



The Case for Strategic Health Diplomacy: A Study of PEPFAR

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Executive Summary



The Strategic Health Diplomacy Concept

Healthier populations make for more prosperous and stable societies. When the United States helps improve the health of people in other countries, Americans gain goodwill and strengthen U.S. national security. As President Obama’s 2015 National Security Strategy states: “The United States is safer and stronger when fewer people face destitution, when our trading partners are flourishing, and when societies are freer.”¹ Good health is a prerequisite for all of that to happen.

There is no better example of the power of a well-executed global health initiative than the President’s Emergency Plan for AIDS Relief (PEPFAR), established originally by George W. Bush. PEPFAR is also a potential example of what we call strategic health diplomacy (SHD). It is the idea that, by addressing global

health, America advances its own national strategic interests. Global health interventions should be a critical element of U.S. national security policy, giving U.S. policymakers a means to improve the lives of people around the globe, and thereby build stronger, more stable, more prosperous, and more capable partners.

PEPFAR’s Strategic Impact

HIV/AIDS is the sixth leading cause of death worldwide, ahead of such scourges as diabetes, hypertension, and vehicular accidents.² The disease is also a destabilizing force in some of the world’s poorest and most vulnerable societies. At the turn of the millennium, American leaders recognized that the devastation caused by HIV/AIDS would depress economic development, inhibit good governance, and decrease the size and productivity of the workforce—conditions that breed instability and conflict. In July

2000, President Bill Clinton declared AIDS to be a “national security threat” and, under the George W. Bush administration, Secretary of State Colin Powell warned that the disease posed “a clear and present danger to the world.”³

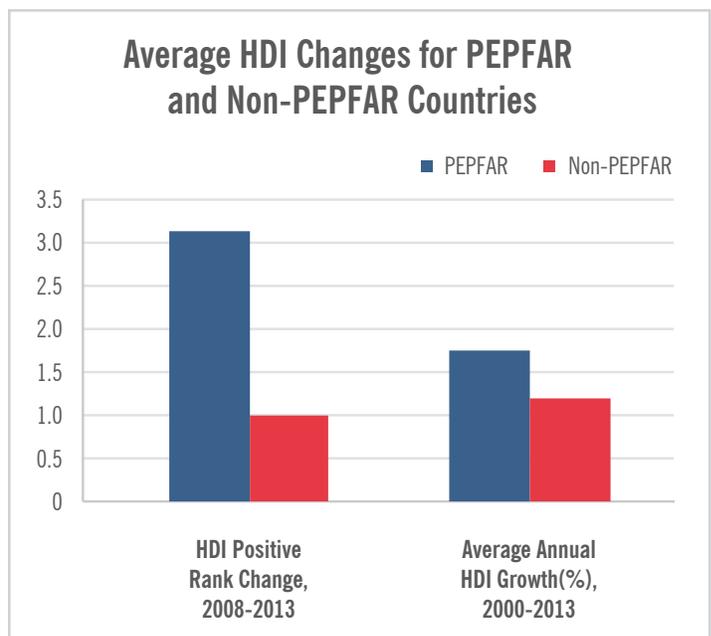
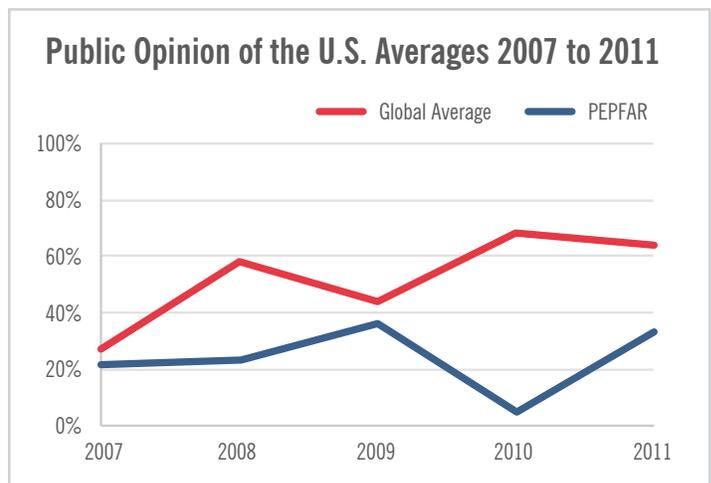
With nearly 37 million people affected by HIV/AIDS, the United States responded to this crisis with the greatest ever example of humanitarian action by a single country in history.⁴ In 2003, President Bush announced the launch of PEPFAR and Congress approved it with strong bipartisan support. The initiative established bilateral aid programs to enhance HIV/AIDS treatment in 15 low-and middle-income target countries. PEPFAR was renewed by Congress in 2008—with a near-tripling of its budget—and again in 2013. PEPFAR now reaches 65 countries worldwide.⁵

PEPFAR’s positive health impacts over the last decade are indisputable: it has reduced HIV/AIDS-related mortality and morbidity and rapidly expanded access to anti-retroviral treatments for more than 7.7 million men, women, and children.⁶ Equally important is that PEPFAR may have had key secondary effects on public opinion, socio-economic development, and state stability, which all in turn boost U.S. national security objectives.⁷

- Studies have shown that PEPFAR has contributed to a positive opinion of the United States in target countries—a finding that holds true across all 12 PEPFAR countries in Sub-Saharan Africa receiving funds since 2003.⁸ According to Gallup poll data collected on public opinion of U.S. leadership from 2007 to 2011, PEPFAR countries have had an average approval rating of 68 percent compared with the global average of 46 percent.⁹
- PEPFAR’s ability to decrease mortality, morbidity, and the prevalence of HIV/AIDS limited the loss of human capacity. Since PEPFAR’s inception, target countries have fared substantially better on socio-economic indices as compared with non-PEPFAR countries in the region. For example, PEPFAR countries improved on United Nations Human Development Index (HDI) scores—a composite measure of socio-economic development—more

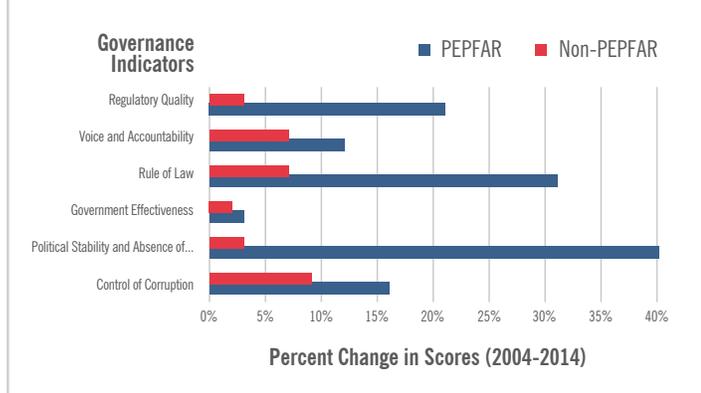
quickly than non-PEPFAR countries. Since 2008, PEPFAR countries on average increased their positive HDI rank by more than three points compared with just one point for non-PEPFAR countries.¹⁰

- PEPFAR has also played a role in security, stability, and governance. According to World Bank data, since 2004, PEPFAR countries in Sub-Saharan Africa reduced political instability and violent activity by 40 percent compared with only 3 percent among non-PEPFAR countries in the region.



* The UN Human Development Index measures and ranks countries’ levels of socio-economic development based on four criteria: life expectancy at birth, mean years of schooling, expected years of schooling, and gross national income per capita.

Change in Worldwide Governance Indicator Scores for PEPFAR and Non-PEPFAR Countries



Given that these secondary effects may be indirectly related to the introduction of PEPFAR, we believe that the concept of SHD is promising and one that warrants more focused research and attention.

Despite PEPFAR's positive impact, as well as the emergence of new global health challenges—including pandemic threats like the H1N1 flu and Ebola, other infectious diseases, and non-communicable diseases—advancing more U.S. global health programs of the same scope will be a challenge due to fiscal pressures.

Any retreat from continued U.S. leadership in global health would be shortsighted. PEPFAR has worked, and the United States should do more. Investments in the well-being of others pays not just humanitarian dividends but potentially strategic dividends as well.

Considerations for Future Strategic Health Diplomacy

In a resource-constrained environment, it is important to select future global health programs that have clear strategic benefits and design them to have the biggest possible impact. Based on our study of PEPFAR's strategic impacts, there are six key lessons for designing SHD initiatives:

- have clear goals and identify policies needed to achieve them;

- address real needs with visible effect;
- be sensitive to local contexts;
- be in it for the long-term;
- build capacity;
- be transparent and accountable.

Further, when selecting SHD programs and initiatives in the future, implementers should take care to consider three main criteria:

- prevalence of a disease;
- its treatment potential;
- the strategic value of stricken areas.

These important measures will lay the foundation for successful global health initiatives—those that provide tangible boons to public health in partner countries while potentially strengthening U.S. national interests. As policymakers debate how to engage the world—and how to secure U.S. interests and mitigate foreign threats under budgetary constraints—strategic health diplomacy should be considered an effective tool to meet these challenges.

Introduction to Strategic Health Diplomacy



The relationship between foreign policy and the health of foreign states is not new. Historically, the health impact of foreign policy decisions was often unintended and negative. Through war, exploration, colonization, and trade—or lack thereof—a government’s decisions frequently affected the health of populations outside its own borders.

Modern technologies that have sped up travel and communication have rendered national borders increasingly porous. The result is an unprecedented scale of interdependence that overwhelms national sovereignty. Events in one corner of the world—the collapse of a government, the failure of a bank, or the spread of a new disease—not only reverberate around the globe, but exceed the ability of national governments to contain or address them alone.

The interaction of health and foreign policy, however, need not be purely negative or reactive. China and Cuba, for example, have leveraged health promotion in order to gain international support since the 1960s. China has sent more than 15,000 doctors to Africa and has treated nearly 180 million African patients, which has helped to ensure its long-term foreign policy interests in energy and food security.¹¹ Cuba has sent medical staff and “medical diplomats” to about 70 countries and provided free medical training in return for various benefits, including oil from Venezuela.¹²

Increasingly, public health advocates are learning how to use the diplomatic toolbox to spur international efforts to improve global health. *Strategic health diplomacy* is the idea that national governments do good by actively working to improve public health abroad and, by doing so, may also further their own foreign policy

agenda. This paper explores this particular concept and, using the President's Emergency Plan for AIDS Relief (PEPFAR) as a case study, presents evidence that the United States, by promoting health abroad, can secure its national interests.

Strategic Health Diplomacy

Following World War II, as the United Nations (UN) Charter states, the construction of a system of international institutions “to promote social progress and better standards of life in larger freedom” has allowed the tools of foreign policy and international institutions to achieve humanitarian goals of improving global health, giving rise to the practice of “global health diplomacy (GHD).”¹³ The advisory and consulting firm, Health Diplomats, defines GHD as “the chosen method of interaction between stakeholders engaged in public health and politics for the purpose of representation, cooperation, resolving disputes, improving health systems, and securing the right to health for vulnerable populations.”¹⁴ This burgeoning field has made major contributions to global health thus far, especially over the last 15 years.¹⁵

The practice of our proposed *strategic health diplomacy* (SHD) is a corollary to the practice of GHD: the realization that investments in global health not only save lives but are an effective tool for furthering national security interests. According to the Obama administration, “Investments in global health are a pillar of American leadership—advancing our national interests, making other countries more stable and the U.S. more secure.”¹⁶ Ensuring global health abroad is vital to our own objectives in three key ways: (1) producing goodwill so that countries will collaborate with the United States in strategic objectives; (2) strengthening economies for viable trade partnerships; and (3) building state capacity to produce stable countries, which helps to mitigate chaos, war, and disruption.

Fundamentally, SHD is the exercise of U.S. leadership in order to make potentially strategic commitments in health. The largest and most successful potential example of this is PEPFAR.

PEPFAR Background



In the late 1990s, the World Health Organization (WHO) announced that HIV/AIDS had become the fourth most deadly disease worldwide and the number one killer in Africa, accounting for 19 percent of deaths in 1998.¹⁷ With rates of HIV/AIDS infection reaching into the tens of thousands each day, and life expectancies in Sub-Saharan Africa plummeting as a result, world leaders began to recognize the negative impact of the growing AIDS epidemic not just on global health, but also on peace and security. “The HIV/AIDS pandemic, if unchecked, may pose a risk to stability and security,” stressed a July 2000 UN Security Council Resolution. In that same year, U.S. President Bill Clinton declared AIDS to be a “national security threat.”¹⁸ U.S. spending on global HIV/AIDS relief amounted to approximately \$3.1 billion between 1998 and 2003.

In response to the September 11, 2001, attacks, which originated

from a country unable to govern and police its own territory, international development and support for weak states became essential elements of America’s national security strategy. Recognizing that health and development were inextricably linked, President George W. Bush made global health a central pillar of his presidency. His 2002 National Security Strategy declared, “In countries afflicted by epidemics and pandemics like HIV/AIDS, malaria, and tuberculosis, growth and development will be threatened until these scourges can be contained.”¹⁹ That same year, Bush launched the \$500 million Mother-and-Child HIV Prevention Initiative to prevent infections transmitted during pregnancies.²⁰

President Bush announced a larger effort toward combating the disease in his 2003 State of the Union Address stating: “Seldom

has history offered a greater opportunity to do so much for so many. To meet a severe and urgent crisis abroad, tonight I propose the Emergency Plan for AIDS Relief, a work of mercy beyond all current international efforts to help the people of Africa.”²¹

In 2003, Congress approved PEPFAR with overwhelming bipartisan support. PEPFAR initially focused on 15 countries: Botswana, Cote d’Ivoire, Ethiopia, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, Vietnam, and Zambia.²² These countries were some of the most severely affected by the epidemic, collectively home to nearly half of the world’s 33 million HIV-positive people and 8 million of the children orphaned or made vulnerable because of the disease.²³

The scope and funding appropriated to PEPFAR was groundbreaking in the field of global health. With nearly \$65 billion expended across two presidential administrations, PEPFAR is the biggest single-disease global health initiative in history.²⁴ Aside from PEPFAR, the United States—along with the WHO and The Group of Eight—is a founding member and the largest contributor to the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund), a public-private partnership founded in 2002 to bring in and distribute resources to prevent and treat these deadly diseases.²⁵ To date, the Global Fund has spent more than \$30 billion in grants, with U.S. funding accounting for nearly one-third of those investments.²⁶

Over the past decade, the Bush and Obama administrations have made substantial annual commitments to fighting HIV/AIDS and other communicable diseases. As a result, the successful implementation of health programs and initiatives for beneficiary countries has been substantial (see Appendix 1). The expansion of PEPFAR’s scope and budget over the last decade is indicative of the impact and success it has had not only on mitigating HIV/AIDS mortality and morbidity, but also improving the social fabric of societies within vulnerable populations. The following section aims to highlight both the health and secondary strategic impacts of PEPFAR.

PEPFAR's Impact



Since its inception in 2003, studies suggest that PEPFAR's impact in target countries—both health and otherwise—has been dramatic. The success of PEPFAR in promoting global health and the potential for it to indirectly bolster U.S. national security interests serves as an important case study for policymakers considering both future global health interventions and how to secure U.S. foreign policy objectives.

To demonstrate the most impact, the following analyses highlight trends realized in almost all of PEPFAR's initial focus countries and, where relevant, compared with non-PEPFAR countries in key areas. The methodology used controlled for regional variance and compared PEPFAR and non-PEPFAR countries in Sub-Saharan Africa with high HIV prevalence rates (see Appendix 2). The results demonstrate resiliency and, in many cases, broad improvement on key indicators since PEPFAR's inception.

Health Impacts

When PEPFAR was created just over a decade ago, HIV/AIDS was a fatalistic concern, especially in underdeveloped regions such as Africa. It threatened the very foundation of society by creating orphans, destroying families as a stable unit, halting economic development, and leaving countries in a poverty spiral. According to the WHO's "AIDS epidemic update" in 2003, the HIV/AIDS epidemic was "rampant" with "alarmingly high levels" of HIV prevalence in Southern and Sub-Saharan African countries.²⁷ There, infant mortality doubled, child mortality tripled, and life expectancy plunged by 20 or more years. In that same year, the rate of new HIV infections were increasing exponentially and many were getting sick or dying during the most productive years of their lives.²⁸

Today, there is a more promising story to tell thanks to the help

of modern medical technological advances and successful implementation of programs like PEPFAR.

PEPFAR’s goal is to help create an AIDS-free generation, and its success is measured in lives improved and saved.²⁹ In the years since PEPFAR’s introduction into high-risk HIV/AIDS populations, several academic studies^a have found that PEPFAR causally reduced mortality and morbidity from HIV/AIDS.³⁰ With just over a decade of work, PEPFAR has brought focus countries a long way from where they were in 2003.

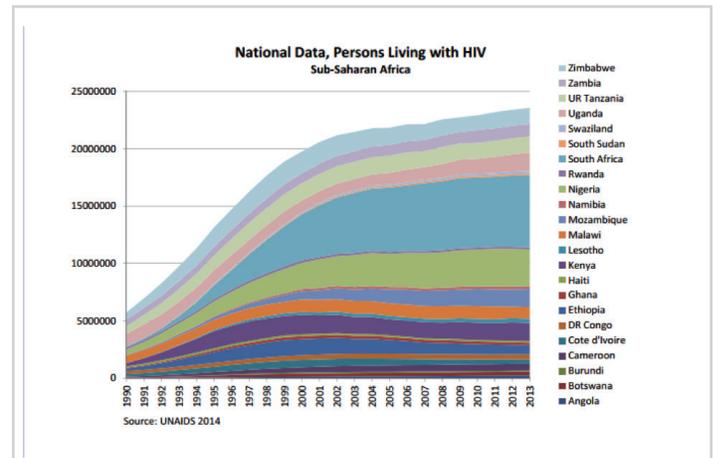
One of PEPFAR’s most significant achievements was rapidly expanding access to anti-retroviral treatments (ART). In addition to the direct benefit of lives saved, the indirect benefits of ART are significant. For every 1,000 people on ART for one year, an estimated 449 children are prevented from becoming orphans—a vulnerable population that can have security implications, which is explored later in this paper.³¹ Further, according to a recent study, providing treatment to HIV-positive people reduces the risk of transmission to partners by at least 96 percent.³²

As of 2014, PEPFAR supported ART for 7.7 million men, women, and children and provided care and support for more than five million orphans and vulnerable children. Additionally, 95 percent of at-risk babies were born HIV-free in PEPFAR countries, and PEPFAR supported training for more than 140,000 new healthcare workers.³³ In 2013, Secretary of State John Kerry announced that the one-millionth baby had been born HIV-free due to PEPFAR-supported prevention of mother-to-child transmission programs.³⁴

There are also more people living with HIV/AIDS, due in part to the growth of the epidemic and, importantly, the availability of life-saving treatment. As treatment programs such as ART are

a A 2012 study examining all PEPFAR countries for which data is available found that the introduction of PEPFAR is associated with reduced adult mortality relative to preexisting mortality trends, and it attributed HIV-specific mortality reductions to the presence of PEPFAR. Moreover, a 2011 academic study found that U.S. HIV funding, which is almost exclusively channeled through PEPFAR, has had a substantial impact on HIV-related deaths.

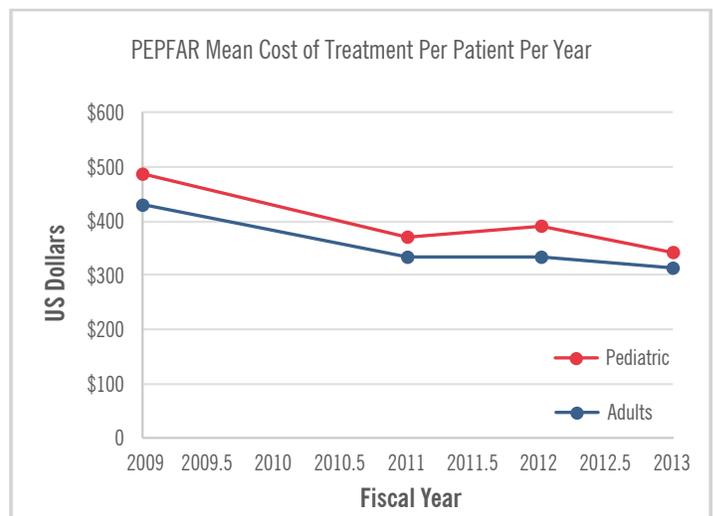
Figure 1. Trends of Persons Living with HIV, Sub-Saharan Africa, 1990–2013³⁵



implemented across partner countries, people with HIV are living longer, more productive lives, as illustrated by Figure 1.

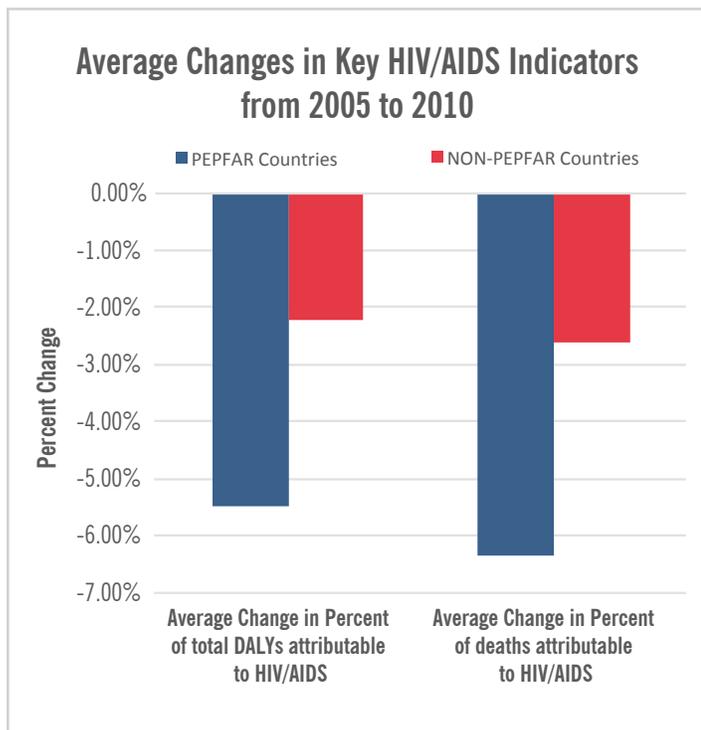
PEPFAR also helped to reduce the cost of ART, allowing for much easier access for low-income households and maximizing the number of lives saved. Figure 2, for example, shows that between 2009 and 2013, PEPFAR, due to the massive size of the program, helped lower the cost of HIV/AIDS ART treatment by hundreds of dollars. These lower prices allowed the United States to purchase more drugs in order to treat more people.

Figure 2. PEPFAR Mean Cost of Treatment Per Patient Per Year³⁶



To further illustrate the overall positive improvements in health since PEPFAR's introduction, Figure 3 shows HIV/AIDS mortality and morbidity data from the Institute of Health Metrics and Evaluation that uses the disability-adjusted life year (DALY) index^b as a useful proxy for morbidity. DALYs describe the burden of disease better than measures of mortality, as they capture morbidity, disability, and early mortality instead of simply the loss of a life. This is important for a disease like HIV/AIDS where many patients live for years on ART but their quality of life and productivity is affected by the disease.

Figure 3. Average Changes on Key HIV/AIDS Indicators in PEPFAR and Non-PEPFAR Countries³⁷



Overall, between 2005 and 2010, PEPFAR countries reduced the amount of DALYs and deaths attributable to HIV/AIDS by a

^b The DALY is a measure of the overall burden of disease, expressed as the number of years lost due to ill-health, disability, and early death. DALYs for a disease are calculated as the sum of the Years of Life Lost due to premature mortality in the population and the Years Lost due to Disability for people living with the disease. Therefore, the less measured DALYs the better.

greater percentage than non-PEPFAR countries. For example, PEPFAR countries on average reduced their measured DALYs by approximately 5.5 percent whereas non-PEPFAR countries managed to reduce this number by only about 2 percent.

Strategic Impacts

As shown, PEPFAR has dramatically helped to improve health conditions and outcomes in target countries. This may well be enough to justify continued initiatives in SHD in and of itself. However, research and data indicate that PEPFAR may have had other far-ranging, indirect effects, contributing to U.S. national interests in meaningful ways. Most significantly, when PEPFAR countries become healthier states, the United States gets more capable partners that can bolster U.S. strategic objectives.

As President Obama's 2015 National Security Strategy makes clear, viable strategic partnerships are the foundation of U.S. national security in a globalized world: "These partnerships can deliver essential capacity to share the burdens of maintaining global security and prosperity and to uphold the norms that govern responsible international behavior. The United States is safer and stronger when fewer people face destitution, when our trading partners are flourishing, and when societies are freer."³⁸

Importantly, PEPFAR has allowed forces shaping positive trends in state stability and socioeconomic development in Sub-Saharan Africa to continue uninhibited by HIV/AIDS. Literature cited below on predicted secondary impacts of high HIV/AIDS prevalence suggests that, as mortality and morbidity are arrested by interventions like PEPFAR, so too are threats to governance, stability, security, and socioeconomic development. Further, tangible improvements to health made possible by PEPFAR lead to better public opinion and goodwill toward the United States abroad.

Secondary Effects of PEPFAR on Public Opinion

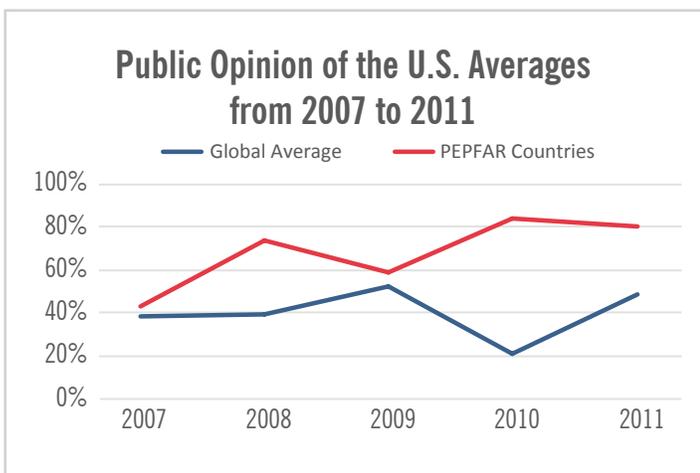
One of America's greatest national security tools is the ability to bolster and maintain the deep reserve of goodwill that exists toward it around the world. Arguably, a chief contributor to that goodwill has been U.S. assistance in the wake of major disasters.³⁹ PEPFAR

appears to operate in a similar way on a much larger scale. A substantial number of people in partner countries have experienced tangible benefits of improved health outcomes and well-being because of PEPFAR. Studies suggest that these widespread benefits have played a role in increasing positive opinion toward the United States.

A 2007 Pew Global Attitudes project found that, of the 11 countries with the most positive opinions of the United States, nine were from Sub-Saharan Africa.⁴⁰ Six of these nine were PEPFAR countries. Poll results further showed that, between 2007 and 2011, PEPFAR countries have had an average approval rating of 68 percent compared with the world average of 46 percent. Notably, PEPFAR countries saw a substantial uptick from 2009 to 2010 when global opinion of the United States had plunged, as shown in Figure 4.

Additionally, the Center for Contemporary Conflict found in 2008 that PEPFAR had contributed more than any government program to a positive view of the United States in Africa.⁴² A recent study adds that PEPFAR has had a substantial impact on public opinion of the United States in PEPFAR countries.⁴³ This study found a significant, positive effect of PEPFAR aid on public opinion toward the United States in 12 initial African target countries, as

Figure 4. Public Opinion of the United States in PEPFAR Countries Around the World⁴¹



demonstrated by Figure 5. But it is not simply the presence of PEPFAR that produced that result. The scholars responsible for this study found that four conditions are necessary for health diplomacy

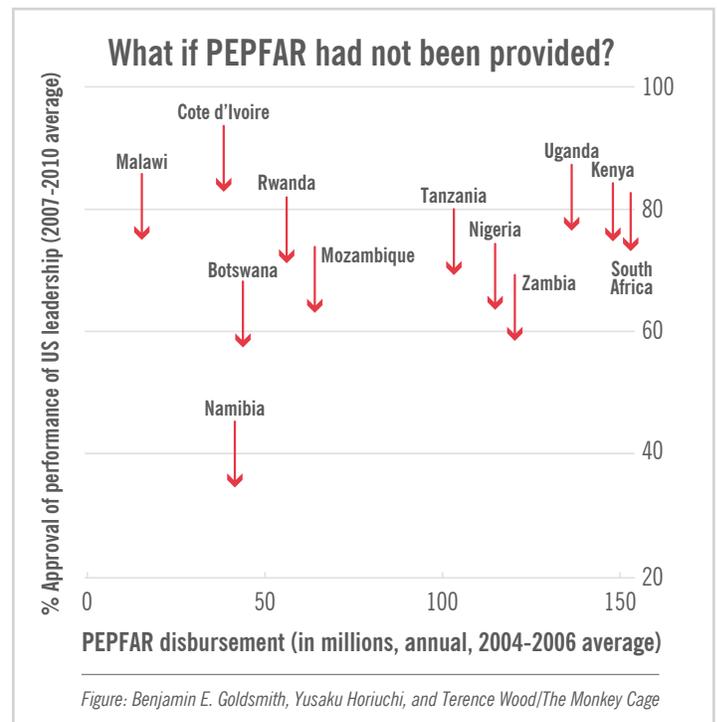
to influence public opinion to such an extent:⁴⁴

- The program must target a widely understood need.
- The program must be sustained over time.
- The program must be demonstrably effective.
- The program must be highly visible.

PEPFAR meets all four requirements perhaps because policymakers were aware of PEPFAR’s potential to influence public opinion. According to a PEPFAR guide, it is important “to ensure appropriate recognition for U.S. programs and contributions to this effort.”⁴⁵ Former Secretary of State Condoleezza Rice said upon its renewal that PEPFAR would captivate “the hearts and minds of people around the world.”⁴⁶ Future SHD initiatives would do well to keep this formula in mind.

A number of studies have attributed PEPFAR to improved public opinion toward the United States in target countries. As such, SHD may be an effective way to curry favor with developing states in the 21st century. Moreover, there are strategic reasons to pursue the goodwill of other states. Competition for securing partnerships with African countries—partly for strategic reasons, partly for economic ones—is building between the United States and China,

Figure 5. Estimates of the Change in Approval toward U.S. Leadership had PEPFAR Aid Not Been Provided⁴⁷



including through the use of health diplomacy.⁴⁸ From 2007 to 2012, total Chinese health aid to Africa amounted to at least \$80 million per year, which included building hospitals and malaria centers, providing anti-malarial drugs and equipment, and sending Chinese medical teams to Africa to provide treatment and training.⁴⁹ SHD can make American economic partnerships easier to forge and maintain through relationships built in the process of developing partner countries' health infrastructure.

Secondary Effects of PEPFAR on Socioeconomic Development

The link between healthier populations and economic growth is well established. Health is fundamental to economic stability and productivity, as both require human capital. Strong economies rely on healthy individuals who are able to work productively and consume goods. According to a study, half of America's economic growth over the last century is associated with improvements to overall health.⁵⁰ Studies further argue that, over the past century, declines in mortality and its reversal due in part to HIV/AIDS has had major economic consequences. One study found: "The impact of health on GDP is substantial—an extra year of life expectancy is estimated to raise a country's per capita GDP by about 4 percent, for example."⁵¹ The WHO estimated that providing basic health services to developing countries would save eight million lives per year by 2010 and generate \$186 billion in economic output by 2015.⁵²

By the early 2000s, countries with high HIV/AIDS prevalence rates were experiencing stalled or backsliding socioeconomic progress. A 2003 UN assessment found that the epidemic was exacerbating preexisting socioeconomic problems in highly affected countries by eroding household and labor force productivity.⁵³

Several academic studies⁶ also found a link between HIV/AIDS and

drops in income, consumption, and economic viability.⁵⁴ Households are the economic unit most dramatically impacted by mortality from HIV/AIDS because the loss of a single income-earning member coupled with the burden of high medical costs can have proportionally greater effects on a household.

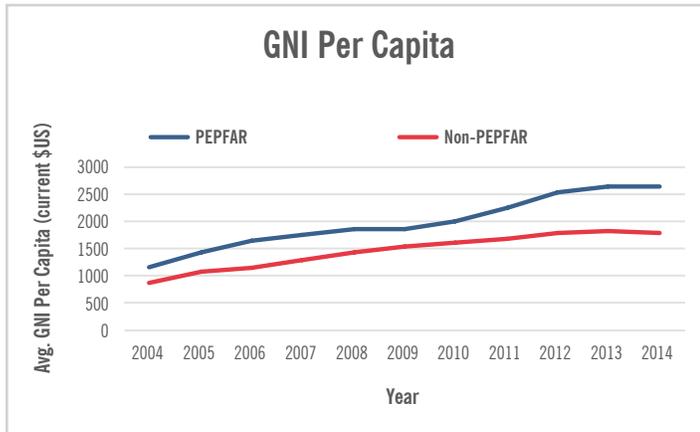
Slowed economic growth is also a destabilizing factor, as a lack of economic prospects or livelihood are push factors that cause disaffected populations to seek alternative and potentially violent means of survival.⁵⁵ This can pose an existential threat to the United States and is important to national security. President Barack Obama, for example, underscored, "Through development, we seek to invest in countries' efforts to achieve sustained and broad-based economic growth, which creates opportunities for people to lift themselves, their families, and their societies out of poverty, away from violent extremism and instability, and toward a more prosperous future."⁵⁶ Poor economies in partner countries also reduce the potential for strategic trade partnerships for the United States.

However, these downward trends have been halted and even reversed, particularly in PEPFAR countries. While the reasons for this are multifaceted, PEPFAR's ability to decrease mortality and morbidity of HIV/AIDS may have played a role in limiting the loss of productivity and human capacity, which subsequently helped to avert the collapse of households and macroeconomic growth.

Figure 6 shows that per capita gross national income (GNI) — the total domestic and foreign outputs of country residents—has continued a steady growth trajectory for PEPFAR countries that is higher than non-PEPFAR countries. While numerous factors influence per capita GNI, the resiliency of households and mitigation of household economic risks are clear.

c A 1991 study in Zambia found that there was a rapid transition from relative wealth to relative poverty as a byproduct of HIV/AIDS mortality. A 2006 study also found substantial evidence of devastating household economic loss when households financed medical care, especially when combined with loss of income due to an inability to work.

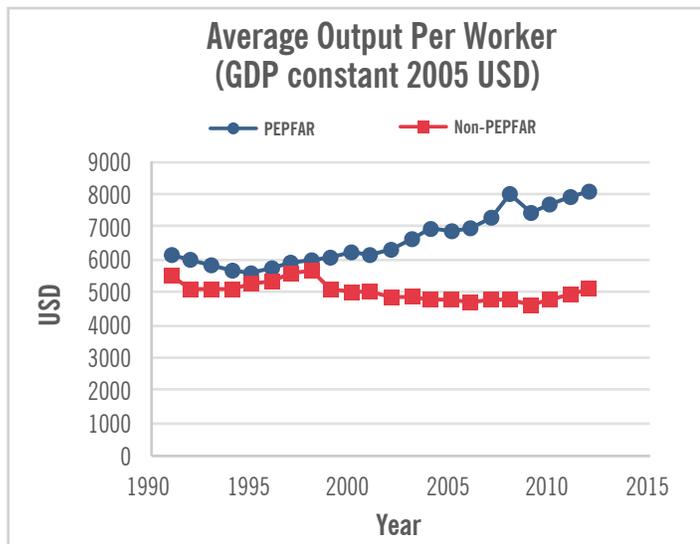
Figure 6. GNI Per Capita for PEPFAR and Non-PEPFAR Countries⁵⁷



The average output per worker for PEPFAR countries and non-PEPFAR countries^d seen in Figure 7 further show that PEPFAR countries have not experienced a significant detriment to their labor productivity and have continued a near constant growth rate through 2012.⁵⁸ Labor force productivity has not exhibited the same growth trend in non-PEPFAR countries and has remained virtually stagnant.

d Chad, Congo, Central African Republic, Cote d'Ivoire, Guinea-Bissau, Kenya, Mozambique, Nigeria, Rwanda, Swaziland, and Togo are missing labor productivity data for all time periods.

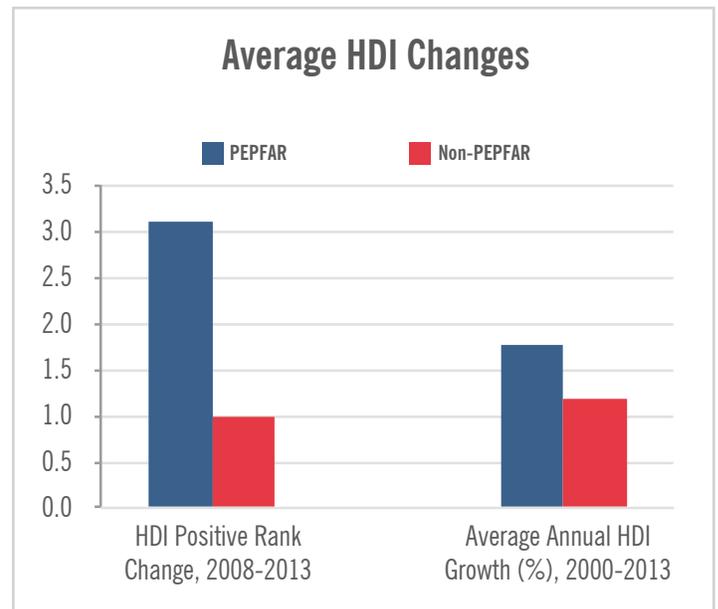
Figure 7. Average Output per Worker in PEPFAR and Non-PEPFAR Countries⁵⁹



To examine macroeconomic impacts inclusive of overall human development, the UN Development Program's Human Development Index (HDI)^e is a useful measure of welfare that encompasses per capita income, mortality, and education. Studies in 1997 and 2001 found that HIV/AIDS negatively impacted HDI scores in countries with high HIV/AIDS prevalence.⁶⁰ Figure 8 demonstrates that PEPFAR countries improved on HDI scores more quickly than non-PEPFAR countries. Since 2008, PEPFAR countries on average increased their positive HDI rank by more than three points compared with just one point for non-PEPFAR countries.

e The UN Human Development Index is a tool developed by the United Nations to measure and rank countries' levels of social and economic development based on four criteria: life expectancy at birth, mean years of schooling, expected years of schooling, and gross national income per capita.

Figure 8. Average HDI Change for PEPFAR and Non-PEPFAR Countries⁶¹



Finally, PEPFAR countries have recently shown progress in the Boston Consulting Group's 2015 Sustainable Economic Development Assessment (SEDA), a new index encompassing both socioeconomic progress and state stability to evaluate how effectively countries are able to convert wealth into well-being.^f On average, PEPFAR country scores are almost 7 points higher than non-PEPFAR countries.

f SEDA scores measure economics, investments, and sustainability and are scored out of 100. A higher score indicates more well-being.

Table 1. SEDA Recent-Progress Scores for PEPFAR and Non-PEPFAR Countries⁶²

	Recent Progress Score
Mean, PEPFAR Countries	71.88
Mean, Non-PEPFAR Countries	64.91
Mean, Lower Income Countries (<1,000 GNI per capita, 2006 (\$))	65.7

Secondary Effects of PEPFAR on State Stability, Governance, and Security

PEPFAR’s proven health benefits also have the potential to enhance state stability, governance, and security in the long run, as exceptionally unhealthy populations are linked to states in crisis.⁶³ Simply put, the more effective state institutions are at providing basic services to their citizens, the less reason they have for seeking alternatives outside of the political system, either by turning to extremist groups that might offer basic goods and services, or by seeking regime change through violence.

Promoting state stability, security, and effective governance abroad is a key U.S. national security objective as outlined in President Obama’s 2010 National Security Strategy:

“Where governments are incapable of meeting their citizens’ basic needs and fulfilling their responsibilities to provide security within their borders, the consequences are often global and may directly threaten the American people. To advance our common security, we must address the underlying political and economic deficits that foster instability, enable radicalization and extremism, and ultimately undermine the ability of governments to manage threats within their borders and to be our partners in addressing common challenges.”⁶⁴

Recognizing further the relationship between health, stability, and

security, the Department of Defense released a memorandum in 2010 establishing medical support operations to improve the overall health and stability of U.S. defense partners.⁶⁵

High mortality and morbidity rates lead to loss of human capacity, as they erode a state’s ability to perform basic duties in governance, especially when the loss of human capacity includes civil servants and highly educated and skilled laborers. In South Africa, for example, up to one-in-seven civil servants were believed to be HIV positive in 1998, illustrating the severity of the epidemic’s impact on key workers.⁶⁶ Given the aggressive decline in life expectancy that HIV/AIDS inflicts, experts in the early 2000s predicted that a national prevalence rate of HIV/AIDS over 10 percent would diminish state stability and undermine social cohesion and state institutions.⁶⁷

In PEPFAR countries, however, these conditions did not materialize and positive trends in state stability and governance have continued and even strengthened. While a multitude of factors influence the quality of governance, making it impossible to assign causation, PEPFAR’s reduction of adult and child HIV/AIDS mortality and morbidity may have played a role in mitigating secondary effects of the epidemic in these areas. It should also be noted that, PEPFAR was successful in Sub-Saharan Africa in part because it was launched during a decades-long period of development, whereby the quality of governance had been steadily improving in the region prior to and during PEPFAR’s introduction.⁶⁸

In PEPFAR countries, HIV/AIDS prevalence rates and the loss of human capacity were casually reduced among two key populations that posed a risk to state stability: military personnel and children.

Military Personnel

Prior to PEPFAR, non-combat deaths in militaries of countries with high HIV/AIDS prevalence were of particular concern. The armed forces in Africa in 1999 were reported to have rates of HIV infection two to three times higher than that of civilians.⁶⁹ The potential loss of life and functional capacity among personnel, especially officers and commanders responsible for protecting the state, presented a

grave threat to security in these countries.

Yet, HIV/AIDS prevalence within militaries and the subsequent impact on state security have shown improvement in PEPFAR countries. PEPFAR-funded programming in Nigeria and South Africa,^g for example, has engaged directly with the militaries of both countries.⁷⁰

Although statistics on HIV/AIDS prevalence within militaries is generally kept confidential, Table 2 shows changes in HIV

Table 2. Estimates of HIV Prevalence in PEPFAR Country Militaries

Nigeria	
1999 ⁷¹	2007 ⁷²
10-20%	8%

Uganda	
1999 ⁷³	2007 ⁷⁴
66%	8%

South Africa	
1999 ⁷⁵	2013 ⁷⁶
66-70%*	8.5%

*Some units estimated as high as 90 percent.

Cote d'Ivoire	
1999 ⁷⁷	2008 ⁷⁸
10-20%*	4.7%

^g In Nigeria, a multiyear PEPFAR-U.S. Department of Defense effort supported surveillance, testing, and treatment abilities of the Nigerian military, and provided training for health personnel. PEPFAR was also responsible for providing funding to the South African National Defense Forces (SANDF) for an HIV/AIDS awareness campaign, which has been credited by South African military officials as lowering SANDF's HIV/AIDS prevalence rate.

prevalence rates in militaries of PEPFAR countries for which data is available. These numbers indicate that HIV/AIDS has been precluded from overwhelming the militaries of these countries since PEPFAR took effect.

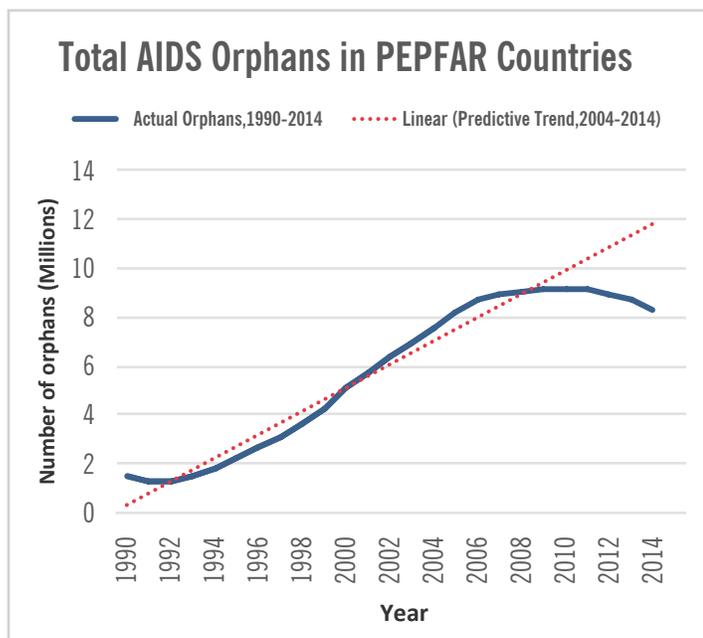
Not only do healthier militaries create for better state security, it also benefits U.S. and UN peacekeeping missions located in at-risk countries. Lower HIV/AIDS prevalence rates among local militaries will mitigate the potential for co-infection among foreign military personnel working closely with these militaries. This ensures greater protection for American service members deployed in these areas. Further, healthier and better-functioning militaries will bolster a state's emergency preparedness to meet domestic and regional security challenges head on, which is a strategic benefit to the America's armed forces. President Obama underscored that the U.S. military "is postured globally to protect our citizens and interests, preserve regional stability, render humanitarian assistance and disaster relief, and build the capacity of our partners to join with us in meeting security challenges."⁷⁹

Children

A second, less obvious concern among the development community was the escalation of the number of HIV/AIDS-related orphans prior to PEPFAR. At the time of PEPFAR's introduction in 2003, the number of orphans created by HIV/AIDS was on the rise.⁸⁰ A high rate of orphaned children is considered a serious risk factor for state fragility, as they comprise a base of dispossessed and disaffected citizens who can be easily recruited and exploited for terrorist, criminal, and militant activities.⁸¹ One study, for example, found that "HIV/AIDS and child soldiering are thoroughly intertwined problems that exert reciprocal influences on each other."⁸² Africa not only has the highest prevalence of HIV/AIDS in the world but also the largest number of child soldiers.⁸³

After PEPFAR, however, rising rates of HIV/AIDS-related orphans were stemmed and eventually sent into decline. According to PEPFAR's 2013 annual report, PEPFAR programs successfully

Figure 9. Total AIDS Orphans in PEPFAR Countries⁸⁵



averted almost two million orphans since its inception.⁸⁴ In Figure 9, a linear predictive forecast extrapolating the trend of AIDS orphans from 1990 until PEPFAR’s implementation and beyond suggests a far higher number of orphans than was actually realized.

Notably, Table 3 shows that eight of the 12 PEPFAR countries saw a drop in the number of orphans from 2004 to 2014, compared with

Table 3. Percent Change in AIDS/HIV Orphans between 2004 and 2014⁸⁶

PEPFAR Countries	Percent Change from 2004-2014
Botswana	-29%
Cote d’Ivoire	-4%
Ethiopia	-24%
Kenya	-31%
Namibia	-2%
Rwanda	-29%
Uganda	-35%
Zambia	-28%

Non-PEPFAR Countries	Percent Change from 2004-2014
Congo	-15%
Malawi	-5%
Zimbabwe	-25%

only three of the 12 non-PEPFAR countries. All three non-PEPFAR countries that experienced a drop in HIV/AIDS-related orphans saw a decline of 25 percent or less, whereas in PEPFAR focus countries, many of the reductions were by more than 25 percent.

Table 4. Change in Failed State Index Scores for PEPFAR and Non-PEPFAR Countries⁸⁷

	Failed State Index Score: Mean Percent Change from 2006-2014 ^h
PEPFAR Countries	-5%
Non-PEPFAR Countries	-2%

Overall, PEPFAR countries have improved on standard indicators of governance since the mid-to-late 2000s. For example, according to the United Nations’ official list of failed states, the Fund for Peace’s Failed States Index (FSI), PEPFAR countries on average have increased their FSI scores since 2006, as shown in Table 4. Although there are many contributing factors to these changes, PEPFAR countries improved their state legitimacy by a greater magnitude than non-PEPFAR countries.

Since 2004, PEPFAR countries also performed particularly well in the World Bank’s worldwide governance indicators,ⁱ shown in Table 5. Notably, PEPFAR countries in Sub-Saharan Africa

^h In the FSI methodology, the lower the FSI score, the better. The magnitude of these changes seems insignificant, but changes in governance are uniquely long-term in nature and therefore smaller shifts in the short term denote more serious progress than in other measures. The earliest available year for data is 2006. Data for Congo (Rep.), Lesotho, and Swaziland begins in 2007.

ⁱ In the World Bank Governance Indicators methodology, the higher the score, the better. Our analysis used World Bank estimates for all six governance indicators pre-selected by the Bank.

Table 5. Change in Worldwide Governance Indicators for PEPFAR and Non-PEPFAR Countries⁸⁸

	PEPFAR Countries: Percent Change 2004-2013	Non-PEPFAR Countries: Percent Change 2004-2013
Control of Corruption	16%	9%
Political Stability & Absence of Violence/ Terrorism	40%	3%
Government Effectiveness	3%	2%
Rule of Law	31%	7%
Voice & Accountability	12%	7%
Regulatory Quality	21%	3%
Aggregate	25%	11%

reduced political instability and violent activity by 40 percent compared with just 3 percent among non-PEPFAR countries in the region.

In a 2013 evaluation of PEPFAR, the Institute of Medicine found that PEPFAR’s work with partner country governments in capacity building, financial management, and technical assistance have translated into stronger governance, especially in the health sector.⁸⁹ Interviewees in the evaluation believed PEPFAR had increased management and leadership capacity. A 2013 study also found a strong link between PEPFAR’s presence in a country and strengthened domestic health systems.⁹⁰ These findings demonstrate the positive results of collaborative intervention, as PEPFAR has been able to increase domestic ownership of programs while simultaneously building capacity and leaving stronger institutions in its stead.

Building on PEPFAR



Due to PEPFAR's early and sustained success, additional initiatives have sought to build upon it. The single most substantial addition linked to PEPFAR is Pink Ribbon Red Ribbon (PRRR). Launched in 2011, PRRR leverages existing PEPFAR funding and infrastructure as well as public-private partnerships to enhance the treatment, care, and prevention of cervical and breast cancer.⁹¹ Because it is linked to PEPFAR, PRRR has operated in many, though not all, of the same countries and has set similar goals. PRRR aims to reduce deaths from cervical cancer in target countries by 25 percent, achieve at least 80 percent coverage of vaccination against human papillomavirus, and screen at least 80 percent of focus populations for pre-invasive cervical cancer—all by 2016.⁹² To date, it is on track to meet these objectives.⁹³

Another extension of PEPFAR includes programs designed to combat gender-based violence (GBV).⁹⁴ With a focus on

Tanzania, Mozambique, and the Democratic Republic of Congo, existing PEPFAR programs have integrated anti-GBV activities for humanitarian reasons but also because GBV contributes to the spread of HIV/AIDS. Although it is difficult to assess the impact of programs that have started so recently (2010 in the case of Tanzania), initial results suggest that anti-GBV programs can have an important impact in target countries. Specifically, these programs have worked to heighten awareness of GBV and its connection to HIV/AIDS while reducing the stigma attached to it, thereby encouraging survivors to seek treatment.

Finally, the President's Malaria Initiative (PMI) is another successful program that was modeled on PEPFAR's principles. PMI was established in 2005 with the goal of reducing malaria-related mortality by 50 percent in 15 high-burden countries in Sub-Saharan Africa. It aims to completely eliminate malaria by 2040 or 2050.

Looking Forward



PEPFAR has made a substantial contribution to improved health outcomes in target countries. This in itself is a desirable outcome, but the effects potentially reach far beyond mortality and treatment rates. As demonstrated in this case study, PEPFAR countries have shown improvement in a number of areas—economic growth, security, stability—that make those countries better places to live, better members of the international community, and better partners for the United States.

While the health impacts of PEPFAR are subject to intense scrutiny through PEPFAR’s own evaluation process, multilateral and international health organizations, as well as academia, its second-order impacts are less well understood. In this study, we have laid out potential correlations between decreasing mortality and morbidity in PEPFAR target countries and various

metrics of public opinion, stability, governance, and development. Much more research is needed to understand the full range of secondary impacts that PEPFAR and similar large-scale global health interventions have on the societies and states in which they are implemented and, even more importantly, to begin to identify the causal mechanisms by which these impacts take place. Such studies will help in designing even more effective strategic health diplomacy programs in the future.

We believe that these potential secondary benefits are not unique to PEPFAR and should not be ignored by policymakers. This one program is a potential example of the role that global health programs could play in the national security toolbox; it is SHD in action. While more study of PEPFAR and the concept of SHD is needed, we identify several conclusions that can be drawn from

the success of PEPFAR for both program implementation and for selecting future SHD initiatives.

Lessons Learned from PEPFAR

PEPFAR, initiated in 2003 and now intended to last through at least 2018, has been perhaps the most visible success of SHD in the 21st century. Through two successive two-term presidential administrations, PEPFAR, PMI, and the Global Fund have been sustained, and family planning and reproductive health as well as maternal, newborn, and child health have been strengthened. Understanding how and why PEPFAR worked so well with suggestive secondary impacts is critical to the design and implementation of successful future SHD programs.

Undoubtedly, PEPFAR's bipartisan support and generous funding are a large part of the equation. Without domestic political support, PEPFAR could not have gotten off the ground. A broad consensus about the value of SHD is a sine qua non, but while it is necessary, it is not sufficient to ensure that global health interventions achieve their maximum potential impact. Based on our study of PEPFAR, we have identified six particularly important lessons learned about how to conduct effective SHD: have clear goals and identify policies needed to achieve them; address real needs with visible effect; be sensitive to local contexts; be in it for the long-term; build capacity; and, be transparent and accountable.

Clearly-Defined Goals, Adaptive Policies

From its founding announcement by President Bush, PEPFAR had a specific mission: "This comprehensive plan will prevent seven million new AIDS infections, treat at least two million people with life-extending drugs, and provide humane care for millions of people suffering from AIDS and for children orphaned by AIDS."⁹⁵

These goals, which could be modified by country or region, provide an attainable, readily visible benchmark for those involved in oversight and give program officials an easy way to monitor ongoing efforts. And since PEPFAR draws on and requires the cooperation of numerous U.S. implementing agencies, partner

countries, the Global Fund, and other multilateral partners and civil society groups, and brings together multiple sectors—education, health, economic and psychosocial—a clear and definitive goal ensures unity of effort while preventing mission creep.⁹⁶

Real Need, Visible Impact

By the early 2000s, HIV/AIDS was ravaging Africa. Policymakers might have noticed the destabilizing effect it was having on the countries stricken with it, but its humanitarian toll was clearly evident to the families and societies dealing with it. By targeting such a widespread disease, PEPFAR had the biggest impact of perhaps any global health intervention to date on the well-being of millions of people. But in defeating such a widely recognized scourge, PEPFAR also imprinted itself on the attitudes, opinions, and worldviews of those whose lives it touched. Perhaps the biggest contribution of SHD, other than direct improvements in health and well-being, is the reputational benefits to the United States that can accrue from visibly tackling widely recognized threats to the lives of people around the world.

Global Goal, Local Focus

No two countries are alike; even within the same country conditions, needs and results will vary. The challenge for global programs is maintaining a singular objective while adapting to how it is achieved at the local level. PEPFAR succeeded because, from the very beginning, context-sensitivity was one of its defining traits. A 2012 study by Nils Daulaire, former assistant secretary for global affairs at the Department of Health and Human Services, touts PEPFAR's success in "using field data as well as current research findings to tailor programs for maximum impact within the local epidemiological and sociocultural contexts."⁹⁷

In other words, the program has the flexibility and local-level community engagement required to work just about anywhere. Despite wide variance in local institutional frameworks, patterns of disease transmission, and cultural norms, PEPFAR was uniformly successful in its mission. And as the program matured it also successfully transitioned from an emergency-response program to

promoting sustainable state-run programs.

Long-Term Commitment

Replicating a global health initiative like PEPFAR will require a long-term and sustained commitment. In the more than ten years since its inception, PEPFAR has dramatically improved health around the world and is slated to continue until at least 2018, which is a testament to its long-term pledge to stem the global HIV/AIDS endemic.

PEPFAR's ability to outlast partisanship and extend its lifespan is a pillar of its success and has allowed it to achieve many of its stated objectives. Not only has consistent and enduring PEPFAR support reduced HIV/AIDS-related mortality and morbidity, but it has also evolved to help countries build stronger institutions and state capacity in its stead. This could not have been achieved without the requisite time, resources, and funding.

According to a study, sustained aid over a considerable length of time is important because it "may increase perceptions of genuine commitment by the donor among recipient populations."⁹⁸ Such was the case with PEPFAR; target countries in Sub-Saharan Africa boast some of the highest approval ratings of the United States. Lasting support allows for information about the effects of the aid and its funder to become disseminated widely, thereby increasing positive opinion and goodwill toward the United States.⁹⁹

Capacity Building

Improving health outcomes is not as simple as airdropping medication to affected populations. Nor can it be achieved by having foreign medical personnel administer global health programs on their own. PEPFAR has been an impactful global health intervention because it focused on building the public health institutions and capacity of its target countries, investing in the facilities, equipment, personnel, and training needed for those countries to eventually take the reins themselves. A 2013 evaluation of PEPFAR by the Institute of Medicine at the National Research Council found that PEPFAR's work with partner-country

governments in capacity building have translated into stronger governance, especially in the health sector.¹⁰⁰ This not only creates palpable and visible benefits for communities, but it also lays a foundation of both general public health competence and effective governance that pay dividends well beyond PEPFAR's specific focus on HIV/AIDS. Such capacity building is the main contribution that SHD can make to national security and should be an integral aspect of SHD programs.

Transparency

PEPFAR offers another important lesson in terms of its successful oversight and transparency. A study found that a key factor of PEPFAR's success was strong accountability, which strengthened the monitoring and evaluation of health systems and facilitated development overall.¹⁰¹

In 2014, PEPFAR was recognized by the International Aid Transparency Initiative—a global campaign to promote accountability in foreign assistance—for its commitment to making data publically available online.¹⁰² This achievement is a result of accountability being made an integral part of PEPFAR's mandate. The PEPFAR Stewardship and Oversight Act requires PEPFAR to fully evaluate all of its programs by engaging all relevant stakeholders—including those involved in program operations, those served or affected by the program, and those who make decisions regarding the program—and publish all evaluation reports online.¹⁰³

Accountability will be an important part of future SHD, especially if it includes more civilian and military agencies. Accountability is vital to successful program implementation because it establishes legitimacy abroad and allows for a program to maintain political support at home. It also contributes to declines in corruption among target countries.

Considerations for Future Strategic Health Diplomacy

With PEPFAR, the United States mounted a global response

to the most devastating disease of the last quarter-century. But even as work continues to battle the scourge of HIV/AIDS, other health concerns continue to sap the wealth, stability, and potential of societies around the world. Through new global health interventions, the United States can help improve the lives of millions, and by developing such programs strategically, informed by the insights garnered from PEPFAR's potential secondary impacts, it can deploy SHD to also build more stable countries, more capable partners, and a more secure world.

In a resource-constrained environment, Congress does not currently have an appetite to expand the foreign affairs budget. In order to get an SHD initiative off the ground, the United States needs a strong, presidential-level commitment to it. As the United States approaches campaign season, we urge candidates from both parties to pledge to do more to fight other diseases around the world. Despite recent partisan discord, we strongly believe that a new bipartisan consensus can and should emerge to build on PEPFAR's successes.

In considering future SHD initiatives, policymakers would do well to follow some guidelines about not just how to design effective global health programs, as discussed above, but also how to maximize their strategic benefits. Based on our study of PEPFAR and its success, we believe there are three key areas to take under consideration: prevalence, treatment potential, and location.

In selecting future SHD programs, addressing communicable or non-communicable diseases with the highest prevalence rates should be at the forefront, as they affect the largest number of people and can therefore do the most good with the highest visibility. PEPFAR, for example, was established at the height of a seemingly insurmountable global HIV/AIDS pandemic and has been successful in stemming its rise.

When targeting a specific disease or diseases, SHD programs must also acknowledge the treatment potential. In this vein, it is important to consider whether viable treatment options exist, the scale for which treatment can be administered to populations, and whether it is a cost-effective intervention.

Finally, identifying appropriate locations and target populations are key to any future SHD program. Health programs aimed at highly vulnerable countries in strategically vital parts of the world should be the priority for policymakers seeking to deploy SHD as an element of U.S. smart power.

Based on these criteria we can begin to identify prospects for future SHD.

Some of the most critical global health concerns today are non-communicable diseases, which are the leading cause of mortality and morbidity in the developed and developing world. According to the Council on Foreign Relations task force on global health, over the next two decades, the non-communicable diseases epidemic will cost approximately \$21.3 trillion in losses in developing countries, which "will undercut potential U.S. trade partners and allies and may reduce domestic support for governments of U.S. strategic interest."¹⁰⁴ In addition, strengthening health systems (e.g., training and surveillance) will be critical to ensuring countries are prepared in the face of new epidemics—a focus just on specific diseases will not be enough.

Widespread and curable diseases such as hepatitis C and malaria also appear to be good candidates for SHD, as there are current U.S. health initiatives dedicated to the prevention of the two diseases. The Viral Hepatitis Action Plan, an initiative by the U.S. Departments of Health and Human Services and other U.S. agencies, for example, aims to identify new developments in treatments for hepatitis C, increase public awareness, and expand access to viral prevention and treatment.¹⁰⁵ While this is currently a U.S.-focused initiative, it could be expanded on a global scale. Additionally, the President's Malaria Initiative, in partnership with the Global Fund, was launched in 2005 with the goal of reducing malaria-related mortality by 50 percent across 15 target countries in Sub-Saharan Africa and is slated to continue through 2020.

Existing or future global health programs would do well to incorporate important lessons learned from PEPFAR's success: have clear goals and identify policies needed to achieve them; address real needs with visible effect; be sensitive to local

contexts; be in it for the long-term; build capacity; and be transparent and accountable. When selecting SHD programs and initiatives in the future, implementers should take care to consider prevalence, treatment potential, and location. These important measures will lay the foundation for successful global health initiatives—those that provide tangible boons to public health in partner countries with the potential to strengthen U.S. national interests.

Appendix 1: History of PEPFAR

Phase I

PEPFAR'S first phase (2003-2008) focused on establishing and ramping up prevention, care, and treatment programs for HIV/AIDS in target countries. To meet these goals, PEPFAR and its partners have:

- provided HIV counseling, testing, and treatment;
- trained health care workers to provide HIV-related health services, including ART services to pregnant women to reduce rates of mother-to-child HIV transmission, and services to reduce medical transmission of HIV through blood safety and injection-safety procedures;
- engaged in community outreach through public education campaigns and assistance in forming school curricula on HIV, prevention, reducing risk behaviors, and combating social stigma;
- and expanded and strengthened health infrastructure through the provision of equipment, support for human resources, laboratories, procurement and supply systems, monitoring and evaluation, data management systems, and more.

PEPFAR operates at multiple levels, working with governments to develop policies and guidelines as well as communities to ensure health practitioners and public educators have the necessary resources and expertise to implement such programs.¹⁰⁶

Phase II

In 2008, Congress reauthorized PEPFAR for another five years via the Tom Lantos and Henry J. Hyde United States Global Leadership against HIV/AIDS, Tuberculosis and Malaria Reauthorization Act of 2008, which authorized \$48 billion to combat the three diseases—nearly triple that of Phase I's budget. In this phase, the program aimed to:

- strengthen partner government capacities so that they can lead in meeting health demands;
- further expand prevention, care, and treatment in concentrated and generalized epidemics;
- integrate and coordinate HIV/AIDS programs with other development initiatives to make health systems more effective;
- and invest in research to evaluate impact, improve services, and yield the best outcomes.¹⁰⁷

Today

In 2013, Congress passed the PEPFAR Stewardship and Oversight Act of 2013, extending PEPFAR through 2018. Originally established as an emergency-intervention program, it has since evolved into a program focusing on strengthening countries' capacity to fight HIV/AIDS, laying the groundwork for transferring ownership of these programs to partner countries.

Future investments are aimed at shared responsibility among all actors involved in the fight against HIV/AIDS, including partner governments, multilateral organizations, the private sector, and faith-based organizations.

Appendix 2: Methodology

Countries were grouped based on their 2004 HIV prevalence rates according to the World Bank.¹⁰⁸ The highest-ranked 26 countries were in Sub-Saharan Africa. After removing the two non-African countries to control for regional variance,^j two groups remain, with 12 countries as PEPFAR countries (the treatment group) and 12 countries as non-PEPFAR countries (the control group). Contingent on availability, all data comparisons begin from 2004 onward.

Rank	Country Name ^k	2004 Prevalence of HIV, total (percent of population ages 15-49)
1	Swaziland	26.2
2	Botswana	25.9
3	Lesotho	22.1
4	Zimbabwe	21.2
5	South Africa	18.3
6	Namibia	16.7
7	Malawi	15.9
8	Zambia	13.8
9	Mozambique	10.8
10	Central African Republic	7.3
11	Kenya	7.0
12	Tanzania	6.9
13	Uganda	6.1
14	Gabon	5.9
15	Cote d'Ivoire	5.6
16	Cameroon	5.3
17	Congo, Rep.	4.2
18	Guinea-Bissau	3.9
19	Togo	3.9
20	Nigeria	3.8
21	Chad	3.7
22	Rwanda	3.5
23	Ethiopia	2.9
24	Liberia	2.6

j These were the Bahamas, ranked 23rd with a prevalence of 3.4 percent, and Haiti, ranked 25th with a prevalence of 2.6 percent.

k Countries in red are PEPFAR countries.

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