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The Politics of PEPFAR

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Abstract

How does the U.S. allocate funds under PEPFAR, and why is PEPAR more successful in some countries than others? President Bush established the U.S. President's Plan for Emergency Relief in 2003 to fight the growing HIV/AIDS epidemic. Since then, it has been incremental in decreasing the spread of the virus and in providing assistance to those already infected. However, the multi-million dollar operation also raises several serious questions. For example, how does the U.S. government decide to allocate funds? With HIV rates of 25.9% among adults, Swaziland has the highest rates of HIV in the world - but in 2011 Mozambique received nearly twice as much PEPFAR funding. Research shows that there are multiple factors in how the U.S. allocates money, such as the willingness of country governments to work with the fund. Another question concerns the "hidden costs" of PEPFAR. For example, has PEPFAR drawn African doctors away from the major health problem of malaria? If so, how many lives has this cost? Research argues that malaria brain drain is a problem, but the exact number of lives cost as a result is arguable. A last question is how PEPFAR benefits the U.S. government and public.

All of these questions, although critical of PEPFAR, can help to strengthen an extremely important program. All of these questions are examined under the broader research question of "Why is PEPFAR more successful in some countries than in others?" and examined through three case studies - Mozambique, Swaziland, and South Africa. These three countries, although in geographical proximity, have different Freedom House rankings (respectively, partly free, not free, and free) and different regime types. They provide three very different examples of how PEPFAR can work. PEPFAR saves lives, and a critical look can help it continue to do so more efficiently.

Introduction

These research questions are important because of the human cost of HIV/AIDS, especially in southern Africa. One third of people with HIV worldwide are between 15 and 24 years old, and 2.6 million young people acquire HIV every year. At least 5 die of the disease per minute, totaling over 7,000 every day. Further, roughly 1.7 million new adolescent HIV infections, over half the world's total, are in Sub-Saharan Africa. About 70% of people with HIV/AIDS are in Sub-Saharan Africa. Additionally, over 80% of AIDS deaths are in Sub-Saharan Africa. Experts estimate that half a million Africans between 15 and 24 will die from AIDS by 2005.[1] In African countries where the epidemic is worst half of the infected people acquire HIV before they turn 25 and die before they turn 35. In 1997 in Zimbabwe half of 15 year old males could expect to die before 50 as compared to 15% in 1983; in the same time period 15 year old females' risk of death before 40 went from 11 to over 40%.[2] Infection of an STD (especially one that causes genital ulcers like herpes or syphilis) makes someone more likely to acquire HIV - sexually active youth in S-S Africa are more likely to acquire an STD.[3] 10-20% of sexually active individuals in S-S Africa is infected with gonorrhea.[4]

Unfortunately, the variety of factors that help to perpetuate HIV/AIDS in the region make it more difficult to combat the virus. For example, it is difficult for unmarried youth to get access to the necessary sexual health services. Cultural, social, and economic norms and pressures often

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1 Pathfinder International, Africa Regional Office. Adolescent Reproductive Health in Africa: Paths into the Next Century. Nairobi, Kenya: The Office, 1999.

2 UNAIDS. Report on the Global HIV/AIDS Epidemic. Geneva: UNAIDS, 2000.

3 Force for Change: World AIDS Campaign with Young People: 1998 World AIDS Campaign Briefing Paper. Geneva: UNAIDS, 1998.

4 Pathfinder International, Africa Regional Office. Adolescent Reproductive Health in Africa: Paths into the Next Century. Nairobi, Kenya: The Office, 1999.

put young women in Sub-Saharan Africa at excess risk for infection. Inadequate sexual health information and limited access to health care are obstacles to lowering adolescent HIV/STD infection rates, and sexual health attitudes and behaviors greatly affect adolescents' risk of infection. Cultural, social, and economic factors also field the HIV epidemic. Many African leaders used to deny HIV/AIDS but now actively fight the pandemic with public addresses and task forces. Business collations and NGOs also lead peer education, advocacy, youth-friendly service delivery, and social marketing. There are NGOs that encourage youth to get involved in finding ways to stop the spread of HIV. Inadequate sexual health information and limited access to health care are both obstacles to lowering adolescent HIV infection rates.[5]

It is important to note that young women are disproportionately affected by HIV/AIDS because PEPFAR funding should, ideally, take this into account. Half of the HIV infections in the world are in women in Africa.[6] One fifth of women between 20 and 25 are infected, and most will not live to 30 as a result. In one city six out of ten women between 20 and 25 were infected; among youth in their early 20s women's rates were three times higher than men's.[7] In Malawi HIV incidence in teenage women is 6% compared to less than 1% in women over 35.[8]

Research Design

Research will be done by utilizing three case studies (Mozambique, South Africa, and Swaziland) to do qualitative research. Reports from governments and international organizations

5 Akukwe C. HIV/AIDS in African children: a major calamity that deserves urgent global action. J HIV/AIDS Prev Educ for Adolesc & Children 1999; 3(3):5-24.

6 Ibid.

7 UNAIDS. Report on the Global HIV/AIDS Epidemic. Geneva: UNAIDS, 2000).

8 UNAIDS. Listen, Learn, Live! World AIDS Campaign with Children and Young People: Facts and Figures. Geneva: UNAIDS, 1999.

are the primary resources. These three case studies have been chosen because of their difference in regime types, relations with the U.S., and economic development. By critically examining three very different countries, I hope to uncover how PEPFAR approaches diversity among recipient countries. Going back to the research questions of how the US decides who gets what under PEPFAR and why PEPAR is more successful in some countries than others, this diversity can help to make each case study an example of similar recipient countries.

The three case studies have different HIV rates. In 2009, Swaziland had the highest rates in the world at 25.9% among adults. South Africa came in at number four with 17.8% while Mozambique was number eight at 11.5%.[9] They also have different Freedom House rankings: Swaziland is not free, Mozambique is partly free, and South Africa is free. Populations differ as well: Swaziland is home to 1.2 million people; Mozambique 24 million; and South Africa 51 million.

My thesis is that PEPFAR's primary purpose is to act as a diplomatic tool for the U.S. and not to be an aid agency. The hypothesis is that high levels of economic development and good diplomatic and economic relations with the U.S. are more likely to increase a recipient country's PEPFAR funding than HIV/AIDS rates or number of individuals living with HIV/AIDS. I choose to test this qualitatively in the first section of the paper because of the complexity and subjectivity of economic development and bilateral relations.

Specifically, a look at the Partnership Frameworks in Mozambique, Swaziland, and South Africa are set up provides insight into the decision-making in PEPFAR. The Partnership Frameworks are especially good for comparative reasons because they exemplify the relationship between the governments of each recipient country with the U.S. government. This is

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[9] UNAIDS. Report on the Global HIV/AIDS Epidemic. Geneva: UNAIDS, 2000.

particularly helpful for examining why the U.S. government responds differently to different regime types, levels of economic development, and HIV/AIDS situations.

The Partnership Frameworks were authorized in 2008 by the Tom Lantos and Henry J. Hyde United States Global Leadership against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act. The law authorized up to $48 billion between 2009 and 2013 to fight HIV/AIDs, tuberculosis, and malaria. As a side note, individuals with HIV are about 20-37% more likely to become infected with tuberculosis. Partnership Frameworks provide 5-year joint strategic frameworks for cooperation between the U.S. government, recipient country governments, and other partners through "service delivery, policy reform and coordinated financial commitments." The ultimate goal is to create a more sustainable approach to fighting HIV/AIDS with stronger country capacity, ownership, and leadership.

Another way to measure relations with the U.S. is to examine the website of the U.S. Trade Representative. In addition, measuring whether each country is eligible for or participating in the African Growth and Organization Act is useful. AGOA was signed into law by President Clinton in 2000 and promotes two-way trade between the U.S. and Sub-Saharan Africa as well as the integration of Sub-Saharan countries into the global economy. AGOA also allows many African goods from participating countries to enter the U.S. duty-free. To be eligible, countries must have or be working towards market-based economies, market-based economies; the rule of law and political pluralism; elimination of barriers to U.S. trade and investment; protection of intellectual property; efforts to combat corruption; policies to reduce poverty, increasing availability of health care and educational opportunities; protection of human rights and worker rights; and elimination of certain child labor practices.[10]

[10] "General Country Eligibility Provisions," African Growth and Opportunity Act.

After this first analysis is complete, I will look at the hidden costs of PEPFAR. The results section is therefore divided into two parts, and each of these parts has three subdivisions for the different case studies. Each section will be used to examine the different variables in the hypotheses.

Results – Economic Development and Bilateral Relations

Mozambique – Development & Relations

During fiscal year 2011, Mozambique received a total of $268.8 million through PEPFAR to support comprehensive HIV/AIDS prevention, treatment and care programs for that year. In the same year, significant progress was attributed to this funding. This included:197,000 individuals receiving antiretroviral treatment; 710,000 HIV-positive individuals who received care and support (including TB/HIV); 141,400 orphans and vulnerable children (OVCs) receiving support; 565,900 pregnant women with known HIV status receiving service; 43,500 HIV-positive pregnant women receiving antiretroviral prophylaxis for PMTCT; 1,809,800 individuals receiving counseling and testing; and 12,653 estimated infant HIV infections averted.[11]

Mozambique's regime type is a republic. It has a constitution and a mixed legal system of Portuguese civil law, Islamic law, and customary law. The president (chief of state), prime minister (head of government), and cabinet comprise the executive branch. The president is elected by popular vote for a five year term and the prime minister is then appointed by the president. The legislative branch is comprised of a Supreme Court and others such as the Administrative Court, the Constitutional Court, customs court, maritime court, courts marshal, and labor courts. Some judges of the Supreme Court are appointed by the president while others

[11] "Partnership to Fight HIV/AIDS in Mozambique," The United States President's Plan for AIDS Relief.

are elected by the assembly. The legislative branch is comprised of the Assembly (250 seats and members directly elected by popular vote for 5-year terms). There are three major political parties, two of which have battled for power since the end of the 16-year civil war.[12]

Mozambique has budding diplomatic relations with the U.S. and established economic relations. According to the U.S. Trade Representative, Mozambique is currently the U.S.'s 121st trading partner with $488 million in two-way goods traded during 2011. In 2011 the U.S. exported $453 million, which was a 101.9% increase from $229 million in 2010. The top exports were vehicles, mineral fuel, cereals, machinery, and aircraft. In the same year, the U.S. imported $35 million worth of goods from Mozambique. This was a 46% decrease from $30 million in 2010. The largest imports in 2011 were titanium ores, edible fruits and cashew nuts, iron and steel products, and precious stones. The U.S. goods trade surplus with Mozambique was $418 million in 2011, which was a 161.8% increase from $258 million in 2010. U.S. foreign direct investment in Mozambique (in stocks) was $4 million in 2009.[13]

Economically, Mozambican relations with the U.S. fall above those of Swaziland but below those of South Africa. It is also relatively less corrupt than Swaziland and more developed. However, corruption is still an issue and hinders U.S. relations. Freedom House points out that elections in particular are "repeatedly riddled with problems" and that power is highly centralized ("Political Rights and Civil Liberties," Mozambique, Freedom House). Mozambique is also eligible for AGOA.

Swaziland – Development & Relations

Through PEPFAR, Swaziland received $130.8 million to support comprehensive

[12] "Government," Mozambique, CIA World Factbook.

[13] "Mozambique," Office of the United States Trade Representative, Executive Office of the President.

HIV/AIDS prevention, treatment and care programs from fiscal year 2009 to fiscal year 2011. As a result, in fiscal year 2011 the following progress was observed in Swaziland: 50,600 individuals received antiretroviral treatment; 328,100 HIV-positive individuals received care and support (including TB/HIV); 25,800 pregnant women with known HIV status received services; 9,100 HIV-positive pregnant women received antiretroviral prophylaxis for PMTCT; 50,900 individuals received counseling and testing; 2,810 estimated infant HIV infections were averted; and 90,300 orphans and vulnerable children (OVCs) received support.[14]

Swaziland is located between Mozambique and South Africa but is almost entirely surrounded by South Africa. It is a relatively small country about the size of New Jersey. According to the government of Swaziland and to Freedom House, the government is a monarchy whose current Head of State is His Majesty King Mswati III has ruled since April 25th, 1986. The political and legal systems are dual because both incorporate traditional institutions and western methods of governance and Roman Dutch common Law. The government also points out that the current Constitution, which came into law on July 26th, 2005, is the supreme law of the land.[15]

In 2011, Swaziland's GDP was $6.313 billion and per capita GDP was $5,400. About 69% of the population lives in poverty. The population of Swaziland is 97% African and 3% European. It is also divided religiously: 40% is Zionist; 20% Roman Catholic; 10% Muslim; 30% other. In July of 2012 the population of Swaziland was 1,386,914 people. 37.4% were between the ages of 1 and 14; 59% were between 15 and 69; and just 3.7% is over 65.[16] All of

[14] "Partnership to Fight HIV/AIDS in Swaziland," The United States President's Plan for AIDS Relief.

[15] "Government," Swaziland, CIA World Factbook.

[16] "People," Swaziland, CIA World Factbook.

these statistics and facts show that Swaziland is a severely underdeveloped country, similar to many recipient countries of PEPFAR.

The political climate of Swaziland is also tumultuous. During the 1990s political unrest pressured King Mswati III to allow political reform and increased democracy. Unfortunately, much of this has been reversed recently. In 2005 the King signed another Constitution, but the legal status of major political parties is still contested. In 2006 the African United Democratic Party unsuccessfully attempted to register as an official party. Then, in 1996 Pudemo announced a campaign of civil disobedience because of the government's failure to respond to previous demands for a multi-party system. Talks over the constitution broke down between the government and progressive groups in 2007.[17]

Swaziland's relations with the U.S. are still developing. According to the Office of the U.S. Trade Representative, it is the U.S.'s 168th largest trading partner. It is also eligible for the African Growth and Opportunity Act (AGOA), which shows movement towards improved relations with the U.S. According to Freedom House, however, corruption is rampant and was a large contributor to the 2011 financial crisis. In October of 2011 the minister of finance reported that the country loses $10.6 million to corruption every month.[18] This is a major roadblock in U.S. relations.

South Africa – Development & Relations

PEPFAR is extremely active in South Africa. During fiscal year 2010, the following was achieved: 917,700 individuals received antiretroviral treatment; 2,160,300 HIV-positive individuals received care and support (including TB/HIV); 386,400 orphans and vulnerable

[17] "Introduction," Swaziland, CIA World Factbook.

[18] "Political Rights and Civil Liberties," Swaziland, Freedom House.

children received support; 682,400 pregnant women with known HIV status received services to prevent mother-to-child transmission of HIV (PMTCT); 207,100 HIV-positive pregnant women received antiretroviral prophylaxis for PMTCT; 39,349 estimated infant HIV infections averted; and 5,034,200 individuals received counseling and testing.[19]

South Africa is the most developed of the three cases and has the best economic and diplomatic relations with the U.S. It is a republic with a mixed legal system of Roman-Dutch civil law, English common law, and customary law. The executive branch is composed of the chief of state (President Zuma), the head of government (also President Zuma), and the cabinet The judicial branch contains the Constitutional Court, Supreme Court of Appeals, High Courts and Magistrate Courts. Lastly, the legislative branch contains a bicameral Parliament consisting of the National Council of Provinces and the National Assembly.[20]

The economy boasts an emerging market and middle income population. It is abundant in natural resources and the financial, legal, communications, energy and transportation sectors are all well-developed. The stock exchange is the 18th largest in the world. The infrastructure is modern and supports the transportation of goods to different urban areas. Unemployment, at nearly a quarter of the workforce, is a major problem. The apartheid era still has a lasting economic impact in the forms of poverty, lack of economic empowerment among disadvantaged groups, and a shortage of public transportation. In 2012 GDP was estimated at $578.6 billion. In the same year, estimated per capita GDP was $11,300.[21]

South African relations with the U.S. are the strongest of the three case studies.

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19 "Partnership to Fight HIV/AIDS in South Africa," The United States President's Plan for AIDS Relief.

20 “Government,” South Africa, CIA World Factbook.

21 “Economy,” South Africa, CIA World Factbook.

According to the Office of the U.S. Trade Representative, it is the U.S.'s 36th largest trading partner with a total of $16.8 billion of goods traded in 2011. In 2012 the two countries signed a Trade and Investment Agreement Framework Agreement.[22]

Results – HIV/AIDS

Mozambique – HIV/AIDS

According to UNAID, Mozambique has an HIV prevalence of 11.4%. There are 1.4 million people living with HIV, 130 thousand new infections each year, and 74 thousand AIDS-related deaths annually. Women do not have control of natural resources and property rights. They are also responsible for most of the reproductive work and some of the productive work while men are only responsible for the productive work. Also, in the past two years women have had to do more of the productive work because men have moved to South Africa in search of jobs as successive droughts hit Mozambique. Some of these jobs include alcoholic drink brewing in Mapai-Ngale and work related to fisheries in Magondzwene. However, men's migration leads to increased decision-making for women. Mozambique's vulnerability to climate extremes is exacerbated by extreme poverty.[23]

Mozambique is one of the few countries in southern Africa not to see a decrease in the epidemic yet, and about 1.6 million people are infected while 510,500 orphaned and vulnerable children directly are affected by the epidemic. The purpose of the Partnership Framework in Mozambique is to create a 5-year strategic plan between the U.S. government and the Mozambican government to fight the epidemic. The plan should outline joint priorities and key policy issues. Specifically, the framework focuses on "evidence-based prevention, quality

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[22] "South Africa," Office of the U.S. Trade Representative.

[23] "The HIV/AIDS Pandemic among Youth in Sub-Saharan Africa," Advocates for Youth. 2008.

treatment and care programs and sustainability by building local capacity, supporting country ownership and leadership, and strengthening health systems to deliver and monitor health services for all people living with HIV.[24]" These are all initiatives that are tailored specifically to Mozambique.

Domestically, the Mozambican National AIDS Council (NAC) is under the leadership of the Prime Minister and promotes the "Three Ones" principle.[25] This means that there is one national AIDS framework, one national AIDS authority and one system for monitoring and evaluation.[26] "High level government commitment and ownership" is the first listed principle of the Partnership Framework, and coordination with the NAC, transparency and accountability, engagement and participation, and flexibility are also highly valued.[27]

PEPFAR initiatives are designed to work alongside domestic policies. Mozambique's Partnership Framework states: "with support of the USG, the GRM endeavors to address the following policy and implementation issues to strengthen the multisectoral HIV response in Mozambique over the next 5 years: implement National AIDS Council alignment process to emphasize their coordination role, develop innovative approaches to generate revenue for public health financing outside of donor sources, and establish standard forms and databases for monitoring programs and support the use of national standard tools by all."[28]

PEPFAR also takes into account country-specific problems when allocating funds. For

[24] The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) HIV/AIDS Partnership Framework with the Government of the Republic of Mozambique, August 2010, 4.

[25] Ibid.

[26] "The 'Three Ones' in action: where we are and where we go from here," UNAIDS.

[27] The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) HIV/AIDS Partnership Framework with the Government of the Republic of Mozambique, August 2010, 5.

example, Mozambique is sorely lacking in medical personnel, with three doctors and 21 nurses for every 100,000 people, and about 50% of the public health sector infrastructure was destroyed during the civil war and has not recovered.[29] This helps to explain why PEPFAR initiatives in Mozambique focus on "local capacity", strengthening the "health system", and prevention and care (4). PEPFAR funding in Mozambique is used to strengthen the entire health care system in addition to HIV/AIDS because current programs reach a mere 30% of Mozambicans in need and 21% of children in need. According to the Framework, "one objective is to assist the government in meeting its national treatment targets […] to achieve this goal, the GRM, with support from the USG, intends to prioritize: the strengthening of a pre-ART program; improving the quality and access to early diagnosis and treatment of STIs;…"[30]

Swaziland – HIV/AIDS

Since independence there have been several important political events in Swaziland concerning the AIDS epidemic. In September of 2001 the king forbid men from sleeping with teenage girls. In March of 2004 the UN AIDS envoy declared Swaziland to have the highest rates of HIV. Then, in November of 2011 Swaziland was hit by what the IMF called a "critical" budget crisis. This was after 2008 elections were boycotted, much like previous elections had been protested, and as civil unrest grew.[31]

Swaziland has the world's highest level of HIV/AIDS. 26% of the adult population is infected. 41% of pregnant women attending antenatal care facilities are infected. Between 1992

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[28] Ibid, 9.

[29] Ibid, 9.

[30] Ibid, 9-10.

[31] "Introduction," Swaziland, CIA World Factbook.

and 2010 the number of pregnant women infected with HIV, from about 5% to over 40%. Current evidence shows some stabilization in rates of HIV among pregnant women. The first case of HIV/AIDS in Swaziland was reported in 1987. Heterosexual contact is the primary mode of infection and women between the ages of 20 and 24 are the most affected demographic. In 2009, there were 180,000 people living with HIV in Swaziland. 100,000 women aged 15 and older were infected with HIV, along with 140,000 children aged 0-14. Also in 2009, there were 7,000 deaths due to AIDS. In the same year an estimated 69,000 children were orphaned due to the epidemic. However, there has been a decline since 1988. This can be partially attributed to increased male circumcision and improved HIV treatment programs.[32]

In 2011 Swaziland joined the international community in signing the Political Declaration on HIV and AIDS, affirming previous commitments made in 2001 and 2006. The Declaration was created in order to compel countries to works towards achieving the sixth Millennium Development Goal of halting and revering the spread of HIV by 2015.[33] In December of 2001 Act of Parliament No 8 created the National Emergency Response Council on HIV and AIDS (NERCHA) with the mandate of facilitating and coordinating the implementation of a multisectoral response to HIV/AIDS. NERCHA's assigned role is to identify and react to social challenges presented by the HIV/AIDS epidemic.[34]

There are several different actors involved in the fight against HIV/AIDS in Swaziland. They include the government, development partners, private sectors, donors partners, networks of those infected, the faith-based sector, non-governmental organizations, community based

[32] "Swaziland Country Report," UNAID.

[33] "Political Declaration on HIV/AIDS," UNAIDS.

[34] "Who is NERCHA," National Emergency Response Council on HIV/AIDS.

organizations, and traditional sectors and communities. A “Three Ones Principle” has been employed in organizing the national response. In this way, NERCHA is the one coordinating body, the National Strategic Framework for HIV and AIDS 2009-2014 the one strategy the one monitoring and evaluation system. In addition to NERCHA, regional and community-based centers have been created. Mother-to-child transmission has been drastically reduced. UNAID also notes that infected persons are seeking treatment and that the number of orphaned children will probably decline in coming years.[35]

Swaziland is currently undergoing a fiscal crisis, but the allocations for HIV/AIDS have been sustained. Specifically, resources for the procurement of drugs and education for children including Orphaned and Vulnerable Children (OVC) are being continued. The National AIDS Spending Assessment in 2011 revealed that government spending for HIV/AIDS is rising. Additionally, a majority of this government spending is used for the education of children. In 2009-10, this comprised a total of 25% of government spending.[36] PEPFAR aims to “support achievement of the goals of the NSF and in so doing, contribute to the PEPFAR goals for prevention, care and treatment" in Swaziland.[37]

The Partnership Framework for Swaziland shows how PEPFAR is tailored to country-specific needs, much like in Mozambique. It aims to "support the goals of the NSF and in doing, contribute to the PEPFAR goals for prevention, care and treatment."[38] Specifically, it

[35] “Swaziland Country Report,” UNAID.

[36] "Responding to HIV & AIDS in Swaziland," United Nations Development Program.

[37] The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) HIV/AIDS Partnership Framework with the Government of the Republic of Swaziland, August 2010.

[38] Ibid, 2.

focuses on several key intervention areas: decentralized and improved quality of care; social and behavioral approaches to prevention; male circumcision among young men; and the impact on vulnerable children.[39] These are specific to Swaziland because they reflect the problems with corruption, poverty, high HIV/AIDS rates, and social behaviors that perpetuate the epidemic.

South Africa – HIV/AIDS

In South Africa, the National Strategic Plan on HIV, STIs, and HB (NSP) for 2012-16 outlines national initiatives to fight the epidemic. The Plan acknowledges concrete progress in the such as a significant reduction in the vertical transmission of HIV and expanding access to a comprehensive package of HIV, STI and TB services. It also points out progress in the form of a clearer understanding of the epidemic and it's challenges by the South African government (1).

The South African government has also expanded it's HIV and AIDS related programs. For example, the antiretroviral treatment program has increased ART facilities throughout the country to about 2,550. Similarly, the program of male circumcision has allowed over 250,000 to be circumcised throughout the country. More condoms are also distributed annually (8).

According to the Partnership Framework, the governments of both the U.S. and South Africa are committed to the principles of South African leadership, innovation to other epidemics, mutual accountability, multi-sectoral engagement, gender sensitivity, financial commitments, and a collaborative partnership.[40] Both governments agreed that PEPFAR support should transition from direct clinical care and treatment services towards support for system strengthening, prevention, support for vulnerable children, and health services innovation.[41]

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[39] Ibid, 3-5.

[40] Partnership Implementation Plan in Support of South Africa's National HIV, STI & TB Response, 7.

[41] Ibid, 8.

The Partnership also notes that the Government of South Africa has made significant process since 2008. HIV prevention, care and treatment programs have been expanded. For example, the national HIV Counseling and Testing Campaign has conducted 20 million tests since its start in 2010. A new program for vulnerable and orphaned children has decreased early transmission by 2.7%. Voluntary male circumcision has increased significantly since 2007 and the ART program has also grown (in 2011 it provided treatment for 1.7 million people, making it the largest in the world).[42]

Analysis of Hypothesis One

A simple chart can help to visualize the factors in the hypothesis.

Country	U.S. Relations	HIV rates	Funding, FY 2011, USD in million
Swaziland	3	1	60.8
South Africa	1	2	549.1
Mozambique	2	3	268.8

This shows that HIV rates are not the leading variable in dollar amount of PEPFAR funding, which supports the first hypothesis that HIV rates are not what PEPFAR considers most when making funding decisions. Further, the leading factor is economic. The rankings in the U.S. relations column of this graph were made using date from the website of the U.S. Trade Representative, which shows that economic relations may be more important than diplomatic ones. This is especially visible when comparing Mozambique and Swaziland. Although they

[42] Ibid, 8.

have similar diplomatic relations with the U.S., Swaziland is the U.S.'s 168th largest trading partner while Mozambique is the 100th.

Another possible explanation for the differences in funding amounts could be population size, but focusing on percentages helps to study the role of HIV in the health system of each country. Instead of focusing only on the number of lives affected by HIV/AIDS, the first hypothesis aims to investigate the connection between the epidemic and each case study's government. This relationship is two directional: on one hand, it looks at how HIV/AIDS funding fits into the broader health system of each country; and on the other hand, it looks at how domestic corruption or regime type might affect HIV/AIDS rates. According to Freedom House, Mozambique is partly free while Swaziland is not free.

Regime types and corruption appear to be less important than economic relations with the U.S., but are extremely relevant in how each case study's government treats HIV/AIDS and therefore how PEPFAR acts in each country. This tailored approach to each country can be seen especially well through the Partnership Frameworks.

Similarities among the Partnership Frameworks (official documents outlining PEPFAR funding in each country) show: sustainability of programs; inclusion of national initiatives; strengthening overall health systems of host countries; multisector approach; coordination; accountability; transparency; and prevention. Each framework also shows how PEPFAR is specifically tailored to the individual needs of each country. Funding reflects the specificity of country-tailored needs as well as relations with the U.S. and the HIV/AIDS situation.

Research - Hypothesis Two

What kinds of hidden costs does PEPFAR incur on recipient countries? What are the overhead costs, and how do they subtract from the overall benefit? For example, building the infrastructure necessary for health systems costs significantly more in underdeveloped than in developed countries. This means the PEPFAR funds that could be used to supply antiretroviral drugs or medical personnel are instead put into construction costs. Another hidden cost is brain drain among African doctors. PEPFAR, similar to other outside programs, often offers higher salaries than domestic programs, which draws domestic doctors away from government work. A third cost is the danger posed to individuals in possession of antiretroviral drugs by others who might want them.

Mozambique

In Mozambique, many of the hidden costs are directly related to the lack of economic development. For example, the Mozambique country plan for 2004 shows that a significant amount of funding in the past has gone towards building the capacity of non-governmental and private health sectors.[43] Similarly, one of the PEPFAR initiatives in 2005 was to strengthen the Federation of Mozambique Business Associations in an effort to spur growth among the entire business sector.[44] These initiatives are important because private health care is difficult to come by in most parts of Mozambique. Remnants of the long civil war still remain in the form of poor infrastructure - there is a severe shortage of health professionals; coverage of public utilities is extremely limited; and access to electricity and water is scarce.[45] This means that funds must be used for infrastructure and the private sector before they can go directly towards male circumcision or antiretroviral drugs.

It is also useful to look at a country plan from 2010 because this is during the second

[43] PEPFAR Country Plan for Mozambique FY 2005, 8.

[44] Ibid., 9.

[45] Ibid, 10.

phase of PEPFAR. As opposed to emergency relief, this phase focuses on strengthening the entire healthcare system. In 2010 37% of the total budget was used for health and human resources while 34% went towards infrastructure. This was relatively less than in previous years, but relatively more of the budget in 2010 went towards prevention and public-private partnerships. These partnerships in particular were given substantially more funding in 2010.[46] This shows that even after a few years of PEPFAR work in Mozambique, the private sector remains severely underdeveloped. It is also important to note that a significant amount of funding (34%) is used for infrastructure, and that this is actually a decrease from previous years.

Swaziland

In Swaziland, the country with the highest rates of HIV/AIDS in the world, hidden costs can be expected to be high. The situation is similar to Mozambique, with funding used for strengthening the health system and prevention. According to the Operational Country Plan for 2010, some of the main causes of the epidemic are social: multiple concurrent partners, inconsistent use of condoms, and lack of male circumcision are at the top.[47] PEPFAR funding is primarily used for prevention, care, and treatment programs and antiretroviral drugs.[48] Since PEPFAR is the principal outside actor in Swaziland, it is uniquely organized among different offices.[49] This interagency model is another hidden cost because the higher levels of organization and extra personnel are more costly. Much like Mozambique, Swaziland is also sorely lacking in infrastructure. However, funding is focused more on changing social behaviors

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[46] "Mozambique Operational Country Plan Report FY 2010," PEPFAR, 3.

[47] "Swaziland Operational Country Plan Report FY 2010," PEPFAR, 2.

[48] Ibid, 4.

[49] Ibid, 3.

than on building infrastructure. The hidden costs associated with this are different. Some are not monetary and instead involve the perception of Swazi citizens of being imposed upon by an outside influence.

South Africa

Although South Africa is the most developed of the three case studies, it is also a pilot country. According to the Operational Country Plan for 2011, the health care system is overworked due to a growing demand for limited resources.[50] South Africa requires additional investment in financial management, improving infrastructure, human capacity, and managerial competence.[51] Funding is used primarily for health systems strengthening and human resources, which is very similar to the funding situation in Mozambique.[52] More specifically, funding is used for five areas: the health workforce, financing, medical products such as vaccines, information, and leadership/governance.[53] Since South Africa is more economically developed than either Mozambique or Swaziland and has more intact infrastructure, hidden costs associated with construction can be expected to be smaller. However, limited resources mean that they still exist in the form of financing doctors and other medical personnel to distribute vaccines, human resources personnel, and financing leadership and governance. However, it is also important to note that South Africa receives outside help from other parties as well. This helps to lessen the effects of hidden costs, as opposed to the situation in Swaziland. For example, the European

[50] "South Africa Operational Country Plan for FY 2011," PEPFAR, 2.

[51] Ibid, 2.

[52] Ibid, 4.

[53] Ibid, 5.

Union, several western European countries, UNAIDS, the World Bank, and more all help to provide technical assistance for health programs.[54]

Brain Drain

Brain drain is a hidden cost worth mentioning because it is prevalent in many recipient countries. Many highly skilled African doctors practice at leading medical institutions outside of Africa. According to one publication from 2008, as of 2000 one in five African physicians and one in ten African nurses were currently working outside of the continent.[55] According to *Reuters*, medical brain drain has cost Sub-Saharan $2 billion over the years. South Africa also seems to fare worse than either Mozambique or Swaziland. One study notes that many of the wealthy countries African doctors emigrate to depend on them to fill a gap created by their own under-training. Additionally, medical brain drain exacerbates already weak health systems in many African countries that are battling epidemics such as HIV/AIDS, malaria, and tuberculosis.[56]

How does this impact the work of PEPFAR? For one, doctors who return to Africa might be drawn towards working with outside groups such as PEPFAR instead of their own country governments. This means that PEPFAR, with its higher pay, is just one more incentive for them to work with an entity that is less permanent than national health services. This case is made stronger by the point that many returning doctors choose to set up their own clinics as opposed to working within the state health systems.[57] They are already drawn towards private practice and

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[54] Ibid, 6.

[55] Boahene, Kofi, "How African doctors can cure medical 'brain drain'", CNN, 16 April 2013.

[56] Kelland, Kate, "Doctor brain drain costs Africa $2 billion," Reuters, 25 Nov 2011.

[57] Boahene, Kofi, "How African doctors can cure medical 'brain drain'", CNN, 16 April 2013.

away from the national health systems. Another hidden cost related to brain drain is that PEPFAR exposes more African doctors to outside health systems and therefore makes it more likely that they will be drawn to working outside of Africa.

Drug Possession

Antiretroviral drugs are expensive, and oftentimes merely possessing them can pose a threat. For example, whoonga is a street drug made with ART drugs and other street drugs that is highly addictive. Smoking whoonga can also make people resistant to ART drugs, and if they pass on this new strain of HIV to others it becomes nearly impossible to cure.[58] Whoonga can also be made by combining valuable ART drugs with rat poison and detergent powder. In South Africa, whoonga costs about $3 for a hit, but the average citizen makes under $2 per day. This means that crime is one of the most widely used methods of affording the drug. People are often mugged as they leave clinics.[59]

Conclusion

PEPFAR makes tremendous progress in its recipient countries, despite its hidden costs. However, taking them into account helps to analyze the overall costs of PEPFAR. My policy recommendation is an annual report to Congress on government programs such as PEPFAR. This way, they can be scrutinized from and outside (and hopefully more objective) perspective. Critically analyzing unintended consequences is complex and may never be perfect, but it is still a step in the right direction. Many critiques of PEPFAR have been completed by different groups, but attempting to formulate a detailed method that can be used for years at a time (and changed over time) could help to create a more accurate and precise summary of PEPFAR's work.

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[58] Knox, Richard. "Dangers of 'Whoonga': Abuse of AIDS Drugs Stokes Resistance," NPR, 18 December 2012.

[59] Hull, Jonah. "Whoonga is the cruelest high," Al Jazeera, 22 Oct 2010.

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