the integration of HIV and TB response infrastructure.</p> <p>b) Strengthen the operational management of the HIV and TB response across all levels.</p> <p>c) Strengthen the primary health care (PHC) model of delivery to ensure equitable access to quality services.</p> <p>d) Strengthen management structures at the provincial, district and sub-district levels.</p> <p>e) Strengthen community participation in the</p>	<p>a) Strengthen the integration of the response system through support to SAG’s management structures at the district and sub-district levels.</p> <p>b) Support SAG efforts to enhance operational management of health facilities across government departments and sectors.</p> <p>c) Support SAG’s pilot initiatives to test innovative ideas and concepts with the potential for replication and scale-up.</p> <p>d) Continue to support community and civil society participation in the planning and</p>	<p>· Early detection and linking to services (Belgium, CHAI)</p> <p>· Technical and direct budgetary support to DoH for strengthening and expanding the delivery of PHC and HIV/AIDS/STI/TB services (CHAI, EU, Italy, UK)</p> <p>· Addressing human rights, increasing access to justice and civil society advocacy (Netherlands, UK)</p> <p>· Direct support to Department of Social Development</p>

	<p>planning, monitoring and delivery of comprehensive health and social welfare services.</p> <p>f) Strengthen supply chain management and procurement systems for commodities related to the HIV and TB response.</p>	<p>provision of comprehensive health and social welfare services.</p> <p>e) Provide technical assistance to strengthen SAG's procurement and supply chain management systems.</p>	<p>(Germany)</p> <ul style="list-style-type: none"> · Strengthen coordination of the response at national and provincial levels (Germany, Sweden, UK, UN) · GIS mapping of facilities and services (Netherlands) · Supporting the establishment of the Parliamentary Oversight Committee on HIV & AIDS (UK) · Direct budgetary support to DoH for strengthening the delivery of PHC and HIV & AIDS services at the district level (EU, Italy, UK)
<p>3.2. Strengthen the use of quality epidemiological and program information to inform planning, policy, and decision making</p>	<p>a) Integrate data management, reporting and indicator systems across all levels of the public and private sectors.</p> <p>b) Strengthen strategic information management to improve health outcomes.</p> <p>c) Strengthen national capacity to implement robust M&E and to conduct operational</p>	<p>a) Support SAG's efforts to integrate data management, reporting and indicator systems at all levels for the HIV and TB response.</p> <p>b) Align PEPFAR reporting with SAG indicators and reporting systems.</p> <p>c) Provide technical assistance to SAG to improve strategic information management and use, including addressing</p>	<ul style="list-style-type: none"> · Technical assistance and funding to strengthen M&E and the strategic use of information within NDOH and the SANAC Secretariat (CHAI, Global Fund Round 9, Sweden, UK, UN) · Technical assistance to support the DoH, key health institutions (e.g.

	and epidemiological research.	<p>the quality of data, its collection, analysis and dissemination for decision-making.</p> <p>d) Strengthen SAG's capacity to conduct operational and epidemiological research and basic program evaluations.</p> <p>e) Support and strengthen the management of M&E and Quality Improvement (QI) across the HIV and TB response.</p>	<p>NHLS), and SANAC (CHAI, Sweden)</p> <ul style="list-style-type: none"> · Direct support for coordination at the provincial level and national levels (<i>Germany, Sweden</i>) · Capacity building in support of DoH services (<i>Belgium</i>) · Capacity development to strengthen partner within HIV prevention (<i>Germany</i>) · Financial and technical assistance to the SANAC Secretariat (<i>Sweden</i>)
3.3. Improve planning and management of human resources to meet the changing needs of the epidemics	<p>a) Plan for and develop a workforce that is able to meet the health and social welfare needs of the country.</p> <p>b) Strengthen the capacity to plan for, recruit, train, retain and manage human resources to meet the needs of the HIV and TB response.</p> <p>c) Increase the number of health and social workers formally engaged in the national HIV and</p>	<p>a) Assist SAG in developing a workforce to meet its health and social welfare priorities through policy reforms, in-service training, and pre-service education.</p> <p>b) Provide technical assistance to strengthen SAG's capacity for planning, recruitment, retention and management of human resources for health and social welfare.</p>	<ul style="list-style-type: none"> · Direct budgetary support to NDoH to strengthen the response to HIV and health (<i>EU, UK</i>) · Support to DoH in all provinces to contract Community Health Workers (CHWs) (<i>EU</i>) · Strengthen coordination of the response at national and provincial levels (<i>Germany,</i>

	<p>TB response.</p> <p>d) Strengthen the operational capacity of the national office for standards compliance.</p>		<p><i>Sweden, UK, UN)</i></p> <ul style="list-style-type: none"> · Support of NDoH M&E and SANAC M&E unit (<i>Sweden, UK)</i>
3.4. Improve health care and prevention financing	<p>a) Strengthen the mobilization of domestic resources to fund the HIV and TB response.</p> <p>b) Improve the coordination and management of the financial commitments from the private sector, civil society, and development partners</p> <p>c) Identify and implement cost-effective and high-impact models of service delivery across the response for both health and social welfare.</p> <p>d) Improve the efficiency of public health expenditures across all SAG departments and levels.</p> <p>e) Improve the management and coordination of current investments across all SAG departments and levels to improve the efficiency and effectiveness of the response.</p>	<p>a) Support SAG's efforts to coordinate the mobilization of necessary resources to fund the unmet needs of the HIV and TB response.</p> <p>b) Strengthen SAG capacity to identify and promote cost-effective and high-impact models of service delivery.</p> <p>c) Strengthen South Africa's capacity to use costing and health and social welfare expenditure analyses to improve resource planning, budgeting, allocation and review.</p> <p>d) Strengthen SAG's commodity procurement, supply-chain and inventory management to improve the cost effectiveness of service delivery systems.</p>	<ul style="list-style-type: none"> · Technical assistance around financing, funding, commodity procurement and drug pricing (<i>CHAI)</i> · Strengthen the management and capacity of municipalities (<i>Netherlands)</i> · Strengthen the management and capacity of NGOs (<i>Belgium, Netherlands)</i> · Strengthen civil society advocacy (<i>UK)</i> · Strengthening coordination of the response at national and provincial levels (<i>Germany, Sweden, UK, UN)</i> · Strengthen situation analyses, country data collation and international reporting (<i>CHAI, UN)</i>

5. Plans for Developing the Partnership Framework Implementation Plan (PFIP)

The PFIP offers the SAG and the USG the opportunity to operationalize the high-level goals and objectives expressed in this Partnership Framework document. The critical information relevant to the development of a baseline country profile and the national HIV & AIDS and TB response as well as relevant policy and financial assessments already exist. The development of the PFIP should aim therefore to focus chiefly on prioritizing among these goals and objectives, developing strategies for the identified priorities and challenges, quantifying the expected inputs and outcomes, articulating plans to jointly monitor progress on mutually decided upon targets, and communicating progress and challenges. The process should also ensure that the PFIP takes into consideration the priorities, programs, and contributions of other development partners active in the HIV & AIDS and TB sectors.

The success of the Partnership Framework is dependent on the development of an implementation plan that is collectively and collaboratively executed by the SAG and the USG. The PFIP development process should be inclusive and highly consultative, guided by the same principles articulated in this document.

The joint SAG-USG Design Team^[9] intends to develop the PFIP with significant contributions from relevant technical working groups and stakeholders.

The proposed timeline for the development of the PFIP is as follows:

- November/December 2010: Design Team start planning for PFIP development;
- December 2010: SAG and USG sign the Partnership Framework;
- January/February 2011: Design Team collects and assesses inputs to Implementation Plan and develops a detailed, milestone-based timeline;
- March/April/May 2011: Design Team drafts and circulates PFIP for comments;
- June/July 2011: Design Team submits draft PFIP to PF Steering and Management Committees and the U.S. Office of the Global AIDS Coordinator for review and feedback;
- August/September 2011: Design team finalizes and submits final Partnership Framework Implementation Plan to PF Steering and Management Committees, the SA National Department of Health, and the U.S. Office the Global AIDS Coordinator for approval.

The PFIP should include an annual joint progress review. It is understood that every aspect of the PFIP may be renegotiated or updated periodically in writing during the life of the Partnership Framework to reflect changing conditions or priorities. However, these negotiated changes are not intended to alter the foundation of the Partnership Framework itself.

6. Management, Coordination, and Communication

The joint management structure for the Partnership Framework is planned to consist of a high level *Steering Committee* assuming responsibility for the governance and strategic direction of the Partnership Framework and a *Management Committee* responsible for the management and coordination of the Partnership.

The **Steering Committee** should have high-level representation from both governments, each naming its representatives prior to the development of the PFIP. The U.S. Ambassador is expected to name the USG representatives. The Director General for Health on behalf of the SAG departments is responsible for ensuring the participation of the appropriate senior level representatives serving on the Steering Committee.

The Steering Committee is envisioned to assume ultimate responsibility for strategic decisions, performance oversight, and conflict resolution relating to the Partnership Framework and PFIP. Should the Partnership Framework require modification, this should be mutually decided upon in writing by the Steering Committee.

The **Management Committee** is envisioned to assume the overall management and coordination responsibilities of the Partnership Framework and liaise between the Steering Committee and the broader community of stakeholders of the national HIV and TB response. It should guide the implementation of the Partnership Framework as recommended by the Steering Committee and in accordance with technical inputs of relevant stakeholder groups. The Management Committee's role includes implementing the strategic direction of the Partnership Framework, developing and monitoring the Partnership Framework Implementation Plan, and ensuring communication among all relevant stakeholders.

The Management Committee is expected to leverage existing stakeholder groups, technical working groups, and relevant SAG provincial and district level structures to implement its responsibilities. The membership and operational structure of the Management Committee, the frequency of its reporting, and other relevant operational issues should be detailed in the Partnership Framework Implementation Plan and is understood to be subject to Steering Committee approval.

7. Signatures

8. Guide to Acronyms

While this document attempts to steer clear as far as is possible from employing technical terminology, this guide to acronyms provides a quick reference for some of the terminology used.

- AIDS Acquired-Immune Deficiency Syndrome
- ART Antiretroviral Therapy
- ARVs Antiretrovirals
- CDC United States Centers for Disease Control and Prevention
- CHAI Clinton Health Access Initiative

- EU European Union
- HCT HIV Counseling and Testing
- HIV Human Immunodeficiency Virus
- M&E Monitoring and Evaluation
- MTSF Medium Term Strategic Framework (2009-2014)
- NIMART Nurse Initiated and Managed ART
- NSDAs Negotiated Service Delivery Agreements
- NSP National Strategic Plan for HIV & AIDS and STIs, 2007-2011
- OVCs Orphans and Vulnerable Children
- PACs Provincial AIDS Councils
- PEPFAR U.S. President’s Emergency Plan for AIDS Relief
- PF Partnership Framework
- PFIP Partnership Framework Implementation Plan
- PHC Primary Health Care
- PLHIV People living with HIV
- PM&E Performance Monitoring and Evaluation
- PMTCT Prevention of Mother to Child Transmission
- SAG South African Government
- SANAC South African National AIDS Council
- STI Sexually Transmitted Infection
- TB Tuberculosis
- UN United Nations
- USAID United States Agency for International Development
- USG United States Government
- VMMC Voluntary Medical Male Circumcision

[1] The United States President’s Emergency Plan for AIDS Relief, or PEPFAR, was launched in 2003. The PEPFAR program in South Africa is elaborated on in greater detail in Section 2.

[2] The official SAG documents referenced in this Partnership Framework include the Medium Term Strategic Framework; the Ministerial Negotiated Service Delivery Agreements; the current and successive versions of the National Strategic Plan for HIV & AIDS and STIs; the TB Strategic Plan; the National HIV & AIDS and TB management policy; the Aid Effectiveness Framework for Health; the Department of Basic Education HIV & AIDS Integrated Strategy (2011-2015); and the Policy Framework for Orphans and Other Children made vulnerable by HIV & AIDS.

[3] The USG Fiscal Year runs from 1st October to 30th September each year.

[6] The current HIV & AIDS and STIs NSP covers the period 2007-2011. A new HIV & AIDS NSP is planned to be developed in 2011 for the period 2012 – 2016. If needed, the Partnership Framework and/or Partnership Framework Implementation Plan should be revised to reflect any shifting priorities.

[7] The TB NSP covers the same period as the HIV & AIDS NSP. Similarly, changes or shifts in priorities should be addressed accordingly.

[8] Robert Hecht: “The long-term costs and financing of AIDS in Southern Africa: Making the right choices” (slide 19). Presentation delivered at the **SADC Technical Meeting on sustaining HIV & AIDS responses in the context of shrinking resources in the SADC region**. 24th August 2010.

[9] The Partnership Framework was developed under the guidance of the joint SAG-USG Design Team.

Source: PEPFAR (2012) “Partnership Framework in Support of South Africa's National HIV & AIDS and TB Response 2012/13 - 2016/17 between the Government of the Republic of South Africa and the Government of the United States of America (December 2010)” <http://www.pepfar.gov/frameworks/southafrica/161215.htm> [19 March 2012].

